MxM fundación

Consentimiento informado para gestar y parir

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WHO ARE WE?

Fundación MxM is a feminist, interdisciplinary, and intergenerational organization based in Tucumán, in northern Argentina.

For nearly 10 years, we have been advocating for access to sexual, reproductive, and non-reproductive rights in general, and to legally permitted abortion in particular.

We are an interdisciplinary and intergenerational team composed of professionals and students in the fields of law, medicine, mental health, social work, communication, and the humanities.

Our goal is to strengthen the sexual sovereignty of women and gender-diverse individuals so that they can exercise full citizenship in a state that guarantees, beyond all religious fundamentalism, full access to a life free from violence.

We engage in litigation, advocacy, research, and the development of educational materials to promote legal literacy and respect for the human rights of

women and diverse communities from a feminist, anti-racist, and intersectional perspective.

We actively work toward a society that makes room for all the uncomfortable, irreverent, defiant, rebellious, and unkempt bodies that patriarchy has historically excluded.

FOREWORD

This work was originally published in 2019 in the legal journal *La Ley*[1]. Subsequently, this work was highlighted

[1] Deza, S. & Álvarez, A. (2019). *Informed Consent for Pregnancy and Childbirth: A Neglected Medical Obligation Regarding Girls*. Thomson Reuters La

by the “Girls, Not Mothers” Committee of the Ministry of Health of the Province of Buenos Aires and by the Bioethics Directorate of the Ministry of Health of Neuquén.

Ley: Autonomous City of Buenos Aires, 150–167.

Currently, we observe that barriers to legal termination of pregnancy (ILE) and voluntary termination of pregnancy (IVE) are growing under the guise of medication shortages and the mismanagement of conscientious objection by unscrupulous professionals who spare no effort in turning our girls into mothers. For this reason, we consider it useful to renew this discussion that sought,
six years ago to deconstruct the notion of motherhood within the context of NNYA.

Consenting to a pregnancy runs counter to the very fabric of the right to choose.

For a long time, society has viewed motherhood as a natural destiny for women. This deeply ingrained idea becomes particularly problematic when applied to girls and adolescents.

But what if we radically changed that perspective, especially when the person involved is a girl or adolescent? What if we considered

pregnancy not only as a biological event, but as one of the most invasive and risky medical procedures a girl may face in her life?

Early motherhood is neither a natural nor an inevitable occurrence. In most cases, pregnancies among girls and adolescents occur in contexts of inequality, sexual violence, a lack of comprehensive sex education, and the absence of effective public policies.

However, when a girl becomes pregnant, the health care system often acts as if that pregnancy were normal, expected, or even desirable, without providing complete information about the risks it poses to her life and health, nor ensuring that the girl can freely decide whether or not she wishes to continue the pregnancy.

In this paper, Soledad Deza and Adriana Álvarez pose a central question:

Why is informed consent required for an abortion, but not for carrying a pregnancy to term and

give birth, when these processes are also invasive and risky, especially for girls?

The objective of this paper is to highlight a frequently overlooked medical obligation: the need to request and document the informed consent of girls and adolescents to continue a pregnancy, carry a child to term, and give birth—just as consent is required to terminate a pregnancy. It is essential to ensure that this decision is truly voluntary and not the result of institutional omissions, pressure, or silence.

Informed Consent for Pregnancy and Childbirth: A Neglected Medical Obligation Regarding Girls

Soledad Deza and Adriana Álvarez

The fertility of girls and adolescents lies at the center of a much broader social conflict that—in most cases—encompasses situations of child sexual abuse, teenage pregnancy, forced motherhood, and gender roles that impose heteronomous life plans outside any possibility of human development.

Currently, the need to obtain consent for a legal termination of pregnancy—in cases of sexual abuse or pregnancies that endanger health or life—is firmly established in the mindset of healthcare providers in the Argentine Republic. However, the unquestionable entrenchment of motherhood as the destiny of the female gender prevents healthcare providers from paying attention to and properly accounting for the particularities that a pregnancy entails in the life of any person.

We believe that the normalization of pregnancy, childbirth, and the postpartum period as inescapable, constitutive aspects of the life of any body with a uterus constructs meanings within the healthcare imagination regarding the inexorability of reproduction in a fertile life; consequently, this makes it difficult to recognize the condition of

risk that these events pose to pregnant bodies.

The objective of this paper is to reflect on a neglected medical obligation: the requirement that girls and adolescents provide informed consent to continue a pregnancy and give birth, which—given the specific risks to their overall health—becomes an indispensable requirement for all healthcare professionals.

Although our local legislation includes different categories to regulate the progressive autonomy of children and adolescents regarding medical treatments, we propose—in accordance with the logic of the CRC (Convention on the Rights of the Child)—that informed consent for pregnancy and childbirth must be obtained from every pregnant person under the age of 18, regardless of whether different procedural requirements apply depending on whether the individual is under 13, between 13 and 16, or over 16 years of age.

The Political Context of Early Motherhood

Behind the drama of "teenage mothers" lies a political narrative deeply entrenched in gender stereotypes that have rigidly tied motherhood to femininity, thereby normalizing not only pregnancy but also the role of motherhood as a destiny. In the shadow of these stereotypes—which crystallize the symbolic violence[2] of the obligation to carry a pregnancy to term and give birth imposed on our girls—bureaucratic barriers to accessing legally permitted abortion also take shape.

This political narrative of motherhood as a public service for poor girls and adolescents has at least three main protagonists: healthcare providers, both in their roles within healthcare institutions and in their roles

[2] Article 5, subsection 5, of Law No. 26,485 defines symbolic violence as that which occurs "through stereotypical patterns, messages, values, icons, or signs that transmit and reproduce domination, inequality, and discrimination in social relations, normalizing the subordination of women in society"

administrative bodies responsible for overseeing public health policy; members of the judiciary and legal practitioners who directly or indirectly intervene in health-related proceedings involving pregnant girls and adolescents; and religious sectors—whether institutionalized or not—which, upon learning of these cases, openly attempt to impose on these pregnant bodies dogmas of faith that mandate motherhood at any cost, including the life, health, and human development of girls and adolescents.

The Health Care System

The health care team, understood in a broad sense[3] and thus comprising both those who provide health care services and those who work in a health care system, includes those who have the power to facilitate or obstruct the progressive autonomy of a girl who seeks care for an unintended pregnancy at

[3] Art. 6, subpar. d) of Decree No. 1011/10, which regulates Law 26,485.

a consultation. A pregnant girl or adolescent has two options: to have an abortion or to give birth; and to ensure that her autonomy is not undermined, she must receive empathetic and ethical information from those who care for her during a health consultation.

The State guarantees access to health care across the three subsectors: public, private, and health insurance. Therefore, it is impossible to ignore that, in general, barriers to access to legal termination of pregnancy (ILE) occur within the public health system, where the scarcity of material and symbolic resources faced by the patient exacerbates the structural inequality she already experiences upon arriving for her health consultation. In this way, the healthcare team weaves what we call the "healthcare fabric" of forced motherhood.

The Judicial Web

Despite having an obligation to remain outside the healthcare sphere—since fertility in childhood and adolescence is a matter that is frankly unrelated to the

administration of justice[4], legal practitioners sometimes unduly encroach upon the health care aspects of a legal abortion—and not always to preserve the girls' autonomy. We believe that any legal professional acting on behalf of the judiciary—for example, in connection with a prosecutor's investigation into sexual abuse, where the victim is a girl who may become or already be pregnant—should ensure, at some stage in the process where the interdisciplinary approach to the violence suffered takes shape, that the girl receives information about her rights in this situation: that is, that the victim knows she has the right both to continue the pregnancy and to

[4] In the ruling "A.F. re: Self-Executing Measure," op. cit. (hereinafter "F.A.L. Ruling"), in the ruling "D.M.A. re: Declaration of Incapacity" dated July 7, 2015, and in the ruling "Albarracini Nieves, Jorge Washington re: Precautionary Measures" dated June 1, 2012, the Supreme Court of Justice of Argentina (CSJN) has already ruled on the unnecessary nature of resorting to the judiciary to request authorization for medical procedures and reiterated that the principle of legality underlies this medical obligation to avoid judicializing patients' private lives—a practice that, although it has become standard medical procedure, is illegal and can be violent in the case of women and abortion.

to terminate a pregnancy that might result from the crime under investigation.

And with regard to legal abortions that are in the process of being provided through a health service, the judiciary's involvement typically takes many procedural forms and can serve to dismantle the unnecessary judicialization of a girl's health care, bringing her *closer to "the enjoyment of the highest attainable standard of* health" and ensuring that she is not *"deprived of her right to enjoy those health services*," as mandated by the CRC; or it may serve to erect health "barriers" that deny the girl any access to justice.

In all cases of undue interference by judges to obstruct or delay a legal abortion in progress, the "best interests of the child" is what the officials say, while their moral, ethical, and religious worldviews—which have "crept" into public office—is what they remain silent about. We call this illegal interference by the legal sphere in the realm of health care the "judicial plot" surrounding early motherhood.

The Confessional Plot

"Religions have had, and continue to have, a decisive impact on the ways in which sexual order is regulated. In particular, the impact of Catholicism in the region has shaped the law by establishing the boundaries between what is legal and illegal in relation to identities and practices linked to sexuality. It is not surprising, then, that struggles to reform rights related to sexuality and reproduction are primarily resisted by the religious hierarchy in defense of a moral order that restricts sexual freedom and diversity"[5] . Abortion is on the political agenda of the ecclesiastical hierarchies, but they do not operate exclusively from that visible position; rather, they also express themselves through other strategic actors who are positioned

[5] **Vaggione,** Juan Marco, and **Monte,** María Eugenia (2018), "Cortes irrumpidas. La judicialización conservadora del aborto en Argentina" in *Rev. Rupturas 9*(1), Costa Rica, Jan–Jun 2019. ISSN 2215-2466. pp. 107–125.

in the social sphere, forming self-organized groups rooted in religion but with a discourse aligned with the human right to life—they call themselves “pro-life”—and it is from this position within the social imagination that they tend to “challenge” any form of sexual autonomy.

These religious sectors, aligned with Catholicism and the Evangelical Church, which mask their dogmas with a discourse of defending human rights, not only publicly campaign against the legalization of abortion at a woman’s request but also challenge Comprehensive Sexuality Education (CSE)—which enables free and autonomous decisions—and obstruct anti-that would prevent a large proportion of unintended pregnancies, and—with regard to abortion permitted by law—they orchestrate actions—more or less veiled depending on the publicity the case receives—to block access to healthcare and, ultimately, to impose a heteronomous and dangerous life plan in terms of girls’ holistic health: that of motherhood as a divine and unyielding design. We call this the “confessional narrative.”

Since time immemorial, medical knowledge has monopolized the legitimate discourse on the body: illness, healing, hygiene, reproduction, and the normality of the human physical dimension are concepts that have historically been defined by medicine. Medical anthropology points out that *"the medical system not only claims to possess true knowledge about the realm of corporeality, but also acts as a powerful system of socialization that demands conformity regarding its its conceptualization of the world and permeates the popular culture of Western societies with its images and* definitions" [6] .

In the biomedical model, the physician's perspective—reproduced on a larger scale within the medical system itself—constructs the idea of "health" according to biologistic parameters that interpret illness as *a "deviation from the norm*

[6] **Imaz**, Elixabete (2010) "Between Gynecologists and Midwives" in "Anthropology, Gender, Health, and Care" (Esteban, Comelles, and Diez, eds.). Bellaterra. Barcelona

biological norm" [7], which is why "curing" is generally equated with the idea of normalizing or returning to normalcy. The health sciences—medicine foremost among them—are a powerful tool for social discipline, and their impact on people's lives will vary depending on the model of care that is promoted.

Currently, our healthcare system is in the process of transitioning from a biomedical model—with a predominantly paternalistic or welfare-oriented approach—toward a comprehensive care model focused on rights, "which incorporates a holistic and coordinated approach to the health-illness-care, which is reflected in practices as they incorporate an approach to health promotion, prevention, and rehabilitation that includes a gender perspective, the notion of autonomy, equity, citizenship, and agency

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[7] **Blázquez Rodríguez**, Maribel (2010) "From the Risk Approach to the Physiological Approach in Prenatal, Childbirth, and Postpartum Care." In "Anthropology, Gender, Health, and Care" (Esteban, Comelles, and Diez, eds.). Bellaterra. Barcelona

and health needs according to the life cycle”[8] .

[8] **Tajer**, Débora (2012) “How to Measure Comprehensive Care and Gender Equity? A Possible Proposal” in “Gender and Health.” Ed. Lugar. Buenos Aires. p. 50

Progressive Autonomy and the Right to Choose

"Progressive competence" or "progressive autonomy" are concepts derived from bioethics that seek to convey the impossibility of assessing decision-making capacity based on a static criterion such as chronological age. Making free and autonomous decisions involves setting aside these immutable categories, which are not useful in health care because they fail to assess each person's level of emotional development, while creating a sort of "generic" child that we rarely encounter in real life.

The CRC defines children according to their attributes and their rights vis-à-vis the State, the family, and society

society. Not "by what they lack to be adults or what hinders their development." Being

child is not to be “less of an adult,” since childhood is not a stage of preparation for adulthood. Childhood and adolescence are ways of being as a person and hold equal value to any other stage of life. It is a mistake to characterize these stages as marked by dependence rather than as a time of effective and progressive development of personal, social, and legal autonomy. Underlying the conception of children as subjects of law is, first and foremost, the idea of legal equality—in the sense that all people are subject to legal norms and have the capacity to hold rights—which then leads to more refined concepts such as equality before the law or equality in rights, which are also enshrined in the CRC.

Article 5 of the CRC first addressed this issue by stipulating that the exercise of children’s rights is progressive in accordance with “the development of their capacities” and that it is the responsibility of parents or other caregivers, as the case may be, to provide “appropriate guidance and direction so that the child may exercise the rights

recognized in this Convention." In turn, it is the State's responsibility to "respect the responsibilities, rights, and duties of parents" or whoever is responsible, in accordance with the principle of non-arbitrary State interference in family life, as recognized in Article 12 of the Universal Declaration of Human Rights and reaffirmed by Article 16 of the CRC. The principle of protecting and promoting autonomy for children and adolescents is based on the right to gradually exercise their rights as their rational capacities allow.

Under the new legislation[9], there are three stages defined by age, and

[9] **Article 26 of the National Civil and Commercial Code:** A minor exercises his or her rights through his or her legal representatives. However, a minor who is of sufficient age and maturity may personally perform the acts permitted by law. In situations of conflict of interest with their legal representatives, they may intervene with legal counsel. A minor has the right to be heard in any judicial proceeding concerning them, as well as to participate in decisions regarding their person. Adolescents are presumed to have

distinct categories based on the scope of authorized actions: those under 13 years of age, those between 13 and 16 years of age, and those over 16 years of age.

The novelty lies in the formal recognition of the category "adolescents," who are granted greater autonomy than children, depending on the type of treatment; and in the presumption that they possess sufficient competence to decide on medical procedures *"that are not invasive, do not compromise their health, or pose a serious risk to their life or physical integrity*." This presumption of sufficient competence held by

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thirteen- and sixteen-year-olds enables them to decide for themselves regarding treatments that are not invasive, do not compromise their health, and do not pose a serious risk to their life or physical integrity. In the case of invasive treatments that compromise their health or pose a risk to their physical integrity or life, adolescents must give their consent with the assistance of their parents; any conflict between the two is resolved by taking into account the adolescent's best interests, based on the medical opinion regarding the consequences of performing or not performing the medical procedure.

"From the age of sixteen, adolescents are considered adults when it comes to decisions regarding the care of their own bodies."

This is very important for adolescents, as it allows us to consider that, within this age group, every girl is capable of forming her own judgment about what is happening to her body and of freely deciding what she wants for herself.

With regard to girls under the age of 12, although the rule is that their decisions are represented—or delegated—by their parents, this never justifies ignoring their opinion. The new paradigm of the child protection system aims to strengthen the individual's role in shaping her own life story and, therefore, designs a system of supports intended to bolster decision-making, not to replace it.

Health care provided within the comprehensive model will examine the girl's own life history to assess her level of maturity—which goes beyond simply verifying her age—and requires evaluating the girl's potential within her specific context. It is possible that a girl who has spent the last 7 (seven) years of her life living with leukemia or a similar chronic condition may be better equipped to decide for herself whether to accept

or reject a proposed treatment than a girl of the same age who is facing the same diagnosis for the first time. Both may be the same age, but they arrive at that consultation in different ways, and their autonomy in making medical decisions has developed to varying degrees due to their experience living with the illness and their familiarity with different treatment options.

Article 26 itself provides an exception to the rule when it states, *"However, a person who is of sufficient age and maturity may personally perform the acts permitted by law*." A correct interpretation of the concept of progressive autonomy leads us to recognize that it is, in essence, open-ended—that is, flexible—so as not to predetermine a mechanical application of the same criterion to all cases. It must be adaptable to the specific circumstances that arise, taking into account the degree of maturity exhibited by each patient.

To argue otherwise would imply a circular path back to the same starting point—the previous codification system

—where chronological age would continue to be the sole reference point, rather than fostering the development of autonomy within the framework of a comprehensive, preferably interdisciplinary, approach to health care that creates conditions conducive to moving beyond strictly organic criteria.

This is without prejudice to the fact that even in the case of a 10-, 11-, or 12-year-old girl, the mere organic or biological fact of a pregnancy would be sufficient for a health professional to recognize her as an autonomous moral agent capable of deciding how it impacts her life, how it affects her health, and whether or not she is willing to face the risks of pregnancy and childbirth.

Finally, the new Civil and Commercial Code (CCyC) recognizes that as of the age of 16, a person is considered an adult capable of making decisions regarding the care of their own body. However, based on the principles of the CRC, we believe that until the age of 18, all

pregnant person. This is because it would be illogical to advocate for the application of the CRC to the embryo without any normative or jurisprudential basis, while disregarding what this Convention actually seeks to protect: the life and human development of all girls.

The principle of progressive autonomy represents a major step forward, as it prioritizes the individual's autonomy over parental authority. Beyond its application to other areas of health and inalienable personal rights, the determination of the appropriate age took into account the need to provide children with legal support for the exercise of their personal autonomy in matters of sexual and reproductive health—a principle already established in the field of bioethics and discussed in Western case law since the

well-known “Gillick” case [10], decided in 1985 by the House of Lords of Great Britain, which enabled minors to seek information and assistance outside the—censoring—gaze of their parents [11].

Pregnancy and motherhood are two issues regarding which it is difficult to imagine a girl being unable to form her own moral judgment about the implications that one or the other circumstance has for her personal life. What will vary until the age of 16 is that, prior to that age, she will always need a support system to give informed consent to continue with a pregnancy—due to its invasive nature—and once she turns 16, the girl will be able to give consent on her own.

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[10] **Kemelmajer de Carlucci**, Aida (2003) “The Child’s Right to Their Own Body” in “Bioethics and Law.” Ed. Rubinzal Culzoni. Santa Fe

[11] **Caramelo,** Gustavo (2014) “Adolescents Decide Their Own Health in the Draft of the New Code.” Available at http://www.infojusnoticias.gov.ar/opinion/los-adolescentes-deciden-sobre-su-salud-en-el-proyecto-de-codigo-civil-82.html

Is a Pregnancy "Invasive"?

We find different possibilities for girls to decide on and consent to medical procedures depending on their age and whether those procedures are invasive or non-invasive. Given this situation, it is important to determine the invasive nature of pregnancy and childbirth in a girl's life, in order to assess the risks to her overall health and thus gain a clearer understanding of why this obstetric event cannot be considered normal during childhood or adolescence.

Resolution No. 65/2015 of the National Ministry of Health, which interpreted the scope of Article 26 regarding the criterion of "invasiveness" in situations related to sexual and reproductive health, did not include pregnancy as a biological and organic process to be considered. This may be because, even for experts, this process—which is so normalized in the lives of all individuals with the biological capacity to gestate—was overlooked when considering it in the context of girls, but not because it does not pose risks—and very severe ones at that—in the lives of all women. However, point 2.2 of the Annex states that *"The*

criterion of invasiveness

used in Article 26 of the Civil and Commercial Code should be interpreted as referring to serious treatments that pose a threat to life or a serious risk to health (…) The assessment of risk in medical practices must be based on scientific evidence that takes into account various aspects of holistic health. The risk of a medical practice is generally defined as the probability of an adverse outcome or as a factor that increases that probability."

According to the **World Health Organization**, pregnancy—the nine months during which the fetus develops in a woman's uterus—is a time of great joy for most women. However, during pregnancy, both the woman and her unborn child face various health risks. For this reason, it is important that prenatal care be provided by qualified healthcare personnel[12] . Every day, worldwide, nearly 830 women die from pregnancy-related complications, and the

[12] World Health Organization. Information available at https://www.who.int/topics/pregnancy/es/

childbirth. In developing countries, conditions related to pregnancy and childbirth are the second leading cause of death among women of childbearing age (after HIV/AIDS)[13] .

There are five main causes of maternal death during pregnancy and childbirth: severe hemorrhage, infections, unsafe abortions, hypertensive disorders (preeclampsia and eclampsia), and medical conditions that complicate pregnancy or are complicated by it, such as heart disease, diabetes, or HIV/AIDS[14] .

Most maternal deaths are preventable. The health interventions to prevent or treat complications are well known. All women need access to prenatal care during

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[13] World Health Organization. Information available at https://www.who.int/features/factfiles/maternal_health/maternal_health_facts/es/

[14] World Health Organization. Information available at https://www.who.int/features/factfiles/maternal_health/maternal_health_facts/es/index1.html

pregnancy, specialized care during childbirth, and care and support in the first weeks after childbirth. Maternal and neonatal health are closely linked. Approximately 2.7 million newborns died in 2015[5], and another 2.6 million were stillborn.[6]

To prevent maternal deaths, it is also essential to prevent **unwanted pregnancies or pregnancies at too young an age**. All women—and adolescents in particular—must have access to contraception, to services that provide safe abortions to the extent that

the law permits, and to quality post-abortion care[15] .

Each year, there are more than 135 million births worldwide. It is estimated that about 20 million of these result in pregnancy-related complications. The list of conditions is long and varied; for example, sepsis, anemia, fistulas, incontinence, infertility, and depression[16] . Maternal health reflects the disparities between the rich and the poor. Of all maternal deaths, less than 1% occur in high-income countries. The maternal mortality ratio in developing countries is 239 per 100,000 births,
compared with 12 per 100,000 in developed countries[17] .

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[15] World Health Organization. Information available at https://www.who.int/es/news-room/fact-sheets/detail/maternal-mortality

[16] World Health Organization. Information available at https://www.who.int/features/factfiles/maternal_health/maternal_health_facts/es/index2.html

[17] World Health Organization. Information available at https://www.who.int/features/factfiles/maternal_health/maternal_health_facts/es/index4.html

The Tragedy of Pregnancy in Childhood and Adolescence

If we analyze the figures on adolescent fertility, Argentina currently ranks above the global average, estimated at 65.6 births per 1,000 women aged 15 to 19, but below the average for Latin America and the Caribbean, which is 79 per 1,000[18]. Among the countries in the region, the adolescent adolescent in Argentina exceeds that of Uruguay, which stands at 60 per thousand; that of Chile, which is 51 per thousand; and that of Brazil, which stands at 56 per thousand; and it is lower than that of Bolivia, which is 89 per thousand, and that of Colombia, which reaches 96 per thousand[19] . In adolescence early (children under 15 years) are ninethe

[18] Report "Teenage Pregnancy in Argentina: 2017 Report," prepared by Amnesty International. Available at https://amnistia.org.ar/wp-content/uploads/delightful-downloads/2017/05/05-Embarazo-Adolescente.pdf

[19] UNICEF (United Nations Children's Fund) (2011), The State of the World's Children 2011: Adolescence—A Time of Opportunity, New York:

UNICEF. Table 11—Adolescents—p. 130

provinces in which the number of babies born to girls aged 10 to 14 increased from one year to the next in 2017. According to public statements by Diana Fariña, Director of Maternal and Child Health at the National Health Secretariat, Buenos Aires was the province with the highest increase, at nearly 53% (from 387 to 591, with almost two-thirds of these births occurring in districts of the Greater Buenos Aires area); Corrientes (from 115 to 123, 11%); Chubut (26 to 28, 7.7%), La Rioja (16
to 21, 23.8%), Salta (191 to 192, 0.52%), Santa Cruz (16 to 24, 33%), Santa Fe (244 to 257, 5%), Santiago del Estero (88 to 103, 14.5%), and Tucumán (132 to 137, 3.64%)[20] . In our country, the highest percentage of teenage pregnancies is observed in the northern provinces. Tucumán has a rate of 19.4% of live births to underage mothers; Santiago and Catamarca have a rate of 20%; Chaco and Formosa have a rate of 24%; and Salta

[20] "Official Data: Pregnancy Among Girls Aged 10 to 14 Has Increased Nationwide and Very Sharply in Buenos Aires." News article published by the Clarín newspaper on February 28, 2019. Available at https://www.clarin.com/sociedad/mortalidad-materna-crecieron-partos-adolescentes-menores-14-

anos_0_ZTcLCSNs6.html

a rate of 22% and Misiones a rate of 23%. At the other end of the spectrum, with 14% of live births to mothers under 19, is the City of Buenos Aires[21] .

In terms of health, and compared to women aged 20 to 24, teenage mothers under 15 are at greater risk of maternal mortality during pregnancy, a higher risk of low birth weight (less than 2,500 grams), a higher risk of preterm birth (before 27 weeks of gestation), a higher risk of perinatal mortality, a higher risk of eclampsia (seizures), a higher risk of postpartum hemorrhage, and a higher risk of endometrial infection[22] .

A study by Pantelides, Fernández, and Marconi published in 2014 shows that: 2.8% of girls under the age of 15

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[21] Data compiled based on official figures from the **DEIS (Directorate of Health Statistics) of** the National Ministry of Health (2018)

[22] **Conde-Agudelo**, A., Belizán, J. M., & Lammers, C. (2005). Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: A cross-sectional study. (Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: A cross-sectional study.) American Journal of Obstetrics and Gynecology, 192(2), 342–349

had a preterm birth, while that figure drops to 9.2% among adolescents aged 15 to 19 and 8.2% among women aged 20 and older. A significant finding concerns the infant mortality rate, defined as the number of deaths of children under one year of age per 1,000 births. This rate was 24.4% among mothers under 15 years of age; 13.9% among mothers aged 15 to 19; and 9.3% among mothers aged 20 and older[23] .

While the infant mortality rate for children born to mothers over 20 years of age is 9.3 per thousand, for mothers aged 15 to 19 it is 13.9 per thousand, and it rises to 24.4 per thousand for mothers under 15 years of age[24] .

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[23] Edith A. **Pantelides**, María de las Mercedes Fernández, and Élida Marconi (2014); "Early Motherhood in Argentina: Mothers Under 15." CENEP.

[24] Edith A. **Pantelides**, María de las Mercedes Fernández, and Élida Marconi, op. cit.

When considering the right to human development of girls and adolescents (Art. 27 of the CRC), it is worth noting that teenage motherhood is more common among girls in vulnerable situations who have a lower level of education and, consequently, a more marginalized status as citizens. According to the Survey on the Conditions of Children and Adolescents conducted by UNICEF in 2013, nearly a quarter of adolescent mothers did not complete primary school[25] . A study conducted by Gogna and Binstock in four provinces of Argentina (Misiones, Chaco, Santiago del Estero, and the Province of Buenos

[25] The Situation of Adolescents in Argentina, National Program for Comprehensive Adolescent Health, UNICEF 2016, p. 37

Aires), whose primary objective was to study the factors associated with the occurrence of adolescent pregnancy and its recurrence, revealed a significant finding: 85% of pregnant adolescents did not complete high school during their first pregnancy, and 94% did not complete it during their second pregnancy[26] .

Sixty-seven percent of the adolescent population that neither attends school, nor works in formal employment, nor seeks employment consists of women who care for children in their homes[27]

In Argentina, terminating a pregnancy resulting from rape or one that puts the pregnant person's health or life at risk has been a legal option since 1921. Under a system known as "permissions" or "grounds," criminal law has excluded these abortions from criminal liability, and the

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[26] **Binstock**, Georgina, and Gogna, Mónica. "Sexual Initiation Among Women from Vulnerable Sectors in Four Argentine Provinces." *Sexuality, Health, and Society: A Latin American Journal*; Location: Rio de Janeiro; Year: 2015, pp. 113–140.

[27] CIPPEC, Young Caregivers: Impacts on Their Social Inclusion. 2017.

The Supreme Court of Justice, in the ruling known as "F.A.L.," clarified that the medical procedure is *"legal insofar as it is* decriminalized"[28] . It has also been legal since 2020 to decide to terminate a pregnancy up to and including the 14th week without providing any explanation. This is known as IVE and operates under a "time-limit" system.

In the case of girls and adolescents, statistics show that the risks of carrying a pregnancy to term are greater for their health due to their age; therefore, abortion for girls and adolescents would be a legal option under what is colloquially known as the "health grounds" (Art. 86, para. 1 of the Penal Code); and, again based on age, it would be a lawful therapeutic alternative in cases known as "rape grounds," given that in many instances such pregnancies

[28] Supreme Court of Justice of the Nation (CSJN), "A.F. re: Self-Executing Injunction." Ruling dated March 13, 2012, available at https://www.cij.gov.ar/nota-8754-La-Corte-Suprema-preciso-el-alcance-del- aborto-no-punible-y-dijo-que-estos-casos-no-deben-ser-judicializados.html

arise from situations of sexual assault [29]that nullify consent to sexual intercourse (Art. 86, subsect. 2 of the Penal Code). In other words, whether due to the health risks of pregnancy at a young age or the coercive nature of the pregnancy, every girl and adolescent always has the right to an abortion.

The Protocol for Comprehensive Care of Victims of Sexual Assault, developed by the National Ministry of Health in 2015, states*: "The right to receive complete information implies the obligation of health professionals to inform the victim of all available options in her situation. This includes emergency contraception* ***and, in the event of pregnancy, information on the legality of abortion and the possibility of accessing the procedure****. This must be documented in the medical record (HC)*

[29] UNICEF. "Child Sexual Abuse in Children and Adolescents: A Guide to Taking Action and Protecting Their Rights." 2017. Available at https://www.unicef.org/argentina/media/1811/file

"that the health care professional provided this information (Law 26,529, Regulatory Decree 1089/2012, Art. 2, subpar. f)"[30] . Only when girls know that they can—because it is their right—terminate a pregnancy will they be able to choose what is best for themselves. If they are unaware of the legality of abortion in their situation, that option will never even occur to them as a possibility.

According to a CLADEM report titled "Pregnancy and Forced Child Motherhood in Latin America," in 2014, 3,007 girls under the age of 14 became mothers. This equates to one girl becoming a mother every 3 hours[31] .

What doubt could there be about how invasive pregnancy and childbirth are in the life of a girl or adolescent? On what medical grounds should consent be required for

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[30] Protocol for Comprehensive Care of Victims of Sexual Rape . Available at http://www.msal.gob.ar/images/stories/bes/graficos/0000000691cnt-protocolo_vvs.pdf

[31] Regional Regional available at http://clademargentina.com.ar/wp-content/uploads/2017/03/Ni%C3%B1as-Madres-Balance-Regional.pdf

termination of a pregnancy rather than its continuation or childbirth, even though both pose a scientifically proven risk to the lives of girls and adolescents?

Regardless of the moral or religious worldview of the healthcare professional who detects a pregnancy in a girl or adolescent, it is clear that the pregnancy itself—"as a health condition" (Art. 59, subpar. a of the CCyC)—must be communicated to the patient along with the two therapeutic alternatives (Art. 3 of the Decree regulating Law 26,529 and Art. 59, subsection e, of the CCyC), which classifies pregnancy and childbirth as obstetric events posing a risk to the patient's life: the option to continue the pregnancy or to terminate it. In both cases, based on the available scientific evidence regarding the risks to the pregnant person's health (Art. 59, subsection d, of the CCyC), and with a special focus on

the risks posed to the

lives of girls and adolescents, the continuation of the pregnancy as a process aimed at achieving childbirth must be consented to by each girl and adolescent, with the support system guaranteed by law in light of the invasiveness inherent in both

Without this information, no one would be in a position to carry a pregnancy to term. Just as informed consent is required for a legal abortion, pregnancy and childbirth must also be consented to, and this consent must be recorded in the medical record that documents the gynecological and obstetric care provided to every girl and adolescent.

“Informed Consent” for Pregnancy, Not Just for Abortion

The The need for infor onsent to access a legal term of pregnancy. This practice, which stems from bioethics to guarantee every patient the freedom to make decisions regarding any medical condition—possible only when reliable and accurate information is available—was first recognized by case law and later incorporated into statute[32] .

[32] **Kemelmajer de Carlucci**, A., Herrera, M., and Lamm, E. (2016). “The Principle of Progressive Autonomy in the Civil and Commercial Code: Some Rules for Its Application.” Available at http://www.redaas.org.ar/archivos-recursos/carlucci%20et%20al.%20autonomia%20adolescentes.pdf

In accordance with Articles 26 and 59 of the Civil and Commercial Code and Law No. 26,529, the Protocol for Comprehensive Care of Persons Entitled to Legally Terminate a Pregnancy includes a form that may be used and/or serve as a guide for the case, along with an affidavit in cases where the pregnancy resulted from sexual abuse. However, it is worth noting that **informed consent is a process**[33] within which the physician provides the patient with all the information

[33] Within the framework of self-determination and the free development of personality, informed consent is the gradual process that takes place within the doctor-patient relationship, by virtue of which the competent or capable individual receives sufficient information from the healthcare provider, in understandable terms, enabling them to participate voluntarily, consciously, and actively in decision-making regarding the diagnosis and treatment of their illness. **Galán Cortes**, Julio César (1999) Revista Médica Uruguay. Vol. 15, No. April 1999. p. 7. **Resolution No. 65/2015 of the National Ministry of Health,** cited above, takes a similar view: "Consent is a process that begins at the start of care and continues throughout the entire healthcare relationship. The purpose of this process is to ensure that the patient makes healthcare decisions based on the information"

they need based on their consultation and thus contributes to the patient's self-directed decision-making [34].

In the context of a pregnancy consultation, every girl or adolescent has the right to be informed about her diagnosis, prognosis, treatment options, the risks, discomforts, disadvantages, and advantages of each option, and to receive all *information "in a clear, sufficient, and appropriate manner, tailored to the patient's capacity for understanding,"*

[34] Art. 5 of Law 26,529.

"*a report on her health status, the tests and treatments that may be necessary, and the expected course, risks, complications, or sequelae of* such procedures"[35] . This information must include statistics regarding the "tragedy"[36] of adolescent pregnancy and, furthermore, must cover all the implications—supported by scientific evidence—of pregnancy and childbirth in a body that is not yet fully developed. Above all, this includes data showing that in developing countries, complications from pregnancy and childbirth are the leading cause of death among adolescents under the age of 16[37] .

If we consider the statistics discussed in the previous sections of this paper regarding the dramatic implications of teenage pregnancy, and taking into account

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[35] Art. 3 of Law 26,529 and Art. 59 of the National Civil and Commercial Code.

[36] Point 2.c of this paper.

[37] For further reading, see: **Holness** N. A global perspective on adolescent pregnancy. Int J Nurs Pract. 2015;21(5):677–681. **Mayor** S. Pregnancy and childbirth are leading causes of death in teenage girls in developing countries. BMJ. 2004;328(7449):1152.

Given the risks that carrying a pregnancy of this nature to term poses to the life and overall health of this age group, it is reasonable to conclude that **just as informed consent is required for an abortion, it is also necessary to obtain (informed) consent to continue the pregnancy and give birth**.

Major obstetric syndromes encompass a spectrum of pregnancy complications, including preeclampsia, low birth weight for gestational age, preterm birth, premature rupture of membranes, late spontaneous abortion, and placental abruption. All of these conditions are characterized by restricted vascular remodeling in the placental bed and the presence of obstructive lesions in the myometrial segment of the uteroplacental spiral arteries. Overall, the epidemiological evidence of an increased risk of major obstetric syndromes in adolescent pregnancies is overwhelming. For example, based on an analysis of the Swedish Medical Birth Registry, Olausson et al. demonstrated an

inverse correlation between the incidence of very preterm births (≤32 weeks) and increasing maternal age, decreasing from 5.9% among very young mothers aged 13 to 15 years to 2.5%, 1.7%, and 1.1% among women aged 16 to
17 years, 18 to 19 years, and 20 to 24 years, respectively. Compared with mothers aged 20 to 24 years, the odds ratios for late fetal death and infant mortality among mothers aged 13 to 15 years were 2.7 and 2.6, respectively. Once again, the adjusted risks decreased with age, indicating that neonatal mortality among very young women is largely explained by higher rates of preterm births[38] .

Conde-Agudelo, Belizán, and Lammers analyzed data from the Latin American Perinatal Information System for the period from 1983 to 2003. The analysis controlled for 16 health and sociodemographic factors and found that younger mothers

[38] **Olausson** PO, Cnattingius S, Haglund B. Teenage pregnancies and risk of late fetal death and infant mortality. Br J Obstet Gynaecol 1999;106:116-21.

had worse outcomes. Girls aged 15 or younger had a fourfold higher risk of maternal mortality compared with the 20–24 age group. A fourfold higher risk of puerperal endometritis was also detected, along with a 60% higher risk of eclampsia (though not statistically significant) and postpartum hemorrhage, and a 40% higher risk of anemia. Compared with children born to mothers aged 20–24, those born to mothers aged 15 or younger were 60% more likely to have low birth weight or be born prematurely; and had a 50% higher adjusted probability of being small for gestational age and of early neonatal death.[39]

[39] **Conde-Agudelo**, A., Belizán, J. M., & Lammers, C. (2005). Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. (Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study.) American Journal of Obstetrics and Gynecology, 192(2), 342–349

In the area of mental health, high rates of symptoms of depression and anxiety have been observed among adolescents during pregnancy and the postpartum period, which are generally higher than those in the adult population[40] .

It is possible that the normalization of motherhood—inevitably associated with femininity—and the construction over time (centuries) of a stereotype that reaffirms motherhood as a gender role destined for all women are two factors that have erroneously contributed to the medical community's view of childbirth as a risk-free obstetric event. The cultural inertia of associating a full or occupied uterus with motherhood leads healthcare providers to believe that

[40] **Beck**, A. T., Steer, R. A., & Brown, G. K. (1993). Beck Depression Inventory: Manual. San Antonio, TX: Psychological

an obstetric event that poses a risk to a girl's life and health, thereby losing its character as an organic process involving risk—a process that requires healthcare personnel to provide comprehensive health information and obtain consent regarding whether or not to undergo that process.

Reflecting on progressive autonomy requires considering two issues from a gender perspective. On the one hand, the healthcare relationship is inherently asymmetrical in terms of power, and a historically paternalistic model based on beneficence rather than autonomy tends to dictate what is best for the patient, rather than promoting free and autonomous decisions. Second, it is important to recognize that every girl is part of a vulnerable group that may also involve multiple overlapping layers of vulnerability[41] and that requires healthcare professionals to uphold an ethical commitment to her overall well-being and the obligation to do her no harm, as well as

[41] **Luna**, Florencia (2008) "Vulnerability: The Metaphor of Layers." Jurisprudencia Argentina, Vol. IV, pp. 30–67.

than the self-referential satisfaction of keeping their own prejudices or moral intuitions intact.

The social characterization of the process of pregnancy and the act of childbirth as inevitable—almost normalizing—events in the life of a gender has, in my view, led healthcare personnel—as well as legal practitioners—to omit including, within the essential clinical documentation that supports healthcare during pregnancy, childbirth, and the postpartum period, an informed consent form that duly notes and records the risks that pregnancy or childbirth pose to the overall health of girls and adolescents. However, this practice must be dismantled, and shaping understanding in this direction is undoubtedly a shared task for both practitioners of the right to health: healthcare providers and attorneys.

Therefore, when dealing with a pregnant girl or adolescent, it is essential that the professional inform her of how—according to scientific evidence—pregnancy and childbirth affect her physical, mental, and social health. And if a prior explanation on the subject is not recorded in the medical

record,

Since the goal is to promote a free and informed choice, consent cannot be presumed for such a pregnancy—a special clinical situation in the case of minors—which could jeopardize her health or her life. Therefore, *"The treating professional must document in the patient's medical record that the health information was* provided" [42].

[42] Art. 4 of Decree No. 1089/12, which regulates Law 26,529.

Without delving too deeply into the specific cases permitted under Article 26 of the Civil and Commercial Code regarding medical treatments for minors [43], it is worth clarifying that even if they are under 13 years of age, girls who demonstrate a sufficient degree of maturity are capable of forming their own judgment about what a current pregnancy and future motherhood may mean in their lives. For this reason, it is essential that they be informed, heard, and, above all, that their opinion be taken into account, regardless of whether they require assistance in that consent process. Above all, given that the interplay between progressive autonomy and the informed consent process must be interpreted harmoniously. And this is why the decision will always rest with the girl.

It will be task of the professional to ensure the participation of the girl and

[43] "Tucumán: An 11-Year-Old Girl Underwent a C-Section." News article from the Mendoza Digital Portal "Sin Gag." Available at https://www.sinmordaza.com/noticia/601580-tucuman-le-hicieron-una-cesarea-a-la-nina-de-11-anos.html

to guarantee her self-determination as a moral agent, without using the informed consent process—designed to ensure participation and self-governance—as a bureaucratic medical obstacle that prevents or hinders her decision: whether it be to carry the pregnancy to term and give birth, or to have an abortion.

And by cross-referencing the guidelines for specific cases provided for in Article 26 of the Civil and Commercial Code, it can therefore be affirmed that: if pregnancy is considered an "invasive" process for a girl, her decision to become a mother must be heard at all times, but when the patient is under 16 years of age, consent to pregnancy and childbirth must always be obtained through the support system provided for by law: whether from her legal representatives—one parent, not necessarily both—or from her close emotional partner.

Remove the "barriers" so the streetlamp can pass[44]

One way to impose forced motherhood on girls—in addition to withholding health information about the risks involved—is to use medical records as an obstacle rather than as a form of protection.

Informed consent for a legal abortion must never become an obstacle to a person's autonomy, much less a barrier to access to healthcare, as this would only deepen a girl's vulnerability under the false pretense of protecting her rights. An institution created for protection cannot become a tool for denying or delaying rights.

In the case of "Lucía" [(45),] there was an issue with the girl's legal guardianship, and

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[44] A popular children's song that has been part of the childhood of several generations in Argentina.

[45] An 11-year-old girl from Tucumán became pregnant in January 2018 by her grandmother's stepfather. Her case came to light due to a series of medical and bureaucratic barriers that, over the course of five weeks,

even though her desire to have an abortion was unequivocal from the start of her medical care (5 weeks before she was granted access to the legal abortion procedure), the Provincial Health System improperly cited "problems with consent," the "request for consent," and the "signature on the consent form" [46] thereby undermining—to the girl's detriment—a legal institution that seeks precisely the opposite: to uphold the decision of any autonomous moral agent with sufficient maturity to understand what a given health circumstance in her life—in this case, a pregnancy—means and to decide what is best for herself, in accordance with her own value system, but above all, knowing the truth.

This obstructed the girl's access to the ILE. See the news article ***"The Ordeal of a Girl Trying to Have an Abortion in Argentina"*** published in the Spanish newspaper El País on March 23, 2019. Available at https://elpais.com/sociedad/2019/03/26/actualidad/1553601793_174624.html

[46] "A cesarean delivery of a baby girl in Tucumán: one ordeal after another." News article from the newspaper La Pampa. Available at https://www.eldiariodelapampa.com.ar/index.php/edicion-digital/nacionales/57512-la-cesarea-a-una-nena-en-

tucuman-una-tortura-tras-otra

In the F.A.L. ruling, the Supreme Court of Justice of Argentina (CSJN) refers on three occasions to the medical and bureaucratic barriers that are unduly imposed to restrict access to abortion. In two of these instances, it describes conduct related to this concept, and in the third, it urges the provinces to eliminate this type of behavior that hinders access to healthcare, which it characterizes as illegal and violent in institutional terms.

The first reference to the idea of a "barrier" concerns requests for opinions or interventions by committees—most commonly ethics or bioethics committees—as well as consultations and inter-consultations. The Court clarified that *"given that the possibility of criminal prosecution has been ruled out for those who perform medical procedures in cases such as those examined in this proceeding, the persistence in behaviors such as those described can only be considered a* ***barrier to access to health services****, and the perpetrators must be held accountable for the criminal and other consequences that their actions may entail*." It also clarifies that this type of delaying medical conduct *"inherently carries the*

potential for an implicit prohibition and is therefore contra legem."

(…) and can be considered, in and of itself, an act of institutional violence" [47]. The point here is to warn the healthcare team that imposing unreasonable requirements—or creating an internal bureaucratic process that slows down medical care whose urgency increases as the gestational age progresses—amounts to a practice that is both illegal and violent.

The second instance in which the CSJN refers to the concept of barriers concerns those erected by society in conjunction with the judicial or police authorities, which require procedural steps—that have nothing to do with access to healthcare—as a condition for access to legal abortion. It is unequivocal and states that *"the requirement that rape victims, in order to qualify for an abortion, must*

[47] Recital No. 24

file charges against their assailant, obtain police from the request police, authorization a court or meet from any other requirement does be that medically necessary, it may become a barrier that discourages those who have legitimate expectations of seeking safe and timely services."[48] Finally, it calls for *"removing all administrative or de facto barriers to access to medical services. In particular, the following measures should be taken: establishing guidelines that guarantee information and confidentiality for the patient; avoiding administrative procedures or waiting periods that unnecessarily delay care and compromise the safety of medical practices; eliminating requirements that are not medically indicated; and establish mechanisms to resolve, without delay and without consequences for the applicant's health, any disagreements that may arise between the treating professional and the patient regarding the*

[48] Recital No. 27.

appropriateness of the requested medical procedure"[49]

The most recent cases of girls who have come forward reveal a common thread: they are girls who are victims of sexual abuse, at advanced stages of pregnancy, and detected late by the health system; and although they were given the option to terminate their pregnancies, in some cases—since a live birth occurred—there was technically no abortion.

And with this, we clarify that we do not share the view recently adopted by a sector of the women's movement[50] that argues that the existence of

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[49] Consideration No. 29

[50] Following the most recent cases that came to public attention in Argentina, the hashtag #CesáreaNoEsILE was launched on social media to signify that an abortion was denied. However, had fetal lysis been performed and had pharmacological treatments intended to mature the fetus's lungs been avoided, a live birth would not have occurred. For this reason, we insist that the cesarean section is not the problem, provided it is chosen by the girl—after being fully informed—as a method to remove the dead product of conception. The problem arises when fetal death is not medically induced prior to performing the cesarean section.

An abortion or medical termination of pregnancy is not precluded by the therapeutic alternative of a cesarean section or microcesarean—if chosen by the girl, with the support system guaranteed to her by law—but rather, if a microcesarean is chosen as the surgical procedure through which to perform a legally permitted abortion, the healthcare professional performing the procedure must avoid unnecessary delays that could promote fetal viability and result in a live birth. And if the girl arrives at a health care facility at an advanced gestational age and there is a viable fetus, the health care professional must take all necessary medical precautions to terminate the intrauterine life prior to performing the surgery, because once the surgery has taken place, it will no longer be an abortion but an induced delivery, and the girl's autonomy will have been violated.

It is essential that those healthcare professionals who are part of *the "healthcare* system" and who do not morally agree with a girl's decision to terminate her pregnancy possess sufficient ethical standards to respect the principle of non-maleficence. For while the law does not compel anyone to have an abortion, nor does it compel a girl to give birth. Meanwhile, the lex artis governing the practice of medicine establishes as an inexcusable obligation the duty to respect autonomy and refrain from harming patients.

It is also essential that all healthcare professionals provide comprehensive information to their pregnant patients and, especially if they are girls, inform them—based on scientific evidence—about the

dangers and risks posed by pregnancy, childbirth, and the postpartum period in the case of early motherhood—based on scientific evidence—so that they can be the true protagonists of motherhood if they choose to face these challenges; or of their abortion, if they decide not to take those risks.

Because if there is one thing about pregnancy in a girl's life, it is that—whether it results from consensual or non-consensual sexual intercourse—it will always pose a risk to her life and health. Therefore, whether under subsection 1 or 2 of Article
86 of the Penal Code, deciding to have an abortion will always be her right and a therapeutic option that every professional must guarantee.

Closing Remarks

Although pregnancy and childbirth, as high-risk biological processes, should be medically explained and subject to informed consent by any person capable of becoming pregnant—regardless of chronological age—we focus in this paper on girls due to the abundant scientific evidence regarding the risks of these obstetric events at a young age and, consequently, the urgency of addressing this issue.

A girl is not a clause in an article of the Penal Code, a provision of the Civil Code, or an interpretation of the Inter-American Court. Nor is a girl an empty or occupied womb, nor a number in a life-or-death statistic. A girl is a holder of rights who, in order to have full, requires state state actions that enable her sexual autonomy. A pregnant girl is a girl to whom the State failed to provide comprehensive sex education and a life free from violence. But above all, a pregnant girl is a user of health services who has two

options to mitigate that state neglect: she can choose to have an abortion—and that therapeutic alternative will always be lawful precisely because she is a girl—or she can choose to continue her pregnancy and give birth.

In both cases, she must go through the informed consent process, which will ensure she makes the freest possible decision regarding her unfortunate choices between life and death. Because a pregnancy—just like an unsafe, clandestine abortion—can result in death or cause serious, permanent, or temporary harm to a girl's health. This is a risk that every healthcare professional has an obligation to assess and explain to their patient, so that after receiving age-appropriate information and support, she—as the sole protagonist of her own health story—can freely decide whether or not to take that risk.

Our health services are called upon to review current practices and gather scientific evidence on the risks of pregnancy and childbirth during childhood and adolescence, in order to demystify motherhood as a predetermined fate and begin to view it

for what it is: a risky biological process that, as such, must be understood and consented to by every girl who enters the health system while pregnant and is returned to society as a “mother.”

View the Informed Consent Form for Pregnancy and Childbirth by scanning the following QR code:

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