

Implementing Adolescent Reproductive Rights Through the Convention on the Rights of the Child

One out of five people in the world is an adolescent. Like many other groups, adolescents all over the world have specific concerns and problems. The Convention on the Rights of the Child (Children’s Convention) addresses the human rights of all persons below age 18.¹ Since most people who are considered adolescents (see box) are below the age of 18, the Children’s Convention encompasses their human rights. The Programme of Action agreed to at the 1994 International Conference on Population and Development (ICPD) and the 1995 Platform for Action agreed to at the Fourth World Conference on Women (FWCW) provide that “reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents.”² The Children’s Convention is one of the key international human rights documents that contain numerous provisions encompassing the reproductive rights of adolescents.

There remains a significant gap between the provisions contained in the Children’s Convention and the reality of adolescents’ reproductive health and lives. The Committee on the Rights of the Child has addressed adolescent reproductive rights issues in many of its Concluding Observations to governments, often stressing the need for governments to take steps to ensure these rights. In too many cases, governments and societies have tended either to ignore adolescent reproductive health issues or to consider them indistinguishable from childhood health concerns. An exception to this statement has been in contexts in which married adolescent girls have begun to bear children. Such adolescents have generally been considered “women,” even though they have not reached physical or emotional maturity.

This briefing paper will examine the major reproductive health and rights issues affecting adolescents in light of governments’ obligations contained in the Children’s Convention. Specifically, it will focus on certain issues that are universal to all adolescent girls — such as education, contraception, sexual violence, HIV/AIDS, abortion, and access to reproductive health care — and those that are of particular regional significance. Issues that fall into the latter category include early marriage and female circumcision/female genital mutilation. For each area of concern, the paper will discuss its coverage as a human right under the Children’s Convention. The paper recommends critical legal and policy measures that all governments should strive to achieve. Several examples of how the Committee on the Rights of the Child has approached the issue in its concluding observations to States Parties are also included. Finally, the paper summarizes one recent legislative or policy initiative that represents a “best practice” in government efforts to address the issue. It does not, however, evaluate adequacy of implementation of the best practice.

Who are adolescents?

The term “adolescents” refers to people between the ages of 10 and 19. In a 1998 joint statement, the World Health Organization, the United Nations Children’s Fund, and the United Nations Population Fund agreed on the following categorizations of young men and women:

Adolescent:	10 to 19 years
Youth:	15 to 24 years
Young people:	10 to 24 years ³

As defined above, adolescents comprise 20% of the world’s population.⁴ While the concept of youth varies across cultures, there is increasing global agreement that adolescence is a distinct and important period in a person’s life. Although the transition from childhood to adulthood in most societies has traditionally been a rapid one, modern education requirements have transformed adolescence in most parts of the world into a distinct period spanning several years.⁵ In many cultures, the onset of adolescence is marked by a special event with a symbolic and/or educational aspect.⁶

I. THE FRAMEWORK: REPRODUCTIVE RIGHTS FOR ADOLESCENTS

The reproductive rights of adolescents remains a controversial subject. For many societies, adolescent sexuality is a sensitive, if not controversial, issue. Nevertheless, recent international conferences such as the ICPD and the FWCW brought increased attention to the subject of adolescent reproductive health needs and concerns. The consensus documents agreed to at ICPD and the FWCW explicitly recognize that “everyone has the right to the enjoyment of the highest attainable standard of physical and mental health,”⁷ which includes the right to reproductive health, defined in both documents as:

... the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.⁸

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These conferences built on the consensus agreed to at previous international conferences addressing human rights and population issues which recognized that all individuals have such rights, without qualification as to marital status, age, or any other classification.⁹

The ICPD and FWCW reflect many of the Children’s Convention’s key provisions related to adolescent reproductive health and rights. In particular, Article 24 recognizes children’s right “to the enjoyment of the highest standard of health and to facilities for the treatment of illness and rehabilitation of health.”¹⁰ It also requires States Parties to take appropriate measures “to develop family planning education and services.”¹¹

Furthermore, while the Children’s Convention requires States Parties to “respect the responsibilities, rights and duties of parents ... to provide ... appropriate direction and guidance in children’s exercise of their rights,”¹² it clearly recognizes that in all matters, the best interests of the child take precedence and the child should be enabled to exercise her rights.¹³ The Children’s Convention was also the first international human rights treaty to explicitly recognize sexual violence and abuse, a major factor related to adolescents’ reproductive and sexual health.¹⁴

II. ADOLESCENT ACCESS TO REPRODUCTIVE HEALTH CARE

BACKGROUND

Article 6 of the Children’s Convention states that every child has an inherent right to life and that the States Parties must ensure to the maximum extent the child’s survival and development. In Article 24, States Parties “recognize the right of the child to the enjoyment of the highest standard of health” and agree to “develop family planning education and services.”²³ The Children’s Convention’s comprehensive approach to the right to health imposes upon governments the obligation to ensure adolescent girls’ access to comprehensive reproductive health services. The Children’s Convention also addresses states’ obligation to ensure children’s privacy,²⁴ to “assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child.”²⁵ Full implementation of these provisions is highly relevant to adolescents’ ability to determine their future lives, including when and whether to bear children.²⁶

Without access to adequate prenatal and maternal health care services, adolescent girls may experi-

- In sub-Saharan Africa, 83% of women have had first intercourse by age 20.¹⁵ For 38% of them, this happened before marriage. Additionally, 55% of women had had their first child by age 20.¹⁶
- In Asia, the Middle East, and North Africa, 48% of women had had first intercourse within marriage by age 20.¹⁷ Thirty-two percent had had their first child by age 20.¹⁸
- In Latin America and the Caribbean, 56% of women had first intercourse by age 20, and they were evenly divided between before marriage and within marriage.¹⁹ Thirty-four percent had their first child by age 20.²⁰
- In the United States, 63% of women become sexually active by age 18.²¹
- Surveys from Great Britain and Northern Ireland indicate that among respondents under 20 years, 18.7% of adolescent girls reported that their first sexual activity was before age 16.²²

ence pregnancies that lead to death or illness due to their physical immaturity. Moreover, without access to a full range of appropriate and freely chosen contraceptives, adolescent girls may experience unwanted pregnancies and sexually transmissible infections (STIs). The Committee has stated its concern regarding adolescents girls' access to reproductive health services and noted that governments must provide adequate maternal health care and address issues related to pregnancy and HIV/AIDS among female adolescents.²⁷

Due to controversies related to adolescent sexuality and the general lack of knowledge about the reproductive and sexual needs of adolescents, very few countries in the world have set up adequate reproductive health care services for adolescents.²⁸ Adolescent reproductive health care needs vary with culture, age, and marital status. But all adolescents need accurate and adequate information about sexual and reproductive health. They also require accessible and affordable reproductive health services. Without easy access to accurate information, adolescents are at risk of being misinformed about sexual and reproductive matters, which may lead them to make decisions that could have negative effects on their lives. Moreover, adolescents need information about safe-sex practices, including negotiation skills to protect them from potentially dangerous and abusive relationships. Since pregnant adolescents face greater risks for health complications than adult women, adolescent access to quality and affordable prenatal care is critical.²⁹

Adolescents are also concerned about privacy and confidentiality regarding reproductive health care. This is particularly important for unmarried adolescents who confront negative attitudes for being sexually active. Such attitudes only serve to alienate adolescents from seeking reproductive health care. These same adolescents also require access to contraception to protect themselves from unwanted pregnancies and sexually transmissible infections, including HIV.

CONCLUDING OBSERVATIONS FROM THE COMMITTEE ON THE RIGHTS OF THE CHILD

“The Committee is concerned ... about the lack of sufficient reproductive health information and services for adolescents [in Paraguay]... [and] further suggests that the State party promote adolescent health by strengthening reproductive health and family planning services to prevent and combat HIV/AIDS, other STDs and teenage pregnancy.”³⁰

“The Committee is ... concerned about the insufficiency of measures taken to address adolescent health issues such as reproductive health and the incidence of early pregnancies [in Hungary] ... and recommends that ... reproductive health education programmes be strengthened and that information campaigns be launched concerning family planning and prevention of HIV/AIDS.”³¹

“Austrian law and regulations do not provide a legal minimum age for medical counselling and treatment without parental consent. The Committee is concerned that the requirement of a referral to the courts will dissuade children from seeking

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medical attention and be prejudicial to the best interests of the child.”³²

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- Governments should remove all legal and regulatory barriers to reproductive health care for adolescents and create comprehensive, age-specific health programs for them as part of the country’s overall health policy.
- These services should be geared toward married and unmarried adolescents, and should include information about and services around reproductive health, sexually transmissible infections, gender roles, sexuality, and responsible use of contraceptives.

BEST PRACTICE

In 1996, the government of **Ghana** enacted the Adolescent Reproductive Health Policy aimed at addressing the reproductive health needs of adolescents and providing a guideline for government agencies.³³ Most importantly, the policy recognizes the rights of adolescents to information and services relating to sexual and reproductive health.

The policy’s primary focus is on adolescents, including those in educational institutions. However, marginalized groups — such as street children, street-involved adolescents, and physically and mentally disabled adolescents — are also included. The secondary focus is on the groups and individuals that influence the behavior and opinion of adolescents. These groups include parents, older spouses or partners, teachers, community and religious leaders, service providers, and law enforcement officials.

The goals of the policy are to promote the physical, mental, and social well being of adolescents in Ghana and to encourage the development and implementation of activities and services to expand the options available to adolescents in the area of reproductive health. The long-term objectives of the policy include the following: promoting education programs on reproductive health for adolescents; implementing programs to reduce early pregnancy, reproductive tract infections, STIs, including HIV, unsafe abortions, female circumcision/female genital mutilation, and early marriage; developing and strengthening programs for marginalized adolescent groups; and pursuing policies to eliminate violence against adolescents and biases against the girl-child. Ghana’s adolescent policy also recognizes the need for targeted research, monitoring, and evaluation of adolescent reproductive health issues and programs.

The strategies for achieving the objectives are numerous. They include sensitizing policy and decision-makers to create a more positive policy environment; improving school curricula and out-of-school programs; and increasing the availability and accessibility of adolescent reproductive health care services.

III. EDUCATION AND ADOLESCENTS

BACKGROUND

A key condition to fulfilling the reproductive rights of adolescents is education. Education enables adolescents to obtain information that they can use to exercise and protect a range of interests and rights, including their reproductive rights.

Articles 28 and 29 of the Children's Convention are strong affirmations of the right of all children to education. States Parties commit themselves to "make primary education compulsory and available free to all."³⁸ In addition, they agree to "encourage the development of different forms of secondary education ... [and] make them available and accessible to every child."³⁹ In Article 29, States Parties agree to direct the education of the child to "the preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, [and] equality of the sexes ..."⁴⁰

- In sub-Saharan Africa, an average of approximately 50% of girls receive at least seven years of education.³⁴ This figure is as low as 10% in Burundi, Mali, Niger, and the Central African Republic.³⁵
- In North Africa, the Middle East, and Asia, between 25% and 50% of girls receive a basic education.³⁶
- In some Latin America and Caribbean countries, more than 60% of girls receive a basic education of at least seven years.³⁷

Despite the fact that the Children's Convention requires that its provisions be implemented "without discrimination ... irrespective of the child's ... sex," many countries continue to lag in improving girls' education. This lag in girls' education con-

stitutes a violation of the right to education that is set forth in the Children's Convention, as well as other human rights instruments, including the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights, which both affirm everyone's right to education.⁴¹

Studies have shown that around the world, across different regions and cultures, educated women have a greater say in their reproductive lives than women who have little or no education.⁴² These studies also indicate that a minimum of five years of education is required to enable a woman to control her reproductive life.⁴³ An educated adolescent is more likely to seek reproductive health information and services than an uneducated one. Moreover, education increases women's self-confidence and self-esteem, employment opportunities, and ability to provide for themselves.

Low school attendance of girls is related primarily to gender and lack of economic resources. With regard to gender, in societies where early marriage is the norm, adolescent girls are often withdrawn from school to get married. Also, in several countries, adolescent girls who get pregnant are expelled from school.⁴⁴ In many rural areas, families cannot afford to send all their children to school, and it is often the daughters' education that is sacrificed.⁴⁵

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Along with formal education, it is equally important to provide adolescents and girls with education about sexual and reproductive matters. Many countries resist such education in a formal setting under the erroneous assumption that educating adolescents about sexuality will encourage early sexual activity. However, studies have shown that sex education actually has the opposite effect of delaying sexual activity.⁴⁶

CONCLUDING OBSERVATIONS FROM THE COMMITTEE ON THE RIGHTS OF THE CHILD

“To prevent early pregnancies, the Committee recommends that sex education be strengthened [in Bulgaria] and that information campaigns be launched concerning family planning.”⁴⁷

“The Committee is concerned at the low levels of school enrolment and at the high drop-out rates [in Ethiopia], especially among girls, at the lack of learning and teaching facilities and at the shortage of trained teachers, especially in rural areas.... Moreover, the Committee expresses the concern ... that primary education has not yet been made compulsory.”⁴⁸

“[T]he Committee is also concerned at the number of children leaving school prematurely [in Iraq] to engage in labour, particularly girls. The Committee recommends that all appropriate measures be taken to provide equal access to education, encourage children, particularly girls, to stay in school and discourage early entry into the labour force.”⁴⁹

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- Governments should enact laws to make primary school attendance mandatory for both sexes and enact policies to encourage education for girls through the secondary and tertiary levels.
- Governments should develop sex education and life-skills programs for all levels of education — primary, secondary, and tertiary.
- Government policies should reflect the special needs of marginalized adolescents such as street children and out-of-school youth.

BEST PRACTICE

In **Bangladesh**, where a large number of adolescent girls have not attended school, the government has undertaken a comprehensive policy initiative to increase adolescent girls' opportunity to obtain a secondary education.⁵⁰ This initiative was reported to the Committee on the Elimination of Discrimination Against Women (CEDAW), which oversees implementation of the Women's Convention, in 1997. The stated objectives of the initiative are to retain female students at the secondary stage and thereby promote higher education; to increase the enrollment rates and reduce dropout rates; and to control the population growth rate by discouraging girls from marrying before 18 years of age.

The initiative includes the following: a nationwide tuition and book stipend for girls in grades six to 10 living outside metropolitan areas; free education until college for only children who are girls living outside metropolitan areas; free food on a monthly basis for girls in exchange for regular school attendance; hiring more teachers; occupational skill training for girls who leave school at or before grade eight; and public awareness campaigns to promote education for girls.

- The age at first marriage has risen considerably in certain Asian countries such as the Philippines and Sri Lanka, where only about 14% of women get married before age 18. However, in Bangladesh almost 75% of women get married before age 18.⁵¹
- In Latin America and the Caribbean, between 20% and 40% of women enter into their first union before 18 years.⁵² In the Middle East and North Africa, this figure is less than 30%, except in Yemen, where it is as high as 50%.⁵³
- In sub-Saharan Africa, the percentage of adolescents getting married before 18 ranges from 75% in Mali and Niger to around 15% in Botswana, Namibia, and Rwanda.⁵⁴
- In Eastern and Central Europe, the average age at first marriage is between 21 and 22 years, and in Southern Europe it is between 24 and 25 years.⁵⁵
- There are often wide age differences between spouses because men tend to marry at a later age than women do.⁵⁶ These age differences are widest in sub-Saharan Africa, North Africa, and the Middle East at an average of five to 10 years.⁵⁷ In Asia, Latin America, and the Caribbean, the age difference is between three and six years.⁵⁸

IV. EARLY MARRIAGE

BACKGROUND

Article 2 guarantees all children the rights set forth in the Children's Convention, without discrimination on the basis of sex. Nevertheless, in many countries, the minimum age at which adolescent girls are permitted to enter into marriage is lower than that for males. The minimum age of marriage for girls is often too low and thereby compromises their rights to education;⁵⁹ full development of their personalities, talents, mental and physical abilities;⁶⁰ and when pregnancy occurs, their health⁶¹ and sometimes their life.⁶² In some countries, girls are compelled to enter into marriage against their will or before they are capable of consenting to marriage in violation of Article 12,⁶³ which requires States Parties to "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child...."

Although the Children's Convention does not explicitly address child marriage, it does require States Parties to "take all appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."⁶⁴ The Committee on the Rights of the Child has recognized early marriage as a harmful traditional practice.⁶⁵ When a child or adolescent is compelled to marry at a young age, her physical and psycho-

logical health may be adversely affected⁶⁶ and, when the adolescent refuses to consent to sexual relations or is too young to knowingly consent thereto, such marriages may result in sexual violence.⁶⁷

Most adolescents who marry young are pressured to begin childbearing prior to physiological maturity, with tragic costs in terms of maternal mortality and mor-

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bility.⁶⁸ Adolescent girls in many societies are subjected to cultural pressure or coercion to marry young and to marry a man chosen for them. Some customs and religious beliefs condone or require forced marriage, child marriage, dowry and bride price arrangements, consanguineous marriage, polygamy, and polygyny.⁶⁹ In many cultures where the female age of marriage remains too low, there is also a significant age differential between the spouses. Larger age differences reinforce gender stereotypes, including women's dependency and powerlessness.⁷⁰

Numerous countries attempt to prevent early marriage by enacting laws regarding the age of first marriage, requiring civil registration of marriages, and preventing betrothal of girls below age 18.⁷¹ Unfortunately, most of these laws are not consistently enforced. In most countries, laws related to the minimum age of marriage apply only when parental consent is lacking. Often, the minimum age is higher for males than it is for females.⁷² Even in countries with adequate laws in place, enforcement is often inadequate or customary laws that permit early marriage coexist with national laws and are permitted to prevail in family matters.⁷³ Thus, legal protection of marital choice for adolescents is extremely limited. Because of cultural pressures, adolescent girls usually respect parental wishes; if they refuse to do so, the law explicitly or implicitly allows these wishes to be imposed.

CONCLUDING OBSERVATIONS FROM THE COMMITTEE ON THE RIGHTS OF THE CHILD

“The Committee notes with deep concern that [in Algeria] the law applicable in the case of rape of a minor excuses the perpetrator of the crime from penal prosecution if he is prepared to marry the victim. Furthermore, in order to legitimize celebration of marriage which would otherwise contravene the law, article 7 of the Algerian Family Code allows the judge to lower the age for marriage if the victim is a minor.”⁷⁴

“The Committee is concerned that the national legislation [of Panama] establishes a different minimum age for marriage between boys and girls and that it authorizes the marriage of girls as young as 14 years of age.”⁷⁵

“[T]he Committee is concerned at the practice of early marriage [in Kuwait]. It recommends that the State party undertake all appropriate measures, including legal measures, awareness-raising campaigns with a view to changing attitudes, counseling and reproductive health education, to prevent and combat this traditional practice which is harmful to the health and well-being of girls and the development of the family.”⁷⁶

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- Governments should enforce existing laws on minimum age of marriage and work toward establishing a uniform statutory marriage law applicable to all marriages.

- Governments should adopt 18 as the minimum age of marriage for both women and men.
- Moreover, governments should enact laws to ensure that marriage is only entered into with the consent of the intending spouses.

BEST PRACTICE

In 1996, **Burkina Faso** amended its Penal Code to include a provision criminalizing the act of compelling or forcing someone to marry.⁷⁷ The preface to the new Penal Code states that this and other new criminal provisions were added to better protect human rights, including preventing violations of women's sexual integrity and ensuring the right to enter freely into marriage.⁷⁸ The penalty for forcing someone to marry is six months to two years imprisonment.⁷⁹ However, imprisonment for one to three years is applicable if the victim is a minor.⁸⁰ If the minor is a girl under 13 years of age, the maximum penalty must be applied.⁸¹ The legal age of marriage in Burkina Faso is 17 for women and 20 for men, but a judge can make an exception for grave reasons.⁸² However, even in these special circumstances, a judge cannot lower the age below 15 for women and 18 for men.⁸³

V. EARLY CHILDBEARING AND CONTRACEPTION

BACKGROUND

The internationally recognized human right to decide freely and responsibly the number, spacing, and timing of one's children lies at the core of reproductive rights and is applicable to all individuals of reproductive age, including children.⁹¹ While the issue of early childbearing is not specifically addressed in the Children's Convention, it does explicitly recognize the individual's right to family planning services and information⁹² and can be interpreted to protect reproductive self-determination.⁹³ Because of the risks to health and life posed by early childbearing,⁹⁴ governments have an obligation to ensure family planning information and services, to enforce laws on minimum age for marriage, and to encourage girls to stay in school. In many cases, unwanted pregnancy among adolescents occurs as a result of sexual abuse and forced or early marriage. States Parties to the Children's Convention are also obligated to address harmful traditional practices⁹⁵ and sexual abuse.⁹⁶

Because adolescents are often not physiologically mature enough for childbearing, early childbearing is associated with high levels of maternal mortality and morbidity.⁹⁷ The risks of early childbearing include hemorrhage, anemia, malnutrition, delayed or obstructed labor, low birth weight, and death for the mother or infant.⁹⁸ In addition to improving the outcome of a pregnancy, there are socioeconomic benefits to delaying early childbearing. An adolescent who delays pregnancy has a better chance at furthering her education, and acquiring skills and knowledge that will allow her to better take care of herself and her future family.

Due to the high level of sexual activity and unplanned pregnancies among adoles-

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cents, one of the best ways to prevent pregnancy is to enhance contraceptive use. Given the importance of having many children in sub-Saharan Africa, few married adolescents use contraceptives.⁹⁹ Contraceptive prevalence among married adolescents in the Middle East and North Africa is also low, as is the case in India and Pakistan.¹⁰⁰ Some of the highest levels of contraceptive prevalence among Southern nations are found in Indonesia and Thailand, and in Latin America and the Caribbean.¹⁰¹ The prevalence of contraceptive use among unmarried sexually active adolescents in sub-Saharan Africa is much higher than for their married counterparts, while in Latin America and the Caribbean, the prevalence for the two groups is about the same.¹⁰²

Unfortunately, many adolescents have little or no information about contraceptives and their proper use.¹⁰³ As previously noted, adolescents face many obstacles in obtaining information about and access to contraceptives. These obstacles are mainly due to traditional beliefs and norms against premarital sexual activity, which have resulted in laws and policies that limit or restrict adolescent access to contraceptives by requiring parental consent. Even when no formal legal barriers exist, service providers may exhibit negative attitudes or refuse to provide contraceptives. Such legal and practical barriers deter the use of contraception among unmarried adolescents who do not want their parents to know about their sexual activity, and among married ones who are unable to negotiate contraceptive use with their spouses.

- Roughly 10% of all births in the world are attributable to adolescents.⁸⁴
- Every year, approximately 14 million young women become mothers.⁸⁵
- In sub-Saharan Africa, more than half the women aged 20 to 24 years gave birth before age 20, as compared with one-third in Latin America and the Caribbean.⁸⁶
- In the United States, 13% of all births can be attributed to teenagers. In fact, every year, almost one million teenage girls become pregnant, and of all teen pregnancies, 78% are unplanned.⁸⁷ Teen pregnancy rates are much higher in the United States than in many other industrialized countries — twice as high as in Canada and nine times as high as in the Netherlands and Japan.⁸⁸
- Statistics from the World Health Organization show that the risk for pregnancy-related death is twice as high for adolescents aged 15 to 19 and five-fold for adolescents aged 10 to 14 as it is for women in their early 20s.⁸⁹
- Levels of unwanted pregnancies vary among adolescents. They range from 25% of all adolescent pregnancies in Guatemala to 50% in Peru; 15% to 30% in the Middle East and North Africa; 10% to 16% in India, Indonesia, and Pakistan, and 20% to 45% in the remainder of the Asian countries; and from as low as 11% to 13% in Niger and Nigeria to 50% or more in Botswana, Ghana, Kenya, Namibia, and Zimbabwe.⁹⁰

CONCLUDING OBSERVATIONS FROM THE COMMITTEE ON THE RIGHTS OF THE CHILD

“The Committee is concerned about the high rate of early pregnancy [in Uruguay], which has negative effects on the health of the mothers and the babies, and on the mothers’ enjoyment of their right to education, hampering the school attendance of the girls concerned and causing high numbers of school drop-outs ... [and] recommends that measures be adopted to provide appropriate family education and services for young people within the school and health programmes implemented in the country.”¹⁰⁴

“The Committee notes with concern that obstacles remain to the effective implementation of the family planning and education programmes in the country, particularly in view of the lack of quality materials and services available in Cuba.”¹⁰⁵

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- Governments should eliminate restrictions on contraception, including excessive regulation and the prohibition of disseminating information.
- Governments should provide universal access to contraceptive information and services for married and unmarried adolescents.
- Governments should provide universal access to pre and postnatal care for pregnant adolescents, regardless of marital status.

BEST PRACTICE

This section will review an initiative by a Northern country, the **United States**, that has sought to ensure adolescent access to contraception through legislation for the past 29 years. The Title X provision of the Public Health Service Act of the United States¹⁰⁶ was enacted in 1970. Its goal is “to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services.”¹⁰⁷ The Title X program provides family planning services such as contraception (including natural family planning and abstinence); the management of infertility (including adoption); preconceptional counseling; education; and general reproductive health care, including diagnosis and treatment of sexually transmissible infections.¹⁰⁸ The program, which is administered by the Department of Health and Human Services, provides funds to both public and private bodies such as family planning clinics and state health departments. Title X also guarantees confidentiality for all participants, including adolescents.¹⁰⁹

In 1978, the U.S. Congress recognized that teenage pregnancies are “often unwanted, and are likely to have adverse health, social, and economic consequences for the individuals involved.”¹¹⁰ Consequently, it amended the original Title X to incorporate language that explicitly included services for adolescents.¹¹¹ Since 1996, however, family planning opponents in Congress have attempted to restrict adolescent access to Title X services by proposing amendments to annual budgetary legislation that would require parental consent, parental notice, emancipation, or judicial bypass for adolescent girls seeking to obtain such services.¹¹² However, a majority in Congress consistently has rejected these amendments, fearing that these measures could deter adolescents from obtaining reproductive health care.¹¹³

VI. UNSAFE ABORTION

BACKGROUND

Lack of safe, legal abortion services for adolescents jeopardizes their health and lives and undermines their right to make decisions concerning childbearing. As discussed above, the Children's Convention protects the right to life and to health of all children without limitation.¹²² Thus, under Article 24's comprehensive approach to the right to health, adolescents who suffer medical complications from unsafe abortion have a right to medically adequate, respectful, confidential care. When a country outlaws or severely restricts a medical procedure that is only needed by women and girls, it violates the prohibition on gender discrimination under international human rights instruments, including the Children's Convention.¹²³

Moreover, if an adolescent is capable of understanding the serious nature of her decision, an adolescent girl faced with an unwanted pregnancy should be entitled to make decisions concerning her pregnancy, including whether to carry the fetus to term. Although the Children's Convention does not explicitly address abortion, it does require States Parties to "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, [such views] being given due weight in accordance with the age and maturity of the child."¹²⁴ Furthermore, the Children's Convention specifies that "[n]o child shall be subjected to arbitrary or unlawful interference with his or her privacy ..."¹²⁵

Unsafe abortion¹²⁶ has particularly serious health implications for adolescents and young women, especially where abortion is either illegal or severely restricted, or difficult for adolescents to access. Abortion's legal status influences rates of abortion-related maternal mortality and morbidity.¹²⁷ These rates are particularly elevated among adolescents.¹²⁸ Moreover, adolescents worldwide are disproportionately victims of unsafe abortions because they have the least access to quality, confidential reproductive health services and information, including contraception. Adolescents are also less likely than older women to have the social contacts,

- Studies from several Southern nations reveal that pregnant, unmarried adolescents decide to terminate their pregnancies more frequently than other groups.¹¹⁴ Between one million and four million adolescent women in Southern nations obtain clandestine, usually unsafe, abortions.¹¹⁵
- Adolescents tend to delay obtaining an abortion until after the first trimester and often seek help from a non-medical provider, leading to higher rates of complications. Self-induced abortion is also common among adolescents in many countries.¹¹⁶
- In Chile and Argentina, more than one-third of maternal deaths among adolescents are a direct result of unsafe abortions.¹¹⁷ In Peru, one-third of women hospitalized for abortion complications are adolescent women aged 15 to 24 years.¹¹⁸
- The World Health Organization has estimated that, in many African countries, up to 70% of all women hospitalized for abortion complications are under age 20.¹¹⁹ In a Ugandan study, almost 60% of abortion-related deaths were among adolescent women.¹²⁰
- Among industrialized countries, the United States has one of the higher adolescent abortion rates. The abortion rates per 1,000 for 15 to 19-year-olds vary from three in Germany, six in Japan, 19 in England and Wales, to 36 in the United States.¹²¹

access to transportation, and financial means to obtain a safe abortion.¹²⁹

Despite a clear trend toward liberalization of abortion laws since 1994, legal and policy restrictions remain in place in many Southern nations, particularly in Latin America, Africa, and the Middle East.¹³⁰ Among countries with a population above one million, where abortion is legal in at least some circumstances, parental authorization is nonetheless required in 28 nations.¹³¹ Such barriers may contribute to delays in obtaining an abortion during the first trimester when it is safest, and to adolescents resorting to clandestine, unsafe procedures to avoid parental involvement.

CONCLUDING OBSERVATIONS FROM THE COMMITTEE ON THE RIGHTS OF THE CHILD

“The Committee is concerned about the relatively high maternal mortality rate, especially as it affects young girls, in Nicaragua. It also notes that clandestine abortions and teenage pregnancies appear to be a serious problem in the country.”¹³²

“The Committee expresses its concern regarding the limited availability of programmes and services [in Belize] and the lack of adequate data in the area of adolescent health, including ... violence and abortion.”¹³³

“While the Committee acknowledges [Guinea’s] efforts in the area of adolescent health, it is particularly concerned at the high and increasing rate of early pregnancy, the high maternal mortality rate and the lack of access by teenagers to reproductive health education and services.”¹³⁴

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- To address unsafe abortion, particularly its high incidence among adolescents, governments should consider enacting laws that permit abortion without restriction as to reason or on broad grounds.
- Law enforcement officials should refrain from prosecuting women who have undergone abortion procedures and the providers who have performed abortions with the consent of their patients.
- In countries where abortion is legal, governments should ensure that all women, including adolescents, have access to the fullest range of high-quality abortion services permitted by law, regardless of income, marital status, and level of education.

BEST PRACTICE

In 1995, Guyana became one of the few countries in South America to enact legislation legalizing abortion. In 1991, septic abortion and incomplete abortion were the third and eighth highest causes of hospitalization, respectively, in Guyana.¹³⁵ Following the enactment of the Medical Termination of Pregnancy

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Act 1995 (MTPA),¹³⁶ a significant decrease in the rates of hospitalization due to unsafe abortion was recorded.¹³⁷ The MTPA recognizes and enhances women's reproductive autonomy by providing them with the option of legally terminating a pregnancy at their discretion.

The MTPA provides for the legal termination of a pregnancy¹³⁸ without restriction as to reason in the first eight weeks¹³⁹ of the pregnancy.¹⁴⁰ Between eight and 12 weeks, there are several circumstances under which abortion is permitted. These include the following: to prevent injury to the physical or mental health of the woman; if there is substantial risk of fetal damage; if the pregnant woman is deemed mentally incapable of taking care of the child; if the pregnant woman is HIV positive; or if the pregnancy is due to contraceptive failure.¹⁴¹ Between 12 and 16 weeks, abortion is permitted if two authorized medical practitioners are of the opinion that the conditions noted above apply to the pregnant woman.¹⁴² After 16 weeks, abortion is permitted if three medical practitioners are of the opinion that the pregnancy endangers the woman's life, or poses a risk of grave permanent injury to the physical or mental health of the woman or the fetus.¹⁴³

The MPTA also stipulates that abortions performed at the request of a woman during the first eight weeks of gestation must be administered or supervised by a medical practitioner.¹⁴⁴ All other pregnancy terminations may be performed only by an authorized medical practitioner and in an approved institution.¹⁴⁵

A medical practitioner who conscientiously objects to performing an abortion may refuse to terminate a pregnancy, unless it is immediately necessary to save the life of the woman or prevent grave permanent injury to her physical or mental health.¹⁴⁶ The MTPA also requires the Minister of Health to promulgate regulations for pre- and post-abortion counseling and for a 48-hour waiting period following the request for an abortion, although the latter may be overridden in an emergency.¹⁴⁷

- Around half of the 333 million new STI infections each year are in people under 25 years old.¹⁴⁸ Roughly one in 20 adolescents each year contracts an STI.¹⁴⁹
- Of the 15.3 million new cases of STIs in the United States in 1996, about a quarter were in adolescents between 15 and 19 years old.¹⁵⁰ Between 30% and 40% of sexually active adolescent girls were infected with chlamydia.¹⁵¹
- Of the 30 million people living with HIV in 1998, at least one-third were aged 10 to 24.¹⁵² There are around 2.6 million new infections among this age group each year.¹⁵³ That is 7,000 new infections every day, or five new infections every minute.¹⁵⁴
- Recent studies indicate that the rate of HIV/AIDS is increasing faster among young women than among young men in low-income countries.¹⁵⁵ In Uganda, for example, HIV infections among adolescent girls 13 to 19 years old are three times higher than among teenage boys.¹⁵⁶
- One clinical study in Zimbabwe revealed that 30% of 15 to 19-year-old pregnant adolescents were HIV-positive and only learned of their condition when they sought prenatal care.¹⁵⁷

III. HIV/AIDS AND OTHER STIs

BACKGROUND

Adolescents' rights to life, health, and reproductive health are severely compromised when governments fail to address HIV/AIDS and other STIs comprehensively. As discussed above, the Children's Convention protects adolescents' rights to life and health.¹⁵⁸ Furthermore, under the Children's Convention and other applicable human rights instruments, the rights to nondiscrimination, to equal treatment for men and women, to enjoy the benefits of scientific progress and all its applications, and to seek, receive, and impart health information of all kinds provide an internationally recognized framework that requires governments to take necessary measures to enable adolescents to protect themselves from STI and HIV infection, and, if HIV positive, to obtain appropriate treatment.¹⁵⁹

Adolescent women are often more vulnerable to HIV/AIDS and STIs than their male counterparts. This increased vulnerability is attributable to factors beyond their control, such as sexual violence and exploitation; early sexual initiation; inability to negotiate safe sex with their partners, who are often older than they; social pressure; lack of formal education, including sex education; and lack of access to contraception and reproductive health services.

In communities that lack contraceptive services at health facilities or restrict adolescent access to male and female condoms, it is nearly impossible for adolescents to protect themselves from STIs, HIV, and unwanted pregnancy.¹⁶⁰ Aggressive legal and policy measures are needed to ensure adolescent access to comprehensive reproductive health information and services, to guarantee that adolescents already suffering from STIs have access to appropriate services and counseling, and to ensure that those infected with HIV/AIDS are protected from discrimination in education, employment, and health services. High HIV/AIDS infection rates, particularly in Africa and especially among adolescent girls, underscore the urgent need for legislative, policy, and programmatic measures to address this issue.

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*"The Committee suggests that [Ghana] strengthen its information and prevention programmes to combat HIV/AIDS and sexually transmitted diseases (STD) as well as discriminatory attitudes towards children affected by or infected with HIV/AIDS."*¹⁶¹

*"The Committee is concerned by the absence of large-scale public campaigns for the prevention of unwanted pregnancies, STDs and HIV/AIDS [in Paraguay], especially for children and adolescents."*¹⁶²

"[T]he Committee expresses its deep concern at the spread of [HIV/AIDS] [in

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Guinea] and its direct and indirect effects on children. The Committee recommends that programmes relating to the incidence and treatment of children infected with or affected by HIV/AIDS should be reinforced. International cooperation from UNICEF, WHO and UNAIDS is encouraged.”¹⁶³

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- Governments should develop compassionate and supportive, nondiscriminatory HIV/AIDS-related policies for the care and protection of infected individuals.
- Government education campaigns for AIDS prevention should be aimed specifically at adolescents, particularly adolescent girls, and should encourage adolescent boys and men to practice safer sexual behavior.

BEST PRACTICE

The rapid spread of HIV/AIDS in **Tanzania**¹⁶⁴ prompted the country’s Ministry of Health to promulgate, in September 1995, its National Policy on HIV/AIDS and STDs (the National AIDS Policy).¹⁶⁵ The overall goal of the policy is to mobilize and sensitize the community to become actively involved in preventing further transmission of HIV and to cope with the social and economic consequences of AIDS. Some of the specific objectives of the National AIDS Policy include creating a national institutional framework to coordinate the mobilization of financial, human, and material resources for AIDS prevention and control; raising awareness; promoting safer sex practices, testing, and counseling; providing infected persons with increased support; and safeguarding their right to be free from discrimination. The rights of infected persons as set forth by the policy include the right to employment, housing, protection of privacy — including with regard to counseling and treatment for AIDS — education, insurance, and use of public transportation.¹⁶⁶

The policy highlights the importance of educating women about their basic health and sexuality rights, and ensuring that services are made accessible to women through the Maternal and Child Health/Family Planning clinics. HIV-transmission protective devices for women are also promoted and provided.¹⁶⁷ Moreover, the policy stresses the importance of confidentiality in testing as well as the need for pre- and post-test counseling, institu-

- Globally, 40% to 47% of sexual assaults are against adolescents and girls aged 15 years and younger.¹⁷¹

- Forty percent of women in the United States who had sexual relations before age 15 report that it was involuntary.¹⁷² In addition, a 1992 study estimated that 61% of sexual assault victims were under 18 years of age.¹⁷³

- A study in Peru found that 90% of adolescent mothers between 12 and 16 were victims of rape, often by a member of their family.¹⁷⁴ Similarly, in Costa Rica most adolescent mothers in their mid-teens were found to be victims of incest.¹⁷⁵

- A study in Uganda reported that 49% of schoolgirls who responded that they were sexually active said they had been forced to have sex.¹⁷⁶ In Zimbabwe, a study showed that about half of reported rape cases involved adolescents and girls under 15 years of age.¹⁷⁷

- Each year around the world about two million girls between five and 15 years of age enter the commercial sex market.¹⁷⁸

tional care, management of STIs (including free treatment), community-based support services, protecting health care workers, and addressing the plight of widows and orphans affected by AIDS.¹⁶⁸ Finally, the policy encourages the criminalization of the willful spread of HIV/AIDS and STIs.¹⁶⁹

Although resource and health infrastructure issues are likely to hamper full implementation of the National AIDS Policy in Tanzania, its promulgation is a crucial first step toward providing a framework for governmental efforts to confront HIV/AIDS and STIs. While the National AIDS Policy does not explicitly address issues related to adolescents, policy guidelines instituted in 1994 as part of Tanzania's family planning program provide for information, education, counseling, and services to be offered to all people of reproductive age, including adolescents.¹⁷⁰

VIII. SEXUAL VIOLENCE AND ADOLESCENTS

BACKGROUND

One of the most blatant violations of the reproductive and sexual rights of adolescents is sexual violence in all its forms. The international community has recognized that governments have an obligation to undertake aggressive measures to protect all women and girls from all forms of violence, including sexual violence, and to punish such violence.¹⁷⁹ The Children's Convention unequivocally recognizes sexual violence against adolescents as a severe human rights violation and requires governments to take appropriate measures to combat it.¹⁸⁰

Although there are relatively few studies regarding sexual abuse of adolescents, those that have been conducted indicate that adolescents around the world are at high risk for various forms of sexual abuse, including rape, sexual assault, incest, commercial sexual exploitation, and sexual slavery.¹⁸¹ Many adolescents around the world report that their first sexual experience was forced or coerced by an older partner.¹⁸² The majority of victims of sexual abuse are adolescent girls.¹⁸³

Lack of information and the low status of women in many societies contribute to making female adolescents one of the groups most vulnerable to sexual abuse. Since the majority of the abuse is committed by acquaintances, family members, and authority figures, girls and adolescents are unlikely to report these incidents. This fear of reporting is compounded by health care providers and law enforcement agencies that are ill equipped to address such abuses. The result has been continued abuse and lack of accountability regarding these violations of adolescents' sexual rights. Without the will and commitment of government actors, perpetrators will have no reason to fear violating the sexual rights of adolescents.

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“The Committee ... recommends that [Myanmar] take all appropriate measures to prevent and combat child abuse, including sexual abuse, and the sale and trafficking of children, child prostitution and child pornography.”¹⁸⁴

“The Committee encourages [Bangladesh] to take all appropriate measures to prevent and combat sexual abuse and sexual exploitation of children and to ensure their physical and psychological recovery and social reintegration.”¹⁸⁵

“[S]erious concern remains in relation to a [Cuban] child’s opportunity to report abuse and other violations of his/her rights in the family, schools or other institutions and to have a complaint taken seriously and responded to effectively.”¹⁸⁶

“The Committee recommends that [Austria] consider undertaking an in-depth study of the ages of sexual consent and sexual relations, taking into account present legislation, its implications and its impact on children ... with a view to ensuring that the legislation is as conducive to the realization of the rights of girls as boys and having due regard to the best interests of the child.”¹⁸⁷

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- Governments should enact laws and policies to levy harsher penalties on violent sexual offenders and actively enforce existing laws against sexual violence and abuse.
- Governments should create programs to sensitize the community, including health care providers and law enforcement officials, to protect the girl child and adolescents against all forms of sexual violence, including rape, incest, and trafficking.

BEST PRACTICE

In 1995, Ecuador passed a comprehensive new law (Law Against Family Violence¹⁸⁸) to prevent and punish violence¹⁸⁹ within families, as well as against present and former cohabiting persons or those with whom a perpetrator has or has had a consensual relationship.¹⁹⁰ This law can be used to address the issue of sexual violence against adolescents by members of their family or current or former spouses or boyfriends. It is important to note that the Law Against Family Violence does not replace or supercede the duties of law enforcement personnel nor the jurisdiction of the judiciary to investigate, prosecute, and punish violations of Ecuador’s laws on rape, incest, assault, and other applicable criminal provisions.

- It is estimated that the worldwide prevalence of FC/FGM is about 130 million women, with an additional two million girls and women undergoing the procedure every year.¹⁹⁴
- FC/FGM is prevalent in about 28 African countries and among some minority groups in Asia.¹⁹⁵ In addition, there are many immigrant women in Europe, Canada, and the United States who have suffered genital mutilation.¹⁹⁶
- The prevalence in African countries varies widely from about 5% in Zaire and Uganda to 98% in Somalia.¹⁹⁷
- It is estimated that 15% of all circumcised women have undergone the most harmful version of FC/FGM — infibulation. However, approximately 80% to 90% of all circumcisions in Djibouti, Somalia, and Sudan are of this type.¹⁹⁸

The Law Against Family Violence allows any person or institution to report a violation and requires the police, the Public Ministry, and health professionals to file complaints within 48 hours of becoming aware of the facts constituting such a violation.¹⁹¹ The legal authorities to whom cases are referred are required to order one or more of a number of measures immediately, such as ordering the perpetrator to leave the house; prohibiting or restricting the perpetrator from approaching the victim; preventing the perpetrator, either on his or her own accord or through another person, from carrying out acts of persecution or intimidation against the victim or any member of the victim's family; granting custody of a victim who is a minor or incapacitated to an appropriate person under existing legal provisions; and ordering measures to ensure assistance to the victim.¹⁹²

Other provisions of the law deal with the duty of the National Directorate of Women to formulate policies, actions, and programs. It must eliminate and prevent all forms of interfamily violence; establish temporary places of refuge for victims and re-education centers for perpetrators; organize and execute educational activities for parents and households; and promote and coordinate training programs for government officials and the judiciary involved in this area.¹⁹³

IX. FEMALE CIRCUMCISION/FEMALE GENITAL MUTILATION (FC/FGM)

BACKGROUND

Female Genital Mutilation (FGM), also referred to as female circumcision (FC), involves the removal of healthy sexual organs without medical necessity and is usually performed on girls between the ages of four and 12,¹⁹⁹ often with harmful physical and psychological consequences. The practice violates a number of provisions under the Children's Convention. Indeed, the Children's Convention was the first international human rights treaty to include a provision that explicitly requires governments to take measures to eliminate harmful traditional practices, such as FC/FGM. Article 24, which encompasses children's right to the highest attainable standard of health, explicitly provides that States Parties "shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."²⁰⁰

Despite the societal pressures faced by girls and their parents to undergo FC/FGM, governments have an obligation to promote the "best interests"²⁰¹ of the child under Article 3, which is clearly violated by the harmful traditional practice of FC/FGM. Article 19 requires States Parties to "take all appropriate legislative, administrative, social and education measures to protect the child from all forms of physical or mental violence ... " While FC/FGM is not undertaken with the intention of harming women and girls, the harmful physical, sexual, and psychological effects that it causes make it an act of violence.²⁰²

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FC/FGM has been practiced for centuries and has become an integral part of the cultures and societies where it is prevalent. FC/FGM is the collective name given to four types of traditional practices that involve the partial or total excision of female genitals. Although several justifications are given for the maintenance of the practice, it appears to be linked primarily to a desire to ensure the chastity and honor of women and girls. In many cultures it is a ritual that marks the transition to adulthood and is considered essential to girls' socialization, curbing their sexuality and establishing their suitability for marriage.²⁰³ FC/FGM has no credible link to religious tenets despite attempts by some to justify its practice on such grounds.²⁰⁴

In traditional settings, FC/FGM generally is performed by older women in the community and often under septic conditions.²⁰⁵ Short-term complications include severe pain and a risk for hemorrhage that can lead to shock and death. In addition, there is a very high risk for local and systemic infections, with documented reports of abscesses, ulcers, delayed healing, septicemia, tetanus, and gangrene.²⁰⁶ Long-term complications, most common with excision and infibulation, include urine retention resulting in repeated urinary infections; obstruction of menstrual flow leading to frequent reproductive tract infections and infertility; and prolonged and obstructed labor.²⁰⁷ HIV and STI transmission can occur during the procedure if the same instrument is used on several girls, or during intercourse later in life once the scar tissue is torn.²⁰⁸ In addition to the physical complications, there are psychological and sexual effects.²⁰⁹

CONCLUDING OBSERVATIONS FROM THE COMMITTEE ON THE RIGHTS OF THE CHILD

“The Committee remains concerned at the persistence of traditional attitudes and harmful practices [in Ghana], such as female genital mutilation, early marriages, teenage pregnancies and Trokosi (ritual enslavement of girls)... [and] recommends that all legislation be reviewed to ensure its full compatibility with children’s rights ...”²¹⁰

“The Committee remains concerned at prevailing traditional attitudes and harmful practices [in Ethiopia], such as female genital mutilations, early marriages and teenage pregnancies, and at the persistence of discriminatory social attitudes against vulnerable groups of children, such as the girl child.”²¹¹

“While welcoming [Guinea’s] innovative measures, both legal and educational, to eradicate the practice of female genital mutilation and other harmful traditional practices affecting the health of girls, the Committee expresses its concern at the limited impact of these measures. The Committee recommends that the State party strengthen its measures to combat and eradicate the persistent practice of female genital mutilation and other traditional practices harmful to the health of the girl child.”²¹²

CENTER FOR REPRODUCTIVE RIGHTS RECOMMENDATIONS

- Governments should apply integrated approaches for the elimination of FC/FGM and involve local and national political leaders, women's groups, medical professionals, legal professionals and law enforcement personnel, and universities in the collection and dissemination of information regarding the harmful effects of FC/FGM.
- Legislators should consider criminal sanctions for medical and non-medical practitioners of the procedure.

BEST PRACTICE

Approximately 80% of girls and women in **Egypt** are circumcised.²¹³ In 1994, the former Minister of Health, Dr. Ali Abdel Fattah, issued a decree banning FC/FGM outside of public hospitals and required physicians to discourage parents from having their daughters undergo FC/FGM. If the parents insisted, the procedure was to be carried out by physicians in hospitals.²¹⁴

In 1995, Dr. Abdel Fattah issued a decree amending the 1994 policy on FC/FGM. Using the rationale that Egyptian parents had been successfully convinced to eschew the practice of FC/FGM, the 1995 decree banned physicians from performing FC/FGM in public hospitals.²¹⁵ However, this decree did not prevent physicians from performing FC/FGM in their private clinics. In 1996 the new Minister of Health, Dr. Ismael Sallam, ended this policy with a decree prohibiting FC/FGM in public hospitals and private clinics, as well as by non-physicians.²¹⁶

Shortly after the 1996 decree was issued, it was challenged in court by proponents of FC/FGM and by medical professionals concerned that the ban would lead to increased clandestine FC/FGM.²¹⁷ The court declared the health minister's decree unconstitutional for infringing upon parliamentary functions and for interfering with the right of physicians to perform surgery.²¹⁸ However, in December 1997, the highest court overturned the lower court's ruling and, in response to proponents of FC/FGM who asserted that Islam requires the practice, declared that Islam does not sanction FC/FGM. The court also declared the practice punishable under the Penal Code.²¹⁹

Other efforts of the Egyptian government to eliminate FC/FGM include educating traditional birth attendants, doctors, and nurses about the dangers of FC/FGM, and developing mass-media public service messages that discourage FC/FGM.²²⁰

CONCLUSION

As this paper highlights, great challenges remain in promoting, protecting, and ensuring the reproductive rights of adolescents. Among adolescent girls, high rates of teen pregnancy, sexual violence, unsafe abortion, maternal mortality and morbidity, HIV/AIDS and other STIs, the continued practice of early marriage and FC/FGM, and low rates of female school enrollment, confirm the substantial gap between the protections set forth in the Children's Convention and the reality of adolescent girls' lives. As evidenced by its Concluding Observations, the Committee on the Rights of the Child has frequently raised issues related to adolescents' reproductive rights with States Parties. The 1994 Programme of Action and the 1995 Declaration and Platform for Action also focused much-needed attention on adolescent reproductive rights issues. However, lack of political will on the part of many governments continues to undermine the implementation of their obligations to adolescents' reproductive rights under the Children's Convention. As the Committee on the Rights of the Child begins its second decade of work, it must continue to reinforce government obligations and it must seek creative enforcement strategies in partnership with United Nations agencies and non-governmental organizations working to ensure adolescents' reproductive rights.

ENDNOTES

- 1 Convention on the Rights of the Child, art. 1, *opened for signature* Nov. 20, 1989, G.A. Res.44/25, U.N.G.A.O.R., 44th Sess., Supp. No. 49, U.N. Doc.A/44/49, *reprinted in* 28 I.L.M. 1448 (*entry into force* Sept. 2, 1990) [hereinafter *Children's Convention*]. The provision states that "[f]or purposes of the present Convention a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier."
- 2 *Programme of Action of the International Conference on Population and Development, Cairo, Egypt, 5-13 September 1994*, in REPORT OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, ¶7.3, U.N. Doc.A/CONF.171/13/Rev.1, U.N. Sales No. 95.XIII.18 (1995) [hereinafter *ICPD Programme of Action*]; *see also the Beijing Declaration and The Platform for Action, Fourth World Conference on Women, Beijing, China, 4-15 September 1995*, ¶95, U.N. Doc. DPI/1766/Wom(1996) [hereinafter *Beijing Declaration and Platform for Action*].
- 3 UNITED NATIONS POPULATION FUND, TECHNICAL AND POLICY DIVISION DRAFT REPORT, THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS 2 (April 1998)[hereinafter *SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS*].
- 4 *Id.* at 4, *citing* UNITED NATIONS, THE SEX AND AGE DISTRIBUTION OF THE WORLD POPULATION (1996).
- 5 *Id.*
- 6 *Id.*
- 7 *ICPD Programme of Action*, Principle 8; *see also the Beijing Declaration and Platform for Action*, ¶89.
- 8 *ICPD Programme of Action*, ¶ 7.3.
- 9 *Proclamation of Teheran, adopted by the International Conference on Human Rights, Tehran, Iran 22 Apr.-13 May 1968*, Res. IX, U.N. Doc. A/CONF.32/41 (1968) [hereinafter *Teheran Proclamation*].
- 10 *Children's Convention*, art. 24.
- 11 *Id.*, art. 24(f).
- 12 *Id.*, art. 5.
- 13 *Id.*, arts. 3(1) and (2), 14(2), 18(1).
- 14 *Id.*, arts. 19 & 34.
- 15 THE ALAN GUTTMACHER INSTITUTE, INTO A NEW WORLD 40 (1998) [hereinafter *INTO A NEW WORLD*].
- 16 *Id.*
- 17 *Id.*
- 18 *Id.*
- 19 *Id.*
- 20 *Id.*
- 21 *Id.*, at 19.
- 22 UNITED NATIONS POPULATION FUND, STATE OF WORLD POPULATION 1997 37 (1997) [hereinafter *STATE OF WORLD POPULATION 1997*].
- 23 *Children's Convention*, art 24(1)(f).
- 24 *Id.*, art. 16.
- 25 *Id.*, art. 12(1)
- 26 The human right to determine the number, timing and spacing of one's children was first recognized at the U.N. International Conference on Human Rights in Teheran in 1968. *See also ICPD Programme of Action*, ¶7.3 and *Beijing Declaration and Platform for Action*, ¶89.
- 27 UNICEF, IMPLEMENTATION HANDBOOK FOR THE CONVENTION ON THE RIGHTS OF THE CHILD 611, et. seq. (1998) [hereinafter *IMPLEMENTATION HANDBOOK*].
- 28 *INTO A NEW WORLD*, *supra* note 15, at 40.
- 29 World Health Day, 7 April 1998, Delay Childbearing, (viewed on Apr. 30, 1998) <<http://who.ch/whday/1998/whd98-04.html>>.
- 30 Concluding observations of the 15th Session of the United Nations Committee on the Rights of the Child: Paraguay, ¶23, 45. June 18, 1997. UN Doc CRC/C/15/Add.75. (website visited August 13, 1999) <<http://www.unhchr.ch>>.
- 31 Concluding observations of the 18th Session of the United Nations Committee on the Rights of the Child: Hungary, ¶¶21, 36. June 5, 1998. UN Doc CRC/C/15/Add.87. (website visited August 16, 1999) <<http://www.unhchr.ch>>.
- 32 Concluding observations of the 20th Session of the United Nations Committee on the Rights of

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- the Child: Austria, ¶15. May 7, 1999. UN Doc CRC/C/15/Add.98. (website visited August 16, 1999) <<http://www.unhchr.ch>>.
- 33 GHANA NATIONAL POPULATION COUNCIL, ADOLESCENT REPRODUCTIVE HEALTH POLICY (1996), *cited in* THE CENTER FOR REPRODUCTIVE RIGHTS AND INTERNATIONAL FEDERATION OF WOMEN LAWYERS (GHANA CHAPTER), WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES — ANGLOPHONE AFRICA 46 (1997).
- 34 INTO A NEW WORLD, *supra* note 15, at 12.
- 35 *Id.*
- 36 *Id.*
- 37 *Id.*
- 38 Children’s Convention, art. 28(1)(a).
- 39 *Id.*, art. 28(1)(b).
- 40 *Id.*, art. 29(d).
- 41 The Universal Declaration of Human Rights, art. 26, G.A. Res. 217 A (III), U.N. Doc. A/810 (1948) [hereinafter UDHR]; International Covenant on Economic, Social and Cultural Rights, art. 13, *adopted* Dec. 16, 1966, 993 U.N.T.S. 3, (*entry into force* Jan. 3, 1976) [hereinafter Economic Rights Covenant].
- 42 STATE OF WORLD POPULATION 1997, *supra* note 22, at 51.
- 43 *Id.*
- 44 ALAN GUTTMACHER INSTITUTE, ISSUES IN BRIEF: RISKS AND REALITIES OF EARLY CHILDBEARING WORLDWIDE (viewed on Jun. 10, 1998) <<http://www.agi-usa.org/pubs/ib10.html>>; MARCELA VILLAREAL, FOOD AND AGRICULTURAL ORGANIZATION OF THE UNITED NATIONS, ADOLESCENT FERTILITY: SOCIO-CULTURAL ISSUES AND PROGRAMME IMPLICATIONS, at 17 (1998).
- 45 INTO A NEW WORLD, *supra* note 15, at 14.
- 46 *Id.*, at 42.
- 47 Concluding observations of the 14th Session of the United Nations Committee on the Rights of the Child: Bulgaria, ¶29. January 24, 1997. UN Doc CRC/C/15/Add.66. (website visited August 13, 1999) <<http://www.unhchr.ch>>.
- 48 Concluding observations of the 14th Session of the United Nations Committee on the Rights of the Child: Ethiopia, ¶17. January 24, 1997. UN Doc CRC/C/15/Add.67. (website visited August 13, 1999) <<http://www.unhchr.ch>>.
- 49 Concluding observations of the 19th Session of the United Nations Committee on the Rights of the Child: Iraq, ¶25. October 26, 1998. UN Doc CRC/C/15/Add.94. (website visited August 16, 1999) <<http://www.unhchr.ch>>.
- 50 Consideration of Reports Submitted by States Parties Under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women, Third and fourth periodic reports of States parties – Bangladesh, CEDAW/C/BGD/3-4- 1 April 1997 (visited on Nov. 17, 1998) <[gopher://gopher.un.org/00/ga/cedaw/17/country/Bangladesh/C-BGD3-4.EN%09%09%2B](http://gopher.un.org/00/ga/cedaw/17/country/Bangladesh/C-BGD3-4.EN%09%09%2B)>.
- 51 INTO A NEW WORLD, *supra* note 15, at 15.
- 52 *Id.*
- 53 *Id.*
- 54 *Id.*
- 55 STATE OF WORLD POPULATION 1997, *supra* note 22, at 39.
- 56 *Id.*, at 17.
- 57 *Id.*
- 58 *Id.*
- 59 Children’s Convention, art. 28 & 29.
- 60 *Id.*, art. 29(1).
- 61 *Id.*, art. 24.
- 62 *Id.*, art. 6.
- 63 Article 16(2) of the Universal Declaration of Human Rights provides that “[m]arriage shall be entered into only with the free and full consent of the intending spouses.”
- 64 Children’s Convention, art. 24(3).
- 65 IMPLEMENTATION HANDBOOK, *supra* note 27, at 334-336.
- 66 Children’s Convention, art. 24(1).
- 67 *Id.*, arts. 9(1) and 34.
- 68 STATE OF WORLD POPULATION 1997, *supra* note 22, at 40.
- 69 *Id.*, at 38.
- 70 *Id.*, at 39.

- 71 For example, in India, the government promulgated the Child Marriage Restraint Act prohibiting the contracting of marriage for girls under 18. The Child Marriage Restraint Act, Act No. 19 of 1929.
- 72 See WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES – ANGLOPHONE AFRICA, *supra* note 33, at 172; THE CENTER FOR REPRODUCTIVE RIGHTS AND DEMUS, ESTUDIO PARA LA DEFENSA DE LOS DERECHOS DE LA MUJER, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES – LATIN AMERICA & THE CARIBBEAN 205-06 (1997); STATE OF WORLD POPULATION 1997, *supra* note 22, at 40.
- 73 WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES – ANGLOPHONE AFRICA, *supra* note 33, at 172.
- 74 Concluding observations of the 15th Session of the United Nations Committee on the Rights of the Child: Algeria, ¶20. June 18, 1997. UN Doc CRC/C/15/Add.76 (website visited August 13, 1999) <<http://www.unhchr.ch>>.
- 75 Concluding observations of the 14th Session of the United Nations Committee on the Rights of the Child: Panama, ¶10. January 24, 1997. UN Doc CRC/C/15/Add.68. (website visited August 13, 1999) <<http://www.unhchr.ch>>.
- 76 Concluding observations of the 19th Session of the United Nations Committee on the Rights of the Child: Kuwait, ¶28. October 26, 1998. UN Doc CRC/C/15/Add.96. (website visited August 16, 1999) <<http://www.unhchr.ch>>.
- 77 Burkina Faso, Law No. 43/96/ADP, art. 376.
- 78 Burkina Faso, Code Penal, Preface (1997).
- 79 Law No. 43/96/ADP, *supra* note 77, art. 376.
- 80 *Id.* A minor is defined as a person under 20 years. There are three instances in which a minor can be legally emancipated – at marriage, at age 16 if she is financially independent and upon the request of a parent or court-appointed guardian, or at age 18 at the request of a court-appointed family council. However, in the latter two cases, the emancipation does not apply to marriage. Burkina Faso, Code des Personnes et de la Famille, arts. 554, 622-24, 626.
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- 90 INTO A NEW WORLD, *supra* note 15, at 24.
- 91 Although it is linked to other previously-recognized human rights, the human right to determine the number, timing and spacing of one's children was first articulated at the U.N. International Conference on Human Rights in Teheran. The Convention on the Elimination of All Forms of Discrimination Against Women requires governments to ensure the right to “decide freely and responsibly on the number and spacing of ... children and to have access to the information, education and means to exercise these rights.” Convention on the Elimination of All Forms of Discrimination Against Women, art. 16.1, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 (*entry into force*

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- Sept. 3, 1981) [hereinafter Women's Convention].
- 92 Children's Convention, art. 24(2)(f).
- 93 *Id.*, arts. 12 and 16.
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- 96 *Id.*, art. 19(1) and 34.
- 97 World Health Day, 7 April 1998, Delay Childbearing, (viewed on Apr. 30, 1998) <<http://who.ch/whday/1998/whd98-04.html>>.
- 98 Adolescent Reproductive Health in Sub-Saharan Africa, *supra* note 89.
- 99 INTO A NEW WORLD, *supra* note 15, at 26.
- 100 *Id.*
- 101 *Id.*, at 28
- 102 *Id.*
- 103 *Id.*, at 31.
- 104 Concluding observations of the 13th Session of the United Nations Committee on the Rights of the Child: Uruguay, ¶¶12 and 22. October 11, 1996. UN Doc CRC/C/15/Add.62. (website visited August 20, 1999), <<http://www.unhchr.ch>>.
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- 106 United States, Public Health Service Act, 42 U.S.C. §§ 300 et seq., Pub. L. No. 91-572, § 2, 84 Stat. 1506 (1970).
- 107 *Id.*, at § 2(1).
- 108 Family planning services under Title X do not include pregnancy care such as obstetric or prenatal care, or abortion services. United States, 42 C.F.R. § 59.2 (1982).
- 109 United States, 42 C.F.R. § 59.15 (1982); United States, 42 C.F.R. § 59.5 (1982).
- 110 United States, H.R. Rep. No. 1191, 95th Cong., 2d. Sess. 31 (1978).
- 111 United States, 42 U.S.C. § 300(a).
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- 114 SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS, *supra* note 3, at 5.
- 115 JUDITH SENDEROWITZ, WORLD BANK DISCUSSION PAPERS, ADOLESCENT HEALTH: REASSESSING THE PASSAGE TO ADULTHOOD 16 (1995) [hereinafter REASSESSING THE PASSAGE TO ADULTHOOD].
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- 118 *Id.*
- 119 Safe Motherhood Factsheet: Address Unsafe Abortion, at 2 (1998), *citing* WORLD HEALTH ORGANIZATION, THE HEALTH OF YOUNG PEOPLE: A CHALLENGE AND A PROMISE (1993).
- 120 *Id.*
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- 123 *Id.*, art. 2(1).
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- 137 Within six months of the new law, at the major public hospital there was a 41% drop in admissions for septic and incomplete abortions and, in 1996, a 35% decrease as compared to the previous year in the volume of blood needed to treat complications of abortion. Yvette M. Delph, *supra* note 135, at 3.
- 138 Termination of pregnancy is defined in Section 1 of the MTPA to mean "termination of human pregnancy with an intention other than to produce a live birth." Act No. 7 of Guyana.
- 139 For the purposes of the MTPA the duration of a pregnancy is determined "by calculating from the first day of the last normal menstruation of the pregnant woman and ending on the last day of the relevant week." *Id.*
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- 141 *Id.*, at §§ (1)(c), 6 (1) and (2).
- 142 *Id.*, at § 6(1).
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