# Young Women and Abortion: Avoiding Legal and Policy Barriers

Patty Skuster
Senior Policy Advisor, Ipas

Ipas
Health. Access. Rights.

ISBN: 1-933095-71-7


Produced in the United States of America

Suggested citation: Skuster, Patty. (2013). *Young Women and Abortion: Avoiding Legal and Policy Barriers.* Chapel Hill, NC, Ipas.

Ipas is a nonprofit organization that works around the world to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We seek to eliminate unsafe abortion and the resulting deaths and injuries and to expand women's access to comprehensive abortion care, including contraception and related reproductive health information and care. We strive to foster a legal, policy and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely.

Ipas is a registered 501(c)(3) nonprofit organization. All contributions to Ipas are tax deductible to the full extent allowed by law.

For more information or to donate to Ipas:
Ipas
P.O. Box 9990
Chapel Hill, NC 27515 USA
1-919-967-7052
info@ipas.org
www.ipas.org



Printed on recycled paper.

# Young Women and Abortion: Avoiding Legal and Policy Barriers

Patty Skuster
Senior Policy Advisor, Ipas


*Acknowledgments: This publication was developed in collaboration with Ipas's Policy Unit and Youth Program.*

# Contents

# Introduction

We must reduce barriers to safe abortion for young women. Young women disproportionally resort to unsafe abortion. They have limited access to sexual and reproductive health services and information—particularly pregnancy prevention—resulting in high rates of unintended pregnancies. Barriers to safe abortion faced by young women include the high cost of services, lack of transportation and accessible facilities, partner influence, fear, stigma, and provider bias (Prata, Weidert & Screenvas, 2012). An estimated three million young women aged 15-19 experienced unsafe abortion in 2008 (World Health Organization, 2011).

Parental involvement requirements in law or policy are common barriers that push young women toward illegal and often unsafe abortion. This resource is designed to help advocates and policymakers promote laws and policies that support access to safe abortion for young women.

# Abortion and Young Women

In some contexts, young women suffer the majority of complications from unsafe abortion. Because of barriers to reproductive health care, young women are more likely than older women to delay abortion, and later abortion carries a greater risk of death and injury. Between 38 and 68 percent of women treated for complications of unsafe abortion are under the age of 20, according to a review of hospital records from developing countries (Olukoya, Kaya, Ferguson & AbouZahr, 2001). In sub-Saharan Africa, where 60 percent of unsafe abortions are among women under the age of 25, up to 70 percent of women hospitalized for abortion complications are under 20 (Shah & Ahman, 2004). A Ugandan study found almost 60 percent of abortion-related deaths were among adolescents (United Nations Population Fund, 2000).

Parental consent and notification requirements are major barriers to safe abortion for young women and can lead them to risk their health and lives through unsafe abortion. Disproportionately affected by sexual violence, young women are also burdened by requirements to report a rape to law enforcement authorities in order to access abortion services for an unwanted pregnancy resulting from rape. Such requirements are a barrier to safe abortion and should also be avoided. Mandated parental involvement does not increase communication within families and fails to address young people who do not live with their parents or who are abused by them. On abortion, the World Health Organization says, "to protect the best interests and welfare of minors, and taking into consideration their evolving capacities, policies and practices should encourage, but not require, parents' engagement" (World Health Organization, 2012).

# Human Rights Protection for Young Women

Children and adolescents enjoy unique protections under international human rights law. The needs of children and the role of parents, guardians and other family members change as children grow into adulthood. State human rights obligations likewise evolve throughout a child's life. In the context of reproductive health care, three principles can help mediate the relationships between parents and other caregivers, children, and government. These principles, explained below, provide guidance for applicable laws and policies when a minor seeks abortion. The Convention on the Rights of the Child (CRC) is the primary source of human rights principles that protect children and adolescents.

## Principle #1: The child's best interests.

The *best interests of the child,* under Article 3 of the CRC, must be the primary concern in all actions concerning them (Convention on the Rights of the Child, 1990). In most cases, parents and other caregivers are assumed to represent the best interests of their children; however, this standard empowers the state to intervene when a child's rights are not protected by parents.

## Principle #2: Evolving capacity.

The CRC acknowledges the role of parents and other caregivers to provide direction and guidance to a child, consistent with the child's *evolving capacity* (Convention on the Rights of the Child, Art. 5, 1990). Under the related principle of capability developed by Cook and Dickens, young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight. A child who is capable of expressing a view has a right to do so and that view must be taken into account, according to her age and maturity (Convention on the Rights of the Child, Art. 12, 1990). As a child's capacity evolves, her rights and responsibilities gradually supersede those of her parents and caregivers (Lansdown, 2005). This happens at no fixed age and may occur at different times for different areas of decisionmaking.

## Principle #3: Confidentiality.

A key component of the right to health for adolescents is *confidentiality.* To ensure that health-care services are accessible to young women, confidentiality must be protected (Committee on Economic, Social and Cultural Rights, 2000). Governments must enact laws or regulations to ensure provision of confidential services for adolescents, under the Convention on the Rights of the Child (Committee on the Rights of the Child, 2003).

# Laws and Policies on Minors' Access to Abortion

Laws and policies such as standards and guidelines that address minors' ability to consent to abortion should promote the best interest of the child, account for minors' evolving capacities, and protect confidentiality. Parental involvement requirements do not uphold these principles.

In most countries, a web of laws concerning different subjects dictates when children are competent to make their own independent decisions and when they should be held as responsible as adults for their actions. These laws are designed to protect children in specific circumstances and may set an age at which a child is considered able to make choices or when they should be held criminally responsible (*Lansdown*, 2005). Some countries dictate specific ages when children may choose their own religion, consent to medical treatment, or leave school, to name a few examples. In others jurisdictions, children are legally entitled to make such decisions once they are judged to have sufficient maturity (Rogoff, Sellers, Ferrous, Fox & Ellis, 1997).

On the issue of minors' consent for abortion, the approach varies significantly across jurisdictions. In several countries, minors alone can consent to abortion under provisions in abortion laws, general health laws, or laws concerning children's health care. For example, this is the case in Ethiopia, Fiji, Finland, France, Guyana, Israel, New Zealand, South Africa and Sweden. On the other hand, some countries—such as Albania, Bosnia, Czech Republic, Kosovo and Lithuania—explicitly require parental consent or notification, creating a barrier to safe abortion for young women.

Other countries set a fixed age at which a minor can consent to medical treatment, including abortion, but also allow for health-care providers to determine that younger children can consent based on their level of maturity. For example, in the United Kingdom, minors aged 16-17 are generally allowed to consent to their own medical treatment, but under *Gillick v West Norfolk and Wisbech Area Health Authority,* children younger than 16 who have sufficient understanding and intelligence such that they are able to understand fully what is involved in the medical treatment concerned may consent to it (Gillick v. West Norfolk…, 1985). The same allowances exist in Canada and Luxembourg. This approach incorporates the principle of evolving capacities somewhat, but differs in that it presumes incapacity for minors younger than the fixed age (Cook, Erdman & Dickens, 2007). Other countries—the United States, Australia, Equatorial Guinea, Monaco and Zimbabwe—similarly set a fixed age but allow younger children to consent based on the decision of a court or committee. Requiring this additional and oftentimes onerous step can be a barrier or cause delay, resulting in later-term abortion at greater risk to young women's health (Dennis, Henshaw, Joyce, Finer & Blanchard, 2009; Henshaw, 1995).

When drafting laws or policies to address whether a minor alone can consent to an abortion, it is important not to assume that a minor legally cannot consent simply because she is a

minor or because another law dictates an age at which a person is legally empowered in other circumstances. For example, laws that address areas such as criminal responsibility, voting, ability to consent to sex or to marry, or statutory rape do not dictate when a young woman alone can consent to abortion. Whether existing law allows a minor to consent to an abortion can only be answered after a search and analysis of directly applicable law, including laws around minors' consent to medical treatment generally and reproductive health specifically. In many countries, the existing law is silent on the issue, leaving the abortion law or standards and guidelines to address whether minors alone can consent to an abortion. Laws or standards and guidelines should address this specifically; otherwise, stakeholders including health-care providers, judges, lawyers, police, parents, and minors seeking abortion may assume that the law requires the consent of parents. Lack of clarity can cause confusion and result in denial of safe services to young women (World Health Organization, 2012).

# Example Laws and Policies

By explicitly stating in laws or standards and guidelines that minors alone can consent to abortion, countries protect the principles of the best interest of the child, evolving capacities, and confidentiality. Example language follows.

## In law: Abortion and child protection acts

*South Africa. Choice on Termination of Pregnancy Act, 1996.*

In the case of a pregnant minor, a medical practitioner or a registered midwife or registered nurse, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

*New Zealand. The Care of Children Act, 2004.*

If given by a female child (of whatever age), the following have the same effect as if she were of full age: … consent to the carrying out on her of any medical or surgical procedure for the purpose of terminating her pregnancy by a person professionally qualified to carry it out."

## In policy: Standards and guidelines

*Ghana. Ghana Health Service. Prevention and Management of Unsafe Abortion, Comprehensive Abortion Care Services Standards and Protocols, 2012.*

The service provider should encourage minors to consult a parent or a trusted adult if they have not done so already, provided that doing so will not put the minor in danger of physical or emotional harm. However, abortion services shall not be denied because such minor chooses not to consult them.

A parent, next of kin, another adult or trained service provider acting in loco parentis (in place of the parent) can give consent on behalf of the minor.

The confidentiality of the minor should be respected, subject to the usual exceptions that apply to patient-provider confidentiality.

*Zambia. Ministry of Health. Standards and Guidelines for Reducing Unsafe Abortion Morbidity and Mortality in Zambia. 2009.*

Standard 3: Facilities should ensure that adolescents and youths make informed and free decisions without coercion from interested parties.

Guidelines:

1. Ensure respect of autonomy in decision making without third party authorization.

3. Providers should act in good faith in the interest of the minor and this may involve leaving out parental or guardian consent.

# Appendix A: Human Rights Recommendations

## Committee on the Rights of the Child General Comment No. 12: The Right of the Child to be Heard (2009)

Paragraph 98: The realization of the provisions of the Convention requires respect for the child's right to express his or her views and to participate in promoting the healthy development and well-being of children. This applies to individual health-care decisions, as well as to children's involvement in the development of health policy and services.

Paragraph 99: The Committee identifies several distinct but linked issues that need consideration in respect of the child's involvement in practices and decisions relating to her or his own health care.

Paragraph 100: Children, including young children, should be included in decisionmaking processes, in a manner consistent with their evolving capacities. They should be provided with information about proposed treatments and their effects and outcomes, including in formats appropriate and accessible to children with disabilities.

Paragraph 101: States parties need to introduce legislation or regulations to ensure that children have access to confidential medical counselling and advice without parental consent, irrespective of the child's age, where this is needed for the child's safety or well-being. Children may need such access, for example, where they are experiencing violence or abuse at home, or in need of reproductive health education or services, or in case of conflicts between parents and the child over access to health services. The right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit.

## Committee on the Rights of the Child General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003)

11. In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters (art. 16). Health-care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.

31. Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.

32. Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the "best interest of the child" (art. 3).

33. With regard to privacy and confidentiality, and the related issue of informed consent to treatment, States parties should (a) enact laws or regulations to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent. Such laws or regulations should stipulate an age for this process, or refer to the evolving capacity of the child; and (b) provide training for health personnel on the rights of adolescents to privacy and confidentiality, to be informed about planned treatment and to give their informed consent to treatment.

## Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN General Assembly. A/66/254. 3 August 2011.

Paragraph 53: …In other instances, States require women to obtain their husband's consent and adolescents to obtain parental consent before acquiring various forms of contraception. Other jurisdictions allow pharmacists, and in some cases pharmacies, to refuse to dispense emergency contraception, which is otherwise legally available. These laws directly infringe upon the right of women and girls to make free and informed choices about their sexual and reproductive health and reflect discriminatory notions of women's roles in the family and society.

Paragraph 55: The obligation to respect the right to health requires that States abstain from limiting access to contraceptives and other means of maintaining sexual and reproductive health. States should therefore remove criminal laws and other legal restrictions, including parental consent laws and other third party authorizations, to ensure access to family planning

and contraceptive goods, services and information. The obligation to protect requires States ensure that neither third parties nor harmful social or traditional practices interfere with access to prenatal and post-natal care and family-planning (see E/C.12/2000/4, para. 35), or curtail access to some or all contraceptive methods. Finally, the obligation to fulfil includes adopting and implementing a national public HR and abortion health strategy, which includes the provision of "a wide range of sexual and reproductive health services, including access to family planning (...) and access to information (see E/CN.4/2004/49, para. 29)".

## Human Rights Council Resolution 19/37: Rights of the Child (2012)

*Right to the enjoyment of the highest attainable standard of health*

37. Calls upon all States:

(a) To take all necessary measures to ensure that the right of the child to life, survival and the enjoyment of the highest attainable standard of physical and mental health is promoted and protected, without any kind of discrimination, including through the development and implementation of laws, strategies and policies, gender-responsive budgeting and resource allocation, and adequate investment in health systems, including comprehensive and integrated primary health care, and in the health work force, including in efforts to achieve health-related international development goals by and beyond 2015, and to ensure access to adequate food and nutrition, safe drinking water and sanitation;

(b) To address, as a matter of priority, the vulnerabilities faced by children affected by and living with HIV, by providing those children, their families and caregivers with support and rehabilitation, including social and psychological rehabilitation and care, including paediatric services and medicines, by intensifying efforts to develop tools for early diagnosis, child-friendly medicine combinations and new treatments for children, particularly for infants living in resource-limited settings, and by accelerating efforts towards the elimination of mother-to-child transmission of the virus;

(c) To ensure confidentiality and informed consent in the provision of health care and services, in particular with regard to sexual and reproductive health, to children and adolescents, according to their evolving capacities.

## Committee on Economic, Social, and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (2000)

*Children and adolescents*

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. The Convention

on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

# Appendix B: Further Resources

Cook, R. & Dickens, B. (2000). Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive health care. *International Journal of Gynecology and Obstetrics*, 70:13-21.

Cook, R., Erdman, J. & Dickens, B. (2007). Respecting adolescents' confidentiality and reproductive and sexual choices. *International Journal of Gynecology and Obstetrics*, 98: 182-187.

Dickens, B. & Cook, R. (2005). Adolescents and consent to treatment. *International Journal of Gynecology and Obstetrics*, 89:179-184.

Ipas. (2011). *Abortion care for young women: A training toolkit.* Chapel Hill: Ipas.

Lansdown, G. (2005). *The evolving capacities of the child.* Giuntina: United Nations Children's Fund.

World Health Organization. (2012). *Safe Abortion: Technical and policy guidance for health systems.* (2nd ed.). Geneva: WHO.

# Appendix C: Workshop Activity for Improving Understanding of Abortion for Young Women

The following activity can be facilitated with advocates and policymakers and is designed to help individuals understand the need to remove barriers to safe abortion for young women.

## Case study on barriers to abortion access for young women

Facilitator notes:

1. Give participants copies of "The Case of Maria" and ask them to discuss the following in groups:

    - What legal, administrative or procedural barriers could prevent Maria from accessing safe abortion?

    - What standards must be in place to ensure she can access safe abortion?

2. Discuss answers with the group. Following the discussion, read additional case study information (below) and the source of the case. Emphasize that the story is true.

Additional information: "Graciela Hernández"[1] reported her father's systematic rapes against her in Guanajuato in 2002 when she was 16 years old. As the result of the rapes, Hernández became pregnant and declared unequivocally that she wished to terminate her pregnancy.

According to representatives from nongovernmental organizations who provided emotional and legal support for Hernández, the public prosecutor later persuaded the adolescent girl to change her accusation against her father from rape to incest—in order for the father to get a shorter jail sentence, as incest is considered a less serious crime than rape. Since abortion in Guanajuato is only legal after rape and not after incest, the abortion was not authorized, and Hernández was forced to carry the pregnancy to term.  This is from the official record.

Source: Human Rights Watch, Mexico. (2006). *The second assault: Obstructing access to legal abortion after rape in Mexico.* Available at www.hrw.org/reports/2006/03/06/mexico-second-assault

1 Maria is used in the case study because it is a common name.

## The Case of Maria

Maria had suffered her father's systematic rapes against her when she was 16 years old. As the result of the rapes, she became pregnant and declared unequivocally that she wished to terminate her pregnancy.

> And my father started to caress my legs and all of my body. And he penetrated me, and it hurt a lot when he penetrated me. I cried and I said to my father that it hurt a lot. … And I asked him if I was no longer a virgin, and my father said that before he penetrated me, yes, but no longer. … After that time, it was every week that my father took me to different hotels outside the city of [name withheld]. And we had sex. …And with regard to my pregnancy, I want to declare that I am certain that the child that I am expecting is my father's … because I never had [sex] with anyone else. … And I want to declare that I don't want to have the child that I am expecting, because I will not be able to love it. Because it is my father's, I will not be able to love it. And I also don't know how it will come about, if [the pregnancy] will go wrong. And I also don't want it because I didn't want to be pregnant, and that's why I want you to help me to have an abortion, because as I already said, I don't want to have this child, because it is my father's and I don't want it.

# Sources

Committee on Economic, Social and Cultural Rights. (2000). General Comment No. 14: The right to the highest attainable standard of health. E/C.12/2000/4.

Committee on the Rights of the Child. (2003). General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/ GC/2003/4.

Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force Sept. 2 1990, Art. 3.

Cook, R., Erdman, J. & Dickens B. (2007). Respecting adolescents' confidentiality and reproductive and sexual choices. *International Journal of Gynecology and Obstetrics,* 98:182–187.

Dennis, A., Henshaw, S., Joyce, T., Finer, L. & Blanchard, K. (2009). *The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review.* New York: Guttmacher Institute.

Gillick v. West Norfolk and Wisbech Area Health Authority and the Department of Health and Social Security. English House of Lords, 1985.

Henshaw, S. (1995). The impact of requirements for parental consent on minors' abortions in Mississippi, *Family Planning Perspectives,* 27(3):120–122.

Lansdown, G. (2005). *The evolving capacities of the child.* Giuntina: United Nations Children's Fund.

Olukoya, A., Kaya, A., Ferguson, B. & AbouZahr, C. (2001). Unsafe abortion in adolescents. *International Journal of Gynecology and Obstetrics,* 75(2):137-147.

Prata, N., Weidert, K. & Screenvas, A. (2012). Meeting the need: Youth and family planning in sub-Saharan Africa. *Contraception,* 2012.10.001. [Epub ahead of print].

Rogoff, B., Sellers, M. J., Ferrous S., Fox N., & Ellis, S. (1997). Age assignment of roles and responsibilities in children: A cross cultural study. *Human Development,* 18(5):353-369.

Shah, I. & Åhman, E. (2004). Age patterns of unsafe abortion in developing country regions. *Reproductive Health Matters,* 12 (24):9-17.

United Nations Population Fund. (2000). *The state of world population 2000. Lives together, worlds apart: Men and women in a time of change.* New York: UNFPA.

World Health Organization. (2011). *WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries.* Geneva: WHO.

World Health Organization. (2012). *Safe Abortion: Technical and policy guidance for health systems.* (2nd ed.). Geneva: WHO.