



# Age Matters!

*Understanding age-related barriers to service access and the realisation of rights of children, adolescents and youth*

Final Synthesis Report – 2018

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## ABBREVIATIONS

Acquired Immune Deficiency Syndrome (AIDS)

Child Rights International Network (CRIN)

Civil Society Organisations (CSO)

Convention on the Rights of the Child (CRC)

European Union (EU)

European Union Agency for Fundamental Rights (FRA)

Human Immunodeficiency Virus (HIV)

Independent Review Board (IRB)

Information and Communication Technology (ICT)

International Labour Organization (ILO)

Minimum age of criminal responsibility (MACR)

Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (OPAC)

UNICEF Country Office (CO)

UNICEF Europe and Central Asia Regional Office (ECARO)

United Nations (UN)

United Nations Children's Fund (UNICEF)

United Nations Educational, Scientific and Cultural Organization (UNESCO)

World Health Organization (WHO)

Youth Policy Labs (YPL)

## DISCLAIMER

This research is ***exploratory***. Its primary aim is to open new avenues for dialogue and policy discussion, and to chart future research paths. It does not aim at influencing government positions, but at contributing to an ongoing debate.

The methodology used in the consultation does not ensure representativeness and does not allow generalisations that would apply to the entire adolescent population. This consultation does not claim to apply to all adolescents nor does it use statistical inference to determine properties of an adolescent population, nor to test any hypotheses. Rather, the consultation aimed at gaining further insights into issues facing adolescents in the region in relation to minimum-age policies and legislation.

While many themes in relation to minimum ages could be explored, the scope of the consultation was limited by considerations of resources and time. For this reason, themes such as safety, security, ICT, or sexual consent – while timely and important – were not addressed at length.

As discovered in the legislative mapping, many laws have several exceptions and considerations (especially minimum age of criminal responsibility, and consent to medical treatment), and therefore the most ***widely applicable ages*** were used in the consultation.

The consultation adhered to the highest ethical standards relating to conducting research with adolescents. All efforts were made to reduce the potential harm that could arise from the consultation, all protocols were followed, and no child was harmed as a consequence of their participation in this project.

Please note that laws and policies change constantly, and neither UNICEF nor Youth Policy Labs takes responsibility for laws that have since changed from the time that they were presented in this report. For up-to-date information on age-related policies and laws, please contact the human rights bodies in your country.

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## Executive Summary

### Why this study?

Legal minimum age legislation is contentious, contextual and contradictory. In more than half of countries around the world, the legal age of majority is 18 years while the global average age of criminal responsibility is 12.1 years. In nearly a quarter of countries around the world, women's marriageable age is younger than that of men, and yet girls often lack the ability to make independent health choices before 18. Voting age is almost universally set at 18 years, but the average global age to stand as a candidate is 22.2 years.

Minimum age definitions directly influence the realities of children, adolescents and young people: when they can make independent health choices, be tried and held in adult courts and prisons, access financial credit for business, be heard in judicial proceedings, or consent to marriage.

*Age Matters!* is a joint United Nations Children's Fund (UNICEF) Europe and Central Asia Regional Office and Youth Policy Labs (YPL) study that explores ways in which the age of a child or adolescent is a factor that influences access to services and the realisation of the rights of a child, with respect to minimum age legislation and their evolving capacities respectively. This study examines age as a frame and an entry-point to take a more nuanced look at issues of protection, capacity, risk, and responsibility. It helps us to better understand which factors contribute to subjective feelings of capacity or incapacity, such as experiences, skills, confidence, and context – in addition to age. It highlights when minimum ages defined in legislation are incongruent with the ages at which adolescents feel they are prepared for responsibilities, where the law assumes capacity after a certain age (say, 18), when in their everyday lives adolescents feel that they are capable at an earlier age, or, surprisingly in some cases, later.

### *Age Matters!* project

*Age Matters!* started with a mapping of minimum age laws and policies conducted in 2016, which mapped 70 pieces of age-related legislation across 22 countries and territories in the Europe and Central Asia region. Taking stock of the ages at which they are currently set, such a mapping of minimum age legislation allowed the authors to detect inconsistencies within countries, and to identify regional and sub-regional trends.

The desk-based review found that throughout the region, legislation in the areas of social inclusion, child protection and juvenile justice was promising in terms of meeting international standards and safeguarding a child's right to be heard. For example, most countries in the region set minimum age of marriage in accordance with international standards.

However, in one domain – health – the mapping found that many countries still kept old policies and legislation often inherited from the Soviet era, setting very high minimum ages (usually 18) for accessing medical services independently without a parent or guardian. With regards to balancing children’s right to both protection and participation in the health domain, it appears that protective considerations outweigh children’s right to participate in matters affecting them. Additionally, the mapping revealed that health remains the area with the most inconsistencies between policy fields. For example, a young woman aged 17 could be married, assume legal emancipation, but require parental consent for contraception.

Numerous other findings showed contradictions in the laws and policies of countries across different domains. For example, some countries had policies that allowed an earlier full-time working age than the end of compulsory schooling age. Such contradictions could cause confusion in the application and monitoring of laws, not least for young people attempting to understand the laws themselves.

The second phase of *Age Matters!*, undertaken in 2017, deepened this analysis by looking at the opinions and lived realities of adolescents, and how age-related legislation affected their ability to access services and realise their rights. This project looked at the *knowledge, perceptions* and *experiences* of adolescents regarding age-related policies in Armenia, Bulgaria, Kazakhstan, Romania, and Ukraine across the domains of civic/legal rights, social participation, economic participation and education, health, and political participation.

This research is **exploratory**. Its primary aim is to open new avenues for dialogue and policy discussion, and to chart future research paths. It does not aim at influencing government positions, but at contributing to an ongoing debate.

### Background: Emancipatory and protective rights in adolescence

The Convention on the Rights of the Child (CRC) was adopted by the United Nations (UN) General Assembly in 1989. Since the Convention entered into force in 1990, it has been an important point of reference for minimum age legislation.

Signatory States “shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention” (Art. 2 and 4), guided by the principles of non-discrimination (Art. 2); best interests of the child (Art. 3); respect for the views of the child (Art. 12), and take into account the evolving capacities of the child (Art. 5).

These principles are overlapping and mutually supportive, and the principles themselves share widespread recognition. Yet, it is a “delicate balance between children’s right to be protected and the recognition that they also have evolving capacities and should therefore have progressive autonomy in making decisions about their lives” (Sedletzki, 2016).

It is exactly this balance that often makes age-related legislation so contested, particularly in adolescence, a period of rapid physical, emotional, and cognitive

development. For adolescents, autonomy – meaning respect for people to make their own choices, express own views, and take responsibility – is not a binary state, but rather depends on adolescents’ continually evolving capacities, in addition to opportunities and their own desires. That is, children must not be forced to take decisions that they do not feel competent or willing to take (Lansdown, 2005).

Cultures and contexts vary widely on their calculations of these factors. For example, behaviours considered dangerous or inappropriate for children and adolescents of a certain age in one society may be considered normal in another. Moreover, children themselves are a highly heterogeneous group, living in a variety of environments, circumstances, and experiences (Lansdown, 2005). In contrast, minimum age legislation, with legally defined minimum ages, essentially relies on chronological, linear definitions of childhood and adolescence.

The limitations of chronological age definitions notwithstanding, a minimum legal age in legislation reflects how a State views childhood, capacity, and risk. In other words, minimum age legislation answers the question: At what age is it appropriate for a child to acquire a right? What is “appropriate” can be seen as conditioned by various factors: how a State defines capacities, what levels of capacity the State deems necessary to make decisions, and what levels of risk does the State deem acceptable (Lansdown, 2005).

#### Minimum ages: The international debate

The need to balance protective rights with participatory or emancipatory rights is one of the most fundamental challenges posed by the Committee on the Rights of the Child. This primary tension between autonomy and protection underlies the international debate on minimum age legislation.

General comment No. 20 on the implementation of the rights of the child during adolescence from the CRC, namely Articles 39 and 40, makes specific recommendations with respect to setting legal ages (emphasis added):

39. States should review or introduce legislation recognizing the right of adolescents to take **increasing responsibility for decisions affecting their lives**. The Committee recommends that States introduce minimum legal age limits, consistent with the right to protection, the best interests principle and respect for the **evolving capacities of adolescents**. For example, age limits should recognize the right to make decisions in respect of health services or treatment, consent to adoption, change of name or applications to family courts. In all cases, **the right of any child below that minimum age and able to demonstrate sufficient understanding to be entitled to give or refuse consent should be recognized [...]**

Consideration should also be given to the **introduction of a legal presumption that adolescents are competent** to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services. The Committee emphasizes that all adolescents have the right

to have access to confidential medical counselling and advice without the consent of a parent or guardian, irrespective of age, if they so wish. This is distinct from the right to give medical consent and should not be subject to any age limit.

40. The Committee reminds States parties of the **obligation to recognize that persons up to the age of 18 years are entitled to continuing protection from all forms of exploitation and abuse**. It reaffirms that the minimum age limit should be 18 years for marriage, recruitment into the armed forces, involvement in hazardous or exploitative work and the purchase and consumption of alcohol and tobacco, in view of the degree of associated risk and harm. [...]

The CRC additionally recommends in General Comment No. 10 that the absolute minimum age of **criminal responsibility** should be 12 years, with encouragement for States to continue to raise it (UN Committee on the Rights of the Child, 2007). General Comment No. 4 suggested that States increase the minimum age for **marriage** with and without parental consent to 18 years, while allowing for exceptional circumstances, in which a mature and capable child over the age of 16 may marry (UN Committee on the Rights of the Child, 2003). However, in 2016, the Committee on the Rights of the Child reaffirmed that the minimum age limit should be 18-years for marriage, with no mention of a lower age exception (UN Committee on the Rights of the Child, 2016).

Additionally, the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (OPAC) calls for a minimum age of 18 for (compulsory) **recruitment into the armed forces** or direct **participation in hostilities**, and for a minimum age of 16 for **voluntary enlistment** (UN General Assembly, 2000). For **admission to employment**, the International Labour Organization (ILO) has called for minimum age legislation:

In ILO Convention No. 138, 1973, the minimum age for admission to hazardous labour is set at 18, with a minimum age of 15 for general work – provided that it is not lower than the age at which compulsory education is completed. Light work is allowed earlier, at the age of 13 – and in countries in development, at the age of 12 (International Labour Organization (ILO), 1973).

Beyond these few cases, there is no specific guidance from the CRC at which certain legal minimum ages should be set, or if they should be set at all. This question is highly contested, not only in the Committee, but in and between States, as well as within the broader child and human rights community.

For the European Union, data on age-related legislation concerning both a child's right to protection and to participation has been collected by the European Union Agency for Fundamental Rights (FRA), which runs a project on minimum age requirements in the European Union.<sup>1</sup> At global level, the Child Rights

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<sup>1</sup> <http://fra.europa.eu/en/project/2016/minimum-age-requirements-european-union>

International Network (CRIN) has published a discussion paper on minimum ages called “Age is arbitrary”, which discusses the principles underlying age-related legislation.<sup>2</sup> UNICEF contributes to this ongoing debate with this project, *Age Matters!*, looking at perceptions on how age is related to the capacity of the child; perceptions and experiences with how age influences access to services; and views on age and subjective wellbeing.

### Project methodology

The primary research question is: how does age-related legislation affect the lives adolescents and youth, in regards to accessing services and realising their rights?

This research is **exploratory**. The methodology used does not ensure representativeness and does not allow generalisations that would apply to the entire adolescent population in the region or in the respective countries. This research does not claim to apply to all adolescents nor does it use statistical inference to determine properties of an adolescent population, nor to test any hypotheses. Rather, the research aimed at gaining further insights into issues facing adolescents in the region in relation to minimum age legislation, and to open new avenues for dialogue and policy discussion, as well as for future research.

The consultation utilised a mixed method approach involving an online survey with 5,725 adolescents to gather quantitative data, and 30 focus groups with 241 adolescents to explore concepts and generate discussion, as well as to illustrate and confirm, clarify and elaborate, or extend topics explored in the survey.

The survey was pre-tested, revised and delivered online in the major local languages spoken in the selected countries through UNICEF Country Offices and partners (e.g. schools, child and youth organisations, and Civil Society Organisations (CSOs)). After the closure of the online survey, the data was collected and analysed using quantitative statistical software (SPSS). The software allowed the researchers to disaggregate the data by demographic indicators including country, region, age and sex, as well as other features, and to cross-tabulate data during the analysis.

Themes in the surveys were further explored in 30 focus groups (six per country), giving rich insights into adolescents’ lives, experiences and opinions. The focus group methodology was pre-tested, revised and delivered by experienced and trained local YPL facilitators. Participants were selected using *stratified* sampling, where populations within schools and youth organisations that have established relationships with the local UNICEF Country Office were selected, and a *simple random* sample from within those organisations. All groups were designed to be *homogenous* by age. Each group was either comprised entirely of participants aged 10-13 or 14-17, with between four and fourteen participants in each group. To ensure representation of a variety of adolescents, groups were either mixed sex or girls only, and either urban or rural. Additional considerations were made for

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<sup>2</sup> <http://www.crin.org/en/node/42535>

adolescents from marginalised or vulnerable backgrounds to be represented in this study. The approach was tailored depending on the age group, with a more child-friendly approach for younger adolescents. Focus groups were recorded (audio only), then transcribed verbatim, then anonymised and translated into English. The transcripts were coded and analysed using MAXQDA, the qualitative data analysis software, followed by interpretation and presentation of results together with survey results. The results of the coding helped to inform the researchers about the salient ideas and group thinking of the participants on the selected themes.

Responses from the survey and data from the focus groups were triangulated through the incorporation of quantitative (survey) and qualitative (focus groups) research methods in the consultation process to ensure a more balanced and nuanced analysis of the adolescents' knowledge, perception and experiences with age-related legislation.

The audience for this research is policymakers, legislators, academics, researchers, and practitioners who work with and/or for children and adolescents in public services, education or civil society. It also includes the children and adolescents themselves who are engaged in the promotion of their own rights and protection.

#### Research scope

To capture the *knowledge, perceptions and experiences* of adolescents regarding age-related policies, a consultation in the form of an **online survey** and **focus groups** was held in Armenia, Bulgaria, Kazakhstan, Romania and Ukraine with adolescents between the ages of 10 and 17.

The countries were selected based on regional representation within Europe and Central Asia region and the expressed interest of UNICEF country offices.

While the mapping in the first phase focused on 70 pieces of legislation, the consultation focused only on seven across five domains.

Domains	Pieces of legislation
Civic/legal rights	Minimum age of criminal responsibility (MACR)
Social participation	Marriageable age
Economic participation and education	Working age (full-time, light work) End of compulsory schooling age
Health	Minimum age to seek medical advice or counselling (including sexual and reproductive health advice)  Minimum age to make decisions on health services or treatment



Political participation	Voting
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The domains were selected in agreement with UNICEF ECARO in consideration of:

- The outcomes of the mapping and the laws which were deemed most contested
- Age-related articles covered in UN Convention of the Rights of the Child and the UN Committee on the Rights of the Child's General comment No. 20 on the implementation of the rights of the child during adolescence, as well as other general comments which have a specific age-related recommendation to State Parties
- Data availability on age-related legislation for the countries selected.

Several other themes, such as laws relating to safety, security & ICT, or sexual consent – while timely and important – were not be addressed at length due to restrictions on resources and time.

## Summary of the main findings

Adolescents' perspectives on the relationship between age and capacities: How capable do adolescents feel?

In practice, the concept of the “evolving capacities of the child” in Article 5 of the CRC means that as children acquire enhanced competencies, there is a reduced need for direction and a greater capacity for the child to take responsibilities for decisions affecting his or her life (Lansdown, 2005). This is particularly pertinent in adolescence, a period of rapid physical, emotional, and cognitive development. During this study, adolescents shared their subjective views of their own capacities, and the factors that affect their capacities across a range of activities:

- **Capacity was deemed to increase with age:** Adolescents who participated in our consultation felt more capable the older they were. Adolescents were asked how capable they felt across various activities in a general sense (e.g. going to the grocery store, deciding own personal dress and style), and in relation to the domains that were explored through this study, including voting age, age to access independent medical advice, marriageable age, minimum age of criminal responsibility, school leaving age/full-time working age, age to give or refuse consent to medical treatment). While there were large differences in the feeling of capacity between younger adolescents (**10-13**) and older adolescents (**14-17**), there seems to be a sub-category spanning the ages of **11-12** where feelings of capacity are distinct. At this early age, respondents already began to see themselves as strongly capable to do several things, such as going to the supermarket by themselves to buy groceries, staying home alone for several hours during the day, and deciding what to do during their free time.

- **Capacity increased with experience:** Many respondents **felt more capable to do a certain activity if they already had the *experience* of doing it.** This related both to everyday activities, such as staying home alone, as well as activities relating to health. For example, those who felt most capable to speak to a doctor independently were those respondents who also reported having a “poor” general health status, or having long-term health problems. Participants in focus groups shared past experiences of doing something independently, giving them further confidence that they were capable enough to do it, as they could attest that these activities could be done alone.
- **No major gender differences were found in relation to subjective capacities:** Males and females had roughly the same views regarding their subjective capacities, and where differences did exist, they tended to be small (usually less than 10%). When disaggregating gender further by age, there were more females than males among those who saw themselves as highly capable of doing all general activities in the 16-17 age group (answering “strongly agree”). For all ages below 16, there were more males who “strongly agreed” in every age group than females, for all general activities.
- **Gendered differences were found in external circumstances that can impact capacities, or compromise protection:** These included social expectations and gender roles. For example, focus groups discussed how females are expected to give up career and educational ambitions to take on housekeeping and child rearing roles. Females were seen as experiencing more parental pressure when it came to marriage than males, compromising their ability to make autonomous decisions and increasing their risk of early marriage.

Adolescents’ perspectives on age, participation and protection in areas related to civic rights, rights to health, political processes, education and work

Participation or emancipatory rights relate to a child’s right to be heard, participate in matters that affect them, and exercising some degree of autonomy. Protective rights, on the other hand, relate to protecting a child from experiences or responsibilities that have a high risk of causing them harm. There is sometimes a tension between these two sets of rights, as the safeguarding of one can sometimes mean restricting the other. This is further complicated by evolving capacities, which means that as a child’s capacities develop, so should their ability to exercise rights on their own behalf. During the consultation, adolescents shared their perspectives on age, capacity, participation, and protection:

- **Adolescents shared a strong desire to be protected from activities or experiences that could cause them harm:** This included activities such as early marriage. They were split on the age at which a young person should be held responsible for criminal acts, though there was near-unanimous agreement that children should not be charged in criminal courts as adults.
- **Where there was perceived to be a tension between participatory and protective rights, adolescents in our consultation were also split:** For



example, in relation to education and work, only 23.2% “agreed” or “strongly agreed” that a young person should be allowed to leave school and work full-time if they wanted to.

- **Adolescents felt strongly capable to exercise their participatory rights in health:** This included seeking medical advice alone without a parent/or guardian, if they wanted. Overall, 62% of respondents “agreed” or “strongly agreed” that they are capable enough to speak to a doctor independently, with capability increasing along with the ages of the respondents. From the age of 14, more than half of respondents from each age group felt that they could speak to a doctor independently.
- **Few felt capable to make their own decisions about medical treatment in a general sense, but the majority felt strongly about giving consent before receiving medical treatment, specifically:** On average, only 30.7% of respondents “agreed” or “strongly agreed” that they were capable enough to make their own medical decisions, while 68.6% “agreed” or “strongly agreed” that they should always give consent prior to receiving a medical treatment.
- **Adolescents were split on their capacity to engage in political processes:** A little more than half (52.8%) of respondents “agreed” or “strongly agreed” that they were capable enough to vote in national elections. Participants in focus groups shared this hesitation, however some individuals who were politically interested felt strongly that young people should be more politically involved and encouraged to do so.
- **Overall, with the exception of marriageable age and voting age, adolescents in the consultation lacked knowledge about minimum age laws:** This can constrain their ability to demand rights that are granted to them, and to be aware of available supports. Information and knowledge about laws and policies is a necessary condition for adolescents to be able to exercise their rights and act on their own behalf.

Adolescents’ perspectives and experiences with minimum age legislation and access to services

Adolescents shared their opinions on how, in their own experiences, their age may have influenced their health-seeking behaviours and access to health services:

- **Age influenced health service access and service seeking:** Adolescents in the consultation stated emphatically that they **did not always have access to the medical advice that they needed**. Approximately 1 in 6 (15%) respondents in the survey reported that they were refused medical advice because of the requirement that a parent or guardian had to accompany them (and they were absent). Close to one third (28.3%) of respondents avoided seeking medical advice for the same reason. Those who reported having a “poor” general health status or long-term health problems were refused advice

or avoided seeking advice at higher rates compared to their “healthier” counterparts.

- **Those who avoided seeking medical advice were not doing so because they lacked the capacity to speak to a doctor by themselves:** Over two-thirds of respondents who avoided seeking advice “strongly agreed” and “agreed” that they were capable to speak to a doctor independently. Therefore, avoidance was more likely because their parents had to accompany them, and they preferred to go alone.
- **The top medical issues that respondents wanted to seek advice on (but avoided doing so because their parents had to be in the room) were: mental health, sexual issues (e.g. pregnancy, avoiding diseases), and sexual orientation:** Females, in particular, highlighted mental health issues as the medical area for which they avoided seeking advice. Males (more than females) selected sexual orientation as an area where they wanted to seek advice but were reluctant to do so.
- **Female respondents were both refused medical advice by a doctor and avoided seeking advice at slightly higher rates than males** (2% more and 6.1% more, respectively). The difference between males and females was starkest when it came to issues for which respondents were avoiding to seek advice: 15.7% more females were avoiding seeking advice on mental health than males, and 8.6% more males than females were avoiding seeking medical advice on sexual orientation.
- **Nearly one-third of respondents received a medical treatment that felt forced by their parents and/or doctor:** Respondents with poor general health or long-term health problems received such treatments at higher rates than healthy respondents. Even if the medical treatment was deemed to ultimately be in the best interests of the child, feeling forced indicates that their voluntary and informed consent was not sought.

Adolescents’ perspectives on age and their subjective wellbeing: How did adolescents think and feel about their lives?

- **Subjective well-being decreased with age:** Overall, among adolescents in the consultation, younger adolescents aged between 10-13 rated their current well-being higher than older adolescents, aged between 14-17. At age 14, well-being appeared to drop, and stayed relatively constant for those between 15 and 17. This dip coincides with a transition from earlier to late adolescence, which is marked by important life events including moving from primary to secondary school, as well as increased emphasis on identity formation, self-awareness and critical thinking (UNICEF, 2011). This might suggest that the beginning of late adolescence is a period that may need particular attention due to potential drops in perceived well-being status.
- **Lower income, “poor” general health or long-term health problems were associated with lower levels of subjective wellbeing:** This is compatible

with other research that indicates that levels of subjective well-being often coincide with levels of objective (or material) well-being.

- **Time and connections were critical factors for well-being:** The two top factors cited as factors that would increase well-being were having more free time, followed by adolescents having more people to talk to about problems. Both can impact mental health, which was the number one issue that respondents wanted to seek advice on, but avoided doing so because their parents had to be in the room.
- **Different age groups ranked factors that could improve their well-being differently, revealing a further split in the ages:** While all age groups valued having more free time the most, respondents aged **10-12** chose having more friends, and online safety as more important (over having more people to talk to about their problems). Respondents aged **13-14 and 15-17** indicated that they would like more people to talk to about problems. Respondents aged 15-17 also saw job opportunities as a factor that could increase wellbeing.
- **While having someone to talk to could improve wellbeing, respondents avoided seeking medical advice for mental health:** As mentioned above, one of the key reasons for this was linked to the requirement that parents have to accompany them. This indicates a clear need to improve adolescent well-being by providing youth-friendly, confidential mental health services and support that adolescents would be able to access independently.

This report provides a regional analysis of the data, looking at insights that emerge across the five countries that took part in the study and that have implications for the region. Country-level data, as well as more information on the desk-based review in phase one of this project, can be found online at [www.agemattersnow.org](http://www.agemattersnow.org)

## 1. Introduction

Minimum age legislation has a direct impact on the lives of adolescents. Age-related laws and policies govern when young people are tried and held in adult court, can access financial credit, or can buy tobacco or alcohol. In setting minimum ages, the United Nations (UN) Convention on the Rights of the Child (CRC) – the most rapidly and widely ratified international human rights treaty in history – calls for States to undertake a delicate balancing act: respecting the right of children to be heard and granting autonomy as their capacities evolve, while protecting them from exposure to risks, in the best interests of the child.

Some laws are emancipatory and safeguard a child's right to participation, such as the right to vote or independently seek health advice. Others provide a right to protection from responsibilities or circumstances that might cause significant harm, such as marriageable age or the minimum age that a young person can be held responsible for a crime. Others still have a strong tension between autonomy and protection, such as the age to leave school and begin full-time work, and the age at which medical treatment can be accepted or refused without parental consent.

*Age Matters!* seeks to understand the ways in which age-related legislation affects the lives of adolescents with respect to accessing services and realising their rights.

*Age Matters!* was commissioned by the United Nations Children's Fund (UNICEF) Regional Office for Europe and Central Asia (ECARO), and was undertaken in collaboration with Youth Policy Labs (YPL).<sup>3</sup> The research benefited from an exchange of ideas with the European Union Agency for Fundamental Rights (FRA) which examined minimum age legislation in European Union (EU) countries and shared with UNICEF their data on EU member states, specifically Bulgaria, Croatia and Romania.

This report provides a regional analysis of the data, looking at insights that emerge across the five countries that took part in the study and that have implications for the region. Country-level data, as well as more information on the desk-based review in phase one of this project, can be found online at [www.agemattersnow.org](http://www.agemattersnow.org)

The first phase of *Age Matters!*, which took place in 2016, mapped 70 pieces of age-related legislation across 22 countries and territories in Europe and Central Asia, and demonstrated the ways in which legal minimum ages in the region are contentious, contextual, and, at times, contradictory.

The desk-based review found that throughout the region legislation in the areas of social inclusion, child protection, and juvenile justice was promising in terms of meeting international standards and safeguarding a child's right to be heard.

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<sup>3</sup> See Annex 1: Terms of Reference for Age Matters Project and Annex 2: Roles and responsibilities of the research team

For example, most countries in the region set the minimum age of marriage in accordance with international standards.

However, in one domain – health – the mapping found that many countries still kept old policies and legislation often inherited from the Soviet era, setting very high minimum ages (usually 18) for accessing medical services independently without a parent or guardian. With regards to balancing children’s right to both protection and participation in the health domain, it appears that protective considerations outweigh children’s right to participate in matters affecting them. Additionally, the mapping revealed that health remains the area with the most inconsistencies between policy fields. For example, a young woman aged 17 could be married, assume legal emancipation, but require parental consent for contraception.

Numerous other findings showed contradictions in the laws and policies of countries across different domains. For example, some countries had policies that allowed an earlier full-time working age than the end of compulsory schooling age. Such contradictions could cause confusion in the application and monitoring of laws, not least for young people attempting to understand the laws themselves.

The second phase of *Age Matters!*, undertaken in 2017, deepened this analysis by looking at the opinions and lived realities of adolescents, and how age-related legislation affected their ability to access services and realise their rights. Across five countries (Armenia, Bulgaria, Kazakhstan, Romania and Ukraine), 5,725 adolescents between the ages of 10 and 17 participated in an online survey, and 241 adolescents shared their views in 30 focus group discussions, giving rich insights into their lives, experiences, and opinions.

The audience for this research is policy-makers, legislators, academics, researchers, and practitioners who work with and/or for children and adolescents in public services, education or civil society, including children and adolescents themselves who are engaged in the promotion of their own rights and protection.

### Scope and purpose of this research

This research focusses on children and adolescents between the ages of 10 and the day of their 18th birthday. This age range covers adolescents in accordance with the CRC (which ends at 18) rather than in accordance with the WHO definition which is until 19 years of age. *Age Matters!* does not seek to define adolescence. The Committee on the Rights of the Child recognises the difficulties in defining the adolescent period in General comment No. 20:

The Committee recognizes that adolescence is not easily defined, and that individual children reach maturity at different ages. Puberty occurs at different ages for boys and girls, and different brain functions mature at different times. The process of transitioning from childhood to adulthood is influenced by context and environment, as reflected in the wide variation

in cultural expectations of adolescents in national legislations, which afford different thresholds for entry into adult activities, and across international bodies, which employ a variety of age ranges to define adolescence. (UN Committee on the Rights of the Child, 2016, para. 5)

Nevertheless, the analysis in this study is framed principally around age: the age at which adolescents feel they can do things, should be able to do things, their well-being at different ages, and the differences between younger and older adolescents in their knowledge, perceptions and experiences with minimum age laws. However, this does not imply that competencies are acquired at fixed ages. Children have diverse life experiences, and the ages at which they acquire competencies will vary according to individual circumstances, as well as environments and culture.

This study examines age as a frame and an entry-point to take a more nuanced look at issues of protection, capacity, risk, and responsibility. It helps us to better understand which factors contribute to subjective feelings of capacity or incapacity, such as experiences, skills, confidence, and context – in addition to age. It highlights when minimum ages defined in legislation are incongruent with the ages at which adolescents feel they are prepared for responsibilities, where the law assumes capacity after a certain age (say, 18), when in their everyday lives adolescents feel that they are capable at an earlier age, or, surprisingly in some cases, later.

It is important to ask adolescents what they think about minimum age policies and legislation, as the laws and programmes that affect their lives use a variety of minimum age definitions, which are sometimes very limiting. There is no general consensus about the ages at which children are able to or should be allowed to make decisions or take action in the various domains of their lives. The age-related laws examined here all rely on a chronological and linear understanding of the phases in a child's development. Most programming, including programming supported by UNICEF and other UN partners, relies on age definitions as a factor for the provision of services. Therefore, while age is an imperfect measure of maturity and capacity, it nonetheless governs how adolescents realise rights and access services, meriting closer analysis.

As emphasised by the Child Rights International Network (CRIN) in its aptly named paper *Age is Arbitrary*: "Capacity is... not just an innate state; it depends on external circumstances which can encourage or inhibit a child's autonomy" (2016).

Therefore, the focus of this research was to better understand adolescents' perceptions and preferences, how various external circumstances may impact on an adolescent's autonomy, and how this may impact their ability to access important services and realise their rights, in addition to a deeper look at the age at which young people feel capable.

Adolescent voices matter

This research takes the position that young people's views matter and that they should be listened to and respected, reinforcing another key article in the convention. Article 12 on participation asserts that State parties,

shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child (UN Committee on the Rights of the Child, 1989, Art. 12 para. 1).

This research promotes the idea that young people are capable of forming and expressing views, and ideally, that those views should have impact by relying on the inputs of adolescents as its primary methodology. While limited to UNICEF's Europe and Central Asia region, this research hopes to act as a pilot for similar research to be deployed in all regions, to allow for greater cross-regional analysis and comparability, and to give adolescents, including the most marginalised, a chance to have their voices and opinions heard.

## 2. Methodology

The primary research question is: how does age-related legislation affect the lives adolescents and youth, in regards to accessing services and realising their rights?

In examining this primary research question, we seek to understand:

- Knowledge of adolescents in relation to age-related legislation and policies
- Perceptions of adolescents in relation to age-related legislation and policies
- Experiences of adolescents in relation to age-related legislation and policies
- How the knowledge, perceptions, and experiences of adolescents in relation to age-related legislation and policies impact their well-being
- How the knowledge, perceptions, and experiences of adolescents in relation to age-related legislation and policies impact their aspirations for the future
- How evolving capacities relates to adolescents' ability to access services and realise their rights

This research is ***exploratory***. The methodology used in this research does not ensure representativeness and does not allow generalisations that would apply to the entire adolescent population in the region or in the respective countries. This research does not claim to apply to all adolescents nor does it use statistical inference to determine properties of an adolescent population, nor to test any hypotheses. Rather, the research aimed at gaining further insights into issues facing adolescents in the region in relation to minimum age legislation, and to open new avenues for dialogue and policy discussion, as well as for future research.

### 2.1. Research scope

To capture the *knowledge, perceptions and experiences* of adolescents regarding age-related policies, a consultation in the form of an **online survey** and **focus groups** was held in Armenia, Bulgaria, Kazakhstan, Romania and Ukraine with adolescents between the ages of 10 and 17.

The countries were selected based on regional representation within Europe and Central Asia region and the expressed interest of UNICEF country offices.

The thematic scope of this consultation was selected in consideration of:

- The desk-based research on existing national age-related legislation completed in the first phase of *Age Matters!*<sup>4</sup>

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<sup>4</sup> See Annex 3: Age Matters Phase 1 Final Report



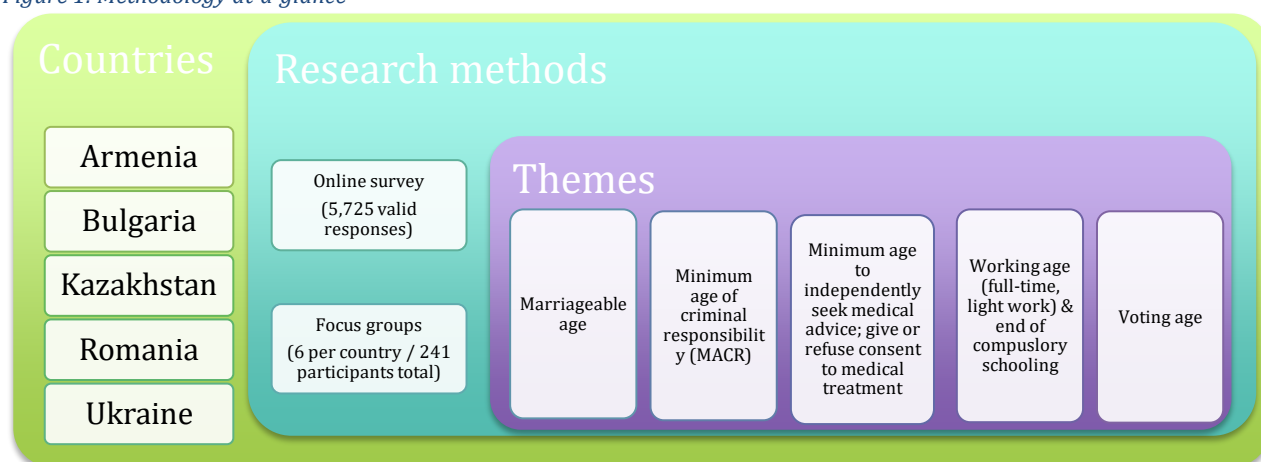
- Age-related articles covered in UN Convention of the Rights of the Child and the UN Committee on the Rights of the Child's General comment No. 20 on the implementation of the rights of the child during adolescence, as well as other general comments which have a specific age-related recommendation to State Parties
- Data availability on age-related legislation for the countries selected.

Priority was given to those areas where a tension exists between national legislation and the provisions in the Convention and associated general comments. Having considered above sources and in agreement with the UNICEF Regional Office, the consultation focused on the following areas:

<b>Domains</b>	<b>Pieces of legislation</b>
Civic/legal rights	Minimum age of criminal responsibility (MACR)
Social participation	Marriageable age
Economic participation and education	Working age (full-time, light work) End of compulsory schooling age
Health	Minimum age to seek medical advice or counselling (including sexual and reproductive health advice) Minimum age to make decisions on health services or treatment
Political participation	Voting

Several other themes, such as laws relating to safety, security & ICT, or sexual consent – while timely and important – were not addressed at length due to restrictions on resources and time.

Figure 1: Methodology at-a-glance



## 2.2. Research methods<sup>5</sup>

The consultation utilised a mixed-method approach involving an online survey to gather quantitative data, and focus groups to explore concepts and generate discussion, as well as to illustrate and confirm, clarify and elaborate, or extend topics explored in the survey.

### Survey

The survey was delivered online in five countries of the region using the Survey Monkey platform.<sup>6</sup> The survey was provided in the major local languages: Armenian (Armenia), Bulgarian (Bulgaria), Kazakh and Russian (Kazakhstan), Romanian (Romania), Ukrainian and Russian (Ukraine). The survey was 43-questions long and included questions on:

- Demographics<sup>7</sup>
- Self-assessment of capabilities to do certain acts relating to general capabilities (e.g. to go to the grocery store, to stay at home alone)
- Self-assessment of capabilities related to key themes (e.g. to get married, to speak to a doctor independently, to decide to leave school)
- Opinions on whether an adolescent their age should be able to do certain acts or not (e.g. to get married, to speak to a doctor independently, to decide to leave school)
- Knowledge of the legal minimum ages in their country for the laws featured in this study<sup>8</sup>
- Experiences with seeking services, namely medical advice and treatment
- Self-assessment of well-being (subjective well-being).

<sup>5</sup> A note on terminology: “Respondents” refers to the adolescents who responded to the online survey, while “participants” refers to adolescents who participated in focus groups. Taken as a whole, they are described as “adolescents who took part in the consultation”.

<sup>6</sup> See Annex 4: UNICEF Age Matters Adolescent Survey - English. Note: the survey was translated into local languages, however is provided in English in the annex for reference.

<sup>7</sup> For more information, see Figure 2: Survey respondent demographic groups at-a-glance

<sup>8</sup> For more information, see in this chapter, “Legal minimum ages used in this consultation”

Before launch, the survey was pre-tested in a printed version with a small group of adolescents engaged by the UNICEF Country Office in Romania. The discussion held after they filled in the survey provided valuable suggestions for improvement. The survey was then tested online with groups of adolescents engaged in all five countries and in all major local languages, using the Survey Monkey platform with an additional feature that allowed respondents to add comments after each question and, at the end of the survey, to provide feedback. Feedback was given regarding word choice, translation quality, and question structure and length. The survey was revised accordingly.<sup>9</sup>

The survey was disseminated through UNICEF Country Offices and partners (e.g. schools, child and youth organisations, Civil Society Organisation (CSOs)).<sup>10</sup> Each Country Office was provided with an information package which included guidance on where and how the survey can be advertised and specially-designed communication tools in local languages (e.g. logos, messaging). The survey was posted online on the UNICEF Country Office websites and online platforms (i.e. Facebook, Twitter, Instagram), and was further disseminated through the partners of each UNICEF Country Office, including schools, youth centres, youth groups and CSOs working with children and youth. The survey was available online for five weeks and covered the period when adolescents started the new school year in September 2017. The number of respondents per country was monitored online through the Survey Monkey platform, and the dissemination strategy was adjusted as necessary (e.g. additional advertising in underperforming regions and for underrepresented groups).

## **Sampling**

Administering an online survey is cost-efficient. It requires less time to process the data, it is convenient for respondents to answer questions, and it can provide access to harder-to-reach populations. However, online surveys have their own limitations, especially sampling, which skews towards older, urban and better-off adolescents. There is little control over access, demographic and other personal characteristics of survey respondents. To address these obstacles, a target sample size was established and protocols were set for YPL facilitators and UNICEF Country Offices disseminating the survey to ensure a wide population was targeted (e.g. ensuring age and geographic coverage when distributing the survey through schools). Additional emphasis was placed on promoting the survey in rural areas, and outside the capital cities, with special targeting to partners and populations in those areas, and in encouraging teachers and CSO partners to provide computer access to young people in their schools and offices to overcome barriers for low-income adolescents who may not have computer access at home. The protocol included where and how to advertise the survey based on country specifics. However, due to limitations of online surveys mentioned above and the

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<sup>9</sup> See Annex 5: Research Process Flow Chart

<sup>10</sup> Annex 6: Email text for partners – Survey and Focus Group Sampling – English. Note: the email text was translated into local languages, however is provided in English in the annex for reference.

access and habits of adolescent internet users, it was difficult to completely mitigate these obstacles, which were acknowledged in the results sections of this report and were not used to claim statistical representativeness of any particular group of adolescents.

The calculated total targeted sample size for all five countries was between 1064-1067<sup>11</sup> respondents. Since it was not possible to achieve a true random sample, given that participants were self-selecting and dissemination was targeted through UNICEF Country Offices and their partners (e.g. schools, youth organisations, CSOs), the numbers were indicative only. They established a rough baseline of target response rates for this survey, but were not used to claim statistical representativeness in the analysis. There were 7,539 collected responses, however after the data cleaning, which focused on speeding, straightlining, patterns and inconsistencies, there remained **5,725 valid responses** (75.9%).

#### Survey respondents by country

	Total response rate	Valid response rate
<b>Armenia</b>	1,446	985
<b>Bulgaria</b>	1,309	1,018
<b>Kazakhstan</b>	708	505
<b>Romania</b>	2,589	2,041
<b>Ukraine</b>	1,487	1,176
<b>TOTAL</b>	<b>7,539</b>	<b>5,725</b>

***Methodological note:** Questions where respondents in a given disaggregated group (e.g. age group) fall below 15, that group were removed from the analysis.*

After the closure of the online survey, the data was collected and analysed using quantitative statistical software (SPSS). The software allows researchers to disaggregate the data by demographic indicators including country, region, age and sex, as well as other features, and to cross-tabulate the data in the analysis (see Data Analysis).

### Focus groups

Themes in the surveys were further explored through the use of focus groups. There were six focus groups per country, and 30 in total.<sup>12</sup> Each lasted around 60 minutes and focused on only three themes, due to the challenges of fatigue and

<sup>11</sup> Targeted sample size based on a 95% confidence level and 3% margin of error using Survey Monkey Sample Size Calculator: <https://www.surveymonkey.com/mp/sample-size-calculator/> and population size of 10-19-year olds in selected countries extracted from: United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision*. Accessed 2 May 2017. Note: the target group of this research is 10-17 years old as per the focus of UNICEF, however UNDESA uses 10-19 years old as its definition.

<sup>12</sup> See Annex 7: UNICEF Age Matters Focus Group Questions and Facilitator Guide – English. Note: the questions were translated into local languages, however is provided in English in the annex for reference.

loss of interest when working with adolescents. Instead, the themes were rotated among the six focus groups in each country, to ensure that each of the five themes would be covered in each country in at least three different focus groups. In that way a variety of opinions were gathered from focus groups with different compositions in each country.

Before launch, the focus group methodology was tested by the local YPL facilitator in the initial pilot focus group discussions with adolescents. Participants gave feedback on approach, style, language and length. Facilitators also gave feedback on the facilitator's notes, ease of delivery, and impressions of how the group received it. Facilitator notes were adjusted accordingly. Moreover, local YPL facilitators shared initial reflections after the first completed focus group among each other and with the rest of the team to adjust and improve the focus group delivery.

Local YPL facilitators were experts in facilitation, with experience in training or educational environments with adolescents, and were provided training via webinar on the focus group methodology as well as the obligatory UNICEF online training course "Introduction to Ethics in Evidence Generation".[INSERT NAMES? – maybe not if we mention them before already]

Focus groups explored the key themes (see Figure 1) using the following activity, facilitated by a trained YPL local facilitator:

- **Reflection:** Participants were asked at what age they thought a young person should be allowed to do a certain act (e.g. to get married, to speak to a doctor alone).
- **Probing questions:** Participants were asked why they chose the age they did; what kind of factors impact whether the age should be higher or lower; and which skills, experiences or capabilities might be needed to do that act.
- **Reveal:** Participants were told what the legal age was in their country and were asked to react to it (i.e. whether they thought the legal age was too young or too old, and why).

The approach was tailored to the specific age groups, with a more child-friendly language used for younger adolescents. Focus groups were recorded (audio only), then transcribed verbatim and then translated into English. Names and other sensitive information of the participants were marked during transcription and afterwards anonymised by YPL facilitators.<sup>13</sup> The coding system<sup>14</sup> was developed for coding of transcripts, followed by interpretation and presentation of results together with survey results.

Focus group limitations include the physical setting and quality of facilitation, such as facilitator's skills in phrasing questions and steering discussions, peer pressure to give similar answers, capturing non-verbal information, a lack of time,

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<sup>13</sup> Following UNICEF *Age Matters!* Safety, Confidentiality and Privacy Protocols. See Annex 8.

<sup>14</sup> See Annex 9: Focus Group Coding System

but also topic sensitivity, confidentiality and the particularity of working with adolescents, to name a few. These limitations were mitigated by:

- Ensuring that the local YPL facilitators had adequate experience in working with adolescents and were extensively trained to facilitate focus group discussions
- Establishing protocols<sup>15</sup> for dealing with various situations
- Anonymising personal data
- Providing instructions for verbatim transcription of the discussions
- Being aware of these considerations in the analysis of focus group discussions.

## **Sampling<sup>16</sup>**

Participants were selected using *stratified* sampling, where populations within schools and youth organisations that have established relationships with the local UNICEF Country Office were selected, and a *simple random* sample from within those organisations was used. The method for the random sample was, for example, selecting students who appear third on a student list in a classroom. Efforts were made to ensure that students did not know each other. For example, only one student per class was selected if the chosen school was big enough. The adolescent focus groups (participants aged 14-17) were held with a minimum of four and a maximum of fourteen participants in each group. Focus groups with younger adolescents (participants aged 10-13) were designed to be smaller, between four and six participants. This was done because at this age, it is more difficult to manage and keep their attention in larger groups. The total number of participants was 241 across all countries.

All groups were designed to be homogenous by age. Each group was either comprised entirely of participants aged 10-13 or 14-17. To ensure representation of a variety of adolescents, groups were either mixed sex or girls only, and either urban or rural.

Additional considerations were made for adolescents from marginalised or vulnerable backgrounds to be represented in this study. These groups were homogenous according to the vulnerable feature (e.g. institutionalised children, low socio-economic status, special ethnic groups) to ensure open spaces for their voices and experiences. The specific vulnerable groups were selected by UNICEF Country Offices according to the local specificities of each country (see box on “Considering vulnerable groups and incorporating a gender perspective”). These participants were sampled by selecting target CSOs which worked with such groups, and then randomly sampling within those CSO-selected adolescent populations. Additional care was taken to protect the confidentiality and safety of these groups.

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<sup>15</sup> Such as UNICEF *Age Matters!* Safety, Confidentiality and Privacy Protocols. See Annex 8.

<sup>16</sup> Annex 6: Email text for partners – Survey and Focus Group Sampling – English. Note: the email text was translated into local languages, however is provided in English in the annex for reference.

## Considering vulnerable groups and incorporating a gender perspective

In this consultation, special steps were taken to ensure that voices of vulnerable and under-researched groups were heard and that a gender dimension was integrated in the research.

### Vulnerable groups

Adolescents in rural areas and low-income adolescents may face digital exclusion and have difficulties in accessing online surveys. To ensure that access did not depend on having a home computer, UNICEF Country Offices and their partner organisations provided computer access in their offices and schools. This step, by itself, does not solve the problem of digital exclusion, but it was taken to mitigate problems of access among vulnerable populations.

For the survey itself, questions were asked relating to gender, location, ethnicity, religion, school level, health status (general and long-term), and a proxy for income. This allowed researchers to disaggregate the responses by specific group and to better contextualise the data with considerations for potential vulnerabilities.

Questions were also included that explicitly sought to understand dimensions of vulnerability.<sup>i</sup> For example, respondents who had avoided seeking medical advice were additionally asked to identify what issues they would have sought advice for. Options included harm from abuse or violence<sup>ii</sup>, mental health, sexual orientation, and sexual issues including unwanted pregnancy. In another question, respondents were asked what would make their life better, and options included living in a safer neighbourhood, going to a better school, marrying who they wanted, or being able to access the internet whenever they needed.

Of the six focus groups conducted in each country, one was specifically designated to be comprised of adolescents from a vulnerable group. This was done to ensure that their unique experiences would be represented in the research, and to provide an environment where adolescents could speak openly with others who have similar experiences. Additional measures were taken, for example relating to confidentiality and sensitivity of topics, during the facilitation of these groups.<sup>iii</sup>

Vulnerable groups were identified by the UNICEF Country Office and were selected in consideration of:

- The characteristics of each country's local context
- Whether the groups had an existing focus in each UNICEF Country Office's strategy or programming
- Whether the UNICEF Country Office had an existing relationship with CSOs or community groups that work with specific vulnerable groups.

The vulnerable groups selected for this study were:

- Armenia: Economically and socially vulnerable adolescents
- Bulgaria: Adolescents belonging to a UNICEF-supported family advisory centre
- Kazakhstan: Adolescents without parents
- Romania: Roma adolescents
- Ukraine: Adolescents affected by HIV/AIDS (personally or someone close to them).

In the analysis of the focus groups, data was coded for vulnerability factors (e.g. sexual orientation, religious belief, class, ethnicity, disability, gender, other) mirroring the dimensions explored in the survey.

### Gender

In the survey phase, a gender perspective was integrated through the ability to disaggregate data by gender, and also with explicit questions relating to gender-specific health issues, such as unwanted pregnancy.

In the focus group phase, two focus groups in each country comprised of girls only (one each with girls aged 10-13 and 14-17) in order to provide a safe place for girls to discuss gender specific issues. All focus group discussions were coded to highlight any gender related issues which were then used in the analysis.

<sup>i</sup> See Annex 4: UNICEF Age Matters Adolescent Survey – English. Note: the survey was translated into local languages, however is provided in English in the annex for reference.

<sup>ii</sup> A note was included with this option, which encouraged respondents to report abuse or violence, and a local crisis number which they can contact. For more information on safety and protection protocols used, see Annex 8: Age Matters Safety, Confidentiality and Privacy Protocols

<sup>iii</sup> See Annex 8: Age Matters Safety, Confidentiality and Privacy Protocols

### 2.3. Data analysis

The mixed methods of quantitative and qualitative data collection and analysis validated the study through the process of triangulation, and provided an increased level of knowledge and different perspectives on the investigated issue. The data collected through the survey and the focus groups allowed the researchers to understand the underlying meanings, motivations, and opinions of the selected group of adolescents.

Data from the survey was collected and analysed using quantitative statistical software SPSS, with the ability to disaggregate by country, region, age, and sex. Open-ended questions were anonymised and translated into English for qualitative data analysis with MAXQDA software.

Quantitative statistical methods were limited to descriptive statistics, including single variable data analysis and cross-tabulation data analysis. As the research is **exploratory**, no statistical inference was applied to determine properties of the adolescent population, nor was a hypothesis tested.

The qualitative data from the focus groups was generated from verbatim transcripts of audio recordings that were translated into English, and then uploaded into the qualitative data analysis software, MAXQDA. The coding system for the analysis of the focus group transcripts was developed by combining concept-driven strategies (Schreier, 2012) based on deductive theoretical preconceptions and the selected topics of the research and those covered in the survey, with data-driven strategies based on subsumption (Mayring, 2000) and the inductive, grounded theory (Glaser & Strauss, 2008) approach of staying close the text itself. The development of the coding system included a trial coding period, which included quality control and discussion between two separate coders to finalise the coding system.<sup>17</sup> The main coding of the transcripts (semantic and thematic coding<sup>18</sup>) was done using MAXQDA. The results of the coding helped to

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<sup>17</sup> See Annex 9: Focus Group Coding System

<sup>18</sup> Following coding principles laid out by Miles, Huberman, & Saldaña, 2014.



inform the researchers about the salient ideas and group thinking of the participants on the selected themes.

Survey results and data from the focus groups were triangulated through the incorporation of quantitative (survey) and qualitative (focus groups) research methods in the consultation process to ensure a more balanced and nuanced analysis of the adolescents' knowledge, perception and experiences with age-related legislation. While both methods have their biases in the type of data they create, as well as the previously discussed limitations, by implementing all mitigating strategies and having justified methodological choices, they still provide a unique and, as much as possible, balanced set of research results that contribute to an ongoing debate in the field and may inform policy choices.

#### 2.4. Involvement of stakeholder groups

The research team<sup>19</sup> engaged various stakeholders throughout the process of research design and implementation – not only the affected population of adolescents, but also their parents/guardians, CSOs/community organisations (including schools), and other research and child-rights organisations. Stakeholders were engaged in the following ways:

- **Adolescents:** Adolescents were involved in validating survey and focus groups and provided with the contact details of the research team at every step in case of additional questions after participation.
- **Parents/guardians:** The targeted dissemination strategy of the survey also targeted parents/guardians to inform them of the survey and encourage them to get in touch with the research team for more information.<sup>20</sup> The front page of the survey encouraged respondents to discuss the survey with their parents/guardians.<sup>21</sup>
- **CSOs/community organisations and other child-rights organisations:** CSOs (including schools) helped to disseminate the online survey in their communities; partnered with UNICEF to host focus groups; and in the case of vulnerable groups, helped to provide access to adolescents that they work with to seek participation in focus groups. Organisations such as the European Union Agency for Fundamental Rights (FRA), provided data on minimum age research from their own projects for Phase I, and kept informed on the developments of the consultation, to explore synergies with their own research and potential for future collaboration.

An ongoing engagement with stakeholders is also achieved through the projects website ([www.agemattersnow.org](http://www.agemattersnow.org)) where information about the results of both phases of the project is presented. The website also lists an

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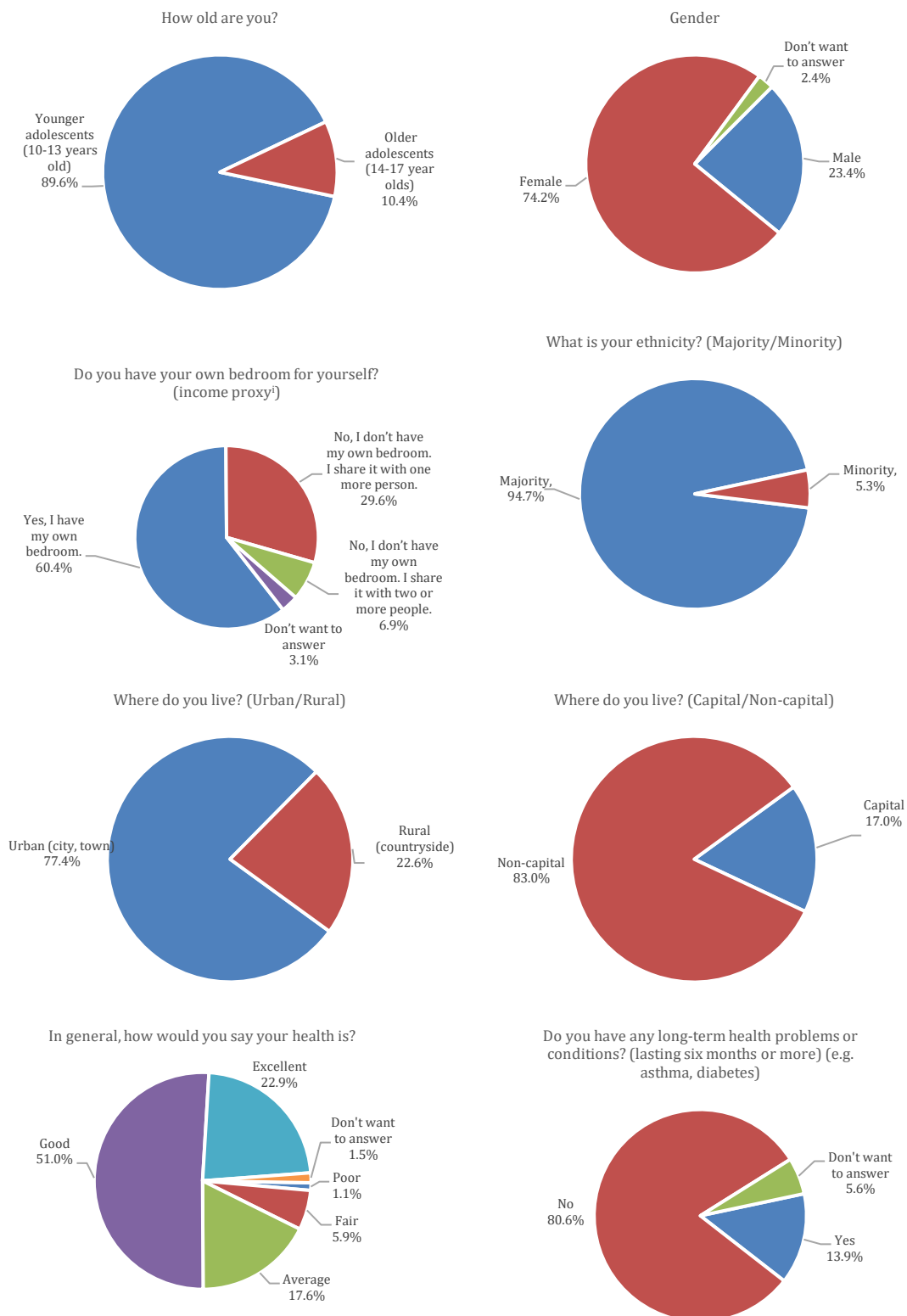
<sup>19</sup> See Annex 2: Roles and Responsibilities of Research Team

<sup>20</sup> See “Securing informed consent of adolescents below the age of 18: Online survey” in the Ethics chapter

<sup>21</sup> See Annex 4: UNICEF Age Matters Adolescent Survey – English. Note: the survey was translated into local languages, however is provided in English in the annex for reference.

email, directed to UNICEF ECARO, which readers can use in case of further questions.

Figure 2: Survey respondent demographic groups at-a-glance



<sup>i</sup> Number of bedrooms in a house is used as a simple proxy variable for income level, where having one's own bedroom is a proxy for high income level; sharing a bedroom with one other person as medium income level; and sharing a bedroom with two or more people as low-income level.

## 2.5. Legal minimum ages used in this consultation

Phase one of *Age Matters* found that in the region, “minimum ages are riddled with exceptions, additions, and considerations. This makes it more complicated to fully understand, monitor, and improve the situation for children and adolescents – not least for them as individuals attempting to understand the laws for themselves” (Ehmke, Farrow, & Karzhaubayeva, 2016, p. 56).

Therefore, it should be noted that while many laws have several exceptions and considerations (especially minimum age of criminal responsibility, and consent to medical treatment), the most **widely applicable ages** are used for discussion in the online survey and focus groups. This is to ensure that ages would be easy to understand by adolescent participants for the sake of discussion.

The list of these simplified minimum age values, and the original source laws, are listed in Figure 3 below.

*Note: The data collected below was verified by UNICEF Country Offices for Phase 1 Age Matters! 2016 report. Data for Bulgaria, Croatia and Romania provided by EU FRA. Data updated on 1 September 2017 by UNICEF Bulgaria Country Office.*

Figure 3: Simplified minimum age values for discussion on age-related legislation

	Armenia	Bulgaria	Kazakhstan	Romania	Ukraine
Minimum age of criminal responsibility (MACR)	14 <sup>a</sup>	14 <sup>b</sup>	14 <sup>c</sup>	14 <sup>d</sup>	14 <sup>e</sup>
Marriageable age (with consent / without consent)	18/16 <sup>f</sup>	18/16 <sup>g</sup>	18/16 <sup>h</sup>	18/16 <sup>i</sup>	18/14 <sup>j</sup>
Full-time working age	16 <sup>k</sup>	16 <sup>l</sup>	16 <sup>m</sup>	16 <sup>n</sup>	16 <sup>o</sup>
End of compulsory schooling	16 <sup>p</sup>	16 <sup>q</sup>	18 <sup>r</sup>	17 <sup>s</sup>	17 <sup>t</sup>
Minimum age to independently seek medical advice or counselling	18 <sup>u</sup>	16 <sup>v</sup>	18 <sup>w</sup>	18 <sup>x</sup>	14 <sup>y</sup>
Minimum age to give or refuse consent to medical treatment	18 <sup>z</sup>	18 <sup>aa</sup>	18 <sup>bb</sup>	18 <sup>cc</sup>	18 <sup>dd</sup>
Voting age	18 <sup>ee</sup>	18 <sup>ff</sup>	18 <sup>gg</sup>	18 <sup>hh</sup>	18 <sup>ii</sup>

<sup>a</sup> Source: Armenia Criminal Code, 2003, Article 24.

<sup>b</sup> Source: Bulgaria Criminal Code, 2 April 1968.

<sup>c</sup> Source: Kazakhstan Criminal Code, 2014 Article 80.

<sup>d</sup> Source: Romania Criminal Procedure Code Law 35/2010.

<sup>e</sup> Source: Ukraine Criminal Code, 2001.

<sup>f</sup> Source: Armenia Family Code, 2013, Article 10.

<sup>g</sup> Source: Bulgaria Family Code, 23 June 2009, Art. 4-5.

<sup>h</sup> Source: Kazakhstan Code "On Marriage and Family", 2011.

<sup>i</sup> Source: Romania Law 287 of 17 July 2009 regarding the Civil Code Article 259(3).

<sup>j</sup> Source: Ukraine Family Code, 2002.

<sup>k</sup> Source: Armenia Labour Code, 2004, Article 15.

<sup>l</sup> Source: Bulgaria Labour Code, 1 April 1986, Art. 301, para. 1

<sup>m</sup> Source: Kazakhstan Labour Code, 2015

<sup>n</sup> Source: Romania Labour Code, 2003, Article 13. (1).

<sup>o</sup> Source: Ukraine CRC State Report III-IV by Ukraine, 2010.

<sup>p</sup> Source: Armenia Law on Education, 1999, Article 18.3 and CRC Report Armenia, 2003.

<sup>q</sup> Source: Bulgaria Public Education Act, 18 October 1991, Art. 7.

<sup>r</sup> Source: Kazakhstan law on education system, 2011, Article 31 and initial CRC report for Kazakhstan, 2002.

<sup>s</sup> Source: Romania Law 1/2011 on national education, Article 16. (2).

<sup>t</sup> Source: CRC State Report II by Ukraine, 2001.

<sup>u</sup> Source: Armenia Law on Medical Care, 1996, Article 10 and UN CRC 2003 for Armenia

<sup>v</sup> Source: Bulgaria, Health Act, 10 August 2004, Art. 87. It is valid only for health consultations, testing and prophylactic check-ups (Health Act). The specific types of counseling services, prophylactic examinations and testing are defined by a separate order of the Health Minister (Note by UNICEF Bulgaria Country Office, 1 September 2017).

<sup>w</sup> Source: Kazakhstan Code "On public health and health care system", 2014 and 2002 CRC Initial Report for Kazakhstan.

<sup>x</sup> Source: Romania Law 95/2006 on healthcare reform, Article 661.

<sup>y</sup> Source: Temporary Standards of Provision of Medical Care to Adolescents and Youth: The Order of the Ministry of Health of Ukraine of 02 June 2009, # 382); Civil Code of Ukraine of 16 January 2003, # 435-IV

<sup>z</sup> Source: Armenia Law on Health protection, 1996, Article 8.

<sup>aa</sup> Source: Bulgaria Health Act, 10 August 2004, Art. 87

<sup>bb</sup> Source: Kazakhstan Code "On public health and health care system", 2014 and 2002 CRC Initial Report for Kazakhstan.

<sup>cc</sup> Source: Romania Law 95/2006 on healthcare reform, Article 661.

<sup>dd</sup> Source: Temporary Standards of Provision of Medical Care to Adolescents and Youth: The Order of the Ministry of Health of Ukraine of 02 June 2009, # 382); Civil Code of Ukraine of 16 January 2003, # 435-IV

<sup>ee</sup> Source: Armenia Electoral Code, 1999, Article 2.

<sup>ff</sup> Source: Bulgaria Constitution 13 July 1991, Art. 42; Bulgaria Elections Code 5 March 2014, Art. 243, 307.

<sup>gg</sup> Source: Kazakhstan Constitutional Law "On elections in the Republic of Kazakhstan", 1995.

<sup>hh</sup> Source: Romania Constitution, Article 36, 1991.

<sup>ii</sup> Source: Inter-parliamentary Union

### 3. Ethical considerations when conducting research with adolescents in the *Age Matters!* project

Conducting research with adolescents is complex, with a need to balance the protection of adolescents while progressing with their participation in research, and ensuring that they participate in matters that affect them. Issues of **harms and benefits, informed consent, privacy and confidentiality** and **payment** require special considerations when conducting research with adolescents. To ensure high quality, ethical research, several considerations were made in the design, implementation and dissemination phases of this project to ensure that the key ethical principles of **respect, benefit, and justice** are upheld at all times, regardless of context.<sup>22</sup> These included:

#### 3.1. A special independent review board: Engaging with the child rights & youth research communities

For this research, a special independent review board (IRB) was convened in order to conduct a thorough review of the possible ethical implications of the study. In accordance with UNICEF guidance, the IRB was made up of three research and practice specialists in the fields of child rights and youth research. The members of the IRB included three reputable specialists with long experience of working on issues of child rights and youth research:

- Gerison Lansdown, an international child rights expert and author of numerous key texts relating to the CRC, participation, and evolving capacities of the child
- Dr. Howard Williamson, Professor of European Youth Policy in the School of Humanities and Social Sciences in the Faculty of Business and Society at the University of South Wales, with over twenty years of experience as a licensed youth worker in the United Kingdom
- Dr. Sally Hartley, a Visiting Research Fellow at Open University in the United Kingdom and experienced researcher with a specialisation in youth-led development and youth-centred research in the Global South.

As seasoned researchers and practitioners, these three experts brought their first-hand experience in working with children and young people to the ethical review process, and through that, an understanding of the ethical dilemmas a researcher can encounter. This enabled practice-oriented ethical reflection on the research design and methodology. Moreover, engaging experts who are currently active within the child's rights and youth research communities is a way to foster collaboration, further promoting the rights, dignity and well-being of children both in and through research.

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<sup>22</sup> The ethical approach of this project is informed by the guidelines and principles outlined in: UNICEF, 2015, *UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis*, CF/PD/DRP/2015-001, and Graham, A., Powell, M., Taylor, N., Anderson, D., & Fitzgerald, R., 2013, *Ethical Research Involving Children*, Florence: UNICEF Office of Research – Innocenti.

The role of the IRB was to:

- Ensure the protection of and respect for human and child rights within the research project, through advanced review of the research design and methodology, protocols and associated documents, identifying any potential risks the research may present to the adolescents
- Assessing any potential harms or concerns
- Making suggestions as to how to maximise the safety of the research subjects. The comments and reflections provided by the IRB were fully incorporated into the research protocol, and all three experts gave their approval to the final research protocol for the study to proceed.

### 3.2. Weighing the harms and benefits of the research

All efforts were made to reduce the potential harm that could arise from the consultation, all protocols were followed, and no child was harmed as a consequence of their participation in this project. Measures used to maximise benefit and reduce harm included:

- Project-specific principles, guidelines and protocols on ensuring subjects' safety and privacy as listed in specifically designed and reviewed UNICEF Age Matters Safety, Confidentiality and Privacy Protocols.<sup>23</sup>
- Selection of qualified local facilitators with a background in working with and conducting research with children, including a mandatory background and police check, training of facilitators on safety and privacy protocols, signing a declaration of adhering to the ethical principles in conducting research with children and adolescents, as well as completion of the UNICEF online course, "Introduction to Ethics in Evidence Generation."
- Provisions for referral and a list of support services in the event that an adolescent reveals they are at risk of harm, in the online survey<sup>24</sup> or focus group discussions, including recording and reporting to the research team and UNICEF Country Office.
- Protocols in the event that an adolescent becomes distressed during focus group discussion.
- Anonymous participation in the online survey, and anonymising/masking identifying information in focus group transcripts, including using pseudonyms for quotes in this report.

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<sup>23</sup> Annex 8: UNICEF *Age Matters!* Safety, Confidentiality and Privacy Protocols

<sup>24</sup> In the online survey, the question "If you avoided seeing a doctor, what were you seeking medical advice for?" included the option "Harm from abuse or violence". Since the online survey is anonymous and voluntary, there are no adequate tools to follow-up directly with an adolescent if they select this option. With this limitation in mind, information on youth-specific helplines for each country, and a note encouraging the adolescent to reach out for support, was provided to all adolescents at the bottom of this page. See Annex 4: UNICEF Age Matters Adolescent Survey – English. Note: the survey was translated into local languages, however is provided in English in the annex for reference.

- Special measures to include vulnerable adolescents in focus group discussions, including snowball method sampling with established UNICEF CSO partners that work directly with vulnerable groups.
- Special measures to include under-researched groups in focus group discussions through targeted sampling of these groups (e.g. girls, rural adolescents, younger adolescents). This included those who may face digital exclusion and cannot access the online survey.
- Internal peer review of this report, to ensure the just and ethical representation of individual adolescents or social groups, in a way that does not perpetuate stigma or discrimination.

The benefits of conducting this research with adolescents were deemed to be numerous:

- Understanding what adolescents think about age-related barriers to service access
- Highlighting which rights adolescents are aware of, and where there are gaps
- Providing direction for rights education and promotion with young people
- Providing adolescents who participated in the research the opportunity to share their views and voice their concerns on age-related issues in laws and policies that affect them
- Giving adolescents new knowledge and insights into how these laws impact the lives and well-being of adolescents
- Opportunities for reflection on how they might be improved or strengthened.

By consulting directly with adolescents, the project has the ultimate aim to promote the fulfilment of rights and well-being of adolescents.

### 3.3. Securing informed consent of adolescents below age 18

#### Online survey

The informed consent of the adolescent was sought on the first page of the online survey. Written in age-appropriate language, the introduction explained:

- The purpose of the research
- What types of questions will be asked and how long it will take
- How their answers will be used
- Which organisations were conducting the research, including contact information and a link to the project website for more information, as well as where the report will be published.

It also emphasised that the survey was voluntary and they can stop at any time, and that their answers would be anonymous and confidential. The adolescent was



asked if they understood everything described, and they had to click “Yes” before the survey began.<sup>25</sup>

Given the nature of the internet itself, parents have little ability to control which websites are accessed by their children except for the most extreme or inappropriate (e.g. by using parental controls or filters). As such, while parental consent was not actively sought, all reasonable steps were taken to inform parents/guardians about the survey, so that they were aware that their child might be participating in case there were objections. These steps included widely disseminating the survey on all public UNICEF communication channels in local languages, with contact details clearly available if parents had any questions. It also included a statement on the front page of the survey that encouraged adolescents to speak to their parents/guardians about the survey, and to tell them that they completed it.

### Focus Groups

All adolescents in the focus groups were required to give their personal written consent prior to participation, in addition to parental/guardian consent. Invited adolescents were provided one information sheet describing the project written in youth-friendly language, one sheet written for their parent/guardian, and were asked to return a signed consent form <sup>26</sup> with both their and their parent’s/guardian’s signature upon arrival to the focus group. Signed consent forms are stored for seven years as per the UNICEF Age Matters Safety, Confidentiality and Privacy Protocols<sup>27</sup>.

Consent forms were signed by parents, in addition to the adolescent, for all participants in focus groups. There were two specific cases that require further elaboration: In one case, a focus group was held during an adolescent convention in Kazakhstan, where adolescents were already gathered. Parental consent was given to attend the convention itself and indirectly, to participate in the focus group. However, recognising the specific situation of not having learned about the focus group until that day, the local facilitator made additional effort to seek signed and informed consent of the adolescents at the beginning of the focus group and it was sought throughout the focus group itself. The second case was with children who participated in a focus group but were without parents, and whose legal guardianship was transferred to an orphanage. In this case, the head of the orphanage provided signed consent.

### 3.4. Privacy and confidentiality: Protecting the identities of adolescents

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<sup>25</sup> Annex 4: UNICEF Age Matters Adolescent Survey – English. Note: the survey was translated into local languages, however is provided in English in the annex for reference.

<sup>26</sup> See Annex 10: Focus Group Information Sheets and Consent Forms - English. Note: the information sheets and consent forms were translated into local languages, however is provided in English in the annex for reference.

<sup>27</sup> Annex 8: UNICEF Age Matters Safety, Confidentiality and Privacy Protocols

Adolescents filled out the online survey anonymously and were only asked demographic information for the purposes of disaggregation (e.g. age, gender, location, ethnicity). Those participating in focus groups were asked their names in the session for easier communication, but their names were not recorded on paper. Focus groups were held in private locations and discussions were held outside of the listening distance of any other person. Participants in focus groups were also asked to uphold confidentiality among each other, and to not share what was said in the group with those outside of it. No photos or videos of the participants were taken.

Names of participants recorded in the audio taping were anonymised in the data transcription and translation, and any other details that could identify them (e.g. school name, neighbourhood) were either masked (i.e. replaced with dummy information) or removed completely. All data is kept in digital files that are password protected, and all data will be destroyed after a period of seven years, as per UNICEF Age Matters Safety, Confidentiality and Privacy Protocols.

Potential limits to confidentiality identified in the protocol include cases where an adolescent:

- Reveals information in a focus group that requires immediate action, such as when researchers suspect that a child is being abused or neglected
- Is being harmed or threatening to harm her/himself or another person
- Has a communicable or sexually transmitted infection which may place them and/or others at risk of harm.

No such incidents, where adolescents revealed they were in immediate harm, occurred during the focus groups.

### 3.5. Payment and compensation: A show of appreciation

Adolescents in the focus groups received a small token of appreciation (e.g. coloured pencils, or a UNICEF-branded souvenir) at the end of their participation. This small gift was neither advertised beforehand nor used as a way to attract adolescents to participate in focus groups, but rather to demonstrate reciprocity with the adolescent and as a way to thank them for their time and contributions in the consultation process.

### 3.6. Reflections on ages and ethics in practice: Research with adolescents in view of their evolving capacities

In our careful consideration of how to conduct research ethically, the implementation of this project is an exercise in how to balance a child's right to participation with the right to be protected in light of their evolving capacities. While strict ethics protocols exist on paper and were carefully followed throughout the research, this project took a reflexive approach, meaning that as the research progressed, the core research team continually reflected on

whether and how the best interests of the child were being upheld. This was not always obvious or straightforward.

Consider, for example, a discussion with respect to parental consent (in addition to the informed consent of the adolescent) for either the online survey or the focus groups. A remark by Dr. Howard Williamson of the IRB:

There is, however, research literature that points to the ethical acceptability of young people of 'sufficient knowledge and understanding' – a British legal principle called the 'Gillick principle' which is often considered to be relevant from around the age of 14, [of adolescents] giving their own consent, without the need for parental consent, certainly on some issues, with some groups of young people who may be at odds with, or without, parents. There is also the question of whether or not active consent is required or whether passive consent (through an absence of parental objection) is more appropriate.

[T]he lack of autonomy of young people and the authority of parents, could mean that tying the pursuance of the study to active parental consent might hinder the engagement of young people with important things to say, and who wish to say them, but who become disabled from saying them because their parents obstruct their participation through withholding *their* consent.<sup>28</sup>

Consider:

- Consent, and when an adolescent is able to provide it
- The role of the parent and other adults as gatekeepers
- The appropriateness of various types of participation, in balance with the potential risk that could be involved.

The challenges of unpacking these ethical issues lie at the heart of the discussions that this project seeks to provoke. These become increasingly important in light of changing digital technologies, and new tools used in research and consultation with adolescents, as discussed above. An auxiliary goal of this research then, is to also further this dialogue within the child rights and research communities, and to promote the production of relevant, high-quality, and ethical research with children and adolescents.

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<sup>28</sup> Edited excerpt from Williamson, H., 2 August 2017, *Guidelines for Independent Ethics Review*, Age Matters! Completed ethics review form.

## 4. Capacities, perception and knowledge relating to minimum age legislation

### Summary of key findings in this section:

#### **Adolescents who participated in our consultation felt more capable the older they were.**

Adolescents were asked how capable they felt across various activities in a general sense (e.g. going to the grocery store, deciding own personal dress and style), and in relation to the six domains selected for this research (voting age, age to access independent medical advice, marriageable age, minimum age of criminal responsibility, school leaving age/full-time working age, age to give or refuse consent to medical treatment). While there were large differences in the feeling of capacity between younger adolescents (**aged 10-13**) and older adolescents (**aged 14-17**), there seems to be a sub-category of adolescents **aged 11-12** where feelings of capacity were distinct. At this early age, respondents already began to see themselves as strongly capable to do several things, such as go the supermarket by themselves to buy groceries, to stay home alone for several hours during the day, and to decide what to do in their free time.

**Adolescents in our consultation also felt strongly capable to exercise their participatory rights in health, such as seeking medical advice alone without a parent/or guardian, if they wanted.** 62% of respondents “agreed” or “strongly agreed” that they were capable enough to speak to a doctor independently, with capability increasing along with the age of the respondent. From the age of 14, more than half of the respondents from each age group felt that they could speak to a doctor independently.

**However, respondents were more reluctant when it came to political participation.** 52.8% “agreed” or “strongly agreed” that they were capable enough to vote in national elections. Participants in focus groups shared this hesitation, however some individuals who were interested in politics felt strongly that young people should be more politically involved.

**Adolescents in our consultation were also split where there was a tension between participatory and protective rights.** For example, only 23.2% “agreed” or “strongly agreed” that a young person should be allowed to leave school and work full-time if they wanted to.

**Few felt capable to make their own decisions about medical treatment (such as receiving injections) in a general sense, but felt strongly about giving consent before receiving medical treatment specifically.** On average, only 30.7% of respondents “agreed” or “strongly agreed” that they were capable enough to make their own medical decisions, while 68.6% “agreed” or “strongly agreed” that they should always give consent prior to receiving medical treatment.

**The subjective capacity of males and females was roughly the same and where differences existed, they tended to be small** (less than a 10% gap). When disaggregating gender further by age, among those who “strongly agreed”, we saw that among 16- and 17-year-olds, there were more females who “strongly agreed” across all general activities than males of the same age. For all ages below 16, there were more males who “strongly agreed” in every age group than females for all general activities.

**But, there remain gendered differences in external circumstances that can impact capacities, or compromise protection.** For example, focus groups discussed how females are expected to give up career and educational ambitions to take on housekeeping and child rearing roles. Females also reported experiencing more parental pressure when it came to marriage than males, compromising their ability to make autonomous decisions about it, and increasing their risk to early marriage.

**Many respondents felt more capable to do a certain activity if they had already done it.** This relates both to everyday activities, such as staying home alone, as well as activities relating to health. For example, those who felt most capable that they could speak to a doctor

independently were respondents who also reported having a “poor” general health status, or having long-term health problems. Participants in focus groups shared past experiences of doing something independently, giving them additional confidence that they were capable enough to do it, as they could attest that these activities could be done.

**Adolescents in the consultation shared a strong desire to be protected from activities or experiences that could cause them harm**, such as early marriage. Moreover, they were split on the age at which a young person should be held responsible for criminal acts, though there was a near unanimous agreement that children should not be charged as adults.

**With exception to marriageable age and voting age, adolescents in the consultation lacked knowledge about minimum age laws.** This constrains their ability to demand rights that are granted to them, and to be aware of the supports that may be available. Information and knowledge about laws is necessary for adolescents to be better able to exercise rights on their own behalf.

#### 4.1. Background: Participation & autonomy vs. protection

The Convention on the Rights of the Child (CRC) introduces the concept of the “evolving capacities of the child” in Article 5, stating that parents or those responsible for a child should provide direction and guidance to the child in a manner consistent with the child’s own capacities to exercise rights on his or her own behalf. In practice, this means that as children acquire enhanced competencies, there is a reduced need for direction and a greater capacity for the child to take responsibilities for decisions affecting his or her life (Lansdown, 2005). This is particularly pertinent in adolescence, a period of rapid physical, emotional, and cognitive development.

As a foundational principle, alongside non-discrimination (Article 2), the best interests of the child (Article 3), and respect for the views of the child (Article 12), the principle of respect for evolving capacities is central to the balance sought in the CRC: respect for a child’s agency and emerging autonomy in the exercise of their own rights, while at the same time ensuring protection for a young person from experiences that are inappropriate or harmful in view of their youth, or from decisions they do not feel competent or willing to take.

The need to balance protective rights with participatory or emancipatory rights, is one of the most fundamental challenges posed by the CRC. This primary tension between autonomy and protection underlies the international debate on minimum age legislation.

Sedletzki explains how a fundamental aim of minimum age laws is for protection:

The primary objective of setting minimum ages in legislation is to protect adolescents from harm. Legal minimum ages aim to protect adolescents from making choices and/or from taking responsibility for actions that they do not have the capacity to understand in their entirety and comprehend the full consequences. The rationale is not to limit the exercise of adolescents’ rights, but to ensure that adolescents are protected from actions that can potentially impair the current or future realization of their

rights. It is not about protecting society from adolescents, but about ensuring that adolescents can develop to their full potential in a protective environment. For this reason, it is essential that the process of setting minimum ages be adolescent-centred and focused on the best interests of adolescents (Sedletzki, 2016, p.11).

However, others such as the Child Rights International Network (CRIN) (2016) as well as Hodgkin & Newell (2007), point out that some minimum age legislation – while aiming for protection – can be obstacles for children to fully realising their rights:

Some “minimum age” issues relate both to increased autonomy and to protection. For example, the child’s right to seek legal and medical counselling and to lodge complaints without parental consent, and to give testimony in court, may be crucial to protection from violence within the family. It is not in the child’s interests that any minimum age should be defined for such purposes (Hodgkin & Newell, 2007, p.5).

#### Capacity, risk, and minimum age legislation

Consideration for evolving capacities complicates the tension between autonomy and protection further. For adolescents, autonomy – meaning respect for people to make their own choices, express own views, and take responsibility – is not a binary state, but rather depends on adolescents’ still evolving capacities, in addition to opportunity and one’s own desire. That is, children must not be forced to take decisions that they do not feel competent or willing to take (Lansdown, 2005).

Cultures and contexts vary widely on their calculations of these factors. For example, behaviours considered dangerous or inappropriate for children and adolescents of a certain age in one society may be considered a norm in another. Moreover, children themselves are a highly heterogeneous group, living in a variety of environments, circumstances, and experiences (Lansdown 2005). Yet, minimum age legislation, with legally defined minimum ages, essentially relies on chronological, linear definitions of childhood and adolescence.

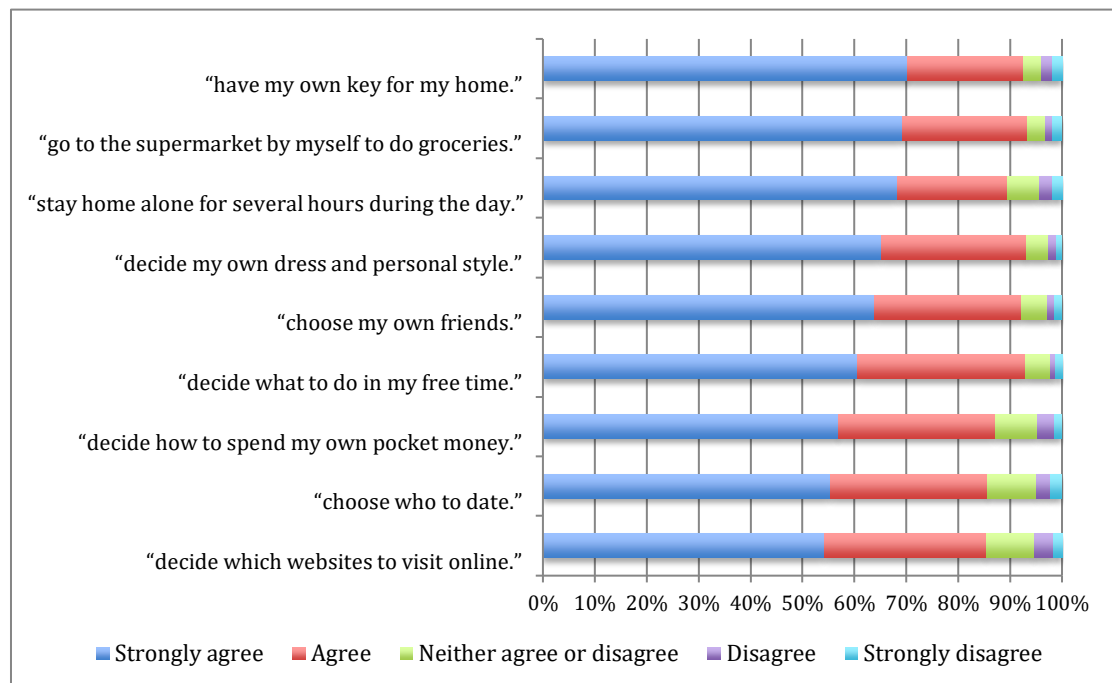
The limitations of chronological age definitions notwithstanding, a minimum legal age in legislation reflects how a State views childhood, capacity, and risk. In other words, minimum age legislation answers the question: At what age is it appropriate for a child to acquire a right? What is “appropriate” can be seen as conditioned by various factors: how a State defines capacities, what levels of capacity the State deems necessary to make decisions, and what levels of risk does the State deem acceptable (Lansdown, 2005).

#### 4.2. Findings: Subjective capacity: General or everyday activities

This consultation asked adolescents several questions relating to how capable they feel – an assessment of their own capacity – across a variety of activities.<sup>29</sup> If minimum age legislation is taken to be a reflection of the age the State sees it appropriate for a child to acquire a right, it would be important to understand how children *themselves* see it – and whether their subjective assessment of themselves converges, or diverges, from State’s conception of them.

Respondents to the online survey were initially asked how capable they are across a range of general activities that an adolescent would typically encounter at this stage in life, to better prepare them for this type of reflection throughout the survey. Overall, respondents felt highly capable to undertake all general activities, such as going to the grocery store by themselves, staying at home alone for several hours of the day, or choosing their own friends.

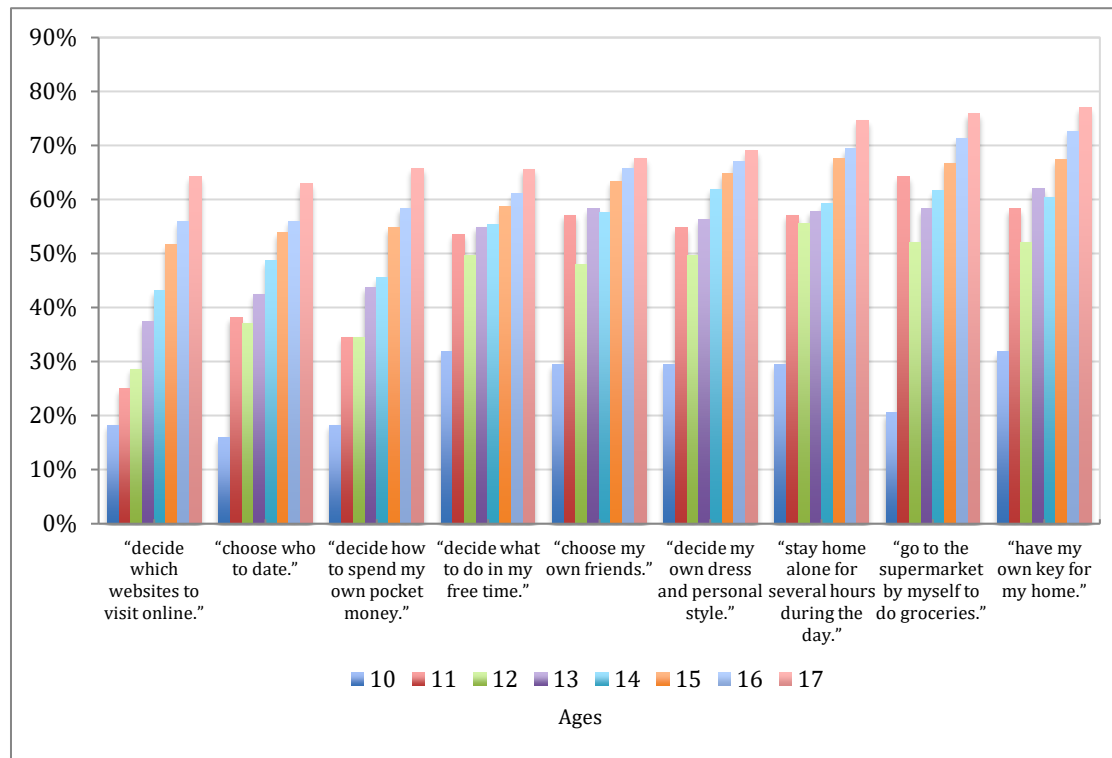
Figure 4: “I am capable enough to...”



When broken down by age, we generally see that the older respondents are, the greater the proportion who feel strongly that they are capable enough to do a variety of activities.

<sup>29</sup> For the sake of simplicity, the online survey and focus groups used the term “capable” for easier comprehension by adolescents when they completed the phrase “I am capable enough to...”. It is more straightforward than completing the sentence, “I have the capacity to...”. However, inherent in a question about how much one is capable are the same key elements of what are considered in “evolving capacities”, as it is conceptualised in international law (Lansdown, 2005), which is broadly speaking: do you have the skill, means, or information to undertake an activity? In our analysis, “is capable to” is used interchangeably with “have capacity to”.

Figure 5: "I am capable enough to..." ("strongly agree" by age)



What emerges is that at approximately **age 11-12 and older**<sup>30</sup>, a majority of respondents "strongly agree" that they are capable enough to do the following activities:

- "go to the supermarket by myself to do groceries"
- "have my own key for my home"
- "stay home alone for several hours during the day"
- "choose my own friends"
- "decide my own dress and personal style"
- "decide what to do in my free time"

By contrast, it is at **age 15 and older** that a majority of respondents "strongly agree" that they are capable for the following activities:

- "decide how to spend my own pocket money"
- "choose who to date"
- "decide which websites to visit online"

This could imply that some activities are not seen as relevant or of interest to younger adolescents, such as dating. Other activities might also be seen as having higher levels of risk, and therefore only feel that they have the capacity to do them when they are older. Conversations about risk, and feeling capable enough to

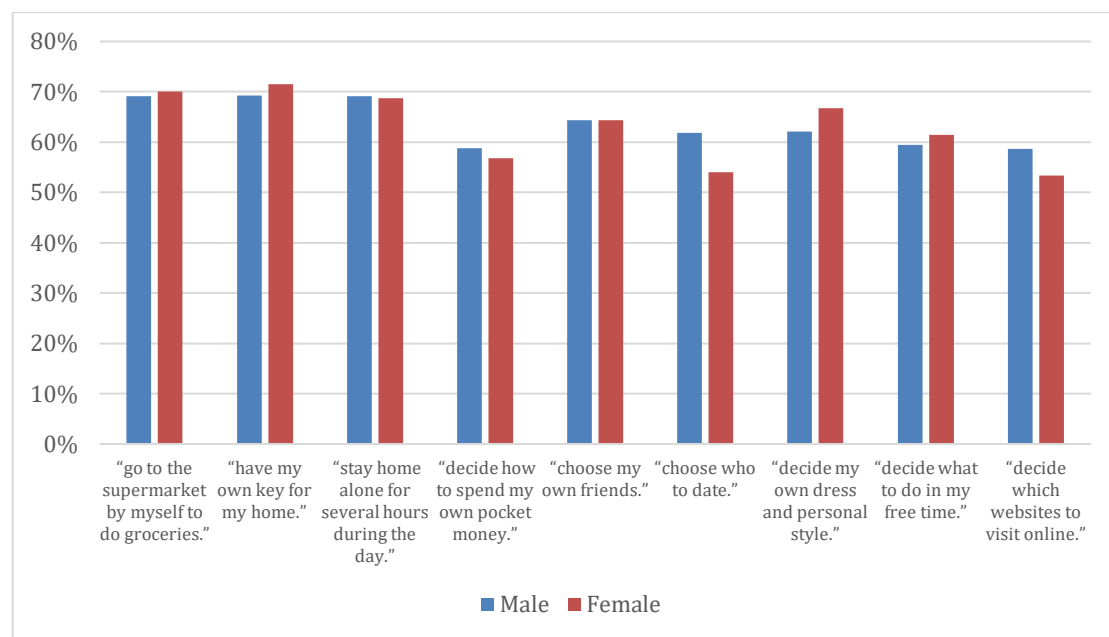
<sup>30</sup> While 50% is reached at age 11, it decreases slightly for 12-year olds, however stays at or around half.



manage certain levels of risk specifically in relation to spending and online safety, are explored in the focus groups, as seen later.

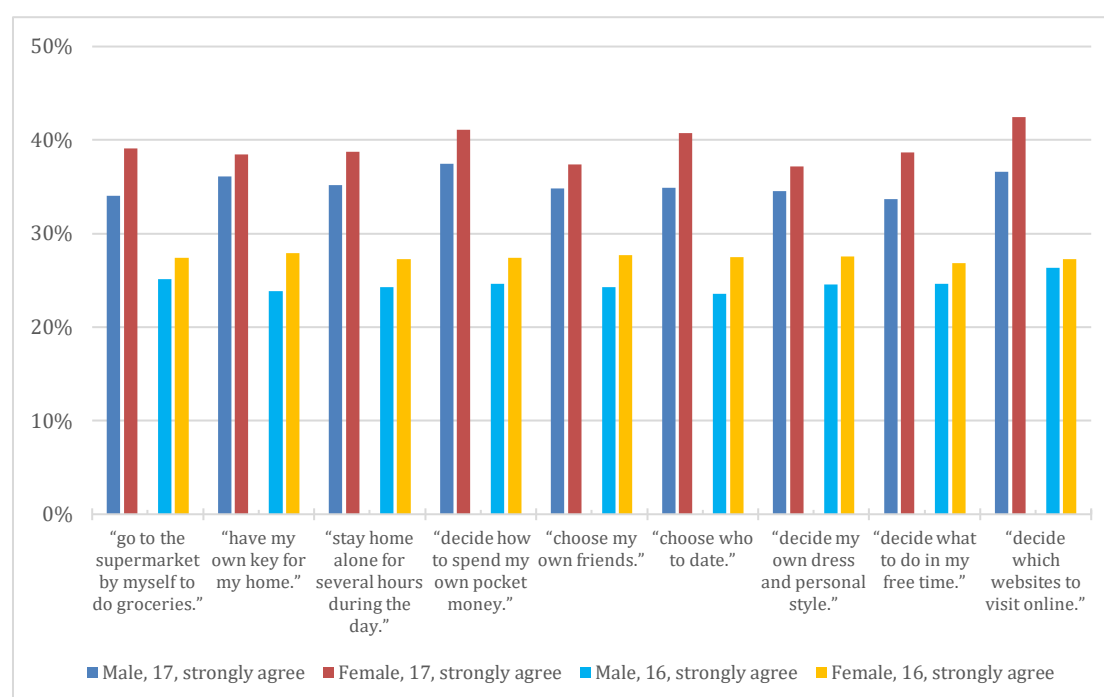
When looking at general capacities by group, there are few divergences within groups, including gender. Males and females mostly rate their capacities the same, with slight divergences only among those who “strongly agree”. Here we see that males and females who “strongly agree” have small differences only in dating (7.8% more for males), websites to visit online (5.3% more for males), and deciding own personal style (4.6% more for females):

Figure 6: “I am capable enough to...” (“strongly agree” by gender)



When disaggregating gender further by age, among those who “strongly agree”, we see that among 16 and 17-year-olds, there are more females who “strongly agree” across all general activities than males of the same age. For all ages below 16, there are more males who “strongly agree” in every age group than females for all general activities.

Figure 7: "I am capable enough to..." ("strongly agree", by 17- and 16-year olds, by gender)



The focus groups further explored subjective capacities across a few general activities. Participants were asked about three general activities: staying home alone, deciding how to spend pocket money, and deciding which websites to visit. In particular, they discussed if they felt they were old enough to do the task (and if not, what age would be appropriate), what is needed to adequately do the task (e.g. skills, information), and other considerations.

Across all focus groups many participants said that adolescents can stay at home from 10-12-years old onwards. This assessment was often tied to **experience** – several participants identified that they had begun to stay at home alone at this age, and in doing so, could attest that it could be done.

Therefore, young people who had the opportunity to stay home alone, gained the **confidence** that they had the capacity to do it, because they had first-hand *experience* of doing it. For many participants, their experience of staying home alone was borne out of necessity – for example, parents are working and must leave children alone on occasion – rather than a conscious decision by their parents to give them the opportunity.

Participants identified **information** – namely "ground rules" of what to do or not do in the house, how to operate the stove properly, and who to call in case of an emergency – as key to their ability to stay at home alone. When equipped with appropriate information, participants were able to calculate when there was very little **risk** to staying home alone.

In regards to holding pocket money, younger participants (10-13-years) were generally sceptical of young people having the capacity to spend pocket money

responsibly. In contrast, older participants felt that their age range, 14-17-years, was the appropriate age to make their own decisions about money. Many participants already had this responsibility – through a weekly allowance, salary from a part-time job, or a scholarship – and therefore *experience* again is a determinant for confidence in their capacity to hold money. In both age groups, participants admitted that a higher *risk* was associated with managing one's own money, especially in larger amounts. Therefore, many felt that they would need more *information* and guidance on how to manage it properly.

Participants recognised that parents had very little ability to modulate or control their internet access, because parents often lacked the know-how or understanding of the internet to control access, or because the nature of the internet meant that young people were often accessing it unsupervised, such as on their own phones or computers in internet cafes.

Younger participants (10-13-years) identified *risks*, ranging from violent or pornographic sites, viruses, to online predators, and for this reason, felt weary of accessing websites on their own. Participants in the 14-17-year groups already felt confident that they could navigate the internet, understanding how to use the internet in positive ways, such as researching for school projects or keeping in touch with friends, and how to avoid the risks. Interestingly, while both younger and older participants identified similar risks, only older participants felt confident enough to navigate them properly. This is also attributed to *experience*, having more experience online, but participants also said that more could be done by way of *information* and education on digital literacy in schools, particularly because parents often lacked the knowledge themselves.

#### 4.3. Subjective capacity: Domains relating to minimum age legislation, by age

The consultation further explored six domains where a minimum legal age is defined in legislation: voting age, age to access to independent medical advice, age to give or refuse consent to medical treatment, minimum leaving school age/full-time working age, marriageable age (with and without parental consent) and minimum age of criminal responsibility. In the online survey, respondents were asked their opinions on:

- How strongly they feel *themselves* **capable**
- At what age they think *young people* can do certain things in their country (**knowledge** of minimum age laws)
- How much they agree or disagree about aspects of a minimum age law (**perception** of minimum age laws).

The focus groups expanded on these topics, further exploring participants views, opinions and experiences across the six domains.

For our analysis, the domains are grouped in the following ways:

**I. Domains relating to participatory rights**

- Voting age
- Age to access independent medical advice

These domains relate to a child's right to be heard and participate in matters that affect them. Age restrictions in these areas do not seem to have any protective purpose, and instead could potentially curb a child's development and right to participation (Child Rights International Network (CRIN), 2016). Here, questions relating to subjective capacity, knowledge, and perception were asked.

**II. Domains relating to protective rights**

- Marriageable age
- Minimum age of criminal responsibility

These domains relate to areas where a child's protection is at risk, such as harms relating to early marriage, or within the justice system. Minimum ages in these areas are intended to provide special protection from experiences or responsibilities that have high risk of causing a child harm. Here, only questions relating to knowledge and perception were asked, and not capacity.

**III. Domains where there exists a tension between participatory and protective rights**

- Minimum leaving school age/full-time working age
- Age to give or refuse consent to medical treatment

These domains relate to both participation and protection, where specific calculations of capacity, risk, and context factor largely in deciding what is in the best interests of the child. Here, questions relating to subjective capacity, knowledge, and perception were asked.

**4.3.1. Domains relating to participatory rights**

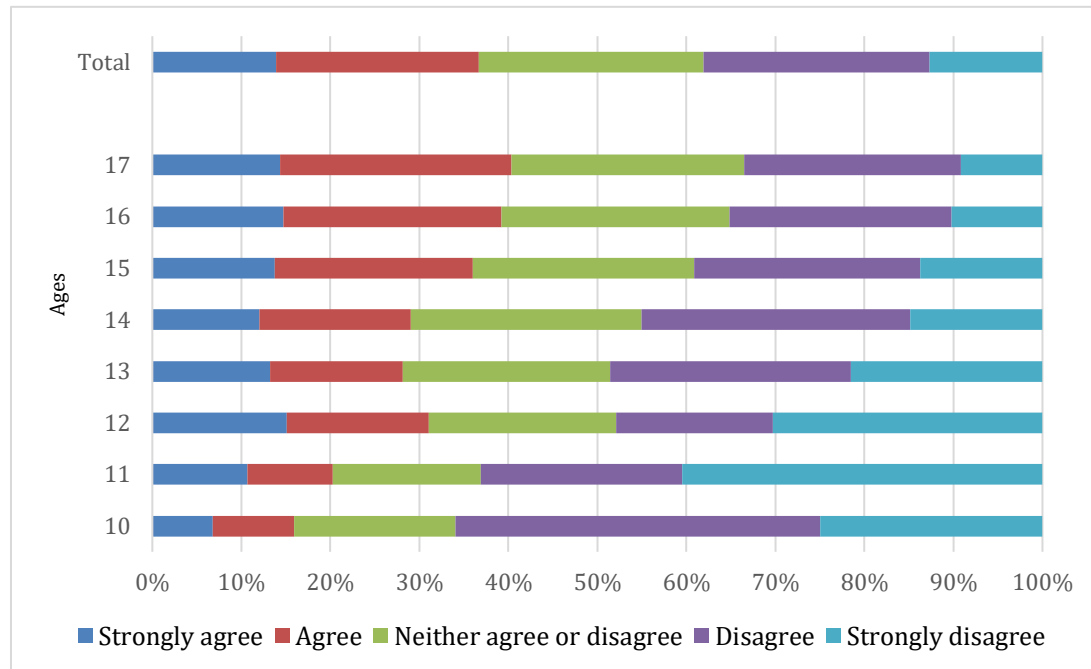
*Voting*

We asked survey respondents to assess their **capacity** on a five-point Likert scale. Overall, a combined total of 52.8% of respondents said they "agreed" and "strongly agreed" that they were capable enough to vote.

This assessment of capacity to vote generally increases with age, meaning that the older the respondents are, the greater the proportion who feel capable. Beginning at age 15, a majority of respondents in each age group "agree" or "strongly agree" that they are capable enough to vote.

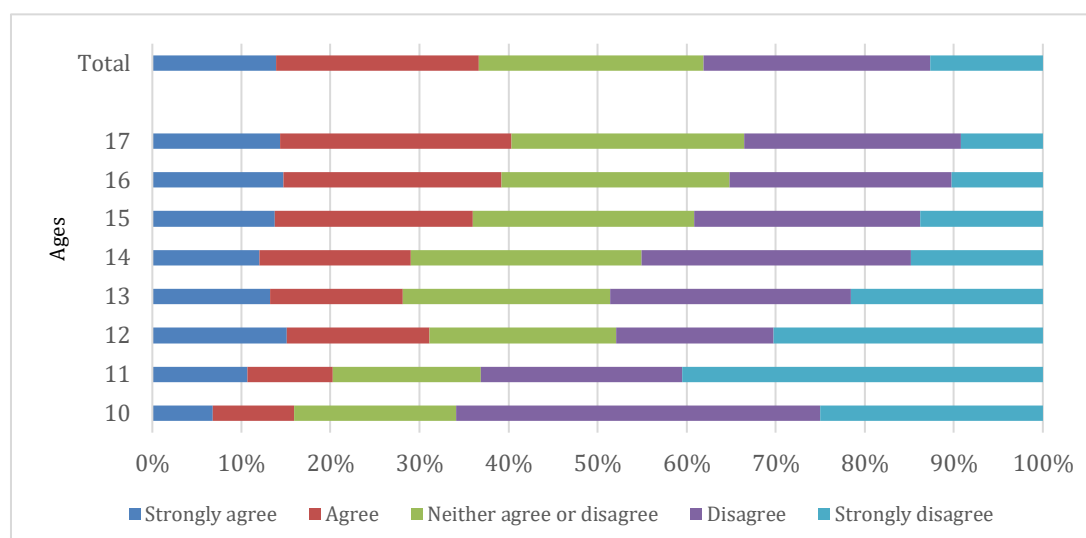
Interestingly, there is a small drop of those who agree and strongly agree between ages 12 and 13. It is important to mention that about a quarter of all respondents in all age groups remain indifferent to this question and choose “neither agree nor disagree”.

Figure 8: “I am capable enough to:” “vote (e.g. in national elections)” by age



Respondents gave a slightly different answer on the **perception** question: “How much do you agree with the following statement? - Young people my age should be allowed to vote (e.g. in national elections)”. There was no majority in any age group of respondents who “agreed” and “strongly agreed” with this statement. The age group with the largest agreement with this statement is 17-year-olds (40.3%). Interestingly, adolescents aged 12 seemed more confident that they should be allowed to vote than older adolescents aged 13 and 14, potentially signalling a jump in civic engagement at this age.

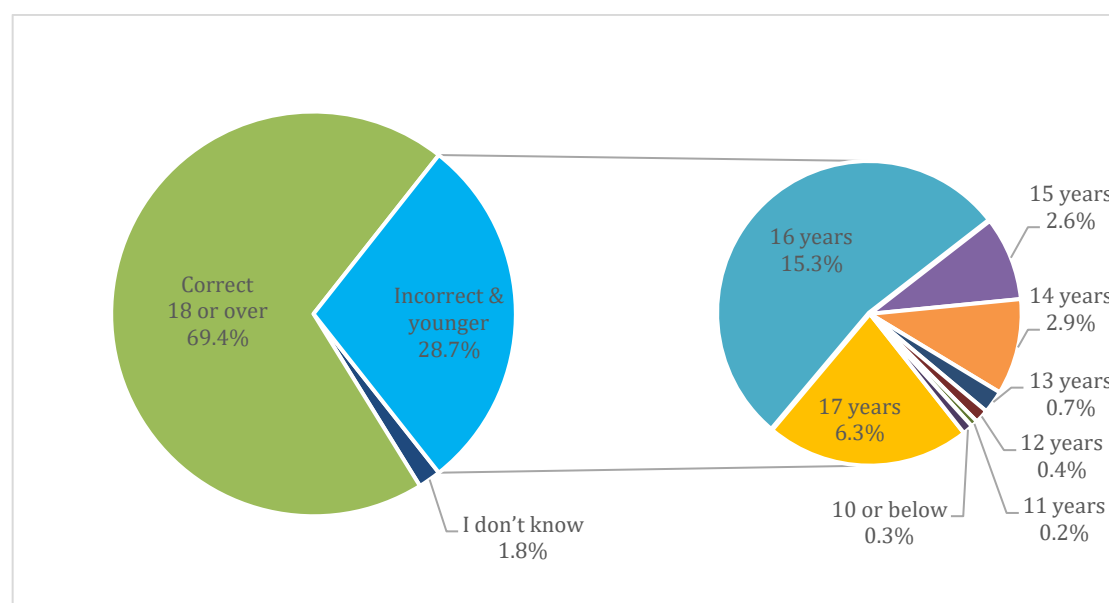
Figure 9: How much do you agree with the following statement? “Young people my age should be allowed to vote” by age



The difference between respondents’ feelings of one own’s capacity (“I am capable enough to vote”) and their perception of the law (“Young people my age should be allowed to vote”) may reflect that respondents see their personal capacity as higher than that of their peers. It could also reflect a feeling that while they feel personally capable to vote, they were less confident that the law should be changed to allow for this to happen.

When asked a **knowledge** question: “from what age can a young person vote (e.g. in national elections)?”, the vast majority of respondents (almost 70%) knew the correct answer, namely 18-years in all five countries.

Figure 10: From what age can a young person vote (e.g. in national elections)?



Note: “Incorrect & older” category has 0% as it was not possible to select an option above 18-years.

Interestingly, when we look closely into what ages respondents choose as their correct answer, the second most guessed age was 16 with 15.3%.

Focus group participants did not all agree on the issue of voting age. In 6 out of the 14 focus groups, there was at least one participant who was in favour of a lowered voting age. On the whole, younger participants (10-13-years) were more sceptical about voting than older participants (14-17-years), for the exception of one 10-13-year-old mixed gender group in Ukraine, where participants were overwhelmingly in favour of voting at a younger age, even as young as 11-years. As explained by a participant<sup>31</sup>:

“If one understands why he/she will vote...well, he/she does this consciously. If one knows that he/she will vote and not regret it later, why not let the person do this at 11?”

- *Inga<sup>32</sup>, 12-years old, discussing the age at which young people should be able to vote in Ukraine in a mixed gender focus group of urban adolescents between the ages of 10 and 13*

Participants who felt that adolescents were capable enough to vote, said that young people were already interested in politics, and that their lives as young people are impacted by the policies and laws of a country, so therefore they should be consulted about them.

There were numerous reasons given by those who disagreed. Politics was too complex for them to understand. Voting has serious consequences and would not be taken seriously by young people. Young people are not yet independent and therefore may not be able to resist the influence of elders, such as parents and teachers. This echoes the survey finding that while many felt capable to vote, they were more sceptical of actually giving adolescents the right to vote.

Interestingly, many felt that age 18 was not old enough to vote, but rather age 20 or 21, after a person has already graduated from high school, and has had a few years of experience, ideally in university.

“18-years old is not enough, you may not have completed the first 12 years of education, you have no knowledge of politics, so you make a bad choice. After all, every vote counts. It could make a difference. So, it doesn’t seem OK to me that we can vote at 18-years old.”

- *Ina, 16-years old, discussing the voting age in Romania in an all-female focus group of urban adolescents between the ages of 14 and 17*

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<sup>31</sup> All personal information, including names of focus group participants, were changed and anonymised throughout research and analysis process following “UNICEF Age Matters Safety, Confidentiality and Privacy Protocols” developed for this project, which can be found online at [www.agemattersnow.org](http://www.agemattersnow.org)

<sup>32</sup> Inga is not her real name – it has been changed to protect privacy and confidentiality of focus group participants.

Moreover, some participants were simply not interested or disenchanted with a political system that seemed ineffective, corrupt, or not responsive to the issues that matter to young people. One participant mentioned that if politicians focused more on issues such as education, health services for young people, and youth unemployment, young people may become more interested in politics.

The Committee on the Rights of the Child has no formal position on the age for voting, but states that if States choose to lower it, it should be matched with adequate citizenship education (UN Committee on the Rights of the Child, 2016). Nonetheless, there is no protective reason for preventing adolescents from voting before 18 years. CRIN argues that the exclusion of young people from political processes is a major reason why their rights continue to be unfulfilled (Child Rights International Network (CRIN), 2016).

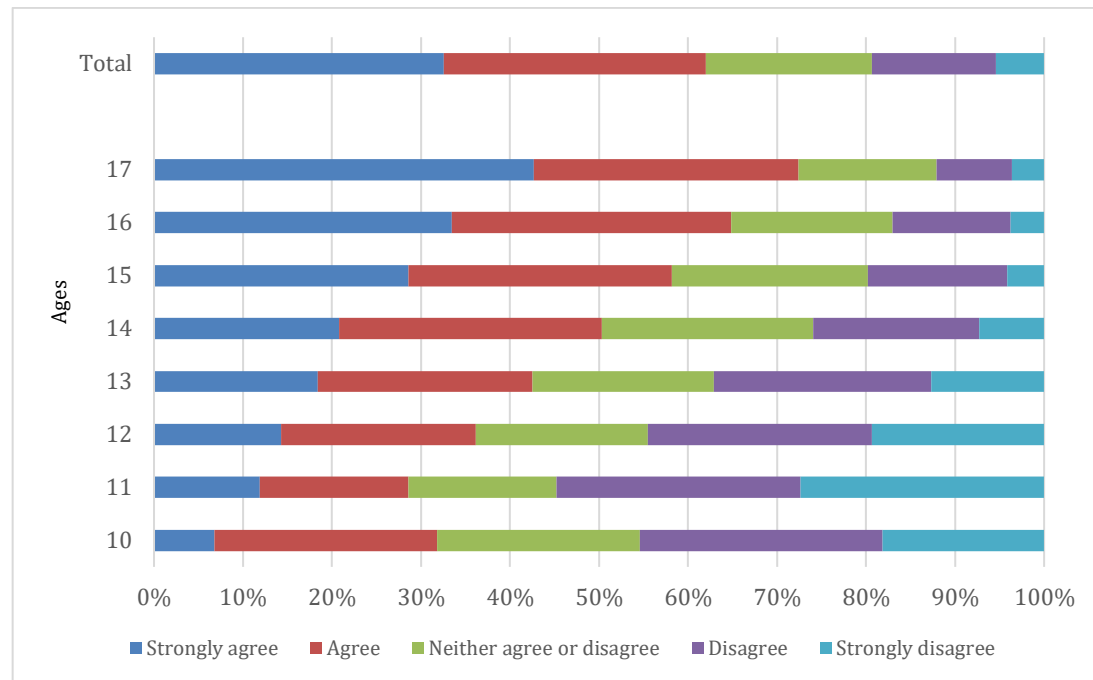
Providing more youth-friendly **information** about politics, which reduces complexity and makes it more interesting for young people, could help prepare them for when they gain the right to vote, and increase overall political engagement. Additionally, more **experience** with decision-making, such as through student councils or youth advisory boards, could enhance a young person's confidence in having this civic responsibility.

#### *Medical advice*

The survey respondents “agreed” and “strongly agreed” (62%) that they are capable enough to talk to a doctor by themselves without their parents/guardians. As in other questions, the older the respondents, the greater the proportion who feel that they are capable. At the age of 14 and older, more than 50% of respondents for each age group think they can seek medical advice independently.

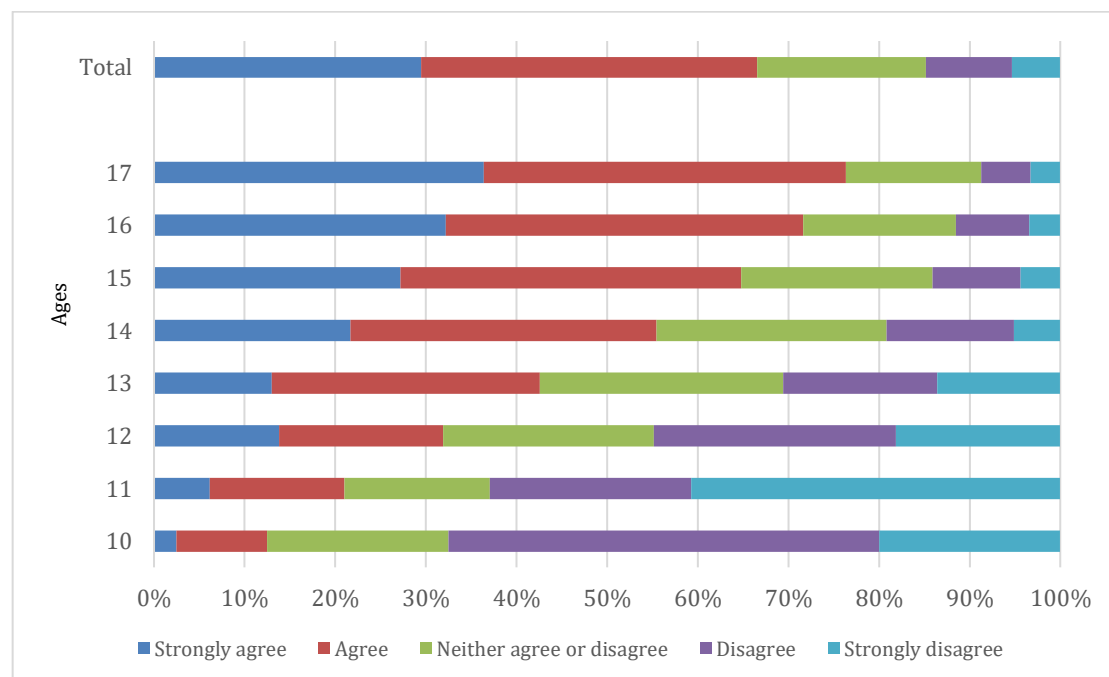


Figure 11: "I am capable enough to:" "talk to a doctor by myself without my parents/guardians" by age



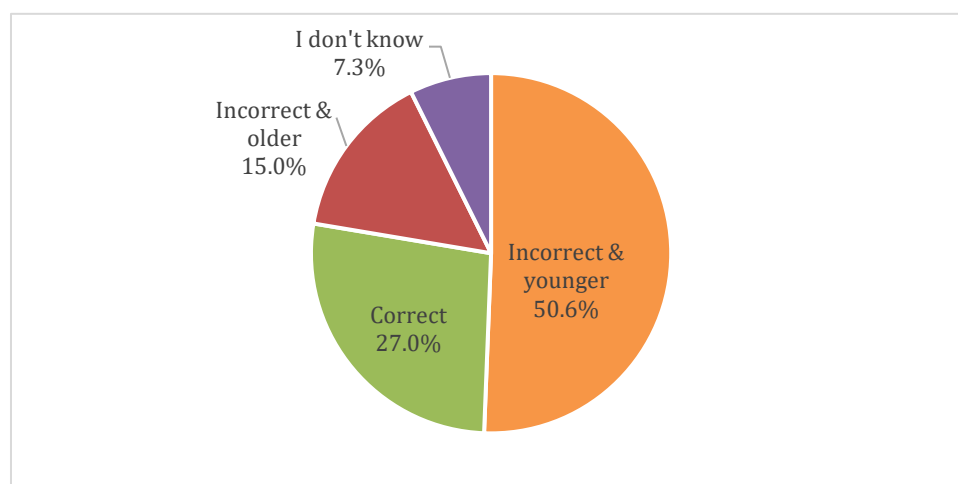
Even more respondents feel that they should be allowed to speak to a doctor independently. When we asked respondents how much they agree that young people their age should be able to seek medical advice independently, the average who "agreed" or "strongly agreed" with this statement was 66.5%, with more respondents agreeing the older they are.

Figure 12: How much do you agree with the following statement? "A young person your age should be able to seek medical advice by themselves without their parents/guardians, if they want to" by age



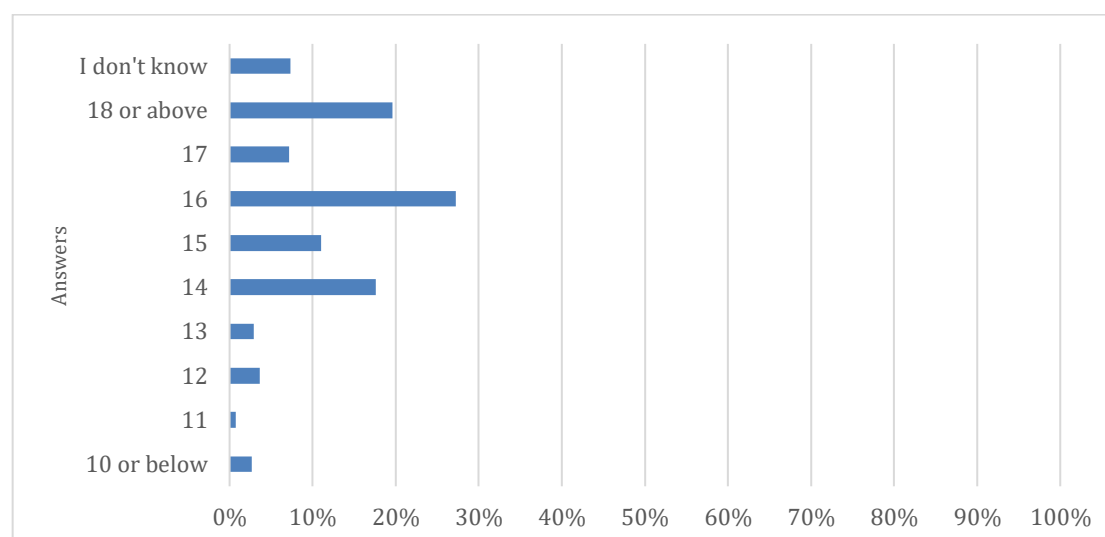
When testing their **knowledge** question of the age that a person can seek medical advice independently, more than half respondents thought that age was lower than it actually is in their respective countries. Only 27% of respondents selected the correct answer.

Figure 13: From what age can a young person seek medical/health advice by themselves?



Most survey respondents (27.2%) thought that they could seek medical advice independently at age 16, followed with 19.6% at age 18 and 17.6% at age 14. The official minimum ages to seek medical advice independently are 16 in Bulgaria<sup>33</sup>, 14 in Ukraine, and 18 in Armenia, Kazakhstan and Romania.

Figure 14: From what age can a young person seek medical/health advice by themselves? by answer



<sup>33</sup> It is valid only for health consultations, testing and prophylactic check-ups (Health Act). The specific types of counselling services, prophylactic examinations and testing are defined by a separate order of the Health Minister (Note by UNICEF Bulgaria Country Office, 1 September 2017).

In the focus groups, many older participants (14-17 years old) who had **experience** visiting a doctor alone, felt confident in their ability to speak about and understand their health issues, but liked having their parents present for moral and emotional support. Here, the discussion was less about having the right to seek medical advice independently, but rather – if it were preferable to be with parents or not. Notably for focus groups in Ukraine, where the age to seek independent medical advice is 14 - the lowest of the participating countries, more participants in the older age group (14-17-years) felt more confident about speaking with a doctor on their own, than others in the same age cohort in the other countries.

However, some focus group participants did express reluctance. Younger participants (10-13-years) felt less capable to accurately describe medical symptoms, or to fully understand a doctor's advice. For these reasons, they preferred to seek advice with parents. For older participants (14-17-years) who preferred to have their parents accompany them, their concern was less about their capacity to communicate effectively with the doctor, but more about how they would not like to handle some issues alone.

While many participants recognised that it is preferable to not hide things from your parents, there are instances where a young person might want to seek medical advice without parents or guardians present. Some scenarios they identified:

- Parents are unsupportive, untrustworthy, do not take your health concerns seriously, or do not have the correct information about your health needs
- Parents are abusive or mistreating you, and are the reason why you seek medical advice
- Issues are too embarrassing to share in front of a parent, such as sexual health
- Issues are too taboo/private to share in front of a parent, such as mental health
- You could get into trouble if your parents knew about the issue, such as with drugs or alcohol.

“Daria: There are some things that you cannot trust [parents] with...for example, they will beat you, punish you, and you do not want to share it with them.”

- *Daria, 16-years old, discussing reasons why a young person may want to speak to a doctor alone, without parents, in Bulgaria in a mixed gender focus group of rural adolescents between the ages of 14 and 17*

“Eric: But is there an explanation or... you know, my hand trembled when I wrote the age? It seems silly

*Eddy: [swear words]*

*Karl: And what does the parent do, exactly? If the parent is there you may even feel more stressed and not know what you want."*

*- Eric (no age); Eddy (no age); Karl, 16-years old; discussing the minimum age to access medical advice independently in Romania in a mixed gender focus group of adolescents between the ages of 14 and 17*

The Committee on the Rights of the Child emphasises that all adolescents have the right to access confidential medical counselling and advice without the consent of a parent or guardian, irrespective of age, if they so wish. General Comment No. 12: The Right of the Child to be Heard, is clear in its argument for this, being in the best interests of the well-being and safety of the child:

"Children may need such access, for example, where they are experiencing violence or abuse at home, or in need of reproductive health education or services, or in case of conflicts between parents and the child over access to health services. The right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit."  
(UN Committee on the Rights of the Child, 2009)

In such instances, where an adolescent may need or want to seek medical advice alone, youth-friendly health services, including **information** and advice that is age-appropriate, could help increase their capacity to speak confidently and accurately about their health needs, without the mediation of their parents.

#### 4.3.2. Domains relating to protective rights

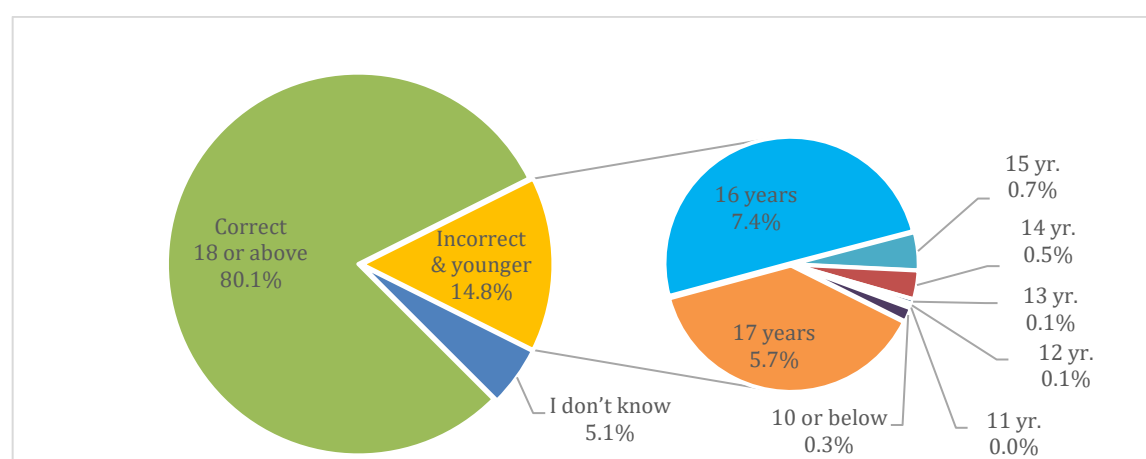
##### *Marriage*

Respondents were tested about their **knowledge** of when a young person can get married without the consent<sup>34</sup> of their parents. A large majority of them knew the correct answer, namely 18 years in all countries. The other ages selected were 16 and 15-years, with 7.4% and 5.7%, respectively.

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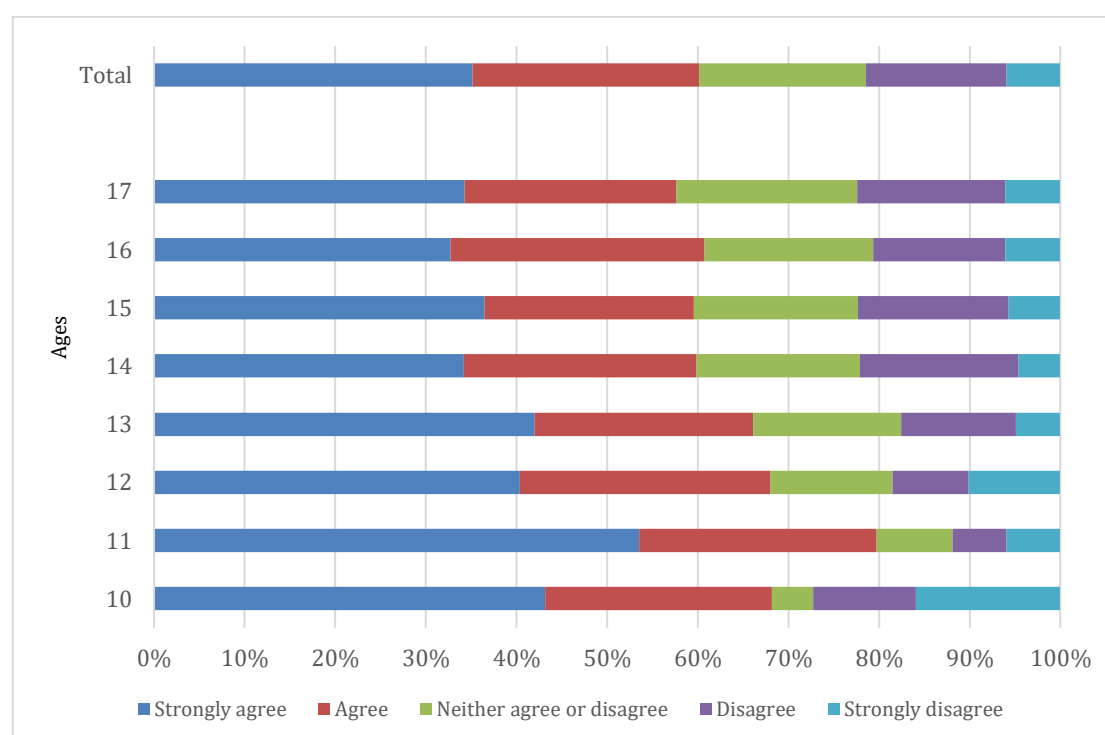
<sup>34</sup> In regards to marriage, the survey provided the following definition for "consent": "Consent means that your parents/guardians must say 'yes' before you can do something"

Figure 15: From what age can a young person get married, without the consent of their parents/guardians first?



On average, 60.2% of respondents agree and strongly agree that no young person under the age of 18 should be able to get married. The percentage of those who agree and strongly agree with this **perception** statement decreases with age, from almost 80% of 11-year olds, to 57.6% of 17-year olds.

Figure 16: How much do you agree with the following statement? "No young person under the age of 18 should be able to get married" by age



In general, participants in the focus groups agreed that age 18 should be the absolute minimum age for a young person to get married. For them, marriage was a very serious decision that could not be taken lightly. Risks associated with marriage earlier than this age included:

- The inability to finish school or university (as they perceived that marriage meant having children)
- Higher chances of divorce (as lack of maturity may mean that one may not have chosen the correct partner)
- A loss of freedom to do as one wishes, such as travel or pursue career dreams.

Girls, in particular, worried about how early marriage would stifle their education and career possibilities, even if it were to occur at 18, as they perceived marriage as synonymous with having children.

In fact, an overwhelming number of participants felt that the minimum age should actually be much higher, somewhere around age 24 or 25. The number one reason for this is because they felt that financial independence would not be reached until this age. It would be misguided to get married before one had a good job, could provide for their family, and buy a house. Young people would have only finished high school at 18, and a university degree was seen as necessary to find a good job.

Lack of emotional maturity was another reason why participants felt that 18 was too young for marriage, as well as a lack of “skills”. The skills mentioned were mostly gendered – participants felt that girls would not yet know how to rear children, and take care of the household chores, whereas boys were not expected to have any of these skills.

“I think that a little girl does not know how to cook food yet, how to clean, for example, so I think the answer is [that she should not get married].”

- *Zhasel, 12-years old, discussing why young girls in Kazakhstan should not be able to get married in an all-female focus group of urban adolescents between the ages of 10 and 13*

Few were comfortable with the fact that parental consent could be given for marriage at a younger age. This coincides with the high percentage of respondents who were against marriage before 18 years in the survey. While many participants personally felt that their parents would not push them into a marriage before they were ready, they recognised how this may occur in some families due to cultural traditions, or for economic reasons. If a family was poor, for example, the calculus might be that marrying off a child (usually a girl) to a richer family would help ease the economic pressure. However, they were disapproving of these scenarios and wished they could be avoided. Participants in Ukraine were especially disapproving of the age of 14 for marriage with parental consent (the lowest minimum age for marriage among the participating countries), as they felt this was too young.

“[P]arents don’t always make the right decision. I don’t like the opinion, that if parents say something, it is always right. Parents are also fallible.

They need to take into account their child’s opinion. If a child does not want to get married, but parents force him or her into marriage, then that is it. They have

to get married. But this is not right. I think again, this is a matter of different generations. Our generation is not the same, we are different.”

- *Sarah, 16-years old, discussing parental consent for marriage at a younger age in Armenia in an all-female focus group of urban adolescents between the ages of 14 and 17*

In a few limited cases, older participants who were in romantic relationships had less opposition to getting married before 18 years, which is echoed in the survey findings above, where older respondents had lower levels of opposition to marriage under 18 than younger respondents. Older respondents are more likely to be dating than younger respondents, and therefore the possibility of marriage may seem more realistic.

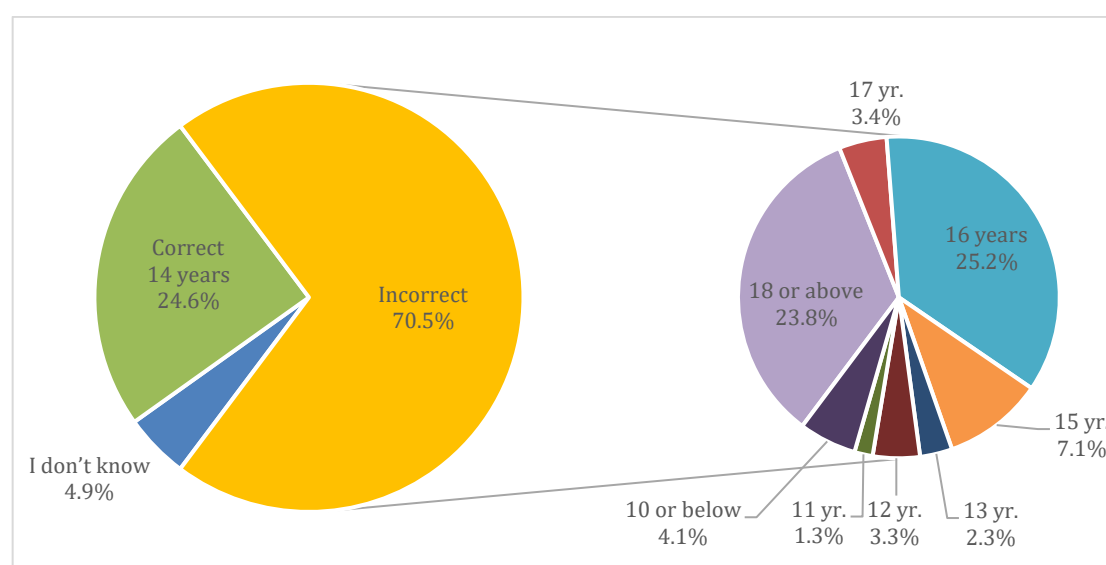
There is mounting evidence of the negative long-term effects of early marriage and pregnancy on adolescents’ health and well-being outcomes, as well as that married children, especially girls, are often obliged to leave their education and are marginalised from social activities (Committee on the Elimination of Discrimination against Women & Committee on the Rights of the Child, 2014). The Committee on the Rights of the Child made a joint general recommendation with the Committee on the Elimination of Discrimination against Women in 2014, which stated the minimum legal age for marriage, with or without parental consent, should be 18-years, but could be allowed in exceptional circumstances permitted by a court of law at 16 (Ibid). In 2016, however, the Committee on the Rights of the Child reaffirmed that the minimum age limit should be 18-years for marriage, with no mention of a lower age exception (UN Committee on the Rights of the Child, 2016).

### *Criminal responsibility*

Criminal responsibility is the one domain where only a **knowledge** question was asked in the survey. Due to the complex nature of the concept of criminal responsibility, it was felt by the research team that it was not appropriate to follow similar pattern of asking respondents in a survey about perception and capacity questions. Instead, a deeper exploration of the criminal responsibility topic was left for focus group discussions with an experienced facilitator who could adequately guide it.

When asked in the survey about knowledge when a young person can be charged if they commit a crime, only 24.6% of respondents selected the correct age, which is 14-years in all countries. Most respondents thought the age of criminal responsibility is older, with about a quarter of respondents thinking it was at 16-years, and a quarter at 18.

Figure 17: From what age a young person can be charged if they commit a crime?



The concept of criminal responsibility, namely if (or when) a young person has the capacity to commit a crime, generated vigorous debate in the focus groups. Participants were split on:

- Whether or not adolescents are always fully aware that they are doing something wrong
- If criminal acts are done with intention versus impulse (and what bearing this should have on consequences)
- The role of peer pressure
- The possible root causes for criminality, such as abusive or unhealthy family life, or poverty.

They could not come to an agreement of when a young person could be said to be fully responsible for their actions, however older focus groups (aged 14-17) most often agreed that age 14 (the minimum age of criminal responsibility in all five countries) was likely too young.

"[14-years old] is too exaggerated. That child does not know how to behave! He does not know how people are. He is not yet standing on his own feet, he does not know what to do in his life."

- *Vio, 11-years old, discussing the age of criminal responsibility in Romania in a mixed gender focus group of urban adolescents between the ages of 10 and 13*

This does not mean that they believe that young people who offend should not bear some consequence. Much discussion was on the various types of consequences, often tied to the type of punishment, with the idea that more severe crimes would have more severe consequences. However, punitive measures were limited to fines, community service, or house arrest, with an emphasis on psychological counselling and education. Participants believed that the aim should be for the young person to understand what they did was wrong and prevent future offending.



Few participants supported detention, where young people would be separated from their parents, and fewer still supported charging minors as adults, even for the worst crimes such as murder. Participants felt strongly that any punishment should not negatively impact future prospects, with the belief that young people who offend can be rehabilitated and reintegrated into society.

“If he is sent to prison, his life will be broken. It is better to have some educational activity. Clearly, it is difficult to determine how to change [behaviour], but, well, it is necessary somehow for these people. Some kind of community service, or some kind of social activity, for example. Give them an alternative.”

- *Igor, 16-years old, discussing the penalties that a young person could face found guilty of breaking the law in Ukraine in a mixed gender focus group of vulnerable urban adolescents between the ages of 14 and 17*

Some countries in the world have a minimum age of criminal responsibility (MACR) set even lower than 14, between 7 and 12 years old, and the Committee on the Rights of the Child considers such low ages to “not to be internationally acceptable” (UN Committee on the Rights of the Child, 2007, para. 32). The Committee instead urges State parties to increase this age, and to design juvenile justice policies that emphasise restorative justice, diversion from judicial proceedings, alternative measures to detention and preventive interventions, with a focus on rehabilitation and reintegration (UN Committee on the Rights of the Child, 2016).

#### 4.3.3. Domains where there exists a tension between participatory and protective rights

##### *Work and school*

For the **knowledge** question on when a young person can decide to stop going to school (end of mandatory education), only 15.5% of respondents answered correctly. Most of them selected an incorrect and older age relative to the age in their country – 42%, versus 28.9% who chose an incorrect and younger age. Most surveyed adolescents (41%) guessed leaving school is possible only when a young person reaches age 18, while 20% thought this was possible at 16. The age of end of compulsory education is 16 in Armenia and Bulgaria, 17 in Romania and Ukraine, and 18 in Kazakhstan.

Figure 18: From what age can a young person decide to stop going to school?

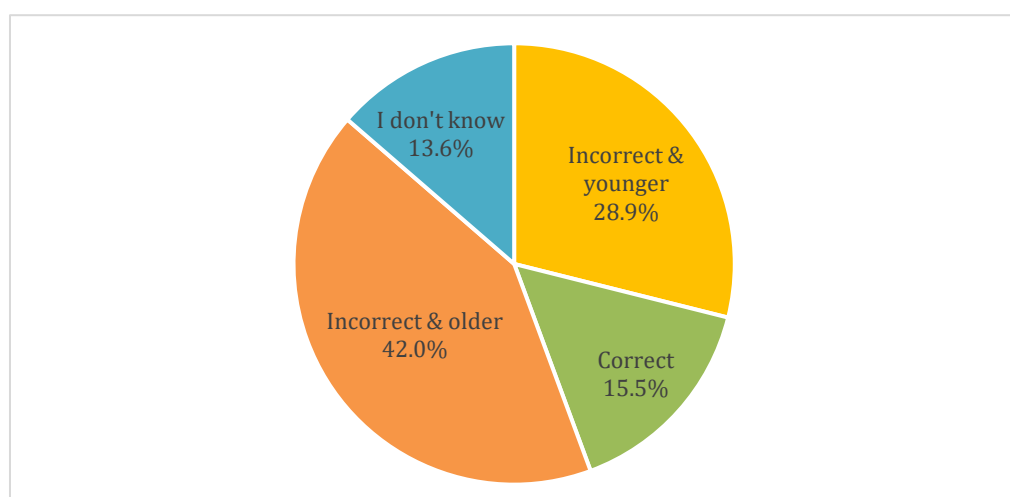
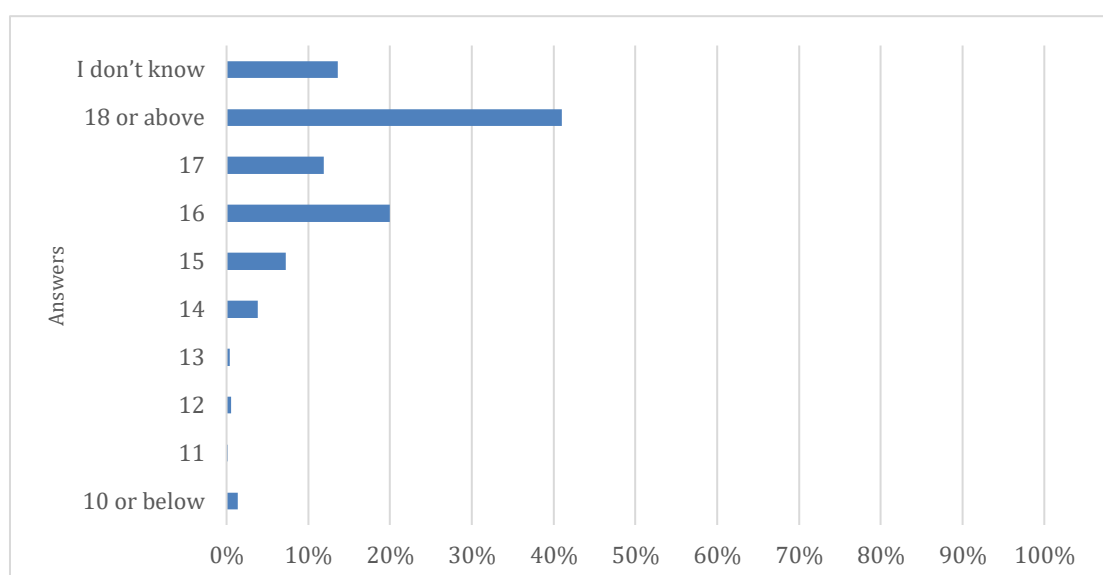


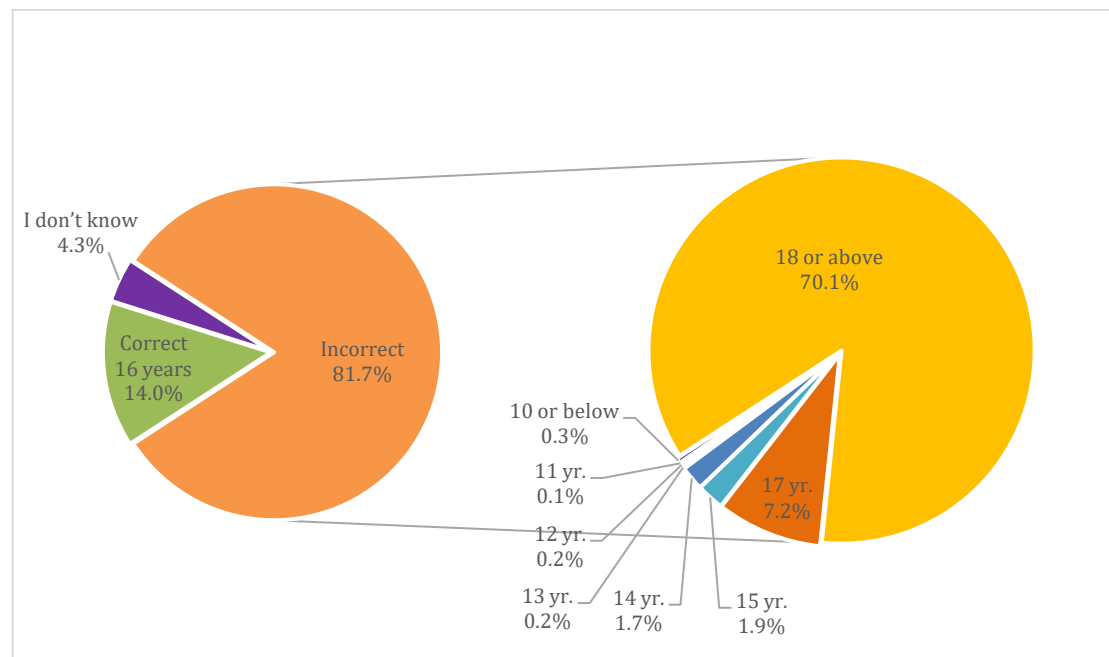
Figure 19: From what age can a young person decide to stop going to school? by answers



Similarly, for the **knowledge** question on when a young person can start working full time, only 14% of respondents guessed the correct answer for their country, and the majority (81.7%) selected an age that was incorrect. Most respondents thought that they could start working when they reach 18-years (70.1%), with the second most guessed age 16 with 14%. Instead, the minimum legal full-time working age is 16 in all five countries.<sup>35</sup>

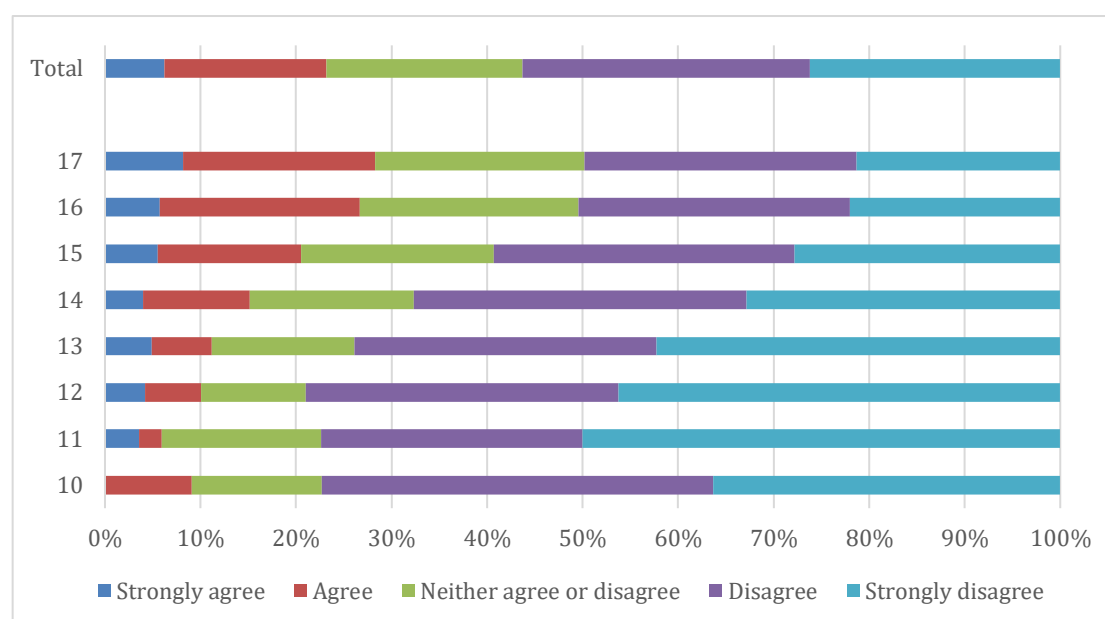
<sup>35</sup> It should be noted that the legal full-time working age is younger than the mandatory school leaving age in Kazakhstan, Romania, and Ukraine. This could lead to young people leaving school earlier than the legislated minimum to go to work. This contradiction in law is further explored in the "Age Matters" Phase 1 report.

Figure 20: From what age can a young person work full-time?



We asked respondents how much they agreed with the statement that a young person their age should be allowed to leave school to work full time. On average only 23.2% of them “agreed” and “strongly agreed” with this statement, compared with 56.2% who “disagreed” and “strongly disagreed”. This indicates that the **perception** of the majority of the adolescents surveyed is that they should not start working before the end of compulsory schooling. Agreement increases the older respondents are, however with only 28.3% of 17-year-olds who agreed and strongly agreed.

Figure 21: How much do you agree with the following statement? "A young person your age should be allowed to leave school to work full-time if they want to" by age



Focus group participants were mostly in favour of young people staying in school for as long as possible, echoing the findings in the survey. Education was seen as vital to personal and intellectual development, and necessary to increase employment prospects and earning power in the future. Many participants, especially in the younger groups (10-13-years), felt that young people should not have the ability to work even after 18-years and up to 25-years, so that they may attend university instead.

Participants said that young people are also at risk of exploitation when they work at too young an age. Adolescents were presumed to not be aware of their rights at work, and are at higher risk of exploitation, especially in the informal sector, where many young people are able to find low-skilled work.

"[A company] can exploit a 15-year-old very easily. For example, if I'm the owner of some factory and I employ a 15-year-old, I will surely exploit him because he doesn't know that the monthly income for working eight hours a day is 80,000 drams while I pay him 40,000 drams for that same amount of work. No one gives him advice to tell him: 'that's wrong and you're being exploited', because now everyone needs money so everyone starts working from a younger age."

- Jane, 16-years old, discussing the lack of knowledge young people have about labour rights in Armenia in a mixed gender focus group of rural adolescents between the ages of 14 and 17

However, participants identified some reasons why a young person may want to leave school for full-time employment at a younger age. These reasons include poverty (i.e. needing to work to help parents provide basic necessities for the family), or when education is of poor quality and working may be a better way of

gaining relevant skills for the future. Older participants (14-17-years) were more sympathetic to young people who were disenchanted with school and wanted to begin working as soon as possible.

Both younger and older participants recognised the value of work, and were strongly in favour of part-time work alongside their studies. They described how work could help them gain real-life skills, provide a sense of efficacy, teach them responsibility, and naturally, would provide them with some money. The ability to earn money, even in small amounts, was seen as a gateway to greater independence from their parents, and many participants, especially the older ones (14-17-years) wished to have this.

“They want to earn experience, they want to earn money for themselves, want to see something new, learn something new. That's how I see it.”

- *Alexey, 14-years old, discussing reasons why a young person may want to leave school to go to work in Kazakhstan in a mixed gender focus group of vulnerable urban adolescents between the ages of 14 and 17*

For admission to employment, not the CRC but the International Labour Organization (ILO) has called for minimum age legislation. ILO Convention No. 138, 1973 calls for a minimum age of 15 for general work (or 14 for developing countries) – provided that it is not lower than the age at which compulsory education is completed. Light work is allowed earlier, at the age of 13 – and in developing countries, at the age of 12. Both the ILO Convention and General comment No. 20 call for a minimum age of admission to hazardous work at 18 (International Labour Organization (ILO), 1976; UN Committee on the Rights of the Child, 2016).

The UN Committee on the Rights of the Child (2016) recommends that for those young people who, after completing the mandatory-years of school, decide to work full-time, greater **information** on employment rights, as well as effective complaint mechanisms, would help decrease their **risk** of exploitation. Moreover, more opportunities should be provided for young people to gain work-related skills through education, such as:

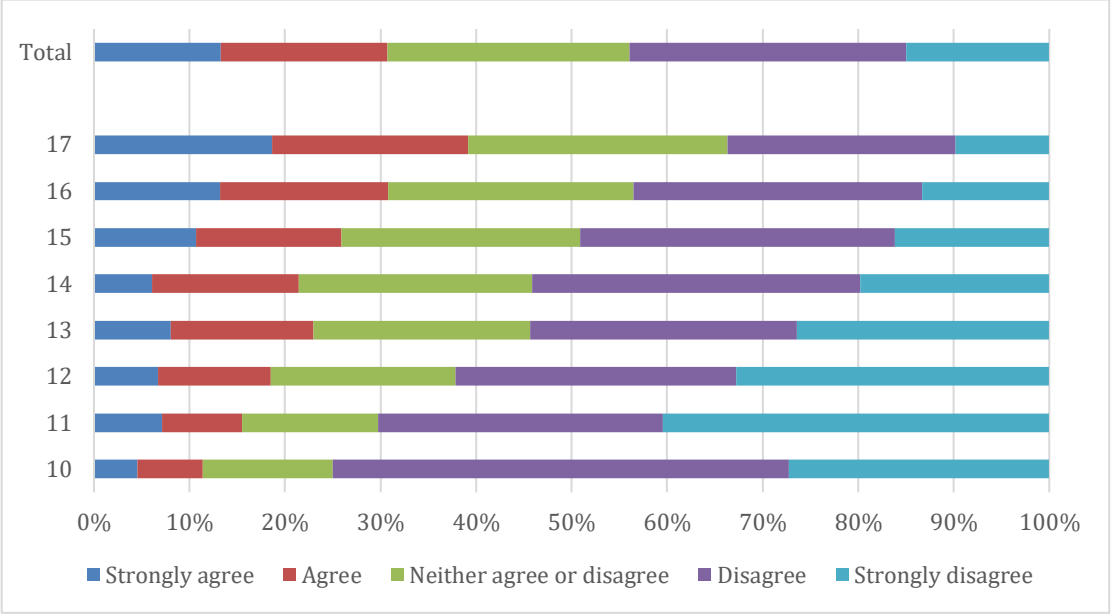
- Integrating soft and transferrable skills into the curricula
- Expanding opportunities for experiential or practical learning
- Developing vocational training based on labour market demand
- Establishing public-private sector partnerships for entrepreneurship, internships and apprenticeships
- Providing guidance on academic and vocational opportunities (UN Committee on the Rights of the Child, 2016).

### *Medical treatment*

On average, 30.7% of survey respondents “agree” and “strongly agree” they are capable enough to make their own decisions about medical treatment. As in other **capacity** questions, the agreement increases with age, apart from a small drop

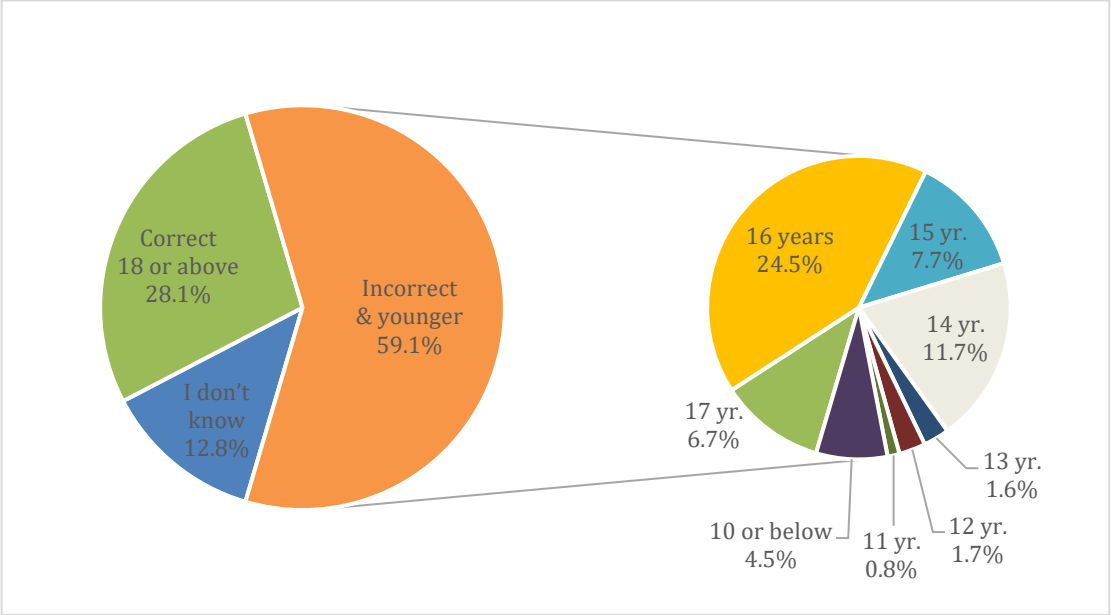
between ages 13 and 14, and it reaches maximum at age of 17 with 39.2% of adolescents who agree with this statement.

Figure 22: “I am capable enough to:” “make my own decisions about medical treatments I could receive (e.g. injections)” by age



When we asked them about their **knowledge** when a young person can refuse medical treatment, 28.1% of respondents chose the correct answer, which is age 18 in all surveyed countries. Majority of them (59.1%) picked an age that was incorrect and younger. Second most guessed age is 16, with 24.5% of adolescents who chose it as an age when they could refuse medical treatment.

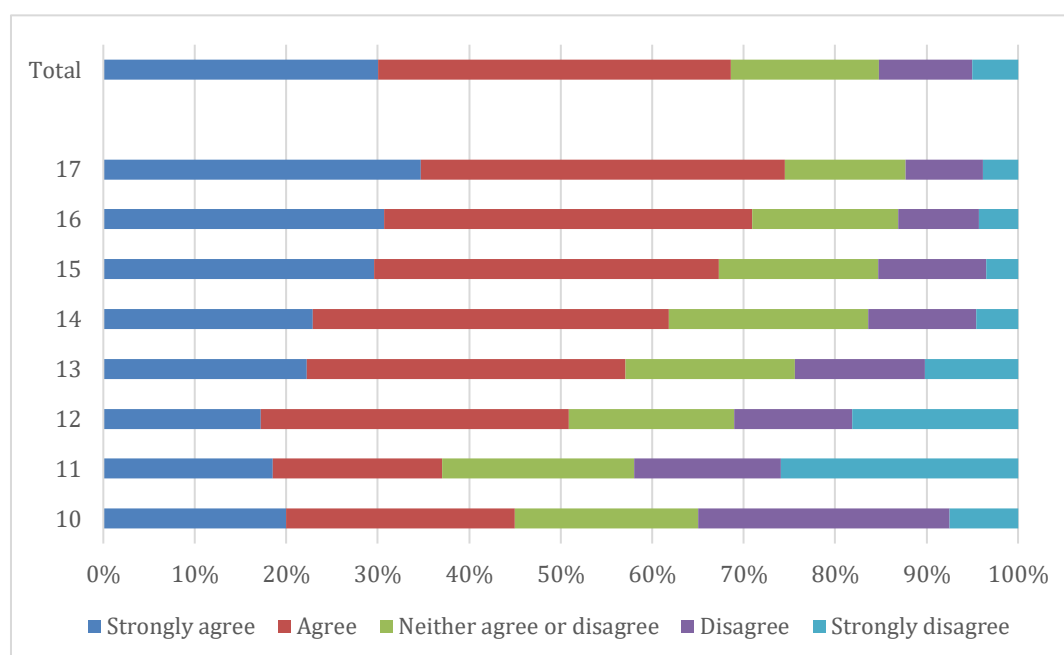
Figure 23: A doctor wants to give a young person medical treatment (e.g. injections). From what age can a young person refuse to receive treatment?



When we asked respondents about their **perception** of if a young person their age should always give consent<sup>36</sup> before receiving medical treatment, a majority (68.6%) of them “agreed” and “strongly agreed” with this statement. As in other questions, the older the respondent, the greater percentage of them agreed with this statement. However, already from age 12, more than 50% of them “agree” and “strongly agree” they should give consent to a medical treatment.

We can notice that more than twice as many respondents “agreed” and “strongly agreed” with a statement that they should give *consent* to medical treatment (68.6%), than they thought they are capable to *make their own decisions* about medical treatment (30.7%). This can be explained with the emphasis the former had on *consent* a young person should give prior to any medical treatment, contrasted with capacity questions that focused on independent decisions about the treatment and complexities associated with it. Nevertheless, it seems that respondents think they should give consent to any medical treatment regardless of how complex the issue is.

Figure 24: How much do you agree with the following statement? “A young person your age should always give consent to a doctor before receiving any medical treatment (e.g. injections)” by age



Discussions on medical treatment in the focus groups were complex, indicating the various considerations and contexts under which an adolescent is capable to give or refuse consent to medical treatment.

Several scenarios were discussed. In the event that a parent is absent, participants talked about if an adolescent could give or refuse consent to a treatment that a doctor recommends. Many, especially younger participants (10-13-years), felt

<sup>36</sup> In regards to medical treatment, the survey provided the following definition for “consent”: “Consent means that you have to say its ok before something is done to you”

that they lacked the understanding to decide about any medical procedure and would be afraid to do so alone. Parents were presumed to have a greater understanding of health, as well a young person's medical history, such as an allergy to a medication.

For older participants (14-17-years), it depended more on the severity of the treatment. If a doctor prescribed medication, they felt comfortable taking it and simply advising their parents after the fact. It should be noted that participants spoke more often of feeling competent to *give consent* to minor treatments (like pills) without their parents. This is not the same as *refusing consent* to treatments independent of their parents – effectively going against the advice of a doctor – which could carry more risk. Participants demonstrated their ability to calculate **risk** and recognised that when the risk was high, they would require more adult support to make a decision:

“I think [18-years] too young and too fragile. A person cannot make such decisions. But it is also the time when you must become accustomed to the idea that you have to deal with things on your own from now on, that your parents will not be always with you, and you have to make decisions alone.”

- *Alia, 12-years old, discussing the age at which a person can accept or refuse medical treatment in Romania in an all-female focus group of urban adolescents between the ages of 10 and 13*

In many cases, participants felt that age 18 (the age at which a person can accept or refuse medical treatment), was too young of an age for a young person to make this decision on their own especially for more serious interventions, such as surgery. Reasons for this included the complexity of the treatment, and not being able to fully understand the benefits and risks. Notably, some participants recommended that the age be increased to as high as 25 or 30.

Overall, many participants said that while the choice should be based on what is in their best interests, their views should be considered, even if the final decision is not necessarily theirs alone to take. In one instance, a participant spoke of a time where she was given a choice in a decision regarding partial or general anaesthesia:

“In my opinion, it must be 16, because I had a case when my parents agreed to partial anaesthesia, for example – I cannot say exactly for what – and I wanted a general [anaesthesia]. They were like, no. But the decision was mine. The doctor said, ‘you decide’. My parents were with me, yes, but it was my decision, not theirs.”

- *Danka, 17-years old, discussing her experience with making medical decisions in Bulgaria in a mixed gender focus group of vulnerable urban adolescents between the ages of 14 and 17*

While Danka disagreed with her parents, we can assume that when provided with full, youth-friendly information about the treatment and possible consequences,



the child, doctor, and parents could come to full agreement on the best course of action for her health.

The Committee on the Rights of the Child does not recommend a specific minimum age at which children should have the right to consent, but rather that children have the right to be actively involved in health decisions, in consideration of their individual capacity, and not just their age.

General comment No. 20 emphasises the importance of obtaining voluntary and informed consent of the adolescent, whether or not the consent of a parent or guardian is required (UN Committee on the Rights of the Child, 2016). Additionally, General Comment No. 12 encourages countries to introduce a minimum age at which the right to consent transfers to the child, and even below this age, their view should be given due weight if they can demonstrate capacity (UN Committee on the Rights of the Child, 2009).

Several considerations should be made to ensure that young people are able to give free and informed consent. As identified by many focus group participants, the principle reason why they feel that they could not consent or refuse health treatment without their parents, is the fear that they may not understand the diagnosis and treatment enough to make an informed decision. Therefore, providing **information** in a youth-friendly way would help to ensure that young people understand the benefits and risks. It should be emphasised that voluntary and informed consent relies on having accurate and accessible information to be able to make an informed decision.

In this context, it is also important to recognise that the age of consent is a particularly complex issue for children and adolescents living with chronic health conditions or disabilities. As a result of their long history of exposure to medical care and **experience** acquired with taking and adhering to various treatments and interventions, they acquire competence and capacity and may have strong views about which treatments they want to continue or refuse. Their competence to make informed choices should be recognised and respected, and their views considered by both the medical community and parents/caregivers. These situations may pose difficult ethical dilemmas when deciding whether to continue or stop particular medical treatments/interventions and need to be considered very carefully by balancing the best interests of the child with the child's competence and rights to have their views respected. In some settings, medical protocols require these children to consent to treatment and medical procedures from as young as eight years old.

CRIN points out that external circumstances, such as social and cultural norms, and power dynamics, can encourage or inhibit a child's ability to exercise autonomy. Choice depends on respect and understanding for children's views, the lack of pressure by adults to decide a particular way (or the skills to resist pressure), as well as other enabling factors such as access to quality education (Child Rights International Network (CRIN), 2016).

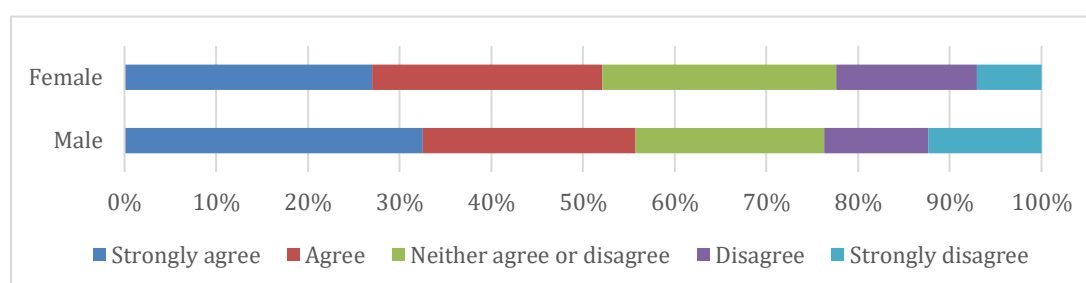
#### 4.4. Subjective capacity: Domains relating to minimum age legislation, by group

While capacities may vary by age, it is important to look at the other ways in which they vary by group. When disaggregating by various demographic features, a few variations between groups are revealed. The most relevant variations are explored below.

##### Gender

As with general capacities, **male and female** respondents responded in a fairly similar way on the capacities questions overall. The only exception is voting, with slightly more males (5.5%) who “strongly agree” that they are capable enough to vote (32.6%) than females (27%):

Figure 25: “I am capable enough to:” “vote (e.g. in national elections)” by gender



In the focus groups, discussions on marriage were instead gendered. For example, having knowledge of household skills, such as cooking, cleaning, and child rearing, was seen to be important only for females to know as a condition for getting married. As such, when a female would get married, it was seen as a full exit from educational or professional life. Therefore, the **risk** posed by marriage – even when one is older than 18 – was seen as much greater for females, who, if they make the wrong choice and would be divorced, would have few economic or professional options, and also often be left with the responsibility for caring for the children alone. Both male and female participants shared this gendered view on marriage, especially among younger adolescents. In some limited cases among older adolescents, male participants would take this view about the role of women in marriage, whereas the female participants would disagree and emphasise how household and child rearing roles should be shared between the sexes.

Female participants more often brought up the issue of parental pressure. While no female participant specifically mentioned that they were being forced to marry before 18-years, some spoke of a strong parental pressure for them to get married eventually, even if it may be contrary to their ambitions. This familial pressure compromises their ability to make autonomous decisions about marriage, and could result in young females being married before they are ready, or even before the minimum age. Participants spoke of hearing about informal or customary marriages of girls under the legal age among their peers, mostly due to cultural norms among some ethnic groups. Child marriages disproportionately involve

young girls. In contrast, such familial pressure was not mentioned by, nor seen to be relevant to, male participants in the focus groups, however they did acknowledge that this pressure does tend to fall on girls.

"I have a dream in my mind: first, I'll build a career, be accomplished professionally, and then maybe I'll get married. And every time I argue with my mother... she has some opinions... 'it's OK, if things don't work out with school, you can always find someone and get married.' And it really bothers me."

- *Ramo, 17-years old, discussing the familial pressure she experiences on the issue of marriage in Romania in an all-female focus group of urban adolescents between the ages of 14 and 17*

### *Income*

While there is hardly any difference in subjective capacities when disaggregating survey respondents by income level, income was discussed in the focus groups as a factor that could either encourage or inhibit an adolescent's capacity or compromise their protection from harm.

For example, poverty impacts the age at which a young person would get married, as some young people could be forced by their parents to marry early to ease the financial burden on their families. This was recognised to disproportionately affect young girls, and not boys. Many focus group participants also saw early marriage as perpetuating a cycle of poverty: parents with lower economic status may push their children to marry early to ease the financial burden. However,, due to early marriage, these children will also be limited in their opportunities for higher education or professional work, maintaining their low economic status, and therefore more likely to replicate this pattern with their own children, who they will eventually force to marry early.

Poverty was also a factor that focus groups participants said could be a reason why a young person would leave school to work full-time. In these cases, leaving school was less of a choice but rather a necessity. As such, those who were from low-income families were more at **risk** of leaving school earlier than others, therefore reducing their potential for finding a better job later on, and remaining in a low-income status.

"Unfortunately, our state cannot provide such living conditions for a family to sustain itself with their net income. This is why when children see how hard it is for their parents to earn money, children volunteer to work during the harvest seasons. This way they help their parents."

- *Max, 14-years old, discussing some reasons why children might go to work in Armenia in a mixed gender focus group of urban adolescents between the ages of 14 and 17*

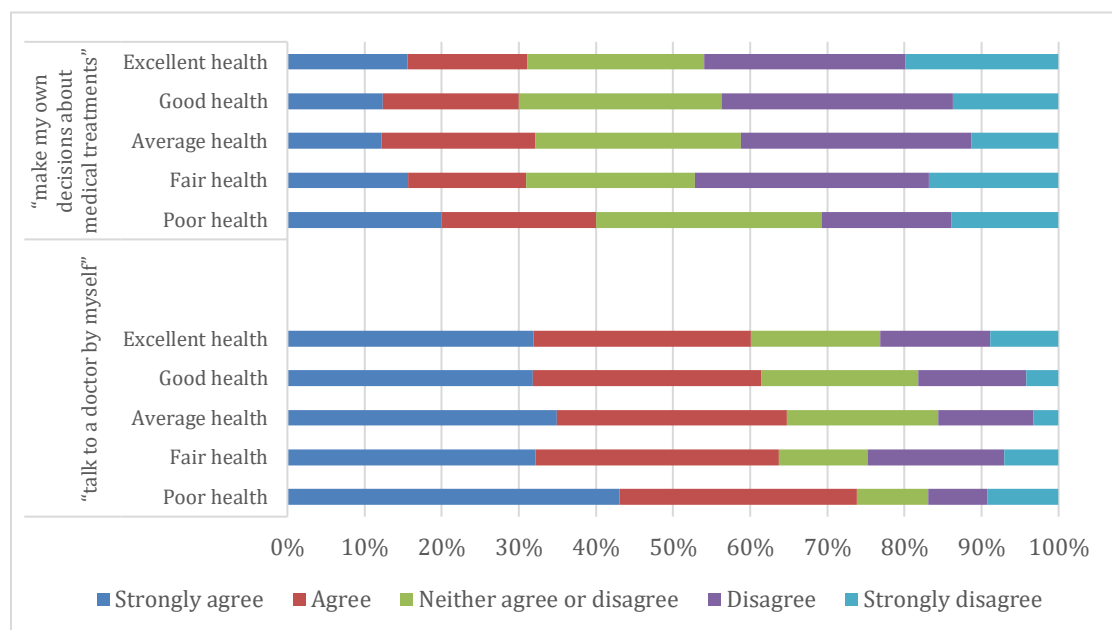
## Health status

We asked survey respondents two questions related to their health status. One was to rate their **general health** on a five-point scale from “poor” to “excellent” health, and other question asked them directly if they had any **long-term health problems**, defined as lasting six months or more, such as asthma or diabetes. The sub-groups of respondents with different general health status and those with and without long-term health problems were then compared with their capacity to undertake various activities as described below.

Survey respondents with “poor” overall health felt more capable to undertake activities relating to health than those who indicated they were healthy. 13.7% more respondents with “poor” health “agreed” and “strongly agreed” that they were capable enough to talk to a doctor by themselves (73.8%) than those with “excellent” health (60.1%). Similarly, with medical treatment, more respondents with “poor” health (40%) “agree” or “strongly agree” that they are capable to make decisions about medical treatment than those with “excellent” health (31.3%).

It should be noted that for those with “poor” health, they felt less capable than healthy respondents across almost all activities (general and legislation-related) *except* those relating to health:

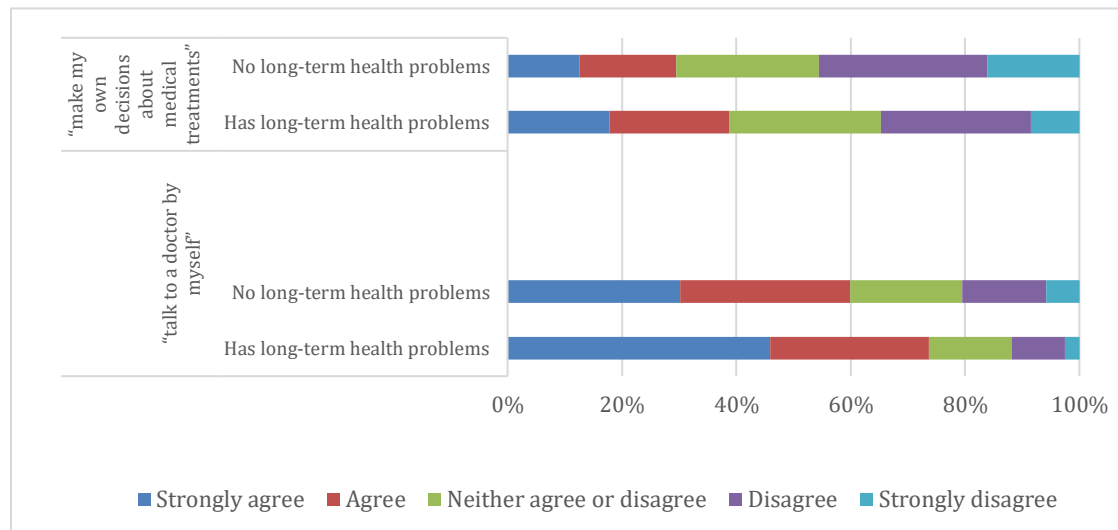
Figure 26: “I am capable enough to:” “make my own decisions about medical treatment” and “talk to a doctor by myself” by general health status



We see a similar trend among those respondents who said they had a **long-term health problem** (defined as lasting six months or more, e.g. asthma or diabetes). More respondents with long-term health problems “agree” and “strongly agree” they are capable to talk to a doctor independently (73.6%) than those who have no long-term health problems (59.9%). We can see similar findings in relation to making health decisions, where more respondents with long-term health

problems “agree” and “strongly agree” (38.9%) that they are capable enough to make health decisions independently, than those without health problems (29.6%):

Figure 27: “I am capable enough to:” “make my own decisions about medical treatment” and “talk to a doctor by myself” by existence of long-term health problems



Respondents with “poor” overall health, or with long-term health problems, have more **experience** with medical services and therefore could feel more capable when dealing with medical professionals and making medical decisions. Previous research (Alderson, 1993, as cited in Lansdown, 2005) demonstrates that children as young as 8-years-old, who have had repeated or sustained experiences with health services due to a serious condition, demonstrate not only the ability to understand their own condition, but also the ability to propose treatments and make wise decisions, even those involving life or death implications (Ibid).

This is echoed in conversations with focus group participants in Ukraine who were affected or impacted by HIV/AIDS (either themselves or someone close to them). These participants held the strongest opinions in relation to medical advice and treatment. Having had direct and multiple experiences with medical interventions, many of these participants advocated strongly for a young person’s right to have input in medical decisions. These participants also recalled stories of when young people were excluded from important health decisions, in some cases to their own detriment:

“Regardless of the parent’s decision, if the child is old enough to orient [themselves on the topic of his illness], he should make decisions himself. And I think that’s a good technique. It would be good if, for example, the young man could, after talking to the doctor, take the decision himself. Because I can tell you at least three stories, when for example, the parents believed that taking antiretroviral therapy was bad and did not allow their child to take it. Then the child died of AIDS.”

- *Katya, 17-years old, discussing the involvement of adolescents in making medical decisions in Ukraine in a mixed gender focus group of vulnerable adolescents between the ages 14 and 17*

## 5. Access to services and minimum age legislation

### Summary of key findings in this section:

**Adolescents in the consultation were not always accessing the medical advice that they needed.** Approximately 1 in 6 (15%) respondents in the survey were refused medical advice because the requirement that a parent or guardian had to accompany them (and they were absent), and over one-quarter (28.3%) of respondents avoided seeking medical advice for the same reason. Those who had “poor” general health status, or had long-term health problems, were refused advice and avoided seeking advice at higher rates compared to their “healthier” counterparts.

**Those who avoided seeking medical advice were not doing so because they lack the capacity to speak to a doctor alone.** Over two-thirds of respondents who avoided seeking advice “strongly agreed” and “agreed” that they could speak to a doctor independently. Therefore, avoidance was more likely due to the required presence of their parents when they preferred to go alone.

**The top medical issues that respondents wanted to seek advice for (but did not because their parents had to be in the room) were mental health, sexual issues (e.g. pregnancy, avoiding diseases) and sexual orientation.**

**Female respondents were both refused medical advice by a doctor and they avoided seeking advice at slightly higher rates than males** (2% more and 6.1% more, respectively). The difference between males and females was starkest where respondents avoided seeking advice: 15.7% more females were avoiding seeking advice on mental health than males, and 8.6% more males than females were avoiding seeking medical advice on sexual orientation.

**Nearly one-third of respondents received medical treatment that felt forced by their parents and/or doctor,** and respondents with poor general health or long-term health problems received such treatments at higher rates than healthy respondents. Even if the medical treatment was deemed to ultimately be in the best interests of the child, feeling forced indicates that their voluntary and informed consent was not sought.

While minimum age legislation has a bearing on the rights and services that impact young people’s lives, most adolescents do not have day-to-day interaction with many of the age-related laws covered in this research. Voting in a national election is currently not available in any of our participating countries before the age of 18. While all five countries allow marriage with parental consent at age 16, 89% of people in this region get married after the age of 18 (Girls Not Brides, 2018); a vast majority of young people will fortunately not have any interaction with the criminal justice system<sup>37</sup> (UNICEF, 2013); and most adolescents will stay in school until the mandatory end of schooling age in this region<sup>38</sup> (UNESCO, 2015).

<sup>37</sup> UNICEF reports that in Armenia there have been approximately 15 children in pretrial detention and 15 children in custodial sentence in the period 2011-2013; in Kazakhstan, 546 children were detained before trial in 2007, and 105 children were detained before trial in 2011; in Ukraine 1,641 children were detained before trial in 2006, and 868 children were detained before trial in 2011 (UNICEF, 2013).

<sup>38</sup> On average in 2007, 97% of children starting primary school in Central and East Europe and 99% in Central Asia reached the last grade (UNESCO, 2015).

The two exceptions that exist are in the areas of medical advice and medical treatment. All young people have health needs that may need attention, and there is a good chance that respondents have had to visit a doctor at least once during their adolescent-years, and perhaps have even received treatment.

We asked respondents in the online survey about their experiences related to medical services:

- If a doctor refused to give them medical advice because their parents were not with them;
- If they ever avoided seeking medical advice because their parents/guardians had to be in the room with them (and if yes, what issue were they seeking advice for),
- If they received a medical treatment that they did not want, but felt forced by a parent/guardian or doctor.

The following analysis does not focus primarily on the *age* at which such occurrences happened, and instead asks if they *ever* had experienced these, to understand the adolescents interact overall with health systems in their countries. Therefore, the analysis is broken down by group, and not age, for the exception of medical issues that adolescents were seeking advice for. There issues are examined by group *and* age to understand the types of medical issues that impact adolescents at various ages.

### 5.1. Medical advice, by group

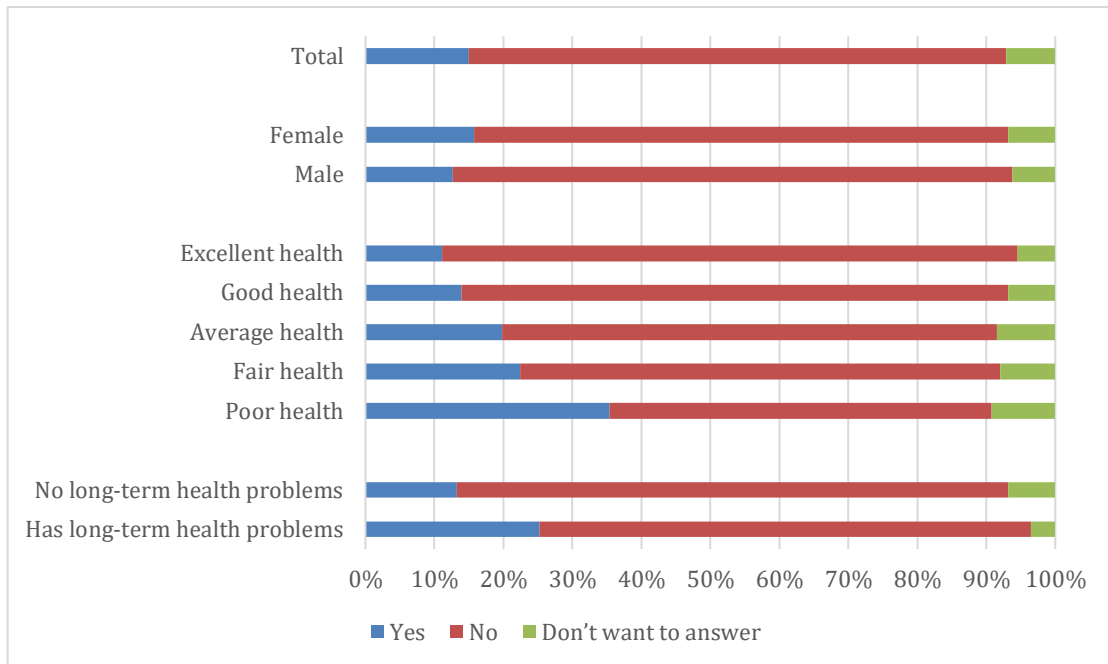
A total of 15% of all survey respondents reported that a doctor refused to give them medical advice because parents were not present with them. When disaggregated by group, rates of refusal are fairly constant. For example, females were refused advice at a rate slightly higher (15.7%) than males (12.7%).

The difference is most noticeable when the data is sorted by health status. More respondents with “poor” health (35.4%) were refused medical advice than those with “average” (19.9%) or “excellent” (11.1%) health.

Similarly, the number of respondents with long-term health problems (defined as lasting six months or more, such as asthma or diabetes) who were refused (25.2%) is nearly double those who have no long-term health problems (13.2%). Someone with “poor” health, or long-term health problems, is more likely to see a doctor than someone who is healthier, and therefore, will have had more opportunities to be refused – which may explain the difference. Nevertheless, it is striking that these individuals, who have increased health needs, report that they were refused medical advice one-quarter of the time.

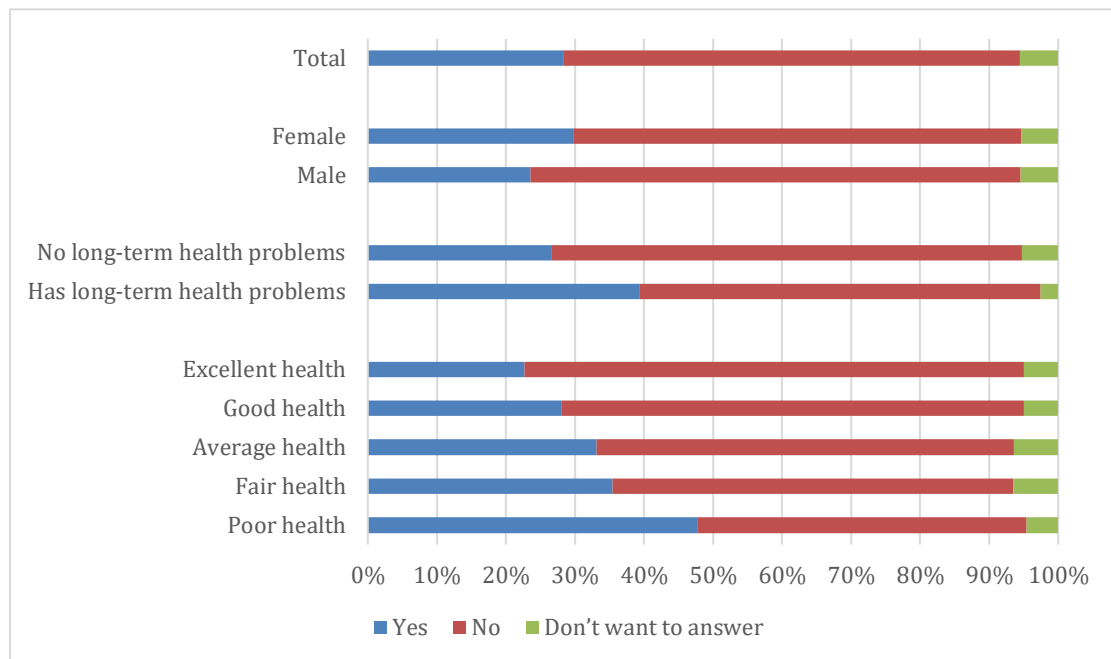


Figure 28: Did a doctor ever refuse to give you medical advice because your parents/guardians were not with you in the room? by gender, general health status, and existence of long-term health problems



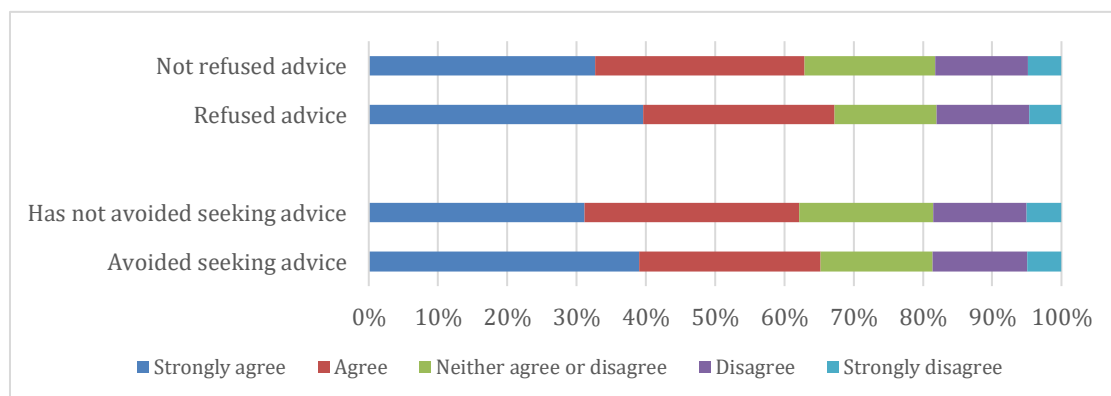
An even higher number of respondents (28.3%) said they avoided seeking medical advice because parents were not present with them in the room. Here we see similar differences by group, where females avoided seeking medical advice (29.7%) at a rate higher than males (23.6%), and where those with “poor” and “fair” general health, and those with long-term health problems, avoided seeking advice at higher rates than their healthier counterparts.

Figure 29: Did you ever avoid seeking medical advice because your parents/guardians had to be with you in the room? by gender, general health status, and existence of long-term health problems



Two-thirds (67.2%) of respondents who were refused advice “agreed” and “strongly agreed” that they were capable enough to speak to a doctor independently, which is 4.4% more than those respondents who were not refused advice. We see a similar trend for avoiding seeking medical advice. Here, 65.2% of respondents who avoided seeking advice because their parents had to be with them felt capable enough (“agreed” and “strongly agreed”) to talk to a doctor by themselves, compared to 62.1% of those who did not avoid it. Although respondents who were refused advice and who avoided seeking it felt slightly more capable to talk to a doctor independently, overall all respondents felt they are capable enough to do so. This can suggest that respondents were refused medical advice or avoided seeing the doctor – not because they were unable or lacked the capacity to do so independently, but because their parents had to be with them.

Figure 30: “I am capable enough to:” “talk to a doctor by myself without my parents/guardians” by being refused advice and avoiding seeking advice



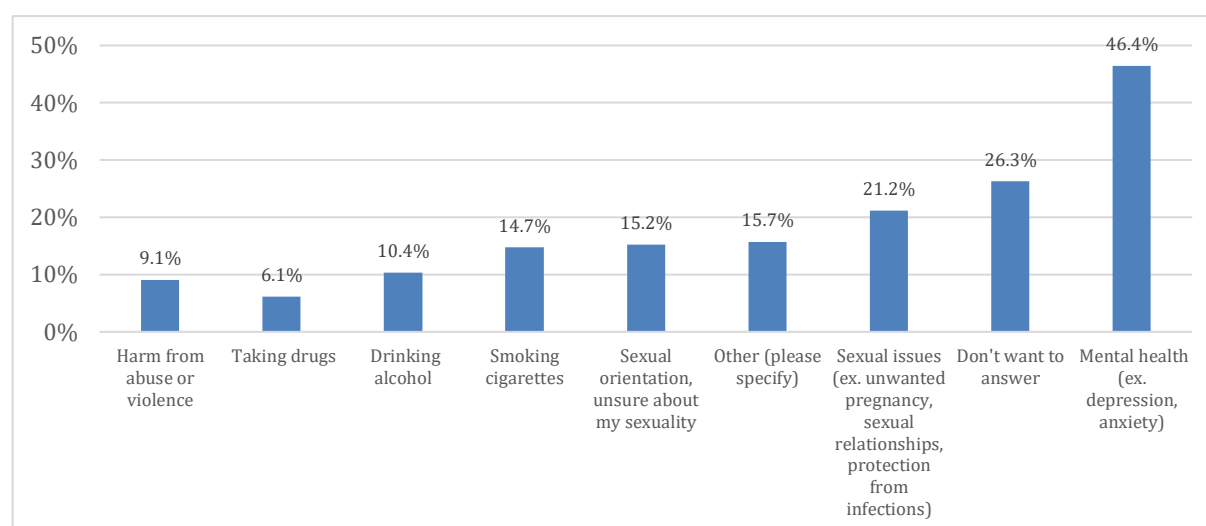
#### 5.1.1. Medical issues for which respondents were seeking advice

For those respondents who wished to receive medical advice, but avoided doing so because their parents had to be in the room, the top issues they were seeking advice for were:

- Mental health (e.g. depression, anxiety) (46.4%)
- Sexual issues (e.g. unwanted pregnancy, sexual relationships, protection from infections) (21.2%)
- Sexual orientation (15.2%).

Notably, 26.3% of respondents preferred to not answer this question and 15.7% selected open ended “other” option.

Figure 31: What were you seeking medical advice for? [select all that apply]



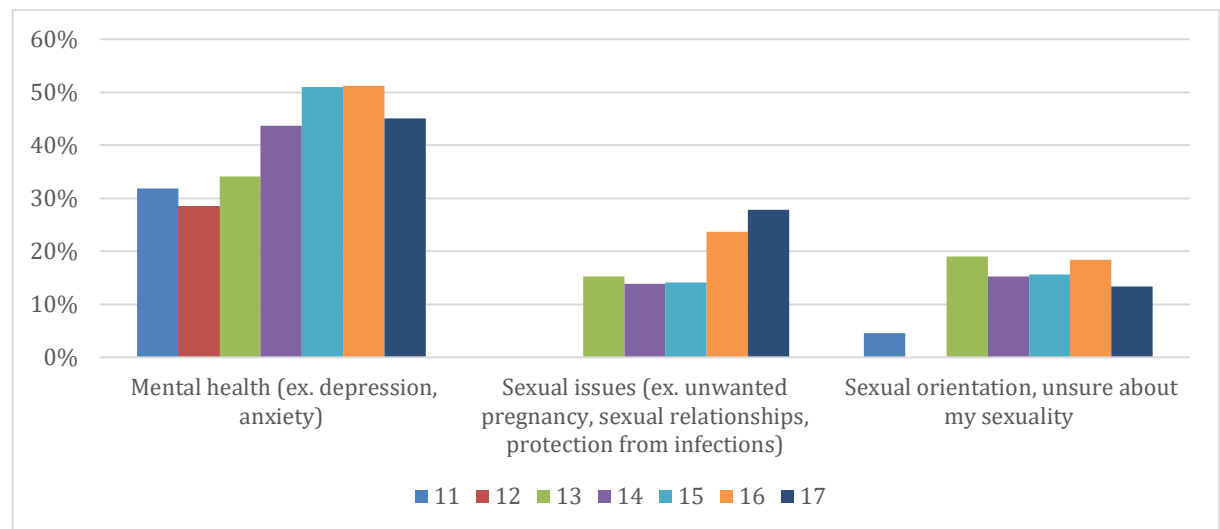
Note: this was a check-box question, where respondents could choose multiple answers, hence percentages do not add up to 100%.

#### 5.1.2. Medical issues, by age

When broken down by age<sup>39</sup>, we see that mental health issues are most prevalent (over 40%) among respondents between the ages of 14-17. Sexual issues were relevant only to respondents beginning at age 13, and increased with older respondents, with a jump between the age of 15 and 16. The 11- and 12-year-old respondents did not select sexual issues at all. Seeking advice on sexual orientation occurs between 13-19% only for respondents aged 13 and older.

<sup>39</sup> Methodological note: Fewer than 15 respondents in the 10-year old age groups answered this question per country, therefore these categories are removed.

Figure 32: What were you seeking medical advice for? (Top 3) by age

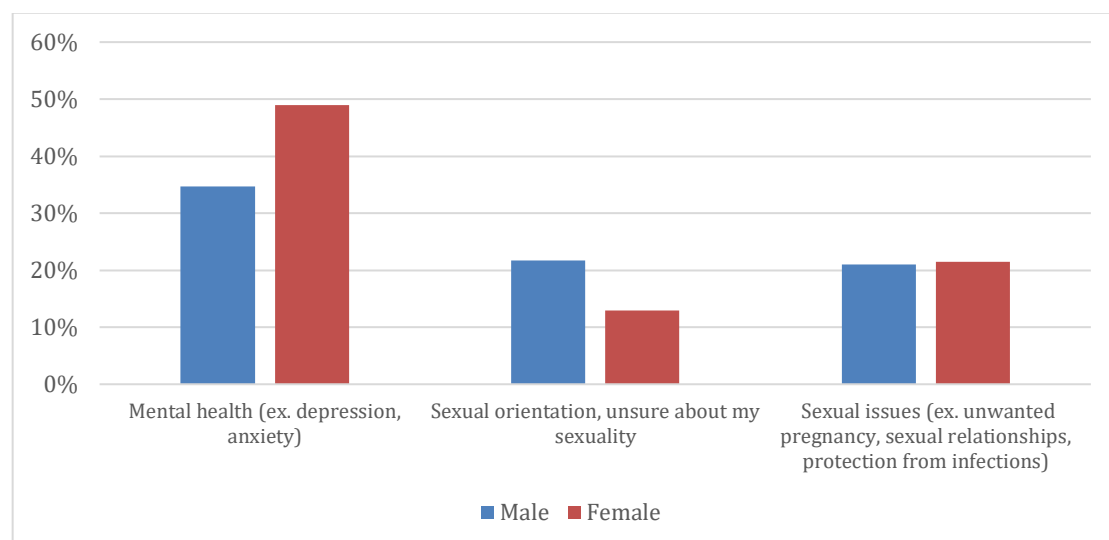


### 5.1.3. Medical issues, by group

Medical issues were mostly selected at the same rates between groups, with divergences seen only when the data was broken down by gender, general health status, or the existence of long-term health problems.

Even when broken down by gender, the top three choices remain the same (mental health, sexual issues, sexual orientation). However, there are gendered differences. More females (49%) were avoiding seeking medical advice on mental health than males (34.7%), while more males (21.6%) were avoiding seeking medical advice on sexual orientation than females (13%). Males and females were mostly even when it came to avoiding seeking advice on sexual issues.

Figure 33: What were you seeking medical advice for? (Top 3) by gender



When comparing respondents' general and long-term health status with issues they were seeking medical advice for, the top three issues remain the same: mental health, sexual issues and sexual orientation, with smoking cigarettes as a close top fourth choice.

Figure 34: What were you seeking medical advice for? (Top 4) by general health status

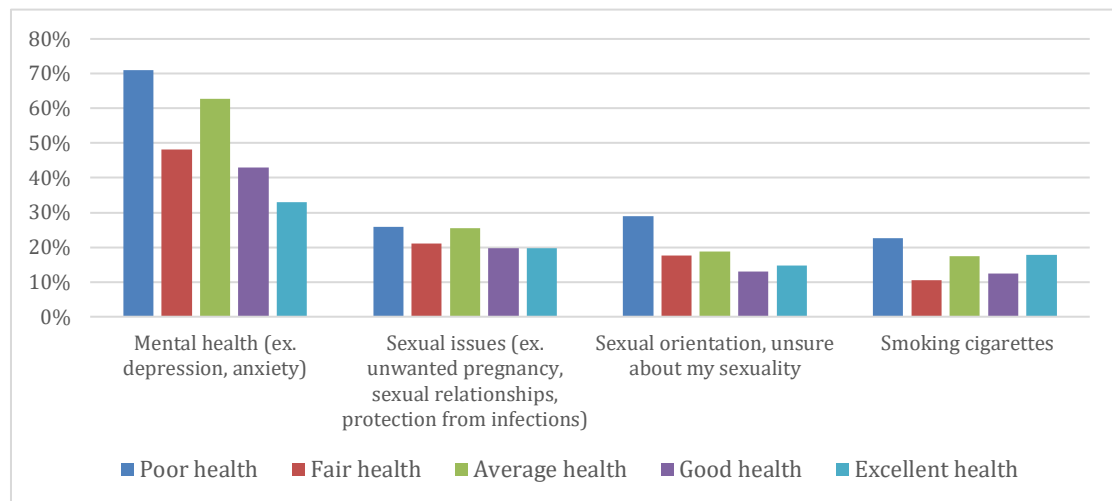
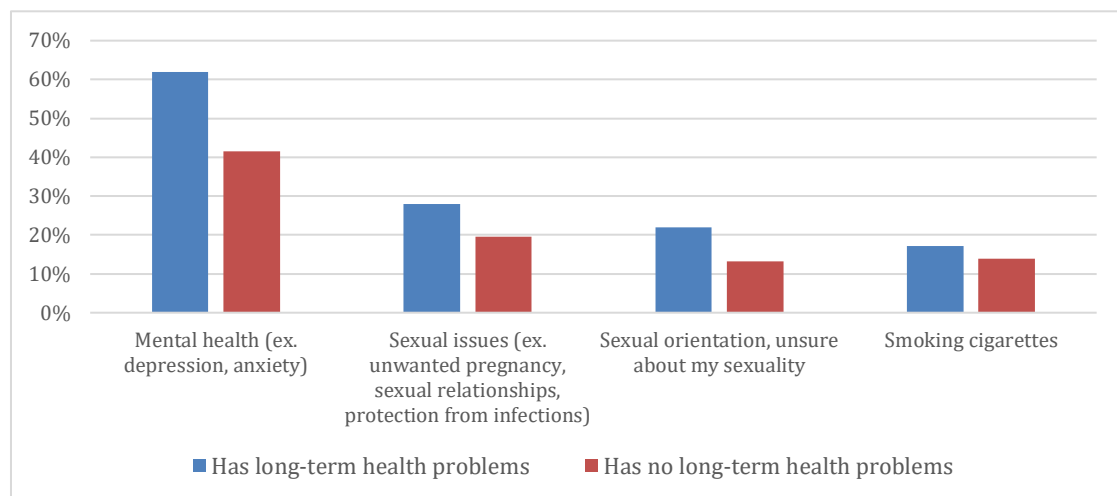


Figure 35: What were you seeking medical advice for? (Top 4) by existence of long-term health problems



Respondents with “poor” general health reported seeking medical advice for all top four issues more than those with “excellent” general health. In particular, 71% of those with “poor” general health selected mental health as an issue they were seeking medical advice for, compared to 33.1% of respondents with “excellent” health.

This is similar to those with long-term health problems, who selected all top issues more than those without long-term health problems. For mental health, 62% of respondents with long-term health problems selected this, compared to 41.6% of those without.

Many participants in the focus groups were hesitant to speak about personal experiences of being refused by a doctor for advice, or avoiding seeking advice from a doctor. Instead, one participant in Armenia mentioned how despite the minimum age of 18-years in her country, she has sought advice from a doctor independently and was not turned away.

“Sarah: It is the law [that the minimum age to seek independent medical advice is 18 years]. But in reality, when we go alone, doctors accept us with pleasure.”

- *Sarah, 16-years old, discussing her experience with seeking medical advice in Armenia in an all-female focus group of urban adolescents between the ages of 14 and 17*

Moreover, participants in focus groups appeared to be willing to talk about some medical issues more than others. For example, despite mental health being a top issue in the online survey, it was not mentioned in the focus groups. This was not the case for sexual issues, which were popular topics of conversation. This may demonstrate the degree to which mental health is taboo among the adolescents who participated in our consultation.

The CRC outlines a child’s right to survival and development (Article 6) and the right to health and health services (Article 24) (UN Committee on the Rights of the Child, 1989). Adolescents should have access to medical advice and services to ensure that they are healthy and safe. For this reason, the Committee on the Rights of the Child (General Comment No. 9) stipulates that the right to medical counselling and advice should not be subject to any age limit (UN Committee on the Rights of the Child, 2009). The minimum age to seek medical advice independently is 16 in Bulgaria<sup>40</sup>, 14 in the Ukraine, while in Armenia, Kazakhstan and Romania, it is 18.

## 5.2. Medical treatment, by group

In most cases, parents and children were in agreement with doctors, accepting advice on the best course of action when receiving medical treatment. However, situations could arise where the child is in conflict with either their parents, or their doctors, or both.

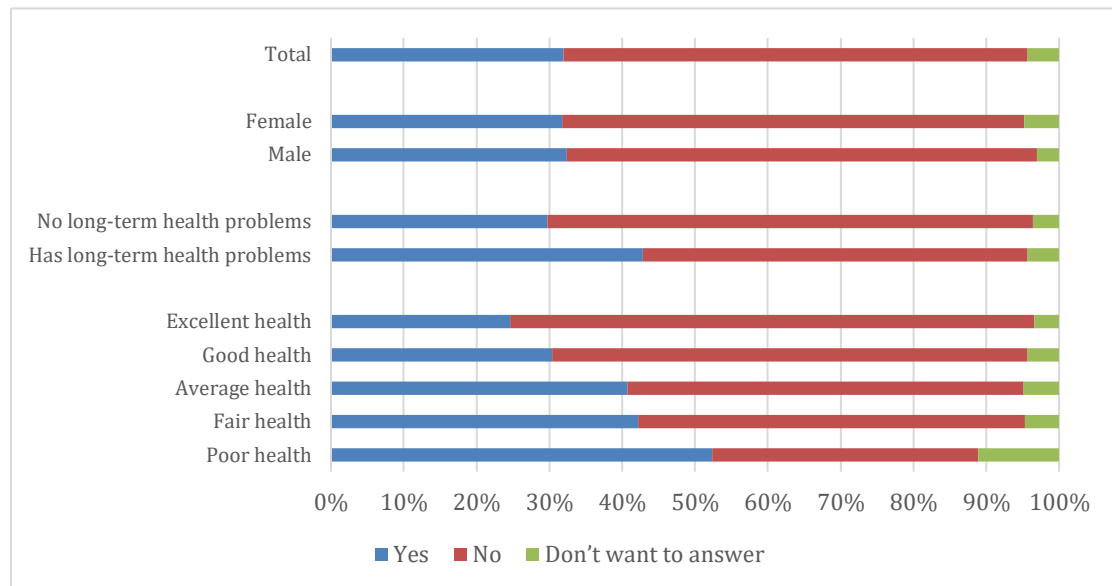
Respondents of the online survey were asked if they ever received a medical treatment that they did not want, but were forced to undertake by their parents/guardians or doctors. While a medical decision may have still been made in the best interests of the child, feeling forced would indicate that they did not have the opportunity to give their voluntary and informed consent, which includes receiving appropriate information about their health and the treatment, being listened to, and having their views taken seriously.

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<sup>40</sup> It is valid only for health consultations, testing and prophylactic check-ups (Health Act). The specific types of counselling services, prophylactic examinations and testing are defined by a separate order of the Health Minister (Note by UNICEF Bulgaria Country Office, 1 September 2017).

Nearly one-third (31.9%) of all respondents received a medical treatment that they did not want but felt forced to take by their parents/guardians or doctors.

*Figure 36: Did you ever have a medical treatment that you did not want, but were forced to by your parents/guardians or doctor? by gender, general health status and existence of long-term health problems*



When broken down by group, we find that the rates of medical treatment that felt forced to be the same in most groups, including by gender. Male and female adolescents reported feeling forced to undertake a medical treatment that they did not want to at approximately the same rates (32.4% for males and 31.7% for females).

There were large divergences among respondents when sorted by general health status and the existence of a long-term health problem. Respondents who indicated they had “poor” general health or had long-term health problems felt forced to receive medical treatments that they did not want at rates much higher than those who were healthy. For example, 52.4% of respondents with poor health said they received forced medical treatments, compared to 24.6% of respondents with excellent health. Similarly, 42.8% of respondents with long-term health problems received forced medical treatments, compared to 29.7% of those without health problems.

Those with “poor” health or long-term health problems were more likely to have received medical treatments, which could explain the difference in responses (with the assumption that healthier respondents are likely to receive fewer or no treatments). However, it is still striking that approximately half of the respondents with health issues felt that treatments which they have received were forced as opposed to voluntary.

The Committee on the Rights of the Child emphasises that respect for the views of the child (Article 12) also applies to medical decisions, where children have the right to say what they think and have their opinions taken into account (UN Committee on the Rights of the Child, 1989). To this end, the voluntary and

informed consent of the adolescent should be obtained regardless of if the consent of a parent or guardian is required for a medical treatment (General comment No. 20) (UN Committee on the Rights of the Child, 2016). The minimum age to give or refuse consent to medical treatment in all five countries is 18.



## 6. Subjective well-being

### Summary of key findings in this section:

**The older the respondent is, the more subjective well-being decreases.** Younger adolescents aged 10-13 rate their current well-being higher than older adolescents aged 14-17. At age 14, well-being appears to drop, and stays relatively constant for those aged 15-17. This dip coincides with a transition to late adolescence, which is marked by life events including moving from primary to secondary school, as well as increased emphasis on identity formation, self-awareness and critical thinking (UNICEF, 2011). It might suggest that the beginning of late adolescence is a period that may need particular attention due to potential drops in perceived well-being status.

**Having more free time, followed by having more people to talk to about their problems,** are the two top factors that would increase well-being. Both can impact mental health, which was the number one issue that respondents were seeking advice for but avoided doing so because their parents have to be in the room.

**Different age groups rank factors that could improve well-being differently, revealing a further split between the age groups.** While all age groups value having more free time the most, respondents **aged 10-12** chose having more friends and online safety over having more people to talk to about their problems. Respondents **aged 13-14** would like to have more people to talk to about problems, as do those aged **15-17**, who additionally begin to think about work opportunities.

**Respondents who are low income, have “poor” general health, or have long-term health problems report lower levels of subjective well-being,** as levels of subjective well-being often coincide with levels of objective (or material) well-being.

**While having someone to talk to could improve well-being, respondents avoided seeking medical advice for mental health.** The reason for this was because their parents had to accompany them. There is a clear opportunity to improve adolescent well-being by providing youth-friendly, confidential mental health services that adolescents can access independently.

Subjective well-being is the measure of how people think and feel about their lives. Distinct from “objective” well-being typically measured through objectively verifiable deprivations in domains such as poverty, health, education, or housing, subjective well-being is a self-assessment undertaken by children and adolescents themselves. Both comprise different aspects of multi-dimensional well-being (Bradshaw, Martorano, Natali, & de Neubourg, 2013). Lee (2009) identified six overall dimensions of child well-being:

- Material well-being (e.g. relative income poverty, households without jobs, reported deprivation)
- Health and safety (e.g. health status, preventable health services, safety)
- Educational well-being (e.g. school achievement, transition to employment)
- Relationships (e.g. family structures, peer relationships)
- Behaviours and risks (e.g. health behaviours, experience of violence)
- Subjective well-being.

This study explores subjective well-being, not necessarily to link it directly to subjective capacity, but rather to explore the levels of adolescent well-being relative to their age and group, and how this well-being may be impacted by the minimum age laws in question.

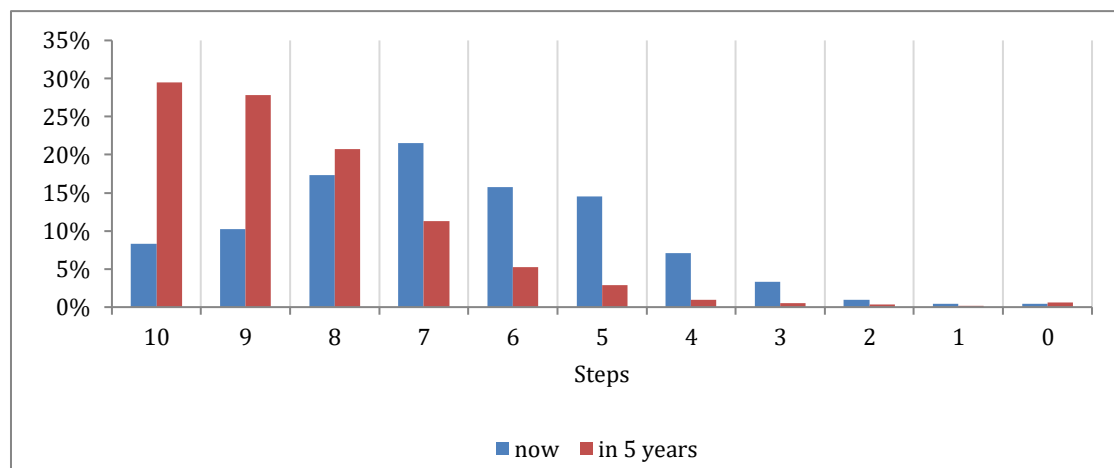
Subjective well-being was not a distinct topic of conversation in the focus groups, as the focus group setting was unlikely to yield honest responses from adolescents about satisfaction or dissatisfaction with their own lives. For example, some social norms can suppress complaints about parents, teachers, peers, or satisfaction with life in general (Bradshaw, Martorano, Natali, & de Neubourg, 2013), and would be in play to a greater degree in a group setting among peers.

As such, questions relating to subjective well-being were restricted to the online survey, where adolescents could answer anonymously.

Survey respondents were asked to assess at which step of a zero-to-ten well-being ladder they stood at the moment they took the survey and in five-years' time. The top of the ladder (10) represents the best possible life and the bottom of the ladder (0) represents the worst possible life.

Overall, survey respondents were more optimistic about their future well-being than their current well-being on the ladder. The average value (arithmetic mean) for all respondents was 6.7 for their current well-being, but it increased dramatically by 1.7 steps to 8.4 for their anticipated future well-being in five years' time. Additionally, only 8.4% of respondents selected the highest step 10 on the ladder for their current life, compared with 29.5% who expected their life to be on step 10 five years into the future.

*Figure 37: On which step of the ladder (0-10) do you feel you stand? by steps on the ladder, at present time and in 5-years' time*

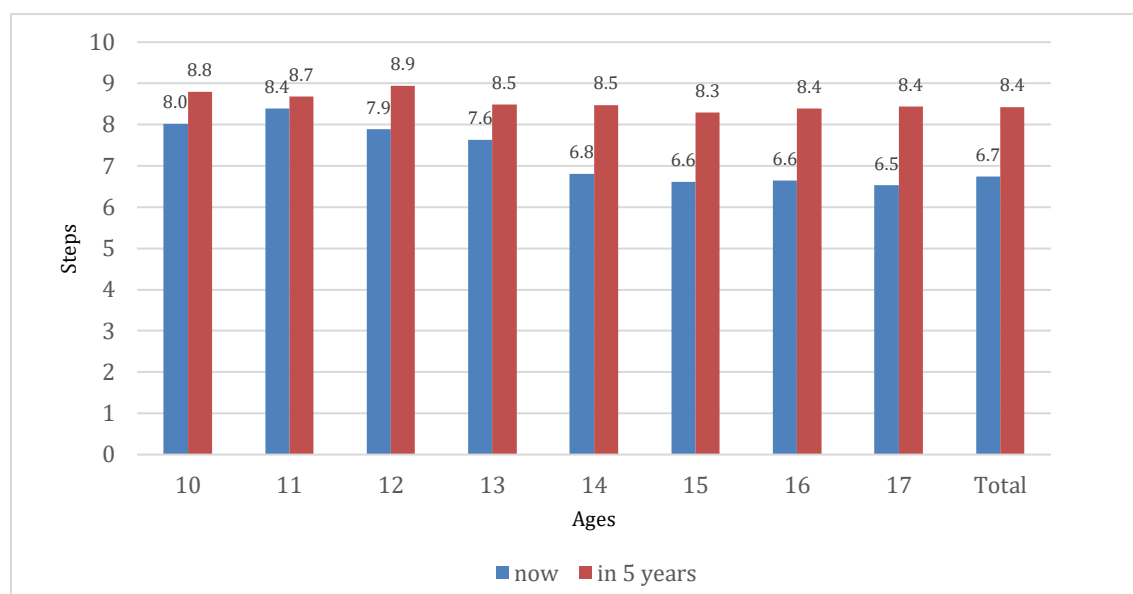


### 6.1. Subjective well-being, by age

When we look closer into how each age group responded to this question, we see that on average, younger respondents rated their current well-being much higher

(between 7.6 and 8.4 on the ladder), than older respondents (between 6.5 and 6.8 on the ladder). This arithmetic mean score generally decreases as the age of the respondent increases, meaning that the older the respondent, the lower he or she rates their current subjective well-being. Respondents aged 11 have the highest average score on the ladder (8.4), while 17-year olds have the lowest average score on the ladder (6.5).

Figure 38: On which step of the ladder do you feel you stand? Average mean values of steps of the ladder by ages, at present time and in five years' time



The biggest decrease in current subjective well-being score occurs at the age of 14, coinciding around the time of transition to late adolescence, which is marked by life events including moving from primary to secondary school, as well as increased emphasis on identity formation, self-awareness and critical thinking (UNICEF, 2011). As a period of both immense possibility but also new challenges, this dip could signal that this transition may have an impact on subjective well-being.<sup>41</sup>

When looking at anticipated future well-being in five years' time, younger respondents similarly reported an average higher well-being than older respondents, however with a much smaller gap between the two age groups. For example, 12-year-olds had the highest future well-being score (8.9), while the lowest future well-being score (belonging to 15-year-olds) was still high (8.3). The largest jump between current and future well-being scores was for 17-year-olds, who jumped 1.9 steps from 6.5 to 8.4.

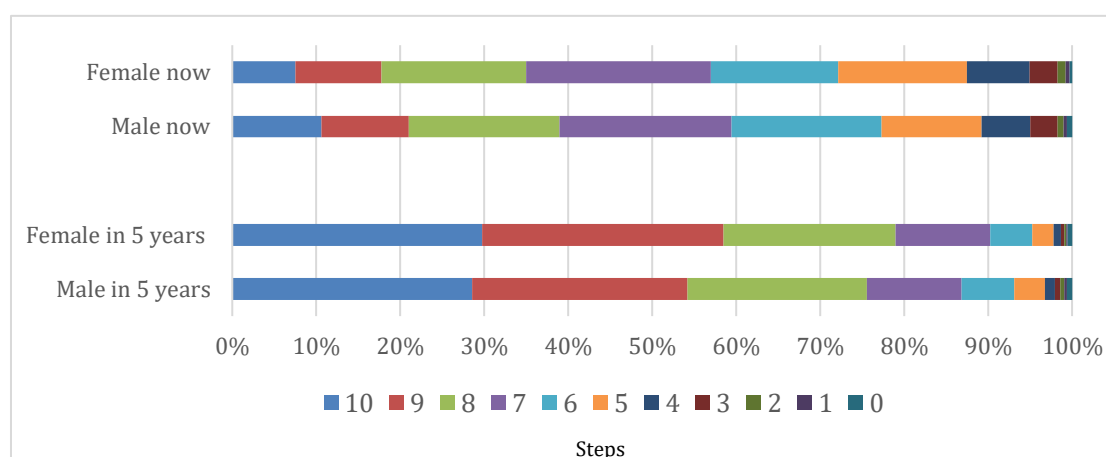
<sup>41</sup> For more information on the transitions between early and late adolescence, see: Johnson, Sara B., et al., 'Adolescent Maturity and the Brain: The promise and pitfalls of neuroscience research in adolescent health policy', *Journal of Adolescent Health*, vol. 45, no. 3, September 2009, pp. 216–221; United Nations Children's Fund, *Adolescence: A time that matters*, UNICEF, New York, 2002, p. 7; United Nations Children's Fund, 'Adolescent Development: Perspectives and frameworks – A summary of adolescent needs, an analysis of the various programme approaches and general recommendations for adolescent programming', Learning Series No. 1, UNICEF, New York, May 2006, p. 3.

## 6.2. Subjective well-being, by group

When disaggregating by group, there were differences in subjective well-being between groups based on gender, income proxy, general health status and presence of long-term health problems only.

When comparing **male with female respondents** and their current subjective well-being, the difference between their average score (arithmetic mean) was 0.2 steps, with male respondents having a slightly higher average (6.9) than females (6.7). However, when looking at future subjective well-being, females had a higher average score (8.5) than males (8.3). In both cases, current and future well-being, the differences between the average scores of the groups were small (0.2).

Figure 39: On which step of the ladder do you feel you stand? by gender, at present time and in 5-years' time



When the respondents are disaggregated by **income status**<sup>42</sup>, **general health** status, and presence of a **long-term health problem**, respondents with higher incomes, better general health and no long-term health problems reported overall higher subjective well-being than their counterparts. As measures of objective (or material) well-being, these results echo other research that demonstrates that in general, higher material well-being and health (alongside other factors such as education and housing) translates to higher subjective well-being and happier children (Bradshaw, Martorano, Natali, & de Neubourg, 2013).

For example, the average current well-being score of respondents who have their own bedroom (proxy for high **income status**) is 0.7 steps above the average score of those who share a bedroom with two or more people (proxy for low income status). This difference is maintained when examining future subjective well-being, albeit with a smaller gap. For both current and future well-being, the higher the income of the respondent, the higher the subjective well-being.

The difference in subjective well-being of those with “poor” **general health** and “excellent” general health is even starker. Those with “poor” general health had an average current well-being score of 4.8, which is 2.9 lower than respondents with

<sup>42</sup> As a proxy for **income**, we have asked respondents to tell us if they have their own bedroom or if they share it with one or two or more people. See Section 1: Methodology Summary.

“excellent” general health. This is similar for future well-being, though with a smaller gap. For both current and future well-being, the better the health of the respondent, the higher the subjective well-being.

When sorting respondents based on whether they suffered from **long-term health problems**, a similar trend emerged as when sorting by general health status. Those with long-term health problems reported on average lower subjective well-being than those without, for both current and future well-being.

It should be noted that respondents with “poor” general health or long-term health problems were seeking advice for mental health issues (but avoided doing so because their parents had to accompany them) at much higher rates than their healthier counterparts.

Figure 40: On which step of the ladder do you feel you stand? by income proxy, at present time and in 5-years' time

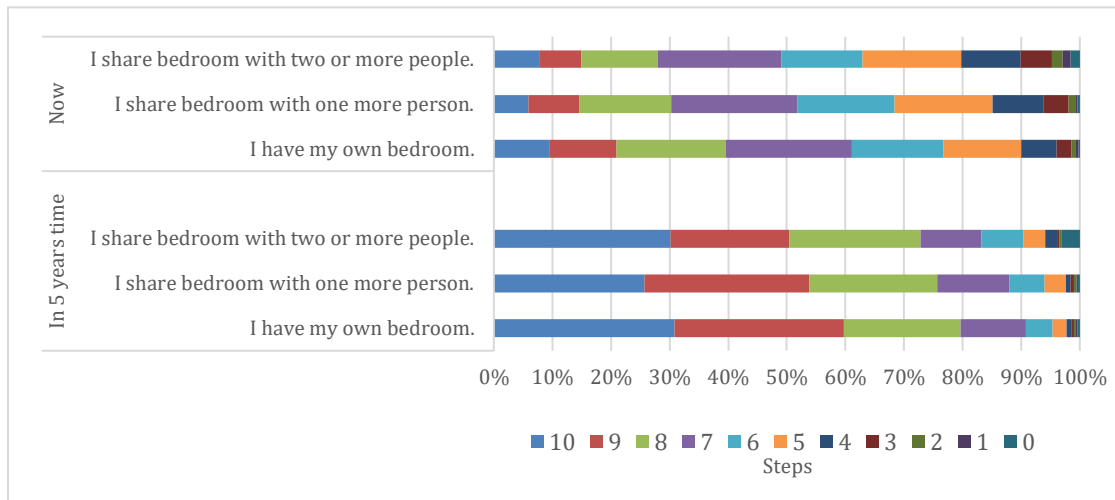


Figure 41: On which step of the ladder do you feel you stand? by general health, at present time and in 5-years' time

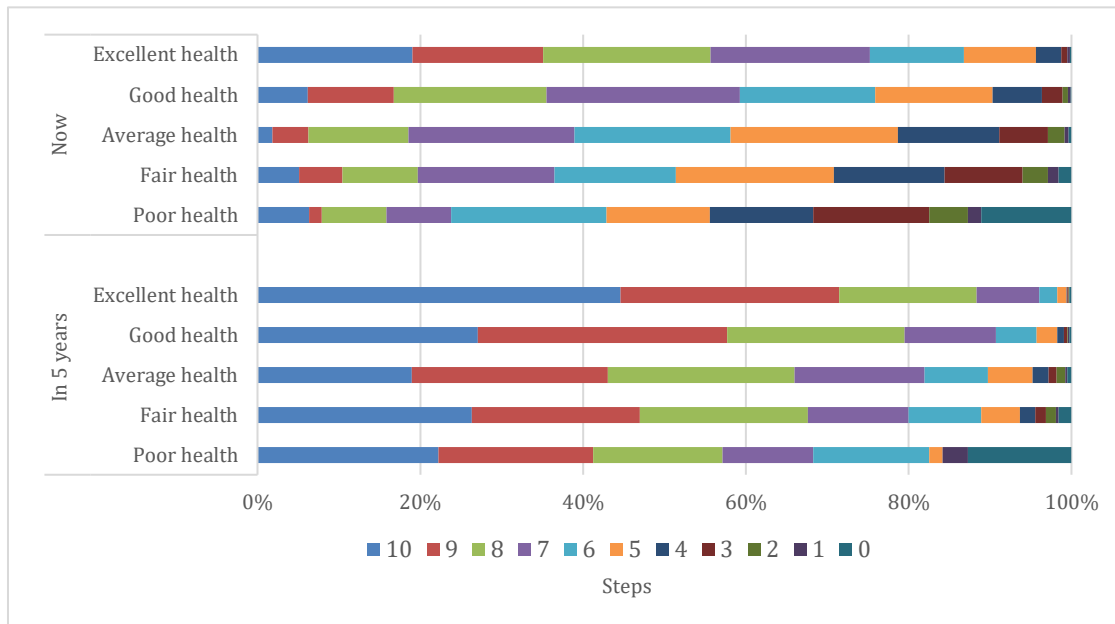
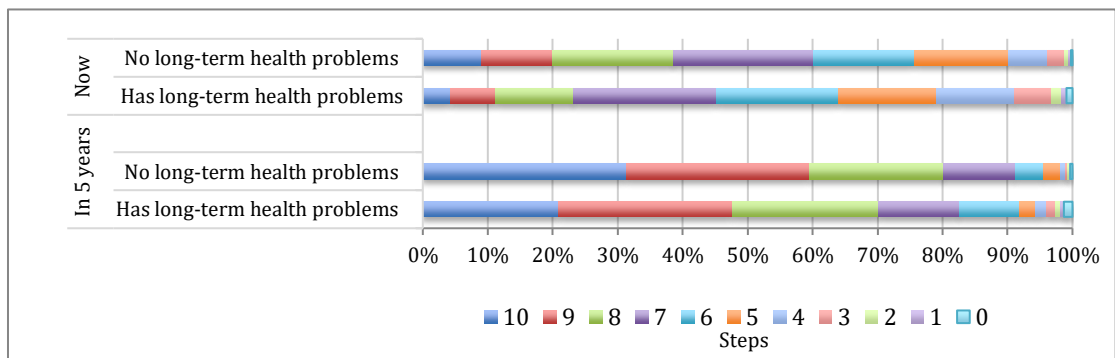


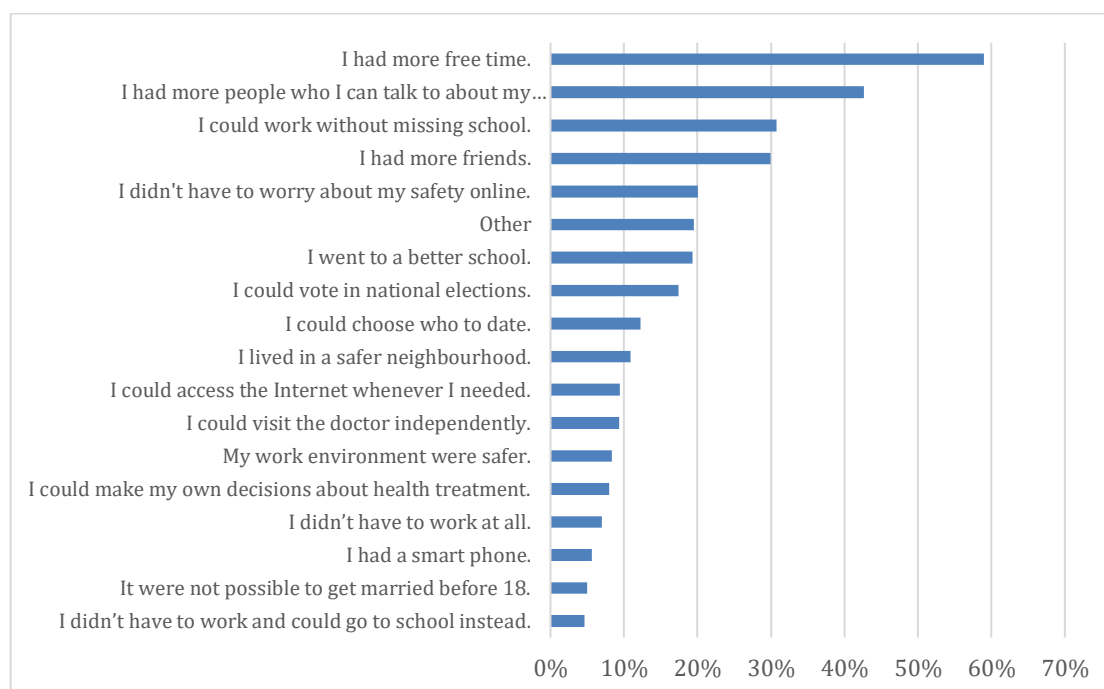
Figure 42: On which step of the ladder do you feel you stand? by long-term health, at present time and in 5-years' time



### 6.3. Factors that could improve subjective well-being

In a follow-up question, we wanted to find out which factors could improve the subjective well-being of respondents and enable them to have **higher standing on the ladder**. We asked them to select from a list of options that apply to them. The top four factors chosen by respondents that would make well-being better were: more free time (59%), more people to talk to (42.6%), possibility to work without missing school (30.8%) and having more friends (29.9%).

Figure 43: "My life would be better if..." [select all that apply]



Note: this was a check-box question, where respondents could choose multiple answers, hence percentages do not add up to 100%.

The top choices were related to leisure time, having more people to talk to, having more friends, and opportunities for work alongside learning. Other options relating more explicitly to material well-being, such as going to a better school, living in a safer neighbourhood, or having a smart phone, were not among the most selected options by survey respondents.

#### 6.3.1. Factors that could improve subjective well-being, by age

Moreover, we see that across all ages, free time is the first choice. However, the second and third choices diverge by age, with some age clusters emerging.

For example, the second choice for those between 10-12 was having more friends (average 34.5%), while the second choice for those aged 13-14 and 15-17 was having more people to talk to (41.7% and 43.7%, respectively).

In third place for those aged 10-12 was online safety (average 31.5%). As examined earlier (Section 2), older adolescents felt more capable to make

decisions on which websites to visit online than younger adolescents, and younger adolescents expressed more worry about online safety in focus groups than their older counterparts. Having more friends was the third choice for those aged 13-14 (33.1%). Respondents between the ages of 15-17 selected work without missing school (33.5%).

It is notable that having more people to talk to about their problems was the second choice for respondents aged 13 and older. As explored in Section 3, mental health was the top medical issue that respondents were seeking advice for (but avoided doing so because their parents had to accompany them), and to a greater degree for older respondents, beginning at approximately age 14. As shown earlier, age 13-14 is also the age at which subjective well-being appears to drop.

Figure 44: "My life would be better if..." (top 5 choices) by age

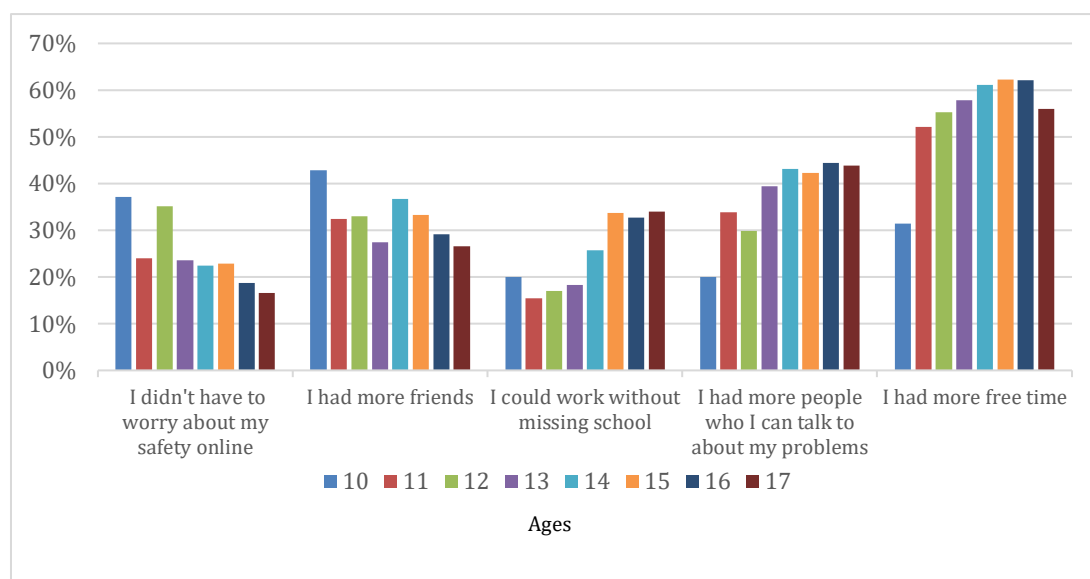
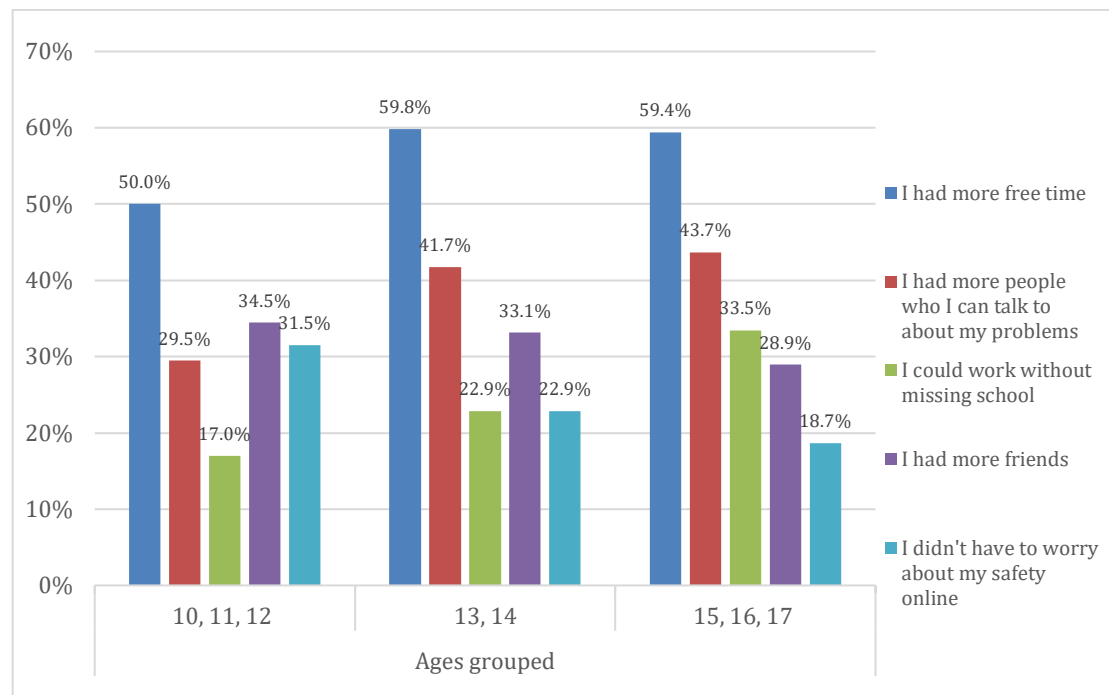




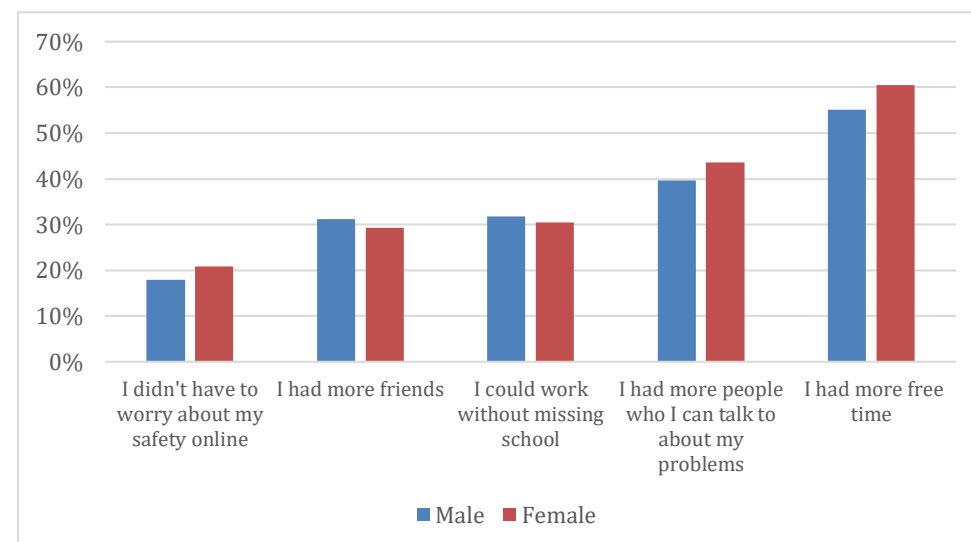
Figure 45: "My life would be better if..." (top 5 choices) by grouped ages



### 6.3.2. Factors that could improve subjective well-being, by group

When looking at the factors by demographic groups, we see hardly any divergence, and all groups have the same top four choices. When disaggregated by **gender**, male and female respondents selected the same top four choices in similar proportions:

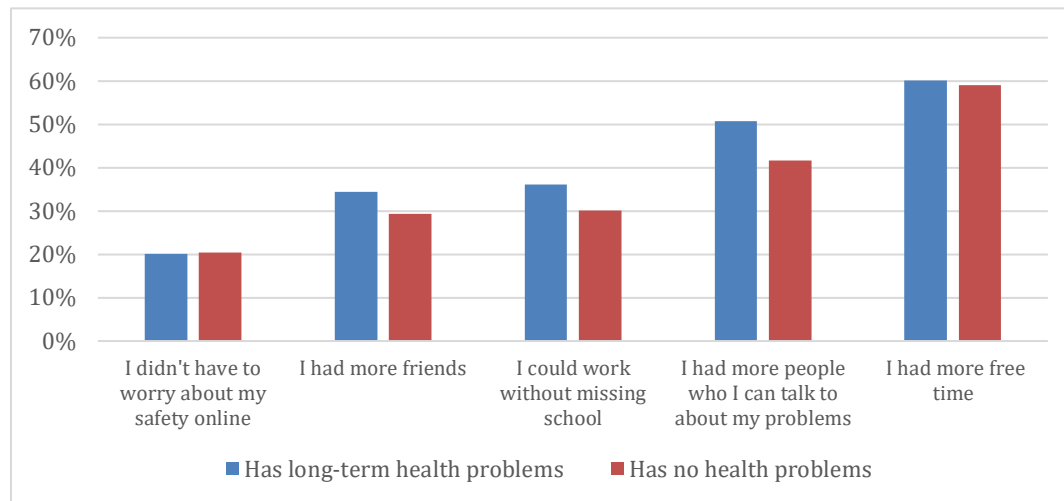
Figure 46: "My life would be better if..." (top 5 choices) by gender



The only demographic group which exhibits a notable difference is those respondents with **long-term health problems**. Here, 50.7% respondents with long-term health problems indicated that their life would be better if they had

more people they could talk to about their problems compared to 41.6% among those with no long-term health problems for a difference of 9.1%. This echoes the findings of Section 3, where mental health was the number one issue that these respondents wanted to seek medical advice for, but avoided because their parents had to be in the room.

*Figure 47: "My life would be better if..." (top 5 choices) by existence of long-term health problems*



## 7. Conclusions

This **exploratory research project** sought to understand how age-related legislation affects the lives of adolescents, in regards to accessing services and realising their rights, with the aim to add to the current debate on minimum ages. The mixed-methods research includes the views of nearly six thousand adolescents across five countries in Europe and Central Asia and focuses on their knowledge, perceptions and experiences with regards to these laws, with respect to their evolving capacities, and the overall impact on their well-being. The following findings emerged:

### Adolescents are capable (and more capable than policymakers assume)

The majority of adolescents who participated in our survey felt themselves perfectly capable of making responsible decisions in a number of areas of their lives. For example, the majority said that they strongly agreed that they were capable enough across a range of everyday activities, from staying home alone for several hours during the day, to deciding how to spend their pocket money and choosing who to date. Participants in the focus groups described adolescents as active agents in their own lives. This was both by necessity (for instance when their parents are at work or out due to other obligations), and by choice (such as when they were navigating the internet and social networks where parents have little control or knowledge).

Most relevant to our research was how young people felt about their capacities in areas where legislation prescribes a minimum age. For example, a majority of respondents aged 14 and older felt capable enough to seek **medical advice** without a parent or guardian, despite legislation preventing them from doing so until the age of 18 in Armenia, Kazakhstan, and Romania, 16 in Bulgaria<sup>43</sup>, and 14 in Ukraine. Seeking independent medical advice is one area where the Committee on the Rights of the Child recommends a removal of all age limits, both in the General Comment No. 12 on the right of the child to be heard (UN Committee on the Rights of the Child, 2009) and in the recently released General Comment No. 20 on the implementation of the rights of the child during adolescence (UN Committee on the Rights of the Child, 2016).

### Looking at capacities adds more complexity to how we define ages in adolescence

The starting premise of the research, informed by UNICEF programming, was to conduct consultations with adolescents between the ages of 10 and 17. Within this group, we looked carefully at younger (10-13) and older (14-17) adolescents. The research findings support this division, but also suggest the possible existence of a 'hidden' age bracket at **approximately the age of 12** where the focus group

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<sup>43</sup> It is valid only for health consultations, testing and prophylactic check-ups (Health Act). The specific types of counselling services, prophylactic examinations and testing are defined by a separate order of the Health Minister (Note by UNICEF Bulgaria Country Office, 1 September 2017).

discussions and the online survey showed that there is a considerable increase of respondents who feel they have more capacities for almost all general everyday activities (such as to go to the supermarket, to have the key for their home, to stay home alone, to choose their friends, to decide their own personal style and to decide what to do in their free time). The assessment of their own capacities for voting jumps at the age of 12 as well.

Furthermore, we noticed that respondents **at approximately the age of 15 and older** feel they have more capacities to decide on using their own money, on whom to date and which websites to visit online. However, respondents between 13 and 15 reported considerably lower well-being and higher rates of seeking mental health advice than younger respondents. Therefore, this transition period may pose both challenges and increased opportunities for autonomy.

There were rights and responsibilities that some adolescents did not feel they would be ready for even at the **age of 18**, such as making independent medical decisions, marriage, and, for some, voting. This echoed recent findings from the Lancet Child & Adolescent Health journal, which argue that the definition of adolescence may benefit from being extended up to the age of 24, instead of 19 (Sawyer, Azzopardi, Wickremarathne, & Patton, 2018). Additional supports may be needed to empower adolescents and ensure that they have the capacity to take on such rights when they are given to them upon legal emancipation, or perhaps, even after the age of 18.

### Protection from experiences or responsibilities that could cause them harm is important to adolescents

When discussing age-related policies and practices it emerged that, for most adolescents, protection from potentially harmful experiences was paramount, and in most cases seemed more important than autonomy. In all five countries that were part of the consultation process, **marriageable age** without parental consent is set at 18, which is in accordance with the CRC recommendation. Adolescents were very aware of their rights with regards to marriage, with a vast majority correctly demonstrating their knowledge about the law. However, many were disapproving of the ability of parents or a judge to give consent to marriage earlier than 18, which in all five countries can happen at 16. Almost two-thirds of respondents “agreed” or “strongly agreed” that no young person under the age of 18 should be able to get married.

Notably, focus group participants felt they would not be capable enough to make this decision even at the age of 18, in part because typical signposts of adulthood (e.g. secure income) are often delayed into their 20s. While this does not imply that they would like the marriageable age to be increased, it does show that young people may require further support beyond the age of majority, and should include particular attention to girls as an especially vulnerable group which, in the focus groups, was identified as having more family pressure to get married earlier than boys. Focus group participants noted that this pressure is compounded for girls from lower income families, who may be pressured into marriage earlier as a way to ease the financial burden on their families.

Young people cannot be held **criminally responsible** before 14 years of age in all countries that participated in the consultation, which is above the internationally acceptable minimum suggested by the Committee on the Rights of the Child. However, some focus group participants expressed strong concern that 14 years of age could be too young to be held criminally responsible. Although setting the minimum age of criminal responsibility at 14 fulfils the right to protection, participants felt there should be expanded services for supporting young people in conflict with the law. They emphasised the need for adequate rehabilitation and support services, especially counselling and rehabilitation services that would help adolescents reintegrate into society. Respondents were nearly unanimously opposed to children being charged for offences in the same way as adults.

Having the opportunity to seek medical advice independently (without parents/guardians) may empower adolescents to more actively seek the medical help they need, and could also increase their well-being

Age restrictions on accessing **medical advice** do not have any protective purpose. The Committee on the Rights of the Child argues for the lifting of all age restrictions for seeking medical advice (UN Committee on the Rights of the Child, 2016). Currently, all five countries have a legal minimum age at which a young person can seek independent medical advice, with Armenia, Kazakhstan and Romania setting this at age 18, Bulgaria at 16<sup>44</sup>, and Ukraine at 14.

One in six respondents of the online survey reported that they were refused medical advice by a doctor because their parents were not in the room, and one in four respondents reported that they avoided seeking medical advice for the same reason. This is contrary to a child's right to health and health services, and to their overall development and survival. The rates at which adolescents reported being denied advice or avoiding services undoes any protective function intended by such legal restrictions.

Findings from this research also challenge arguments for a legal minimum age due to capacity. Respondents overwhelmingly felt that they are capable of talking to a doctor by themselves (62% "agreed" and "strongly agreed") and (66%) thought they should be allowed to do so.

Providing unrestricted access to medical **advice** could also improve well-being. "Having more people to talk to about their problems" was the second factor identified by respondents as potentially increasing well-being, while mental health was the number one issue which respondents avoided seeking medical advice for because their parents had to be in the room. Therefore, access to independent medical advice could also contribute to higher levels of well-being, in addition to responding to medical needs.

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<sup>44</sup> It is valid only for health consultations, testing and prophylactic check-ups (Health Act). The specific types of counselling services, prophylactic examinations and testing are defined by a separate order of the Health Minister (Note by UNICEF Bulgaria Country Office, 1 September 2017).

There are seemingly few dangers or risks associated with allowing adolescents access to confidential medical counselling on their own. On the contrary, such unrestricted access could improve the lives of young people and help prevent and address medical issues that many suffer from but feel too embarrassed to talk about in front of their parents. Furthermore, accessing trustworthy professional advice not only provides a much safer option for adolescents than seeking advice through other potentially unreliable sources, but it also provides an important opportunity for early identification of problems and for linking/referring adolescents to appropriate care and support services. As stipulated in a WHO guidance related to adolescent health, adolescents require unrestricted access to youth-friendly health services and information that is provided confidentially by technically competent, trained and trusted health care providers who will respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, and non-judgmental access to information (World Health Organization (WHO), 2015). This may result in an overall increase in health seeking behaviours by adolescents and in an increased capacity to talk about problems and improve overall health and well-being.

### The right to be heard is not always upheld during medical treatments

While the CRC does not recommend a specific minimum age at which young people should have a right to refuse receiving a **medical treatment or intervention**, it does stipulate that children should be involved in making health decisions that affect them, in relation to their capacities. An overwhelming 68.6% of adolescents participating in our consultations agreed that they should always give consent before receiving medical treatment.

However, nearly one-third of respondents said they received a medical treatment they did not want, but were forced to by their parents/guardians or doctors, implying that their right to be heard was violated. Regardless if that medical decision was made in the best interest of the child, young people should be adequately informed and allowed to express their opinion and give voluntary and informed consent. Improving adolescent rights and their protection could be achieved through youth-friendly health services and approaches that recognise the child's evolving capacities, that present medical information in a youth-friendly manner, and that require obtaining voluntary and informed consent. The WHO has issued clear global standards for improving quality of medical care for adolescents (World Health Organization (WHO), 2015).

### There is an opportunity to improve the right to be heard for adolescents in politics

A common argument against lowering the **voting age** is that young people lack the capacity to understand the political system and make their own decisions, yet more the half (52.8%) of respondents in our consultations "agreed" or "strongly agreed" that they felt capable enough to vote. While respondents did not feel as

capable to vote as they did to do other activities, there is no protective purpose for preventing young people from voting.

Voting could increase an adolescent's well-being. While it was not identified as one of the top five changes to improve well-being, a high proportion (17%) of respondents indicated that their life would be better if they were allowed to vote in national elections. Moreover, it has been argued that the lack of voice in politics is one of the reasons why child rights continue to be unfulfilled (CRIN, 2016). Voting would give adolescents a mechanism through which to influence policy makers, claim their rights and bring duty bearers to account.

While some focus group participants, especially younger ones, were sceptical about a lowered voting age, all agreed that additional support concerning political and citizenship education and youth-friendly information could reduce complexities related to voting and would likely encourage them to participate. Opportunities for hands-on experience, such as participation in school councils or youth advisory boards, could also help increase confidence in voting.

The right to education is paramount, but there is some value in having opportunities to work alongside school

Minimum ages related to **leaving school and working full-time** have a dual protective and participatory function. The standard international recommendation is that these policies should not conflict with each other so that the working age is not lower than the age at which compulsory education is completed. Most survey respondents did not know what the correct age at which they could stop going to school was (only 15.5% answered correctly), and at which age they could start working full-time (only 14% answered correctly). The majority (56.2%) did not think they should be allowed to leave school to work full-time, with older respondents wishing to be allowed to work more than the younger ones.

However, focus group participants recognised the added value of part-time work for gaining additional experience and practical knowledge. It was also seen as a path to independence (tied with the ability to hold their own money) and improving capacities to decide on issues that affect them. Additionally, 30.8% of respondents (and especially older respondents) indicated that their lives would be better if they could work without missing school. Programmes, information and services should be provided to young people regarding employment rights and various opportunities for gaining skills and experience as part of the education system rather than next to schooling.

Age matters, but so does gender, health status, and income

This research reveals that certain groups of respondents have different experiences with relation to subjective capacities, accessing services, and subjective well-being, that could point to increased vulnerability. Each of these groups is examined below:



## Gender

Females who participated in our consultation did not perceive themselves to be less capable than males on most matters. In most general everyday activities, males and females were less than five percent different from each other in terms of how many “agreed” or “strongly agreed” that they are capable of doing something.

One area of concern that potentially points to increased vulnerability was marriage. In focus group conversations about marriage, gender roles were discussed in a way that emphasised the lack of power and autonomy for females. Participants (both males and females) described how females must know domestic skills, such as cooking, cleaning, and child rearing as a condition for getting married, while the emphasis for males was on having economic independence. Marriage for women was seen as a full abdication of educational or professional aspirations, and the risk to women in case of divorce was seen as greater due to the risk of being left with no economic means and also having the sole responsibility for the children.

Moreover, participants discussed parental pressure faced almost exclusively by females, on both when and whom to marry. Participants identified the dangers of child marriage under traditional or cultural customs, where it is predominantly daughters who were married off while they are still children. All countries covered by this research have laws which allow adolescents to marry at 16 with parental or judicial consent, despite the recommendation of the CRC that 18 should be the absolute minimum age (UN Committee on the Rights of the Child, 2016) .

In accessing medical services, female respondents were both refused medical advice by a doctor and they avoided seeking advice at slightly higher rates than males (2% more and 6.1% more, respectively). The difference between males and females is starkest when it comes to issues for which respondents were avoiding seeking advice: 15.7% more females than males reported avoiding seeking advice on mental health.

Females reported their subjective well-being at levels similar to males, though males reported slightly higher well-being than females when taking the survey, while females expected slightly higher well-being than males five year into the future. Despite 15.7% more females than males avoiding seeking medical advice on mental health, females selected that having more people to talk to about their problems as a life improvement factor, about the same rate as males (<4% difference). This could suggest that females seek more formal support for mental health (e.g. psychological or psychiatric services) than males, despite having the same needs.

## Health status



Respondents who reported “poor” general health or having long-term health problems were disadvantaged in comparison to healthy respondents in almost all areas under study:

- They reported lower levels of subjective capacities in nearly all everyday activities
- They reported higher percentages of refusal of medical advice and avoidance in seeking it, and of seeking (and avoiding) help on mental health issues
- They reported having a medical treatment that felt forced at a higher rate
- They had lower current and projected subjective well-being on average.

Despite this, the barriers to rights and services within health that our study reveals may exacerbate problems for adolescents who suffer from “poor” general health or have long-term health problems. While these groups reported that they were more likely to seek medical advice, they also reported higher rates of refusal and avoidance, as well as higher rates of receiving medical treatment administered without their consent or participation. Adolescents with poorer health status also reported somewhat higher incidence of mental health issues for which they did not receive assistance. Adolescents living with chronic health conditions or other health issues may face multiple overlapping vulnerabilities which could threaten their right to health and survival, and may further reduce their well-being. Therefore, health status is an important equity dimension which needs to be addressed (together with gender and poverty) as part of policies and programmes focussed on adolescents.

### Income

Respondents from lower income households (reported using a proxy variable which asked if they have their own bedroom, are sharing their bedroom with one other person, or are sharing their bedroom with two or more people) were not drastically different from those of higher income in subjective capacities or service access, but had lower levels of subjective well-being. These findings echo previous research which shows how material well-being is closely tied to subjective well-being (Bradshaw, Martorano, Natali, & de Neubourg, 2013).

Focus group discussions also looked at how poverty reduces protection and puts a young person at greater risk in the domains under study, for example: to leave school early for full-time work; to be married earlier or even under the legal age (especially for young girls); and to engage in criminal activity, such as theft, to cover basic needs.

## 8. Looking ahead: The ongoing debate

In regards to setting minimum ages, there is no full consensus among countries on when and how these ages should be set, and even within countries, the debate is heated, particularly on sensitive topics such as accessing sexual and reproductive health services, HIV testing, abortion, or addiction services. As explored in this study, setting minimum ages can be contentious, contextual and contradictory.

Some challenge the use of rigid legislative frameworks altogether, in favour of more flexible approaches that respect children's right to participate in decision-making according to their evolving capacities, while still providing appropriate protection, such as:

- Removal of age-limits, substituting a framework of individual assessment to determine competence to exercise any particular right
- Presumption of competence, with the onus on adults to demonstrate incapacity in order to restrict a child's rights
- Providing age-limits but allowing a child to demonstrate competence and acquire the right at an earlier age
- Providing age-limits only for those rights that are at risk of being abused or neglected by adults and introducing a presumption of competence in respect of other rights (Lansdown, 2005).

However, none of the options above fully covers the complexities of risk, capacity, participation, and protection, and there is far from consensus on how to move forward within the minimum age arena. Rather, they contribute to the evolving debate within this contentious field.

General Comment No. 20 makes some recommendations on the implementation of the rights of the child during adolescence from the CRC with respect to setting legal ages, which is pushing the debate forward, while reiterating the core principles set in the Convention of non-discrimination; best interests of the child; respect for the views of the child; and evolving capacities (emphasis added):

39. States should review or introduce legislation recognizing the right of adolescents to take **increasing responsibility for decisions affecting their lives**. The Committee recommends that States introduce minimum legal age limits, consistent with the right to protection, the best interests principle and respect for the **evolving capacities of adolescents**. For example, age limits should recognize the right to make decisions in respect of health services or treatment, consent to adoption, change of name or applications to family courts. In all cases, **the right of any child below that minimum age and able to demonstrate sufficient understanding to be entitled to give or refuse consent should be recognized [...]**

Consideration should also be given to the **introduction of a legal presumption that adolescents are competent** to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services. The Committee emphasizes that all adolescents have the right to have access to confidential medical counselling and advice without the consent of a parent or guardian, irrespective of age, if they so wish. This is distinct from the right to give medical consent and should not be subject to any age limit.

40. The Committee reminds States parties of the **obligation to recognize that persons up to the age of 18 years are entitled to continuing protection from all forms of exploitation and abuse**. It reaffirms that the minimum age limit should be 18 years for marriage, recruitment into the armed forces, involvement in hazardous or exploitative work and the purchase and consumption of alcohol and tobacco, in view of the degree of associated risk and harm. [...]

However, General Comment No. 20 is far from complete in providing guidance in all the areas of life that impact on an adolescent's well-being, which is challenging in constantly changing political and policy environments, and technological innovations. Further research is required to better understand the situation of adolescents, with respect to their perception, knowledge, and experiences with minimum age legislation. This study closes with a call for more adolescent participation in research in particular, reinforcing Article 12 of the CRC that young people's views matter. Consulting with, and also ideally working together with adolescents as producers of research, promotes the idea that young people are capable of forming and expressing views, and ideally, that those views should have impact.

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