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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Respecting adolescents' confidentiality and reproductive and sexual choices

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Abstract Adolescents, defined as between 10 and 19 years old, present a growing challenge to reproductive health. Adolescent sexual intercourse contributes to worldwide burdens of unplanned pregnancy, abortion, spread of sexually transmitted infections (STIs), including HIV, and maternal mortality and morbidity. A barrier to contraceptive care and termination of adolescent pregnancy is the belief that in law minors intellectually mature enough to give consent also require consent of, or at least prior information to, their parental guardians. Adolescents may avoid parental disclosure by forgoing desirable reproductive health care. Recent judicial decisions, however, give effect to internationally established human rights to confidentiality, for instance under the Convention on the Rights of the Child, which apply without a minimum age. These judgments contribute to modern legal recognition that sufficiently mature adolescents can decide not only to request care for contraception, abortion and STIs, but also whether and when their parents should be informed.

1. Introduction

Ambivalence about whether adolescents are more comparable to adults than to children, or vice versa, is reflected in international definitions. The World Health Organization (WHO) defines "adolescence" as occurring between the ages of 10 and 19 years [1], whereas the almost universally ratified United Nations Convention on the Rights of the Child (CRC) states in Article 1 that a "child" is "every human being below the age of 18 years," unless applicable law provides for earlier attainment of majority status, such as on marriage. Accordingly, many "adolescents" under the WHO test are "children" under the CRC.

Parents who have reared their adolescent children from birth and remain familiar with their earlier childish behavior and immature or innocent judgments may be slow to recognize their children's emerging sexuality and evolving capacity to make their own choices, and to bear responsibility for their choices. Paternalistic societies, better described as parentalistic societies, may reflect the same reluctance to acknowledge that particularly younger adolescents can exercise responsible or moral choice in sexual and reproductive matters. Adolescents' growing physiological sexual maturity is often not accompanied by parental or social acceptance of their psychological maturity to act responsibly as sexual beings.

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The reproductive and sexual health needs of the world's adolescent population present a serious challenge for gynecologists, particularly in economically developing countries. It has been estimated that of the more than 1.2 billion of the world's population aged from 10 to 19 years, 87% live in developing countries [2]. A deplorably high proportion of adolescents, in countries at all stages of economic development and particularly females, are vulnerable to sexual abuse and exploitation of dependency, so that their participation in sexual acts is nonconsensual even when non-violent [3]. The medical profession joins in their defence by the reinforcement of familial and social protections. The profession's special responsibility arises, however, regarding adolescents' voluntary sexual activity, due to their observed greater tendency than adults to engage in sexual experimentation and risk taking, including unprotected sex and concurrent sexual partnerships. Most adolescent sexual activity remains unprotected worldwide [4].

Rates among adolescents of sexually transmitted infections (STIs), including HIV, and pregnancy resulting in childbirth or abortion (frequently unsafe), and of maternal mortality and morbidity, demonstrate the urgent need to supply reproductive and sexual health services, and to remove social, legal and other barriers to their delivery. Worldwide, 15- to 24-year olds exhibit highest reported rates of STIs, with up to 60% of newly infected people and one half of people living with HIV being in this age group [4]. In 2005, over half the estimated 5 million people worldwide who contracted HIV were in this age group, the majority being young women and girls [5]. In sub-Saharan Africa, 75% of HIV infections in this age group are among females [6].

Young age, aggravated for instance by poverty, malnutrition, poor education, low or marginalized social status and inaccessibility of health services, contributes to adolescent pregnancy, which is not less threatening to maternal survival and health because it occurs within marriage. Each year, more than 14 million adolescents give birth [7], over 90% in developing countries [8], accounting for an estimated 15% of the global burden of disease due to maternal conditions and 13% of maternal deaths [9]. Further, adolescents account for over 14% of all unsafe abortions [9], between 2.2 and 4 million of an estimated 19 million illegal abortions each year involving adolescents [10].

2. Legal capacity

Laws often set age barriers to adolescents engaging in activities such as purchasing or consuming alcohol and tobacco products, voting or standing for public office, making commercial contracts, driving motor vehicles, marrying, and having sexual intercourse. Many of these laws mark a strict, chronological divide, rendering activity that is unlawful on every day up to a decisive birthday lawful at the stroke of midnight.

However, laws on ages of consent to medical procedures tend to be applied more contextually, recognizing that some who are below the legally specified age for medical consent may possess sufficiently mature understanding of material considerations to make choices for themselves. For instance, an 8-year old who suffers an injury, such as in play, a traffic accident, or a domestic activity, can give legally effective consent to receive appropriate medical care, even in the absence of emergency. Laws do not require the legal minor to continue to suffer or risk infection or disability until a person with parental authority approves treatment. The different approach is because adults with parental responsibility for minors bear legal duties to provide or consent to their medically indicated care, and risk liability under penal and/or child welfare laws for refusal or failure to approve such care.

The concept in medical law of the "mature minor" has received wide acceptance [11], reinforced by its recognition by courts that respect human rights instruments and law [12]. The issue of receipt of contraceptive advice and care arose in 1986, when the highest court in the UK held, in the widely influential *Gillick* judgment, that girls aged under 16 could consent, without their parents' approval or knowledge, if they possessed legal capacity. General guidelines for determination of capacity were agreed by the court [13], but one judge added further that:

> It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law…there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such [contraceptive] treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment [14].

Several courts claiming to apply the concept of the mature minor have not applied this expansive criterion in assessment too strictly, since it may cause girls who fail to satisfy this standard of capacity but decline to have their parents involved, to be left without medical care, and at risk of contracting STIs, including HIV, and of responding to pregnancy. For instance, the Alberta Court of Appeal found a minor competent to give her own consent to abortion despite her parents' objection that she lacked necessary moral comprehension [15].

3. Human rights of children

A further consideration judges are coming to take into account is the changing legal environment due to respect for human rights law, particularly the UN Convention on the Rights of the Child, which all but two countries of the world have accepted. Article 5 requires that "States Parties shall respect the responsibilities, rights and duties of parents…to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance." Article 14 similarly applies the concept of evolving capacity, to require that:

> "1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.