

# THE REPRODUCTIVE RIGHTS OF ADOLESCENTS:

## A Tool for Health and Empowerment

“At the most basic level, all young people have the right to education, health and safety. If they are given information, choices and opportunities, they will live healthier and more productive lives.”

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*UN Under-Secretary General*<sup>1</sup>

## Table of Contents

### Part I

Introduction	3
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### Part II

Framing Advocacy: Respect, Protect, and Fulfill Adolescents' Reproductive Rights	4
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### Part III

Core Challenges	5
<b>Ensuring Informed Decision-Making</b>	5
Information: Comprehensive Sexuality Education	5
Access to Confidential and Adolescent-Friendly Services	7
<b>Ensuring Protection for Reproductive Rights and Autonomy</b>	9
Child Marriage and Education	9
Sexual Violence and the Threat of Violence with Impunity	11
Female Genital Mutilation	12

### Part IV

Recommendations	15
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## The Reproductive Rights of Adolescents:

### I. Introduction

Adolescents and young people comprise almost half the world's population.<sup>2</sup> They have reproductive rights, just as adults do, but their low social status, lack of autonomy, and physical vulnerability make it more difficult for them to exercise those rights. The rights violations they encounter include a lack of comprehensive sexuality education; a lack of access to confidential health care services; child marriage; sexual violence; and female genital mutilation. Governments have a duty to empower adolescents to make informed choices and to protect themselves. Governments that impose restrictions on adolescents' access to reproductive health information and services violate international human rights standards. Those that fail to implement laws and policies that protect adolescents from discrimination, violence, and child marriage also violate those standards.

Advocating for adolescents' reproductive rights can be challenging. Despite the critical health issues at stake, discussing the sexuality of young persons typically sparks controversy. A further challenge for advocates is confronting and refuting the assertion of culture as a justification and a defense for adolescents' rights violations. When adolescence intersects with other factors, such as poverty, race, and gender, it compounds the challenges young women face in exercising their basic human rights.<sup>3</sup>

#### Who Are Adolescents?

- Adolescents: *People between the ages of 10 and 19.*<sup>4</sup>
- Young people: *People between the ages of 10 and 24.*<sup>5</sup>
- *Almost half the world's population - nearly 3 billion people—is under 25.*<sup>6</sup>
- *Of that number, 2 billion are under 18.*<sup>7</sup>

This briefing paper outlines the general framework of adolescents' reproductive and sexual rights. It addresses core concerns for adolescents rights and discusses governments' legal duties to address those concerns. The areas of focus are sexuality education; access to confidential health care; child marriage and lack of educational opportunity; sexual violence; and female genital mutilation (FGM). Promoting adolescent health and autonomy should be the primary goals for advocates and lawmakers. Because adolescents do not fit within the traditional categories of child or adult, they require particular legal consideration. An effective government response includes creating and implementing laws and policies that enable adolescents to flourish and achieve their full potential.

## II. Framing Advocacy

### *Adolescent Reproductive Rights*

International law recognizes adolescence—a critical developmental stage—as a time when young women’s capacities are evolving.<sup>9</sup> Not only do adolescent women experience rapid biological change, but their emotional maturity also develops more rapidly at this time than perhaps any other time in life. International human rights law provides a framework for states’ obligations. Governments have a duty to “respect, protect, and fulfill” rights that are recognized under international law.<sup>10</sup> The duty to *respect* requires governments to refrain from taking action that directly violates rights. For example, governments should reform laws or policies that undermine adolescents’ access to information about safe sex and confidential services. The duty to *protect* requires governments to prevent or punish violations of rights by private actors, such as family or community members. This duty requires governments to implement and enforce laws that prevent abusive practices such as child marriage or FGM. State protections are necessary because many adolescents do not have the authority within family structures, experience in the workplace, or financial independence to provide for themselves. The duty to *fulfill* requires governments to adopt concrete measures and, in some cases, make expenditures that enable adolescents to exercise their rights. For example, complications from pregnancy and childbirth are the two leading causes of death for 15- to 19-year-old girls worldwide.<sup>11</sup> Governments’ duty to fulfill human rights requires them to invest in providing reproductive health care services and take affirmative measures to enable adolescents to exercise their reproductive autonomy.

### Human Rights Standards that Apply to Adolescents’ Reproductive Rights

- *The right to life, liberty, and security*<sup>12</sup>
- *The right to reproductive self-determination*<sup>13</sup>
- *The right to consent to marriage*<sup>14</sup>
- *The right to health*<sup>15</sup>
- *The right to be free from discrimination*<sup>16</sup>
- *The right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment*<sup>17</sup>
- *The right to be free from sexual violence*<sup>18</sup>
- *The right to education and information*<sup>19</sup>

### III. Core Challenges

#### Ensuring Informed Decision-Making

To make reproductive decisions, adolescents require information and access to confidential health care. The Convention on the Rights of the Child (Children’s Rights Convention), the principal treaty granting special protections to minors, recognizes the importance of adolescent autonomy. The Children’s Rights Convention acknowledges that minors have “evolving capacities” to make decisions affecting their lives<sup>20</sup> and recognizes that some minors are more mature than others depending on individual circumstances.<sup>21</sup> Furthermore, while the Children’s Rights 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,”<sup>22</sup> 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.<sup>23</sup>

The Committee on the Rights of the Child (Children’s Rights Committee), which monitors states compliance with the Children’s Rights Convention, refers to adolescence as a time of “reproductive maturation” as well as a time to develop critical thinking about reproductive choices.<sup>24</sup> The Children’s Rights Committee has repeatedly voiced concern about the “lack of sufficient health information and services for adolescents”<sup>25</sup> in its concluding observations to states parties and has frequently criticized governments for failing to promote education about family planning for adolescents.<sup>26</sup> The Committee on the Elimination of Discrimination against Women (CEDAW Committee) also encourages states parties to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) “to address the issue of a woman’s health throughout the woman’s lifespan,” understanding that “women includes girls and adolescents.”<sup>27</sup>

#### *Information: Comprehensive Sexuality Education*

Providing adolescents with information is the first step toward allowing them to make meaningful choices. To protect themselves from unwanted pregnancy and sexually transmissible infections (STIs), including the human immunodeficiency virus (HIV), adolescents need comprehensive sexuality education.<sup>28</sup> Without complete information, adolescents’ rights to health and reproductive self-determination are significantly compromised.

The Children's Rights Committee recommends the following to all countries:

Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours.<sup>29</sup>

The Children's Rights Committee frequently recommends to countries that they improve adolescent reproductive health care education policies.<sup>30</sup> The CEDAW Committee also comments on the importance of comprehensive sexuality education, especially with regard to preventing the spread of HIV/AIDS.<sup>31</sup> For example, the CEDAW Committee recommends the following:

States parties [should] intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them ...[and] give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection.<sup>32</sup>

“Sexuality education” refers to educational goals that are broader than simply biology. At minimum, sexuality education should include information about anatomy and physiology, puberty, pregnancy, and STIs, including HIV/AIDS.<sup>33</sup> However, it should also address the relationships and emotions involved in sexual experience.<sup>34</sup> It approaches sexuality as a natural, integral, and positive part of life, and covers all aspects of becoming and being a sexual person.<sup>35</sup> It should promote gender equality, self-esteem, and respect for the rights of others.<sup>36</sup> One goal of sexuality education is to help young people develop autonomy using skills such as communication, decision-making, and negotiation.<sup>37</sup> Learning to be responsible for one's health and choices promotes a successful transition to adulthood in good sexual health.<sup>38</sup>

Opponents of comprehensive sexuality education typically argue that providing adolescents with information about sex encourages them to engage in it.<sup>39</sup> This proposition has been proven false in a number of studies.<sup>40</sup> These opponents promote a policy commonly called “abstinence-only” education, which does not teach how pregnancy occurs or how STIs are spread, but instead teaches that unmarried people should simply abstain from sex.<sup>41</sup> Often messages of abstinence are accompanied by lessons promoting stereotypical gender roles that reinforce girls' subordinate status.<sup>42</sup>

## The Reproductive Rights of Adolescents:

There are several problems with this approach. First, it violates women's right to reproductive self-determination. Whether married or not, all women have a right to information that will help them plan the number and spacing of their children and protect themselves from STIs. Given the reality that many unmarried adolescents are sexually active, denying them comprehensive sexuality education poses a real threat to their health and lives.<sup>43</sup> Second, the approach violates the right to life, liberty, and security of married adolescents because it does not address the risk of exposure that they have to HIV and other STIs when their spouses have more than one sexual partner.<sup>44</sup> By not acknowledging premarital sex and sex outside of marriage, abstinence-only policies leave women unable to protect themselves against diseases. Finally, the messages of gender inequality often incorporated into abstinence-only curricula violate girls' right to equality and nondiscrimination.

Sexuality education should reach all individuals, including the most vulnerable sectors of a population. To achieve this goal, sexuality education should not just be a school-based service, because in many countries most young people (especially girls) have left school by the age of 15, and many are married between the ages of 15 and 19.<sup>45</sup> Thus, it is imperative that sexuality education not only begin at the earliest stages in school, but that governments initiate programs to reach the large number of young people outside the school system.<sup>46</sup> Parents, community organizations, religious groups, friends, peers, and health care delivery centers can, with proper training, become part of this effort.<sup>47</sup>

### *Access to Confidential and Adolescent-Friendly Services*

Adolescents need reproductive health care services from specially trained providers who offer confidentiality and adolescent-friendly services. Access to such services is important to (1) prevent unwanted pregnancy; (2) prevent unsafe abortions; and (3) reduce the spread of STIs, including HIV/AIDS. Adolescents' rights to life, health and privacy entitle them to have access to confidential and adolescent-friendly services.<sup>48</sup>

International treaty monitoring bodies routinely comment on the importance of access to confidential reproductive health services.<sup>49</sup> The Children's Rights Committee,<sup>50</sup> the CEDAW Committee,<sup>51</sup> and the Human Rights Committee<sup>52</sup> all agree that access to services is critical.<sup>53</sup> The Children's Rights Committee has asserted time and again that adolescents must have access to confidential health care.<sup>54</sup> The Children's Rights Committee recently interpreted Article 16 of the Convention on the Rights of Child, which protects adolescent privacy, as follows:

In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters. Health care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention.

Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.<sup>55</sup>

Open engagement with health care providers fosters an adolescent girl's self-determination regarding her reproductive life and health. Armed with information, counseled within a secure, confidential environment, she can determine for herself the course of action that best serves her.<sup>56</sup> Failure to ensure confidentiality, therefore, constitutes a barrier to comprehensive reproductive health care. Adolescents may be deterred from seeking sexual and reproductive health care if they believe that their parents may learn that they are—or are considering becoming—sexually active.<sup>57</sup> International bodies are aware that requiring parental involvement in adolescents' reproductive health care decisions impedes access to necessary services. For example, the Children's Rights Committee has strongly advocated that adolescent reproductive health services be available without parental consent<sup>58</sup> and the CEDAW Committee has asked states parties to eliminate parental consent for contraception.<sup>59</sup>

Adolescent-friendly care is nonjudgmental. Many adolescents are concerned about stigma or shame culturally associated with sexual activity, pregnancy, and STIs.<sup>60</sup> This stigma not only makes it difficult for adolescents to find nonjudgmental medical advice and guidance,<sup>61</sup> but it also makes them less willing to seek counseling and care.<sup>62</sup> Providers can and should be specially trained to work directly with adolescents and provide information about how to protect adolescents' health without judging their choices.<sup>63</sup>

### Adolescent Health Care in Crisis

- *Girls aged 10 to 14 are five times more likely to die in pregnancy or child birth than women aged 20 to 24; girls aged 15 to 19 are twice as likely to die.*<sup>64</sup>
- *One-third of all women living with HIV are between the ages of 15 and 24.*<sup>65</sup>
- *The United Nations estimates that every 14 seconds, a young person is infected with HIV/AIDS. At this rate, 6,000 youth are newly infected every day.*<sup>66</sup>
- *4.4 million women aged 15 to 19 undergo unsafe abortions annually.*<sup>67</sup>



## The Reproductive Rights of Adolescents:

### Ensuring Protection for Reproductive Rights and Autonomy

Many adolescents face violence and coercion within their families and communities—abuses that make it impossible to exercise their basic rights to informed decision-making. Because adolescence is a vulnerable stage of transition out of childhood, adolescents require added protections against coercion or mistreatment by third parties such as family members, community members, or even private medical practitioners. State protections enable adolescents to exercise their reproductive rights with autonomy. Governments have affirmative duties to safeguard adolescents' rights during the period of transition from childhood to adulthood.

#### *Child Marriage: Robbing Girls of Opportunity and Autonomy*

Child marriage violates the rights to life, liberty, self-determination, and health. Child marriage has been defined as “any marriage carried out below the age of 18 years, before the girl is physically, physiologically, and psychologically ready to shoulder the responsibilities of marriage and childbearing.”<sup>68</sup> In practice, many girls as young as ten years old are married to men who are much older than they.<sup>69</sup> These marriages are often not even registered in state marriage registries, making the extent of the practice difficult to document. Child marriages result in violations of adolescents' right to make decisions regarding their sexuality and reproductive lives. Once married, adolescents are trapped in a situation that threatens them physically—by forced sex, early and frequent pregnancies, and, in many cases, exposure to HIV/AIDS.

International standards firmly oppose child marriage. The International Covenant on Economic, Social, and Cultural Rights, echoing the Universal Declaration of Human Rights, declares that “[m]arriage must be entered into with the free consent of the intending spouses.”<sup>70</sup> The Committee on Economic, Social, and Cultural Rights condemns the practice.<sup>71</sup> The CEDAW Committee routinely condemns child marriage.<sup>72</sup> It recommends public awareness campaigns to change local attitudes<sup>73</sup> and makes policy recommendations, such as the implementation of a marriage registry system to combat the practice.<sup>74</sup> The Children's Rights Convention explicitly requires states parties to “take measures to abolish traditional practices that are harmful to children's health.”<sup>75</sup> The Children's Rights Committee calls child marriage a harmful practice and a form of gender discrimination.<sup>76</sup> The Human Rights Committee has expressed concern over the practice<sup>77</sup> and recommends, among other measures, legal reform to eliminate it.<sup>78</sup>

Child marriage limits adolescents' control over their reproductive and sexual lives, thereby severely compromising their rights. Forcing a young girl into marriage interrupts her education and social development.<sup>79</sup> Child brides are either not enrolled in school, or pulled out and never return. For example, in Guatemala, of the one-fifth of girls aged 15 to 19 who are married, only 2% are enrolled in school, compared with 40% of unmarried girls of the same age.<sup>80</sup> Without education, a girl's chances of leading an autonomous life and becoming financially self-sufficient are severely hindered.<sup>81</sup>

There are other detrimental effects of interrupted education.<sup>82</sup> A joint report by UNFPA, UNAIDS, and UNIFEM found that women with more education are more likely to make use of reproductive health services, less likely to be subjected to FGM, and more likely to exercise sexual decision-making power regarding family planning and contraception usage.<sup>83</sup> Child mothers without education are more likely to have children with low literacy rates and low educational success rates.<sup>84</sup> These trends perpetuate a cycle of poverty.

At least two powerful forces encourage child marriage: economic incentives and local custom.<sup>85</sup> Economic necessity is cited as a reason for child marriage—which happens almost exclusively in low-income countries, particularly in rural areas.<sup>86</sup> In South Asia generally, 48% of 15 - to 24 - year - olds were married before they reached the age of 18.<sup>87</sup> But if one examines a particular rural, poor area like Bihar, India, the percentage leaps to 71%.<sup>88</sup> Young girls are either sold into marriage because their families cannot support them, or bought as brides so that their husbands and their families can benefit from their labor. Investing in adolescent girls' education and autonomy is viewed as a lost investment because the girl leaves her parents' home to join her husband's, so her economic contributions are to that home.<sup>89</sup> Therefore, many parents betroth their daughters as early as infancy.<sup>90</sup> Some experts even note that dowry rates are lower when the girl is married young,<sup>91</sup> suggesting that the older a girl becomes, the more costly it is for a family to shift her into another household.

### Child Marriage

- *Eighty-two million girls ages 10 to 17 in low income countries marry before their 18th birthday.*<sup>92</sup>
- *It is estimated that one third of girls in the developing world are married before the age of 18.*<sup>93</sup>
- *In Africa, 42% of girls marry before the age of 18.*<sup>94</sup>
- *In East and West Africa, this number is 60%<sup>95</sup> and in regions such as northern Nigeria, it rises to 73%.*<sup>96</sup>

## The Reproductive Rights of Adolescents:

The strong incentives to send young adolescent girls into marriage make the case for government intervention all the more compelling. Governments should adopt laws prohibiting child marriage as well as take measures to counter the economic incentives for continuing the practice. To address cultural norms that support child marriage, governments and non-governmental organizations should engage in outreach campaigns to raise awareness of the rights and health consequences of child marriage. At the same time, broad measures to promote girls' status—for example, measures to keep girls in school—are essential to the success of any strategy to stop child marriage.

### *Sexual Violence and the Threat of Violence with Impunity*

Violence against women is one of the most brutal consequences of the economic, social, political, and cultural inequalities that exist between men and women. It is also perpetuated by legal and political systems that have historically discriminated against women, because the pervasive political and cultural subordination resulting from these systems create a climate in which women are especially vulnerable to violence. When these gender-based inequities are compounded by the vulnerabilities of youth, the problem of violence becomes further entrenched. The Beijing Declaration and Platform for Action defines “violence against women” as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.”<sup>97</sup> Without a doubt, violence directly interferes with adolescents' human rights to security, liberty, and physical integrity.

Article 9 of the International Covenant on Civil and Political Rights protects the right of individuals to liberty and personal security. International treaty monitoring bodies routinely comment on the importance of eradicating violence against women and girls.<sup>98</sup> The Children's Rights Convention states:

States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse...<sup>99</sup>

The CEDAW Committee's General Recommendation 12 also instructs state parties to adopt legislation that protects women from “all kinds of violence in everyday life...including sexual violence, abuses in the family, [and] sexual harassment at the workplace ...”<sup>100</sup>

Adolescents are particularly vulnerable to violence in both the public and private spheres. Institutions and environments that should nurture and foster adolescents' independence - such as schools, clinics, the workplace, and the home, often become traps where violence cannot be avoided.<sup>101</sup> For example, the Inter-American Commission presided over the case of a 19-year-

old, rural Peruvian woman who went alone to a hospital to seek treatment for head and body pains she had been suffering since a traffic accident three months prior. The doctor led her into his private office, where he administered anesthesia to make her unconscious and then raped her.<sup>102</sup> In a landmark settlement, the Peruvian government agreed to pay the young woman reparations, report the doctor for professional disciplinary proceedings, and establish a commission to ensure rights protections in public health facilities.<sup>103</sup> However, the abuses experienced by the woman in this case are not unique. The power differential in the provider-client relationship can facilitate abuse. Women seeking reproductive health care or counseling in clinics have suffered rape, humiliating verbal abuse, and violations of their reproductive autonomy, including their right to give informed consent.<sup>104</sup> The patients' lack of knowledge about appropriate examination procedures and their legal rights also helps perpetuate the acts of violence. In addition, providers often have access to social and institutional networks, allowing them to conceal their behavior, secure legal defense, and exert pressure on the women who report them.<sup>105</sup>

Schools are institutions where adolescent women should be able to learn, grow, and develop their autonomy. Instead, school corridors and classrooms often become traps of violence and abuse. Latin American girls have attested that sexual violence is present in schools.<sup>106</sup> Studies show that educational environments are the principal settings for sexual violence in Ecuador, with 22% of female students reporting sexual abuse<sup>107</sup> and 36% reporting their male teachers as the aggressors.<sup>108</sup> The case of Paola Guzmán, a student in Ecuador, is an example. Paola was a 16-year-old who had been sexually abused by her school's vice-principal for two years and committed suicide after learning of her pregnancy.<sup>109</sup> Paola's rights to life, personal integrity, personal security, freedom from violence, and nondiscrimination were violated. Her case has been brought before the Inter-American Commission.<sup>110</sup> The pattern of violence in schools repeats itself all over the world. For example, a report has documented that in South African schools, girls are raped, sexually assaulted and sexually harassed by their male classmates and teachers in restrooms, empty classrooms, hallways, and dormitories.<sup>111</sup> Variations on these events happen throughout the world, especially where laws and policies do not recognize, target, and punish such violence.

#### *Female Genital Mutilation (FGM)*

While FGM can be performed as early as infancy or well into adulthood, girls most commonly undergo the procedure between four and twelve years of age, and in many places it has

## The Reproductive Rights of Adolescents:

been considered a rite of passage into adulthood.<sup>112</sup> FGM is prevalent in about 28 African countries, parts of Yemen, and among some minority groups in Asia.<sup>113</sup> Prevalence varies significantly from one country to another. In addition, there are many immigrant women in Europe, Canada, and the United States who have undergone FGM.<sup>114</sup>

FGM is a cultural practice that girls are usually subjected to when they are too young to protest and too dependent—financially and socially—on their families to have any escape. The World Health Organization defines FGM as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.”<sup>115</sup> Although there are variations of FGM,<sup>116</sup> the majority of reported cases involve at least partial excision of the clitoris and the labia minora.<sup>117</sup> An estimated 130 million women worldwide have undergone FGM, with an additional 3 million girls and women undergoing the procedure every year.<sup>118</sup>

Subjecting girls and women to FGM violates a number of rights protected in international and regional instruments, including the right to be free from all forms of gender discrimination,<sup>119</sup> the rights to life<sup>120</sup> and to physical integrity,<sup>121</sup> and the right to health.<sup>122</sup> FGM is a form of gender discrimination because it is aimed primarily at controlling women’s sexuality and assigning them a subordinate role in society. In addition, FGM compromises the recognition and enjoyment of women’s other fundamental rights and liberties. FGM violates the right to life in the rare cases in which death results from the procedure. Acts of violence that threaten a person’s safety, such as FGM, violate a person’s right to physical integrity. Also implicit in the principle of physical integrity is the right to make independent decisions in matters affecting one’s own body. An unauthorized invasion of a person’s body represents a disregard for that fundamental right. Finally, because complications associated with FGM often have severe consequences for a woman’s physical and mental health, the practice violates women’s right to health. But even in the absence of complications, where FGM results in the unnecessary removal of healthy tissue, a woman’s right to the “highest attainable standard of physical and mental health” has been compromised.<sup>123</sup>

International treaties directly condemn the practice of FGM. The Children’s Rights Convention<sup>124</sup> and other treaties, such as CEDAW<sup>125</sup> and the African Charter on the Rights and Welfare of the Child,<sup>126</sup> all condemn practices that threaten the health and rights of women and girl children. Female genital mutilation is addressed most explicitly in Article 5 of the 2003 Protocol to the African Charter on the Rights of Women in Africa, which reads:

States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards... [and] shall take all necessary legislative and other measures to eliminate such practices, including: creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes; prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them; provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counseling as well as vocational training to make them self-supporting; protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.<sup>127</sup>

In addition to international condemnation, many countries have passed national laws that criminalize FGM. Eighteen African countries have enacted laws criminalizing the practice.<sup>128</sup> The penalties range from a minimum of six months to a maximum of life in prison. Several countries also impose monetary fines. There have been reports of prosecutions or arrests in cases involving FGM in several African countries.<sup>129</sup> Twelve high-income countries that receive immigrants from countries where FGM is practiced have passed laws criminalizing it.<sup>130</sup> In the United States, the federal government and 17 states have done so. One country—France—has relied on existing criminal legislation to prosecute both practitioners of FGM and parents procuring the service for their daughters.<sup>131</sup>

The international community and many national governments have condemned FGM on paper. The charge to advocates is to use public awareness and legal challenges to stop the practice. Advocates can push governments to criminalize FGM. They can also pressure national governments to adopt laws that deter FGM, such as professional sanctions against medical providers who practice FGM. National governments should fund education programs about the rights implications and health effects of FGM and also provide health care resources for the treatment of complications from FGM.

## IV. Recommendations

Governments, non-governmental organizations, and individual advocates and health care providers all play a role in ensuring adolescents' reproductive health and well-being. Though the primary responsibility for respecting, protecting, and fulfilling adolescents' human rights lies with national governments, the international community must hold governments accountable

## The Reproductive Rights of Adolescents:

to broadly accepted human rights standards. These recommendations, which call for both access to services and protection from abuse, are aimed at ensuring adolescents' ability to make and act on informed reproductive decisions.

A number of legal and policy approaches should be taken to guarantee the right to security, the right to liberty, the right to be free from sexual violence and exploitation, and the right to health care. These recommendations include greater enforcement of existing international legal protections.

### FOR GOVERNMENTS

#### **Ensure adolescents' access to needed health care services and education.**

This requires governments to allocate resources to youth-friendly clinics that offer comprehensive and confidential reproductive health care. In addition, they should provide financial and political support to comprehensive sex-education campaigns.

#### **Adopt and enforce legal measures and employ outreach strategies to protect adolescents' rights.**

Governments should adopt legislation to ban child marriage and FGM and engage in public education campaigns and other activities to discourage these practices. They should explicitly criminalize sexual harassment and abuse in institutions meant to empower adolescents, such as schools, legal clinics, and the domestic arena.

#### **Empower married and pregnant adolescents.**

Ensure married adolescents' access to educational and job training opportunities.  
Prohibit the expulsion of pregnant adolescents from school.

#### **Raise public awareness of adolescents' rights.**

Adopt policies reflecting the government's recognition of the rights of adolescents in the area of sexual and reproductive health. Engage in public education campaigns to raise awareness of adolescents' rights and foster sensitivity to the reproductive health concerns of adolescents.

## FOR ADVOCATES

### **Utilize international human rights instruments to build and strengthen legal standards that recognize and safeguard adolescents' rights.**

Use international instruments to encourage governments to respect, protect, and fulfill adolescents' reproductive rights and to seek accountability for violations. To this end, submit shadow reports to U.N. treaty monitoring bodies and send communications to U.N. and regional special rapporteurs covering issues of health and violence against women and girls. Bring cases on behalf of individual victims of rights violations to national, regional, and U.N. human rights accountability bodies.

### **Apply political pressure to governments that lack the legal framework and enforcement capacity to protect adolescents from violence, child marriage, and female genital mutilation.**

In all regional and international human rights norm-setting conferences, emphasize reproductive health of adolescents as a key human rights concern.

## FOR HEALTH CARE PROVIDERS

### **Ensure that health facilities are youth-friendly and provide confidential, comprehensive services.**

Facilities should be staffed with specially trained health care providers who can listen without judgment and empower adolescents to make safe choices regarding their reproductive health. Providers should be trained to understand adolescents' reproductive rights and their capacity to make health care decisions.

### **Provide adolescents who seek reproductive health care with information about their rights as patients.**

For example, adolescents should be made aware of their right to give informed consent and should know about administrative and legal remedies available to them should they experience violations of their rights.

### **Provide adolescents with comprehensive information regarding pregnancy and the transmission of STIs.**

**Censure health care providers who perform FGM.**

**Ensure that providers are able to offer care to address complications of FGM.**



## ENDNOTES

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## The Reproductive Rights of Adolescents:

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## The Reproductive Rights of Adolescents:

90. *Id.*
91. *Id.*
92. UNFPA, ENDING CHILD MARRIAGE, *supra* note 88, at 10.
93. POPULATION COUNCIL, TRANSITIONS TO ADULTHOOD, <http://www.popcouncil.org/ta/mar.html> (last visited Sept. 28, 2007).
94. UNICEF, EARLY MARRIAGE 4, *supra* note 85.
95. *Id.*
96. UNFPA, ENDING CHILD MARRIAGE, *supra* note 88, at 10.
97. *Beijing Declaration*, *supra* note 12, para. 114.
98. CEDAW, *supra* note 13, arts. 5, 8; Children's Rights Convention, *supra* note 9, arts. 19, 34, 39; Civil and Political Rights Covenant, *supra* note 12, arts. 6, 7, 9; Economic, Social, and Cultural Rights Covenant, *supra* note 14, art. 12; Convention against Racial Discrimination, *supra* note 15, arts. 5(b), 5(e); Convention against Torture, *supra* note 17, arts. 1, 3.
99. Children's Rights Convention, *supra* note 9, art. 19.
100. CEDAW Committee, *General Recommendation 12: Violence against women*, U.N. Doc. A/44/38 at 75 (1990).
101. *See generally* CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS IN THE INTER-AMERICAN SYSTEM FOR THE PROMOTION AND PROTECTION OF HUMAN RIGHTS, *available at* [http://www.reproductiverights.org/pdf/pub\\_bp\\_rr\\_interamerican.pdf](http://www.reproductiverights.org/pdf/pub_bp_rr_interamerican.pdf); HUMAN RIGHTS WATCH, SCARED AT SCHOOL: SEXUAL VIOLENCE AGAINST GIRLS IN SOUTH AFRICAN SCHOOLS (2001), *available at* <http://www.hrw.org/reports/2001/safrica/>.
102. *See, e.g.*, CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS IN THE INTER-AMERICAN SYSTEM, *supra* note 101, at 12.
103. *Id.*
104. *Id.*; *see also*, CENTER FOR REPRODUCTIVE RIGHTS & FEDERATION OF WOMEN LAWYERS – KENYA, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 37 (2007).
105. CENTER FOR REPRODUCTIVE RIGHTS, SILENCE AND COMPLICITY: VIOLENCE AGAINST WOMEN IN PERUVIAN HEALTH FACILITIES 57 (1999).
106. UN SECRETARY GENERAL, OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS (OHCHR), UNICEF, and WHO, VIOLENCE AT SCHOOL AND IN EDUCATIONAL ENVIRONMENTS, REPORT OF THE REGIONAL SECRETARIAT FOR THE STUDY OF LATIN AMERICA, CUBA AND THE DOMINICAN REPUBLIC IN THE CARIBBEAN, A DESK REVIEW 33 (2005).
107. SHAWNA TROPP & MARY ELLSBERG, ADDRESSING VIOLENCE AGAINST WOMEN WITHIN THE EDUCATION SECTOR 2, prepared for the World Bank's Gender and Development Group, PREM (2005).
108. COMITÉ DE AMERICA LATINA Y EL CARIBE PARA LA DEFENSA DE LOS DERECHOS DE LA MUJER- ECUADOR, ET AL., INFORME SOMBRA: UNA MIRADA ALTERNATIVA A LA SITUACION DE DISCRIMINACION DE LA MUJER EN ECUADOR 7 (1998).
109. *See, e.g.*, Paola Guzmán, Inter.-Am. C.H.R, Petition No. 1055-06. (filed Oct. 13, 2006), description *available at* [http://www.reproductiverights.org/crt\\_violence.html#ecuador](http://www.reproductiverights.org/crt_violence.html#ecuador).
110. *Id.*
111. HUMAN RIGHTS WATCH, SCARED AT SCHOOL, *supra* note 101, at 49.
112. ANIKA RAHMAN & NAHID TOUBIA, FEMALE GENITAL MUTILATION: A GUIDE TO LAWS AND POLICIES WORLDWIDE 5 (2000).
113. UNICEF, INNOCENTI DIGEST, CHANGING A HARMFUL SOCIAL CONVENTION: FEMALE GENITAL MUTILATION /CUTTING 3 (2005).
114. CENTER FOR REPRODUCTIVE RIGHTS, FEMALE GENITAL MUTILATION (FGM): LEGAL

- PROHIBITIONS WORLDWIDE (2007), *available at* [http://www.reproductiverights.org/pdf/pub\\_fac\\_fgm\\_0307.pdf](http://www.reproductiverights.org/pdf/pub_fac_fgm_0307.pdf).
115. OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, ELIMINATING FEMALE GENITAL MUTILATION: AN INTERAGENCY STATEMENT 4 (2008), *available at* [http://www.who.int/reproductive-health/publications/fgm/fgm\\_statement\\_2008.pdf](http://www.who.int/reproductive-health/publications/fgm/fgm_statement_2008.pdf).
  116. The World Health organization classifies the various forms of female genital mutilation as follows: “Type I - excision of the prepuce, with or without excision of part or all of the clitoris; Type II - excision of the clitoris with partial or total excision of the labia minora; Type III - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation); Type IV - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue, scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts), introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it, and any other procedure that falls under the definition given above.” *See id* at 23.
  117. UNFPA, *Frequently Asked Questions on Female Genital Mutilation/Cutting*, <http://www.unfpa.org/gender/practices2.htm#3> (last visited July 16, 2008).
  118. UNICEF, INNOCENTI DIGEST, *supra* note 113, at vii, 1.
  119. CEDAW, *supra* note 13, art. 1.
  120. Civil and Political Rights Covenant, *supra* note 12, art. 6.
  121. Civil and Political Rights Covenant, *supra* note 12, art. 9; African Charter on Human and Peoples’ Rights, *adopted* June 27, 1981, art. 6, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M.58 (1982) (*entered into force* Oct. 21, 1986) [hereinafter Banjul Charter].
  122. Economic, Social, and Cultural Rights Covenant, *supra* note 14, art. 12; Children’s Rights Convention, *supra* note 9, art. 24.
  123. For a longer analysis of the rights violations inherent to the practice of female genital mutilation, see CENTER FOR REPRODUCTIVE RIGHTS, FEMALE GENITAL MUTILATION, A MATTER OF HUMAN RIGHTS: AN ADVOCATE’S GUIDE TO ACTION 11-16 (2006).
  124. *See* Children’s Rights Convention, *supra* note 9, art. 24.3, condemning harmful cultural practices; *see also* Committee on the Rights of the Child, *Concluding Observations: Central African Republic*, paras. 58-59, U.N. Doc. CRC/C/15/Add.138 (2000); Committee on the Rights of the Child, *Concluding Observations: Côte d’Ivoire*, para. 6, 44-45, U.N. Doc. CRC/C/15/Add.155 (2001); Committee on the Rights of the Child, *Concluding Observations: Democratic Republic of the Congo*, paras. 56-57, U.N. Doc. CRC/C/15/Add.153 (2001); Committee on the Rights of the Child, *Concluding Observations: Djibouti*, paras. 43-44, U.N. Doc. CRC/C/15/Add.131(2000); Committee on the Rights of the Child, *Concluding Observations: Egypt*, paras. 45-46, U.N. Doc. CRC/C/15/Add.145 (2001); Committee on the Rights of the Child, *Concluding Observations: Ethiopia*, paras. 14-15, 64-65, U.N. Doc. CRC/C/15/Add.144 (2001); Committee on the Rights of the Child, *Concluding Observations: Guinea*, para. 26, U.N. Doc. CRC/C/15/Add.100 (1999); Committee on the Rights of the Child, *Concluding Observations: Lesotho*, paras. 47-48, U.N. Doc. CRC/C/15/Add.147 (2001); Committee on the Rights of the Child, *Concluding Observations: Sierra Leone*, paras. 61-62, U.N. Doc. CRC/C/15/Add.116 (2000); Committee on the Rights of the Child, *Concluding Observations: South Africa*, para. 33, U.N. Doc. CRC/C/15/Add.122 (2000).
  125. CEDAW Committee, *General Recommendation 14: Female circumcision*, U.N. Doc. A/45/38 at 80 (1990); *see also* CEDAW Committee, *Concluding Observations: Burkina Faso*, para. 261, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations: Cameroon*, paras. 53-54, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*,



## The Reproductive Rights of Adolescents:

- para. 215, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations: Netherlands*, para. 207, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations: Senegal*, para. 721, U.N. Doc. A/49/38 (1994).
126. African Charter on the Rights and Welfare of the Child, art. 21, O.A.U. Doc. CAB/LEG/24.9/49 (1990) (*entered into force* Nov. 29, 1999).
127. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, art. 5, *adopted* July 11, 2003, 2<sup>nd</sup> African Union Assembly, Maputo, Mozambique.
128. Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, Senegal, South Africa, Tanzania, and Togo. *See* CENTER FOR REPRODUCTIVE RIGHTS, FEMALE GENITAL MUTILATION: LEGAL PROHIBITIONS WORLDWIDE, *supra* note 114.
129. *Id.*
130. Australia, Belgium, Canada, Cyprus, Denmark, Italy, New Zealand, Norway, Spain, Sweden, United Kingdom, and United States. *See* CENTER FOR REPRODUCTIVE RIGHTS, FEMALE GENITAL MUTILATION: LEGAL PROHIBITIONS WORLDWIDE, *supra* note 114.
131. CENTER FOR REPRODUCTIVE RIGHTS, FEMALE GENITAL MUTILATION: LEGAL PROHIBITIONS WORLDWIDE, *supra* note 114.