



## Plan International, Inc.

# WRITTEN SUBMISSION ON CHILDREN'S RIGHT TO HEALTH

Geneva, 30-31 October

## INTRODUCTION

1. Plan has developed this paper to inform the forthcoming report by the Office of the High Commissioner for Human Rights (OHCHR) on the right of the child to the enjoyment of the highest attainable standard of health, which will be presented at the Human Rights Council's annual full day of discussion on child rights in March 2013. It outlines the challenges, barriers and good practice related to realizing children's and adolescents' right to sexual and reproductive health. The submission focuses on the situation of adolescent sexual and reproductive health rights (ASRHR) in the Latin-American context, building on Plan's situational analysis of the realization of sexual and reproductive rights in the region.<sup>1</sup> It presents examples of good practice, and provides a series of recommendations to States and other actors at the global level.
2. Plan is an international, non-profit, child-centered, rights-based development organization that works without religious, political or governmental affiliation in 50 developing countries across Africa, Asia and the Americas to promote child rights and gender equality. Founded 75 years ago, Plan is one of the oldest and largest children's development organizations in the world. In 2011, Plan facilitated and implemented programmes, including in collaboration with partners, reaching 56.5 million children in 58,053 communities. Plan's vision is of a world in which all children realize their full potential in societies that respect people's rights and dignity. The right of children and adolescents to sexual and reproductive health, including HIV prevention, care and treatment, represents one of Plan's priority programme areas.

## ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH): INTERNATIONAL LEGAL FRAMEWORK

3. Children's and adolescents' right to health including sexual and reproductive health is stipulated in the Convention of the Right of the Child (art 24), the Committee on the Rights of the Child General Comment No. 3 on HIV/AIDS (2003)<sup>2</sup> and General Comment No. 4 on adolescent health and development (2003)<sup>3</sup>, as well as a number of other international human rights instruments. The importance of, and commitment to, the right to sexual and reproductive health including care and services is also reflected in a number of international agreements, such as the *Programme of Action of the International Conference on Population and Development* (ICPD PoA, Cairo 1994), the *Beijing Platform for Action* (1995) and the addition of MDG target 5b which aims to achieve universal access to reproductive health by 2015. The need for more concerted effort to promote and protect adolescent sexual and reproductive health has also been considered in recent political commitments, including the United Nations Global Strategy for Women's and Children's Health, the Political Declaration of the UN General Assembly High Level Meeting on AIDS (2011) and the MDG Summit 2010 Outcome document. Despite these positive advances, gaps in the realization of these rights are enormous. Around the world, a

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<sup>1</sup>Including consultations and research in eleven countries of the region : Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, Perú

<sup>2</sup> CRC/GC/2003/3

<sup>3</sup> CRC/GC/2003/4



significant proportion of children and adolescents living in poverty and social exclusion are growing up being denied their right to the highest attainable standard of sexual and reproductive health.

## MAJOR CHALLENGES RELATED TO ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN LATIN AMERICA

4. In Latin America, significant proportions of children and adolescents grow up - and begin their sexual lives - without access to timely, appropriate and quality information, education and services, and lack the knowledge, skills and opportunities to make and negotiate informed, autonomous decisions for the exercise of a healthy, safe and enjoyable sexuality - free of coercion, violence or discrimination<sup>4</sup>. The consequences of this situation are significant. A review of the common concerns expressed by the United Nations Treaty Bodies, the Human Rights Council's Special Procedures and the Inter-American Human Rights System regarding the girl child and the adolescent girl in Latin America and the Caribbean, highlighted the situation of adolescent sexual and reproductive health as one of *the three most commonly mentioned concerns in all three sub-regions*<sup>5</sup>.
5. Main challenges include:
  - **High teenage pregnancy rates.** Across the region, 38% of women become pregnant before reaching the age of 20: in no other region do teenager birth rates contribute so significantly to the total number of births<sup>6</sup>. Teen pregnancy accounts for 18% of all pregnancies, through this proportion increases to 62% in some rural Central American communities<sup>7</sup>. A significant proportion of these are unplanned<sup>8</sup>. Teenage pregnancy is generally associated with higher rates of maternal mortality and morbidity compared to the adult population and higher rates of infant mortality<sup>9</sup>. In Latin America in 2005, it was estimated that complications from pregnancy and childbirth represented the main cause of death amongst female adolescents aged 15 – 19 years<sup>10</sup>. Unsafe abortions represent one of the three most important causes of maternal deaths in a significant proportion of countries in the region and are more likely to occur amongst adolescents<sup>11</sup>. Meanwhile, Plan's research identified teenage pregnancy as one of the main barriers to girls completing primary and secondary school and to economic independence in the region<sup>12</sup>.

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<sup>4</sup> While trends in the age of first sexual intercourse differ between countries, according to the UNGASS 2008 Country Reports, up to 36% of young people between 20-24 years old reported that their first sexual intercourse occurred before the age of 15 and rates of unprotected sexual intercourse were high.

<sup>5</sup> Southern Cone, Mexico and Central America, and Andean Region. UNICEF 2012

<sup>6</sup> Desafíos: Maternidad adolescente en América Latina y el Caribe. Tendencias, problemas y desafíos. CEPAL, UNICEF 2007

<sup>7</sup> The limited data available suggests rising pregnancy rates amongst girls aged 10 -14; it is thought that a significant proportion of these occur following sexual violence. In addition, rates of second pregnancy in adolescence are high in some communities. See also ECLAC 2007

<sup>8</sup> It is estimated that between 35% and 52% of teen pregnancies are unplanned, with highest rates in countries of the Andean sub-region. The limited evidence available suggests that a significant proportion of pregnancies amongst girls under 15 years are the result of sexual violence/coercion. Juventud y desarrollo: nuevos desafíos con las y los jóvenes de Ibero América. OIJ, CEPAL, UNFPA, FLACSO, SGI, 2008.

<sup>9</sup> A study in Latin America found that maternal death rates for adolescents under 16 are 4 times greater than for women in their 20s. World Health Organization, Making Pregnancy Safe Notes 2008

<sup>10</sup> Jóvenes de Ibero América y los ODM. Organización Iberoamericana de la Juventud 2007

<sup>11</sup> The average maternal mortality ratio in LA remains high at 137 deaths/100,000 live births. Abortion is illegal in most countries, nevertheless estimates are that 22% of all pregnancies in the region end in abortion, 43% of all abortions occur amongst women aged 15-24 years and up to 95% of these are unsafe. (Guttmacher Institute, UNFPA, WHO). The Pan American Health Organization estimates that nearly 5,000 women die and one million are hospitalized every year due to complications of unsafe abortions. .

<sup>12</sup> Qué factores aportan o limitan el pleno desarrollo de las niñas en América Latina y el Caribe? Plan ROA 2012



- **HIV epidemic.** In most Latin-American countries (LAC), HIV transmission is increasingly affecting women, adolescents and youths. It is estimated that 40% of people living with HIV in LAC are between 15 and 24 years of age. The incidence of other sexually transmitted infections (STIs) is high in the region and in several countries is on the increase among adolescents and youth. Estimates are that 15% of young people in Latin America acquire an STI each year<sup>13</sup>.
6. Sexual and reproductive ill-health disproportionately affects children and adolescents from populations and specific groups that have historically been discriminated against and that in general live in poverty, including children and adolescents living with a disability; sexual minorities; displaced populations or populations affected by emergencies; afro-latino communities and indigenous populations<sup>14</sup>.
  7. Even where comprehensive sexuality education (CSE)<sup>15</sup> is included in the national curriculum, it is often not implemented in the schools. When schools do include sexuality education, the teaching is rarely rights- and life-skills based: instead it tends to have a risk-based, biomedical bias and reinforces gender stereotypes and discrimination against people living with HIV and people with a sexual orientation that is not heterosexual<sup>16</sup>. Teachers feel poorly prepared to integrate sexuality education into the classroom and are provided limited materials to do so<sup>17</sup>.
  8. Plan's consultations with adolescents confirm major gaps with respect to available, accessible, acceptable, quality and effective adolescent sexual and reproductive health (ASRH) services. Reproductive health services are usually aimed at pregnant, married or in-union adolescents or adult women (with 10 – 14 year olds and young men particularly excluded). Coverage is often patchy and concentrated in urban areas. Where services are available, a failure to ensure adequate privacy, accessible hours of operation, together with the negative attitudes of healthcare providers, and an insistence on parental consent (even where this is not legally required) often act as deterrents to use.
  9. While data is limited, **rates of sexual coercion and violence** – which represent violations of the sexual and reproductive health and rights of girls and young women in particular - are thought to be disturbingly high. Surveys using school-based samples conducted in different Latin American countries have found that between 5% and 40% of adolescents report having been sexually abused at some point in their lives.

## MAIN BARRIERS TO IMPLEMENTING THE RIGHT OF ADOLESCENTS TO SEXUAL AND REPRODUCTIVE HEALTH

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<sup>13</sup> Ibid 7 and CEPAL/UNFPA (2009).

<sup>14</sup> Del Pópulo F, López, M, Acuña, M. Juventud indígena y afro-descendiente en América Latina: inequidades sociodemográficas y desafíos de políticas. CELADE, CEPAL, OIJ.2009. WHO/UNFPA guidance note: Promoting sexual and reproductive health for persons with disabilities, 2009. Guttmacher Institute, UNFPA. Latin America and the Caribbean: Facts on Investing in Family Planning and Maternal and Newborn Health, December 2009.

<sup>15</sup> Comprehensive sexuality education (CSE) aims to provide scientifically accurate, accessible, appropriate and comprehensive information regarding sexual and reproductive rights and health; is centered on a positive approach to sexuality, sexual and reproductive rights, emotional relations and autonomy; is adapted to the culture of children, respectful of diversity, gender-sensitive and promotes alternative models of masculinity and femininity, and emphasizes learning and life-skills strengthening through art, dialogue, bodily awareness and other active methodologies. It is oriented to the strengthening of individual, group and social capabilities for self-care and self-protection; for making autonomous and positive decisions about one's life, health and dignity; for communication, negotiation and the construction of equal, respectful and non-violent relationships. Also see International Planned Parenthood (IPPF) *Framework for CSE*, 2010.

<sup>16</sup> Regional study on comprehensive sexuality education (CSE) carried out by the National Institute of Public Health of Mexico in 2008.

<sup>17</sup> IWHC 2007



10. While all Latin-American countries have ratified the key international human rights treaties providing for the rights of children and adolescents, Constitutional frameworks and National Child and Adolescence Codes in the greater majority of cases do not make explicit reference to sexual and reproductive rights. In recent years, legislative frameworks to comprehensively protect sexual and reproductive rights of children, adolescents and adults have been blocked prior to approval in several countries, while in others there have been reversals in hard-won gains in legislation<sup>18</sup>. The 2008 Ministerial Declaration “Preventing through Education,” signed by twenty-eight States, committed these to implement cross-sector strategies for CSE and the provision of adolescent sexual and reproductive health services. However in February 2011 a review of implementation found limited progress<sup>19</sup> and most countries continue to lack a comprehensive policy for CSE or adolescent sexual and reproductive health services. In most countries, debates around sexuality education, HIV prevention, abortion, and sexual and reproductive health services for adolescents continue to be sensitive and politicized, with religious groups exercising significant influence on the definition and implementation of rights-based sexual and reproductive health programming, particularly in the area of comprehensive sexuality education.
11. Limited progress has been made in terms of inter-sectoral collaboration and implementation. The spaces and opportunities for genuine citizen participation - including the participation of adolescents - in the planning and monitoring of policy and programmes in this area are limited. Meanwhile official development assistance for SRH has fallen as donors have progressively directed their aid to other regions and this area has become less of a priority<sup>20</sup>.
12. In most countries, parents, care-givers, service providers and other adults have negative perceptions of adolescents and of their knowledge and behaviors associated with sexuality, and provide them with limited opportunities to participate in decision-making about their sexuality and health.
13. Poverty and a lack of employment opportunities for adolescents lead to many resorting to transactional sex to meet survival needs or leaving their communities for economic reasons: in turn migration is a risk factor for sexual and reproductive health problems<sup>21</sup>.
14. While progress has been made in recent years with respect to non-discrimination against persons due to their sexual orientation<sup>22</sup>, legal recognition of these groups has been minimal; few countries – particularly in Central America - have specific legislation in place to protect their rights;<sup>23</sup> and homophobia remains a major issue. Latin America and the Caribbean is considered by some experts as the region with the highest number of homophobic crimes in the world<sup>24</sup>. The issue of discrimination based on sexual orientation or preference is almost completely absent in the school curriculum<sup>25</sup>.

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<sup>18</sup> For instance legislation for SRH was blocked prior to approval in Bolivia [2004], Paraguay [2007], Peru [2007], Paraguay [2012] Reversals include the penalization of therapeutic abortion in Nicaragua (2006); the Supreme Court of Honduras’ upholding of a decree imposing a blanket ban on the sale and use of emergency contraception (even for rape survivors) (2012); the amendment of Peru’s Criminal Code (by Law No. 28.704) in 2006 which defined any sexual intercourse involving persons aged under 18, whether consensual or not, as a criminal offence and rape.

<sup>19</sup> Mesoamerican Coalition for Comprehensive Sexuality Education (IPPF and Demysex initiative)

<sup>20</sup> In 2007, only 4.5% of Official Development Assistance to the region was directed to population activities. CEPAL, UNFPA 2009.

<sup>21</sup> An estimated 6 million people from Latin America and the Caribbean have migrated within and some 25 million outside the region.

Recent estimates suggest that around 1 in 5 migrants is a child or adolescent and that migration amongst adolescents – often unaccompanied – is increasing. Challenges: Children and international migration in Latin America and the Caribbean. CEPAL, UNICEF 2010

<sup>22</sup> For example, the civil union of gay and lesbian partners has been legalized in some countries (Colombia (2007), Uruguay (2007), Ecuador (2008)) or parts of countries (Mexico, Brazil); same sex marriage has been legal since 2010 in Argentina; and in most countries, same-sex consensual sexual relations are not penalized.

<sup>23</sup> CLADEM. Dossier: Diez años de avances después del Cairo. 2004

<sup>24</sup> Campaigns against homophobia in Argentina, Brazil, Colombia, and Mexico. Washington, D.C: OPS, © 2006

<sup>25</sup> Only Uruguay reports that it is included in all programmes, while Colombia and Argentina report that it is addressed in most programmes. Demaría et al 2009, quoted in Report of the United Nations Special Rapporteur on the right to education to the UNGA 2010



15. Gender inequality and discrimination represent key underlying causes of violations of, and gaps in, the realization of sexual and reproductive health and rights. The gendered roles, norms and stereotypes that prevail in Latin America determine societal expectations around the reproductive role and sexuality of girls and women, boys and men and generate gender-specific vulnerabilities to sexual and reproductive health problems for both sexes<sup>26</sup>.

## GOOD PRACTICE FOR THE IMPLEMENTATION OF THE HIGHEST ATTAINABLE STANDARD OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH: EXAMPLES FROM PLAN'S EXPERIENCES

16. Plan has been facilitating and implementing programmes - in partnership with civil society organisations and government institutions - for the promotion of the rights of children and adolescent to sexual and reproductive health, including the prevention of HIV, for over ten years in the region of the Americas. Good practices identified through these programmes include:

**17. *Promotion of the participation of young people in public policy, planning and resource decision making relevant to their sexual and reproductive health.*** Plan's work in this respect has included:

- Training for adolescent counselors and groups on adolescents' right to sexual and reproductive health including: legal frameworks, public policy and programmes; governance, social control and citizenship; data analysis, communication and advocacy, together with supporting adolescent networks and peer education initiatives.
- Training for public decision-makers and planners to strengthen their incentives, attitudes and behaviors with respect to public accountability, transparency and participatory governance.
- Facilitating spaces/mechanisms at the national and local levels to bring young people and state actors together regularly for capacity building, joint situation analyses and to elaborate plans and policies.
- Creating adolescent-led processes for the quality monitoring of public services<sup>27</sup>

**18. *Adaptation and implementation of methodologies and pedagogical approaches that offer opportunities for reflection, awareness-raising and active learning around sexuality, sexual identity, gender relations and alternative models of masculinity and femininity:*** This involves creating "safe spaces" in which people can speak with confidence and reflect on how social, cultural, religious and economic factors – including inequalities related to gender, age and sexual orientation - influence their exercise of sexual and reproductive rights<sup>28</sup>.

**19. *The adoption of a life-cycle approach for sexuality education:*** Comprehensive Sexuality Education needs to commence well before adolescence, while always ensuring that age-appropriate content and methodologies are

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<sup>26</sup> In many countries girls are provided more limited or are even denied information about their sexuality and reproduction; and are denied access to SRH services. Boys meanwhile are socialised based on a hegemonic model of masculinity within which they are expected to be dominant, knowledgeable and powerful with regards to sexual activity, and to prove that they are "macho" through early sexual initiation and through multiple heterosexual partners.

<sup>27</sup> In Nicaragua, Bolivia, El Salvador, Plan's youth governance initiatives in SRH involved support for adolescent/youth-led research and analysis (including a political analysis and power mapping) as a first step to them "setting the agenda" and defining priorities: following this Plan facilitated mechanisms for joint municipal planning for ASRH (Nicaragua, El Salvador) and for adolescent-led advocacy for the incorporation of ASRHR into National Youth Law (Bolivia). In Bolivia, the program included use of score-cards for service quality monitoring.

<sup>28</sup> Plan is working with adolescents and youths (and training them as peer educators) using the regional version of the Stepping Stones training package on HIV, Communication and Relationship Skills, SRR, Gender and inter-Generational Relations, and Community Mobilization in several countries and is also expanding use of methods such as Program H and M to promote alternative models masculinity and femininity.



identified and adopted for each life-stage: Plan works to promote inclusion from first grade of primary school and where possible from pre-school (in El Salvador and Peru).

20. The provision of technical support to Ministries of Education to **develop comprehensive sexual education curricula and teaching materials that avoid a purely biomedical, risk-based focus on reproduction and disease**<sup>29</sup>.
21. **The development and implementation of teacher training packages to prepare teachers to incorporate comprehensive, rights-based sexuality education in the classroom** using specially designed curricula that extend beyond basic knowledge around reproduction and disease transmission<sup>30</sup>.
22. **The development of service norms and training programs for health-workers** for the implementation of **differentiated adolescent sexual and reproductive health services** that reflect existing best-practice technical and practice standards; *incorporate a gender equality and rights-based approach*; and ensure adequate attention for children and adolescents victims of sexual violence and abuse<sup>31</sup>.
23. **The promotion of inter-cultural approaches in both sexuality education and “differentiated” adolescent sexual and reproductive health services**: ensuring that service providers are prepared to recognize and respect the different “world views” of child and adolescent sexuality while ensuring that services guarantee the best interests of the child<sup>32</sup>.
24. **The implementation of awareness-raising and education processes for the promotion of social change and the engagement and support of parents and other caregivers in sexuality education initiatives for children and adolescents**; focused on strengthening their support for their children’s sexual and reproductive rights; strengthening their ability to communicate and provide guidance to their children around sexuality and reproduction; on the transformation of gendered and inter-generational power relations and on promoting community-wide mobilization and action<sup>33</sup>.
25. **The promotion of broader, inter-sectoral and inter-institutional approaches and action**: involving not only the health and the education sectors, but also actors from other key sectors of relevance to ASRH, including the justice sector and institutions responsible for the protection of children against violence and abuse<sup>34</sup>.

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<sup>29</sup>Plan has worked with both Ministries of Education and local educational authorities supporting the development of curricula for primary-school CSE with a rights-based, gender equality and intercultural approach in Peru, El Salvador, Guatemala and Colombia.

<sup>30</sup> These rights-based teaching training materials/guides are designed to provide teachers with an opportunity to reflect on their own sexuality, demystify taboos and myths, and transform negative perceptions around adolescents and their ability to make informed decisions about their sexuality and reproduction. An example is “Pienselo Bien” from Colombia.

<sup>31</sup> Plan has worked with Ministries of Health to develop frameworks, norms, treatment protocols and quality indicators for integrated, differentiated, user-friendly services for ASRH in several countries, including El Salvador, Nicaragua, Ecuador.

<sup>32</sup> In Ecuador and Guatemala, this work has been founded on studies conducted by Plan on cultural patterns and norms which influence how children and adolescents experience sexuality, which are related to teenage pregnancy and which need to be taken into consideration in sexuality education. At the regional level, Plan is currently undertaking a multi-country study on the cultural, emotional and social factors that influence the high rates of teenage pregnancy in Latin America.

<sup>33</sup>The Stepping Stones method has been found to be an effective approach for both individual and community-wide change.

<sup>34</sup> In several countries, Plan has integrated work to promote ASRRH with action to prevent sexual violence: this has included successful public education campaigns on the issue of violence against children (the “Six Senses Campaign”) in El Salvador and Colombia, the development of a guide for the prevention of sexual violence in schools (Bolivia) and work with educational authorities, school supervisors and teachers to strengthen their capacities for the prevention of sexual violence and abuse in the school setting (Ecuador) and the direct engagement of public servants from the child protection and justice departments in the primary school sexuality education program in Colombia.



## KEY RECOMMENDATIONS FOR GOVERNMENTS

**1) State parties should adopt rigorous national legislation and policies to ensure the effective enjoyment of the right to the highest attainable standard of sexual and reproductive health for all. This could include the following measures:**

- Review national legislation related to the enjoyment of the right to comprehensive sexual and reproductive health education, information and adolescent friendly services, to identify and address gaps and weaknesses and eliminate legislative barriers to the enjoyment of sexual and reproductive health and rights, in accordance with the general comments and recommendations from respective UN treaty bodies (CRC, CEDAW and CESCR), including the CRC General Comments No 3 and 4.
- The full integration of adolescent sexual and reproductive health and rights into national development plans and relevant strategies, policies, budgets and programs.
- Where necessary, amend or introduce legislation to guarantee 18 as the minimum age of marriage for both boys and girls, and the necessary measures to ensure its implementation, enforcement and monitoring.
- Strengthen official information systems to guarantee the availability of relevant, disaggregated data to inform policy responses aimed at the realization of the right to sexual and reproductive health.
- Strengthen legislation, policies, mechanisms and networks for the protection of children and adolescents against violence, including sexual violence, ensuring that the justice system upholds and protects the right to sexual and reproductive health of children, adolescents and provide comprehensive healthcare, assistance and psycho-social support for children and adolescents who experience sexual violence.
- Ensure that all girls are able to attend school, receive and complete at least 9 years of quality education, through addressing the financial barriers that keep girls out of school; tackling gender-based violence in schools; ensuring that teaching methods and curricula promote gender equality, respond to girls' needs and develop their skills, abilities and full potential; ensuring the reform and enforcement of laws and policies that provide for girls' continuation of their education during or after pregnancy and childbirth.

**2) States parties should strengthen their efforts to ensure *available, accessible, acceptable, quality and effective* health services for children and adolescents<sup>35</sup>. This would include:**

- Providing comprehensive adolescent sexual and reproductive health services<sup>36</sup> (provided preferentially through primary healthcare services) and the training and support of healthcare workers.
- Ensuring that services are provided in accordance with age, maturity and evolving capacities of the adolescent and that adolescents have access to comprehensive information and services regardless of their marital status, their sexual orientation and whether their parents or guardians are present or consent.
- Prioritising access for the most excluded and marginalized populations - including children and adolescents from displaced populations, living with disabilities or with HIV, and young lesbian, gay, bisexual, transgender and intersex (LGBTI) persons.

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<sup>35</sup> In line with the criteria for performance and implementation expressed in the CRC General Comment No 3 and 4

<sup>36</sup> Including culturally sensitive counseling, treatment and care with respect to family planning and contraception (including emergency contraception), gender-based violence, prevention of sexually transmitted infections including HIV, maternal healthcare, provision of safe termination of pregnancy where this is legal and the provision of quality post-abortion care, information and services.



**3) States parties should strengthen their efforts to provide and facilitate access to, comprehensive sexuality education for children and adolescents. This would include:**

- Including comprehensive sexuality education in the school curriculum<sup>37</sup>, wherever possible starting from the pre-school years.
- Providing high-quality, specialised teacher training for comprehensive sexuality education, ensuring that these offer opportunities to local education authorities, teachers and school directors.
- Providing comprehensive sexuality education for adolescents who are out of school.
- Encouraging the participation and inclusion of families and communities in the design and implementation of the comprehensive sexuality education program.

**KEY RECOMMENDATIONS FOR GOVERNMENTS, THE HUMAN RIGHTS COUNCIL, UN BODIES, CIVIL SOCIETY AND OTHER STAKEHOLDERS**

**4) States parties, UN agencies and civil society organizations should promote processes of social transformation, aimed at generating community and social mobilization and support for the sexual and reproductive health and rights of adolescents, through:**

- Designing and implementing awareness-raising and educational processes for fathers, mothers, families and communities to foster changes in socio-culturally determined attitudes, perceptions, norms and practices related to gender, sexuality, sexual and reproductive rights, lesbian, gay, bisexual, transgender and intersex (LGBTI) persons, HIV and violence, taking into account the cultural particularities of the communities.
- Ensuring that policy and programmes aim to transform unequal gender relationships; identifying and promoting changes in the social, economic and cultural causes of discrimination and supporting the construction of new masculine and feminine identities.

**5) States parties, UN agencies, civil society organizations, communities and families should facilitate and support adolescents to make autonomous informed decisions regarding their sexuality and reproduction and to participate in planning, implementation, monitoring and evaluation of programs and services relevant to their SRH. This would include:**

- Identifying and implementing participatory processes and mechanisms that allow the incorporation of adolescents' input into public policy and programming processes, ensuring that State actors are trained to facilitate this participation.
- Investing in the capacity-strengthening and leadership and communications skills of adolescents, in order that they are empowered as advocates of their own rights .

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<sup>37</sup> Comprehensive Sexuality Education (CSE); see note 11.





- Engaging and educating parents, families, caregivers and communities to strengthen inter-generational communication and to gradually transform their attitudes regarding adolescence, adolescent sexuality and the capacities of adolescents for informed, autonomous decision-making.

**6) The international community, UN agencies, the Human Rights Council and Treaty Bodies and civil society organizations, should provide increased political and practical support to State parties for the actions described above. This would include:**

- Strengthening the collection, analysis and communication of evidence regarding children’s and adolescents’ right to sexual and reproductive health, (building on research of cultural patterns and norms that influence these).
- Ensuring the participation of civil society organisations, in particular adolescent/youth organisations, in the elaboration and monitoring of policies, plans and budgets designed to guarantee children’s and adolescents right to sexual and reproductive health.
- Strengthening the monitoring of the progress of States parties in responding to key commitments and recommendations related to ensuring children’s adolescents right to sexual and reproductive health.<sup>38</sup>
- The Human Rights Council should request States to provide information on progress made and problems encountered in their efforts to ensure children’s adolescents’ enjoyment of their right to sexual and reproductive health at the time of their consideration by the Universal Periodic Review mechanism.

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<sup>38</sup> Including those in the CRC General Comments no 3 and 4, the ICPD Program of Action, The Beijing Platform for Action, and the recommendations made to the General Assembly by the UN Special Rapporteur on Education in 2010 on sexuality education.