



Danger Ahead: how restricting teens' access to safe abortion threatens their lives and health

Ipas Policy briefing paper

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Introduction

Citizens on both ends of the political spectrum in the United States are interested in lowering rates of teenage pregnancies. Where they differ is on the question of supporting measures to help young women prevent and cope with unwanted pregnancies. For example, some favor comprehensive sexuality education that instructs teenagers about abstinence, condoms and other forms of birth control as pregnancy-prevention tools, while others believe abstinence is the only acceptable method for young people. Some want young women who have been unable to prevent an unwanted pregnancy — for example, because their contraception failed or they could not obtain emergency contraception² — to have the option of an abortion, preferably as early in pregnancy as possible. Others wish to restrict this possibility.


It is in this context that new laws are being passed and challenged at both the state and federal levels.

On November 30th, the U.S. Supreme Court will begin hearing the case of *Ayotte v. Planned Parenthood*[®] of *Northern New England, et al.* The case — the first related to abortion to be heard by the Court in five years — will determine the constitutionality of a New Hampshire law requiring minors to notify their parents before having an abortion.

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² Emergency contraception includes use of hormonal pills taken up to five days after unprotected intercourse to prevent pregnancy. Emergency contraceptive pills are ineffective once the process of implantation has begun and therefore do not cause abortion. (WHO, 2005)





The First Circuit Court of Appeals affirmed a district court decision that found the law — known as the Parental Notification Prior to Abortion Act — unconstitutional. The Court held that the law places an “undue burden” on the right to abortion because it lacks an exception to protect the health of the pregnant minor, and because its death exception is too narrow. Regarding a health exception, the First Circuit Court of Appeals applied the decisions in *Roe*³, *Casey*⁴ and *Stenberg*⁵, finding that the Constitution requires a health exception where the state statute is enacted with any valid state interest, including the interest of protecting minors. The court also ruled that the law’s death exception too narrowly requires doctors to predict accurately whether death will occur within 48 hours of the moment a minor seeks an abortion, and fails to safeguard doctors’ judgment from liability. Kelly A. Ayotte, the Attorney General of New Hampshire, is challenging this decision. Plaintiffs are Planned Parenthood of Northern New England, the Concord Feminist Health Center, the Feminist Health Center of Portsmouth, and Wayne Goldner, M.D. The decision under review can be found at <http://www.ca1.uscourts.gov/pdf/opinions/04-1161-01A.pdf>.

The Court’s decision in *Ayotte* could have critical implications for young women’s health and their ability to access safe-abortion services. For this reason, *Ayotte* offers an important occasion for U.S. policymakers to consider more fully the causes and effects of adolescent unplanned pregnancy and to examine how we can better serve young women who become pregnant and seek to terminate their pregnancies.

To protect women’s health, our highest priority should be to reduce unwanted adolescent pregnancies as much as possible. Nevertheless, eliminating teen pregnancy completely will be impossible because of the multiple factors that lead to unplanned pregnancy, including adolescents’ lack of knowledge about sexual and reproductive health, their lack of access to birth control, contraceptive failure, and sexual assault. While many adolescents may choose to carry unplanned pregnancies to term, some will wish to terminate unwanted pregnancies.


This document does not “promote” abortion for adolescents but acknowledges that abortion is legal in all U.S. states and therefore remains an option for women faced with an unwanted pregnancy. While 48 percent of women in the United States who have abortions are over the age of 24, and the majority of women who have abortions already have at least one child, 19 percent of abortions are obtained by women in their teens (AGI, 2005a). Each year, roughly 13,000 women have abortions for pregnancies resulting from rape or incest (AGI, 2005a). The fact that abortion remains a medical procedure surrounded by controversy should not prevent us

³ The 1973 Supreme Court decision in *Roe v. Wade* that asserted women’s constitutional right to abortion. <http://laws.findlaw.com/us/410/113.html>

⁴ In 1992, the Supreme Court’s decision in *Planned Parenthood v. Casey* upheld the right to abortion, but permitted states to enact law restricting abortion as long as they did not impose an “undue burden” on women. <http://laws.findlaw.com/us/505/833.html>

⁵ In *Stenberg v. Carhart* (2000), the Supreme Court ruled that a Nebraska law banning so-called partial birth abortion violated the constitution by lacking an exception to protect the woman’s health. The Court also found that the law placed an undue burden on women, as the vague language of the law outlawed more than one procedure, including a technique used in abortions at earlier gestations. <http://laws.findlaw.com/us/000/99-830.html>





from addressing this crucial area of adolescent health care. Doing so will help protect young women's well-being and prevent avoidable injury and death from clandestine abortion. Drawing on data and experiences from around the world, this briefing paper highlights the needs of adolescents who experience unwanted pregnancies. It demonstrates that when young women encounter barriers to sexual- and reproductive-health information and safe abortion, their health and lives are endangered since many girls and young women will resort to unsafe methods when safe-abortion services are restricted.

We first describe briefly the potential risks of pregnancies in young women. The paper demonstrates the high incidence of unsafe abortion where young women face barriers to safe reproductive-health services, including requirements for parental involvement in an abortion decision. Teenagers' reasons for not involving their parents in their decision to have an abortion are also addressed. By undermining adolescents' abilities to make decisions about their own health care and impeding their access to safe, legal health services, such barriers jeopardize their health, well-being and, in some cases, their lives. The concluding recommendations outline measures both for preventing unwanted teen pregnancy and for improving young peoples' access to reproductive-health information and services.

The problem of unwanted adolescent pregnancy

Leaders of the world's nations joined together in 2002 at the United Nations General Assembly Special Session on Children to affirm that adolescent girls need special attention in policymaking and service provision, including their sexual and reproductive health (UN General Assembly, 2002). For adolescent girls everywhere, prevention and management of unwanted pregnancy and its consequences is a key health issue.


■ The facts about adolescent pregnancy

Young people aged 15-24 years comprise 18 percent of the world's population; children up to the age of 15 years account for another 30 percent of the global population (United Nations, 2005). About 25 percent of the young people in less developed countries are living in extreme poverty, surviving on less than \$1 per day (UNFPA, 2005). In the United States, 17.8 percent of children (13 million) currently live in poverty, and 11.2 percent of children (8.3 million) under the age of 18 have no health insurance. Young people between the ages of 12 and 17 are less likely to be insured than those under the age of 12 (DeNavas-Walt, et al., 2005).

On average, younger women are more fertile than older women (Dunson, et al., 2002), and about 10 percent of pregnancies worldwide occur among teenagers (Senanayake & Faulkner, 2003; UNICEF, 2002). In the United States, many adolescents using prescription contraceptives reported that they did not begin using the method until they had been sexually active for one or more years (Klein and the Committee on Adolescence, 2005).

Most international reports on adolescent pregnancy refer to women aged 15-19 years. However, many girls reach puberty at a younger age and are therefore able to become pregnant. The Pan American Health Organization (PAHO) reports that in the Latin American and Caribbean region, the onset of menstruation occurs on average between the ages of 9-11 years and data indicate that first sexual intercourse may occur within two years of a girl's first period (Schutt-Aine & Maddaleno, 2003). It may take place even earlier, however; in the last few years, cases of pregnancies in girls as young as 8-10 years have been reported in Brazil and Costa





Rica (BBC, 1998; López Vigil, 2003). A 1992-1993 study in the United States among girls aged 3-12 years who visited pediatricians found that 48.4 percent of black and 14.5 percent of white girls were in puberty by the age of 8 years⁶; the average age at menarche was 12.2 and 12.9 years, respectively (Conard & Blythe, 2003).

In developing countries, on average one-third of young women give birth before the age of 20 years (UNFPA, 2005). In the United States, more than 900,000 teenagers become pregnant each year; more than 40 percent of women are pregnant at least once before they reach the age of 20 years and 25 percent of births to adolescents are not first births (Klein and the Committee on Adolescence, 2005). These pregnancies are both intended and unintended.


Some teenage girls do want to become pregnant, often to fulfill a wish to be able to love, nurture and raise a child. Unmarried adolescents may see motherhood as a way to achieve adult status or as a strategy to get a sexual partner to care for or marry them. Girls who marry young may begin childbearing soon after marriage because of familial and societal expectations; globally, most adolescent pregnancies occur within marriage (UNICEF, 2002; Greene et al., 2002).

Still, while some adolescent pregnancies are planned, the rates of unplanned pregnancies among adolescents can be very high. In the Latin America and Caribbean region, 35-52 percent of adolescent pregnancies are unplanned (Schutt-Aine & Maddaleno, 2003). In the United States, more than 90 percent of pregnancies to girls aged 15-19 years are unintended (Klein and the Committee on Adolescents, 2005). Unplanned pregnancies are the result of various factors, including a lack of knowledge about menstruation and pregnancy, a lack of access to, and knowledge about how to use birth control; difficulties in using birth control because of a partner's or family objections; contraceptive failure; and sexual assault.

In some countries (including the United States), one- to two-thirds of sexual assault victims are under the age of 15 (Jewkes et al., 2003). Estimates of the number of pregnancies resulting from coerced sex vary. A U.S. study that followed over 4,000 women for three years found a 5 percent rape-related pregnancy rate among women aged 12-45 years; in Mexico and Ethiopia, 15-18 percent of pregnancies were reported by rape victims to be the result of sexual assault by (Jewkes et al., 2003). Many women suffering sexual assault are adolescents who are raped by perpetrators known and often related to them (Holmes et al., 1996; Garza-Aguilar & Diaz-Michel, 1997; Martínez-Ayala et al., 1999); they face particular challenges in addressing and managing the consequences. Considerable numbers of adolescents are living without the support of one or both parents, such as young people who are in single-parent or migrant families, or who are orphans, streetchildren or refugees.

⁶ Puberty in girls begins when hormones trigger growth and change in the ovaries; it is accompanied by growth and maturation of other internal and external reproductive organs and the start of menstruation (menarche). It is a process that takes several years, ending in medical terms when the menstrual cycle has been established and is regular. Precocious puberty occurs when these developments begin before eight years of age (Larson, 1996).





Lack of accurate information about sexual and reproductive health can further compromise young people's abilities to make healthy decisions and avoid unwanted pregnancy. Research on abstinence-only sex education programs, which bar discussion of contraceptive options, has shown that such programs do not have a significant impact in promoting behaviors that prevent unintended pregnancies. For example, a U.S. study on programs in which youth pledged to remain virgins until marriage showed they abstained from sex for 18 months on average, but were one-third less likely than non-pledging peers to use contraceptives when they did become sexually active (Bearman & Brückner, 2001). On the other hand, comprehensive sexuality education, which discusses the benefits of both delaying sexual intercourse and of using condoms and other contraceptives when adolescents become sexually active, has been shown to contribute to delaying the onset of sexual intercourse, reducing the number of sexual partners and increasing use of birth control (Schutt-Aine & Maddaleno, 2003; SIECUS, 2004).

■ **Adverse outcomes of adolescent pregnancy**

Even when pregnancies are planned, they may have adverse consequences for adolescents. In many countries, including the United States, adolescent motherhood is linked to poverty. Girls who marry young are likely to have children in quick succession, without sufficient birth spacing to protect their health (UNICEF, 2002). In the United States, 83 percent of adolescents who give birth are from low-income families, and studies indicate that between 50-60 percent of adolescents who become pregnant have histories of physical or sexual abuse (Klein and the Committee on Adolescence, 2005). Studies in various countries have documented that pregnant adolescents are less likely to seek prenatal care than older women (Reynolds & Wright, 2004). A World Health Organization (WHO) literature review concluded that a considerable number of adolescents do not receive adequate prenatal care because they attempt to hide pregnancies, are embarrassed or dissatisfied with health services, or encounter financial barriers to care (Treffers, 2002).

Furthermore, pregnancy during adolescence carries potential health risks. Conditions such as anemia and iodine deficiency, which may contribute to adverse pregnancy outcomes, are found frequently among young women living in underprivileged circumstances. Adolescents younger than 15 years are more likely than older women to have miscarriages and stillbirths (Senderowitz et al., 2002). An adolescent younger than 17 years may not yet be physically mature; when her pelvic bones and birth canal have not fully developed, the pelvis may be too narrow to accommodate the baby's head and she may suffer prolonged or obstructed labor, increased risks of hemorrhage and infection, or permanent danger to her bladder and bowels (Eure et al., 2002; Senderowitz et al., 2002; Treffers, 2002).

According to studies in industrialized countries, younger adolescents tend to have a higher prevalence of adverse pregnancy outcomes such as premature births and low birth weight babies than older women, and though the risk of maternal death is low, it is twice as high for adolescents under the age of 17 than for adult women (Satin et al., 1994; Fraser et al., 1995; Jolly et al., 2000; Klein and the Committee on Adolescence, 2005). The babies of young mothers may also suffer high mortality rates; research indicates that the neonatal death rate of babies born to adolescent mothers is nearly 3 times higher (UNICEF, 2002; Klein and the Committee on Adolescence, 2005). A U.S. study on women aged 12-29 years having their first child found that the risk of death was greater for babies born to mothers 15 years or younger than for mothers aged 23-29 years; the rates of infant deaths owed to neglect or abuse were highest among the younger age group (Phipps et al., 2002).



■ Unsafe abortion

Teens seek abortions for many reasons, even when abortion is prohibited or highly restricted by law. These reasons may include (in no particular order):

- ▶ becoming pregnant as a result of incest or sexual abuse
- ▶ becoming pregnant due to lack of contraceptive use or contraceptive failure
- ▶ fears of upsetting parents or bringing shame to the family
- ▶ fears of expulsion from the family home, school or jobs
- ▶ lack of a stable relationship
- ▶ lack of financial means to care for a child
- ▶ a desire to complete their education or achieve other goals
- ▶ already having a young child for which to care
- ▶ fears of difficulty in finding a marriage partner (in areas where men prefer to marry virgins)
- ▶ disliking the man who caused the pregnancy or having a poor relationship with him (Olukoya et al., 2001; Moore et al., no date)

When performed by a trained health-care provider with the proper equipment and under safe conditions, abortion is one of the safest medical procedures (WHO, 2003). But where laws restrict access to abortion or services are inadequate, women often resort to unsafe methods to terminate unwanted pregnancies. Around the world, an estimated 67,000 women die annually as a result of unsafe abortion (WHO, 2003). In many countries where abortion is legally restricted, wealthy women can still obtain safe-abortion care in the private sector. Restricting access to safe, legal abortion therefore disproportionately affects women who do not have the means to procure safe procedures, including poor women, rural women, and adolescents (WHO, 2003). It is currently estimated that 2-4 million unsafe abortions occur among adolescent women in developing countries each year (UNFPA, 2005). These unsafe procedures are either self-induced or done by a licensed or unlicensed medical practitioner. The techniques used vary widely, and include drinking concoctions made of animal dung or herbs, inserting crude tools into the vagina, self-inflicting physical trauma, and overdosing on antimalarial drugs (Nzioka, 2004; AGI, 1999).

Fortunately, most abortions in the United States are still safe; however, current restrictions are leading teenagers to take desperate measures in this country as well. For example, a teenager in the state of Michigan asked her boyfriend to end her pregnancy by hitting her belly with a baseball bat; the couple was afraid to tell their parents that she was pregnant, and Michigan's laws require teens to notify their parents before seeking an abortion (Associated Press, 30 September 2005). The young man was charged with "intentional conduct against a pregnant individual causing miscarriage or stillbirth," and received probation (the girl was not charged). In the state of Texas, a 17-year-old girl pregnant with twins also asked her boyfriend to help her cause a miscarriage; he received a life sentence for two counts of murder after stepping on her stomach (Associated Press, 6 June 2005).



Where induced abortion is highly restricted by law, adolescents have the highest risks of suffering serious complications from unsafe abortions (Treffers, 2002). Women younger than 20 years account for 38-68 percent of patients admitted to hospitals for treatment of unsafe abortion complications in many developing countries (Olukoya et al., 2001). These complications include: cervical or vaginal lacerations, sepsis, hemorrhage, bowel or uterine perforation, tetanus, pelvic infections or abscesses, chronic pelvic inflammatory disease and secondary infertility (WHO, 1994; Olukoya et al., 2001).

Thirteen studies from seven sub-Saharan African countries showed that 39-72 percent of women treated for abortion-related complications were adolescents (Holschneider, 1998). One-third of women who develop serious abortion-related infections in Latin America and the Caribbean are adolescents (Diaz, 1999); in Argentina and Chile, more than one-third of maternal deaths among adolescents are due to complications of unsafe abortions (Miranda, 2003; Schutt-Aine & Maddaleno, 2003; United Nations, 2004).

Worldwide, many teenagers seek abortions at a later stage of pregnancy when the risk of complications is higher (Olukoya et al., 2001); this is also the case in the United States. Adolescents may postpone having abortions until after the first trimester because they do not recognize or acknowledge the pregnancy, they fear the abortion procedure or parental reactions, or they need time to find money to pay for the procedure (Paul et al., 1999). In 2000, a typical abortion at ten weeks gestation cost between \$150 and \$4000, with an average cost of \$372. Few abortions (only 14 percent) are paid for with public funds, and only under specific circumstances (AGI, 2005a). Because of school or work commitments and lack of experience with the health-care system, young women may also find it difficult to find and make appointments with service providers. Clinicians in the United States have noted that clients who seek abortions at 12-18 weeks of pregnancy tend to be younger than those who seek abortions earlier in pregnancy (Castleman, 2003). The Women's Reproductive Rights Assistance Project in Los Angeles, California, which provides financial assistance to women seeking abortions, found that, in 2003, girls aged 10-17 years had the highest percentage in any age group of pregnancies over 20 weeks when they sought an abortion, often because the pregnancies were discovered at a late stage. A similar project in Seattle, Washington, found that 80 percent of the girls aged 12-17 years who they helped in 2002-2003 were in their second trimester when they sought assistance to terminate their pregnancies (Towey & Poggi, 2004).

It should be noted that while the risk of complications increases with gestational age, later abortions performed by skilled providers are still very safe. However, to reduce the possibility of future unwanted pregnancies, special considerations for adolescents' needs should factor into clinical practice, as well as counseling before and after the procedure. Health systems and providers should work to make youth-friendly services available (WHO, 2003; de Bruyn & Packer, 2004). A study of 360 teens in Baltimore who all sought pregnancy tests revealed that those who had obtained abortions following the test were less likely to become pregnant again and slightly more likely to use contraceptives than the other study participants. Those who had abortions were also more likely to have graduated high school and were better off financially. (Zabin et al., 1989)



Worldwide, adolescents differ from adult women regarding induced abortion in the following ways:⁷

- ▶ Because adolescents are less likely to have information about abortion or resources to access safe services, they more often use unsafe methods, including self-induced abortion.
- ▶ Adolescents are more likely seek abortion from unskilled providers.
- ▶ Adolescents tend to delay seeking abortion from qualified providers for many reasons. Some young women do not recognize pregnancy at earlier stages; others fear stigma and discrimination, or lack money to pay for an abortion.
- ▶ Adolescents also frequently delay seeking care for complications from a clandestine abortion due to lack of transportation, lack of knowledge about where care can be obtained, fears of health-care providers' attitudes, or lack of money to pay for services.
- ▶ Adolescents are likely to experience isolation and emotional stress because of a frequent lack, or perceived lack, of support from their parents or partners.

Reproductive rights and abortion

The U.N. Committee on the Rights of the Child, which monitors compliance with the International Convention on the Rights of the Child, has stated that **governments must take measures to combat unsafe abortions among adolescents**, urging “States parties (a) to develop and implement programmes that provide access to sexual- and reproductive-health services, including family planning, contraception and safe-abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes toward adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education” (Committee on the Rights of the Child, 2003).

Countries also implicitly endorse the right to health when they provide financial resources to international and national agencies that promote or provide health care. The United States is one of the largest funders of WHO, which recognizes the right to health as part of its organizational constitution (WHO, no date). Adolescent health is a major focus for WHO and their guidelines on provision of safe, legal abortions state that attention should be given to the special needs of adolescents (WHO, 2003).

⁷ This box draws on the following sources: Olukoya et al., 2001; WHO, 1997; Khuat, 2003.



■ ■ Legal obstacles to safe induced abortion for adolescents

Most countries permit abortion by law for at least some reasons, including pregnancies resulting from rape and incest, those that may endanger a woman's health or life, or those involving fetal abnormalities. In more than 50 countries, including the United States, abortion is available to women at their request, at least in the first trimester (Center for Reproductive Rights, 2005).

Although the United States has not ratified the Convention on the Rights of the Child, it has acknowledged that young people have a right to health care by virtue of the many federal and state programs that focus on child and adolescent health, as well as through nationally-recognized teen pregnancy prevention programs. The Supreme Court's *Roe v Wade* decision also acknowledged that both adult and adolescent women have a right to legal abortion. *Roe* protects women's right to abortion under a right to privacy, making any state law that prohibits abortion unconstitutional. However, states can and do impose regulations on the provision of abortion services, such as implementing waiting periods, limiting the stage of pregnancy in which an abortion can be obtained, requiring non-essential medical equipment or hospital admission privileges for the provider, and requiring parental involvement. Between 1995 and 2004, states enacted 409 legislative measures restricting access to abortion (NARAL Pro-choice America, 2005).


■ Parental notification and consent

One common barrier teens face in getting an abortion is the legal requirement of parental involvement. As of October 2005, 43 states had adopted laws requiring young pregnant women to obtain parental consent or to notify one or both parents before having an abortion. State courts in nine of these states have temporarily or permanently enjoined such laws, finding them in violation of their states' constitutions. Of the 34 states currently mandating parental involvement, 21 require consent and 13 require notification. Some state laws have exceptions for medical emergencies and in cases of abuse or neglect, or allow for consent or notification from another adult relative. Every state with a requirement in place except Utah permits minors to seek a judicial bypass (permission from a court) as an alternative to parental involvement (AGI, 2005b).

The process of obtaining a judicial bypass can be daunting and difficult for adolescents, particularly those with few resources or lacking supportive social networks, or those with limited English-language capacity. Studies in two states showed that some judicial officials were unprepared to implement bypass procedures because they were not aware of them, despite the fact that the laws had been in place for several years (Planned Parenthood Federation of America, 2004).

Ideally, any young woman who faces an unwanted pregnancy should be able to count on her parents or guardians for support, and most do. Indeed, in most cases in the United States, adolescents do involve their parents and guardians in their decisionmaking. A 1991 national survey in the United States investigated abortion decisionmaking among 1,519 unmarried adolescents in states without parental involvement laws (Henshaw & Kost, 1992). The study showed that only 39 percent had an abortion without the knowledge of either parent; 54 percent of this group were already 17 years old, 43 percent were employed, 15 percent lived apart from their parents and 9 percent had already had a baby. Among the adolescents younger than 15 years, 90 percent of their parents knew about the abortion. The same study showed that 30 percent of the teens who did not involve their parents had experienced family violence, feared such violence or were afraid they would be forced to leave home.





Unfortunately, parental support is not always forthcoming, especially in cases of sexual assault by family members. Some adolescents do not have supportive relationships with their caregivers and fear involving them in decisionmaking around unwanted pregnancies. Even a young person who has a close relationship with her parents or guardians may fear that an unplanned pregnancy or abortion will threaten or strain that relationship or upset her parents. In such cases, adolescents may prefer to seek guidance from other adults, such as other family members, adult family friends or social welfare and health professionals. Such options are made difficult by laws that require parental consent for adolescent abortion; such laws exist in 23 countries in addition to the United States (de Bruyn & Packer, 2004).

A few countries encourage, but do not require parental involvement. In France, minors⁸ seeking abortions are required to see a trained, qualified counselor and obtain a document attesting to the consultation. At least one week after counseling, the minor must then present consent for the procedure from a parent or her legal representative. However, if the minor wishes to maintain confidentiality or has not obtained consent, she can choose to terminate her pregnancy and receive any associated medical treatment and care at her request if she is accompanied by an adult of her choice (France, no date).

Parental consent requirements, or adolescents' perceptions of them, can unnecessarily cause young women to delay seeking abortions. This is a major concern because abortion is safest in the first 12 weeks of pregnancy; while still very safe, second-trimester procedures are less accessible, more expensive, and have a higher complication rate. The Alan Guttmacher Institute calculated that second-trimester abortions among adolescents in Missouri increased by 17 percent after that state enacted its parental consent law (ACLU Reproductive Freedom Project, 2001). In such cases, adolescents may attempt to induce miscarriage or resort to abortions in unsafe circumstances.

■ ■ International agreements and the rights of the child

International law has come to accept the principle of "evolving capacity of the child" (United Nations, 1990). This principle recognizes the right of a child to participate in decisionmaking processes relevant to his or her life insofar as the child's development and maturity allow. Parental involvement in a child's exercise of human rights must be consistent with the child's evolving capacity or maturation.

⁸ Criteria to determine the status of an "emancipated minor" - that is, a teenager who is free from parental control - vary in different legal settings but may include attributes such as living away from the parental home, being married, having graduated from high school, being a member of the armed forces and being pregnant (Cook et al., 2003; Bennett et al., 2004).

“This principle [of the evolving capacities of the child]... has profound implications for the human rights of the child. It establishes that as children acquire enhanced competencies, there is a reduced need for direction and a greater capacity to take responsibility for decisions affecting their lives.... children in different environments and cultures who are faced with diverse life experiences will acquire competencies at different ages, and their acquisition of competencies will vary according to circumstances. It also allows for the fact that children’s capacities can differ according to the nature of the rights to be exercised. Children, therefore, require varying degrees of protection, participation and opportunity for autonomous decision-making in different contexts and across different areas of decision-making.” (Lansdown, 2005).

The U.N. Committee on the Rights of the Child expressed its concern that “early marriage and pregnancy are a significant factor for health problems related to sexual and reproductive health” and said that governments should provide adolescents with access to information on birth control and the dangers of early pregnancy without requiring prior consent from parents or guardians (Committee on the Rights of the Child, 2003). Legal experts state that as a rule, “adolescents capable of freely choosing to be sexually active without parental control are equally capable of receiving reproductive health counseling and care without parental consent” (Cook & Dickens, 2000).


The Pan-American Health Organization (PAHO) has taken such recommendations into account in developing a new conceptual framework to address adolescent sexual health and development. PAHO describes sexually healthy adolescents as those who will “practice abstinence or use contraceptives effectively to avoid unintended pregnancy... [and] act consistent[ly] with one’s own values in dealing with an unintended pregnancy” (Schutt-Aine & Maddaleno, 2003).

Many countries permit adolescents to receive testing and treatment for sexually transmitted infections without parental notification or consent. For example, in Kenya, the national guidelines on voluntary HIV counseling and testing (VCT) state that “mature minors” (individuals younger than 18 years who are parents, married, pregnant, or engaged in behavior that puts them at risk) do not need parental consent for VCT (Finger, 2002). In the United States, all states permit minors to consent to confidential diagnosis and treatment of sexually transmitted infections (STIs) (Conard & Blythe, 2003).

Many laws also recognize the rights of minors to place their children for adoption; in the United States, 46 states and the District of Columbia permit mothers younger than 18 years to place their children for adoption without their parents’ consent (Dudley, 2003). Various countries have laws stating that minors who become mothers can be considered of majority age and capable of making decisions regarding their children’s medical care (Cook & Dickens, 2000).

Since young women are considered mature enough to make decisions for their children, they should also be considered mature enough to make decisions about their own reproductive health, including abortion care. In Great Britain, women younger than 16 years of age are encouraged to involve a parent or supportive adult, but a physician can perform an abortion if s/he thinks it is in the patient’s best interests and deems the young woman capable of giving informed consent (Royal College of Obstetricians and Gynaecologists, 2004).





Given the great vulnerability of adolescents to the consequences of unsafe abortion, respected professional agencies and associations, such as the American College of Obstetricians and Gynecologists and the Commonwealth Medical Trust, an international health organization based in the United Kingdom, have declared that adolescents should have access to safe, legal abortion (American College of Obstetricians and Gynecologists, 2003; Commonwealth Medical Trust, no date). The American Academy of Pediatrics has also spoken out on the issue.

“...the American Academy of Pediatrics (AAP) reaffirms its position that the rights of adolescents to confidential care when considering abortion should be protected... Adolescents should be strongly encouraged to involve their parents and other trusted adults in decisions regarding pregnancy termination, and the majority of them voluntarily do so. Legislation mandating parental involvement does not achieve the intended benefit of promoting family communication, but it does increase the risk of harm to the adolescent by delaying access to appropriate medical care...”

Committee on Adolescence, American Academy of Pediatrics, 1996

What should be done?

The previous sections have laid out the barriers adolescent girls face trying to prevent or end an unwanted pregnancy. Denied access to information on contraception or abortion, the lives, health and futures of many young women are at grave risk. However, a number of policy measures can be taken to address too early and unwanted adolescent pregnancies and unsafe abortions.

■ Prevent unwanted pregnancy

There is an urgent need to implement policy measures that can contribute to preventing unwanted pregnancies and abortions among adolescents. The following elements can contribute to appropriate policies:

- ▶ Support for comprehensive sexuality education in schools and through out-of-school programs for young people. Ensuring that young people receive information on the risks of too early pregnancy and unsafe abortions, information about birth control, and options for addressing an unwanted pregnancy, including safe, legal abortion.
- ▶ Elimination of legal and regulatory barriers to birth control for teenagers, including emergency contraception. Studies in the United States have shown that increased use of emergency contraception contributed substantially to an 11 percent decrease in abortion rates from 1994-2000 (Jones et al., 2002).



- ▶ Health services designed to meet adolescents' needs. Adolescents are more likely to seek sexual- and reproductive-health care when they are able to access youth-friendly services characterized by a welcoming, non-judgmental setting that offers a range of services such as sexuality education; contraceptive counseling and provision; HIV/STI diagnosis, testing and treatment; and pregnancy testing and information about abortion. Youth-friendly services will also have information available on youth programs that address issues such as self-esteem and self-respect, decisionmaking, and negotiation in romantic and sexual relationships.

■ Information on abortion

Abortion is often avoided in information and education for adolescents, or addressed only in terms of the dangers of unsafe abortion. For example, in the United States, the influence of anti-abortion advocates has made it appear that most people are against informing adolescents about the possibility of pregnancy termination. In fact, a 2003 national survey in the United States, which included an over-sampling of parents, showed that 85 percent of respondents believed that it was appropriate to address the topic of abortion in middle and high schools (National Public Radio et al., 2004). In addition, a survey of sexuality education teachers in 1999 found that 89 percent believed that students should have received factual information about abortion by the time they reach grade 12, while 84.4 percent thought schools should have taught students about ethical issues related to abortion by that grade (Darroch et al., 2000).


Policies should ensure that steps are taken to inform young people about abortion in a factual and neutral manner and permit the following measures:

- ▶ Incorporating information on pregnancy termination into sexuality education for young people. Adolescents should be told when pregnancies can be legally terminated, as well as the legal requirements and exceptions.
- ▶ Enabling adolescents to gain access to reproductive-health services that combine neutral counseling on pregnancy diagnosis and pregnancy outcome options (parenting, temporary foster care, adoption, abortion).
- ▶ Ensuring that local opposition to abortion and/or lack of knowledge on the part of providers and legal authorities does not impede implementation of laws that permit termination of pregnancy.
- ▶ Ensuring that clinicians understand the conditions for legal abortion with a focus on adolescents' needs (for example, judicial bypass options).
- ▶ Ensuring that social welfare and health-care professionals, counselors and peer educators can provide referrals for safe, legal abortion care and that adolescent-health services offer such care.

■ Increase adolescents' access to safe, legal abortion services

Parental consent and notification laws impose daunting and often insurmountable barriers to safe-abortion care that must be prevented or eliminated. Such provisions may result in a young woman delaying abortion to a later gestational period (at which time the risks of complications and the cost of abortion increase), attempting to end a pregnancy through unsafe means, or carrying a pregnancy to term despite her desire to have an abortion. Where parental consent requirements and judicial bypass provisions are in place, service





providers can mitigate the negative effects for adolescents by assisting them to navigate the legal system. In addition, other steps that can be taken to increase access to safe, youth-friendly services include the following:

- ▶ Making services more affordable and accessible for adolescents by providing free services, fees based on a sliding scale or subsidized fees.
- ▶ Eliminating unnecessary administrative requirements and medical regulations that impede adolescents' access to safe, legal abortions.
- ▶ Collecting data on the stage of pregnancy in relation to abortion clients' ages, together with information on why women have later rather than early abortions, to determine whether adolescents experience greater barriers to accessing services than adults.
- ▶ Documenting both female and male adolescents' experiences with abortion and abortion care so that policies and services can be improved by meeting their needs.

In conclusion...

"We do not have access to contraception. We are stigmatized if we have a child before marriage. We do not have the right to abortion. What a dilemma! How can we not die if we are exposed to risky abortions? How can we not resort to abortion if a child before marriage is a sacrilege? How can we avoid having children when there are no contraceptive services?... We wish to affirm that one of the best weapons in the fight against risky abortions among the young is to respect our rights, starting with the right to information."

- Brison Ebaya, *Association for Changes in Behaviour in the battle against HIV/AIDS and for education in SRH [sexual and reproductive health] for the young, Kinshasa, Democratic Republic of Congo (IPPF, 2003).*


Unwanted pregnancy in adolescents is an issue that cannot be ignored. Many pregnant adolescents want or need to end a pregnancy to avoid psychological trauma, socioeconomic turmoil, and risks to their lives and health. Because adolescents face certain risks in pregnancy and abortion not experienced by older women, special care should be taken to address their needs.

Implementation of the recommendations above can assist policymakers and care providers in meeting the special needs of adolescents faced with unwanted pregnancies and the decision to have an abortion. As has been shown recently in the cases in Michigan and Texas reported above, ignoring the needs of adolescents can have disastrous consequences.

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