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Adolescents Under International Law: Autonomy as the Key to Reproductive Health

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ABSTRACT

As a matter of policy, the reproductive and sexual health of adolescents matter because they comprise almost one half of the world's population. As a matter of international human rights law, adolescents have reproductive and sexual health rights. This article outlines how the international community must ensure adolescents' access to and exercise of those reproductive health rights. Governments must enable informed decision-making while also offering state protections for this vulnerable population. Without laws and policies that uphold adolescent health worldwide, future generations will needlessly suffer.

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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.

—Thoraya Ahmed Obaid, Executive Director, United Nations Population Fund

I. ADOLESCENCE: AN INCREASINGLY RELEVANT LEGAL CONCERN

Adolescents and young people comprise almost half the world's population.\(^1\) It might surprise some that adolescents have the same rights to reproductive health as adults.\(^2\) Unfortunately, their low social status, lack of autonomy, and physical vulnerability make it harder for them to exercise those rights.\(^3\) Governments have a duty to empower adolescents with the tools to make informed choices and protect themselves.\(^4\) Governments have a duty under international law to provide comprehensive sex education, access to confidential healthcare services,\(^5\) protection from child marriage,\(^6\) protection from sexual

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6. CRC, supra note 5, at art. 24; see generally R. Cook & B.M. Dickens, Recognizing Adolescents' 'Evolving Capacities' to Exercise Choice in Reproductive Healthcare, 70 INT'L. J. GYNECOL. & OBSTETRICS 13 (2000) (examining the specific duties of the government and health service providers in order to implement adolescent rights regarding their sexual and reproductive health needs).

violence,\textsuperscript{8} and protection from the practice of female genital mutilation.\textsuperscript{9} When governments impose restrictions on adolescents' access to reproductive health information and services, they violate international legal standards.\textsuperscript{10} When governments fail to implement laws and policies that protect adolescents from violence, child marriage, and female genital mutilation, they also violate international legal standards.\textsuperscript{11} However, because adolescents do not have a collective voice that is as strong as adults', and because they are enmeshed with their caretakers or the state, the human rights community has not invested as much concern for this group as it should.\textsuperscript{12} Often a paternalistic nostalgia for childhood overshadows adolescents' voices and concerns, which in turn creates insufficient concern in the human rights community.\textsuperscript{13}

Advocating for adolescents' reproductive rights is fraught with politicization. Because adolescence is a borderline stage of life, it often becomes a legal battleground for control over provocative issues, such as sex, contraception, abortion, and sexually transmitted diseases.\textsuperscript{14} Despite the critical health issues at stake, discussing the sexuality of young persons typically sparks controversy.\textsuperscript{15} Sometimes the issue is age or maturity level.\textsuperscript{16} The charge is that talking to teens about sex is tantamount to pushing them into sexual encounters.\textsuperscript{17} Sometimes the issue is the relativity of rights.\textsuperscript{18} Advocates in this scenario are confronted with the assertion of culture as a justification and a defense for violations of adolescents' rights.\textsuperscript{19} Refuting the cultural relativist defense opens one up to charges of human rights imperialism and a lack of respect for local culture because of a refusal to accept the dictates of local authority.\textsuperscript{20} Despite these challenges, all

\begin{itemize}
\item 8. CRC, supra note 5, at art. 34.
\item 9. See id. at art. 24, ¶ 3 (indicating signatory countries agree to abolish traditional practices that are "prejudicial to the health of children"); id. at art. 19 (indicating signatory countries agree to prevent physical abuse and maltreatment, including sexual abuse).
\item 10. Id. at art. 24.
\item 11. Id. at arts. 19, 24, 34.
\item 12. Cook & Dickens, supra note 6, at 15-16.
\item 13. Id.
\item 14. See, e.g., PROMISE OF EQUALITY, supra note 4, at 50-52.
\item 15. Steve Sternberg, Sex Education Stirs Controversy, USA TODAY, July 11, 2002, at 8D.
\item 17. Sternberg, supra note 15.
\item 19. Id.
\item 20. Id.
\end{itemize}
of which have strong replies in moral theory and social science, the importance of advocating for adolescent reproductive health rights is only growing as the adolescent population grows.\textsuperscript{21} Despite the fact that adolescent autonomy is often a political issue, policies concerning adolescents' reproductive health are becoming more prevalent alongside a growing acknowledgment of adolescents as agents of development and change.\textsuperscript{22}

To get a sense of just how relevant adolescents are in today's global health calculus, consider the following facts. The term "adolescents" refers to persons between the ages of ten and nineteen.\textsuperscript{23} The term "young people" refers to persons between the ages of ten and twenty-four.\textsuperscript{24} Almost half of the world's population — nearly three billion people — is under twenty-five.\textsuperscript{25} Of those three billion, two billion are under eighteen.\textsuperscript{26} More than eighty-five percent of the world's young people live in developing low-income and middle-income countries.\textsuperscript{27} Further, when adolescence intersects with other factors, such as poverty, race, and gender, it compounds the challenges adolescent women, in particular, face in exercising their basic human rights.\textsuperscript{28}

In this article, I argue that advocates and lawmakers can best foster adolescent reproductive health by promoting adolescents' autonomy. I outline the framework of adolescents' reproductive and sexual rights, noting at each turn that they do not fit within the traditional categories of child or adult, and therefore, adolescents require particular legal consideration. This article highlights core rights concerns for adolescents and discusses governments' legal duties to address those concerns. I focus on sexuality education, access to confidential healthcare, child marriage, lack of educational opportunity, sexual violence, and female genital mutilation ("FGM"). I conclude that an effective government response to adolescent reproductive and sexual health issues includes laws and policies that blend protection and freedom, thereby enabling adolescents to flourish and achieve their full potential.

\textsuperscript{21} PROMISE OF EQUALITY, supra note 4, at 45.
\textsuperscript{22} Id.
\textsuperscript{23} Id.
\textsuperscript{24} Id.
\textsuperscript{25} Id.
\textsuperscript{28} PROMISE OF EQUALITY, supra note 4, at 45.
II. Framing Advocacy

A. Adolescent Reproductive Rights

International law recognizes adolescence — a critical developmental stage — as a time when young women’s capacities are evolving. Article 5 of the Convention on the Rights of the Child introduces the term “evolving capacities” into human rights law and marks a radical shift in how human rights law conceives of adolescents. Adolescents are viewed as persons who, at differing rates, have the competence to be responsible for themselves. Governments, then, must foster this competence and protect adolescents while they develop the ability to be self-governing. Not only do adolescent girls experience rapid biological change, but their emotional maturity also develops more rapidly at this time than perhaps any other time in life. Though adolescence may be messy, the laws and legal standards regulating government obligations to adolescents are clear. International human rights law provides a framework for states’ obligations. Governments have a duty “to respect, protect and fulfil [sic] rights that are recognized under international law.”

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

29. CRC, supra note 5, at art. 5; see also Cook & Dickens, supra note 6, at 13-21.
30. CRC, supra note 5, at art. 5.
31. Cook & Dickens, supra note 6, at 14.
36. Id. at 694.
37. Id.
also requires governments to implement and enforce laws that prevent abusive practices, for example child marriage or FGM.\textsuperscript{38} State protections are necessary because many adolescents do not have the authority within family structures, workplace experience, or financial independence to provide for themselves.\textsuperscript{39}

The duty to fulfill requires governments to adopt concrete measures and, in some cases, make expenditures that enable adolescents to exercise their rights.\textsuperscript{40} For example, complications from pregnancy and childbirth are the two leading causes of death for fifteen to nineteen-year-old girls worldwide.\textsuperscript{41} Governments' duty to fulfill human rights requires them to invest in providing reproductive healthcare services and take affirmative measures to enable adolescents to exercise their reproductive autonomy.\textsuperscript{42}

### Human Rights Standards that Apply to Adolescents' Reproductive Rights:

- The right to life, liberty, and security\textsuperscript{43}
- The right to reproductive self-determination\textsuperscript{44}
- The right to consent to marriage\textsuperscript{45}
- The right to health\textsuperscript{46}
- The right to be free from discrimination\textsuperscript{47}

\textsuperscript{38} Id. at 694-97.
\textsuperscript{39} See CRC, supra note 5, at arts. 5, 18, 32.
\textsuperscript{40} Combrinck, supra note 35, at 694.
\textsuperscript{42} Id. at 20-26; Combrinck, supra note 35, at 694.
\textsuperscript{43} See CRC, supra note 5, at art. 6; International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), art. 6, ¶ 1, art. 9, ¶ 1, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (Dec. 16, 1966) [hereinafter ICCPR]; Universal Declaration of Human Rights, supra note 33, at art. 3. The concept of the right to life, liberty, and security in the context of reproductive rights is also underscored in the ICPD Programme of Action, supra note 3, at ¶¶ 7.3, 7.17, and the Beijing Declaration, supra note 7, at ¶¶ 96, 106(g).
\textsuperscript{44} See CEDAW, supra note 7, at art. 16, ¶ 1(e); ICPD Programme of Action, supra note 3, at Principle 8; Beijing Declaration, supra note 7, at ¶ 223.
\textsuperscript{45} See CEDAW, supra note 7, at art. 16, ¶ 1, art. 16, ¶ 2; ICCPR, supra note 43, at art. 23, ¶¶ 2-4; ICESC, supra note 34, at art. 10, ¶ 1; Universal Declaration of Human Rights, supra note 33, at art. 16, ¶ 1; Beijing Declaration, supra note 7, at ¶ 274(e); ICPD Programme of Action, supra note 3, at Principle 9.
\textsuperscript{46} See CRC, supra note 5, at art. 24; CEDAW, supra note 7, at art. 10(h), art. 12, ¶¶ 1-2, art. 14, ¶ 2(b); ICESC, supra note 34, at art. 10, ¶ 1, art. 12, ¶¶ 1-2; International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), Annex, at art. 5(e)(iv), U.N. GAOR, 20th Sess., 1406th plen. mtg., U.N. Doc. A/6014 (Dec. 21, 1965) [hereinafter ICERD]; Beijing Declaration, supra note 7, at ¶¶ 91, 92, 94; ICPD Programme of Action, supra note 3, at Principle 8, ¶¶ 7.2, 7.46, 8.34; Vienna Declaration, supra note 33, at ¶ 41.
\textsuperscript{47} See CRC, supra note 5, at art. 2, ¶¶ 1-2; CEDAW, supra note 7, at art. 1, art. 2, art. 11, ¶ 2; ICESC, supra note 34, at art. 2, ¶ 2; Universal Declaration of Human
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The right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment.

The right to be free from sexual violence.

The right to education and information.

III. CORE CHALLENGES

A. Ensuring Informed Decision-Making

To make an informed decision about their reproductive health, adolescents require information and access to confidential health-care services. The Convention on the Rights of the Child ("CRC"), which is the principal treaty that grants special protections to minors, recognizes the importance of adolescent autonomy. The CRC acknowledges that because minors have “evolving capacities” to make decisions affecting their lives, some minors are more mature than others depending on individual circumstances. Furthermore, while the CRC 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, it recognizes that the best interests of the child take precedence and that the child should be enabled to exercise her rights.

The Committee on the Rights of the Child ("Committee") refers to adolescence as a time of “reproductive maturation,” as well as a
time to develop critical thinking about reproductive choices. The Committee has repeatedly voiced concern about the "lack of sufficient reproductive health information and services for adolescents" in its concluding observations to States Parties and has frequently criticized governments for failing to promote education about family planning for adolescents. 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 women's health throughout the woman's lifespan," understanding that "women' includes girls and adolescents."  

1. Information: Comprehensive Sexuality Education  

Providing adolescents with information is the first step toward teaching them to make meaningful choices. Article 10(h) of CEDAW explicitly obliges States Parties to provide "[a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." Sex education is, ultimately, education. The Special Rapporteur on the Right to Education recently noted that a "crucial issue for the elimination of gender discrimination [is] . . . access to sex education." To protect themselves from unwanted pregnancy and the spread of sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV), adolescents need comprehensive sexuality education. Without complete information, adolescents' rights to health and reproductive self-determination are significantly compromised.

57. Comment on Rights of the Child, supra note 32, at ¶ 2.
58. CRC, Concluding Observations of the Committee on the Rights of the Child for the following countries: Paraguay, ¶¶ 23, 45, U.N. Doc. CRC/C/15/Add.75 (June 18, 1997); Hungary, ¶ 36, U.N. Doc. CRC/C/15/Add.87 (June 24, 1998).
61. CEDAW, supra note 7, at art. 10(h).
The CRC 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. 64

The CRC has frequently recommended to countries that they improve adolescent reproductive healthcare education policies. 65 The CEDAW Committee also comments on the importance of comprehensive sexuality education, especially with regard to preventing the spread of HIV/AIDS. 66 For example, the CEDAW Committee recommends the following:

That States parties 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]
That programmes to combat AIDS should 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. 67

“Sexuality education” refers to educational goals that are broader than simply biology. 68 At a minimum, sexuality education should include information about “anatomy and physiology, puberty, pregnancy and STIs, including HIV/AIDS.” 69 It should also address the

64. Comment on Rights of the Child, supra note 32, at ¶ 26.
67. Id. at 240.
relationships and emotions involved in sexual experience. It approaches sexuality as a natural, integral and positive part of life, and covers all aspects of becoming and being a sexual, gendered person. It should promote gender equality, self-esteem, and respect for the rights of others. The goal of sexuality education is to help young people develop autonomy using skills such as communication, decision-making, and negotiation. Learning to be responsible for one's health and choices promotes a successful transition to adulthood in good sexual health.

Opponents of comprehensive sexuality education argue that providing adolescents with information about sex encourages them to engage in it — a proposition that has been proven false in a number of studies. 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. Often messages of abstinence are accompanied by lessons promoting stereotypical gender roles that reinforce girls' subordinate status.

71. SEXUAL AND REPRODUCTIVE HEALTH EDUCATION, supra note 69, at 1. See POPULATION COUNCIL & UNFPA, ADDRESSING GENDER AND RIGHTS IN YOUR SEX/HIV EDUCATION CURRICULUM: A STARTER CHECKLIST (Eleanor Timreck et al. eds., 2007); Rogow & Haberland, supra note 68, at 336-37.
72. Rogow & Haberland, supra note 68, at 335, 337-78.
73. ALFORD, CHEETHAM & HAUSER, supra note 70, at 6.
78. See Rogow & Haberland, supra note 68, at 334, 336-40.
There are several problems with this approach. First, it violates women's rights 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.

Second, the approach violates the right to life, liberty, and security of married women, because it does not address the risk of exposure that married women have to HIV and other STIs when their spouses have more than one sexual partner. 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' rights 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 twenty, and many are married between the ages of fifteen and nineteen. 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. Ultimately, "[p]arents, community organizations, religious groups, friends and peers, and healthcare delivery centers can, with proper training, become part of this effort."

79. CEDAW, supra note 7, at art. 16.
83. See supra note 78 and accompanying text.
84. CEDAW, supra note 7, at art. 16.
86. Singh, Bankole & Woog, supra note 82, at 325, 329.
87. SEXUAL AND REPRODUCTIVE HEALTH EDUCATION, supra note 69, at 2.
2. Access to Confidential and Adolescent-Friendly Services

Adolescents need reproductive healthcare services from specially trained providers who offer confidentiality and adolescent-friendly services.⁸⁸ 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.⁹⁻⁰ Adolescents’ rights to life, health, and privacy entitle them to have access to confidential and adolescent-friendly services.⁹⁻⁰

International treaty monitoring bodies routinely comment on the importance of access to confidential reproductive health services.⁹⁻¹ The Children’s Rights Committee,⁹⁻² CEDAW,⁹⁻³ and the Human Rights Committee⁹⁻⁴ all agree that access to services is critical.⁹⁻⁵ The CRC has asserted time and again that adolescents must have access to confidential health care.⁹⁻⁶ The CRC recently

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⁸⁸. Id.
⁹⁻⁰. Id.
⁹. CRC, supra note 5, at arts. 6, 24; ICCPR, supra note 43, at art. 6.
interpreted Article 16 of the CRC, 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 (art. 16). 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.97

Open engagement with healthcare providers fosters an adolescent girl’s self-determination regarding her reproductive life and health.98 Armed with information, counseled within a secure, confidential environment, she can determine for herself the course of action that best serves her.99 Failure to ensure confidentiality, therefore, constitutes a barrier to comprehensive reproductive healthcare.100 Adolescents may be deterred from seeking sexual and reproductive healthcare if they believe that their parents may learn that they are — or are considering becoming — sexually active.101 International bodies are aware that requiring parental involvement in adolescents’ reproductive healthcare decisions impedes access to necessary services. For example, the CRC has strongly advocated that adolescent reproductive health services be available without parental consent,102


97. See Comment on the Rights of the Child, supra note 32, at ¶ 11.
99. Id.
100. Id.
and the CEDAW Committee has asked States Parties to eliminate parental consent for contraception. 103

Adolescent-friendly care is nonjudgmental. Many adolescents are concerned about stigma or shame culturally associated with sexual activity, pregnancy, and STIs. 104 This stigma not only makes it difficult for adolescents to find nonjudgmental medical advice and guidance, 105 but it also makes them less willing to seek counseling and care. 106 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. 107

The fate of adolescent girls’ health is in crisis. Girls aged ten to fourteen are five times more likely to die in pregnancy or childbirth than women aged twenty to twenty-four. 108 Girls aged fifteen to nineteen are twice as likely to die. 109 One-third of all women living with HIV are between the ages of fifteen and twenty-four. 110 The United Nations estimates that every fourteen seconds, a young person is infected with HIV/AIDS. 111 At this rate, 6000 youth are newly infected every day. 112 Of more than 4.4 million abortions occurring among fifteen to nineteen year old girls every year, forty percent take place under unsafe conditions. 113 These numbers come to life with the stories reported from across the world. 114

105. See Aid for Women v. Foulston, 441 F.3d 1101, 1114 (10th Cir. 2006).
109. Id. at 6.
111. UNFPA, STATE OF THE WORLD POPULATION 2003, supra note 85, at 23.
112. Id.
114. Id.
B. 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, for example family members, community members, and 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 marriages violate adolescents' rights to life, liberty, self-determination, and health. Child marriage has been defined as "[a]ny 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." In practice, many girls as young as ten to fourteen years old are married to men who are much older than they are. 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.

116. Id.
118. Id. at 21-22.
119. Id. at 7 (citation omitted).
120. INNOCENTI RESEARCH CTR., UNICEF, EARLY MARRIAGE: CHILD SPOUSES 2-4 (2001) [hereinafter INNOCENTI RESEARCH CTR., CHILD SPOUSES].
121. Id. at 4.
122. Id. at 9.
123. INT'L PLANNED PARENTHOOD FED'N & FORUM ON MARRIAGE & THE RIGHTS OF WOMEN & GIRLS, supra note 117, at 7, 11.
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.” The CEDAW Committee routinely condemns child marriage. It recommends public awareness campaigns to change local attitudes and makes policy recommendations, such as the implementation of a marriage registry system to combat the practice. The CRC explicitly requires States Parties to take measures to abolish traditional practices that are harmful to children’s health. The CRC calls child marriage a harmful practice and a form of gender discrimination. The Human Rights Committee has expressed concern over the practice and recommends, among other measures, legal reform to eliminate it. Finally, the Committee on Economic, Social, and Cultural Rights (“CESCR”) also condemns the practice.

124. Id. at 6.  
125. ICESC, supra note 34, at art. 10, ¶ 1; see Universal Declaration of Human Rights, supra note 33, at art. 16, ¶ 2.  
129. CRC, supra note 5, at art. 24, ¶ 3.  
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. Child brides either are not enrolled in school or are pulled out and never return. For example, in Guatemala, of the twenty-six percent of Mayan girls aged fifteen to nineteen who are married, only two percent are enrolled in school, compared with forty percent of unmarried girls of the same age. Without education, a girl's chances of leading an autonomous life and becoming financially self-sufficient are severely hindered. There are other detrimental effects of interrupted education. 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. Child mothers without education are more likely to have children with low literacy rates and low educational success rates. This perpetuates a cycle of poverty.

At least two powerful forces encourage child marriage: economic incentives and local custom. Economic necessity is cited as a reason

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139. UNAIDS et al., supra note 138, at 39-40.


142. See Judith Bruce & Shelley Clark, Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy 20 (2004); UNICEF, Early
for child marriage, which happens almost exclusively in low-income countries, particularly in rural areas.\textsuperscript{143} In South Asia, generally forty-eight percent of fifteen to twenty-four year-olds were married before they reached the age of eighteen.\textsuperscript{144} But if one examines a particular rural, poor area like Bihar, India, the percentage leaps to seventy-one.\textsuperscript{145} Two economic justifications for forcing young girls into marriage are because their families cannot support them, or they are bought as brides so that their husbands and their families can benefit from the girl’s labor.\textsuperscript{146} 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 that her economic contributions are to that home.\textsuperscript{147} Therefore, many parents betroth their daughters as early as infancy.\textsuperscript{148} One expert noted that dowry rates are often lower when the girl is married young.\textsuperscript{149}

The statistics around child marriage are alarming not just for the numbers themselves, but because these numbers only represent the stories that are reported. Eighty-two million girls ages ten to seventeen in low-income countries marry before their eighteenth birthday.\textsuperscript{150} In Africa, forty-two percent of young girls marry before the age of eighteen.\textsuperscript{151} In East and West Africa, this number is sixty percent,\textsuperscript{152} and in regions such as northern Nigeria, it rises to seventy-three percent.\textsuperscript{153} Due to the fact that many marriages are not registered and the available evidence is anecdotal, far more girls than this are sent into child marriage, and their fate is unknown by the international community.\textsuperscript{154}

\begin{thebibliography}{99}
\bibitem{143} \textit{BRUCE \& CLARK, supra} note 142, at 20; \textit{UNICEF, EARLY MARRIAGE, supra} note 142, at 5-6, 15.
\bibitem{144} \textit{UNICEF, EARLY MARRIAGE, supra} note 142, at 4.
\bibitem{145} \textit{INT’L PLANNED PARENTHOOD FED’N \& FORUM ON MARRIAGE \& THE RIGHTS OF WOMEN \& GIRLS, supra} note 117, at 10.
\bibitem{146} \textit{INNOCENTI RESEARCH Ctr., CHILD SPOUSES, supra} note 120, at 2, 6.
\bibitem{148} \textit{Id.}
\bibitem{149} \textit{Id.}
\bibitem{150} \textit{UNFPA, STATE OF WORLD POPULATION 2003, supra} note 85, at 15.
\bibitem{151} \textit{UNICEF, EARLY MARRIAGE, supra} note 142, at 4.
\bibitem{152} \textit{INT’L PLANNED PARENTHOOD FED’N \& FORUM ON MARRIAGE \& THE RIGHTS OF WOMEN \& GIRLS, supra} note 117, at 10.
\bibitem{153} \textit{Id.}
\bibitem{154} \textit{INNOCENTI RESEARCH Ctr., CHILD SPOUSES, supra} note 120, at 9, 12; \textit{INT’L PLANNED PARENTHOOD FED’N \& FORUM ON MARRIAGE \& THE RIGHTS OF WOMEN \& GIRLS, supra} note 117, at 9.
\end{thebibliography}
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.

2. 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. 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." 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. The Children's Rights Convention states:

155. INT'L PLANNED PARENTHOOD FED'N & FORUM ON MARRIAGE & THE RIGHTS OF WOMEN & GIRLS, supra note 117, at 28.
156. Id. at 23-24, 26, 29.
157. UNFPA, STATE OF WORLD POPULATION 2003, supra note 85, at 15.
158. Beijing Declaration, supra note 7, at ¶ 118.
159. UNFPA, STATE OF WORLD POPULATION 2003, supra note 85, at 20.
160. Beijing Declaration, supra note 7, at ¶ 113.
161. UNFPA, STATE OF WORLD POPULATION 2003, supra note 85, at 12.
162. ICCPR, supra note 43, at art. 9.
163. CRC, supra note 5, at arts. 19, 34, 39; Convention Against Torture, supra note 48, at arts. 1, 3; CEDAW, supra note 7, at arts. 5, 8; ICCPR, supra note 43, at arts. 2, 6, 7, 23, 24; ICESC, supra note 34, at arts. 2, 12; ICERD, supra note 46, at arts. 5(b), 5(d).
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 . . . . 164

CEDAW's General Recommendation 12 also instructs States Parties to adopt legislation that protects women from "all kinds of violence in everyday life including sexual violence, abuses in the family, sexual harassment at the workplace etc." 165

Adolescents are particularly vulnerable to violence in both the public and private spheres. 166 Institutions that should nurture and foster adolescents' independence, such as schools, clinics, the workplace, and the home, often become traps where violence cannot be avoided. 167 For example, the Inter-American Commission presided over the case of a nineteen-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. 168 The doctor led her into his private office, where he administered anesthesia to make her unconscious and then raped her. 169 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 protection in public health facilities. 170 The abuses experienced by the woman in this case, however, are not unique. The power differential in the provider-client relationship can facilitate abuse. 171 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. 172 The patients' lack of knowledge about appropriate examination procedures and their legal rights perpetuate the acts of violence. 173 In addition, providers often

164. CRC, supra note 5, at art. 19.
166. PROMISE OF EQUALITY, supra note 4, at 48, 66.
168. Id. at 12.
169. Id.
170. Id. at 13.
171. Id. at 15-16.
172. Id. at 13; see also CTR. FOR REPROD. RIGHTS, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 22 (2007).
173. LATIN AM. & CARIBBEAN COMM. FOR THE DEF. OF WOMEN'S RIGHTS & CTR. FOR
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.\textsuperscript{174}

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.\textsuperscript{175} In a recent study, Latin American girls attested that sexual violence is present in schools.\textsuperscript{176} Studies show that educational environments are the principal settings for sexual violence in Ecuador: forty-four percent of female students reported knowledge of cases of sexual violence in schools, and thirty-six percent of adolescents reported male teachers as the aggressors.\textsuperscript{177}

The case of Paola Guzmán, a student in Ecuador, is an example. Paola was a sixteen-year-old student who had been sexually abused by her school’s vice principal for two years.\textsuperscript{178} After learning of her pregnancy that resulted from the abuse, she committed suicide.\textsuperscript{179} Paola’s family argued that her rights to life, personal integrity, personal security, freedom from violence, and nondiscrimination were violated.\textsuperscript{180} Her case has been brought before the Inter-American Commission for Human Rights.\textsuperscript{181}

The pattern of violence in schools repeats itself all over the world. In South African schools, girls are raped, sexually abused, sexually harassed, and assaulted by their male classmates or teachers.\textsuperscript{182} These abuses occur in school restrooms, empty classrooms and corridors, hostel rooms, and dormitories.\textsuperscript{183} Variations on these events


\textsuperscript{175} Id.

\textsuperscript{176} U.N. Regional Secretariat for the Study of Latin America, Cuba & the Dominican Republic in the Caribbean, Violence Against Children in Latin America: A Desk Review 11,12 (2005).

\textsuperscript{177} Id.


\textsuperscript{180} Id.

\textsuperscript{181} Id.


\textsuperscript{183} Id.
happen throughout the world, especially where laws and policies do not recognize, target, and punish such violence.\(^{184}\)

3. Female Genital Mutilation (FGM)

Although FGM can be performed as early as infancy or well into adulthood, girls most commonly undergo it between four and twelve years of age.\(^{185}\) In many places it has been considered a rite of passage to adulthood.\(^{186}\) FGM is prevalent in at least twenty-eight African countries, parts of Yemen, and certain minority groups in Asia.\(^{187}\) Its prevalence varies significantly from one country to another.\(^{188}\) In addition, there are many immigrant women in Europe, Canada, and the United States who have undergone FGM.\(^{189}\)

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.\(^{190}\) 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.”\(^{191}\) Although there are variations of FGM,\(^{192}\)

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184. See, e.g., id.


186. Id.


188. Id.


191. Id.

192. Id. 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);
roughly eighty percent of reported cases involve the excision of the clitoris and the labia minora. An estimated 130 million women worldwide have undergone FGM and an additional three million girls and women undergo the procedure every year.

Subjecting girls and women to FGM violates a number of rights protected in international and regional instruments, such as: the right to be free from all forms of gender discrimination, the rights to life and to physical integrity, and the right to health. FGM is a form of gender discrimination because it aims primarily to control women's sexuality and assigns them a subordinate role in society. Furthermore, FGM compromises the recognition and enjoyment of women's other fundamental rights and liberties, as it 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 or alteration 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, because FGM results in the removal of bodily tissue necessary for the enjoyment of a satisfying and safe sex life, a woman's right to the "highest attainable standard of physical and mental health" has been compromised.

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.

*Id.*

193. *Id.*
199. FEMALE GENITAL MUTILATION: A GUIDE TO LAWS AND POLICIES WORLDWIDE, *supra* note 185, at 5.
200. *Id.* at 23.
201. *Id.*
202. *Id.*
203. *Id.* at 26.
International treaties directly condemn the practice of FGM.\(^{205}\) The Children’s Rights Convention\(^{206}\) and other treaties, such as CEDAW\(^{207}\) and the African Charter on Human and Peoples’ Rights\(^{208}\) (African Charter), all condemn practices that threaten the health and rights of women and girls. 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:

(a) creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;

(b) 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;

(c) provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;

\(^{205}\) Id. at 25-26.


\(^{208}\) African Charter, supra note 197, at art. 18.
(d) protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.  

In addition to international condemnation, many countries have passed national laws that criminalize FGM. 210 Fifteen African countries have enacted laws criminalizing the practice. 211 The penalties range from a minimum of six months to a maximum of life in prison. 212 Several countries also impose monetary fines. 213 There have been reports of prosecutions or arrests in cases involving FGM in several African countries. 214 Twelve high-income nations that receive immigrants from countries where FGM is practiced have passed laws criminalizing it. 215 In the United States, the federal government and seventeen states have done so. 216 "France [ ] has relied on existing criminal legislation to prosecute both practitioners of FGM and parents procuring the service for their daughters." 217

The international community and many national governments have condemned FGM on paper. 218 The charge to advocates is to use public awareness and legal challenges to stop the practice. 219 Advocates can push governments to criminalize FGM. 220 They can also pressure national governments to adopt laws that deter FGM, such as professional sanctions against medical providers who engage in the practice of FGM. 221 National governments should fund education programs about the rights, implications, and health effects of FGM and also provide healthcare resources for the treatment of complications from it. 222

210. CTR. FOR REPROD. RIGHTS, FGM, supra note 189.
211. These are Benin, Burkina Faso, Central African Republic, Chad, Côte d’Ivoire, Djibouti, Ethiopia, Ghana, Guinea, Kenya, Niger, Senegal, South Africa, Tanzania, and Togo. Id.
212. Id.
213. Id.
214. E.g., Burkina Faso, Egypt, Ghana, Senegal, and Sierra Leone.
215. These are Australia, Belgium, Canada, Cyprus, Denmark, Italy, New Zealand, Norway, Spain, Sweden, United Kingdom, and the United States. Id.
216. Id.
217. Id.
218. See generally CTR. FOR REPROD. LAW & POLICY, FEMALE GENITAL MUTILATION, supra note 204 (assessing the duties of governments under human rights law).
219. Id. at 25.
220. Id.
221. Id. at 25, 30.
222. Id. at 32-35.
Governments, non-governmental organizations, individual advocates, and healthcare providers all play a role in ensuring adolescents' reproductive health and well-being.223 Though the primary responsibility for respecting, protecting, and fulfilling adolescents' human rights lies with national governments, the international community can help hold governments accountable to broadly accepted human rights standards.224 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.225

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 approaches must include greater enforcement of existing international legal protections.

A. What Governments Can Do

There are several steps governments can take to begin meeting obligations to international standards. First, governments must ensure adolescents' access to needed healthcare services and education regarding FGM.226 Governments need to allocate resources to youth-friendly clinics that offer comprehensive and confidential reproductive health care.227 They should also provide financial and political support to comprehensive sex-education campaigns.228

Second, governments must adopt and enforce legal measures and employ outreach strategies to protect adolescents' rights.229 This includes adopting legislation to ban child marriage and FGM, as well
as engaging in public education campaigns or other activities to discourage these practices.\textsuperscript{230} Furthermore, governments should explicitly criminalize sexual harassment and abuse in institutions meant to empower adolescents, such as schools, legal clinics, and the domestic arena.

Third, governments must empower married and pregnant adolescents.\textsuperscript{231} They can do this by providing married adolescents with access to educational and job training opportunities.\textsuperscript{232} Governments must also pass legislation which prohibits the expulsion of pregnant adolescents from school.\textsuperscript{233}

Finally, governments should be responsible for raising public awareness of adolescents' rights.\textsuperscript{234} To achieve this, they can adopt policies reflecting their recognition of the rights of adolescents in the area of sexual and reproductive health.\textsuperscript{235} They can also engage in public education campaigns to raise awareness of adolescents' rights and foster sensitivity to the reproductive health concerns of adolescents.\textsuperscript{236}

\textbf{B. What Advocates Can Do}

Advocates are the most agile of players in the legal system. They can use the international human rights instruments to build and strengthen legal standards that recognize and safeguard adolescents' rights.\textsuperscript{237} First, advocates must use international instruments to hold governments to their legal obligations to respect, protect, and fulfill adolescents' reproductive rights. Advocates should also use international law to hold national governments accountable for human rights violations.\textsuperscript{238} To achieve this, they can submit shadow reports to the U.N. treaty monitoring bodies, or send communications to U.N. and regional special rapporteurs covering issues of health

\begin{footnotes}
\footnotetext[230]{Id.}
\footnotetext[231]{Id. at 20-22, 24.}
\footnotetext[232]{Id.}
\footnotetext[233]{Id. at 22.}
\footnotetext[234]{INT'L PLANNED PARENTHOOD FED'N & FORUM ON MARRIAGE & RIGHTS OF WOMEN & GIRLS, supra note 117, at 28; SEXUAL AND REPRODUCTIVE HEALTH EDUCATION, supra note 69, at 2.}
\footnotetext[235]{CRC, supra note 5, at arts. 19, 24; ICCPR, supra note 43, at arts. 6, 9, 24.}
\footnotetext[236]{See e.g., ALFORD, CHEETHAM & HAUSER, supra note 70; SEXUAL AND REPRODUCTIVE HEALTH EDUCATION, supra note 69, at 2.}
\footnotetext[237]{See FEMALE GENITAL MUTILATION, supra note 185, at 73.}
\footnotetext[238]{CTR. FOR REPROD. LAW & POLICY, FEMALE GENITAL MUTILATION, supra note 204, at 46-51.}
\end{footnotes}
and violence against women and girls. Advocates can also bring cases on behalf of individual victims of rights violations to national, regional, and U.N. human rights accountability bodies.

Second, advocates can operate in tandem and through organizations to apply political pressure to governments that lack the legal framework and enforcement capacity to protect adolescents from violence, child marriage, and female genital mutilation. Finally, in regional and international human rights norm-setting conferences, advocates may emphasize reproductive health of adolescents as a key human rights concern.

C. What Health Care Providers Can Do

Health care providers have the ability to make an impact at the individual and local level. Because they are the most direct point of contact with adolescents, the measures they take to promote adolescent autonomy are likely the most important. First, health care providers can ensure that health facilities are youth-friendly and provide confidential, comprehensive services. Second, providers can also make certain that facilities should be staffed with specially trained healthcare 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.

Third, health care providers should inform adolescents seeking reproductive health care 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. Healthcare providers should also give adolescents comprehensive information regarding pregnancy and the transmission of STIs.

239. *Id.* at 49.
240. *Id.*
241. *Id.* at 45-50.
242. *Id.* at 51.
244. *Id.; see also EC/UNFPA, supra* note 98, at 1-2; *Kirby, Laris & Rolleri, supra* note 76, at 41-42; *Palmer, supra* note 107, at 1-3.
246. *Id.*
247. *Id.*
CONCLUSION

As a matter of policy, the reproductive and sexual health of adolescents matter because they comprise almost one half of the world’s population. As a matter of international human rights law, adolescents have reproductive and sexual health rights. This article outlines how the international community must ensure adolescents’ access to and exercise of those reproductive health rights. We must enable informed decision-making while also offering state protections for this vulnerable population. Without laws and policies that uphold adolescent health worldwide, future generations will needlessly suffer.

249. Ocampo, supra note 2, at iii.