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An Adolescent Girl Seeking Sexual and Reproductive Health Care

Case Study

Miss B, an unmarried 15-year-old young woman, has come to Dr CD's office and asked for contraceptive care. She explains that for several months she has been sexually active with a young man a few years older than she is whom she intends to marry, but the social circumstances of both of them preclude marriage before two years' time. A pregnancy would be socially disastrous in her situation. Her family knows about her relationship with the young man, but not its sexual nature. When asked, she replies that she believes that her boyfriend had sexual experience with other girls before they met, but that she is confident that she is now his only sexual partner. What are Dr CD's responsibilities, given medical, ethical, legal, and human rights considerations?

1. *Background*

Adolescence has been defined by the WHO as being between the ages of 10 and 19 years, and youth as between 15 and 24 years.[1] The Convention on the Rights of the Child defines a 'child' as a human being who is below the age of 18 years. Adolescence is the period of transition from childhood to adulthood. National definitions of a child, an adolescent, and a youth vary markedly, as do laws and policies governing adolescents' access to reproductive and sexual health services.[2]

Biologically, adolescence is a period of health. The principal risks to adolescent health are not due to biomedical conditions, but to social health hazards. The social health morbidities of adolescence include substance abuse, injury

[1] WHO, *The Health of Young People* (Geneva: WHO, 1993), 1.
[2] Center for Reproductive Law and Policy, *Reproductive Rights 2000: Moving Forward* (New York: CRLP, 2000), 57–67.

from accidents and violence, sexual exploitation and abuse, sexually transmitted diseases (STDs), and adolescent pregnancies.

Young people are a sizeable group of the world population. In the year 2000, people aged 10–24 accounted for 27 per cent of world population, 20 per cent in more developed regions, and 29 per cent in less developed regions.[3] The proportion is projected to decrease in the next century, but the numbers overall will increase. By 2025, the number is expected to increase from about 1,663 million in 2000 to about 1,796 million. In more developed regions, the number is projected to decrease from about 241 to 198 million. In less developed regions, the number is expected to increase from about 1,423 to 1,597 million.

During the period of adolescence, three developments take place.[4] Biological development progresses from the initial appearance of the secondary sex characteristics to that of sexual maturity; psychological processes and cognitive and emotional patterns develop from those of a child to those of an adult; and a transition is made from the state of total socio-economic dependence to one of relative independence. Two trends are taking place in almost every society, though at different paces: a trend towards an earlier onset of biological maturation, and a trend towards delay in socio-economic maturation, with a resultant wider bio-social gap in human development. Today, girls everywhere are becoming sexually mature at an earlier age than in previous generations. Genetic, health, and socio-economic factors influence the wide variations in age of menarche among different countries. Since boys and girls have now to spend more years in school, learning, and training, before they can enter the complex labour market, the period of socio-economic dependence is often prolonged.

Adolescents are left with difficult choices in socio-sexual behaviour: premarital sex, early marriage, or abstinence. The different patterns predominate in different countries, and patterns of transition exist. Premarital sex is now the predominant pattern in developed countries and some parts of the developing world including parts of Latin America and the Caribbean. There is also evidence of a similar trend in other regions. This choice often carries with it an increased prevalence of sexually transmitted infections, unwanted pregnancy, and abortion, with adverse health and social consequences. There is often a double standard between boys and girls. Early marriage is a predominant pattern in many parts of the developing world, notably Asia and Africa. It carries with it a curtailing of the socio-economic development of girls, often limiting their role and opportunities in life to a career of childbearing and childrearing,

[3] Population Reference Bureau, *The World's Youth 2000 Data Sheet* (Washington, DC: Population Reference Bureau, 2000), 10, 18.
[4] M. F. Fathalla, *From Obstetrics and Gynecology to Women's Health: The Road Ahead* (New York and London: Parthenon, 1997), ch. 17, 'Adolescent Sexual and Reproductive Health', 215–21.

and the assumption of parental responsibility before social maturity. Abstinence and delayed marriage seems to be a declining pattern, with the possible exception, at least until recently, of China.

In addition to the widening bio-social gap in human societies today, the family no longer serves in the dominant role of transmitting intergenerational knowledge. Communication between parents and adolescents has greatly decreased. The problem of communication is not in adolescence itself, but in the need to come to grips with the new realities of adolescence, with which parents may be unfamiliar. Misconceptions are contributing to turning what should be a normal, positive phase in growth and development into a problem.

While female adolescents are clearly more likely to face adverse reproductive health consequences than adult women are, it is misleading to lump all adolescents together. It is important to indicate that adolescents are not a homogeneous group, and that younger female adolescents are particularly disadvantaged in terms of adverse health consequences.

2. *Medical Aspects*

2.1. *General points*

Adolescents have reproductive health needs related to sexuality, protection from sexually transmitted infections, fertility regulation, and pregnancy. The response should not be fragmentary. Irrespective of the reason for contact with the reproductive and sexual health system, adolescents' needs should be addressed in their totality. Respect, confidentiality, and privacy should be observed. An adolescent girl seeking a method for fertility regulation would not be well served if her needs for protection from sexually transmitted infections are not addressed. It should also be kept in mind that the adolescent seeking non-specific medical advice may have a 'hidden agenda' and may be waiting for the health professional to bring up the subject of sexuality. Accordingly, health professionals should be prepared to offer and provide comprehensive reproductive and sexual health advice and care.

2.2. *Sexuality*

The female adolescent's approach to a sexual relationship is often different from that of the adolescent boy. It is usually directed to the search for love, tenderness, and closeness, rather than for sexual release. In time, she will learn to enjoy and seek sex as much as the male, and the male may also begin to develop a more caring and loving approach towards the female. Until recently, the subject of adolescent sexual activity was too sensitive to discuss. Information is

now available from a number of surveys, however, to indicate that the trend in most countries is for earlier sexual initiations among both boys and girls.

Statistics on rape from several countries suggest that between one-third and two-thirds of rape victims worldwide are 15 years old or younger.[5] Male adolescents need to be educated about responsible sexual behaviour. Studies have also shown high rates of adolescent pregnancies to result from older males' sexual abuse of younger girls.[6] The males may be related to them, or be in positions of authority or influence over them. When adolescent females seek contraceptive or other reproductive health care, the question of whether their sexual relationships are voluntary or involuntary is relevant.

2.3. *Sexually transmitted infections and contraception in adolescents*

Young people aged 15 to 24 have the highest rates of sexually transmitted infections, including HIV.[7] Adolescents should be informed that any sexual relationship, other than a stable mutually monogamous one, carries a risk of sexually transmitted infections; a partner may be infective without having any lesion or even being aware that he or she is infected. A condom should be used in any sexual intercourse carrying a risk of transmission of infection.

For the non-married adolescent, in terms of protection, saying NO is the best oral contraceptive when refusal of sexual advances is a realistic option. The condom is the best method of contraception if there is a risk of STD transmission and an adolescent can require her partner to use it. When she cannot and does not have access to the female condom, provision of contraception for her may leave her exposed to STDs. Emergency contraception is a useful backup method after unprotected intercourse that, unfortunately, is greatly underutilized. It can prevent many unwanted pregnancies, and should be more widely taught and learned.

2.4. *Adolescent pregnancy*

Thirty-three per cent of women in developing countries give birth before the age of 20, ranging from a low of 8 per cent in East Asia to 55 per cent in West Africa.[8] In more developed countries, about 10 per cent of women give birth by age 20; however, in the United States, the level of teen childbearing is significantly higher, at 19 per cent. Only a few of the teenage pregnancies are really wanted by the young mothers. Many have been coerced by social pressure into early marriage and early pregnancy, or pregnancy has resulted from

[5] Fathalla, *From Obstetrics and Gynecology to Women's Health*, 215–21.

[6] L. Heise, M. Ellsberg, and M. Gottemoeller, 'Ending Violence Against Women', *Population Report Series L.*, 11 (1999), 9.

[7] Population Reference Bureau, *2000 Data Sheet.*

[8] Ibid. 1.

unmarried adolescents being denied free access to contraception. Adolescents account for at least 10 per cent of all induced abortions.

Marriage occurs earlier in developing than in developed regions, with regional variations ranging from 4 to 37 per cent.[9] The percentage of women aged 15–19 who are currently married is estimated at 19 per cent worldwide, 6 per cent in developed countries, 21 per cent in developing countries, and 26 per cent in developing countries excluding China. The young bride will be under societal pressure to prove her fertility, which in some societies is the basis of her worth.

Births to unmarried adolescents are increasing. This is due both to an increased exposure to the risk of pregnancy and to limited access to information and means for protection. Opportunities for sexual activity without and outside of marriage have increased, social mores are changing, and in some areas, young women exchange sexual favours to meet their material needs. Access to contraception, including information and education, is still limited for the unmarried adolescent in many societies.

Complications of pregnancy, childbirth, and unsafe abortion are major causes of death for women aged 15–19 in less developed regions. Adolescent pregnancy can have short-term and long-term adverse health consequences. In the short term, the outcome of pregnancy is more likely to be unfavourable. One reason is biomedical. The pregnant adolescent girl is more likely to suffer from toxemia of pregnancy and cephalo-pelvic disproportion (when the bony pelvis did not have enough time to complete its growth), and is more likely to have a low birth weight baby. Another reason for an unfavourable outcome is the poor utilization of health services and poor compliance with medical advice among adolescents. A third reason for an unfavourable outcome is social, since adolescent pregnancy is more common among lower socio-economic levels of communities. There is evidence that the nutritional needs of the adolescent mother increase, to satisfy the cumulative needs of the still growing young girl and the nutritional requirements of the growing foetus, and poor nutrition will affect both.

The impact of unwanted pregnancy on the mental health of the adolescent should not be under-estimated. If the girl decides to terminate an unwanted pregnancy, and safe abortion services are not available or accessible, the girl may risk her health and her life. In the long term, adolescent pregnancy may have adverse social consequences, particularly for the unmarried adolescent. The girl is likely to drop out from school, and in some cases becomes liable to expulsion. In addition, as a single parent, the girl may have economical problems in rearing her child and making a living. She may be forced into an undesirable marriage. An unmarried mother can be a social outcast in some

[9] Population Reference Bureau, *2000 Data Sheet*. 10, 18.

countries, and she may even be at risk of being killed by a member of her family 'to bury their shame' and assert their honour. In several countries, so-called 'honour killings' are exempt from punishment or where they are punishable they are rarely investigated or prosecuted, or are only lightly punished.[10]

Teenage girls facing unwanted pregnancies often seek abortions. Teenagers are more likely than older women to be forced to have an unsafe abortion. They also tend to delay obtaining the procedure until later in pregnancy, when the procedure becomes more difficult and may carry more risk. Adolescents, therefore, account for a disproportionate number of abortion complications.

3. *Ethical Aspects*

The ethical principle of justice, that like cases be treated alike and different cases differently, raises the question of whether adolescents are to be treated like mature adults, or children. The answer may be that they are like both, to different degrees. Sexually active adolescents who request contraceptive protection appear to exercise adult prudence, and may be treated as adults regarding both information of their options for prevention of pregnancy and STD infection, and protection of their confidentiality. However, some parent-like protection, or paternalism, is often an appropriate element in their care. Their inexperience in adult relationships makes it ethical to warn them of their vulnerability to exploitation and abuse, even in relationships with partners they trust, and for instance that their protection against unplanned pregnancy may not be protection against STDs, including HIV infection.

Protection in their family and community settings may also be appropriate. In cultures where unmarried adolescent sexual activity is recognized, even if not condoned, as an aspect of courtship preceding marriage, the consequences of adolescent sexuality, for educational, family, and comparable security will usually be less severe than in cultures where sex before marriage is unacceptable and heavily punished. In the latter case, however, both advice against violating social expectations and protection against pregnancy are likely to be more urgent, recognizing that the sanctions against pregnancy outside marriage are more threatening to the female who experiences it than to the male responsible for causing it.

Where adolescent health care involves payments that the adolescents cannot make, their parents' involvement may be necessary for payment, directly or through private or public insurance plans. Parents may therefore learn of gynaecological treatment, but ethically the adolescent patients' confidentiality

[10] See the laws of Jordan, Pakistan, and Syria, discussed in CRLP, *Reproductive Rights*, ch. 6 on 'Rape and Other Sexual Violence', 45–50.

must nevertheless be protected. Disclosure of the particular forms of care requested and given should not be made without patients' clearly given consent. If patients inform their medical service providers that they require protection against sexual involvements to which they are being compelled involuntarily to submit, however, notification of others such as parents or police authorities that are obliged to provide protection will be ethically appropriate.

4. *Legal Aspects*

Laws differ among countries about the legal definition of an individual who can give informed, legally effective consent. The governing legal rule is that mentally competent individuals such as adults may act according to their wishes, even when what they wish to do appears contrary to their best interests. When legal minors wish to act in ways that appear against their interests, there is a tendency to presume that this shows that they are not competent to make decisions for themselves. However, some legal systems recognize two categories of minors, namely 'mature minors' and 'emancipated minors'. 'Mature minor' is the term used for older teenagers who understand the risks and benefits of medical care and can give informed consent. The term 'emancipated minor' generally refers to teenagers who are free from parental control: married, members of armed forces, pregnant, or living away from home.

Legal systems tend to recognize that mature minors, and emancipated minors to the extent of their emancipation, may give legally effective consent to medical care without their parents' approval, or knowledge. That is, their consent prevents medical examinations and treatment from amounting in law to an assault. Legal recognition may be based on Ministry of Health regulations, legislation, or court decisions. Moreover, the law requires that these adolescent patients are entitled to confidentiality in the care they receive.

Laws exist in some countries that make consensual sexual intercourse with adolescents below a given age, such as 16, a criminal offence, sometimes described as 'statutory rape' because underage consent is legally ineffective. Such laws, however, do not make offenders of the adolescents themselves, but only of those who have intercourse with them. Therefore, health service providers who afford underage adolescents protection against pregnancy and STDs are not parties to any offence. Providers may be at legal risk, however, if they counsel and equip adolescents' sexual partners to have relations with them safely. Education and information given to adolescent males of a general nature is legally appropriate, for instance, for their own protection against STDs. However, giving advice on safety in intercourse with particular adolescent partners may implicate providers in the offence the males may commit.

5. *Human Rights Aspects*

The Children's Convention provides in Article 24(1) that states shall strive to ensure that no child is deprived of access to health care services. This means that parents cannot veto such services that are appropriate in an adolescent's circumstances. The Convention requires respect for parents' rights, but Article 14(2) requires that parental rights be exercised 'in a manner consistent with the evolving capacities of the child'.

The Cairo Plus Five Report echoed the central role of families, parents, and other legal guardians to educate their children about sexual and reproductive health, consistently with the 'evolving capacities of adolescents'.[11] These provisions embody the legal consent of the mature minor, who is capable of enjoying the rights, and of bearing the responsibilities, of an adult. They give effect to the transcending human rights principle that, when adolescents are capable of adult judgement and responsibility, they should not suffer discrimination on grounds of their chronological age.[12]

In addition, the adolescent has a right to health information, education, and services, and has a right to privacy and confidentiality. Governments have adopted the following provisions of the Programme of Action at the United Nations International Conference on Population and Development (ICPD), held in Cairo in 1994:[13]

> Countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents. (para. 7.45)
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> Countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually-transmitted diseases and sexual abuse. . . . These services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent. (para. 7.45)
>
> Countries with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies. (para. 7.46)
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> Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to

[11] UN, General Assembly, *Report of the Ad Hoc Committee of the Whole of the Twenty-First Special Session of the General Assembly: Overall Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development*, A/S-21/5/Add.1 (New York: UN, 1999) (hereinafter Cairo+5), para. 73(*d*).

[12] R. J. Cook and B. M. Dickens, 'Recognizing Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Healthcare', *Int. J. Gynecol. Obstet.* 70 (2000), 13–21.

[13] UN, *Population and Development*, i. *Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994* (New York: UN, Department for Economic and Social Information and Policy Analysis, 1994), ST/ESA/SER.A/149.

respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family planning practice, family life, reproductive health, sexually-transmitted diseases, HIV infection and AIDS prevention. Sexually active adolescents will require special family planning information, counselling and services. (para. 7.47)

Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities and services concerning reproductive and sexual health. (para. 6.15)

The Cairo Plus Five Report amplified duties arising under these subparagraphs 7.45–7.47 of the Cairo Programme, and requires countries to 'ensure that programmes and attitudes of health-care providers do not restrict access of adolescents to appropriate services and the information they need . . . and . . . remove legal, regulatory and social barriers to reproductive health information and care for adolescents'.[14]

6. *Approaches*

6.1. *Clinical duty*

Dr CD must speak to Miss B in order to assess her capacity to maintain a sexual relationship, and to protect her emotions in forming a romantic attachment to her partner. In the event of uncertainty, Dr CD should have Miss B speak to a colleague as well, to obtain a second assessment, or seek guidance on indicators of Miss B's maturity. Miss B should be advised about the available options for the contraceptive service she has requested, and also about protection against STDs. She should also be advised to request her partner to ensure his own reproductive health, and to use condoms at least until he tests negative for STDs, including HIV infection, and perhaps thereafter until he is prepared for the responsibilities of fatherhood. Dr CD should encourage Miss B to ensure her partner's education regarding sexual and reproductive health. If there is a risk of legal liability due to Miss B's age, Dr CD should not undertake that education of the male partner, but facilitate his receiving independent reproductive health counselling from another source. Miss B should be encouraged, in any event, to be self-reliant in her protection against unplanned pregnancy.

Dr CD should ensure that Miss B's confidentiality is protected by all physicians and office staff aware of her identity and care. If Miss B's parents will learn of Dr CD's care of Miss B because of payment for services and products

[14] Cairo+5, para. 73(*f*).

she requires, Dr CD should nevertheless not present detailed information to them, but give only a generalized description of care of a gynaecological condition. If police or other such authorities seek access to Miss B's medical record in investigating her partner's possible offence, Dr CD should invoke medical confidentiality to refuse disclosure, and consult with appropriate professional and clinical licensing authorities and professional associations if pressed.

6.2. *Health care systems obligations*

The General Recommendation 24 on Women's Health of the Committee on the Elimination of Discrimination against Women (CEDAW) states that:

the obligation to respect rights requires states parties to refrain from obstructing action taken by women in pursuit of their health care . . . states parties should not restrict women's access to health services or to the clinics that provide those services on the grounds that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. (para. 14)

The CEDAW General Recommendation 24 also states that: 'in particular, states parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality' (para. 18).

General Comment 14 on the right to the highest attainable standard of health, of the Committee on Economic, Social and Cultural Rights, states that: 'the realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services' (para. 23).

Dr CD should ask what reproductive and sexual health education Miss B has had, including during her schooling and, through her, what education her partner has received. Dr CD should also investigate how effectively general and specialist medical practitioners and other health care providers are organized, and collaborate with governmental and non-governmental agencies to provide necessary adolescent counselling and services. Dr CD should also consider whether to present information on the adequacy or inadequacy of services at the next meeting of the national or regional society of obstetrician/gynaecologists. Dr CD probably knows whether colleagues have faced similar issues in the provision of care to adolescents and whether there might be interest in developing professional guidelines on adolescent reproductive and sexual health care. Dr CD should also consider whether development of such guidelines would provide valuable opportunities to assess how principles such as respect for the evolving capacities of adolescents could be adopted through national or regional policies.

The calibre of preventive reproductive and sexual health care services should be assessed. Dr CD should pay regard to public tolerance and intolerance of adolescent sexual expression and the balance between social, including religious, restraints that emphasize sexual abstinence before marriage and the practical burden of unplanned adolescent pregnancy, childbirth, abortion, and STD infection.

6.3. *Social action for underlying conditions*

Dr CD should reflect on family and social determinants of Miss B's request, and identify whether she is exercising mature prudence against untimely pregnancy and STD, or is fearful that disclosure of her sexual activity would jeopardize her and her family's social standing, her physical security, or her very life. Dr CD should also address whether provision of medical advice and services to Miss B would be regarded in the community as conscientious routine care, or misunderstood as immoral complicity in a young couple's misconduct. Social leaders sometimes believe that education in sexual health and hygiene itself promotes adolescent sexual curiosity and misconduct. Dr CD should collaborate with health care colleagues and associations and governmental and non-governmental organizations to show the dysfunction of adolescent ignorance about sex, sexuality, and preventive health care. They could demonstrate that professional reproductive and sexual health education and services are compatible with parents' concerns for their adolescent children's best health care and interests.