The Center for Reproductive Rights (the Center) thanks the Independent Accountability Panel (IAP) for the opportunity to contribute to its upcoming report on accountability to adolescents. The Center greatly appreciates the work of the IAP, noting that its inaugural report, *Old Challenges, New Hopes*, acknowledges the interplay of different sectors on the outcomes of the health system – calling for the engagement and involvement of the judicial system, as well as for the reformation and strengthening of laws and policies, in support of the right to health.

The Center is pleased with the increased focus on adolescents in the updated *Global Strategy on Women’s, Children’s and Adolescents’ Health* (Global Strategy). Despite increased attention, significant gaps remain in adolescents’ knowledge about their sexual and reproductive health and rights (SRHR) and in their ability to access essential sexual and reproductive health (SRH) services and information. In support of the Global Strategy, States should be held accountable for addressing key legal and policy issues that prevent or deny adolescent access to essential SRH care and services. States must enact strong legal frameworks that sufficiently recognize adolescents’ evolving capacity, emerging autonomy and reproductive self-determination. In this context, international treaty bodies and other human rights mechanisms have established progressive norms and standards that facilitate adolescent access to SRH services and information. Using these normative developments, the Center’s submission focuses on the following issues: third party authorization, presumption of capacity, prevention of force or coercion in reproductive health choices, confidentiality and access to justice. This submission will discuss the accountability gaps around these issues for adolescents, highlight positive approaches that can be used to resolve them, and make recommendations for States to enable adolescents to access SRH services and to realize their sexual and reproductive rights.

I. Accountability Gaps

Adolescents face various legal and practical barriers in accessing SRH services and in realizing their rights to health, bodily integrity and reproductive autonomy. In many contexts, the laws and policies related to adolescent and SRH services, or lack thereof, act as barriers to accessing such services. For example, some laws and policies explicitly deny adolescents the right to access SRH services or require parental notification or authorization.\(^3\) Such restrictions may apply to all minors or only to those under a certain minimum age.\(^4\) Where laws and policies are silent on whether adolescents can access specific services, stigma surrounding adolescent sexuality may result in health care providers imposing their own restrictions that prevent adolescent access.\(^5\) Discrimination against vulnerable groups of adolescents, such as girls, remains a significant challenge that States must also address.
A. Third-party Authorization Requirements

i. Parental Authorization

Studies demonstrate that where adolescents are required to receive parental authorization for SRH services, they may opt to forgo such services, although they will still engage in sexual activity. Adolescents may not want to include their parents in decisions surrounding their SRH for numerous reasons. Stigma surrounding adolescent sexuality may make them fearful of a negative parental response, particularly for girls, who generally face greater stigma and discrimination surrounding their sexuality. In some instances, such a revelation about their sexual activity could result in violence at the hands of their parents or other family members, or in being kicked out of the family’s home, leaving the adolescent without shelter or a way to support him or herself financially. Furthermore, where adolescents decide to disclose their reproductive health needs to their parents, they may simply refuse to provide consent, thereby resulting in the denial of sexual and reproductive health information and services.

ii. Judicial Authorization

In some instances, in lieu of parental authorization, adolescents can seek judicial authorization to access particular SRH services by filing a petition and appearing before a judge. Judicial authorization requirements are particularly problematic for adolescents due to the range of barriers they face in accessing formal judicial mechanisms and the stigma surrounding SRH services. Furthermore, judges are afforded significant discretion and may simply deny the request. For example, in 2012 in the U.S. state of Nebraska, a pregnant 16-year-old was denied judicial authorization to terminate a pregnancy, thereby compelling her to carry the pregnancy to term against her will. Paradoxically, the court found that she was not “sufficiently mature and well-informed to decide on whether to have an abortion,” even though this meant that she would be forced to carry the pregnancy to term against her will and become a parent.

B. Provider-Imposed Restrictions

In addition to rigid parental consent requirements, studies from across the globe demonstrate that provider-imposed restrictions also constitute a major barrier to adolescents’ access to SRH services. Such restrictions may take the form of providers refusing to administer services based on the patients’ status as a minor or imposing a parental consent requirement, even though it is not required by law. For example, a study by the Guttmacher Institute in Senegal found that 57% of public-sector health care providers reported imposing a minimum age for access to contraception, even though this is not written into the law. For birth control pills, providers imposed a median minimum age of 17 years, while for injectable forms of contraception, providers required a median minimum age of 18 years. Similarly, a report on Managua, the capital city of Nicaragua, found that only 13% of pharmacists surveyed would administer emergency contraception to minors without parental consent, even though this is not required by law. Provider-imposed restrictions have been found to occur in other countries across the globe, including India, Nigeria, and Uganda, among others.
C. Discrimination and Gender Inequality

Adolescents may face various forms of discrimination in realizing their SRHR. As the Special Rapporteur on the Right to Health notes, adolescence, as a phase of the life cycle, can be a basis for discrimination. Adolescents may be treated as incompetent to make their own decisions due to their age. While not every differentiation of treatment constitutes discrimination, such differentiation must be reasonable and objective, and must serve a legitimate aim. This test is not met in the context of access to SRH services for adolescents. The inadequate realization of adolescents’ right to access SRH services undermines the realization of their human rights and exposes them to grave risks to their lives and health.

Twenty-five percent of adolescent girls aged 15-19 worldwide have an unmet need for contraception. As a result, nearly one-fifth of girls in the developing world become pregnant before the age of 18 and over 7 million girls under the age of 18 give birth each year worldwide. Unprepared physically to bear the burden of childbirth or unable to access quality maternal health care, 70,000 girls die each year as a result of complications during pregnancy or childbirth, making it the leading cause of death for girls aged 15-19 in developing countries. Furthermore, 3.2 million minors in developing countries undergo clandestine, unsafe abortions annually, placing their lives and health in jeopardy.

Gender inequalities become more exacerbated during adolescence. Discriminatory attitudes towards, and the marginalization of, girls in society can lead to serious human rights violations, including child, early and forced marriage (CEFM), early pregnancy, and gender based violence, including sexual violence. CEFM and early pregnancy are significant factors in SRH-related health problems, including HIV and AIDS. This is particularly true in contexts where adolescents already face barriers in accessing SRH services and information, and where such services and information are not youth-friendly. Married girls are in a potentially more vulnerable situation due to the likelihood of being exposed to gender based violence. Additionally, unplanned pregnancy has a drastic impact on girls’ lives, affecting their access to education, economic opportunities, and ability to participate in public and political life. For many girls, pregnancy is a precursor to the end of their formal education, either due to expulsion by the school as a sanction for becoming pregnant, or the need to drop out due to their childrearing obligations or inability to financially support a child. Stigma around girls’ sexuality and gender norms can also result in girls being denied access to family resources, such as the financial means to pay for health services; receiving less information about their SRHR; and having greater household responsibilities, resulting in less time to seek and access health services.

II. Promising Approaches to Addressing Gaps in Legal Accountability to Adolescents

While there are various challenges to adolescents’ universal access to SRH services, legal norms and standards may provide a strong framework to help resolve these issues. This work is built upon the recognition that adolescents have a right to the full range of SRH services and
The Committee on the Rights of the Child (CRC) has been at the forefront of affirming this principle. The CRC has urged States to “ensure that health systems and services are able to meet the specific sexual and reproductive health needs of adolescents.” In this regard, the full range of SRH services includes maternal health care; contraceptive information and services, including short- and long-term methods of contraception and emergency contraception; safe abortion services and post-abortion care; and information and services to prevent and address sexually transmitted infections. Further, the CRC has urged states to “decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services.”

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. Specifically, these bodies have called on States to ensure girls access to safe abortion services; affordable modern contraception, including emergency contraception; and proper care during pregnancy and childbirth.

A. Using International Norms to Create an Enabling Environment for Adolescents to Exercise their Sexual and Reproductive Rights

i. Third-party Authorization Should Not Be a Barrier to Access

International law 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.” The Special Rapporteur on the Right to Health echoed this in his recommendation to remove “all legal barriers to health facilities, goods and services, such as consent laws that unduly infringe upon the rights of adolescents to be heard and to be taken seriously and, ultimately, upon their right to make autonomous decisions.” The Rapporteur specifically recognized 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.” These normative developments reinforce the principle that parental authorization requirements constitute a barrier to health services. 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.

ii. Presumption of Capacity for SRH Services

In December 2016, the CRC 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.” This approach is also endorsed by the Special Rapporteur on Health. Under this framework, the fact that an adolescent recognizes his or her
need for such services and takes the initiative to seek them out evidences that he or she has the requisite capacity to make decisions about and use such services appropriately.46

Furthermore, the CRC 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.”47 The CRC has further called on States to ensure that “girls can make autonomous and informed decisions on their reproductive health.”48 This normative development demonstrates the unique and critical nature of SRH services for adolescents and represents a shift toward recognizing that adolescents have an inherent right to make autonomous decisions about their reproductive health.

Under the presumption of capacity framework, where a provider has concerns about the capacity of an adolescent seeking SRH services, the provider could follow the course of action that is in line with the adolescent’s best interests, with this assessment weighted towards the course of action chosen by the adolescent. This approach should take into account:

- why the adolescent is seeking particular sexual and reproductive health services;
- if the services are most appropriate for the adolescent’s needs;
- whether the adolescent is capable of following the treatment regimen; and
- the consequences for the adolescent if the provider denies him or her these services.49

Importantly, both the CRC and the Special Rapporteur on the Right to Health state that all adolescents have a right to independently seek confidential medical counselling and information, regardless of age.50

iii. Prevention of Force and Coercion in the context of SRH

Adolescents’ right to SRH services should also include protection from such services being forced upon them.51 International law recognizes that adolescents who are particularly vulnerable to discrimination are often less able to exercise their right to make autonomous decisions related to their health,52 and has called on States to ensure that the voluntary and informed consent of adolescents, free from pressure, violence or coercion, be required for all medical treatments and procedures.53 For example, adolescents with disabilities may be at greater risk for human rights violations related to their sexuality and reproduction, particularly including forced medical procedures such as forced sterilization, forced contraception, and forced abortion.54 The CRC has emphasized respect for adolescents’ physical and psychological integrity, and condemned forced treatments and surgeries, including for adolescents with intersex conditions.55

Furthermore, States should take measures to empower adolescents to make healthy and informed decisions about their sexuality and reproduction, including decisions to refuse or forego reproductive health-related practices or treatments. Such measures include the provision of comprehensive and non-discriminatory sexuality education, addressing the stigma surrounding sexuality, challenging gender stereotypes and harmful practices rooted in gender inequality, and establishing programs for girls’ empowerment and sensitization for men and
boys. States should also guarantee adolescents access to the full range of SRH services and options.

iv. Right to Confidentiality
Adolescents have a right to confidentiality in the provision of health services, including SRH services, and violations of this right implicate violations to the rights to health and privacy. The CRC has called on States to ensure health care providers keep adolescents’ medical information confidential, and the CEDAW Committee recognizes that lack of confidentiality deters women and girls from seeking health services, particularly SRH services and in instances of physical or sexual violence. In *P&S v. Poland*, the European Court of Human Rights addressed the disclosure of a minor’s confidential medical information, finding that she “was entitled to respect for her privacy regarding her sexual life,” and recognizing that this can result in ostracism and deter people from seeking health services.

**Special Measures of Protection**
In recognition of their unique vulnerabilities and evolving capacities, States are required to take special measures of protection for children. This includes taking “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…” States should pay particular attention to the forms of abuse, neglect, violence and exploitation that have a greater effect on minors. Within this context, adolescents’ dignity and integrity must be respected and promoted, by viewing them as rights-bearers, as opposed to “victims.”

Through individual cases, treaty monitoring bodies have found that the denial of sexual and reproductive health services to adolescents can violate their right to special measures of protection. In *KL v. Peru*, wherein an adolescent carrying an anencephalic fetus was denied legal abortion services and forced to carry the pregnancy to term, the Human Rights Committee recognized KL’s special vulnerability as a minor, finding that the State’s failure to provide her with the requisite medical and psychological support during and after her pregnancy amounted to a violation of the right to special measures of protection as a minor. In *LC v. Peru*, where a minor was denied urgent spinal surgery due to her pregnancy as well as abortion services, in finding a violation of the right to health, the CEDAW Committee recognized the heightened severity of the violation due to LC’s status as a minor and a victim of sexual abuse. Finally, in *P&S v. Poland*, wherein a 14-year-old who became pregnant as the result of rape was denied abortion services and subjected to intimidation and harassment, in finding a violation of the right to be free from ill-treatment, the European Court of Human Rights noted that P’s status as a minor was of “cardinal importance,” and the fact that she had been sexually abused placed her in a position of great vulnerability.

**B. Improving Adolescent Access to Justice**
For various reasons, adolescents may face significant barriers in accessing justice and redress, including lack of information/knowledge about their rights, lack of avenues for redress, inadequate resources, intimidation and stigma. Recognizing the unique barriers that adolescents face in seeking remedies for human rights violations, it is paramount that States implement adolescent-friendly redress mechanisms. International law calls for States to ensure that children have access to child-sensitive procedures to access an effective remedy, including by providing "child-sensitive information, advice, [and] advocacy, including support for self-advocacy." States should also provide “access to independent complaints procedures and to the courts with necessary legal and other assistance.” Where children’s rights have been violated, States must provide appropriate reparations, including compensation, measures of non-repetition and, where needed, measures to promote physical and psychological recovery. The Office of the High Commissioner for Human Rights has called for States to adapt their remedies to take into account the special vulnerabilities of children, including adolescents, such as by putting in place structural and proactive interventions to enable all children to have access to an effective remedy.

For such mechanisms to be effective, there must be an enabling environment to support adolescents to know their rights, as well as recognize and react to violations:

- States must enshrine the right to access SRH services into laws and policies and disseminate information to adolescents and other relevant stakeholders (i.e. health care providers, parents/guardians) about this right;
- Adolescents must have knowledge about their rights and access to mechanisms of redress for human rights violations. Such information must be "conveyed in language children are able to understand and which is gender- and culture-sensitive, and supported by child-sensitive materials and information services;"
- Legal systems must have authority to adjudicate claims from adolescents and/or filed on their behalf. This is particularly critical for SRH violations, as adolescents may be unwilling to seek assistance from a parent or other adults. The law must also recognize that violations of the right to access SRH services and information are justiciable;
- States must ensure that adolescents participating in judicial, legal or other proceedings are guaranteed the right to non-discrimination, which requires States to actively identify both individual and groups of adolescents who may require additional measures of protection.
- Access to justice should also be affordable, meaning that States should subsidize or grant adolescents cost-free access to complaint procedures and judicial mechanisms;
- States should also ensure children are provided with other appropriate assistance, such as social workers, legal counsel, and psychologists, as needed.

If it is appropriate, access to justice and redress for adolescents may also be brought before regional and global-level courts. Litigation before regional courts such as the Inter-American Court on Human Rights and the European Court of Human Rights, as well as before global...
bodies such as the Human Rights Committee or CEDAW Committee, may be other judicial mechanisms that can support legal accountability to adolescents’ SRHR.

III. Recommendations
There is a need for increased legal accountability to adolescents to ensure that they can access SRH services and information, in order to realize their sexual and reproductive rights. We hope that the IAP’s report will highlight the abovementioned issues and call for States to ensure that:

1. Adolescents have the ability to independently access the full range of SRH services, including maternal health care; contraceptive information and services, including short- and long-term methods of contraception and emergency contraception; safe abortion services and post-abortion care; and information and services to prevent and address sexually transmitted infections. This includes the legalization of safe abortion services.

2. Third party authorization requirements are not barriers for adolescents to access SRH services and information. States should repeal rigid parental consent requirements for adolescents to access SRH services, as such requirements violate their rights to health, non-discrimination, and other rights by inhibiting adolescents’ access to such services.

3. There are established policies and guidelines that guarantee access for all adolescents seeking SRH services and information. States should begin with the presumption that a minor seeking preventive or time-sensitive sexual and reproductive health services has the requisite capacity to access such services and make clear that it is in adolescents’ best interests to be enabled to access the full range of SRH information and services.

4. Adolescents’ bodily autonomy and reproductive self-determination are at the center of all decisions surrounding their SRHR. The administration of all SRH services to adolescents must be consented to voluntarily, free from pressure, violence or coercion. Where certain populations face greater risks of or previously have been subjected to pressure, violence or coercion in this context, States should take special measures to prevent, address and eliminate such practices.

5. Adolescents must have their right to confidentiality respected when seeking SRH services and information.

6. If adolescents experience SRHR-related violations, they have access to child-friendly, affordable/free mechanisms for redress and remedy. Adolescents must have knowledge of their rights and of redress mechanisms, and such mechanisms must be equipped to address their specific needs. The legal systems must also recognize SRHR claims as justiciable and hear claims on behalf of adolescents.

---

1 The Center is a non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C. The Center uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill.
Since its inception over twenty years ago, the Center has advocated for the realization of adolescent’s rights on a broad range of issues, addressing the right to access sexual and reproductive health services; prevention of sexual violence in schools; and eradication of harmful traditional practices, including female genital mutilation and child marriage.

2 Adolescents are defined as people between the ages of 10-19, as outlined by the World Health Organization (http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/).

3 For example, a number of countries’ abortion laws explicitly require parental authorization for minors seeking abortion services. See INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF), QUALITATIVE RESEARCH ON LEGAL BARRIERS TO YOUNG PEOPLE’S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES 13 (June 2014) [hereinafter IPPF, LEGAL BARRIERS TO YOUNG PEOPLE’S ACCESS TO SRH SERVICES]; Ministry of Health, Order No. 50 of 28 January 1994 on Procedures for Performing a Surgical Termination of Pregnancy, annex no. 1, art. 1.6 (Lithuania) (“The written consent of one of the parents, foster parents, guardians, caregivers, or persons actually raising the child is mandatory in cases of a termination of pregnancy to be performed on a minor girl under the age of 16”); Law of Jan. 7, 1993 on Family Planning, Human Embryo Protection, and Conditions of Legal Pregnancy Termination amended as of Dec. 23, 1997, art. 4a.4 (Pol.) (“In the case of a minor or fully incapacitated woman, the written consent of her legal representative is required”); Zákon č. 73/1986 Zb. o umelom prerušení tehotenstva v znení zákona č. 419/1991 Zb. [Act No. 73/1986 Coll. on Artificial Termination of Pregnancy as amended by the Act No. 419/1991 Coll.] (1986), sec. 6 (1-2) (Slv.) (“(1) In the case of a woman who has not yet reached the age of 16, artificial interruption of pregnancy in accordance with Section 4 may be performed with the consent of her legal representative or of the person who has been assigned responsibility for raising her. (2) If artificial interruption of pregnancy in accordance with Section 4 has been performed on a woman between 16 and 18 years of age, the health facility shall notify her legal representative.”); Committee on the Elimination of Discrimination Against Women (CEDAW Committee), Concluding Observations: Slovakia, para. 30(c), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).

4 For example, Croatia’s abortion law only requires parental authorization for minors under the age of 16.


7 See Melanie Zuch, Amanda J Mason-Jones, et al., Changes to the law on consent in South Africa: implications for school-based adolescent sexual and reproductive health research, BMC INTERNATIONAL HEALTH & HUMAN RIGHTS 3, 4 (April 10, 2012), available at http://bmcinternationalhealthrights.biomedcentral.com/articles/10.1186/1472-698X-12-3 (noting that “discussions surrounding sexuality are often shrouded in stigma and parent-child communication with regards to sex and sexuality is often limited. An adolescent therefore may not feel comfortable confronting a parent or guardian about participation in a sexual and reproductive health research study or may face disapproval if he or she chooses to do so”); see also Derek A. Kreager & Jeremy Staff, The Sexual Double Standard and Adolescent Peer Acceptance, 72 SOCIAL PSYCHOLOGY QUARTERLY 2, 143 (2009), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4256532/ (exploring the “sexual double standard” wherein boys are praised while girls are stigmatized for engaging in sexual activity).

8 See Martin Donohoe, Parental Notification and Consent Laws for Teen Abortions: Overview and 2006 Ballot Measures, MEDSCAPE (Feb. 9, 2007), available at http://www.medscape.com/viewarticle/549316 (noting that a significant portion of minors not revealing their abortion to a parent had experienced or feared violence or feared being forced to leave home).

9 Judicial authorization requirements can also appear as a requirement imposed on both adults and minors to access abortion services where restrictive abortion laws are in place.
10 IPPF, LEGAL BARRIERS TO YOUNG PEOPLE’S ACCESS TO SRH SERVICES, supra note 3, at 13; P. and S. v. Poland, supra note 5, para. 76; Código Penal (C.P.), Título VIII, Capítulo II [Penal Code, Title VIII, Chapter II] (1972), art. 266 (Bol.) (“When the abortion has been the consequence of the crime of rape, abduction not followed by marriage, statutory rape, or incest, no penalty shall be imposed, as long as penal action has been initiated. Neither shall it be punishable if the abortion has been performed for the purpose of preventing danger to the life or health of the mother and this danger could not be prevented by other means. In both cases, the abortion must be practiced by a doctor, with the consent of the woman and judicial authorization where applicable.”)


14 Id.


18 Id.


20 See UNITED NATIONS POPULATION FUND (UNFPA), MOTHERHOOD IN CHILDHOOD: FACING THE CHALLENGE OF ADOLESCENT PREGNANCY 37 (2013) [hereinafter UNFPA, MOTHERHOOD IN CHILDHOOD].

21 Id., at v.

22 Id., at 1.

23 Id., at iv.

24 UNFPA, MARRYING TOO YOUNG: END CHILD MARRIAGE 11 (2012) [hereinafter UNFPA, MARRYING TOO YOUNG].

25 See UNFPA, MOTHERHOOD IN CHILDHOOD, supra note 20, at iv.
Committee on the Rights of the Child, General Comment No. 20 on the implementation of the rights of the child during adolescence, para. 27, U.N. Doc. CRC/C/GC/20 (Dec. 2016) [hereinafter CRC Committee, Gen. Comment No. 20].


28 Committee on the Rights of the Child, General Comment No. 13: The right of the child to freedom from all forms of violence, para 72(g), U.N. Doc. CRC/C/GC/13 (Apr. 2011) [hereinafter CRC Committee, Gen. Comment No. 13].


30 UNFPA, MOTHERHOOD IN CHILDHOOD, supra note 20, at 25-26.

31 See CHANGU MANNATHOKO & HEATHER MILKIEWICZ, EMPOWERING ADOLESCENT GIRLS THROUGH EDUCATION ELIMINATING EXCLUSION AND DISCRIMINATION 8 (2012) (noting that “Direct costs of schooling (for instance: school fees, exam fees, uniforms, books and stationary supplies) diminish opportunities for children to access and/or remain in school. This contributes to the high number of girls being pushed out of school, especially in favor of boys for whom education is accorded higher priority in many societies. Indirect costs (such as the opportunity cost in terms of lost income or household labor from girls) further diminish girls’ participation in education.”), available at http://www.worldwewant2015.org/file/290405/download/31481; INTERNATIONAL LABOUR OFFICE, GENDER EQUALITY AT THE HEART OF DECENT WORK 61-65 (2009), available at http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_105119.pdf.

32 See, e.g, paras. 56 & 69-70.


34 See generally id.

35 CRC Committee, Gen. Comment No. 20, supra note 26, para. 60.


40 CRC Committee, Gen. Comment No. 20, supra note 26, para. 60.


42 Id., at para. 59.

43 CEDAW Committee, General Recommendation No. 24: Article 12 of the Convention (women and health), (20th Sess., 1999), in Compilation of General Comments and General Recommendations Adopted by Human Rights
privacy and includes appropriate education of adolescents is dependent on the development of youth-oriented systems and policies.


52 CRC Committee, Gen. Comment No. 15, supra note 33, para. 21.

53 CRC Committee, Gen. Comment No. 20, supra note 26, para. 39.

54 See SR Health, Report on the health of adolescents (2016), supra note 17, at para. 86; CRC Committee, Gen. Comment No. 20, supra note 26, at para. 31; see WORLD HEALTH ORGANIZATION & THE WORLD BANK, WORLD REPORT ON DISABILITY 61, 78 (Box 3.6) (2011);


57 See CRC Committee, Gen. Comment No. 15, supra note 33, at para. 70 (urging states to guarantee access to a broad range of contraceptive options); Committee on the Elimination of Discrimination against Women, Concluding Observations: Cyprus, para. 30(b), U.N. Doc. CEDAW/C/CYP/CO/6-7 (2013) (urging the state to guarantee women and girls a comprehensive range of contraceptive methods).

58 CRC Committee, Gen. Comment No. 4, supra note 27, at para. 11 (indicating that adolescents’ medical 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.”); CEDAW Committee, General Recommendation No. 24, supra note 43, para. 12(d); P. & S. v. Poland, Eur. Ct. H.R., supra note 5, at para. 128; See Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health (Art. 12), (22nd Sess., 2000), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 78, para. 23, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) (“The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.”).

59 CRC Committee, Gen. Comment No. 4, supra note 27, para. 11.

60 CEDAW Committee, Gen. Recommendation No. 24, supra note 43, para. 12(d).

61 P. & S. v. Poland, supra note 5, para. 134.

62 Id., para. 128.


CRC Committee, Gen. Comment No. 4, supra note 27, para. 12.


P. & S. v. Poland, supra note 5, para. 161.

Id., para. 162.