Sexual and Reproductive Rights of Young People:

Autonomous decision making and confidential services
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YOUTH AUTONOMY AND RIGHT TO CONFIDENTIALITY

Prologue

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Aproximately 14 million girls and women under age 20 give birth every year worldwide.\(^1\) Furthermore, it is deemed that teenagers undergo 2.5 million out of the approximately 19 million unsafe abortions taking place every year in the developing world.\(^2\) These numbers speak for themselves. They show that governments and societies must recognize the young as sexually active, and therefore ensure their sexual and reproductive rights through specific policies, laws, and programs.

There is a preliminary agreement in several countries concerning the need to support young people’s access to health services and to reduce unwanted adolescent pregnancies and the transmission of HIV/STIs. Yet there is no consensus with regard to the way to achieve these goals. Such lack of accord is due to disapproval and denial of sexual life, desire, diversity of sexual orientation, and new models of couple relations, which constitutes a deeply entrenched obstacle. The very notion that young people have rights – in fact, that human rights in general apply to young people as well – is relatively new. This notion was enshrined internationally as recently as 1989 in the Convention on the Rights of the Child, which has been ratified by 191 countries.

The Committee on the Rights of the Child, which watches over compliance with this convention, has stated its concern regarding the high indices of

\(^1\) UNFPA. Adolescents and Youth, Main Health and Development Issues. In State of World Population 2004.
maternal mortality and unsafe abortions among young women, as well as young people’s lack of access to youth services that protect their sexual health. The Convention introduces the principle of evolving capacities, which bears profound implications. The International Planned Parenthood Federation adopted this principle in its Sexual Rights Declaration, which asserts that “the rights and protections guaranteed to people under age eighteen differ from those of adults, and must take into account the evolving capacities of the individual child to exercise rights on his or her own behalf.”

IPPF considers that the differences between youth rights and protections and adult rights pertain to all aspects of human rights but require a particular approach in connection with sexual rights. At IPPF/ WHR we start from the premise that people under age eighteen are rights holders, and that different rights and protections will be more or less relevant at different stages of infancy, childhood, and adolescence.

Article 5 of the Convention on the Rights of the Child establishes that the guidance and direction provided by parents and by other people who are responsible for the child must take into account the latter’s ability to exercise rights in his or her own benefit. The concept of evolving capacity calls for a balance between recognizing children as active agents in their own lives and entitled to be respected as citizens, persons, and rights holders with increasing autonomy, on the one hand, and recognizing their right to be protected in keeping with their relative degree of vulnerability, on the other.

This concept acknowledges that protection levels regarding participation of minors in activities that might cause them harm will decrease in accordance with their evolving capacities. In relation to minor’s sexual and reproductive health, adolescence must be identified as a critical stage in the transformation of these capacities. Such transformation bears significant implications regarding parents’ responsibilities, rights, and obligations. It is important to keep in mind that even though adolescence is recognized as a stage of personal development, how this stage is experienced also depends on the social and cultural context. For instance, in many regions of the world early marriage is still considered a rite of passage to adulthood, and young women’s human rights are violated because their sexual rights are not recognized. These rights depend on young
women’s evolving capacities, which are based on their sexual development and are reflected on social, physiological, and psychological changes.

In the context of access to sexual and reproductive health – including access to safe abortion services – girls’ evolving capacities include their physiological capacity to reproduce, their psychological capacity to make informed decisions on counseling and healthcare, and their emotional and social capacities to adopt sexual behaviors in accordance with the responsibilities and roles such behaviors entail. In addition, the evolving capacity principle combines respect for children, their dignity, and their right to protection from every kind of damage, with the acknowledgment of the value of their own contribution to their protection. Societies must create environments where children may reach their optimum capacities, and where their potential to participate and take responsibility for their decisions about their own lives is due greater respect.

For IPPF/WHR, the adoption of the Sexual Rights Declaration constitutes a very significant step that will further promote our educational activities and our sexual health services directed to young people. At the same time, it will enable us to strengthen our advocacy activities by urging governments to protect, respect, and promote the rights of the young, especially the right to sex education. At IPPF/WHR, however, we try to advance even further. We seek to go from words to concrete action. Not only do we recognize and promote young people’s sexual rights, but we also take every step within our reach to ensure the effective exercise of these rights.

By means of this publication, IPPF/WHR aims to contribute to young people’s exercise of their rights by presenting five articles written by experts. These essays include thoughts and recommendations concerning key elements that foster the development of adolescents’ capacities. We are referring specifically to their ability to make autonomous decisions regarding their sexual and reproductive health in a confidential environment. The articles particularly stress the aspects that must be taken into account in the context of health services provision, including comprehensive care services for unwanted pregnancies. The latter is a topic of special interest for IPPF/ WHR and its Member Associations, and a prevailing problem in Latin America and the Caribbean.
Each paper was developed on the basis of a question that triggered reflection. The following essays resulted from such reflection:

- **Informed Consent: The Capacity of Under-age People to Make Decisions about Their Sexual and Reproductive Health.** *Written by Ana Cristina González and Juanita Durán* - Colombia

- **Legal Regulation of Adolescents’ Capacity in Some Latin American Countries, and Its Impact on Sexual and Reproductive Health.** *Written by Lidia Casas Becerra and Ester Valenzuela Rivera, Attorneys, Diego Portales University-Chile*

- **The Context of Decisions Made by Adolescents: The Case of Sexual and Reproductive Health.** *Written by Juan Guillermo Figueroa Perea* - Mexico

- **Professional Secrecy in Adolescent Healthcare.** *Written by Martín Hevia* - Argentina

- **Laws on Parental Participation: Are They Actually What We Need?** *Written by Yali Bair, PhD, Ana Sandoval, and Annie Lundahl, MSW. Revised by Nora Vargas-EEUU*

Each of these documents served as the basis for discussion at the forum “Young People, Autonomy, and Confidentiality,” held in Argentina in June 2009. As a conclusion to this publication, we include the main agreements and recommendations that resulted from this meeting. We hope they will both guide the efforts of IPPF/WHR and its Member Associations and contribute to the work of other civil society organizations and public sector agencies catering to adolescents.
Informed consent: the capacity of minors to take decisions regarding their sexual and reproductive health

Ana Cristina González Vélez
Juanita Durán

Introduction

Minors often face multiple barriers when they want to make decisions regarding their sexual and reproductive health or need access to health services. First, they face the same barriers as adults, though these obstacles are more pronounced because, as minors, they are in a more vulnerable situation within the healthcare system and are not always entitled access to services.

These barriers, common to the adult population, may be of different types:

- Access (concentration of provision in urban areas, absence of integrated services, limited hours of operation)
- The exercise of rights (lack of privacy of service, absence of

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3 Written by Ana Cristina González V., M. D. IPPF consultant, with the support of Juanita Durán, lawyer.
4 Ana Cristina González Vélez is a physician and holds a master’s degree in social research. She was Colombia’s National Public Health Director (2002-2004), and physician and consultant at PROFAMILIA, in Bogotá (1996-2000). She specializes in sexual and reproductive rights, health and health sector reforms, and advocacy, and has been a member of a variety of national and international boards of directors [Instituto Nacional de Salud (National Health Institute), and Cofciencias, and Asociación por los derechos de las mujeres (Association for Women’s Rights) and WHO Senior Technical Advisory Group, respectively]. Dr. González Vélez has actively participated in the women’s movement both nationally and internationally. She has published articles in international journals and books on sexual and reproductive health. She has been consultant and researcher [WHO, PAHO, Rockefeller Foundation, Centro por los Derechos Reproductivos (Center for Reproductive Rights), UNFPA, IPPF, Ford Foundation], and is currently social affairs officer at CEPAL’s Gender Affairs Division.

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guaranteed confidentiality, request for third-party consent, inadequate information, lack of quality care)

- Financial (lack of resources to access services)
- Administrative (additional requirements that delay access to procedures; lack of certainty regarding the conditions for accessing services)6

For example, while deficiencies in the way in which services are organized—such as limited hours of operation or the location of healthcare centers solely in urban areas—create barriers to adult access, they have an even greater impact on minors, who have limited control over their time and less freedom to travel to health facilities.

Secondly, minors face specific barriers that do not affect the adult population,7 such as the cultural or social conditioning of their parents and their parents’ religious beliefs or expectations on what age children should become sexually active. These types of beliefs and cultural mores may make it difficult for minors to seek services, as their parents may not give them money, may place controls on their time or explicitly prohibit them from doing so. This prevents them from receiving support and guidance and encourages them to turn to unlawful options. They also have to face concerns by service providers, who may question whether to treat patients whose decision-making capacity and autonomy may be in doubt. The professional action of physicians is often not clearly defined within the regulatory framework related to informed consent, creating worries concerning the measures that parents or the judicial authorities may take against them.8

The aim of this article is to provide guidance to the IPPF/WHR member association services and providers in overcoming and removing both general and specific barriers minors face in order to encourage access to sexual and reproductive health services. It is based on an assumption that delayed

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6 Idem. pp.148-157. These barriers were originally proposed in relation to the legal termination of pregnancy, but are applicable to other situations of access to sexual and reproductive health services.
8 Idem. pp. 9 and 10.
or impeded access to sexual and reproductive health services due to these barriers is a violation of the fundamental right of minors to health, life, integrity, autonomy, dignity, equality and privacy, all of which are protected by international human rights law.

Ensuring the informed consent of minors is a mechanism that contributes to protecting their sexual and reproductive rights. Conceptually, it implies access to full, accurate and appropriate information and autonomous decision-making, along with monitoring on the part of service providers. Informed consent is one way of overcoming barriers to sexual and reproductive health services and offering minors effective access to the services they want.

This article starts by defining the concept of minor to specify the scope of other norms considered throughout the text and decision-making capacity, including an explanation of different limitations that can be anticipated in the case of minors. Then, it explains the protection provided by international human rights law for the decision-making autonomy of minors in the area of sexual and reproductive health and the law’s involvement when conditions for an autonomous decision are lacking. The article then reviews the elements of informed consent in general and the requirements for minors in particular and ends by summarizing the key position arguments in regard to the consent of minors.
1- Concepts of minority of age and capacity of minors to take decisions on their sexual and reproductive health

While there are various perspectives from which minority of age can be categorized or defined (psychological, anthropological, sociological, legal), the most important for the purposes of considering informed consent is the definition that imposes legal limits on full decision-making capacity, in other words, the minority of age as established by regulatory instruments.

On an international level, the Convention on the Rights of the Child, ratified by all countries in America except the United States,9 provides the most important normative framework of a standard for minority of age. According to Article 1, children are considered minors until 18 years of age unless the domestic legislation of a country establishes otherwise. The Convention’s definition is consistent with the domestic legislations of most Latin American countries, which adhere to an objective standard of age to determine whether a person is a minor. This varies between 18 and 21 years of age.10

For those under 18 years old, the IPPF recognizes three stages at which certain rights and protections take on greater importance: infancy, childhood and adolescence.11 When considering autonomous decisions with regard to sexual and reproductive health, adolescence is crucial. According to the World Health Organization, adolescence spans from 10 to 19 years of age, the period during which an individual gains the capacity to reproduce, moves from the psychological patterns of childhood to adulthood and consolidates his or her financial independence.12 The heightened exposure to risk and the gradual entry into adulthood mean adolescents increasingly seek to exercise their independence, but at the same time face restrictions on their decision-

9  http://www.unhchr.ch/pdf/reportsp.pdf
10  For example: Colombia 18, Peru 18, Argentina 21, Chile 18 and Ecuador 18.
making capacity imposed by legal regulations, a perceived barrier to building their adult lives.

Defining the age of minority has a dual purpose. First, and most importantly, it establishes greater protection of minors by placing them in a priority position in society. That position ensures that their rights take precedence over those of other age groups (e.g., adults) and are specifically protected by the State, society and family. Given that minors are more vulnerable in practical terms, laws, public policies and all actions that affect them must be aimed at protecting them. Minority of age must not become a factor of vulnerability nor should it be used to enable or cause harm, as in a failure to protect the health rights or integrity of minors, which occurs when they are denied the ability to make decisions about their sexuality and reproduction.

The second purpose of defining the age of minority is to impose restrictions on minors’ exercise of their rights and obligations. In other words, it delays their involvement in some activities until it can be assumed that they have sufficient maturity to understand their decisions and take responsibility for the consequences of their actions. However, minors always continue to hold rights despite limitations to their exercise. Although their autonomy of decision-making may be questioned, they continue to hold all rights to health, life and physical integrity, among others.13 Limitations to a minor’s exercise of his or her rights are balanced by the parents’ authority or right to fulfil their duty to protect and care for their child. This has often led to the disproportionate exercise of authority over minors, for example, the infliction of physical punishment,14 which discourages the exercise of autonomy.

These two aims of minority of age (protection and limitations to the exercise of rights) are closely linked and must always be applied together. On the one hand, minors are protected by imposing some restrictions on the

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exercise of their rights in order to prevent their lack of judgment from causing them harm. On the other hand, these restrictions aim to protect them, not cause them harm, and must be interpreted and applied with this in mind. The protection of minors is expressed as a restriction of the exercise of their rights, which in turn is restricted by the need to protect them.

Restrictions associated with minority of age focus particularly on the decision-making capacity of minors in areas that require particular maturity and responsibility, such as marriage, consenting to sexual relations, purchasing alcohol, driving and voting. Domestic legislation in Latin American countries varies on these restrictions. In some regions, they are absolute; in others, they may be lifted if certain conditions are fulfilled. For example, in Colombia, Argentina, Ecuador, Chile and Peru, minors cannot enter into marriage if they are under the age of 18 unless their parents give their consent and the minor has reached a certain minimum age.

Civil legislation in some countries also allows for the possibility of minors acquiring full exercise of their rights before reaching the age of majority. The circumstances that give rise to this emancipation depend on local regulations but often include obtaining legal authorization to marry, have children or establish financial or housing independence. The scope for emancipated children to exercise their rights also depends on local regulations; this emancipation sometimes can be absolute while other times is limited to specific actions, including many healthcare decisions.15

Limitations on the exercise of the right to health, and particularly sexual and reproductive health, differ because health is a human right, protected by regulations based on freedom, dignity and equality,16 such as the Convention on the Rights of the Child.17 Exercise of the right to health is of great importance to the lives of minors as freedom of decision can radically change future of their lives. Limiting the freedom of a minor to

hold a driver’s license, for example, is not the same as limiting the right of a minor to terminate a pregnancy. Refraining from driving until a certain age is irrelevant in terms of rights, while continuing with a pregnancy and possibly bringing up a child, as well as the potential effects on health and life, has a direct impact on a minor’s fundamental rights. What’s more, the likelihood that minors will not drive until they reach a certain age is far greater than the likelihood that they will delay their first sexual encounter. Sexual activity does not typically respond to formal prohibition; peer pressure is strong and is coupled with the need to explore one’s own body and sexuality and the limited or nonexistent information provided by health services and in schools.

The area of sexual and reproductive health is full of contradictions in theory and practice. Limitations on decision-making in this realm often depend on the procedure. For instance, minors may be allowed to make enquiries regarding a possible sexually transmitted infection and treatment, but are prohibited from deciding whether to terminate a pregnancy. These restrictions are not necessarily linked to the invasive nature of the procedure or the level risk it has for the person’s health but to societal, religious or moral views or the perspectives of medical professionals. In the United States, for example, some states prohibit decision-making on low-risk procedures, such as Early Termination of Pregnancy (ETP) in the first term, but permit adolescents to make decisions about unsafe birth and caesarean section procedures.18

The definition of an age under which it is illegal to have sexual relations, while debatable as a way to protect the rights of minors,19 must in practice operate as a measure to prevent abusive sexual relations20 and not as an obstacle to minors obtaining information on sexual and reproductive health or accessing services. In other words, the “age of consent” cannot

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be taken as an age at which sexual and reproductive health services are finally provided.\textsuperscript{21}

The limitations on a minor’s capacity to make decisions must always be interpreted restrictively, as often as possible respecting his or her autonomy and requiring whoever opposes the child’s autonomous decision-making to prove incapacity.\textsuperscript{22} These restrictions must also be interpreted as a form of protection, not limitation, and must not be used to leave minors unprotected.

\textit{In Gillik vs West Norfolk & Wisbech Area Health Authority, the English courts considered a lawsuit brought by the mother of five daughters, who considered the availability of family planning methods by legal regulation in contradiction to the Constitution. She argued that it affected her parental authority and made health professionals accomplices to a crime when it involved minors under the age of consent. The Court disagreed on the basis that the important issue when providing contraception to a minor was his or her maturity and intelligence and in the current social climate, it was necessary to recognise that young people were no longer under strict parental care long before they reached the age of 18.}

\textit{(House of Lords). Gillik vs West Norfolk & Wisbech Area Health Authority. United Kingdom. 1985.)}

2- Respect for the informed consent of minors

Informed consent, which will be considered in more detail in the next section, consists of a person making an autonomous decision that

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expresses his or her will on the basis of full, accurate, appropriate and sufficient information.

The Convention on the Rights of the Child refers to two concepts of great importance in the informed consent of minors: their best interests and their evolving capacities. Both are based on the notion that parental protection must give way to the gradual capacity of minors to take decisions, so they gradually take control over the decisions that affect their lives as they transition to adulthood.

This vision of a minor’s decision-making capacity also assumes that the holding of rights is full and cannot be surrendered, but that their exercise is gradual and depends on the acquisition of tools essential for doing so.23

Two concepts will be developed in this section: the evolving capacities of the minor—including the rule of the “mature minor”—and the best interests of the child. Evolving capacities and the mature minor are founded on the concept of gradual autonomy, in which a child progressively moves from childhood to full autonomy while the holding rights specific to adulthood,24 regardless of age. The best interests of the child, while also recognizing this gradual development of autonomy, is meant as a guide decisions when the child’s decision-making capacity is substituted by that of an adult to ensure that the interests of those making decisions for the child will not cause the child harm.

These two concepts are underpinned by the Convention on the Rights of the Child is highly relevant in Latin America, because the Convention has been ratified, is of binding force and must be reflected in the domestic legislation of the countries that have signed it, though this process is gradual in some cases. Considering these concepts from the perspective of international human rights law establishes newfound dimensions of respect, protection and guarantee, along with the ability to construct local arguments and apply them in concrete cases, even if they are not set out in legal regulations.

Evolving capacities and the rule of the mature minor

The concept of evolving capacities of the child refers to increasing restriction on parents’ authority to decide for their children as the children gain the necessary capacities to make decisions autonomously about their life and exercise the rights that they hold.25

Although protection of children has traditionally been the essential framework for parental relations, there are legitimate and illegitimate uses of this power. Parental control exercised over minors who effectively require some kind of protection due to the instability of their judgment and discernment is legitimate, as these shortcomings could lead the children to make harmful decisions. But when authority is based on denying minors their decision-making capacity, it is illegitimate.26 The evolving capacities of the minor can be understood as a restriction on the exercise of parental authority, which gradually grows until parental intervention is completely replaced by the minor’s independent

exercise of their rights and freedoms. This freedom includes authority over their own sexual and reproductive health, even if they choose a direction that runs counter to their parents’ beliefs and expectations.27

In some European countries, such as England28 and Spain, the concept of mature minor is the rule by which evolving capacities of the child is established. According to the rule of the mature minor, the adolescent must be the one who decides29 when he or she is capable of understanding the information provided, the scope of their actions, the risks and consequences. This is based on an empirical observation that minors achieve “moral maturity” long before reaching the age of majority, although some may do so later than others. This approach assumes that minors may exercise their rights from the moment they are able to enjoy them.30

From a practical point of view, the application of the evolving capacities of the minor and the mature minor raises a number of questions:

- Who specifically should assess whether a minor has sufficient capacity to decide on an issue?
- What must this assessment take into account?
- What stages or procedures must be exhausted?
- What elements must be provided to the minor to promote their autonomy?

These questions are challenges that have to be resolved on a case-by-case basis, and within the regulatory context of the country in question. There are, however, some tools that can contribute to an resolution.

First, the maturity of a minor to make decisions on his or her sexual and reproductive health must be assessed according to the specific procedure in question. A minor who is immature in some aspects of his or her social life (e.g.,

28 Idem. P. 182.
a preference for children’s activities) may fully understand the risks, advantages and consequences of a concrete sexual health situation and be capable of making an independent decision.31 Not all decisions require the same level of maturity nor are all aspects of maturity always relevant to a decision. The requirements should be proportional to the seriousness of the decision to be taken.32

Other signs need to be taken into account as indications of their maturity. For instance, the fact that the minor has visited the health service to ask for advice, which demonstrates an awareness of self-care and responsibility for one’s actions, or an adolescent’s request to terminate a pregnancy, because she considers herself unready to face motherhood.33 This does not mean that those who do not seek services in an appropriate or timely manner lack maturity, considering how few opportunities minors have for accessing such services. Just the fact that a minor freely makes decisions regarding his or her sexual behaviour should be sufficient to receive sexual health counseling without consulting his or her parents.34 Confidence in one’s own ability to take an autonomous decision is also indicative of the maturity of a minor, although such confidence may also be encouraged or inhibited by environment. Therefore, distrust in oneself should not be taken as an indication of immaturity per se but rather an aspect that needs to be strengthened in order to guarantee autonomy.35

The fundamental guarantee that a minor’s evolving capacities over their sexual and reproductive health operate in their favor rests with the health professionals, whose duty it is to actively promote autonomy while simultaneously assessing the minor’s capacity to make autonomous decisions. When access to services is requested, it is not the responsibility of the minor to prove that he or she has sufficient maturity to make decisions. On the contrary, it is the duty of the health professionals and service providers to create the conditions under which the minor can exercise his or her autonomy by providing clear, complete and appropriate explanations, taking the minor’s concerns seriously, encouraging

them to make decisions independently, among many other possible actions. Health professionals also have the responsibility of assessing a minor’s decision-making capacity before seeking parental consent.36

The maturity of minors in terms of exercising their autonomy is not only an issue of cognitive and moral development but depends to a large extent on the context in which their maturity is being assessed. It has been demonstrated that minors have greater capacity for showing their understanding of situations in contexts that are familiar to them, and that their capacity to take responsibility or display maturity is highly sensitive to the way in which their competence is evaluated.37 A minor forced to make a decision while being treated with hostility, afraid that his or her behavior may be divulged, assessed with inquisitive or prejudiced questions, in spaces that lack privacy or without receiving answers to his or her concerns is less likely to be able to make mature and autonomous decisions regarding the exercise of rights. Health providers are responsible for the way in which they handle and support the decision-making process of a minor and their role is extremely important in determining the maturity of a minor and promoting his or her autonomy.

It is crucial that parents, educators and health professionals respect the autonomy of minors by preparing them for autonomous decision-making, cultivating their decision-making capacity, promoting their autonomy in concrete cases and providing the support they need to exercise their rights.38 The capacity to decide is determined in part by the extent to which a person is exposed to decision-making, even minor and unimportant issues. Such issues refine minors’ skills and gradually prepare them for increasingly important decisions. The maturity of the minor must not be viewed in terms of maturity/immaturity but rather evaluated through a dialogue that enables the minor to decide autonomously.39

37 Lansdown, Gerison. Evolving capacities of the child. Op.Cit. p.43. Here, various studies related to assessing the competences of minors in different contexts are explained.
In addition to observing that the minor possesses the appropriate competence with which to make an autonomous decision, the health professional must encourage them to take ownership of this competence and place the minor in contexts where they are able to effectively exercise them.

(ii) **Best interests of the child**

In cases where, having exhausted all possible recourse to promote autonomy, a minor is considered to have insufficient maturity to make decisions regarding his or her sexual and reproductive health. Then, the minor is protected under the concept of the best interests of the child, while he or she continues to play an important role in the decisions. In these cases, at a minimum, health professionals must:

- Provide complete and accurate information that is understandable to minors
- Answer their questions and concerns
- Ensure a friendly context, appropriate to their specific needs
- Guarantee their confidentiality and privacy
- Listen carefully to their opinions, comments, concerns and worries
- Promote the exercise of the minor’s autonomy by all means possible, depending on the specific nature of each case

When minors\(^\text{40}\) do not demonstrate the capacity to make autonomous decisions, as a general rule, each country sets out the procedure to be followed with regard to decision-making. This procedure almost always involves a substitution of consent in which a person close to the minor, such as a parent or other family member, has the task of consenting *for* them.

In these cases, the consent given by third parties must be guided by the best interests of the child. This concept is noted in the *Convention on the Rights of the Child*, which clearly establishes best interests as a guiding principle for all those participating in decisions that affect minors.\(^\text{41}\) The Convention defines

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40 We use the term minors to refer to women and men in order to avoid repeating she and he throughout the text, making it easier to read. We hereby take note of this limitation of the language.

the best interests of the child as the protection of their rights, as recognised in international human rights law:health, life, integrity, information, autonomy, equality, dignity, and many more. Apart from guiding the action of those involved in making decisions for minors, best interests provides a limit on their actions.43

The best interests of the child, as described in the Convention, cannot be used to make decisions that run counter to the rights recognised in that document or counter to child protection. Best interests ensures that measures or decisions are taken on the child’s behalf and that those measures and decisions promote and protect their rights rather than violate them.44

The best interests of the child transcend the culture context in which the concept is defined or applied. Some legitimate practices in a particular culture (for example, damaging the sexual organs of girls) may violate the rights of minors as stated in the Convention, such as the right to health or life, and must give way to the best interests of the child.45

The best interests of the child is also a criterion for resolving conflicts that may arise when applying protection rules or when there is a conflict of rights, thereby ensuring that solutions that best protect the rights of minors are adopted. The best interests also provide framework in cases where no specific rule exists, such as when regulation adoption processes or the State’s protection of vulnerable minors. Again, parents or legal representatives must seek the greatest protection of the minor.46

In practice, protecting the best interests of the child is particularly complicated when the child’s sexual and reproductive health needs are in conflict with the parents’ beliefs.47 For instance, a pregnancy presents a health risk for a minor, who lacks the maturity to decide on a termination, but her parents’ religious beliefs do not permit abortion that they consider the risk to
the minor’s health and life legitimate. In this case, there are three important consequences for protection that stem from the best interests of the child: (i) the minor’s lack of capacity to take a decision must not become a disadvantage in protecting her health and life; (ii) the exercise of the parents’ freedom of religion, well protected and included as a component of the child’s education, must yield to the right to preserve the minor’s life and integrity, and (iii) no one can make decisions for a third party who doesn’t have capacity to avoid them that cause direct negative consequences, such as harm to well-being.

When minors lack the capacity to make direct decisions on issues relating to their health, the guiding principle that must replace autonomy is their well-being and health.

When making decisions on a minor’s sexual and reproductive health, the following can be concluded:

- The autonomy of minors to make decisions regarding their sexuality and reproduction must be actively promoted.
- When it is impossible for minors to decide autonomously, those who are responsible for making decisions for them must do so in line with their best interests (i.e., protecting his or her rights).
- Decisions that violate minors’ right to health, physical integrity, life or freedom, etc., are prohibited. Decisions made in the exercise of minors’ sexual and reproductive rights must always protect their rights to sexual and reproductive health and health in general.

This mandate can also be viewed from the perspective of bioethical principles of beneficence and non-maleficence. In other words, decisions made with regard to the exercise of the sexual and reproductive health of minors must always be of benefit to them, and no decision can be made that would cause harm to the person whose will is being substituted. 48

Minors must be listened to even when it is determined that they do not have sufficient maturity to make decisions regarding their sexual and reproductive health. Their opinions must guide those that have the duty to take the decision

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for them. They must also be informed of the decision made and be allowed to voice their agreement or disagreement with the decision, discuss its relevance to their future life—a decision to use oral contraception does not have the same impact as one regarding a tubal ligation, for example—and comment on the conditions under which the intervention will take place. The reluctance of a minor to give consent to treatment must be considered when it represents a risk to his or her life or health or has long-term consequences.49

The US Court considered a Massachusetts law that required unmarried minors to obtain parental permission before obtaining an abortion. Only if the parents refused would they be permitted to seek judicial authorization, which could be denied if it was considered contrary to the best interests of the child. The Court indicated that, although the limitations placed on the decision-making capacity of minors were well founded, the termination of pregnancy was a decision of a special kind. The decision to marry, for example, could be postponed in the face of a legal restriction, but the termination of a pregnancy could not. Furthermore, pregnancy represents risks for all women, and they are compounded for minors. The Court decided that minors could seek authorization from a judge without first going to their parents and, if the minor was mature, the judges had to give authorization. If the minor was immature the courts had to make the decision in accordance with their best interests.


3- Informed consent in minors

Informed consent has two components:

• The right to receive clear, accurate and appropriate information on all aspects of the object of consent

• The right to decide autonomously, exercising free will, without interference, manipulation or coercion. Broader than information,

this does not sufficiently express the personal facet of the will to exercise consent.\textsuperscript{50}

The informed consent of minors is made up of all the guarantees allowed for adults along with some specific ones, depending on the circumstances.

The informative component of consent requires health professionals to acknowledge that the information has been adequately understood, beyond a simple statement of the risk. At a minimum, information for consent must refer to the object of the consent, alternatives, risks and advantages. However, the health professional must in each case assess the amount and type of information provided. In fact, health professionals have an active role to play in providing information for the consent of minors, aimed at ensuring that the person who makes the decision is effectively informed and exercising his or her right autonomously.\textsuperscript{51}

(i) Information

There must be no difference between the information given to minors and to adults. In other words, minors must not be given more limited information with regard to procedures (risks, benefits, alternatives) simply because they are minors. However, the way in which information is provided to minors is crucial given that their decisions are highly influenced by the health professional, the information this person provides and the way in which they are treated.\textsuperscript{52}

- An adolescent may be more vulnerable than an adult to negative, threatening or pejorative value judgements with regard to their sexual and reproductive behaviour.
- He or she may have less capacity to discern whether information is incomplete, inaccurate, or false or to identify

\textsuperscript{50} Jimena Quesada, Luís. La tutela constitucional de la salud: entre el consentimiento informado y la información consentida. La salud: intimidad y libertades informativas. Tirant lo Blanch and Valencia University. Valencia. 2006. p. 44.


\textsuperscript{52} García, Diego; Jarobo, Yolanda; Espíldora, Nieves Martín; Ríos, Julián. Toma de decisiones en el paciente menor de edad. Op. Cit. p. 184.
Manipulation of the information.
- He or she may be more afraid of the negative effects of some medical procedures, when faced with the information.

Given these special vulnerabilities, the information provided must have some specific features. Health professionals must offer an environment of trust and safety that empowers the minor to exercise his or her rights. The dialogue between health professional and minor should contain the following features as a minimum:
- Building conditions of trust
- Respect
- Confidentiality
- Promotion of autonomy

Building conditions of trust requires that professionals assume a friendly and understanding attitude, using a language that is familiar and understandable to the minor. An environment of trust will encourage the minor to express his or her concerns frankly and assuage his or her doubts. It is also key to ensuring that the minor feels safe and responsible for his or her decision.

Respect means taking minors, along with their needs, opinions and image of the future seriously. It also means recognizing their legitimacy in the dialogue, even if the health professional disagrees with the opinions expressed and the decisions taken. It is often difficult to recognize and respect a decision that’s made with maturity when it departs from conventional standards or from the subjective judgements of the health professional.53

Confidentiality is perhaps one of the guarantees most sought by minors, who fear that their sexual behaviour may be divulged to their parents. This fear can create a disincentive to visit the required services and encourage them to seek services outside the legal and institutional sector. A failure to guarantee confidentiality can cause minors to use inadequate methods of contraception, to reject them altogether, or to seek illegal and unsafe abortion services.54

There is empirical evidence, for example, that the majority of late abortions in minors can be explained as a fear of their parents finding out. There is also evidence that a majority of minors seeking sexual and reproductive health services would not do so if their parents were going to be informed that they were using contraceptives, although only 1 percent would be prepared to stop having sexual relations.\textsuperscript{55}

The importance of confidentiality increases when minors’ opinions on sexual and reproductive behaviour are in contradiction to the beliefs of their parents, who may be interested in dissuading, or preventing if legal norms permit, minors from making certain decisions.\textsuperscript{56}

Finally, information must be given from a perspective of promoting the autonomy of minors, encouraging a dialogue that enables them to fully understand their actions, including the characteristics, consequences, risks and alternatives, the legal situation and anything necessary to ensure they are in a position to be able to decide. This information must be provided in understandable language and health professionals must answer all questions and concerns that may arise, avoiding moralistic or prejudiced language\textsuperscript{57} and without influencing the outcome of the decision.

Other seemingly incidental aspects of informed consent may be crucial in the case of minors. For example, hours of operation compatible with their needs, prices or payment systems compatible with their capacity, the location of services in areas accessible to them, and a guarantee of privacy.

The process of providing minors with information to make an autonomous decision is not limited to the moment they request services from health professionals. Minors cannot always obtain information due to the prejudices of their parents and health professionals, who believe that offering information at too early an age may simply encourage them to commence sexual relations.\textsuperscript{58}


\textsuperscript{57} Idem. p. 18.

\textsuperscript{58} R.Cook, B.M.Dickens. Recognizing adolescents’ ‘evolving capacities’ to exercise choice in
In some countries, insufficient or inadequate information is considered the primary cause of teenage pregnancy.\(^{59}\) The process of informing minors so that they can exercise their right to autonomy requires joint work and commitment from family members, the educational system and health professionals. Continually providing accurate, appropriate and complete information decisively contributes to the gradual consolidation of a minor’s autonomy and exercise of his or her rights. Some believe the State should intervene to ensure education within the family encourages autonomy.\(^{60}\)

(iii) Consent

It is essential that minors exercise their will free from pressure or coercion on the part of parents or other professionals. Decision-making based on misleading or distorted information that induces guilt or fear cannot be considered autonomous. When providing information to minors, health professionals must remain strictly objective, because adolescents may have less capacity to detect bias or partial information than adults.

The right of minors to make autonomous decisions about their sexual and reproductive health creates at least two obligations for the health professional: (1) to make all resources necessary for an autonomous decision available to them, and (2) to respect their decisions, and refrain from hindering, delaying or preventing their implementation, even if they run counter to the way in which the health professional sees things.

Not providing services to minors with decision-making capacity who request and require them is in violation of the principle of non-maleficence, as it can lead to death through unsafe abortions, the contraction of STIs, unwanted pregnancies and consequences for their reproductive system, as well as changes in their future prospects.\(^{61}\)
Inadequate or no intervention, through bad or negligent medical practice, can create liability on the part of a health professional at any stage in the informed decision-making process: when providing information, respecting the decision, providing support for its implementation, providing services, etc.

The Peruvian Manual on Sexual and Reproductive Health Counseling defines a different system for counseling adolescents on the basis that they may have special needs. For example, their difficulty obtaining integrated services or their fear that their parents may learn that they are seeking contraception. The guide refers to (1) the moment when counseling must be provided, which it specifies must be ongoing, recognizing that it is appropriate to provide information to adolescents at any time; (2) the content, which must include information on contraception and related aspects such as STIs, HIV/AIDS, emergency contraception, sexual violence, and ways of accessing the services they require, and (3) the need to provide services in a friendly manner, giving full information and recognizing the characteristics of the stage through which the adolescents are passing.


4- Key position arguments

Minority of age and decision-making capacity

- According to the Convention on the Rights of the Child, minority of age lasts until 18 years old, unless the domestic legislation of the country sets a lower age.
- By defining minority of age, legal limits are imposed on a person’s full decision-making capacity. In other words, a normative value for minority of age is set.
- The definition of age of minority has a dual purpose: (1) to establish greater protection of minors within society and (2) to impose restrictions on the exercise of rights and obligations.
• Minority of age cannot become a factor of vulnerability nor can it be used to commit or cause harm, such as causing a lack of protection of the right to health and integrity of minors, when they are denied the possibility of making a decision.

• Minors continue to hold rights even though limitations are placed on their exercise. Even when a minor’s autonomy for decision-making is questioned, he or she continues to hold all rights to health, life and physical integrity, etc.

• Restrictions imposed on a minor’s decision-making capacity are targeted at the exercise of rights, given that their holding of these rights is full and permanent.

• The limitations on a minor’s decision-making capacity must be understood in accordance with the following rules:
  • They must be interpreted restrictively as they entail a limitation of rights.
  • They are a means of protecting minors because they cannot cause them harm.
  • Anyone considering that a minor does not have the capacity to make a decision in a given situation has the responsibility of proving it.

**Respect for the informed consent of minors**

• The two overriding concepts in the informed consent of minors are: the evolving capacities and best interests of the child.

• Both concepts involve the idea of gradual autonomy, in which the authority of the parents gradually cedes as the minor develops his or her capacities for autonomous decision-making.

• The evolving capacities of minors can best be understood as a limitation on the exercise of parental authority that gradually becomes stronger until the latter is completely removed in favor of the minor’s independence. As minors gain the necessary capacities for making autonomous decisions over their lives, they increasingly exercise the rights they hold, even if those are in opposition to their parents’ expectations and beliefs.

• When evaluating evolving capacities, the following must be kept in mind:
  • The maturity of the minor in each case
  • Health professionals must promote the exercise of autonomy when
assessing a minor’s decision-making capacity.

- Minors do not have the responsibility to prove their maturity.
- The maturity of minors has a contextual component. Friendly services may encourage a minor to feel more comfortable and thus more able to make a decision.
- Health professionals are responsible for the support they give the minor in the decision-making process.
- The best interests of the child must guide decisions when a minor’s decision-making capacity is substituted to ensure that the decisions do not cause the minor harm. In other words, the aim is always to protect the minor’s rights to health, life, integrity, information, autonomy, equality, dignity, and so on.

- Health professionals and service providers have a duty to create conditions in which minors can exercise their autonomy, providing clear, complete and appropriate explanations on the medical services available in that particular case.
- Providers are responsible for the way in which they address and support the decision-making process of a minor; their role is highly important in determining the maturity of the minor and promoting their autonomy.
- When assessing minors, professionals must consider the following criteria:
  - Their ability to understand important information and communicate their concerns
  - Their ability to reflect and choose, with some independence
  - Their ability to assess risks, benefits and harm

- The application of the best interests of the child implies that all available alternatives for a child to decide autonomously have been exhausted.
- As a minimum health professions must: (1) have provided full and accurate information that is understandable to minors and (2) answered their questions and concerns (3) in a friendly context, committed to their specific needs, with a guarantee of confidentiality and privacy, (4) respecting their opinions, comments, concerns and worries and (5) promoting the exercise of the minor’s autonomy by all means available, according to the nature of the concrete case.
• The best interests of the child consists of protecting minors rights to health, life, autonomy, equality, dignity, etc. and comes into play in those cases where a minor does not make a decision but appoints a third party to decide for them.

• When applying the concept of best interests, the following must be kept in mind:
  • In addition to guiding all actions, it limits them.62
  • It cannot be used to legitimate decisions that run counter to the rights of the minor.
  • It is a criterion for resolving conflicts and filling normative gaps.
  • Decisions that are taken for minors regarding access to sexual and reproductive health services must be aimed at protecting their sexual and reproductive rights.
  • In all cases, the opinion of the minor must be listened to.

**Informed consent of minors**

• Informed consent comprises the right to information and the right to make a decision through the exercise of one’s autonomy.

• In relation to information for consent, it is necessary that health professional:
  • Offer the same guarantees as for adults.
  • Be active in the provision of information, ensuring that it is sufficient and that it is understood.
  • Remember that minors are more vulnerable to the way in which information is provided, so there must be an environment of trust and security that enables them to be empowered to exercise their rights.

• The dialogue with a minor has specific features and should contain the following, as a minimum:
  • Building conditions of trust
  • Respecting the opinions and decisions of minors, even when they differ from those of the professional

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62 That is, it limits actions that are opposed to the best interests of the child, for example, prohibiting them.
• Confidentiality, particularly in relation to their parents
• Promotion of autonomy

• In relation to the act of consent:
  • The health professional must ensure that the minor is not subject to coercion or pressure.
  • The health professional must be particularly careful with his or her own prejudices, as minors have less capacity for perceiving bias.
  • Building conditions of trust requires professionals assume friendly and understanding attitudes towards minors, using a language that is familiar and understandable to them.
  • The provision of ongoing information (accurate, appropriate and complete) forms a decisive contribution to the gradual consolidation of a minor’s autonomy and an awareness of how to exercise his or her rights.
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Legal regulations in some Latin American countries with regard to the capacity of adolescents and their impact on sexual and reproductive health

Lidia Casas Becerra
Ester Valenzuela Rivera

1. Introduction: defining the problem

The liberalization of abortion laws in some Latin American countries has highlighted the issue of access by adolescents to sexual and reproductive health services. In addition to the problems common throughout the population, teenagers suffer from specific obstacles when they independently try to obtain confidential services, such as age and legal capacity. The perceptions and beliefs of healthcare providers can lead to inefficient services or, in extreme cases, the implementation of complete parental rights. Therefore, it is vital to understand abortion legislation in different Latin American countries and to consider which elements of the law facilitate or hinder adolescent access to sexual and reproductive health services.

In addition, the scope of the term “youth” must be considered, since services for adolescents under the age of 15 aren’t the same as services for 18 to 25 year olds. Above all, the first group has not yet reached the age of majority and therefore cannot access some health services. To clarify this issue, we will examine the Ibero-American Convention on the Rights of Youth and the Convention on the Rights of the Child. The former is a new international tool designed to fill a normative gap and lay down a series of rights for the 15- to 24-year-old age group.

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In a broad sense, this article aims to provide an overview of legal instruments in the countries prioritized by the IPPF (Argentina, Bolivia, Colombia, Chile, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Peru and Venezuela). It also briefly examines the way the issue is handled in Spain and the UK, two countries that have introduced relevant reproductive rights legislation.

As there are enormous differences between legal capacity, age of consent and involvement in decision-making in different legal contexts, the first part of this report will review the criminal laws of each nation that have an impact on adolescent consent. We will provide an overview of the laws and legal or technical regulations and point out the conditions under which adolescents are able to achieve independent consent. We also will look at the circumstances that require the intervention of a third party to obtain legal abortion services, reproductive advice, provisions and prescriptions for contraception, and other sexual and reproductive health services.

After the following regulatory map has been plotted, we will be able to highlight the opportunities and challenges facing IPPF member associations in treating and caring for underage youths. The second part of this report aims to provide recommendations to the associations on advocacy work for legal reform, information dissemination, awareness raising among healthcare providers (both within the associations and in public health systems). In addition, we will offer suggestions on training that will enable the associations take a position in ongoing discussions within the local community and empower them with knowledge of key elements of these issues, such as third-party intervention and the availability of services to support adolescents making decisions about their sexual and reproductive health.

I. Regulatory overview of the capacity of adolescents

1. Laws on sexual integrity

Legislation in Latin America has, in general, undergone numerous changes over the last two decades in order to adapt to international treaties protecting women from gender violence, such as the Inter-American Convention on the
Prevention, Eradication and Punishment of Violence against Women (the Convention of Belem do Pará) and the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW)—both of which are based on the universal system of human rights protection and demands for gender justice in law. There are also other treaties, such as the Convention on the Rights of the Child and the Ibero-American Convention on the Rights of Youth. The classification of criminal offences has historically had a marked androcentric focus, in which sexual stereotypes and prejudices—particularly of women—were common.

During the 1990s, criminal codes relating to sexual crimes were amended in Argentina, Colombia, Chile and Peru. It was established that the classification of criminal offences had to protect legal rights of women from sexual violence, which were not previously considered. The new codes moved from a position of safeguarding integrity, modesty, and the honor and good standing of the family to one that protected the freedom and sexual integrity of all. While criminal provisions previously had referred only to the concept of carnal “access,” which inferred that only women could be the victims of rape, now a majority of the region’s countries consider rape (or carnal access or aggravated sexual abuse) to be vaginal, anal or oral penetration with the penis or another object.

A second legislative change relates to the age of the victim, which is crucial in defining whether the sexual conduct in question is unlawful or not. The age of sexual consent is the age at which the consent given by a boy or girl to sexual relations can be considered effective. Most countries have set the age of consent at 14 years (cf. summary table below), regardless of the fact that the penalties applied depend on the age of the victim. For example in Peru the rape of a child under the age of 7 carries a life sentence.

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64 This is the case of the amendment to the Chilean Criminal Code in 1999, whereby crimes protecting honour and virtue now refer to sexual autonomy. Luisa Cabal, Julieta Lemaire and Mónica Roa, editors, Cuerpo y Derecho. Legislación y Jurisprudencia en América Latina, Center for Reproductive Law and Policy, Universidad de los Andes y Temis, Bogota, 2001, p. 138.
65 This is the case of the amendment to the Argentine Criminal Code of 1999. The title was changed from “crimes against virtue” to “crimes against sexual integrity”. Ibid., pp. 68-69.
66 Legislative Decree 896, 23 May 1998.
Guatemala is an exception among Latin American countries in that age of consent has remains at 12 years with regard to sexual crimes and the law still maintains the classification of “virtuous woman” with regard to some of them.

Legislation in the region has subsequently undergone further revision, penalties being toughened and, in some cases, the age of sexual consent being raised. The Peruvian Code was amended in 2004 with regard to sexual crimes, by means of Law 28,251. Although child prostitution was addressed in Chile through the creation of new criminal classifications, a 2006 law raised the age of sexual consent to 18 years, thus criminalizing any carnal access with a minor. In keeping with the Spanish model, the criminal law provides for different penalties depending on the age and circumstances in which the carnal access occurred, maintaining the regional trend towards establishing one age for contracting marriage (16 years) and another for acknowledging children (14 years), in accordance with Articles 241 and 46 of the Civil Code.

In Peru, the age of consent was also increased, though without considering the socio-cultural context and rights of adolescents. This was resolved partially in Chile with a law on adolescent criminal responsibility. In the Peruvian case, a bill of law that had been approved by Congress would have decriminalized sexual relations between adolescents over the age of 14. Parliamentary scrutiny of the bill revealed a number of problems and resulted in an executive. Despite its subsequent shelving, some sectors of Peruvian society want to keep the rule.

Apart from healthcare-related problems, which we will discuss later, this situation has led to different responses from the criminal system from shelving of complaints to the prosecution of perpetrators of crimes.
In the past there was some similarity between the ages of consent in Latin American and Caribbean criminal and civil legislations. Drawing on the 1804 Napoleonic Code, civil legislation in the region distinguishes between infants (under the age of 7), prepubescents (older than 7 but younger than 12 or 14 depending on the sex and country) and adult minors (older than 12 or 14). Different ages at which boys and girls could marry were, *inter alia*, established; girls could marry at 12 with their parents’ consent, while boys could marry at 14. It could be held, therefore, that the exercise of sexuality within marriage was being legitimized since minors did not require consent but assent, which had different consequences in law. This situation also has undergone significant changes, following recommendations from the United Nations Human Rights Committee, which in its *General Comment No. 28* on equality of men and women urged countries to set the same minimum age for marriage for both sexes. Bolivia still retains a different age at which boys and girls can marry in its family legislation—14 for girls and 16 for boys.

Age can set certain limits on a person’s capacity to exercise his or her sexuality within a marital context or not. In civil matters, this can affect the person’s capacity to do business and solemnize formal acts *intuitu personae*, including making a will and acknowledging a child.

In criminal matters, the minimum age given in sexual integrity laws operates as a presumption of valid consent and only under certain circumstances (e.g.,

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74 It should be noted that, under the rules of civil law, adolescents also had - and continue to have - a legal capacity for business from puberty onwards.


76 It should be noted that our legislations pick up the principle by which adult minors, namely girls over 12 but under 18, and boys between the ages of 14 and 18, are able to formalise a series of contracts and actions in law. One example of this is Chile, where an adult minor (i.e., under 18 but over 12 or 14) may, without authorisation or representation: make a will (Arts. 261 and 1005 Civil Code.); manage their own professional wealth, which assumes that they have fully exercised their right to work, choosing a professional area in which to operate and enter the labour market (Arts. 246 and 439 Civil Code), without prejudice to the consent of the responsible adult and other restrictions imposed by the Labour Code (Arts. 13.2; 13.3; 14.2 and 16); purchase goods and chattels (Art. 723.2 C.C.); act as agent (Art. 2128 Civil Code.); commit by means of a necessary deposit (Art. 2238 C.C.); acknowledge a child (Art. 262 Civil Code); and, if over 16, enter into marriage with the assent required by law (Art. 105 Civil Code). In these cases, the personal and independent action of the minor is permissible if a sufficient degree of maturity to do so has been achieved, depending on the nature of the act, such as acknowledgement of a child or the capacity to make a will, which are intuitu personae.
use of violence, force, deceit or blackmail, or the abuse of a relationship of power) would the consent be understood as being impaired.

So far, the issue seems fairly peaceable in terms of doctrine, which considers that adolescents are at a stage in their development. The law fulfils the role of protection, while recognising that the age set in any normative framework can be arbitrary in determining when an adolescent is able to give informed consent on sexual matters.

This was the case of the amendment to Chile’s Criminal Code in 2003 when age was again considered in relation to crimes of pornography and pedophilia. The catalyst was a case purportedly involving public figures. Some Congressmen proposed that the same age limits (12 for girls, 14 for boys) should be maintained, while others pushed to raise the limit to 14. A third group suggested a consensus age of 13, as in Argentina. The latter justified their argument using sexual behaviour studies conducted by the Ministry of Health that suggested a percentage of the youth population under 14 were having consensual sexual relations at a very young age either with adolescent partners who were older or younger than them or with older adults.77

Some criminal classifications adjust penalties depending on the age of the victim (e.g., under the age of sexual consent) or establish special crimes, such as rape of a minor, depending on the circumstances under which the boy or girl granted sexual consent. For instance, consent may have been given but was impaired and therefore ineffective if the minor had sexual relations following deceit or blackmail.

An amendment to Argentina’s Criminal Code in 1999 raised the age of sexual consent. It specifies certain rules for different situations, as established in Articles 119 and 120 of the Criminal Code. The first provision considers

77 Casas Lidia, Confidencialidad de la información médica, derecho a la salud y consentimiento sexual de los adolescentes. Informe en Derecho, Revista de la Sociedad Chilena de Obstetricia y Ginecología Infantil y de la Adolescencia, Vol. 12 Nº 3, 2005. Some of the issues raised by the change in age limit were partially rectified in the Law on Juvenile Criminal Responsibility, which decriminalises sexual relations between adolescents provided there is no more than two years’ age difference between the “victim” and the perpetrator. In other words, a girl of 13 could have sexual relations with her 15-year-old boyfriend without any criminal recrimination.
that consent is effective from 13 years of age. However, when there is violent carnal access or rape of a minor, or an adult has relations with adolescents between 13 and 16 years of age, special rules exist, regardless of the sex of the victim. In Bolivia, the Criminal Code establishes that adolescents can give sexual consent when they reach puberty, without specifying the age at which puberty is reached. It is possible to assume that civil law rules will apply when defining puberty. In Chile, regulations governing adolescent consent only refer to sexual consent between heterosexuals; consent to homosexual relations remains at 18 years of age.

Sexual experience does not conform to the limits imposed by social or legal norms. It moves along a parallel path, transecting at some points along the way. Adolescents will have sexual relations with partners of the same or different sex, with adolescents of their own age or adults. In criminal law, age is an objective element in the presumption of consent, regardless of whether there was force, abuse of power, deceit or blackmail in the sexual relations or acts. Criminal doctrine refers to these cases as sexual assault (or sexual abuse), known in common law as statutory rape laws. This is clearly laid out in Article 216 of the Criminal Code of Panama:

**ARTICLE 216.** Anyone having sexual access to a person of either sex, using their genitals or other parts of their body, or introducing any object into the genitals, mouth or anus of the victim, shall be punished by 3 to 10 years in prison in the following cases:

1. When violence or intimidation is used;
2. When the victim is lacking in reason or sense or when, through physical or mental illness or any other cause, they are unable to resist;
3. When the victim is in custody or prison and entrusted to the perpetrator to guard them or take them from one place to another, and
4. With a person of either sex that has not yet reached 14 years of age, even if none of the above circumstances are present. (Emphasis is ours.)

78 Republic of Argentina, Law 25,085 of 7 April 1999.
79 See Article 365 of the Criminal Code.
Cases that have now emerged as problematic are those in which adolescents are involved in sexual behaviour below this age, or below the threshold. The problem is clear when adolescents, particularly girls, under the age of sexual consent request sexual and reproductive services like contraception. Under criminal law, they should be considered victims of abuse or rape and, being a prosecutable offence, the authorities should be alerted to this unlawful act. As we shall see later, criminal responses have followed different paths in the field of healthcare and services.

Summary Table 1. Regulations on sexual integrity laws by Country, Sex Crimes (SC), Rape (R) and Other.

<table>
<thead>
<tr>
<th>Country</th>
<th>SC</th>
<th>R</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>13</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Bolivia</td>
<td>14*</td>
<td>14</td>
<td>Between puberty and ≤17, rape.</td>
</tr>
<tr>
<td>Colombia</td>
<td>14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Chile</td>
<td>14</td>
<td>14</td>
<td>Not applicable when ≤2 years between the minor and partner. **</td>
</tr>
<tr>
<td>Ecuador</td>
<td>14</td>
<td>14</td>
<td></td>
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<tr>
<td>El Salvador</td>
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<td>14</td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
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<td>12</td>
<td></td>
</tr>
<tr>
<td>Mexico***</td>
<td>12</td>
<td>12</td>
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</tr>
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<td>Nicaragua</td>
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<td></td>
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<tr>
<td>Panama</td>
<td>14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Peru</td>
<td>18</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Venezuela</td>
<td>12</td>
<td>12</td>
<td>Seduction: ≤16 years and ≥21, promise of marriage to woman known to be virtuous. Carnal access: ≤12 and ≥16.</td>
</tr>
</tbody>
</table>

* Bolivia’s Criminal Code does not define the age at which puberty is reached.
** Chile’s Criminal Code does not have the same rules for acts of a sexual connotation between people of the same sex, see Article 365 of the Criminal Code. See Law on Juvenile Criminal Responsibility.
*** Mexico is a federal republic and criminal regulation is the responsibility of each state. Nevertheless, the Criminal Code of Mexico City acts as a model for the other states.
2. Laws on health

In the Latin American countries being examined, there is similar regulatory handling of the sexual consent of adolescents and criminal protection in relation to sex crimes. There are clear differences, however, between criminal regulations and the administrative and legal norms and technical guidelines that refer to an adolescent’s capacity to consent to health services. These are not always clear and may result in problems of interpretation and assimilation of a heterogeneous and fragmented normative corpus, which is evident in health services requiring more invasive or surgical interventions, such as abortions in countries where legal abortion exists. In this section, the normative details of adolescent consent to health services will be discussed, starting with special legislation in the area of health, particularly sexual and reproductive health.

As a federal country, Argentina has no law on sexual and reproductive health. But it does have but numerous special regulations, which are established at the level of province or, sometimes, municipality. The Autonomous City of Buenos Aires and the provinces of Mendoza and Neuquén, for example, have their own special laws that explain the rights, guarantees and guidelines protecting sexual and reproductive health. Some of these are given below.

Buenos Aires Province passed the Reproductive Health and Responsible Procreation Law 13,066 on 28 May 2003,\footnote{All of Argentina’s provincial laws can be found at Notivida} which recognizes that, to ensure the best interests of the child, all minors over 14 years of age should have access to confidential contraception services. For children under 14, parental consent is required. It also states that priority will be given to barrier methods for STI prevention, but in cases “where the beneficiary opts for a non-natural method, options will need to be limited to one of those on the list of non-abortive, temporary and reversible methods that ANMAT [National Administration of Medicines, Food and Medical Technology] produces. The Ministry of Health will be responsible for cooperating with this body, for the purposes of implementing this regulation.” The option can only be chosen following a clinical assessment. If the prescription is of a medical nature, providers may not want to prescribe other methods—particularly emergency contraception—under the pretext of the “clinical assessment” of the patient.
In terms of abortion, Buenos Aires Province passed Special Resolution 304/2007 on legal abortions (Art. 86 paras 1° and 2° of the Criminal Code), on 29 January 2007, which expressly stipulates that if a person does not have legal capacity, the consent of a legal representative is required:

The action of legal abortion in the case of a pregnant woman without legal capacity must be undertaken according to the following procedure:

- Informed consent given by the legal representative, whose status must be proven by corresponding documentation, with duly certified signature.
- Declaration of insanity, with duly certified signature or medical opinion from an interdisciplinary mental health team, in accordance with the provisions herein established.
- Legal or police report noting the perpetration of rape.

In the case of the unjustified refusal of the legal representative to consent to the medical action, the procedure established in Article 61 of the Civil Code shall be followed.

If the interests of the legally incapable person are in opposition to the interests of his or her representative, the legal representative must withdraw and a special guardian must be appointed to take over. This regulation has the stated aim of avoiding unnecessary delays in obtaining an abortion under lawful conditions. However, this provision is not necessarily applied in other provinces.

The Autonomous City of Buenos Aires passed Resolution 1174 of May 2007, which also regulates legal abortion. In the case of informed consent of minors, the legislation requires the consent of the legal representative or the intervention of the Consejo de los Derechos de Niñas, Niños y Adolescentes (Council for the Rights of Children and Adolescents) and/or the Asesoría General Tutelar de la Ciudad Autónoma de Buenos Aires (General Tutelary Advisory Board of the Autonomous City of Buenos Aires). These regulations were created in response to court cases in Argentina that argued the rights minors seeking an abortion.

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82 City of Buenos Aires, Resolution 1174, Ministry of Health, 7 June 2007.
abortion were diametrically opposed to arguments put forward in the “Defender of the Incapable,” which represents the interests of an unborn child.\(^{83}\) In Argentina, the ability of a sexually active minor to use an intra-uterine device as contraception has also been argued in court. This type of contraception must be authorized by her mother.\(^{84}\)

The law on reproductive health in Córdoba Province reiterates the provisions of the Buenos Aires law in broad terms but remains silent on the issue of services for adolescents and whether they are considered confidential.\(^{85}\) Resolution 878/2003 of Corrientes Province created a responsible sexual and reproductive health program that includes all women of child-bearing age and, as a priority, those under 19 years old who are sexually active. From this it would seem that care is provided within a framework of confidentiality.

The Bolivian Civil Code has a special rule on organ donation that ensures the donor’s full capacity to act. Organ donation from a living person is prohibited if the action involves serious injury or risk to physical safety, and in all cases, a favorable report is needed from a medical team in order to donate an organ. Adolescents cannot donate organs as the Civil Code only empowers minors to act in civil actions relating to purchase and sale (Arts. 590-592) and actions related to the private wealth of a minor. In addition, the 1999 Bolivian Code on Childhood and Adolescence expressly establishes a provision on the right to free health for all minors through programs implemented and guaranteed by the State. This normative corpus does not make a distinction between gender, class, race or ethnic group, thereby upholding a principle of non-discrimination. From this, it seems there is no difficulty in providing sexual and reproductive health services to the adolescent population.

Chile does not have a general law on health. However, legal guidelines in the country are based on the constitutional text (Art. 19 No 9 of the Political

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\(^{83}\) For example, see Supreme Court of Justice of Buenos Aires Province, Agreement 2078, C 100-459, victim of sexual abuse OMV, La Plata, March 2007; Supreme Court of Mendoza Province, Case 87,985, Gazzoli Ana Rosa in J. 32.051 and others, 22 August 2006. Both in Notivida.

\(^{84}\) Case No 167/1, Final Res. No 41, Civil and Trade Appeal Court - La Matanza, 18 December 2001, San Justo, Buenos Aires Province. In Notivida.

Constitution of the State), which requires the State to implement actions of health promotion, prevention and recovery. The protection and provision of health actions is contained within the framework of the national sexual and reproductive health policies of the Ministry of Health (of the Women’s Health Program), which approved the National Rules governing Fertility.\textsuperscript{86} With regard to children and adolescents, the Ministry of Health also has a “National Plan for Childhood and Adolescence 2000-2010.”

The technical and administrative guidelines set out in the National Rules governing Fertility establish confidentiality in health services to adolescents without the intervention of parents or legal representatives. This confidentiality provision has faced judicial appeal, based on Article 5 of the Convention on the Rights of the Child, which specifically states that parents have a duty to give appropriate direction and guidance so a child can exercise the rights recognized in the Convention, as his or her capacities evolve. The Santiago Appeals Court ruled that the provision of confidential services was not in violation of the constitutional right of parents to educate their children.\textsuperscript{87} This same argument formed the basis of an appeal before the Chilean Constitutional Court in relation, \textit{inter alia}, to counselling, the prescription of contraception methods and the provision of sexual and reproductive health services to adolescents without the consent of their parents. In April 2008, the Constitutional Court unanimously rejected this part of the appeal, indicating that the State’s actions on sexual and reproductive health do not challenge a parent’s right to educate their children.\textsuperscript{88} These rulings indicate that health professionals must provide all necessary care, as well as prescribe and provide methods of contraception to adolescents under 14 (minors in terms of sexual consent). Without prejudice, service providers must inform authorities, such as the Attorney General or the police, about any adolescent who may have been the victim of sexual violence, in keeping with the laws on sexual assault.

In relation to HIV/AIDS, Chilean law has taken a somewhat different approach. Minors are not permitted to access HIV tests without their parents or

\begin{itemize}
\item \textsuperscript{86} Republic of Chile, Supreme Decree 48, 2 February 2007.
\item \textsuperscript{87} Santiago Appeals Court, “Zalaquett y otros contra Ministra de Salud”, list 4693-06 of 10 November 2006.
\item \textsuperscript{88} Constitutional Court, Requerimiento de inconstitucionalidad al D.S. 48 del Ministerio de Salud, rol 740-07, 18 April 2008.
\end{itemize}
legal representatives being informed. Neither the Regulation on Examination for Detection of the Human Immunodeficiency Virus, Decree N° 182 of 2005, nor the General Law on HIV/AIDS 19,779 of 2001 supply specific rules with regard to children and adolescents. They only set out in general terms a right to confidentiality in Article 8, which states that “…confidentiality is a fundamental right of HIV carriers. No one may, either publicly or privately, refer to suffering from this illness without the patient’s prior consent.” Although this law should be applied to adults and adolescents, in practice health services demand the presence of a parent or legal representative whenever adolescents request an HIV test.

Colombia has technical family planning regulations\(^89\) that aim to provide men and women of reproductive age with information, education and the methods necessary to respond to their sexual and reproductive rights. The entire population of reproductive age can benefit, whether they are affiliated with the State-run contributory or subsidized schemes. The guiding principles of the regulations are, \textit{inter alia}, a right to freedom, equality and privacy, and they expressly include the use of emergency contraception as one of the methods offered within the public health system. However, it is noteworthy that Law 1146 on the integrated care of child and adolescent victims of sexual abuse does not include emergency contraception, especially considering that it does expressly include the use of antiretrovirals to prevent the transmission of HIV/AIDS.\(^90\)

Ecuador, a signatory of the Ibero-American Convention on the Rights of Youth, has a Childhood and Adolescence Code that establishes the right of boys and girls to integral protection. The Organic Health Law recognizes the gender gap in access, actions of health promotion and prevention and establishes that all actions undertaken should be inspired by principles of universality, equality and solidarity. This provision is applicable to all public and private institutions involved in health sector networks.\(^91\) There are no specific references to health actions aimed at adolescents.

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\(^89\) Republic of Colombia, Resolution 00412 of 2000, \textit{Technical Regulation for Care to Men and Women in Family Planning}.


\(^91\) Republic of Ecuador, , 25 September 2002.
Guatemala has general regulations on family planning. Article 3 of Decree 85-2005 on universal and fair access to family planning services stipulates that the whole population can benefit, particularly women, adolescents, couples and men in rural areas without access to basic health services. The law’s express aim is to ensure fair and universal family planning services. For this reason, it is compulsory for public services (and, in accordance with the Article 2, NGOs that provide basic health care) to guarantee this. The decree contains a special section on adolescents, urging the integral training of adolescents in areas of sex education, health protection and teenage pregnancy. There are no provisions on confidentiality for the adult population or minors.

In Mexico, the 1999 Law for the Protection of Children and Adolescents is applicable at the federal state level and the federative states and municipalities level. One of the law’s features is the inclusion of the right to health protection. Although it contains no regulations on confidentiality of services, the stipulations contained in Article 4 para 2 states that “the rights of adults will not be taken as a pretext to obstruct the full exercise of the rights of children,” therefore indicating the right of minors to obtain confidential health services.

In Panama, the Technical-Administrative Norms relating to family planning establish that all women of reproductive age, regardless of age, have a right to treatment. However, when it refers to legal abortion, it expressly indicates that the consent of a legal representative is required for minors.

Peruvian general legislation on health, the General Health Law 26,842, refers to the consent that must be given by adults responsible for adult minors. It stipulates that individuals can undergo medical or surgical treatment only with their own consent or that of the person legally required to give it. Should the legal representative refuse, the treating doctor or the health establishment must communicate the situation to the judicial authorities. The case of K.N.L. vs. Peru before the UN Human Rights Committee was very particular and involved a hospital that required the consent of an adolescent’s mother, her legal representative, before they would terminate the girl’s pregnancy (her

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94 General Health Law of Peru.
fetus was anencephalic), and a mother who refused to give her consent though she had the power to do so. The general health law has a special provision on confidentiality (Article 15, sections a and b), which stipulates that people have the right to privacy and the confidentiality of medical acts and actions are guaranteed. From this it can be deduced that other health care actions, with the exception of abortion, would not require the intervention of a parent or legal representative.

In addition to the legal regulations governing the right to health, Peru has Clinical Guidelines on Sexual and Reproductive Health dating back to 2004 that recognize the rights of all people to health access and establish sexual and reproductive rights as human rights. The document provides no guidance with respect to treating adolescents as it presupposes that all people have a right to health care in the context of confidentiality. The Peruvian Ministry of Health has defended sexual and reproductive health rights, even in the case of adolescents, by approving policies that recognize the sexual and reproductive rights of adolescents, such as the Sectoral Policy Guidelines on Adolescent Health 2005-2015, the Sexual and Reproductive Health Strategy 2004, the Strategy for STI and HIV Prevention and Control 2004 and the Policies for Improving Sexual and Reproductive Health Care 2004. There is also an Integrated Healthcare Model responsible for the healthcare of Peruvians in the Stage of Childhood that includes an objective to monitor, encourage and implement the National Action Plan for Childhood and Adolescence. It must be stressed, however, that the inclusion of emergency contraception in the technical regulations does not mean that it was distributed through public health services, which is only possible after a court ruling.

All this bears witness to the fact that the Ministry of Health’s rhetoric recognizes the sexual and reproductive health rights of adolescents. The intention has not been reflected in reality, however, nor has it resulted in changes at a normative level. Sex education and effective access to public health services remain absolutely inadequate when it comes to ensuring adolescents can exercise these rights. The policies, programs and technical norms for the sexual health of adolescents contain a more liberal discourse than the legal regulations. They include guiding ideas and principles—such as gradual autonomy and sexual

95 HR Committee, individual communication, Llantoy v Peru, CCPR/C/85/D/1153/2003/Rev.1, views adopted on 24 October 2005.
and reproductive rights—which are not necessarily included in the legislation. The difficulty lies in the authority of these norms given the absence of express stipulations on confidentiality in providing health services.

This tension became evident when the age at which adolescents under 18 could consent to sexual relations was amended. Although the technical norms and health law guarantee the right to health, there is a regulation (Law 26,842, Article 30) that requires any doctor providing medical care to a person injured by knife, gun, traffic accident, other type of violence or criminal abortion to automatically report it as a possible prosecutable crime.96 Any minor visiting a health service provider because of pregnancy or presenting clear signs of sexual activity will be considered a victim. Similarly in Chile, adolescents who visit health services asking for reproductive health services other than care for a pregnancy or birth fear that their sexual activity will become known to their parents. In the worst cases, partners are prosecuted as offenders if they are adolescents or criminally convicted for having relations with a minor if they are adults and there is clear proof of pregnancy.97

This means that adolescents are inhibited from obtaining timely care from any kind of sexual and reproductive health service, and the concrete obligation to provide confidential services, in accordance with the health law, becomes ineffectual because the system criminalizes any sexual behaviour that is outside the law.

In Chile, although the policies of the Ministry of Health explicitly recognize the sexual and reproductive health rights of adolescents, they do not always have a normative correlate. For example the National Policies in favour of Childhood and Adolescence 2000-2010 and the guiding principles in the Convention on the Rights of the Child.

96 General Health Law 26,842 of 9 July 1997. It is interesting to note this norm in the light of the De la Cruz Flores vs. Peru case, Inter-American Court of Human Rights, Series C/115, 18 November 2004, which found the Peruvian State wrong to have prosecuted a doctor who treated a gunshot wound without informing the police of the event, in line with the provisions of the Criminal Procedure Code. The relevant chamber of the Court indicated that the medical action was protected not only by the Peruvian Constitution but also by international instruments, paras. 90-103 of the decision. See extracts from the decision at the end of this text.

Article 69 para 1 of Venezuela’s Organic Health Law establishes “respect for dignity and privacy, without possibility of discrimination for reasons of a geographical, racial, social, sexual, financial, ideological, political or religious nature.” It does not indicate age as a dubious distinction of discrimination. However, the same provision guarantees confidentiality of information.

From this description of Latin America’s normative framework, it is possible to conclude that the different recognition of the rights of children and adolescents in each state is made concrete in health policies that recognize young people based on their attributes rather than their deficiencies. One obvious problem, however, is the wide gap between rhetoric and the reality of public health services, as well as the minimal or nonexistent level of sex education in many countries.

In Nicaragua, for example, the National Sexual and Reproductive Health Strategy recognizes the capacity of adolescents to freely and spontaneously make decisions about their own sexual and reproductive health. However, on a normative level, there are restrictions regarding the effective exercise of sexual and reproductive rights, such as Law 603 of 2006, which abolished therapeutic abortion, thereby creating serious consequences for the country’s poorest women, in particular the adolescent population.

The laws regarding the medical treatment of adolescents are generally vague and confusing. Legal provisions on confidentiality of health services vary depending on the age of the adolescent and the medical treatment he or she requires. The dichotomy between rhetoric, reality and regulations is present in most of the countries, with an unjustifiable gap between what the legislature says and what ultimately they do in regulatory and actual terms.

Health laws tend to refer to the adolescent population as a beneficiary group. However, the clinical regulations give greater content to the meaning and scope of informed consent for adolescents. As seen in Argentina and Chile, populations opposed to recognizing sexual and reproductive rights are calling on the courts to declare any regulation that establishes the confidentiality of treatment for adolescents unconstitutional, arguing that it runs counter to the right of parents to educate their children and undermines parental authority.
Social security regulations do not expressly govern how healthcare is provided, as this depends on the institutional practices and IT systems of each country. In Córdoba, for example, an adolescent girl must show her health card but will have a separate one from the parent who pays the social contributions. In Chile, adolescents have access to their own health card in the public (FONASA) and private health systems, and this document has to be presented when paying for or obtaining free treatment, as appropriate.

There are IT systems in public and private health services and clinics where adolescents simply have to give their digital fingerprint (electronic subscription) to be recognized as beneficiaries of the social security system and pay the corresponding joint payment charge. This system does not give parents information on the services the adolescents have obtained.

In terms of surgical interventions, the laws state that adolescents must have the consent of their parents or legal authorization. The rule is that abortion is equivalent to a surgical intervention and therefore requires the intervention of parents and legal representatives. Perhaps this is the case because traditionally abortion had been an invasive procedure and, as in any surgical procedure, women had to be aware of the medical risks involved. Or it’s possible that these rules are trying to provide a stricter framework, given that the decision to terminate a pregnancy is considered an important one for the individual.

There is no integral overview of children and adolescents in the legislation and policies of these Latin American countries, a serious failing as this population is highly vulnerable to sexually transmitted infections, HIV, unwanted pregnancies and illegal abortions. Abortion is generally illegal throughout Latin America, which results in risk to the infant and juvenile populations, above all the poorest segments. The juvenile age bracket represents more than a third of all Latin Americans, making the health risks caused by inadequate and nonexistent care an overwhelming reality.
II. Comparative law

In comparative law, and particularly in continental European law, the age of consent mirrors that of Latin America. In most countries, the age at which marriage can be entered into has been raised; it is possible to marry with parental or judicial authorization at 14 and without authorization at 16.\(^{99}\) In Spain, the age of consent is 13, in accordance with the provisions of Articles 181 and following of the Criminal Code, without prejudice to the penalties for having sexual relations by deception with a person over 13 but under 16.\(^{100}\) In terms of health, *General Law 14/1986 on Health* indicates that the State is required to guarantee access to health recovery and promotion for all of the country’s inhabitants, emphasizing the principle of gender equality and reiterating the need to avoid any kind of discrimination.\(^{101}\) The rights of minors are also protected by means of *Organic Law 1/1996 on the Legal Protection of Minors*, which guarantees the right to privacy, honor and image (Article 4) and to seek, receive and use information in accordance with their development (Article 5).\(^{102}\)

In the United Kingdom, the age of consent is 16, although case history has made a clear distinction between the criminal norms and the age necessary to request sexual and reproductive health services in total confidentiality. Two cases that have marked out the regulatory framework. *Gillick v West Norfolk and Wisbech Health Authorities* (1986), ruled on by the House of Lords, established that a minor can be considered as having the necessary maturity and capacity to obtain medical services without parental intervention, in a context of confidentiality.\(^{103}\) *Axon v The Secretary of State for Health* involved a mother suing health authorities over the content of the Ministry of Health’s regulations and clinical guidelines, which permit counselling and the provision or prescription of emergency contraception. Basing some of her allegations on court decisions in Argentina and Chile, she argued that emergency contraception was considered abortive, and that the administration or prescription of it was in

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99 See, in this regard, the discussion in Rodrigo Barcia, La capacidad de los adolescentes para recibir la denominada ‘píldora del día después’, Revista de Derecho Privado, Nº 7, 2006, pp. 150-152.
violation of a parent’s right to educate his or her children. The High Court judge rejected the suit on the basis of the Gillick case.

In France, the law now expressly stipulates that adolescents are fully able to purchase the “morning after” pill in pharmacies without a prescription and school nurses are authorized to provide it.  

The notion of adolescents exercising rights independent of their parents has long been consolidated in Europe, following discussions on the implications of adopting the European Charter of Children’s Rights (1992). Council of Europe Recommendation 1121 on the rights of children indicates that “in addition to the right to be protected, children have rights they may independently exercise themselves—even against opposing adults.”

**Brief references to international human rights law**

Designed as a true Fundamental Charter of Rights, the *Convention on the Rights of the Child* is the treaty with most signatories in the universal system. By signing it, States Parties have taken a commitment to adopt concrete measures that satisfy basic health, housing, education, recreation and protection needs. Its application has been complex, however, and has come up against major obstacles in domestic legislation. The *Convention on the Rights of the Child* is based on the principle of the child as a subject of rights, an active participant who can act according to his or her own well-being and take his or her involvement into account. It is a concept that requires radical transformation in public policy and cross-cutting regulatory proposals. To avoid establishing age limits or giving definitions of arbitrary maturity, the Convention introduces the concept of “evolving capacities,” which stipulates that a child’s progress to adult independence must be respected and promoted throughout the whole of his or her childhood. This argument is strengthened by the requirement of Article 12 that “the views of the child [must] be given due weight in accordance with the age and maturity of the child.”

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Although the Convention does not explicitly comment on sexual and reproductive rights, it can be argued—on the basis of an extensive interpretation of rights related to sexuality and reproduction—that they are a part of the envisaged gradual autonomy (Article 5), right to privacy (Article 16) and non-interference in personal or family privacy, freedom from discrimination, freedom of expression and, as stated in Article 24 para 1, “the right of the child to the enjoyment of the highest attainable standard of health.”

The right to health has been developed in more detail by the Committee on the Rights of the Child in its General Comment Nos. 3 and 4\(^{107}\) which refer to the right to access sex education, family planning and to have accurate and complete information in a context of confidentiality. In a similar vein, General Comment Nº 14\(^{108}\) of the Committee on Economic, Social and Cultural Rights sets out the duty of States Parties to provide adolescents with a safe and supportive environment that ensures the opportunity to participate in decisions affecting their health. It also establishes that adolescents who exercise the right to health will receive care that respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

The Ibero-American Convention on the Rights of Youth, signed in 2005 and ratified by Ecuador, Spain, Honduras and the Dominican Republic (as of December 2008)\(^{109}\) is an international instrument that expounds areas, such as recognition of sexual orientation, by establishing the principle of non-discrimination (Article 5) and stipulating the right to identity (Article 14), considering sexual orientation as part of the identity of every young person. It also prescribes (Article 6) gender equality between young people, the right to sex education (Article 23), and the right to health (Article 25), including free primary healthcare. It recognises in its preamble that serious deficiencies and omissions can be observed among the region’s youth population, which affect their integral education, as there are rights of which they are deprived or limited.

\(^{109}\) Ibero-American Convention on the Rights of Youth.
such as the right to education, work, health, environment, participation in social and political life and in decision making, among other things. The Convention also sets out the need to overcome prejudices and pejorative, paternalistic or utilitarian conceptions of young people, as well as to understand them as not only subjects of rights but strategic development players, ascribing a function to them and valuing their contribution. To this end, it expressly establishes rights that are only gradually being developed within international law doctrine, in particular with regard to sexual heteronormativity. It also specifies the age group at which it is directed, “young people” and “youths” aged between 15 and 24 years. From this point of view, the Convention that limits rights, given that national regulations consider these rights to begin before 15 years of age.

Conclusions

1. Criminal legislation recognizes that adolescents have sexual relations. The age at which their consent is effective varies among the countries being studied but, on average, they are adult minors at 14 years of age and can effectively consent to acts of a sexual nature.

2. The above does not contradict the existence of a number of criminal offences that protect other legal rights and affect ages above those indicated. One exception and concern is the Peruvian criminal legislation, which recognises that valid consent exists only at 18 years of age.

3. The laws on the right to health state that there is no age distinction in the delivery of information and provision of sexual and reproductive health rights and expressly prohibit any discrimination. It is probable that the barriers to access are not legal but stem from institutional cultures, as the programs and policies are open to providing services to all women of reproductive age. However, minors who are unable to give consent may fall under “protection measures” that urge health professionals to communicate their sexual activity to the authorities in order to protect them, forming a barrier to access.
4. No conditions are noted in the advice, delivery or prescription of contraceptives nor in the rules requiring parental intervention when adolescents attempt to access emergency contraception.

5. The revised legislations and technical regulations demand the intervention of parents or legal representatives whenever a child or adolescent requires surgery. In some cases, the law expressly indicates that when there is discrepancy between the interests of the child and the legal representatives concerning the intervention, the case must be decided by the courts.

6. The revised legislations treat abortion in the same way as surgical interventions. Hence the consent of a parent or legal representative is required for an adolescent minor to be able to terminate a pregnancy.

7. It is not clear if there are mechanisms by which adolescents can enforce their rights. While in some countries like Chile there is the concept of the “Defender of the Incapable” or curator ad litem, this does not mean that institutions will support an adolescent’s decision, as their intervention must follow what the institution or curator understands as “the best interests of the child.”

8. There are erroneous concepts as to the scope of parental authority, and this has led to a belief among health providers and their institutions that they cannot carry out certain procedures, such as the provision of contraception or counselling services, without parental intervention.
c) **Criminalisation of the medical act**

90. In the case pursued against the alleged victim, on 16 September 1995 the Fourteenth Criminal Court of Lima issued an order to commence proceedings against Ms María Teresa De La Cruz Flores and others for “being members of the Communist Party of Peru - Shining Path, who gave medical care, treatment and operations, provision of medicines and medical instruments for the care of terrorist criminals[,] actions [which] form a crime provided for and penalised by Article 4 of the [D]ecree [L]aw [No.] 25[,]475.”

91. On 1 April 1996, the Public Prosecutor of the Fourteenth Provincial Public Prosecutor’s Office of Lima indicated in his report (above para 73.22) that Ms María Teresa De La Cruz Flores had “exploited her professional activities in the field of [m]edicine[…and] that her action had been aimed at saving assets […] such as human life”.

92. On 7 June 1996 the Senior Public Prosecutor of Lima issued his report (above para 73.23) in which he indicated that, with regard to Ms María Teresa de La Cruz Flores, “her involvement had consisted of providing medical care to activists.”

93. In relation to Ms. María Teresa De la Cruz Flores, the ruling of 21 November 1996 (above para. 73.27) considered that [in proceedings] documentation found in 1992 with Víctor Zavala Castaño, Francisco Morales Zapata, Eduviges Crisóstomo Huayanay, Felipe Crisóstomo Huayanay, Rosa Esther Malo Vilca and Miriam Rosa Juárez Cruzatt, involves the accused, in which she appears under the pseudonym of “Elíana”; in one of these documents reference is made not only to meetings held with the accused but also to a whole analysis of her doctrinal and ideological development within the organisation, indications of the talks in which the doctor was involved, that she participated in an operation as second surgical doctor, as well as the problems that arose within the Health
Sector, all of which was corroborated [...] by the accused Elisa Mabel Mantilla Moreno, who in the presence of the Public Prosecutor maintains that she at one time met with María Teresa De la Cruz as “person in charge”, for the purposes of different coordinating tasks; [...] by the accused herself, who [...] accuses her of being one of the support elements responsible for providing medical care and surgical interventions, [...] accuses her of participating in an operation conducted on “Mario”[.] who had burnt his hand, which coincides with what has been previously indicated, that is, that she participated as second surgeon in an operation of skin grafting; it being clear that the denial of the accused, on a judicial level[,] is given with the aim of avoiding her criminal responsibility, which is sufficiently proven[.]

94. The Court observes that medical acts are recognised in numerous declaratory and regulatory documents relevant to the medical profession. By way of example, Article 12 of the Ethical and Professional Code of Conduct of the Peruvian Medical Association states that, “[a] medical act is any action or provision that a doctor undertakes in the exercise of his or her medical profession. Diagnostic, therapeutic and prognostic actions that the doctor undertakes in the integral care of patients must be understood as such, as well as those resulting directly from this. The medical acts stated can only be undertaken by a medical professional.”

95. By way of information, the Court recalls that Article 18 of the First 1949 Geneva Convention indicates that, “No one may ever be molested or convicted for having nursed the wounded or sick.” Moreover, Article 16 of Protocol I and Article 10 of Protocol II, both Protocols to the 1949 Geneva Conventions, stipulate that “Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.” At the time of the occurrence of the actions in this case, Peru was already a party to said international instruments.

d) Obligation on the part of doctors to report possible criminal actions

96. The ruling of 21 November 1996 (above para. 73.27) considered, moreover, “that when a physician merely presumes or has knowledge of the
unlawful origin of the injuries caused to an individual, s/he is required to report the action or make it known to the authorities so that they can carry out the respective investigations.”

97. In this regard, the Court considers that the information that a doctor obtains while exercising his or her profession is privileged by patient confidentiality. For example, the International Code of Medical Ethics of the World Medical Association specifies that, “a physician shall respect the secrets confided in him or her, even after the death of the patient.”

98. In this regard, Article 2.18 of the 1993 Peruvian Constitution, which takes priority over any other domestic legislation in the Peruvian legal code, establishes that all persons have the right to keep their political, philosophical, religious or any other convictions secret, as well as to maintain professional confidentiality.

99. In turn, Article 141 of the Criminal Procedural Code stipulates that, “the following may not be forced to make a statement: 1. priests, lawyers, doctors, notaries and obstetricians, with regard to secrets that may have been confided to them in the exercise of their profession.”

100. The Human Rights Committee has now recommended that national laws be amended to protect the confidentiality of medical information.

101. The Court considers that doctors have a right and a duty to maintain confidentiality over information to which they have access as doctors.

102. Consequently, in the light of the aforementioned conclusions, the Court considers that by passing the ruling of 21 November 1996, the state was in violation of the principle of legality by: taking into account, as elements creating criminal responsibility, the membership of a terrorist organisation and the failure to comply with the obligation to inform and, nonetheless, applying only an article not classifying this conduct; by not specifying which of the conducts specified in Article 3 of Decree Law 25.475 were committed by the alleged victim in order to be responsible for the crime; by criminalising a medical act that is not only essentially lawful but the duty of a doctor to provide; and by
imposing on doctors an obligation to report the possible criminal behaviour of their patients on the basis of information obtained during the exercise of their profession.

103. By virtue of the above, the Court considers that the State was in violation of the principle of legality established in Article 9 of the American Convention, to the detriment of Ms. De La Cruz Flores.”
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Is there a Legal Obligation to Respect Patient Confidentiality in the Medical Treatment of Adolescents?

Martín Hevia

This paper is based on the premise that adolescents hold rights that increase in importance with age but effective exercise of those rights requires the creation of practical mechanisms, such as integrated services aimed at their specific needs. Health professionals play a key role in this area given the impact of their interventions and it is therefore necessary to consider the issue of patient confidentiality in the care and treatment of minors.

Difficult scenarios in the confidentiality of children’s sexual and reproductive health are all too common. Take, for example a sexually-abused teenager who asks the hospital staff not to make her situation known; or a girl who is accompanied to a clinic by a much older partner and does not want her parents to find out; or a young girl suffering from a blood infection caused by an unsafe abortion, which is seriously endangering her health but who asks that her parents should not be informed.

Defending respect for confidentiality in the medical treatment of adolescents is highly important in the context of the IPPF’s objectives. This paper argues in favour of this idea and explains why patient confidentiality is fundamental. Section 1 considers the importance of patient confidentiality, Section 2 looks at times when a doctor may suspend confidentiality, and Section 3 address the reasons why confidentiality has to be respected when dealing with adolescents. Section 4 offers recommendations in this regard.

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I. Professional Confidentiality

Confidentiality is justified by the interest in protecting the privacy, personal development, freedom, life and health of individuals, in accordance with the human rights treaties signed by the Latin American and Caribbean countries.\(^\text{111}\) It is based on the fact that the patient probably does not want to have information passed on that he or she considers private,\(^\text{112}\) and so the decision to do so must be a conscious one, i.e., free, informed and responsible. A patient’s “informed consent” is, in fact, based on the premise that “the obligation to reveal private information is a violation of personal freedom.”

Confidentiality promotes trust in doctors, encouraging patients to be more open. When this is lacking, patients may lie, making the doctor’s task more difficult and leading to deficiencies in the care and treatment.\(^\text{113}\) Lack of confidentiality is a barrier to accessing health care because the fear of revealing sensitive information may prevent patients from seeking professional healthcare and turn them towards unsafe treatments. In a broader sense, a lack of confidentiality violates the right to health and therefore endangers people’s lives.

In sexual and reproductive health, the fear that the doctor may reveal sensitive information can prevent patients from being completely honest, afraid that the information may be made public (which could have serious criminal implications). This can lead them to self-medicate without professional advice.

Medical Codes of Conduct explicitly establish a duty not to disseminate information of which a doctor may become aware during the course of his or her medical duties, and this duty extends to the rest of the health team. Similarly, healthcare center administrators who do not form part of the patient

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\(^{111}\) See PROMSEX, Médicos en Conflicto entre la Cura y la Denuncia: Artículo 30 – Análisis de la Constitucionalidad de la Ley General de Salud sobre la Obligación de Médicos y Médicas de Denunciar p. 7.

\(^{112}\) The principle of personal autonomy goes as follows: an individual’s free choice of a plurality of life plans is valuable. The State and other individuals cannot interfere with such autonomous decisions. The State must simply design institutions that prevent mutual interference in life plans and even facilitate the pursuit of such plans. See, for example, Carlos Nino, Ética y Derechos Humanos Buenos Aires, Astrea, 1989, ch. 5.

\(^{113}\) See Iniciativas Sanitarias, El Secreto Profesional-Confidencialidad.
care team must also act with discretion and patients and their companions must be able to identify the duty they are performing. In particular, the patient’s clinical history and other records must be handled discreetly, meaning that they are not kept where third parties can have access to them or made visible to other patients or companions but held under lock and key or password, depending on the storage medium, and transported in containers that do not bear the patients’ names.

It is therefore crucial that all medical students, particularly those new to a health institution or novices in the management of technological tools, also become familiar with the importance of confidentiality and put it into practice in the same way that professionals do. The importance of patient confidentiality is reflected in various legislative texts, which establish that a doctor who reveals information about a patient without his or her consent is committing an offence and neither a criminal nor a civil judge can release the doctor from this obligation, only the patient can. The duty to maintain patient confidentiality is crucial, and it must be maintained even in the case of the patient’s death.

In Argentina, for example, the obligation to maintain confidentiality begins with the Hippocratic Oath and is reflected in professional codes of conduct. Article 4 of Law 23,277 imposes an obligation on psychologists to “maintain the most rigorous confidentiality with regard to any prescription or action they take in accordance with their specific tasks, along with the information or facts communicated to them by virtue of their professional activity, in terms of the physical, psychological or ideological aspects of individuals.” For its part, the criminal system protects confidentiality (Art. 156 of the Criminal Code), establishing that “anyone becoming aware, by virtue of their status, office, job, profession or art, of a secret the divulgation of which could cause harm, and who reveals it without just cause” will be punished with a fine and disqualification. This is why, in principle, doctors can only break patient confidentiality when they have a “just cause” for doing so.

114 Iniciativas Sanitarias, El Secreto Profesional-Confidencialidad, above note 3.
115 Idem.
116 Idem.
Paragraph 1 of Article 177 of the Criminal Procedure Code establishes the duty of all civil servants or public employees to report the perpetration of any crimes that they may become aware of during the course of their duties. Paragraph 2 even establishes the duty to report “crimes against life and physical integrity that they may become aware of when providing their professional services, unless the actions made known are protected by professional confidentiality.” Article 244, however, establishes that the duty not to disclose information received in the course of their duty extends to “secret actions that may have become known to the priests of an accepted form of worship; to lawyers, prosecutors and notaries; to doctors, pharmacists, midwives and other health workers; to soldiers and public employees in relation to State secrets, by virtue of their status, office or profession.” In this respect, only the interested party can, in principle, release the doctor from this duty of confidentiality.

In Latin America, the leading case on confidentiality was that of *De la Cruz Flores vs. Peru*, in which the defendant was accused of having provided medical treatment to alleged terrorists. The case was heard by the Inter-American Court of Human Rights in 2004, which ruled that the aim of a medical action was not to damage legal rights but to preserve the fundamental legal right that is the life of a person. The Court referred to the Peruvian Constitution, Article 2.18, which establishes the right to maintain professional confidentiality. It also referred to a recommendation of the United Nations Human Rights Committee with regard to protecting professional confidentiality by means of legislation.

Similarly, given that an expectation of confidentiality is a basic and specific assumption in the doctor/patient relationship, the former can in no way be obliged to report the latter. However, despite the decision in *De la Cruz Flores* and the explicit language of Article 2.18 of the Peruvian Constitution, Article 30 of Law N. 26842, *General Law on Health* establishes that “a doctor who treats a patient wounded by a knife, bullet, traffic accident or who is injured by any other violent means that may form a crime liable to prosecution, or when there are signs of criminal abortion, is obliged to make the act known to

119 In addition, the Court made it quite clear that although, of course, doctors can be prosecuted for committing crimes, they cannot be prosecuted for exercising their profession.
a competent authority.” This creates a serious conflict for doctors as they can either comply with their ethical and legal duty to respect patient confidentiality or obey the stated law. In any case, in the area of sexual and reproductive health, a requirement forcing doctors to report their patients when there are signs of criminal abortion is not an ideal way of protecting the life of the fetus or solving the public health problem caused by backstreet abortions. Faced with the fear of being reported by doctors, women tend to opt for secret and unsafe abortions, thereby creating a direct link between maternal mortality and the termination of pregnancies under unsafe conditions. In order to protect life, the State could take measures that neither violate professional confidentiality nor affect the right to health—and even life—of the women who have to make these decisions. The most convincing measure would undoubtedly be to change the restrictive legislation, but other more immediate actions could also be taken, such as closing down centers that provide unsafe abortions, prosecuting those who endanger the lives of women by carrying out unsafe abortions, organizing sex education campaigns and distributing contraceptives through official health centers.120

The doctor’s role is not to investigate crimes but to care for all people equally, regardless of their religious, political or legal status, or of the origin of their injuries or illness. Forcing them to report their patients distorts the relationship of trust between doctor and patient. Just like the priest who hears confessions, or the lawyer to whom clients or even potential clients confess crimes, doctors have an obligation to maintain patient confidentiality.121 In this regard, the State must provide their work with guarantees.122 As Judge García Ramírez said in the De la Cruz Flores case:

the State cannot weaken a doctor’s responsibility to protect health and life through rules or interpretations that dissuade the doctor from fulfilling his duty....because they may force him to deviate from the task required of him and take on another that is in conflict with the former, raises unacceptable dilemmas and changes the crux of the doctor/patient relationship, as would be the case

121 See the reasoned opinion of Judge Garcia Ramirez in De la Cruz Flores, above note 9.
122 Idem.
if doctors were forced to inform on the patients in their care. The same would happen if, in their sphere of activity, lawyers were required to report illegal acts committed by their clients when they found out about them through their relationship of assistance and defense, or a priest had to reveal the secrets confided to him through confession.\(^{123}\)

2. Exceptions to the Duty to Maintain Professional Confidentiality

What is the scope of the duty of confidentiality? Are there any exceptions? One rule that has emerged from court decisions is that the obligation to confidentiality ceases *only* when the doctor knows that the patient is going to cause serious harm to another.\(^{124}\) This must not, however, result in the criminalization of people living with HIV/AIDS, who are frequently pressured into revealing information about their status.

The Supreme Court of California maintained that confidentiality ceases when the doctor knows that his patient is going to seriously harm another.\(^{125}\) The Supreme Court of Canada adopted a similar standard, arguing that the risk must be (1) clear and with an identifiable object, (2) of serious bodily harm or death and (3) imminent.\(^{126}\)

3. Patient Confidentiality in the Treatment of Adolescents

Medical professionals treating adolescents are often faced with a decision whether to notify their parents or guardians. This is due to their lack of knowledge of the applicable law on whether adolescents have the legal

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123 Idem.
124 See, for example, Elaine Gibson, Medical Confidentiality and Protection of Third Party Interests 6(2) The American Journal of Bioethics 23-25.
125 Tarasoff v. Regents of the University of California (Supreme Court of California, 529 p. 2d 553, Cal. 1974).
126 Smith V. Jones (1999), 169 Dominion Law Reports (4th) 385 (Supreme Court of Canada).
capacity to receive information about their treatment. The countries of Latin America and the Caribbean have ratified the Convention on the Rights of the Child, Article 1, which defines “child” as any human being under 18 years of age (unless national law indicates that majority is attained earlier) and Article 5, which introduces the concept of “evolving capacities of the child,”127 or the principle that children are the subjects of rights and, as their capacities evolve, they are able to exercise these rights on their own behalf.128 It also establishes an obligation on the part of states to respect this evolution,129 which is not incompatible with respect for the autonomy of the family. The Convention’s Preamble states that this is “the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children,” while Article 18 notes that the responsibility for the upbringing and development of the child falls to the parents.130

The aim is to achieve a balance between the rights of the family and those of the child. If the role of parents is to guide and direct their children properly in their personal development and in a responsible life, then in the process of evolving their capacities the parents do not necessarily have to support their opinions, although they must clearly explain to them why their decision is different. However, it is important not to overwhelm children with responsibilities inappropriate to the stage of development of their capacities.131

In Latin America, the adoption of the Convention on the Rights of the Child implied a very important change as it moved from a paradigm of “guardianship”

127 “States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.” Emphasis added.
129 Article 5: States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.
131 Idem., p. 20, 23.
and “assistance” to one of “integral protection,”132 in which children have rights and are the exclusive holders of those rights due to their status as individuals at a stage in their growth.133 The concept of “competence” was adopted. Commonplace in bioethics, competence is most appropriate for the exercise of children’s personal rights134 and more flexible than “capacity” (cf. “incapable”) as there is no specific age at which children stop being incompetent. While capacity occurs without intervention, competence is gradual; it is shaped as the child develops his or her personal autonomy.135

The fundamental criterion when determining how doctors should act in relation to adolescent patients is the principle of the “best interests of the child.”136 This is key to the Convention, Article 3.1, which establishes that “in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.”

Position Arguments

Doctors have to make decisions whether to treat underage patients who do not have parental consent, according to the best interests of the child, and ensure that he or she clearly understands the nature of the treatment being received.

134 Idem., p. 45.
135 In contrast to this vision, some Argentine authors maintain that Law 26,061 in no way affects the system of civil capacity established in the Civil Code. This vision distinguishes between “civil capacity” and “capacity for protection” when referring to public policies on children. However, the system of integral protection includes not only the implementation of policies aimed at guaranteeing children’s protection but also the way in which said rights are exercised. Hence gradual capacity includes both civil capacity and the exercise of social and political rights. Idem., p. 48.
136 See the opinion of Lord Fraser in the Gillick case, Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL).
The fundamental principles that must guide this conduct are the same as those governing the treatment of adults, such as respect for patient confidentiality, avoiding a greater evil, and minimizing harm to the patient’s health.

One example of model regulation can be seen in the Autonomous City of Buenos Aires (CABA), whose regulations make it compulsory to provide healthcare to any adolescent visiting Regional Health Ministry healthcare providers, whether alone or accompanied by an adult. In addition, it establishes that the Regional Health Ministry’s healthcare provision must promote appropriate mechanisms aimed at removing administrative barriers that could arise and specifies that it is irrelevant whether the adolescent patient has identity documents, even to communicate the situation to the authorities. The law also presumes that all adolescents requiring treatment have the necessary maturity to form their own judgments, which means that health professionals have the responsibility to respond to their requests.

In this context, the following two situations can be distinguished: (1) the adolescent patient who is accompanied by an adult and (2) the adolescent patient who visits alone. In the first case, the doctor must make it known to the adult that the adolescent patient will be treated without their intervention, and the doctor will then have a meeting with the patient to reiterate his or her right to confidentiality; and if it is not possible to keep this confidentiality, the child will need to be informed of the reasons. If the health or life of the patient is at risk, the doctor will need to assess whether the child understands the magnitude of the danger and, if the doctor considers the child incapable of facing up to the situation alone, will need to ask the patient to designate someone to help, emphasising that the third person should be someone the child trusts. Doctors thus have to inform adolescents when strict respect for patient confidentiality does not apply, such as when seeking contraception as a form of protection from sexual abuse and the most appropriate course of action would be to contact the competent authorities. In another case, if the guardians of an

137 See Resolution N° 1.252/05 and Resolution N° 1.253/05.
138 See Arts. 1 and 2, Resolution N° 1.252/05.
139 Idem., art. 2.
140 Art. 2, Resolution N° 1.253/05.
141 See the CABA Sexual Health and Reproductive Programmes and Law 418 of the Autonomous City of Buenos Aires on Reproductive Health and Responsible Procreation.
adolescent are managing a course of medical treatment, the doctor needs to inform them of what medication has been prescribed to identify their contra-indications. If the patient visits the center on their own, the criterion is the same:

“In the case of adolescent girls/boys who visit without an accompanying adult and who, according to an assessment made by a professional interdisciplinary team, do not have the necessary capacities to effectively exercise their own personal right to health, a responsible adult that the child or adolescent recognizes as such must be called upon. Should an interdisciplinary assessment body not be involved, the health staff that establish ‘first contact’ shall proceed in a similar manner. If no responsible adult is given, then contact will need to be made with the Permanent Cover of the Advisory Council for the Rights of the Child and Adolescent (CDNNyA), and this body will ensure the necessary means to implement their right to health … Should the children and adolescents who visit healthcare providers without an accompanying adult be in an emergency and/or urgent situation, the necessary care must first be provided in order to guarantee their right to health as a priority.”143

In jurisdictions where there are no regulations, doctors must actively work to get them established for the Convention on the Rights of the Child, apply human rights principles and promote the best interests of the child, public health and reduced harm to adolescent patients at all times.

With regard to access to HIV tests, the Committee on the Rights of the Child recommended that voluntary access to advisory services and confidential tests should be backed up by respect for children’s right to health.144 In turn, Article 24 of the Convention establishes that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to

143 See Articles 5 and 6, Resolution N° 1.252/05. Art. 6 continues as follows: “Subsequently, and only in those cases where there is opposition from the child or adolescent and/or their legal representatives to the medical practice to be conducted (or that is to be conducted in the future), or when it is a matter of practices requiring judicial authorisation, such as organ mutilation, sex change or transplants, the corresponding authorization will be requested from the “General Supervisory Consultancy for Minors and those Lacking Legal Capacity in the City of Buenos Aires....”

144 Comment N. 3 (2003), HIV/AIDS and the Rights of Children, 17/3/03.
facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.” This may imply that children should have access to advisory services and confidential medical examinations.

Article 14.1 is highly significant as it recognizes that one consequence of a child’s right to freedom of thought, conscience and religion is a debate about whether religious restrictions on the use of contraception and abortion should be observed, which falls outside the sphere of parental authority.

145 Article 14:
1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.
2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.
3. Freedom to manifest one’s religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.
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Parental Involvement Laws: Are They What We Really Need?

Yali Bair, PhD
Ana Sandoval
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For three out of the last four years, Planned Parenthood affiliates, along with our coalition partners in California, have faced three ballot initiatives that would have required teens to notify their parents before they were able to obtain abortion services in the State. We defeated these dangerous initiatives through a campaign that combined empathic messaging, sound research and grassroots action that not only won at the ballot box, but also won this emotional debate in the court of public opinion. Yali Bair, PhD, is the Vice President for Public Policy for Planned Parenthood Affiliates of California and has been a women’s health researcher and policy advocate for almost 20 years. Ana Sandoval is the Director of Communications and Operations with a 14-year history in strategic communications and Annie Lundahl is the Statewide Field Organizing Specialist, with a background in non-profit Administrative and Direct service primarily with women and teens.

Parental Involvement: Sounds Like a Good Idea

To the general public, parental Involvement laws – legislation that would require either parental notification or parental consent before a teenager could have an abortion – sound like a good idea. In fact, it’s normal and natural for

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parents to want to be involved in their teenagers’ lives. As a result, the first inclination regarding this emotional issue is to support parental involvement laws because people, whether parents or not, believe these laws are what’s best for the teen. How we talk about the dangers of parental involvement laws is a critical first step toward overcoming the public’s natural inclination to support these laws.

To win this emotional debate in the court of public opinion for California voters meant having to reframe the issue in the public’s mind. It became necessary to find ways of talking about parental involvement laws so that the public understood the inherent dangers of these laws and came to the position that opposing parental involvement laws is what “good” parents would do to protect their daughter.

To achieve this reframing, the public had to be taken out of its idealized world regarding parenting – where all teens are happy, wholesome and have supportive parents who are willing to talk to them about anything. During the research phase of our messaging, which included focus groups on the issue, when groups participants were asked to imagine what a teen in this situation would do, they thought of the fear and desperation that teens would feel – even those teens who came from homes with good parent communications. So in order to achieve this same position through messaging, spokespeople used “emotional cues” and talked about the “real world” implications of parental involvement laws. They asked people to “think outside their bubble” about teens who couldn’t talk to their parents because they fear being beaten or kicked out of their homes and spoke of “scared, desperate teens.” They also asked people to think about the dangerous things teens might do – like taking matters into their own hands (such as seeking illegal or self-induced abortions) or forgoing needed medical care.

Simultaneously there was a need to calm people’s fears about what most teens do when faced with a decision regarding their pregnancy. Citing information from studies, we assured the public that most teens DO involve their parents when making decisions regarding an unintended pregnancy. We also reinforced the fact that there are other more successful and less dangerous solutions to the problem of teen pregnancy such as access to comprehensive
sex education, access to family planning and the support of strong caring families throughout a teen’s life.

By focusing on the importance of teen safety and good parenting and how “in the real world” parental involvement laws can actually harm teens, it created an atmosphere that allowed the public to give itself the permission to oppose laws that sounded good on the surface. This is because in an emotional hierarchy, ensuring that teens are safe actually trumps a parent’s “right to know.” So for the public, opposing laws that threaten teen safety equals protecting teens. Our foundational message for these campaigns explains it best:

*If my daughter couldn’t come to me, for whatever reason, I’d want her to be safe. Her safety is more important than the government notifying me.*

**Parental Involvement Laws: What do they mean for teens?**

As of 2008, in the US, 34 states have parental involvement laws in effect and another 7 have laws that are not implementable due to conflicts with state constitutions. In order to enact parental involvement laws, states are required to provide minors with an alternate option, typically involving the juvenile court.

At the heart of the debate about parental involvement is the concept that intervention is necessary to compel teen to talk with their parents about sexual activity and pregnancy. Recent studies indicate that the majority of adolescents involve at least one parent in discussions about sexual activity, contraception and abortion. It is conceivable that conversations with parents about sexuality may be easier to have than conversations about abortion. In the United States, minors account for approximately 7% of all abortions, and the majority of these (60%) involve at least one parent in the decision. It is clear that teens can and will involve parents in sexual health decisions if the relationship and home environment are conducive to such discussions. Compelling teens to talk to parents may be an unnecessary solution for most teens, and a dangerous one for others.
Parental Involvement Laws: What do teens say they would do?

One of the key issues that informs the thinking around parental involvement laws is the expectation of what teens would choose to do if such laws were to be enacted. A recent study in California[3] found that 90% of teens would not stop having sex, less than half would continue to seek family planning and services for sexually transmitted disease (even if the law only applied to abortion) and almost half would seek alternative solutions such as traveling out of state. These findings and our experience in health centers show that lack of confidentiality, or suspected lack of privacy, is a clear deterrent to teens seeking reproductive health care. Parental involvement laws that seek to reduce teen abortion could ironically lead to increased abortion rates if they lead fewer teens to seek reproductive health care, including family planning. This study highlights the importance of seeking real solutions that address teen pregnancy such as policies that promote comprehensive sexuality education and confidential access to low or no cost family planning services.

Parental Involvement Laws: What do teens actually do?

A recent summary of research on parental involvement laws in the US finds little effect on the outcomes most of interest to parents and policymakers. While study methodology is mixed and outcomes are influenced by local and regional factors, the body of research in this area points to these laws doing more harm than good.

Teen pregnancy rates either decline slightly or do not change. With regard to abortion and birth rates, the data is less clear. The majority of studies showed decreases in abortion rates for minors in states with parental involvement laws. However, abortions have also been shown to increase in states without parental notification laws that are adjacent to those with these. Teen birth rates increase slightly or show little change. This may parallel the changes seen in pregnancy rates and likely reflects the incomplete data about pregnancy outcome or the
fact that some older teens will postpone abortions to their 18th birthday in order to avoid parental notification.

This summary of studies also indicates that parental involvement laws result in an increase in second trimester abortion and an increase in mean gestational age among first trimester abortions. Second trimester abortions are more complicated, carry more health risks and are more difficult to access than early procedures. Some communities have very limited access to second trimester abortion providers, and women are required to travel hundreds of miles for what is often a multiple day procedure. These laws could potentially endanger the health of young women due to delays in seeking care. The strongest finding among the studies analyzed is an increase in the number of minors who travel out of states with parental involvement laws to obtain abortions in places without these regulations. This validates the study referenced above that asked teens to predict their behavior under parental involvement laws. Additionally, studies indicate that, parental involvement laws don’t improve parental involvement in teens’ decisions about sexuality.[5]

Parental Involvement Laws:
How do they affect providers?

Confidential reproductive health services by trusted providers are an important component of healthy sexual development for teens. Without access to quality, respectful and confidential care teens will seek information and services from unreliable sources and may forgo needed care. While there has been no formal research on the impact of parental involvement laws on providers, it is clear that the policy changes associated with these laws have the potential to negatively impact the provision of care and the provider patient relationship. Parental involvement laws are often associated with increased reporting mandates. Providers may be required to report pregnant teens to the state or to parents, regardless of the abortion decision. They may be asked to report teen pregnancy as automatic grounds for child abuse suspicion or to document and report every abortion performed on a minor. All patients, but especially teens, value the confidentiality of the patient physician relationship.
Undermining that trust in any way is problematic for both the patient and the provider, who ultimately wants to do what is best for the patient. Parental involvement laws introduce a third party to which the physician is potentially held accountable (the parents) and places the provider in a difficult position of having to comply with a law that may not be in the best interest of the patient.

In addition, there can be concerns about increased provider liability. One version of a proposed parental notification law in California expanded the statute of limitations for provider liability to four years after a parent learns of an abortion performed that was not reported, even if this knowledge comes to light 20 or 30 years after the procedure. Parental involvement laws do not protect providers, rather they often place providers at increased risk of legal liability and may create a disincentive to caring for adolescents or providing reproductive health care services.

**Parental Involvement Laws: Youth Involvement in Advocacy**

Youth are an important population to include in advocacy around Parental involvement laws, and yet are many times overlooked in the initial stages of advocacy. Youth are not only the most affected by the implementation of these laws but are also the individuals who can speak from firsthand experience either because they themselves have been in a situation or have known peers who have dealt with teen pregnancy. In our experience, once informed of the specifics of Parental Notification, teens were able to very quickly understand the implications of this law and the impact that it would have on the youth in our state. As was stated earlier, the majority of minors involve their parents in decision making around abortion, not only do teens know this anecdotally but they also have more intimate knowledge of the reasons some teens do not involve their parents.

This quick awareness of teens to the complexity of issues surrounding parental involvement laws means that young people are some of the easiest to persuade and engage in advocacy. The fact that many of the youth,
because of their age, were not able to vote gave them even more reason to make their voice heard through advocacy. Involving youth early in a campaign or organizing effort can result in advocacy on many levels; spokespeople, organizers, and volunteers.

Parental Involvement Laws:
The Role of Community

Reproductive health care providers, educators, parents and young people would benefit from real solutions to teen pregnancy, rather than increasingly punitive rules that impede the ability to provide and receive good care. All of the people and groups of professionals who actually care for teens on a daily basis took an official position in opposition to California’s proposed parental notification initiatives. Teachers, physicians, nurses, social workers, and counselors all opposed this kind of rule because they knew that these laws don’t work and don’t provide communities with real solutions. These community leaders are in positions of trust and can advocate for resources and programs that promote healthy sexuality education, including parental involvement.

Parental involvement and communication about sexuality and health are a critical component of healthy adolescent development. Open, accurate and early communication about sexuality is both necessary and difficult to achieve. Parents need resources about the latest facts about reproductive health and about how best to deliver healthy sexuality messages that are rooted in the family’s values system. None of this is achieved through parental notification laws, and can in fact be undermined by these rules. Parents and teens alike are their own best advocates when it comes to seeking community based resources to meet their individual needs.
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The environment for adolescent decision-making: the case of sexual and reproductive health

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Introduction: decision-making and adolescence

There are two crucial elements to adolescent decision-making in sexual and reproductive health (SRH): the actual condition of being adolescent and the diverse ways the adolescent can learn to make decisions. This article seeks to provide tools to contemplate the rights and responsibilities of adolescents and their interaction with adults.

It is customary to consider an adolescent as a minor, someone who lacks all of the necessary requirements to access certain rights and capacities; or in a more general sense, someone who falls short of full legitimacy. This concept is deceptive, however, because it assumes that adults are prototypical citizens when it comes to holding rights, without having to demonstrate or confirm this status in any other respect but age. The maturity necessary to make responsible decisions is therefore based on the number of years lived, rather than on learning or gaining particular competence.

From a legal point of view, the adult population can legitimately make decisions, a right that implies a greater degree of responsibility and accountability for negative consequences. Although adolescents with significant clarity of mind

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and information may be able to assume similar responsibilities, legally they are not allowed to because of their age. An adolescent’s legal representative (i.e., the parents or guardian) may even make a decision that is contrary to the wishes of the adolescent based on the guardian’s knowledge and beliefs of the situation. It may also be the case that adults who do not legally require an intermediary can lack decision-making capacity or the capacity to take on basic responsibilities.

Questions arise when guardians make “immature” decisions that affect adolescents and fail to consider the complexity of the situation. Therefore, the weight of the adolescent’s opinion must always be considered in decisions concerning him or her.

1. Decisions from the adolescent experience

Any study of the legal legitimacy of adolescents as holders of rights and social guarantees has to identify the limits of their decision-making power, bearing in mind their physiological development (e.g., the development of their cerebral cortex and their emotional identity) and their relative inexperience and corresponding gaps in information. It is important to consider whether the mere fact of having reached a specific age is a defining element in decision-making, along with the quality of information received, the freedom available and the quality of perceived support. SRH issues require support that provides significant information while at the same time inspiring confidence. This is achieved when the support staff attempts to understand and empathize with the adolescent’s concerns, thereby being perceived by the adolescent as trustworthy. A lack of support, for example, can be paralyzing and have the adverse effect of encouraging the adolescent to delegate his or her responsibilities.

Trust is a requirement of critical and respectful dialogue. It can lead to effective communication if adults accept the possibility of a constructive exchange in which they contribute their experience but also recognize the limitations of their conclusions and opinions. This provision is complicated in the case of a guardian or a minor’s representative, who may not be easily
reconcilable with biological or social parents, because the relevance of one is often disregarded in the face of the other. Ultimately, the validity of intervening as an adult representative who opposes an adolescent’s decision—whether a biological parent or legally-appointed guardian—is a critical issue worth exploring when contemplating the SRH of adolescents.

2. The decision-making environment from different disciplinary approaches

In the literature on ethics, law and pedagogy, responsibility is defined as a free decision taken in full knowledge of the consequences (i.e., informed consent). When either of these two stipulations is not guaranteed, there is an attenuation of responsibility, particularly when the person was unaware of the consequences of their actions because there was no obligation to be informed or there was coercion.

The idea that the educational process should aspire to developing a child’s autonomy (Piaget in Kamu, undated, and Freire, 1971), in other words, education is a process of consolidating freedoms through practice, is a valuable one. Education provides a supportive environment that encourages dialogue on the positive and negative consequences of actions without an indiscriminate punishment of errors, which results in an exchange about the implications of freedom in its broadest sense. As human beings, we constantly exercise our freedom, even when that means giving away the freedom or unthinkingly accepting the decisions of others.

The capacity to reflect on the consequences of one’s decisions is specific to humankind (Álvaro Vieira Pinto, 1973) and enables us to consider actions before we take them. This puts us in a position of being able to plan, anticipate and mould reality according to our own wishes. While humans can use the capacity for anticipation to make and remake our circumstances (Freire, 1971), animals follow their instincts and adapt to the world around them. What then are the resources adolescents can draw on when making decisions?
Social settings that censure the correction of errors or punish all errors are not favorable to responsible decision-making, as they encourage customary responses or fundamentalist obedience towards established methods, while considering this synonymous with maturity (Figueroa and Fuentes 2001). Under this system only those reaching the age of “formal legality” can be recognized and will know what decisions to make (Ortega y Gasset, 1968). This maturation has been described as a domestication of people (Hierro, 1989) and warnings have been given about its capacity to detract from the reflective capacity of human beings (Illich, 1977).

Tension exists between the progressive approaches to decision-making and more paternalistic frameworks, which though they may be well intentioned—they aim to protect minors from making faulty decisions—ignore or minimize a minor’s innate capacities and lead to negative consequences in the development of his or her initiative and future responsibility. In contrast, pedagogical analyses call for and encourage rebelliousness as a positive force in the development of new decision-making abilities, as long as what is at stake is the right of the adolescent to seek and build his or her own identity (Figueroa 2001). Rather than breaking the rules, it is a way for minors to make themselves visible in an environment where they perceive they are not being taken into account. Considering these ambitions, we have to ask ourselves what the criteria are for evaluating the adolescent population, who should do this, from what language, and on the basis of what world vision (Stern 2008).

We must also ask whether encouraging or hindering decision-making in adolescents, particularly responsible decision-making, has bearing on sexual and reproductive development. Some key elements to examine are the importance of belonging to a certain social group, the educational level attained by the minor’s parents or guardians, the social value assigned to being a man or a woman, access to formal schooling and social resources, and the adolescent’s relationship with religious traditions. Some of these are cultural issues defined long before the child was born and to which he or she is expected to adapt, sometimes without any outlet to express dissent.

Social, family and individual conditions can also support the development of a person’s critical capacities, especially in relation to how he or she responds to
societal norms. According to the gradual exercise of freedom (Nunner Winkler, 1992), adolescents initially perceive how to do what they want, then how to act with knowledge (i.e., autonomy), and finally, how to influence the social criteria that underpin any exercise of freedom (i.e., self-determination). Through this process individuals gain the capacity to understand the rules, position themselves in relation to them and take responsibility for their decisions. While this may appear to idealize the adolescent mind, the aim is to reflect on their role as a source of renewal and the consequences of ignoring them in collective construction processes.

Another essential element in the evolution adolescent decision-making is the perception of future consequences and the responsibilities that accompany them. A clear distinction can be made between deontological (two values, acceptable or not) and teleological positions, which involve understanding the reasons and motivations behind an action in order to support the person making the decision (Sánchez Vázquez, 1982 and Lamas, 1993). The openness of the latter is necessary to understand that an adolescent acts in a context where the rules already exist, defined by people with established authority. When encouraging autonomous decision-making (Piaget in Kamu, undated, and Freire, 1971), however, the rules must be conceived as social constructs that are continuously updated as a collective resource of the entire social community. Rather than focusing on the dichotomy of obeying the rules or not obeying rules, teleological positions seek to stimulate reflection and greater decision-making capacity.

Instead of analyzing whether adolescents are conforming to established social mores, it is of greater value to recognize the moral authority of adolescents in the decisions affecting their lives and encourage responsible (i.e., free and informed) decision-making with regard to SRH issues, as these issues are ultimately their responsibility.
3. The decisions of adolescents in sexual and reproductive health

Sexual and reproductive health issues have been recognized and defined as fundamental human rights, or conditions essential to the personal development of individuals, which makes avoiding all discrimination in regard to SRH and protecting people from harmful consequences of utmost importance, particularly in adolescent populations.

Two fundamental issues have been emphasized in regard to the role of information, or full-awareness, in decision-making: what does having information on possible consequences of a decision mean and how can we know that a decision has been made freely. To avoid hindering the right to act as a person (Correa and Petchesky, 1994) with extreme probing, we should put these considerations into a framework to avoid the paralysis that comes from exhaustive deliberation.

It is therefore advisable to design open strategies, subject to constant review, that aim to assess the importance of knowledge (using analytical categories of pedagogy) and identify external and internal forms of coercion (Sánchez Vázquez, 1996) that hinder or prevent decision-making. External coercion relates to social and institutional obstacles; internal coercion occurs during an adolescent’s personal development. Freedom depends on reducing the external and internal forms of coercion, which causes an adolescent’s world view and social relationships within his or her community to take on greater importance.

There may be specific difficulties when making decisions regarding sexual and reproductive health issues, based on age, inexperience, lack of significant information, delegation of responsibility to an authority or restrictive and Manichean support, all of which are a violation of minors’ rights. It is vital to consider the importance of correcting a decision that has been identified as wrong and review it in the specific context of minors, who perceive possible reactions of adults as firmly set in concrete.

With that in mind, an analysis should be conducted on the components of SRH to identify the social, family and individual difficulties that arise when making
decisions, with the assumption that well-informed, educated and supported adolescents are able to take responsibility for their own actions. There are three stages of SRH, which significantly overlap: (a) the sexual environment where reproductive events occur, (b) the process of pregnancy that may result in childbirth or in termination, and (c) the development, socialization and support of the child produced by the pregnancy. This initiative will enable us to highlight the specific needs that must be addressed by programs, public policies and sexual and reproductive health services. In addition, proposals for revised relationships of power could be sketched out, also recognizing the different forms of authority that adolescents encounter, such as family, school, civic institutions, media, and legislative frameworks that govern their social relations.

It is likewise important to define the minimum information needed for an adolescent to make responsible decisions regarding his or her sexual and reproductive life, depending on age, socio-cultural environment, and emotional development. For reference, high quality publications are available on teenage pregnancy (Stern and Garcia, 2001), sexually transmitted infections (Aggleton, 2001) and the abortion environment (Lista, 2001).

An analysis of SRH issues must include the perspective of adolescents without idealizing them. It is of particular importance to highlight the gulf that exists between assuming that a pregnancy is a social problem to be avoided and viewing a pregnancy through the conditions, motivations and resources of the people involved (Stern and Garcia, 2001). It is essential to consider the views one has of different populations, in particular what is acceptable and what is not (Aggleton, 2001).

By focusing on a collective reflection, which includes adolescents, the analysis should be able to determine what “significant knowledge” means in relation to making responsible SRH decisions. Adults must also be ready and willing to learn how to decide with the adolescent, not instead of the adolescent.
4. Some conclusions in the ongoing reflection process

There are three levels on which to analyze the decision-making process and generate specific recommendations: a) the capacity for concern, b) the pre-decisional environment; and c) the way in which the consequences of a decision are handled.

In the case of capacity for concern, recommendations include helping adolescents to notice, feel and carefully think about situations before they actually experience them. In other words, help to focus attention not only on information but on experiences that are meaningful to the adolescents.

In the pre-decisional environment, learn about the sources of information that influence the adolescent, such as the home, school, written and audiovisual media and health services. The aim is to guide the adolescent toward an understanding of the cognitive and contextual resources that influence or coerce him or her.

In handling the subsequent consequences, it is recommended that the decision be conceived of as a process and not as a single action, which avoids an unequivocal or compulsory action. It is worthwhile to provide formal tools that can help in the decision-making after its complexity has been considered, particularly decisions that relate to unknown horizons, such as parenthood.

Without this process, the adolescent may end up paralyzed, even encouraged to delegate his or her freedom of decision to others. Throughout, it is crucial to provide a guarantee to the adolescent that tolerance will prevail in the development of decision-making capacity and to ensure an trustworthy environment, particularly when dealing with feelings of guilt and building self-esteem and confidence.

I will conclude by reiterating the need to reconsider the adolescent population as people who must first be recognized as active subjects, with different needs and expectations, in addition to providing them with the greatest amount of
cultural, economic, educational resources and information so they can best undergo the process of autonomous decision-making. For this, we have to redefine the subjects and recognize that if they are not viewed as citizens possessing human rights, it will be difficult for the actions implemented to be ethical, despite being to their benefit. (Figueroa and Rodríguez, 2000, p.117).
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The five documents presented in this publication provide readers with the elements that must be taken into account when supporting capacity building among adolescents, more particularly, the capacity to make autonomous decisions regarding their sexual and reproductive health in a confidential environment. What follows are specific recommendations for action in the spheres of public policy, legislation, and programs; health services provision; and information, education, and communication.

**Public policy, legislation, and programs**

1. It is important to point out the relevance of having public policy, legislation, and programs that enable young people to exercise their human rights in general, and their sexual and reproductive rights in particular. Legislation in many countries already includes the recognition of underage people’s capacities, as these countries have incorporated the Convention on the Rights of the Child to their national laws. Nonetheless, these laws have not been translated into standards, protocols, guidelines, or action plans that may guide the work of health and education professionals. Civil society organizations must initiate advocacy processes oriented toward the production of such responses.

2. It is important to review the local legislative and regulatory frameworks in order to ensure that confidentiality is guaranteed in the healthcare context, without any form of discrimination (e.g. age). If there are restrictions to confidentiality, organizations must combine their efforts to change this situation. Professional secrecy is pivotal to ensure client-provider privilege
and to guarantee users’ exercise of their right to health, including sexual and reproductive health.

3. In countries where the law demands the consent of legal representatives to perform services such as abortion (or surgical services in general), organizations need to set in motion advocacy processes to review such measure. In this sense, increased use of medical abortion (with medication that terminates pregnancy) may offer new opportunities to develop different protocols or clinical practice guidelines that will enable adolescents to give their consent regarding the service they are requesting, without the mandatory involvement of parents or tutors. It is worth mentioning here that suggesting that mandatory parental or third-party consent measures be revised does not mean ignoring the value of the support these adults may offer to adolescents making decisions in view of an unwanted pregnancy.

4. It is important to develop advocacy processes aiming to modify clinical practice guidelines that have not incorporated emergency contraception into the healthcare protocols for sexually assaulted girls, adolescents, and women.

5. Youth participation both in changing public policy, legislation, and programs impinging on the exercise of their sexual and reproductive rights, and in health and education services, is itself a device to build adolescents’ capacities. For this reason, we must make every effort to ensure that the right of young people to participate in all decisions affecting their lives and their environment will be recognized, and take steps to facilitate their exercise of such right.

Services

1. Public and private healthcare institutions, especially those that provide counseling and care services to adolescents in the area of sexual and reproductive health, must develop and disseminate a confidentiality policy. Such policy must be shared not only among health professionals, but also
in waiting rooms, offices, and other facilities, so that young people can learn about it and demand this right. Institutions must make sure that information is conveyed in a simple language that can be understood by diverse youth audiences.

2. Protocols and service guidelines must support the work of health professionals who provide services to adolescents. They must inform providers about the factors they need to take into account when assessing the particular situation of a young person who comes to the health center. These include:

- The ability to understand and communicate relevant information: adolescents must be able to understand the alternatives available to them, manifest a preference, formulate their concerns, and raise pertinent questions.
- The ability to think and choose with a certain degree of independence: adolescents must be able to make a choice without being coaxed and to carefully ponder the situation by themselves.
- The ability to assess potential benefits and risks: adolescents must be able to understand the consequences of their various possible choices, how they will affect them, the risks they pose, and their implications in the short and long run.148

The professional’s assessment aims to determine not whether or not young people have the right to make decisions, but the degree of support they require to appropriate and make use of the capacities that enable them to exercise their rights.

3. If there is suspicion that a young person is being sexually abused, health professionals must start a dialogue with the user in order to respond to this situation. To better support him or her, health professionals should explore: age, level of understanding of situations associated with the exercise of his or her sexuality (e.g. consent in sexual relations, decision to come to the clinic), the minor’s living conditions (family, companions, education),

148 Taken from Lansdown, Gerison. The Evolving Capacities of The Child: Innocenti Insight, p. 52-3
behavior (e.g. signs of anxiety), behavior of the partner (e.g. if the partner has forbidden the adolescent to talk about him or her, and his or her age). If this exercise leads to the discovery of sexual abuse, health professionals must have the tools to support the young person either through institutional services or through referrals, and to provide information about legal implications, particularly in relation to the confidentiality of the visit.

4. The medical history must allow health professionals to acquire information about the adolescent’s physical and mental health conditions. It must also explore the context where the young person lives and the support networks that are available to him or her when carrying out decisions, especially when the latter pertain to his or her sexual and reproductive life. In this way, in view of an adolescent’s decision to terminate her pregnancy, it is important to find out whether she is aware of risks, benefits, and options; if she will be able to realize her decision without being pressured; and if she will have the necessary financial support or means to ensure a safe service. As a result of this dialogue, health professionals may recommend the involvement of the parents, of other adults, or of peers who may act as a support network, without making this into a requirement for the timely provision of the service requested.

5. Institutions must review and strengthen their quality policies based on the notions of adolescent autonomy and right to confidentiality. To this end, they must engage in active monitoring (adherence to protocol, monitoring services by means of both medical audit and user opinion) and passive monitoring (suggestions boxes and other modes of user evaluation).

Information, education and communication

1. Institutions need to initiate sensitization and training processes so as to eliminate cultural barriers that prevent good provision of services to adolescents in public health centers. These barriers may affect the staff of both public and private healthcare institutions, thus impairing timely and effective service provision. Consequently, both current and future health
professionals (health sciences students) must be engaged in the debate on the rights of young people, the exercise of the right to confidentiality, and the mandatory nature of professional secrecy.

2. Implementation of educational processes that strengthen adolescents’ capacity to make autonomous decisions, their knowledge of their rights, and the appropriation of their exercise, especially sexual and reproductive rights, may also be considered. Such processes must support reflection from rights and gender perspectives on everyday situations faced by adolescents that require them to make decisions regarding their sexual and reproductive health and their life in general. Educational activities must be connected with healthcare services so that they can provide information about existing mechanisms to exercise the right to health. Examples of such activities are peer education programs, reflection and debate activities in health center waiting rooms, and activities conducted at community centers or schools.

3. Information materials offered by health centers, such as pamphlets, posters, or videos, must always mention young people’s right to make autonomous decisions and the right to confidentiality in healthcare provision.

Information, education, and communication processes must also involve parents. They must make allies out of parents and engage them in the process of building adolescents’ capacities to make autonomous decisions, as well as in the search for the right conditions that will benefit young people. For instance, parents must be partners in any initiative to promote and advocate legislative changes connected with adolescents’ sexual and reproductive rights. For that purpose, they must be involved in intergenerational reflection and debate, and become a target population for communication campaigns on this topic.

Programs that foster youth participation (e.g. peer education programs) must be evaluated to make sure that they do not just offer information, but also open a space to think about exercising autonomy, about confidentiality, and about sexual and reproductive rights in general.