

Drawing on the disciplines of Anthropology and Philosophy, this thesis examines the influence of societal conditions and attitudes on adolescent sexual health. Chapters I, II, and IV focus on the United States, where the adolescent pregnancy rate is 34.2/1000¹, and Chapter III further supports my argument through my ethnographic research from Costa Rica, where the adolescent pregnancy rate is 55.2/1000². In both countries, effective contraceptive technologies are available to teens, yet teen pregnancy rates remain high. I argue that teenage sex is not inherently harmful, but that negative perceptions of adolescent sexual behavior are damaging to teen sexual health.

Through academic research in the United States and ethnographic interviews in Costa Rica, I emphasize how invisible barriers, including shame, rigid gender roles, socioeconomic inequality, and lack of opportunity, inhibit teen sexual healthcare access. Finally, I construct an ethical argument for adolescent reproductive healthcare access based on the existing duty of society to protect its young citizens.

¹ Joyce A. Martin et al., "Births: Final Data for 2010" *National Vital Statistics Reports*. 61, no. 1 (2012) http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf#table02

² United Nations Statistics Division, "Table 10: Live births by age of mother and sex of child, general and age specific fertility rates: latest available year." *Demographic Yearbook 2009 – 2010* (New York, NY: United Nations, 2011).
<http://unstats.un.org/unsd/demographic/products/dyb/dyb2009-2010.htm>

**LA PRIMERA BARRERA SOMOS NOSOTROS:
SOCIETY, STIGMA, AND ADOLESCENT SEXUAL HEALTH**

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INTRODUCTION: WE ARE THE FIRST BARRIER

When relatives become pregnant at 14, 15, 18, it surprises me. How did it happen? In reality, they have everything in their hands, all the tools, all the information, so why don't they put it in practice and use it? They are intelligent, but how did it happen? What happened? What were they thinking? They have all the information on TV, on the internet, on the computer but what happens?

–B., 37, female. Monte Verde, Costa Rica

Adolescent behavior is at once universally relatable—every adult was once a teenager—and completely foreign. In the case of adolescent pregnancy, the characterization of adolescents as beyond comprehension has led us to misattribute deeply entrenched social problems to the recklessness of youth. In my thesis, I seek to move past this perception of adolescents as irrational or careless, and encounter the logic in their nonuse of contraception, even in cases where it is available. To do so, I place adolescent sexuality and pregnancy in context of history, society, and place, confronting the factors that influence and constrain choice.

My decision to research the topic of adolescent access to contraception in Monte Verde, Costa Rica emerged from a discussion in which community members expressed alarm about the frequency of adolescent pregnancies in the zone, despite access to free contraceptives at the local government-run clinic. The dominant public health paradigm often focuses on provision of contraceptives, coupled with education, as the way to address teen pregnancy. As indicated by high adolescent pregnancy rates in Monte Verde, and in Costa

Rica as a whole, where 55.2/1000³ births are to adolescent mothers, apparently this model is not sufficient. Where are these apparent gaps between availability and access? What invisible obstacles exist, and why?

As I began to unearth answers to those questions through my interviews in Monte Verde, a new, more complex, question arose: How do implicit and explicit societal attitudes about sex shape the actual health outcomes of teenagers? Many of the barriers to adolescent contraceptive access in Monte Verde are tacit, shaped by the stigma adolescents come to associate with sexual activity through growing up in a society that perpetuates this view. Though teens could access contraceptives, they don't, because the immediate shame of being exposed as sexually active engenders more fear than a distant, hypothetical, unplanned pregnancy. My research in Monte Verde shows that the existence of contraceptives is irrelevant if adolescents face significant obstacles to access.

When I returned to the United States, I began to engage with these ideas on a deeper level, considering the broader applications of this research in my home country, where the adolescent pregnancy rate is the highest in the developed world, at 34.2/1000⁴ births to teen mothers. I did this through reading academic literature, but also through turning a critical eye to the

³ United Nations Statistics Division, "Table 10: Live births by age of mother and sex of child, general and age specific fertility rates: latest available year." *Demographic Yearbook 2009 – 2010* (New York, NY: United Nations, 2011). <http://unstats.un.org/unsd/demographic/products/dyb/dyb2009-2010.htm>

⁴ Joyce A. Martin et al., "Births: Final Data for 2010" *National Vital Statistics Reports* 61, no. 1 (2012) accessed 10 October 2013 http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf

constant onslaught of news media articles about teen sex, which present an exaggerated caricature of adolescent sexuality, represented through constant hand-wringing about deviant teen trends like “rainbow parties,”⁵ “sex bracelets,”⁶ and “sexting.”⁷ Furthermore, it was impossible not to connect my research to my own lived and observed experience as someone who was a teenager only a few years ago. In this sense, my research has personal significance to me, and it should to everyone—we have all been and known teenagers. I hope that I have illustrated the challenges that adolescents face in navigating sexuality, stigma, and healthcare in a manner that makes clear the necessity of societal change.

In the next four chapters, I ask and answer a number of critical questions about the effect of stigma on teen sexual health. My perspective is interdisciplinary, primarily using the disciplines of anthropology and philosophy to inform my approach. In anthropology, I find a discipline that evinces my commitment to understanding the logic of adolescents’ choices. The discipline of anthropology gave me the ethnographic methods and theoretical tools to conduct and frame my research in Costa Rica. Drawing on the subset of critical medical anthropology has allowed me to illuminate the

⁵ Tamar Lewin, “Are These Parties for Real?” *New York Times*, 30 June 2005, accessed April 14, 2013
http://www.nytimes.com/2005/06/30/fashion/thursdaystyles/30rainbow.html?pagewanted=all&_r=0

⁶ “Parents: Brace Yourselves,” *TIME*, 19 October 2003, accessed April 14, 2013
<http://www.time.com/time/magazine/article/0,9171,524487,00.html>

⁷ Michael Hefland, “Sexting: What Every Parent Should know” *Parent Further*, accessed April 14, 2013 <http://www.parentfurther.com/teens-and-sexting>

political and societal factors within adolescent contraceptive (non)use and pregnancy. I anchor my argument in the existing base of anthropological literature about adolescent sexuality.

The discipline of philosophy offers fewer direct perspectives on adolescent sexuality. Rather, it provides a framework through which to challenge my own assumptions and make clear ethical claims. I draw on philosophy to examine and justify my use of a social constructivist analysis and to construct an ethical framework for viewing adolescent sexual behavior. Philosophy, specifically applied ethics, offers the tools to answer the underlying questions of my argument: is adolescent sexual behavior a moral entity? Does providing birth control to adolescents cross definitive ethical lines?

The four chapters in this thesis contain distinct arguments that serve to advance the whole. First, I explore the origins of modern-day adolescence, adolescent sexuality, and adolescent pregnancy, highlighting the variability of these norms. Turning to history shows that changing norms is possible, which is necessary in order to advocate for change throughout the rest of my thesis. In my second chapter, I introduce the central argument of the thesis: that stigma against adolescent sexual behavior is directly harmful to adolescent sexual health. I focus on the United States, advocating for an approach to adolescent pregnancy prevention that considers societal factors such as stigma and inequality. I also examine the strategies used in countries with very low

rates of adolescent pregnancy, noting that those who actively combat stigma are most successful. In the third chapter, I use Costa Rica as a case study to illustrate the role of stigma in adolescent sexual health. My research in Monte Verde demonstrates that making contraceptives available is ineffective against teen pregnancy if the force of stigma is too strong for adolescents to overcome. Philosophy informs the final chapter of my thesis, in which I put forth an argument for the right of adolescents to access sexual healthcare, and the moral duty of society to provide it. In the final chapter, I both backtrack, making explicit assumptions contained within the first three chapters, and look forward, outlining a plan for practical action based on the principle that adolescents have a moral right to access the sexual health services that will protect them from poor health outcomes.

In response to my final interview question, “what are some possible barriers, if any, to confidential contraceptive access in the Monte Verde zone?” one interview participant inadvertently titled my thesis. Her answer, “la primera barrera somos nosotros,” or “we are the first barrier” summarizes the argument I put forth in the next four chapters. In recognizing the influence of society on adolescent development and sexual health, we can move deliberately towards cultivating a healthier society.

CHAPTER I CONSTRUCTING ADOLESCENCE

There are certain concepts so deeply embedded within our cultural narrative that they are difficult to question. Adolescence, a stage of life that we all experience, is one of these. To gain a clear view of and challenge the norms that surround adolescent sexuality, it is crucial to first understand their origins. Remnants of late 19th century thinking about adolescent sexuality are still reflected in ideas and rhetoric today. Realizing the relative historical newness and variability of ideas around adolescence opens the concept up to critical analysis about its relevance in today's world. In this chapter, I will examine the coevolution of societal conceptions of adolescence and adolescent sexuality and pregnancy. As "adolescent" became a separate classification, adolescent sexuality and pregnancy emerged as distinct concerns. By beginning with the examination of the emergence of adolescence as a distinct life stage, these norms are illuminated within the context of their origins, and can be viewed more accurately as products of their times and not necessarily fixed realities. I assemble the framework for the argument of this thesis through historical analysis and a critical examination of the roots of the rhetoric surrounding adolescence, adolescent sexuality, and adolescent pregnancy.

As I argue here for the socially constructed nature of adolescence, it is necessary to acknowledge that classifying a concept as socially constructed does not undermine that concept's power. Because of this, I will also carefully examine the concept of social constructs, their development, and their impact.

Part i. Teens in the 21st Century

The concept of adolescence, defined by Merriam-Webster's dictionary as "the transitional period between childhood and adulthood"⁸ has enormous influence over many aspects of contemporary culture. Cultural expectations of adolescents are often very different than those of either children or adults. Adolescence is a time of transition, full of both turmoil and self-discovery, and the adolescent life-stage shapes the standard biographical narrative of every individual. The importance placed on this period is reflected in the popularity of coming-of-age stories in literature and film, stories which celebrate and analyze the frustration, turbulence, and beauty of this life stage. Adolescents occupy a liminal space, gaining independence by degrees legally and culturally, often talked about but rarely heard from.

Conversations about teenagers often seem to be imbued with societal anxiety. Nancy Lesko, in her book *Act Your Age: A Cultural Construction of Adolescence*, supports this, arguing that "adolescence became a social space in

⁸ Merriam-Webster's Dictionary Online, s.v. "adolescence" accessed 10 October, 2013, <http://www.merriam-webster.com/dictionary/adolescence>

which to talk about the characteristics of people in modernity, to worry about the possibilities of these social changes, and to establish policies and programs that would help create the modern social order and citizenry.”⁹ In other words, adolescents attract such a degree of concern because society is trying to mold them into adults who reflect the values of the times, and deviation from the “correct” path is seen as a rejection of those values.

Adolescence is considered a time of both experimentation and vulnerability, and therefore teens are considered at-risk for a number of harmful activities. Adolescents’ at-risk designation is driven by scientific research that states that they give more weight to rewards than to consequences when considering a possible course of action.¹⁰ The Center for Disease control compiled a list of teenage risk behaviors for parental perusal. These behaviors include:

“Alcohol & Drug Use, Body Piercing, Dating Abuse, Eating Disorders, Electronic Violence (Cyber Bullying), School Violence, Sexual Risk Behaviors, Sexual Violence, [...], Suicide Prevention, [...] Smoking, Teen Drivers [Auto accidents], Teen Pregnancy, [...] Tobacco Use, [...] Youth Violence.”¹¹

Clearly, adolescence is a time of special concern. Parents expect clashes, and there are thousands of parenting books—a quick Amazon search turned up 3,557, with titles like “Parenting Your Out-of-Control Teenager: 7 Steps to

⁹ Nancy Lesko, *Act Your Age! A Cultural Construction of Adolescence: (Critical Social Thought)*, (Florence, KY: Routledge, Taylor & Francis Group, 2001), 5.

¹⁰ Albert, Dustin, and Laurence Steinberg. "Judgment and decision making in adolescence." *Journal of Research on Adolescence* 21, no. 1 (2011)

¹¹ “Teens (Ages 12-19) - Risk Behaviors,” Centers for Disease Control and Prevention, Last modified November 21, 2012, http://www.cdc.gov/parents/teens/risk_behaviors.html

Reestablish Authority and Reclaim Love” and “Stop Negotiating With Your Teen: Strategies for Parenting Your Angry, Manipulative, Moody, or Depressed Adolescent”-- directed at parents of teens.¹² Adolescence is synonymous with trouble in our social language.

We have long relied on the discipline of psychology to explain our teens. Adolescent development is a strong subfield of psychology, and is responsible for providing the academic explanation for the social facts of adolescent turmoil. Psychology offers the most commonly referred to explanation, that teens do not yet have a fully developed prefrontal cortex, the area of the brain that regulates impulse control, future planning, and weighing short-term rewards against long-term goals.¹³ The frontal lobes of the brain are not fully connected, and the nerve cells that link the frontal lobes and the brain are slow and not fully developed.^{14 15} This explanation provides a scientific basis for adolescent behavior and the societal and legal regulations that govern it. It is important to note, however, that while it is easy to see how scientific studies on adolescent brain development affect societal treatment of

¹² Amazon. Books > ‘parenting, teenager’ Last modified 2013.

http://www.amazon.com/s/ref=nb_sb_noss?url=search-alias%3Dstripbooks&field-keywords=parenting%2C+teenager&rh=n%3A283155%2Ck%3Aparenting%5C+teenager
Accessed 20 Feb. 2013

¹³ Cheryl L. Sisk and Douglas L Foster, "The neural basis of puberty and adolescence," *Nature Neuroscience* (2004): doi:10.1038/nn1326
<http://www.nature.com/neuro/journal/v7/n10/full/nn1326.html>

¹⁴ Sisk and Foster, "The neural basis of puberty and adolescence"

¹⁵ Elizabeth R. Sowell et al., “Mapping cortical change across the human lifespan” *Nature Neuroscience* (2003): doi:10.1038/nn1008
<http://www.nature.com/neuro/journal/v6/n3/pdf/nn1008.pdf>

adolescents, it is more difficult to quantify how ideas of adolescence influence the results of those studies.

Adolescence is considered a turning point, the fork in the road between becoming an upstanding citizen and a failure. The phase is spoken of as one to “get through” successfully, but also as one of significant personal development. However, adolescence can serve as a point of stagnation from which one rarely recovers—we hear about adults who made bad choices as teens that affect them through their whole lives. Teenagers are thought of often primarily in terms of their future potential, and they are encouraged to stay away from anything that could disrupt that potential (for example, sexual activity).

The norms around adolescents—that they are impulsive, risk-taking, moody, and troublesome—have been generalized and applied to the entire group, and then encoded and cemented in policy. In my next section, I will examine the origins of these norms and how they influenced and were influenced by economic and social conditions.

Part ii.

Adolescence and Adolescent Sexuality: Historical Considerations

Because of the central role of the teenager in our cultural narratives, it may be surprising to learn that adolescence only emerged as a distinct life

stage in the late 1800s and early 1900s.¹⁶ In the United States, adolescence and childhood both surfaced out of industrialization and urbanization. Even before adolescence gained a name in 1904, it was clear that defining the boundaries of childhood and adulthood took on additional significance during that time. Child labor laws give some insight into the parameters of childhood in those days—in 1881 the American Federation of Labor advocated for age fourteen as the minimum age of employment.¹⁷ The age that a person could legally consent to marriage and sexual activity was established at twelve for women and fourteen for men.¹⁸ Although few Americans actually married that young, it does indicate a societal acceptance of adolescent sexuality, as long as it was within the bounds of marriage.¹⁹ These new ideas about the necessity of protecting childhood influenced the development of pediatrics as a specialty and the introduction of compulsory schooling laws. This attitude “both resulted from and encouraged the process by which children were being excluded from the nation’s economic life,”²⁰ thus designating children as an vulnerable group in need of protection.

These new ideas and laws designating childhood as distinct from adulthood coincided with the 1904 publishing of psychologist G. Stanley

¹⁶ Kristin Luker, *Dubious conceptions: The politics of teenage pregnancy* (Cambridge: Harvard University Press, 1996), 26

¹⁷ *Ibid.*

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ *Ibid.*, 28.

Hall's two-volume work entitled *Adolescence*.²¹ This work detailed the unique situation of young people who had reached puberty but were still below marriageable age.²² Before this concept came to light, adolescents were lumped in the same category as "youth", an ambiguous term that could encompass anyone from age seven to age 30, and were thought of as inferior adults.²³ Adolescence emerged out of this time period for several reasons. Young people were increasingly separated from adults because of the expansion of the public school system, which required students to be sorted by age.²⁴ This made visible the distinction between children and adults, and thus between adolescents and children. Age was consequently privileged as a manner of categorization more than ever before. School curriculums were developed according to age grading from 1870 on, and variability in age-based expected development levels was no longer as tolerated.²⁵ Furthermore, due to improved nutrition, young people went through puberty much earlier, lowering the age of sexual maturity. Finally, young men underwent a much longer period of training and education for their jobs, causing them to delay marriage until they were financially secure.²⁶ These changes lengthened the gap between sexual maturation and marriage, drawing attention to the liminality of the adolescent phase.

²¹ Jeffrey Moran, *Teaching sex: The shaping of adolescence in the 20th century* (Cambridge: Harvard University Press, 2000), 1.

²² *Ibid.*

²³ *Ibid.*, 2.

²⁴ *Ibid.*, 15.

²⁵ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 25

²⁶ Moran, *Teaching sex: The shaping of adolescence in the 20th century*, 15

Because the concept of adolescence emerged at the end of the Victorian era, Victorian values and anxieties about sexuality were deeply embedded within it. Victorian values centered on social responsibility, personal discipline, and moral rectitude, and many of these were entangled with sexual regulation.²⁷ Nineteenth century scientific experts conceived of the body as a fixed-energy system. Therefore, energy spent on sexuality was energy lost. Exercise to strengthen the will, especially resisting sexual temptation, was considered paramount to developing necessary willpower and fortitude.²⁸ Adolescence, therefore, was positioned as a critical period of development: spiritually, physically, emotionally, sexually, and psychologically. Scientific experts of the time, including G. Stanley Hall, recognized the sexual frustration inherent to adolescence and emphasized the importance of sublimating that desire into other pursuits as a vital part of the maturation process.²⁹ Hall even asserted that the emotional and physical health of adolescents' future children hinged on their ability to control themselves sexually during adolescence.³⁰

Hall's work was the first indication that puberty was not simply a milestone, but a turning point with psychological and social ramifications.³¹ When Hall defined adolescence, ages 13-19 took on new significance. This was particularly apparent in terms of sexuality. As adolescents were now at a

²⁷ Ibid., 6

²⁸ Ibid.

²⁹ Ibid., 20

³⁰ Ibid.

³¹ Luker, *Dubious conceptions: The politics of teenage pregnancy*, 28.

critical point, they were not to be burdened with the trappings of adulthood—marriage, work, and sex—that might disrupt or hasten their development. A century earlier, adolescents were considered emotionally capable of marriage, sex, and childbirth, and that belief was written into law.³² Now, adolescents needed protection from life events that were previously considered normal.

Nineteenth and twentieth century anxieties about race and immigration also became deeply entangled with the concept of adolescence. In the 1800s, scientists including German zoologist Ernst Haeckel claimed that each individual child's development mirrored the progression from pre-humans (babyhood) to the tribal period (childhood) to the medieval period (boyhood) to the monarchical period (adolescence) and finally to civilization, or adulthood.³³ This idea was called Recapitulation Theory. Contemporary ideas about race were at the center of this theory, as scientists believed that white male children were equal to a number of other “savage” races whose development had supposedly arrested at that stage. Children, animals, and adult “savages” were equated, and childrearing methods echoed colonial relationships. In order to achieve the status of adulthood, white children were expected to cast off their intrinsic vestigial savagery.³⁴ The adolescent phase marked a distinctive turning point, where the white boy-man could either take up his mantle as a leader of society, or fail to do so and be relegated to the

³² Ibid., 29

³³ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 50

³⁴ Ibid., 51

status of a “lesser” race. In this way, the concept of adolescence and the anxiety it generated was motivated by concerns about maintaining white hegemony. The uncertainty about whether the adolescent male would achieve his full potential served as a stand-in for concerns about upholding race and class hierarchy during changing times.

According to contemporary theory, adolescents’ ability to control themselves sexually during that period of their life did not only determine their own health and the health of their future offspring, but the health of their race as well. According to Hall’s mentor, William James, “No one need be told how dependent all human social elevation is upon the prevalence of chastity...hardly any factor measures more than this the difference between civilization and barbarism.”³⁵³⁶ Contemporary anthropologists emphasized the association between sexual control and evolution, highlighting the sexual immorality of supposedly savage cultures around the world and even of the influx of immigrants from Eastern and Southern Europe.³⁷ According to Sanford Bell, one of Hall’s colleagues: “Pubescence marked the beginning of the distinctively sexual experience of both sexes” in lesser races, while civilized youth adhered to “the system of sex inhibitions that are considered an essential part of the ethical habits of our young people.”³⁸ While

³⁵ Moran, *Teaching sex: The shaping of adolescence in the 20th century*, 16.

³⁶ William James, *The Principles of Psychology*. (Digireads.com Publishing, 2004), 19.

³⁷ Ibid.

³⁸ Ibid., 17.

“civilized” youth sublimated their sexual desire into self-betterment, “savage” youth were already sexual beings.³⁹

The construction and acceptance of the adolescent phase during the late 1800s and early 1900s illustrates how conventions surrounding sexuality and marriage age often fluctuate with the social and economic conditions of the times. Perspectives on adolescence from ancient cultures also demonstrate the variability of moral norms surrounding adolescent sexuality. In his article, “Sex in Adolescence: Trends and Theories from Ancient Greece to the present,” Vern Bullough’s exploration of the historical and cross-cultural treatment of adolescent sexuality highlights the importance of questioning held beliefs about universality.⁴⁰ Expression of adolescent sexuality took varied forms across cultures, many of which would be judged immoral in the present day. These different permutations of adolescent sexual expression frequently reflect the economic and social realities of the times. One of the most widely studied examples is the socially acknowledged sexual relationships between adult males and adolescent boys in ancient Greece.⁴¹ This practice emerged in 650-625 BCE, and was widely accepted by society as a significant part of a boy’s coming of age.⁴² Bullough argues that this practice originally emerged as a means of population control when the

³⁹ Ibid.

⁴⁰ Vern Bullough, “Sex in Adolescence: Trends and Theories from Ancient Greece to the Present,” in *Adolescent Sexuality: A Historical Handbook and Guide*, ed. Carolyn Cocca et. al (Westport: Praeger, 2006).

⁴¹ Ibid., 6.

⁴² Sarah Iles. Johnston, *Religions of the ancient world: A guide*. (Cambridge: Harvard University Press, 2004) 446

population spiked as a result of newly built Greek settlements. His argument is supported by Aristotle's statement: "and the lawgiver has devised many wise measures to secure the benefit of moderation at table, and the segregation of the women in order that they may not bear many children, for which purpose he instituted association with the male sex."⁴³ Several other authors, including William A. Percy and Jan Bremmer, have argued that some ancient societies practiced same-sex relationships with adolescent boys as a form of delaying procreative sexual relationships.⁴⁴⁴⁵ In much of the world today, adult-adolescent sexual relationships are considered ethically problematic, and homosexual relationships are taboo. In some ancient societies, however, that type of relationship filled a necessary purpose for economic and societal development, and was therefore socially acceptable. This further illustrates the variability of thought on certain sexual practices in accordance with economic and social conditions.

Due to the popularity of Recapitulation Theory, adolescent boys were the primary focus of 19th and 20th century discourse about youth because of their particular role in advancing white male supremacy.⁴⁶ Adolescent girls, however, also had a specific function and therefore were the entity onto which different anxieties were projected. As Lesko discusses, preserving the

⁴³ Aristotle, *Politics* (Oxford, Clarendon Press, 1908), 2.1272a 22-24

⁴⁴ William Armstrong Percy III, "The Institutionalization of Pederasty," *Pederasty and Pedagogy in Archaic Greece*, (Urbana : University of Illinois Press, 1996)

⁴⁵ Jan Bremmer, *Greek religion (New Surveys in the Classics No. 24.)* (Cambridge: Cambridge University Press, 1994)

⁴⁶ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 60

emotional and physical integrity of adolescent women was presented as a moral duty, critical to maintaining the health of the race and nation. This rhetoric was particularly strong in the early 1900s, and was reflected in girls' educational curriculum in both Britain and the United States.⁴⁷ The importance of conformity to societal ideals of female sexuality in order to maintain hegemonic order was an underlying current of discussion regarding adolescent girls at that time. In the United States, managing the sexuality of adolescent girls became a primary objective and was the focus of most school programs and state intervention in general. In the late 1800s, girls were frequently brought up in front of a court and punished for displays of early sexuality.⁴⁸ The charges generally fell under the category of "immorality," which ranged from actual sexual acts to "showing signs in their appearance that they had had intercourse in the past or 'might do so in the near future'."⁴⁹ In Milwaukee, for example, each supposed delinquent girl was subject to a gynecological exam, which determined not only the status of her virginity but if she had ever engaged in "self-abuse"(masturbation). If she was found to have done so, she was placed under supervision of the state, which usually involved placement in a rural setting isolated from males.⁵⁰

This intense scrutiny of adolescent girls, and the state's role in it, was borne out of some concern for the girls—specifically in regard to their future

⁴⁷ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 68

⁴⁸ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 70

⁴⁹ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 70

⁵⁰ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 71

capacity as mothers—but also out of concern for their influence on adolescent boys. Adolescent girls occupied and continue to occupy the position of gatekeepers and modifiers of male behavior; hence their degree of moral rectitude is of the utmost importance. Only adolescent girls have the power to tame the boys (who will, after all, be boys) through their own staunch moral virtuousness, though they are also cautioned to fear them. Adolescent girls have never been a group imbued with institutional power, but the status of their moral and physical integrity has long inspired great anxiety from those in power. Adolescent girls are, quite literally, the future of society—future wives and mothers with arguably the greatest degree of influence over their dominant male counterparts.

The rhetoric around adolescent female sexuality still has shades of old anxieties, despite new contraceptive technologies and changes in paternity laws that render many concerns outdated. A historical analysis of adolescence and adolescent sexuality is so critical to my argument because so many of these ideas are reflected in rhetoric and policy today. Society's obsession with the behavior of adolescent girls remains strong, and I argue that this is one reason why adolescent pregnancy and parenting is such a source of societal concern. White men, who were responsible for the academic and social advancement of these ideas, are still the most socially and economically privileged majority, and as demographic shifts threaten this they cling to these ideals in the hope that it will fortify their power. This can be seen in concern

about the relatively high rates of pregnancy among Black and Latina teenagers⁵¹—consider the “welfare mother” or “anchor baby” rhetoric—that reflect fears about changing demographics and waning white supremacy in the United States. The sexuality and fertility of adolescent girls is still considered dangerous, and fears about race and class continue to influence the discourse.

Part iii.
Adolescent Childbearing: Multiple Meanings

In future chapters, using primary and secondary research in philosophy and anthropology, I demonstrate that eliminating stigma associated with adolescent sexuality is critical to facilitating adolescent reproductive health access. Within an argument for teenage contraceptive access is the inherent assumption that, in contemporary times and in the industrialized world, high teen pregnancy rates are something worth combating. Teen pregnancy has transitioned from a normal occurrence to a highly medicalized and problematized state of being with the increasing industrialization of the societies that drive this rhetoric. With the rise of potential opportunities for girls and women beyond motherhood, teenage motherhood is seen as something to avoid at all costs in order to pursue those other opportunities. When the female role is primarily that of a wife and mother, as it has been

⁵¹ Gladys Martinez, Casey E. Copen, and Joyce C. Abma. "Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2006-2010 National Survey of Family Growth." National Center for Health Statistics *Vital and health statistics* 23 (2011) http://www.cdc.gov/nchs/data/series/sr_23/sr23_030.pdf Accessed 10 October 2013

throughout history, there are few incentives to delay childbearing. However, this analysis often leads to the idea that adolescent childbearing is the causal trigger for a lifetime of struggle. In reality, adolescent pregnancy in industrialized societies is often a symptom of constrained reproductive choice due to economic, social, and legal factors. In the past, this lack of choice for women was nearly universal, which led to a greater acceptance of adolescent pregnancy. The complexity of the adolescent pregnancy issue demands a holistic approach that considers economic and social context as well as simple contraceptive access. My intent in this thesis is not to disparage adolescent mothers, but rather to advocate for a societal environment that supports adolescents to make informed and unfettered reproductive choices. Unfortunately, even planned adolescent pregnancy is often the result of constraining economic and social circumstances.

In his book *Destinies of the Disadvantaged: The Politics of Teen Childbearing*, Frank F. Furstenberg explores the “pre-problem stage” of teenage childbearing.⁵² He argues that average age of family formation rises with the transition from agrarian to industrialized economies. Early marriage and childbearing makes sense in a land-based economy, where children make up for what they cost in resources by providing a valuable work service on the farm, and where economic activity is based at home so childcare is integrated within the work day. In an agrarian society, early childbearing did not mean

⁵² Frank F. Furstenberg, *Destinies of the disadvantaged: The politics of teenage childbearing*. (New York: Russell Sage Foundation Publications, 2007), 8.

the forfeiture of future opportunities, because these opportunities did not exist for women. In an industrialized society, early childbearing is an obstacle to the financial stability achievable in a capitalist industrialized economy.⁵³ I will more fully discuss this idea of opportunity constraint and family structure in Chapter II, and again in my interviews in Chapter III.

Public sentiment about teen childbearing was influenced by G. Stanley Hall's "discovery" of adolescence. Along with the inception of the term came a new list of rules and regulations, especially for women. Medicine reflected this change in ideology—physicians claimed that until a woman reached the age of 20, her pelvis was not fully formed enough to have sex or give birth.⁵⁴ However, adolescent childbearing did not become a full fledged "problem" or target of serious state intervention until the 1970s, though the peak of teenage childbearing in recent history in the United States came right after World War II, reaching a peak of 97.3 births per 1000 women ages 15-19 in 1957.⁵⁵ The lack of public outcry about this "epidemic" was perhaps due to the fact that many of these women were married. As the age of marriage increased, teenage mothers no longer conformed to the comfortable category of *married* mothers, and hence teen pregnancy became more visible as a deviation from societal norms. Between 1960 and 1977, out of wedlock births to teens more

⁵³ Furstenberg, *Destinies of the disadvantaged: The politics of teenage childbearing*, 10

⁵⁴ Luker, *Dubious conceptions: The politics of teenage pregnancy*, 29.

⁵⁵ Maris A. Vinovskis, "An 'Epidemic' of Adolescent Pregnancy? Some Historical Considerations." *Journal of Family History* 6, no. 2 (1981): 205-230.

than doubled from 92,000 to 249,806.⁵⁶ However, these data do not indicate that more planned children were born into happy marriages in 1960, but rather that teens in 1960 were more likely to get married after conceiving due to societal pressure than in 1977.⁵⁷ Early marriage was a way to legitimize sexual activity and resultant pregnancy in a time before widespread contraceptive availability.

Historical perspectives indicate that adolescent childbearing is only defined as a problem in certain societal and economic contexts. With more opportunities available for women and the rise of the nuclear family model instead of a multi-generational household, adolescent childbearing becomes a societal problem because it is seen as inhibiting these opportunities and ideals.⁵⁸ However, there are current circumstances in which, due to economic disadvantage, delaying childbearing will not result in better outcomes for the mothers or their children. The “delay childbearing to pursue dreams” analysis ignores the fact that though more opportunities for women (further education, career-track jobs) exist, even in contemporary times they are frequently out of reach for many girls. Therefore, choosing to delay childbearing does not always have the potential to change a disadvantaged young woman’s life trajectory. This is demonstrated through Arlene Geronimus’ 1997 article about adolescent parenting, entitled “Teenage Childbearing and Personal

⁵⁶Ibid., 210.

⁵⁷Ibid., 212.

⁵⁸ Luker, *Dubious conceptions: The politics of teenage pregnancy*, 30.

Responsibility: An Alternative View.” Geronimus argues that adolescent childbearing is an adaptive response to poverty. She theorizes that disadvantaged teens who delay childbearing do not have better outcomes than those who become adolescent parents. To support her statement, she used several different studies, using the receipt of welfare as a yardstick of economic status. One study, which compared pairs of sisters, one of whom was an adolescent mother and one who was not, found no significant difference in welfare receipt by the sisters after age twenty-five.⁵⁹ As far as education is concerned, another study of sisters found no difference between school graduation rates and future income level between the sister who was a teenage mother and the sister who was not.⁶⁰ When teens are faced with economic immobility, they see no benefit to delaying childbearing, and therefore have little incentive to do so.

It is also important to note that, in the United States, most teenage parents are actually legal adults: two thirds of teenage mothers are eighteen and over.⁶¹ These women are nevertheless placed in the same category demographically as mothers as young as thirteen. Conflating thirteen-year-old mothers with nineteen-year-old mothers only propagates the idea that all

⁵⁹ Mary E. Corcoran and James P. Kunz, “Do unmarried births among African-American teens lead to adult poverty?” *The Social Service Review* (1997) 274-287, accessed 10 October 2012.

⁶⁰ Arline T. Geronimus and Sanders Korenman. “The socioeconomic costs of teenage childbearing: evidence and interpretation.” *Demography* 30 (1993) 281-90, accessed 10 October 2012.

⁶¹ Kathryn Kost, Stanley Henshaw, and Liz Carlin. “Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity” *Guttmacher Institute*, 2010, <http://www.guttmacher.org/pubs/USTPtrends.pdf>, Accessed 10 October 2012

teenage mothers are children themselves. Most of the disadvantages associated with early childbearing do not apply to 18 and 19 year old women.⁶² This also emphasizes the difficulty of defining “adolescence” and measuring any traits associated with it across such a wide expanse of age and maturity.

The very fact of adolescence relies on a temporal ordering that is disrupted by teenage motherhood.⁶³ Adolescence is, by definition, a state of constraint, and paths that differ from the order defined as normal are met with societal outcry. The stigma associated with teen childbearing is augmented because it is visible—unlike other problems that plague adolescents, like eating disorders, drugs and alcohol, and even sexually transmitted diseases, pregnancy is a public state. Society has little room for or tolerance of adolescent narratives that deviate from a defined norm, and adolescent childbearing is a permanent and visible reminder of that deviation.

Part iv. Philosophical Perspectives on Social Construction

As we explore the construction of adolescence, adolescent sexual behavior, and adolescent pregnancy, it is important to recognize the baggage

⁶² Dorothy Nortman. “Parental Age As a Factor in Pregnancy Outcome and Child Development,” *Reports on Population/Family Planning* 16 (1974): 3, accessed 10 October 2012, http://pdf.usaid.gov/pdf_docs/PNAB1510.pdf

⁶³ Lesko, *Act Your Age, A Cultural Construction of Adolescence*, 54

that accompanies the concept of social construction. The term “social construction” is frequently used in academic discourse as code for something that is unreal. Philosopher Ian Hacking challenges the false dichotomy between social construction and reality. What is defined as real, and why does it matter? Hacking uses the categories of interactive and indifferent kinds to unpack the language around social construction. Indifferent kinds are not affected by how we classify them—Hacking uses the example of a quark as something that is unaware of and unaffected by societal classification or discussion of it.⁶⁴ Indifferent kinds are not necessarily “natural”, many are still created by humans, but they do not interact with the idea of their own existence and classification. Natural kinds are also usually indifferent—Hacking uses the example of horses, stating: “in denying that *horse* is an interactive kind, I am not denying that people and horses interact. I am saying that horses are no different for being classified as horses.”⁶⁵

On the other hand, *interactive* kinds respond to and are affected by, and therefore influence and are influenced by, classification of their group. By virtue of being placed in a certain group or given a certain classification, people experience themselves differently.⁶⁶ Adolescence, I argue, belongs in this category—teenagers think of themselves as teenagers, and therefore perhaps comply with the norms associated with the category of “teenager.”

⁶⁴ Ian Hacking, *The Social Construction of What?* (Cambridge, MA: Harvard University Press, 1999), 104.

⁶⁵ *Ibid.*, 107.

⁶⁶ *Ibid.*, 104.

This gets at what Hacking calls the “looping effect”—people are placed into groups, and then behave in ways that accord with the behavior of the group. This then reifies the norms around that particular group, and reinforces those behavior standards and societal treatment of that group. This phenomenon is perfectly illustrated by the construction of adolescence and subsequent reorganization of societal and legal norms around that concept, which reinforced the expected behavior norms of that group. The dominant narrative of the irresponsible, immature adolescent can subtly inform way adolescents think about themselves, and consequently their behavior.

The looping effect is apparent when applied to adolescents. Anne Solberg, a Norwegian sociologist who argues that childhood is a social construction, uses the term “social age” to describe how children of the same age are considered “older” and “younger” based on a number of factors.⁶⁷ She specifically focused on the designation of twelve-year-olds as “big” or “little” based on their role in the family and how many responsibilities they were given. A twelve-year-old who contributes to household chores and is given a monetary allowance occupies a more socially adult role than another twelve-year old who does not do chores and does not manage her own money. Their roles are created due to beliefs of their parents about their social age, and then reinforced through their behavior in those roles. Children are perceived as

⁶⁷ Anne Solberg, “Negotiating Childhood: Changing constructions of age for Norwegian Children,” in *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood* ed. Allison James et. al (London: UK Falmer Press, 1990) 123-140.

older or younger in their families because of the responsibilities they have, which are given or not given by their parents because of perceptions of their social age.⁶⁸ This does not discount the fact that twelve-year-olds can naturally have variant levels of emotional and physical development. Biology may influence the social role they occupy, but parental treatment can serve to further reinforce their classification as “big” or “little”. Twelve-year-olds can be perceived as adolescents or children depending on their social role, and that designation is reflected in their behavior.

As adolescence was constructed and accepted, the behavior of the people who occupied that position changed alongside altered norms, and the social construction became reality. The category of adolescence enforced adherence to norms, which were further cemented by that adherence. The fact that something is socially constructed has no bearing on its effects. For example, it is accepted that race is socially constructed within cultural contexts as opposed to a genetic reality, but the effects of racism are certainly real and systemic. Though we have seen that the concept of adolescence, and hence the stigma against adolescent sexuality, is socially constructed, it certainly has real effects on the members of that category. Where distinguishing socially constructed concepts from biological facts is helpful is in the realization that socially constructed concepts are not fixed across time periods or cultures, and therefore are subject to further evolution. The

⁶⁸ Ibid., 130

objective of this broad analysis of historical and cultural permutations of adolescence and its socially constructed nature is to demonstrate that both the concept of adolescence and the taboos against adolescent sexuality have varied drastically throughout history in accordance with the cultural, social, and economic climate of the times. Though these norms seem thoroughly embedded, in reality they are not permanent, which indicates that changing them to facilitate healthier attitudes about adolescent sexuality is possible.

Alice Schlegel in “A Cross Cultural Approach to Adolescence” analyses a broad selection of cultures’ approach to adolescence. Her analysis places the development of sexuality at the center of adolescence’s purpose. She argues that the permissibility of adolescent sexuality in each society varies with the “consequences of these activities for the adults who are responsible for them”.⁶⁹ Schlegel’s assertion supports the claim that constraints on adolescent sexuality are constructed in accordance with the possible social consequences of sexuality. This analysis challenges present day conceptions of adolescent sexual activity as a risk behavior, when its risks can be mitigated through modern technologies, an idea which I will expand upon in the next chapter.

Within my research, I encountered a few challenges that further capture the socially constructed nature of adolescence. Although all individuals experience the biological process leading to reproductive maturity,

⁶⁹ Alice Schlegel, “A Cross-Cultural Approach to Adolescence,” in *Adolescent Identities: A Collection of Readings* ed. Deborah L. Browning (New York: The Analytic Press, 2008) 31.

the “adolescent social stage”⁷⁰ is experienced differently across time periods and cultures. Verne Bullough, in his article “Sex in Adolescence: Trends and Theories from Ancient Greece to the present” outlines a common problem present in the historical study of adolescence that persists today: the lack of clear definition of age in historical primary sources. Past cultures did not always state explicitly subject’s ages in art or literature, making it difficult to know which works concern the subject of adolescence specifically. This illustrates the ambiguity of adolescence in the past but complicates present-day study of it. Bullough sums up the ever-changing nature of adolescence as follows: “It is probably best, therefore, to think of adolescence as an ongoing process of reorganization rather than giving it an age date for completion.”⁷¹ The variable ways that adolescence is defined has been one of the greatest challenges in researching this thesis. Although many studies consider adolescence to be equivalent to the teenage years, ages 13 to 19, different sources cited throughout this thesis have defined young adolescence as beginning as early as age 10, and ending as late as age 21. Especially when discussing adolescent sexuality and pregnancy, the metrics used to define adolescence are important, as a thirteen year old inhabits a completely different stage of development and social context than a nineteen year old. Remaining mindful of this, I have cited the age ranges used in the studies as

⁷⁰ Bullough, “Sex in Adolescence: Trends and Theories from Ancient Greece to the Present,” 1.

⁷¹ Bullough, “Sex in Adolescence: Trends and Theories from Ancient Greece to the Present,” 4.

often as possible. Although this issue complicates a discussion of adolescence, it also reinforces my core argument that conceptions of adolescence are not static, but fluctuate according to and within their context.

I have now shown that present day norms of adolescence in the United States were formed in response to ideas that we now do not explicitly accept. These ideas continue to govern our concept of adolescence, and thus influence thinking and policy today. It is important to recognize and question the context of these norms in order to realize that they are not static. Society was reorganized in accordance with this view of adolescence, and the institutional acceptance of these ideas has served to cement these views. My argument is not that these views are necessarily bad and in need of complete overhaul, but that perceptions of adolescent sexual behavior and characterizations of adolescents as immature are often reinforced by existing preconceptions of adolescents.

The arguments contained within the next three chapters rely on the normative definition of adolescence described in Part i. of this chapter that I have so closely questioned. Although this definition is reinforced by science and psychology, I am aware that it is not without strong elements of social construction. My objective in this chapter was to highlight that the group we now call “teenagers” has occupied different roles over time, emphasizing that views of adolescent sexuality and pregnancy are entirely context dependent. Moving forward, I will focus on contemporary context, using a normative

view of adolescents, because this definition is what mainstream society has relied on to develop the policies and regulations that now govern adolescent sexual behavior and contraceptive access.

CHAPTER II INVISIBLE BARRIERS: TEEN SEXUAL HEALTH IN THE UNITED STATES

My previous chapter highlighted the origins of adolescence and norms around adolescent sexuality and pregnancy. These norms evolved out of a tangle of Victorian era ideas about sex, race, gender, and economics, as well as concerns about adolescent pregnancy disrupting a narrative of teen success. In this chapter, I will explore their influence on adolescent sexual health today. Before the age of reliable contraception, engaging in sexual behavior as an adolescent carried a high risk of pregnancy and subsequent early marriage. These days, the existence of safe and effective contraceptive technologies has changed the nature of sex, loosening its link with reproduction. Nevertheless, the dominant attitude towards adolescent sexual behavior is to define it as a risk behavior, and the adolescent pregnancy rate in the United States remains troublingly high, at 34.2/1000 births to adolescent mothers.⁷² The dominant public health discourse positions sex education and contraceptive access as the key to addressing this high rate. This analysis misses the influential role of

⁷² Joyce A. Martin et al., "Births: Final Data for 2010" *National Vital Statistics Reports* 61, no. 1 (2012) accessed 10 October 2013
http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf

social and economic factors on adolescent sexual health. I argue that negative societal perceptions of adolescent sexuality inhibit adolescent sexual healthcare access both directly and indirectly, further reinforcing the idea that teenage sexual behavior is inherently risky. Furthermore, deep inequalities within the United States create circumstances in which some adolescents do not have motivation to delay childbearing, regardless of access. It is clear that existence of contraceptives and STI preventative technologies is not enough. To ensure access to and facilitate use of these resources we must move towards societal acceptance of adolescent sexual behavior and greater economic and social equality.

My aim in this chapter is to highlight the complexities involved in contraceptive access and teen pregnancy prevention, and to argue for an approach that emphasizes changing attitudes towards teen sexuality and actively addresses the role of socioeconomic inequality in adolescent pregnancy. My intent is not to minimize the importance of contraceptive availability, but to argue that the capacity of adolescents to protect themselves from the emotional and physical risks of sex is directly shaped by dominant societal attitudes towards adolescent sexuality. I will demonstrate this through examining research and literature about this issue, focusing primarily on the United States. In my next chapter, I will use my own research from Monte Verde, Costa Rica, to demonstrate that even in a community with freely available contraceptives, stigma against adolescent sexuality ensures that

many adolescents are unable to access these resources. In many cases, stigma against adolescent sexuality creates a barrier that no amount of simple contraceptive or reproductive healthcare provision will allow teens to overcome.

Acceptance of adolescent sexual behavior is critical to adolescent health. In the United States, the median age of adolescent sexual debut is 17.2.⁷³ Yet, fear of promoting teen sex is commonly cited as rationale for withholding information about sexual health. That logic privileges the nebulous moral of virginity over adolescent health, and assumes that it is possible to stop adolescent sexual behavior. Arguing for the acceptance of teen sex does not imply that it is a moral good, and my argument is not in favor of or against teen sex itself. Rather, I argue that adolescent sexual behavior is not inherently harmful or morally wrong; the “goodness” or “badness” of adolescent sexual behavior is entirely dependent on the context and circumstances of the individual adolescents involved. Broad, overarching declarations about teen sexual behavior rarely capture this nuance. I will more fully argue this point in Chapter IV. The focus of discussions on adolescent sexual behavior should be redirected from the act itself to facilitating access to the resources that would mitigate possible risks. Even if sexual behavior *were* unhealthy emotionally or physically, as it can be in some circumstances, even

⁷³ Jacqueline E. Darroch, Susheela Singh, Jennifer J. Frost, “Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use,” *Guttmacher Institute Family Planning Perspectives* 33 (2001) accessed 10 October, 2013 <http://www.guttmacher.org/pubs/journals/3324401.html>

for adults, adolescents should still have the tools to protect themselves from greater harm. Stigma and shame associated with adolescent sexuality encourage secrecy around sex, which inhibits access to sexual health resources and is isolating in cases of exploitation or abuse. Adolescents who do choose to engage in sexual activity should be given every possible chance to protect themselves, and this can only be realistically achieved by a societal shift away from moralization and towards radical acceptance.

Part i.
Is Sex A Risk Behavior for Adolescents?

As I argue for the acceptance of teenage sexual behavior in order to mitigate risk, I must first examine what risks surround teenage sexual behavior. In doing so, it is difficult but important to parse out religious or moral definitions of risk from secular ones. Although religious rhetoric influences many arguments against teenage sexual behavior, persuasive secular arguments against teen sexual behavior certainly exist, and are usually rooted in concern for teens' welfare.

Secular arguments for delaying sex usually fall into one of two categories: physical or emotional. Sexually active adults and adolescents can avoid physical risks, such as pregnancy and sexually transmitted diseases, through use of barrier methods, contraceptive technologies, and consistent reproductive healthcare. Although abstinence is the only 100 percent effective pregnancy and STI prevention method, combining a long-acting

contraceptive, such as the progestin implant, (.05% failure rate with typical use)⁷⁴ with consistent and correct condom use dramatically reduces chances of an unwanted pregnancy or sexually transmitted infection. Sex does involve a small degree of physical risk, but the existence of highly effective contraceptive methods can successfully address these concerns.

The emotional risks of sex are much more complex, and require deeper consideration. Although emotional risks are not limited to teens, teens are often more vulnerable to exploitation and risk taking behaviors. Teens under eighteen are legally considered minors for a reason--it is generally accepted that parental guidance is necessary to protect them from harm. Does it follow, then, that societal acceptance of teen sexual behavior leaves teens more vulnerable to exploitation and emotional harm?

The fact that teens are minors in need of protection and guidance is a strong argument for the acceptance and de-stigmatization of adolescent sexual behavior. Shielding teens from information about sex and discouraging discourse effectively isolates them. Part of the objective of comprehensive sexual education programs should be to teach teens how to recognize and avoid abusive relationships, creating an opportunity for dialogue. When sex is stigmatized within society, sexually active teenagers are forced to conduct their sexual lives in secret. This secrecy makes teens more vulnerable to abuse, as they may avoid getting help from an adult in a bad situation.

⁷⁴ James Trussell, "Review Article: Contraceptive failure in the United States" *Contraception* 83 (2012) 397–404 doi:10.1016/j.contraception.2011.01.021

Furthermore, the lack of foresight and impulsive behavior attributed to adolescence is a very strong argument for making contraceptives and reproductive healthcare as accessible as possible, thus removing barriers to positive decision-making. By accepting the probability that teens will have sex, adults can promote healthy sexual relationships and use of protection through education and dialogue.

The existence of effective contraceptive technologies should result in low teenage pregnancy rates. Unfortunately, relatively high teenage pregnancy rates in the United States show that existing technologies are not being used frequently and effectively.⁷⁵ Some may attribute this to the recklessness of youth, but that rhetoric is dismissive, failing to understand root causes of the discrepancy between availability and use. Using the framework of medical anthropology, an effective analysis must look upstream at the economic, social, and political factors behind adolescent pregnancy.⁷⁶

⁷⁵ Gladys Martinez, Casey E. Copen, and Joyce C. Abma, "Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2006-2010 National Survey of Family Growth," National Center for Health Statistics *Vital and health statistics* 23 (2011) Accessed 20 October, 2013 http://www.cdc.gov/nchs/data/series/sr_23/sr23_030.pdf

⁷⁶ Merrill Singer, "Reinventing medical anthropology: Toward a critical realignment." *Critical Medical Anthropology: Theory and Research* 30(2012):179–187, Accessed 15 November, 2013.

Part ii.
Availability vs. Access: Invisible Barriers

The United States is one of the few industrialized nations in the world without a universal health care system. The United States health care system, which is currently under extensive reform due to the 2010 Patient Protection and Affordable Care Act, operates under a mostly private insurance model. The Affordable Care Act aims to increase health insurance coverage of all citizens. It does so by forcing insurance companies to extend fixed-rate coverage to all citizens, including those with pre-existing conditions.⁷⁷ Under the Affordable Care Act, contraception must be covered free of cost under all insurance plans, although exemptions exist for religious institutions.⁷⁸

Policies on prescription contraceptive availability to minors vary by state.⁷⁹ Twenty-one states explicitly allow minors to obtain contraceptive services without the permission of their parents; twenty-five allow some minors to obtain contraceptive services without parental consent under special circumstances, such as marriage, prior pregnancy, health hazards, high school graduate status, or demonstration of maturity; and four states have no policy or law.⁸⁰ A few states, such as Texas and Utah, also include restrictions on the

⁷⁷ “2012 Adolescent Brain Development: Maturation of the Prefrontal Cortex.” U.S. Department of Health and Human Services: Office of Population Affairs, accessed October 30, 2012.
http://www.hhs.gov/opa/familylife/tech_assistance/etraining/adolescent_brain/Development/prefrontal_cortex/

⁷⁸ Ibid.

⁷⁹ “Minors’ Access to Contraceptive Care” Contracept, last modified December 1, 2005, accessed 15 October 2013, <http://www.contracept.org>.

⁸⁰ Ibid.

use of state funds. No states explicitly ban contraceptive care for minors. Despite the purported availability of contraceptives, the United States has the highest rate of adolescent pregnancy in the industrialized world.⁸¹

Adolescents become pregnant for many reasons. In some cases, teens are not motivated to prevent pregnancy because they are mired in poverty, and fail to see how delaying childbearing would create opportunity. Even if an adolescent does actively want to prevent pregnancy, there are many barriers to contraceptive access, including unavailable or unaffordable contraceptives, lack of education, and more subtle factors such as the stigma surrounding teen sexuality. Practical and societal barriers influence each other: societal attitudes around sex influence the development of policy, and policy then reinforces societal attitudes.

Lack of knowledge due to inadequate sex education is an important contributing factor to the high teen pregnancy rate in the United States. The United States is particularly resistant to the condoning of teen sex that school-based sex education supposedly implies. According to a 2006 report by the Guttmacher Institute, forty-six percent of teen boys and 33 percent of teen girls did not receive any formal instruction about contraception prior to their first time having sex.⁸² About one in four adolescents receives their information about sex from abstinence-only education, which asserts that

⁸¹ Jacqueline E. Darroch, Susheela Singh, Jennifer J. Frost, "Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use," *Guttmacher Institute Family Planning Perspectives* 33 (2001)

⁸² L.D. Lindberg, "Changes in Formal Sex Education: 1995-2002," *Perspectives on Sexual and Reproductive Health* 38(2006):182-189.

abstinence is the only way to protect oneself from STIs and pregnancy, and does not provide information on contraceptives.⁸³ Advocates of abstinence-only education believe that withholding information about birth control will make adolescents less likely to become sexually active.⁸⁴ This idea has not been supported through research. In a large-scale study comparing data between states with abstinence-only or comprehensive sex education, University of Georgia researchers Kathrin Stanger-Hall and David Hall found that states that emphasized abstinence-only education in law and policy had the highest rates of teen pregnancy, even when controlling for other factors such as poverty, education level, and ethnicity.⁸⁵ The lowest teen pregnancy rates were in states with comprehensive sex education programs.⁸⁶ This suggests that abstinence-only education does not correlate with lowered rates of teen pregnancy. No study to date has found that abstinence-only sex education stops adolescents from having sex, and considerable evidence indicates that holistic programs emphasizing risk reduction through contraceptive use are the most successful at preventing pregnancy and STIs.⁸⁷

Abstinence-only education withholds important health information from

⁸³ Ibid., 184.

⁸⁴ Kost, Henshaw, and Carlin, "Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity"

⁸⁵ Stanger-Hall and Hall, "Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S."

⁸⁶ Ibid.

⁸⁷ Sue Alford, "Science and Success: Sex Education and Other Programs that work to Prevent Teen Pregnancy, HIV, and Sexually Transmitted Infections Executive Summary," *Advocates for Youth* (2012), accessed 1 March 2013

<http://www.advocatesforyouth.org/storage/advfy/documents/thirdeditionexecutivesummary.pdf>

adolescents in order to promote the moral ideal of abstinence, implying that deterring adolescent sexual behavior is worth the possible health casualties that may result from lack of information. This negative attitude towards sex influences the information that adolescents receive and perpetuates an intimidating environment for sexually active adolescents.

When a teen is informed enough to seek contraception, accessibility and affordability are additional obstacles. Although the Affordable Care Act provides contraception free of cost to the insured, one must be able to access a doctor's office or clinic to take advantage of it. Though teens can access contraceptives when they have coverage under their parents' insurance, they may be deterred from doing so because of privacy concerns related to insurance billing practices. Though doctors' visits are confidential, insurance companies routinely send out an explanation of benefits, including services received, after each visit or prescription to the primary policyholder.⁸⁸ According to the Guttmacher Institute, this practice impedes adolescents from accessing these services.⁸⁹ If a teen does not want her parents to know she is sexually active, she must schedule doctors' or clinic appointments around school hours, find transportation, and pay for a visit without alerting her parents. Ideally, of course, teens will feel comfortable discussing contraceptive needs with the adults in their lives, but this is often unrealistic.

⁸⁸ Abigail English, Rachel Benson Gold, Elizabeth Nash and Jane Levine. "Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies," *Guttmacher Institute* (2012). <http://www.guttmacher.org/pubs/confidentiality-review.pdf>

⁸⁹ *Ibid.*

Parental attitudes toward teen contraceptive use vary widely, but even in cases where parents are accepting of their teen's sexual activity, it can be difficult for the teen to initiate an open discussion. An adolescent informing a parent that they are sexually active marks a symbolic move towards autonomy and a separate adult reproductive life and the independence that accompanies that. Teens may feel embarrassed to discuss sex with a parent because it violates implicit US norms about parent-child social roles.

Without a doctor's visit, the methods of contraception available for teens to purchase at the drugstore include male and female condoms, spermicides, the sponge, and emergency contraception. These methods, although useful especially in cases of infrequent sexual activity, are less effective and have a higher likelihood of user error than prescription methods, and are prohibitively expensive for teens who are regularly sexually active.⁹⁰ In April 2013, a federal court ordered that a levonorgestrel-based emergency contraceptive pill, "Plan B", be made available over the counter to girls under seventeen, when it had previously been available to teens only by prescription.⁹¹ The FDA originally called for this measure in December 2011 after a careful review of safety and efficacy concerns, but the US Health and Human Services secretary Kathleen Sebelius overturned it, citing additional caution. President Obama supported her decision, releasing a statement that

⁹⁰ Trussell, "Review Article: Contraceptive failure in the United States," 398.

⁹¹ Jessica Dye, "U.S. judge widens 'morning-after' pill access for young girls," *Reuters*, April 5, 2013, accessed 15 April 2013, <http://www.reuters.com/article>.

said "as the father of two daughters, I think it is important for us to make sure that we apply some common sense to various rules when it comes to over-the-counter medicine."⁹² In the 2013 ruling, the Judge Edward Korman stated that Sebelius' decision was based on political, not safety, concerns, calling it "arbitrary, capricious, and unreasonable."⁹³ Reproductive rights interest groups praised the court's decision. At this time, the government has not challenged the ruling, which means that it will go into effect on May 6th, broadening over the counter contraceptive options for adolescent girls. Still, drugstore options, though they may be the easiest to access, are not the most effective contraceptive methods or the best for teenage girls.⁹⁴

Although most sexually active teens have used contraceptives at one time, maintaining continuous use is a particular problem for adolescents.⁹⁵ In response to this issue, 2012 guidelines from the American College of Obstetricians and Gynecologists state that long-term reversible contraceptives, such as the implant or IUD, are the best choice for teen girls and first-time contraceptive users.⁹⁶ Though these methods are more invasive than the Pill, requiring a doctor's visit to insert the device, they are the most effective methods overall, carry no risk of user error, and are safe for teen use.

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Trussell, "Review Article: Contraceptive failure in the United States," 398.

⁹⁵ Martinez, Copen, and Abma, "Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2006-2010 National Survey of Family Growth," 22.

⁹⁶ "IUDS and Contraceptive Implants Safe for Teens," The American Congress of Obstetricians and Gynecologists, last modified September 20, 2012, accessed April 20, 2013, http://www.acog.org/About_ACOG/News_Room/News_Releases/2012

However, if a teen cannot use insurance, these methods are prohibitively expensive, requiring a large payment up front. Out of pocket, the ParaGard IUD with all associated medical expenses costs \$500 to \$1,000 at Planned Parenthood, and requires a preliminary and follow-up appointment in addition to insertion, effectively placing it out of reach for teens without parental support.⁹⁷ Because of these issues, the best methods for teens are unfortunately the least accessible. Furthermore, determining which type of contraception works for an individual's body and lifestyle is sometimes a long process, and teens may stop using one type of contraception because of frustration over side effects and be unable to obtain another easily.

Societal attitudes towards adolescent sexuality are reflected in the controversy around sex education and contraceptive accessibility in the United States. However, the social factors that inhibit contraceptive use are much more complex and subtle than issues of availability. Stigma and shame around sexuality create invisible barriers to accessible sexual healthcare. The rhetoric around sexually transmitted infections effectively illustrates this. The stigma surrounding sexually transmitted infections produces the idea that STI carriers must be a distinct type of individual. This can be seen in the language surrounding STIs—"clean" is synonymous with STI-free. Because of this, people often feel a false sense of safety when engaging in sexual relations without protection because they believe their partners must not be that

⁹⁷ "IUD," Planned Parenthood, accessed April 20, 2013, <http://www.plannedparenthood.org/health-topics/birth-control/>.

supposed type. Furthermore, once someone contracts an STI due to this mode of thinking, he or she often neglects to seek screening and treatment for fear of incurring stigma.⁹⁸ Although many STIs are easily treatable or manageable, the way in which they are stigmatized directly inhibits patients' willingness to seek sexual health care, resulting in the further spread of STIs. This is a simple example that demonstrates the role of stigma in sexual health care, even for adults. Imagine the difficulty that an adolescent might face in the same situation, with fewer resources and little support, and the additional burden of hiding her situation from her parents. Given that grim picture, it's unsurprising that a study from the CDC released in 2008 indicated that one in four girls age 14-19 has a sexually transmitted infection, and that prevalence of STIs was 40% among those who self-reported as sexually experienced.⁹⁹

Adolescent girls bear the heaviest burden of shame and stigma. Sociologist Kristin Luker discusses how gender roles and social pressure constrain young people's contraceptive use. She argues that women are at an inherent disadvantage during contraceptive negotiations because of societal expectations concerning female sexuality, and that teens are particularly vulnerable to social pressure.¹⁰⁰ Because of the value placed on female purity, young women must negotiate appearing both sexually desirable and virtuous,

⁹⁸ J.D. Fortenberry, et. al, "Relationships of stigma and shame to Gonorrhea and human immunodeficiency virus screening," *American Journal of Public Health*, 92 (2002): 378-381

⁹⁹ Adam Sonfield, "New Study Points to High STI Rates Among Teens, Major Disparities Among Population Groups," *Guttmacher Policy Review*, 11(2008): <http://www.guttmacher.org/pubs/gpr/11/2/gpr110220.html>.

¹⁰⁰ Luker, *Dubious conceptions: The politics of teenage pregnancy*, 146

which often precludes them from taking an active role in sexual decision-making.¹⁰¹ It is a cultural expectation that adolescent women and men are positioned opposite from one another: young women acting as the gatekeepers of their purity, young men testing boundaries until the woman relents to pressure. To be a “nice girl”, young women therefore must appear as if they are not too prepared for sex, leaving the responsibility of contraception to the male partner, who faces fewer repercussions from an unplanned pregnancy.¹⁰² In addition to practical barriers, teen girls must overcome a lifetime of social conditioning and messaging about sex and womanhood to access contraception, defying the traits that define “nice girls”: passivity, modesty, sexual inexperience, and deference to others.¹⁰³ Teens must also consciously make the decision to put their long-term welfare over temporary pleasure, overcoming the impulsivity often attributed to adolescence. Luker asserts that young women are “caught in a net of double binds,”¹⁰⁴ as they are expected to handle contraceptive responsibilities, yet only be interested in sex as a surrogate for love and intimacy, as a passionate act that occurs when the right guy sweeps them off their feet.¹⁰⁵ Furthermore, in obtaining contraception, young women admit to themselves that they are and will continue to be sexually active, which is difficult if they feel ashamed.

¹⁰¹ Ibid., 147.

¹⁰² Ibid.

¹⁰³ Ibid., 148.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

Adolescents in the United States seeking contraceptives must overcome practical and societal obstacles to access and use. Adolescents are impeded from accessing sexual health services by anxieties stemming from societal shame about sex, especially adolescent sex. This reflects deeply embedded anxieties about adolescent sexuality and is in turn reflected in the high rate of teen pregnancy in the United States. Even progressive approaches towards teen pregnancy prevention frequently take a downstream approach, advocating for the provision of contraceptives and increased sexual education in middle and high schools. Sex education and contraceptive availability are critical to effective prevention efforts. It is apparent, however, that they are not sufficient on their own. For teens to access and benefit from these resources, a radical shifting of ideas around adolescent sexuality is necessary. Education and contraceptive provision should be a part of an extensive strategy that aims for a dramatic shift away from secrecy and shame. With the significant challenges of accessing contraception in mind, a teen must be exceptionally motivated to obtain and use contraception consistently. Adolescents with ambitious educational aspirations are more likely to use contraception than those without.¹⁰⁶ Teens who are most aware of the effect of pregnancy on future opportunity, and who have access to those opportunities to begin with, are most likely to go to the lengths necessary to prevent pregnancy.

¹⁰⁶ Ibid., 144.

Part iii.**Unequal Footing: Race, Class, and Contemporary Adolescent Pregnancy**

Teens who have ambitious aspirations and promising futures are exceptionally driven to overcome barriers to access in order to prevent pregnancy. The opposite is also true: teens without access to opportunities because of their circumstances, and without hope of their circumstances changing, lack incentives to delay childbearing. As I discussed in Chapter I, adolescent pregnancy takes on a different meaning for teens with expected opportunity and those without. For middle and upper class educated adolescents, a pregnancy during teen years disrupts the trajectory to success expected by them and their parents, while those expectations often do not exist for poor adolescents. In privileged families, adolescents are potential—not there yet, but on their way to greatness, defined in this instance as college, a job, marriage, and a family, in that order. A reordering of that sequence has lasting social consequences on the adolescents and their families. Poor adolescents who already lack opportunity face fewer consequences from an early pregnancy, and are therefore much less motivated to prevent pregnancy. Encouraging teen contraceptive use without accounting for the reproductive realities of poor teenagers fails to address the most essential question in pregnancy prevention: does the teen want to prevent pregnancy? An extensive 1995 literature review from the Institute of Medicine illuminated the complex issue of teens' attitudes towards contraceptives. Contraceptive

decision-making is based on a cost-benefit analysis, weighing the social and financial costs of a contraceptive method against the benefits of pregnancy avoidance.¹⁰⁷ The Institute of Medicine report emphasizes that some adolescents, particularly poor adolescents for whom delaying childbearing would not give way to certain opportunity, feel indifferent towards the possibility of becoming pregnant, and thus are unmotivated to use contraception.¹⁰⁸ These data highlight the complexity of adolescent pregnancy, and serve as a caution against oversimplified prevention efforts. Increasing contraceptive access and sex education alone will not encourage young women to delay childbearing. Young women will only delay childbearing if they can clearly see the benefits.

Significant research has demonstrated the connection between poverty and teen childbearing. But independently of poverty itself, income inequality is a substantial factor in adolescent childbearing, especially in the United States. A study by economists Melissa S. Kearney and Phillip A. Levine looking at inequality across states finds that teens in states with the most significant income inequality are more likely to give birth than those in states with more equal income.¹⁰⁹ The authors argue that income inequality creates a

¹⁰⁷ “Personal and Interpersonal Determinants of Contraceptive use” in *The Best Intentions: Unintended Pregnancy and the Well-being of Children and Families*. (Washington, DC: The National Academies Press, 1995), 164.

¹⁰⁸ Ibid.

¹⁰⁹ Melissa Schettini Kearney and Phillip B. Levine, “Why is the Teen Birth Rate in the United States so High and Why Does it Matter?,” *National Bureau of Economic Research*, (Cambridge: 2012). Accessed 10 April 2013.
http://www.nber.org/papers/w17965.pdf?new_window=1.

profound sense of economic immobility, and therefore teens not believe that delaying childbearing would help to achieve economic stability. The authors point to the research discussed in Chapter I, which demonstrates that adolescent mothers fare no worse than their childless counterparts when they are in poverty to begin with. This article illuminates the inefficacy of concentrating narrowly on contraceptive and sex education provision when discussing adolescent pregnancy prevention, and the necessity for broader societal reforms.

Poor mothers, particularly poor mothers of color, also face discrimination that cannot be fully avoided by delaying childbearing. Middle and upper class teen girls, particularly if they are white, will become women whose reproduction is celebrated and encouraged in the dominant discourse. Conversely, the childbearing of poor women, especially those dependent on welfare, is subject to criticism whether they are teens or adults. This is exemplified in some movements to eliminate welfare programs, which argue implicitly that poor women potentially dependent on welfare should not have children. Conversely, wealthy women can, and are often encouraged to, employ any means necessary to have children, even taking an alternative (and expensive) path to childbearing in the event of fertility issues. This stratification of reproduction¹¹⁰ has been historically enforced through the forcible or coercive sterilization of poor women of color and teenage mothers,

¹¹⁰ Faye D. Ginsburg, and Rayna Rapp, eds. *Conceiving the new world order: the global politics of reproduction* (Berkeley: University of California Press, 1995)

which still happens today in some parts of the world.¹¹¹ In the United States, this rhetoric is hardly subtle: in 2008, a Republican congressman named John LaBruzzo proposed a program that would pay poor women 1,000 dollars in exchange for undergoing permanent sterilization.¹¹² He developed this program in response to concerns that people receiving government aid are having more children than the affluent, educated population, contributing to a generational reliance on welfare. The program would also offer tax incentives for affluent, college educated couples to have more children, privileging of one type of parent over another.¹¹³ Poor adolescents are not likely to gain societal validation for their parenting choices whether or not they delay childbearing. In this way, the meaning of adolescent motherhood changes with its context and circumstance. Though an unplanned pregnancy may damage the narrative of an upper class teen, disadvantaged adolescents do not have that same narrative. This emphasizes the significant role of economic and social circumstances in adolescent pregnancy.

As this research and that in Chapter I demonstrate, adolescent pregnancy is a symptom of poverty, not a cause. In addition to barriers to sexual healthcare access created by stigma and shame, an unequal society creates conditions that cause some teens to feel ambivalence about whether or

¹¹¹ Kim Severson, "Thousands Sterilized, a State Weighs In," *The New York Times*, December 9, 2011, accessed 15 April 2013, <http://www.nytimes.com/2011/12/10/us/>

¹¹² Mark Waller, "LaBruzzo Considering Plan to Pay Poor Women 1,000 to have Tubes Tied," *The Times-Picayune of Greater New Orleans*, September, 23, 2008, accessed 22 April 2013, <http://www.nola.com/news/index.ssf/2008/>

¹¹³ Ibid.

not they even want to prevent pregnancy. This emphasizes the influence of society on adolescent sexual health, and generates important questions about the effectiveness of adolescent pregnancy prevention efforts in the absence of radical economic reform. Unfortunately, determining what specific reforms are needed to fight the inequalities that contribute to teen pregnancy is beyond the scope of this thesis. Certainly, reduction of stigma, combined with the policy changes necessary to ensure affordable and accessible sexual healthcare, may limit the effects of poverty on sexual health and adolescent pregnancy. Genuine reproductive justice in the United States, however, cannot be achieved without educational, economic, and racial equality.

In this chapter, I have established that societal factors, including stigma, shame, and inequality, are significant barriers to adolescent reproductive health that must be directly addressed. Unfortunately, instead of targeting these factors, some adolescent pregnancy prevention initiatives use shame as a campaign tool. New York City, as part of a strategy to combat adolescent pregnancy, recently implemented a subway ad campaign featuring photos of crying toddlers with messages like: “I’m twice as likely not to graduate high school because you had me as a teen.”¹¹⁴ The program is supposedly intended to scare childless adolescents into staying abstinent or using contraceptives, but instead suggests a message of shame for adolescent parents and stigma for their children. The ads place the emphasis on teens to

¹¹⁴ Kate Taylor, “Posters on Teen Pregnancy Draw Fire,” *The New York Times*, March 6, 2013, accessed 10 March 2013, <http://www.nytimes.com/2013/03/07/nyregion/city>.

take personal responsibility for their reproductive health outcomes. In response to criticism, the mayor's office stated that it is "'past time' to be 'value neutral' about teenage pregnancy and that it was important to 'send a strong message that teen pregnancy has consequences — and those consequences are extremely negative, life-altering and most often disproportionately borne by young women.'"¹¹⁵ The ads direct attention to the challenges of adolescent parenting, using them as a symbolic cautionary tale, and fail to disseminate any information about how to prevent unplanned pregnancy. Perhaps this heavy emphasis on personal responsibility would be more appropriate in a society where teens already know how to access contraceptives easily, and have the tools to do so, and can see opportunities that are more immediately attractive and possible than teenage parenthood. In a country where so many factors out of adolescents' control constrain their reproductive health and choices, this kind of messaging seems unproductive. The program has come under fire by advocates such as Planned Parenthood, who have emphasized that poverty usually contributes to adolescent childbearing, not the other way around. Haydee Morales, Vice President of Education and Training at Planned Parenthood of NYC, states:

The latest NYC ad campaign creates stigma, hostility, and negative public opinions about teen pregnancy and parenthood rather than offering alternative aspirations for young people...the City's money would be better spent helping teens access health care, birth control,

¹¹⁵ Ibid.

and high-quality sexual and reproductive health education, not on an ad campaign intended to create shock value.¹¹⁶

Emphasizing the potential negative effects of adolescent parenthood has its place in discussion of adolescent pregnancy prevention, but this advertising campaign uses statistics in a misleading way, ignoring long-term studies stating that early childbearing has little effect on a mother's long-term economic status, especially if she is already poor.¹¹⁷ The campaign positions early childbearing as the etiology of inequality, instead of inequality as the etiology of early childbearing. Furthermore, it places an even greater burden of stigma on adolescent parents, using them as the face of a variety of social problems.

Shame has been effective as a tool of behavior change in public health. The exemplary case is the decline in smoking commonly attributed to widespread societal shaming and policy change. Bioethicist Daniel Callahan argues that this should be applied to other public health interventions, particularly obesity. As a former smoker, he feels that “the force of being shamed and beat upon socially was as persuasive for me to stop smoking as the threats to my health.”¹¹⁸ He believes that shame creates a social pressure that can empower individuals to take charge of their own health, encouraging behavioral change, and that individuals will moderate their behaviors in order

¹¹⁶ “Planned parenthood of new york city in the news,” Planned Parenthood, modified March 6, 2013, accessed 10 March 2013, <http://www.plannedparenthood.org/nyc/3-6-13-41037.htm>.

¹¹⁷ Kearney and Levine, “Why is the Teen Birth Rate in the United States so High and Why Does it Matter?”

¹¹⁸ Daniel Callahan, “Obesity: Chasing an Elusive Epidemic,” *Hastings Center Report* 43, no. 1 (2013): 34-40. DOI: 10.1002/hast.114

to avoid stigma. Shame-based campaigns do not make sense, however, when applied to adolescent pregnancy. Campaigns like New York City's stigmatize a condition that is already permanent. Unlike smokers, for whom quitting is possible but difficult, adolescent parents cannot change their parental status through personal willpower. Even if the campaign deters other teens from becoming pregnant, it is not worth making adolescent parents the target of additional shaming and stigmatization. Furthermore, research on abstinence only sex education shows that shame does not deter teens from having sex, but creates barriers to safe sex.¹¹⁹ Finally, as I discuss in the next section, countries with the lowest rates of teen pregnancy do not rely on shame-based messaging to deter teens from sex. Rather, the most successful interventions seem to be ones that offer information and access to contraceptives and place sex in the context of normal development.¹²⁰

Part iv. What Works?: Perspectives from Western Europe

What does a country with a healthy view of teenage sexuality look like? In her book Not Under My Roof: Parents, Teens, and the Culture of Sex, sociologist Amy Schalet argues that progressive societal views surrounding

¹¹⁹ Kathrin F. Stanger-Hall, David W. Hall, "Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.," *PLoS ONE* 10(2011): 1-11.

¹²⁰ L.L. Lottes, "Sexual Health Policies in Other Industrialized Countries: Are There Lessons for the United States?" *Journal Of Sex Research*, 39 (2002): 79-83.

teenage sexuality in the Netherlands contribute to a very low teenage pregnancy rate. The Netherlands is a model country in all facets of sexual health: it has had the lowest rates of unplanned pregnancy, abortion, and teen pregnancy in the western world for many years.¹²¹ In the year 2011, only five out of 1000 births were to adolescent mothers.¹²² Schalet attributes this low rate to the societal acceptance of teenage sexual behavior as normal and natural, which serves to facilitate education and contraceptive access.¹²³ The dominant attitude is that sexual development is a normal and acceptable part of adolescence, not a behavior to discourage.¹²⁴ The lack of stigma is evident in parental attitudes. Schalet states that sexual relationships are the subject of an ongoing conversation between parents and teens, and parents emphasize the importance of being ready for sex, but do not discourage the practice. Nine out of ten Dutch parents interviewed said that they would allow teens to have a sleepover with a boyfriend or a girlfriend in their house.¹²⁵ Schalet argues that this permissive attitude towards adolescent sexual behavior discourages secrecy, which means that teens' emerging sexuality does not become a divisive issue within the family.¹²⁶ The Netherlands also utilizes the mass media in their public health campaign with the specific objective of reducing

¹²¹ Darroch, Singh, and Frost, "Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use," 5.

¹²² Ibid.

¹²³ Amy T. Schalet, *Not Under My Roof: Parents, teens, and the culture of sex* (Chicago: University of Chicago Press, 2011), 9.

¹²⁴ Lottes, "Sexual Health Policies in Other Industrialized Countries: Are There Lessons for the United States?," 81.

¹²⁵ Schalet, *Not Under My Roof: Parents, teens, and the culture of sex*,

¹²⁶ Schalet, *Not Under My Roof: Parents, teens, and the culture of sex*

stigma and emphasizing ethics, open discussion, and responsibility around sex.¹²⁷ These progressive attitudes translate into policy, and clinics are set up specifically to facilitate teenage access. Besides covering costs of reproductive healthcare under the nationalized health system, Dutch clinics employ several strategies to encourage teens to access contraceptives:

[clinics] (b) guarantee anonymity or confidentiality, (c) waive PAP smear and pelvic exams as prerequisites for initial contraceptives, (d) provide nonjudgmental service, and (e) require minimal paperwork and no parental consent¹²⁸

Through studying countries with low adolescent pregnancy rates, the distinction between availability and access is made clear. In the United States, contraceptives are available to adolescents, but stigma against adolescent sexuality is reflected in both policy and attitudes. In contrast, the Netherlands makes it a priority to erase stigma-related barriers to adolescent sexual health, and encodes that aim into policy. The Netherlands also has uncontroversial abortion, comprehensive sex education, and low economic inequality, which the US has not achieved. Though comparisons can be drawn between these countries, the Netherlands is very different from the United States, and from Costa Rica, which I discuss in my next chapter. However, it provides a concrete example of the link between societal acceptance of teenage sexual behavior and improved adolescent reproductive health outcomes.

¹²⁷ Lottes, "Sexual Health Policies in Other Industrialized Countries: Are There Lessons for the United States?," 80

¹²⁸ Linda Berne, and Barbara Huberman. "European approaches to adolescent sexual behavior & responsibility: Executive summary and call to action." *Washington, DC: Advocates for Youth* (1999).

A comprehensive report entitled “Sexual Health Policies in Other Industrialized Countries: Are There Lessons for the United States?” supports the view that countries with more progressive attitudes about sex have much lower rates of adolescent pregnancy and STIs.¹²⁹ In the three countries studied, Germany, the Netherlands, and France, the approach to adolescent sexual health was based on the values of “rights, responsibility, and respect”,¹³⁰ and avoids promoting negative ideas about sex and sexuality.

Government and the general society consider it not only a duty to provide accurate information and confidential contraceptive services to the young, but also that provision of such services and information to adolescents is part of their rights. There is no attempt to motivate behavior of teenagers through a collective effort to demand abstinence. Thus, the goal is not to prevent adolescents from having sex but to educate and thereby empower them to make responsible decisions. By respecting the independence and privacy of adolescents the expectation is that, in return, the majority will act responsibly to try to avoid pregnancy and STDs. The more tolerant attitude toward sexual expression of teenagers also makes it easier for them to get the services they need. Teenagers do not have to feel guilty or ashamed of using contraceptives. In fact, they will more likely feel they have been irresponsible if they fail to use it.¹³¹

A non-shaming attitude towards sexual behavior does not mean that there are no moral standards around sex, simply that the act of sex itself is not morally weighted. In these model countries, the government believes that the duty to protect the country’s youth includes a duty to protect their sexual health. This principle, which I argue for in my final chapter, is crucial to a successful teen

¹²⁹ Lottes, “Sexual Health Policies in Other Industrialized Countries: Are There Lessons for the United States?”, 80.

¹³⁰ Ibid.

¹³¹ Ibid.

pregnancy prevention model. Reports from countries with low rates of adolescent pregnancy suggest that adolescent pregnancy prevention will only be successful through promotion of positive attitudes towards teen sexuality.

There is a clear relationship between social stigma and concrete barriers to adolescent reproductive health access. Negative attitudes towards teen sexuality affect the development of policies, which in turn reinforce these negative attitudes. When a teenage girl becomes pregnant from unprotected sex she is pointed to as an example of negative outcomes resulting from adolescent sexual behavior. This is an oversimplification of the issue: if an adolescent cannot access sexual health care because of fear of shame, the negative consequences of her sexual behavior are resultant from that societal attitude of shame that inhibits her access, not from her sexual behavior itself. With the use of modern contraceptive and STI prevention technology, adolescent sex is not an inherently risky or negative behavior, but it is still treated as one in the United States. The treatment of teen sexuality as a negative behavior is reflected both in formal policies governing access and in attitudes of teens towards their own sexualities. Through analysis of attitudes around sex, particularly adolescent sex, in the United States, the reasons for high adolescent pregnancies and STI rates are complex but clear.

The United States is a highly stratified society rife with economic and social inequality. This socioeconomic immobility means that delaying childbearing will not improve the circumstances of many young women. In

addition to this unequal footing, attitudes about sex are confusing: sexually transmitted diseases and unplanned pregnancies are treated as punishments for bad behavior, but teens are also stigmatized and shamed for trying to protect themselves. Highly unrealistic portrayals of sex are being packaged, commodified, and sold on every TV screen in the nation, and yet adolescents are told that sex is a harmful and dirty practice unless it is validated by marriage. If adolescents are to develop a healthy sexuality within society, the societal view of sexuality must be healthy. There is a long road ahead towards achieving these goals, but as I will show in my next chapter through research in Costa Rica, contraceptive provision will be ineffective against high teen pregnancy rates if it is not combined with shifting beliefs around adolescent sexuality. There are two categories of steps that that societies must take to address this issue. The tangible steps--education reforms and policies promoting increased contraception access--seem simple compared to the more subtle, difficult to achieve steps--profound shifts in societal attitudes and reduction of socioeconomic and racial inequality. Although these objectives are daunting, working towards them is paramount to the happy and healthy development of the next generation. In my final chapter, I will make recommendations on where to start.

CHAPTER III

MAS QUE TODO ES LA SOCIEDAD: A CASE STUDY FROM MONTE VERDE, COSTA RICA

The case of Monte Verde, Costa Rica illustrates perfectly the influence of societal barriers on adolescent sexual health. In Costa Rica, free contraceptives are available at government-run clinics as part of an excellent healthcare system, and yet 55/1000 births are to mothers 15-19 years old.¹³² Available contraceptives and comprehensive sex education are integral parts of a strategy to combat unwanted teenage pregnancy, but adolescents face sometimes insurmountable barriers to benefitting from these services. In Monte Verde, the chasm between availability and accessibility is apparent. My interview participants discussed the role that society plays in impeding contraceptive access and then condemning the adolescent pregnancies that result. The limited success of Costa Rica's free contraceptive access on reducing teen pregnancy rates demonstrates the complexity of adolescent pregnancy and the myriad ways in which the issue is intertwined with political, societal, and cultural factors that cannot be addressed only through a

¹³² United Nations Statistics Division, "Table 10: Live births by age of mother and sex of child, general and age specific fertility rates: latest available year." *Demographic Yearbook 2009 – 2010* (New York, NY: United Nations, 2011). <http://unstats.un.org/unsd/demographic/products/dyb/dyb2009-2010.htm>

biomedical approach. This research serves as a case study for the central argument of my thesis: that societal barriers inhibit adolescent sexual health access, and thus must be directly addressed.

Part i.
Background on Costa Rica and the Monte Verde Zone

Reproductive Health Care in Costa Rica: A General Overview

Costa Rica has a strong peaceful democratic tradition, an advanced healthcare system, and a relatively high life expectancy of 79 years. Because of this among other factors, the country rates highly on the human development index, a measurement meant to denote quality of life developed by the United Nations World Development Programme.¹³³ Costa Rica's health care system comes in right before the United States' at number 36 in the 2000 World Health Organization healthcare system rankings.¹³⁴ Costa Rica employs a system of universal public health care, commonly known as the *Caja*, or *Caja Costarricense de Seguro Social*.¹³⁵ By law, the government must provide free healthcare to all of its legal residents and citizens, including contraceptive coverage. Costa Rica's healthcare system is divided into three

¹³³ United Nations World Development Programme, "International Human Development Indicators", 2011, accessed 10 October 2012 <http://hdr.undp.org/en/statistics/>

¹³⁴ World Health Organization, "World Health Report 2000," (Geneva, Switzerland, 2000) accessed 5 October, 2013 http://www.who.int/whr/2000/en/whr00_en.pdf

¹³⁵ María del Rocío Sáenz, Juan Luis Bermúdez, and Mónica Acosta, "Universal Coverage in a Middle Income Country: Costa Rica" *World Health Background Report* 11 (2010) accessed 20 October 2012 http://www.who.int/whr/2000/en/whr00_en.pdf

levels of care.¹³⁶ At the first level are around 947 basic clinics, one for every 400 to 3,500 residents, which provide basic healthcare, including reproductive healthcare. At the second level are major clinics, peripheral hospitals, and regional hospitals, which provide care for emergencies, minor surgeries, and other specialized care. The third level is comprised of large national hospitals and specialized hospitals, which provide high technology treatments and major surgeries.¹³⁷

In theory, contraceptive care is quite accessible for Costa Ricans. Data from the *Primera Encuesta Nacional de Percepción de Los Derechos Humanos de Las Mujeres en Costa Rica* indicated that 74.7% of Costa Ricans stated that they have “easy access” to contraception.¹³⁸ At their town *clínicas*, Costa Rican citizens can access the following contraceptives free of charge:

male condoms, intrauterine devices (Copper T 380A), oral contraceptives (Norgyl® y Norgylen®) and injectable contraceptives (Depo-provera®) and surgical contraception (Salpingectomy).¹³⁹

Adolescents are legally able to obtain free contraceptive pills and condoms at the clinics through an appointment with a doctor.¹⁴⁰

¹³⁶ Ibid.

¹³⁷ Ibid.

¹³⁸ Instituto Nacional de Las Mujeres “Primera Encuesta Nacional De Percepción de Los Derechos Humanos de Las Mujeres en Costa Rica” 16(2008) accessed 3 November 2012, http://www.inamu.go.cr/index.php?option=com_content&view=article&id=1195&Itemid=1738

¹³⁹ CAJA COSTARRICENSE DE SEGURO SOCIAL DIRECCIÓN DE FARMACOEPIDEMIOLOGIA COMITÉ CENTRAL DE FARMACOTERAPIA “Lista Oficial de Medicamentos 2008” accessed 2 March, 2013 <http://www.binasss.sa.cr/libros/lista2008.pdf>

¹⁴⁰ Irene S. Rodriguez, “Vergüenza y Falta de Acceso: Los Obstáculos de la Anticoncepción,” *La Nación*, 11 June 2012, accessed 4 October 2012.

Birth rates in Costa Rica have declined sharply in the past few decades. In 1988, the average fertility rate per woman was 3.3 children, compared with only 1.8 children in 2011.¹⁴¹ The TFR decline is consistent with rapidly shifting family dynamics throughout the country, including the rise of divorce and female-headed households. While the total fertility rate has declined, adolescent fertility rate still remains quite high, at 55.1 per 1000 births to adolescent mothers in 2010.¹⁴² A 2011 joint report from the United Nations Committee on the Elimination of Discrimination Against Women highlighted potential barriers that Costa Rican women face when managing their fertility. The *Caja's* contraceptive offerings are not as comprehensive as the offerings of private pharmacies, which may influence rates of contraceptive use. The oral contraceptive pill formulations offered are an older formulation of combined pill (estrogen and progestin) that lack the advances of more recent formulations.¹⁴³ Furthermore, women are unable to use estrogen-based contraceptive methods while breastfeeding, limiting their post-natal temporary contraceptive options to condoms or the Depo-Provera shot.¹⁴⁴ Surgical female sterilization, which became available on demand in

<http://www.nacion.com/2012-06-11/Portada/Verguenza-y-falta-de-acceso--los-obstaculos-de-la-anticoncepcion.aspx>

¹⁴¹ World Bank “Fertility Rate, total (births per woman)” accessed 15 October 2012.

<http://data.worldbank.org/indicator/SP.DYN.TFRT.IN>

¹⁴² United Nations Statistics Division, “Table 10: Live births by age of mother and sex of child, general and age specific fertility rates: latest available year.”

¹⁴³ Mónica Arango Olaya et. al, “Supplementary Information on Costa Rica Scheduled for review by the CEDAW Committee in its 49th Session” United Nations Committee on the Elimination of Discrimination Against Women 25 May 2011, accessed 5 March 2013. http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/JointNGORepor_CostaRica49.pdf

1999, is the most popular contraceptive method in Costa Rica (29.6%).¹⁴⁵ Second and third are oral contraceptives (21%) and injectable contraceptives (3.4%).¹⁴⁶ These data has implications for adolescent contraceptive use, as nulliparous minors are not permitted to use injectable methods or sterilization. Therefore, their options are limited to combined oral contraceptive pills, which some women cannot tolerate, and condoms. Rates of condom use are relatively low, especially among adolescents. Although 90% of people surveyed had used a condom at some point, only 43.7% of girls and 66.1% of boys aged 15 - 19 years had used one the last time they had sex.¹⁴⁷

Perhaps the most detrimental policy to reproductive health in Costa Rica is the dual issue of unavailable emergency contraception and illegal abortion. Abortion is illegal, though a provision was made in 1971 that does not make abortion a punishable offense if the woman's life or health is in danger. Legal access is almost impossible even under those circumstances, since Costa Rica does not have guidelines for doctors about abortion care, nor a judicial procedure for women to access abortion services (as of May 2010).¹⁴⁸ Each year in Costa Rica an average of five abortions are performed

¹⁴⁵ Fondo de Población de las Naciones Unidas (UNFPA) Costa Rica, "Salud presenta resultados de la encuesta nacional de salud sexual y reproductiva" 23 March 2011, accessed 5 March 2013. <http://www.unfpa.or.cr/actualidad/3-actualidad/537-salud-presenta-resultados-de-la-encuesta-nacional-de-salud-sexual-y-reproductiva>

¹⁴⁶ UNFPA Costa Rica "Salud presenta resultados de la encuesta nacional de salud sexual y reproductiva"

¹⁴⁷ Instituto Nacional de Las Mujeres "Primera Encuesta Nacional De Percepción de Los Derechos Humanos de Las Mujeres en Costa Rica"

¹⁴⁸ Arango Olaya et. al, "Supplementary Information on Costa Rica Scheduled for review by the CEDAW Committee in its 49th Session"

legally through the health care system, while an estimated 10,000 are performed illegally outside of the public system.¹⁴⁹ Emergency contraception (Plan B), though not illegal, is completely unavailable in Costa Rica.¹⁵⁰ Because of the dual unavailability of emergency contraception and legal abortion, women have no legal recourse after contraceptive failure or in cases of rape. These issues are especially pertinent to adolescent health care, where accessible emergency contraception has been named as critical in the fight against unwanted pregnancy.¹⁵¹

Although the *Primera Encuesta Nacional de Percepción de Los Derechos Humanos de Las Mujeres en Costa Rica* survey indicates easy access to contraceptives, there are disparities between urban and rural areas, with only 69.8% of women living in rural areas reporting “easy access”. Furthermore, it is clear from the data that there is a missing piece between stated facility of access and knowledge and actual use. In the same survey 52.5% of the population reported that they were not using any form of contraception.¹⁵² Women 18-24, who report both easy access to and very high levels of personal knowledge about contraceptives, state only a 50% rate of use.¹⁵³ As the age of marriage rises and settling down becomes less of a

¹⁴⁹ Ibid.

¹⁵⁰ Ibid.

¹⁵¹ AAP “Policy Statement on Emergency Contraception for Teens” *Pediatrics* 130 (2012) accessed 5 March 2013.

<http://pediatrics.aappublications.org/content/130/6/1174.full.pdf+html>

¹⁵² Instituto Nacional de Las Mujeres “Primera Encuesta Nacional De Percepción de Los Derechos Humanos de Las Mujeres en Costa Rica”

¹⁵³ Ibid.

priority, the likelihood of premarital sex increases, even in a country with strong Catholic influences like Costa Rica.¹⁵⁴ According to the UNFPA report, 22% of boys and 11.2% of girls had first sex before age 15, while 67.9% of boys and 51.4% of girls had sex before age 18.¹⁵⁵ The clear discrepancy between purported access and high teen pregnancy rates (in contrast with low overall birthrates) indicates that Costa Rica's healthcare system is not meeting the sexual health needs of minors.

Sex education is a vital part of a multi-pronged approach to achieve good sexual health outcomes for teens. Costa Rica is in the middle of a protracted political battle about sex education in the schools. As is the case in the United States, the controversy lies at the intersection of religion, emotion, politics, values, and family, and it is complex to unravel. In response to growing concern about teenage pregnancy, the Costa Rican Ministry of Education plans to implement a new comprehensive sexual education program in public schools in 2013.¹⁵⁶ In the summer of 2012, under considerable pressure from Catholic conservatives, the Constitutional Chamber of Costa Rica decided to designate this course as elective within the public schools.¹⁵⁷ However, even with limited public sex education, Costa Rican teens generally

¹⁵⁴ Hilda Patricia Núñez Rivas and Ana Rojas Chavarría "Revisión Conceptual y Comportamiento Del Embarazo En La Adolescencia En Costa Rica, Con Énfasis En Comunidades Urbanas Pobres" *Revista Costarricense De Salud Pública* 7, 38-54

¹⁵⁵ Ibid.

¹⁵⁶ EFE "Chinchilla pide debate sin "radicalización" sobre educación sexual en escuela," *El País*, 2012 accessed 9 October 2013. http://elpais.cr/frontend/noticia_detalle/1/70093

¹⁵⁷ EFE "La educación sexual en Costa Rica será una clase opcional en los colegios. Telenoticias 7" *El País*, 2012 accessed 9 October 2013. http://www.telenoticias7.com/detalle_especiales.php?id=141175

report knowledge of contraceptives methods and where to obtain them, and 79 percent of Costa Rican women aged 15-19 state that they have used a contraceptive method at some time.¹⁵⁸ This knowledge coupled with the purported accessibility and affordability should contribute to a lowered rate of teenage pregnancy, but it clearly does not fully address root causes behind lack of access.

Interviews published in the international Spanish language newspaper *La Nación* reflect the issues that Costa Rican teens face in accessing contraception, which were mirrored in my interviews in Monte Verde. To acquire free pills or condoms, teens must first have an appointment with the free clinic in order to obtain a prescription, and appointments can be difficult to access. A consultant for UNFPA quoted in the article, Oscar Valverde, shares his concerns with the system: "What teenager is going to get up at 5 am to stand in line for an appointment in an Ebais to be given condoms?"¹⁵⁹ Another pertinent concern for teens is the likelihood of seeing an acquaintance at the clinic, a fear that is amplified in small towns such as Monte Verde.¹⁶⁰

The results of several small Costa Rican studies on the reasoning behind contraceptive decision-making presented by Patricia Nuñez, Hilda Rivas, and Ana Rojas Chavarría, including one of 205 adolescents in an urban area, found that 78% of teen girls and 82% of teen boys did not use any

¹⁵⁸ Nuñez Rivas and Rojas Chavarría "Revisión Conceptual y Comportamiento Del Embarazo En La Adolescencia En Costa Rica, Con Énfasis En Comunidades Urbanas Pobres"

¹⁵⁹ Rodriguez, "Vergüenza y Falta de Acceso: Los Obstáculos de la Anticoncepción,"

¹⁶⁰ Ibid.

contraception at first intercourse.¹⁶¹ Their findings about barriers to use reflect Luker's argument about social barriers and gender roles discussed in the previous chapter. In response to questions about why they did not use contraception, teens said that sexual intercourse had been unplanned, and that responsibility was diffused between partners. When contraceptive responsibility falls to the woman, gender roles may constrain access, and when it falls to the man, he faces fewer repercussions from an unplanned pregnancy and therefore may not be as motivated to use contraception. The authors found that young women face difficulties in contraceptive negotiations because of their expected passivity, and this is exacerbated by common age imbalances between partners.¹⁶² This study also found that young women who had grown up with traditional *machismo* familial dynamics had a higher likelihood of becoming pregnant as adolescents, emphasizing the effect of socialization on health outcomes.¹⁶³ Young women also reported a sense of anxiety about future infertility resultant from contraceptive use.¹⁶⁴ Societal constraints such as gender roles and *machismo* clearly play a significant role in adolescent reproductive healthcare access, and this was further reflected in my research in Monte Verde.

¹⁶¹ Núñez Rivas and Rojas Chavarría "Revisión Conceptual y Comportamiento Del Embarazo En La Adolescencia En Costa Rica, Con Énfasis En Comunidades Urbanas Pobres"

¹⁶² Ibid.

¹⁶³ Ibid.

¹⁶⁴ Ibid.

The case of Costa Rica demonstrates the immense power of social and cultural factors in inhibiting contraceptive use, even in a country where contraceptive services are free of cost and legally available to teens. My research in Monte Verde illustrates the actual on-the-ground realities of adolescent contraceptive access, in contrast with the stated policies.

Introduction to Monte Verde

The Monte Verde Zone is located within the Cordillera Tilarán, about a four-hour drive from the Central Valley. Despite its isolated location at the end of a long dirt road, Monte Verde is internationally recognized as a popular ecotourism destination due to the beautiful Monteverde Cloud Forest. The Monte Verde Zone is an umbrella term that refers to several different communities in the “milk shed”, a broad region of about fifteen villages that span two provinces (Puntarenas and Guanacaste), of which the main source of economic activity was formerly the Monteverde Cheese Factory, and is now the ecotourism economy.¹⁶⁵ These communities, which include Santa Elena, Monteverde, Cerro Plano, San Luis, and La Cruz, differ considerably in demographics, economic activities, and lifestyle. In my research, I concentrate mainly on Monteverde and Santa Elena (which I define as both Santa Elena proper and the area spanning the road to Monteverde known as Cerro Plano), where my interview participants and I resided.

¹⁶⁵ Luis A. Vivanco, *Green Encounters: Shaping And Contesting Environmentalism in Rural Costa Rica* (Berghahn Books, 2006), 5

Quaker settlers from Alabama established the village of Monteverde, the area located closest to the Cloud Forest, in 1951. The settlers chose Costa Rica because of its commitment to peace, as they were spurred to leave the United States after four young men were put in prison for their conscientious objector status after refusing to register for the draft.¹⁶⁶ Today, the village of Monteverde is still populated mostly by these original Quaker settlers and their descendants, in addition to many other recent immigrant expats from all over the world, especially Europe and the United States. Because of this, the population in Monteverde is fairly transient, especially the population of researchers who spend part of the year in Monteverde and part elsewhere. Located a 50 minute uphill walk from the majority Costa Rican town of Santa Elena—the commercial hub of the Zone—Monteverde is the focus of most tourist activity and international attention, as it contains the entrance to the Cloud Forest reserve that draws around 70,000 visitors a year.¹⁶⁷ The unique flora and fauna present in the Cloud Forest reserve are the subject of many research and conservation projects, and as a result the (primarily Anglo) residents of Monteverde are usually the international voice for interests of the Zone.¹⁶⁸

¹⁶⁶ Ibid.

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.

Although Santa Elena, home to about 6,500¹⁶⁹ permanent residents, mostly native Costa Ricans, is rarely the headliner in tourist guidebooks about the area, it is the location of the commercial center and most of the tourist attractions apart from the Cloud Forest. Most of the area's restaurants, stores (including a supermarket), hotels, bars, and the public high school, Colegio Técnico Profesional, are located at the center of town. Santa Elena also contains several small, tight-knit residential neighborhoods, and many families in the area have deep roots in the community. A public bus, filled with Friends' School students, cheese factory workers, and tourists alike, connects Santa Elena center to the Monteverde reserve, stopping in Cerro Plano, the neighborhood on the hill that bridges the two towns.

Likely due in part to the abundance of biological research topics, there is a strong academic and educational presence in Monte Verde. Apart from the public school in Santa Elena, there are two popular private schools in the area, which are attended by both international transplants and Costa Rican families. The Monteverde Friends School, a Quaker institution, is located almost all the way up the hill from Monteverde, and The Cloud Forest School is located in Cerro Plano. Both are completely bilingual schools consisting of kindergarten through 12th grade, and most graduates go on to college. Higher education options within Monte Verde cater mostly to visiting students and researchers. The Monteverde Institute, where I studied during my time in Monteverde, is a

¹⁶⁹ Ibid.

research and study abroad institution dedicated to fostering environmental sustainability-focused projects and community engagement. It hosts programs of various lengths for graduate and undergraduate students in different disciplines, and also serves as a home base for biological science and social science researchers. University of Georgia has a campus in San Luis, a more rural part of the Monte Verde Zone, dedicated to scientific and environmental research. There are several other study abroad programs in the area, including some Spanish-language immersion institutes. Monte Verde also attracts many biologists interested in studying the unique species endemic to the area.

The Monte Verde zone is an excellent microcosm of the enormously successful Costa Rican ecotourism economy. Martha Honey, in her 2008 book “Who Owns Paradise?” explores and raises critiques about the effect of the ecotourism economy on the Costa Rican people. Beyond its natural beauty, Costa Rica’s booming tourism economy is supported by several other factors: the country’s democracy, political stability, and respect for human rights. Costa Rica’s high standard of living, stemming from its large middle class, universal health care and public education, and focus on conservation, combined with a welcoming attitude towards foreigners, make it a comfortable and attractive destination for conscientious tourists.¹⁷⁰

Monte Verde has struggled to maintain balance among the good and bad effects of the ecotourism industry. Though the ecotourism trade is

¹⁷⁰ Martha Honey, *Ecotourism and Sustainable Development, Second Edition: Who Owns Paradise?* (Island Press, 2008), 160.

profitable, it has narrowed residents' options.¹⁷¹ The focus on conservation has created new opportunities, as guides, business owners, and ecologists, for young people who wish to stay in Monte Verde.¹⁷² However, jobs outside of the tourism trade that once dominated the Monte Verde economy, such as farming, are now economically unsustainable, and Monte Verde's economic stability is dependent on the fickle whims of international tourism. Furthermore, gaps in social and economic equality, as well as the sometimes clear divide between the Quaker and Costa Rican community, have widened due to the tourism trade.¹⁷³ Cost of living has increased substantially as English-speaking professionals and academics are drawn to Monteverde by the business and research opportunities and bilingual culture.¹⁷⁴ Farmers, some of whom have had land in their family for generations, are pressured to convert their land into eco-businesses or sell it because farming is no longer profitable. Outside developers without an understanding of the community, seeing a business opportunity, have created eco-hotels or expensive restaurants that specifically cater to tourists, which Monte Verde residents must work in to support their families.¹⁷⁵ The way the tourism industry has augmented inequality is illustrated by a three-year study from the Monteverde Institute that suggests a strong link between food insecurity and the tourist economy. The study points to more frequent consumption of processed

¹⁷¹ Ibid.,190.

¹⁷² Ibid.

¹⁷³ Ibid.

¹⁷⁴ Ibid., 188.

¹⁷⁵ Ibid., 190.

convenience foods by tourist industry workers, due to the time constraints imposed by the long hours required of the industry. Furthermore, although hours and wages for tourism workers fluctuate dramatically by season, the cost of food remains static, which creates feelings of anxiety around obtaining food in the off seasons.¹⁷⁶

Monte Verde has several different public and private options for medical care, the most popular of which is the public Clínica Santa Elena. There is also a Red Cross outpost, an emergency clinic, and two private physicians, one specializing in Gynecology. Additionally, there is one private pharmacy, Drugstore Vitosi, and an alternative natural medicine shop specializing in women's health, Macrobiótica Mundo Saludable, which closed in late 2012 and is now run out of the owner's home. More serious or complex medical issues, such as surgeries or childbirth, require transportation to the larger regional hospital, about two hours away in Puntarenas, and very specialized issues may require transportation to San José.

Throughout my time in Monte Verde, I got the sense that Monte Verde is a particularly challenging place to be an adolescent. Conversations with parents of adolescents revealed that Monte Verde lacks a space for teen recreation and extracurricular activities beyond the local bars. Community leaders have noted this deficiency and have tried to address it with summer

¹⁷⁶ David A. Himmelgreen et. al, "'The Tourist Season Goes Down But Not the Prices.' Tourism and Food Insecurity in Rural Costa Rica," *Ecology of Food and Nutrition* 4 (2006).

camps and other programs. There are also few job opportunities outside of the tourist trade. Parental supervision is often difficult and uneven due to the long hours required of jobs in the tourist trade during the season. These issues combined with the small-town atmosphere of Monte Verde are a concern to parents of adolescents, who believe that teen boredom and frustration encourage activities such as drinking and sexual activity.

My project would not have been possible without the incredible supports already in place due to the academic community, the Monteverde Institute, and the welcoming and kind attitude of Monte Verde residents towards student researchers. Participants were willing and eager to share their nuanced understanding of the issues facing adolescents in the zone, and I am grateful to them for their patience and kindness towards me throughout my project.

Part ii.
Community Perceptions of Adolescent Contraceptive Access in the Monte Verde Zone

Research Objectives

My research project, titled “Community Perceptions of Adolescent Contraceptive Access in the Monte Verde Zone” was intended to explore factors behind high rates of teen pregnancy in the Monte Verde Zone despite purported access to contraceptive technologies. I decided to do a research project in Monte Verde based on conversations with Dr. Lynn Morgan, a Mount Holyoke professor of medical anthropology with extensive research

experience in Costa Rica. When I arrived in Costa Rica, my research topic evolved further based on extensive consultation with Dr. Kate Brelsford, a resident medical anthropologist and public health researcher, and Jeny Peña, the Monteverde Institute's director of public health. Through these conversations, I learned that the community has identified adolescent pregnancy as significant issue of community concern. My objective was to develop a study that would begin gathering information about this issue that would be of some use to the community. My research is intended to continue the conversation about barriers to access contraceptives for adolescents, and to gain some perspectives on teen contraceptive access, pregnancy, and parenting from a small sample of adults in the community.

Methods

I lived with a host family in Santa Elena from January to May 2012 while studying at the Monteverde Institute. After deciding on my research topic, I began developing my survey. I aimed to develop a short survey with several open-ended interview questions to initiate a conversation, and several questions to gather basic quantitative information about community and personal opinions surrounding contraceptives. The survey I developed, entitled *Percepciones de la Comunidad de la disponibilidad de anticonceptivos y el acceso para los adolescentes en Monteverde, Costa Rica*, (see appendix) comprises 38 questions in three sections: 13 brief questions intended to collect personal information such as age, job, and number of

children, nine open ended interview questions, and 16 scale questions in two sections intended to measure both the individual's view of overall community perception and the individual's personal view. In light of my small sample size, and through looking at my quantitative data, I decided to limit the scope of this paper to analysis of my qualitative interview, which I felt was more representative of community voices. Because the survey was short, the interview participant was able to control the length of the interview based on his or her own knowledge, interest, and time. The shortest interview lasted seven minutes, and the longest lasted 33.

I began the interviews by asking for demographic information, followed by open-ended questions from the survey. I conducted twenty of the interviews in Spanish, and the rest in English. I recorded all but three interviews with a tape recorder in order to get verbatim quotes. Interviews were conducted in various locations depending on what was convenient for the participant. The interviews were intended to gather societal views on adolescent sexuality and contraceptive use and to measure community knowledge about contraceptive availability for adolescents. In my analysis, I have used single pseudonym initials and identifying details such as gender and age to place my participants in context while still protecting their privacy.

I chose survey participants based on several factors, and my objective was to interview people who reflected the demographics of Monte Verde. Although my project is about adolescent contraceptive access, I interviewed

adults, partially because of the additional complexity involved in conducting research with minors. The adult perspective is particularly important, however, because adults generally drive the public conversation around teen pregnancy, and thus interviews with adults reflect more accurately the dominant societal views on adolescent sexuality. I was particularly interested in getting the perspectives of parents raising children in Monte Verde. I interviewed 23 people, 18 women and five men, aged 26-62. All participants had lived in Monte Verde for at least two years, though most had lived there much longer. My intention was to focus on the perspectives of long-term community members, as they tend to be the most knowledgeable about community issues. Eighteen out of 23 survey participants were native Costa Ricans, and other nationalities represented included Argentinean, Spanish, Nicaraguan, Colombian, and Ecuadorian. Ten participants are single, 10 are married, three are in a *union libre*, a committed domestic partnership, and one is separated. Seventeen out of 23 participants are parents. Of those participants, age at birth of first child ranged from 18 to 41, but was concentrated mostly in the twenties and thirties. Out of the 16 participants with children, 10 participants said their children attended a private school only, two said that their children attended only public school, and three said that their children had attended both at some point.

Education levels and current employment among participants varied widely. Four participants reported attending school for the minimum amount

of time required by the Costa Rican compulsory education system, through the sixth grade, and four have obtained a master's degree, the rest are somewhere in between. All participants but one mother worked outside the home. Seven participants were self-employed or owned businesses in some way; nine participants work in positions related to education, ranging from work as a cleaner at an educational institution to administrative positions; three participants work at hotels; and the remaining four have other jobs, including food service positions.

Responses to the question of religious affiliation were complex. Fifteen participants said that they had a Catholic background, but of those participants only eight identified themselves as Catholic without a qualifying remark. In response to the question of religion, one participant qualified her answer, "Catholic", with air quotes. One participant identified with Evangelical Christianity, one mentioned Jehovah's Witness but did not identify strongly with it, mentioning that she does not attend church. Five identified as nonreligious or spiritual without also mentioning Catholicism. Although many of the participants identified as religious, there did not appear to be a correlation in my study between negative feelings surrounding teen contraceptive use and strong religious beliefs.

There are several limitations to my study that are important to note. First, as an outsider in the community, I found my participant group mostly through connections at the Monteverde Institute, which included many

employees of MVI as well as several host families. My sample is skewed towards participants who are comfortable discussing adolescent contraceptive use, although no community member whom I invited to participate declined. One notable absence from my participant pool is members of the Quaker community. Furthermore, my incomplete understanding of the community after four months as well as my imperfect grasp of the Spanish language may affect my data in ways that I cannot fully realize myself. Finally, despite my best attempts, I am unsure if the clinic maintains records of statistical data on actual adolescent pregnancy rates in Monte Verde, and if such records do exist I was unable to access them. In spite of these limitations, my study illuminates the perspectives of Monte Verde community members on the barriers to adolescent sexual healthcare access in the community, and I hope that my findings can spark further conversations.

Results

As the Costa Rican healthcare system policy permits minors to access contraceptive care confidentially and free of cost (in theory), it follows that there are barriers to contraceptive access and use for adolescents that may not be immediately identifiable.

Before beginning my research, I anticipated that some participants would be uncomfortable with the topic of sex, especially adolescent sex, and tried to account for that in the development of my survey questions. In the early stages of developing a research project, I originally wanted to ask

women about their own contraceptive use, but ultimately decided against it because I feared it would be too personal. I was surprised, then, when many women volunteered that information in my interviews during our discussion about contraceptives. I initially believed that the proscription of premarital sex within the highly influential Catholic Church would encourage silence and denial around teen sexual behavior and contraceptive use, especially among participants who identified as religious. Most of my participants emphasized the role of negative attitudes towards sex in preventing contraceptive access, but did not perpetuate those negative attitudes themselves. Although many participants pointed to religion as part of the complex etiology of stigma, there was no apparent correlation between religious beliefs and negative attitudes towards sexuality among my interview participants. The exceptional open-mindedness of my interview participants towards sex and sexuality raises questions about where dominant attitudes on teen sexuality originate and are perpetuated. These questions could be answered through interviewing a larger sample size of Monte Verde residents in order to see whether my sample was representative of broader community attitudes. Further insights into the development of societal attitudes can be found on page 61, where interview participant W., a 51-year-old long time Monte Verde resident, offers his perspective on how dominant attitudes are slowly changing. Before beginning my research, my hypotheses on what I would find were informed by my own unobvious understanding of stigma. Religion and negative attitudes towards

teen sex certainly play a significant part in inhibiting access, but in less obvious ways than I had imagined. The contrast between stated attitudes towards teen sexuality among my interview participants and the stigma-created difficulties adolescents encounter while accessing contraception reveals the nuanced and persistent nature of societal barriers.

Section I: Why Delay Childbearing?: A Critical Question

Interview participants in Monte Verde identified adolescent pregnancy as a significant problem in the community. Why is teen pregnancy a problem, and to whom? As I discuss in Chapter I, society defines adolescent pregnancy as a problem only in certain circumstances, and this holds true in Costa Rica. Family structure in Costa Rica has undergone significant changes over the last few decades, with increasing rates of divorce, female-headed homes, declining fertility rates, and declining marriage rates.¹⁷⁷ Sylvia Chant, an anthropologist and researcher, examines the numerous interpretations of this shift. While some mourn the demise of the “nuclear family”, others cheer the increasing rates of female participation in income-generating labor.¹⁷⁸ Throughout the 20th century in Costa Rica, as in much of Latin America, “men’s domain was the public realm of the street (*calle*), whereas women’s

¹⁷⁷ Sylvia Chant. “Researching gender, families and households in Latin America: from the 20th into the 21st century,” *Bulletin of Latin American research*, 21 (2002). 545-575. DOI: 10.1111/1470-9856.00059

¹⁷⁸ Chant. “Researching gender, families and households in Latin America: from the 20th into the 21st century,” 547.

sphere was the secluded, private world of the house (*casa*).”¹⁷⁹ Men worked, brought home money, and acted as heads of the household, while women cared for children and took care of the house.

As in much of the world, early childbearing underwent a shift from normal to pathologized in Costa Rica with the advent of industrialization.¹⁸⁰ In the current configuration of Costa Rican society, adolescent childbearing inhibits educational and career opportunities and contributes to increased reliance on family at the same time as greater adult responsibilities. According to interview participants, early childbearing impacts both the individual and the entire community. Many of the effects sustained by the individual from adolescent pregnancy are the consequences of an accelerated growing up process, such as working to support the child instead of studying further or going out with friends. Some interview participants argued that what impacts an individual also impacts the entire community, while a few said that the effect begins and ends with the mother and her family. Some of the negative individual impacts of adolescent childbearing are actually perpetuated by the community, such as stigma against adolescent mothers affecting work, educational opportunities, and social standing.

Interview participants agreed that an adolescent pregnancy had the strongest impact on the girl who became pregnant. Although they also affected the child’s father, the family, and the Monte Verde community, all of

¹⁷⁹ Ibid., 548.

¹⁸⁰ Ibid.

which I will discuss later in this chapter, the adolescent girl was the main focus of most of the responses. The practical and social impacts of adolescent childbearing influence each other significantly, and social practices have the potential to mitigate harms sustained from practical effects (for example, social stigma against adolescent mothers is a significant barrier to their economic welfare). Furthermore, policy changes, such as more social supports for adolescent mothers so they can pursue educational opportunities, could also alleviate the harms sustained from early childbearing.

Narrative Disruption

Many interview participants framed adolescent pregnancy as a disruption to the expected progression of modern-day life. Educational disruption, which I will discuss more fully, was one of the most significant of these, but concerns about narrative disruption ran deeper than practical concerns. My interviews reflected the felt importance of the progression of child to adolescent to adulthood that is damaged by a teenage pregnancy, which mirrors the Victorian ideal discussed in Chapter I. Adolescence was seen as a time of learning, both in and out of school, and of experimenting with independence without the need to take on the harsher responsibilities of adulthood. When adolescents have children, they are “thrown into a world they don’t know, of adult women” (C., female, 43) and the era of personal development is cut short or bypassed. Interview subjects spoke in mournful

terms of the loss of this important period of growth and recreation for adolescent mothers.

It affects them because they already need to assume the responsibility, so they can't live the life of teenagers who don't have children. They have to study, care for the baby, get the food for the baby, sit with the baby, they can't go out with friends like before, because they need to care for the baby. (T., female, 59)

It's a big change for them. They have to grow up very fast, they can't enjoy their adolescence, they can't enjoy this phase. It affects an adolescent because they can't enjoy that phase, they have to become mothers and learn more things very fast, and they forget the rest[...] They mature very fast, and don't have an opportunity for the experiences of maturing that come with that life stage. (B., female, 37)

Interview subjects valued adolescence as a vital life stage that should be protected from adult responsibilities. As I discussed in Chapter I, this protective view of adolescence has emerged within the last few centuries, and is a core value of teen pregnancy prevention. The rhetoric among my interview subjects reflects the popular view of adolescence as a sacred time of personal development that is incompatible with childrearing. It also reflects practicalities of the times—the nuclear family model in industrialized societies is not configured to support adolescent childrearing. Besides the normal challenges of parenting, adolescent parents have additional difficulties finishing education and finding employment and childcare. They must instantly cast off adolescent innocence and assume adult responsibilities, without the transition period from school to work to parenting that many adults experience. This narrative disruption is a characteristic component of discussion around adolescent pregnancy and sexuality.

Education

Educational interruption was the most frequently named negative impact of adolescent pregnancy individually and on society. The emphasis on education among my interview subjects reflects the high value placed on education in Costa Rica. Education has been both free and compulsory in Costa Rica since 1869, when it was one of the first countries to make it so.¹⁸¹ Now, schooling is compulsory for nine years, which is reflected in the 96.2 percent adult literacy rate.¹⁸² As of 2009, 23.1% of total government expenditure was on education.¹⁸³

Although adolescent mothers certainly benefit from those nine compulsory years of education, participants said that leaving school early negatively affects future job prospects. According to one participant, T., a 59 year old woman, pregnant adolescents used to be pressured or forced into leaving school when they became pregnant or had children. Now, “it is a right of childhood to continue studying even if they get pregnant.” (T., female, 59) Still, pregnant and parenting adolescents face stigma that compels them to leave school, in addition to the financial pressures to get a job and the time pressures to take care of their child. Several participants discussed this issue:

They don't continue studying most of the time, [...] I remember a girl who I know became pregnant and couldn't study more or find work,

¹⁸¹ Unesco Institute For Statistics “Education (all levels) profile Costa Rica,” last updated 2010, accessed 10 March 2013, http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=121&IF_Language=en&BR_Country=1880

¹⁸² Ibid.

¹⁸³ Ibid.

but they are underage so it's not like they can get whatever work. The majority of these girls end up working as cleaning ladies, service people in hotels, cleaning rooms and floors (F., female, 34)

Practically, more than anything it affects her in her availability for future studies, because generally if you have children you already have to work very young. It's the most common and worst effect (J., female, 62)

It's also more difficult to study for these girls because many times their babies don't sleep through the night, or are sick, so it's a little more complicated. It's a big job to be a mother (T., female, 59)

A baby is forever, and with it comes many things, like me, I didn't finish my studies, so it's hard to enter life without education. Because I gave so much to my child, and now I can continue studying but it's more difficult because my child takes up my time. (M., female, 26)

Combining the new physical and mental pressures of motherhood with stigma for adolescent mothers in schools does not create an ideal learning environment for these girls. Adolescent mothers, even if they are dependent on familial support, often need to work to earn funds to care for their child, which forces them to leave school. And with low educational status comes additional stigma for teen mothers and their children. Interview participants generally framed this issue in terms of concern for both the adolescent mother and for the children's eventual educational outcomes.

[It affects them] In education, because if she doesn't finish her education, her children are also not going to have a good education (I., female, 33)

Yes, it has an effect on the community, I think especially on the student community because many young people must abandon their studies because they become pregnant very young. (J., female, 62)

It affects them socially, and in the development of the community. Many adolescents who should be studying or preparing themselves to

be professionals need to start to work or abandon their studies because they have a pregnancy, to start working or to care for their children. (L., male, 36)

They stagnate, they don't continue studying. (M., female, 26)

The effects of interrupted education can reverberate throughout the family and the community, and are perceived as a community concern because they affect the workforce and the education level of the community. Framing dropout due to adolescent pregnancy as a community matter engenders questions about what the community should be doing to address it. T. expressed frustration about the lack of action in Monte Verde to address this, especially considering successful programs in other communities:

[I]n some places, like San José, young people who are pregnant or who have small children, the state helps them and provides them with a special center so that their babies can be cared for while they are studying. It's a student's classroom conjoined with a nursery for their babies. But here in Monte Verde there isn't anything like this.[...] The government has a program called "Red de Cuido" for single mothers, where they can leave their babies in a nursery while they work and study. (T., female, 59)

The lack of a state-facilitated childcare program in Monte Verde leaves the entire burden of childcare with the adolescent parents and their families. A program like *Red de Cuido* would alleviate some of the stress of early childbearing, and perhaps facilitate improved outcomes for adolescent mothers. Discussions of government-run support programs like *Red de Cuido*, or welfare in the United States, raise questions about the responsibility of the state in providing these services. The Costa Rican constitution and policies

manifest values about protection and care for its citizens. Article 51 of the Costa Rican constitution states: “The family, as a natural element and foundation of society, is entitled to State protection. Mothers, children, the elderly and the destitute infirm are also entitled to such protection.”¹⁸⁴ This commitment to protection is exemplified through the provision of universal healthcare by the Costa Rican government, and through the development of additional social programs to meet stated needs. *La Red Nacional de Cuido y Desarrollo Infantil* (National Network for Childcare and Development) is an institutional network of childcare developed by the Costa Rican government.¹⁸⁵ It aims to meet an identified need for reliable childcare during critical periods of child development to increase female participation in the labor market and break cycles of poverty.¹⁸⁶ The government states that they will expand the program by 75% over the next few years.¹⁸⁷ Since Monte Verde is a small community, implementing a state-funded childcare program may not be the best use of limited resources. Several interview participants, however, noted the importance of childcare in Monte Verde, due to the long working hours required of the tourist industry. Costa Rica has identified the importance of providing childcare for its citizens in the interest of facilitating

¹⁸⁴ Constitution of the Republic of Costa Rica, English Translation “Article 51,” 5 Oct 2005 http://www.servat.unibe.ch/icl/cs00000_.html

¹⁸⁵ Instituto Mixto de Ayuda Social Costa Rica “Red de Cuido y Desarrollo Infantil” http://www.imas.go.cr/ayuda_social/red_de_cuido.html

¹⁸⁶ Presidencia Republica de Costa Rica “¿Que es la Red Nacional de Cuido?” <http://www.casapres.go.cr/index.php/99-casa/591-red-nacional-de-cuido>

¹⁸⁷ Presidencia Republica de Costa Rica “¿Que es la Red Nacional de Cuido?” <http://www.casapres.go.cr/index.php/99-casa/591-red-nacional-de-cuido>

healthy child development and mothers in the workplace. Perhaps an extension of this program to Monte Verde would address some of the barriers to continued education that adolescent mothers face.

Education is highly valued in Costa Rica, and this is reflected in the concerns from interview participants about the future of dropout adolescent parents, as well as in the perpetuation of stigma against undereducated adolescent mothers and the discrimination they face in the workplace. Stigma is not just associated with lack of education, however, and there is much more complexity to the stigma that adolescent mothers face.

Stigma

Stigma against adolescent sexual behavior is a powerful force that inhibits adolescents from obtaining reproductive healthcare and contraceptive services. It is unsurprising, then, that adolescent mothers, as visible reminders of the existence of adolescent sexuality, are the targets of stigma and shaming. As we have also seen in the United States, the stigmatization of adolescent mothers under the guise of concern for their welfare and the welfare of their children is influenced by negative attitudes towards adolescent sexuality. Stigma against adolescent parents was revealed both explicitly and implicitly in my interviews. Several participants lamented the difficulties that adolescent parents face, while others reproduced the cultural stigma in their own words, perpetuating negative views of adolescent parents. L., a 36 year old man,

spoke candidly about his perceived inability of young, single mother to create a stable home for their children:

Single women, very young women with children cannot create a home environment of family, of values, where children can grow and become good people, many times they grow up with broken values, homes formed with women and children, single women. I think it's because in society, because it isn't a nuclear family, it's not stable, so the upbringing is not of quality. (L., male, 36)

This quote demonstrates the simultaneous valuing of the nuclear family and devaluing of single, young mothers, reproducing the outcry discussed by Chant in "Whose Crisis."¹⁸⁸ "Family values" are seen as restricted to two-parent homes, and mothers are seen as incomplete without their natural counterpart, fathers. His analysis also focuses on the young woman, placing the father out of the picture, rendering him a passive actor in the narrative. This illustrates the tendency to blame the mother, ignoring the father's active role in shaping household composition through his departure. All of my interview subjects, including and especially L., were remarkably compassionate and thoughtful about these issues. Later in his interview, L. critically examined the role of machismo in single motherhood and contraceptive access. As his comments here demonstrate, however, negative views about adolescent mothers are pervasive and persistent. In my interviews, facing stigma was framed as a direct outcome of adolescent parenting, and as a reason to delay childbearing, and rarely as a societal

¹⁸⁸ Sylvia Chant. "Families on the verge of breakdown? Views on contemporary trends in family life in Guanacaste, Costa Rica." *Journal of Developing Societies* 18, no. 2-3 (2002): 109-148.

construction to actively fight. This mirrors Daniel Callahan's rhetoric discussed in Chapter II, where stigma is presented as an effective deterrent to negative behaviors.¹⁸⁹ Perhaps the hope is that in a country with a high rate of adolescent pregnancy, encouraging the perpetuation of stigma may deter adolescents from early childbearing. The hope may be that framing adolescent parenting even more difficult and arduous than adult parenting may discourage young people from becoming pregnant.

[It is hard to be an adolescent mother] because they are marked (stigmatized) by others, and sometimes don't even have the support of their own family (F., female, 34)

They live some type of [...] social discrimination. And it's more difficult to get work if they are pregnant or have babies. I believe this is because of the *machista* culture, which puts more responsibility on the woman than the man. (W., male, 51)

The stigma and discrimination that adolescent mothers face amplifies every other practical difficulty. Without stigma, they may be more successful in finishing school, finding work, and caring for their children. Sexually active adolescents are in a bind: they face stigma when accessing contraception, yet even more stigma if they fail to use contraception and become parenting adolescents.

Planned Adolescent Pregnancies

Despite negative attitudes towards adolescent parenting, some teens do plan pregnancies. Several of my interview participants described a new kind

¹⁸⁹ Daniel Callahan, "Obesity: Chasing an Elusive Epidemic," *Hastings Center Report* 43, no. 1 (2013): 34-40. DOI: 10.1002/hast.114

of familial construction by young women and their male partners, who get pregnant on purpose to attain greater independence. I., a 33-year-old woman who was very well-informed about this topic, described what she has observed of this phenomenon:

[Now] it's significant but perhaps a little more ordered, not like pregnant adolescents within their parent' homes, but a teenage couple going to make their own home. The concept may have changed a bit, before it was more "oops" but now it's like 'I am going to live with my boyfriend'. So it's a societal problem as well, creating families irresponsibly. Most I've seen recently are adolescents, [but they] already live with their partners. They aren't accidental, they are much more planned. There has always been an existence of adolescents [being sexually active] but this is a new concept from my point of view and what I know. (I., female, 33)

Perhaps this new manner of constructing a family stems from a rebellion against the relatively recent model of school-university-marriage-children that is expected of this generation but wasn't necessarily expected of their own parents. As I discussed in Chapter II, adolescents who become pregnant often feel constrained by their circumstances and do not see the benefit in delaying childbearing. The phenomenon that I. describes, however, seems much more deliberately aimed at attaining independence or maturity. In her article, "Planned Adolescent Pregnancy: What They Wanted" Kristen S. Montgomery determined several consistent themes among adolescents who had become pregnant on purpose.¹⁹⁰ "The desire to be or be more perceived as grown

¹⁹⁰ Kristin S. Montgomery, "Planned adolescent pregnancy: what they wanted," *Journal of pediatric health care* 16 (2002) 282-289 <http://dx.doi.org/10.1067/mpH.2002.122083>, 286

up”¹⁹¹ and “the pregnancy was the next natural step [for the teen]”¹⁹² were named as two primary reasons for planning a pregnancy. Adolescents who plan pregnancies disrupt their own expected narratives, accelerating the shift from childhood to adulthood. Though adults may view this as damaging to the “natural” order of life, adolescents may believe that they will feel empowered by the different kind of independence that accompanies childbearing. Symbolically, adolescent parents abandon their position as dependent children and take up the role of the caretaker. There is a logic to this dramatic and decisive manner of achieving independence, and it is easy to see why it may be attractive to adolescents who cannot fully understand (as no non-parent really can) the demands of parenting. This view is compatible with that of another interview participant, who argued that the education and economic status of the girl has little to do with whether or not she will become pregnant. She discussed a case she has seen:

Not a matter of lack of education, or that their parents have done little schooling, one of these kids was from the [private school], a product of a San Luiseño and an American, and she had this teenage pregnancy. And she was attending the [private school], so it wasn't “Oh, because it's a more removed rural community where there's no knowledge on this, and where you expect throughout the world that teenagers get pregnant early”[..]And then the other one just recently—another girl from the [private] school [...]just recently gave birth, and she's 16! (U., female, 40)

Whether or not the pregnancies of those two girls were intended, it's clear that there are other factors at play besides economic and knowledge constraints.

¹⁹¹ Ibid.

¹⁹² Ibid.

Adolescent pregnancy can affect girls from all socioeconomic classes, and this is especially visible in Costa Rica because abortion is illegal: “For those cases that I know they just carry on, not even a consideration of abortion. You get pregnant and you just deal with it.” (U., female, 40) Once a Costa Rican teenager of any socioeconomic standing becomes pregnant, whether it is planned or not, she has little recourse beyond “just deal[ing] with it”.

Accessing an abortion, though illegal, is certainly possible in Costa Rica. However, given the challenges that adolescents face when accessing contraception, which is free and illegal, abortion is not an easy option for teens.

One community member discussed the “contagious” nature of adolescent pregnancies. She believed that when adolescent pregnancy is common in a community, as girls see their friends getting pregnant and having children, it becomes normalized and may trigger additional pregnancies. This is a very common argument against social supports and destigmatization of adolescent pregnancy and sexuality. G. argues that visible adolescent pregnancy leads to neglectful safer sex practices:

It affects the community in that it perpetuates the habit of sex without protection, because it’s very common to see pregnant adolescents, and it’s very accepted within the community. Obviously we have to accept it, but society just said “Oh okay, another one falls” instead of saying “This is a problem, it would be better to stop the situation or work to change and educate the young people more”. So when there is more adolescent pregnancy, it continues to perpetuate it and there are more and more cases. (G., female, 40)

Here she articulates the tension of walking the line between accepting and condoning adolescent pregnancies. As with all adults I interviewed, G. would like to see fewer cases of adolescent pregnancy, but does not want to make things harder for teens who are already pregnant or parenting. Is there a middle ground between shaming adolescent mothers and discouraging early childbearing?

According to participants, narrative disruption (including financial instability), educational disruption, and stigma were the most compelling reasons to delay childbearing. Adolescent parenting is a difficult endeavor, they said, and delaying childbearing is in most young women's best interest. It is also clear that available contraceptives and sex education are not sufficient pregnancy prevention tools. Perhaps the best way to approach teen pregnancy prevention gently, without encouraging the shaming of adolescent parents, is to use a teen-centered approach. W., a 51 year old father of three daughters, laid out his ideal framework for teen-focused contemplation about adolescent pregnancy, which may lead to more effective prevention than simply providing contraceptives or discouraging sex:

The topic of contraception is much more than buying a pill, than buying sometimes. It's an issue of personal maturity [...] I think that it's not only having the methods available, but a process of education about expectations for life. What are my expectations of life when I'm an adolescent? What do I want to be? What do I want for my life in the future? Do I want children now? If I don't want them, then I don't take the risks. But if I don't want them ever, why don't I want them? Understand the consequences [...] when two people decide to have a child, they are creating another person [...] I believe that the decision to have children is a decision where you also think about the new

person [...] Also, conception or contraception of children is more than the individual decision of two people. We have to think also a little more about society, about humanity, about the planet [...] Especially in the time of adolescence, there's little thought about this, almost nothing. But we need to work with this analysis from much earlier, so that children understand that individual actions have social impacts. (W., male, 51)

Most adolescent pregnancy prevention initiatives lack that degree of thoughtfulness. In traditional sex education, teens take a passive role, taking in information from the teacher. In W's framework, teens would be encouraged to contemplate their own objectives, without the pressure of a right or wrong answer. This approach leaves room for a multitude of responses from the teens, but they are permitted to come to their own conclusions while understanding the weight of making parenting decisions. While presenting basic information about reproductive health and providing contraceptives are certainly necessary, W's holistic approach provides a reflective space for adolescents rarely seen in traditional sex education practices.

Section II: La Primera Barrera Somos Nosotros: Barriers to Adolescent Reproductive Healthcare Access

In progressive circles, teenage pregnancy is commonly thought of in terms of lack of access to resources and information. To “solve” the “problem” of teenage pregnancy, we must provide sex education and access to contraceptives for teens. It is made clear in the case of Monte Verde that the answer is much more complex. There are a number of factors that contribute to the high rate of adolescent pregnancy in Monte Verde and in Costa Rica in

general, and none of them are immediately identifiable looking in from outside. Teens in Monte Verde can access condoms, pills, and other reproductive health services legally and freely at a clinic within walking distance of their school. They are given a rudimentary education about sex and sexuality. And yet teen pregnancies still occur at a rate deemed problematic by community leaders. As many of my interview participants emphasized, early childbearing is a detriment to future success. Participants emphasized that leaving school early does not set young people up for a promising future. So why do adolescent women and men in Monte Verde continue to bear children despite the resources available to them?

The answer to this question necessitates a deeper analysis that many of the participants were eager to offer. Most participants moved immediately beyond an explicit focus on contraceptive use and availability while answering interview questions, highlighting the apparent need for a fundamental education and societal shift. Provision of contraceptives and condoms were viewed as a quick fix that is ineffective without a deeper focus on the roots of the problem. My fairly straightforward question: “From your point of view, what kind of contraceptives should be available to adolescents and why?” generated deeply considered and complex responses that were much more than a list of contraceptive technologies. The primary practical barriers, which would be the easiest to address, were gaps in education and knowledge and issues of accessibility, safety, and affordability surrounding

contraceptive methods. Interview participants cited persistent societal barriers such as insufficient family communication, confidentiality issues, and *machismo*, as most significantly inhibiting contraceptive access. All of these issues influence and are influenced by stigma surrounding adolescent contraceptive access, creating impenetrable barriers that negatively affect adolescent reproductive health outcomes. These barriers must be targeted directly in order to ensure that adolescents can access reproductive health services.

Sex Education and Knowledge Gaps

A pervasive theme in my surveys was the lack of consistency between interview subjects when asked basic questions about regulations surrounding contraceptive availability for adolescents. Many participants did not realize that adolescents are legally entitled to access contraceptives. The majority of interview participants are deeply rooted and active in the community, and many lacked knowledge about policies that should be clear to citizens. Some interview subjects expressed frustration that the clinic was not using its public health platform to effectively distribute information about contraception. One interviewee, a 46 year old man named V., who grew up in Monte Verde, said:

What usually happens in the clinic is that you go, one visit, only if you are sick or if you need something. Then there is little accessible information they give, and they could be very good at the clinic since it is very accessible to people. But this is a place where...it's for medicine, but not this type of information that is necessary to get out to the public.

V.'s concerns about the difficulty of accessing information, even for adults, was reflected in the varied responses to my second interview question, "What are all of the contraceptive methods available for adolescents under 18 in Monte Verde, and where can they be obtained?" I asked this question to determine what the "common knowledge" was surrounding contraceptive methods for adolescents. The responses varied widely. A few participants were unsure if adolescents were permitted to access contraception at the clinic at all. V. believed that neither adolescents nor adults could obtain contraceptives through the clinic, with the exception of specific cases. Another participant, T., a 59-year-old artist and longtime Monte Verde resident, said that adolescent women could not get contraception from the clinic unless they are married. A few of the participants stated that adolescents had access to all of the same contraceptive methods as adults: IUDs, injections, copper T, pills, and condoms at the clinic, birth control pills at the pharmacy, and condoms in the supermarkets. Eleven participants stated that pills and condoms were the most accessible, and two stated that only condoms are available to adolescents. The information about what methods are available for adolescents is not widely known or disseminated, even among the well-informed group of adults that I interviewed, some of whom are parents to teens. This lack of information may be a serious barrier to adolescent access.

Responses to my question about common sources of sexual health information for Monte Verde teens revealed more concerns about lack of quality information. Participants discussed the pervasive role of *la calle* (the street), the extent to which students receive an “inappropriate” (I., female, 33) sexual education among friends. The media takes a prominent role in sex education, and was discussed in both positive and negative terms. The Internet and radio were named as good sources of information for learning more about contraceptive methods, but several participants acknowledged the damaging effect of confusing or unrealistic media portrayals of sex. Several participants cautioned about *la calle* and the media replacing the parents and schools as the primary education source if the parents do not take a proactive role in educating their children.

Most participants believed that parents should take the primary role in teaching their children about sexual health, but many also mentioned the schools and the clinic as sources to reinforce parental lessons or provide additional information. Although participants told me that there was sex education taught in both the public and private schools, many discussed concerns about manner of presentation and content. C., a 43-year-old female health coordinator, who has two children, discussed how sex education in the schools tends to both scare and bore adolescents:

...sometimes they don't receive enough information. In the schools, in some occasions, the teachers develop topics, and the problem is in the case of young people, when you receive information about sexual health, if it were a lesson, it's not interesting. “How many sperm eject

during an ejaculation? How do the ovaries function?” This doesn’t interest young people. And commonly when they talk about these themes in school, it’s very biological, and they also scare them with all of the STIs that exist. During sexual education, they almost never take into account responsibility, pleasure, and all of that. Very taboo still, including for health educators. The first thing they talk about is sexually transmitted diseases, with tons of horrible photos, about sicknesses, and deaths, how ugly! There isn’t a beautiful vision of sexuality. So, the young people aren’t interested. It’s like “How scary”, but then they forget it. They feel better if they don’t remember. (C., female, 43)

According to C., sexual education should strike a balance between presenting accurate information about sexual health, while also discussing the role that sex plays in one’s life. This holistic approach to sex education was proposed by several of the participants, with the objective to normalize sex and place it in the context of a full life and a loving relationship. Sex education, they argued, focused too much on the negative or harmful aspects of sex. If adolescents are averse to the medicalized lecture presentation of sex and sexuality, they will not successfully absorb the information presented and instead try to ignore it. Placing sex in context and stepping back from scare tactics may make adolescents pay attention.

However, not all participants wanted to dispose of scare tactics. M., a 26 year old woman with one child, spoke in terms of her own experience, believing that what would have worked best for her is “see[ing] the consequences that there are.” (M., female, 26)

I know by my own experience and I hope that they receive frequent lectures, not only visually but listening to personal testimonials of people who have had venereal diseases, maybe, maybe that they see

the physical effects of this, a naked man or human with venereal disease, a virus that deforms the body. This would be good, to make them aware. We need to tell them how it is, have them see with their eyes, with the light of truth what are STIs and pregnancies, of which I think that hardest is a sickness. But a sickness has an end. On the other hand, a baby is forever, and with it comes many things. Like me, I won't finish my studies, so it's hard to enter life without education. Because I gave so much to my child, and now I can continue studying but it's more difficult because my child takes up my time. So it would be good to do lectures in high schools and clinics and everything, from people who suffer from diseases. So they see this with their mind, through what they have seen, and understand that sexual relations that one has are something serious and solid that has consequences. Because with only "blahblahblah", with only talking, there are young people that I have seen, including me when I was in high school, who went to lectures and were like "ooh", not listening...they were bored, only people who really have maturity and understand the importance take interest in these things and listen. If they just talk, the kids don't understand. And they are so young, so "blahblahblah" with facts...I think it could be much better. And if they see [pictures of] nude people with diseases. That would be best for me. (M., female, 26)

M.'s approach was uncommon among my study participants but reflects an attitude that is central in much thought about sex education. Her approach is an honest one—STIs can be devastating to young people's health, especially if not treated, and unwanted pregnancies often mark the end of a young woman's studies. By framing sex in terms of its consequences, M.'s approach seeks to deter young people from engaging in sexual behaviors for fear of harm. If promoting abstinence were effective, young people would be spared any consequences resulting from sexual activity until after they were able to better emotionally and financially handle it. M. felt strongly about her beliefs, which originated from her own experiences, and spoke with a great deal of care about adolescent health outcomes. She did not follow the trope of a

punishment-driven abstinence advocate, but instead discussed her deeply considered ideas borne out of concern for the adolescent community. Preventing sexual activity, if possible, would be the most effective way to promote harm resulting from sexual activity, and her ideas reflect this conviction. M.'s sex education philosophy is also situated within a broader philosophy revealed in her interview, which focuses on parental guidance and emphasizes accurate information in addition to abstinence.

Both C. and M. agree that sex education is not currently as effective as it could be, but disagree on how to address the issue to best reach teens. Both methods are honest: sex is pleasurable and a part of life, and it also has the potential to cause harm. This is part of the challenge of sex education programs—what works for one teen may not work for another. Maybe M. would have benefitted from the shock of seeing and hearing from people with STIs, but this type of programming would not be effective for other teens.

Gaps in education and knowledge do play a role in adolescent access in Monte' Verde. Most troubling is the apparent lack of knowledge about clinic resources for adolescents, even among a group of well-informed community members. Increasing clinic outreach may be a way to remedy this. Community perception of sex education in schools varies, and there is a stated discrepancy between the public and private schools. Interview participants generally agreed that parents play the most important role in sex education,

but there was some concern about how well parents fulfill that role, as I discuss later.

Contraceptive Methods: Accessibility, Affordability, and Safety

Everything. If you don't give them everything, they won't access it. They will continue to get pregnant. It's an issue of thinking, I think that everything should be available when it's good for your health. (I., female, 33)

In response to my question about which contraceptives should be available to adolescents, many participants stated that while they felt many types should be available to facilitate use, they were concerned about safety of synthetic hormones for young women.

I think that every type that's suitable should be available. In the case of the girls, sometimes pills aren't recommended. I'm not pro-pill, this type of product...I always use an alternative method, like natural methods in combination with condoms, with spermicides, or with the diaphragm. In Costa Rica it's not so well known. It gives more control to the woman, to her body, her decisions. (C., female, 43)

[...] the condom is safe and easy, it doesn't have side effects. Pills are easy to access, but my suggestion is not to buy the cheapest, not to buy the *brutos*. Even though the mentality is often that the women can't but them, they have to use generic method or methods of poor quality that can bring side effects to women. So, I don't recommend those, I don't recommend girls of 14 or 15 taking pills, medical, pills or hormones. Condoms. (L., male, 36)

I think the most effective is the condom. It's the easiest to use and get and with the fewest health consequences for women of all the methods. Contraceptives have an effect on women's health. In the case of contraceptive pills, the hormones can cause gastritis, tissue inflammation, extraordinary bleeding, changes in mood, and side effects for young people. Condoms also have their effects, but they are less than the others. (T., female, 59)

The contraceptive method must consider the health of the woman and the man. The contraceptive method should have alternatives for shared

responsibility, the method shouldn't depend only on the woman or only on the man. (W., male, 51)

Discussions with several participants indicated a mistrust of hormonal contraceptives due to side effects and discomfort with hormone disruption. A few married women with children stated that they themselves used condoms or the Fertility Awareness Method (FAM) to avoid messing with their hormonal cycle. One interview participant, A., who is 39 with three children, half-jokingly said that she was consuming papaya seeds to achieve infertility naturally. Concerns about side effects were amplified when discussing the health of adolescent women and hormonal contraceptives' effect on their future fertility. Some of these concerns are reflected in Costa Rican policies around adolescent contraceptive use: Depo-Provera (an injectable progestin contraceptive) is available for adults and minors who have had a child, but not for nulliparous adolescent women because of concerns that it will affect their development.

The majority of participants emphasized the importance of condom use, alone or in addition to other methods. In one of my first interviews, B., a 37 year old woman, said: "1. Condoms 2. Condoms 3. Condoms" in response to my question about what types of contraceptives adolescents could use. Although my questions were formulated to, perhaps shortsightedly, focus only on adolescent pregnancy prevention; sexually transmitted disease prevention was a clear concern among participants. Although one woman, N., noted that

condoms feel “muy feo,” she also said that they prevented illness and were the cheapest. Participants favored condom use as the best method for a number of reasons. Condoms do not disrupt the growth or hormonal processes of young women, they protect against STIs, and they are accessible not only in the clinics but in the supermarkets.

Condoms are also viewed as a progressive method to promote gender equality. Using condoms necessitates shared responsibility and a level of communication that the adolescent girl obtaining and taking the pill does not. However, a number of drawbacks associated with condoms were also clear to some participants. The fact that condoms necessitate cooperation between the genders is sometimes hindered by the fact that women face greater consequences than men of a contraceptive failure and resulting unplanned pregnancy. The level of maturity needed from young men to recognize that and take charge of contraceptive responsibilities was a concern:

And condoms...girls aren't going to buy condoms, because here, they are considered for men only. Men are the ones that buy the condoms, and maybe they have problems when they want to have sex because if men are very young, they don't have money, or it makes them ashamed to buy condoms, so then they don't buy condoms. (F., female, 34)

This view of “who buys condoms” reflects deeper issues such as the presence of *machismo* in contraceptive negotiations, which I will discuss later. Burden-sharing only works with ample communication, and that standard may be difficult to achieve for adolescent partners.

The economic factor is especially evident in the case of condoms, because they are also available from supermarkets and *pulperías* (corner stores) around town. Adolescents may wish to circumvent the issues around obtaining contraceptives at the clinic by purchasing condoms from a store. Economic cost was named as a definite barrier to contraceptive access despite the purported availability of free contraceptive services at the *Caja*:

Contraceptive methods, at least the pills, are very expensive. For a young person, it's a little expensive. (F., female, 34)

One obstacle is economic, it costs money. And sometimes, not just a little bit of money (G., female, 40)

Although adolescents can obtain free condoms or pills at the clinic, they may not do so for a number of reasons: fear of stigma, fear of talking to a doctor, confidentiality issues, or lack of information about the clinic's services.

Purchasing condoms at the supermarket, the pharmacy, or the many small *pulperías* (or purchasing contraceptive pills at the private pharmacy) in town may afford them more privacy, but it also costs money. This is significant to adolescents, who may not yet have a paying job or be unable to weigh distant concerns of pregnancy or STIs over more immediate financial worries.

Familial Influence on Adolescent Sexual Health

Shifting family structure in Costa Rica has been a key focus of anthropologists and demographers. Some have characterized the increase in female-headed households as a breakdown of traditional family values, and

some have championed it as empowering for women. Marriage rates have also been dropping and divorce rates rising.¹⁹³ Anthropologist Sylvia Chant chronicled the reaction to changing family dynamics in her work “Families on the Verge of Breakdown?”. A wide variety of societal ills, including adolescent depression, violence, drugs, and homosexuality have been attributed to *desintegración familiar*. The Catholic Church asserts that increased sexual freedom causes many of these social problems. Chant highlights the number of academic and press articles that espouse concern about the changing role of parents in a dual-income household. As Costa Rica becomes an increasingly industrialized economy, both women and men pursue work outside of the household, leaving the socialization of the children to nannies much of the time. Much of the concerns about family breakdown can be seen as reflecting concerns about changing societal demographics and power balances, including the increase of women in the workforce.

Family, and specifically shifts in types of families, is currently a pertinent topic of discussion in Costa Rican society, and that was consistently reflected in my interviews. Family relationships were spoken of as a deeply influential factor of adolescent sexual health outcomes, and the effects of an unwanted teen pregnancy deeply reverberate throughout the whole family. Furthermore, teen pregnancy influences the construction of the families that

¹⁹³ Sylvia Chant. "Families on the verge of breakdown? Views on contemporary trends in family life in Guanacaste, Costa Rica." *Journal of Developing Societies* 18, no. 2-3 (2002): 109-148.

make up the fabric of society. Therefore, concerns, insights, and discussions of families play an important role in the discussion of teen pregnancy and contraceptive access in Monte Verde.

Parental communication and guidance, or lack thereof, was frequently discussed as a strong influencing factor in adolescent outcomes. Many participants, parents and non-parents alike, emphasized the positive role of parents and family in shaping the sexual and emotional health of children:

Families and parents should be educated to teach their kids to feel comfortable talking about these sorts of issues so that when their daughter or son is ready to start or has already started their sexual life, you can be comfortable to say "Hey, if you're already having relationships take care of yourself, you can trust us, and tell us if you need to get pills or condoms or so forth.' It's stupid to consider the idea that teens are not gonna do it, it's natural and happens for everyone. We need to see it with those eyes. It's gonna happen, it's not something you can avoid. It's something you can educate a person and let her know what she or he is getting into, physically and emotionally speaking. (E., male, age 29)

I think that parents need to prepare their children for this. In this day and age there are parents who don't tell their children that there are STDs, that there are pregnancies. The kids learn everything on the street then. We have this taboo...I want to speak the truth with my son [...] my son says "what am I? What do I have? Vagina or penis?" These are things that stimulate children to find out, and that as a parent you must speak with them openly and correctly.. They shouldn't learn it on the street. (M., female, age 26, one child)

These interview subjects took a holistic approach, viewing sexual health not simply as the absence of disease or unwanted pregnancy, but as inextricably intertwined with healthy sexual and romantic relationships and self-image. In their view, teaching children about sexual health is part of the work of raising

a child, and as building a foundation for that child's eventual receptiveness to school-based sex education initiatives and safer sex practices. Family-based and school-based education were not positioned as opposing, but rather as complementary. According to many participants, parents should shape their child's values around sex, while schools should talk about the mechanics and the basics of safer sex practices.

Many participants believed that undesirable consequences arose from disruptions in this model due to weak parental guidance. When parents neglect to raise these issues with their children, it leaves an opening for less desirable influences, such as less knowledgeable friends or the media. Furthermore, it teaches the child that sex should not be talked about, encouraging secrecy. Parental silence on issues of sexual health was believed to be a strong negative influence that contributes heavily to lack of contraceptive use.

For good reproductive health, you need [education] in the schools and in the families, but many families don't do that. (I., female, 33)

In many cases, parents don't know, because of communication errors, a lack of communication. The adolescents are afraid of telling their parents, they have a lot of fear. It's [...] something social that impedes them, really, they don't have the peace or liberty to tell their father "I need pills because I have sexual relations with my boyfriend and don't want to get pregnant". (L., male, 36)

They don't go [to the clinic] because they think their parents will find out. (A., female, 39)

Many interview subjects believed that without open discussions of sex within the family, adolescents do not feel empowered to access sexual health services through the clinic. This is for multiple reasons: because of a sense of shame

about their sexuality perpetuated through silence, because of lack of knowledge about safer sex practices, and because of the probable fear that their parents would find out. Furthermore, as demonstrated through adult responses to the question of whether adolescents could legally obtain contraceptives and sexual health services from the clinic without parental permission, it's likely that many adolescents do not access the clinic because they wrongly believe that they would need accompaniment from their parents. When asked if adolescents under 18 could legally obtain contraceptive and sexual health services from the clinic without parental permission, eight participants responded that they could, 12 that they could not, and two that they didn't know. Adolescents can in fact access free contraceptives from the clinic with a doctor's appointment. The clinician will then write them a prescription for 30 free condoms, which can be filled at the clinic pharmacy. There are no contraceptives available for free without these procedures in place, partially to incentivize adolescents to see a doctor for sexual healthcare, and partially because the government-funded *Caja* has limited resources that they must allocate sparingly (hence no free condom bowl in a discrete corner of the waiting room).¹⁹⁴

Although official Costa Rican health policy does allow adolescents over 13 to receive confidential contraceptive services, the reality in Monte Verde is more accurately reflected in the participants' responses. One

¹⁹⁴ Dr. Kate Brelsford, information from speaking with the clinic, April 2012

participant, a 43 year old woman health worker named C. who has worked closely with the clinic, said: “In theory, [they do not need permission], but...it depends on the doctors. It scares them to attend to young people alone because of the fear of sexual abuse, stuff like that.” (C., female, 43) Doctors feel trepidation about treating young people alone, especially for sexual healthcare, because of the fear of false sexual abuse accusations. This fear may reflect the idea that discussing sex with a minor without parental presence crosses some invisible line of conduct and violates the bond between parent and child. This common idea perhaps reveals a deep uncertainty around how to treat adolescent patients—they must be treated differently than children, yet they are still technically minors. It is possible that this trepidation on the doctors’ part may contribute to the culture of adolescents avoiding clinic for their birth control needs. The close-knit nature of the Monte Verde community also negates the possibility of completely anonymous medicine. Aside from lack of confidentiality, which I will discuss later in more detail, doctors may fear overstepping parental boundaries when treating adolescents in the community, particularly if they are acquainted with the child’s parents.

It was apparent to the interview participants that adolescents rarely obtained birth control from the clinic regardless of its actual legality. A., a mother of three daughters, said: “it’s a possibility, but they don’t go because they think their parents know, they prefer to buy it in the supermarket.”(A,

female, 39) According to W., the clinic has identified this issue and is trying to draw more adolescents:

“I heard a lecture from the nurse at the clinic and I understand that they are trying to motivate adolescents so they can go and get contraceptives. Even without the guidance of the parents. Because they trust [the adolescents to use contraception], but they don’t trust them to talk to their parents.” (W., male, 51)

That strategy, however, would position adolescents against their parents and may continue to drive a wedge of secrecy between them, which many of the participants discussed as being counterproductive for healthy sexuality and parent-child communication. Especially as participants consistently identified parental guidance and strong family relationships as positive influences on adolescent reproductive health and general well-being, encouraging secrecy may actually have a negative effect on health outcomes. However, it is important to note that confidentiality is beneficial in cases where parents are not open with their children or will prohibit contraceptive use. Obviously, an open and honest parent-child relationship is ideal, but when that is not achievable confidential contraceptive services play a vital role in increasing adolescent access.

The significant effect of adolescent pregnancy on families was revealed through my own language confusion when I began my interviews. One of my questions intended to discuss the effect of adolescent pregnancy on the male partners of adolescent women. I misphrased the question as asking how adolescent pregnancy affects the “padres”, a word which can mean either

“parents” or “fathers.” Several of my interview subjects thought I was asking about the parents of the adolescent who becomes pregnant. Even after I clarified my mistake, many subjects returned to the influence of teenage pregnancy on the whole family.

It affects them because many leave their studies, end up dependent on their mothers. The grandmothers will take care of the babies, because the girls have to work to bring home money and food to their children. (G., female, 40)

They live with their own families, in a room, together, not in their own house but in their families houses or they rent an apartment. We are creating a population that is accustomed to living in small rooms with a baby, but the stress is greater that way. However, this is the new attitude that the population is adopting. (I., female, 33)

Participants discussed the disruptive nature of teenage pregnancy to a family, due to the necessity of parental economic and emotional support and cramped living conditions. This represents a change of lifestyle from a few decades ago in Costa Rica and much of the rest of the world, when families were expected to live together and share childcare responsibilities. This may be attributed to the increasing industrialization of Costa Rican society, a shift from only several decades ago when women worked primarily inside the home. In an agrarian economy, when the primary responsibility of women was to raise and bear children, it was more acceptable to live in multi-generational houses.¹⁹⁵

¹⁹⁵ Sylvia Chant, “Households, gender and rural-urban migration: reflections on linkages and considerations for policy,” *Environment and Urbanization* 10, (1998)
<http://eau.sagepub.com/content/10/1/5.full.pdf>

However, with the rise of industrialization and capitalism came increased value placed on the nuclear family, in which one works and raises their children with the eventual promise of freedom in the form of retirement. It's understandable, then, that women who have raised their own children and worked all their life will be wary of providing childcare for their teenage daughters. Furthermore, in contrast with the homesteads of the agrarian economy, there is simply less room in the houses, apartments, and properties of the industrialized economy for multi-generational families. A teenage daughter with a baby who cannot afford her own housing thus represents a disrupted capitalist success narrative for the entire family.

W., a 51 year old man with three daughters, explained how he interprets the hesitance that some parents feel when trying to approach these issues with their children:

We have fear, we have no confidence. Sometimes it is a fear based on the recognition that neither the school nor the family nor religion are doing a good job of education. But it is also a fear that has a foundation in that other societal forces have already won, and now we need to create a concept that sexuality is much more than just immediate pleasure. (W., male, 51)

Although participants highlighted the importance of parental involvement, some felt that parents were fighting a losing battle against pervasive and damaging societal ideas about sexuality. This raises questions about the extent that conscientious parenting around these issues can counteract day-to-day socialization, especially when the parents themselves were raised with the same ideas.

“Pueblo Pequeño, Infierno Grande”: Confidentiality and Shame

Throughout my time in Monte Verde, the term “Pueblo Pequeño, Infierno Grande” (Small Town, Big Hell) was a recurrent refrain among residents describing their lives in the town. The phrase was always said with a gentle mixture of pride and candor, and it came to be the perfect representation of one of the most significant barriers to adolescent reproductive health. In both my formal interviews and informal conversations with Monte Verde residents, the close-knit nature of the Monte Verde community was a consistent theme. As a foreign student, I loved the fact that every time I left my house I ran into someone I knew. However, Monte Verde residents, while expressing pride about the true community nature of their hometown, noted the difficulties of growing up in a small town where *chisme* (gossip) is constant background chatter. One resident said: “It’s not easy. You are always in the spotlight. There are no secrets in this life.” (S., female, 34)

In Monte Verde, privacy is a difficult goal, especially when that privacy is related to information other people may find curious or troubling, like sexual activity in general, or adolescent sexual activity in particular. This issue is not unique to adolescents in the community; in my study abroad program with the Monteverde Institute my fellow students and I were continually warned about the public nature of any kind of illicit or sexual behavior in the community. Excessive drinking, strange behavior, or sexual relationships are certain to be noticed by the community, and will reflect poorly on us and, to a lesser extent,

our host families and institution. My host family frequently recounted stories to me of wild behavior from former students in my program and other programs, always telling me to keep the information secret. I consistently observed the size and nature of the community as an explicit or implicit regulatory force for study abroad students' behavior, and I imagine that this effect is amplified for residents.

It is easy to see how challenging it is to maintain privacy and move past events in such a small community. If this was a common issue for short-term study abroad students, it's hard to imagine growing up and making mistakes in a community with such a long memory for *chisme*. This is not to undermine the close and supportive nature of the Monte Verde community that I experienced while living there, but rather to highlight the ambivalent nature of growing up somewhere where everyone knows your name.

This lack of privacy is a particular challenge to adolescent contraceptive access for several reasons. As I've discussed throughout my thesis, lack of privacy has been named as a significant barrier for adolescents seeking reproductive healthcare all over the world. In Monte Verde, although the actual doctors' visit is protected by doctor-patient confidentiality, the reality is that an adolescent visiting the clinic to ask for contraceptives is highly visible in such a small community, removing the safety of confidentiality. An interview participant summed it up thusly:

The main barrier is a small town! Everyone knows each other. And everything will comment "ohh...she's using...[contraception]" Gossip,

no? So, maybe not everyone, but many people. The first barrier is a small town. (C., female, 43)

[...] I can imagine that because everyone knows everyone here, a fifteen year old showing up to the clinic and saying hey I want some pills that...[makes] people [talk], the privacy, the confidentiality. (S., female, 33)

Since the town is so small, adolescents are likely to run into someone they know in the waiting room or the receptionist's desk, and news travels quickly in Monte Verde. This acts as a significant deterrent to access, as adolescents are afraid that rumors will spread about them and that their parents will eventually find out. Even in a case where parents are supportive of a teen's desire to access sexual health care, the teen may not want the entire community to know about her private life. Adolescents in Monte Verde seeking sexual healthcare are made highly visible by the close-knit nature of the town, despite best efforts by the clinic at maintaining confidentiality.

Stigma against adolescent sexuality is at the roots of this confidentiality issue, and is the ultimate barrier to access once again. Adolescents are reacting not to the fear of being discovered to be sexually active, but to the expected retribution from family and community. If sexual behavior were viewed as value neutral, seeking reproductive healthcare at the clinic would be the same as seeking any other kind of healthcare. Getting a regular checkup at the clinic may carry with it the same issues of running into your neighbor, but it does not engender the kind of proliferation of gossip as seeking sexual healthcare because it does not carry cultural baggage. This

issue is best illustrated by the difference between being treated for strep throat vs. being treated for chlamydia. Both are fairly common infections that are easily curable with antibiotic treatment, and can be resolved with few lasting effects. However, most people have no qualms about telling their family and friends or calling into work sick with strep, but chlamydia is usually associated with such a degree of secrecy and shame that many people avoid being tested or treated for fear of stigma. The only significant difference between the two diseases—the way they are transmitted—has weighty implications for how the two illnesses and their sufferers are viewed. Similarly, the only distinction between regular healthcare and reproductive healthcare is the baggage associated with the latter, which is the primary barrier to adolescent access. Adolescents fear societal judgment and stigma for accessing reproductive health care, so they do not access it. Interview participants discussed the intense scrutiny that adolescents face around their reproductive choices, and the potential social consequences of obtaining contraceptives:

A lack of communication and knowledge, fear of asking about or buying contraceptives. A big part of it is fear of buying the contraceptives, feeling shame about going to the supermarket where everyone knows each other. In a small community everybody will know, and there are prejudices in society. (B., female 37)

Another barrier is that they need to buy them secretly. Because they don't want their neighbors or families to see. (G., female, 40)

It's that society judges them. More than anything it's society, the parents, the family, the neighbors, who judge them. (I., female, 33)

As illustrated in my interviews, the core issue is not simply a fear of privacy loss, but of the ramifications a teenager might face from their family and community if they are discovered to be sexually active. Especially during adolescence, rumors can be devastating to social standing and self-esteem, and although this issue is common within high schools, rumors take on new weight when they cross the boundary from the adolescent social sphere to the adult one. In a larger town or more spread out community, rumors may not have the same direct impact on all social spheres of an adolescent's life. The existence of the stigma and shame associated with sexuality, and thus seeking reproductive healthcare, is certainly not specific to Monte Verde or other small communities, but the fact that confidentiality cannot practically be preserved aggravates the challenges adolescents face.

Machismo, Gender Roles, and Fatherhood

The existence of stigma around sexual behavior was considered by interview participants to be the most severe intangible barrier to access. Etiology for the deeply entrenched cultural taboo against adolescent sexuality and its embodied, visible reminders such as pregnant adolescents or adolescents seeking reproductive healthcare, is difficult to determine. When pondering the origins of the societal stigma, and thus the root cause of the barrier, *machismo* was named as a pervasive and difficult mentality to overcome. Interview participants used the term *machismo* to describe a mindset of patriarchy and a man who embodies it through his behavior. For

example, machismo could be used to describe the double standard of expecting young women to remain sexually pure while boys are encouraged to become sexually active, or it could describe a man who believes that a woman's job is to take care of the house. For this question, the male perspective was especially valuable. The five men I interviewed were thoughtful with their answers throughout the whole interview process, and their experiences were particularly helpful in defining the role of machismo in Monte Verde. Although it certainly holds true that it's more difficult to see an injustice if you are its beneficiary, the conscientious men I interviewed contributed carefully considered and sensitive analysis of the issue.

W., one of the five men I interviewed, a 51 year old father of three girls, outlines his views on the role of machismo in society, especially in relation to reproduction:

[...]because of the *machista* culture, which puts more responsibility on the woman than the man, the girl has a heavier load due to her adolescent pregnancy than her sexual partner. In the traditional *machista* culture the man is given more liberty to have sexual relations with different women. The *machista* culture also gives more responsibility to the woman for pregnancy prevention. It's like the woman has to take charge of the prevention. The man will not have much responsibility for that. And there's a little paternalism, like if an adolescent woman becomes pregnant her parents take on the responsibility for her and the pregnancy. Not so for her sexual partner. These are gender roles that the culture has imposed, different for the woman than the man. A part of this culture is that the man takes on less participation in the process, especially the initial process of caring for the children. The culture dictates that the man leaves to work, and the woman takes care of the children. So, from the moment an adolescent woman becomes pregnant the man has the attitude that the woman bears the majority of the responsibility for childcare. And the man is poorly socialized, he believes he is incapable of educating the

children, this is the woman's role. And for the man it isn't merely a negative action for himself, he refuses his own capacity to work to care for his children. He feels a little incapacitated because his parents have not educated him to be a caretaker of children. Not a caretaker in terms of money, a caregiver because he is with them, gives them love, talks with them, goes to school to see how their education is, things like that. (W., male, 51)

W's carefully considered description of how a *machista* society oppresses women and subtly incapacitates men was reflected in the low expectations of teen fathers recurrently discussed throughout my interviews. W's words were also echoed by the research of Sylvia Chant, who discusses men's iron grip on the productive sphere:

On the other side of the fence, men's primary identification with the productive sphere arguably helps to explain why men themselves are holding back from housework and childcare. Men's apparent unwillingness to participate in reproductive labour may well derive from attempts to protect the remaining vestiges of 'masculine identity' in a world in which women's activities are widening, not to mention encroaching upon 'male territory' If men were to start sharing women's domestic and parenting work in any major way, their claims on paid labour as a 'male preserve' might conceivably weaken.¹⁹⁶

Men are dually empowered and crippled by their designation as providers. They benefit from the *machista* mentality in innumerable ways, but a more relaxed configuration of gender roles would benefit men, too. The patriarchy is universally constraining.

¹⁹⁶ Sylvia Chant, "Men in crisis? Reflections on masculinities, work and family in north-west Costa Rica," *The European Journal of Development Research* 12, no. 2 (2000): 199-218.

Some of the most critical words about teen fathers and the *machista* culture came from L, a male interview subject recounting what he has seen among his fellow young men:

The fathers? Many of the fathers are irresponsible. They don't have the maturity to assume the responsibility of having a child. Many are cowards, they are scared, they flee...and there is machismo. Even though it doesn't appear that way, machismo exists...this conception that a woman with children, a young single woman with children is not of equal worth, ...it's like a cycle of negative value. When a man isn't interested in his children, and some boy is interested in a girl just to achieve something, brief pleasure, not intending to stay with her. It doesn't affect the men as much because of the issue of machismo. Because many simply leave, how do you say...play her. It's [the woman's] child, they feed it, be with it. Unlike men, I've seen cases where a man has two children, three children, one with one woman one with another, because they aren't responsible. Machismo exists [here] even though people say the opposite. (L., male, 36)

The child is seen as the mother's responsibility, and the mother then seen as less-than for having a child without a male partner. The *machista* culture permits the man to leave, and then blames the woman for his departure and her ensuing single status. It's a vicious cycle that perpetuates a stigma against young mothers and their children, influencing the discrimination that many other participants discussed. Interview participants did not condone the practice of leaving a pregnant girlfriend without taking responsibility, but they certainly expected it, and narratives of responsible teen fathers were treated as exceptional. The most commonly espoused view was that the fathers were either irresponsible and left, or they stayed but the pregnancy affected them primarily economically. Their responsibilities were not discussed in terms of a

burden of care, but rather as a financial burden only. W.'s view on the role of fathers as providers and little else is contained within this view.

The fathers? It affects them economically. (O., male, 34)

[Parenting has] much less impact. Because normally the adolescent boys don't leave their house, keep living with their families, and therefore it can be that yes, it affects them because they have a baby, but they don't care for it like their child, they don't live there. Normally they don't live together, the adolescent boys with the baby. Each adolescent lives in their family's house and the baby stays with the mother. So, yes it affects the boys, but very little. They continue living their lives, they aren't conscious of the significance of the change for the girl. (G., female, 40)

Teen fathers occupy the privileged position to opt-out of immersive fatherhood, contributing money or nothing instead. However, even when they choose to embrace fatherhood, they are relegated by society to the provider role, while the woman has the duty to be the primary caregiver. These expectations are oppressive for women, but they are also constraining for men. When they do step up as fathers, they are portrayed as both exceptional and somewhat clumsy and incapable, and possibly motivated by outside forces.

[I'm] impressed by the fact that a teenage girl has a boyfriend and then she gets pregnant and then they stay together, I think that I've seen in San Jose more that the guy just disappears, and here maybe because it's a small community you're supposed to, you know, you have more pressure to stay together or something. (R., female, 33)

Here, the interview subject positions the size of the community as the primary motivating factor for teen fathers. The small size of the community influences and constrains men's choices, setting them up to take responsibility while they

may not need to in a more anonymous large city. Even when the fathers stay with their children, however, they do not always do so in a way that is beneficial for the families. E., a 29-year-old man says:

It's really sad but once a girl gets pregnant the guy is not necessarily going to take responsibility for that. Normally if he does take responsibility he will do it in his way, not necessarily in the position to do the best for the kid and the mom financially or emotionally speaking, he's another kid. (E., male, 29)

So even if the father stays, he may be an additional burden or object of care for the mother. Even if he provides financially, the stress of keeping a tenuously bonded family together may add to the collective burden.

Machismo is not only a type of behavior; it is also a societal mindset.

Interview participants named religion and the church a main contributor to the *machista* mentality and thus to the taboos against sex.

Another important barrier is the machista mentality: sins, young people shouldn't have an active sexuality, the vision or idea that sexuality is bad, a fault. A conservative mindset. These are important barriers. The machista, conservative, moral mentality. This affects it also. (C., female, 43)

That overall mentality was named as a main barrier to knowledge, discussion, and access of reproductive healthcare and contraceptives. Although religion was not demonstrated to be a direct barrier—again, most study participants were religious but their beliefs did not seem to correlate with their feelings on contraceptives—the inherent sexism and anti-sex in the religious teachings of the Catholic Church does help construct the backbone of a *machista* society. In a country with a strong religious presence such as Costa Rica, it is difficult

to avoid the messages about sexuality as sin, even if they are not taught explicitly.

Although *machismo* is an ever-present barrier to reproductive health access in most places in the world, the acknowledgement of and frustration about the *machismo* society displayed by the men and women in my interviews indicated that there is certainly an active desire to change it. W. considered the changing mindset he's observed throughout the years and expressed a hopeful message about the changing directions of the Catholic Church and of the *machista* mindset and gender roles in general, and the importance of education in this fight:

Things have changed. There aren't studies, there isn't research that shows more clearly how things have changed, and how much. However, one observes that things have changed by the example of the generation, my generation, and younger generations, the change is greater. Those who are fifty years old, we are at this age, even though the majority has many of the old culture, the old views. In my case, I think I have more culture change maybe because of my opportunity to study at University, this has helped me a little, maybe from my relationship, the partnership I have with my wife, there's an education I this, and maybe because of my constant interest in education. To have an interest in education is to have an interest in understanding why things are as they are, and why they are not different. Others who are younger than me, maybe people who are 40 or 30, have less influence from the old culture, and more influence from global cultures, from other people who come from other countries, who have other customs in regards to gender relations, and who are more open to change the gender roles in society. And also, in the time when I was a child, much of my education depended on my parents, the teacher, and the church. Parents, teacher, church were my principle sources of information. In the present children also have parents who influence them a lot, but parents of a new generation, they have teachers, but teachers whose professional formation is much broader, and who have learned about the understanding that teachers have a responsibility in the general formation of the person, not just math and science. And the

church is evolving. The Catholic Church was the most...traditional in the gender roles also. It was *machista*. The church has changed a little bit. So the children and young people of now have...can have a broader vision, a more flexible vision of the role of man and woman. (W., male, 51)

Clearly, deeply embedded *machismo* is difficult to combat, and it is clearly impossible to have reproductive health equity without a more equitable society. Gender roles in Costa Rica, as in all over the world, have changed dramatically in the last century, and continue to change. The role of men in reproductive health access is vital, and until expectations of teen fathers and teen boys in general are higher, it will be difficult to achieve equity. In Monte Verde, it is evident that there are men highly equipped to be a part of the education needed to combat restrictive gender roles.

Part iii. Conclusion and Recommendations for Further Study

My research in Monte Verde demonstrates that reproductive healthcare availability is only a part of reproductive access, which is in turn only a small part of reproductive health equity. Although adolescents in Monte Verde can access reproductive health care free of cost and confidentially in theory, in practice it is much more complex. A number of practical and intangible factors combined make accessing contraceptives a difficult endeavor for adolescents, contributing to a high teen pregnancy rate. Pregnant and parenting teens then face barriers to success and little support. Encouraging teens to delay childbearing in Monte Verde was identified as an important

objective for several reasons, most notably because of narrative disruption, educational disruption, and the stigma and shame that contribute to an additional burden for teen parents. Although delaying childbearing is considered important to allow for pursuance of educational and career opportunities as well as financial stability, Monte Verde still has an incidence of teen pregnancy that community leaders consider problematic. To fill the obvious gaps between reproductive health availability and access, there were a few areas that community members identified as important to address.

Some barriers are simpler to address than others. Perhaps the easiest to address would be lack of information about clinic resources. My interview subjects did not come to consensus on what types of methods were available at the clinic, what was available for adolescents, whether or not adolescents could seek services without their parents, and at what age they could seek services. This seems like it would be relatively simple to address with more outreach from the clinic to the schools and in the community in general, and would go a long way towards reducing some of the confusion apparent during my interviews. The clinic could place pamphlets in the schools, create a website to answer frequently asked questions about contraceptives, or maintain a confidential hotline for questions. The schools could bring in clinic staff during their sex education units to clarify what is accessible to adolescents. The second practical issue, concerns about side effects, is more difficult for Monte Verde to address directly. The contraceptive pills available

at the *clínicas* throughout Costa Rica are older formulations that may cause more side effects. Among my interview participants, there was a heightened concern about damaging young women's (and even older women's) reproductive systems or bodies due to the hormones in the pill. Some of this may be due to the high concentration of participants interviewed who prefer natural medicine in general, but the heightened incidence of side effects incurred from older pill formulations is certainly of concern. The healthcare system should also allow and encourage adolescents to access long-acting reversible contraceptive methods, such as the IUD, which is already available in Costa Rica to adults. Reproductive health research has shown that LARCs are the best methods for first-time contraceptive users, and eliminate the chance of user error.¹⁹⁷ Especially since condom use rates are so low among adolescents in Costa Rica, increasing the availability of newer pill formulations or other methods for adolescents could help. This would take initiative from the government, which may be difficult to mobilize considering the careful resource allocation necessary in a universal healthcare system. In addition, the lack of availability of emergency contraceptive pills and legal abortion, which are both especially important to adolescent reproductive health, is a significant problem. Both of these issues cannot be addressed at the Monte Verde level, however, and will persist until the Costa Rican government changes their views. The steps necessary to change this

¹⁹⁷ "IUDS and Contraceptive Implants Safe for Teens," The American Congress of Obstetricians and Gynecologists

regulations would require deeper research into Costa Rican abortion and reproductive health policy, and are germane to my thesis topic but unfortunately beyond the scope of this research. However, the impact of government regulations on contraceptive availability perfectly illustrate the influence of politics and the state on reproductive health, and demonstrate why it is so important to look upstream when confronting the issue of adolescent pregnancy.

Although these practical issues are certainly significant barriers, conversations with my interview participants always meandered back to the societal issues. Societal issues are more difficult to define and more challenging to directly address. Societal attitudes influence and are influenced by the practical issues, creating concrete barriers to access. Stigma and shame are at the root of all societal barriers described by interview participants, who hypothesized that this shame has its roots in machismo and religion, among other complexities. This shame then contributes to a lack of family discussion around sexuality, and a fear of parental knowledge of sexual activity, which was named as a barrier to access. Furthermore, in a small town like Monte Verde, lack of confidentiality is simply a reality. However, this lack of confidentiality becomes a barrier when adolescents fear consequences if they are found to be sexually active. All of these factors together combine to make a hostile environment for sexually active teens.

Adolescents face a particular challenge with these barriers. It is easy to delay performing a task with certain immediate repercussions (gossip and rumors) in favor of far-off hypothetical consequences (an unplanned pregnancy). An interview participant illustrated the tough double-bind faced by Monte Verde teenagers: “If they don’t take precautions, the people talk, if they do, the people talk [...]It’s your health, you can’t care about what others think.” (D., female, 31) There are few immediate rewards and many immediate social drawbacks to seeking preventative reproductive healthcare as an adolescent. As I’ve discussed previously, adolescents may struggle to balance long-term rewards with immediate gratification. This is especially challenging in terms of accessing contraceptives, which necessitates delaying sexual pleasure to take potentially unpleasant (uncomfortable, costly, side-effect ridden) precautions against a theoretical future risk. This illustrates why removing as many barriers as possible to reproductive health access is critical.

When studying issues pertaining to adolescents, it is difficult to avoid privileging adult perspectives. Adolescents are rarely given a chance to contribute to the scholarly field concerned with their behavior. Throughout my thesis, I try to use my advantage of relative youth to more closely consider the vital adolescent perspective, at twenty-one my adolescent years seem recent and yet incredibly distant. However, my most deeply held conviction about any future study on this issue in Monte Verde is that it *must* include adolescents themselves. Talking with their parents, teachers, and adult

community members was enlightening, and I am excited to imagine what kinds of insights adolescents themselves would bring to the table. Any program directed at youth must include them at every level. Furthermore, after four months in Monte Verde I learned about the community and my ideas on why the adolescent pregnancy rate is so high changed completely. I am sure that a more seasoned anthropologist and Monte Verde resident would identify more issues that I have missed. I will prepare a condensed version of this report in Spanish for public health workers in the community, and make the full thesis available through the Monteverde Institute. My hope is that my report will be of use to the community and in some small way contribute to the fight for adolescent contraceptive access.

In the context of my thesis, the case of Monte Verde should serve as support for my argument: adolescent contraceptive access is a necessary but not a sufficient condition for good teen reproductive health outcomes. The harm that adolescents sustain from sexual behavior (unwanted pregnancy, STIs) is not the inevitable consequence of sexual behavior itself (which is intrinsically value-neutral) but is a product of the context that surrounds sexual behavior. Practicing safe and healthy sex is made difficult for adolescents by a number of societal and practical constraints. As Monte Verde demonstrates, improving health outcomes for adolescents is not as simple as providing contraceptive services. To attain positive reproductive health

outcomes, a successful approach must consider the significant role of stigma and shame in inhibiting access, and address those variables directly.

CHAPTER IV: AN ETHICAL ARGUMENT FOR ADOLESCENT REPRODUCTIVE HEALTH ACCESS

In January of 2011 the New York City Department of Education launched an initiative to provide contraception (including hormonal methods) through school-based health centers at 13 city public schools.¹⁹⁸ Through the program, adolescents are able to access birth control confidentially and without parental consent. The schools notified the parents about the program by letter, and gave them the ability to opt out. City officials stated that there was little resistance to the program, and that only about two percent of parents barred their children from participating. Despite this, controversy arose through the media when the program began being widely reported in September. The New York Post, the outlet that first reported the program, published an Op-Ed entitled “Out of (Birth) Control” that put forth concerns about the program. The author, Andrea Peyser, railed against the high schools, “where students may score a free condom, but forget about Tylenol” “effectively encouraging teens to engage in life-threatening unprotected

¹⁹⁸ Alexandra Sifferlin, “New York City Plans to Offer Plan B to High School Students,” *Time Magazine*, September 25, 2012, accessed April 23, 2013, <http://healthland.time.com/2012/>.

sex.”¹⁹⁹ The author assumes that providing hormonal contraception will cause teens to neglect condom use, hence the fear of “unprotected” sex. The author quotes several people who express fears about the state usurping the parental role: a mother of two teens girls, who states that this is “[o]bviously [an] aggressive mandate aimed at putting the state in charge of the rearing of children”, and the spokesman for the New York Archdiocese, who says that “society for millennia understood the unique role parents have...and here comes the city saying, ‘We know better.’”²⁰⁰

The controversy surrounding this program illustrates the divisive nature of the issue of access to reproductive health services for adolescents. On one side are concerned citizens with questions about the legal and ethical legitimacy of state-provided sexual healthcare access without parental knowledge, and the propensity of adolescents to engage in sexual activity as a direct result of having access to those services. On the other side are people who doubt that a “just say no” strategy will address high teen pregnancy and STI rates in the United States. Both sides aim to protect adolescents from harm related to sexual activity, but they disagree vehemently about how to do it. This debate gets at some of the central questions around this issue, which I will answer in this chapter. Can adolescents consent to medical treatment?

What ethical and legal rights should adolescents have to sexual health

¹⁹⁹Andrea Peyser, “Out of (birth) control,” *New York Post*, September 27, 2012, accessed April 23, 2013.

http://www.nypost.com/p/news/national/out_of_birth_control_xi9oDHoTIBUTWcHvmDBG8N.

²⁰⁰Ibid.

services? What is the role of the parent and the role of the state in this debate? Are programs like this one grossly overstepping boundaries, or are they the next stage in the pursuit of improved adolescent sexual health outcomes?

In my previous chapters, I demonstrated how stigma against adolescent sexual behavior is harmful to adolescent reproductive health outcomes. This perpetuates a cycle of negative consequences attributed to sexual behavior that could be mitigated by better access to health care. Poor access to healthcare harms adolescents, and therefore harms the next generation of citizens. Unplanned pregnancy is a clear concern, and steps must be taken to address the barriers that result in negative outcomes for adolescents. Though minors in both the United States and Costa Rica can legally access contraceptives, there is often significant pushback when attempts are made to expand and facilitate access (for example, through school-based programs), demonstrating a lack of consensus on this issue. Allowing minors access to prescription contraceptive technologies and sexual health services without parental permission is controversial, considering that adolescents are still under the legal guardianship of their parents until the age of eighteen. The discipline of philosophy, specifically medical and practical ethics, can offer some unique insights into the special problem of adolescent sexual health that address issues of informed consent and bodily autonomy as well as parental and societal duty. My argument thus far has relied on the premise that teen sexual behavior and contraceptive access are morally

permissible. In this chapter, I will critically examine and argue for this assumption through discussion of the legal, ethical, and philosophical issues around both sexual healthcare and sexual ethics for minor adolescents. Then, I will build an ethical case for adolescent sexual healthcare access. The argument in this chapter, like those in the first two, is focused on the United States.

I argue that society has a duty to protect adolescents from harm, and for this reason sexual health services should be available to adolescents. The basic structure of my argument is as follows:

- (1) Society has a duty to protect adolescents from harm.
- (2) Sexual healthcare is necessary to protect adolescents from harm.
- (3) Therefore, society has a duty to facilitate *accessible* sexual healthcare for adolescents.

This argument is deceptively uncontroversial. It is difficult to disagree that there are many existing laws and regulations with the specific goal of protecting adolescents and facilitating their healthy transition into adulthood. Right now, the United States is not fulfilling this duty in regards to sexual and reproductive adolescent health. Data from the 2003–2004 National Health and Nutrition Examination Surveys (a survey which draws data from medical testing instead of self-reports) shows that one in four US women aged 14-19, or 40 percent of sexually experienced adolescent women, has a sexually

transmitted infection.²⁰¹ Each year, 750,000 US women aged 15 to 19 become pregnant, and 82 percent of those pregnancies are unplanned.²⁰² Because of negative attitudes towards sexuality, particularly adolescent sexuality, society is failing its children in regards to a critical aspect of their health and well-being. Accessible preventative reproductive and sexual healthcare should be accepted as another uncontroversial protective measure. Ensuring access to these services is not just a progressive way to protect adolescent minors from unwanted pregnancies or STIs; it is fulfilling society's ethical duty towards its children.

Throughout this thesis, I have argued that education and sexual healthcare access can only go so far in addressing the complex issue of adolescent pregnancy. Why, then, do I focus so narrowly on these two strategies within this chapter? My first three chapters highlight the difficulty of adolescent pregnancy prevention without offering any positive solutions. I have argued that adolescent contraceptive access will remain challenging as long as stigma and inequality persist. However, it is easy to argue for the elimination of inequality, but much more difficult to accomplish that kind of profound societal change. As policy is influenced by societal attitudes, societal attitudes are also influenced by policy. Establishing and encoding in

²⁰¹ Adam Sonfield, "New Study Points to High STI Rates Among Teens, Major Disparities Among Population Groups," *Guttmacher Policy Review*, 11(2008): <http://www.guttmacher.org/pubs/gpr/11/2/gpr110220.html>.

²⁰² "Facts on American Teens' Sexual and Reproductive Health," Guttmacher Policy Institute, accessed April, 23, 2013, <http://www.guttmacher.org/pubs/FB-ATSRH.html>.

policy a conclusive ethical, as well as legal, right to sexual healthcare access for adolescents would eliminate concrete barriers to access, and place the acceptance of adolescent sexual behavior as default. Addressing inequalities and stigmas is challenging, and ensuring and facilitating contraceptive access is the simplest first practical step. Based on the difficulty of directly addressing societal barriers, the Guttmacher Institute has advocated for a “Contraceptive Convenience Agenda”,²⁰³ which acknowledges the prevalence of social barriers while implementing practical strategies to circumvent them. Making free contraceptives widely available for adolescents through discrete and confidential access in schools, pharmacies, and other accessible locations would not solve the teen pregnancy problem, but it is an important first step towards addressing it.

No discussion of reproductive healthcare is complete without a mention of abortion. Accessible abortion is a cornerstone of reproductive health. Furthermore, abortion restrictions do not necessarily lead to low abortion rates: a recent study from the Guttmacher Institute has indicated that countries with restrictive abortion laws do not have lower rates of abortion than those with permissive laws.²⁰⁴ Countries with the lowest rates of adolescent childbearing do not tend to have high abortion rates, which indicates that widespread use of contraception is effective in preventing

²⁰³ Sneha Barot, “Making the Case for a ‘Contraceptive Convenience’ Agenda,” *Guttmacher Policy Institute*, 11 No. 4 (2008), accessed April 23, 2013.

²⁰⁴ Stanley K. Henshaw, Susheela Singh and Taylor Haas, “The Incidence of Abortion Worldwide,” *Family Planning Perspectives*, 25(1999), accessed April 23, 2013.

unplanned pregnancy and resultant abortions. The Netherlands, which has the lowest teen birth rate in the western world (5/1000 births to girls 15-19)²⁰⁵, also has one of the lowest overall abortion rates, (6.5/1000 pregnancies).²⁰⁶ In the interest of simplicity, my argument in this chapter focuses on the preventative care aspect of reproductive healthcare (contraception and STI prevention). I limit my explicit argument within this paper to preventative reproductive healthcare because abortion and adolescent access remain exceptionally contentious within the United States. The careful consideration of the laws and ethical arguments surrounding abortion required to argue explicitly for adolescent access goes beyond the scope of this thesis. Accessible abortion services are critical to facilitating reproductive health and autonomous choice, and abortion will always be an important part of reproductive healthcare. However, as we have seen through the example of the Netherlands and other countries with low adolescent birth and abortion rates, accessible contraception services are the first line strategy to prevent teen pregnancy. Therefore, my argument within this paper focuses on contraceptive and other preventative reproductive health services.

Although my argument is simple, there are hidden several claims on which it hinges. I will establish these premises first, and then return to my argument.

²⁰⁵ Darroch, Singh, and Frost, "Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use,"

²⁰⁶ Henshaw, Singh and Haas, "The Incidence of Abortion Worldwide,"

Part i.
Is Adolescence Special? Consent and Adolescence

The crux of the special problem regarding adolescents is that they reach sexual maturity before legally recognized maturity, creating a need for sexual health services while they are still considered minors. In the United States, this complexity is reflected through age of consent laws, which designate the age at which a minor can legally consent to sexual activity. As with many regulations regarding adolescents, these laws are inconsistent by state (ages vary from 16-18) and sometimes contain clauses that would prohibit sexual activity between a 15 and a 16 year old, limiting their practical application.²⁰⁷ Healthcare regulations also consider adolescence a unique category in certain cases, but are similarly inconsistent. Adolescents are in a difficult position—their status as legal minors indicates that they cannot be trusted to have their own best interests in mind, yet treating them as children ignores their burgeoning autonomy and independence. The variability present in the legal treatment of adolescents reveals the societal uncertainty surrounding teenagers.

The legal system reflects the distinction between adolescents and children, granting graduated privileges to adolescents as they gain more maturity with years. These laws function to afford adolescents more

²⁰⁷ “Legal Age of Consent,” Age of Consent By State: Information on the Legal Age of Consent in the United States, accessed April 23, 2013.

independence as they transition to adulthood, while still guiding them into healthy choices. For example, adolescents begin the process of getting a driver's license at age 15 or 16, but in most states in the US they cannot drive after a certain time of night or with friends in the car for at least six months after getting their license. Existing governmental and societal regulations regarding adolescence support my claim that adolescents are a special case and therefore need special rules and ethical codes that account for developmental realities.

Informed consent, or the process by which a patient participates in choices about her own healthcare, is one of the central tenets of medical ethics that has dramatically shaped the climate of medicine. The term "informed consent" as it is used today in medicine was developed during a 1957 lawsuit regarding a case in which a doctor neglected to inform a patient that a procedure carried a risk of paralysis. The judge determined that the physician has the duty to disclose "any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."²⁰⁸ The emerging idea that a patient should be fully informed and participate in decision-making caught on quickly. RM Berry, a legal and ethical scholar on informed consent, writes: "in 1961, 90% of physicians reported that they would not tell patients of a cancer diagnosis; in 1977, 97% reported that they would."²⁰⁹ The

²⁰⁸ Roberta M. Berry, *Informed Consent Law, Ethics, and Practice: From Infancy to Reflective Adolescence*, 17 No. 1(2005): accessed April 23, 2013, 65.

²⁰⁹ *Ibid.*, 67.

stratified nature of medicine, in which a highly educated physician makes often life-altering choices about the course of treatment for an uninformed patient, is strongly paternalistic. Placing an emphasis on informed consent highlights the importance of educating the patient and respecting their autonomy, thus tempering the paternalistic nature of medicine. Informed consent practices were formulated to protect a patient's right to self-determination, a fundamental societal value that must be preserved even during medical treatment. Respect for bodily autonomy is one of four widely used central principles of medical ethics developed by Tom Beauchamp and James Childress in their book *Principles of Biomedical Ethics*. These values are:

Respect for autonomy: the right of the patient to determine his or her care.

(*Voluntas aegroti suprema lex.*)

Beneficence: a physician should act in the best interest of the patient.

(*Salus aegroti suprema lex.*)

Non-maleficence: "first, do no harm" (*primum non nocere*)

Justice: distributive fairness in cases of scarce resources.²¹⁰

The principle of autonomy recognizes and upholds societal respect for individual self-determination. As society accepts that adults have their own best interests in mind, informed consent procedures provide adult patients

²¹⁰ Tom L. Beauchamp, James F. Childress. *The Principles of Biomedical Ethics* (New York: Oxford University Press, 1994), 12.

with the necessary knowledge to make informed autonomous choices about their medical treatment.

A patient must be considered competent to consent to a procedure, and he must consent voluntarily with no discernable element of coercion. A discussion of informed consent involves the following, which a patient must fully understand:

The patient's diagnosis, if known;
 The nature and purpose of a proposed treatment or procedure;
 The risks and benefits of a proposed treatment or procedure;
 Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance);
 The risks and benefits of the alternative treatment or procedure; and
 The risks and benefits of not receiving or undergoing a treatment or procedure.²¹¹

Assessing competence is often complex. Even in patients who are otherwise of sound mind, anxiety due to illness can influence them to make choices out of fear. Furthermore, the inherent imbalance of power between a patient and a physician can introduce elements of coercion. The degree of discussion that must occur in order to obtain consent varies due to the seriousness of the procedure. In some cases, basic verbal consent can be attained quickly, while others necessitate deeper discussion.²¹²

Determining the competence and capacity to consent of adolescent patients is often complex and fraught with conflict. This can be seen even as

²¹¹ "Informed Consent," The American Medical Association, accessed April 23, 2013, <https://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page>.

²¹² Berry, *Informed Consent Law, Ethics, and Practice: From Infancy to Reflective Adolescence*

far back as the 19th century, when adolescents (here defined as anyone under 21) were considered legal property of their fathers in England and the early United States, when a physician could be sued for treating an adolescent simply because they were undermining the father's control.²¹³ Today, laws and practices are more convoluted, formulated to carefully walk the line to avoid overstepping parental authority while providing necessary treatment to adolescents. In her article "From Chattel to Consenter: Adolescents and Informed Consent,"²¹⁴ Angela Roddey Holder, a scholar of law and bioethics, examines the intricacies and conflicts of adolescent consent from a historical and legal standpoint.

The legal ability of adolescents to consent to care varies by state in the United States. Some states have consent statues dictating that minors of a specific age may consent to medical care, while other states employ the "Mature Minor" rule.²¹⁵ According to this rule, if a physician believes that any adolescent over 14 years of age can give the same degree of informed consent as an adult, the physician can treat the minor without parental consent. The Mature Minor rule is regarded as a right of the adolescent patient, but was also formulated to protect physicians from future lawsuits from parents or from the patient himself, if he were to later regret his medical decision. Physicians possess a large amount of discretionary decision-making power according to

²¹³ Angela Roddey Holder, "From Chattel to Consenter: Adolescents and Informed Consent," *Yale Journal of Biology and Medicine*, 83(1): 35-41, 2010.

²¹⁴ Ibid.

²¹⁵ Ibid.

the Mature Minor rule, and usually the Mature Minor rule is not invoked in cases of serious surgeries, but instead in relatively minor procedures.²¹⁶

Medical treatment related to sexual health and drugs is a unique category subject to separate regulations. Minors can consent to treatment for drug and alcohol problems and diagnosis and treatment of sexually transmitted diseases without parental knowledge. This policy was deemed necessary to motivate adolescents to get treatment for serious issues without fear of parental retribution. In the 1960s, the statutes concerning STDs were enacted due to pressure from medical organizations, as adolescents with STDs did not seek treatment for fear of informing their parents, thus spreading the diseases.²¹⁷ Implementing confidential services halted the epidemic and contributed to a decrease in infections, reinforcing the importance of accessible, confidential services.²¹⁸

Contraceptive access is also subject to unique regulations. Adolescents are legally able to access contraceptives without parental consent from federally funded family planning clinics according to Title 10 of the Public Health Service Act of 1970.²¹⁹ As I discuss more fully in Chapter II, all states allow adolescents to access some types of contraceptives without parental consent, though Texas and Utah have since enacted statutes that require

²¹⁶ Ibid.

²¹⁷ Ibid.

²¹⁸ Ibid.

²¹⁹ Ibid.

parental consent for contraceptives paid for by state funds.²²⁰ The Guttmacher Institute defines a federally funded family planning center as “a site that offers contraceptive services to the general public and uses public funds, including Medicaid, to provide free or reduced-fee services to at least some clients.”²²¹ In 2006, teenagers represented one-fourth of all clients served by federally funded family planning clinics, demonstrating the significant role they play in teen contraceptive access.²²²

As I have shown through the cases of the United States and Costa Rica, existing legal rights of adolescents to sexual health services belie the actual accessibility of these services. Truly fulfilling the ethical duty to protect adolescents is clearly not a simple matter of implementing laws. However, it is clear that exceptionalism in the case of reproductive health services for adolescents is necessary to address the discrepancy between sexual and legal maturity that often arises for adolescents. Adolescence is a distinct and unique phase of life that demands special treatment, and this is correctly reflected in policies regarding adolescent healthcare, though these policies do not always translate into access.

²²⁰ “Facts on American Teens’ Sexual and Reproductive Health,” Guttmacher Policy Institute

²²¹ “Facts on Publicly Funded Contraceptive Services in the United States,” Guttmacher Policy Institute, last modified May 2012, accessed April 23, 2013.

²²² *Ibid.*

Part ii.
Adolescence and Sexual Ethics

Although medical ethicists and clinicians have grappled with the issue of adolescent reproductive healthcare and the complexities it sometimes engenders, there has been little philosophical work done specifically concerning sexual ethics for adolescents in a nonmedical context. Unlike medical anthropology, a field in which literature on adolescent sexual behavior is abundant, there is a dearth of serious academic work in the field of practical ethics on this topic. Expanding the field of philosophical-ethical literature around this issue will enrich the academic and practical conversation around adolescent sexual behavior and contraceptive access.

The two main contributors to the fledgling field of adolescent sexual ethics are Dutch philosophers Jan Steutel and Agnes Tellings. As I have discussed previously, Dutch attitudes towards adolescent sexuality are exceptionally permissive, focusing on ensuring that sexually active adolescents are safe and ethical in their practices instead of discouraging teen sexual behavior. In 2009, Jan Steutel, a philosopher at University of Amsterdam, stated that he was unaware of any scholarly work at all within practical ethics that focuses on adolescent sexual relationships. Citing a need for more work of this type, he published a paper entitled “Towards a sexual ethics for adolescence”, in which he attempts to develop a liberal framework of sexual ethics for adolescents that explicitly defines conditions under which adolescent sex is morally permissible. The key component of liberal sexual

ethics is consent, and Steutel argues that adolescents cannot meet the criteria to give consent because they do not possess self-determination.²²³ For adult sexual contact to be morally permissible, it must satisfy two conditions: that it is consensual, and that it does not cause undue harm or offense to innocent outsiders (for example, adultery or public sex). If these two conditions are satisfied, under a liberal framework the encounter is considered morally permissible since it is assumed that adults are acting with sexual self-determination in their own best interest. Drawing on John Stuart Mill's utilitarian framework in "On Liberty", Steutel states that persons with the "status" of adulthood (all of the rights and privileges given to those who have attained a generally accepted marker of adulthood) know what practices and behaviors will promote their own well-being.²²⁴ Therefore, respecting the freedom of adults to live life in accordance with their own personal views is in the general interest of society. Adults are granted this right because it is assumed that they possess and are acting with good judgment, including in matters of sexual conduct.

Adolescents are regarded as unfit to act in their own best interest because they have not yet developed the capacity of self-determination, and therefore are not considered adults. Therefore, adolescents cannot give consent, which Steutel argues has far reaching implications: per liberal sexual

²²³ Jan Stuetel, "Towards a sexual ethics for adolescence," *Journal of Moral Education* 38, no. 2 (2009).

²²⁴ Ibid.

ethics, all adolescent sexual contact is morally unacceptable. Steutel upholds this liberal view of sexual ethics, and believes that the erosion of the criteria for sexual self-determination would undermine its integrity. His central task now is imagining a third criterion that would allow for some degree of morally permissible sexual contact for adolescents while addressing the lack of judgment considered inherent to adolescence.

Steutel replies to the most common argument against the acceptance of adolescent sexual behavior: that designating all adolescent sexual conduct immoral would protect adolescents from the physical and emotional harms associated with sex at an age at which they may be too young to process the consequences in a healthy way. Frequently, advocates of abstinence-only sex education use this kind of rhetoric to support their stance, believing that a societal disapproval of sexual behavior will be an adequate deterrent to impressionable young people. In addition to the practical concerns associated with that view, which outlined in Chapter II, Steutel believes that forbidding sexual behavior would be detrimental to the adolescents themselves because of the benefits associated with sexual behavior. Steutel argues that adolescents are in a unique position where their sexualities are developed while their brains are still maturing, and they therefore should be permitted to explore the benefits of sexual behavior while being protected from the damages.

Steutel's third criterion for morally permissible behavior follows the example of informed consent for minors for any other procedure, from ear

piercing to surgery: parental consent. Steutel argues that it is generally accepted that parents act in the best interest of their children, which is why they are designated as decision-makers for important decisions while the child is a minor. Parents know their child best, and possess a developed view of long-term consequences and benefits for their child. Therefore, Steutel argues that in order for adolescent sexual contact to be morally permissible, in addition to the consent of the adolescents involved and the nonharmful/inoffensive nature of the contact, parents must “[give] their consent to the sexual contact on the basis of their considered belief that the sex will not harm the welfare of the adolescents involved.”²²⁵ This condition, if accepted, would allow adolescents to engage in sexual behavior, if the parent, who is generally believed to have the child’s best interests in mind, takes charge of managing the risk. Steutel also argues that this would facilitate the child’s decision making capacities, as adolescents be required to engage in a conversation with their parents about the perceived benefits and detriments of specific sexual encounters, thus shaping the adolescent’s idea of a healthy sexual relationship.

Although Steutel’s paper to succeeds in highlighting the critical lack of a code for adolescent sexual conduct and the struggle within liberal sexual ethics to define one without conflict, his framework would be impossible to implement practically. Although one could object that many codes of ethics

²²⁵ Ibid.,193.

are ideals instead of necessary basic conditions, the basic liberal code of sexual ethics is actually quite practical, built into many legal and moral codes worldwide, and generally enforced by law and society. If sexual contact is initiated without consent, it is rape or sexual assault, which is punishable by jail time. Consensual sex that is harmful to a third party—adultery—carries with it no automatic legal punishment, at least in the United States, but is grounds for divorce. Consensual sex that is offensive is murkier, but public sex or lewd conduct is punishable by arrest. However, the additional criterion of parental consent for adolescent sexual contact is impractical, difficult to enforce, and problematic, thus failing on the grounds of applicability.

Steutel's conclusion in favor of a paternalistic approach towards adolescent sexual relationships may in part reflect his own Dutch cultural influences. The Dutch approach towards teen sexuality tends to center on parental acceptance and approval of sexual partners, this "sleepover culture" a phenomenon that sociologists have examined in relation to positive teen sexual health outcomes.²²⁶ A compelling argument can be made that other countries should move towards this model due to the excellent health outcomes experienced by sexually active Dutch teens. The US is very far behind in terms of parental acceptance of teen sexual behavior in comparison with the Netherlands, and therefore Steutel's proposal seems preposterous when applied. However, Steutel is writing from the point of view of a culture

²²⁶ Schalet, *Not under my roof: Parents, teens, and the culture of sex*, 12.

where parental approval of sexual partners is already ingrained in the culture, and his leap to making it a criterion for moral sexual behavior may not seem so drastic in this context. Perhaps Steutel's criteria would be useful in the Netherlands, but his argument highlights the difficulty of universalizing standards for such personal acts.

Steutel's third criterion for consent neglects an aspect of the societal model of adolescence: that adolescence is frequently a time for separation from parents and the development of a private life. Although I agree that parents should be involved in protecting their children from harm, including harm related to sexual behavior, codifying instead of encouraging discussions around sexuality might widen the chasm between parents and adolescents. Such a drastic shift of norms would spark some pushback, and if the choice is between hiding sexual behavior and offering up sexual partners for parental approval, I fear that adolescents may choose the former option, perpetuating the harmful effects of secrecy on adolescent reproductive health outcomes.

Agnes Tellings, in her response to Steutel, highlights another practical objection to Steutel's paternalistic approach. Steutel assumes that adolescent sexual contact is always planned well enough that adolescents could attain parental approval prior to the act. This reflects a hopeful ideal, but unfortunately is not in accordance with findings on teenage sexual

behavior.²²⁷ Although responsible advance planning and discussion of sexual contact between partners should be encouraged, the implication that unplanned sexual behavior between adolescents cannot be morally acceptable is too strong a claim.

Furthermore, although Steutel's model mirrors the medical model of parental consent, I argue that matters of sexuality are much more personal, subtle, and complex than consent to surgery or ear piercing. Whether or not the exceptional nature of sexual behavior is socially constructed is certainly debatable, but it is treated as a unique category. It follows from the fact that society's view of sexuality is frequently warped and morally loaded that parents may reflect that view while making choices for their children. Because of the persistent negative view of sexuality, especially adolescent sexuality, in the United States, parents may be unable to see the positive attributes of adolescent sexual relationships that Steutel seems to think are obvious. Parents are people who possess their own prejudices, and it's easy to see where Steutel's theory will become problematic—for example, in the case of a gay adolescent whose parents are homophobic, or an adolescent dating a person of a different race whose parents are prejudiced. Steutel's theory implies that those teens could not have morally acceptable sexual contact with their partners, based only on the fact of their parents' disapproval. This

²²⁷ Agnes Tellings, "A Sexual Ethics for Adolescence? Jan Steutel's View as a Starting Point," *Journal of Moral Education*, (2009) 38 No. 2, 199-211, 206.

criterion is also problematic because of the importance of privacy, which Tellings argues in her response to Steutel is a moral value.²²⁸ She asserts that that forcing teens to inform their parents about sexual acts violates their right to privacy, and is a harmful requirement in itself.²²⁹

My argument against Steutel follows a similar path as the argument against parental-notification laws for adolescents seeking reproductive healthcare or abortions. Although perhaps an adolescent seeking an abortion should be encouraged to discuss it with her parents to benefit from their support, the law should not be constructed so that they are required to notify or seek parental permission in order to protect teens with special circumstances. This leaves it up to the teen to accurately assess their relationship with their parents, and protects teens for whom telling their parents would put them in danger. Requiring parental notification assumes an ideal parent-child relationship, and privileges parental control over adolescent safety and autonomy. Though encouraging parental involvement is ideal, the absence of such a legal requirement protects those who are most vulnerable. Implicit in many laws regarding adolescent sexual health is the assumption that sexual health and sexuality are treated as special, a concept which Steutel's framework ignores. Like the interview participants in Chapter III, I agree that parental involvement in matters of adolescent sexuality should be encouraged, which parents themselves are in the best position to facilitate

²²⁸ Ibid., 206.

²²⁹ Ibid., 206.

through beginning open discussion early in a child's life. However, based on the practical unfeasibility of implementation, Steutel's criteria fail as an ethical framework for adolescent sexual behavior.

Agnes Tellings' response to Steutel briefly outlines her proposed improvements to the code of sexual ethics for adolescents. Her system attempts to rectify Steutel's rigidity, but fails on practical grounds, which she readily admits.²³⁰ She suggests that adolescents be assessed individually for their competence level by parents, relatives, or school counselors, and be permitted to engage in sexual activities gradually in accordance with their level of competence and critical judgment. By attempting to counter Steutel's rigid statement that no adolescents can engage in morally permissible sexual acts (without his third criterion), Tellings creates a framework that does not sustain even gentle challenging. What governing body would decide which sexual acts would be permitted according to each level of competence? I assume that teens would be permitted to practice riskier sexual acts as they developed greater competence, but defining levels of emotional or physical risk beyond pregnancy or STI susceptibility is difficult. More importantly, splitting hairs by assigning greater weight to one sexual act over another codifies and therefore reinforces problematic ideas of virginity and value, mirroring the deeply damaging rhetoric that sexual intercourse is a defining life event, while other types of sex supposedly don't count. Tellings also fails

²³⁰ Ibid., 210.

to address concerns of compliance. Who would enforce these rules? Would it fall to the teen himself? It is difficult to imagine an adolescent who feels ready for a certain level of sexual behavior telling his partner “No thank you, the guidance counselor told me I’m not ready.”

Steutel and Tellings’ ethical codes lack understanding and consideration of the adolescent subject. I agree with the authors that “sexual experience is actually a phenomenon in the life of a majority of adolescents, often at a relatively early age”²³¹ and that the examination of ethical issues surrounding adolescent sexual behavior is critical. However, I disagree with their approaches to adolescent sexuality, which is shown in the impracticality of their ethical frameworks. The rigidity of Steutel’s code of ethics for adolescent sexual behavior is at odds with the nature of adolescence as a period of transition, and the practical implications of both Steutel and Tellings’ proposals render the proposals difficult to take seriously. Although their papers are an admirable and necessary attempt to begin a scholarly dialogue in philosophy about adolescent sexual ethics, their failure to account for the lived experience of adolescents exemplifies the occasional blind spot in the philosophical approach to practical issues that I will be careful to avoid in my own argument.

The failure of Steutel and Tellings’ arguments illustrate the difficulty of establishing moral parameters for adolescent sexual behavior beyond the

²³¹ Ibid., 207.

simple principles of consent and non-harming that succeed in practical application. With this in mind, I put forth my own argument: an ethical framework for adolescent sexual behavior should focus on ensuring that adolescents have the tools to make sure the principles of consent and non-harming are satisfied in their sexual encounters. Adolescent sex could be morally acceptable on the same grounds of adult sexual behavior, while still paying special attention to adolescents' greater risk for exploitation. This generous criteria for moral adolescent sexual behavior is simpler to enforce and practically applicable. The principle of consent, while murky legally, could be satisfied by adolescent sexual relationships in which enthusiastic consent is obtained from both participants, and no significant power imbalances, especially related to age and maturity, exist. This would satisfy the intention of the Age of Consent Laws—to legally protect teens from exploitation by older sexual partners. Prohibiting adult-adolescent sexual relationships where a significant age gap exists would protect teens while permitting consensual adolescent sexual relationships. In addition to these considerations of abuse, providing adolescents with the resources—contraceptives and STI preventative tools—to protect themselves from physical harm related to sexual activity can address the principle of non-harm. A code of ethics that focuses on outlining the simple criteria (consensual, non-harming) that an adolescent sexual encounter must meet, and emphasizes the

role of adults in providing the infrastructure to support this, will be most successful on practical and moral grounds.

Part iii
The State vs. the Family: Who is responsible?

Although Steutel and Tellings ultimately fail at formulating compelling arguments, their arguments bring up a pertinent point about the role of the state and the family. Steutel argues for a family-centered approach, removing the state entirely. Tellings involves the state in the form of school guidance counselors assessing adolescent competence, although she does suggest that parents should be involved, as they know their children best. To what extent should the state determine and enforce the regulations surrounding adolescent sexuality? Sexuality and sexual behavior is very personal, and a compelling argument can be made for removing regulations in favor of a family-based approach. Although Steutel's proposal takes parental involvement a little too far, I accept that parents know their children best and generally have their best interests in mind. Why, then, should the state be involved at all? Here, I will present two alternative views on the state's role. Then, I will argue that society's duty to protect adolescents should be enforced by the state. This is especially important in the case of access to reproductive healthcare, as adolescents face significant societal barriers to access that may be perpetuated within families and communities.

There is a strong precedent in the United States for the state's role as enforcer of regulations that are crucial for adolescent or child health.

Adolescents are designated minors by the legal system until the age of eighteen, which means that they are beholden to their parents in, at minimum, the legal sense. Government also takes a paternalistic and protective role for legal minors, reinforcing and occasionally superseding parental authority. For activities that are not regarded as inherently harmful, such as ear piercing, an adolescent is required to be accompanied by a consenting parent. Parents are not permitted to grant their children permission for activities that are considered inherently harmful. For example, it is illegal for minors to buy or possess cigarettes, even with parental permission, because smoking is regarded as an unhealthy behavior. The legal system contains many laws and regulations that assume a protective role for minors when parental protection fails. These laws contain the belief that the healthy development of adolescents is within the best interest of society and should therefore be upheld even in cases of poor parental judgment.

It can be argued that imposing a broad ethical principle for adolescent contraceptive access disregards the variance of individual families and communities. Some believe that all responsibility for child welfare should be with the family, and that it is therefore the responsibility of the parents to determine what their child can and cannot do without state interference. This approach emphasizes the role of the family and the community in ensuring

child and adolescent well-being, and questions the idea that state intervention is necessary. Both liberalist and communitarian principles can be used to argue against the state's role. The United States has a long tradition of classical liberalism and individualism. The political philosophy of libertarianism seeks to infuse this tradition into government, promoting individual liberties and minimizing the role of the state.²³² Libertarianism is committed to full self-ownership, and denies the right of the state to restrict the activities of individuals. One of the most persistent questions in libertarian philosophy is the treatment of children. Children, and adolescents, are not autonomous self-governing adults, nor are they the private property of their parents. Some libertarians, though not all, allow for paternalism in the parent-child relationship, as parents can act as protectors of their children's natural rights.²³³ The United States Libertarian political party platform categorically rejects the necessity of the state in child-rearing, stating:

We believe that families and households are private institutions, which should be free from government intrusion and interference. We believe that government involvement in traditional parenting responsibilities has weakened families and replaced family-taught morals with government-taught morals.

Parents, or other guardians, have the right to raise their children according to their own standards and beliefs, without interference by government, unless they are abusing the children.²³⁴

²³² "Libertarianism." Stanford Encyclopedia of Philosophy, last modified June 20, 2010, accessed April 23, 2013.

²³³ Jason Sorens, "Libertarian Theory and Children's Rights: The Fiduciary Model, Rationality, Interests, and the Challenge of Abortion," (London: Libertarian Alliance, 2001).

²³⁴ "Families and Children" Libertarian Party Platform, accessed April 23, 2013.

<http://www.dehnbase.org/lpus/library/platform/fac.html>.

There are several competing values when applying this position to adolescent contraceptive access. The right to purchase and use contraceptives (though not under government insurance plans) falls under the right to autonomy over one's own body protected by libertarianism. Adolescents, however, are not yet autonomous adults, and therefore have additional considerations. Adolescents are still governed by their parents, and under libertarian philosophy their ability to access contraception would be dictated by their parents' views, not the state.

Philosopher David Wong offers an alternative perspective on the role of the family, drawing on Confucianism and communitarianism. As libertarianism places focus on the rights of family members as individuals, communitarianism focuses on the family as a unit. Wong examines the compatibility of liberalism and communitarianism, proposing that liberal morality should uphold the value of community.²³⁵ Within a family, principles of liberal autonomy may be deferred if it promotes overall familial well-being.²³⁶ Wong argues that maintaining familial and communal harmony is essential, and that advancing that goal ought to be the objective of morality. He emphasizes the variance between families, discussing how a mother reading her child's mail is acceptable within many traditional Chinese families, yet a violation of privacy within Western families. He uses this

²³⁵ David B. Wong, "Natural Mortalities: a defense of pluralistic relativism," (New York: Oxford University Press), 150.

²³⁶ *Ibid.*, 156.

example to underscore the importance of accounting for a “range of adequate moralities”²³⁷ between cultures and families. This positioning of families and communities as the central moral agents of society would necessitate a familial approach to decision-making, which, as we have seen in Steutel’s argument, becomes complex when it is applied to adolescent contraceptive access. Wong’s emphasis on familial harmony, however, may not be incompatible with the ethical argument for adolescent contraceptive access as long as it is not codified into law.

Libertarian and communitarian philosophies offer different perspectives about the role of the state. I argue, however, that the state must facilitate access to contraceptives for adolescents in order to ensure success. Although in most cases parents are the best judges of their children’s capacities, it is important that government and legal regulations exist to protect children from the outlier cases. The most effective kind of legal regulations therefore protect the rights of adolescents while not undermining parental authority. In terms of sexual health services, the right kind of regulation would ensure that adolescents have the legal right to these services, and that services are, in actuality, accessible. As my interviews in Monte Verde demonstrated, fear of punishment from parents is as a significant inhibitor of contraceptive access for adolescents. Requiring parental notification for adolescents to access contraception may further inhibit access. However, the ethical right of

²³⁷ Ibid., 155.

adolescents to access contraceptives does not subvert parental authority. Establishing this ethical right does not undermine the role of the parents to teach their own beliefs about sex to their child. Parents still have the right to discuss familial values and impose rules about sex and dating for their child, and can make clear their beliefs and encourage their child to abstain from sexual activity. Promoting personal beliefs about sexual activity, beyond those that directly protect citizens (such as the illegality of nonconsensual sex), is not the role of the government. Legally enforcing adolescents' right to accessible sexual health services is, however, consistent with protective measures that serve the societal goal of a healthy population. The parent can punish the child for disobeying their rules, but withholding medical care as punishment is unethical and should not be condoned by the state. In 1977, The United States Supreme court asserted that denial of contraceptive services cannot be used as a deterrent to sexual activity.²³⁸ Similarly, the state cannot dictate what an adolescent *should* or *should not* do, that is the parent's role. The state should, however, act in its own best interest of ensuring a healthy population of adults by providing the measures to protect adolescents from harm. Providing sexual health care to adolescents is in the state's best interest.

²³⁸ "Parental Consent and Notice for Contraceptives Threatens Teens and Teen Health and Constitution." Center for Reproductive Rights. Accessed April 23, 2013. <http://reproductiverights.org/en/document/parental-consent-and-notice-for-contraceptives-threatens-teen-health-and-constitutional-rig> .

Part iv.
Health Before “Virtue”

I accept that adolescent sexual behavior is in need of philosophical and ethical examination. A code of ethics should be realistic minimal standards of behavior with the objective of protecting its subjects from exploitation from outside parties or each other. Much of the rhetoric surrounding adolescent sexuality rests on the assumption that society has the duty to protect children from harm, both individually and through policy legislation. There is a fundamental disagreement about the best way to achieve this. Some groups argue that promotion of complete abstinence and denial of reproductive health services is the most effective tactic. Even when groups cite religious bans on adolescent sexuality, the core intent is still protection, whether it is from unplanned pregnancy or eternal damnation. Therefore, to demonstrate my argument that failing to provide accessible and confidential reproductive healthcare to teens is unethical, I must prove that accessible reproductive healthcare is necessary to protect teens.

By the time teens in the United States reach their senior year of high school, 62 percent are sexually active.²³⁹ The median age at first sex in the

²³⁹ Gladys Martinez, Casey E. Copen, and Joyce C. Abma, "Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2006-2010 National Survey of Family Growth," *Vital and Health Statistics*. 23 no. 31 (2011): 1.

US, at 17.2, is fairly consistent among industrialized countries.²⁴⁰ Teen pregnancy rates, however, are much higher in the United States, indicating that the risks of adolescent sexual activity can be better managed. The approach that other industrialized countries such as France, Germany, and the Netherlands, have taken to adolescent sexual behavior does not attempt to deter adolescent sex, but emphasizes managing its potential dangers.²⁴¹ I can see an objection here: how can I say that we should give up on fighting a social ill? Since domestic violence (for example) has not been ended by decades of crusade against it, should we give up on fighting that, too? I reject the assumption inherent in that argument that adolescent sexual behavior is an intrinsically damaging behavior.

Like most pursuits in life, sexual behavior has risks, namely disease and unplanned pregnancy. It also has positive attributes, including development of a sexual identity, facilitation of intimacy, and pleasure. Sexual behavior, along with eating and sleeping, is one of the only activities shared by almost every animal on earth. It's difficult to argue that sex is an unnatural or wrong practice, although people have certainly tried. However, engaging in sexual behavior is often framed as inherently detrimental to the development and well being of adolescents. Delaying sexual behavior is encouraged by

²⁴⁰ Jacqueline E. Darroch, Susheela Singh, Jennifer J. Frost, "Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use," *Guttmacher Institute Family Planning Perspectives* 33 (2001) <http://www.guttmacher.org/pubs/journals/3324401.html> accessed 10 October, 2013

²⁴¹ <http://www.advocatesforyouth.org/component/content/article/419-adolescent-sexual-health-in-europe-and-the-us>

most mainstream sexual education programs and health experts, and is generally considered to be a good thing. The rationale for this is that the longer sexual behavior is delayed, the more the adolescent's brain will develop, facilitating more responsible choices. This is certainly true, but responsible choices can also be facilitated through education and reproductive health access. Furthermore, adolescent sexual behavior is not an inherently harmful practice if precautions are taken. The risks associated with sexual behavior are manageable through attention to reproductive healthcare and preventative measures. Therefore, I reject that objection and argue that adolescent sexual behavior is absent of inherent moral weight. Like all sexuality, it can be experienced in a beneficial or detrimental way, depending on many different variables. Consensual adolescent sexual behavior is not a moral virtue, but neither is it a moral wrong.

Because of the moral neutrality of sexual behavior, I argue that instead of proscribing sexual behavior, society should take steps to minimize the potential harm that adolescents face. My argument, while appealing to the philosophical notion of duty, is informed by the practical reality of the unnecessarily high rates of teenage pregnancy and STIs that stem from inaccessible sexual healthcare and societal stigma. My argument does not attempt to quantify the deeper nature and meaning of sexual behavior, as does conservative philosopher Roger Scruton in his book, *Sexual Desire*. Scruton would object to my argument for adolescent contraceptive access because of

his deeper beliefs about what constitutes a fulfilling sexual life. Although he may acknowledge that adolescents could be harmed by denial of sexual health care, condoning adolescent sexual activity would undermine his deeply held conviction that “the moral life is more than simply leading a fulfilled biological life.”²⁴²

Scruton’s objective is to construct a sexual morality that is not rooted in religious belief, but instead in human nature. He believes that philosophy is in the position to address the questions about the place of chastity, modesty, shame, sexual desire, and indulgence in attaining a fulfilling and healthy sexual life. The concept of personhood as distinct from animal is central to Scruton’s argument. Per Scruton, sexual desire is a uniquely human attribute, in that it is individualized and intentional—one desires another human specifically, not just sex in general. When this becomes perverted, sexual behavior becomes destructive. Per Scruton, sexual desire becomes sexual consumption when we focus on the body rather than the person. Sexual desire should instead be a piece of a broader Aristotelian approach to happiness, or “flourishing” as people, and all attempts to define a sexual morality must keep this in mind.

²⁴² Roger Scruton, “Sexual Desire: A Philosophical Investigation,” (London : Weidenfeld and Nicolson, 2006), 322.

The crux of Scruton's argument as it applies to mine is in Chapter 11 in *Sexual Desire*, entitled "Sexual Morality". He describes the role of sexual morality as follows:

"The personal and the sexual can become divorced in many ways. The task of sexual morality is to unite them, to sustain thereby the intentionality of desire, and to prepare the individual for erotic love."²⁴³ His framework of sexual morality relies heavily on Aristotelian virtue ethics, with an emphasis on temperance and self-control. Scruton argues that curbing sexual impulses must be taught to children because cultivation of virtue and discipline is what distinguishes people from animals and is part of a bigger picture that allows people to flourish in the Aristotelian sense. Although his argument is secular in nature, it takes on shades of the Victorian argument against sex: that subverting sexual impulse is necessary to build discipline and virtue. Developing virtue by choosing to act or not act on a desire in pursuance of strength or character or discipline is an integral part of moral development. By developing virtue and educating children to do so, we are able to "flourish" in the Aristotelian sense, to attain happiness. Per Scruton, children are not able to identify and act in a way that takes into account their overall flourishing and happiness, which necessitates adults doing so for them: "I take an overview of [the child's] future life. I see that there is reason for him to

²⁴³ Ibid., 343.

have some desires rather than others, even if he cannot at present appreciate this fact.”²⁴⁴

Scruton’s argument relies on problematic and value-laden rhetoric about sex and virginity, especially casual sex, as disruptive to innocence and moral virtue. This type of rhetoric positions the type of sex a person has as important to their personhood. Scruton disputes the mind/body separation inherent to the dualist approach to sex, arguing that casual sex treats the body as a mere instrument to pleasure. He reasons that sexual desire is a sacred and personal exchange, and that casual sex corrupts this essence. He discusses the merits of traditional sex education:

“The most important feature of traditional sexual education is summarized in anthropological literature as the ‘ethic of pollution and taboo.’ The child was taught to regard his body as sacred, and as subject to pollution by misperception or misuse. [...] the most important root idea of personal morality is that I am in my body, not [...] as a pilot in a ship, but as an incarnate self [...] sexual purity is the precious guarantee of this.”²⁴⁵

Per Scruton, permissive attitudes towards sex separate sex from love and promote the idea of mind/body dualism. Deviating from the coupling of sex and love to focus only on the physical, as in casual sex, eliminates consideration of the interpersonal. Scruton, however, uses a dualist framework himself, assigning different objective meanings to sex based on his own beliefs. Sex can be good, per Scruton, but casual sex is, by its nature, bad.

²⁴⁴ Ibid., 326.

²⁴⁵ Ibid., 340.

This follows the conflicting rhetoric used in many purity and abstinence movements, which believe that casual sex violates a principle of purity when outside of marriage, yet within the bounds of marriage is a sacred act. Sex certainly has variable meanings according to context, but designation of those meanings should be left to individuals, not broad philosophical statements.

In “Sexual Morality,” Scruton does not argue explicitly against adolescent sexual activity, though his argument certainly supports a proscription. Furthermore, Scruton actually has very little to say about contraception in the whole of *Sexual Desire*, except to note that

[i]t is certainly true that our disposition to divorce the sexual act from reproduction has brought about a vast, and morally significant, change in the project of love-making. Clearly, practices which remove the likelihood that new and wholly overwhelming personal responsibilities will issue from an act can change the moral nature of the act.²⁴⁶

Our arguments are not explicitly at odds. We both have the same desired outcome: a society with a healthier outlook on sex. However, Scruton emphasizes a highly moralized view of sex and sexuality that I firmly reject. Placing numerous moral stipulations on consensual and personal sexual relationships seems to undermine the very personal nature of sexuality that Scruton is supporting. If two consenting parties engage in sexual behavior, who is Scruton specifically to say if they are in love enough or treating the act with enough sacredness? As I discussed previously, we need a framework of sexual ethics to protect one another from harm (for example, condemning rape

²⁴⁶ Ibid., 288.

and abuse), but I do not believe that it should extend to the particularities of personal feelings.

Although I do disagree with the tenets of Scruton's argument, I also wonder what his suggestions for practical applications would be. How would he apply his sexual ideals to policy? Although he briefly discusses the role of marriage²⁴⁷ he does not put forth any implications of his argument on policy. Perhaps his work was intended as a lofty philosophical ideal to consider and try to embody in one's own life. If so, I accept it, though I do not agree. However, I believe that Scruton, based on his comments about sexual education, would disagree vehemently with the argument I have put forth. He may object to my assertion that adolescent sexual behavior is not inherently harmful, because adolescents by definition cannot act in the interest of their own virtue. I define the quantifiable harm resultant from (consensual) sexual activity as unwanted pregnancies and sexually transmitted diseases, and believe that this issue can be addressed through contraceptive technologies and sexual education. Scruton would argue that the harm resultant from sexual activity that does not fall in line with his definition of correct would damage the very soul and not allow the person to "flourish". My argument is based on the promotion of health, which I believe is a noble objective. But Scruton would disagree: "Health is the state in which I flourish as an animal;

²⁴⁷ Ibid., 360

happiness the state in which I flourish as a person.”²⁴⁸ So, Scruton would accept my argument that adolescents may be harmed physically without access to sexual health care, but would argue that promotion of sexual integrity and virtue is a much more important goal to flourishing than physical health.

I endorse the promotion of trust and love between partners in sexual education. However, the practical implications of Scruton’s privileging of “flourishing” over health are difficult to reconcile. Denying healthcare to young people and putting them at risk in order to service a lofty philosophical goal seems shortsighted. This is not what Scruton is explicitly arguing for, but rather the logical conclusion of his argument, and the rhetoric behind the common argument against providing contraception because it may promote sexual activity. At its core, this common and damaging argument privileges a perceived lofty moral good—teenage abstinence—over the actual sexual health of teens. Steve Massey, a pastor at the Hayden Bible Church who wrote an Op Ed for the Spokesman-Review entitled “Free Birth Control Encourages Irresponsibility” argued this point:

The no-cost-birth-control provision of Obama’s Affordable Care Act encourages a mindset of unrestraint. And it contributes to the sense of sexual entitlement that is a primary cause of abortion, sexually transmitted diseases, and the erosion of the family.²⁴⁹

²⁴⁸ Ibid., 327.

²⁴⁹ Steve Massey, “Free birth control encourages irresponsibility,” *The Spokesman-Review*, October 6, 2012, accessed April 23, 2013, <http://www.spokesman.com/stories/2012/>.

According to this argument, contraception should not be accessible because it encourages sexual entitlement. Never mind that abortion and sexually transmitted diseases, which Massey attributes to this culture of entitlement, can be effectively eliminated with use of contraceptives. The fact that discussing contraceptives with teens does not encourage them to have sex is actually irrelevant to this conversation. A 2007 report by the National Campaign to Prevent Teen Pregnancy (a nonpartisan organization) found that a significant minority, 44 percent, of teens believes that a discussion of birth control use does encourage sexual activity.²⁵⁰ Even if discussing birth control did encourage teens to have sex (or empower them to realize that sexual activity is not inherently harmful), it is still morally correct to provide that information and access to them, and to preserve the concrete objective of health over the slippery objective of virtue.

I have now established the essential foundation of my ethical case, that the adolescent sexual behavior (1) exists and (2) is absent of moral weight. Furthermore, I have established that both adolescence and sexual health are special categories and therefore necessitate special rules. Recall the structure of my argument:

- (1) Society has a duty to protect adolescents from harm
- (2) Sexual healthcare is necessary to protect adolescents from harm.
- (3) Therefore, adult society has a duty to facilitate accessible sexual healthcare for adolescents.

²⁵⁰ Bill Albert, "America's Adults and Teens Sound off about Teen Pregnancy," (Washington DC: The National Campaign to Prevent Teen Pregnancy, 2007)

Here, I define society as the institutions that contribute in some way to the shaping of laws and regulations. Obviously, the government has a large degree of control over these matters, but crucial also are the voters and the pharmacies, school systems, and doctors' offices that would have direct contact with adolescents seeking reproductive healthcare. The role of government in the protection of its adult citizens is hotly debated, particularly in an individualistic society such as the United States. Despite this, it is uncontroversial that minors need guidance, both from their parents and institutional systems such as the government. I have already established premise 1, which is reflected in laws governing children and adolescents. Adult society has a duty to protect adolescents, and this duty is in the best interest of society because adolescents will very soon be a part of adult society, and society functions better if its members are healthy and well.

What is the best way to carry out this duty? We have already established that adolescents have an existing legal right to access reproductive healthcare. Until this legal right is successfully challenged, programs that discourage contraceptive use in the hopes that it will discourage sexual behavior are dishonest and wrong. The best way to protect against the risks associated with sexual behavior is to address the specific risk outcomes themselves instead of attempting to stop the behavior. Almost every behavior carries with it some degree of risk, and it's important for both the individual and the government to assess risks and benefits before engaging in the

behavior. The governing body has the additional task of enforcing risk-management practices to mitigate harmful effects of the behavior. For example, riding in a car is also a risky endeavor, with 93 people killed per day due to auto accidents in 2009.²⁵¹ Instead of prohibiting car travel, safety measures such as seatbelts, traffic laws, and driver's education have been implemented. These measures have not eliminated automobile accidents, but they have contributed to a 15% decrease in deaths from 1979 to 2005. Similarly, implementing sexual health programs and accessible contraceptives and STI prevention tools targeted to adolescents would decrease the possibility of harm resulting from sexual activity. These are clearly not analogous cases (the harms resultant from auto accidents are both more severe and measurable than those resulting from sexual behavior), but the risk-management model is the best way to address adolescent sexual behavior.

Experts in the field have extensively studied which models of adolescent pregnancy and STI prevention are most successful. The 2003 Best Practices in Teen Pregnancy Prevention Practitioner Handbook outlines ten essential components of effective teen pregnancy prevention strategies: youth development, involvement of family and other caring adults, male involvement, culturally relevant interventions, community-wide campaigns, service learning, employment opportunities, sexuality and AIDS education,

²⁵¹ "Motor Vehicle Traffic Fatalities and Fatality Rate: 1899-2003," Advocates for Highway and Auto Safety, accessed January 12, 2013.
<http://www.saferoads.org/federal/2004/TrafficFatalities1899-2003.pdf>

outreach, and access to reproductive health services.²⁵² A strategy that combines all of these components would be the most effective, and thus the most protective, strategy for adolescents. An Advocates For Youth report on successful models of adolescent pregnancy prevention in western Europe found that there were two consistent components in the countries studied: “1) societal openness and comfort in dealing with sexuality, including teen sexuality; and 2) pragmatic governmental policies”²⁵³, which included free and convenient access to contraception, including long acting reversible contraceptive methods. This supports my Premise 2, that sexual health care access, instead of denial, is the way to protect adolescents from harm associated with sexual activity. However, as I have emphasized in previous chapters, reproductive healthcare is a necessary but not a sufficient condition for good adolescent reproductive health outcomes. Contraceptive access is a small piece of a larger holistic approach to reproductive healthcare.

Throughout this thesis, I have discussed some of the practical and societal barriers facing adolescents in accessing reproductive health care. In this chapter, I have shown not only that adolescents have a legal right to this access, but that society has a moral duty to facilitate sexual health care access

²⁵² “Best Practices in Teen Pregnancy Prevention Practitioner Handbook.” Teen Pregnancy Prevention Program. 41 No. 2. (2003). Accessed January 12, 2013.

²⁵³ “Adolescent and Sexual Health in Europe and the United States,” Advocates for Youth, accessed April 13, 2013, <http://www.advocatesforyouth.org/storage/advfy/documents/>.

for adolescents. As I have shown through the case of the US and Costa Rica, as well as through the positive example of the Netherlands, this initiative must include both actively combatting societal discomfort with adolescent sexuality and implementing policies that make contraceptive access convenient and easy for adolescents. Just as stigma and policy influence each other, codifying and facilitating the right of adolescents to access contraceptives will lessen stigma against adolescent sexual behavior. Combatting barriers against adolescent contraceptive access is difficult, as barriers are complex and deeply embedded. However, we have a societal duty to do so, and up until this point we have not fulfilled it. Contraceptive access programs like the New York City Department of Education's have made critical steps towards acting on our ethical duty towards adolescents, but we have a long way to go until our moral obligation is met.

CONCLUSION: SOCIETAL PROBLEMS, SOCIETAL SOLUTIONS

We are worried about the teens of today. According to one report, nearly two-thirds of adults surveyed thought that 85% of young people today are sexually active by age seventeen.²⁵⁴ In another survey, 50% percent of adults said that the teen pregnancy rate has increased in the past twenty years.²⁵⁵ Sixty-five percent of adults attribute the alleged promiscuity of teens to “a decline in moral values” among this generation of adolescents.²⁵⁶

As historical analysis has demonstrated, adults have always thought that kids today are not what they used to be, no matter when “today” is: in 1946, 43% of adults surveyed felt that teenagers were behaving worse than they had as teens.²⁵⁷ However, public perceptions and media representation show an exaggerated view of teen sexual behavior that does not match up with the truth. Despite the barriers that exist to adolescent reproductive health access, teen sexual health outcomes in the United States are actually improving. Contrary to public opinion, only 48% of teens are sexually active by age seventeen, a pattern that has held fairly steady for decades, and they

²⁵⁴Meg Bostrom, “21st Century Teen: Public Perception and Teen Reality,” Frameworks Institute (2001), 19.

²⁵⁵The National Campaign to Prevent Teen and Unplanned Pregnancy, “Survey Says: The Greatest Story Never Told,” 2013

²⁵⁶Meg Bostrom, “21st Century Teen: Public Perception and Teen Reality,” 19.

²⁵⁷Rebecca Wind, “Perceptions of Young Adolescent Sexual Activity are Greatly Exaggerated,” *Guttmacher Institute* (2013)

are increasingly likely to use contraceptives.²⁵⁸ Likely due in part to increased contraceptive access, the adolescent pregnancy rate in the United States has plummeted by an impressive 42% since 1990.²⁵⁹

These encouraging statistics indicate that we are on the right track to facilitating access here in the United States. We still, however, have a long way to go before we achieve the excellent teen sexual health outcomes of other industrialized countries like the Netherlands. Ensuring that contraceptives and sexual health services are available and affordable to teens will help improve outcomes, but as the case of Monte Verde, Costa Rica, has shown, there are additional barriers that inhibit access. All over the world, women have fought for our rights as equal citizens in the public sphere, and we are no longer solely confined the role of wife and mother. However, many women's choices are constrained due to social and economic inequalities, rendering advanced opportunities unattainable. Without the possibility of educational or economic advancement, many adolescents do not see the benefits to delayed childbearing. Greater social, economic, gender, and racial equality is necessary to improve teen sexual health outcomes.

Even when adolescents want to delay childbearing, they face obstacles to accessing the reproductive health services that will allow them to do so. Through my research in Monte Verde, I saw what invisible barriers exist to teen access, even when contraceptives are freely available. As in the United

²⁵⁸ Ibid.

²⁵⁹ Ibid.

States, many of these barriers are rooted in societal discomfort about sex and stigma against adolescent sexual behavior. In order to make progress with adolescent sexual health outcomes, we must cultivate healthier attitudes towards sex within society. Instead of treating teen sexual activity as a harmful risk behavior and trying to put a stop to it, we should look at teen sex as a normal part of life, and our policies should reflect this. To achieve these goals, adults must listen sincerely to teen voices, and not dismiss adolescents as irrational or foolish. Our best chance of addressing teens' reproductive health needs is working with them to understand the problems they face in accessing care. This is my strongest recommendation for further study: that researchers in Monte Verde, the United States, and beyond talk to adolescents about their lived experiences to gain an understanding of their perspectives. As this thesis has shown, society must fully commit to combatting stigma against adolescent sexuality to facilitate reproductive health access. If “la primera barrera somos nosotros,” then we must also be the solution.

APPENDIX**1. Percepciones de la Comunidad de la disponibilidad de anticonceptivos y el acceso para los adolescentes en Monteverde, Costa Rica**

Edad:

Género:

Trabajo:

Estado civil:

¿Cuántos hijos tiene usted?

¿Cuáles son las edades de sus hijos?

¿Qué edad tenía usted cuando nació su primer hijo?

Nacionalidad:

¿Hasta que grado estudió en la escuela?

¿Cuántos años ha vivido en la zona de Monteverde?

¿Si usted se identifica con una religión, cuál es?

¿Usted tiene hijos en el sistema escolar en Monteverde? Si es así, a cuales escuelas asisten?

¿Cuando usted necesita atención médica, ¿a dónde va?

Cuales son todos los métodos anticonceptivos (los métodos y herramientas que se pueden usar para prevenir el embarazo) disponibles en Monteverde/Santa Elena y donde se pueden obtenerlos:

Cuales son los métodos anticonceptivos (o los métodos y herramientas que se pueden usar para prevenir el embarazo) disponibles para los adolescentes menores de 18 años en Monteverde y donde se pueden obtenerlos?

¿Los adolescentes necesitan permiso de sus padres para ir a la Clínica y obtener servicios de anticoncepción?

Si

No

¿En cuanto usted sepa, donde reciben los adolescentes en Monteverde su educación acerca de los anticonceptivos y la salud sexual?

¿Desde su punto de vista, los embarazos de adolescentes en Monteverde tienen un efecto en la comunidad? ¿Si es así, ¿cómo?

En su opinión, ¿el embarazo tiene efectos en la vida de las adolescentes que se quedan embarazadas? Si es así, ¿cómo les afecta?

¿Y la situación de los embarazos no planeados tiene efecto en la vida de los chicos adolescentes? Si es así, ¿cómo les afecta?

Desde su punto de vista, ¿qué tipo de métodos anticonceptivos deben estar disponibles para los adolescentes, y por qué? (Ask why for each method listed)

Desde su punto de vista, ¿cuáles son algunas de las posibles barreras, si las hay, al acceso confidencial de anticonceptivos para los adolescentes en Monteverde?

Percepciones de la Comunidad

El propósito de estas preguntas es medir la percepción de usted en cuanto al punto de vista de la comunidad de Monteverde con respecto al acceso a los anticonceptivos para los adolescentes. Por favor, indique su acuerdo o desacuerdo con las siguientes afirmaciones:

El embarazo adolescente afecta a la comunidad de Monteverde					
1	2	3	4	5	No
se					
(estoy de acuerdo)		(neutral)		(no estoy de acuerdo)	

Hay una elevada incidencia de embarazos de adolescentes menores de 18 años en la comunidad de Monteverde					
1	2	3	4	5	No
se					
(estoy de acuerdo)		(neutral)		(no estoy de acuerdo)	

Definiciones:

Educación acerca de la abstinencia del sexo sólo enseña que la abstinencia sexual hasta el matrimonio es la única forma moralmente correcta, y la única manera de protegerse contra las infecciones de transmisión sexual y el embarazo. Los anticonceptivos y profilácticos se pueden mencionar, pero sólo para hablar de sus fracasos.

La educación sexual comprensiva enseña que la abstinencia es la manera más segura de evitar las infecciones de transmisión sexual y el embarazo, sin embargo también enseña sobre prácticas sexuales más seguras como los anticonceptivos y condones.

La mayoría de los miembros de la comunidad creen que la educación acerca de la abstinencia debe ser enseñada a los adolescentes en las escuelas públicas

1	2	3	4	5	No
se					
(estoy de acuerdo)		(neutral)		(no estoy de acuerdo)	

La mayoría de los miembros de la comunidad creen que la educación acerca de la abstinencia debe ser enseñada a los adolescentes en las escuelas privadas

1	2	3	4	5	No
se					
(estoy de acuerdo)		(neutral)		(no estoy de acuerdo)	

La mayoría de los miembros de la comunidad creen que la educación sexual comprensiva debe ser enseñada en las escuelas públicas

1	2	3	4	5	No
se					
(estoy de acuerdo)		(neutral)		(no estoy de acuerdo)	

La mayoría de los miembros de la comunidad creen que la educación sexual comprensiva debe ser enseñada en las escuelas privadas

1	2	3	4	5	No
se					
(estoy de acuerdo)		(neutral)		(no estoy de acuerdo)	

SU PUNTO DE VISTA PERSONAL

El propósito de estas preguntas es medir la percepción de usted con respecto al acceso a los anticonceptivos para los adolescentes. Por favor, indique su acuerdo o desacuerdo con las siguientes afirmaciones:

Los adolescentes en Monteverde pueden obtener los servicios de anticoncepción (condones y otros métodos) de una manera confidencial

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

Los servicios anticonceptivos disponibles actualmente para los adolescentes en Monteverde son adecuados

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

Los servicios de anticoncepción están al alcance económico de los adolescentes en Monteverde

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

Servicios confidenciales para conseguir anticonceptivos deben estar disponibles a los adolescentes de Monteverde

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

Los adolescentes deben poder obtener condones sin permiso de los padres

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

Los adolescentes deben poder obtener todo tipo de servicios de anticoncepción, sin permiso de los padres

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

Definiciones:

Educación acerca de la abstinencia del sexo sólo enseña que la abstinencia sexual hasta el matrimonio es la única forma moralmente correcta, y la única manera de protegerse contra las infecciones de transmisión sexual y el embarazo. Los anticonceptivos y profilácticos se pueden mencionar, pero sólo para hablar de sus fracasos.

La educación sexual comprensiva enseña que la abstinencia es la manera más segura de evitar las infecciones de transmisión sexual y el embarazo, sin embargo también enseña sobre prácticas sexuales más seguras como los anticonceptivos y condones.

La educación acerca de abstinencia debe ser enseñada a los adolescentes en las escuelas públicas

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

La educación de abstinencia debe ser enseñada a los adolescentes en las escuelas privadas

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

La educación sexual comprensiva debe ser enseñada en las escuelas públicas

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

La educación sexual comprensiva debe ser enseñada en las escuelas privadas

1	2	3	4	5	No
(estoy de acuerdo)		(neutral)	(no estoy de acuerdo)		

¡Gracias!

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