

**SEXUAL AND
REPRODUCTIVE
HEALTH AND
RIGHTS**

PLAN INTERNATIONAL'S POSITION PAPER

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: PLAN INTERNATIONAL'S POSITION STATEMENT

Plan International believes that all children, adolescents and young people have the right to make their own free and informed choices and to have control over their sexual and reproductive health and lives, free from coercion, violence, discrimination and abuse. Girls and young women in particular are denied the ability to exercise these rights. Fulfilling the rights of all children, adolescents and young people is fundamental to achieving gender equality.

HUMAN RIGHTS STANDARDS AND INTERNATIONAL COMMITMENTS RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

- Plan International believes that States must ratify and fully implement all ratified conventions or agreements relating to sexual and reproductive health and rights, including all action points that are listed in such documents, as well as general comments and treaty body recommendations. This requires governments to align all national and local laws and policies accordingly.
- We respect cultural traditions, religious beliefs and social norms, but believe that they should not constitute reasons for countries to make reservations to international conventions and agreements in relation to sexual and reproductive health and rights.
- We believe it is important to collect data disaggregated by age, sex, ethnicity, religion, disability, location, wealth, marital status, sexual orientation and gender identity, and migratory status (with due protections for privacy and human rights). This must include the age range 10 to 14 years in order to make younger adolescent girls and their needs visible and to track progress against commitments, policies and programmes on girls and young women.
- Plan International also supports the call in the Convention on the Elimination of All Forms of Discrimination against Women¹ for States to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against girls and women.

SOCIAL NORMS AND GENDER INEQUALITY

- Plan International believes that it is crucial to challenge gender inequality and social norms which hinder fulfilment of the sexual and reproductive health and rights of children, adolescents and young people, and in particular of girls and young women.

Traditional, cultural or religious grounds should not be used to justify these norms. Upholding sexual and reproductive rights in accordance with human rights standards and international agreements² is a priority for Plan International.

- To bring about change in attitudes, norms and behaviour, it is crucial to engage and promote inter-generational dialogue on sexual and reproductive health and rights as well as to challenge stereotypical attitudes and expectations around sexuality and reproduction. Dialogue should include the participation of children, adolescents, young people, parents, caregivers, traditional and religious leaders, health workers and teachers.³
- We believe that creating positive change in behaviours requires an approach that engages boys and men as much as girls and women. Involving boys and men as beneficiaries, rights holders and as agents of change is key to challenging dominant norms of masculinity, and to developing equality, safety, respect and responsibility in relationships, and thus to realising the sexual and reproductive health and rights of all children, adolescents and young people.
- We also recognise the role and responsibility of governments, including national health and education systems, in challenging harmful norms and gender inequality.
- Plan International is committed to working with others to challenge discriminatory attitudes, norms and behaviours which drive stigma, discrimination and violence towards children, adolescents and youth who identify as lesbian, gay, bisexual, transgender, intersex, questioning.

COMPREHENSIVE SEXUALITY EDUCATION

- Plan International believes that all children, adolescents and young people – without discrimination – are entitled to comprehensive sexuality education to gain knowledge, explore values and attitudes, and develop the skills they need to make conscious, healthy and respectful choices about relationships and sexuality. Parents and educators should be supported to embrace

children's learning about their bodies, relationships and sexuality from early childhood to allow children to explore, clarify and form life-long healthy attitudes and practices, free from coercion, violence and discrimination.

- Comprehensive sexuality education should be accessible for all children, adolescents and young people, in both formal and non-formal educational settings. Co-curricular activities which complement the formal curriculum are also important as are parental and community involvement and links to gender-responsive, child- adolescent- and youth-friendly healthcare and other services.⁴ Comprehensive sexuality education should be provided in a way that is non-judgemental, non-discriminatory, scientifically accurate, accessible, inclusive, rights-based, gender-transformative and adapted to the evolving capacity of the child, adolescent or young person.

ACCESS TO ADOLESCENT- AND YOUTH-FRIENDLY SRHR SERVICES

- Plan International believes that sexual and reproductive health and rights services should be gender-responsive, rights-based, adolescent- and youth-friendly and available to all adolescents and young people, including during conflicts and disasters. The services should be available and accessible to the most vulnerable and excluded adolescents and young people, including but not limited to migrants, those from ethnic minorities and indigenous groups, those living with disabilities and those identifying as lesbian, gay, bisexual, transgender, intersex, questioning.⁵
- Sexual and reproductive health and rights services should be linked with interventions to end violence against girls and women.
- It is important that health services are available and accessible to everyone, regardless of age or marital status.⁶ Services should respect privacy and confidentiality. They should be free of requirements for judicial, spousal, parental or guardian consent.
- We believe well-trained and supported health personnel are critical to delivering quality, gender-responsive adolescent- and youth-friendly services. A dedicated health budget for these services is essential so that user fees and expenses can be reduced or eliminated, making them accessible and affordable to all adolescents and young people.
- In order to ensure that services are fit-for-purpose and meet the needs of adolescents and young people, there needs to be a greater focus on ensuring their participation in the planning, implementation and monitoring of services.⁷

MENSTRUATION

- Plan International believes that the taboo nature of menstruation and sensitivity around discussing this with girls at home, in school and more broadly within society reinforces and perpetuates gender inequality. All girls and young women should have access to separate and hygienic sanitary facilities in all public spaces, especially in schools, as this is critical to ensure their attendance. They should also have access to accurate information about menstruation and to clean sanitary equipment.
- We believe that public and private water, sanitation and hygiene service providers should consult with girls and young women to ensure facilities meet their needs, and to enable them to practise good menstrual hygiene management.
- We will work with others to contribute to strengthening knowledge on the impact of social and cultural norms around menstruation and poor menstrual hygiene management.

ADOLESCENT PREGNANCY

- Plan International is committed to tackling adolescent pregnancy, particularly pregnancy in younger adolescents, and to supporting adolescent mothers. We recognise that adolescent pregnancy is a major contributor to maternal mortality and morbidity, which are grave violations of girls' rights.
- We believe that early unintended and unwanted adolescent pregnancy can and should be prevented. This requires challenging gender discriminatory norms and ending sexual violence against girls; strengthening girls' agency and ability to make autonomous and informed decisions about their reproductive health; ensuring the provision of comprehensive sexuality education and ensuring that health systems and services meet the specific needs of adolescents (in line with the Committee on the Rights of the Child General Comment No. 15, paragraph 56).
- Education can be a powerful tool for delaying adolescent pregnancy and early childbirth. We also recognise that adolescent pregnancy can be a driver for, or a consequence of child, early and forced marriage. This is particularly important for countries and regions that are projected to experience rising rates of adolescent pregnancy, such as Latin America.
- Plan International believes that all girls and young women have the right to access quality maternal health and obstetric care services. Health budgets must include adequate resourcing for their provision including emergency obstetric care and treatment of fistula.

CONTRACEPTION

- Plan International believes that all sexually active adolescents, including younger adolescents, and young people with an unmet need for family planning should be able to access modern contraception. In line with the Committee on Economic, Social and Cultural Rights General Comment No. 14, contraceptive services should be provided free of discrimination, stigma and coercion, and free of spousal, parental, guardian or judicial consent, and in accordance with the evolving capacities of the person in question.
- Plan International agrees with the Committee on the Rights of the Child General Comment No. 4 that adolescents should have access to information and services regarding contraceptives and family planning.

ACCESS TO SAFE ABORTION

- Plan International believes that abortions should be rare and that priority should be given to avoiding unintended pregnancy, through the provision of comprehensive sexuality education including accurate information on contraceptives as well as access to quality contraceptive services (including emergency contraception) for all girls and women.
- In line with the Convention on the Elimination of Discrimination against Women Committee,⁸ Plan International recognises reproductive rights to include the right of girls and women to make autonomous decisions about their health. Denying girls and women access to safe abortion services prevents them from exercising this right. Plan International does not provide medical health services.
- We believe that the provision of services for safe abortion should be available and accessible to all girls and women.
- Where abortion is legal, the provision of services should be within the fullest extent of the legal framework of the country.
- In countries where abortion is illegal or restricted we recognise that girls and women will still undergo unsafe abortions. In such countries, we take the stand that girls and women who seek or obtain abortions should neither be prosecuted nor penalised.
- Plan International acknowledges that unsafe abortion is a preventable cause of death and ill-health of girls and women across the world and often a consequence of violations of girls' and women's fundamental human rights. The right to health and gender equality are advanced by access to safe and legal abortion.

- Irrespective of the legal status of abortion, Plan International believes that quality post-abortion care as well as psychosocial counselling and support for all girls and women should be accessible.

HIV AND AIDS

- In line with Committee of the Rights of the Child General Comment No. 3 on HIV/AIDS and the rights of the child,⁹ Plan International believes that all children, adolescents and young people, including girls and young women, should have the ability to acquire the knowledge and skills they need to protect themselves and others from HIV infection.
- Plan International strongly emphasises the need to eliminate stigma and discrimination experienced by HIV-positive children, adolescents and young people both on an institutional and community or individual level. This requires challenging negative social norms around adolescents' and young people's sexual activity, as well as the provision of scientifically accurate information on HIV and AIDS transmission.
- We believe that all children, adolescents and young people should have equal access to the necessary health services, treatment and support they need. All services should have particular regard for the right to privacy and confidentiality.¹⁰
- We also recognise that gender inequality is a driver of the rising number of girls and young women living with HIV and AIDS, and that effective approaches for prevention, treatment and care need to be gender-transformative, empowering girls and young women to have control over their bodies and their lives.

FEMALE GENITAL MUTILATION/CUTTING

- Plan International strongly condemns female genital mutilation/cutting under all circumstances. Female genital mutilation/cutting is a human rights violation and needs to be treated as such.
- Female genital mutilation/cutting is linked to harmful norms and gender stereotypes as well as a perceived need to control female sexuality. Plan International believes that every girl and woman should have the autonomy and necessary knowledge to be able to make free and informed decisions about her body. Local actors need to be supported to challenge social norms and successful projects should be scaled up.
- Plan International believes that it is important to tackle female genital mutilation/cutting both through effective legislation as well as through awareness-raising about the physical and mental harm and long-term adverse impacts that can result from this practice.

- Engaging families, communities and traditional and religious leaders in changing attitudes and norms around this harmful practice is crucial to ensure that it is no longer perceived to be acceptable, beneficial or tolerated and is instead condemned as a human rights violation which needs to be eliminated.
- Plan International notes that achieving the target to eliminate female genital mutilation/cutting included in the 2030 Agenda for Sustainable Development will require urgent attention, given current population growth rates¹¹.
- We also recognise the critical role that child protection services can play in preventing abuse and extending assistance to victims.
- Plan International stresses the importance of the provision of care and support to survivors of violence, including the provision of safe houses. Healthcare providers and support services should respond to gender-based violence in a way that does not reinforce harmful attitudes.
- Protective measures for victims of violence, including sexual violence and rape, should include effective mechanisms to ensure care, support and protection, including access to healthcare (including emergency contraception), psychosocial support, access to safe abortion services and effective means to seek justice and redress.

CHILD, EARLY AND FORCED MARRIAGE

- Plan International strongly condemns the practice of child, early and forced marriage¹² and calls for the prohibition of the practice under national and customary law, and for the full and effective enforcement of these laws. In line with the Committee on the Rights of the Child General Comment No. 4, Plan International believes that the minimum age for marriage should be 18 and that this should apply equally to both men and women, regardless of any provisions concerning parental or judicial consent.
- Engaging communities and traditional and religious leaders, as well as girls and boys themselves, is critical to changing norms and eliminating this practice.
- We recognise that education is a powerful tool for preventing child, early and forced marriage. Girls who benefit from a quality education are less likely to marry while they are still children. Therefore, governments must ensure all girls, including married girls, can access and complete primary and secondary education in line with their commitments to the 2030 Agenda.

GENDER-BASED VIOLENCE

- Plan International believes that all children and young people have the fundamental human right to live free from violence.¹³
- We recognise that gender-based violence disproportionately affects girls and women. The root causes of gender-based violence are discriminatory social norms and unequal power dynamics between men and women. Changing these deep-rooted norms and attitudes that normalise and excuse violence against girls and women is critical to ending gender-based violence.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN HUMANITARIAN CONTEXTS

- Plan International believes that human rights should be ensured in times of crises and all actors involved in humanitarian responses should take all possible measures to ensure that all children, adolescents and young people, including girls and young women, are able to realise their sexual and reproductive health and rights.
- Sexual and reproductive health and rights are not only critical in their own right, but also to achieving humanitarian objectives in other sectors such as child survival and education. The sexual and reproductive health and rights of children and young people should be protected and fulfilled before, during and after disasters and conflicts.
- Disaster risk reduction, resilience building and the planning and implementation of humanitarian responses must take full account of the risks faced by children, adolescents and young people, in particular girls and young women, and protect and fulfil their sexual and reproductive health and rights. Plan International also firmly believes that all humanitarian actors should ensure that a gender and age lens is applied to all aspects of humanitarian response, and that all possible measures are taken to prevent and respond to sexual and gender-based violence.

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Introduction

Plan International believes that all children, adolescents and young people have the right to make their own free and informed choices and to have control over their sexual and reproductive health and lives, free from coercion, violence, discrimination and abuse. Girls and young women in particular are denied the ability to exercise these rights. Fulfilling the rights of all children, adolescents and young people is fundamental to achieving gender equality.

However, gender inequality and discriminatory social norms mean that girls and young women often lack the voice, agency and autonomy to make their own decisions in relation to their sexual and reproductive health and are frequently denied access to quality sexual and reproductive health information and services. This can leave them vulnerable and unable to protect themselves from unwanted pregnancy and sexually transmitted infections (including HIV), as well as from complications related to pregnancy and childbirth. It can also result in serious psychological harm. Girls and young women are frequently subjected to serious human rights violations, including coerced sex, sexual violence and harmful practices, such as female genital mutilation/cutting and child, early and forced marriage.

This is a position statement for Plan International, Inc. ("PII"). It presents our position on sexual and reproductive health and rights (SRHR), as well as an analysis of: the current global situation; the legal and political framework; and specific issues related to SRHR, in particular for girls and young women. This paper supports the new Global Strategy, in which SRHR is identified as a priority, and our work in relation to the 2030 Agenda and the Sustainable Development Goals – in particular Goals 3 and 5. A number of high-level recommendations are included to guide advocacy, however, a more specific advocacy framework will be developed.

The analysis and positions are founded on human rights, global evidence and Plan International's programmatic work, as well as a youth consultation with members of Plan International's youth advisory panels at the global level and in four countries; Bangladesh, El Salvador, Togo and Uganda, as well as young people who have been part of Plan International's programmes in these countries.

PII's country, regional, and liaison offices (including our "field country national organisations" (i.e. India and Colombia)) will be expected to put the position statement into practice using their judgement and analysis of the key issues in their specific context.

VOICES OF YOUNG PEOPLE

"There is no proper way to dispose of sanitary pads in my school. Most of the girls in my school didn't even use toilets when they needed to because it wasn't hygienic enough. I think proper steps must be taken to establish healthcare systems in schools."

Girl, aged 18, Bangladesh.

"The community looks at girls as future mothers – if they see them going for condoms, they are perceived as sexually active and cannot be managed so cannot make a good wife."

Young man, aged 22, Uganda.

"My experience is that, in our community there was a clinical camp. But it was difficult to find young girls going for services because they were shy to receive the services from a male provider and yet they received similar services comfortably from a fellow female provider."

Young man, aged 22, Uganda.

"Some parents feel that young girls are a source of income for the family and therefore marry them off."

Girl, Uganda.

"I am a girl. This is not my only identity. I am also a human being. Even though I am a girl I have some fundamental rights."

Young woman, aged 22, Bangladesh.

"Do you really believe a girl can **decide** only by herself? In our society to resort to modern contraception without parents' authorisation? Even at the hospitals, the health workers will tell her to go and come back with her mother..."

Boy, aged 17, Togo.

"In the rural areas it is a common understanding that a certain age, when youths become a bit rowdy or undisciplined, the way to 'fix' them is to get them married off. For a girl it has become time to find her a husband."

Young woman, aged 21, Bangladesh.

"I thought I received information on adolescent health from my mother, but the information was incorrect. For example, she told me that if the first menstrual blood touches any other part of the body, then physical growth is **constrained**."

Girl, Bangladesh.

"I have been a victim of exclusion because of my sexual orientation. Being a homosexual man makes you a **second class citizen**, which is wrong, and should change."

Young man, aged 19, El Salvador.

"Some service providers don't keep secrets. For example, you find a health worker telling another health worker how that girl came to us for a condom yesterday. Now she is here again for the same; what is she doing with them?"

Young woman, aged 23, Uganda

"A friend of mine got pregnant unexpectedly and consulted her friends on medical services for abortion. They discouraged her from seeking it from the government health centres for fear of prosecution (since abortion in Uganda is illegal) but then she went to a private clinic and was provided with safe abortion. She is now feeling very happy because her parents did not know, and she is continuing with her education and hoping for a good future."

Young man, aged 24, Uganda.

"Reinforce the vision of a secular state so women can retain autonomy over their own bodies. Women must be **demystified** so that they are not seen as solely reproductive beings."

Young man, aged 19, El Salvador.

DEFINITIONS

ABORTION is the termination of a pregnancy before the foetus has reached viability, i.e. become capable of independent extra-uterine life.¹⁴

ADOLESCENT: While adolescence is difficult to define, not least because individual experiences of puberty vary considerably, Plan International adopts the UN definition of an adolescent as a person between the ages of 10 and 19.¹⁵

CHILD: Plan International adopts the definition of the UN Convention on the Rights of the Child (CRC), which defines a child as anyone under the age of 18.¹⁶

CHILD-, ADOLESCENT- AND YOUTH-FRIENDLY HEALTH SERVICES: These are services targeting children, adolescents and youth that are sensitive and responsive to their particular needs, non-judgemental, gender-sensitive and that ensure confidentiality and privacy. Specific attention should be paid to the Availability, Accessibility, Acceptability and Quality¹⁷ of the services. In addition, services should be scientifically and medically appropriate with personnel trained to care for children, adolescents and youth as well as adequate facilities and scientifically accepted methods.¹⁸

COMPREHENSIVE SEXUALITY EDUCATION: UNESCO defines comprehensive sexuality education as a culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality. The term "comprehensive" emphasises an approach to sexuality education that encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make informed decisions about their health and sexuality.¹⁹

GENDER-BASED VIOLENCE is defined as "acts of physical, mental or social abuse that is attempted or threatened, with some type of force and is directed against a person because of his or her gender roles and expectations in a society or culture. A person facing gender-based violence has no choice to refuse or pursue other options without severe social, physical, or psychological consequences. Forms of gender-based violence include sexual violence, sexual abuse, sexual harassment, sexual exploitation, early marriage or forced marriage, gender discrimination, denial (such as education, food, freedom) and female genital mutilation/cutting.²⁰

LESBIAN, GAY, BISEXUAL, TRANSGENDER, INTERSEX, QUESTIONING (LGBTIQ) CHILDREN, ADOLESCENTS OR YOUTH: This is a broad category of those who self-identify as being lesbian, gay, bisexual, transgender, intersex, questioning. It also includes those who are questioning their sexual orientation and/or gender identity. Issues relating to LGBTIQ can emerge at different ages. For example, some people's intersex identity is clear at birth, and some transgender people are aware from early childhood that their real gender identity differs from that assigned at birth. Many realise their sexual orientation during adolescence. Being LGBTIQ is central to a person's identity and their physical and emotional wellbeing.²¹

REPRODUCTIVE HEALTH: Defined by the International Conference on Population and Development as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" which "implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so."²²

REPRODUCTIVE RIGHTS: These are defined by the International Conference on Population and Development as embracing "certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence."²³

SEXUAL HEALTH: Defined by the World Health Organization as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."²⁴

SEXUAL ORIENTATION refers to each person's capacity for profound emotional, affectionate and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.²⁵

SEXUAL RIGHTS: According to World Health Organisation, these embrace certain human rights that are already recognised in international and regional human rights documents and other consensus documents and in national laws. These include the rights: to equality and non-discrimination; to be free from torture or from cruel, inhumane or degrading treatment or punishment; to privacy; to the highest attainable standard of health (including sexual health) and social security; to marry and to found a family and enter into marriage with the free and full consent of the intending spouses; and to equality in and at the dissolution of marriage; to decide the number and spacing of children; to information, as well as education, freedom of opinion and expression; and the right to an effective remedy for violations of fundamental rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regards for the rights of others and within a framework of protection against discrimination.²⁶

SEXUALITY: According to World Health Organisation "a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."²⁷

UNSAFE ABORTION is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.²⁸

VIOLENCE AGAINST WOMEN is defined 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 in private life".²⁹

YOUTH/YOUNG PERSON: Youth is best understood as a period of transition from childhood to adulthood. Plan International adopts the UN Secretariat definition of youth/young person to mean a person between the ages of 15 and 24.³⁰

Overview of current global situation

Around the world, many children, adolescents and young people grow up and become sexually active without access to timely, appropriate, gender-responsive, quality SRHR information and services.

Harmful social norms, gender stereotypes, power imbalances between males and females, perceptions of girls' and young women's sexuality and other inequalities are significant barriers in restricting children's, adolescents' and young people's access to SRHR. Despite efforts of advocates from around the world, Sexual and Reproductive Health and Rights (SRHR) is not an internationally agreed concept. Governments have only agreed to recognise Sexual and Reproductive Health and Reproductive Rights.³¹ Sexual rights have not been recognised in international agreements.³² Nevertheless, the term SRHR is commonly used amongst rights-based groups and organisations.

There have been significant advances over the last 20 years in certain aspects of SRHR – such as maternal health, HIV prevention, treatment and care, and contraceptive use. However, other areas, such as deaths due to complications of pregnancy, childbirth and unsafe abortion³³ and sexual violence remain alarmingly high.

Girls and young women are disproportionately affected by and vulnerable to SRHR violations due to entrenched gender inequalities and the lower value attributed to girls and women in many societies. They are often denied the autonomy or knowledge to make informed decisions to be able to exercise a healthy, safe and enjoyable sexuality, free from coercion, subjugation, violence and discrimination. This is particularly true for girls and young women who live in poverty, in crisis or emergency settings or who belong to vulnerable and excluded groups,³⁴ who often face additional risks to their health and wellbeing due to the intersection of multiple forms of discrimination. Restrictions on mobility and freedom of movement can specifically limit girls' and young women's equal access to sexual and reproductive health services.³⁵

Complications due to pregnancy and childbirth is still the second leading cause of death for adolescent girls aged 15 to 19 globally, exceeded only by suicide.³⁶ Suicide is the leading cause of death among adolescent girls aged 15 to 19 globally.³⁷ The highest rates can be found in South-East Asia, where suicide is the cause for one in six deaths among adolescent girls.³⁸

Younger adolescents under the age of 15 face even higher risks related to pregnancy and childbirth³⁹ and it is estimated that 2 million births occur among this younger age group in low-resource countries each year.⁴⁰ Ninety-nine per cent of all maternal deaths occur in developing countries and a majority of these could be prevented.⁴¹

Girls and young women not only face increased risks related to pregnancy and childbirth – they are also more seriously affected by complications than older women.⁴² For example, up to 65 per cent of women with obstetric fistula develop this as adolescents.⁴³ At the same time, a large proportion of adolescent girls and young women who want to delay or space pregnancy are not using any form of modern contraception. In developing countries 23 million girls and young women aged 15 to 19 have experienced an unmet need for modern contraceptives.⁴⁴ Every year, some 3 million girls aged

15 to 19 undergo unsafe abortions putting themselves at risk of death.⁴⁵

Gender inequality, violation of girls' and young women's rights, such as sexual abuse, child, early and forced marriage and age-disparate sexual relationships, and other social and economic inequalities, put girls at risk of acquiring HIV. Girls accounted for more than 60 per cent of the 220,000 adolescents (aged 15 to 19) who contracted HIV in 2014.⁴⁶

Girls and young women continue to experience extremely high levels of violence, including sexual abuse. More than a third – 35.6 per cent – of women around the world have experienced either non-partner sexual violence or physical or sexual violence by an intimate partner, or both.⁴⁷ In some countries up to 68 per cent of women are reported to have experienced these forms of intimate-partner violence.⁴⁸ However, actual figures may be even higher, as sexual violence and domestic abuse are often underreported. Violence against girls and women results in considerable physical and psychological consequences, including injuries, disabilities, increased risk of HIV infection and unwanted pregnancy from sexual violence.⁴⁹

Harmful practices such as child, early and forced marriage and female genital mutilation/cutting also continue to have devastating effects on girls' and women's sexual and reproductive health and wellbeing. Some 200 million girls and women alive today are estimated to have been subjected to female genital mutilation/cutting⁵⁰ and the current rate of progress on ending child marriage needs to be accelerated to eight times faster than the current rate in order to meet the target of eliminating the practice by 2030.⁵¹

There are strong links between girls' and women's health and nutritional status and their children's survival, growth and development: deaths during the first month of life constitute 44 per cent of child deaths, and most result from inadequate maternal healthcare before birth and during delivery.⁵²

In humanitarian contexts, existing gender inequalities are exacerbated, placing girls and women at a heightened risk of gender-based violence, exploitation and abuse.⁵³ Loss of support and protection mechanisms, financial pressures and the absence of reliable healthcare and judicial systems render girls and women particularly vulnerable and makes it difficult for them to realise their sexual and reproductive rights.⁵⁴

During conflict, girls and women may also be deliberately targeted and subjected to various forms of violence and abuse, including arbitrary killings, torture and mutilation, sexual violence, forced marriage, forced prostitution, forced impregnation, forced termination of pregnancy and sterilisation.⁵⁵ However, sexual violence is often underreported due to the trauma suffered by survivors as well as fear of stigmatisation and retribution as well as the limited availability of services.⁵⁶

In addition, disruption to essential health services, which often occurs during times of crisis, increases the likelihood of unplanned pregnancy and severe sexual and reproductive health problems and complications. Approximately three-fifths of all maternal deaths take place in humanitarian and fragile contexts.⁵⁷ Girls and women are also at greater risk of contracting sexually transmitted infections including HIV and AIDS as a result of sexual violence, transactional sex and other risks which are exacerbated during times of crisis.⁵⁸

Given that we now have the largest generation of adolescents the world has ever seen, it is critical to ensure their access to sexual and reproductive health information and services, as these are fundamental to their lifelong health.⁵⁹ In 2014, the world was home to 1.8 billion 10 to 24 year-olds, of whom most were adolescents.⁶⁰

Human rights standards and international commitments relating to SRHR

Sexual and reproductive rights⁶¹ are stipulated in a number of human rights instruments and international agreements. These include (but are not limited to) the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, the International Covenant on Economic, Social and Cultural Rights, the Programme of Action of the International Conference on Population and Development, the Beijing Declaration and Platform of Action and the 2030 Agenda for Sustainable Development. There are also a number of regional human rights instruments and frameworks that address SRHR. However, for the purpose of this paper, we will be focusing on international conventions and agreements.

Annex 1 provides a more detailed analysis of the international legal framework and key human rights and international consensus documents that guide our work in this area. Below we present a brief overview of the most important documents that guide Plan International's work in this area.

Convention on the Rights of the Child

Article 24 of the Convention on the Rights of the Child (CRC) clearly expresses that all children have the right to enjoy the highest attainable standard of health and that no child should be deprived of his or her right to access such healthcare services.⁶² The Committee of the Rights of the Child General Comment No. 4 on Adolescent Health and Development emphasises that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, recommending that States reform legislation to provide for a minimum age of marriage with and without parental consent to 18 years for both boys and girls.⁶³ It also stresses the need for States to provide adolescents with access to sexual and reproductive information, including information on family planning and contraceptives; the dangers of early pregnancy; and the prevention and treatment of sexually transmitted infections, including HIV, regardless of marital status and parental or guardian consent.⁶⁴ It places particular emphasis on the need to respect adolescents' rights to privacy and confidentiality including with respect to advice and counselling on health matters.⁶⁵ Furthermore, States are urged to take effective measures to ensure that adolescents are protected from all forms of violence, abuse, neglect and exploitation.⁶⁶

The Committee on the Rights of the Child General Comment No. 3 on HIV/AIDS emphasises the obligation on States to ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.⁶⁷ It

also calls on States to guarantee the equal access of children to all relevant services with particular regard for the child's right to privacy and confidentiality.⁶⁸ It also emphasises the need for services to be friendly and supportive, accessible, affordable, non-judgemental and free from any requirement for parental consent.⁶⁹

Convention on the Elimination of All Forms of Discrimination Against Women

Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women requires States to take all appropriate measures to eliminate discrimination against women when it comes to healthcare and accessing services. Of particular relevance for SRHR, the convention requires that States ensure that women have equal access to family planning services, as well as access to services during pregnancy and the postnatal period.

General Recommendation No. 24⁷⁰ provides further clarification on the scope of Article 12. It clarifies that its recommendations apply equally to girls and adolescents as well as women. Of particular note, the General Recommendation clarifies that where a health worker refuses to perform certain health services on the grounds of conscientious objection, the State is required to introduce measures to ensure that women are referred to alternative health providers.⁷¹ It goes on to note that States should not restrict women's access to health services on the grounds that they lack the authorisation of their husbands, partners or health authorities or because they are unmarried or women.⁷²

The General Recommendation further recommends that "States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality".⁷³

2030 Agenda for Sustainable Development

Gender equality is embedded in the 2030 Agenda for Sustainable Development (often referred to as Agenda 2030 and the Sustainable Development Goals) as a whole and also addressed in a stand-alone goal. The 2030 Agenda also tackles cross-cutting issues which hinder the realisation of SRHR, such as child marriage; poverty; violence; stigma and discrimination. It also contains two targets specifically addressing SRHR and access to health services.

Target 3.7 provides: "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes".

Target 5.6 provides: "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences".

Implementation of international frameworks and agreements

All of Plan International's work is grounded in international human rights law. In line with Article 1 of the Universal Declaration of Human Rights, we believe that "all human beings are born free and equal in dignity and rights". This of course includes girls and young women. Too often however, their sexual and reproductive rights are not upheld. This cannot be ensured where governments have not yet ratified relevant conventions and agreements in relation to SRHR.

Many countries have ratified conventions or agreed to consensus documents, but made reservations to certain provisions, thereby effectively undermining them. Many countries have also ratified conventions or agreements but have failed to implement them. This is a challenge for the international community as it prevents real progress in realising international frameworks and agreements and thus hinders implementation of human rights.

Frequently, States also challenge the legality of general comments and international consensus agreements and fail to implement action points within these documents. While not legally binding, these documents are nevertheless persuasive in character and indicative of the direction that the international law is heading.

Other shortcomings include weak legal frameworks and inadequate enforcement of laws that can result in impunity for perpetrators.

Plan International's position:

- **Plan International believes that States must ratify and fully implement all ratified conventions or agreements relating to sexual and reproductive health and rights (SRHR), including all action points that are listed in such documents, as well as general comments and treaty body recommendations. This requires governments to align all national and local laws and policies accordingly.**
- **We respect cultural traditions, religious beliefs and social norms, but believe that they should not constitute reasons for countries to make reservations to international conventions and agreements in relation to sexual and reproductive health and rights.**
- **We believe it is important to collect data disaggregated by age, sex, ethnicity, religion, disability, location, wealth, marital status, sexual orientation and gender identity, and migratory status (with due protections for privacy and human rights). This must include the age range 10 to 14 years in order to make younger adolescent girls and their needs visible and to track progress against commitments, policies and programmes on girls and young women.**
- **Plan International also supports the call in the Convention on the Elimination of All Forms of Discrimination against Women⁷⁴ for States to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which**

constitute discrimination against girls and women.

Recommendations to promote and protect sexual and reproductive rights:

- **Governments should adopt, budget for, implement and monitor national legislation and policies to ensure the effective enjoyment of the right to the highest attainable standard of sexual and reproductive health for all children, adolescents and young people. This should include legislation that protects girls and young women from violence and harmful practices. Legislation and policies should also be fully consistent with international human rights law and take precedence over conflicting customary or religious laws.**
- **Governments should remove legal, regulatory and policy barriers to sexual and reproductive health information, education and services for all children, adolescents and young people, including girls and young women, and create an enabling environment so that they can have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, stigma, discrimination or violence.**
- **Governments should ratify all relevant conventions and agreements in relation to SRHR. Governments that have ratified conventions but made reservations to provisions relating to SRHR should withdraw these reservations.**

Key SRHR issues

Having outlined the current status of SRHR for children, adolescents and young people at a global level, this section examines in more detail how the fulfilment of SRHR is linked to gender and age.

This section therefore focuses particularly on the challenges that girls and young women face to realise their SRHR and presents Plan International's position and recommendations on each issue.

Social norms and gender inequality

Social norms and expectations around how girls and boys or young women and young men should behave – and perceptions about their sexuality in particular – are important drivers of sexual and reproductive ill health and the non-fulfilment of rights.⁷⁵ For example, the perception that female sexuality needs to be controlled and that girls and women should not experience sexual pleasure is deep-rooted and also serves as a driver of harmful practices such as female genital mutilation/cutting.⁷⁶ It can also result in girls and young women entering sexual relationships under the impression that they should be submissive and that they should not express their needs and desires.

Inequality, discriminatory social norms and attitudes towards girls and young women mean that they are often denied the voice, agency and autonomy to make their own decisions in relation to their SRHR.

For example, a girl who engages in sexual relationships before marriage, or who insists that her partner uses condoms, may in some contexts be seen as promiscuous.⁷⁷ Young women, both married and unmarried, report that men's attitudes towards contraceptives constitute the largest barrier to their use.⁷⁸

A girl taking part in a youth consultation workshop in Bangladesh said that one of her friends had been expelled from her school after a condom was found in her bag. The school authority had thought that she was having premarital sex and therefore considered her "a wicked girl". Later it was found that the girl's sister had mistakenly kept the condom in her bag, but the school authority did not allow the girl to return.

Furthermore, cultural norms often glorify marriage, motherhood and fertility in a manner that limits girls' and women's autonomy in exercising life choices.⁷⁹ Girls and women may be valued according to their marriageability or their ability to produce children. This often results in families seeking to marry their daughters early and puts pressure on girls to become pregnant soon after they

have entered into marriage, regardless of their often very young age. This pressure to reproduce quickly – and ideally to have male children – can lead to adverse health consequences as a result of repeated pregnancies spaced too closely together.⁸⁰ Girls and young women may also be cast out of marriages if they are considered unable to reproduce on the presumption that they have fertility issues.⁸¹

At the same time, perceptions of manhood and masculinity may include expectations that boys and men should engage in unsafe sex and other risk-taking behaviour; that they need to use violence to resolve conflict; and that they should be knowledgeable about sex from an early age.⁸²

Boys participating in a youth consultation workshop in Bangladesh said that they are influenced by their peers, and by older boys to have premarital sex. Between peers there might be a state of competition and there might even be ongoing bets for relationships and sex. Individuals like *kobiraj* (quack doctors) had also encouraged boys to engage in premarital sex "as a solution to satisfy their sexual frustrations or wants" - eg. to "cure" wet dreams. One boy, aged 17, said that as a result of these pressures they might go to sex workers.

These expectations may dissuade boys and men from seeking information and services. It can also make it difficult for them to speak out against abuse and sexual exploitation. Inevitably, these perceptions of masculinity have many negative consequences for the health of boys and young men as well as girls and young women. They also tend to fuel homo- and transphobia.⁸³

Long-term solutions are needed to address the drivers of gender inequality, patriarchy, the norms that perpetuate and normalise violence against girls and women and impunity for perpetrators as well as the inadequate protection of human rights.⁸⁴ The sexual and reproductive health of girls and young women is intrinsically intertwined with that of boys and young men.⁸⁵ Efforts are needed to tackle the negative attitudes of boys and men towards girls and women as well as the negative self-images that many girls and women have as a result of societal norms and expectations. Cultural and social norms influence girls' and young women's self-esteem through idealised body images and objectification. The pressure to fit in and adhere to these as well as the impact of the sexualisation of girls and young women in many societies is significant.

Gender inequality can also affect access to and the quality of care, for example through prejudicial attitudes to unmarried girls and women. Service providers may

CASE STUDY: Plan International's Champions of Change programme – promoting gender equality through peer-to-peer mobilisation

Plan International has implemented Champions of Change, an innovative model for promoting gender equality and girls' rights through youth engagement and peer-to-peer mobilisation, in countries across Latin America.

The model includes a comprehensive set of curricula for both girls and boys, providing teams with cohesive tools for promoting girls' empowerment and engaging boys to promote gender equality. It also seeks to drive social norm change and challenge stereotypes of gender roles and masculinities. The Champions of Change Curriculum covers all elements of comprehensive sexuality education. It seeks to provide young people with a solid foundation from which to make their own decisions regarding their bodies and sexuality and to decide their own futures.

also refuse to provide girls and young women with access to contraceptive information and services or impose conditions such as spousal, parental or guardian consent.⁸⁶ This can present a significant barrier to girls' and young women's realisation of their rights and may leave them unable to protect themselves against early or unwanted pregnancy, unwanted sexual relations and sexually transmitted infections, including HIV. In addition, social norms and taboos around sex and sexuality restrict them from gaining and practising skills, such as negotiation skills, required to exercise agency in these matters.

As outlined in Plan International's [Tackling Exclusion Framework](#), gender norms and inequalities intersect with other forms of exclusion⁸⁷ and patterns of discrimination. For example, girls and young women who live in poverty in rural areas, who belong to indigenous groups or who are disabled face additional barriers to accessing sexual and reproductive health information and services. People with disabilities have often been denied the right to establish relationships and make decisions regarding family planning. Lesbian, gay, bisexual, transgender, intersex, questioning adolescents and youth may also face multiple challenges to accessing the SRHR services required, for example due to discriminatory laws or attitudes and lack of technical expertise among service providers.

Part of the challenge also lies in the contradictory way in which society views adolescents. On the one hand, adolescents are recognised as rights holders, yet on the other hand, adolescents are also considered to be vulnerable, weak, rebellious and unable to make decisions for themselves.⁸⁸ In many countries, talking about sexual activity and relationships is a taboo topic between children and their parents, which can leave children, adolescents and young people without the necessary knowledge to be able to make informed decisions. In addition, there is resistance from conservative religious and community leaders as well as in some States to condemn child sexual activity within marriage even though it is often coerced rather than based on free consent. At the same time, these actors oppose children's and adolescents' access to SRHR services and to comprehensive sexuality education. They also oppose the notion that girls have sexual and reproductive rights rather than just sexual duties in marriage, denying the concept of autonomy and consent.⁸⁹

Plan International's position:

- **Plan International believes that it is crucial to challenge gender inequality and social norms which hinder fulfilment of the SRHR of children, adolescents and young people, and in particular of girls and young women. Traditional, cultural or religious grounds should not be used to justify these norms. Upholding sexual and reproductive rights in accordance with human rights standards and international agreements⁹⁰ is a priority for Plan International.**
- **To bring about change in attitudes, norms and behaviour, it is crucial to engage and promote inter-generational dialogue on SRHR as well as to challenge stereotypical attitudes and expectations around sexuality and reproduction. Dialogue should include the participation of children, adolescents, young people, parents, caregivers, traditional and religious leaders, health workers and teachers.⁹¹**

- **We believe that creating positive change in behaviours requires an approach that engages boys and men as much as girls and women. Involving boys and men as beneficiaries, rights holders and as agents of change is key to challenging dominant norms of masculinity, and to developing equality, safety, respect and responsibility in relationships, and thus to realising the SRHR of all children, adolescents and young people.**
- **We also recognise the role and responsibility of governments, including national health and education systems, in challenging harmful norms and gender inequality.**
- **Plan International is committed to working with others to challenge discriminatory attitudes, norms and behaviours which drive stigma, discrimination and violence towards children, adolescents and youth who identify as lesbian, gay, bisexual, transgender, intersex, questioning.**

Recommendations for addressing gender inequality and harmful norms:

- **Governments, UN bodies and civil society organisations should actively engage communities, families, children, adolescents, young people (including girls and young women), traditional and religious leaders, health workers and teachers on achieving positive change on gender equality and SRHR, in particular with regard to sexuality and reproduction. This should be with a view to raise awareness of children's, adolescents' and young people's SRHR and the impact of harmful social and gender norms as well as to mobilise these actors to change harmful attitudes and norms.**
- **Governments need to implement all international and regional agreements that refer to governments' commitments to work towards achieving gender equality and engaging boys and men, such as the Beijing Declaration and Platform for Action, as well as more recent agreements such as the Commission on the Status of Women 48 agreed conclusions.**
- **Boys and men should be supported and enabled to actively participate as agents of change, rights bearers and beneficiaries to challenge existing gender inequalities and harmful gender stereotypes around SRHR.**
- **Local, national and international media should engage children, adolescents and young people, including girls and young women, to influence how the media portrays adolescent and youth sexuality responsibly. In particular they must avoid reinforcing gendered stereotypes, sensationalising sexuality and normalising sexual violence.**
- **Governments, UN bodies, and civil society organisations should help children, adolescents and young people, especially girls and young women, to understand and claim their rights, including through human rights education and dissemination of human rights information in child- and youth-friendly formats.**

Comprehensive sexuality education

The provision of comprehensive sexuality education (CSE) for both boys and girls is key to promoting an understanding and awareness of SRHR and to developing the skills, knowledge, autonomy, confidence and ability to make free and informed decisions about their sexual and reproductive lives, to enjoy fulfilling and healthy relationships and to protect themselves and their partners against ill health, violence and unwanted pregnancy. CSE intersects with the rights to education, health, participation and protection.⁹²

The term “comprehensive” emphasises a holistic approach to sexuality education that encompasses the full range of information, skills and values to enable children, adolescents and young people to exercise their sexual and reproductive rights, and to make decisions about their health and sexuality.⁹³ It includes information on contraception and safer-sex practices and contrasts with “abstinence-only” education. Abstinence-only education does not take a rights-based approach, and evidence demonstrates that it is less effective in practice.⁹⁴

A technical guidance note on sexuality education from UNESCO states that topics and learning objectives in CSE should cover the following components: information; values, attitudes and social norms; interpersonal and relationship skills; and responsibility.⁹⁵ These areas cover a wide range of topics that are relevant for successfully delivering CSE. This includes learning about relationships, gender equality, sexual and gender-based violence, sex, sexuality and SRHR.

Research shows that CSE does not lead to an earlier onset of sexual activity, but rather can delay the age of first sexual experience and can have a positive impact in terms of safer sexual practices.⁹⁶ The Committee on the Rights of the Child has clarified that adolescents’ right to information about HIV and AIDS is part of the right to information and that States should not withhold, censor or intentionally misrepresent health information, including sexuality education.⁹⁷ The International Conference on Population and Development recommended that information and services should be made available to adolescents to help them understand and enjoy their sexuality and to protect them from unwanted pregnancies, sexually transmitted infections and the subsequent risk of infertility. It also emphasised the importance of addressing gender inequality and educating young men to respect women’s self-determination and to share responsibility with women in matters of sexuality and reproduction.⁹⁸

Evidence demonstrates that CSE programmes, if delivered correctly, have a positive impact. In a meta-analysis of 87 studies⁹⁹ two-thirds demonstrated positive impact on behaviour, including increased self-efficacy related to condom use and refusing sex.¹⁰⁰ This same rigorous review of evidence demonstrated increased HIV knowledge across almost all programmes, with two-thirds demonstrating positive impact on behaviour, including a reduced number of sexual partners; delayed sexual debut; increased self-efficacy related to condom use and refusing sex; increased contraception and condom use.¹⁰¹

At the same time, robust evidence shows that abstinence-only approaches have proven ineffective.¹⁰² According to the same analysis, abstinence messages actually had no impact on adolescent sexual behaviour

in terms of the initiation of sex, abstinence or a decrease in the number of sexual partners. Despite this, abstinence-only approaches are still delivered in many countries.

Various human rights committees including the Committee on the Rights of the Child¹⁰³ and the Committee on the Elimination of All Forms of Discrimination Against Women¹⁰⁴ have also urged States to make CSE mandatory in primary and secondary education. However, while there has been some progress in introducing sexuality education in schools, there are significant gaps in coverage and the content is often not as comprehensive as it needs to be. As such, access to high quality CSE is difficult or impossible for many children, adolescents and young people – particularly in many low- and middle-income countries.¹⁰⁵ This was also highlighted as a key issue in the youth consultations.

A Plan International report from the Asia region noted that programmes often focus on HIV prevention but neglect other areas such as the link to the rights framework and issues of stigma and discrimination.¹⁰⁶ There is also a tendency for such programmes to be driven by the national strategic plan on HIV and AIDS without adequate alignment with education sector plans.¹⁰⁷

A further report commissioned by Plan International UK in 2016¹⁰⁸ highlighted that although a proven practice, CSE is often poorly implemented and its success relies heavily on adequate fidelity to the factors that ensure effectiveness: the quality and content of the curricula, including the methods and pedagogy used; effective linkages with SRHR services; trained facilitators; and youth engagement.

In a workshop with young people in Bangladesh, it was revealed that some of the participants had discussed issues related to sex with their parents. However, the information provided by the parents was not complete and consisted of taboos or misinformation. Village elders provided participants from rural areas with traditional and incorrect information. Girls tended to have closer relations with their mothers, who served as the main source of information on topics related to sex. On the other hand, boys mostly received their information from peers, who had in turn received their information from various sources, including pornography. Boys specifically mentioned their inability to talk about SRHR with their fathers or other elders in the family.

Other critical and enabling factors include: supportive government and school policies; supportive executive leadership in schools; community engagement with parents, caregivers, religious leaders and the wider community; and adequate monitoring and evaluation. Curricula that are rights-based and gender-aware, delivered with efforts to expand access to high quality, adolescent- and youth-friendly services, make CSE even more effective. In curriculum design, increased attention is required to develop key competencies, including critical thinking, and on examining how gender norms, religion and culture influence learners’ attitudes and behaviour. The most effective teaching methods are participatory and learner-centred, providing opportunities for self-reflection and encouraging children, adolescents and young people to connect what they are learning in the classroom to their wider worlds. Lack of adequate training for CSE facilitators is a critical barrier and there

is a need to invest specifically in training educators to deliver CSE effectively.

CSE has the ability not only to empower children, adolescents and young people to make informed, autonomous decisions regarding their SRHR and current and future relationships,¹⁰⁹ but it can also be part of a holistic approach to challenging gender inequalities and preventing and responding to gender-based violence.¹¹⁰ As such, it is a powerful tool in the realisation of SRHR and can trigger positive shifts in social norms which underpin violence against girls and women. For example, CSE can address harmful notions of masculinity, gender roles and stereotypes both in school and the wider community.¹¹¹

In a youth consultation workshop held in Uganda, it was revealed that a majority of the participants would like sexuality education to be taught in schools, using various methods including school health clubs. One participant said that “sex education should be taken to both primary and secondary schools.”

In times of crisis, CSE is equally important, given increased risks of sexual violence, sexually transmitted infections and pregnancy, and the breakdown of traditional methods of support for children, adolescents and young people. However, schooling can be severely disrupted in a crisis, resulting in significant gaps and limitations in education, let alone in providing CSE.¹¹²

There is strong evidence to demonstrate the impact and outcomes of CSE in terms of a range of SRHR outcomes, notably in reducing sexually transmitted infections, including HIV, as well as unintended pregnancy; increasing contraceptive use; addressing gender inequality and unequal power relations, with the potential to reduce violence against girls and women; increasing critical thinking, negotiation and self-efficacy skills and the capacities of children, adolescents and youth to claim their rights; promoting strong citizenship; supporting educational outcomes, including the potential to sustain school enrolment (particularly for girls) and to foster a safer school environment. In addition, there is also evidence to support the cost-effectiveness of CSE programmes and their “value for money”, based on the number of negative health outcomes that can be averted.

Plan International's position:

- **Plan International believes that all children, adolescents and young people – without discrimination – are entitled to comprehensive sexuality education (CSE) to gain knowledge, explore values and attitudes, and develop the skills they need to make conscious, healthy and respectful choices about relationships and sexuality. Parents and educators should be supported to embrace children's learning about their bodies, relationships and sexuality from early childhood to allow children to explore, clarify and form life-long healthy attitudes and practices, free from coercion, violence and discrimination.**
- **CSE should be accessible for all children, adolescents and young people, in both formal and non-formal educational settings. Co-curricular activities which complement the formal curriculum are also important as are parental and community involvement and links to gender-responsive, child-adolescent- and youth-friendly healthcare and other services.¹¹³ CSE should be provided in a way that is non-judgemental, non-discriminatory, scientifically accurate, accessible, inclusive, rights-based, gender-transformative and adapted to the evolving capacity of the child, adolescent or young person.**

Recommendations for improving access to CSE:

- **Governments and other service providers should ensure the provision of universal access to CSE for all children, adolescents and young people, both in and out of school. CSE should start in the pre-school years, with the content tailored to the evolving capacities of the child. Those conducting CSE should be trained and equipped to deliver CSE that is non-discriminatory, inclusive and accessible, non-judgemental, scientifically accurate, rights-based, gender-transformative and effective. Information should be available to parents, caregivers, traditional and religious leaders and other gatekeepers to enhance their understanding of topics covered in CSE and to increase their support.**

CASE STUDY: Plan International Bangladesh – delivering CSE in schools and madrasahs

Plan International Bangladesh has partnered with the United Nations Population Fund (UNFPA) and the Ministry of Education to deliver sexuality education to adolescents in schools and madrasahs. By having the Ministry of Education as an implementing partner, and through creating a platform for repeated interaction among headmasters, teachers, bureaucrats and policy makers, the project has been able to address the sensitivity around providing SRHR education in Bangladesh – especially in the school and madrasah setting. Plan International Bangladesh has also partnered with the Directorate General of Family Planning as well as the Ministry of Health & Family Welfare in providing adolescent- and youth-friendly health services.

At the same time, Plan International has made innovative use of interactive materials like board games, computer games and a radio show to impart sexuality and gender education. As the materials are self-learning, there is less reliance on adolescent leaders who function only as facilitators for group activities. The weekly radio programme is aired nationally, thereby reaching a wider audience than in the project areas. The programme also promotes a helpline on SRHR counselling and referral services for adolescents, which is operated by Plan International Bangladesh.

- **Governments and other service providers should ensure the provision of relevant and rights-based information about relationships, sex, sexuality and gender equality to adults, in order to facilitate and support inter-generational dialogue on topics related to SRHR.**
- **Governments and donors should ensure adequate funding of formal and non-formal CSE. The delivery of non-formal CSE should be sub-contracted to civil society organisations and other providers.**

Access to adolescent- and youth-friendly SRHR services

Financial, physical, social and cultural barriers, including harmful social norms, are hindering access to timely and quality health services. This inequity in access particularly affects the most vulnerable and excluded in society, including adolescents and young people. For example, a study across 70 developing countries found that only a minority of sexually active adolescent girls who had experienced a sexually transmitted infection or showed symptoms of one had sought care in a health facility.¹¹⁴

As such, service provision must be reviewed and pursued with the health and human rights principles of availability, accessibility, acceptability, affordability and quality in mind. This should be resourced with adequate financing to ensure access for all.

In a youth consultation workshop in Uganda, the distance to services was perceived as a major barrier to access, as health centres are often located far from young people. Some participants also cited limited availability of services; for example, stating that condoms are not always easy to receive.

Also, the attitude of health workers was seen as a key barrier to accessing services. For example, one participant said young people would be asked “why do you need condoms at your age?” Many participants felt that such questions were disempowering and they discouraged many young people from going back to the health facilities. One of the girls, aged 17, said that when she went for cancer screening she was told “what are we going to do with you at this moment; we are only dealing with adult women”.

In accordance with the Committee on the Rights of the Child General Comment No. 4, adolescents and young people should have access to services for sexual and reproductive health that are of appropriate quality and sensitive to adolescents’ concerns.¹¹⁵ Furthermore, the services also need to be available without coercion or discrimination on any grounds.¹¹⁶

Major gaps with respect to adolescent- and youth-friendly health services include failure to ensure adequate privacy and accessible hours of operation, the prevalence of negative and judgemental attitudes among healthcare providers and the request for parental or spousal consent.¹¹⁷ For example, social stigma is a major barrier that adolescents face in obtaining services.¹¹⁸ Girls and young women in general, and unmarried girls in particular, are likely to experience discrimination and judgemental attitudes from service providers. In many places, health providers will refuse to provide unmarried adolescents with contraceptive information and services because they do not approve of premarital sexual activity.¹¹⁹

In a youth consultation workshop in Bangladesh, the participants stated that they do not seek the help of health services unless they have “a massive problem”; attempts are made to address the problem at home using local and home remedies. All participants said that they tended to get medicine themselves from the pharmacy without consulting a doctor or even talking to a trained pharmacist. Some of the young people, particularly those from rural areas, had also sought help from *kobiraaj*. One boy, aged 17, said he had gone with his friend to one of these doctors: “There they gave him the leaves and roots of some plant, after having which he became very sick and vomited profusely.”

Weak infrastructure for health, communications and transport can make access to services in rural areas particularly difficult.¹²⁰ Service providers may also fail to cater for the sexual and reproductive health needs of young people. Services are generally aimed at adults and may be viewed as inappropriate sources of care by adolescents and young people.¹²¹

Among the services most needed by adolescents and young people are information about and access to male and female contraception; prevention and treatment of sexually transmitted infections, and HIV and AIDS; menstrual hygiene management; maternal health services throughout pregnancy, delivery and postpartum; safe abortion and treatment for the complications of

CASE STUDY: Plan International Uganda – youth empowerment and youth-friendly services

In Uganda, Plan International is implementing a youth-led programme, which seeks to empower adolescents and young people with skills and knowledge to advocate for access to SRHR and for a reduction in gender-based violence.

Young people are working with Civil Society Organisations to demand that local authorities as well as the government are accountable for implementing human rights instruments that promote and protect adolescents and young people.

The programme specifically targets adolescents and young people who are not in formal education through a peer-to-peer approach, supplemented by community theatre and radio talk shows.

Plan International in Uganda also works to increase the availability of youth-friendly services by educating health workers and working with the government to increase the number of youth-friendly facilities and lobbying for a particular focus on vulnerable adolescents. Young girls and boys are linked to a toll-free, confidential telephone hotline for on-the-spot counselling and referral services, provided by counsellors who have received training on offering youth-friendly advice.

unsafe abortion, including post-abortion care; and prevention, timely detection and treatment of cancers of the female reproductive system.¹²² Survivors of sexual violence need access to quality clinical post-rape care, which includes post-exposure prophylaxis (within 72 hours) to minimise the chance of HIV transmission, emergency contraception, antibiotics to prevent sexually transmitted infections, broader medical care, as well as mental health and psychosocial support and legal support.¹²³ Continued efforts to improve the availability, accessibility, affordability and resilience of adequate services for all adolescents and young people – and girls and young women in particular – are essential to enable them to realise their sexual and reproductive rights.¹²⁴ Improving services would increase the likelihood that adolescents and young people will use contraceptives and also access vital information about other related areas of health, such as antenatal care, HIV and sexually transmitted infections.¹²⁵

Dissemination of SRHR information through schools, communities and the media have proven effective in improving services for adolescents and young people.¹²⁶ However, stand-alone youth centres and peer education have been less successful.¹²⁷

In humanitarian settings, the Minimum Initial Service Package, which was introduced by the Inter-Agency Working Group on Reproductive Health in Crises in 1998, is now the international standard for protecting the SRHR of women and girls in the acute phase of conflicts and disasters. However, it does not include criteria for children and adolescents.

Plan International's position:¹²⁸

- **Plan International believes that SRHR services should be gender-responsive, rights-based, adolescent- and youth-friendly and available to all adolescents and young people, including during conflicts and disasters. The services should be available and accessible to the most vulnerable and excluded adolescents and young people, including but not limited to migrants, those from ethnic minorities and indigenous groups, those living with disabilities and those identifying as lesbian, gay, bisexual, transgender, intersex, questioning.** ¹²⁹
- **SRHR services should be linked with interventions to end violence against girls and women.**
- **It is important that health services are available and accessible to everyone, regardless of age or marital status.**¹³⁰ **Services should respect privacy and confidentiality. They should be free of requirements for judicial, spousal, parental or guardian consent.**
- **We believe well-trained and supported health personnel are critical to delivering quality, gender-responsive adolescent- and youth-friendly services. A dedicated health budget for these services is essential so that user fees and expenses can be reduced or eliminated, making them accessible and affordable to all adolescents and young people.**
- **In order to ensure that services are fit-for-purpose and meet the needs of adolescents and young people, there needs to be a greater focus**

on ensuring their participation in the planning, implementation and monitoring of services.¹³¹

Recommendations for improving access to and quality of health services for adolescents and youth:

- **Governments need to ensure equitable access to quality, affordable, gender-responsive, adolescent- and youth-friendly sexual and reproductive health services for all adolescents and young people, including those engaged in prostitution, free of discrimination, violence or coercion and regardless of marital status. Services should be provided in a non-judgemental, respectful way, guaranteeing privacy and confidentiality. Services should be provided in accordance with the evolving capacities of the person in question and free of any requirements for parental, spousal, guardian or judicial consent.**
- **Governments should take all necessary measures to strengthen health systems including by training healthcare providers. They should ensure the delivery of sexual and reproductive health services closer to underserved areas, especially in rural, remote and impoverished urban areas.**
- **Governments should ensure that the training of health workers is gender-responsive and addresses judgemental attitudes towards adolescents and young people and their sexuality, and in particular towards girls and young women.**
- **Governments should ensure that national strategies and plans to address sexual and reproductive health issues employ a coordinated, multi-sector approach, including other relevant sectors such as education, justice and child protection services to ensure that cross-cutting issues are addressed in a comprehensive way.**
- **Governments need to ensure systematic, reliable and high quality data collection on SRHR to inform service delivery and public awareness. Data should be disaggregated by income, gender, age, race, ethnicity, migratory status, disability and geographic location, in line with the commitments under the 2030 Agenda.**¹³² **Plan International further calls on governments to also disaggregate data collection by gender identity and sexual orientation (with due protections for privacy and human rights) as these factors will be particularly important in the context of improving SRHR services for all.**
- **Governments and other service providers need to develop strategies and programmes for implementing SRHR services in consultation with adolescents and young people, particularly girls and young women. They should be meaningfully engaged in the implementation, monitoring and evaluation as well as policy formulation.**

Menstruation

Menstruation is the bleeding (also known as a period) that occurs in girls and women as part of the monthly menstrual cycle. Menstruation can last, on average, for between three and five days a month.¹³³ The first time a girl has a period is often seen as marking the onset of puberty, and this typically occurs between the ages of eight and 15, although this varies greatly. If not properly managed, menstruation can interrupt daily life. For example, many girls and women, especially adolescent girls, experience extremely painful periods which can negatively affect their attendance and performance at school.¹³⁴

Menstruation is linked to girls' and young women's dignity and has a tremendous impact on their access to education and performance in school, as girls will often miss days when they are menstruating. For example, 95 per cent of girls in Ghana sometimes miss school when they are menstruating.¹³⁵ The reasons for missing school can vary – it can be due to a lack of adequate facilities and materials; because girls' movements are restricted during their period; or because they feel ashamed or "unclean".

Myths, misconceptions and social norms restrict girls' choices and their participation in society at the time of their period. For example, 67 per cent of girls from Nepal are not allowed to attend religious functions, while 28 per cent are not allowed to sleep near their family members.¹³⁶ Girls and women are often expected to refrain from certain normal activities, such as bathing or cooking.¹³⁷ In fact, 51 per cent of girls in Iran do not take a bath for eight days after the onset of their period.¹³⁸

These restrictions and negative attitudes towards menstruation have a negative effect on girls' self-esteem. For example, 90 per cent of girls in rural areas of Ghana felt ashamed during their period.

Restrictions on girls' and women's activities during the time of their period are often imposed on the basis of beliefs that certain activities have negative consequences for either the girls or women themselves or for their immediate environment.¹³⁹ For example, in Bangladesh, women and girls bury their cloths to prevent them from being used by evil spirits.¹⁴⁰ Lack of accurate information about menstruation can leave girls feeling scared when they first start their period, and some believe that menstruation is a disease.¹⁴¹ Girls and young women taking part in the youth consultation workshop in Bangladesh also revealed several challenges they face in relation to menstruation. A lack of information was highlighted as one of the main obstacles, as girls are often left with only a brief, sometimes inaccurate explanation about what happens to their bodies.

Menstrual hygiene management (MHM) is a significant concern. According to a conservative estimate, around 500 million girls and women lack access to adequate facilities for MHM.¹⁴² Positive MHM requires a minimum level of knowledge and awareness on how to manage menstruation effectively and hygienically, while having access to facilities to wash or dispose of used sanitary materials in appropriate ways.¹⁴³ In addition, MHM must also address societal beliefs and taboos surrounding menstruation. MHM is linked to the broader issue of adequate and equitable access to safe water, sanitation and hygiene, which is addressed in Goal 6 of the Sustainable Development Goals.¹⁴⁴

Plan International's position:

- **Plan International believes that the taboo nature of menstruation and sensitivity around discussing this with girls at home, in school and more broadly within society reinforces and perpetuates gender inequality. All girls and young women should have access to separate and hygienic sanitary facilities in all public spaces, especially in schools, as this is critical to ensure their attendance. They should also have access to accurate information about menstruation and to clean sanitary equipment.**
- **We believe that public and private water, sanitation and hygiene service providers should consult with girls and young women to ensure facilities meet their needs, and to enable them to practise good menstrual hygiene management.**
- **We will work with others to contribute to strengthening knowledge on the impact of social and cultural norms around menstruation and poor menstrual hygiene management.**

Recommendations for addressing issues related to menstruation:

- **Governments should ensure the availability of separate sanitary facilities particularly with regard to MHM for girls and young women in all schools and public spaces.**
- **Ministries for health and sanitation should ensure that all public sanitation facilities have separate facilities for females and males and include adequate facilities for MHM.**
- **Ministries of education should ensure that national curricula include education about menstruation for both boys and girls as part of comprehensive sexuality education and also include information about good MHM for girls.**
- **Partnerships are needed between the private sector and civil society organisations and/or governments in order to ensure that materials for MHM are easily available and affordable for all girls and young women.**
- **Parents, caregivers and traditional and religious leaders should receive scientifically correct information in order to break down taboos and misconceptions around menstruation.**

Adolescent pregnancy

Each year, approximately 19 per cent of girls in developing countries become pregnant before the age of 18¹⁴⁵ and an estimated 2.5 million births occur among girls aged 12 to 15 in developing countries,¹⁴⁶ with the highest rates in sub-Saharan Africa. However, by 2020, the rate of adolescent fertility in Latin America is predicted to surpass that of sub-Saharan Africa, to become the highest in the world.¹⁴⁷ Currently, one-third of pregnancies in Latin America occur among girls aged below 18 with almost 20 per cent among girls under the age of 15.¹⁴⁸

The causes of adolescent pregnancy include a lack of information and education as well as inadequate access to services for adolescents and young people. Societal expectations on girls to become mothers early can also be a cause.¹⁴⁹ Sexual violence is another driver,

particularly where there are significant age and power gaps within couples (this is particularly prevalent in the case of girls aged below 15).¹⁵⁰

However, broader forms of gender-based violence including psychological and economic violence have also been linked to adolescent pregnancy.¹⁵¹

There is also a strong correlation between child, early and forced marriage and adolescent pregnancy.¹⁵² Approximately 90 per cent of births to adolescent mothers in developing countries occur within marriage.¹⁵³ However, this number varies across regions, with lower numbers of births to married adolescent girls occurring in Eastern and Southern Africa as well as in South America.¹⁵⁴ The highest number of births to married adolescent girls can be found in Western Asia and Northern Africa, where 99 per cent of all births to adolescents occurred within marriage.¹⁵⁵ Many married girls have no access to contraception, have little power in the relationship and are often under pressure to prove their fertility shortly after becoming married. Equally, in many societies, those who become pregnant when unmarried come under pressure to marry early to avoid the stigma attached to having a child out of wedlock. This is often the case in Latin America, where child, early and forced marriage often follows an unintended pregnancy.

Socio-economic factors such as the characteristics of the household, the parents' income and educational level also have a bearing on the likelihood of early motherhood. Adolescent girls and young women who have a low educational level are five times more likely to become a mother than those with higher levels of formal education.¹⁵⁶ At the same time, girls and young women who become pregnant or who are married may be forced to leave school due to policies in place or because of the stigma they face. In most countries, adolescent births are concentrated among poorer, less educated girls and young women, thereby further compounding disadvantage by disrupting school attendance and limiting future livelihood opportunities.¹⁵⁷ However, contextual factors such as a lack of access to comprehensive sexuality education and to modern methods of contraception are also contributing factors.¹⁵⁸

About half (49 per cent) of pregnancies among adolescents aged 15 to 19 in developing countries are unintended and more than half of these end in induced abortion.¹⁵⁹ In more than two-thirds of cases, the abortion occurs in countries where it is prohibited or highly restricted.¹⁶⁰ In these cases, adolescents typically

resort to clandestine procedures that are often unsafe – performed by persons lacking the necessary skills or in an environment lacking minimum medical standards, or both.¹⁶¹

Complications related to pregnancy and childbirth are the second leading cause of death for girls aged 15 to 19.¹⁶² The risk of dying during pregnancy, childbirth or postpartum is doubled for girls who become pregnant before the age of 15.¹⁶³ Physical and sexual violence against girls and women during pregnancy is also linked to higher levels of maternal mortality and induced abortion.¹⁶⁴ In order to meet the Sustainable Development Goals target 3.1 of reducing the global maternal mortality ratio to less than 70 per 100,000 live births, efforts to tackle this issue need to be accelerated almost three-fold.¹⁶⁵

Girls and adolescents face increased health risks and are more seriously affected by complications relating to pregnancy and childbirth than older women, in part because they may be undernourished and may not have completed physical development; and in part because they are more likely to live in disadvantaged circumstances.¹⁶⁶ However, context can vary greatly both between and within countries.

Inadequate health services such as the lack of emergency obstetric care services, low rates of skilled attendance at delivery and the persistent denial of sexual and reproductive rights in many countries also contribute to maternal mortality. Even where services exist, judgemental attitudes of some service providers and requirements for judicial, parental, spousal or guardian consent can result in girls and young women being reluctant to make use of the services on offer.¹⁶⁷

A lack of access to adequate services can lead to serious health problems for adolescents who give birth. For example, up to 65 per cent of women with obstetric fistula develop this as adolescents.¹⁶⁸ This serious injury is caused by prolonged and obstructed labour without access to emergency obstetric care. Adolescents are at particular risk of obstructed labour and, as a result, of developing obstetric fistula, since their bodies are not physically mature.¹⁶⁹ Obstetric fistula is a hole between the birth canal and bladder or rectum, which leaves girls and women constantly leaking urine, faeces or both. This in turn often leads to chronic medical problems, social isolation and deepening poverty.

It is estimated that more than 2 million young women live with untreated obstetric fistula in Asia and sub-Saharan Africa.¹⁷⁰ Between 50,000 and 100,000 girls and women

CASE STUDY: Plan International Togo – addressing early pregnancy and sexual violence

Plan International Togo is implementing an early pregnancy prevention project which aims to reinforce both communities' and girls' capacities in fighting early, unwanted pregnancy and other sexual violence against girls. With Plan International's support, the implementation communities developed "Community charters for education and child protection." These charters contain commitments that each community has given itself to ensure children's schooling and to protect girls against sexual violence and early pregnancy. These commitments are accompanied by sanctions that the community applies to persons who are perpetrators of abuse against girls.

The charters use the Community Based Child Protection Mechanisms (CBCPM) approach that Plan International is putting in place progressively in the West Africa Region. The CBCPM includes complaints procedures and referral mechanisms from the community level up to national, public authorities.

The girls themselves are also equipped with life skills training to help them set their own life objectives, and to give them the voice, confidence and agency to discuss issues of concern with boys and their parents.

The system is helping to reduce the number of unwanted, early pregnancies within the implementation area.

are estimated to develop the condition every year.¹⁷¹ However, obstetric fistula is almost entirely preventable by delaying the age of childbearing, ending harmful practices such as female genital mutilation/cutting and ensuring that all girls and women have access to timely and high quality obstetric care.¹⁷² The condition often affects the most vulnerable and excluded girls and women – those who are young, poor and who live in remote and rural areas.¹⁷³

Adolescent pregnancy is not only associated with serious health risks for the young mother but also for her baby. The younger the mother, the greater the risk to the baby.¹⁷⁴ Stillbirths and deaths in the first week of life are 50 per cent higher among babies born to mothers who are aged 19 or younger, compared to mothers aged between 20 and 29.¹⁷⁵

Premature birth and low birth weight are also more common among babies born to young mothers. This is in turn linked to higher risk of intellectual, language and socio-emotional delays.¹⁷⁶ Infants born to adolescents face a 50 to 100 per cent higher risk of death during the first month of life.¹⁷⁷

Maternal under-nutrition is also a risk factor for low birth weight, premature birth and increased child mortality, contributing to an estimated 800,000 neonatal deaths a year.¹⁷⁸ Adolescent mothers are more likely to be undernourished, as scarcity of food has a disproportionate impact on pregnant and lactating girls. Girls often face discrimination within families, which contributes to their malnutrition,¹⁷⁹ but are also physiologically prone to vitamin and iron deficiencies. Early pregnancy can exacerbate the cycle of malnutrition.

Increases in pregnancy rates are also common after disasters, which can be attributed to a number of causes, including the desire to compensate for the loss of a child; a lack of access to information or to methods of contraception and an increase in sexual violence.¹⁸⁰ Risks for pregnant girls are particularly acute in humanitarian contexts when antenatal and obstetric care infrastructure and services may be destroyed, damaged or disrupted.¹⁸¹ Without access to these services, many women and girls give birth without access to basic emergency obstetric and new-born care and are at greater risk of infection, miscarriage, premature delivery, stillbirths, unsafe abortions, severe long-term morbidity and mortality, such as obstetric fistula, and death. Three in five maternal deaths and 45 per cent of neonatal deaths occur in conflict, displacement and disaster situations.¹⁸²

In addition, the tendency to focus on adolescent maternity with little regard to the issue of adolescent paternity results in limited knowledge and information about young men as partners and fathers.¹⁸³ It also reproduces the idea that pregnancy is solely an issue for girls and women.¹⁸⁴

Currently, efforts and resources invested in the prevention of adolescent pregnancy often focus on adolescent girls aged 15 to 19 years. However, the most vulnerable girls, and those with a higher risk of complications related to pregnancy and childbirth are those aged 14 or younger. They are often overlooked in national and global statistics and development interventions. Further research is needed to provide a more holistic response to the issue.

Plan International's position:

- **Plan International is committed to tackling adolescent pregnancy, particularly pregnancy in younger adolescents, and to supporting adolescent mothers. We recognise that adolescent pregnancy is a major contributor to maternal mortality and morbidity, which are grave violations of girls' rights.**
- **We believe that early unintended and unwanted adolescent pregnancy can and should be prevented. This requires challenging gender discriminatory norms and ending sexual violence against girls; strengthening girls' agency and ability to make autonomous and informed decisions about their reproductive health; ensuring the provision of comprehensive sexuality education and ensuring that health systems and services meet the specific needs of adolescents (in line with the Convention on the Rights of the Child (CRC) General Comment No. 15, paragraph 56).**
- **Education can be a powerful tool for delaying adolescent pregnancy and early childbirth. We also recognise that adolescent pregnancy can be a driver for, or a consequence of, child, early and forced marriage. This is particularly important for countries and regions that are projected to experience rising rates of adolescent pregnancy, such as Latin America.**
- **Plan International believes that all girls and young women have the right to access quality maternal health and obstetric care services. Health budgets must include adequate resourcing for their provision including emergency obstetric care and treatment of fistula.**

Recommendations for addressing issues related to adolescent pregnancy:

- **Governments with other development actors should develop and implement strategies to prevent adolescent pregnancy. This should include access to contraceptives and quality safe education including comprehensive sexuality education, for adolescents and young people.**
- **Governments, UN bodies and civil society organisations should work with research and national statistics institutions to increase the collection of data and knowledge that can inform policies and programmatic interventions, in particular for 10 to 14 year olds.**
- **Governments should implement all necessary measures to ban and eliminate the practice of child, early and forced marriage, which often leads to early pregnancies.**
- **Governments should take all necessary measures to support pregnant girls and young mothers of all ages to continue and complete their education. Governments should develop retention strategies and life skills programmes for pregnant girls and young mothers, including married girls, through targeted outreach and support programmes, initiating evening or part-time formal schooling and vocational training**

opportunities, and following up with students who drop out of school.

- **Governments should prohibit discriminatory practices such as mandatory pregnancy testing of girls, discrimination based on adolescent pregnancy, and expulsion of pregnant girls from school.**

Contraception

The right to the highest attainable standard of health includes the right to access information and services. As the world's population of 15 to 19 year olds grows beyond 600 million, countries face an increasing demand for information about and access to contraceptive services (including emergency contraception) from this demographic.¹⁸⁵ Younger adolescents are often missed in statistics yet may also require access to contraceptive services, particularly where they are sexually active, married or victims of sexual violence.

At present, 38 million girls and young women aged 15 to 19 in developing countries need contraception because they are sexually active, but do not want a child for at least two years.¹⁸⁶ However, 60 per cent of these girls and young women – that is, 23 million – are not using a modern contraception method. Of these, the vast majority (84 per cent) are not using any contraception at all, while the remainder use traditional methods, which are less effective than modern methods.¹⁸⁷ Although younger adolescents (aged 10 to 14) are also a critical demographic, far less information is available for this age group as they are usually excluded from national surveys.

In Africa and Asia, more than two-thirds (68 per cent and 69 per cent, respectively) of sexually active adolescents (aged 15 to 19) who want to avoid pregnancy experience an unmet need for contraception,¹⁸⁸ as they want to prevent or delay pregnancy but do not have access to contraception. In Latin America and the Caribbean, the proportion of adolescents who have an unmet need is 36 per cent.¹⁸⁹

In Africa, unmet need is highest among married adolescents (aged 15 to 19)¹⁹⁰ whereas in Asia, the situation is the opposite with a higher unmet need among unmarried adolescents (aged 15 to 19), due to the social stigma attached to unmarried sexual activity and pregnancy out of wedlock.¹⁹¹ For Latin America and the Caribbean, unmet need is similar among both married and unmarried adolescents (aged 15 to 19).¹⁹²

In a youth consultation workshop held in Uganda, it was concluded that none of the participants felt they were able to freely access modern contraception if they needed to. A young man, aged 22, said:

“A Village Health Team ‘denied’ young people condoms – when you go to them, they keep telling you ‘come tomorrow’, you go back the following day, they again say ‘come tomorrow’. Tomorrow becomes tomorrow until you give up.”

Adolescent girls and young women's reasons for not using contraception include having infrequent sex, not being married, concerns about side effects, breastfeeding, not having resumed menstruation after a birth, and their or their partner's opposition to the use of contraception.¹⁹³ In addition, many have insufficient knowledge on correct use of methods of birth control pills. Another concern for many children and young people is the lack of confidentiality and privacy¹⁹⁴ and requirements for parental, guardian, judicial or spousal consent to access contraception services.

The limited range of contraceptive options available also deters adolescents and young people from using the services on offer. Nevertheless, barrier methods remain crucial for preventing sexually transmitted infections, including HIV.

Gender norms and lack of agency as well as power to negotiate with male partners remains a challenge for girls and young women when trying to use contraception. Women, both married and unmarried, report that the attitudes of their partners constitute the single largest barrier to consistent use of contraceptives.¹⁹⁵

Financial and logistical barriers present a real obstacle given that adolescents and young people are unlikely to have control over financial resources to pay for the services or the transport needed to get there.¹⁹⁶ Legal and policy barriers can also impede access, for example where they prohibit access to contraceptives for adolescents and unmarried young people. Only 49 out of the 93 countries providing information to World Health Organisation have laws and regulations that allow young adolescents to obtain contraceptives without parental or spousal consent.¹⁹⁷ A lack of knowledge about the legal rights of adolescents to obtain contraception can also hinder access¹⁹⁸ and issues of availability of supplies can also pose problems even where services are available.

CASE STUDY: Plan International Brazil – Sexual and Reproductive Rights Passbook

In Brazil, Plan International is implementing an Educational Strategy around the Carnival time with innovative educational materials that promote sexual and reproductive health. It has a peer-to-peer youth model focused around streets and communities. The passbook includes sexual and reproductive rights information relating to methods of contraception as well as health information. It also includes guidance on timeframes for vaccinations, pills and the menstrual cycle. The passbook is tailored according to gender and the package includes a female and male condom.

Young people participating in a workshop in El Salvador felt that access to contraceptive information and services was limited due to their age. According to the participants, adolescents younger than 18 have a lesser chance of accessing modern contraceptive methods. While the participants said that there had been some progress, they recognised that overall the access to contraceptives is limited because of taboos and the misguided belief that contraception can be equated with abortion.

However, increased use of contraceptives could have a huge impact in terms of preventing unwanted and unintended¹⁹⁹ pregnancies, saving lives and improving health.²⁰⁰ If all adolescents and young women who want to use modern contraception were able to access it, this could reduce unwanted pregnancies by 6 million a year (59 per cent), with 3.2 million fewer abortions (57 per cent), of which 2.4 million would have been unsafe.²⁰¹ In addition, maternal deaths due to complications of pregnancy and childbearing for those aged 15 to 19 would drop from 17,000 per year to 11,500, with most deaths averted in Africa (4,800).²⁰² This would also spare girls, young women and their families the adverse consequences of early childbearing, save considerable costs in terms of maternal and child healthcare in addition to improving the educational and economic prospects of girls and young women.²⁰³ In humanitarian settings, family planning is also a sound investment with each \$1 spent on contraceptive services saving between \$1.70 and \$4 in maternal and new-born healthcare costs.²⁰⁴

The need for contraceptive information and services includes the need to access emergency contraception. This is a type of contraception that is used to avoid pregnancy after a single act of unprotected sexual intercourse (due to lack of use or failure of a contraceptive). Emergency contraceptive pills prevent ovulation, fertilisation, and/or implantation. However, they are not effective once the process of implantation has begun and will not cause abortion.²⁰⁵

Two major initiatives, Family Planning 2020 and the UN's Global Strategy for Women's, Children's and Adolescents' Health, are pushing for girls' and women's contraceptive need to be met.²⁰⁶ These initiatives also help to advance the 2030 Agenda, in particular, Goals 3, 4 and 5, which call for improved health and education and for gender equality and which depend on a significant improvement in the lives and health of adolescent girls and women.²⁰⁷ However, while Sustainable Development Goals targets 3.7 and 5.6 seek to improve information about and access to contraception, the indicators that will measure progress against these targets will focus solely on girls and women aged 15 to 49. As such, younger adolescents will continue to be overlooked.

Plan International's position:

- **Plan International believes that all sexually active adolescents, including younger adolescents, and young people with an unmet need for family planning should be able to access modern contraception. In line with the Committee on Economic, Social and Cultural Rights General Comment No. 14, contraceptive services should be provided free of discrimination, stigma and coercion, and free of spousal, parental, guardian or judicial consent,**

and in accordance with the evolving capacities of the person in question.

- **Plan International agrees with Committee on the Rights of the Child General Comment No. 4 that adolescents should have access to information and services regarding contraceptives and family planning.**

Recommendations for improving access to contraception:

- **Governments should take the necessary measures to provide a full range of affordable, safe, reliable and good quality modern contraceptive services, including counselling and emergency contraception, to meet the needs of all adolescents and young people, paying specific attention to girls and young women.**
- **Contraceptive information and services should be provided in a non-judgemental way, with respect for privacy and confidentiality and free of discrimination, stigma and coercion and regardless of marital status. Information and services should be provided in accordance with the evolving capacities of the person in question and free of any requirements for parental, guardian, spousal or judicial consent.**
- **Governments should develop costed and budgeted national action plans on increasing access to contraceptive services, with a special focus on populations with an unmet need for contraception.**
- **Governments, UN bodies and civil society organisations should work with traditional, community and religious leaders and parents to change negative attitudes towards use of contraception.**
- **Boys and men should be actively involved in the use of contraception. They should be encouraged to participate in decisions about using contraception as well as actively engaged in efforts to raise awareness of the positive impacts of using contraception to delay pregnancy and prevent sexually transmitted infections.**

Access to safe abortion

Unsafe abortion is a preventable cause of death and ill health among girls and women around the world and is often a reflection of the denial of their fundamental human rights. In particular, the right to health is undermined by lack of access to safe abortion.²⁰⁸

The UN Human Rights Committee concludes that restricting legal access to safe abortion has the effect of subjecting girls and women to cruel, inhumane and degrading treatment.²⁰⁹

The International Conference on Population and Development has spelled out that all reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children.

High levels of unmet need for contraception help to explain the prevalence of abortion.²¹⁰ Most women who undergo abortion do so because they become pregnant

when they did not intend to. Eighty-one per cent of unintended pregnancies in developing countries occur among women who have an unmet need for modern contraception.²¹¹

Globally, some 56 million girls and women undergo abortions each year.²¹² The proportion of abortions that are performed under unsafe conditions is unknown, but complications from unsafe abortions are common in developing regions, where the procedure is often highly restricted. Estimates indicate that 6.9 million women in developing regions were treated for complications from unsafe abortions in 2012.²¹³ Recent figures also suggest that approximately 40 per cent of women who experience complications from unsafe abortion never receive treatment.²¹⁴

Adolescents tend to delay obtaining an abortion and when they do, frequently resort to informal and unskilled providers, leading to a higher rate of complications.²¹⁵ Self-induced abortion is also common among adolescents in many countries.²¹⁶

The most common complications from unsafe abortion are incomplete abortion, excessive blood loss and infection. Recent studies also estimate that between 8 and 18 per cent of maternal deaths worldwide are due to unsafe abortion, with almost all abortion-related deaths occurring in developing countries, the highest number being in Africa.²¹⁷ In 2014 the number of abortion-related deaths is estimated to be in the range of 22,500 to 44,000.²¹⁸ Other less common consequences include septic shock, perforation of internal organs and inflammation of the peritoneum.²¹⁹ However the impact of unsafe abortion extends beyond the immediate health consequences. Girls and women who have suffered complications from an unsafe abortion may also see a reduction in their economic productivity where the adverse health consequences impact on their ability to work, increasing the economic burden on poor families.²²⁰

Recent figures estimate that 97 per cent of women aged 15 to 44 in Latin America and the Caribbean live in countries with restrictive abortion laws.²²¹ This figure is 90 per cent for women of the same age range in Africa.²²² This is in spite of the large number of African countries that have ratified the Protocol to the African Charter on the Rights of Women in Africa (the 'Maputo Protocol'), which provides for comprehensive access to reproductive healthcare, including safe abortion.

World Health Organisation analysis of abortion laws globally²²³ shows that:

- 95 per cent of all countries allow abortion to be performed if a woman's life is threatened;²²⁴
- 67 per cent and 64 per cent of countries respectively allow women to seek abortion to preserve their physical health and to preserve their mental health;
- 51 per cent of all countries permit abortion in the case of rape and incest;
- 50 per cent of countries allow abortion upon diagnosis of foetal impairment;
- 30 per cent of countries allow abortion upon request of the pregnant woman.

However, the likelihood of a woman having an abortion for an unintended pregnancy is about the same regardless of the legal status of abortion.²²⁵ World Health Organisation notes that: "Legal restrictions do not result in fewer abortions, nor do they result in significant

increases in birth rates. However, a lack of legal access to abortion services is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality. Legal restrictions lead many women to seek services from unskilled providers or under unhygienic conditions, exposing them to a significant risk of death or disability".²²⁶ The evidence demonstrates that laws and policies facilitating access to safe abortion reduce maternal mortality due to unsafe abortion.

Not only does the lack of access to safe, legal abortion services put girls' and women's lives in danger, it undermines their right to make decisions concerning childbearing.²²⁷ In addition, laws that persecute girls and women who seek and/or obtain an abortion in countries where it is illegal, fail to address the underlying societal and public health issues affecting many of these girls and women in the first place.²²⁸ Such laws lead girls and women to rely on less safe methods of abortion without access to medical guidance.²²⁹ Girls and women from low-income settings are particularly exposed to the many legal barriers to safe abortion care, as well as to barriers to other medical and social support for pregnancy and miscarriage. In addition, they are also most vulnerable to being targets of prosecution and imprisonment.²³⁰

The UN Human Rights Committee recommended that restrictive laws that only permit abortion where the mother's life is in danger should be reformed to allow "effective, timely and accessible procedures for pregnancy termination".²³¹

To reduce the high levels of morbidity and mortality that result from unsafe abortion, the provision of post-abortion care needs to be improved and expanded.²³² Particular attention needs to be paid to poor and rural girls and women who tend to depend on unsafe methods of abortion and on untrained providers.²³³

Treating medical complications from unsafe abortion places a considerable financial burden on public health care systems and on girls and women and their families in developing regions. According to estimates for 2014, the annual cost of providing post-abortion care in developing countries was US\$232 million. However, this number does not reflect the true scale of the problem as many girls and women are not receiving treatment – if all those who needed treatment received it, the actual cost would be approximately US\$562 million.²³⁴

Sex-selective abortion is particularly prevalent in certain parts of the world (for example, India, China). At least 117 million girls are "missing" across the world largely due to sex-selection in favour of boys. This practice is a symptom of pervasive injustices against girls and women, and reinforces deeply embedded gender inequality in society.

Young people participating in a workshop in El Salvador were asked what they thought would be the most important issue for Plan International to address in this position paper.

"Abortion"; the promotion of "an open debate on the right to voluntarily interrupt an unwanted pregnancy"; and a debate on "decriminalising abortion, with an emphasis on having autonomy over your own body" were the answers from three young women, aged 20, 22 and 24.

Plan International's position:

- Plan International believes that abortions should be rare and that priority should be given to avoiding unintended pregnancy, through the provision of comprehensive sexuality education including accurate information on contraceptives as well as access to quality contraceptive services (including emergency contraception) for all girls and women.
- In line with the Committee on the Elimination of all Forms of Discrimination against Women,²³⁵ Plan International recognises reproductive rights to include the right of girls and women to make autonomous decisions about their health. Denying girls and women access to safe abortion services prevents them from exercising this right. Plan International does not provide medical health services.
- We believe that the provision of services for safe abortion should be available and accessible to all girls and women.
- Where abortion is legal, the provision of services should be within the fullest extent of the legal framework of the country.
- In countries where abortion is illegal or restricted we recognise that girls and women will still undergo unsafe abortions. In such countries, we take the stand that girls and women who seek or obtain abortions should neither be prosecuted nor penalised.
- Plan International acknowledges that unsafe abortion is a preventable cause of death and ill-health of girls and women across the world and often a consequence of violations of girls' and women's fundamental human rights. The right to health and gender equality are advanced by access to safe and legal abortion.
- Irrespective of the legal status of abortion, Plan International believes that quality post-abortion care as well as psychosocial counselling and support for all girls and women should be accessible.

Recommendations for improving access to safe abortion:

- In countries where abortion is legal or decriminalised, governments should ensure that girls and women who wish to have an abortion have access to safe, quality and affordable abortion services to the fullest extent of the law, free of any requirements for judicial, parental or spousal consent, and that healthcare professionals provide accurate, non-judgemental information on obtaining safe abortion services.
- In countries where abortion is currently criminalised or highly restricted within the law, governments should ensure the non-prosecution and non-penalisation of girls and women who want to access safe abortion services or who have had an abortion.
- Furthermore, in all countries, governments should ensure that girls and young women are provided with accurate information and

counselling about their options including information about reducing harm from unsafe abortion and accessing treatment for subsequent complications.

- Irrespective of the legal status of abortion in the country, Plan International calls on governments to ensure the availability of quality post-abortion care that meets World Health Organisation guidelines, comprehensive information and services on quality family planning and contraception (including emergency contraception) and psychosocial counselling and support.
- Governments should make every attempt to reduce the need for abortion by ensuring timely, confidential and affordable access to good quality modern methods of contraception, including emergency contraception and male and female condoms, as well as counselling to all persons in need, regardless of age and marital status; and they should support provision of information about prevention of pregnancy and contraception through civil society groups, community outreach, and school and youth programmes.

HIV and AIDS

Sexual transmitted infections, including HIV and AIDS, in general disproportionately affect adolescent girls and young women. Younger adolescents are also increasingly affected and improving awareness and knowledge of sexually transmitted infections and how to prevent them should be part of all sexual health education and services.²³⁶

Key populations are particularly vulnerable to acquiring HIV. This includes gay and bisexual men and boys, transgender people, people who inject drugs, and people who work in prostitution.²³⁷ Recent data from UNAIDS suggest that 90 per cent of all new HIV infections in Central Asia, Europe, North America, the Middle East and North Africa in 2014 were from these key populations.²³⁸ In contrast, in sub-Saharan Africa, key populations accounted for more than 20 per cent of new infections, whilst the majority of new infections occurred within the rest of the population.²³⁹ In Asia, data from 2014 show that 95 per cent of young people aged 15 to 24 diagnosed with HIV are from at least one of these key vulnerable populations.²⁴⁰

The Committee on the Rights of the Child²⁴¹ has clarified that adolescents have a right to information about HIV and AIDS and that States should not withhold, censor or intentionally misrepresent health information, including sexuality education.²⁴²

While there has been a decline globally in the rate of new HIV infections,²⁴³ the number of girls and women living with HIV has increased significantly in recent years. Gender inequality and intimate partner violence prevents many girls and women, from protecting themselves against HIV.²⁴⁴ Adolescent girls made up two-thirds of the 250,000 adolescents who contracted HIV in 2013.²⁴⁵

Approximately 80 per cent of women living with HIV are in sub-Saharan Africa, with 9 per cent in South and South-East Asia, 3 per cent in Latin America and 3 per cent in Eastern Europe and Central Asia.²⁴⁶

In addition, while the prevention of mother-to-child HIV transmission in pregnant women living with HIV has now reached 62 per cent, there are significant variations in coverage within and across countries.²⁴⁷ Of the 125 million women who give birth each year, 1.5 million are living with HIV, more than one-third of whom are not receiving the antiretroviral care they need to prevent transmission of the virus to their new-born babies and to protect their own health.²⁴⁸

Violence against girls and women is a driver of HIV infections but being diagnosed with HIV can also lead to increased vulnerability to violence, due to the stigma attached to having HIV.²⁴⁹ Such stigma and discrimination can also create additional barriers in terms of accessing services.²⁵⁰

In humanitarian contexts, risks of HIV infection are often higher, with an increase in sexual violence, transactional sex and high-risk behaviour. Yet at the same time, work on HIV prevention is often put on hold.²⁵¹ For children, adolescents and young people living with HIV, antiretroviral regimes may be disrupted as drugs may be unavailable. Nevertheless, humanitarian settings can also present opportunities for improved care for those living with HIV or for reaching those who had not previously been able to access it.²⁵²

Plan International's position:

- **In line with the Committee of the Rights of the Child General Comment No. 3 on HIV/AIDS and the rights of the child,²⁵³ Plan International believes that all children, adolescents and young people, including girls and young women, should have the ability to acquire the knowledge and skills they need to protect themselves and others from HIV infection.**
- **Plan International strongly emphasises the need to eliminate stigma and discrimination experienced by HIV-positive children, adolescents and young people both on an institutional and community or individual level. This requires challenging negative social norms around adolescents' and young people's sexual activity, as well as the provision of scientifically accurate information on HIV and AIDS transmission.**
- **We believe that all children, adolescents and young people should have equal access to the necessary health services, treatment and support they need. All services should have particular regard for the right to privacy and confidentiality.²⁵⁴**
- **We also recognise that gender inequality is a driver of the rising number of girls and young women living with HIV and AIDS, and that effective approaches for prevention, treatment and care need to be gender-transformative, empowering girls and young women to have control over their bodies and their lives.**

Recommendations for improving access to health services and information about HIV and AIDS:

- **Governments should address the rising incidence of HIV and AIDS for girls and women as well as other sexually transmitted infections by focusing on prevention, including wider**

access to scientifically accurate information and to male and female condoms, and on developing and ensuring access to accurate, affordable and rapid diagnostic tests and treatment, particularly for use in low-resource and remote settings.

- **All children, adolescents and young people, regardless of their sex, ethnicity, gender identity, sexual orientation or disability status should have equal access to the necessary health services, treatment and support which they need, including voluntary and confidential HIV testing and counselling and access to antiretroviral therapy. Such services should have particular regard for the right to privacy and confidentiality and be gender-responsive, child-, adolescent- and youth-friendly, accessible, affordable and non-judgemental. Services should be free of any requirements for judicial, parental, guardian or spousal consent.**
- **Governments should ensure that scientifically accurate information about HIV and AIDS is included as part of comprehensive sexuality education and provided to all children, within schools. Governments and other service providers should also ensure that information is available to children, adolescents and young people in out-of-school settings, such as youth clubs and safe spaces particularly for girls, and on local radio stations to facilitate dialogue on this issue.**

Harmful practices

Harmful practices carried out in the name of social, cultural and religious tradition take place in many countries across the globe. These practices impact most on children, and on girls in particular, and are intricately linked to issues of value, power and control.²⁵⁵ They constitute deep-rooted gender inequality and discrimination, are a form of gender-based violence and a violation of human rights.

The international community has agreed to accelerate efforts to eradicate harmful practices. The 2030 Agenda for Sustainable Development includes a target to eliminate these practices by 2030, specifically female genital mutilation/cutting (FGM/C) and child, early and forced marriage (CEFM). In this paper, we focus on two of the most pervasive harmful practices – female genital mutilation/cutting and CEFM. Other harmful practices linked to SRHR include breast flattening; marriage by abduction/rape; corrective rape; virginity testing; ostracism linked to menstruation; incest and sexual initiation practices. More research is needed on many of these practices in order to develop a better understanding and response to them.

Female genital mutilation/cutting

At least 200 million girls and women alive today are estimated to have been subjected to female genital mutilation/cutting (FGM/C).²⁵⁶ These procedures, which are typically carried out on young girls, involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.²⁵⁷ FGM/C is a violation of the human rights of girls and women. It is traumatic and painful and commonly results in complications both immediate (including infection, haemorrhage, psychological trauma and even death) and long-term (including chronic pain,

chronic urinary problems, obstetric complications including fistula and sexual problems).²⁵⁸ FGM/C has no known health benefits. Although the practice is becoming less common, owing to population growth the number of girls and women actually being cut is increasing.²⁵⁹ The practice is most common in the western, eastern and north-eastern regions of Africa, in some countries in the Middle East and Asia as well as among migrants from these areas.²⁶⁰ As such, it is an issue of global concern.

Gender inequality and discriminatory social, cultural and religious norms relating to girls' and women's positions in the family, community and society underlie harmful practices such as FGM/C and prevent girls and women from enjoying their human rights.²⁶¹ In many cases, parents and perpetrators of FGM/C do not intend to cause girls deliberate harm and believe that such practices are necessary to secure the girls' future and acceptance in the community, to make them viable for marriage or to protect them from violence.²⁶² However, these perceptions and beliefs stem from patriarchal structures and power relations that drive the control or suppression of girls' and women's sexuality.²⁶³ It is believed that by mutilating the girl's genital organs, her sexuality will be controlled and her virginity before marriage will be guaranteed.²⁶⁴ Tackling these views and changing norms and attitudes is critical to eliminating FGM/C. Research shows that if practising communities themselves decide to abandon FGM/C, the practice can be eliminated very quickly.²⁶⁵

In 2012, the United Nations General Assembly adopted a milestone resolution calling on the international community to intensify efforts to end the practice of FGM/C.²⁶⁶ However, current progress is insufficient to keep up with increasing population growth and there is a danger of FGM/C increasing significantly in the next 15 years if current trends continue.²⁶⁷

Plan International's position:

- **Plan International strongly condemns female genital mutilation/cutting (FGM/C) under all circumstances. FGM/C is a human rights violation and needs to be treated as such.**
- **FGM/C is linked to harmful norms and gender stereotypes as well as a perceived need to control female sexuality. Plan International believes that every girl and woman should have the autonomy and necessary knowledge to be able to make free and informed decisions about her body. Local actors need to be supported to challenge social norms and successful projects should be scaled up.**
- **Plan International believes that it is important to tackle FGM/C both through effective legislation as well as through awareness-raising about the physical and mental harm and long-term adverse impacts that can result from this practice.**
- **Engaging families, communities and traditional and religious leaders in changing attitudes and norms around this harmful practice is crucial to ensure that it is no longer perceived to be acceptable, beneficial or tolerated and is instead condemned as a human rights violation which needs to be eliminated.**

- **Plan International notes that achieving the target to eliminate FGM included in the 2030 Agenda for Sustainable Development will require urgent attention, given current population growth rates.²⁶⁸**

Recommendations for ending FGM/C:

- **Governments should put in place effective legislation banning FGM/C, including forbidding the medicalisation of the practice. The bans must be fully implemented and enforced.**
- **Governments and other development actors should invest in awareness-raising about girls as rights holders and about the laws that protect them from FGM/C. They should support behaviour change by working with traditional, community and religious leaders as well as parents, teachers, girls, boys and community members, to bring about an end to the practice.**
- **Governments should strengthen the health sector response to FGM/C, providing appropriate guidelines, training and support to health professionals on how to detect FGM/C and providing medical care and counselling to all girls and young women who are living with FGM/C. Health workers should be penalised if found to perform FGM/C and should be engaged as agents of change to address social norms and attitudes in relation to FGM/C.**
- **Communities should be engaged in transforming social norms and gender roles in order to address root causes of FGM/C.**

Child, early and forced marriage

The practice of child, early and forced marriage²⁶⁹ (CEFM) is another example of a deeply concerning harmful practice which is also a powerful driver of early childbearing, maternal mortality and morbidity and a human rights violation.²⁷⁰

Across the globe, more than 700 million women alive today were married before their 18th birthday.²⁷¹ More than one in three – about 250 million – were married before age 15.²⁷² In spite of considerable efforts to tackle the issue of CEFM, progress needs to be accelerated eight-fold in order to meet the Sustainable Development Goals 5.3 target of ending child marriage by 2030.²⁷³

Higher proportions of girls and women marry during adolescence in Africa (particularly sub-Saharan Africa) than in Asia, Latin America and the Caribbean.²⁷⁴ Most of the 25 countries with the highest rates of child marriage are considered as fragile states or at high risk of natural disaster.²⁷⁵ However, in all those regions, poor, rural girls and women marry younger than those who are wealthier and living in urban areas.²⁷⁶

CEFM also affects boys, but to a far lesser degree than girls. Data on the number of boys affected by child marriage is scarce, but data from 2016 suggests that in nine countries, more than 10 per cent of boys are married before age 18.²⁷⁷ CEFM is driven by issues of gender inequality and compounds the impact of poverty. This results in the loss of educational and economic opportunities for girls and women and limits the power that they have in a wider range of matters.

Girls who marry are not only denied their childhood, they are often socially isolated – cut off from family and friends and other sources of support.²⁷⁸ Child brides are

often unable to effectively negotiate safer sex due to the power imbalance, leaving them vulnerable to sexually transmitted infections, including HIV, along with early pregnancy.²⁷⁹ There is also a strong link between CEFM and sexual violence.²⁸⁰

The pressure to become pregnant once married can be high, and child brides typically end up having many children to care for while still young. In Nepal, for example, more than one-third of women aged 20 to 24 who married before their 15th birthday had three or more children. This compares to only 1 per cent of women who married as adults having three or more children. Child brides are also less likely to receive proper medical care while pregnant.²⁸¹

There is evidence that crises can exacerbate the problem of CEFM, especially in protracted displacement settings. It is sometimes viewed by families as a means of protecting the “honour” of young girls, which may be at risk if food insecurity forces girls to resort to survival or transactional sex.²⁸² Studies have found that during crises the practice of CEFM may be expanded among families that would not have considered it before, and threatens even younger girls.²⁸³

Birth registration is an essential element in the effective prevention of child marriage, as it provides girls with proof of their age.²⁸⁴ However, only half of all children under the age of five in the developing world have had their births registered.²⁸⁵

Plan International’s position:²⁸⁶

- **Plan International strongly condemns the practice of child, early and forced marriage²⁸⁷ (CEFM) and calls for the prohibition of the practice under national and customary law, and for the full and effective enforcement of these laws. In line with the CRC General Comment No. 4, Plan International believes that the minimum age for marriage should be 18 and that this should apply equally to both men and women, regardless of any provisions concerning parental or judicial consent.**
- **Engaging communities and traditional and religious leaders, as well as girls and boys themselves, is critical to changing norms and eliminating this practice.**
- **We recognise that education is a powerful tool for preventing CEFM. Girls who benefit from a quality education are less likely to marry while they are still children. Therefore, governments must ensure all girls, including married girls, can access and complete primary and secondary education in line with their commitments to the 2030 Agenda.**

Recommendations for ending CEFM:

- **Governments should set a minimum legal age of 18 for marriage for both men and women, regardless of parental, judicial or religious consent. This should also override any conflicting customary or religious provisions regarding the age of marriage.**
- **When implementing legislation that seeks to eliminate CEFM, governments should also engage, sensitise and provide relevant training to judges, including customary judges, as well as to traditional, community and religious leaders.**

- **Governments should ensure that support systems and mechanisms are available to girls and women who have been married as children or against their will. This requires a multi-systemic response from the local level to the national level, including legal assistance, healthcare, psychosocial support and educational services.**
- **Governments should ensure efficient and effective linkages with and coordination between relevant sectors with a child protection remit, including the health, education and justice sectors.**
- **Governments should strengthen civil registration and vital statistics systems in order to achieve universal birth registration, which can help protect girls against CEFM by providing evidence of their age.**
- **Governments and other development actors should also work with communities, traditional and religious leaders, girls and women, boys and men to change attitudes and norms that accept CEFM.**
- **Governments should invest in raising public awareness of how CEFM is a violation of the law and children’s rights, as well as the harmful consequences of the practice.**

Gender-based violence

It is estimated that 120 million girls globally – approximately one in ten – have experienced rape or other sexual coercion.²⁸⁸ For most girls their first experience of being sexually victimised occurs between the ages of 15 and 19,²⁸⁹ but across 15 countries, one in five girls reported this first happening between the ages of 10 and 14. Girls who become pregnant before 18 years also face a heightened risk of experiencing violence during pregnancy within marriage or partnership, in comparison with girls who get pregnant after 18 years.

However, data also indicates that the proportion of adolescent girls who have experienced sexual violence varies widely. One study of 40 countries found that 22 per cent of adolescent girls in Cameroon had experienced sexual violence, while there were no reported cases in Kyrgyzstan.²⁹⁰ Comparable data on forced sexual intercourse and other forced sexual acts among boys are only available for four countries: Bolivia, Cameroon, Mozambique and Uganda. In Mozambique for example, adolescent girls were three times as likely as adolescent boys to have reported experiences of sexual violence.²⁹¹ Likewise, in Uganda, adolescent boys were nearly two times less likely than their female counterparts to have reported forced sexual intercourse or other forced sexual acts.²⁹²

Lesbian, gay, bisexual, transgender, intersex, questioning children, adolescents and youth are often targeted as a result of their sexual orientation or identity. One study conducted in Thailand found that 56 per cent of self-identified lesbian, gay, bisexual and transgender students had been bullied within the past month.²⁹³ Among them, 31 per cent experienced physical abuse, 29 per cent verbal abuse, 36 per cent social abuse and 24 per cent sexual abuse.

In a youth consultation workshop in Bangladesh, participants from both genders admitted that boys would blackmail and threaten girls into doing sexual acts, sometimes through the use of hidden cameras or incriminating photos or videos.

Every year, an estimated 246 million children suffer school-related violence.²⁹⁴ One of the major forms of this violence is gender-based sexual violence, including explicit threats or acts of sexual violence, harassment, abuse, coercion, exploitation and rape. Research has shown that girls are more likely to experience sexual violence in school than boys; it is estimated to have affected 150 million girls and 73 million boys under 18 across the world.²⁹⁵ Globally, nearly half of all sexual assaults are committed against girls under the age of 16.²⁹⁶

Evidence strongly suggests that most cases of sexual violence are perpetrated by someone known to the child, including teachers. While teachers are often key allies in preventing violence at school, they can also exploit their authority and power over their students and pressurise girls, and boys, to engage in sex for grades or the waiving of school fees.²⁹⁷ School-related gender-based sexual violence is a major barrier in the achievement of global quality education, and a serious violation of children's rights.

In a youth consultation workshop in Bangladesh, it was revealed that several participants had experienced violence. Various scenarios and examples were discussed, ranging from cases of domestic violence, where mothers had been tortured and abused by fathers for failing to produce sons (with children in the family also abused); sexual harassment such as taunts and molestation in public places, public transport or even in schools; and girls getting into abusive or exploitative relationships after their families had failed to provide for their needs.

Gender-based violence (GBV) disproportionately affects girls and women because of their subordinate status to men and boys. World Health Organisation has labelled violence against girls and women as a "global health problem of epidemic proportion."²⁹⁸ More than one-third of all women have reportedly experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives.²⁹⁹ However, actual numbers may be even higher, as data can only be collected when survivors of GBV report this. Due to the shame and stigma that survivors often face when coming forward, current global statistics do not reveal the true magnitude of gender-based and sexual violence.³⁰⁰

GBV is the result of unequal power dynamics and discriminatory social and gender norms. It has many forms and has significant consequences for the physical, sexual and mental health of girls and young women,³⁰¹ including a range of sexual and reproductive health problems, both short and long term.³⁰² Violence against girls and women permeates all sections of society and is prevalent in every country in the world. In recognition of this, eliminating violence against girls and women is one of the targets included in the 2030 Agenda.³⁰³

While there is some variation in figures, all regions across the world have unacceptably high rates of

violence against girls and women.³⁰⁴ The most common perpetrators of sexual violence against girls and women are a current or former boyfriend, husband or partner.³⁰⁵ Intimate partner violence causes emotional, psychological and physical harm, and can ultimately cause death³⁰⁶ – almost half of female homicide victims are killed by their intimate partner or by family members, whereas the rate for men is much lower at 1 in 20.³⁰⁷

The youth consultation workshop in Bangladesh revealed that while bullying was particularly common among boys, girls had experienced high levels of sexual violence, either in public spaces or in their homes.

Girls also face a heightened risk of being subjected to violence when they are pregnant.³⁰⁸ Data collected from 30 countries showed that the prevalence of physical violence against pregnant girls ranged from 1 per cent, up to 17 per cent in Pakistan.³⁰⁹ In six of the countries studied – Cameroon, the Democratic Republic of Congo, Equatorial Guinea, Gabon, Haiti and Pakistan – more than 10 per cent of girls had experienced physical violence during pregnancy. In several countries, including Haiti and Pakistan, the rates of physical violence during pregnancy for adolescents were also found to be substantially higher than those among older women. In many cases, the violence is perpetrated by the victim's partner.

In humanitarian contexts, levels of violence often increase. Pre-existing forms of sexual violence may be exacerbated in addition to the emergence of new threats for girls and women. Sexual violence and the systematic rape of girls and women is a common occurrence in the context of wars and armed conflict³¹⁰ and the International Criminal Court has recognised that it can constitute a war crime or a crime against humanity.

Sexual violence can have long-term consequences for children. A Plan International study in Liberia found that children who had been abused by the fighting forces during the war had significantly higher rates of depressive illness and thoughts of suicide, with most of those girls having survived multiple and repeated episodes of rape and gang rape. They were also exposed to different forms of violence and brutality, but the experiences of sexual violence were nevertheless major traumatic events in their lives.³¹¹

The study in Liberia also found that girls who had experienced sexual violence were much more likely to be engaged in transactional sex later in their lives. Other studies have corroborated this, and shown that a high proportion of women in prostitution suffered sexual abuse during their childhood.³¹² Some girls who had experienced rape reported that they viewed themselves and their bodies differently and that one method of protecting themselves from traumatic memories was to trivialise sexual intercourse and use it for survival and income.³¹³ Girls and women in prostitution also run a very high risk of being subjected to violence, including sexual assault and rape.³¹⁴

Girls are also particularly vulnerable to trafficking. Two out of three child trafficking victims are girls.³¹⁵ There has been a continued increase in the number of detected trafficked children, particularly girls under the age of 18, who currently comprise one-fifth of trafficked persons worldwide.³¹⁶ Girls who are trafficked are often exposed to grave human rights abuses, including sexual exploitation and abuse.

Alarmingly, the majority of girls and women who experience violence do not seek help or support. There are various reasons for this though a major barrier is the persistence of discriminatory attitudes and social norms that permit GBV against girls and women and lead to it being viewed as acceptable. Other factors include issues with the quality of the support services that are available which often fail to provide respectful, adequate, gender-responsive treatment, as well as concerns about victimisation and stigmatisation. Other shortcomings include weak legal frameworks and inadequate enforcement of laws that can result in impunity for perpetrators – for example, where the law dictates that a perpetrator will not be punished if he agrees to marry his victim.³¹⁷

Plan International's position:³¹⁸

- **Plan International believes that all children and young people have the fundamental human right to live free from violence.**³¹⁹
- **We recognise that GBV disproportionately affects girls and women. The root causes of GBV are discriminatory social norms and unequal power dynamics between men and women. Changing these deep-rooted norms and attitudes that normalise and excuse violence against girls and women is critical to ending GBV.**
- **We also recognise the critical role that child protection services can play in preventing abuse and extending assistance to victims.**
- **Plan International stresses the importance of the provision of care and support to survivors of violence, including the provision of safe houses. Healthcare providers and support services should respond to GBV in a way that does not reinforce harmful attitudes.**
- **Protective measures for victims of violence, including sexual violence and rape, should include effective mechanisms to ensure care, support and protection, including access to healthcare (including emergency contraception), psychosocial support, access to safe abortion services and effective means to seek justice and redress.**

Recommendations for addressing gender-based violence:

- **Governments should take action – including by passing and implementing relevant legislation – to eliminate all forms of violence against children and young people, particularly girls and young women.**
- **Governments should ensure efficient and effective linkages with and coordination between relevant sectors with a child protection remit, including the health, education and justice sectors to effectively prevent and respond to GBV.**
- **Governments should provide universal access to and gender-responsive critical services for all survivors of violence. This includes access to appropriate health services, including emergency contraception and psychosocial support; legal assistance; confidential reporting**

services; and safe houses.

- **Members of the emergency response system, police and judiciary at local, regional and national levels should be required to undergo training on detection and response to GBV and gender sensitivity to ensure appropriate judicial and health response mechanisms to incidences of harmful practices, sexual violence and exploitation.**
- **Government, working with others, should take effective action to challenge social norms that accept GBV and that dictate the subordination of girls and young women as well as support initiatives that enable girls and young women to exercise their agency.**

SRHR in humanitarian contexts

Many risks that children, adolescents and young people – and especially girls and young women – face tend to multiply in humanitarian contexts, including gender-based and sexual violence, child, early and forced marriage, trafficking, sexually transmitted infections (including HIV), unintended pregnancy, maternal morbidity and death.³²⁰ Children and adolescents with disabilities – especially girls – as well as unaccompanied and separated girls are also particularly vulnerable to abuse and exploitation. In fact, around three-fifths of all maternal deaths take place in humanitarian and fragile contexts.³²¹ At the same time, structures, networks and systems that can protect girls may be weakened or destroyed. Access to SRHR information and services may also be hindered or limited in times of crisis.

In humanitarian situations, issues concerning safety and security can restrict girls' and women's social roles as well as their free movement. Families might place tighter restrictions on girls' movements or give them increased responsibilities around the home.³²² This can create further barriers for girls and women in relation to accessing SRHR services.

During crises, usual protection mechanisms can also be eroded due to factors such as the lack of parental care, and the breakdown of community structures. Lack of protection mechanisms particularly affects girls whose parents have died or been injured, and who are in the care of a relative, or an unrelated adult, or an institution. Because of their sex and age, adolescent girls are particularly susceptible to exploitation and violence – including rape, abuse, early marriage and abduction – both during and in the immediate aftermath of a natural disaster or conflict.³²³ The nature of humanitarian contexts can also increase the exposure of girls and women to risks of sexual violence. They often have to walk further for fuel and water, and experience a lack of privacy, adequate lighting and security in displacement settings such as refugee camps.

Furthermore, girls and women may face abuse by the very people who are meant to protect them – including camp officials, humanitarian workers, peacekeepers, government employees and teachers – a situation again made more likely by weaker protection, reporting and response mechanisms.

In addition, women and girls can also become systematic targets for sexual violence in conflict situations. Sexual violence can become a weapon to terrorise and break apart families and communities and in some instances to change the ethnic make-up of

future generations. Where sexual violence is deployed systematically, to achieve military or political objectives, it constitutes a war crime under international law.³²⁴ When rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation or another form of sexual violence is committed as part of a widespread or systematic attack directed against a civilian population, it constitutes a crime against humanity.³²⁵ Perpetrators of sexual violence in conflict and post-conflict settings are often allowed to act with impunity, leaving survivors with little chance of accessing justice, reparations or the care and services they need.³²⁶

Adolescent girls as a group are often missed in traditional child protection interventions in emergencies, but may also not be reached with the programming used to reach adult women.³²⁷ For example, adolescent girls may not feel comfortable visiting a safe space designated for adult women. Adolescent girls may also be missed by efforts to provide sexual and reproductive health services; the Minimum Initial Service Package, which is the international standard for protecting women's and girls' SRHR in the acute phase of conflicts and disasters, does not include criteria for children and adolescents.

Plan International's position:

- **Plan International believes that human rights should be ensured in times of crises and all actors involved in humanitarian responses should take all possible measures to ensure that all children, adolescents and young people, including girls and young women, are able to realise their SRHR.**
- **Sexual and reproductive health and rights are not only critical in their own right, but also to achieving humanitarian objectives in other sectors such as child survival and education. The SRHR of children and young people should be protected and fulfilled before, during and after disasters and conflicts.**
- **Disaster risk reduction, resilience building and the planning and implementation of humanitarian responses must take full account of the risks faced by children, adolescents and young people, in particular girls and young women, and protect and fulfil their SRHR. Plan International also firmly believes that all humanitarian actors should ensure that a gender and age lens is applied to all aspects of humanitarian response, and that all possible measures are taken to prevent and respond to sexual and gender-based violence.**

Recommendations for improving SRHR in humanitarian contexts:

- **Governments and UN bodies should ensure that the assessment of disaster risk and planning for disaster risk reduction and preparedness takes into account the specific and intersecting risks and vulnerabilities faced by girls and young women. The development of disaster risk reduction policies and plans should involve the direct participation of girls and young women.**
- **Governments should take measures to enhance the resilience of sexual and reproductive health**

services, especially at the local level, in order to ensure the continuity of services during disasters, crises and conflicts. This includes investing in strong primary healthcare systems that incorporate sexual and reproductive health services; developing the capacity of health workers in applying and implementing disaster risk reduction approaches and ensuring that sexual and reproductive health and the specific needs of girls and young women are part of preparedness measures within the health and education sectors.

- **Governments (both host and donor), UN bodies and civil society organisations should ensure that disaster needs assessments reflect the specific needs and risks faced by girls and young women, including those related to SRHR. This includes measures such as ensuring that teams are gender-balanced, integrating fully disaggregated data into all disaster needs assessments, including data on sexual and reproductive health indicators, and ensuring the participation of girls and young women in the assessment process.**
- **Providers of humanitarian assistance should commit to the full and swift implementation of the Minimum Initial Service Package including awareness-raising about sexual and reproductive health services, and the earliest transition to comprehensive services and supplies based on a detailed needs assessment and longer-term programme planning. The Minimum Initial Service Package should also be strengthened to incorporate specific criteria on adolescent sexual and reproductive health.**
- **Providers of humanitarian assistance should take all possible measures to address sexual and gender-based violence during all phases of a crisis.**
- **All governments and international institutions must systematically hold all perpetrators of sexual violence and war crimes to account and stop the rampant impunity that is witnessed in humanitarian contexts around the world. States that have not already adopted national legislation in line with international norms, including the outlawing of all forms of gender-based violence, particularly against girls and women, must do so without delay. In addition, the national justice system must respond swiftly to any instances of sexual violence and ensure access to justice.**
- **Donors should increase funding for SRHR in emergency responses, with a particular focus on girls' and young women's SRHR as a neglected area.**

Plan International's work on SRHR

Plan International supports a large number of SRHR programmes – and it is a growing area of work, which links closely to other areas such as child, early and forced marriage, child protection and female genital mutilation/cutting.

In 2015, 82 per cent of all country offices reported that they have SRHR programmes (including family planning); 66 per cent have HIV and AIDS prevention, treatment and care programmes; and 80 per cent support comprehensive sexuality education and life skills programmes.³²⁸ In 2015, €25 million was invested in SRHR programmes, including sexuality education, family planning and HIV and AIDS programmes.³²⁹

Plan International's Regional Office in Latin America created the first regional framework on SRHR in 2010. This covered the importance of working with disabilities, lesbian, gay, bisexual, transgender, intersex, questioning populations and SRHR in the context of emergencies.

Plan International has made advances in taking a multi-sectoral approach to promoting SRHR, involving a wide range of stakeholders (including civil society organisations, children, adolescents and young people, parents, communities, religious and community leaders, government institutions, teachers and service providers). Plan International also engages in advocacy to improve legal frameworks and to ensure that they are being effectively implemented.

Plan International's overall programme and influencing objectives are to contribute to the realisation of sexual and reproductive health and rights and the protection of bodily autonomy for all children, adolescents and young people, including girls and young women, children, adolescents and youth with disabilities and those who identify as lesbian, gay, bisexual, transgender, intersex, questioning.

Under the new global strategy these objectives will support our work across the four global outcome areas Learn, Lead, Decide and Thrive.

Key areas of focus include the following:

- To support all children, adolescents and young people to access high quality, rights-based and gender-transformative comprehensive sexuality education in formal and non-formal settings.
- To strengthen the provision of quality, non-judgemental, gender-responsive, child-, adolescent- and youth-friendly SRHR and HIV services that are accessible, affordable, acceptable, equitable, appropriate and effective.
- To influence legal and policy reform and budgetary support to meet children's, adolescents' and young people's SRHR, including the particular needs and rights of girls and young women. This includes work relating to Sustainable Development Goals influencing and monitoring the progress of governments to implement the 2030 Agenda as well as other human rights commitments.
- To support meaningful engagement and leadership in SRHR programmes and decision-making by children, adolescents and young people, including by girls and young women.

- To transform harmful social and gender norms that underpin violations of sexual and reproductive rights, including harmful practices such as child, early and forced marriage and female genital mutilation/cutting, and structural drivers such as poverty and gender inequality that impact negatively on SRHR.
- To build on our existing SRHR work to progressively strengthen our capacity to contribute to the delivery of the Minimum Initial Service Package in emergencies.³³⁰
- To conduct joint research, consultations with girls as well as advocacy with the United Nations Special Rapporteur on Disability on the SRHR of girls with disabilities.

Annex 1: Human rights standards and international commitments relating to SRHR

Sexual and reproductive rights are derived from a number of international human rights instruments and consensus documents. These include (but are not limited to) the United Nations Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, the International Covenant on Economic, Social and Cultural Rights, the Programme of Action of the International Conference on Population and Development at Cairo (the International Conference on Population and Development Programme of Action), the Beijing Declaration and Platform of Action and the 2030 Agenda for Sustainable Development. There are also a number of regional human rights instruments and frameworks that address SRHR. However, for the purpose of this paper, we will be focusing just on the international documents.

Although there is no internationally agreed formal definition of sexual rights, nor any legally binding treaty that enshrines these rights per se, sexual rights are interpreted and understood from other human rights contained in and protected by international human rights standards and law.³³¹ These are elaborated further in other international consensus documents that, while not legal in nature, are nevertheless persuasive in character and indicative of the direction that the international law is heading. Furthermore, in 2004 the UN Special Rapporteur on the right to health commented that he had

*“...no doubt that the correct understanding of fundamental human rights principles, as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights. Sexual rights include the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference”.*³³²

International Conference on Population and Development Cairo 1994

In terms of shaping the current discourse around SRHR, the International Conference on Population and Development (ICPD) in Cairo in 1994 marked a significant turning point with the recognition that sexual and reproductive health is fundamental to the wellbeing of all persons, couples and families, as well as for the social and economic development of communities and nations. This position was developed further in the ICPD Programme of Action, which states in Principle 8:

“Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health”.

The Programme of Action also clarified that reproductive rights include certain human rights that are already recognised in national legal frameworks, international human rights law and other relevant documents of the United Nations and

*“...rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents”.*³³³

The Programme of Action also helped draw attention to the sexual and reproductive health needs of refugees:

*“Refugees, particularly refugee women, should be involved in the planning of refugee assistance activities and in their implementation. In planning and implementing refugee assistance activities, special attention should be given to the specific needs of refugee women and refugee children. Refugees should be provided with access to adequate accommodation, education, health services, including family planning, and other necessary social services.”*³³⁴

In relation to SRHR services, the 20-year review of the ICPD³³⁵ in 2014 noted that few countries had made measurable progress towards integrated sexual and reproductive health services or comprehensive education on human sexuality for all adolescents and youth. The review document went on to emphasise that:

“...if women are to enjoy their human rights and contribute fully to the enrichment and growth of society, to innovation and to sustainable development, they must be able to decide on the number and timing of their children, free from discrimination, violence and coercion, with access to sexual and reproductive health services necessary to prevent illness, disability or death and with confidence in the probable health and survival of their children”.

Beijing Declaration 1995

One year later, during the IV World Conference on Women in Beijing (1995), the positions taken at the International Conference on Population and Development were endorsed and built upon. The Platform of Action from the Beijing Conference also established that human rights include the right of women freely and without coercion, violence or discrimination to have control over and make decisions concerning their own sexuality, including their own sexual and reproductive health.³³⁶

While the Cairo and Beijing agreements are not legally binding per se, they hold significant weight as the vast majority of governments have endorsed them.³³⁷ Both conferences adopted without a vote the final documents on 13 September 1994 and 15 September 1995 respectively and the documents were subsequently endorsed by resolutions of the United Nations General Assembly.³³⁸ As such, it has been argued that they “embody globally accepted policy norms and recommendations”.³³⁹

In 2014, two decades after the Cairo conference, the International Conference on Population and Development+20 review process took stock of the status of the Cairo Programme of Action in terms of implementation. While progress had been made on areas such as maternal mortality and primary school enrolment and completion, SRHR remained a neglected issue. In a similar vein, the recent review document of the Beijing Declaration and Platform of Action³⁴⁰ noted that 20 years on, many of the barriers and challenges remain in place, with serious stagnation and even regression in some areas.

As such the recommendations contained in the International Conference on Population and Development and the Beijing Declaration and Platform of Action remain as relevant as ever. Furthermore, the 2030 Agenda makes explicit reference to these frameworks and their review documents in Sustainable Development Goal 5.6, which concerns universal access to sexual and reproductive health and reproductive rights though it does not explicitly refer to sexual rights.

Convention on the Rights of the Child

Convention on the Rights of the Child (CRC) Article 24 makes clear that all children have the right to enjoy the highest attainable standard of health and that no child should be deprived of his or her right to access such healthcare services.³⁴¹ Article 24 also imposes an obligation on States parties to ensure appropriate prenatal and postnatal healthcare for mothers, to provide family planning education and services and to take all measures with a view to abolishing traditional practices which are harmful to the health of children.

The Committee on the Rights of the Child General Comment No. 3 on HIV/AIDS and the rights of the child³⁴² notes the extent to which children are at the heart of HIV and AIDS epidemics, with girls and women becoming increasingly affected. The General Comment emphasises the obligation on States to ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality, clarifying that children should receive

*“...relevant, appropriate and timely information which recognizes the differences in levels of understanding...is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality in order to protect themselves from HIV infection”.*³⁴³

The General Comment also calls on States to guarantee the equal access of children to all relevant services with particular regard for the child’s right to privacy and confidentiality.³⁴⁴ It also emphasises the need for services to be friendly and supportive, accessible, affordable, non-judgemental and free from any requirement for parental consent.³⁴⁵

The Committee on the Rights of the Child General Comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child places particular emphasis on the need to respect adolescents’ rights to privacy and confidentiality including with respect to advice and counselling on health matters.³⁴⁶ It calls on States to take effective measures to ensure that adolescents are protected from all forms of violence, abuse, neglect and exploitation³⁴⁷ and emphasises that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, recommending that States reform legislation to provide for a minimum age of marriage with and without parental consent to 18 years for both boys and girls.³⁴⁸ The General Comment also emphasises the need for States to provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV and AIDS, and the prevention and treatment of sexually transmitted diseases, regardless of marital status and whether their parents or guardians consent.³⁴⁹

With regard to access to essential services, the General Comment urges States parties to:

*“(a) develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education”.*³⁵⁰

The Committee on the Rights of the Child General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health is also relevant as it emphasises the need for the best interests of the child to be assessed and taken as a primary consideration in all health-related decisions concerning a child.³⁵¹ It also emphasises the importance of children’s participation, allowing children to express their views and to have those views seriously taken into account.³⁵² The freedom to control their health and body, including to make choices about their sexual and reproductive health and to access a range of facilities, goods and services is also noted.³⁵³

Paragraph 31 provides that

“...in accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child’s best interests”.

It also calls on States to

“...review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion”.

Paragraph 56 also specifically refers to the high rates of pregnancy among adolescent girls and asks States to ensure that healthy systems are able to meet the specific SRHR needs of adolescents including family planning and safe abortion services. It also calls on States to ensure that girls can make autonomous and informed decisions on their reproductive health and to prohibit discrimination based on adolescent pregnancy.³⁵⁴ Furthermore, the Committee on the Rights of the Child has expressed concern about maternal mortality in adolescent girls stemming from unsafe abortion – a violation of their right to life – and urged States to reform punitive abortion legislation and ensure access to safe abortion services, irrespective of the legality of abortion.³⁵⁵

The Committee on the Rights of the Child has also accepted that the age at which individuals can give sexual consent is not the age at which they attain adulthood (age 18). It also clearly distinguished the age of sexual consent from the age of marriage (which is set at 18) and made clear that the age at which individuals can consent to homosexual and heterosexual activity should be the same.³⁵⁶

Convention on the Elimination of All Forms of Discrimination Against Women

Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)³⁵⁷ is central to the health and wellbeing of girls and women. It requires States to eliminate discrimination in access to healthcare services throughout the life cycle, particularly in the areas of family planning, pregnancy and

confinement and during the postnatal period. In particular, it requires States to take

“... all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services including those related to family planning”.

It goes on to require States parties to also ensure that women have appropriate services for “*pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation*”.

The Committee on the Elimination of All Forms of Discrimination Against Women General Recommendation No. 24³⁵⁸ provides further clarification on the scope of Article 12 of CEDAW and makes clear that its recommendations apply equally to girls and adolescents as well as to women. Of particular note, the General Recommendation clarifies that the convention not only aims to put women on equal footing with men in terms of access to healthcare, but that States also need to recognise the particular (reproductive) needs of women:

“Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.”

It goes on to also note that States should not restrict women’s access to health services on the grounds that they lack the authorisation of their husbands, partners or health authorities or because they are unmarried or women.³⁵⁹ The General Recommendation further recommends that

*“States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality”.*³⁶⁰

It also calls on States to

*“...prioritise the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion”.*³⁶¹

In conflict settings, General Recommendation No. 30 of the Committee on the Elimination of All Forms of Discrimination Against Women, has called on governments to:

“Ensure that sexual and reproductive health care includes access to sexual and reproductive health and rights information; psychosocial support; family planning services, including emergency contraception; maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care; safe abortion services; post-abortion care; prevention and treatment of HIV/AIDS and other sexually transmitted infections, including post-exposure prophylaxis; and care to treat injuries such as

*fistula arising from sexual violence, complications of delivery or other reproductive health complications, among others”.*³⁶²

The Committee on the Elimination of All Forms of Discrimination Against Women has also made clear that the fundamental principles of non-discrimination and equality require that the rights of a pregnant woman be given priority over an interest in prenatal life.³⁶³

International Covenant on Economic, Social and Cultural Rights – General Comment 22 on the right to sexual and reproductive health

General Comment 22 makes clear that the right to sexual and reproductive health is an integral part of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, which is enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights. As such, it calls on States to ensure unhindered access to a whole range of health facilities, goods, services and information that ensure all people full enjoyment of the right to sexual and reproductive health.

It emphasises the need for available, accessible, affordable, acceptable and quality goods, information and services related to sexual and reproductive health for all and recognises the discrimination, coercion and violence which many girls and women face in trying to realise their SRHR. To address this situation, it notes that States need to repeal or amend discriminatory laws, policies and practices in the area of sexual and reproductive health (including through liberalising restrictive abortion laws and provisions requiring parental, spousal or judicial consent) and remove barriers that prevent girls and women from accessing SRHR information, goods and services. Among the information and services which need to be made available and accessible, the General Comment lists safe and effective contraceptives, comprehensive sexuality education, guaranteeing girls and women access to safe abortion services and quality post-abortion care.³⁶⁴

Of particular note, it also makes clear that States are obliged to ensure that adolescents have full access to appropriate information on sexual and reproductive health regardless of their marital status and whether their parents or guardians consent, with respect for their privacy and confidentiality.³⁶⁵

Convention on the Rights of Persons with Disabilities

Article 23 of the Convention (CRPD) states:

“States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

- a. *The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;*
- b. *The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means*

necessary to enable them to exercise these rights are provided;

- c. *Persons with disabilities, including children, retain their fertility on an equal basis with others.*"

Article 25 of the CRPD³⁶⁶ confirms that persons with disabilities have the right to enjoyment of the highest attainable standard of health, including sexual and reproductive health, without discrimination on the basis of disability. Article 25a provides that States Parties shall

"Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes."

General Comment No. 2³⁶⁷ emphasises the importance of accessibility in health services:

"Health care and social protection would remain unattainable for persons with disabilities without access to the premises where those services are provided (...) All information and communication pertaining to the provision of health care should be accessible through sign language, Braille, accessible electronic formats, alternative script, and augmentative and alternative modes, means and formats of communication. It is especially important to take into account the gender dimension of accessibility when providing health care, particularly reproductive health care for women and girls with disabilities, including gynaecological and obstetric services."

The 2030 Agenda for Sustainable Development

The 2030 Agenda for Sustainable Development includes direct targets on SRHR as well as some that address underlying factors that hinder the realisation of SRHR, such as child, early and forced marriage; poverty; gender inequality; violence; stigma and discrimination. Two targets need specific mention, namely Sustainable Development Goal 3.7 and Sustainable Development Goal 5.6.

Target 3.7 provides: *"By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes"*.

Target 5.6 provides: *"Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences"*.

However, the 2030 Agenda has come under some criticism for failing to include explicit provisions concerning sexual rights, comprehensive sexuality education, discrimination on the basis of sexual orientation or gender identity; the right to access quality,

safe abortion services; and the importance of high quality, confidential and timely sexual and reproductive health services, including for children and adolescents. It will also be imperative to ensure that the goals and targets set out in the 2030 Agenda apply equally in times of crisis and in refugee settings if it is to achieve its objective of leaving no one behind.

Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and its accountability framework was launched by the UN Secretary General in 2015 to help countries begin implementing the 2030 Agenda. It goes further than the 2030 Agenda in explicitly referencing some critical SRHR issues which were not included in the 2030 Agenda such as comprehensive sexuality education, safe abortion, post-abortion care and sexual orientation.

Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/General comment No. 18 of the Committee on the Rights of the Child on harmful practices

The committees state that governments who have ratified the conventions

"...have a duty to comply with their obligations to respect, protect and fulfil the rights of women and children. They also have a due-diligence obligation to prevent acts that impair the recognition, enjoyment or exercise of rights by women and children and ensure that private actors do not engage in discrimination against women and girls, including gender-based violence..."

The Sendai Framework for Disaster Risk Reduction

This framework³⁶⁸ contains a stronger gender perspective than its predecessor, the Hyogo Framework for Action, and emphasises the importance of including women in planning and designing disaster preparedness. It also makes specific reference to the importance of sexual and reproductive health services, stating:

*"At national and local levels, it is important to... strengthen the design and implementation of inclusive policies and social safety-net mechanisms, including through community involvement, integrated with livelihood enhancement programmes, and access to basic health care services, including maternal, newborn and child health, sexual and reproductive health ... to empower and assist people disproportionately affected by disasters."*³⁶⁹

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- 11 Target 5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
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- The Secretary-General first referred to the current definition of youth in 1981 in his report to the General Assembly on International Youth Year (A/36/215, para. 8 of the annex) and endorsed it in ensuing reports (A/40/256, para. 19 of the annex).
- 31 A/CONF.171/13: Report of the ICPD (94/10/18)
- 32 Resistance from States to recognise sexual rights stems from their negative attitude to access to safe abortion, rights for people who identify as lesbian, gay, bisexual, transgender, intersex, questioning, and guaranteeing girls and women control over their own sexuality including making decisions that are linked to their sexuality.
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351 Committee on the Rights of the Child, General Comment 15, para 12.

352 Committee on the Rights of the Child, General Comment 15, para 19.

353 Committee on the Rights of the Child, General Comment 15, para 24.

354 Committee on the Rights of the Child, General Comment 15, para 56.

355 See, e.g., CRC Committee, concluding Observations to: Chad, 30, U.N. Doc. CRC/C/15/Add.107 (1999); Chile, 55, U.N. DOC. CRC/C/CHL/CO/3 (2007); Palau, 46, U.N. Doc. CRC/C/15/Add.149 (2001); Uruguay, 51, U.N. Doc. CRC/C/URY/CO/2 (2007)); CRC Committee, General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health, (62nd Sess., 2013), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, 70, U.N. Doc. CRC/C/GC/15 (2013).

356 Committee on the Rights of the Child, Concluding Observations: Austria, (1999) UN Doc. CRC/C/15/Add.98; see also Council of Europe, L. and V. v. Austria, Applications nos. 39392/98 and 39829/98, Judgement of 9 January 2003, and S.L. v. Austria, Application No. 45330/99, Judgement of 9 January 2003.

357 Convention on the Elimination of All Forms of Discrimination Against Women 1979.

358 CEDAW General Recommendation No. 24: Article 12 of the Convention. Adopted at the 20th session of the Committee on the Elimination Against Women (1999) A/54/38/ Rev.1, chap.1)

359 Ibid General recommendation No. 24, para 14

360 Ibid General recommendation No. 24 para 18

361 Ibid. General Recommendation No. 24 para 31(c)

362 Committee on the Elimination of Discrimination Against Women, General Recommendation No. 30, para 52(c)

363 This statement is an interpretation of the CEDAW View No. 22/2009 case L.C. v. Peru the where CEDAW Committee found that the government had violated a pregnant girl's rights by prioritising the foetus over her health. The CEDAW Committee held that the denial of a therapeutic abortion and the delay in providing the surgery constituted gender-based discrimination and violated her

rights to health and freedom from discrimination. (L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

364 Committee on Economic, Social and Cultural rights, General Recommendation No. 22 (paras 28, 34, 41)

365 Committee on Economic, Social and Cultural rights, General Recommendation No. 22 (para 44)

366 Convention on the Rights of Persons with Disabilities 2006, entered into force on 3 May 2008

367 Committee on the Rights of Persons with Disabilities, General comment No. 2, para 40

368 The framework was adopted by UN Member States in March 2015 as the first major agreement of the Post-2015 development agenda. It aims to achieve “the substantial reduction of disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries.”

369 UNISDR (United Nations International Strategy for Disaster Reduction). 2015. Sendai Framework for Disaster Risk Reduction 2015-2030. Geneva: United Nations Office for Disaster Risk Reduction. Paragraph 30j states: “At national and local levels, it is important to.... strengthen the design and implementation of inclusive policies and social safety-net mechanisms, including through community involvement, integrated with livelihood enhancement programmes, and access to basic health care services, including maternal, newborn and child health, sexual and reproductive health, ... to empower and assist people disproportionately affected by disasters.”