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Rebecca J. Cook

Joanna N. Erdman, *Dalhousie University Schulich School of Law*

Bernard Dickens, *University of Toronto*

UNIVERSITY OF
TORONTO
FACULTY OF LAW

University of Toronto Faculty of Law

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Rebecca J. Cook
Joanna N. Erdman
Bernard M. Dickens

Faculty of Law – University of Toronto

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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Respecting adolescents' confidentiality and reproductive and sexual choices

R.J. Cook^a, J.N. Erdman^b, B.M. Dickens^{a,*}

^a Faculty of Law, Faculty of Medicine and Joint Centre for Bioethics, University of Toronto, Toronto, Canada

^b Health Equity and Law Clinic, Faculty of Law, University of Toronto, Toronto, Canada

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

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1. Introduction

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

"adolescents" under the WHO test are "children" under the CRC.

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

* Corresponding author. Tel.: +1 416 978 4849; fax: +1 416 978 7899.

E-mail address: bernard.dickens@utoronto.ca (B.M. Dickens).

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

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

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

2. Legal capacity

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

However, laws on ages of consent to medical procedures tend to be applied more contextually, recognizing that some who are below the legally specified age for medical consent may possess sufficiently mature understanding of material considerations to make choices for themselves. For instance, an 8-year old who suffers an injury, such as in play, a traffic accident, or a domestic activity, can give legally effective

consent to receive appropriate medical care, even in the absence of emergency. Laws do not require the legal minor to continue to suffer or risk infection or disability until a person with parental authority approves treatment. The different approach is because adults with parental responsibility for minors bear legal duties to provide or consent to their medically indicated care, and risk liability under penal and/or child welfare laws for refusal or failure to approve such care.

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

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

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

3. Human rights of children

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

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

2. States Parties shall respect the rights and duties of the parent...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."

Accordingly, in May 2006, the Constitutional Court of Colombia ruled unconstitutional a Penal Code provision that criminalized any abortion performed, even with her free and informed consent, on an adolescent of less than 14 years of age [16]. The Court found that constitutional jurisprudence, reflecting the CRC, recognizes that minors of all ages are entitled to self-determination appropriate to their individual intellectual and emotional maturity, including that with regard to their reproductive health and choice.

Human rights may be in conflict between a parent's claim of entitlement to notification before a daughter's request is granted for medical advice concerning contraception, STI treatment or abortion, and an adolescent's entitlement to medical confidentiality. This was resolved in the *Axon* case in the English High Court, in January 2006, in favor of the adolescent's human right to confidentiality [17]. The Court endorsed the *Gillick* decision of 1986, setting guidelines for the delivery of reproductive health care without parental notification [13], but noted that the judge providing the guidelines had also observed that "social customs change, and the law ought to and does, in fact, have regard to such changes when they are of major importance" [18].

The judge in *Axon* cited with approval a 2005 decision of the English Court of Appeal, on determination of children's capacity, which emphasized legal obligations to comply with the CRC and European Convention on Human Rights. The judgment required that "judges correctly focus on the sufficiency of the child's understanding and, in measuring that sufficiency, reflect the extent to which, in the 21st century, there is a keener appreciation of the autonomy of the child and the child's consequential right to participate in decision making processes that fundamentally affect his family life" [19].

The *Axon* decision echoed this in observing that "the right of young people to make decisions about their own lives by themselves at the expense of the views of their parents has now become an increasingly important and accepted feature of family life" [20]. The supporting jurisprudence of the European Court of Human Rights was cited, in which "The Court reiterates that in judicial decisions where the rights... of the parents and those of the child are at stake, the child's rights must be the paramount consideration" [21].

The human rights approach differs from the "mature minor" approach in that, in the latter, children below a legally specified age for medical consent are presumed to lack capacity, but evidence may show that they have achieved sufficient maturity, whereas human rights are inherent in human being of all ages. Accordingly, adolescents may invoke their human rights as of right, and those opposing them have the burden of showing that adolescents' assertions of their rights impermissibly offend the human rights of others. In *Axon*, for instance, it was ruled that adolescents' right to medical confidentiality does not offend parents' rights to involvement in their adolescent children's choices.

4. Reproductive and sexual health

4.1. Sexual début

It has been observed that "one important impetus for marrying girls at an early age is that it helps to prevent premarital sex. Many societies prize virginity before marriage and this can manifest itself in a number of practices designed to 'protect' a girl from unsanctioned sexual activity" [22]. Such practices may be motivated to protect a girl's and her family's honor and may include criminalization of sex with unmarried women or under aged girls, and parental medical consent or notification laws. However, human rights law does not specify any minimum age of marriage. The CRC is silent on the matter, but the International Covenant on Civil and Political Rights (ICCPR) requires recognition of the rights "of men and women of marriageable age to marry," (Art. 23(2)) and that "No marriage shall be entered into without the free and full consent of the intending spouses" (Art. 23(3)). This suggests that, in principle, adolescents incapable of giving free and full consent cannot marry.

In many societies, under educational and economic reforms, women marry at later ages than in the past, but their sexual awareness begins earlier. Therefore, the period between their initiation of sexual activity and marriage is prolonged. Adolescents' entry into sexual relationships does not require parental consent, or even knowledge, and courts are recognizing that laws that impair adolescents from protecting themselves against associated risks of STIs and pregnancy are anachronistic, and violate adolescents' human rights to reproductive and sexual choice, and health.

A worldwide aspect of many adolescent and younger children's first experience of sexual intercourse is that it is nonconsensual, and perhaps violent. Vulnerability is greater where the belief is held that men's HIV infection can be cured by intercourse with a virgin. Conditioning lawful care of STIs and pregnancy on parental approval in these circumstances is dysfunctional. Accommodation of a parental veto would violate Article 24 of the CRC, which recognizes "the right of the child to the enjoyment of the highest attainable standard of health." Where sexual assaults are reasonably anticipated, such as during military conflicts and in displaced or refugee communities, the same Article is relevant, since it requires access to "preventive health care...and family planning education and services" (Art. 24(2)(f)).

4.2. Contraception

Human rights provisions reinforce such court judgments as in *Gillick* and *Axon* to establish adolescents' legal rights of access to counselling and services. Experience also shows that prevention of access does not significantly reduce adolescents' voluntary or involuntary exposure to sexual activities [23], but leaves them vulnerable to STIs and pregnancy, so prohibitions designed for their "protection" are liable to be counter-productive. Practices such as in Tanzania, where over a third of family planning service providers placed age restrictions on condom supply [24], appear dysfunctional and misguided, in leaving both sexes exposed to STIs including HIV and females to pregnancy.

The claim for age restrictions on daughters' access to contraception made in the *Gillick* case was that English law makes sexual intercourse with females aged under 16 years a criminal offence. This provision is intended, however, to protect young females, not to make them juvenile offenders. Even if their partners commit offences, the females themselves do not. Health service providers who counsel and supply contraceptive services to adolescent females, for their protection against STIs and pregnancy, are not parties to any offence in which these females are voluntarily or involuntarily involved.

4.3. Abortion

In the English *Axon* case, it was argued that, even if the claim for parental notification before delivery of contraceptive or STI counselling or services should fail, abortion is qualitatively different. It involves an invasive, irreversible intervention, with physical and emotional consequences that may be prolonged. Several judgments of US courts were cited to support a parental prior notification requirement. However, the trial judge found these irrelevant, because they responded to a peculiar preoccupation with abortion in US public life, and ignored adolescents' human rights entitlements under the European Convention on Human Rights, and the CRC, which the US is alone (with Somalia) in not ratifying.

When abortion is medically indicated for preservation of the pregnant adolescent's life or physical or mental health, it is justified under even the most restrictively expressed legislation. Before the Constitutional Court of Colombia, for instance, the Attorney-General defended the Penal Code's apparent total prohibition on the ground that it allowed a defence of medical necessity to procure abortion to save life and treat life-endangering illness [12]. Further, parents of pregnant adolescents who do not satisfy criteria of being mature minors have no legal discretion to deny their consent to medically indicated abortion, since their legal duty is to provide their dependent children with medically indicated care. Indeed, when hospital and government officials in Peru conspired to obstruct an adolescent's abortion of an anencephalic fetus, and compelled delivery and breast feeding for several days before the baby's death, the UN Human Rights Committee held the government responsible for multiple violations of the ICCPR, including failure to provide health protection to a minor, and for imposing cruel and unusual treatment [25]. Governments have comparable responsibility to ensure parental compliance with their legal duties of care for dependent children.

When adults responsible for adolescents' health and well-being deny or obstruct abortion services medically indicated for protection of their physical or mental health, there are stronger grounds to assess the adolescents as capable of providing consent for themselves. Legislation and leading courts increasingly recognize the dysfunction, amounting even to cruelty, of denying abortion to adolescents who competently request it, or who lack sufficient maturity to decide. For instance, the South African High Court upheld legality of the country's Choice on Termination of Pregnancy Act, 1996, which allows females under the age of 18 to give their informed consent to abortion [26].

4.4. Sterilization

A mature adolescent might give independent consent to a medically indicated procedure, such as for malignancy, that would unavoidably cause or risk sterility, but a practitioner who undertook a purely elective, contraceptive sterilization of an adolescent on the basis of such consent would be vulnerable in facing professional disciplinary and/or judicial accountability. The legal duty of competent counselling would require health care providers to disclose long-acting contraceptive alternatives that preserve future options [27]. Similarly, parents of immature or intellectually impaired adolescents cannot consent to their contraceptive sterilization and thereby foreclose the adolescents' future reproductive choice. However, judicial approval of such consent might be available in a case of adolescent chronic intellectual impairment, to promote subsequent social and sexual normalization free from risk of uncomprehended pregnancy [28]. Parents do not require judicial approval of their consent to medically indicated procedures that would unintentionally cause or risk sterility.

4.5. STIs/HIV

It is estimated that every day, more than 7000 young people become infected with HIV, accounting for at least half of all new infections [29]. Discounting the female condom, contraceptive services to female adolescents will not reduce this burden. Counselling female adolescents on premarital abstinence from intercourse is appropriate, with supporting advice on means to negotiate partners' use of condoms in case of a lapse; abstinence-only education and counselling often fail to protect against disease and pregnancy in practice [30].

Abstinence advice affords no protection against rape and comparable nonconsensual intercourse, of course and, while educating young females on avoidance of risk-laden behaviors, such as illicit drug and alcohol use, is helpful, strict enforcement of anti-risk strategies can deny them social normalization and induce unjustified apprehension. Health service providers may bear special educational responsibilities in the protection of adolescents against sexually transmitted infections including HIV. The techniques of accommodating diversity that underpin education in life skills, such as negotiation of safer sex, may not be taught in schools committed to fidelity to religious beliefs [31].

5. Confidentiality

The *Axon* judgment [17] confirmed the legality of the English Department of Health's Guidance to health professionals on the advice and treatment provided to under 16-year olds on contraception and sexual and reproductive health [32]. This provides in its Summary that:

Doctors and health professionals have a duty of care and a duty of confidentiality to all patients, including those under 16.

This guidance applies to the provision of advice and treatment on contraception, sexual and reproductive health, including abortion.

Research has shown that more than a quarter of young people are sexually active before they reach 16 [reference omitted].

Young people under 16 are the group least likely to use contraception and concern about confidentiality remains the biggest deterrent to seeking advice.

On Action, the Guidance requires that:

- All services providing contraceptive advice and treatment to young people should:
 - Produce an explicit confidentiality policy making clear that those under 16 have the same right to confidentiality as adults.
 - Prominently advertise services as confidential for young people under 16, within the service and in community settings where young people meet.
- Health professionals who do not offer contraceptive services to those under 16 should ensure that arrangements are in place for them to be seen urgently elsewhere.

On Confidentiality, the Guidance provides that:

The duty of confidentiality owed to a person under 16, in any setting, is the same as that owed to any other person. This is enshrined in professional codes [reference omitted]...

The duty of confidentiality is not, however, absolute. Where a health professional believes that there is a risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy, they should follow locally agreed child protection protocols... If considering any disclosure of information to other agencies, including the police, staff should weigh up against the young person's right to privacy the degree of current or likely harm, what any such disclosure is intended to achieve and what the potential benefits are to the young person's well-being.

On Duty of Care, the Guidance adds that, even if the professional's decision is not to provide treatment, "the duty of confidentiality applies, unless there are exceptional circumstances as referred to above." This follows the provision on Confidentiality that "Except in the most exceptional of circumstances, disclosure should only take place after consulting the young person and offering to support a voluntary disclosure." That is, health service providers' first duty is to propose, and to offer to support, adolescents' allowance of disclosure to appropriate others, including their parents. In the second paragraph of the 156 paragraph *Axon* judgment, the judge accordingly stated "I stress that there is nothing in this judgment which is intended to encourage young people to seek or to obtain advice or treatment on any sexual matter without first informing their parents and discussing matters with them. Indeed, everybody must hope that all young people will discuss these sexual matters with their parents at the earliest opportunity."

The trial judge approved the Guidance, however, because it gives required emphasis to human rights

principles. The judgment endorsed the 1997 finding of the European Court of Human Rights that:

Respecting the confidentiality of health data is a vital principle in the legal system of all the Contracting Parties to the [European Human Rights] Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general [33].

This was reinforced by the pragmatic evidence the judge received that between the English Court of Appeal decision in December 1984, in the *Gillick* case, allowing parental disclosure, and the House of Lords reversing this decision and reinstating the requirement of confidentiality in October 1985, the number of young women aged under 16 who sought advice on contraception fell from 1.7 per thousand residents to 1.2, a reduction of almost one third, and attendance rates at counselling centers did not return to pre-December 1984 levels until 1988–9. This gave emphasis to the warning of the European Court of Human Rights that, in the absence of patients' reliance on medical confidentiality,

those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and even from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community [33].

The latter observation shows how preservation of confidentiality, including of adolescents, transcends clinical health care to acquire a public health role.

6. Conclusion

In respecting adolescent patients' reproductive and sexual choices, and their confidentiality, health care providers act in compliance with evolving legal and ethical human rights requirements. Mandatory reporting laws place providers in conflicts of conscience [34]. However, in maintaining adolescent patients' confidentiality, providers do not become replacements, rivals or adversaries of parents. Providers will discuss and encourage patients' disclosure to their parents, by the patients themselves or by providers with the patients' consent. If it becomes evident, however, that patients eligible for care will forgo it rather than permit disclosure, incurring risks to their own health and perhaps that of others, advice and treatment should be given in confidence, in the same provider–patient partnership that providers seek to establish with adult patients [35].

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