

**YOUTH**   
**REPRODUCTIVE**  
**EQUITY** 

**ADOLESCENCE POST-DOBBS:  
A POLICY-DRIVEN RESEARCH AGENDA FOR  
MINOR ADOLESCENTS AND ABORTION**

Julie Maslowsky, PhD

Laura Lindberg, PhD

Emily S. Mann, PhD

**Suggested citation**

Maslowsky, J., Lindberg, L., Mann, E. S. (2024). Adolescence Post-Dobbs: A Policy-Driven Research Agenda for Minor Adolescents and Abortion. Ann Arbor, MI: Youth Reproductive Equity. <https://dx.doi.org/10.7302/22808>

Please direct all inquiries to [youthrepro@umich.edu](mailto:youthrepro@umich.edu).

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# EXECUTIVE SUMMARY

## Overview of the Report

Minors, or adolescents under age 18, are vastly underrepresented in research on abortion in the United States. Their absence limits researchers' ability to monitor and address the impacts of the rapidly changing abortion policy environment on this important population—failing to produce needed research on minors and abortion is a health equity issue. The overarching aim of this report is to present an actionable research agenda on abortion policy and its impacts on minors. This report's target audiences include researchers, funders of research, and individuals and organizations who help translate research evidence into policy.

### The report's goals are to:

- Describe the need for research on minors and abortion.
- Identify the challenges that limit research on minors and abortion and the translation of research evidence to policy.
- Demonstrate that, despite extant challenges, research on minors and abortion is feasible and impactful.
- Lay out a clear and actionable path for generating and translating rigorous, equitable, and impactful research on minors and abortion.

The report includes: a review of the importance of minors' abortion access and reasons for its absence to date (**Chapter 1**); methods used in our expert convenings and overarching research principles to guide the conduct of equitable, actionable, and impactful research in this area (**Chapter 2**); a scan of the abortion policy landscape with a focus on minors (**Chapter 3**); a detailed policy-responsive research agenda to advance knowledge and evidence-based policy (**Chapter 4**); detailed research questions to be addressed across identified policy domains (**Chapter 5**); summary of overarching challenges that have historically hampered research on minors' abortion and recommended strategies for overcoming those challenges (**Chapter 6**); and key recommendations for bringing the proposed research agenda to fruition (**Chapter 7**).

## Objective

Despite the significant progress made in the field of sexual and reproductive health research in emphasizing equity and centering the populations most affected by changes in policies related to abortion,<sup>1,2</sup> minors have thus far been overlooked. Following the Supreme Court's *Dobbs* decision, more than half of U.S. adolescents ages 13-19 now live in a state with severely restricted or no legal abortion access.<sup>3</sup> Minors already faced additional barriers to accessing abortion prior to *Dobbs*. Now, minors are disproportionately impacted by new abortion restrictions and are either targeted by restrictive policies or overlooked in protective policies at the state level. Minor abortion access is regulated by all the laws that impact adults as well as many minor-specific laws. Even when minors can overcome legal obstacles to abortion care, they face greater barriers related to cost, information, and access than adults.<sup>4,5</sup> Minors' rights are often restricted as a compromise in order to secure votes for abortion policies that apply to adults.<sup>6,7</sup> Restricting the rights of minors sets a dangerous precedent for other marginalized groups. Yet minors are systematically underrepresented in research on abortion. The objective of this report is to guide the conduct of equitable, actionable, and impactful research in this area.

## Our Process

We conducted three environmental scans to assess the state of the current research and synthesize the available evidence and key informant interviews with individuals and organizations currently engaged in research on abortion policies to facilitate the development of an actionable research agenda. In a series of four convenings, we assembled 30 experts representing the following constituencies: young people, researchers, clinicians, leaders of nonprofit and reproductive justice-focused organizations, and legal and policy experts. We established four overarching research principles to guide research on minors and abortion:

- 1 RESEARCH NEEDS TO INCLUDE DIVERSE SAMPLES OF MINORS.**
- 2 ACCURATE EVIDENCE ABOUT MINORS' CAPABILITIES SHOULD INFORM RESEARCH AND POLICY.**
- 3 REPRODUCTIVE JUSTICE PRINCIPLES NEED TO BE INCORPORATED INTO RESEARCH.**
- 4 RESEARCH SHOULD INCORPORATE MINORS' PERSPECTIVES AND LIVED EXPERIENCES.**

The research agenda, themes, priorities, and gaps presented here were developed through this process.

## KEY FINDINGS

### Policy Scan

We conducted a policy landscape scan in June 2023 to identify state abortion policies that are specific to minors and/or likely to disproportionately impact minors, including both protective and restrictive policies. After completing the policy scan, we classified policies into four categories: (1) minors' access to abortion, (2) minors' access to information about abortion, (3) parental and adult involvement in minor adolescent abortion, and (4) minors' privacy and confidentiality about abortion. We outline detailed research questions for each category of policies focused on producing specific data that can inform evidence-based policies.

### Research Agenda

Our expert panel identified key components of a policy-responsive research agenda and associated recommendations for action (**Table 1**). The agenda is organized into three research areas: (1) conceptual and bioethics; (2) legal; (3) and social and behavioral. We conclude by identifying specific research needs for each research area.

We present a novel typology of methods for increasing minors' representation in sexual and reproductive health research. To proactively include minors in social and behavioral research relevant to abortion, we propose studying both the **direct** impacts on pregnant minors who do or do not receive an abortion and the **indirect** impacts of abortion policies on the general population of minors. Studying direct impacts can be accomplished through 1) **expanding** studies that have traditionally focused on adults to encompass minors or 2) **tailoring** studies specifically focused on minors. Indirect impacts on the total population of minors can be studied by 3) **contextualizing**: conducting population-representative studies of adolescents that are not solely focused on abortion or sexual and reproductive health but capture relevant contexts of adolescents' lives as abortion access is changing.

**TABLE 1: RESEARCH AREAS AND RECOMMENDATIONS**

**Conceptual and Bioethics Research**

- 1** Develop an overarching conceptual framework to guide research on adolescents' sexual and reproductive health as a whole and minors' abortion experiences specifically.
- 2** Develop and disseminate bioethics research responsive to the unique sexual and reproductive health experiences and needs of minors to guide IRB oversight of this research.

**Legal Research**

- 3** Conduct a legal analysis of existing restrictive and protective policies to determine their applicability to minors and those assisting them in accessing abortion.
- 4** Translate legal research into state-specific legal guidance on minors' abortion rights for health care providers and the general public.
- 5** Create and maintain a comprehensive, longitudinal database of state abortion policies, including those specific to minors.
- 6** Conduct legal epidemiology and other studies to document differential experiences and outcomes across a range of domains among minors exposed to different policy environments.

**Social and Behavioral Research**

- 7** Increase and improve the inclusion of minors in patient population studies and state and national abortion surveillance.
- 8** Present age-specific data and analyses, with minors presented separately from adults, to allow identification of minors' experiences.
- 9** Field a longitudinal study of pregnant minors over time, across different abortion policy environments.
- 10** Conduct dedicated studies of abortion among systems-involved and multiply marginalized youth.
- 11** Field timely studies of the general population of minors to understand their current knowledge, attitudes, and behaviors related to changing abortion access.
- 12** Promote and support federal, state, and private efforts to expand and improve sexual and reproductive health data collection from minors with attention to sample size and measurement quality.
- 13** Field a population-representative longitudinal survey of adolescents that allows for research on the impact of the post-*Dobbs* environment on minors' behavior, education, economic, and health outcomes into adulthood.
- 14** Conduct developmental science studies on adolescents' development as it relates to abortion experiences and decision making.
- 15** Apply developmental science to the creation of developmentally optimized policies and clinical practices for minors in abortion and sexual and reproductive health.
- 16** Enrich research on minors by studying attitudes and actions of adults who are influential in minors' abortion experiences.

**Building Capacity and Overcoming Challenges**

We identify six enduring and overarching challenges related to infrastructure, oversight, and workforce composition, and capacity that systematically hamper the field's ability to produce actionable research evidence related to minors and abortion. We propose recommendations to address these challenges:

Challenge	Recommendation
1. Researcher training: The field of sexual and reproductive health research has traditionally not trained researchers to focus on minors.	Train researchers on how and why to include minors in sexual and reproductive health research, including research focused on abortion.
2. Researcher composition: Scholars from marginalized groups are underrepresented.	Diversify the abortion research workforce to include more scholars from marginalized and traditionally underrepresented groups.
3. Need for interdisciplinary expertise: Siloing of expertise and approaches limit the production of relevant research.	Encourage adolescent-focused researchers to integrate an attention to abortion into their work and, correspondingly, encourage abortion researchers to integrate a focus on minors into their work.
4. IRB: Overreaching IRB oversight often creates unnecessary obstacles to conducting abortion research with minors.	Create best practice guidelines for researchers seeking IRB approval for abortion research with minors and for IRBs on how to review proposals on minors' abortion.
5. Funding: Funders fail to prioritize research on minors in their funding strategies.	Expand funding to support minor-focused research, including training and development and dissemination of best practice guidelines.
6. Need for additional translation and dissemination of research.	Translate research on minor abortion into actionable tools and recommendations for practitioners and policymakers.

## Conclusion

U.S. abortion policy is changing rapidly, and minors are disproportionately affected every day. Minors have historically been vastly understudied compared to adults in abortion-related research. This gap in knowledge has become a liability given the lack of evidence the field has generated to refute unfounded claims used to justify restrictions on minors' abortion access and, eventually, expand those restrictions to other populations. There is an urgent need to generate evidence to inform policies that govern minors' abortion access. The experts we convened to develop this roadmap are confident in the field's ability to produce high-quality, actionable research evidence to inform policy on minor abortion access. We urge researchers, professional organizations, funders, and policy advocates to join together in the pursuit of evidence-based policy that supports adolescents' human right to bodily autonomy and advances reproductive equity.

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## EXPERT PANELISTS

### Elizabeth Alderman, MD

PROFESSOR OF PEDIATRICS AND OBSTETRICS & GYNECOLOGY AND WOMEN'S HEALTH, [ALBERT EINSTEIN COLLEGE OF MEDICINE](#)

### Arpita Appannagari, MPH

ASSOCIATE DIRECTOR OF POLICY AND PARTNERSHIPS, [NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH](#)

### Shayla Astudillo

ABORTION OUT LOUD ORGANIZER, [ADVOCATES FOR YOUTH](#)

### Karen Bernstein, MD, MPH\*

DIRECTOR, DIVISION OF ADOLESCENT MEDICINE, [UNIVERSITY OF ILLINOIS AT CHICAGO](#)

### Lotte Brewer\*

MATERNAL AND CHILD HEALTH GRADUATE STUDENT, [UNIVERSITY OF ILLINOIS AT CHICAGO](#)

### Naomi Cahn, JD

PROFESSOR AND CO-DIRECTOR, FAMILY LAW CENTER, [UNIVERSITY OF VIRGINIA SCHOOL OF LAW](#)

### Kate Coleman-Minahan, PhD, RN, FNP-BC

ASSISTANT PROFESSOR, COLLEGE OF NURSING, [UNIVERSITY OF COLORADO](#)

### Jacki Davidoff\*

PRINCIPAL AND SENIOR CONSULTANT, [DAVIDOFF STRATEGY](#)

### Kelly Davis

EXECUTIVE DIRECTOR, [NEW VOICES FOR REPRODUCTIVE JUSTICE](#)

### Jennifer Driver

SENIOR DIRECTOR OF REPRODUCTIVE RIGHTS, [STATE INNOVATION EXCHANGE](#)

### Deborah Effon

MEMBER OF THE YOUNG WOMEN OF COLOR FOR REPRODUCTIVE JUSTICE COLLECTIVE, [ADVOCATES FOR YOUTH](#)

### Abigail English, JD

DIRECTOR, [CENTER FOR ADOLESCENT HEALTH & THE LAW](#)  
SENIOR POLICY FELLOW, [SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE](#)

### Keemi J Ereme, MD, MPH

COMPLEX FAMILY PLANNING FELLOW, [UNIVERSITY OF WASHINGTON](#)

### Jonah Fleisher, MD, MPH\*

ASSISTANT PROFESSOR OF CLINICAL OBSTETRICS & GYNECOLOGY, [UNIVERSITY OF ILLINOIS AT CHICAGO](#)

### Liza Fuentes, DrPH, MPH

DIRECTOR OF HEALTH EQUITY RESEARCH, [BOSTON MEDICAL CENTER](#)

### Amitha Ganti, MD, FACOG

PEDIATRIC AND ADOLESCENT GYNECOLOGY FELLOW, [BAYLOR COLLEGE OF MEDICINE](#)

### Kami Geoffray, JD

CONSULTANT, [GEOFFRAY STRATEGIES](#)

### Vinita Goyal, MD, MPH

PHYSICIAN RESEARCHER, [COMPLEX FAMILY PLANNING](#)

### Elle Grano

DIRECTOR OF ADVOCACY AND PARTNERSHIPS, [JANE'S DUE PROCESS](#)

### Debra Hauser

PRESIDENT, [ADVOCATES FOR YOUTH](#)



## **Erica Hinz, MD, MPH, FACOG\***

ASSISTANT PROFESSOR OF CLINICAL OBSTETRICS & GYNECOLOGY,  
**UNIVERSITY OF ILLINOIS AT CHICAGO**

## **Marsha Jones**

EXECUTIVE DIRECTOR, **AFIYA CENTER**

## **Jonathan D. Klein, MD, MPH\***

MARRON AND MARY ELIZABETH KENDRICK PROFESSOR  
OF PEDIATRICS, DIVISION OF ADOLESCENT MEDICINE,  
**STANFORD UNIVERSITY**

## **Emilyn Lagger**

CHAPTER PRESIDENT OF URGE (UNITE FOR REPRODUCTIVE EQUITY),  
**THE UNIVERSITY OF TOLEDO**

## **Shannon Lightner**

DEPUTY DIRECTOR, OFFICE OF WOMEN'S HEALTH AND FAMILY  
SERVICES, **ILLINOIS DEPARTMENT OF PUBLIC HEALTH**

## **Laura Lindberg, PhD\***

PROFESSOR, DEPARTMENT OF URBAN-GLOBAL PUBLIC HEALTH,  
**RUTGERS UNIVERSITY**

## **Emily S. Mann, PhD\***

ASSOCIATE PROFESSOR OF HEALTH PROMOTION, EDUCATION, AND  
BEHAVIOR, **UNIVERSITY OF SOUTH CAROLINA**

## **Julie Maslowsky, PhD\***

ASSOCIATE PROFESSOR OF HEALTH BEHAVIOR AND BIOLOGICAL  
SCIENCES, **UNIVERSITY OF MICHIGAN**

## **Diana Parker-Kafka**

EXECUTIVE DIRECTOR, **MIDWEST ACCESS COALITION**

FOUNDING BOARD MEMBER, APIARY FOR PRACTICAL SUPPORT,  
**ELEVATED ACCESS**

## **Mayra Pineda-Torres, PhD**

ASSISTANT PROFESSOR, SCHOOL OF ECONOMICS, **GEORGIA  
INSTITUTE OF TECHNOLOGY**

## **Lauren Ralph, PhD, MPH**

EPIDEMIOLOGIST AND ASSOCIATE PROFESSOR, ADVANCING  
NEW STANDARDS IN REPRODUCTIVE HEALTH, **UNIVERSITY OF  
CALIFORNIA SAN FRANCISCO**

## **Sara Redd, PhD, MSPH**

ASSISTANT PROFESSOR, ROLLINS SCHOOL OF PUBLIC HEALTH,  
**EMORY UNIVERSITY**

## **Jessie Romero Silver**

TEEN STAFF WRITER, **SEX, ETC.**

## **Pamela Shaw, MD, FAAP**

PROFESSOR OF PEDIATRICS, **KANSAS UNIVERSITY  
MEDICAL CENTER**

## **Simran Singh Jain**

MEMBERSHIP COORDINATOR, **SISTERSONG WOMEN OF COLOR  
REPRODUCTIVE JUSTICE COLLECTIVE**

## **Kylee Sunderlin**

LEGAL SUPPORT DIRECTOR, **IF/ WHEN/ HOW**

## **Ena Suseth Valladares**

DIRECTOR OF PROGRAMS, **CALIFORNIA LATINAS FOR  
REPRODUCTIVE JUSTICE**

## **Sri Tharika Jothipuram Jayakumar**

PEER EDUCATOR, **PLANNED PARENTHOOD OF MICHIGAN**

## **Valentina Turner**

YOUTH FACILITATOR, **ILLINOIS CAUCUS FOR ADOLESCENT HEALTH**

## **Zoe Unger, MPH**

DIRECTOR OF ABORTION ACCESS, **POWER TO DECIDE**

## **Krishna Upadhyia, MD, MPH**

**PLANNED PARENTHOOD FEDERATION OF AMERICA**

# ABOUT YOUTH REPRODUCTIVE EQUITY

**Youth Reproductive Equity is a national, multidisciplinary research collaborative composed of researchers and clinician-scientists.**

Youth Reproductive Equity is the go-to source of scientific expertise and thought leadership on adolescent and young adult sexual and reproductive health, inclusive of abortion and contraception.

We envision a world where every adolescent and young adult in the United States has the power to make informed choices about their own body and can access a full range of evidence-based sexual and reproductive health services to support their health and well-being throughout their life.

We work to ensure that adolescents are included in research and action to advance sexual and reproductive health; policies and practices related to adolescent and young adult sexual and reproductive health are evidence-based; and public narratives about adolescent sexuality are grounded in science and center bodily autonomy.

To achieve these goals, we expand capacity for scholarship on adolescent and young adult sexual and reproductive health, conduct research to document and understand the current status of adolescent and young adult sexual and reproductive health and inform solutions, communicate strategically to disseminate evidence, and convene coalitions to visibly and actionably support adolescent and young adult sexual and reproductive health.

For more information, visit [www.youthreproequity.org](http://www.youthreproequity.org).

## **Statement on Inclusive Language:**

Youth Reproductive Equity believes abortion access is a fundamental human right for all who can become pregnant, including transgender, gender-expansive, and intersex individuals. Adopting gender-neutral language is crucial to ensuring equitable research, legislation, and public dialogues that reflect the experiences and needs of all who have abortions. While efforts towards inclusivity are increasing, existing research and surveillance systems often lack data differentiating sex assigned at birth from gender identity. To accurately reflect researchers' findings, we will only use gendered language when referencing studies that employ such terminology. We call upon our colleagues researching abortion to join us in integrating inclusive language into their practices and finding new ways to collect data that amplifies the voices and needs of gender-diverse people.<sup>1</sup>

## INTRODUCTION

### **Scope of the report: Abortion, minors, and the broader context of sexual and reproductive health and adolescents of all ages**

Minors, who are adolescents under age 18, are vastly underrepresented in research on abortion. The overarching aim of this report is to present an actionable research agenda on abortion policy and its impacts on minors. This agenda was formulated through a series of expert convenings hosted by Youth Reproductive Equity. Our target audiences are: researchers, funders of research, and individuals and organizations who help translate research evidence into policy.

#### **Our goals are to:**

- Describe the need for research on minors and abortion.
- Identify the challenges that limit research on minors and abortion and the translation of research evidence to policy.
- Demonstrate that, despite extant challenges, research on minors and abortion is feasible and impactful.
- Lay out a clear and actionable path for generating and translating rigorous, equitable, and impactful research on minors and abortion.

While our focus in this report is specifically on abortion policies and evidence needed to inform them, most of the underlying challenges that we identify apply to adolescent sexual and reproductive health more broadly. As such, many of our recommendations would benefit the broader field of adolescent sexual and reproductive health research and would support evidence-based policies on sexual and reproductive health beyond abortion. Similarly, although in this report we focus specifically on minors, which includes all pregnancy-capable adolescents under age 18, because of minors' unique standing in the law, many of the issues identified herein apply to adolescents of all ages. Our recommended action steps would benefit adolescents of all ages, their families, and their communities.

### **Failing to produce needed research on minor adolescents and abortion is an equity issue**

The field of sexual and reproductive health research, including research focused specifically on abortion, has made significant progress in emphasizing equity and centering the populations most affected by the issues.<sup>2,3</sup> The reproductive justice movement is the primary catalyst for this shift. Reproductive justice is the human right to maintain personal bodily autonomy, have children, not have children, and parent the children one has in safe and sustainable communities.<sup>4,5</sup> The human right to bodily autonomy includes abortion access and the ability to exercise self-determination over one's reproductive future. The reproductive justice movement was created by women of color and explicitly centers racism as a structural determinant of reproductive inequities and race as the key axis of identity and lived experience through which reproductive injustices are examined.

The reproductive justice movement has been a powerful and transformative force in the field. However, it has not traditionally had a strong focus on minors. People of all ages, including minors, are entitled to the

human right to bodily autonomy. Minors are subject to the same interlocking systems of oppression as adults, including racism, sexism, heterosexism, and cisgenderism, in addition to systematically differential treatment based on age category—sometimes referred to as adultism. Given their differential treatment under the law and by society at large, being a minor under age 18 is also a marginalized status in our society. Applying an intersectional lens to age-based inequities allows for a holistic understanding of how adolescents’ access to abortion is a reproductive justice and an equity issue, which can more effectively inform policy solutions.

Researchers and funders who prioritize historically underrepresented populations in their work should recognize that minors are marginalized in our society and are consistently underrepresented in abortion research, creating an effective blind spot about any abortion occurring before the age of 18 and undermining the body of work that does exist. The field of abortion research should not tolerate such a large gap in its knowledge, which has become a liability given the lack of evidence the field has generated to refute unfounded claims used to justify restrictions on minors’ abortion access. We offer suggestions throughout this document for bringing together experts in reproductive justice and adolescent health and development to support bodily autonomy for minors.

## Background: Abortion and Minors

Following the US Supreme Court’s Decision in *Dobbs v. Jackson Women’s Health Organization* in June 2022, fourteen states have banned abortion entirely, three states have bans under litigation, and seven states have lowered their gestational threshold for abortion to 20 weeks or less (as of February 2024).<sup>6</sup> More than half of U.S. adolescents, ages 13-19, now live in a state with severely restricted or no legal abortion access.<sup>7</sup> Minors already faced additional barriers to accessing abortion prior to this decision. Minors are disproportionately impacted by new abortion restrictions and are often targeted by restrictive state abortion policies or overlooked in protective policies. See **Box 1** for recent abortion-related current events where minors’ abortion rights were among the first to be targeted by new abortion restrictions, are publicly mischaracterized to drive state abortion rights discussions, and are often compromised during political negotiations.

### BOX 1

## CURRENT EVENTS EXAMPLES: MINORS’ ABORTION RIGHTS

### MINORS ARE:

**AMONG THE FIRST TO BE  
TARGETED BY NEW ABORTION  
RESTRICTIONS**

**PUBLICLY MISCHARACTERIZED  
TO DRIVE STATE LEGISLATIVE  
DISCUSSIONS**

**OFTEN COMPROMISED  
DURING POLITICAL  
NEGOTIATIONS**

May 2023: Idaho passes **House Bill 242**, which amends the state’s definition of human trafficking to include obtaining or supporting access to out-of-state abortion care for a person younger than 18 without parental knowledge, creating a new crime termed “abortion trafficking.” In the months that follow, several states (Mississippi, Tennessee, Oklahoma) propose similar laws.

November 2023: Ohio passes **Issue 1**, a constitutional amendment to protect abortion rights in the state. The text of the amendment states in part: **“Every individual has a right to make and carry out one’s own reproductive decisions...”** The amendment makes no specific mention of minors or parental involvement. In making arguments against the amendment, elected officials claimed that the amendment erases parental rights by ending parental notification and “cuts parents out of the most important decisions in their children’s lives, while allowing abortion promoters to pressure those children behind closed doors.”<sup>27</sup> Abortion opponents use fear-mongering techniques in advertisements to portray exaggerated circumstances of minors seeking abortions without parental consent. In the days leading up to the election, four pediatricians and leading reproductive rights activists publish a piece in the *Columbus Dispatch* stating that Issue 1 would not remove parental consent requirements already laid out in the state’s medical consent laws.<sup>28</sup> Minors’ rights activists view this as another example of even committed advocates sacrificing minors’ rights in political negotiations and emphasize that minors would continue to be subject to additional constraints on their abortion access despite Issue 1’s passage.

## ABORTION AMONG MINORS

Minors, or individuals under age 18, account for approximately 4% of all abortions within the formal US healthcare system. This means that prior to *Dobbs*, at least 25,000 minors received abortion care each year in the United States.<sup>8</sup> An unknown number were unable to obtain a wanted abortion. Pregnancies to minors are much more likely to end in an abortion (1023 abortions per 1000 births among minors ages 15 and younger, 476 abortions per 1000 births among minors ages 16-17) compared to those ages 18-19 or 20-24 (379 and 330 abortions per 1000 births, respectively).<sup>9</sup> Minors' desire for abortion care is driven by their experience of unintended pregnancy; more than 2/3 of pregnancies to minors are unintended, far exceeding other ages.<sup>10</sup> Minors also face greater barriers to preventing undesired pregnancy than adults, including barriers to contraception and limited access to comprehensive sex education, which result in an increased need for abortion.<sup>11-13</sup>

## LEGAL AND LOGISTICAL BARRIERS

Compared to adults, minor adolescents face disproportionate legal, financial, logistical, and social barriers to abortion. Minor abortion access is regulated by all the laws that impact adults as well as many minor-specific laws, which we review later in this document. Even when minors can overcome legal obstacles, they face greater barriers related to cost, information, and access than adults.<sup>14,15</sup> Minor adolescents are in a vulnerable position legally. In political negotiations, minors' rights are often restricted as a compromise in order to secure votes for abortion policies that apply to adults.<sup>16,17</sup> Restricting the rights of minors sets a dangerous precedent for other marginalized groups. As scholars have noted, historically, abortion restrictions for minors have seldom stopped with minors; minors are an easy target for initial restrictions, which then sets a precedent and allows restrictions to be expanded to other groups.<sup>18</sup>

## MINORS ARE SYSTEMATICALLY UNDERREPRESENTED IN RESEARCH ON ABORTION

Compared to adults, there is far less research and data on minors' abortion access and experiences and the impact of policies on them. A key theme in our expert panel discussions was that minors are frequently left out or regarded with ambivalence by the reproductive health research community, policymakers, and funders. There are a number of reasons, longstanding and more recently emerging, for this. Throughout this report, we address these ongoing challenges head-on and offer specific strategies for overcoming them.

### Frequently cited challenges to doing research on abortion in minors, and where in this document we address them:

- **Mischaracterization of adolescents' competence to make reproductive health decisions.**  
*See [Box 2](#) for evidence from developmental science on adolescent development and reproductive health decision making.*
- **Perception that abortion among minors is too controversial to the public.**  
*See [Box 3](#) for recent success stories for adolescents' bodily autonomy, including recent examples of how states are formulating abortion policies specifically for minors.*
- **Lower rates of pregnancy and abortion among minors than adults created challenges for sampling and recruitment of minors.** *See [Chapter 4: Policy-Responsive Research Agenda](#) for guidance on a variety of study designs and methodologies that can and should be used to study the wide array of research questions around minors and abortion.*
- **Constraints of research capacity.** *See [Chapter 6: Building Research Capacity](#) for approaches to Institutional Review Boards, composition and training of the researcher workforce, disciplinary siloing and need for interdisciplinary research approaches, funding priorities of major funders, and need for additional dissemination and translation of research to policy and practice.*

## ADOLESCENT DEVELOPMENT AND REPRODUCTIVE HEALTH DECISION MAKING

**Many policies restricting minors' bodily autonomy are predicated on a non-evidence based popular narrative that minors are not mature enough to make their own decisions.**

Developmental science research has demonstrated for decades that by mid-adolescence, young people are comparable to adults in their ability to make deliberative decisions, including specific abilities in working memory, logical reasoning, weighing risks and benefits, and anticipating consequences of their actions.<sup>19-21</sup> For example, studies show that most adolescents comprehend package labeling on emergency contraceptives, can accurately assess the gestational duration of their pregnancy when seeking abortion, and demonstrate high levels of capacity to make a medical decision about hormonal contraception in a pharmacy setting.<sup>22-24</sup> Additional research focused specifically on the abortion context is needed to inform the policies and practices governing adolescents' ability to make their own reproductive health decisions. This should include synthesizing existing evidence on minors' competency and ability to consent to medical care and conducting new studies on adolescent competency and decision-making related specifically to abortion. See **Chapter 6** for additional recommendations.

## SUCCESS STORIES FOR MINORS' REPRODUCTIVE RIGHTS AND ACCESS

**These three success stories reflect reforms that occurred following extensive campaigns that combined research with advocacy, testimony, and public engagement. They demonstrate that there is both public and political will for expanding minors' reproductive rights and access.**

### REPEALING STATE LAWS REQUIRING PARENTAL CONSENT AND NOTIFICATION FOR MINORS' ABORTION

**June 2022:** Illinois repeals the Parental Notice of Abortion Act, removing the requirement for parents of minors to be notified prior to the minor's abortion. The repeal follows years of advocacy by a youth-led coalition that drew on research evidence, youth testimony, and legal arguments to make their case.<sup>25</sup> Illinois now allows minors of any age to obtain an abortion without parental consent or notification.

### MAKING ORAL CONTRACEPTIVES AVAILABLE OVER THE COUNTER TO PEOPLE OF ALL AGES

**July 2023:** For the first time, the FDA authorized over-the-counter sales of oral contraception: Opill, a progestin-only oral contraceptive pill. One key consideration, according to the FDA, was whether over-the-counter (OTC) availability was appropriate for minors. Proponents made the case that minors should have OTC access via a combination of research evidence, testimony, and formal political participation through the public comment components of the FDA's regulatory process. Research evidence demonstrated the safety and effectiveness of Opill among minors, their ability to use it properly in the OTC setting, and the public health importance of OTC availability of contraception for minors. Testimony from medical professionals, researchers, advocates, and minors themselves emphasized the many barriers that minors currently face in accessing effective contraception and the need for additional options. The public comment portal largely reflected this same sentiment, with a notable minority opposing minors' access to OTC contraception on largely values-based grounds. The FDA's scientific advisory committee voted unanimously to approve Opill for OTC use and to impose no age restrictions on its sale. Several members of the scientific advisory committee specifically addressed the importance of minors' access to the product and referenced the strength of both the scientific evidence and the public demand for this product. The FDA followed the recommendation of its scientific advisory committee and authorized Opill for OTC sales without age restrictions. It is expected to be available to all consumers in 2024.

**SUCCESS STORIES FOR MINORS' REPRODUCTIVE RIGHTS AND ACCESS (CONT.)****EXPLICITLY  
ADDRESSING  
MINORS' RIGHTS AND  
PARENTAL CONSENT  
REQUIREMENTS IN  
STATE LEGISLATION**

**July 2023:** Oregon passes House Bill 2002 focused on protecting reproductive rights in the state (Oregon HB 2002, 2023). The bill explicitly addresses minors' right to consent to abortion, stating that any minor age fifteen and over can consent to the procedure without parental involvement. Consent by minors under age 15 is also allowed if the health care provider believes that requiring parental consent would result in abuse to the minor or that consent is otherwise not in the minor's best interest.

In the chapters that follow, we first present an overview of our methods and approach, including overarching research principles to guide the conduct of equitable, actionable, and impactful research in this area (**Chapter 2**). Next, we summarize the abortion policy landscape with a focus on minors (**Chapter 3**). **Chapter 4** contains a policy-responsive research agenda to advance knowledge and evidence-based policy in this area. **Chapter 5** presents detailed research questions to be addressed by policy domain. **Chapter 6** identifies overarching challenges that have historically hampered research on minors' abortion and recommends strategies for overcoming those challenges. **Chapter 7** ends with our key recommendations for bringing the research agenda to fruition.

## METHODS AND APPROACH

### Preliminary work

Prior to convening the expert panel, we conducted three environmental scans to assess the state of the current research and synthesize the available evidence. The first characterized the multiple ways in which adolescents experience disproportionate impacts of abortion access restrictions in the United States.<sup>29</sup> The second was a systematic review of the literature on barriers that adolescents experience when seeking abortion care. The third was a policy scan of current state policies on abortion access, with an emphasis on those that are specific to minors. We also conducted key informant interviews with individuals and organizations currently conducting research on abortion policies to get their input on developing an actionable research agenda.

### Expert panelist selection

We identified five key constituencies related to adolescent abortion access: young people, researchers, clinicians, leaders of nonprofit and reproductive justice-focused organizations, and legal and policy experts. We invited 6 participants representing each constituency to join the expert panel for a total of 30 participants. Panelists were selected based on their experience working in the reproductive health and reproductive justice space specifically with young people.

### Convenings

We convened four virtual meetings of our expert panel from May-September 2023, each three hours in length. Each meeting was led by a professional facilitator with experience in multi-stakeholder coalitions. The convenings consisted of facilitated large group brainstorms and discussions, small group work sessions, and guest presentations on illustrative case studies.

#### Throughout these convenings, panelists:

- reviewed the state of the current evidence on adolescent abortion and identified initial policy opportunities.
- discussed the role of reproductive justice in research on adolescent abortion.
- discussed how research evidence informs policy (see [Box 4](#)).
- identified and prioritized problems and policy principles the research agenda should address as well as the most impactful and feasible research gaps and opportunities to address these gaps.
- translated research gaps into research and policy priorities and actions aimed at levers of policy change.
- identified research principles to drive the conduct of adolescent abortion research.

The research agenda presented here consists of collated results from our preliminary work and the four expert panel convenings. Themes, priorities, and gaps identified by the report's authors were reviewed by panelists at each session to ensure the final report was comprehensive and accurately represented their prior discussions.



## Research justice approach to research on minors and abortion

Throughout our work we focused on bringing an intersectional research justice approach to the research on adolescent sexual and reproductive health policy.<sup>30</sup> Research justice aims to transform how research is conducted and used to inform policy and practice. By recognizing and valuing multiple forms of knowledge and forging a collaborative approach to research, research justice methodologies center the knowledge and experiences of marginalized groups to ensure that research, and in turn, policy, is responsive to their needs and concerns. Central to research justice methodologies is intersectionality, which attends to how interlocking systems of oppression have inequitable consequences and impacts for groups located at varied intersections of gender, race, social class, ability, sexuality, and age.

### An intersectional research justice approach to adolescent abortion access:

**CENTERS  
REPRODUCTIVE  
JUSTICE  
PRINCIPLES  
IN RESEARCH AND  
POLICY**

**ATTENDS TO HOW  
INTERSECTIONALITY  
INFORMS ADOLESCENTS' LIVED  
EXPERIENCES AND ACCESS TO  
RESOURCES, INCLUDING HOW THEIR  
BODILY AUTONOMY IS ENHANCED  
AND/OR CONSTRAINED**

**INCLUDES  
ADOLESCENTS  
AND THEIR  
KNOWLEDGE AND  
EXPERIENCES  
IN RESEARCH TO  
INFORM POLICY**

Our focus in the current report is on abortion policies that impact minors, in order to draw attention to one timely and understudied issue. However, the goal is not to silo abortion care from other reproductive justice issues. We recognize and embrace the broad principles of reproductive justice, which value bodily autonomy and all pregnancy options. Our recommendations are offered in the spirit of supporting evidence-based policies on abortion that support bodily autonomy, health, and well-being for all.

## Overarching Research Principles

Driven by the research justice perspective, our expert panel identified four overarching principles that should be applied to all future research on minors and abortion.

### 1 RESEARCH NEEDS TO INCLUDE DIVERSE SAMPLES OF MINOR ADOLESCENTS

Minors are typically not included in abortion research, likely due to perceived constraints regarding conducting research with this population.<sup>31</sup> This omission leads to a lack of high-quality, inclusive research that can be harnessed to inform policy. Abortion research designs should include diverse groups among minors, to allow attention to how structural inequalities impact minors' abortion access at the intersections of age category, race and ethnicity, social class, gender status and gender identity, sexual orientation, ability, systems involvement, nativity and immigration status, geographical location, and English language proficiency.

### 2 ACCURATE EVIDENCE ABOUT MINORS' CAPABILITIES SHOULD INFORM RESEARCH AND POLICY

Widespread assumptions about adolescents under age 18 cast them as inherently incapable of making decisions for themselves and their futures, which is not supported by developmental science (See [Chapter 1, Box 2](#)). These assumptions reflect and reinforce bias in public dialogue about adolescent abortion access, leading to harmful policy decisions. Research that uses a strengths-based approach to highlight minors' capabilities and center their views and experiences is needed to redress deficit-based approaches.

### 3 REPRODUCTIVE JUSTICE PRINCIPLES NEED TO BE INCORPORATED INTO RESEARCH

While abortion research is increasingly inclusive of a reproductive justice lens, this is less the case in research on minor abortion access. By drawing on reproductive justice principles, abortion researchers can engage community partners and empirically examine if and how policy protects or constrains minors' human right to bodily autonomy, including the right to decide whether to continue or end a pregnancy.

### 4 RESEARCH SHOULD INCORPORATE MINORS' PERSPECTIVES AND LIVED EXPERIENCES

Central to reproductive justice-informed research is a focus on centering the perspectives and experiences of marginalized populations. This approach seeks to challenge prevailing power relations and to ensure that people who are disproportionately impacted by harmful policy decisions are able to give voice to their experiences and be included in the process of redressing reproductive injustices. Research on minors' abortion access needs to incorporate the views and experiences of minors by creating pathways for their engagement throughout the research process.

#### BOX 4

### HOW RESEARCH EVIDENCE INFLUENCES POLICY

**It can sometimes seem as though research and evidence have no impact on policy,** particularly when one focuses on the part of the legislative process that the public is most likely to see: the floor debates and the final vote. However, scholars of evidence-based policymaking have pointed out that there are many steps in the policymaking process that occur prior to the final vote and are very impactful in the final policy results. In our work, we used the framework of evidence-based policy making by Bogenschneider & Corbett, developed after interviewing hundreds of state legislators about the role of research evidence in state policymaking.<sup>32</sup> They found that legislators use evidence in a myriad of ways throughout the legislative process. Crucially, many of the uses of evidence occur outside of the moments the public is most likely to see—final votes on drafted legislation—and instead inform the evolving positions of legislators over time. For example, legislators employ evidence when educating colleagues and constituents, bringing to light an issue that has previously received little policy attention, earning trust among colleagues as a credible source on a topic, and enhancing the nuance of dialogue on an issue. When it comes to crafting specific legislation, legislators may use evidence to inform their position on an issue, to determine appropriate allocation of public resources, and/or to weigh several policy alternatives.

Thus, there are actually numerous avenues by which research evidence is employed in policy making, and ensuring the availability of high-quality evidence is essential to support this, as one state legislator remarked:

**“ WHEN LEGISLATORS ARE FAMILIAR WITH RESEARCH EVIDENCE,** it can help them frame questions that can clarify the underlying root causes of the problem and the implications of various policy alternatives... These are the ‘Have you thought about this’ kinds of input that transform the debate or shift it in a new direction. This is perhaps the broadest use of research and is intended to elevate the level of discussion within the political body from a debate to a dialogue.”<sup>32</sup>

Of course, research and data are not the only influences on policy. Richmond and Kotelchuck described three essential components for advancing public health policy: **knowledge base, social strategy, and political will.**<sup>33</sup> Rigorous and thorough research is an essential component to building the requisite public knowledge base that informs policy change. A social strategy that uses that knowledge base includes communicating the experiences and opinions of the public through testimony, media, protest, direct communications with legislators, and more. Poignant representation of the lived human experience that is impacted by policies is an important complement to empirical evidence generated by research and can help to generate political will to make change.<sup>33</sup>

## THE POLICY LANDSCAPE

Thousands of state and federal policies regulate abortion access. We conducted a policy landscape scan in June 2023 to identify current state abortion policies that are specific to minors and/or likely to disproportionately impact minors. We included both protective and restrictive policies. We also identified opportunities for future policies that would protect minors' abortion rights. The full list of identified policies, including examples from specific states where the policy is in place, is in [Appendix B](#). After completing the policy scan, we classified policies into four categories described below: (1) **Minors' access to abortion**, (2) **Minors' access to information about abortion**, (3) **Parental and adult involvement in minor abortion**, and (4) **Minors' privacy and confidentiality about abortion**. This scan is meant to serve as a starting point for much-needed comprehensive policy tracking and analysis specific to minors' abortion rights.

### 1 Minors' access to abortion

As with adults, minors' ability to access abortion is heavily dictated by the legality and accessibility of abortion services in their home state. **Restrictive policies** governing minors' access to abortion include those that apply to people of all ages, such as: outlawing abortion completely or at a particular gestational age, enacting waiting periods, prohibiting the use of telemedicine for abortion services, restricting the types of providers who can prescribe medication abortion, and regulating the types of facilities in which abortion services can be delivered. In addition, minor-specific policies include so-called "abortion trafficking" laws that restrict minors' ability to travel for abortion care and target the adults who help them. **Protective policies** regarding minors' access to abortion include those that apply to people of all ages, such as: state constitutional amendments and other policies that protect and codify abortion access and shield laws protecting patients, providers, and third-party actors who facilitate abortion care. Not all protective policies specifically address minors, often leaving a legal gray area as to whether minors are covered by those policies. Some states do lay out specifically the extent to which their policies protect or codify minors' ability to access reproductive health care including abortion. **Future opportunities** to protect minors' access to abortion include enacting policies that specifically codify or protect minors' access to abortion using language that indicates abortion rights apply to minors as well as adults and developing and implementing policies that create telehealth access to medication abortion for minors in states where it is not currently available.

### 2 Minors' access to information about abortion

Minors' ability to make informed decisions about their healthcare is impacted by their ability to access timely and accurate information about abortion and the resources required to attain it. **Restrictive policies** governing minors' access to information about abortion include those that provide state funding for anti-abortion centers (sometimes referred to as crisis pregnancy centers), mandate that abortion providers share medically inaccurate or misleading information about abortion and long-term health risks, and prohibit school-based sex education from discussing abortion. **Protective policies** include those that promote public education about anti-abortion centers and their practices, require anti-abortion centers to disclose that they do not offer abortions, and require that information about abortion or pregnancy options be included in school sex education curricula. A **future protective policy** opportunity in this area is to codify minors' right to information about abortion care.

### 3 Parental and adult involvement in minor abortion

The ability of minors to access abortion is shaped by policies governing their ability to consent to care and the degree to which they must involve their parents in their care. **Restrictive policies** governing parental and adult involvement include parental consent and notification requirements and judicial bypass

laws that require minors to obtain approval from a court in order to access abortion care without parental involvement. **Protective policies** include explicitly allowing minors to consent to their own sexual and reproductive health care, allowing non-parent adult relatives to consent to minors' abortion care, and allowing emancipated and homeless youth to consent to their own health care. **Future protective policy** opportunities in this area include repealing parental consent and notification requirements. Parental involvement laws are one of the most well-researched topics with regards to minors' access to abortion, providing substantial evidence to inform policy in this area. See **Box 5** for a summary.

## BOX 5

### PARENTAL INVOLVEMENT LAWS AND MINOR ABORTION: WHAT WE KNOW

#### Parental involvement laws are one of the most frequently researched topics related to minors' abortion access.

Historically, research on parental involvement requirements for minors' abortion examined the impact of these laws on the frequency and timing of abortion seeking among young people. Rigorous studies, namely those that included a pre-post study design and/or an appropriate comparison/control group of those not exposed to law, document adverse impacts of the law on minors' ability to obtain desired abortion care. In a large national study spanning multiple decades, living in a state that implemented a parental involvement requirement (notification or consent) was associated with a 3% increase in birth rates from 1993-2016 to young people ages 15 to 18.<sup>34</sup> This increase in births is consistent with studies documenting reductions in the numbers of minors seeking abortions and in abortion rates to minors after implementation of parental notification and consent requirements.<sup>35,36</sup> Notably, while in the past, out of state travel to a state without parental involvement requirements explained some of the decline in abortion rates in states with such requirements, that appears to be less so currently as the distance necessary to avoid a state with a parental involvement law has grown significantly.<sup>34,37</sup> **Together, these data suggest that at least some minors are not able to achieve their desired pregnancy outcome due to parental involvement requirements.**

Prior research also documents harms of parental involvement requirements among those who obtain a desired abortion. **Several studies document evidence of delays in care seeking after introduction of a parental involvement requirement, in particular for those traveling from out of state for care.**<sup>35,36,38,39</sup> Delays are even more pronounced among those who cannot involve a parent and instead seek judicial bypass. For example, studies of minors seeking judicial bypass in Massachusetts and Illinois highlight that they obtain abortion care 5-6 days later than those who satisfy parental consent or notification requirements, sometimes pushing them past the 10-week limit for medication abortion and limiting their options for care.<sup>40,41</sup> Judicial bypass has also been shown to cause emotional harm and trauma to young people seeking abortion and to not consistently function as a true alternative to parental involvement in some settings where requests for bypass are denied.<sup>42,43</sup>

**There is minimal research supporting some of the purported benefits of parental involvement requirements for minors, for example that they result in increased productive involvement of parents.**

For example, an Illinois study demonstrated that while implementation of the state's parental notification requirement was associated with an increase in the proportion of minors who involved a parent, there were no changes in levels of parental support for the decision. Instead, there were increases in the proportion of minors who felt forced into their decision and who were less certain of their decision.<sup>43</sup> Reflecting that minors often turn to diverse sources of social support in their pregnancy decision-making, a study of New Hampshire's parental involvement requirement revealed an increase in the proportion of minors involving a parent, but no changes in overall levels of adult involvement.<sup>44</sup>

This research has been applied to inform recent legislative decisions to reduce or remove parental involvement requirements in states including Illinois, Massachusetts, and Oregon.<sup>45-47</sup>

**In summary, research has shown that parental involvement requirements are associated with inability for some minors to obtain their desired pregnancy outcome, delays in receiving wanted abortions, and psychological harm to youth while not achieving their intended outcome of productive involvement of parents.**

## 4 Minors' privacy and confidentiality about abortion

Respecting individual privacy has long been a legal and ethical reason for protecting abortion access, but minors are often not afforded the same privacy rights as adults. **Restrictive policies** governing minors' privacy and confidentiality about abortion include those that criminalize self-managed abortion and those that facilitate sharing of electronic medical record information across providers without protecting abortion information. Specific to minors are policies that require physicians to inquire about paternity for minors seeking abortion care. **Protective policies** include policies that prohibit individuals from being penalized for self-managed abortions, protect digital privacy of individuals seeking abortions and, specific to minors, policies that explicitly protect the confidentiality of minors insured as dependents and those that provide a confidential medical release from school for sexual and reproductive health services, including abortion. **Future protective opportunities** in this space include banning law enforcement from using private reproductive health data in investigations and developing policies that protect minors' digital privacy.

We hope that our efforts to identify and classify relevant policies can serve as a vital tool to policy advocates, as we have identified policies that states can proactively implement to expand abortion access for minors or prevent further restrictions. The policy environment informs the development of the broad research agenda we lay out in **Chapter 4** and the specific high-priority research questions by policy category in **Chapter 5**.

## POLICY-RESPONSIVE RESEARCH AGENDA

Our expert panel identified key components of a policy-responsive research agenda and associated recommendations for action. The agenda is organized into three research areas: conceptual and bioethics, legal, and social and behavioral. In each research area, we identify specific types of work needing to be done and provide a clear research recommendation for each. See [Table 1](#) for a summary of research areas and research recommendations.

**TABLE 1: RESEARCH AREAS AND RECOMMENDATIONS**

Conceptual and Bioethics Research	Social and Behavioral Research
<ol style="list-style-type: none"> <li>1 Develop an overarching conceptual framework to guide research on adolescents' sexual and reproductive health as a whole and minors' abortion experiences specifically.</li> <li>2 Develop and disseminate bioethics research responsive to the unique sexual and reproductive health experiences and needs of minors to guide IRB oversight of this research.</li> </ol>	<ol style="list-style-type: none"> <li>7 Increase and improve the inclusion of minors in patient population studies and state and national abortion surveillance.</li> <li>8 Present age-specific data and analyses, with minors presented separately from adults, to allow identification of minors' experiences.</li> <li>9 Field a longitudinal study of pregnant minors over time, across different abortion policy environments.</li> <li>10 Conduct dedicated studies of abortion among systems-involved and multiply marginalized youth.</li> <li>11 Field timely studies of the general population of minors to understand their current knowledge, attitudes, and behaviors related to changing abortion access.</li> </ol>
Legal Research	<ol style="list-style-type: none"> <li>12 Promote and support federal, state, and private efforts to expand and improve sexual and reproductive health data collection from minors with attention to sample size and measurement quality.</li> <li>13 Field a population-representative longitudinal survey of adolescents that allows for research on the impact of the post-<i>Dobbs</i> environment on minors' behavior, education, economic, and health outcomes into adulthood.</li> <li>14 Conduct developmental science studies on adolescents' development as it relates to abortion experiences and decision making.</li> <li>15 Apply developmental science to the creation of developmentally optimized policies and clinical practices for minors in abortion and sexual and reproductive health.</li> <li>16 Enrich research on minors by studying attitudes and actions of adults who are influential in minors' abortion experiences.</li> </ol>
<ol style="list-style-type: none"> <li>3 Conduct a legal analysis of existing restrictive and protective policies to determine their applicability to minors and those assisting them in accessing abortion.</li> <li>4 Translate legal research into state-specific legal guidance on minors' abortion rights for health care providers and the general public.</li> <li>5 Create and maintain a comprehensive, longitudinal database of state abortion policies, including those specific to minors.</li> <li>6 Conduct legal epidemiology and other studies to document differential experiences and outcomes across a range of domains among minors exposed to different policy environments.</li> </ol>	

## RESEARCH AREA: Conceptual and Bioethics Work

Two foundational areas of work that would facilitate the empirical research agenda laid out below are conceptual and bioethics research. The field of sexual and reproductive health research lacks a comprehensive framework to guide research on minors' sexual and reproductive health as a whole and minors' abortion experiences specifically. Existing conceptual frameworks generally do not integrate age -- as an individual, interpersonal or policy influence -- as a key component, despite its relevance and influence on minors' experiences. To provide a cohesive guide for researchers, a new framework should integrate essential perspectives from reproductive justice, adolescent developmental science, social and behavioral science, and adolescent medicine.

### RESEARCH RECOMMENDATION 1:

Develop an overarching conceptual framework to guide research on adolescents' sexual and reproductive health as a whole and minors' abortion experiences specifically.

Secondly, there exists a need for advancements in bioethics scholarship specifically addressing the inclusion of minors in abortion studies. As we will discuss further in **Chapter 6** on challenges to conducting abortion research with minors, existing research ethics guidelines have not been sufficient to guide researchers and Institutional Review Boards in conducting and evaluating this type of work. A robust exploration of the ethical considerations regarding how and why minors should be involved in such research is imperative for fostering a responsible and ethical research environment as well as supporting the growth of studies including minors.

### RESEARCH RECOMMENDATION 2:

Develop and disseminate bioethics research responsive to the unique sexual and reproductive health experiences and needs of minors to guide IRB oversight of this research.

## RESEARCH AREA: Legal Research

Legal research is needed to clarify the abortion legal landscape as it applies to minors, compile state policies on abortion and related topics over time, and conduct research on the impacts of policy change.

### Legal analysis

Although minors are frequently directly and indirectly a focus of abortion policies, minors' legal rights regarding abortion are not clearly understood in practice or by the general public. For example, it is untested whether protective policies written to cover all people's abortion access will protect minors' abortion access or the legal rights and liabilities of individuals supporting minors in obtaining access. There is a need for a robust body of legal research focused on minors' abortion rights and subsequent communication of this research to key audiences and actors.

### RESEARCH RECOMMENDATION 3:

Conduct a legal analysis of existing restrictive and protective policies to determine their applicability to minors and those assisting them in accessing abortion.

### RESEARCH RECOMMENDATION 4:

Translate legal research into state-specific legal guidance on minors' abortion rights for health care providers, minors themselves, and the general public.

## Policy surveillance

In the post-*Dobbs* environment, abortion-related policies are changing frequently and quickly. But there is no central source of longitudinal data on state policies on abortion, including those specific to minors. Policy surveillance enables legal epidemiology research, which examines variation in behaviors and outcomes by the abortion legal and access environment.<sup>48</sup> Similarly, researchers can examine variation between state policy environments or changes to policies within a single state over time to examine the impact of abortion policies on minors' experiences.

### RESEARCH RECOMMENDATION 5:

Create and maintain a comprehensive, longitudinal database of state abortion policies, including those specific to minors.

## Legal epidemiology

Legal epidemiology is the scientific study and deployment of law as a factor in the cause, distribution, and prevention of disease and injury in a population.<sup>48</sup> Importantly, legal epidemiology studies of the impact of changes in abortion policy do not require individual-level measures of abortion receipt, but instead focus on population-level aggregate impacts abortion access or on more readily available measures such as educational or economic outcomes. Conducting legal epidemiological studies will require consistent monitoring and documentation of state abortion policies, as well as improved epidemiological surveillance of key demographic and behavioral indicators in minors. For example, research can link state birth records and state abortion laws to monitor changes in minors' birth rates related to the abortion policy environment.<sup>49</sup>

### RESEARCH RECOMMENDATION 6:

Conduct legal epidemiology and other studies to document differential experiences and outcomes across a range of domains among minors exposed to different policy environments.

## RESEARCH AREA: Social and Behavioral Research

A key call to action of this research agenda is to ensure that research designs and analyses include the experiences of minors. The current national data infrastructure does not support even basic monitoring of minors' abortion prevalence, let alone the longitudinal and causal work needed to understand the impacts of abortion access policy on minors. Below, we discuss the social and behavioral research infrastructure needed to study minors' sexual and reproductive health, abortion, and long-term outcomes and inform evidence-based policy. Currently, minors' experiences are often omitted from research, or minors are included in such small numbers as to hinder generalization.

To proactively include minors in social and behavioral research relevant to abortion, we propose studying both the **direct** impacts on pregnant minors who do or do not receive an abortion and the **indirect** impacts of abortion policies on the general population of minors.

### Studying direct impacts can be accomplished through:

- **Expanding** studies that have traditionally focused on adults to encompass minors
- **Tailoring** studies specifically focused on minors.

### Indirect impacts on the total population of minors can be studied by:

- **Contextualizing:** the contexts of adolescents' lives as abortion access is changing by conducting population-representative studies of adolescents that are not solely focused on abortion or SRH.



**TABLE 2: APPROACHES TO STUDYING MINORS AND ABORTION**

Impact Type	Approach	Age group		Population	Subject matter	
		CONVENTIONAL FOCUS	RECOMMENDED ADDITIONAL FOCUS		CONVENTIONAL FOCUS	RECOMMENDED ADDITIONAL FOCUS
DIRECT	<b>Expanding</b> Allows for comparison between minor and adult experiences; allows investigation of the full population receiving abortions	Adults	Minors	Abortion-focused <sup>1</sup>	SRH including abortion	
	<b>Tailoring</b> Provides in-depth examination of unique minor experiences related to abortion and how that impacts other domains of minors' lives		Minors	Abortion-focused <sup>1</sup>		SRH including abortion and health and well-being
INDIRECT	<b>Contextualizing</b> Captures contexts of all minors' lives relevant to changes in abortion policy and access, regardless of whether they have personal experience with abortion	Minors		National or state representative	Health and well-being	SRH including abortion

1. Abortion-focused samples may include some or all of the following: pregnant individuals or those who recently gave birth regardless of pregnancy outcome, people who received an abortion, people who were unable to obtain a wanted abortion.

## Expanding

The first social and behavioral research approach to studying **direct** impacts of changes in abortion policy, **expanding**, involves **broadening the age range of abortion-focused studies to include minors**. Implicit in this strategy is the recognition that research questions worthy of study among adults are also pertinent to minors; expansion enables the investigation of the same research questions across the entire reproductive age range. Researchers must give attention to ensuring an adequate sample size for the minor subgroup in their studies, to permit robust analyses both *within* the age group of minors and *between* minors and adults. Merely relying on random or opportunistic sampling and recruitment may fall short. Deliberate oversampling and targeted recruitment efforts of minors are needed. Recruiting large samples of minors is likely to be resource intensive. It may require different methods of recruitment than adult-focused studies typically employ, additional training of study staff to work effectively with minors, and changes to research instruments and protocols to ensure they are developmentally appropriate. Investigators will benefit from partnering with colleagues who are experienced in conducting research with minors, who have developed evidence-based and developmentally appropriate strategies for conducting studies with minors and can help to facilitate this work.

## Quantifying and describing minors' abortion experiences

Accurate counts of the number of minors who have an abortion are foundational to policy decisions and to planning and conducting research. National abortion surveillance efforts pre-*Dobbs* have been limited

by small samples of minors. For example, the Guttmacher Institute's 2021-2022 Abortion Patient Survey obtained usable surveys from 6698 individuals accessing clinical abortion care, but only 152 respondents were aged 17 or younger.<sup>50</sup> Real-time data collection since *Dobbs*, by the Guttmacher Institute's Monthly Abortion Provision Study or the Society of Family Planning's #WeCount effort, do not collect patient age, leaving a critical gap in surveillance of minors' receipt of abortion care.<sup>51,52</sup> Federal abortion surveillance by the Centers for Disease Control (CDC), while absent in some states and of variable quality in the others, does collect some data on patient age. However, surveillance of minors' receipt of abortion care is again missing from this effort, as CDC does not report on minors separately, instead grouping adolescents as <age 15 and 15-19.<sup>53</sup> In most states, age 18 is considered adult for policy purposes and age 17 and under is a minor. Age groupings should align with policy; data should be reported for ages 17 and under separately from ages 18 and older.

In addition to counts of abortion prevalence among minors, it is important to capture policy-relevant details about their abortion experience, which are detailed in [Chapter 5](#) under **Key Research Questions: Minors' access to abortion services**. More in depth study of minors' abortion experiences will require the inclusion of minors in patient population studies.

#### RESEARCH RECOMMENDATION 7:

Increase and improve the inclusion of minors in patient population studies and state and national abortion surveillance.

#### RESEARCH RECOMMENDATION 8:

Present age-specific data, with minors presented separately from adults, to allow identification of minors' experiences.

## Tailoring

The second social and behavioral approach to studying **direct** impacts of changes to abortion policy, **tailoring**, entails **designing abortion-focused studies tailored specifically to minors**, presenting an opportunity for innovative study designs and research questions. This approach acknowledges the unique aspects of minors' experiences and allows for focused attention to policies focused on this age group's abortion access.<sup>14,29</sup> As detailed below, tailoring research to focus on minors may include studies of minors' pregnancy options decision making or studies of key subpopulations such as systems-involved youth.

### Studies of minors' pregnancy options decision making, as well as their experiences of obtaining or being denied an abortion or choosing to parent

Previous research on the effects of being denied an abortion has been impactful. The Turnaway Study was an innovative and impactful longitudinal study that continues to shape research, policy, and public discourse. The Turnaway Study compared short- and long-term outcomes of pregnant people seeking an abortion, some of whom received an abortion and some of whom were turned away because they had passed the gestational limit for abortion. However, this study was not able to examine the unique experiences of minors. Of the nearly 1,000 pregnant people seeking abortions recruited for the study, only 42 minors' experiences were included.<sup>54</sup> Older research offers alternative models of longitudinally following teenagers who had an abortion; for example, a study of black teenagers from Baltimore in the 1980s found that those who had an abortion were more likely to continue their education than those who gave birth or those who had never been pregnant.<sup>55</sup> But more recent research of this type is lacking.

While designing and implementing a cohort study of pregnant minors would be challenging, there is a great need for research that examines minors' pregnancy decision making and their experiences of obtaining or being denied an abortion, choosing parenthood, or choosing adoption. This study design could also include measures of the short and longer-term educational, economic, social, and health impacts of obtaining an abortion, being denied an abortion, choosing to parent, or placing a child for adoption, similar to the Turnaway Study. While a range of methodological approaches can be valuable to collect these data, qualitative study designs are especially critical for centering minors' lived experience of pregnancy-related decision making, including obtaining or being denied an abortion.

### RESEARCH RECOMMENDATION 9:

Field a longitudinal study of pregnant minors over time, across different abortion policy environments.

#### Focused studies of systems-involved and multiply marginalized minors

Systems-involved and multiply marginalized minors include those who are involved in the criminal justice, child welfare, and/or immigration detention systems. Multiply marginalized minors include those who are members of multiple, historically marginalized racial, ethnic, socioeconomic, sexual, ability, and/or gender groups. Systems-involved and multiply marginalized minors are likely to be most impacted by abortion policies. However, these young people are underrepresented in national studies, which excludes their experiences. Further, specific measures and research designs are likely necessary to validly represent the experiences of systems-involved and multiply marginalized minors. Consonant with a reproductive justice approach, it is critical to include adolescents whose lives are directly controlled by the state to ensure we advance policy-based efforts to support their bodily autonomy within these systems.

In order to study these impacts, dedicated studies focusing specifically on systems-involved and multiply marginalized adolescents are necessary. Key priorities include monitoring pregnancy and abortion rates for systems-involved minors and identifying barriers to desired abortion care; documenting the policies and procedures governing adolescents' abortion access by the state and criminal justice, child welfare, and/or immigration detention systems; understanding how parental involvement requirements are implemented for systems-involved minors; documenting minors' own preferences and experiences related to abortion care; and understanding the role and authority of caseworkers and other professionals in facilitating abortion access for systems-involved minors.

### RESEARCH RECOMMENDATION 10:

Conduct dedicated studies of abortion among systems-involved and multiply marginalized youth.

#### Contextualizing

Although most minors will not become pregnant or receive an abortion prior to adulthood, all minors still may be indirectly impacted by changes in abortion policy and access. The third approach, **contextualizing**, examines **indirect** impacts of abortion policies on the general population of minors in population-representative studies of minors that are not solely focused on abortion but capture important contexts of adolescents' lives, including other SRH behaviors and outcomes. Changes in minors' perceived ability to access abortion, or more broadly in their perceptions of their state's policy climate, are likely to impact their current behaviors, choices, and physical and mental health.

**There is much that can be learned about the impacts of changes in abortion policy on minors' SRH and abortion-related knowledge, attitudes, behaviors, and health outcomes without having to sample minors who have experience with pregnancy or abortion, which can be resource-intensive.**

#### Minors' knowledge, attitudes, and behaviors related to changing abortion access

It is important to understand what minors know about changing policies, how they feel about them, and to what extent their lives are impacted by them. For example, a recent series of mixed-methods studies querying a national sample of minors and young adults revealed that they are knowledgeable about changes to abortion-related policy, are discerning and mindful in seeking information about abortion online, are changing their sexual, relationship, and contraception behavior based on changes in abortion policy and access, and understand the barriers they would face and resources they would need if they were to travel for abortion care.<sup>15,56,57</sup> More such studies are needed, especially across diverse policy environments.

### RESEARCH RECOMMENDATION 11:

Field timely studies of the general population of minors to understand their current knowledge, attitudes, and behaviors related to changing abortion access.

## Epidemiological surveillance of sexual and reproductive health indicators in minors across abortion policy environments

There is a compelling need for new cross-sectional and longitudinal data on the sexual and reproductive health of the post-*Dobbs* generation of adolescents. Federal and state survey systems specifically designed to include adolescents' sexual and reproductive health experiences are increasingly unable to provide relevant high-quality data for ongoing epidemiological monitoring and research. Moreover, they either do not collect data about abortion experiences directly or have well-recognized measurement limitations. Still, with targeted improvements they could offer an opportunity to examine the influence of abortion policies on minors' sexual and reproductive health and behaviors.

For example, the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS) is a series of cross-sectional surveys of high school students, but an increasing number of states are choosing to not participate in the YRBSS at all, or to limit data collection on sexual behaviors. This reduces the coverage of this surveillance system and the ability to compare minors' experiences across states. Additionally, it excludes the experience of out of school and incarcerated youth. Similarly, while the National Survey of Family Growth (NSFG), a cross-sectional household-based survey, oversamples teens ages 15-19, the sample size in this age range is underpowered for many analyses, especially among sexually experienced teens. This limits the ability to study an array of health and policy relevant issues, especially variation among teens by race/ethnicity or other sociodemographic characteristics, as the subgroup sample sizes get very small. It also excludes the experience of incarcerated or homeless teens not residing in a household.

State-level variation in abortion policies creates the need for data collection on minors' behaviors and outcomes at the state level. Strengthening the YRBSS by increasing state participation and robust measurement of sexual and contraceptive behaviors could provide valuable state-level data. Additionally, currently measures of state of residence are available for the NSFG only through a costly and time-consuming restricted data application process; simplifying access to this restrictive data could support more researchers and more equitable access. The Pregnancy Risk Assessment Monitoring System (PRAMS) currently fields representative state-level surveys of mothers of new births. While this could be used to study birth and parenting experiences of minors across different abortion policy environments, small sample sizes of minors limit its use. Still, researchers could consider approaches to pooling data across years or states. Other surveys that include potentially relevant measures do not include minors in their sample, such as the CDC's Behavioral Risk Factor Surveillance System, which includes contraceptive use and sexual activity, but not prior abortion experiences.

### RESEARCH RECOMMENDATION 12:

Promote and support federal, state, and private efforts to expand and improve sexual and reproductive health data collection from minors with attention to sample size and measurement quality.

## Longitudinal population-representative data on minors' health and development into adulthood

Also of concern is the lack of a current health-focused national longitudinal survey of adolescents including minors. While a substantial body of research on adolescents' sexual and reproductive health resulted from the National Longitudinal Study of Adolescent to Adult Health (Add Health), the original high school sample was selected in the mid-1990s, and no additional cohorts have been added.<sup>58</sup> Other longitudinal studies designed to focus on young people's experiences, such as the National Longitudinal Study of Youth or the Panel Study of Income Dynamics' Transition Into Adulthood supplement also do not reflect the experiences of current minors nor do they collect a rich set of SRH measures. New data collection is needed to study how coming of age in a post-*Dobbs* environment will shape minors' behavioral, educational, economic, and health outcomes into adulthood. New longitudinal data will also allow investigation of the experiences of minors who are not directly impacted because they do not experience a pregnancy or abortion but are exposed to the policy environment; this might include metrics such as change in behaviors in anticipation or reaction to policies, stress or anxiety about the policies, political engagement, relationship and family formation, and decisions about where to live or go to school.

### RESEARCH RECOMMENDATION 13:

Field a population-representative longitudinal survey of adolescents that allows for research on the impact of the post-*Dobbs* environment on minors' behavior, education, economic, and health outcomes into adulthood.

### Developmental science studies to inform developmentally appropriate policies

Many policies restricting minors' reproductive rights are predicated on a non-evidence based popular narrative that minors are not mature enough to make their own decisions. For example, in judicial bypass hearings, judges are asked to rule on whether the pregnant minor is mature enough to make the decision to have an abortion, yet they are not provided with evidence-based guidance on how to do so. As reviewed in **Box 1, Chapter 1**, developmental science research has demonstrated adolescents' ability to make competent, deliberative decisions such as those about their own reproductive health. Additional research focused on the abortion context is needed to inform the policies and practices governing minors' ability to make their own reproductive health decisions. This should include synthesizing existing relevant evidence on minors' competency and ability to consent to medical care and conduct new studies on competency and decision-making related specifically to abortion.

### RESEARCH RECOMMENDATION 14:

Conduct developmental science studies on adolescents' development as it relates to abortion experiences and decision making.

Further, developmental science can inform how to best support minors by creating developmentally optimized state policies and clinical practices. Research from developmental science can support evidence-based policy making and debate as policy questions involving minors' rights and capacity are discussed. Clinical practice in family planning is often not developmentally tailored for minors. The science of adolescent health and development can be applied to improve minors' experience of care and the quality of care they receive. For example, the Adolescent Health Initiative has pioneered a research-based model of developmentally appropriate clinical care for adolescents that could be modified for abortion care.<sup>59</sup>

### RESEARCH RECOMMENDATION 15:

Apply developmental science to the creation of developmentally optimized policies and clinical practices for minors in abortion and sexual and reproductive health.

### Studies of the systems and contexts involved in minor abortion information, access, and care, and the adults within those systems

Our research agenda concerning minors and abortion policy recognizes the systems and contexts in which minors operate, with adults often playing influential interpersonal roles, whether as parents, health care providers, or educators. Indeed, new and emerging state policies seek to limit the behaviors not just of providers, but of other adults who may provide information or support to minors' seeking abortion.

In order to inform policies that involve adult actors in minors' lives, it is imperative to gather comprehensive data not only from minors but also from the adults and systems with whom they interact. There is a need for new measures and investigation of adults' attitudes towards minors, including sexual stereotypes and gender stereotypes, adults' perceptions of whether minors have the capacity to make their own decisions, and how adults interact with minors around issues of sexual and reproductive health including abortion. Additionally, there is a need to study the behaviors of these adult actors that influence minors' abortion access and care, such as provision or gatekeeping of information and supportive or coercive engagement.

### RESEARCH RECOMMENDATION 16:

Enrich research on minors by studying attitudes and actions of adults who are influential in minors' abortion experiences.

## RESEARCH QUESTIONS FOR SPECIFIC POLICY TYPES

This chapter builds on the research agenda presented in **Chapter 4** by listing specific research questions to be investigated for each of the four policy categories discussed in **Chapter 3**: minors’ access to abortion services, minors’ access to information about abortion, parental and adult involvement in minor abortion, and minors’ privacy and confidentiality about abortion. Each section contains a table summarizing the relevant policies in that category. The full table containing all policies identified in our review is in **Appendix B**. Each table contains three sections: a list of current policies existing in some states that are protective of abortion rights, a list of current policies existing in some states that are restrictive of abortion rights, and a list of future policy opportunities that have not yet been enacted but could be enacted to protect minors’ abortion rights. Policies are divided into those that apply to people of all ages and those that apply only to minors.

POLICY LANDSCAPE: MINORS’ ACCESS TO ABORTION SERVICES		
Current or Future	Age Group Affected	Policy Type
<b>Restrictive Current Policy</b>	<b>All Ages</b>	Outlaw abortion with few to no exceptions, completely or at a certain gestational age. <sup>1</sup>
		Enact medically unnecessary mandatory waiting periods. <sup>2</sup>
		Permit only physicians to prescribe mifepristone and misoprostol. <sup>3</sup>
		Require individual to be in physical presence of a clinician to take an abortion pill. <sup>4</sup>
		Provide protection to health care providers who refuse to offer abortion care and pharmacists who refuse to dispense abortion medications. <sup>5</sup>
		Restrict what facilities abortion services can be delivered in. <sup>6</sup>
		Prohibit the use of telemedicine for abortion medication. <sup>7</sup>
		Prohibit or restrict abortion coverage in the state’s Health Exchange plans. <sup>8</sup>
		Prohibit or restrict private insurance plans from covering abortion services. <sup>9</sup>
	Prohibit the mailing of abortion pills. <sup>10</sup>	
	<b>Minors</b>	Laws, such as “abortion trafficking” laws that limit minors from traveling out of state and/or criminalize those who help them. <sup>11</sup>

CONTINUED...

## POLICY LANDSCAPE: MINORS' ACCESS TO ABORTION SERVICES

Current or Future	Age Group Affected	Policy Type
Protective Current Policy	All Ages	State constitutional provisions and other policies that protect and codify abortion and reproductive rights. <sup>12</sup>
		Expand which healthcare professionals can provide abortion services. <sup>13</sup>
		Shield laws to protect patients, providers, and third-party actors who facilitate abortion access from civil and criminal legal action. <sup>14</sup>
		Shield laws that protect providers who prescribe abortion pills through telehealth services to patients across state lines. <sup>15</sup>
		Provide state funding for abortion services and abortion-related costs (e.g., travel, lodging, service navigation and coordination). <sup>16</sup>
		Include abortion care in state Medicaid coverage. <sup>17</sup>
	Promote clinic safety and allocate funds to do so. <sup>18</sup>	
Future Protective Opportunity	All Ages	Protect/codify one's ability to access reproductive health care including abortion, regardless of their age. <sup>19</sup>
		Federal constitutional amendment and other policies that protect abortion/reproductive rights.
		Repeal existing gestational bans.
		Protect access to mifepristone.
	Implement patient safeguards to ensure timely and appropriate care for individuals whose healthcare providers refuse to provide abortion services. <sup>20</sup>	
Minors	Enact explicit policies that protect minors' access to abortion in states where age is not mentioned in current abortion protections.	
	In states where telehealth medication abortion is legal, develop and implement policy guidance that creates and/or protects access to telehealth for medication abortion for minors.	

- 19 States have laws that prohibit abortion at any point in pregnancy with few to no exceptions. 14 states have these laws in effect as of December 2023. <https://lawatlas.org/datasets/abortion-bans>
- As of October 2022, 29 States have laws that require a waiting period prior to obtaining an abortion. <https://lawatlas.org/datasets/abortion-waiting-period-requirements>
- As of May 2023, 23 States have laws that permit only physicians to prescribe abortion medications. 5 of these state's laws are not in effect due to legal challenges. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
- As of May 2023, 20 States have laws stating that providers must administer medication abortion in-person. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
- As of November 2022, 45 states allow some health care providers to refuse to provide abortion services. Only 3 States provide protections for patients whose healthcare provider or institution refuses to provide said care. <https://lawatlas.org/datasets/refusal-to-perform-abortions>
- Example:** Utah's Abortion Changes Act, passed March 2023, enjoined May 2nd 2023 <https://le.utah.gov/~2023/bills/static/HB0467.html> <https://attorneygeneral.utah.gov/wp-content/uploads/2023/05/Memorandum-Decision-002-1.pdf>
- As of May 2023, 8 states explicitly prohibit the use of telehealth to provide an abortion <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>

8. As of October 2022, 24 states prohibit or restrict abortion coverage in their Health Exchange plans. 22 of these states outline limited circumstances in which the state allows coverage of abortion in Health Exchange plans, such as rape, incest, or fetal anomaly. <https://lawatlas.org/datasets/restrictions-on-insurance-coverage-of-abortion>
9. As of October 2022, 12 states restrict private insurance coverage of abortion. 3 of these states provide exceptions allowing for private coverage in instances of rape, incest, and life endangerment. <https://lawatlas.org/datasets/restrictions-on-insurance-coverage-of-abortion>
10. As of May 2023, 8 states prohibit the mailing of abortion pills. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
11. **Example:** Idaho Code § 18-623 <https://legislature.idaho.gov/statutesrules/idstat/Title18/T18CH6/SECT18-623/>
12. As of December 2023, the state constitutions in 9 states provide protection for abortion and/or reproductive freedom. <https://reproductiverights.org/maps/abortion-laws-by-state/>
13. As of May 2023, 14 states have laws allowing healthcare providers such as Nurse Practitioners, Physicians Assistants, and Advanced Practice Clinicians, to provide abortion care. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
14. **Example:** Hawaii Act 002 of 2023 <https://trackbill.com/bill/hawaii-governor-message-1102-act-002/2405880/>
15. **Example:** New York S01066-B provides legal protections for reproductive health service providers who provide legally protected health activities including protection from extradition, arrest and legal proceedings in other states relating to such services; restricts the use of evidence relating to the involvement of a party in providing legally protected health activity to persons located out-of-state. <https://nyassembly.gov/Press/?sec=story&story=106524>
16. **Example:** California Abortion Practical Support Fund [https://leginfo.ca.gov/faces/codes\\_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=2.&article=2.3](https://leginfo.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=2.&article=2.3)
17. As of December 2023, 14 States cover abortion services under their state Medicaid plan. <https://reproductiverights.org/maps/abortion-laws-by-state/>
18. **Example:** New Jersey's Reproductive Health Security Grant Program (RHSGP) <https://www.njohsp.gov/grants/state-reproductive-health-security-grant-program>
19. **Example:** Minnesota Protect Reproductive Options (PRO) Act <https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/4/>
20. **Example:** Illinois' Patient and Provider Protection Act prevents insurers from charging higher out-of-pocket costs for certain insurance plans when patients are forced to seek out-of-network provider care due to an in-network provider raising moral objections under the Health Care Right of Conscience Act. <https://www.illinois.gov/news/press-release.25906.html>

## Key Research Questions: Minors' access to abortion services

The most direct policy actions on abortion relate to individuals' access to abortion care, including regulations on clinical spaces and practices, on self-managed abortion, and on the practical support that people often need in order to access care (including funding and coordination of clinical care, travel, childcare, and other related expenses). Studies evaluating the impacts of existing abortion policies on minors should seek to capture both the objective consequences of those policies and the subjective experiences of those impacted by the policies. Key research questions in this area are:

### 1 QUANTIFY ADOLESCENT ABORTION ACCESS AND DOCUMENT DISPARITIES

- How many minors obtain abortions each year?
- How many minors are unable to obtain wanted abortions each year?
- What proportion of pregnancies among minors result in abortion?
- What method of abortion do minors prefer and, and to what extent are they able to obtain their preferred method (procedural, medication, other)?
- Through what service delivery models do minors prefer to access care, and to what extent are they able to obtain care via their preferred model (in person, telehealth, self-managed)?
- How many minors travel to another state to access abortion care? To which state(s) and from which state(s)?
- What are the demographic characteristics (including age, race/ethnicity, state of residence) of minors who do and do not obtain wanted abortions? Which groups are disproportionately affected by restricted access, and to what extent?
- How many minors seek support for abortion care through practical support networks such as abortion funds? What are their demographic characteristics? What kind of support do they desire (money, childcare, transportation, service coordination, other)? How many minors who are seeking abortion care did not seek practical support? How many sought support but did not receive any/adequate support?



## 2 UNDERSTAND MINORS' EXPERIENCES OF ABORTION ACCESS

Quantitative and qualitative research that captures the lived experience of minors from diverse backgrounds throughout the abortion access process is essential.

### DECISION-MAKING

- How do pregnant minors decide whether to seek an abortion? What factors influence their decision-making?
- How do pregnant minors decide whether to seek formal practical support for accessing abortion care?
- What factors influence whether they seek out support from their social networks when desiring an abortion?

### NAVIGATING ACCESS

- How do minors who have an abortion obtain access? How do they locate a provider? How do they navigate the process of obtaining an abortion?
- How do adolescents locate formal sources of practical support? What is their experience of receiving or not receiving practical support?
- What barriers do minors encounter when attempting to obtain abortion care? How do they overcome these barriers (or not)? What helps them to obtain abortion care?
- What barriers do minors encounter when trying to access practical support? What enables the minor to overcome practical barriers they encounter?
- What barriers do minors experience to traveling for care, even if they are provided with needed practical support? What facilitates minors' ability to travel within or across states to receive abortion care?

### ABORTION EXPERIENCES

- What are minors' experiences with accessing abortion? What are minors' experiences with having an abortion? What is the experience after having an abortion?
- What constitutes a positive abortion experience according to minors?
- What are minors' experiences with unsuccessfully trying to obtain an abortion?
- What is the experience of traveling to another state to access abortion care? What are the impacts of interstate travel restrictions (if implemented)?

## 3 DOCUMENT NEEDS AND CONCERNS OF ABORTION PROVIDERS AND OTHER HEALTH CARE PROVIDERS RELATED TO PROVIDING ABORTION CARE TO MINORS

- What legal and other concerns do abortion providers have about providing care to minors?
- What challenges do abortion providers encounter when supporting minors' abortion access?
- What support do abortion providers need in order to serve minors?
- How do primary care providers interact with pregnant minors who are considering or seeking abortion care? Are they willing to provide comprehensive pregnancy options counseling and/or referrals for abortion care? What challenges and barriers do primary care providers experience when serving pregnant minors considering or seeking abortion care?
- What kinds of adolescent-friendly practices (e.g., extended hours, clear information online, specific appeals to/indications of support of adolescents) do abortion providers implement?
- What guidelines exist for abortion providers who wish to provide adolescent-friendly care to minors?

#### 4 DOCUMENT NEEDS AND CONCERNS OF PRACTICAL SUPPORT PROVIDERS RELATED TO PROVIDING PRACTICAL SUPPORT FOR MINORS' ABORTION CARE

- What legal and other concerns do practical support providers have about supporting minors?
- What challenges do practical support providers encounter when supporting minors?
- What types of support do practical support providers need in order to serve minors?
- What guidelines and best practices exist for practical support providers who wish to serve minors?

### POLICY LANDSCAPE: MINORS' ACCESS TO INFORMATION ABOUT ABORTION

Current or Future	Age Group Affected	Policy Type
<b>Restrictive Current Policy</b>	<b>All Ages</b>	Provide state funding for anti-abortion centers. <sup>21</sup>
		Mandate providers share medically inaccurate or misleading information about abortion and long-term health risks. <sup>22</sup>
	<b>Minors</b>	Prohibit school-based sex education from discussing abortion. <sup>23</sup>
<b>Protective Current Policy</b>	<b>All Ages</b>	Promote public education about anti-abortion centers and their practices. <sup>24</sup>
		Designate a state agency to develop and maintain a website for individuals to access accurate information about abortion and accessing abortion in that state. <sup>25</sup>
		Require anti-abortion centers to disclose that they do not offer or provide referrals for abortion or contraceptive services and, if applicable, that they do not have medically trained staff on site. <sup>26</sup>
	<b>Minors</b>	Require information about abortion or pregnancy options to be included in school-based sex education. <sup>27</sup>
<b>Future Protective Opportunity</b>	<b>Minors</b>	Codify minors' right to seek information about abortion care.

- As of January 2024, at least 18 states directly fund pregnancy resource centers through state grants and allocated federal welfare funds. <https://equityfwd.org/anti-abortion-centers#key-facts>
- As of August 2023, 8 states require providers share medically inaccurate information that a medication abortion can be stopped after the patient takes the first dose of pills. 5 states that include information on breast cancer inaccurately assert a link between abortion and an increased risk of breast cancer. <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>
- As of 2022, 6 States prohibit school-based sexual health education from discussing abortion as a possible pregnancy outcome. 1 additional state require school-based information about abortion to dissuade students from viewing abortion as an acceptable pregnancy outcome. <https://siecus.org/wp-content/uploads/2021/09/2022-Sex-Ed-State-Law-and-Policy-Chart.pdf>
- Example:** Massachusetts FY 2023 budget resolution to include \$1 million public awareness campaign focused on the dangers of crisis pregnancy centers and pregnancy resource centers <https://www.mass.gov/news/governor-healey-signs-389-million-supplemental-budget>
- Example:** Cal. Health & Safety Code § 123430(a)(1) requires the California Health and Human Services Agency, or an entity designated by the agency, to establish an internet website where the public can access information on abortion services in the state. [https://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=HSC&sectionNum=123430](https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123430).
- Example:** Colorado Deceptive Trade Practice Pregnancy-related Service Act <https://leg.colorado.gov/bills/sb23-190>. While policies like this are protective in theory, they have been difficult to enforce in recent years and faced a series of legal challenges. In 2018, The Supreme Court of the United States struck down a similar policy in California in NIFLA v Becerra. [https://www.supremecourt.gov/opinions/17pdf/16-1140\\_5368.pdf](https://www.supremecourt.gov/opinions/17pdf/16-1140_5368.pdf)
- Example:** Vermont 16 V.S.A. § 131 <https://legislature.vermont.gov/statutes/section/16/001/00131>.

## Key Research Questions: Minors' access to information about abortion services and policies

Policies regulating minors' access to information about abortion services and policies impact all minors, not just those who are pregnant or seeking abortion care. Studies of these policies should focus on the national population of minors to understand the extent to which these policies impact their knowledge, awareness, and views of abortion and abortion policies. Key research questions to understand the impact of these policies are:

### 1 MINORS' KNOWLEDGE, OPINIONS, AND EXPERIENCE OF ABORTION POLICY

- To what extent are minors aware of recent changes in abortion access policy? What do they know and not know?
- What are minors' opinions about restrictive and protective abortion policies?
- How do minors experience abortion policy in their daily lives? Does it impact their behavior (sexual and contraceptive behavior), their mental health, their life choices (where to live and study), their civic/political engagement, and if so, how?

### 2 MINORS' PREGNANCY- AND ABORTION-RELATED KNOWLEDGE

- How and when do minors identify their pregnancies?
- How do minors understand the different types of abortions available?
- How many minors are reached by abortion and pregnancy options information in school-based curricula? How many receive incomplete, inaccurate, or no information about abortion in school-based curricula?
- How can sexual education support minors' access to abortion information?

### 3 MINORS' INFORMATION-SEEKING ABOUT ABORTION

- How and where do minors access information about abortion? Does this vary for medication abortion versus procedural abortion? Telehealth versus in person? Self-managed abortion versus within the healthcare system?
- Are minors able to distinguish between reliable and unreliable information on abortion?
- What are the best means of disseminating accurate information to minors?
- Do adult brokers of information (parents, clinicians, school officials) tell adolescents about abortion access policies? What do they tell them, and how?

## POLICY LANDSCAPE: PARENTAL AND ADULT INVOLVEMENT IN MINOR ABORTION

Current or Future	Age Group Affected	Policy Type
Restrictive Current Policy	All Ages	Restrictive requirements for consent to abortion for individuals under guardianship or conservatorship regardless of the individual's age or capacity. <sup>28</sup>
	Minors	Parental consent and parental notification requirements. <sup>29</sup>
		Judicial bypass laws that require minors to obtain approval from a court in order to access abortion care without parental involvement. <sup>30</sup>
Protective Current Policy	Minors	Explicitly allow minors to consent to their own health care, including sexual and reproductive health care. <sup>31</sup>
		Policies that acknowledge a variety of family structures and allow other adult relatives, besides biological parents and legal guardians, to consent to minors' abortion care in states where consent is required. <sup>32</sup>
		Allow minors not living with their parents (e.g., emancipated and homeless youth) to consent to their own healthcare services. <sup>33</sup>
Future Protective Opportunity	All Ages	Explicitly allow individuals under guardianship or conservatorship to consent to their own reproductive healthcare services, including abortion.
	Minors	Repeal parental consent and notification requirements. <sup>34</sup>

28. Laws establishing a guardian's authority to consent to abortion or sterilization are often unclear and inconsistent because the authority for a guardian to consent to abortion or sterilization is not always memorialized by statute. Each jurisdiction applies its own statutes and case law. One of the only explicit laws that prevents conservators from consenting to another person's abortion in some circumstances is Washington D.C. Code § 21-2047.01 (2015) [https://code.dccouncil.gov/us/dc/council/code/sections/21-2047.01#:~:text=Limitations%20on%20temporary%2C%20limited%2C%20and%20general%20guardians.,\"A%20guardian%20shall&text=\"\(6\)%20To%20prohibit%20the.and%20order%20of%20the%20court.](https://code.dccouncil.gov/us/dc/council/code/sections/21-2047.01#:~:text=Limitations%20on%20temporary%2C%20limited%2C%20and%20general%20guardians.,\)
29. As of September 2023, 36 states require parental involvement in a minor's decision to have an abortion. <https://lawatlas.org/datasets/abortion-requirements-for-minors>
30. As of October 2022, 31 States require parental consent prior to a minor's abortion and have a legal process that allows a judge to waive parental involvement requirements. States having varying criteria outlining the circumstances in which a judge can waive this requirement. Critics of these policies note however that in practice Judges are given wide discretion to make their decisions and often impose additional requirements onto young people that are informed by harmful biases. <https://www.advocatesforyouth.org/resources/policy-advocacy/judicial-bypass-procedures/>
31. **Example:** Oregon H.B. 2002, 82nd Leg., Reg. Sess. (Or. 2023), amending OR. REV. STAT. § 109.640. <https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2002>
32. As of September 2023, 6 states permit a minor to obtain an abortion if a grandparent or other adult relative is involved in the decision. <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortion>
33. **Example:** New York Public Health (PBH) CHAPTER 45, ARTICLE 25, TITLE 1 <https://www.nysenate.gov/legislation/laws/PBH/2504>
34. **Example:** Illinois Youth and Safety Act <https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4232&ChapterID=5>

## Key Research Questions: Parental and adult involvement in minor abortion

Parental and adult involvement in minor abortion is one of the most active, controversial, and publicly visible areas of policy making for minors' abortion access. The following are key research questions needed to inform evidence-based policy making in this area.

### 1 PARENTS' VIEWS OF AND EXPERIENCES WITH MINOR ABORTION

- What are parents' views of minors' reproductive rights? What are parents' views of parental rights with regards to reproductive health?
- What are parents' opinions of parental involvement policies for minor abortion? What are the reasons they are supportive or not supportive of forced parental involvement policies for minor abortion access?
- Do parents and guardians think their children are capable of making their own health care decisions? Why or why not?
- What is the experience of parents whose child becomes pregnant and considers or seeks an abortion? How are they involved in the minors' decision making, supporting them, facilitating their access to abortion?

### 2 LEGAL AND POLICY PROFESSIONALS

- How do policymakers view the legal framework of minors' reproductive rights? What factors do they consider when creating new policies related to minors' reproductive rights? What evidence would be helpful to inform the policy making process?
- How do legal professionals advising hospital systems view and assess minors' access to abortion? What factors do they consider? What evidence would help support their decision making?
- How do judges make decisions in judicial bypass cases? What factors do they consider? What evidence would help support their decision making?
- How do lawyers prepare to represent a minor in a judicial bypass case? What evidence would help support their efforts?

### 3 MINORS' EXPERIENCES OF ADULT INVOLVEMENT

- How do minors understand parental involvement policies, and what are their opinions of them?
- How would minors ideally want their parents and other adults to be involved in their abortion decision and care?
- What is the experience of minors who are compelled to involve their parents in their abortion decision against their wishes?

### 4 SYSTEMS-INVOLVED MINORS

- How are parental involvement requirements implemented for systems-involved minors?
- What is the role and authority of caseworkers in abortion access for systems-involved minors?

## POLICY LANDSCAPE: MINORS' PRIVACY AND CONFIDENTIALITY ABOUT ABORTION

Current or Future	Age Group Affected	Policy Type
Restrictive Current Policy	All Ages	Criminalize self-managed abortion. <sup>35</sup>
		Requirements for sharing patients' electronic medical record information without mechanisms to protect abortion data. <sup>36</sup>
	Minors	Require physicians to inquire about paternity for minors seeking abortion care. <sup>37</sup>
Protective Current Policy	All Ages	Prohibit individuals for being penalized for self-managed abortions. <sup>38</sup>
		Protect the digital privacy of individuals seeking or receiving abortion. <sup>39</sup>
		Policies that prohibit healthcare providers, law enforcement, and other actors from cooperating or assisting in another state's legal proceedings regarding abortion. <sup>40</sup>
		Policies that protect the confidentiality of individuals insured as dependents. <sup>41</sup>
	Minors	Policies that explicitly protect the confidentiality of minors insured as dependents. <sup>42</sup>
		A confidential medical release from school for sexual and reproductive health services including abortion. <sup>43</sup>
Future Protective Opportunity	All Ages	Prohibit use of an individual's reproductive health data against the individual in legal proceedings and law enforcement investigations.
		Strengthen Protections for Sexual and Reproductive Health Information under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.
		Develop policies that protect minors' digital privacy without parental control/ involvement.

35. **Example:** Nevada §200.220 <https://www.leg.state.nv.us/nrs/nrs-200.html#NRS200Sec220>

36. **Example:** The 21st Century Cures Act <https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf>

37. **Example:** Alabama Women's Health and Safety Act (Section 26-23E-10 - Paternity Inquiries of Pregnant Minor Child) <https://law.justia.com/codes/alabama/2022/title-26/chapter-23e/section-26-23e-10/>

38. As of May 2023, 7 States and The District of Columbia prohibit individuals from being criminalized for self-managed abortions. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>

39. **Example:** Washington My Health My Data Act <https://app.leg.wa.gov/billsummary?BillNumber=1155&Year=2023#documentSection>

40. As of May 2023, 19 states and Washington DC have implemented interstate shield laws that prohibit outlined parties from assisting in civil or criminal investigations concerning abortion in other states. Examples of cooperation explicitly prohibited include but are not limited to disclosure of medical records, issuance of a subpoena or warrant, and enforcement of out-of-state judgements. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>

41. As of August 2023, 14 states have provisions that serve to protect the confidentiality of individuals insured as dependents. 6 states allow individuals insured as dependents to request confidential communications from their insurance provider via a written request. <https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents>

42. **Example:** Washington. Admin. Code § 284-04-510. [https://apps.leg.wa.gov/wac/default.aspx?cite=284-04-510#:~:text=\(1\)\(a\)%20Notwithstanding%20other,or%20part%20of%20that%20information](https://apps.leg.wa.gov/wac/default.aspx?cite=284-04-510#:~:text=(1)(a)%20Notwithstanding%20other,or%20part%20of%20that%20information)

43. **Example:** California Educ. Code § 48205; 87 Ops. Cal. Atty. Gen. 168, 172 (2004)

## Key Research Questions: Minors' privacy and confidentiality about abortion

Research questions related to privacy and confidentiality focus on two main areas: 1) digital privacy and 2) mandatory reporting and criminalization of abortion. Note that parental involvement requirements overlap with this set of policies. Key research questions focus on both adults who are mandatory reporters and minors' experiences and responses to these policies.

### 1 DIGITAL PRIVACY

- Are minors aware of the limitations on digital privacy?
- How do they navigate digital spaces when they have privacy concerns?
- Do digital privacy concerns limit their ability to access the information they need?
- Can privacy be improved in the digital context by changes in corporate practice?

### 2 MANDATORY REPORTERS

- What are health care providers' and other mandatory reporters' knowledge about requirements for mandatory reporting of minors' pregnancies and their views of the impacts of these laws?
- To what extent do mandatory reporting requirements (for sexual abuse, self-managed abortion) influence minors' decision to obtain an abortion?
- What are current demographic patterns in age of minors' sexual partner? This information is needed to quantify the potential scope of policies requiring mandatory reporting of sexual abuse or consent issues.

## BUILDING RESEARCH CAPACITY

Our expert panel identified six enduring and overarching challenges relating to infrastructure, oversight, and workforce composition and capacity that systematically hamper the field's ability to produce actionable research evidence related to minors and abortion. They proposed recommendations to address these challenges.

### 1. Researcher training

**The field of sexual and reproductive health research has traditionally not trained researchers to focus on minors.**

A three-pronged approach to training is needed to support researchers' inclusion of minors in studies related to abortion. First, the development of accessible trainings on the meaningful inclusion of minors in ethical and developmentally appropriate research will ensure that abortion researchers can effectively include minors in their studies. Second, training on reproductive justice principles and methodologies is needed to enhance abortion researchers' capacity to effectively and inclusively incorporate minors in their studies. And third, training in public-facing communication is needed to ensure that researchers can successfully disseminate policy-relevant research findings to multiple audiences. Recognizing that public-facing research translation can be challenging for some researchers, there is also a need to identify and support entities who specialize in research-to-policy translation and ensure that researchers know how to get their research into the hands of research translators.

#### **BUILDING CAPACITY RECOMMENDATION 1:**

Train researchers on how and why to include minors in sexual and reproductive health research, including research focused on abortion.

### 2. Researcher composition

**Scholars from marginalized groups are underrepresented.**

The researcher workforce is in need of diversification to ensure that the people doing the research on minors and abortion reflect the diversity of the people whose experiences they are studying. Building a diverse pipeline of researchers will ensure that researchers are well-equipped to conduct studies with minors from underrepresented groups. Central to building this pipeline is the creation of training and mentoring opportunities that support early-career scholars from a wide range of backgrounds and allow them to flourish as researchers.

#### **BUILDING CAPACITY RECOMMENDATION 2:**

Diversify the abortion research workforce to include more scholars from marginalized and traditionally underrepresented groups.

### 3. Need for interdisciplinary expertise

**Siloing of expertise and approaches limit the production of relevant research.**

Abortion research has historically been siloed from other related disciplines and stigmatized. There is a



need for interdisciplinarity in the study of abortion, whereby collaborations among legal, social science, public health, and reproductive justice scholars are incentivized and forged. To produce research on minors and abortion, there is a particular need for adolescent experts to engage in abortion research. Just as the field of sexual and reproductive health has largely neglected to include minors in their work, many disciplines with relevant expertise have not included abortion in their research. Conducting research with minors requires a specialized skill set, including knowledge of adolescent development, use of developmentally appropriate research protocols and procedures, and ability to meaningfully engage minor participants in the development, conduct, and dissemination of the research. By encouraging adolescent-focused researchers to integrate an attention to abortion into their work, we can expand the abortion researcher workforce. Similarly, by encouraging abortion researchers to integrate a focus on minors into their work, we can ensure better representation of minors in abortion research that can be harnessed to inform policy.

#### **BUILDING CAPACITY RECOMMENDATION 3:**

Encourage adolescent-focused researchers to integrate an attention to abortion into their work and, correspondingly, encourage abortion researchers to integrate a focus on minors into their work.

## **4. Institutional Review Board**

### **Institutional Review Board oversight often creates unnecessary obstacles to conducting abortion research with minors.**

Despite professional consensus indicating that adolescents should be allowed to participate in research on sexual and reproductive health and that in many cases parental consent for that participation should be waived,<sup>60-61</sup> Institutional Review Boards (IRBs) often serve as obstacles to abortion research with minors. Although existing guidance from the Department of Health and Human Services (HHS) does indicate conditions under which it is appropriate for minors to participate in research on topics deemed sensitive such as sexual and reproductive health and to do so without parental consent, this topic is still a source of inconsistency and confusion to both IRBs and individual researchers. Clearly, further definition and guidance are needed. By creating best practice guidelines for both IRBs and researchers seeking IRB approval for abortion research with minors, we can demystify the assumptions both IRBs and researchers may make about including minors in such research, which disincentivizes their inclusion. Professional organizations and the U.S. Department of Health and Human Services should take a leading role in these efforts.

#### **BUILDING CAPACITY RECOMMENDATION 4:**

Create best practice guidelines for researchers seeking IRB approval for abortion research with minors and for IRBs on how to review proposals on minors' abortion.

## **5. Funding**

### **Funders fail to prioritize research on minors in their funding strategies.**

Funding is needed for research, training, interdisciplinary collaborations, and dissemination of findings on minors' abortion. However, private and public funding agencies rarely provide support for abortion research focused on minors. This lack of support reflects ongoing but unfounded concerns about the feasibility of abortion research with minors. It may also reflect the same political expediency that plays out in other sectors, including policymaking, where avoiding the controversial topic of minors is easier than addressing it directly. Funders who prioritize historically underrepresented populations in their funding strategy should recognize that minors are consistently underrepresented in abortion research, creating an effective blind spot about any abortion occurring before the age of 18 and undermining the body of work that does exist. Outreach and advocacy are needed to persuade funding sources to support both the original research and its dissemination and translation to practice.

#### **BUILDING CAPACITY RECOMMENDATION 5:**

Expand funding to support minor-focused abortion research, including training and development and dissemination of best practice guidelines.

## 6. Need for additional translation and dissemination of research

### Research evidence must make it into the hands of those who can apply it in policy and practice.

Evidence is most useful when translated into actionable, usable format. For example, once the recommended legal research has been done to clarify minors' legal abortion rights, that information should be disseminated widely to public, practitioner, policy, and researcher audiences via up-to-date, online, and searchable tools. Legal research can also be used to craft model language or legislation for proactive policies seeking to protect minors' abortion access. We know that in political negotiations, young people's abortion access is often restricted as part of a compromise. Research can be used to produce evidence-based key talking points to support advocacy and educate policymakers on the importance of minors' access to abortion throughout the legislative process. Because minors are uniquely positioned under most state laws, there is a need for translation and dissemination resources that are specifically focused on minors. In addition, minors' needs should be included in broader research dissemination efforts focused on abortion policy generally, in order to avoid further siloing and stigmatizing minors' needs.

Translation and dissemination are high-resource endeavors that the typical researcher or standard research grant are not equipped to do alone. Researchers and funders should partner with organizations that specialize in research translation and dissemination and allocate time and resources to support timely, thorough, and effective translation and dissemination.

#### **BUILDING CAPACITY RECOMMENDATION 6:**

Translate research on minor abortion into actionable tools and recommendations for practitioners and policymakers.

## CONCLUSION: A WAY FORWARD

U.S. abortion policy is changing rapidly, and minor adolescents are affected every day. Minors have historically been vastly understudied compared to adults in the abortion literature. The field of abortion research should not tolerate such a gaping hole in its knowledge, which has become a liability given the lack of evidence the field has generated to refute unfounded claims used to justify restrictions on minors' abortion access and potentially expand those restrictions to other populations. There is an urgent need to generate evidence to inform policies that govern minors' abortion.

### Research on minors and abortion should be guided by our four Overarching Research Principles:

- 1 RESEARCH NEEDS TO INCLUDE DIVERSE SAMPLES OF MINOR ADOLESCENTS.**
- 2 ACCURATE EVIDENCE ABOUT MINORS' CAPABILITIES SHOULD INFORM RESEARCH AND POLICY.**
- 3 REPRODUCTIVE JUSTICE PRINCIPLES NEED TO BE INCORPORATED INTO RESEARCH.**
- 4 RESEARCH SHOULD INCORPORATE MINORS' PERSPECTIVES AND LIVED EXPERIENCES.**

Our **16 Research Recommendations** for specific types of research needed in a policy-driven research agenda on minors and abortion are listed below. The specific research questions investigated in each type of study should be chosen to align with the categories of policies affecting minors' abortion access outlined in **Chapters 3 and 5**:

- 1 Develop an overarching conceptual framework to guide research on adolescents' sexual and reproductive health as a whole and minors' abortion experiences specifically.
- 2 Develop and disseminate bioethics research responsive to the unique sexual and reproductive health experiences and needs of minors to guide IRB oversight of this research.
- 3 Conduct a legal analysis of existing restrictive and protective policies to determine their applicability to minors and those assisting them in accessing abortion.
- 4 Translate legal research into state-specific legal guidance on minors' abortion rights for health care providers, minors themselves, and the general public.
- 5 Create and maintain a comprehensive, longitudinal database of state abortion policies, including those specific to minors.
- 6 Conduct legal epidemiology and other studies to document differential experiences and outcomes across a range of domains among minors exposed to different policy environments.
- 7 Increase and improve the inclusion of minors in patient population studies and state and national abortion surveillance.

- 8 Present age-specific data, with minors presented separately from adults, to allow identification of minors' experiences.
- 9 Field a longitudinal study of pregnant minors over time, across different abortion policy environments.
- 10 Conduct dedicated studies of abortion among systems-involved and multiply marginalized youth.
- 11 Field timely studies of the general population of minors to understand their current knowledge, attitudes, and behaviors related to changing abortion access.
- 12 Promote and support federal, state, and private efforts to expand and improve sexual and reproductive health data collection from minors with attention to sample size and measurement quality.
- 13 Field a population-representative longitudinal survey of adolescents that allows for research on the impact of the post-Dobbs environment on minors' behavior, education, economic, and health outcomes into adulthood.
- 14 Conduct developmental science studies on adolescents' development as it relates to abortion experiences and decision making.
- 15 Apply developmental science to the creation of developmentally optimized policies and clinical practices for minors in abortion and sexual and reproductive health.
- 16 Enrich research on minors by studying attitudes and actions of adults who are influential in minors' abortion experiences.

While there are challenges to conducting research on abortion among minors, those challenges are not insurmountable. Our **6 Building Capacity Recommendations** to facilitate research on minor abortion and overcome the challenges that have historically hampered this field of research are:

- 1 Train researchers on how and why to include minors in sexual and reproductive health research, including research focused on abortion.
- 2 Diversify the abortion research workforce to include more scholars from marginalized and traditionally underrepresented groups.
- 3 Encourage adolescent-focused researchers to integrate an attention to abortion into their work and, correspondingly, encourage abortion researchers to integrate a focus on minors into their work.
- 4 Create best practice guidelines for researchers seeking IRB approval for abortion research with minors and for IRBs on how to review proposals on minors' abortion.
- 5 Expand funding to support minor-focused abortion research, including training and development and dissemination of best practice guidelines.
- 6 Translate research on minor abortion into actionable tools and recommendations for practitioners and policymakers.

Our panel of experts are confident in the field's ability to produce high-quality, actionable research evidence to inform policy on minor abortion access. We urge researchers, professional organizations, funders, and policy advocates to join together in the pursuit of evidence-based policy that supports adolescents' bodily autonomy and reproductive rights.

We invite inquiries at [youthrepro@umich.edu](mailto:youthrepro@umich.edu).

For more information about Youth Reproductive Equity and our work, visit [www.youthreproequity.org](http://www.youthreproequity.org).

## ACKNOWLEDGEMENTS

This work was funded by the William T. Grant Foundation and by the Center for Clinical and Translational Science at the University of Illinois Chicago.

We thank Abigail English, JD, Adrienne Ghorashi, JD, Naomi Cahn, JD, Megan Kavanaugh, DrPH, MPH, Cynthia Osborne, PhD, and Lauren Ralph, PhD, MPH for their thoughtful review and comments.

We thank our expert panelists for their invaluable expertise and insights and the members of Youth Reproductive Equity for ongoing consultation on this project. We thank the Coalition to Expand Contraceptive Access for guidance on our convening process.

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## GLOSSARY OF KEY TERMS

### Adolescents

Adolescents are individuals experiencing a transitional stage of physical, psychological, and sociological development between childhood and adulthood. Adolescence is often marked by the onset of puberty, but the age at which it ends is defined differently by various disciplines, depending on their area of interest and definition of adulthood. Youth Reproductive Equity is concerned with the health and well-being of adolescents across a wide age range, including minors, older adolescents, and young adults. In this report, we will use the term *adolescents* to refer to individuals across this spectrum of ages and *minors* to describe a subset of adolescents under age 18.

### Anti-Abortion Centers

Anti-Abortion Centers, also known as crisis pregnancy centers, are clinics or mobile vans that look like real health centers but are run by anti-abortion organizations that aim to scare, shame, or pressure people out of getting an abortion. They do this by targeting pregnant people who are looking for pregnancy options support or abortion care, posing as medical professionals, and providing them with false information about abortion. Crisis pregnancy centers are often strategically placed near clinics that provide abortion access to divert or confuse patients.<sup>62</sup>

### Dobbs

*Dobbs v. Jackson Women's Health Organization* was a landmark decision of the United States Supreme Court in which the court ruled that the Constitution of the United States does not federally protect an individual's right to abortion. The court's decision overruled both *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992). The *Dobbs*' ruling means that each state now has the full power to regulate any aspect of abortion not protected by federal law. *Dobbs* has resulted in numerous states restricting or criminalizing those who provide, seek, or facilitate abortion care.

### Judicial Bypass

In states with parental involvement laws, a judicial bypass is a court order allowing minors to obtain abortions without parental notification or consent. Judicial bypass is utilized when minors do not want to involve their parents in their care, believe involving them would be harmful, or cannot meet the requirements of their state's parental involvement laws. Criteria for granting bypass varies by state, with many requiring a judge rule based on whether they believe there is evidence that the young person is "sufficiently mature," and that abortion is in their best interest. What a judge may believe, however, is often subjective. In many circumstances, an individual's ability to access abortion is informed by the personal or political beliefs of the judge assigned to their case.<sup>63</sup>

### Minors

In the United States, individuals under the age of legal adulthood (usually 18 years old) are classified as minors. Minors encompass a series of age groups, ranging from infants to school-age children to adolescents, each with their own development, social, and legal needs. Unless otherwise stated, throughout this report, the term minors will be used to describe adolescents who are at an age where it is biologically possible to become pregnant and fall under this distinct legal categorization.



## Parental Involvement Laws

Parental involvement laws are policies that dictate when and how a minor must involve their parent(s) in their decision to have an abortion. Parental involvement laws primarily consist of parental consent laws, which require that a parent grant consent to their child to receive an abortion, and parental notification laws, which require one or more parents to be notified before a minor's abortion. States have different laws outlining how this involvement must be conducted and the circumstances in which a minor can be exempt from this requirement.

## Reproductive Justice

Reproductive Justice is a strategic framework that asserts “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”<sup>65</sup> Founded by women of color, the reproductive justice movement advocates for the holistic resources, policies, and culture shifts required for marginalized communities to thrive. Using an intersectional framework, reproductive justice is a lens that can be used to fight for numerous human rights, including but not limited to abortion. Reproductive justice emphasizes that the legal right to abortion is not a sufficient end goal, as the legal right to abortion is meaningless if one does not have the adequate resources to obtain the high-quality, affirming care they need.<sup>64</sup>

## Research Justice

Research justice is a strategic framework and methodological approach that aims to transform how research is conducted and used to inform policy and practice. By recognizing and valuing multiple forms of knowledge and forging a collaborative approach to research, research justice methodologies center the knowledge and experiences of marginalized groups to ensure that research, and in turn, policy, is responsive to their needs and concerns. Central to research justice methodologies is intersectionality, which attends to how interlocking systems of oppression have inequitable consequences and impacts for groups located at varied intersections of gender, race, social class, sexuality, and age.<sup>30</sup>

## Sexual and Reproductive Health

Sexual and reproductive health (SRH) is a field of research and health care that relates to the health of an individual's reproductive system and their greater sexual well-being during all stages of their life. Sexual and reproductive health is not assessed by the mere absence of disease in one's reproductive system, but rather by the overall state of one's “physical, emotional, mental, and social wellbeing in relation to their sexuality.”<sup>65</sup> Abortion is one of many health and social issues encompassed within sexual and reproductive health.

## POLICIES IMPACTING MINORS' ABORTION ACCESS

POLICY LANDSCAPE: MINORS' ACCESS TO ABORTION SERVICES		
Current or Future	Age Group Affected	Policy Type
Restrictive Current Policy	All Ages	Outlaw abortion with few to no exceptions, completely or at a certain gestational age. <sup>1</sup>
		Enact medically unnecessary mandatory waiting periods. <sup>2</sup>
		Permit only physicians to prescribe mifepristone and misoprostol. <sup>3</sup>
		Require individual to be in physical presence of a clinician to take an abortion pill. <sup>4</sup>
		Provide protection to health care providers who refuse to offer abortion care and pharmacists who refuse to dispense abortion medications. <sup>5</sup>
		Restrict what facilities abortion services can be delivered in. <sup>6</sup>
		Prohibit the use of telemedicine for abortion medication. <sup>7</sup>
		Prohibit or restrict abortion coverage in the state's Health Exchange plans. <sup>8</sup>
		Prohibit or restrict private insurance plans from covering abortion services. <sup>9</sup>
		Prohibit the mailing of abortion pills. <sup>10</sup>
	Minors	Laws, such as "abortion trafficking" laws that limit minors from traveling out of state and/or criminalize those who help them. <sup>11</sup>
Protective Current Policy	All Ages	State constitutional provisions and other policies that protect and codify abortion and reproductive rights. <sup>12</sup>
		Expand which healthcare professionals can provide abortion services. <sup>13</sup>
		Shield laws to protect patients, providers, and third-party actors who facilitate abortion access from civil and criminal legal action. <sup>14</sup>
		Shield laws that protect providers who prescribe abortion pills through telehealth services to patients across state lines. <sup>15</sup>
		Provide state funding for abortion services and abortion-related costs (e.g., travel, lodging, service navigation and coordination). <sup>16</sup>
		Include abortion care in state Medicaid coverage. <sup>17</sup>
		Promote clinic safety and allocate funds to do so. <sup>18</sup>

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## POLICY LANDSCAPE: MINORS' ACCESS TO ABORTION SERVICES

Current or Future	Age Group Affected	Policy Type
Protective Current Policy	Minors	Protect/codify one's ability to access reproductive health care including abortion, regardless of their age. <sup>19</sup>
	All Ages	Federal constitutional amendment and other policies that protect abortion/reproductive rights. Repeal existing gestational bans. Protect access to mifepristone. Implement patient safeguards to ensure timely and appropriate care for individuals whose healthcare providers refuse to provide abortion services. <sup>20</sup>
Future Protective Opportunity	Minors	Enact explicit policies that protect minors' access to abortion in states where age is not mentioned in current abortion protections. In states where telehealth medication abortion is legal, develop and implement policy guidance that creates and/or protects access to telehealth for medication abortion for minors.

## POLICY LANDSCAPE: MINORS' ACCESS TO INFORMATION ABOUT ABORTION

Current or Future	Age Group Affected	Policy Type
Restrictive Current Policy	All Ages	Provide state funding for anti-abortion centers. <sup>21</sup> Mandate providers share medically inaccurate or misleading information about abortion and long-term health risks. <sup>22</sup>
	Minors	Prohibit school-based sex education from discussing abortion. <sup>23</sup>
Protective Current Policy	All Ages	Promote public education about anti-abortion centers and their practices. <sup>24</sup> Designate a state agency to develop and maintain a website for individuals to access accurate information about abortion and accessing abortion in that state. <sup>25</sup> Require anti-abortion centers to disclose that they do not offer or provide referrals for abortion or contraceptive services and, if applicable, that they do not have medically trained staff on site. <sup>26</sup>
	Minors	Require information about abortion or pregnancy options to be included in school-based sex education. <sup>27</sup>
Future Protective Opportunity	Minors	Codify minors' right to seek information about abortion care.

## POLICY LANDSCAPE: PARENTAL AND ADULT INVOLVEMENT IN MINOR ABORTION

Current or Future	Age Group Affected	Policy Type
Restrictive Current Policy	All Ages	Restrictive requirements for consent to abortion for individuals under guardianship or conservatorship regardless of the individual's age or capacity. <sup>28</sup>
	Minors	Parental consent and parental notification requirements. <sup>29</sup>
		Judicial bypass laws that require minors to obtain approval from a court in order to access abortion care without parental involvement. <sup>30</sup>
Protective Current Policy	Minors	Explicitly allow minors to consent to their own health care, including sexual and reproductive health care. <sup>31</sup>
		Policies that acknowledge a variety of family structures and allow other adult relatives, besides biological parents and legal guardians, to consent to minors' abortion care in states where consent is required. <sup>32</sup>
		Allow minors not living with their parents (e.g., emancipated and homeless youth) to consent to their own healthcare services. <sup>33</sup>
Future Protective Opportunity	All Ages	Explicitly allow individuals under guardianship or conservatorship to consent to their own reproductive healthcare services, including abortion.
	Minors	Repeal parental consent and notification requirements. <sup>34</sup>

## POLICY LANDSCAPE: MINORS' PRIVACY AND CONFIDENTIALITY ABOUT ABORTION

Current or Future	Age Group Affected	Policy Type
Restrictive Current Policy	All Ages	Criminalize self-managed abortion. <sup>35</sup>
		Requirements for sharing patients' electronic medical record information without mechanisms to protect abortion data. <sup>36</sup>
	Minors	Require physicians to inquire about paternity for minors seeking abortion care. <sup>37</sup>
Protective Current Policy	All Ages	Prohibit individuals for being penalized for self-managed abortions. <sup>38</sup>
		Protect the digital privacy of individuals seeking or receiving abortion. <sup>39</sup>
		Policies that prohibit healthcare providers, law enforcement, and other actors from cooperating or assisting in another state's legal proceedings regarding abortion. <sup>40</sup>
		Policies that protect the confidentiality of individuals insured as dependents. <sup>41</sup>

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# POLICY LANDSCAPE: MINORS' PRIVACY AND CONFIDENTIALITY ABOUT ABORTION

Current or Future	Age Group Affected	Policy Type
Protective Current Policy	Minors	Policies that explicitly protect the confidentiality of minors insured as dependents. <sup>42</sup>
		A confidential medical release from school for sexual and reproductive health services including abortion. <sup>43</sup>
Future Protective Opportunity	All Ages	Prohibit use of an individual's reproductive health data against the individual in legal proceedings and law enforcement investigations.
		Strengthen Protections for Sexual and Reproductive Health Information under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.
		Develop policies that protect minors' digital privacy without parental control/ involvement.

- 19 States have laws that prohibit abortion at any point in pregnancy with few to no exceptions. 14 states have these laws in effect as of December 2023. <https://lawatlas.org/datasets/abortion-bans>
- As of October 2022, 29 States have laws that require a waiting period prior to obtaining an abortion. <https://lawatlas.org/datasets/abortion-waiting-period-requirements>
- As of May 2023, 23 States have laws that permit only physicians to prescribe abortion medications. 5 of these state's laws are not in effect due to legal challenges. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
- As of May 2023, 20 States have laws stating that providers must administer medication abortion in-person. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
- As of November 2022, 45 states allow some health care providers to refuse to provide abortion services. Only 3 States provide protections for patients whose healthcare provider or institution refuse to provide said care. <https://lawatlas.org/datasets/refusal-to-perform-abortions>
- Example:** Utah's Abortion Changes Act, passed March 2023, enjoined May 2nd 2023 <https://le.utah.gov/~2023/bills/static/HB0467.html> <https://attorneygeneral.utah.gov/wp-content/uploads/2023/05/Memorandum-Decision-002-1.pdf> <https://attorneygeneral.utah.gov/wp-content/uploads/2023/05/Memorandum-Decision-002-1.pdf>
- As of May 2023, 8 states explicitly prohibit the use of telehealth to provide an abortion <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
- As of October 2022, 24 states prohibit or restrict abortion coverage in their Health Exchange plans. 22 of these states outline limited circumstances in which the state allows coverage of abortion in Health Exchange plans, such as rape, incest, or fetal anomaly. <https://lawatlas.org/datasets/restrictions-on-insurance-coverage-of-abortion>
- As of October 2022, 12 states restrict private insurance coverage of abortion. 3 of these states provide exceptions allowing for private coverage in instances of rape, incest, and life endangerment. <https://lawatlas.org/datasets/restrictions-on-insurance-coverage-of-abortion>
- As of May 2023, 8 states prohibit the mailing of abortion pills. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
- Example:** Idaho Code § 18-623 <https://legislature.idaho.gov/statutesrules/idstat/Title18/T18CH6/SECT18-623/>
- As of December 2023, the state constitutions in 9 states provide protection for abortion and/or reproductive freedom. <https://reproductiverights.org/maps/abortion-laws-by-state/>
- As of May 2023, 14 states have laws allowing healthcare providers such as Nurse Practitioners, Physicians Assistants, and Advanced Practice Clinicians, to provide abortion care. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
- Example:** Hawaii Act 002 of 2023 <https://trackbill.com/bill/hawaii-governor-message-1102-act-002/2405880/>
- Example:** New York S01066-B provides legal protections for reproductive health service providers who provide legally protected health activities including protection from extradition, arrest and legal proceedings in other states relating to such services; restricts the use of evidence relating to the involvement of a party in providing legally protected health activity to persons located out-of-state. <https://nyassembly.gov/Press/?sec=story&story=106524>
- Example:** California Abortion Practical Support Fund [https://leginfo.ca.gov/faces/codes\\_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=2.&article=2.3](https://leginfo.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=2.&article=2.3)
- As of December 2023, 14 States cover abortion services under their state Medicaid plan. <https://reproductiverights.org/maps/abortion-laws-by-state/>
- Example:** New Jersey's Reproductive Health Security Grant Program (RHSGP) <https://www.njohsp.gov/grants/state-reproductive-health-security-grant-program>
- Example:** Minnesota Protect Reproductive Options (PRO) Act <https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/4/>
- Example:** Illinois' Patient and Provider Protection Act prevents insurers from charging higher out-of-pocket costs for certain insurance plans when patients are forced to seek out-of-network provider care due to an in-network provider raising moral objections under the Health Care Right of Conscience Act. <https://www.illinois.gov/news/press-release.25906.html>
- As of January 2024, at least 18 states directly fund pregnancy resource centers through state grants and allocated federal welfare funds. <https://equityfwd.org/anti-abortion-centers#key-facts>
- As of August 2023, 8 states require providers share medically inaccurate information that a medication abortion can be stopped after the patient takes the first dose of pills. 5 states that include information on breast cancer inaccurately assert a link between abortion and an increased risk of breast cancer. <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>

23. As of 2022, 6 States prohibit school-based sexual health education from discussing abortion as a possible pregnancy outcome. 1 additional state require school-based information about abortion to dissuade students from viewing abortion as an acceptable pregnancy outcome. <https://siecus.org/wp-content/uploads/2021/09/2022-Sex-Education-State-Law-and-Policy-Chart.pdf>
24. **Example:** Massachusetts FY 2023 budget resolution to include \$1 million public awareness campaign focused on the dangers of crisis pregnancy centers and pregnancy resource centers <https://www.mass.gov/news/governor-healey-signs-389-million-supplemental-budget>
25. **Example:** Cal. Health & Safety Code § 123430(a)(1) requires the California Health and Human Services Agency, or an entity designated by the agency, to establish an internet website where the public can access information on abortion services in the state. [https://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=HSC&sectionNum=123430](https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123430)
26. **Example:** Colorado Deceptive Trade Practice Pregnancy-related Service Act <https://leg.colorado.gov/bills/sb23-190>. While policies like this are protective in theory, they have been difficult to enforce in recent years and faced a series of legal challenges. In 2018, The Supreme Court of the United States struck down a similar policy in California in NIFLA v Becerra. [https://www.supremecourt.gov/opinions/17pdf/16-1140\\_5368.pdf](https://www.supremecourt.gov/opinions/17pdf/16-1140_5368.pdf)
27. **Example:** Vermont 16 V.S.A. § 131 <https://legislature.vermont.gov/statutes/section/16/001/00131>
28. Laws establishing a guardian's authority to consent to abortion or sterilization are often unclear and inconsistent because the authority for a guardian to consent to abortion or sterilization is not always memorialized by statute. Each jurisdiction applies its own statutes and case law. One of the only explicit laws that prevents conservators from consenting to another person's abortion in some circumstances is Washington D.C. Code § 21-204701 (2015) [https://code.dccouncil.gov/us/dc/council/code/sections/21-204701#:~:text=Limitations%20on%20temporary%2C%20limited%2C%20and%20general%20guardians,-%20guardian%20shall&text=\(6\)%20to%20prohibit%20the,and%20order%20of%20the%20court](https://code.dccouncil.gov/us/dc/council/code/sections/21-204701#:~:text=Limitations%20on%20temporary%2C%20limited%2C%20and%20general%20guardians,-%20guardian%20shall&text=(6)%20to%20prohibit%20the,and%20order%20of%20the%20court)
29. As of September 2023, 36 states require parental involvement in a minor's decision to have an abortion. <https://lawatlas.org/datasets/abortion-requirements-for-minors>
30. As of October 2022, 31 States require parental consent prior to a minor's abortion and have a legal process that allows a judge to waive parental involvement requirements. States having varying criteria outlining the circumstances in which a judge can waive this requirement. Critics of these policies note however that in practice Judges are given wide discretion to make their decisions and often impose additional requirements onto young people that are informed by harmful biases. <https://www.advocatesforyouth.org/resources/policy-advocacy/judicial-bypass-procedures/>
31. **Example:** Oregon H.B. 2002, 82nd Leg., Reg. Sess. (Or. 2023), amending OR. REV. STAT. § 109.640. <https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/2002>
32. As of September 2023, 6 states permit a minor to obtain an abortion if a grandparent or other adult relative is involved in the decision. <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortion>
33. **Example:** New York Public Health (PBH) CHAPTER 45, ARTICLE 25, TITLE 1 <https://www.nysenate.gov/legislation/laws/PBH/2504>
34. **Example:** Illinois Youth and Safety Act <https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4232&ChapterID=5>
35. **Example:** Nevada §200.220 <https://www.leg.state.nv.us/nrs/nrs-200.html#NRS200Sec220>
36. **Example:** The 21st Century Cures Act <https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf>
37. **Example:** Alabama Women's Health and Safety Act (Section 26-23E-10 - Paternity Inquiries of Pregnant Minor Child) <https://law.justia.com/codes/alabama/2022/title-26/chapter-23e/section-26-23e-10/>
38. As of May 2023, 7 States and The District of Columbia prohibit individuals from being criminalized for self-managed abortions. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
39. **Example:** Washington My Health My Data Act <https://app.leg.wa.gov/billssummary?BillNumber=1155&Year=2023#documentSection>
40. As of May 2023, 19 states and Washington DC have implemented interstate shield laws that prohibit outlined parties from assisting in civil or criminal investigations concerning abortion in other states. Examples of cooperation explicitly prohibited include but are not limited to disclosure of medical records, issuance of a subpoena or warrant, and enforcement of out-of-state judgements. <https://lawatlas.org/datasets/post-dobbs-state-abortion-restrictions-and-protections>
41. As of August 2023, 14 states have provisions that serve to protect the confidentiality of individuals insured as dependents. 6 states allow individuals insured as dependents to request confidential communications from their insurance provider via a written request. <https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents>
42. **Example:** Washington. Admin. Code § 284-04-510. [https://apps.leg.wa.gov/wac/default.aspx?cite=284-04-510#:~:text=\(1\)\(a\)%20Notwithstanding%20other,or%20part%20of%20that%20information](https://apps.leg.wa.gov/wac/default.aspx?cite=284-04-510#:~:text=(1)(a)%20Notwithstanding%20other,or%20part%20of%20that%20information)
43. **Example:** California Educ. Code § 48205; 87 Ops. Cal. Atty. Gen. 168, 172 (2004)