

Independent submission to the
Committee on the Rights of the Child
on the consideration of the combined 5th and 6th periodic reports
of the Government of the Philippines

NGO alternative report on the status of adolescents' reproductive rights in the Philippines

For the adoption of the list of issues
in the Committee's 87th session on June 1-5, 2020

Respectfully submitted on

1 March 2020

by

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REPRODUCTIVE
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1. The undersigned coalition of civil society groups submits supplemental information for the upcoming adoption of the list of issues (LOI) for the Republic of the Philippines (state party) by the Committee on the Rights of the Child (the Committee). We hope to further the work of the Committee by providing independent information on the status of adolescents' reproductive rights since the Committee's last periodic review of the state party in 2009 concerning the status of the implementation of obligations under the Convention on the Rights of the Child (the Convention).¹

I. Overview of international human right standards on adolescents' reproductive rights

1. The Committee has been at the forefront of establishing international human rights norms on the importance of providing adolescents access to sexual and reproductive health services. The Committee has urged states to "ensure that health systems and services are able to meet the specific sexual and reproductive health needs of adolescents."² In this regard, **the Committee has made clear that adolescents should have access to the full range of sexual and reproductive health services**, including maternal health care; contraceptive information and services for short- and long-term methods and emergency contraception; safe abortion services and post-abortion care; and information and services to prevent and address sexually transmissible infections.³ Further, **the Committee has urged states to "decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services."**⁴ These standards have been reinforced by other treaty monitoring bodies, such as the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), the Committee on Economic, Social and Cultural Rights (ESCR Committee), and the Human Rights Committee.⁵ For example, these bodies have called on states to ensure girls access to safe abortion services;⁶ affordable modern contraception, including emergency contraception;⁷ and proper care during pregnancy and childbirth.⁸
2. In 2016, the Committee's General Comment 20 on the rights of adolescents and the Special Rapporteur on the Right to Health's Report on Adolescents significantly bolstered the understanding of **adolescents' evolving capacities, autonomy and decision-making in the context of their sexual and reproductive health and rights.**⁹ Both of these documents call on states to put in place appropriate measures to enable adolescents to exercise their sexual and reproductive rights and fill a critical gap in the human rights framework's conceptualization of evolving capacities as it pertains to adolescents' sexuality and reproduction. Notably, the Committee recognizes that **there should not be any "barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization."**¹⁰ The Special Rapporteur on the Right to Health further recognizes parental consent and notification requirements as a barrier to health services for adolescents, as they "make adolescents reluctant to access needed services so as to avoid seeking parental consent, which may result in rejection, stigmatization, hostility or even violence."¹¹ These normative developments reinforce the CEDAW Committee's recognition that parental authorization requirements constitute a barrier to health services.¹² While it may be suitable for a healthcare provider to encourage an adolescent to consult with his or her parent or guardian, compelling an unwilling adolescent to receive parental authorization or denying him or her sexual and reproductive health services does not advance the adolescents' best interests and can expose adolescents to serious risks.
3. Adolescents' evolving capacities impact their ability to make independent decisions about their health. In General Comment 20, **the Committee has, for the first time, called on states to consider introducing a "legal presumption that adolescents are competent to seek and**

have access to preventive or time-sensitive sexual and reproductive health commodities and services.”¹³ This approach is also endorsed by the Special Rapporteur on Health.¹⁴ Therefore, when adolescents recognize the need for such services and take the initiative to seek them out, it shows that they have the capacity to make decisions about and use such services appropriately.¹⁵ Furthermore, the Committee has urged states to review their legislation in order to guarantee “the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions.”¹⁶ The Committee has further called on states to ensure that “girls can make autonomous and informed decisions on their reproductive health.”¹⁷ States have also been urged to take measures to empower adolescents to make healthy decisions about their sexuality and reproductive health, such as through the provision of comprehensive and non-discriminatory sexuality education, addressing the stigma surrounding sexuality, challenging gender stereotypes, and establishing programs for girls’ empowerment and sensitization for men and boys.¹⁸ These normative developments demonstrates the unique and critical nature of sexual and reproductive health services for adolescents and represents a shift toward recognizing that adolescents have an inherent right to make autonomous decisions about their reproductive health.

II. Positive legal and policy developments and remaining challenges in advancing adolescents’ reproductive rights

1. ***Positive legal and policy developments since 2009.*** Since the Committee’s review in 2009, the state party has enacted the Responsible Parenthood and Reproductive Health Act (RPRHA) which guarantees the right to reproductive health services including universal access to the full range of modern contraceptives and access to age- and development-appropriate reproductive health education.¹⁹ The RPRHA declares as one of its guiding principles the “respect for protection and fulfillment of reproductive health and rights which seek to promote the rights and welfare of every person particularly couples, adult individuals, women and adolescents.”²⁰ In 2016, the Philippine Commission on Human Rights (PCHR) conducted the first ever national inquiry on reproductive health and rights and, as will be further discussed below, found the state party accountable for reproductive rights violations including those affecting adolescents.²¹
2. Other positive developments since 2009 include actions from various government offices and agencies defending the constitutionality of the RPRHA against challenges by conservative religious and anti-choice groups before the Supreme Court.²² In 2017, the Food and Drug Administration also ensured women’s and girls’ access to modern contraceptives by certifying 51 contraceptive products as “non-abortifacients” and made them legally available.²³ Further, the state party included in its Ten-point Socio-Economic Agenda the strengthened implementation of the RPRHA²⁴ and issued Executive Order 12 (E.O. 12) which directed various government offices and agencies to address the unmet need for family planning, reduce the number of adolescent pregnancies, implement comprehensive sexuality education in the school curriculum, and integrate adolescent reproductive health concerns in the development agenda and strategies.²⁵ To support the implementation of E.O. 12, the Department of Health (DoH) enacted an administrative order outlining priority strategies and population groups as well as specific guidelines for the state party and civil society groups to reduce the unmet need for modern family planning services.²⁶ Finally, in the Nairobi Summit on the 25th anniversary of the International Conference on Population and Development (ICPD), the state party reiterated its commitment to, among others, “fully implement [its] sexual and reproductive health and population-related policies” and “accelerate integrated efforts to reach and optimize demographic dividend through scaling up of maternal and infant

health programs in the first one thousand days of life of the child, and accelerate demographic transition through redoubled implementation of our population and family planning program”.²⁷

3. ***Remaining challenges in advancing adolescents’ reproductive rights.*** Despite these positive legal and policy developments, there are continuing legal and practical barriers and restrictions that inhibit the realization of adolescents’ rights to equality and non-discrimination, life, to express their views, to seek, receive and impart information including reproductive health related information, to privacy, to access reproductive health services and facilities, to the highest attainable standard of health, to be free from all forms of abuse and exploitation, as well as from torture and ill-treatment guaranteed under articles 2, 4, 6, 12, 13, 16, 24, 34, and 37 of the Convention. As will be discussed, grave violations of these fundamental rights committed by the state party result from (1) **barriers to adolescents’ access to contraceptive information and services including dedicated emergency contraceptives**, (2) **restrictive laws on abortion**, and (3) **criminalization of factually consensual and non-exploitative sexual activity between adolescents**. Certain gaps, restrictions, and ambiguities in the current legal framework have prevented adolescents from fully exercising their fundamental human rights guaranteed under the Convention. As reflected below, specific laws, policies, and judicial decisions continue to harm adolescents’ capacity to consent in the context of sexual conduct or in the context of accessing sexual and reproductive health services.

III. Overview of the status of adolescents’ reproductive rights in the Philippines

1. Adolescents’ reproductive rights are guaranteed under various national laws and policies.²⁸ However, notwithstanding these legislative milestones, adolescents’ reproductive rights have yet to be fully realized. Key findings of the state party’s 2017 National Demographic and Health Survey (NDHS) reported that 2% of adolescent girls had sexual intercourse before the age of 15.²⁹ The 2017 NDHS also reflected that **there is a high unmet need for contraceptives among adolescents compared to other age groups (28% versus 13%-18%)³⁰ with a substantial decrease in the number of young women (aged 15 to 24) who have correct knowledge of their fertile period (from 30% in 2008 to 17% in 2017).**³¹ Overall, 9% of women aged 15-19 have begun childbearing: 7% have had a live birth and 2% were pregnant with their first child.³² Further, comparing the data from 2011 and 2018, **there has been a 63% increase in the number of births delivered by girls aged 10 to 14** with around 2,250 babies born to girls in 2018.³³
2. Early childbearing exposes many young girls to preventable pregnancy-related risks and harms particularly among those that belong to the lowest wealth quintile and educational background.³⁴ Complications during pregnancy and childbirth are the leading cause of death for 15–19 year old girls globally.³⁵ Pregnant adolescents (ages 10–19 years) are more likely to experience and suffer from eclampsia, puerperal endometritis, and systemic infections than those between the ages of 20 and 24 years, and babies of adolescent mothers also face higher risks of low birth weight, preterm delivery, and severe neonatal conditions.³⁶ In a 2017 report, the state party noted that **the maternal mortality ratio in 2015 (MMR) is 204 per 100,000 live births**³⁷ which failed to meet the MMR target under the Millennium Development Goals (52 per 100,000 live births by 2015)³⁸ and is far from the target under the Sustainable Development Goals (70 per 100,000 live births by 2030).³⁹ As admitted by the state party in a 2018 report on the implementation of the RPRHA, leading causes of maternal deaths are “preventable and can be averted by quality obstetrics care.”⁴⁰

IV. Barriers to adolescents' access to contraceptive information and services (arts. 2, 3, 4, 6, 12, 13, 16, 17, 24)

1. In its 2009 review, the Committee expressed serious concerns on the status of adolescents' reproductive health in the Philippines. It took note of the high numbers of teenage pregnancies and maternal deaths as a result of inadequate reproductive health services and information, low contraceptive use, difficulty in obtaining access to modern contraceptives.⁴¹ The Committee recognized that "particular beliefs and religious values" are preventing the full realization of women's and girls' reproductive rights and urged the state party to adopt a national reproductive health law, ensure access to reproductive health information and services including by "providing wide access to a broad variety of contraceptives without any restrictions" and "strengthen[ing] formal and informal sex education with focus on the prevention of early pregnancies, sexually transmissible infections and family planning."⁴²
2. As mentioned above, since the Committee's review, the state party has enacted the RPRHA. The law identified "adolescent and youth reproductive health guidance and counseling" and "reproductive health education for the adolescents" as two of the 12 elements of reproductive health care.⁴³ However, as will be discussed in this section, the delay in the full implementation of the RPRHA and the decision of the Supreme Court to strike down several provisions have prevented minors particularly adolescents from freely accessing contraceptive services and receiving comprehensive sexuality education.
3. Since 2009, treaty monitoring bodies have been calling upon the state party to take measures to ensure access to sexual and reproductive health information and services. In 2012, the Human Rights Committee called on the state party to "ensure that reproductive health services are accessible for all women and adolescents" and to "increase education and awareness-raising programmes, both formal (at schools and colleges) and informal (in the mass media), on the significance of using contraceptives and the right to reproductive health."⁴⁴ In 2013, the Committee asked the state party to "intensify sexual and reproductive health education and services in all educational institutions, including awareness-raising on the prevention of HIV/AIDS and the dangers of sexual exploitation of children."⁴⁵ In 2015, the CEDAW Committee noted that unplanned and unwanted pregnancies, unsafe abortions, unnecessary and preventable deaths, and women's growing exposure to HIV and other sexually transmissible infections are direct consequences of the state party's failure to provide the full range of sexual and reproductive health services.⁴⁶ In 2016, the ESCR Committee expressed its concern at the "high level of unwanted pregnancies and at the limited access to reproductive health information and services, including contraceptives, particularly among adolescents and women in rural areas, despite the [RPRHA]."⁴⁷ It further noted that the limited access to reproductive health information and services have been made worse by judicial orders and the lack of access to emergency contraceptives, among other factors.⁴⁸ The Committee against Torture also expressed its concerns about "inadequate access to sexual and reproductive health services, including misinformation about modern methods of contraception..." and urged the state party to "[p]rovide universal access to a full range of the safest and most technologically advanced methods of contraception, ensure rights-based counselling and information on reproductive health services to all women and adolescents and restore access to emergency contraceptives for victims of sexual violence."⁴⁹

A. Adolescents' lack of access to comprehensive sexuality education (arts. 2, 3, 4, 12, 13, 24)

Suggested question: What are the steps taken by the state party to ensure that adolescents have access to comprehensive and quality sexuality education? Please provide information on the status of implementation of Department of Education Order No. 31, series of 2018 and how comprehensive sexuality education has been integrated in relevant subjects at the informal and nonformal educational system as mandated under the Responsible Parenthood and Reproductive Health Act of 2012.

1. Under the RPRHA, the state party is mandated to “provide age- and development-appropriate reproductive health education to adolescents which shall be taught by adequately trained teachers in informal and nonformal educational system and integrated in relevant subjects”⁵⁰ While this provision among others was challenged by religious and conservative groups as a violation of parents’ right to raise their children according to their own beliefs, the Supreme Court in *Imbong v Ochoa (Imbong)* upheld its constitutionality not only because the challenge was premature but also because the “legal mandate provided under the assailed provision supplements, rather than supplants, the rights and duties of the parents in the moral development of their children”.⁵¹
2. In July 2018, more than five years after the RPRHA was adopted into law, and more than four years since the *Imbong* decision, **the Department of Education (DepEd) issued Department Order No. 31 (DepEd Order No. 31) also known as “Policy Guidelines on the Implementation of the Comprehensive Sexuality Education.”**⁵² Under DepEd Order No. 31, the Comprehensive Sexuality Education Framework included core topics and subtopics on sexual and reproductive health which are intended to be part of the K to 12 Basic Education Program or K-12.⁵³ However, in 2019, **when DepEd issued Department Order No. 21 also known as the “Policy Guidelines to K to 12 Basic Education Program”, these comprehensive sexuality education (CSE) concepts were identified only for teaching in Grade 8 thereby creating a vacuum of information for those in other grade levels.**⁵⁴
3. There is limited information on the status of implementation of DepEd Order No. 31. In its report to the Committee, the state party only noted that the recommendation to strengthen sex education “has been addressed by Republic Act No. 10354 which requires provision of developmentally appropriate sex education in all schools through the DepEd, which is also tasked with the monitoring of its implementation.”⁵⁵ Local groups have urged the state party to expedite the implementation of the CSE as continued misinformation on sexuality and reproductive health have contributed to the increasing number of adolescent pregnancies and school dropout rates particularly among adolescent girls.⁵⁶ The state party through DepEd have recognized that there are remaining challenges to the full integration of the CSE in the school curriculum including the need to build the capacity of teachers and develop appropriate information resources.⁵⁷
4. Access to age-appropriate, comprehensive and inclusive sexual and reproductive health education is crucial to the realization of adolescents’ reproductive rights. The Committee emphasized that adolescents should have “access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education, available both online and in person, including on family planning, contraception, including emergency contraception, prevention, care and treatment of sexually transmitted infections,

counselling, pre-conception care, maternal health services and menstrual hygiene.”⁵⁸ It has reminded states that “unequal access by adolescents to information, commodities and services amounts to discrimination.”⁵⁹ Further, the Committee noted the importance of grounding sexual and reproductive health education on scientific evidence and human rights standards.⁶⁰ Consistent with the obligations in relation to the rights to health and information under the Convention, state parties have been urged to “ensure that children have the ability to acquire knowledge and skills to protect themselves and others as they begin to express their sexuality.”⁶¹ The Committee also underscored that state parties should “refrain from censoring, withholding or intentionally misrepresenting health related information, including sexual education and information.”⁶² Further, the Committee noted that access to information should be provided without regard to the marital status of adolescents and whether or not their parents or guardians consent to accessing such information.⁶³ The World Health Organization (WHO) similarly emphasizes the importance of comprehensive sexuality education among adolescents.⁶⁴ Referencing the Committee’s recommendations, WHO also noted that “all children and adolescents, including those who are not in school, should have access to such information and education, which should be free, confidential, adolescent-responsive and non-discriminatory.”⁶⁵

B. Restrictions on adolescents’ access to modern contraceptives including emergency contraceptives (arts. 2, 3, 4, 6, 12, 13, 16, 24)

Suggested question: What steps have been taken to reduce the number of unintended pregnancies and maternal deaths among adolescent girls and to provide them access to the full range of contraceptive services including dedicated emergency contraceptives? Please provide information on steps taken to ensure women’s and girls’ reproductive autonomy including by removing third-party authorizations i.e. parental consent requirements for minors.

1. When the RPRHA was enacted in 2012, parental consent was required for all minors to access modern contraceptives except for those who are already parents or have suffered a miscarriage.⁶⁶ However, the exception was declared as unconstitutional when the Supreme Court in its *Imbong* decision held that removal of the need for parental consent in the cases of such minors was “anti-family” and an “affront to the constitutional mandate to protect and strengthen the family as an inviolable social institution.”⁶⁷ In its inquiry report, the PCHR noted how the *Imbong* decision had adversely affected adolescents’ access to reproductive health goods and services. **The PCHR identified as one of the legal and policy barriers to the implementation of the RPRHA the “required consent from parents for adolescents to access [reproductive health] services and to have themselves tested for HIV.”**⁶⁸ It also found that the parental consent requirement does not contribute to efforts to reduce the increase in adolescent pregnancies.⁶⁹
2. Age is a prohibited ground of discrimination, and as noted above, unequal access by adolescents to sexual and reproductive health information and services amounts to discrimination.⁷⁰ States should therefore provide health services that are responsive to the particular needs and human rights of all adolescents and “ensure that girls can make autonomous and informed decisions on their reproductive health.”⁷¹ As discussed above, the Committee has called upon states to recognize the right of adolescents to make decisions with respect to health services or treatment when imposing age limits and to introduce a “legal

presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services.”⁷² It is crucial that adolescents do not face any “barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization.”⁷³

3. Access to the full range of modern contraceptives should include dedicated emergency contraceptives. However, since 2009, **the state party has not taken any step to re-list a dedicated emergency contraceptive or repeal the provision under the RPRHA which expressly prohibits national hospitals from purchasing or acquiring emergency contraceptives.**⁷⁴ This is despite the recommendation under the 2014 Family Planning Manual of the DoH for the use of the levonorgestrel-only pill to prevent pregnancies in instances of unprotected sex and the recognition by the World Health Organization of the levonorgestrel-only pill as an essential drug.⁷⁵ While the drug Postinor—a levonorgestrel-only pill—was previously approved in 1999 by the state party for victims of sexual violence, it was de-listed from the Philippine registry of drugs by the FDA in 2001.⁷⁶
4. Lack of access to dedicated emergency contraceptives not only poses a threat to women’s and girls’ lives and well-being in general but also discriminates against thousands of women and girls in the country, including victims of sexual violence particularly adolescent girls who are exposed to possible risks of serious traumatic stress and mental suffering from pregnancies resulting from rape. While the number of women between 15-49 years of age who had experienced sexual violence had declined over the past decade (from 8% in 2008 to 5% in 2017), the 2017 NDHS reported that many girls and young women continue to become victims of sexual violence with 2% of them experiencing it by age 18, and 3% by age 22.⁷⁷ Further, **statistics from the Philippine National Policies between January-May 2018 reflected that at least one woman or child is raped every 72 minutes, and at least twenty rape cases are reported daily.**⁷⁸
5. UN human rights bodies have recognized that restrictions on free distribution of emergency contraception may violate a number of rights, including the rights to health, non-discrimination, gender equality, and freedom from ill-treatment.⁷⁹ They have previously urged the Philippines to reintroduce emergency contraceptives to prevent early and unplanned pregnancies and in cases of sexual violence.⁸⁰ The PCHR also found that the lack of access to emergency contraceptives is a barrier to the implementation of the RPRHA and it “fail[s] to protect women and girls who are victims of sexual violence [as well as] limit the autonomy of women and girls over their bodies....”⁸¹

V. Restrictive laws on abortion (arts. 2, 3, 4, 6, 12, 13, 16, 24, 37)

Suggested question: What steps have been taken by the state party to reduce the number of unsafe abortions particularly among adolescent girls? Please provide information on the specific measures adopted to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, as well as review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions.

1. The country’s Revised Penal Code of 1930 provides for the penal provisions on abortion and imposes prison sentences up to 6 years for an individual found guilty of performing or

providing assistance to an abortion with the consent of the woman, or on the woman herself having an abortion.⁸² However, since 1930, the state party has not taken any steps to repeal or amend these discriminatory provisions. While a liberal interpretation of such laws allows certain cases of abortion and the state party has recently reported to the Human Rights Committee that abortion to “protect the life and health of the pregnant woman” may be justified under the country’s penal laws, women and girls still can neither freely seek nor immediately access abortion on any grounds because of lack of clear exceptions.⁸³ Fears of arrests and prosecutions widespread given the regular media reports of women seeking abortions and people providing or assisting them being arrested.⁸⁴

2. Because of the restrictive legal environment on abortion, official data on the number of abortions in the country has been very limited. However, **independent studies estimate that around 610,000 induced, and potentially unsafe, abortions took place in the Philippines in 2012, an increase from 560,000 in 2008.**⁸⁵ Women below the age 25, who comprised 46% of abortion attempts in a 2004 survey, cited reasons which are related to their age—they wanted to avoid interrupting their schooling, had problems with their partner or considered themselves too young to have a baby.⁸⁶ While abortion is a safe medical procedure when done according to the World Health Organization’s standards,⁸⁷ legal restrictions cause many women in the Philippines to suffer life-threatening complications. Induced abortion is one of the leading causes of maternal deaths in the Philippines.⁸⁸ The number of women hospitalized for abortion complications increased from 90,000 in 2008 to 100,000 in 2012.⁸⁹ These numbers can be expected to continue rising as the Philippine population and demand for services increases.⁹⁰ Common complications of unsafe abortion include blood loss, hemorrhage, sepsis, infection, perforation of the uterus, damage to other internal organs, and death.⁹¹ An estimated 1,000 maternal deaths were attributed to abortion complications in 2008 translating to around three women dying every day as a result of unsafe abortions.⁹² Pregnant women who are poor, with more children, and those burdened with household chores and tasked with child care are more likely not to seek services from a health care facility and therefore suffer from deaths and complications.⁹³
3. The Committee has recognized that “risk of death and disease during the adolescent years is real, including from preventable causes such as childbirth [and] unsafe abortions...”⁹⁴ As noted earlier, it has recommended that states “decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions.”⁹⁵ Other UN and regional human rights bodies agree that denial of abortion services to a child or adolescent may amount to grave human rights violations including the rights to privacy; special protection as a minor; access legal remedies; freedom from cruel, inhuman and degrading treatment; and freedom from gender stereotyping.⁹⁶
4. UN human rights bodies have repeatedly urged the state party to amend its law on abortion. In 2015, the CEDAW Committee expressed concerns on the unsafe abortions and unnecessary and preventable maternal deaths in the country and called for the state party to “legalize abortion in cases of rape, incest, threats to the life and/or health of the pregnant woman, or serious malformation of the fetus, the decriminaliz[ation] of all other cases where women undergo abortion, and the adopt[ion] of necessary procedural rules to guarantee effective access to legal abortion”.⁹⁷ In 2016, the ESCR Committee urged the state party to “take all measures necessary to reduce the incidence of unsafe abortion and maternal mortality including through amending its legislation on the prohibition of abortion to legalize abortion

in certain circumstances.”⁹⁸ The Committee against Torture also called for a review of the Revised Penal Code “to allow for legal exceptions...in specific circumstances such as when the pregnancy endangers the life or health of the woman, when it is the result of rape or incest and in cases of foetal impairment.”⁹⁹ The recommendations to review the current laws on abortion have been echoed by the PCHR.¹⁰⁰

VI. Criminalization of adolescents for factually consensual and nonexploitative sexual activity (arts 2, 3, 4, 16, 34)

Suggested question: What steps has the state party taken to ensure that adolescents of similar age are not criminalized for factually consensual and non-exploitative activity? Please provide information on how the state party’s laws and policies balance protection and evolving capacities of adolescents while ensuring that its laws distinguish between non-coercive sexual conduct between adolescents and coercive sexual activity.

1. The state party’s current minimum age of sexual consent is 12 years of age.¹⁰¹ Any sexual activity with a child below 12 years old is considered rape and punishable with imprisonment of up to 40 years.¹⁰² In 2009, the Committee urged the state party to “take all necessary measures to ensure the full and effective implementation of its domestic laws in order to better protect the rights of the child and to harmonize its legislation fully with the provisions and principles of the Convention, including through the expeditious adoption of...the Age of Statutory Rape and Acts of Sexual Abuse Act...”¹⁰³ In its recent report to the Committee, the state party noted that the current legislative agenda includes “increasing the age of statutory rape and acts of sexual abuse.”¹⁰⁴
2. Since 2009, several bills have been filed before the state party’s Congress to increase the age of sexual consent. **As of February 2020, there are four pending bills that seek to amend the current law and raise the minimum age of sexual consent to 18 years of age.**¹⁰⁵ All these bills have been premised on the need to protect children from sexual violence, abuse, and exploitation. However only Senate Bill 163 proposed for an exemption from criminal liability when the sexual activity is proven to be consensual, non-abusive, and non-exploitative and the victim is between 14 and 18 years of age and the age difference between the perpetrator and victim is not more than 4 years.¹⁰⁶ **The rest of the pending bills do not make any distinction between consensual sex and exploitative sex among adolescents. They also do not define whether and in what contexts adolescents can consent to sex.** Therefore, under these proposed laws, an adolescent may be held both criminally and civilly liable for factually consensual and non-exploitative sexual conduct with another adolescent.¹⁰⁷
6. Use of the criminal law to regulate non-coercive sexual conduct among adolescents punishes them for a natural part of their development. It often results in adolescent males being imprisoned and reinforces the stigma against adolescent sexual activity.¹⁰⁸ It also deters and prevents access to sexual and reproductive health services by penalizing adolescent sexuality and in some cases requiring third parties to report adolescent sexual activity to the police which violates adolescents’ right to privacy and confidentiality.¹⁰⁹ This can create a chilling effect for adolescents seeking sexual and reproductive health information and services. **The Committee has explicitly called on states to “avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity.”**¹¹⁰ As emphasized by the Committee, states have an obligation to ensure they are putting in place special measures

of protection for adolescents and avoid barriers to commodities, information and counselling on sexual and reproductive health and rights.¹¹¹ At the same time, states should balance the need to protect children with the recognition that children's capacities evolve as they grow in maturity and understanding.¹¹²

Considering the grave human rights violations resulting from the barriers and restrictions affecting adolescents' reproductive rights, we hope that this information is useful to the Committee as it prepares to review the state party's compliance with the provisions of the Convention. If you have any questions or would like further information, please do not hesitate to contact Jihan Jacob of the Center for Reproductive Rights at jjacob@reprorights.org.

¹ Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC].

² Committee on the Rights of the Child, *General Comment 15: The right of the child to the enjoyment of the highest attainable standard of health*, para. 56, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee, *General Comment No. 15*].

³ *See generally id.*

⁴ Committee on the Rights of the Child, *General Comment No. 20: On the implementation of the rights of the child during adolescence*, para. 60, U.N. Doc. CRC/C/GC/20 (2016) [hereinafter CRC Committee, *General Comment No. 20*].

⁵ Human Rights Committee, *Concluding Observations: Paraguay*, para. 13, U.N. Doc. CCPR/C/PRY/CO/3 (2013); Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee), *Concluding Observations: Bolivia*, para. 29(b), U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015); *Concluding Observations: Poland*, paras. 36, 37(e), U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations: Lithuania*, para. 22, U.N. Doc. E/C.12/LTU/CO/2 (2014).

⁶ CEDAW Committee, *Concluding Observations: Denmark*, para. 32, U.N. Doc. CEDAW/C/DNK/CO/8 (2015); ESCR Committee, *Concluding Observations: Romania*, para. 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014).

⁷ CEDAW Committee, *Concluding Observations: Ecuador*, para. 33(d), U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); CEDAW Committee, *Concluding Observations: Eritrea*, para. 35(d), U.N. Doc. CEDAW/C/ERI/CO/5 (2015); CEDAW Committee, *Concluding Observations: Gabon*, para. 35(c), U.N. Doc. CEDAW/C/GAB/CO/6 (2015).

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REP. ACT NO. 9344, sec. 6 (2005) as amended by AN ACT STRENGTHENING THE JUVENILE JUSTICE SYSTEM IN THE PHILIPPINES, AMENDING FOR THE PURPOSE REPUBLIC ACT NO. 9344, OTHERWISE KNOWN AS THE "JUVENILE JUSTICE AND WELFARE ACT OF 2006" AND APPROPRIATING FUNDS THEREFOR, REP. ACT NO. 10630, sec. 3 (2013) (The minimum age of criminal responsibility is 16 years old. A child 15 years of age or under at the time of the commission of the offense shall be exempt from criminal liability but shall be subjected to an intervention program. Anyone who is 16 years of age and below 18 shall be criminally liable if he or she acted with discernment in the commission of the offense.)

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