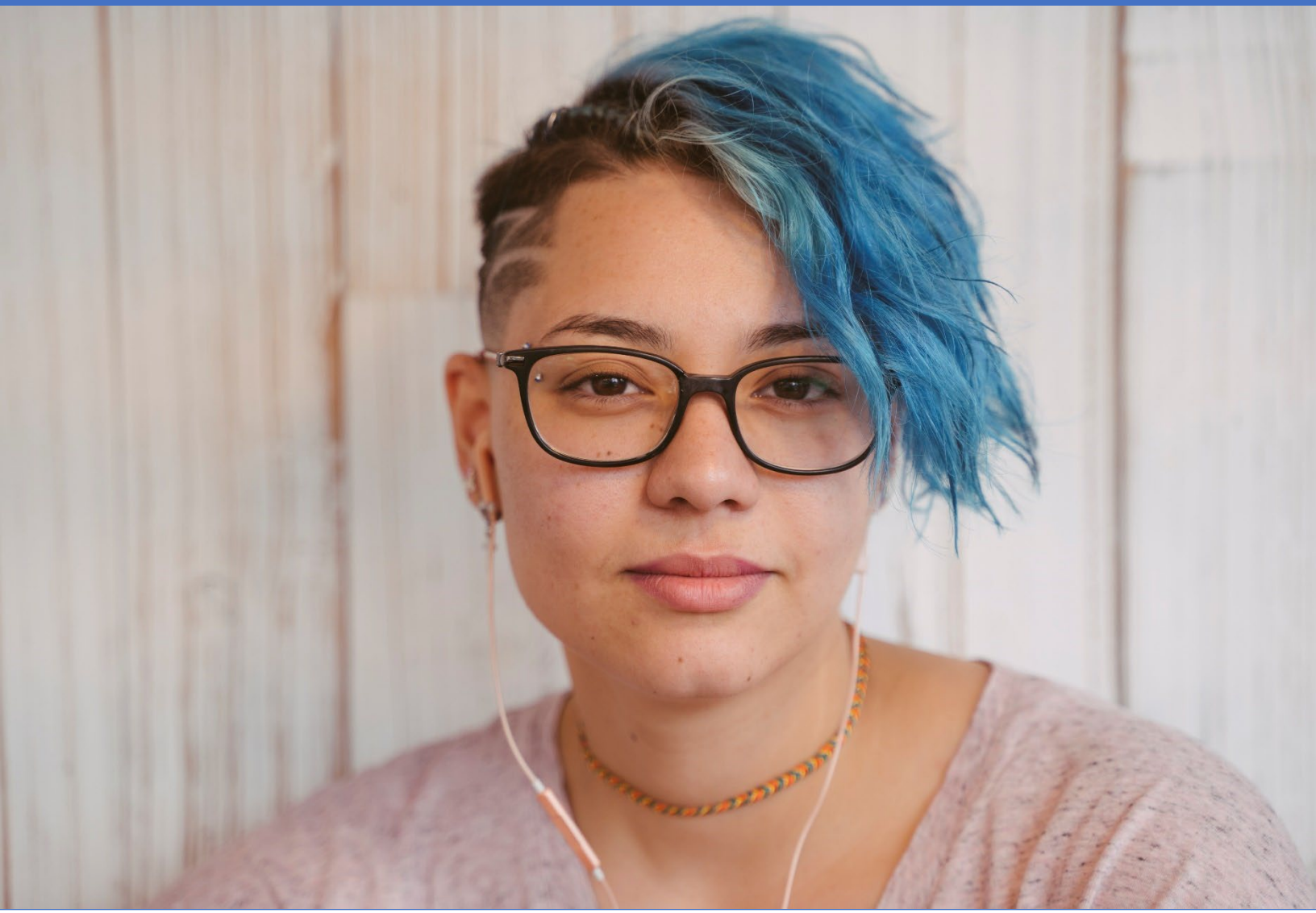
Equitable Access to Sexual and Reproductive Health Care for All Youth



A collaborative initiative of the American Academy of Pediatrics

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Introduction

Foreword

The American Academy of Pediatrics (AAP) is a membership organization representing 67,000 pediatricians and pediatric subspecialists that is committed to the optimal physical, mental, and social health and well-being for all, infants, children, adolescents, and young adults. AAP develops and disseminates policies designed to achieve this. Special attention is focused on issues that leave some children more vulnerable than others. In recent years, AAP has officially recognized racism as a core social determinant of health and a driver of health inequities. It has also acknowledged its own history of bias and racist attitudes. In an effort to achieve health equity and actualize its goals to become an equitable, diverse, and inclusive organization, AAP set forth an equity agenda in 2020 to promote a diverse Academy membership, leadership and pediatric workforce; apply an equity lens to Academy policy, advocacy, and education; and equip AAP members with the capacity to foster equity in their practices, institutions, and communities.

The Academy's commitment to equity, diversity, and inclusion is advanced through its programs. With generous support from the Collaborative for Gender and Reproductive Equity (CGRE), AAP engaged collaborators with lived experiences or who serve communities that are historically under-resourced including adolescents, federal agencies, community organizations, academic researchers, and legal experts to create a resource that supports pediatric health clinicians, community leaders, and public health professionals in identifying strategies and key partnerships to expand equitable access to reproductive health care, including comprehensive sex education, contraception, and abortion for all youth. During each project phase, AAP engaged collaborators with lived experiences or who serve under-resourced communities, including adolescents, federal agencies, community organizations, academic researchers, and legal experts.

Project approach

At the beginning of the project, AAP launched an initiative to engage with key collaborators to discuss and inform a published resource on the ramifications of expanded bans and limitations on access to sexual and reproductive health services, including comprehensive sex education, contraception, and abortion, for adolescents, families, pediatric health clinicians, and communities.

Collaborators with lived experiences, areas of specialized studies, and professional positions in sexual and reproductive health were identified and meaningfully engaged to serve as planning committee members, presenters, and participants in all phases of the project. This includes adolescents as well as academic researchers, legal experts, and representatives from federal agencies and community organizations.

First, AAP hosted a series of listening sessions focused on the current landscape of youth access to sexual and reproductive health care services and the impact of bans and limitations to access to care. Collaborators shared their perspectives, which resulted in the key themes incorporated into the agenda of a larger virtual summit. These collaborators, in addition to other identified experts, served as panelists, presenters, and participants.

During the *2021 Youth Summit on Youth Access to Reproductive Health Care*, youth participated in conversations with clinical, community, and academic leaders to examine the importance of equitable access to sexual and reproductive health care, describe barriers to accessing comprehensive sex education, contraception, and abortion services, and share solutions that support and expand youth access to reproductive health care.

After the Summit, two focus meetings – one with youth from communities that are underrepresented and one with those who deliver sexual and reproductive health services to youth from communities that are underrepresented – explored the added barriers experienced by youth who are historically disenfranchised and underserved by comprehensive sex education, contraception, and abortion services. Special considerations for how clinicians and public health professionals can support and expand equitable reproductive health care access were examined.

Meaningfully engaging individuals who have been historically disenfranchised and/or adversely impacted by the issues being addressed is considered a best practice in equity-centered work. Elevating the perspectives of those directly impacted by our policies is one important way to create policy and systems changes that benefit the communities we are aiming to serve.

Key Terminology

For the purposes of this resource:

- The words "**people**" and "**pregnant people"** are generally used to describe individuals who are accessing sexual and reproductive health services, including comprehensive sex education, contraception, and abortion. The terms were chosen because they are inclusive to all people who access the full spectrum of health services, including cisgender women, cisgender men, people who identify as non-binary, and people who identify as transgender. Sometimes the word "women" is used when describing specific research or data that use that term to describe their study population.
- References to the term "**pediatric health clinicians**" are intended to include all health clinicians who provide sexual and reproductive health care to youth and young adults, including (but not limited to) pediatricians, pediatric medical subspecialists, pediatric surgical subspecialists, pharmacists, family physicians, obstetricians, gynecologists, subspecialists, mental and behavioral health professionals, nurses, nurse practitioners, physician assistants, medical assistants, school nurses, and any other clinician who provides health care to youth.
- Use of the terms "**under resourced**" and "**underrepresented**" when describing a population or community (eg, racial, religious, or cultural group) refers to a population or community whose access to institutional and structural power has been severely limited regardless of its relative population size.
- References to the term "**parent/caregiver**" are meant to include anyone who serves in a parental role in a young person's life, including, but not limited to, adoptive parents, biological parents, foster parents, grandparents, stepparents, and guardians.
- References to "**youth**" and/or "**young people**" are meant to include all adolescents and young adults from 11 to 25 years in age.
- The phrase "**Reproductive Justice"** can be defined as the human right to maintain bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.[i]
- Use of the term "**Reproductive Health Care**" encompasses comprehensive sexual education, contraception, and abortion.
- The use of the acronym "**LGBTQ2S+"** stands for lesbian, gay, bisexual, transgender, queer, two-spirit, and attempts to define individuals that do not experience the same power and privilege as individuals who are heterosexual and/or cisgender.
- References to youth with **disabilities** is referring to youth physical disabilities, intellectual disabilities, learning disabilities, chronic medical conditions, and/or autism. It's important to note that every individual's spectrum of ability ranges and each's unique needs be considered when developing

strategies that supports and expands an individual's access sexual and reproductive health care.

Perspective: Yael Benvenuto Ladin, Youth activist

Think about the last time you needed reproductive healthcare: where you were, who you were with, and why you sought care. Did you get what you needed? How far did you travel? How much did it cost to get there and to pay for your care? How did you figure out where to go and what to ask for? Did you expect to be listened to, treated with respect? Did you have to hide that you sought care? For many of us, these concerns are not restricted by age, and for youth, especially, encountering these hurdles can be overwhelming. Young people are so much more likely to be in the dark about critical and urgent issues: bodily processes, available and appropriate care, where it can be found, and how to ask for it. For youth of color, queer and trans youth, young people from rural communities and facing economic injustice and inequity, the fear, barriers, and risks involved in seeking out reproductive healthcare are compounded. This is what compels me to advocate and provide support for youth access.

As a young person advocating for youth access to reproductive healthcare, I have a message for you. We need you, allies, and we appreciate you so much. We also know what we need, what we deserve, and how we want to get there. We have skills, energy, and power. Young people are the experts on youth experience, we know the barriers we face and how it feels to come up against them. Listening to our contributions and uplifting them is recognizing that you have the ability to do what many others do not: take us seriously. These issues are critical– we are fighting for our autonomy, our right to safe, comprehensive, trauma-informed care and our right to education. You– the pediatrician, the youth advocate, the public health professional, the policy maker– can take our words, our work, and our vision for youth access to sexual and reproductive healthcare into spaces that reject and overlook us.

Perspective: Krishna Upadhya MD MPH FAAP

Adolescents and young adults need access to developmentally appropriate sexual and reproductive health care and information in order to achieve optimal health. As all pediatricians know, the onset of romantic relationships and sexual experience are developmentally expected during adolescence. Having the skills and support needed to navigate these milestones sets the foundation for a key aspect of adulthood. Comprehensive sex education and services including contraception, prevention and treatment of sexually transmitted infections, and pregnancy care, including abortion, support healthy adolescent development and have benefits to communities and society that are well documented around the globe. Those of us who work with young people also have many, rich anecdotal experiences to validate the data in personal terms.

Unfortunately, it is also very clear that too many people in the United States face unnecessary and unacceptable barriers to the sexual health information and services they need to be healthy. And while 2022 is a particularly acute inflection point for access, especially to abortion care, threats and barriers to this care and information have existed for decades. The barriers have also harmed some people more than others, with adolescents, people in historically disenfranchised and underserved racial groups and those with low incomes particularly impacted. Policies and practices restricting access to abortion and other sexual and reproductive health care and information are significant contributors to the poor reproductive health outcomes reflected in our national data: why maternal and infant mortality in the US occur at much higher rates than in other high income countries; why women who are Black are more than 4 times as likely to suffer maternal mortality than white women; and why young people account for almost 50% percent of sexually transmitted infections even though they only represent 25% of the sexually active population.

Pediatric health clinicians who work with families and young people are critical to changing the trajectory, improving sexual and reproductive health outcomes and advancing health equity. Pediatricians impact patients and their families directly with their care, provide subject matter expertise to schools and community organizations, and also can be

powerful advocates with policy makers. As we think about what we can do to make change we must keep at the center what those who have experienced the greatest harms and barriers, including our young people, have been speaking up about and advocating for. Access to sexual and reproductive health care is essential because everyone should have the freedom and power to control their own body, decisions, and lives. Thank you for taking the time to engage with this resource and for doing what you can to ensure that all people can access the care and information they need to be their healthiest selves.

A call to action

Equitable access to comprehensive sex education, contraception, and abortion is a critical component of adolescent health. Pediatric health clinicians play an important role in supporting and expanding access to sexual and reproductive health care for all adolescents and young adults:

- **Education:** Educating self, colleagues, and other key partners about local/state laws on access to care, institutional policies surrounding delivery of care services, and identification of sexual and reproductive health organizations in the community for collaboration and referral opportunities.
- **Promotion:** Speaking out on the importance of equitable access to sexual and reproductive health care for youth, and educating patients and their families about sexual health, reproductive health, contraception, pregnancy options, abortion, and other related health services.
- **Primary Prevention:** Providing direct prevention interventions to support sexual and reproductive health of youth in clinical and community settings. Examples include addressing sextually transmitted infection (STI) and pregnancy prevention as a part of clinical services, talking with patients about healthy relationships, communication, and consent, talking with parents or caregivers of children and adolescents about having healthy discussions about puberty and sexuality with youth, providing options counseling to pregnant patients, combating misinformation about sexual health, speaking out against stigma, and raising awareness about the importance of sexual and reproductive health.
- **Advocacy:** Promoting policy priorities that impact your community, such as increasing access to affordable, effective, evidence-based sexual and reproductive health services, fostering healthy sexual development for youth and young adults, increasing payment and insurance coverage, building the sexual and reproductive health workforce, and developing the evidence base to address disparities. More information can be found in the *Policy Priorities for Promoting Youth Access to Sexual and Reproductive Health Care*.
- **Partnerships:** Collaborating with key partners, including but not limited to youth, families, schools, youth-serving organizations, school-based health clinics, and mobile clinic providers expands youth access to reproductive health care services and resources.

Note: This resource is designed to support pediatric health clinicians and other youth advocates in supporting and expanding access to sexual and reproductive health care for all youth while also supporting the inclusion of reproductive justice in pediatric care. It is a dynamic document that is meant to provide information that is current, accurate and easy to understand. As a consumer of this resource, you may bring lived experiences, areas of specialized studies, professional positions, and/or passion to this space and are therefore a valuable partner in this work. If, while engaging with this resource, you notice an outdated link or a missing resource or tool, please complete this form and your request will be reviewed by AAP staff.

The importance of equitable access to sexual and reproductive health services for youth

Sexual and reproductive health care is a critical component of adolescent health.

Comprehensive, confidential, and accessible sexual and reproductive health care is a cornerstone of a young person's health and well-being. All youth are entitled to have access to information and sexual and reproductive health services that are: available in adequate numbers, accessible physically and economically, accessible without discrimination, medically accurate, and culturally appropriate.

Enabling young people to make informed and autonomous decisions about their sexuality and reproductive health is critical for fulfilling their human rights and enables self-management of care.

Pediatric health clinicians play a critical role in supporting youth to make informed decisions about their health, and to delivering or linking young people to the sexual and reproductive health care services they need. Because of this, the AAP has long advanced policy, care guidelines, and advocacy priorities that reflect the importance of fostering sexual health and well-being at all developmental stages.

Even so, access to such essential care is severely limited for many young people nationwide. Longstanding systemic inequities impact the ability of many to access sexual and reproductive health services, a crisis that is exacerbated by an increase in legislation to further restrict access.

Access to reproductive health care is a health equity issue.

Efforts are needed to address disparities in youth access to sexual and reproductive health services. Many populations have traditionally experienced added barriers when accessing comprehensive sex education, contraception, and abortion.

Clinical efforts to support and expand access to sexual and reproductive health care are needed to provide comprehensive, effective, and culturally appropriate care to youth populations, including (but not limited to):

- Youth who are Black and Hispanic.
- Youth who are Indigenous and American Indian/Alaska Native.
- Youth who are Asian-American and Pacific Islander.
- Youth who are Immigrant.
- Youth who identify as lesbian, gay, bisexual, transgender, queer, or two-spirit (LGBTQ2S+), non-binary, asexual, and intersex.
- Youth in rural and medically underserved areas.
- Youth involved with the child welfare system or those who have experienced family disruption.
- Youth involved with the juvenile justice system.
- Youth who are undocumented.
- Youth with special health care needs, including youth with developmental disabilities.
- Youth who live in states that require parental involvement in sexual and reproductive health decisions, including abortion.

Note: There are not inherent or generic physiologic differences that lead to disparities in sexual and reproductive health care outcomes. Rather, youth may experience discrimination or long-standing health, social, or systemic inequities that may impact their development and access to reproductive health care services, like comprehensive sex education, contraception, and abortion.

Systemic inequities that impact access to reproductive health care services include:

- Racism.
- Homophobia or transphobia.
- Economic inequities, including being under-insured or having no health insurance.
- Under-resourced schools.
- Medically underserved areas.
- Sexism.
- Lack of school and community-based reproductive health education.
- State legislation that prevents access to local reproductive health providers.

Pediatric health clinicians can promote health equity in adolescent sexual and reproductive health care:

- AAP policy states that pediatric health clinicians should be trained to understand and address the impact of systemic racism and discrimination on health.
- Youth and family experiences with systemic discrimination should be incorporated into clinical history taking and counseling discussions.
- Pediatric health clinicians should consider discussing topics such as sexual orientation and gender identity in a way that includes non-judgmental listening and promotes inclusion.

Universal screening can support equity in youth access to sexual and reproductive health care:

- Universal screening helps ensure that specific questions to address the sexual and reproductive health care needs are asked of all patients, not just those deemed by the pediatric health clinician to be in-need or at high-risk for these services.
- AAP policy states that pediatric health clinicians should use sexual and reproductive health care related interventions that are patient-centered and focus on the emotional, intellectual, physical and social aspects of a young person's sexual and reproductive health, and address physical, social, and/or emotional challenges.
- AAP recommends that pediatric health clinicians provide confidential time during health maintenance visits to discuss sexuality, sexual health promotion, and risk reduction.

Pediatric health clinicians can address disparities by discussing cultural considerations when providing reproductive health services. Specific strategies include:

- Ensuring all care comprehensive, patient-centered, and is delivered with a reproductive justice lens and following best practices in trauma-informed care.
- Remembering that any decision a young person makes may be rooted in strongly held beliefs that vary across culture, religion, and individual values.
- Reaching out to and engaging members of the community when developing office protocols and patient care resources.
- Recognizing that health care tends to be heteronormative/cisgender-normative in focus and working to use inclusive language and avoid assumptions about identity or behavior.
- Asking about a young person's goals related to sexual health, relationships, and parenting and framing all care accordingly.
- Integrating reproductive health into the life course approach to health, to be clear that sexual and reproductive health is part of overall health, and not something separate.
- Beginning developmentally-appropriate reproductive health conversations at a young age and continuing them throughout childhood and adolescence.

- Reflecting upon cultural differences and ensuring all services are provided in a way that centers the patient's needs, feelings, and experiences.
- Respecting that patients may have different levels of health literacy and meeting them where they are, both physically where they are (eg, offering care in the community, vs an office), but also in language (eg, not over-medicalizing visits).
- Integrating methods to engage and educate parents/caregivers to serve as champions and supporters of their child's sexual and reproductive health.
- Provide assurances of confidentiality and establish limits of confidentiality by clarifying state and/or institutional laws and limits of confidentiality, including how it will be maintained throughout the billing process.

Pediatric health clinicians can build a welcoming practice to serve all patients by:

- Focusing on the safe, stable, and nurturing relationships that surround each youth. These relationships buffer adversity and build resilience.
- Encouraging clinicians and staff to recognize and reflect on their own biases and work to prevent these biases from impacting care delivery.
- Using inclusive language and imagery in signage, materials, and office art.
- Asking patients about their names and pronouns and using them consistently during clinical visits.
- Using respectful language when interacting with patients and families.
- Utilizing translation services, interpreters, and assistive technology to support accessible written, electronic, and verbal communication.
- Providing opportunities for confidential discussions.

Equitable access to sexual and reproductive health services for youth is important

All adolescents deserve access to comprehensive sexual and reproductive health care.

Youth advocates play a critical role in supporting a young person's ability to make informed and autonomous decisions about their sexuality and reproductive health is critical for fulfilling their human rights and self-manage their own health care.

The importance of access to comprehensive sex education

Comprehensive sex education is a critical component of sexual and reproductive health care.

Developing a healthy sexuality is a core developmental milestone for child and adolescent health.

To achieve this milestone, youth need developmentally appropriate information about their sexuality and how it relates to their bodies, community, culture, society, mental health, and relationships with family, peers, and romantic partners.

Education about sex and sexuality can be taught in schools, families, and clinical and community care settings. To best meet the needs of children and adolescents, it is important that this education is comprehensive.

AAP supports broad access to comprehensive sex education, wherein all children and adolescents have access to developmentally appropriate, evidence-based education that provides the knowledge they need to:

- Develop a safe and positive view of sexuality.
- Build healthy relationships.
- Make informed, safe, positive choices about their sexuality and sexual health.

Defining comprehensive sex education

Comprehensive sex education involves teaching about all aspects of human sexuality, including:

- Anatomy.
- Consent.
- Cyber solicitation/bullying.
- Healthy sexual development.
- Body image.
- Sexual orientation.
- Gender identity.
- Pleasure from sex.
- Sexual abuse.
- Sexual behavior.
- Sexual reproduction.
- Sexually transmitted infections (STIs).
- Abstinence.
- Contraception.
- Interpersonal relationships.
- Reproductive coercion.
- Reproductive rights.
- Reproductive responsibilities.

Comprehensive sex education programs have several common elements:

- Utilize evidence-based, medically accurate curriculum that can be adapted for youth with disabilities.
- Employ developmentally appropriate information, learning strategies, teaching methods, and materials.
- Provide basic functional knowledge around 6 key topics:

    - **Human development**, including anatomy, puberty, body image, sexual orientation, and gender identity.
    - **Relationships**, including families, peers, dating, marriage, and raising children.
    - **Personal skills**, including values, decision making, communication, assertiveness, negotiation, and help-seeking.
    - **Sexual behavior**, including abstinence, masturbation, shared sexual behavior, pleasure from sex, and sexual dysfunction across the lifespan.
    - **Sexual health**, including contraception, pregnancy, prenatal care, abortion, STIs, HIV and AIDS, sexual abuse, assault, and violence.
    - **Society and culture**, including gender roles, diversity, and the intersection of sexuality and the law, religion, media, and the arts.
- Create an opportunity for youth to question, explore, and assess both personal and societal attitudes around gender and sexuality.
- Focus on personal practices, skills, and behaviors for healthy relationships, including an explicit focus on communication, consent, refusal skills/accepting rejection, violence prevention, personal safety, decision making, and bystander intervention.
- Help youth exercise responsibility in sexual relationships.
- Include information on how to come forward if a student is being sexually abused.
- Address education from a trauma-informed, culturally responsive approach that bridges mental, emotional, and relational health.

Comprehensive sex education should occur across the developmental spectrum, beginning at early ages and continuing throughout childhood and adolescence:

- Sex education is most effective when it begins before the initiation of sexual activity.
- Young children can understand concepts related to bodies, gender, and relationships.
- Sex education programs should build an early foundation and scaffold learning with developmentally appropriate content across grade levels.
- AAP Policy outlines considerations for providing developmentally appropriate sex education throughout early childhood, middle childhood, adolescence, and young adulthood.

Most adolescents report receiving some type of formal sex education before age 18. While sex education is typically associated with schools, comprehensive sex education can be delivered in several complementary settings:

- **Schools:**
    - Schools can implement comprehensive sex education curriculum across all grade levels
    - The Sexuality Information and Education Council of the United States (SIECUS) provides guidelines for providing developmentally appropriate comprehensive sex education across grades K-12.
- **Clinical practice:**
    - Pediatric health clinicians and other health care providers are uniquely positioned to provide longitudinal sex education to children, adolescents, and young adults.
    - Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents outlines clinical considerations for providing comprehensive sex education at all developmental stages, as a part of preventive health care.
- **Community or faith-based organizations:**
    - Research suggests that community-based organizations should be included as a source for comprehensive sexual health promotion.

- Faith-based communities have developed sex education curricula for their congregations or local chapters that emphasize the moral and ethical aspects of sexuality and decision-making.

- **At Home:**
  - Parents and caregivers can serve as the primary sex educators for their children, by teaching fundamental lessons about bodies, development, gender, and relationships.
  - Many factors impact the sex education that youth receive at home, including parent/caregiver knowledge, skills, comfort, culture, beliefs, and social norms.
- **Online**
  - Virtual sex education can take away feelings of embarrassment or stigma and can allow for more youth to access high quality sex education.

Benefits of comprehensive sex education

Comprehensive sex education provides children and adolescents with the information that they need to:

- Understand their body, gender identity, and sexuality.
- Build and maintain healthy and safe relationships.
- Engage in healthy communication and decision-making around sex.
- Practice healthy sexual behavior.
- Understand and access care to support their sexual and reproductive health.

Comprehensive sex education programs have demonstrated success in reducing rates of sexual activity, sexual risk behaviors, STIs, and adolescent pregnancy and delaying sexual activity. Many systematic reviews of the literature have indicated that comprehensive sex education promotes healthy sexual behaviors:

- Reduced sexual activity.
- Reduced number of sexual partners.
- Reduced frequency of unprotected sex.
- Increased condom use.
- Increased contraceptive use.

However, comprehensive sex education curriculum goes beyond risk-reduction, by covering a broader range of content that has been shown to support social-emotional learning, positive communication skills, and development of healthy relationships.

A 2021 review of the literature found that comprehensive sex education programs that use a positive, affirming, and inclusive approach to human sexuality are associated with concrete benefits across 5 key domains:

Benefits of comprehensive sex education programs	
Appreciation of Gender and Sexual Diversity	Lower rates of homophobia.
	Reductions in homophobic bullying.
	Expanded understanding of gender and gender norms.
	Recognition of gender equity, rights, and social justice.
	Improved knowledge, attitudes, and reporting of DV and IPV.

Prevention of Dating Violence (DV) and Intimate Partner Violence (IPV)	Decreased rates of DV and IPV.
	Increased bystander intention and behaviors.
Healthy Relationships	Increased knowledge, attitudes, and skills.
	Improved communication skills and intentions.
Prevention of Child Sex Abuse	Improved knowledge, attitudes, skills, and social-emotional outcomes related to personal safety and touch.
	Improved disclosure skills.
Other Benefits	Social emotional learning.
	Media literacy.

Adolescents need equitable access to comprehensive sex education

When children and adolescents lack access to comprehensive sex education, they do not get the information they need to make informed, healthy decisions about their lives, relationships, and behaviors.

Several trends in sexual health in the US highlight the need for comprehensive sex education for all youth.

Education about condom and contraceptive use is needed:

- 55% of US high school students report having sexual intercourse by age 18.
- Self-reported condom use has decreased significantly among high school students.
- Only 9% of sexually active high school students report using both a condom for STI-prevention and a more effective form of birth control to prevent pregnancy.

STI prevention is needed:

- Adolescents and young adults are disproportionately impacted by STIs.
- Cases of chlamydia, gonorrhea, and syphilis are rising rapidly among young people.
- When left untreated, these infections can lead to infertility, adverse pregnancy and birth outcomes, and increased risk of acquiring new STIs.
- Youth need comprehensive, unbiased information about STI prevention, including human papillomavirus (HPV).

Continued prevention of unintended pregnancy is needed:

- Overall US birth rates among adolescent mothers have declined over the last 3 decades.
- There are significant geographic disparities in adolescent pregnancy rates, with higher rates of pregnancy in rural counties and in southern and southwestern states.
- Social drivers of health and systemic inequities have caused racial and ethnic disparities in adolescent pregnancy rates.
- Eliminating disparities in adolescent pregnancy and birth rates can increase health equity, improve health and life outcomes, and reduce the economic impact of adolescent parenting.

Misinformation about sexual health is easily available online:

- Internet use is nearly universal among US children and adolescents.
- Adolescents report seeking sexual health information online.
- Sexual health websites that adolescents visit can contain inaccurate information.

Prevention of sex abuse, dating violence, and unhealthy relationships is needed:

- Child sexual abuse is common: 25% of girls and 8% of boys experience sexual abuse during childhood.
- Youth who experience sexual abuse have long-term impacts on their physical, mental, and behavioral health.
- Dating violence (DV) is common among US high school students.
    - 1 in 11 female and 1 in 14 male students report physical DV in the last year.
    - 1 in 8 female and 1 in 26 male students report sexual DV in the last year.
- Youth who experience DV have higher rates of anxiety, depression, substance use, antisocial behaviors, and suicide risk.

The quality and content of sex education in US schools varies widely.

There is significant variation in the quality of sex education taught in US schools, leading to disparities in attitudes, health information, and outcomes. The majority of sex education programs in the US tend to focus on public health goals of decreasing unintended pregnancies and preventing STIs, via individual behavior change.

There are three primary categories of sex educational programs taught in the US:

- Abstinence-only education, which teaches that abstinence is expected until marriage and typically excludes information around the utility of contraception or condoms to prevent pregnancy and STIs.
- Abstinence-plus education, which promotes abstinence but includes information on contraception and condoms.
- Comprehensive sex education, which provides medically accurate, age-appropriate information around development, sexual behavior (including abstinence), healthy relationships, life and communication skills, sexual orientation, and gender identity.

State laws impact the curriculum covered in sex education programs. According to a report from the Guttmacher Institute:

- 26 US states and Washington DC mandate sex education and HIV education.
- 18 states require that sex education content be medically accurate.
- 39 states require that sex education programs provide information on abstinence.
- 20 states require that sex education programs provide information on contraception.

US states have varying requirements on sex education content related to sexual orientation:

- 10 states require sex education curriculum to include affirming content on LGBTQ2S+ identities or discussion of sexual health for youth who are LGBTQ2S+.
- 7 states have sex education curricular requirements that discriminate against individuals who are LGBTQ2S+.Youth who live in these states may face additional barriers to accessing sexual health information.

Abstinence-only sex education programs do not meet the needs of children and adolescents.

While abstinence is 100% effective in preventing pregnancy and STIs, research has conclusively shown that abstinence-only sex education programs do not support healthy sexual development in youth.

Abstinence-only programs are ineffective in reaching their stated goals, as evidenced by the data below:

- Abstinence-only programs are unsuccessful in delaying sex until marriage.
- Abstinence-only sex education programs do not impact the rates of pregnancy, STIs, or HIV in adolescents.
- Youth who take a "virginity pledge" as part of abstinence-only education programs have the same rates of premarital sex as their peers who do not take pledges, but are less likely to use contraceptives.
- US states that emphasize abstinence-only education have higher rates of adolescent pregnancy and birth.

Abstinence-only programs can harm the healthy sexual and mental development of youth by:

- Withholding information or providing inaccurate information about sexuality and sexual behavior.
- Contributing to fear, shame, and stigma around sexual behaviors.
- Not sharing information on contraception and barrier protection or overstating the risks of contraception.
- Utilizing heteronormative framing and stigma or discrimination against students who are LGBTQ2S+.
- Reinforcing harmful gender stereotypes.
- Ignoring the needs of youth who are already sexually active by withholding education around contraception and STI prevention.

Abstinence-plus sex education programs focus solely on decreasing unintended pregnancy and STIs.

Abstinence-plus sex education programs promote abstinence until marriage. However, these programs also provide information on contraception and condom use to prevent unintended pregnancy and STIs.

Research has demonstrated that abstinence-plus programs have an impact on sexual behavior and safety, including:

- HIV prevention.
- Increase in condom use.
- Reduction in number of sexual partners.
- Delay in initiation of sexual behavior.

While these programs add another layer of education, they do not address the broader spectrum of sexuality, gender identity, and relationship skills, thus withholding critical information and skill-building that can impact healthy sexual development.

AAP and other national medical and public health associations support comprehensive sex education for youth.

Given the evidence outlined above, AAP and other national medical organizations oppose abstinence-only education and endorse comprehensive sex education that includes both abstinence promotion and provision of accurate information about contraception, STIs, and sexuality.

National medical and public health organizations supporting comprehensive sex education include:

- American Academy of Pediatrics.
- American Academy of Family Physicians
- American College of Obstetricians and Gynecologists.
- American Medical Association.
- American Public Health Association.

- Society for Adolescent Health and Medicine.

Pediatric clinics provide a unique opportunity for comprehensive sex education.

Pediatric health clinicians typically have longitudinal care relationships with their patients and families, and thus have unique opportunities to address comprehensive sex education across all stages of development.

The clinical visit can serve as a useful adjunct to support comprehensive sex education provided in schools, or to fill gaps in knowledge for youth who are exposed to abstinence-only or abstinence-plus curricula.

AAP policy and Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents provide recommendations for comprehensive sex education in clinical settings, including:

- Encouraging parent-child discussions on sexuality, contraception, and internet/media use.
- Understanding diverse experiences and beliefs related to sexuality and sex education and meeting the unique needs of individual patients and families.
- Including discussions around healthy relationships, dating violence, and intimate partner violence in clinical care.
- Discussing methods of contraception and STI/HPV prevention prior to onset of sexual intercourse.
- Providing proactive and developmentally appropriate sex education to all youth, including children and adolescents with special health care needs.

Perspective: Karen Torres, Youth activist

There were two cardboard bears, and a person explained that one bear wears a bikini to the beach and the other bear wears shorts—that is the closest thing I ever got to sex ed throughout my entire K-12 education. I often think about that bear lesson because it was the day our institutions failed to teach me anything about my body, relationships, consent, and self-advocacy, which became even more evident after I was sexually assaulted at 16 years old. My story is not unique, I know that many young people have been through similar traumas, but many of us were also subjected to days, months, and years of silence and embarrassment because we were never given the knowledge to know how to spot abuse or the language to ask for help. Comprehensive sex ed is so much more than people make it out to be, it teaches about sex but also about different types of experiences, how to respect one another, how to communicate in uncomfortable situations, how to ask for help and an insurmountable amount of other valuable lessons.

From these lessons, people become well-rounded, people become more empathetic to other experiences, and people become better. I believe comprehensive sex ed is vital to all people and would eventually work as a part to build more compassionate communities.

Barriers to equitable access to comprehensive sex education

Many US children and adolescents do not receive comprehensive sex education; and rates of formal sex education have declined significantly in recent decades.

Barriers to accessing comprehensive sex education include:

Misinformation, stigma, and fear of negative reactions:

- Misinformation and stigma about the content of sex education curriculum has been the primary barrier to equitable access to comprehensive sex education in schools for decades.

- Despite widespread parental support for sex education in schools, fears of negative public/parent reactions have led school administrators to limit youth access to the information they need to make healthy decisions about their sexuality for nearly a half-century.
- In recent years, misinformation campaigns have spread false information about the framing and content of comprehensive sex education programs, causing debates and polarization at school board meetings.
- Nearly half of sex education teachers report that concerns about parent, student, or administrator responses are a barrier to provision of comprehensive sex education.
- Opponents of comprehensive sex education often express concern that this education will lead youth to have sex; however, research has demonstrated that this is not the case. Instead, comprehensive sex ed is associated with delays in initiation of sexual behavior, reduced frequency of sexual intercourse, a reduction in number of partners, and an increase in condom use.
- Some populations of youth lack access to comprehensive sex education due to a societal belief that they are asexual, in need of protection, or don't need to learn about sex. This barrier particularly impacts youth with disabilities or special health care needs.
- Sex ed curricula in some schools perpetuate gender/sex stereotypes, which could contribute to negative gender stereotypes and negative attitudes towards sex.

Inconsistencies in school-based sex education:

- There is significant variation in the content of sex education taught in schools in the US, and many programs that carry the same label (eg, "abstinence-plus") vary widely in curriculum.
- While decisions about sex education curriculum are made at the state level, the federal government has provided funding to support abstinence-only education for decades, which incentivizes schools to use these programs.
- Since 1996, more than $2 billion in federal funds have been spent to support abstinence-only sex education in schools.
- This has impacted state laws about sex education:
    - 34 US states require schools to use abstinence-only curriculum or emphasize abstinence as the main way to avoid pregnancy and STIs.
    - Only 16 US states require instruction on condoms or contraception.
- It is not standard to include information on how to come forward if a student is being sexually abused, and many schools do not have a process for disclosures made.
- Because of this, abstinence-only programs are commonly used in US schools, despite overwhelming evidence that they are ineffective in delaying sexual behavior until marriage, and withhold critical information that youth need for healthy sexual and relationship development.

Need for resources and training:

- Integration of comprehensive sex education into school curriculum requires financial resources to strengthen and expand evidence-based programs.
- Successful implementation of comprehensive sex education requires a trained workforce of teachers who can address the curriculum in age-appropriate ways for students in all grade-levels.
- Education, training, and technical assistance are needed to support pediatric health clinicians in addressing comprehensive sex education in clinical settings, as a complement to school-based education.

Lack of diversity and cultural awareness in curricula:

- A history of systemic racism, discrimination, and long-standing health, social and systemic inequities have created racial and ethnic disparities in access to sexual health services and representation in sex education materials. The legacy of intergenerational trauma in the medical system should be acknowledged in sex education curricula.
- Sex education curriculum is often centered on a white audience, and does not address or reflect the role of systemic racism in sexuality and development.
- Traditional abstinence-focused sex education programs have a heteronormative focus and do not address the unique needs of youth who are LGBTQ2S+.
- Sex education programs often do not address reproductive body diversity, the needs of those with differences in sex development, and those who identify as intersex.
- Sex education programs often do not reflect the unique needs of youth with disabilities or special health care needs.
- Sex education programs are often not tailored to meet the religious considerations of faith communities.
- There is a need for sex education programs designed to help youth navigate sexual health and development in the context of their own culture and community.

Disparities in access to comprehensive sex education.

The barriers listed above limit access to comprehensive sex education in schools and communities. While these barriers impact youth across the US, there are some populations who are less likely to have access to comprehensive to sex education.

Youth who are LGBTQ2S+:

- Most sex education curriculum is not inclusive or representative of LGBTQ2S+ identities and experiences.
    - Only 8% of students who are LGBTQ2S+ report having received sexual education that was inclusive.
    - Students who are LGBTQ2S+ are 50% more likely than their peers who are heterosexual to report that sex education in their schools was not useful to them.
    - Only 13% of youth who are bisexual+ and 10% of youth who are transgender and gender expansive report receiving sex education in schools that felt personally relevant.
    - Only 20% of youth who are Black and LGBTQ2S+ and 13% of youth who are Latinx and LGBTQ2S+ report receiving sex education in schools that felt personally relevant.
- Youth who are LGBTQ2S+ face additional access barriers depending on geography:
    - Only 10 US states require affirming content on LGBTQ2S+ relationships in sex education curriculum.
    - 7 states have sex education curricular requirements that discriminate against individuals who are LGBTQ2S+.Youth who live in these states may face additional barriers to accessing sexual health information.

Youth with disabilities or special health care needs:

- Youth with disabilities or special health care needs have a particular need for comprehensive sex education, as these youth are less likely to learn about sex or sexuality form their parents, healthcare providers, or peer groups.
- Youth with disabilities are far less likely than other youth to receive sex education at school.
    - In a national survey, only half of youth with disabilities report that they have participated in sex education.

- Typical sex education may not be sufficient for youth with Autism Spectrum Disorder, and special methods and curricula are necessary to match their needs.
- Youth with special health care needs often have limited access to sex education due to inaccurate beliefs that they:
    - Lack the desire or maturity for romantic or sexual relationships.
    - Are not subject to sexual abuse.
    - Do not need sex education.
- Only 3 states explicitly include youth with disabilities within their sex education requirements.

Youth from historically underserved communities:

- Students who are Black in the US are more likely than students who are white to receive abstinence-only sex education, despite significant support from parents and students who are Black for comprehensive sex education.
- Youth who are Black and female are less likely than peers who are white to receive education about where to obtain birth control prior to initiating sexual activity.
- Youth who are Black and male and Hispanic are less likely than their peers who are white to receive formal education on STI prevention or contraception prior to initiating sexual activity.
- Youth who are Hispanic and female are less likely to receive instruction about waiting to have sex than youth of other ethnicities.
- Tribal health educators report challenges in identifying culturally relevant sex education curriculum for youth who are American Indian/Alaska Native.
- In a 2019 study, youth who were LGBTQ2S+ and Black, Latinx, or Asian reported receiving inadequate sex education due to feeling unrepresented, unsupported, stigmatized, or bullied.
- In survey research, many young adults who are Asian American report that they received inadequate sex education in school.

Youth from rural communities:

- Adolescents who live in rural communities have faced disproportionate declines in formal sex education over the past two decades, compared with peers in urban/suburban areas.
- Students who live in rural communities report that the sex education curriculum in their schools does not serve their needs.

Youth from communities and schools that are low-income:

- Data has shown an association between schools that are low-resource and lower adolescent sexual health knowledge, due to a combination of fewer school resources and higher poverty rates/associated unmet health needs in the student body.
- Youth with family incomes above 200% of the federal poverty line are more likely to receive education about STI prevention, contraception, and "saying no to sex," than their peers below 200% of the poverty line.

Youth who receive sex education in some religious settings:

- Most adolescents who identify as female and who attended church-based sex education programs report instructions on waiting until marriage for sex, while few report receiving education about birth control.
- Young people who received sex education in religious schools report that education focused on the risks of sexual behavior (STIs, pregnancy) and religious guilt; leading to them feeling under-equipped to make informed decisions about sex and sexuality later in life.

- Youth and teachers from religious schools have identified a need for comprehensive sex education curriculum that is tailored to the needs of faith communities.

Youth who live in states that limit the topics that can be covered in sex education:

- Students who live in the 34 states that require sex education programs to stress abstinence are less likely to have access to critical information on STI prevention and contraception.
- Other state laws that may impact youth access to critical health information include:
    - Prohibitions on addressing abortion in sex education or mandates that sex education curricula include medically inaccurate information on abortion designed to dissuade youth from terminating a pregnancy.
    - Limitations on the types of contraception that can be covered in sex education curricula.
    - Requirements that sex education teachers promote heterosexual, monogamous marriage in sex education.
    - Lack of requirements to address healthy relationships and communication skills.
    - Lack of requirements for teacher training or certification.

The impact of limited access to comprehensive sex education

Comprehensive sex education has significant benefits for children and adolescents.

Youth who are exposed to comprehensive sex education programs in school demonstrate healthier sexual behaviors:

- Increased rates of contraception and condom use.
- Fewer unplanned pregnancies.
- Lower rates of STIs and HIV.
- Delayed initiation of sexual behavior.

More broadly, comprehensive sexual education impacts overall social-emotional health, including:

- Enhanced understanding of gender and sexuality.
- Lower rates of homophobia and related bullying.
- Lower rates of dating violence, intimate partner violence, sexual assault, and child sexual abuse.
- Healthier relationships and communication skills.
- Understanding of reproductive rights and responsibilities.
- Improved social-emotional learning, media literacy, and academic achievement.

Comprehensive sex education curriculum goes beyond risk reduction, to ensure that youth are supported in understanding their identity and sexuality and making informed decisions about their relationships, behaviors, and future. These benefits are critical to healthy sexual development.

Impacts of a lack of access to comprehensive sex education.

When youth are denied access to comprehensive sex education, they do not get the information and skill-building required for healthy sexual development. As such, they face unnecessary barriers to understanding their gender and sexuality, building positive interpersonal relationships, and making informed decisions about their sexual behavior and sexual health.

Impacts of a lack of comprehensive sex education for all youth can include:

- Less use of condoms, leading to higher risk of STIs, including HIV.

- Less use of contraception, leading to higher risk of unplanned pregnancy.
- Less understanding and increased stigma and shame around the spectrum of gender and sexual identity.
- Perpetuated stigma and embarrassment related to sex and sexual identity.
- Perpetuated gender stereotypes and traditional gender roles.
- Higher rates of youth turning to unreliable sources for information about sex, including the internet, the media, and informal learning from peer networks.
- Challenges in interpersonal communication.
- Challenges in building, maintaining, and recognizing safe, healthy peer and romantic relationships
- Lower understanding of the importance of obtaining and giving enthusiastic consent prior to sexual activity.
- Less awareness of appropriate/inappropriate touch and lower reporting of child sexual abuse.
- Higher rates of dating violence and intimate partner violence, and less intervention from bystanders.
- Higher rates of homophobia and homophobic bullying.
- Unsafe school environments.
- Lower rates of media literacy.
- Lower rates of social-emotional learning.
- Lower recognition of gender equity, rights, and social justice.

In addition, the lack of access to comprehensive sex education can exacerbate existing health disparities, with disproportionate impacts on specific populations of youth.

Youth who identify as women, youth from communities of color, youth with disabilities, and youth who are LGBTQ2S+ are particularly impacted by inequitable access to comprehensive sex education, as this lack of education can impact their health, safety, and self-identity. Examples of these impacts are outlined below.

A lack of comprehensive sex education can harm young women.

- Young women have unique needs related to STI and pregnancy prevention:
    - Female bodies are more prone to STI infection and more likely to experience complications of STI infection than male bodies.
    - Female bodies are disproportionately impacted by long-term health consequences of STIs, including pelvic inflammatory disease, infertility, and ectopic pregnancy.
    - Female bodies are less likely to have or recognize symptoms of certain STI infections.
    - Human papillomavirus (HPV) is the most common STI in young women, and can cause long-term health consequences such as genital warts and cervical cancer.
    - Women bear the health and economic effects of unplanned pregnancy.
    - **Comprehensive sex education addresses these issues by providing medically-accurate, evidence based information on effective strategies to prevent STI infections and unplanned pregnancy.**

- Young women are at higher risk of abuse and violence:
    - Students who identify as female are more likely to experience sexual or physical dating violence than their peers who identify as male. Some of this may be attributed to underreporting by males due to stigma.
    - Students who identify as female are bullied on school property more often than students who identify as male.

- Young women ages 16-19 are at higher risk of rape, attempted rape, or sexual assault than the general population.
- **Comprehensive sex education addresses these issues by guiding the development of healthy self-identities, challenging harmful gender norms, and building the skills required for respectful, equitable relationships.**

A lack of comprehensive sex education can harm youth from communities of color.

- Youth of color deserve to see themselves represented in sex education curricula:
  - Youth of color benefit from seeing themselves represented in sex education curriculum.
  - Sex education programs that use a framing of diversity, equity, rights, and social justice, informed by an understanding of systemic racism and discrimination, have been found to increase positive attitudes around reproductive rights in all students.
  - There is a critical need for sex education programs that reflect youth's cultural values and community.
  - **Comprehensive sex education can address these needs by developing curriculum that is inclusive of diverse communities, relationships, and cultures, so that youth see themselves represented in their education.**

- Youth of color have unique needs related to STI and pregnancy prevention:
  - A history of systemic racism, discrimination, and long-standing health, social and systemic inequities have created disparities in access to sexual and reproductive health services, leading to:
    - Racial and ethnic disparities in STI and HIV infection.
    - Racial and ethnic disparities in unplanned pregnancy and births among adolescents.
  - **Comprehensive sex education addresses these issues by providing medically-accurate, evidence based information on effective strategies to prevent STI infections and unplanned pregnancy.**

- Youth of color face higher risks of abuse and violence:
  - Nearly half of youth who are Black ages 13-21 report having been pressured into sexual activity.
  - Adolescent experience with dating violence is most prevalent among youth who are American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and multiracial.
  - Adolescents who are Latinx are more likely than their peers who are non-Latinx to report physical dating violence.
  - Youth who are Black and Latinx and who experience bullying are more likely to suffer negative impacts on academic performance than their white peers.
  - Students who are Asian American and Pacific Islander report bullying and harassment due to race, ethnicity, and language.
  - **Comprehensive sex education addresses these issues by guiding the development of healthy self-identities, challenging harmful stereotypes, and building the skills required for respectful, equitable relationships.**

- Youth of color are negatively impacted by misperceptions in the media:
  - Young people of color—specifically those from Black, Asian-American, and Latinx communities– are often hyper-sexualized in popular media, leading to societal perceptions that youth are "older" or more sexually experienced than their white peers.

- Young men of color—specifically those from Black and Latinx communities—are often portrayed as aggressive or criminal in popular media, leading to societal perceptions that youth are dangerous or more sexually aggressive or experienced than white peers.
- These media portrayals can lead to disparities in public perceptions of youth behavior, which can impact school discipline, lost mentorship and leadership opportunities, less access to educational opportunities afforded to white peers, and greater involvement in the juvenile justice system.
- **Comprehensive sex education addresses these issues by including positive representations of diverse youth in curriculum, challenging harmful stereotypes, and building the skills required for respectful relationships.**

A lack of comprehensive sex education can harm youth with disabilities or special health care needs.

- Youth with disabilities benefit from being included and represented in sex education curricula:
  - Youth with disabilities need inclusive, developmentally-appropriate, representative sex education to support their health, identity, and development.
  - Youth with special health care needs often initiate romantic relationships and sexual behavior during adolescence, similar to their peers.
  - Youth with disabilities and special health care needs benefit from seeing themselves represented in sex education to access the information and skills to build healthy identities and relationships.
  - **Comprehensive sex education addresses this need by including positive representation of youth with disabilities and special health care needs in curriculum and providing developmentally-appropriate sex education to all youth.**

- Youth with special health care needs have unique needs related to abuse and violence:
  - When youth with disabilities and special health care needs do not get access to the comprehensive sex education that they need, they are at increased risk of sexual abuse or being viewed as a sexual offender.
  - Youth with disabilities and special health care needs are more likely than peers without disabilities to report coercive sex, exploitation, and sexual abuse.
  - Youth with disabilities and special health care needs report more sexualized behavior and victimization online than their peers without disabilities.
  - Youth with disabilities are at greater risk of bullying and have fewer friend relationships than their peers.
  - **Comprehensive sex education addresses these issues by providing education on healthy relationships, consent, communication, and bodily autonomy.**

A lack of comprehensive sex education can harm youth who are LGBTQ2S+.

- Youth who are LGBTQ2S+ benefit from being represented in sex education curricula:
  - Most sex education curriculum is not inclusive or representative of LGBTQ2S+ identities and experiences.
  - Because school-based sex education often does not meet their needs, youth who are LGBTQ2S+ are more likely to seek sexual health information online, and thus are more likely to come across misinformation.
  - The majority of parents support discussion of sexual orientation in sex education classes.
  - **Comprehensive sex education addresses these issues by including positive representation of LGBTQ2S+ individuals, romantic relationships, and families.**

- Non-inclusive curriculum hurts youth who are LGBTQ2S+:
    - Sex education curriculum that overlooks or stigmatizes youth who are LGBTQ2S+ contributes to hostile school environments and harms the healthy sexual and mental development.
    - Youth who are LGBTQ2S+ face high levels of discrimination at school and are more likely to miss school because of bullying or victimization.
    - Ongoing experiences with stigma, exclusion, and harassment negatively impact the mental health of youth who are LGBTQ2S+.
    - **Comprehensive sex education provides inclusive curriculum and has been shown to improve understanding of gender diversity, lower rates of homophobia, and reduce homophobic bullying in schools.**

- Youth who are LGBTQ2S+ have unique needs related to STI and pregnancy prevention:
    - Youth who are LGBTQ2S+ are more likely than their heterosexual peers to report not learning about HIV/STIs in school.
    - Lack of education on STI prevention leaves LGBTQ2S+ youth without the information they need to make informed decisions, leading to discrepancies in condom use between LGBTQ2S+ and heterosexual youth.
    - Some LGBTQ2S+ populations carry a disproportionate burden of HIV and other STIs: these disparities begin in adolescence, when youth who are LGBTQ2S+ do not receive sex education that is relevant to them.
    - **Comprehensive sex education provides the knowledge and skills needed to make safe decisions about sexual behavior, including condom use and other forms of STI and HIV prevention.**

- Youth who are LGBTQ2S+ are at disproportionate risk of bullying and dating violence:
    - Youth who are LBGTQ2S+ or are questioning their sexual identity report higher rates of dating violence than their heterosexual peers.
    - Youth who are LGBTQ2S+ or are questioning their sexual identity face higher prevalence of bullying than their heterosexual peers.
    - **Comprehensive sex education teaches youth healthy relationship and communication skills and is associated with decreases in dating violence and increases in bystander interventions.**

A lack of comprehensive sex education can harm youth who are in foster care.

- Youth who are in foster care are at higher risk of abuse and violence:
    - More than 70% of children in foster care have a documented history of child abuse and or neglect.
    - More than 80% of children in foster care have been exposed to significant levels of violence, including domestic violence.
    - Youth in foster care are racially diverse, with 23% of youth identifying as Black and 21% of identifying as Latinx, who will have similar experiences as those highlighted in earlier sections of this report.
    - Removal is emotionally traumatizing for almost all children. Lack of consistent/stable placement with a responsive, nurturing caregiver can result in poor emotional regulation, impulsivity, and attachment problems.

- **Comprehensive sex education addresses these issues by providing evidence-based, culturally appropriate information on healthy relationships, consent, communication, and bodily autonomy.**

Comprehensive sex education is the cornerstone of healthy sexual development

Sex education is often the first experience that youth have with understanding and discussing their gender and sexual health.

Youth deserve to a strong foundation of developmentally appropriate information about gender and sexuality, and how these things relate to their bodies, community, culture, society, mental health, and relationships with family, peers, and romantic partners.

Decades of data have demonstrated that comprehensive sex education programs are effective in reducing risk of STIs and unplanned pregnancy. These benefits are critical to public health. However, comprehensive sex education goes even further, by instilling youth with a broad range of knowledge and skills that are proven to support social-emotional learning, positive communication skills, and development of healthy relationships.

The importance of access to contraception

Contraception is a core component of sexual and reproductive health care.

Contraceptive education and counseling are best practices in adolescent anticipatory guidance and pediatric health clinicians play a fundamental role in assuring contraception counseling and access are available to everyone.

Youth need developmentally appropriate information about their contraceptive options prior to becoming sexually active and want information about potential impacts to their bodies, personal beliefs and feelings, cultural values and norms, mental health, and relationships with family, peers, and romantic partners.

Education about contraceptive options can be taught in clinical and community care settings, in schools, and at home. To best meet the needs of adolescents and young adults, it is important that this education is proactive, non-stigmatizing, comprehensive, and ongoing.

AAP supports patient-centered counseling as the most effective approach to providing individual counseling about sexual and reproductive health topics.

Note: While there is evidence to suggest economic benefits of having access to contraception, the connection between economic gains (especially societal) and contraception access are often not patient-centered. Additionally, these connections can ignore or oversimplify the experiences of communities who may have access to sexual and reproductive services, but – due to systemic racism– never attain the liberation or economic freedom that contraception claims to have. For these reasons, arguments of the economic benefits of contraception access are not included in this section.

Methods of contraception

Various methods of contraception are available to adolescents, including:

- Abstinence.
- Emergency contraception.
- Progestin, progestin implants, and progestin injections.
- Combined oral contraceptive pills.
- Transdermal contraceptive patch.
- Progestin-only pills.
- Internal and external condoms.
- Other barrier methods.
- Fertility awareness and other periodic abstinence methods.
- Withdrawal.
- Vaginal ring.
- Cooper intrauterine device (IUD).

Contraceptive counseling conversations should emphasize a patient-centered framework, taking place before adolescents are sexually active and include discussions about contraception, consent, and sexually transmitted infections (STIs). Bright Futures outlines clinical considerations for promoting healthy sexual development.

Key elements relevant to taking a sexual history that involves discussions about contraception include creating a safe environment and taking a sexual history.

Creating a safe environment

Establish rapport:

- Normalize the discussion. State that all patients are asked the same questions.
- Minimize note-taking, particularly during sensitive questions.
- Screen for broad risk assessment which involves issues relating to home, school, and substance use.
- Provide assurances of confidentiality and establish limits of confidentiality. Patients are more likely to disclose sensitive information if consent and confidentiality are clearly explained. Clarify laws and limits of confidentiality, including how it will be maintained throughout the billing process.

Avoid assumptions of heteronormativity or behaviors:

- Understand the difference between gender and sexuality and how it may apply to your patients.
- Use gender-neutral language.
- Be familiar with colloquial terminology that patients may use.
- All clinicians and office staff should be nonjudgmental and supportive.
- Offer open-ended encouragement, such as "Tell me your story." When seeking to understand a youth's current situation.
- Ask developmentally appropriate questions.
- Ask open-ended questions.
- Avoid the surrogate parent role. Instead, look for opportunities to offer relevant and appropriate risk reduction information.
- Be concrete and specific with your questions.
- Describe how screening tests and results will be delivered.

Taking a Sexual History – *adapted from* A Pediatrician's Guide to an LGBTQ+ Friendly Practice

Introductions	"Hi, I'm Dr ____ and my pronouns are she, her, and hers. How are you today? What name do you go by and what pronouns should we use?" "If I make a mistake with name or pronouns, or other information, please correct me so I can do better. Feeling that you are respected and comfortable when talking to me is very important.
Partners	"In the past 6 months, how many sex partners have you had?" "What are the genders of your partners?" "Were any partners known to be HIV positive?"
Practices	"Do you feel more like a boy, girl, or neither? How do you feel about being ____?"

	"What kind of sexual contact do you have or have you had? Genital (penis in the vagina)? Anal (penis in the anus)? Oral (mouth on penis, vagina or anus)? Other (e.g., digital/finger in vagina or anus)?" "If you've had anal sex, have you had receptive anal sex (the "bottom"), insertive anal sex (the "top"), or both ("versatile")? If you've had insertive anal sex, do you insert your penis, fingers, or sex toys?"
Protection from sexually transmitted infections (STIs)	"Do you use barriers, such as condoms or dental dams, consistently? If not, in which situations are you most likely to use or not to use a barrier?" "How many times did you have vaginal or anal sex without a barrier, such as a condom or dental dam?" "Did you use a barrier, such as a condom or dental dam, at your last sexual encounter?"
Pregnancy intentions	"Are you currently trying to conceive a child?" "Are you interested in pregnancy/having a child in the next year?" "Are you concerned about getting pregnant or getting your partner pregnant?" "Are you using contraception or practicing any form of birth control? Do you need any information on birth control (or a referral)?" "Have you used emergency contraception in the past year? If so, how many times?"
Additional questions to identify risk of HIV and hepatitis	"Have you or any of your partners been diagnosed with HIV or hepatitis B or C?" "Do you have sex when you have been using drugs or after drinking alcohol?" "Have you had the hepatitis A vaccines (two doses)?" (Recommended for men who have sex with men and injection drug users) "Have you ever taken pre-exposure prophylaxis (a medication to prevent against HIV)? Or used a partner's medication to avoid getting HIV?"

	"Have you ever taken post-exposure prophylaxis (a medication taken within 72 hours after sex to prevent against HIV)?"
Interacting with Patients' Families	"There are all kinds of families. How would you describe your family?" "Tell me more about how your family accepts and supports you?" "Does your family know about your identity, sexual orientations, or relationships? Would you like support in talking to your family or anyone else about this?"
Completing the history	"Is there anything else about your sexual practices that I need to know about to ensure your good health care?" "Do you have any sexual concerns you would like to discuss?" "Thank you for being open and honest."

While contraceptive education is associated with clinical settings, it can and should be simultaneously delivered in other complementary settings:

- **Schools:**
  - Schools can incorporate content on contraception into comprehensive sex education curriculum.
  - The Sexuality Information and Education Council of the United States (SIECUS) provides guidelines for providing developmentally appropriate education on contraception as part of its Guidelines for Comprehensive Sexuality Education.
- **Community and Faith-based Settings:**
  - Community and faith-based settings can provide safe and nonjudgmental spaces to educate youth on contraception methods.
  - Education and health service delivery programs can be tailored to the populations served.
- **At Home:**
  - Parents and caregivers can provide developmentally appropriate contraceptive information to their children.
  - Many factors impact the sex education that youth receive at home, including parent/caregiver knowledge, skills, comfort, culture, beliefs, and social norms.
- **Online**
  - Online resources that provide evidence-based information on contraception options and effectiveness exist.
  - Few websites offer up-to-date, accurate information on effective contraception options, including long-acting reversible contraception (LARC) . This could present a barrier to promoting its utilization among youth, especially those who are part of historically franchised or underserved communities.

Benefits of contraception

Access to contraception allows adolescents to maintain:

- Personal bodily autonomy.
- Healthy decision making.
- Self-management of their own health care.

There are many demonstrated benefits of contraception, including improved health and well-being and reduced global maternal mortality. A large and growing body of literature explores the social and economic benefits of a person's ability to use reliable contraception:

- Improved health and well-being.
- Reduced global maternal mortality, which disproportionally affects people who are non-Hispanic Black and American Indian/Alaskan Native.
- Health benefits of pregnancy spacing for maternal and child health.
- Educational attainment.
- Female engagement in the work force.
- Economic self-sufficiency.
- Pregnancy prevention, particularly after sexual abuse.
- Regulation and shorter, lighter menstrual periods.
- Treatment of menstrual cramps, which relates to menses and quality of life for many people who menstruate throughout the world.
- Suppression of painful ovarian cysts.
- Treatment for endometriosis.

Nearly half of all pregnancies in the United States are unintended – with a higher rate (75%) unintended for those 15-19yrs old – and individuals who have lower incomes are disproportionately affected. Healthy People 2030 focuses on reducing unintended pregnancy by increasing use of birth control and family planning services to those who want it, including among adolescents.

A person's ability to avoid unintended pregnancy is related to their perceived level of risk for unintended pregnancy, the strength of their motivation to avoid pregnancy, and their pattern of contraceptive use. These factors, in turn, are often associated with:

- Demographic and socioeconomic background.
- Characteristics of their sexual partnerships.
- Confidentiality.
- Their STI concerns and risks.
- Their experiences with and attitudes towards pregnancy and contraception.
- Access.
- Affordability.

Although unintended pregnancy occurs among people of all backgrounds, levels are highest among those who:

- Have lower incomes.
- Have not completed high school.
- Are members of racial or ethnic minority groups.
- Are aged 18-24.
- Are unmarried (particularly those who are cohabitating with a partner).

The most effective way to prevent unintended pregnancy is by improving access to improving access to patient-centered reproductive health care that includes access to comprehensive and affordable contraception.

Adolescents need equitable access to contraception

When adolescents lack access to patient-centered care, including comprehensive and affordable contraception, they lack the tools they need to make informed, healthy decisions about their bodies, lives, relationships, and behaviors.

Several trends in sexual health in the US highlight the need for increasing access to contraceptive services for all youth.

National data indicate that adolescents under-use effective methods of contraception:

- 55% of US high school students report having sexual intercourse by age 18.
- Self-reported condom use has decreased significantly among high school students.
- Only 9% of sexually active high school students report using both a condom for STI-prevention and a more effective form of birth control to prevent pregnancy.

Adolescents and young adults are disproportionately impacted by STIs:

- Cases of chlamydia, gonorrhea, and syphilis are rising rapidly among young people.
- When left untreated, these infections can lead to infertility, negative pregnancy and birth outcomes, and increased risk of acquiring new STIs.

Contraceptive access can support prevention of unintended pregnancy among adolescents:

- Overall US birth rates among adolescent mothers have declined for 3 decades.
- There are significant geographic disparities in adolescent pregnancy rates, with higher rates of pregnancy in rural counties and in southern and southwestern states.
- Social drivers of health and systemic inequities have caused racial and ethnic disparities in adolescent pregnancy rates.
- Eliminating disparities in adolescent pregnancy and birth rates can increase health equity, improve health and life outcomes, and reduce the economic impact of adolescent parenting.

Access to contraception across the US varies widely.

Ensuring access to contraception is important for supporting reproductive autonomy, preventing unintended pregnancies, and promoting equitable reproductive health. There is significant variation in contraception access and use across the US, leading to disparities in health information, methods used, and outcomes.

One example of the many steps that an adolescent must manage in order to access prescribed contraception via a traditional primary clinic.

Example Steps to Access Prescribed Contraception via Primary Care Clinic
Outlined by Tracey A. Wilkinson MD MPH FAAP

1. Know that the clinic exists.
2. Find the phone number for the clinic.
3. Find a time between 8am – 4:30pm to call.
4. Understand how to navigate the phone appointment system.
5. Know their insurance information.
6. Know their social security number.
7. Be able to attend the clinic between 8am – 4:30pm on specific days of the week.
8. Know their schedule far enough in advance to schedule and be able manage self until then.
9. Remember the appointment.
10. Know the location of the clinic.
11. Be able to afford and/or arrange transportation.
12. Find the clinic from the parking lot.
13. Have necessary information and co-pay for check-in.
14. Wait.
15. Have the courage to visit with the clinician:
    a. Exam.
    b. Testing.
    c. Disclosure.
16. Be willing to risk breach of confidentiality.
17. Have transportation to pharmacy, perhaps repeatedly.
18. Have funds for co-pay.
19. Ability to follow-up, as needed.

Access to comprehensive contraceptive care and methods are impacted by the following factors:

- Health insurance: Disparities in same-day access to health insurance and variations in individual plan coverage of all FDA-approved contraceptives without cost sharing can impact access.
- Adequate funding: Programs to offset the cost of contraceptives can support access for low-income individuals.
- Ability to access tools (such as a reliable phone or internet access) required for telehealth visits.
- Comprehensive sex education: Youth education around methods and use can encourage use of contraception.
- Confidential care: Dedicated confidential time during a clinical visit and legislation mandating parental involvement can dissuade some youth from seeking contraception.
- Partnerships with alternative providers and method: Partnerships with healthcare providers who have specialized training in various methods of contraception (eg, long-acting reversible contraceptives, or LARC) can increase access for youth seen by providers who do not have this training.
- Public and health care provider education: Requiring education about guidelines for contraceptive care can increase access for youth seen in medical settings.
- Institutional and systematic changes: Inclusion of all contraceptive methods on all payer and hospital formularies and payment policies that support immediate postpartum and postabortion provision of contraception can increase access.

State laws also impact a minor's access to contraceptive services. According to a report from the Guttmacher Institute:

- 23 state and the District of Columbia explicitly allow all minors to consent to contraceptive services
- 24 states explicitly permit minors to consent to contraceptive services in one or more circumstances:
    - 2 states allow minors to consent to contraceptive services if a physician determines that the minor would face a health hazard if they were not provided with contraceptive services.
    - 19 states allow a married minor to consent to contraceptive services.
    - 5 states allow a minor who is a parent to consent.
    - 5 states allow a minor who is or has ever been pregnant to consent to services.
    - 10 states allow a minor to consent if they meet other requirements, including being a high school graduate, reaching a minimum age, demonstrating maturity or receiving a referral from a specified professional, such as a physician or member of the clergy.

There are strides to expand contraceptive access.

Contraception is starting to become available via new avenues, including mail order (MO) purchasing, pharmacist-prescribed prescriptions (also known as pharmacy access), over-the-counter (OTC) sales, and telehealth. Each method is described in more detail below:

Mail order:
Mail order contraception is a new avenue made possible by a range of companies including Pandia Health, Nurx, Plush Care, The Pill Club, and Lemonaid. To place an order: 1) the individual must fill out an online health profile and answer questions regarding their medical history, 2) the company's medical team will review the health history and work with the patient to select the best option, and then 3) contraception is prescribed and delivered to the patient's door (with options for automatic refill available). MO contraception consult/prescription fees vary by company, as do the available methods, telemedicine visit requirements, and age qualifications (which are impacted by state law).

Pharmacy prescribed contraceptives:
"Pharmacy access" laws authorize pharmacists to prescribe contraceptives, which can make contraceptive care more accessible and affordable by eliminating the need for a separate visit to a health care provider to obtain a prescription. Importantly, pharmacist prescribing of contraceptives has been proven to be safe and effective.

Pharmacy Prescribing Process

- Pharmacist completes additional training on contraception provision.
- Patient completes a self-screener for medical contraindications.
- Blood pressure is measured by pharmacy staff.
- Options for contraception based on self-screener and BP measurement presented to patient.
- Chosen contraceptive method is dispensed to patient.

Guttmacher reports that there are over 15 states and the District of Columbia allow pharmacists to provide contraceptive care and 3 states that explicitly allow pharmacists to refuse to prescribe contraceptives. Several national medical and public health organizations, including the American College of Obstetricians and Gynecologists, the American Public Health Association, and the American Pharmacists Association, support pharmacist-provided contraception to increase access to contraception, with over-the-counter access to hormonal contraception being the ultimate goal.

Over the counter (OTC) sales:

OTC access to hormonal contraception is available without a prescription in over 100 countries globally. In the US, emergency contraception is available OTC but can be cost-prohibitive and difficult to find in-stock. More than 100 organizations, including those that serve youth, have voiced their support. Furthermore, data show that 3 in 10 teens have interest in OTC access and 1 in 4 teens not already using a birth control method would consider an OTC contraceptive pill. These youth could be reached via the provision of school-based health centers, which already play an important role in expanding access to contraceptive services. Lastly, the evidence suggests that OTC contraception patients are capable of self-screening, and users continue to access preventive care while taking an OTC pill. To help bring such affordable, available, insurance-covered OTC to the US, the Oral Contraceptives OTC Working Group – a coalition of advocates, researchers, and health care providers – has been collaborating since 2004, and two companies are pursuing the necessary research to provide the FDA the data needed to approve the OTC transition.

Telehealth:
The COVID-19 pandemic has greatly expanded the adoption and use of telehealth. Many states expanded telehealth access and coverage during this time to allow access to medical care while reducing people's exposure to COVID-19. Both telephone and video platforms have shown to be well suited to delivering contraceptive counseling, and provision and maintenance of regular and emergency contraception. Resources are available that describe high-level information about the telehealth policies in each state.

School-based programs:
Access to sexual and reproductive health care services at school-linked programs residing in high schools, colleges and universities, and vocational settings, play a critical role in meeting the health care needs of youth. Many school-based health services provide a limited range of prescription contraceptive methods on-site, including oral contraceptive pills. There have been examples of expanded access to contraception at schools via adding long-acting reversible contraceptive methods (LARCs) to health services provided and university student organizations setting up vending machines to dispense emergency contraception. Providing prescription contraceptive services on-site can reduce common barriers to contraception for students, including limited knowledge of off-campus locations for health service clinics and clinicians, lack of trust in clinicians, and lack of time or transportation to access a clinic.

AAP and other national medical associations support access to contraception for youth.

Given the evidence outlined above, AAP and other national medical organizations endorse counseling and access to a broad range of contraceptive services for their adolescent patients. This includes education about safe and effective contraceptive methods.

National medical and public health associations supporting contraception education, counseling, and access include:

- American Academy of Pediatrics.
- American Academy of Family Physicians.
- American College of Obstetricians and Gynecologists.
- American Osteopathic Association.
- American Medical Association.
- American Public Health Association.
- Society for Adolescent Health and Medicine.

Pediatric clinics provide a unique opportunity for contraception counseling and access.

Pediatricians and other pediatric health clinicians are a trusted source of sexual health information and typically have long-term care relationships with their patients and families, and thus have unique opportunities to address contraception with their adolescent patients.

Pediatric health clinicians have the opportunity to deliver care with a reproductive justice approach, which means to explore patients' priorities and trust young people's decisions when it comes to their bodies. While prescribing contraception to adolescents is an important form of reproductive health advocacy, a reproductive justice mindset recognizes the socio-economic and cultural inequalities that provide some people with "easier access to self-determination and bodily autonomy than others."

The clinical visit is an opportunity to counsel about and ensure access to a broad range of contraceptive services for adolescent patients in a way that is caring and nonjudgmental. Contraceptive needs, expectations, and concerns should be discussed routinely. It can also serve as a useful adjunct to support other sources of sexual health information.

AAP policy and Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents provide recommendations for addressing contraception in clinical settings, including:

- Clinicians having their own working knowledge of contraception options and effectiveness for adolescents.
- Regularly assessing adolescent patients' sexual history.
- Incorporating confidentiality and consent into contraceptive care.
- Counseling about and ensuring access to a broad range of contraceptive services, describing the most effective methods first.
- Educating adolescent patients about all safe and effective contraceptive methods or identifying clinicians in the community to whom patients can be referred for these services.
- Addressing contraceptive needs using a patient-centered approach.
- Following up to support adherence and monitor adverse effects and complications.
- Being aware of programs and community clinics that provide confidential and free or low-cost reproductive health care services and supplies, including contraception.

Barriers to equitable access to contraception still remain

Many adolescents do not have access to contraceptive serves they want or need. Despite declines in recent decades, rates of unintended pregnancies in the US remain high.

Barriers to accessing contraception include:

Knowledge deficits, misinformation, mistrust:

- The emphasis on abstinence-only sexuality education may contribute to misperceptions around contraceptive effectiveness, a lack of understanding of how various methods of contraception work, and incorrect concerns about safety that can influence contraceptive use and method selection.
- Few websites offer up-to-date, accurate information on effective contraception options, including long-acting reversible contraception (LARC) . This could present a barrier to promoting its utilization among youth, especially those who are part of historically franchised or underserved communities.
- People with periods of contraceptive nonuse report misconceptions about pregnancy risk.
- One study found gender queer participants experienced a lack of self-concept and a fear of stigma from both queer and health care communities as contraceptive users.

- Historical coercive contraceptive practices, rooted in systemic racism, and related policies designed to restrict childbearing in specific populations have led to misinformation and mistrust of the healthcare system.
- Individuals who are LGBTQ2S+ are often not provided with medically accurate education materials that address their sexual health needs.

Bias:

- Pediatric health clinicians may have knowledge deficits or attitudes and biases that can limit their ability to offer appropriate contraceptive methods to their patients.
- Contraceptive counseling can be based on clinician assumptions about a patient's sexual behavior (eg, a mistaken belief that women who have sex with women do not need contraception), and as a result, non-contraceptive benefits of birth control may not be taken into consideration.
- Some practices may require or pressure youth to agree to other sexual and reproductive health services, like STI screening, when trying to access contraception.

Legal and legislative climate:

- While the Affordable Care Act (ACA) mandates that private insurance cover all contraceptives approved by the FDA without excessive cost-sharing, regulations allow employer exemptions from the contraceptive coverage rules.
- Rulings like the US Supreme Court's *Burwell v Hobby Lobby* state that corporations can exclude contraceptive coverage from workers' insurance benefits based on the company owner's religious beliefs.
- Some states that require insurance plans to cover prescription drugs do not specify or cover prescription contraceptives.
- Measures that define life as beginning at fertilization assert that most methods of contraception act as abortifacients because they may prevent a fertilized egg from implanting and therefore assert that these methods are illegal.
- Despite national organizations recommending confidential care to adolescents, legislation requiring parental involvement for minors who receive contraceptive care provide legal barriers to access.

Cost and insurance:

- High out-of-pocket costs, deductibles, and copayments for contraception limit contraceptive access – even for those with private health insurance.
    - Out-of-pocket costs for contraception are nearly double that of out-of-pocket costs for non-contraceptive drugs.
- Individuals who have private insurance from employers who do not cover contraception or who are uninsured may not be able to afford the cost of the most effective methods, such as IUDs.
- While access to an extended supply of contraceptives is cost effective and has been shown to increase adherence and continuation rates, insurance plans restrict many individuals' abilities to receive more than a single month's supply of contraception at a time.
- Some insurers, clinic systems, or pharmacy and therapeutics committees require people to "fail" certain contraceptive methods before the cost of a more expensive method, such as an IUD or implant, will be covered.
- The majority of unintended pregnancies in the US care caused by gaps in contraceptive use, most often due to interruptions in insurance coverage or inability to cover co-pays.

Objection to contraception:

- Health systems sponsored by religious institutions often provide limited access to reproductive health services, including contraception.
    - It is estimated that 30-37% of hospital admissions statewide are to religiously affiliated hospitals, and 40% of hospital beds are in religiously affiliated hospitals.
- Reports of pharmacies refusing to fill contraception prescriptions or provide emergency contraception are increasing.
- Six states have laws or regulations that specifically allow pharmacies or pharmacists to refuse medication dispersion for religious or moral reasons without critical protections for patients, such as requirements to refer or transfer prescriptions.
- Areas where health care options are limited, such as rural areas, may be exacerbated by these barriers.

Repetitive clinical visits:

- Requiring a clinical visit that includes a pelvic examination prior to initiating hormonal contraception is not evidence-based and may deter an adolescent from seeking a more effective form of contraception and facilitate use of over-the-counter methods.
- Requiring multiple clinical visits:
    - For use of long acting reversible contraception (LARC).
        - STI testing can occur on the same day as LARC placement and people do not require cervical preparation for insertion.
    - For use of non-LARC methods, such as only dispensing 1-2 months of contraception for repeated, frequent visits.

Institutional and payment barriers:

- Variable compensation for contraceptive services may disincentivize clinics from providing the full range of contraceptive options.
- Healthcare providers face inadequate reimbursement for LARC devices in certain settings.

Health care inequities:

- Rates of adverse reproductive health outcomes are higher among people who are low-income and who live in under resourced communities.
- Individuals who are low income, historically disenfranchised, and underserved have higher rates of nonuse of contraceptives and are more likely to use less effective reversible methods such as condoms.
- Individuals who are low income face health system barriers to contraceptive access because they are more likely to be uninsured, a major risk factor for nonuse of prescription contraceptives.
- Many people who are eligible for publicly funded contraception live in contraceptive deserts.
- Publicly funded programs that support family planning services, including Title X and Medicaid, are increasingly underfunded and cannot bridge the gap in access for vulnerable people.

A 2021 report from the Guttmacher Institute indicates that the COVID-19 pandemic has impacted fertility preferences and access to care. Key findings indicate that the pandemic:

- Has shifted fertility preferences with 15% of respondents wanting fewer children or to have children later.
    - Pandemic-related shifts in fertility preferences were more likely to be experienced by respondents of color, LGTBQ2S+ respondents, respondents who are low-income, and those who experienced financial and employment difficulties in the past year than by their counterparts who are white, straight, cisgender, and financially better-off or employed.
- Impedes access to sexual and reproductive health care, including contraceptive services.

    - Respondents of color, LGTBQ2S+ respondents, low-income respondents, and those who experienced financial and employment difficulties in the past year were more likely than others to experience COVID-19–related barriers to SRH care.
    - Respondents who were higher-income Hispanic (23%) and Black (22%) were more likely than respondents who were lower-income white (15%) to report difficulty obtaining SRH care in the previous 12 months.
- Has disproportionate effects on the SRH of those already experiencing systemic social and health inequities.
    - Respondents who were Hispanic and Black were more likely to report financial or employment challenges, such as financial instability and job loss, than respondents who were White.

Disparities in access to contraception.

The barriers listed above limit access to full contraceptive options. While these barriers impact youth across the US, there are some populations who are less likely to have access to contraception. One significant limitation is the disparity in racial and ethnic representation in research studies: most studies recruit predominately white populations, which leads to a lack of understanding about tailored sexual and reproductive health care for specific communities and identities.

Youth who are LGBTQ2S+ face added barriers to contraception:

- One study found people who are queer and can get pregnant are more likely than their counterparts who are straight to have an unintended pregnancy or a pregnancy before they are aged 20, indicating structural barriers to contraceptive care and a need for LGTBQ2S+ inclusive care.
- Contraception counseling guidelines specific to people who are LGBTQ2S+ do not yet exist, a significant gap in care for family planning needs.
- Nearly a quarter of patients who are transgender have delayed seeking health care because of the fear of being mistreated, which can impact their ability to seek contraceptive counseling.
- Patient who are LGTBQ2S+ are more likely than straight patients to be uninsured and even those with insurance may face insurance denials because of gender markers in their patient profile.

Youth with disabilities or special health care needs face added barriers to contraception:

- Many individuals with disabilities or special health care needs experience assumptions from providers that they are not sexually active and/or do not need contraception.
- Most individuals with physical disabilities experience problems accessing clinic rooms and examination tables.
- Logistical barriers exist, including lack of accessible transportation, difficulty scheduling appointments around transportation constraints, and lack of understanding from insurance companies and providers about their specific needs.
- People with disabilities who also live at the intersection of another marginalized identity face compounded barriers to accessing care, ranging from lack of language access, to not having their symptoms taken seriously, to having their expressed health goals ignored.
- Contraception education materials are often not tailored for disabilities, such as sight impairment.
- There is limited research on the safety and efficacy of various contraceptive methods for people with disabilities and that may impact if and how a provider recommends or prescribes contraceptives.

Youth from historically underserved communities face added barriers to contraception:

- Medical racism has resulted in a culture of fear and mistrust of health care institutions for some individuals, which can make it more difficult for people who are Black to access contraceptive coverage and care.
    - One study found that IUDs were recommended more often to women of color who are low-income women compared to white women who are low-income.
    - Another study found that women's preferences regarding contraceptive selection or removal were not honored.
- Youth who are female and Black are less likely than peers who are white to receive education about where to obtain birth control prior to initiating sexual activity.

The impact of limited access to contraception education and services

Access to contraception has significant benefits for adolescents and future generations.

Access to contraception impacts adolescents' sexual behavior:

- Students in schools that make condoms available without requiring parental notification are less likely to have ever had sexual intercourse than students at schools that don't provide condoms confidentially.
- Moreover, in schools where condoms are readily available, those teens who do have sex are twice as likely as other students to have used a condom during their last sexual encounter.

Meeting the contraceptive needs of adolescents is essential to improving their social and economic well-being:

- Improving and expanding contraceptive services is key to preventing unintended pregnancies.
- Access to contraceptive services increases opportunities for education.

Access to comprehensive contraceptive education, counseling and services are critical for empowering adolescents to maintain bodily autonomy, make informed decisions about their bodies, and attain economic benefits. Efforts to expand access, including pharmacist-initiated prescriptions (also known as pharmacy access), over-the-counter (OTC) sales, and mail-order (MO) purchasing, can reduce barriers to access that adolescents may experience. These strides are critical to adolescents maintaining bodily autonomy and also have a positive impact on public health.

Impacts of a lack of access to contraception.

When youth are unable to freely access contraception services, they are unable to make informed decisions about their body and sexual behaviors or protect themselves from STIs or unintended pregnancies.

Limiting access to contraception can have impacts on all youth, including:

- Foregoing contraception use.
- Stopping access to some or all reproductive health care services.
- Increased risk of unintended pregnancy.
- Increased possibility of exposure to sexually transmitted infections.

Limiting access to contraception can exacerbate existing health disparities, with disproportionate impacts on specific populations of youth.

Youth who identify as women, youth from communities of color, youth with disabilities, and youth who are LGBTQ2S+ are particularly impacted by inequitable access to contraception, as this lack of education can impact their health, safety, and self-identity. Examples of these impacts are outlined below.

A lack of contraception access can harm young women.

- Young women are greatly impacted by parental notification and/or consent laws:
    - One study found that, among adolescents who are female and sexually active, if parental notification was required to receive a contraception prescription:
        - 47% would stop accessing all reproductive health care services from the clinic.
        - 12% would stop using some reproductive health care services or would delay HIV/STD testing or treatment.
        - Nearly all adolescents who are female would stop or delay reproductive health care services indicated they would continue being sexually active.

A lack of contraception access can harm youth from communities of color.

- Youth of color have unique needs related to STI and pregnancy prevention:
    - A history of systemic racism, discrimination, and long-standing health, social and systemic inequities have created disparities in access to sexual and reproductive health services, leading to:
        - Racial and ethnic disparities in STI and HIV infection.
        - Racial and ethnic disparities in unplanned pregnancy and births among adolescents.

A lack of contraception access can harm youth with disabilities or special health care needs.

- Youth with disabilities benefit from comprehensive sexual and reproductive health care tailored to their individual needs:
    - Youth with special health care needs often initiate romantic relationships and sexual behavior during adolescence, similar to their peers.
    - Youth with disabilities are often not asked about contraception or abortion needs because it is assumed they are asexual, infertile, or incapable of having or consenting to sex.
    - Youth with disabilities can be treated as a monolithic group and contraceptive factors may not be considered for the individual person and their disability, such as their comfort level with different types of contraceptive methods, ease of use, or interactions with other characteristics of their disability, adaptive technologies, or medications they may take.
    - Youth with disabilities or with special health care needs are more like to be under conservatorship or guardianship, leading to a lack in confidential contraceptive services or autonomous decision making.

A lack of contraception access can harm youth who are LGBTQ2S+.

- Youth who are LGBTQ2S+ benefit from gender affirming care:
    - Youth who identify as LGBTQ2S+ may experience unique challenges with insurers, leading some to forego an insurance plan altogether or to stick to the birth gender on their insurance ID cards.
    - Youth who identify as LGBTQ2S+ have federal support for insurance coverage of sex-specific preventive services to people who are transgender.

- Youth who are LGBTQ2S+ have unique needs related to STI and pregnancy prevention:
    - Youth who are LGBTQ2S+ are more likely than their heterosexual peers to report not learning about HIV/STIs in school.
    - Lack of education on STI prevention leaves youth who are LGBTQ2S+ without the information they need to make informed decisions, leading to discrepancies in condom use between youth who are LGBTQ2S+ and heterosexual.
    - Some populations of LGBTQ2S+ people carry a disproportionate burden of HIV and other STIs: these disparities begin in adolescence, when youth who are LGBTQ2S+ do not receive sex education that is relevant to them.

Contraception access is key for adolescent well-being

Adolescents have a right to comprehensive, patient-centered contraception access.

Youth deserve reasonable access to the full range of contraceptive services so that they can make well-informed decisions about their bodies without concern about misinformation or bias, legality, or cost.

Data have demonstrated that contraceptive access is essential to reducing risk of unintended pregnancy, figures that remain high in the US compared to countries with similar economic circumstances. These benefits are critical to youth and to public health.

The importance of access to abortion

Access to safe abortion is a core component of sexual and reproductive health care.

AAP supports the right of an adolescent to access an abortion to terminate an unintended pregnancy.

Timely receipt of pregnancy options counseling and access to a wanted abortion is critical for pregnant adolescents, because of the potential medical, personal, social, and economic consequences of an unplanned pregnancy during adolescence.

Adolescents who are facing an unplanned pregnancy deserve access to medically accurate, unbiased, developmentally appropriate information about abortion, and support in obtaining this care if they so choose.

AAP policy affirms that it is an adolescent's right to decide the outcome of their pregnancy and the people who should be involved. Pediatric health clinicians should encourage adolescents to engage their parents/caregivers or a trusted adult in their decision-making around pregnancy and abortion; however, if adolescents choose not to do so, their decision should be respected.

Abortion is a safe and effective medical procedure.

Abortion is a medical procedure that is used to end a pregnancy.

There 4 types of abortions performed by medical facilities in the United States (US). One can be performed at home, while the other 3 are performed in a clinical setting. Length of gestation and patient preference impact the type of abortion procedure used to end a pregnancy. Most abortions performed in the United States are medication or aspiration abortions.

Types of abortions recognized in the US:

- Medication abortion (also called self-managed abortion or the abortion pill).
    - This method uses two medications: mifepristone and misopristol.
        - Mifepristone blocks progesterone, which makes the uterus unable to support a pregnancy.
        - Misoprostol causes cramping and bleeding to empty the uterus.
    - Medication abortions are very effective in ending pregnancy.
    - This method can be used until 11 weeks after the last period.
    - This method can be performed in a clinic or at home.
    - In many states, abortion pills are available by mail.

- Suction abortion (also called vacuum aspiration).
    - This method uses gentle suction to empty the uterus.
    - Suction abortions are very effective in ending pregnancy.
    - This method can be used until 14-16 weeks after the last period.
    - This method is performed in a clinic.

- Dilation and evacuation abortion (also called D&E).
    - This method uses suction and medical implements to empty the uterus.
    - D&E abortions are very effective in ending pregnancy.

    - This method can be used beyond 16 weeks after the last period; it is typically used when a suction abortion is no longer feasible.
    - This method is performed in a clinic.
    - Some states have passed laws making D&E abortion illegal or inaccessible to people who are pregnant.

- Induction abortion (also called medical abortion).
    - Induction abortions are very rare in the US.
        - In 2018, induction abortions accounted for <2% of US abortions performed after 14 weeks gestation.
    - This method uses medications to induce labor and delivery of a fetus.
    - Induction abortions tend to be slower, more expensive, and more physically uncomfortable than D&E abortions; as such, they are used less frequently.
    - Induction abortions are very effective in ending pregnancy.
    - This method is performed in a clinic and can sometimes require a hospital stay.

The National Academy of Sciences has concluded that abortion does not increase the risk of physical or mental health conditions:

- There is no link between abortion and infertility, pregnancy-related hypertension, abnormal placentation, pre-term birth, or breast cancer.
- Abortion does not increase risk of depression, anxiety, or posttraumatic stress disorder.
- There is a body of misleading published literature that claims there is a link between abortion and mental/physical health conditions. These studies do not meet the standards for rigorous, unbiased research.

Abortions performed by medication, suction, D&E, or induction are safe and effective.

Abortion is a common medical procedure.

A 2017 Guttmacher report found that one in four women in the US report having an abortion before age 45.

Approximately 18% of pregnancies in the US end in abortion.

Multiple factors impact incidence of abortion, including access to sexual and reproductive health services, access to contraception, availability of abortion providers, state regulations around abortion, and economic circumstances.

Abortion rates in the US have declined in recent decades due to decreases in unintended pregnancies and increased contraceptive access and use. Abortion rates among adolescents have seen greater declines than among adults.

Abortion rates vary by age group:

- Young adults in their 20's have the highest rates of abortion.
- Younger adolescents (<15) have the lowest rates of abortion.
- Adolescents (<15 and 15-19) have the highest ***ratio*** of abortion, which is the rate of abortion relative to the rate of live births in their age group.

AAP policy and abortion

AAP supports options counseling for youth who are pregnant.

In June 2022, AAP reaffirmed its position that adolescents who are pregnant have the right to be informed and counseled on their pregnancy options. Pediatricians should:

1. Inform the pregnant adolescent of all their options, which include continuing the pregnancy and raising the child; continuing the pregnancy and making an adoption, kinship care, or foster care plan; or terminating the pregnancy.
2. Be prepared to provide a pregnant adolescent with accurate information about each of these options in a developmentally appropriate manner involving a trusted adult, when possible; support the decision-making process; and assist in making connections with community resources that will provide quality services during and after the pregnancy.
3. Be familiar with laws and policies impacting access to abortion care, especially for minor adolescents, as well as laws that seek to limit health care professionals' provision of unbiased pregnancy options counseling and referrals for abortion care. Pediatricians should oppose efforts by state governments to interfere in the patient-physician relationship or to levy criminal sanctions on physicians for the provision of care.
4. Examine their own beliefs and values to determine whether they can provide nonjudgmental, factual pregnancy options counseling that includes the full range of pregnancy options. If they cannot fulfill this role, they should facilitate a prompt referral for counseling by another knowledgeable professional in their practice setting or community who is willing to have such discussions with adolescent patients. The impact on the patient should be minimized and the patient should not know the reasons a referral to another provider is needed. When referral is not possible or feasible, the pediatrician has an ethical obligation to provide this counseling. The AAP acknowledges the tension that pediatricians may face between their ethical duty to the patient and their duty to observe the law, and that pediatricians may choose not to follow these AAP recommendations when it is illegal to do so.

AAP supports the right to confidential care when considering abortion.

AAP policy from June 2022 reaffirms its position that the right of adolescents to access confidential care when considering abortion for an unintended pregnancy should be protected. AAP conclusions and recommendations are as follows:

- Although the stated intent of mandatory parental involvement laws is to enhance family communication and parental responsibility, there is no supporting evidence that these effects are achieved. There is evidence that such legislation may have an adverse impact on some families and pose medical and psychological harm to some adolescents. Similarly, judicial bypass provisions do not ameliorate risks and may delay access to safe and appropriate care.
- Because of the harms of restrictive abortion laws and the dangers associated with unsafe abortions, adolescents should have access to legal abortion services.
- When safe and appropriate, health care professionals should encourage adolescents to seek adult guidance and support when considering their pregnancy options.
- It should be recognized that most adolescents do involve a parent or trusted adult when making the decision to proceed with legal abortion therapy. Ultimately, the pregnant adolescent's right to decide

whom to involve in the decision to seek abortion care should be respected. This approach is consistent with basic ethical, legal, and health care principles.
- Health care professionals should understand state and regional laws regulating abortion services, including restrictions on health care professionals' counseling about or referring.

Adolescents have the ability to make personal healthcare decisions:
- Adolescents under age 18 are just as competent as adults in consenting for abortion services.
- Adolescents understand the risks and benefits of their options for an unintended pregnancy.
- Adolescents are capable of making rational, voluntary, and independent decisions.

Most adolescents who are pregnant engage trusted adults in their decisions around abortion:
- Family dynamics, including trusting and warm relationships impact parental engagement.
- Most adolescents who are pregnant tell their parent about their intent to have an abortion.
- Younger adolescents are more likely to engage their parents than older adolescents.
- Adolescents who do not engage their parents typically involve another trusted adult.

AAP opposes mandatory parental involvement in abortion.

AAP is opposed to legislation that mandates parental involvement in abortion.

Mandatory parental involvement:
- Does not achieve the stated benefit of improving family communication or relationships.
- Puts youth at risk for punishment, coercion, or abuse.
- Delays access to timely medical care.
- Deters adolescents from seeking health services.
- Delays termination of pregnancy, which can increase medical risk, increase financial costs, or eliminate abortion as an option.

States with mandatory parental involvement legislation typically allow judicial bypass proceedings, wherein a judge determines whether a minor adolescent is mature enough to choose to have an abortion without parent involvement.

Judicial bypass provisions do not eliminate the risks of mandatory parental involvement, and can delay access to safe and appropriate abortion, making it a more complicated procedure or eliminating abortion as an option.

Judicial bypass provisions are harmful to adolescents' emotional health:
- Adolescents have reported that the judicial bypass process is stressful and humiliating.
- In these proceedings, young people are required to share the details of their sexual history and private life with many people involved with the court system, in order to obtain a hearing with a judge.
- The proceeding itself may be traumatic for the adolescent, and may delay care, making the procedure more costly or removing abortion as an option entirely.

Youth deserve broad, equitable access to abortion

Access to a wanted abortion is a critical component of sexual and reproductive health for youth who are able to become pregnant.

Pregnant adolescents deserve the information, resources, and supports that they need to:

- Make informed decisions about whether to carry their pregnancy to birth or obtain an abortion.
- Obtain a wanted abortion using the method that is best suited to their needs and preferences.
- Have access to a wanted abortion without hardship or barriers.
- Be supported in their decisions about their sexual and reproductive health.

In order to support adolescents and all people in accessing the abortion care they deserve, pediatric health clinicians and health professionals can advocate for a future with broad, equitable access to abortion, where:

- The right to an abortion is codified by law, and the government cannot infringe upon this right.
- Abortion is affordable for all people who are pregnant.
- Abortion is covered under public and private insurance plans.
- All people who are pregnant who are seeking an abortion have access to the full range of abortion services, via in-person care, telehealth, or self-managed care at home.
- The workforce of abortion providers/clinical staff are fully trained in developmentally and culturally appropriate care.
- Patients and abortion providers are protected from discrimination, harassment, and violence.
- Abortion is fully integrated into the healthcare system.

The World Health Organization has characterized access to safe, timely, affordable, and respectful abortion care as a critical public health and human rights issue.

Many factors influence the decision to obtain an abortion.

There are many reasons that adolescents and other people who are pregnant may choose to seek an abortion.

Common factors influencing the decision to seek an abortion include:

- Barriers to access to comprehensive sex education.
- Barriers to access to contraception.
- Educational consequences of an unintended pregnancy.
- Economic consequences of an unintended pregnancy.
- Relationship impacts of an unintended pregnancy.
- Failure of contraception.
- Rape.
- Incest.
- Intimate partner violence or dating violence.
- Fetal anomalies.
- Pregnancy complications.
- Worsening of a pre-existing health condition.

Abortion is healthcare.

Abortion is an essential component of healthcare for adolescents, women, and other people who are pregnant.

Just like other forms of medical care, decisions about abortion should be made by patients, in consultation with their healthcare provider and without interference from external forces.

Bans or restrictions on abortion impact autonomy and health outcomes

Bans or restrictions on abortion interfere with the right to bodily autonomy.

Bodily autonomy is the right for a person to decide and control what happens to their body.

The right to make one's own decisions about their body and reproductive health is at the core of the basic human rights to equality and privacy, as outlined in the United Nations' (UN) International Covenant on Civil and Political Rights.

In 2017, the UN Human Rights Working Group reaffirmed that people who are pregnant have the right to decide whether to continue or terminate a pregnancy, as this decision has significant implications for one's personal life, family life, and human rights.

Adolescents and all people who are pregnant have the right to make autonomous decisions about whether to carry or terminate a pregnancy, and should receive safe, effective, appropriate medical care to support this decision.

Bans or restrictions on abortion access cause an increase in unsafe abortions.

Bans or restrictions on abortion do not reduce the number of abortions; instead, they force people who are pregnant to seek unsafe abortions to terminate an unintended pregnancy.

When abortion is banned or restricted, people who are pregnant seek unsafe means of terminating their pregnancies, including:

- Self-inflicted injury to their bodies.
- Self-medication with drugs or chemicals.
- Seeking treatment from an unqualified abortion provider.

The World Health Organization (WHO) defines an unsafe abortion as a procedure for terminating an unintended pregnancy that is performed "either by persons lacking the necessary skills, or in an environment lacking minimum medical standards, or both."

Unsafe abortions result in the death of approximately 47,000 women per year worldwide and leave millions more with significant physical health consequences.

Deaths and injuries from unsafe abortions are entirely preventable via:

- Comprehensive sex education.
- Contraception and family planning.
- Provision of safe, legal abortion.

Access to safe and effective abortion is a health and safety concern for adolescents and other people who are pregnant.

Bans or restrictions on abortion increase morbidity and mortality in people who are pregnant.

Limitations on abortion access increase pregnancy-related morbidity and mortality rates and poor maternal health outcomes.

Pregnancy involves a range of health risks, many of which are severe:

- More than 50,000 people who are pregnant in the US face severe complications of pregnancy each year.
- Approximately 700 people who are pregnant in the US die from pregnancy or delivery complications each year.

Abortion is safer than childbirth in the US:

- Abortion, when provided safely via the medication, suction, D&E, or induction procedures outlined above, poses lower risks of morbidity and mortality than childbirth.
- The risk of death from childbirth is 14 times higher than the risk of death from abortion.

A 2021 study found that a ban on abortion would increase pregnancy-related deaths in the US by 7% in the first year following the ban, rising to 21% in subsequent years.

This study projected disproportionate impacts on mortality in communities that are Black and Latinx :

- Populations that are white would see an estimated 4% increase in the first year, and 13% increase in subsequent years.
- Populations that are Black would see an estimated 12% increase in the first year, and 33% in subsequent years.
- Populations that are Latinx would see an estimated 6% increase in the first year, and 18% in subsequent years.

In the *Birth Equity Organization Amicus Brief in Dobbs v Jackson Women's Health*, numerous communities, including those that are Indigenous and American Indian/Alaska Native, describe how *Dobbs v Jackson Women's Health Organization* would exacerbate the harms already imposed on communities that are Indigenous, including increased morbidity and mortality in people who are pregnant.

These disparities are particularly problematic as communities that are Black already face disproportionate levels of maternal mortality due to systemic inequities and structural racism.

Bans or restrictions on abortion exacerbate disparities in access to care.

When bans or restrictions on abortion are enacted, people with sufficient economic resources can travel to obtain safe and legal services in other areas or seek private care.

Adolescents and people who are pregnant without these economic resources are thus disproportionately impacted by bans.

Populations that face disproportionate logistical and economic challenges to accessing abortion include:

- Communities that are low-income.
- Populations of refugee and migrant individuals.
- Adolescents.
- People who are pregnant and are LGBTQ2S+.
- People who are as Indigenous or American Indian/Alaska Native .
- People who are pregnant and who are Black or Latinx.
- People who are pregnant and who live in rural areas.

There are already significant geographic disparities in access to abortion:

- 27% of women in the US would need to travel at least 30 miles to the nearest abortion clinic.
- 38% of women ages 15-44 live in a county that does not have an abortion clinic.

If the US Supreme Court weakens or overturns federal protections for abortion, 26 states are likely to ban abortion. This will increase disparities in access to care by requiring people who are pregnant in those states to travel to access an abortion.

Bans or restrictions on abortion exacerbate disparities in sexual and reproductive health outcomes.

When discussing disparities in sexual health, it is critical to note that health outcomes are not directly tied to race, sexuality, or community. Rather, they are caused by systemic inequities in social drivers of health, structural racism, and disparities in access to care, including comprehensive sex education, contraception, and other sexual health services.

These systemic inequities and discrimination have resulted in disparities in sexual and reproductive health outcomes:

- Individuals who are Black and Latinx have higher rates of unintended pregnancies than communities that are white.
- Individuals who are Black and Latinx have higher rates of HIV and STIs than the general population.
- Individuals who are Black and Latinx, Indigenous or American Indian/Alaska Native are overrepresented among abortion patients.
- Individuals who are LGBTQ2S+ and can get pregnant are more likely to experience unintended pregnancy or seek an abortion than their peers who are straight.

Abortion restrictions have been shown to worsen maternal and child health and associated disparities.

State-level bans or restrictions on abortion are associated with:

- Poorer health outcomes for women and children.
- Increased risk of infant mortality.
- Increased probability of pre-term birth in individuals who are Black compared to peers who are non-Black.
- Increased probability of low birthweight in people without a college degree compared to college graduates.

The current trend in state legislation to lower gestational age for abortion disproportionately affects adolescents, who:

- May not access care when first miss menses
- May have irregular cycles (common up to 2 years after menarche) and may not know they are pregnant
- May have conditions that cause irregular cycles, such as untreated polycystic ovary syndrome (PCOS) and may not realize they are pregnant.

States with more restrictive abortion policies also tend to have fewer policies supporting maternal and child health through the lifespan.

Perspective: Tammi Kromenaker BSW; Clinic Director, Red River Women's Clinic, Fargo ND.

In the US, abortion is heavily regulated. This is especially true when it comes to youth access to abortion, specifically for those under the age of 18. Many of these laws are enacted by legislatures that made certain assumptions about family dynamics and make up: for example, the idea of an intact, nuclear family consisting of a biological female parent, a biological male parent, and their children all living under the same roof with the ability to safely navigate difficult and intimate discussions regarding sex, sexuality, reproductive healthcare needs, and abortion. Another assumption under which restrictive abortion laws have been written is a patriarchal obsession with the idea of "protecting" young, vulnerable girls who fall prey to much older men working in collusion with abortion providers. These assumptions do not reflect reality and undermine the diversity of experiences and circumstances that impact youth seeking abortions in the US. It all adds up to a literal obstacle course of differing rules, regulations and hoops minors must jump through in order to fulfill each differing state's legal requirements.

In North Dakota, where I operate the only abortion clinic in the state, we have some of the most restrictive abortion laws in the country for minors. A minor has two options when seeking abortion care in our state. They can either 1) inform both biological parents of their intention to have an abortion, the physician/provider must then send out a certified letter to each parent and then the custodial parent(s) must give their consent. The other option is for 2) the minor to seek a judicial bypass, in the county in which they live, if they cannot inform or involve one or both of their biological parents. This difficult set up poses confidentiality issues for minors living in small, rural counties where just being seen walking into the local courthouse can become community gossip.

Abortion providers and advocates for young people have undergone herculean efforts in order to break down many of the barriers' minors face when accessing abortion care. There are numerous organizations, agencies and research that has been done in this area.

Common barriers to abortion access

Adolescents and other people who are pregnant face many barriers to abortion access. Common barriers are outlined below.

Legislative barriers to abortion access.

The current legal climate in the US is threatening abortion rights.

Since the 1973 US Supreme Court decision in *Roe v. Wade* that affirmed the constitutional right to abortion, US states have enacted over 1200 laws and policies restricting abortion access.

In 2021, 13 US states attempted to ban abortion at 6 weeks gestation or earlier. When implemented, these bans have been successful in stopping abortion clinics from providing evidence-based, safe medical care to people who are pregnant.

Common legislative restrictions on abortion access include:

- Targeted Regulation of Abortion Providers (TRAP Laws), which apply costly and medically unnecessary requirements on abortion providers and women's health centers.
- Restrictions on medication abortion, including limits on the type of prescribing-practitioners that are allowed to prescribe abortion pills, or bans on telemedicine appointments to facilitate a medication abortion.

- Abortion refusal laws, which allow individual providers and institutions to refuse to provide or pay for abortion care or even provide information/referrals related to abortion.
- Biased counseling provisions, which force healthcare providers to give patients information that discourages abortion or provide medically inaccurate information.
- Mandatory waiting periods, which require a waiting period of 18-72 hours between a pre-abortion counseling visit and an abortion; thus, requiring two trips to a clinic and delaying access to care.
- Forced ultrasounds, which require patients seeking an abortion to undergo a medically unnecessary ultrasound prior to accessing an abortion.
- Mandatory parental involvement, which require adolescents under 18 to notify or obtain permission from their parents prior to obtaining an abortion or endure a lengthy judicial bypass process.
- Regulations on insurance coverage, which limit, restrict, or ban coverage of abortion services in public or private health insurance plans.
- State laws, like in Texas and Idaho, that ban most abortions and authorize enforcement from citizens, or state bills, like in Louisiana, that would make having an abortion grounds to be charged with homicide.

Economic barriers to abortion access.

There are significant economic disparities in a person who is pregnant's ability to access an abortion.

Many people seeking an abortion are facing economic challenges:

- Half of people who seek an abortion have an income below the Federal Poverty Level.
- The most common reason to seek an abortion is concern about not being able to financially support a child.

A first-trimester abortion costs approximately $550, and cost increases as the pregnancy progresses.

- Over half of people seeking abortion report that the out-of-pocket costs (including medical expenses and travel costs) are more than 1/3 of their monthly income.
- 54% of people seeking an abortion report that having to raise funds to cover expenses delayed their abortion care.

Insurance coverage can help with the cost of abortion care, however, there are significant gaps in insurance coverage in both private and public insurance.

Public insurance gaps in abortion coverage:

The Hyde Amendment, passed in 1977, bans federal Medicaid dollars from being used to cover abortion expenses (with limited exceptions for rape, incest, or if the abortion is needed to save the life of the woman).

The Hyde Amendment restricts access to abortion in 2 ways:

- Directly prohibits Medicaid coverage for abortion in 34 states and Washington DC. (The remaining 16 states provide alternative funding for abortion coverage for people enrolled in Medicaid).
- Withholds abortion coverage from millions of people who are insured through other federal programs, including:
    - Federal employees.
    - Military veterans and active-duty personnel.
    - Indigenous and American Indian/Alaska Native communities.

    - People who are imprisoned or detained by the federal government.

The Hyde Amendment exacerbates racial and ethnic disparities in access to abortion.

- Due to the economic impacts of systemic racism, women who are Black and Latinx are more likely to enroll in Medicaid.
- Half of people impacted by the Hyde Amendment are women of color.

Private insurance gaps in abortion coverage:

US states have the power to ban or limit abortion coverage in private insurance plans, including those sponsored by employers and those offered through insurance exchanges, such as the Affordable Care Act.

- 11 US states restrict abortion coverage in all private insurance plans written in the state.
- 25 US states restrict abortion coverage in all insurance plans offered through health insurance exchanges.
- 22 states restrict abortion coverage in insurance plans for public employees.

In addition, individual employers can restrict coverage for abortion services through their employer-sponsored health plans.

- 10% of US workers with employer-based insurance have abortion coverage excluded from their health plan.
- Exclusion of abortion coverage in an employer-sponsored health plan varies by:
    - Company size.
    - Ownership structure.
    - Company's religious affiliation.

Economic barriers to abortion can delay care, resulting either in a more expensive procedure or eliminating abortion as an option due to stage of gestation.

Geographic barriers to abortion access.

A person who is pregnant's ability to access an abortion in the US varies by where they live. This disparity in access to health services based on location is called spatial inequity.

Abortion clinics are concentrated in urban areas, creating access barriers for people who are pregnant in rural communities.

People who are pregnant and live farther from abortion clinics are less likely to access a wanted abortion.

When states pass laws restricting access to abortion, people who are pregnant are forced to travel—often across state lines—to access the care they need.

Needing to travel to an abortion clinic creates logistical barriers:

- Traveling to a clinic requires people to take time off work and arrange for transportation and childcare.
- In states that require mandatory waiting periods between abortion counseling and an abortion procedure, people who are pregnant may have to take multiple days off work or pay for a hotel stay.
- People who travel to access abortion care report challenges with travel logistics, navigating the healthcare system, limited clinic options, and expenses.
- These barriers to care can delay abortion services and negatively impact mental health.

Geographic barriers exacerbate economic disparities in abortion care; as people with lower incomes have fewer resources to pay for transportation and may face greater challenges in taking time off work.

Furthermore, state of residence impacts how late in a pregnancy a person can obtain an abortion.

- Approximately 4,000 people each year are denied an abortion because there are no clinics in their area that perform abortion at their stage of gestation.

Stigma as a barrier to abortion access.

Perceived stigma around abortion from a person's family, community, or society can serve as a barrier to accessing abortion.

More than half of people who are pregnant and seeking an abortion report perceived stigma in their communities or families, noting that they believed people would look down on them if they knew they had sought an abortion.

People who are pregnant and who report that their partner was not involved in the abortion decision report higher levels of perceived stigma than those who report that their partner wanted to carry the pregnancy to term.

People who are pregnant and who report lower perceived stigma are more likely to tell other people that they are seeking an abortion.

People who encounter protestors when arriving at an abortion clinic are more likely to report perceived stigma.

People who are pregnant and who report high levels of abortion stigma at the time of seeking their abortion are more likely to report psychological distress in future years.

Crisis pregnancy centers as a barrier to abortion access.

Crisis pregnancy centers (CPCs) seek to discourage people who are pregnant from considering abortion, often by using misleading and unethical practices.

CPCs take an anti-abortion approach to care:

- Pregnancy options counseling in CPCs is typically limited to adoption or parenting.
- CPCs do not refer to abortion clinics.

CPCs are designed to look like healthcare facilities, however, there are many limitations to the care provided:

- CPCs are exempt from the regulatory, licensure, and credentialing oversight that applies to medical settings.
- CPCs are often staffed by lay volunteers who are not licensed medical providers.
- CPCs fail to adhere to medical standards around sexual and reproductive health care and informed consent.
- CPCs frequently provide misleading or false information about abortion risks and contraception.
- Only 66% of CPCs offer limited medical services beyond pregnancy testing and counseling.

There are over 2,500 CPCs in the US:

- CPCs outnumber abortion clinics 3 to 1.
- CPCs exist in all 50 states but are most prevalent in the southern and midwestern US.
- CPCs are more common in states that provide direct funding for them.
- CPCs are more prevalent in states with other legislation that restricts abortion access.

National medical associations have highlighted ethical concerns with CPCs:

- The American Medical Association Journal of Ethics has categorized that the misinformation provided at CPCs is an ethical violation that harms the health of women and people who are pregnant.
- The Society for Adolescent Health and Medicine (SAHM) and North American Society of Pediatric Adolescent Gynecologists (NASPAG) published a joint position statement asserting that CPCs pose a risk to adolescent health by failing to adhere to medical and ethical standards of practice.
- SAHM and NASPAG encourage health professionals to educate themselves and their patients about CPCs to help youth better identify safe and medically-accurate sources of sexual and reproductive health care.

Being denied a wanted abortion negatively impacts people who are pregnant

Being denied a wanted abortion removes a person's ability to make decisions about their body and health and changes the decisions they are able to make about their future.

95% of people who have an abortion report that they made the right decision, 5 years later.

People who are pregnant and who are denied a wanted abortion face negative impacts on their health, finances, and well-being.

The Turnaway Study:

Much of what is known about the impacts of accessing or being denied a wanted abortion comes from the Turnaway Study, a longitudinal study that examines the impact of unintended pregnancy on the lives of people who are pregnant:

- In over 50 publications, the authors of the Turnaway Study have outlined the health and socioeconomic consequences of receiving an abortion versus carrying an unintended pregnancy to term.
- The Turnaway Study was led by a team of scientists at the University of California, San Francisco.
- The Turnaway Study compared the experiences of people who have abortions and those who are denied a wanted abortion over a 5-year period.
- The study tracked the outcomes of a diverse cohort of 1,000 women, recruited from 30 abortion facilities across the US.

The main findings of the Turnaway Study indicate that:

- Receiving an abortion does not harm the health and well-being of people who are pregnant.
- Being denied a wanted abortion has negative health, family, and financial impacts.

A selection of results from the Turnaway Study are highlighted below.

Being unable to access a wanted abortion impacts physical health.

People who are pregnant and who are denied a wanted abortion are more likely to experience serious pregnancy complications:

- Eclampsia.
- Post-partum hemorrhage.
- Death.

People who are pregnant and who are denied a wanted abortion are more likely to report poor health outcomes:

- Chronic pain.
- Headaches and migraines.
- Gestational hypertension.

Being unable to access a wanted abortion impacts mental health.

People who are pregnant and who are denied a wanted abortion have a higher risk of short-term impacts on anxiety, self-esteem, and stress.

Anxiety:

- People who are pregnant and who are denied a wanted abortion report more anxiety than their peers who received an abortion.
- Anxiety is highest around the time of denial and in the following months and reduces over time.
- Prior mental health history and history of abuse increase incidence of anxiety after seeking an abortion.

Self-esteem:

- People who are pregnant and who are denied a wanted abortion report lower self-esteem than their peers who receive an abortion.
- Self-esteem and life satisfaction tends to improve or remain steady over time.

Stress:

- People who are pregnant and who are denied an abortion and go on to parent report high levels of stress after being turned away.
- Stress levels are higher among people who are pregnant seeking abortions in their 2nd trimester, compared with peers seeking abortions in the 1st trimester.

Other mental health outcomes:

- Accessing or being denied a wanted abortion does not impact risk of depression, suicidal thoughts, or post-traumatic stress symptoms.
- Prior experience with mental health symptoms, violence, abuse, or sexual assault are most strongly linked to poor mental health outcomes after an abortion.

The most significant mental health impacts of abortion denial happen in the short term. This indicates that people who are pregnant and who are denied an abortion are resilient, and able to find ways to cope emotionally in the long-term, despite economic and health impacts.

Being unable to access a wanted abortion impacts economic outcomes.

Many people who are pregnant and who seek an abortion are already experiencing economic hardship.

- Not having enough money to care for a child or support another child is the most common reason for seeking an abortion.
- Many women who seek an abortion have incomes below the Federal Poverty Level and report that they do not have enough money for basic expenses.

Being denied a wanted abortion often exacerbates economic challenges: women who carry an unintended pregnancy to term are 4 times more likely to have an income below the Federal Poverty Level.

People who are pregnant and who are denied a wanted abortion report:

- Higher levels of unemployment.
- Higher likelihood of being unable to pay for basic needs, such as food, transportation, and housing.
- Lower credit scores, higher debt, and more negative financial effects (eg, bankruptcies, evictions).

People who are pregnant and who are denied a wanted abortion often seek support from federal programs, such as Temporary Assistance for Needy Families (TANF), Women Infants and Children (WIC), Medicaid, and food assistance (SNAP). These programs are important, but do not protect families from falling below the Federal Poverty Line.

People who are pregnant and who do receive a wanted abortion report more financial stability in the future.

Being unable to access a wanted abortion increases the likelihood of staying with a violent partner.

People who are pregnant and who are unable to access a wanted abortion are more likely to remain in an abusive relationship.

This can impact experience of domestic violence or intimate partner violence over time:

- People who are pregnant and who access a wanted abortion report a reduction in physical violence from the partner involved in their pregnancy over time.
- People who are pregnant and who are denied a wanted abortion are more likely to experience sustained violence.
- Intimate partner violence has documented negative health consequences on both the victim of the violence and on any children in the family.

Being unable to access a wanted abortion impacts the health and development of all children in the family.

People who are pregnant and denied a wanted abortion are more likely to raise children alone, without the support of a partner or family.

Children who are born as the result of an abortion denial are more to live below the Federal Poverty Line.

People who are pregnant and who go on to parent a child after an abortion denial report poorer maternal bonding, and higher rates of resenting the baby or feeling trapped than they experience with their subsequent children.

The other children of people who are pregnant and who are denied a wanted abortion have poorer developmental outcomes.

People who are pregnant and who do receive a wanted abortion raise their other children under more economically-stable conditions, and are more likely to have a child from a wanted pregnancy in the future.

Being unable to access a wanted abortion impacts outlook on the future.

People who are pregnant and who are unable to access an abortion are less likely to have aspirational goals or plans for the future.

However, it is important to note that the likelihood of achieving personal goals is similar among people who receive a wanted abortion and those who are denied this care. This indicates that people who are pregnant and who are denied an abortion are resilient in achieving the goals they set.

The current abortion climate impacts on healthcare providers

Healthcare providers are also impacted by bans or limitations on abortion.

Bans or limitations on abortion interfere with providers' ability to deliver basic medical care.

Bans or restrictions on abortion prevent pediatric health clinicians and other healthcare providers from providing safe, effective, clinically-indicated medical treatment to their patients.

- Common restrictions include TRAP laws, restrictions on care provision, or requirements to provide inaccurate information.
- These restrictions are politically motivated, and not based in evidence, science, or medicine.
- These restrictions cause complications and stressors for providers, harm patient-provider relationships, and interfere with the practice of medicine.
- *For more information, see "Common Barriers to Abortion Access," earlier in this resource.*

AAP and other front-line physician groups oppose government restrictions on the information that patients can receive from their doctors. In a 2018 joint statement, AAP and its partners affirmed that:

- Patients expect medically accurate, comprehensive information from their doctors
- Provision of accurate information is critical to the integrity of the patient-physician relationship
- No governmental body should interfere in a physician's obligation to provide evidence-based information to patients.

Stigma around abortion impacts the training and practice experiences of healthcare providers.

The current climate around abortion in the US reinforces cultural stigma, which can impact the training and clinical practice experiences of abortion providers.

There is a documented shortage of trained abortion providers in the US, even among obstetrician-gynecologists.

The gap in the abortion care workforce is influenced by systemic factors, including:

- Lack of access to training on abortion in residency programs.
- Options to "opt-out" of abortion care during medical school, residency, and advanced-practice clinician education.
- State-level limitations on the types of physicians or advanced-practice clinicians that can perform abortion procedures.

Abortion care in the US is separated from the rest of the healthcare system, which reinforces stigma and limits access to care:

- Most abortions are often performed in freestanding clinics, separated from other health facilities.
- Patients seeking abortion report that they would prefer to receive this care from their family doctor instead of at a specialized clinic.
- Abortion services are concentrated in urban areas, contributing to significant geographic disparities in access.
- Primary care providers can provide first-trimester abortions with appropriate training, however, many elect not to pursue this training due to stigma and politically-motivated restrictions on this care.
- Further integration of abortion care into primary care settings—particularly in rural and medically-underserved areas—could increase access to abortion care in the US.

Abortion providers report personal and career-related challenges related to the factors above, including:

- Limited training availability.
- Marginalization within their profession.
- Stigma and isolation.
- Concerns about personal safety.

Abortion providers face violence and safety risks.

Bans or restrictions on abortion promote stigma around a safe and effective medical procedure, and abortion providers and other medical staff at risk of discrimination and harassment.

Abortion patients, providers, and clinics face threats of violence, harassment, and intimidation.

From 1993-2016, 11 people in the US were murdered in incidents of violence against abortion providers, and 26 more survived attempted murder.

The National Abortion Federation tracks incidents of violence against abortion providers, including:

- Murder.
- Attempted murder.
- Bombings and bomb threats.
- Arson.
- Vandalism.
- Burglary.
- Assault.
- Death threats.
- Stalking.
- Harassment via phone, mail, or internet.

Rates of violence and harassment against abortion patients, providers, and clinics have escalated in recent years.

Anti-abortion violence limits access to abortion care and puts abortion providers and their families in serious danger.

Best practices for adolescent sexual and reproductive health care in clinical settings

Using evidence-based best practices to deliver sexual and reproductive health care to adolescents can improve health outcomes and support healthy behaviors, communication, and relationship development.

AAP policy and resources provide key strategies for delivering adolescent-centered sexual and reproductive health care in clinical settings. Considerations for care delivery are outlined below.

Preserving confidentiality.
AAP policy, Bright Futures, and other national medical organizations' policy highlights the importance of confidentiality in adolescent health care. Preserving confidentiality for adolescent patients supports youth in taking ownership over their own health, facilitates open communication about sensitive topics (eg, sexual health, mental health, and substance use), and supports the transition to adulthood.

When adolescents know their confidentiality is protected, especially over multiple visits, they are more likely to access health care, communicate about sensitive topics regarding behaviors, partners, or gender issues; and return for care. Confidentiality also allows for self-management of an individual's sexual and reproductive health care.

AAP provides clinical resources and videos to support confidential care for adolescents.

Clinicians can support adolescent confidentiality for sexual and reproductive health care in many ways:

Education:

- Train all office staff and clinicians to discuss confidentiality with all parents and youth beginning at an early age, to set the expectation that patients will begin to have one-on-one time with their pediatric health clinician during adolescence.
- Ensure all clinicians and staff understand state laws surrounding informed consent and confidentiality related to contraceptive services; STI testing and treatment; and HIV testing and treatment.
- Ensure all clinicians and staff know how to detect sexual violence or abuse, and understand the legal requirements for reporting sexual violence or abuse.

Office policies and procedures:

- Develop an office policy that explicitly outlines the right of adolescent patients to confidential care and share the policy with patients and families. Post it in a visible location in your office.
- Require education for clinical and office staff about the importance of protecting adolescent confidentiality in all aspects of care delivery, including medical records, appointments, test results, after-visit summaries, explanation of benefits forms, and follow-up care.
- Consider confidentiality concerns in follow-up care and referrals. For example, when providing a prescription for contraception, refer adolescents, especially minors, to pharmacies where their confidentiality will be respected and where the pharmacist will call the health provider and not the parents with questions about a prescription.
- Clinics that serve an entire community may need to take extra steps to ensure confidentiality for young people, including use of confidential codes and/or separate waiting rooms for adolescents.

Communications with adolescents and families:

- Talk directly with adolescent patients and their families about the protections of confidentiality at every visit and allocate time for a one-on-one conversation between the patient and clinician during every visit. Some examples for talking about confidentiality include:
    - To adolescents: "I want to take a few minutes today to talk about your sexual health, which is a big part of your overall health. Before we get started, I want to make sure that you know that what we talk about is confidential, meaning it's private between you and I, and I don't discuss any of this with your parents. Unless there is a concern of your safety or someone else's safety. Is that OK?"
    - To parents: "Now it's time for the one-on-one portion of the visit. As you both know, I spend time alone with all my patients ages 11 and above so we can have a confidential conversation. Mrs. Smith, I am going to have you step out so that John gets practice talking about his own health care and answering questions related to his health. This will help John as he transitions to adulthood."
- Pediatric health clinicians have opportunities with families and caregivers to introduce topics such as healthy sexual development and exploration while limiting risk of harm.
- When talking to adolescent patients about their sexual and reproductive health concerns, encourage them to engage their parent/caregiver or other trusted adult in their care. Many patients choose to involve their parents/caregivers in their reproductive health care. To support them in doing so, offer to talk to the parent/caregiver together during the visit.
- If the patient does not want to engage their parents/caregivers in their care and are not at risk of hurting themselves or someone else, respect their wishes within the limits of your state's laws around confidentiality.
- Be sure to get a cell number and/or private e-mail address for youth for quick and reliable communications.

Creating an adolescent-friendly office environment.
An adolescent-friendly office culture can facilitate the delivery of patient-centered sexual and reproductive health care.

Specific strategies to promote an adolescent-friendly office environment include:

Incorporating sexual and reproductive health services into the clinic visit:

- Providing the full range of sexual and reproductive health services in one location (eg, screening, counseling, STI prevention and treatment, contraception, pregnancy-related care, abortion), and advertising the breadth of services provided.
- Offering same-day sexual and reproductive procedures or helping adolescents make referral appointments for specialized services, and providing clear directions and instructions, assurances of continuing confidentiality, and information about fees, if any.
- To the extent possible, ensuring continuity of care by making every effort to have adolescents see the same provider at every appointment.
- Involving families in the care of adolescents as much as possible; for example, the provider can "wrap up" the visit with the parent or guardian for nonconfidential issues and/or, if the adolescent or young adult wishes, to disclose anything with the pediatric health clinician present for support.
    - Simultaneously, it is important to educate parents on the benefits of the physician having a parallel, independent care relationship with their child to ease transition of the relationship to primarily focus on the patient/provider, and not the parent/provider, over time.
- Incorporate puberty, sexuality, and sexual health assessment into psychosocial history taking. Example screening questions include:

    - Puberty: "Do you have any concerns about how your body is developing?"
    - Sexuality: "Many people your age begin to have attractions physically or romantically. Have you thought about that? What are the genders of the people that you are attracted to?"
    - Sexual health assessment: "What types of sexual experiences have you had?"
- Encourage transition-planning for youth, with a focus on ensuring that reproductive health care, including contraception and pregnancy care, continues as youth transition from pediatric to adult care.

Offering a range of hours and services that cater to adolescent schedules:

- Offering flexible hours, walk-in hours, same-day appointments, and appointments in the evening and on weekends.
- Offering telehealth appointments to adolescents to increase options for accessing care.
- Following best practices for adolescent telehealth visits (eg, asking if a parent is present in the room, encouraging use of headphones or the chat function to protect the privacy of conversations).

Creating a welcoming office culture:

- Establishing clear, unambiguous policies against discrimination on the basis of sex, age, race/ethnicity, sexual orientation, religion, gender identity, ability/disability, and gender expression. Make sure the health center is a safe place for all patients and staff.
- Hiring diverse, well-trained clinicians and staff, and making efforts to hire candidates that live in the community or reflect the demographics, culture, and language of the patient population.
- Delivering supportive, non-judgmental care to all youth who access the office or clinic.
- Using clinical forms and/or questionnaires that allow patients to write in their own gender and sexual identity and by allowing differentiation between sex assigned at birth and affirmed gender.
- Establishing continuous ongoing training regarding cultural diversity, sexual orientation, gender identity, and cultural norms, particularly those cultures of the adolescents served.
    - Encourage accountability for all clinicians and staff by coordinating training during work hours or building into continuing education requirements.
    - Any culturally appropriate tools, trainings, or interventions should be leveraged to support both clinicians and non-clinician providers alike.

Providing free or low-cost services:

- Offer free or greatly reduced-fee services to adolescents. This can be especially important for STI testing and treatment.
- Set up private billing accounts for adolescents who seek confidential services. Arrange for laboratory fees for confidential tests to be billed directly to the health center. Work out a nominal payment plan with the adolescent. At the same time, bill the adolescent's insurance for provider time, using confidential codes, so that information forms sent to the parents will not betray youth's confidentiality.
- Where permitted by state law, dispense free or low cost prescriptions to adolescents.
- Stock exam rooms and bathrooms (not just the waiting room) with baskets of condoms along with signs saying that youth are free to take as many as they like, at no charge.
- School nurses and providers at school-based or school-linked health centers can assist students and families in obtaining health insurance as needed and can represent the school on community coalitions to advocate for increased resources for school-based health care.

Removing barriers to access:

- If possible, offer transportation vouchers or bus tokens to youth who need them. If this is not possible, link with community health centers around the county or geographic area so you can offer youth the option of using a health center closer to home or work.
- Offer a special help-line that adolescents can use to inquire about services, make appointments, and request follow-up care. Where possible, consider establishing a text-messaging line or web page which can provide youth with information about where and when to access youth-friendly health services.
- Offer solutions to increase access for youth with physical disabilities, including wheelchair accessibility and exam table access.

Knowing and collaborating with community resources:

- Building strong referral systems and/or establishing collaborative partnerships with agencies who serve communities of youth with unique sexual health needs, including young parents, youth in foster care, youth who live in homeless shelters, youth engaged in the juvenile justice system, and youth enrolled in substance abuse programs.
- Connecting with local emergency rooms to guide referrals for family planning or contraceptive service needs.
- Involving young people in assessing the policies and services offered in the practice and taking their recommendations seriously.
- Choosing gender-neutral décor for waiting rooms and include art, posters and resources in waiting and examination rooms that is inclusive of diverse races, ethnicities, abilities/disabilities, family structures, relationship types, and gender identities.

Providing strengths-based, trauma-informed, patient-centered care.
Within the context of a sexual and reproductive health visit, pediatric health clinicians can provide strengths-based, trauma-informed, patient-centered care to best meet the needs of each individual patient.

Pediatric health clinicians can consider the following strategies when delivering care:

- Delivering care through a reproductive justice framework, which includes:
    - Asking youth about their priorities and concerns related to sexual and reproductive health without bias or making assumptions:
        - Use unbiased and inclusive language during conversations about behaviors, partners, sexual orientation, gender identity.
        - Ask about and follow patients' wishes about contraceptive methods (eg, clinicians should not push individuals to use a specific form of contraception, such as LARC).
    - Supporting each adolescent's right to body autonomy:
        - Talk with adolescent patients about their bodily autonomy, and ways to proactively assert and protect their autonomy in their healthcare, relationships, and behaviors.
        - Integrate aspects of sex positivity and discussion about the normalcy to find intimacy pleasurable into sexual health counseling.
    - Using patient-centered language:
        - Communicate with adolescents using their vernacular and ask questions about the patient's goals, rather than making assumptions. Overly medical terminology, even about anatomy may not resonate.
        - Ask patients their pronouns.

        - Ensure that patients can communicate with staff in their own language. This may mean hiring bilingual staff or compensating staff who learn additional languages.
        - Ensure that high-quality adolescent health education materials are available in all the languages that adolescents in the community speak and for various reading levels, include low literacy.
- Providing adolescents with the realistic, unbiased information and education needed to make informed decisions about their sexual health—including choices around contraception, pregnancy, parenting, adoption/kinship care, or abortion—and then provide support to implement whatever decision is made.
- Integrating principles of trauma-informed care into clinical interactions:
    - Leadership commitment by annual reviewing policies and procedures to ensure a safe work environment and setting to provide trauma-informed care, to reduce secondary traumatic stress and burnout, and to promote sensitivity to the needs of trauma survivors.
    - Patient and family empowerment by seeking meaningful input in the development of policies and practices, particularly regarding cultural, historical, and gender issues.
    - Continuous through the Health Care System including primary, secondary, and tertiary prevention strategies.
    - Recruitment and Training of a Trauma-Informed and Compassionate Workforce including all administrators, clinicians, and staff, both clinical and nonclinical.
    - Coordination of Care Across Family-Serving Systems in the Community that establish and support collaborative, interdisciplinary relationships among community and public health agencies that serve the population of focus to coordinate care for those exposed to trauma.

Why trauma-informed care is important in delivery of sexual and reproductive health services

Exposure to a traumatic experience, such as intimate partner violence, is more common than most people think. Some child and adolescent populations are at a higher risk for trauma, including youth who are LGBTQ2S+, have development disabilities, are in foster or kinship care, are incarcerated, are living in deep poverty, or are immigrants. Additionally, racial, ethnic, or religious bigotry magnifies the risk inherent to other special populations.

Trauma-informed care is important in the delivery of sexual and reproductive health services to adolescents for several reasons, including:

- It presents an opportunity to promote family resilience and relational health.
- It can be considered primary prevention of stress-related disturbance.
- It can also provide patient-centered care for youth who been impacted by sexual abuse or other forms of trauma.
- Trauma-informed practices also support relational health as an important protective factor for those who have been exposed to persistent adversity or potentially traumatic events.
- It can help connect patients with culturally-informed care and services.

Considerations for providing sexual and reproductive health services in school-linked settings

Schools and school-based health centers are in a unique position to provide students with comprehensive sexual and reproductive health care and referrals, due to their accessibility to school-aged children and adolescents and ability to provide health education targeted to young people. School-based health centers support the physical and mental health needs of young people young by providing health services in school or

on school grounds and improve access to health care services by decreasing financial, geographic, age, and cultural barriers. School based health centers have been proven to improve student access to health care, improve health outcomes, and reduce health disparities.

Clinicians and staff who provide sexual and reproductive health care to adolescents in school-linked settings can support and expand access in the following ways:

Expanded hours and services:

- Consider being open year-round and not just during the academic school year.
- Ensure the school based health center is open before and after school, not solely during school hours.
- Consider expanding services to include recent graduates.

Policies and procedures:

- School nurses and health providers in school-based health centers can partner with schools to establish policies which allow students to see medical providers during the school day.
- Develop strategies that promote and incentivize transition of care for sexual and reproductive health when students graduate.

Referrals:

- Provide students with referral information along with available community resources to improve access to care.
- School nurses and school-based health center staff can follow-up with students if they are referred to a community health clinic to ensure that the adolescent understood what was discussed during their appointment and to ensure they will follow through with the recommended next steps (e.g., scheduling a follow-up appointment or taking a prescribed medication).

Youth populations that are underrepresented need equitable access to sexual and reproductive health services

Due to a longstanding history of systemic inequities that impact access to reproductive health care services, the above considerations are particularly important to certain populations of youth. Clinicians and staff who are delivering sexual and reproductive health care should be aware of the following:

- **Some populations of youth need extra assurances of confidentiality**, including youth that are HIV-positive, older youth, youth who are LGBTQ2S+, and youth who are pregnant and parenting.
- **Provision of respectful, strengths-based, trauma-informed care is particularly important for some populations of youth**, including youth who are parents, youth who are LGBTQ2S+, youth who are HIV-positive, youth who are historically underserved, and youth who are survivors of sexual or physical assault.
- **Integrated care is especially important to some populations of youth,** including young adults, youth who are pregnant, youth who are LGBTQ2S+, youth who are HIV-positive, and youth who are survivors of sexual or physical assault.
- **Cultural competency is highly important to particular populations of youth:**
    - Men who are gay and bisexual often rely heavily on the experiences and recommendations of their peers. Good client-staff interactions with one young man will be likely to come to the attention of other young men who are gay and bisexual. While most adolescents rely heavily on the experiences and recommendations of their peers, youth who are LGTBQ2S+ may be more attune to this because of concerns about discrimination, oppression, and lack of knowledge. Be aware that young males who are gay and bisexual have the same need as their peers who are

heterosexual to be treated holistically and to receive optimal care that addresses their physical, emotional, and psychosocial health.

- Youth of color need to know that they are seen as individuals, not as someone's stereotype of their race/ethnicity. Remember that any individual adolescent is no more and no less likely than any other to participate in or to avoid risk-taking behaviors. All need the same individual counseling and care.

Perspective: Frankie Heightchew-Howard, Youth activist

As caretakers, it is necessary to work with underrepresented communities without bias. This does not mean to work with the mindset that we are all the same: it is necessary to be conscious of the unique care that may be required for different communities.

To provide adequate care for people who are LGBTQ2S+, first create a space in which patients feel as comfortable as possible. Due to the long history of medical abuse within underrepresented communities, particularly within reproductive and sexual health, there is a lot to unpack and conquer in just this step alone. Receiving sexual and reproductive healthcare is one of the most vulnerable positions to be in, and when patients have accumulated traumas related to their sexuality and/or gender, this becomes even more complex. It is important that sexual and reproductive health spaces establish themselves in their community as a source of support to queer people.

Ask, and be willing to listen to each patient's unique needs and wants, and not make assumptions about what care they need. In this work, it is important to remember that sexuality does not equate to the genitalia of a person's partner or partners, that trans people may not be out to all people around them and may use different names and pronouns with other people you may interact with, and to be careful not to alienate queer patients, they are not research subjects. We each have a duty to learn and develop our understanding of trauma-informed care, and of the health needs and wants of patients who are LGBTQ2S+. It is a primary responsibility to be able to provide proper care to all patients and to be constantly learning and engaging with their worldview.

Steps that can be taken to make spaces where youth who are LGBTQ2S+ receive sexual and reproductive health services feel safer include: providing gender-neutral bathrooms; introducing yourself using your name and pronouns and not requesting this of patients, instead allowing them to share if they feel comfortable; and adding preferred names and pronouns to EHR systems and paperwork and ensuring all staff are trained to use these. Be aware and make connections with local resources for people who are LGBTQ2S+ and where they could have referred them for specialized care. ***Report any discriminatory behavior, as there is no space in health care for bigotry****. Get comfortable with the most current language being used within the LGBTQ2S+ community, because language is important. Signal to patients in as many ways as possible that you are their advocate, and that the space they are in is supportive. The people providing our care should reflect the world around us, Advocate for hiring from within the communities you serve.* ***No true radical change can be made for a group of people without said group involved.***

Adolescents deserve best practices in the receipt of sexual and reproductive health services

The provision of adolescent-friendly services is a key component of ensuring young people receive the sexual and reproductive care they want and need. Access to such services helps young people to lead healthy lives.

Building partnerships to support and expand youth access to reproductive health care

Supporting and expanding youth access to sexual and reproductive health care is a complex issue that requires cross-sectional partnerships between medical experts, schools, community leaders, policymakers, youth, and families.

This section of the resource outlines strategies for building partnerships and provides concrete examples of activities that can support access to reproductive health care in your community.

Identifying community partners.

Anyone can play a role in supporting and expanding youth access to the full spectrum of sexual and reproductive health services. Cross-sectoral partnerships with health professionals, educators, community members, youth, and families are essential to promoting youth access to education and health services in their communities.

The first step in promoting access to sexual and reproductive health care in your community is to check in with partners who are already doing this type of work. Identify individuals and community organizations who are working on health equity and sexual and reproductive rights in your community or state. Consider the following types of organizational partners:

- Schools or school districts across all grade levels.
- Colleges, universities, and vocational settings.
- Student organizations.
- Organizations representing educators or school health personnel and their state chapters.
- Parent-teacher associations.
- Faith-based or religious organizations.
- Community leaders.
- Tribal elders.
- Youth groups (including peer-education groups, school clubs, youth advocates).
- Organized extracurriculars, such as Boys and Girls Clubs, 4H Clubs, or Scout troops.
- Sports organizations.
- Group and residential care organizations.
- Juvenile justice system.
- Foster and adoptive groups for parents.
- Elected officials.
- Organizations serving youth with special health care needs or disabilities.
- Organizations that support LGBTQ2S+ individuals.
- Health clinics, including county or community health centers.
- City or county health departments.
- Your local chapter of the American Academy of Pediatrics.
- National and local chapters of reproductive health organizations, including:
    - Advocates for Youth.
    - Black Women's Health Imperative.
    - Center for Reproductive Rights.
    - National Latina Institute for Reproductive Justice.
    - Planned Parenthood.

- Power to Decide.
- SIECUS: Sex Ed for Social Change.
- Sistersong.
- South Asian Sexual and Mental Health Alliance.
- Unite for Reproductive and Gender Equity.

Promoting health equity in sexual and reproductive health services.

When building partnerships to advance sexual and reproductive health, it is critical to center the needs and experiences of populations facing disparities in access to care. Deliberate, proactive work is needed to achieve equitable access to the full range of sexual and reproductive health services—including comprehensive sex education, contraception, and abortion.

Youth have disparate opportunities and experiences in their schools and communities, due to social drivers of health, family and community resources, and structural factors such as systemic racism, social inequities, and discrimination.

Youth face barriers to accessing the sexual and reproductive health services they need, based on many factors:

- Race.
- Ethnicity.
- Gender identity.
- Sexual orientation.
- Having a disability or other special health care needs.
- Cultural or language differences.
- Being involved in the child welfare system.
- Being involved in the juvenile justice system.
- Geography.
- Level of community resources.
- Attending an under-resourced school.

There are not inherent or generic physiologic differences that lead to disparities in sexual and reproductive health care outcomes. Rather, youth and families may experience barriers or discrimination based on long-standing systemic inequities that impact their options, choices, access to care, and overall health.

Engaging authentically with partners that serve diverse cultural populations.

To promote equity in sexual and reproductive health care, it is critical to engage meaningfully with community members and organizations that serve youth and families from diverse cultures. Sustained engagement with community partners can help reduce barriers to care and increase utilization of sexual and reproductive health services, ultimately impacting health and reproductive outcomes.

Public health scholars have outlined important considerations for authentic engagement around health issues with community partners, including:

- Be aware and acknowledge differences in lived experience.
- Center the perspectives and needs of the population-of-focus.
- Consider cultural factors and strengths of the population-of-focus.
- Practice humility in learning from diverse partners.

- Develop strategies and action plans collaboratively with community members, health professionals, policy makers, and other key partners.
- Consider co-creating messages and materials that are culturally and linguistically tailored for the community.
- Communicate regularly and openly.

Case study: Reproductive health access project (RHAP)

The Reproductive Health Access Project (RHAP) is a project that is run for young people by young people that works to increase education and access to sexual and reproductive health services. Youth who work as peer educators at the RHAP clinic presented during the AAP Summit on Youth Access to Reproductive Health Care and a synopsis of their program is included as a case study.

This program offers free pregnancy testing, STI testing, and treatment, various methods of birth control, counseling, comprehensive sex education, menstrual products, gender-affirming clothing items, among many other essential services. Our program is incredibly special because it works by listening to young people first, spotting where there are gaps or barriers to services, and then working to fill those gaps and overcome those barriers. For example, RHAP saw some of the barriers were cost, transportation, confidentiality, and access to education, so we created a clinic system where all those barriers are addressed. Young people will come to our clinic, see our peer educators for a sex education session where we talk about all the services, they have access to, answer questions, and hear whatever they wish to share before they see a provider. This allows young people who often have never been to an appointment for sexual and reproductive health-related services to get all the information they need to make a decision that is right for their life and to be able to advocate for themselves whenever they see a provider. I think that part of our advocacy that makes us unique is how our clinic system works to put the power in the hands of the young people.

Building a new partnership.

When building a new partnership to address sexual and reproductive health in your community, follow 6 key steps to set your strategic priorities and identify collective goals and measures of success:

Step 1: Define the problem	• There are a wide range of services included under the umbrella of "sexual and reproductive health services." All are important and interconnected. • However, it is often easiest to focus on one specific goal in your community, especially when beginning a new initiative. • Select a priority that is an important need in your community, for example "*promoting comprehensive sex education in our local middle and high school,*" or "*advocating against a proposed state law that would restrict abortion services.*" • Identifying the problem may take some research: if you're passionate about sexual and reproductive health but aren't sure where to begin, consider reaching out to one of the community partners listed above to learn about their priorities and how you can help.
Step 2: Understand the scope of the issue & the key players	• Work to understand what's currently happening in your community • For example: ○ If you're interested in STI prevention, consult your local health department for data on disease prevalence in your community.

	○ If you're focusing on sex education in schools, find out what curriculum is currently being taught in schools and what it covers. • Before launching a new effort, find out what is already happening to address the issue, and identify the individuals and organizations who are working in this arena.
Step 3: Find shared goals	• When building partnerships, be clear about the individual missions, goals, and priorities of each partner organization and illustrate how they are aligned. • Open communication can help identify and overlap in mission and leverage each organization's strengths and capacities for greatest impact.
Step 4: Identify operational differences	• When building partnerships, work to identify any differences in organizational capacity, standards of operation, priorities, constituents, and communication styles. • Open communication can help each partner understand shared and individual priorities, work-styles, and strengths, which can be leveraged for a successful partnership. • Understanding differences early on can help avoid miscommunications or difficulties down the road.
Step 5: Establish the value of the partnership	• To determine the value of a partnership, outline the individual organizations' values, priorities, strengths, and constituencies. • Partnering across organizations and sectors can facilitate greater progress than individual efforts, as you can leverage the strengths, resources, and reach of each organization. • Understanding shared values and priorities can help individual organizations articulate the importance of this partnership to internal and external stakeholders.
Step 6: Outline measures of success	• Work with partners to identify common metrics for the success of your work. • Agree upon how these metrics will be monitored, calculated, and communicated throughout the course of the work. • Having shared measures of success allows all partners to work toward a common goal. • Communicate small wins along the way: this helps keep partners engaged and enthusiastic over the long-haul.

Strategies to support youth access to sexual and reproductive health care in community settings

Promoting equitable access to sexual and reproductive health services for youth is a broad goal, with work that can be done across many domains and settings. In this resource, we have focused on 3 key priorities: comprehensive sex education, contraception, and abortion.

There are many ways that clinicians, public health professionals, community leaders, educators, youth, and families can advance access to sex education, contraception, and abortion in their communities. Some practical strategies are outlined below.

Practical ideas for working with schools.

- Schools play a critical role in advancing and supporting the sexual and reproductive health of students.
- Most school-based sexual and reproductive health priorities fall under two key domains:
    - Sex education.
    - School-based health services.
- Promoting comprehensive sex education in schools:
    - Speak to your local school board/school administration about the important role that schools can play in providing youth with the knowledge and skills they need to achieve healthy sexual development.
    - Share information on the broad benefits of comprehensive sex education.
    - Share the SIECUS Guidelines for Comprehensive Sex Education, which provide a framework for the key concepts, topics, and messages that a strong sex education program should include.
    - Share the CDC Health Education Curriculum Analysis Tool (HECAT) to assess and improve the health education – including sex education—curriculum used by the school district.
    - Partner with schools to ensure that youth with disabilities have access to a developmentally appropriate sexual education that includes knowledge building around sexual victimization, safer sex practices, consent, and respect through their Individualized Education Programs or as part of the typical curriculum.
    - Encourage schools in your community to adopt evidence-based, comprehensive sex education programs for youth in grades K-12. Examples of these programs include:
        - Family Life and Sexual Health (FLASH).
        - Get Real: Comprehensive Sex Education that Works.
        - In-clued LGBTQ2S+-focused sexual health education.
        - Promoting Health Among Teens! Comprehensive Abstinence & Safer Sex (PHAT).
        - Rights. Respect. Responsibility.
- Promoting delivery of clinical sexual and reproductive health services in schools:
    - Advocate for sexual and reproductive services in the context of a full spectrum of physical and mental health services for all students which promotes a holistic approach to health and does not identify or stigmatize the school-based service as being solely related to sexual activity.
    - Speak to your local school board/school administration about the important role of schools in providing clinical sexual and reproductive health services to students.
    - Understand the promote the critical roles of school nurses and school-based health centers in improving sexual and reproductive health.
    - Share information on evidence-based programs to promote sexual health in schools, including:
        - Condom availability programs.
        - On-site sexual health services:
            - STI and HIV testing and treatment.
            - Contraceptive services.
            - Health guidance and counseling.

        - Developing a referral guide to link students with youth-friendly services in the community.
        - Building relationships with healthcare providers to promote collaborative care.
        - Information campaigns for students and parents to promote sexual health.
        - Resources and tools for coaches and youth advocates
- Work with schools to promote student-centered, trauma-informed practices when educating and caring for youth:
    - Systemic racism, unconscious bias, and discriminatory policies have caused disparities in experiences with school discipline. For example, students who are Black or American Indian/Alaska Native, and students with disabilities are disproportionately more likely to be suspended or expelled for behavioral challenges.
    - Systemic racism and societal inequities can impact the health and experiences of youth from communities of color, causing intergenerational trauma.
    - Students can experience trauma both inside and outside the school settings, which impacts their health, academic achievement, and social-emotional well-being.
    - Trained educators and school support professionals can promote diversity, equity, and inclusion and build supportive school environments that foster health and positive outcomes for all students.
    - Utilizing trauma-informed practices in schools can help educators and administrators recognize symptoms of trauma and respond accordingly to help students succeed and thrive in school.

Practical ideas for working with the juvenile justice system.

- Talk with the leadership and staff of local juvenile detention facilities about the importance of ensuring access to sexual and reproductive health services for justice-involved youth.
- Work with juvenile detention facilities on best practices for sexual and reproductive health services, including:
    - Ensuring detained youth receive the same level and standards of healthcare as youth accessing care outside of the juvenile justice system.
    - Encouraging sex education for youth living in detention settings including:
        - Counseling on safe sex practices.
        - STI and HIV prevention.
        - Barrier methods.
        - Contraception, including hormonal contraception, long-acting reversible contraception (LARC), and emergency contraception. In the US, there is a history of forced sterilization among individuals who are incarcerated; therefore, any contraception should only be given once non-coerced consent has been obtained from the patient.
    - Promoting reproductive health care for youth living in detention settings, including:
        - Assessment of youth sexual behaviors and practices.
        - STI and HIV screening and treatment.
        - Trauma counseling.
        - Access to the range of contraception options, including LARC.
        - Emergency contraception as needed.
        - Pregnancy screening.
        - Pregnancy options counseling, including information on abortion, adoption, or parenting.
        - Provision of appropriate pregnancy and post-partum care.

        - Providing menstrual products to youth who need them.
    - Providing gender-affirming care in detention settings, including:
        - Continuation of hormone therapy without interruption for transgender youth.
        - Management of medical and surgical transgender care following accepted standards developed by professionals with expertise in transgender health care.
        - Providing gynecological, family planning, and obstetrical care when clinically indicated, regardless of gender identity.
    - Utilizing trauma-informed care in detention settings.
    - Providing access to wanted abortion for young people.
    - Recognizing and responding to the unique health needs of justice-involved youth with chronic medical conditions and developmental needs.
- Share relevant resources from the American Academy of Pediatrics (AAP) and National Commission on Correctional Health Care (NCCHC):
    - AAP: Advocacy and Collaborative Care for Justice-Involved Youth.
    - NCCHC: Women's Health Care in Correctional Settings.
    - NCCHC: Transgender and Gender Diverse Health Care in Correctional Settings.
- Encourage transition-planning for youth, with a focus on ensuring that reproductive health care, including contraception and pregnancy care, continues without interruption.

Practical ideas for working with the child welfare system.

- Connect with local leadership and staff from the child welfare system, group homes, and foster care agencies, about the importance of ensuring uninterrupted, confidential access to sexual and reproductive health care services for youth living in foster care.
- Require the use of trauma-informed care when working with youth and families in the child welfare system.
- Work with child welfare personnel on best practices for sexual and reproductive health services, including:
    - Ensure that all clinicians who care for the patient are reminded that the confidentiality afforded to youth living with their families should be the same as youth living in foster care.
    - Requiring an initial comprehensive health assessment—to include STI screening, pregnancy screening, and assessment for physical and sexual abuse, exploitation, and trafficking —no later than 30 days of a new placement, and a follow-up assessment within 60-90 days.
    - Gaining the adolescent patient's consent to share the following:
        - Incorporating the results of health assessments into the child's court-approved social service case plan.
        - Educating foster caregivers, caseworkers, birth parents, adoptive parents, and youth about the child's health and treatment plan within the guidelines of the law. Information which is protected should not be shared unless express permission is granted by the patient.
    - Advocating for the provision of health services—including sexual and reproductive health services—in the context of a medical home.
    - Addressing the unique sexual and reproductive health needs of children and adolescents with special health care needs involved in the child welfare system.
    - Understanding and addressing the impact of trauma, toxic stress, abuse, neglect, and ongoing uncertainty, transitions, and loss on child and adolescent health.

    - Building collaborative partnerships between the practice, caseworkers, foster parents, family of origin, and other professionals to promote integrated care for sexual and reproductive health needs.
- Support caseworkers in having the capacity to provide access to age-appropriate, medically accurate, culturally sensitive information about:
    - Gender identity.
    - Prevention of unplanned pregnancies.
    - Sexual development.
    - Sexual and reproductive health care.
    - STI prevention and treatment.
    - The full spectrum of contraception options.
    - The full spectrum of pregnancy options, including abortion, adoption, and parenting.
    - Trauma.
    - Trauma symptoms/stress responses.
    - Trauma-informed care.
- Educate child welfare leaders, staff, and families about common barriers to sexual and reproductive health services for youth in the welfare system and support them in addressing these barriers. Common challenges include:
    - System losing track of youth's insurance eligibility or medical card and residence when transitioning between placements.
    - Youth needing support in scheduling medical appointments.
    - Stigma around sexual and reproductive health services.
    - Transportation barriers.
    - Placement in families/group homes that prohibit or confiscate contraception.
    - Placement in families/group homes that limit pregnancy options, including abortion.
    - Mistrust of the medical system.
    - Lack of confidentiality.
- Encourage transition-planning for youth aging out of the foster care system, with a focus on ensuring that reproductive health care, including contraception and pregnancy care, continues without interruption.

Practical ideas for working with youth- and parent-focused organizations.

- Engage with the leadership of youth- or parent-focused organizations to talk about the importance of youth having information to medically accurate, age-appropriate information about their gender and sexuality.
- Work with groups to identify evidence-based sex education curriculum or programming to incorporate into organizational activities.
- Offer to host an educational session for parents or youth about a topic related to sexual and reproductive health, such as consent, healthy relationships, STI prevention, or gender identity.
- Connect with leadership of a youth- or parent-focused organization about opportunities to advocate together to increase youth access to comprehensive sex education, contraception, or abortion in your community. Advocating together with representatives from multiple sectors gives you a stronger voice than advocating alone.

Practical ideas for making your voice heard.

- Engage with your AAP chapter or the local chapter of other medical groups (eg, physician or pharmacist organizations, nursing organizations, professional associations) to engage your colleagues in advocacy efforts to promote access to sexual and reproductive health services for youth.
- Write a letter to the editor, an op-ed in your local paper, or a blog to highlight the importance of youth access to sexual and reproductive health services, and strategies to expand this access.
- Participate in advocacy activities that support youth access to comprehensive sex education, contraception, and abortion.

Organizations working to advance youth access to sexual and reproductive health services

There are many opportunities to partner with organizations who have existing expertise and structures to expand youth access to sexual and reproductive health care in your community.

A selection of organizations that provide programs and resources for community-based sexual and reproductive health activities is listed below. This list is not intended to be exhaustive, and inclusion of programs should not be interpreted as official endorsement by AAP.

Abortion Care Network

- Abortion Care Network (ACN) is the national association and network for independent community-based abortion care providers and allies.
- ACN fights to protect access to abortion care and keep independent clinics open to continue providing essential health care for communities.
- Learn more here: https://abortioncarenetwork.org/

Advocates for Youth

- Advocates for Youth works to promote adolescent reproductive and sexual health programs and policy.
- Programs include youth leadership, activism, educational resources, curricula, and building the capacity of youth serving professionals.
- Learn more here: https://www.advocatesforyouth.org/

Association of American Indian Physicians

- The Association of American Indian Physicians (AAIP) works to provide educational programs and services to American Indian and Alaska Native communities.
- Learn more here: https://www.aaip.org/

Black Women's Health Imperative

- Black Women's Health Imperative is dedicated to improving the health and wellness of our nation's Black women and girls through signature programs and special initiatives.
- Core components of BWHI programs include reproductive justice, shared lived experiences, training in policy and advocacy, and anti-racism strategies.
- To get involved, learn more here: https://bwhi.org/take-action/

Bold Futures

- Bold Futures advocates for reproductive health care policy change, research, place-based organizing, and culture shift by and for people of color in New Mexico.
- Learn more here: https://www.boldfuturesnm.org/

B.Y.E LLC

- Bringing You Excellence (B.Y.E) LLC operates through a trauma-informed lens and encourages the prioritization of wellness over productivity in the workplace.
- B.Y.E works with philanthropic and government partners providing advocacy curriculum and SRH programs.
- Learn more here: https://www.byellc.org/

Center for Reproductive Rights

- Center for Reproductive Rights is a global human rights organization of lawyers and advocates working to ensure reproductive rights are protected in law as fundamental human rights.
- Get involved here: https://reproductiverights.org/get-involved/

El Rio Health

- The El Rio Reproductive Health Access Project (RHAP) works to improve access to sexual reproductive health care and education through peer-designed initiatives.
- SRH services include STI's/HIV counseling and treatment, and free confidential peer-led walk-in teen clinics.
- Learn more here: https://www.elrio.org/service/teens/

Feminist Women's Health Center

- Feminist Women's Health Center provides safe and affordable abortion and reproductive health services to all without judgement.
  Services include Sexual Health + Wellness, Trans Health Initiative, Abortion Care, Birth Control Options, and Emergency Contraception.
- Learn more here: https://feministcenter.org/

Geoffray Strategies

- Geoffray Strategies is a consulting firm offering policy and strategy solutions for healthcare clients.
- Learn more here: https://www.geoffraystrategies.com/

Guttmacher Institute

- Guttmacher Institute works to advance sexual and reproductive health care and rights worldwide through high-quality research, evidence-based advocacy, and strategic communications.
- Learn more here: https://www.guttmacher.org/

Gyrls in the H.O.O.D Foundation

- Gyrls in the H.O.O.D (Healthy, Optimistic, Outstanding, and Determined) Foundation is on a mission to increase positive reproductive health outcomes for young people living in urban Chicagoland areas.
- Learn more here: https://gyrlsinthehood.com/

Howard Brown Health

- Howard Brown Health is rooted in LGBTQ2S+ freedom, providing reproductive health care and social justice for communities.
- Services include, and are not limited to, OBGYN services, Trans & Nonbinary services, HIV/AIDS case management, and sexual harm response program counseling.
- Get involved here: https://howardbrown.org/get-involved/

If/When/How

- If/When/How helps to ensure all people can decide if, when, and how to create and sustain families and to actualize sexual and reproductive wellbeing. They work to support the advancement of reproductive justice in our legal system.
- Learn more here: https://www.ifwhenhow.org/

Ignite Young Asian People Power

- Asian American Organizing Project (AAOP) – Ignite Young Asian People Power empowers young Asian people in Minnesota to create systems change for an equitable society.
- Programs include civic engagement, gender justice campaigns and youth action teams.
- Learn more here: https://aaopmn.org/

In Our Own Voice: National Black Women's Reproductive Justice Agenda

- A national/state partnership designed to amplify Black voices in the fight to secure reproductive justice for all.
- This organization partners with eight Black women's reproductive justice organizations to educate and mobilize Black people on abortion access, comprehensive sex education and contraceptive equity.
- Learn more here: https://blackrj.org/

Jane's Due Process

- Jane's Due Process helps young people in Texas navigate parental consent laws and confidentially access birth control and abortion care.
- Services include case management, legal support, and stigma-free sexual and reproductive health care.
- Learn more here: https://janesdueprocess.org/

Midwest Access Project

- Midwest Access Project works to ensure every person has access to high quality, comprehensive sexual and reproductive health care in their community.
- Services include individual clinical training, and provider and community education.
- Learn more here: https://midwestaccessproject.org/

National Association of Nurse Practitioners in Women's Health

- National Association of Nurse Practitioners in Women's Health (NPWH) is a national professional membership organization leading the way for women's health care across their lifetime.
- Learn more here: https://www.npwh.org/

National Family Planning and Reproductive Health Association

- National Family Planning and Reproductive Health Association (NFPRHA) is a membership organization representing providers committed to helping people get family planning education through training and advocacy.
- Learn more here: https://www.nationalfamilyplanning.org/

National Latina Institute for Reproductive Justice

- National Latina Institute for Reproductive Justice (the Latina Institute) fights for the fundamental human right to reproductive health care and justice. They center and amplify Latina/x voices, mobilize communities and drive policy change.
- Get involved here: https://www.latinainstitute.org/en/get-involved

National Network of Abortion Funds

- National Network of Abortion Funds works with members to remove financial and logistical barriers to abortion access and care.
- Learn more here: https://abortionfunds.org/

Northwest Portland Area Indian Health Board

- The Northwest Portland Area Indian Health Board (NPAIHB) is a tribal advisory organization serving the forty-three federally recognized tribes of Oregon, Washington, and Idaho.
- NPAIHB is engaged in many areas of Indian health, including legislation, health promotion and research.
- Learn more here: https://www.npaihb.org/

Physicians for Reproductive Health

- Physicians for Reproductive Health is an organization of doctors using evidence, training, and organized action for fundamental health care rights.
- They focus on abortion care, equitable access to contraception, comprehensive sex education, and defending/improving American's access to care services.
- Learn more here: https://prh.org/

Power to Decide

- Power to Decide provides trusted, high-quality information on sexual health and contraceptive methods to allow young people to make informed decisions.
- Get involved here: https://powertodecide.org/get-involved

Preterm

- Preterm works to advance reproductive health and justice by providing safe, respectful, and accessible abortion and sexual healthcare.
- Preterm is Ohio's only independent, non-profit abortion clinic.
- Learn more here: https://www.preterm.org/

Red River Women's Clinic

- The Red River Women's Clinic offers abortion care and family planning services to the Fargo-Moorhead area, all of North Dakota, Northwestern Minnesota and South Dakota.
- Services include abortion care, birth control education, emergency contraception, STI testing, pregnancy testing and miscarriage management.
- Learn more here: https://www.redriverwomensclinic.com/

Resources for Abortion Delivery

- Resources for Abortion Delivery (RAD) protects abortion access by investing charitable resources in the U.S. independent abortion sector.
- Learn more here: https://www.radprogram.org/index.php

SIECUS: Sex Ed for Social Change

- SIECUS advocates for the rights of all people to access and enjoy accurate and comprehensive sex education, information, and related health services.
- SIECUS creates policy briefs, advocacy tools, and hosts events related to sex education.
- To get involved, learn more here.

Sistersong

- Sistersong is a Southern based, national membership organization with a purpose to create a network to improve institutional policies and systems that impact the reproductive health of marginalized communities.
- Learn more here: https://www.sistersong.net/

Society for Adolescent Health and Medicine (SAHM)

- SAHM is a multidisciplinary organization working to improve the health and well-being of adolescents through advocacy, clinical care, health promotion and research.
- Learn more here: https://www.adolescenthealth.org/Home.aspx

Society of Family Planning

- Society of Family Planning fights for equitable abortion and contraception informed by science.
- Learn more here: https://societyfp.org/

South Asian Sexual and Mental Health Alliance (SASMHA)

- SASMHA seeks to celebrate the diversity of South Asian experiences and interrogate oppressive cultural values and traditions.
- Programs include Sexual and Reproductive Health, Racism & Anti-Blackness, and LGBTQ2S+ Issues & Sexuality.
- Learn more here: https://www.sasmha.org/

Southcentral Foundation

- Southcentral Foundation works together with the Native Community to achieve wellness through health services.
- Learn more here: https://www.southcentralfoundation.com/

Southern Birth Justice Network

- Southern Birth Justice Network works to make reproductive health care accessible to all – especially communities that are Black, Brown, youth, immigrant, indigenous, LGBTQ2S+, and low-income
- Learn more here: https://southernbirthjustice.org/

Unite for Reproductive and Gender Equity (URGE)

- URGE is driven by young leaders through campus chapters and Community Activist Networks. Members educate their communities and advocate for local, state, and national policy.
- Programs include integrated voter engagement, reproductive justice leadership and abortion positive campaigns.
- Learn more here: https://urge.org/

Whole Woman's Health

- Whole Woman's Health offers compassionate, affordable abortion care in-clinic and online and provides high-quality reproductive healthcare and advocacy for SRH rights.

- Learn more here: https://www.wholewomanshealth.com/

Young Women's Freedom Center

- Young Women's Freedom Center works to empower trans and gender-expansive young people who have been disproportionately impacted by incarceration, racist and sexist policy, and/or the underground street economy.
- Learn more here: https://www.youngwomenfree.org/

Policy priorities for promoting youth access to sexual and reproductive health services

Access to comprehensive, medically accurate, evidence-based sexual and reproductive health services is a cornerstone of adolescent health.

All people, regardless of age, race, gender identity, sexual orientation, marital status, socioeconomic status, or geographic location should have equitable access to sexual and reproductive health services.

Pediatric health clinicians, other medical professionals, public health professionals, and community members can advocate for policies that promote equitable access to sexual and reproductive health services for all youth.

Policy and advocacy priorities for promoting youth access to sexual and reproductive health services are outlined below. These strategies can be pursued at the community, state, or federal level.

Increase youth access to affordable, effective, evidence-based sexual and reproductive health services

Promote universal access to comprehensive sex education for all youth.

- Establish national standards for comprehensive sex education in schools that:
    - Provide medically accurate education around anatomy, sexual development, gender identity, sexual behavior, sexually transmitted infection (STI) prevention, and reproductive health care.
    - Teach skills and behaviors for healthy relationships, communication, consent, and decision-making
    - Address social pressures and influences from a trauma-informed and culturally responsive lens
    - Rely on evidence-based and developmentally appropriate curriculum.
    - Include tailored curricular materials that are responsive to the diverse needs of all historically disenfranchised and underserved.
- Encourage school-based comprehensive sex education programs that emphasize prevention of unintended pregnancy and sexually transmitted infections (STIs).
- Oppose abstinence-only sex education in schools.
- Oppose federal funding for abstinence-only sex education curriculum.
- Incentivize and support pediatricians and healthcare providers to provide comprehensive, developmentally appropriate, longitudinal sex education to children, adolescents, and young adults in the context of primary care.

Promote equitable access to contraception for all youth and young adults who are sexually active or considering becoming sexually active.

- Promote policies that reduce barriers to accessing contraception, including:
    - Mail-order purchasing of contraceptives without age-limits.
    - Encouraging FDA review of oral contraceptives for over-the-counter use, and approval for all age groups as supported by the data.
- Promote low-cost or free nonprescription access to emergency contraception, regardless of age and insurance coverage and without cost-sharing.
- Encourage federal agencies to make regulatory decisions around contraception based on sound evidence, not politics.

- Oppose policies limiting the distribution of contraception or emergency contraception on school property.

Promote equitable access to abortion for all youth and young adults who wish to terminate a pregnancy.

- Oppose legislative efforts to restrict access to abortion for adolescents and adults.
- Promote the expansion of access to medication abortion.
- Support the use of telehealth services for medication abortion.
- Support policies that prohibit interference in medical care and decision making.
- Support the codification of affirmative protections for abortion care in state and federal law.
- Oppose state policies designed to prevent people from seeking abortions by instating:
    - Logistical/financial burdens (e.g., mandatory waiting periods, requiring multiple clinic visits to obtain an abortion).
    - Interference in care delivery (e.g., mandatory ultrasounds, requirements to provide misleading information, or other clinical interventions that are not based in scientific evidence).
- Oppose laws that criminalize abortion for patients or providers.
- Oppose targeted restrictions for abortion providers or "TRAP" laws.

Promote adolescents' right to confidential care when accessing gender, sexual, and reproductive health services.

- Promote and incentivize confidential care and private, one-on-one time for all adolescent patients.
    - This includes promotion and incentivization of financial resources and reimbursement for additional staffing and longer patient visits to enable confidential time.
- Promote adolescents' right to confidential care when accessing contraception and abortion.
- Oppose mandatory parental consent and notification laws for sexual and reproductive health services, including abortion services.
- Oppose judicial bypass provisions for abortion care, as these do not ameliorate risk to adolescents and may delay access to safe and appropriate care.
- Promote and incentivize adolescent confidentiality protections in electronic health record (EHR) systems and insurance coverage and ensure confidentiality in billing and issuance of explanation of benefits (EOB).
    - Pharmacy benefits managers (such as SureScripts) can share information about contraception dispensed in school-based health centers with pediatric health clinicians, even when the young person's insurance is not paying for the contraception.
    - This promotion and incentivization includes confidentiality protections for immunization registries in states where youth who are sexually active and consent to receive the human papillomavirus (HPV) vaccine without parental consent.
- Oppose efforts to penalize/criminalize pediatric health clinicians and other clinicians for providing evidence-based, age/developmentally-appropriate gender, sexual, and reproductive health care. Pediatric health clinicians can consider collaborating with allied medical specialties and other youth advocates in opposition to such measures.

Support adolescent access to evidence-based, medically accurate sexual and reproductive health services in their communities.

- Support and incentivize the provision of clinical sexual and reproductive health services in schools and on college campuses.
- Support resources and funding for outpatient clinics providing comprehensive sexual and reproductive health services, including STI screening and treatment, contraception, pregnancy testing and care, pregnancy options counseling, and abortion services.
- Promote timely and complete HPV vaccination for adolescents.
- Oppose the provision of federal funding to crisis pregnancy centers.

Increase funding and resources to promote innovative care strategies for sexual and reproductive health services in medically underserved areas, including efforts to support:

- Telehealth services.
- Teleconsultation models.
- Collaborative or integrated care models.
- Health educators.
- Community health workers.

Strengthen linkages between medical settings, social services, and other youth-serving systems to address intersecting needs of youth and families where they are, including:

- Schools.
- Colleges, universities, and vocational settings.
- Primary and subspecialty care.
- Juvenile justice.
- Child welfare system.

Promote and incentivize clinician education and training in developmentally appropriate, gender-affirming, patient centered care for sexual and reproductive health services, including:

- Sexual development.
- Gender identity.
- Prevention of STIs and unintended pregnancies.
- Counseling, education, and provision of all safe and effective contraceptive methods.
- Provision and use of emergency contraception.
- Options counseling for adolescents who are pregnant.
- Reproductive justice in pediatric training.

Promote sexual, reproductive health, and reproductive justice competencies during training and in continuing medical education requirements across disciplines, including:

- Pediatricians.
- Adolescent medicine physicians.
- Family medicine physicians.
- Internal medicine physicians.
- Obstetrics/Gynecology.
- Primary care physicians.

- Subspecialty care physicians.
- Nurse practitioners.
- Nurses.
- Physician assistants.
- Community health workers.
- Other medical clinicians.

Address disparities in access to sexual and reproductive health services

Educate providers, policymakers, and the public on disparities in access to sexual and reproductive health services and the social, health, and economic impacts of these disparities.

Support policies that improve access to sexual and reproductive health services for communities of color and promote health equity.

Promote sexual and reproductive health care services in schools:

- Support funding to increase the workforce of school nurses, pediatric health clinicians, and other school-based health personnel to provide services in schools.
- Support programs to increase delivery of sexual health services, including STI screening, in schools and on college campuses.
- Promote trauma-informed care principles in schools.
- Provide incentives to ensure school-based health providers are adequately trained to recognize and respond to sexual and reproductive health needs.
- Normalize conversation about sexual and reproductive health in schools.

Promote sexual and reproductive health services for youth in the child welfare system:

- Ensure all youth entering the child welfare system have timely access to initial and ongoing comprehensive health assessments and all necessary services indicated during assessment, including the full spectrum of sexual and reproductive health services.
- Expand access to trauma-informed, evidence-based, and confidential community-based care for youth in the child welfare system.
- Promote education about adolescents' rights to sexual and reproductive health care for all foster parents, case workers, administrators, and youth involved in the welfare system.
- Promote policies to support youth involved in the child welfare system, including those with special health care needs, as they transition to adulthood and adult medical care.
- Promote training for caregivers and child welfare professionals in using trauma-informed care to provide support to youth who have experienced sexual abuse and exploitation, including trafficking.

Promote sexual and reproductive health services for youth in the juvenile justice system

- Promote efforts to ensure that confined youth receive at least the same level and standards of healthcare as non-confined youth accessing care in their communities.
- Support implementation of trauma-informed care in detention settings.
- Promote continuation of Medicaid coverage for youth while in juvenile detention.

- Support confinement facilities in recognizing and responding to the unique health needs of youth who are justice-involved, including those with chronic medical conditions and developmental needs.

Promote equity, diversity, and inclusion in sexual and reproductive health services

- Promote policies, training, and hiring practices to establish culturally and linguistically competent clinics, clinicians, and care navigators.
- Require anti-bias and cultural sensitivity training during medical training, continuing education, and board certification.

Encourage parental education and family involvement surrounding sexual and reproductive health

- Encourage family-centered gender, sexual, and reproductive health care with parental involvement or consultation with another trusted adult where appropriate.
- Provide parent education about adolescent gender, sexual, and reproductive development to foster improved outcomes for youth.
- Provide counseling for parents of youth with special health care needs to understand their unique gender, sexual, and reproductive health needs, including typical developmental behavior for children who are functioning cognitively at a level younger their chronological age and potential for increased risk for sexual abuse for specific subpopulations.

Foster healthy sexual development for youth and young adults

Encourage funding and resources for evidence-based community/school programs intended to increase knowledge of sexual health and support healthy sexual development in youth and families.

Increase funding for research to develop and scale up-stream interventions to promote sexual and reproductive health in youth and families.

Promote sexual and reproductive health in online spaces frequented by adolescents and young adults by incentivizing the promotion of evidence-based information and content and the removal of misinformation.

Support policies and programs that address and mitigate the underlying risk factors that can impact sexual and reproductive health, including:

- Poverty.
- Discrimination.
- Racism.
- Stigma.
- Gaps in access to health care.
- Gaps in insurance coverage.
- Gaps in education or school resources.

Increase funding and support for community programs that foster youth engagement, connection, and participation in activities to promote sexual and reproductive health.

Increase payment and insurance coverage for sexual and reproductive health services for youth

Ensure adequate payment to primary care providers for provision of appropriate sexual and reproductive health care to adolescents and young adults.

Support provider payment for sexual and reproductive health services, via development (if necessary), recognition, and appropriate valuation of codes used to report necessary services.

- Preventive services.
- Sexual and reproductive health screening and counseling.
- STI screening.
- Counseling around contraceptive options.
- Options counseling for pregnant adolescents.
- Telehealth for sexual and reproductive health services.
- Expedited partner therapy.
- Care management.
- Consultation services.
- Team-based approaches to care.

Incentivize screening and follow-up for sexual and reproductive health services at adolescent well-child visits.

Incentivize financially sustainable collaborative care models for sexual and reproductive health needs.

Support the development of payment models that better account for patient needs across specialties and clinical disciplines.

Preserve and extend public and private insurance coverage for sexual and reproductive health services for adolescents and young adults.

Build the sexual and reproductive health workforce

Increase availability of providers in medically underserved areas.

Increase diversity of sexual and reproductive health workforce.

- Support the development and funding of pipeline programs to increase diversity in the sexual and reproductive health workforce.
- Incentivize fellowship training and college programs to recruit diverse groups of students to pursue careers in sexual and reproductive health.
- Support the development and funding of programs that mentor diverse groups of people over the course of their education, training, and careers in sexual and reproductive health.

Increase provider knowledge and capacity in identifying and providing treatment for sexual and reproductive health needs.

Expand workforce training programs.

Recognize health educators, and community health workers as important members of the health care team providing sexual and reproductive health education.

Build the evidence base to address disparities in youth access to sexual and reproductive health services, including comprehensive sex education, contraception, and abortion

Expand funding for culturally informed research into sexual and reproductive health services.

- Understanding and addressing stigma around sexual and reproductive health.
- Establish and validate culturally and developmentally appropriate education, screening, and intervention programs to promote sexual and reproductive health.

Expand funding for research to increase access to sexual and reproductive health services for youth who are Black, Indigenous, Latinx, Asian-American, and other underrepresented, with a focus on studies that aim to:

- Identify risk and protective factors that influence sexual and reproductive health.
- Understand cultural views of sexual and reproductive health.
- Explore utilization, engagement, and attitudes toward sexual and reproductive health services.
- Adapt and validate existing screening tools for youth from diverse cultural backgrounds.
- Build, adapt, and validate evidence-based care pathways and interventions that are developmentally, culturally, and linguistically appropriate.
- Understand and address practical, systemic, and cultural barriers to sexual and reproductive health services.
- Understand the health and economic impacts of systemic barriers to care.

Expand funding for research to increase access to sexual and reproductive health services for youth who identify as lesbian, gay, bisexual, transgender, queer, questioning, or two-spirit (LGBTQ2S+), with a focus on studies that aim to:

- Identify risk and protective factors that influence sexual and reproductive health.
- Understand cultural views of sexual and reproductive health.
- Explore utilization, engagement, and attitudes toward sexual and reproductive health services.
- Adapt and validate existing screening tools for youth who are LGBTQ2S+.
- Build, adapt, and validate evidence-based care pathways and interventions that are developmentally, culturally, and linguistically appropriate.
- Understand and address practical, systemic, and cultural barriers to sexual and reproductive health services.
- Understand the health and economic impacts of systemic barriers in access to care.

Expand funding for research to increase access to sexual and reproductive health services for youth with special health care needs, with a focus on studies that aim to:

- Identify risk and protective factors that influence sexual and reproductive health.
- Explore utilization, engagement, and attitudes toward sexual and reproductive health services.
- Understand how to implement developmentally appropriate screening protocols, education, and health services for youth with disabilities.
- Understand the health and economic impacts of systemic barriers in access to care.
- Understand the intersectionality of sexuality, disability and health equity, including racism, gender dysphoria, and poverty.

Expand funding for research to understand the impact of policy changes on access to sexual and reproductive health services.

Require that research studies addressing sexual and reproductive health services include communities of color, LGBTQ2S+ populations, and other diverse populations in their sampling.

Promote diversity in sexual and reproductive health research:

- Prioritize diversity in allocation of grant funding and in study section membership, including race, gender identity, sexual orientation, and age.
- Encourage the continued investment and expansion of research programs that increase funding to researchers from underserved communities.
- Encourage researchers and funders to engage lower-resourced institutions that are more likely to support underserved communities.
- Prioritize efforts to enhance the workforce pipeline to engage new researchers from communities that are underrepresented in medicine and science.

Resources

This resource is designed to support pediatric health clinicians and other youth advocates in supporting and expanding access to sexual and reproductive health care for all youth while also supporting the inclusion of reproductive justice in pediatric care. It is a dynamic document that is meant to provide information that is current, accurate and easy to understand. As a consumer of this resource, you may bring lived experiences, areas of specialized studies, professional positions, and/or passion to this space and are therefore a valuable partner in this work. If, while engaging with this resource, you notice an outdated link or a missing resource or tool, please complete this form and your request will be reviewed by AAP staff.

AAP Policy and Resources

Policy statements to support this work:

- The Adolescent's Right to Confidential Care When Considering Abortion.
- Sexuality Education for Children and Adolescents.
- Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents.
- Promoting Healthy Sexuality for Children and Adolescents with Disabilities.
- Sexual and Reproductive Health Care Services in the Pediatric Setting.
- Options Counseling for the Pregnant Adolescent Patient.
- Diagnosis of Pregnancy and Providing Options Counseling for the Adolescent Patient.
- Emergency Contraception.
- Unique Needs of the Adolescent.
- Barrier Protection Use by Adolescents During Sexual Activity.
- Long-Acting Reversible Contraception: Specific Issues for Adolescents.
- Care of Adolescent Parents and Their Children.
- The Impact of Racism on Child and Adolescent Health.
- Health Care Issues for Children and Adolescents in Foster Care and Kinship Care.

Non-AAP Resources

There are many opportunities to partner with organizations who have existing expertise and structures to expand youth access to sexual and reproductive health care in your community.

A selection of resources for community-based sexual and reproductive health activities is listed below. This list is not intended to be exhaustive, and inclusion of programs should not be interpreted as official endorsement by AAP.

Comprehensive sex education:

- Advocates for Youth 3Rs curriculum.
- Advocates for Youth's Amaze program.
- Amaze: Educational Videos.
- amaze jr. videos.
- Awk Talk.

- CPS: *Sexual Health Education Policy.*
- Euki Sexual Health App.
- Future of Sex Education Initiative's National Sex Education Standards.
- Lifting Latinx Voices Initiative.
- Planned Parenthood: Roo Sexual Health Chatbot.
- Positive Prevention PLUS.
- SIECUS' Community Action Toolkit.
- Texas is Ready.
- *Three Decades of Research: the Case for Comprehensive Sex Education* by Goldfarb and Lieberman.
- United Nations Educational, Scientific and Cultural Organization (UNESCO) International technical guidance on sexuality education.
- US Office of Adolescent Health's *Checklist for Integrating a Trauma-Informed Approach Into Teen Pregnancy Prevention Programs.*
- WeRNative: Educational Videos

Contraception:

- Advocates for Youth's #FreeThePill Campaign.
- Coalition to Expand Contraceptive Counseling.
- Illinois Government: *Minors Access to Birth Control in Illinois.*
- National Women's Law Center CoverHer
- Oral Contraceptives OTC Working Group.
- Planned Parenthood's Direct App for birth control or UTI treatment without insurance.
- Planned Parenthood's Spot On app for tracking period, cycle, and birth control.
- Power to Decide's Advancing Contraceptive Access Toolkit.
- Power to Decide's BCBenefits.
- Power to Decide's Bedsider & Bedsider Provider Portal.
- Power to Decide's Contraceptive Desert Map.
- Addressing the Contraceptive Needs of Refugee Youth and Women.

Abortion:

- ACLU: Laws Restricting Teenagers' Access to Abortion.
- Access, Delivered Toolkit for Family Practice Providers.
- Advocates for Youth: Abortion and Parental Involvement Fact Sheets.
- Center for Reproductive Rights' *What if Roe Fell* Map.
- Guttmacher Institute State Laws and Policies Resources.
- House of Representatives' Women's Health Protection Act.
- If/When/How: Judicial Bypass Wiki and Judicial Bypass Convening Report.
- Jane's Due Process: Judicial Bypass and Pregnancy Resources.
- Kari White et al 2020 Study: *Parental Involvement Policies for Minors Seeking Abortion in the Southeast and Quality of Care.*

- Law Atlas Policy Surveillance Program Abortion Law Database.
- National Abortion Federation.
- National Network of Abortion Funds.
- North Dakota Women in Need Abortion Access Fund.
- Power to Decide's AbortionFinder.Org.
- RAD/RAAP, and RAAP's Medication Abortion by Telehealth: Legal Issues for Providers.
- Reproaction's The Fake Clinic Database.
- Repro Legal Helpline.
- RHEDI program.
- University of Georgia College of Public Health's CPC Map.

Sexual and reproductive health care:

- Advocates for Youth's Youth Leadership and Activism Programs.
- Bold Futures.
- Boston Children's Hospital's Center for Young Women's Health.
- California Latina's for Reproductive Justice.
- CDC's Teen Access and Quality Initiative (TAQ).
- Center for Reproductive Rights.
- Congressional Black Caucus' Black Maternal Momnibus Act of 2021.
- Expanding medical education and training programs to become more holistic and integrate reproductive health care into all care:
    - The RHEDI program and Innovating Education in Reproductive Health are 2 good models.
- Guttmacher Institute.
- Guttmacher Institute: *State-by-State Minor Consent Laws Overview.*
- Guttmacher Institute: Teenagers' Access to Confidential Reproductive Healthcare Services.
- Healthy Native Youth – Implementation Toolbox.
- Healthy Native Youth – Resources and Support.
- Hoosier Action.
- Illinois Department of Public Health: *Illinois National Electronic Disease Surveillance System.*
- Illinois Government: *Minors Access to Health Care Services in Illinois*
- Indigenous Women Rising.
- National Academies Report, *Promoting Positive Adolescent Health Behaviors and Outcomes.*
- National Academies Report, *The Promise of Adolescence: Realizing Opportunity for All Youth.*
- Northwest Portland Area Indian Health Board: Celebrating Our Magic Toolkit.
- Northwest Portland Area Indian Health Board: Paths (Re)membered Project Gender Diverse Resources.
- Planned Parenthood affiliates.
- Protecting Privacy to Promote Interoperability Workgroup.
- Quality and Access for Reproductive Health Equity for Teens (QARE for Teens Project).
- RHAP Video Overview.

- SiX (State Innovation Exchange).
- Sonya Rahder's course, *Policy in Human Sexuality: Cutting-Edge Analyses.*
- Teen Doula Project from Perinatal Safe Zone: Supporting Healthier Pregnancies Together, with training provided by Doula Trainings International.
- WeRNative.
- Reproductive Health Access Project, which trains and supports clinicians to make reproductive health care accessible to everyone.

Best practices to deliver sexual and reproductive health care to adolescents:

- Advancing New Standards in Reproductive Health (ANSIRH) research on OTC medication abortion.
- Advocates for Youth's Virtual Professional Development .
- CDC resource: Teen Health Services and One-On-One Time with A Healthcare Provider.
- Examples of trauma-informed approaches include the Teen Pregnancy Prevention Programs Checklist from the Office of Adolescent Health.
- Family Planning National Training Center's *Counseling Adolescents Seeking Family Planning Services: A Checklist for Providers.*
- National Clinical Training Center for Family Planning podcasts.
- Nursing License Map's blog, *How to Use Inclusive Language in Healthcare.*
- PATH Framework for Clarifying Reproductive Goals and PATH Questionnaire.
- Physicians for Reproductive Health's Advocacy Training, Medical Education and Direct Physician Support resources.
- Power to Decide's One Key Question.
- Reproductive Health National Training Center's Telehealth Etiquette for Family Planning Visits.
- Some youth may experience discomfort in verbally communicating their needs; alternative measures (pen/paper, texting, tablet-based questionnaire, the Q Card Project) may help.
- *UCSF's Guidelines for Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.*
- University of Michigan's Adolescent Health Initiative's LGBTQ+ Youth Spark Training Series.
- University of California San Francisco's Beyond the Pill Trainings.

Other resources:

- The Health Improvement Project for Teens (HIPTeens) program adapted an evidence-based sex risk reduction program for implementation with girls who are refugees.
- The Hellooo America miniseries explores the often-stigmatized conversations around sexual health and rights in the community of refugee youth.
- A Black Mama's Guide to Living and Thriving discusses mental health, self-love, pleasure, nourishment, financial wellness, and "#ReclaimingBlackBirth."

Acknowledgements

This resource was authored by the American Academy of Pediatrics (AAP). The content and strategies outlined herein were developed at the *2021 Summit on Youth Access to Reproductive Health Care*, hosted by AAP in September 2021, and received critical contributions and comprehensive review by experts who have lived experiences, areas of specialized studies, and professional positions in sexual and reproductive health.

AAP would like to extend a special thank you to the Collaborative for Gender and Reproductive Equity (CGRE) for their generous support in funding this work.

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AAP would like to thank the following individuals for their meaningful contributions to this work. We thank you for your time and expertise. (Please note, affiliations were accurate at the time of the *2021 Summit on Youth Access to Reproductive Health Care.)*

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AAP would like to thank the following AAP member groups for their critical contributions in reviewing this resource:

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- AAP Council on Community Pediatrics
- AAP Council on Foster Care, Adoption, and Kinship Care
- AAP Council on School Health
- AAP Section on Adolescent Health

- AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness
- AAP Section on Telehealth Care

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AAP would like to thank the following individuals and organizations for participating in the *2021 Summit on Youth Access to Reproductive Health Care*. We appreciate your vulnerability and thank you for your passion to support and expand access to sexual and reproductive health care for all youth. (Please note, affiliations were accurate at the time of the *2021 Summit on Youth Access to Reproductive Health Care.)*

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