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Examining clinical personnel's roles in facilitating person-centered abortion care for minors in the Southeastern United States

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An Abstract of a Thesis
Submitted to the Rollins School of Public Health
Emory University
in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Health

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Abstract

Abortion care is extremely stigmatized in the United States. While abortion for adults is more commonly discussed in scientific literature, in comparison, abortion care for young people specifically may be overlooked. As clinical personnel play an important role in supporting young patients, this thesis sought to explore clinical personnel's perspectives on their roles in providing person-centered care for young people seeking an abortion. More specifically, this thesis used secondary qualitative data on abortion providers' narratives to answer the question: how do clinical personnel's self-perceived roles, responsibilities, and interactions facilitate person-centered reproductive health equity for young people under the age of 18 seeking an abortion in the Southeastern United States? Findings highlight four key themes of person-centeredness that are facilitated by abortion providers: dignity/autonomy, privacy/confidentiality, communication, and support. Abortion providers play mediatory roles between young patients and parents to ensure that decisions are patient-led and free of coercion. Abortion providers also facilitate privacy for young patients by periodically separating patients and parents at the clinic. To ensure young patients can receive the care they desire, providers spend much of their time explaining parental involvement laws and providing logistical support so patients fulfill the requirements. This thesis argues that parental involvement laws impose challenges for person-centeredness in abortion care for both patients and providers and explores recommendations for facilitating person-centered care under the current political environment.

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Chapter I. Introduction

Abortion in the Southeastern United States

Abortion access in the United States is regulated by various policies set by each state. The Southeastern United States (defined here as Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia) is one of the most hostile regions toward abortion in the country. The majority of Southeastern states prohibit abortions after 20 weeks of pregnancy (dating post-fertilization), with a few setting the limit to 24 weeks (Table 1). Many states also require patients to receive counseling and to wait at least 24 hours after counseling before receiving their abortion procedure (Table 1). People seeking an abortion need to search for abortion-specific facilities, especially when the large majority of Southeastern states allow providers and institutions to refuse to provide and/or participate in abortion care. Due to the complex regulations, patients have to navigate gestational limits, limited funding options, waiting periods, and other laws set by the state before receiving an abortion.

Extensive and restrictive abortion laws in the United States may limit patients' access to abortion care, especially for young patients, as they are required to include parents in the process due to parental involvement laws. Thirty-seven states require parental consent or notification before a person under the age of 18 can receive an abortion, including the majority of Southeastern states – which require consent from at least one parent (Table 2; Figure 1). A few states also require parents to show identification and proof of parenthood when giving parental consent, which may add another complication during the care-seeking process.

When young people cannot receive support from a parent or legal guardian, individuals may seek a judicial bypass to obtain approval of their decision to have an abortion from the court

instead. Although the judicial bypass provides an alternative pathway for some young people, it also requires additional effort to navigate. In some states, young people who wish to obtain a judicial bypass need to first obtain a sonogram from the clinic, as well as appear before a judge for a hearing to determine if the decision to have an abortion is either 1) in the best interests of the young person or 2) the young person is mature enough to make the decision themselves. Requirements regarding granting a judicial bypass also vary across states, and the requirements are not always clear for young patients (Floridians for Reproductive Freedom; Jane's Due Process). For example, Florida requires that young people prove to the judge that they are mature enough to make the decision using "clear and convincing evidence," which is unspecified in the law and therefore up to each judge's interpretation (Floridians for Reproductive Freedom). If the judge grants a judicial bypass, a young person can schedule an abortion appointment with a clinic.

Problem Statement

Southern states have been identified as more hostile to abortion rights than other regions of the country (Figure 2). The widening gap in abortion policies by regions also sheds light on the polarized lived experiences in the United States. As of 2021, a total of 1,338 abortion restrictions have been enacted since *Roe v. Wade* in 1973; among all the restrictions, 44% were enacted in the past year (Nash, 2021b). One of the most hostile regulations introduced in 2021 was Texas' six-week abortion ban, which the Supreme Court has since refused to block.

Young people are a small but important group that requires abortion services. Around 60% of abortion patients are in their 20s, and 16% of them are under the age of 20 (Jerman, Jones, & Onda, 2016). Given their age, legal status, and stage of emotional development, young people may face unique barriers when seeking an abortion. For example, as young patients take,

on average, seven weeks to learn of their pregnancy, early gestational age limits often simulate a total ban on abortion (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2006). Therefore, it is important to better understand young people's experiences in the current abortion care-seeking pathway and provide appropriate support to young patients.

Young people's perceived barriers to obtaining an abortion are frequently documented in the literature. First, the logistical requirements young people must comply with (such as document requirements, procedural costs, and arrangements for visiting abortion facilities) are one of the most reported barriers (Bearak, Burke, & Jones, 2017; Coleman-Minahan, Stevenson, Obront, & Hays, 2019; Finer et al., 2006; Guendelman, Yon, Pleasants, Hubbard, & Prata, 2020; Kavanaugh, Jerman, & Frohwirth, 2019; Pleasants, Guendelman, Weidert, & Prata, 2021; Upadhyay, Weitz, Jones, Barar, & Foster, 2014). Second, the lack of perceived support from family, community members, and the judicial system is also a common reason that makes the abortion-seeking process even more daunting for young people (Biggs, Brown, & Foster, 2020; Foster, Kimport, Gould, Roberts, & Weitz, 2013; Kavanaugh et al., 2019; Rocca, Samari, Foster, Gould, & Kimport, 2020).

Clinical personnel play an important role as advocates for young abortion patients, with the ability to mediate these potentially adverse experiences. Previous studies have thoroughly examined abortion-seeking experience from the patient's perspective, but less is known about how abortion clinical personnel perceive their roles when supporting young patients. Examining clinical personnel's self-perceived roles and responsibilities in abortion care could help further assess abortion care quality for young people and explore potential unmet needs in the United States.

Theoretical Framework

According to the Institute of Medicine's healthcare quality framework, there are six domains that characterize quality care in clinical settings: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (Institute of Medicine, 2001). Tailoring patient-centeredness (i.e., person-centered care) to reproductive health care, the World Health Organization (WHO) conceptualized the bidirectional process between providers' provision of care and patients' experience of care (Tunçalp et al., 2015); more recently, this conceptualization has informed the Person-Centered Care Framework for Reproductive Health Equity (i.e., the Reproductive Health Equity Framework) by Sudhinaraset et al. (2017), which I used as the conceptual framework for this thesis. This is a relatively new framework that describes multilevel factors that all contribute to one's reproductive health outcomes.

To encompass the complexity of reproductive health care, the Reproductive Health Equity Framework pulls from three models that describe different socio-ecological factors (Sudhinaraset et al., 2017). First, WHO's Quality of Care for maternal and newborn health (Tunçalp et al., 2015) is incorporated because support and health services provided at abortion clinics play an influential role in mitigating a person's experience in abortion care. Second, the Cultural Health Capital theory (Dubbin, Chang, & Shim, 2013) connects social experiences with individual care-seeking behaviors because perceived barriers and other personal considerations also influence people's help-seeking pathway. Finally, societal and community-level determinants such as gender norms, ethnicity, stigma, and social capital can impose great barriers to some people's experience during the care-seeking process for reproductive health (Sudhinaraset et al., 2017). Consideration of these structural inequities allows the Reproductive Health Equity Framework to account for inequities in reproductive health.

The Reproductive Health Equity Framework underscores the relationship between the experience of care and health outcomes at the health facility level. While the eight domains – dignity, autonomy, privacy/confidentiality, communication, social support, supportive care, trust, and abortion facility environment – for person-centered care are not mutually exclusive, each identifies an important aspect of care that should be present (Figure 3). While most person-centered reproductive care frameworks were initially developed for maternal health care in low- and middle-income countries, the authors anticipated the Reproductive Health Equity Framework to be applied in other reproductive contexts such as family planning and abortion care.

To further tailor WHO's Quality of Care in the Reproductive Health Equity Framework, Sudhinaraset et al. (2017) redefined domains under the context of reproductive health. For this thesis project, domain definitions are adapted once more for abortion patients under the age of 18 (as illustrated in Table 3). For example, in this study, dignity captures the respect young patients should receive during abortion care, and autonomy describes young patients' ability to make informed choices. Privacy and confidentiality in this context should be consistent with the same concept for adult patients, which considers patients' right to discreet communication with health care professionals and confidentiality of medical records. In terms of communication, clinical personnel may tailor their communication methods for young patients. This consideration connects closely with the supportive care and trust domains, as clinical personnel attempt to provide care compassionately.

Research Goal and Question

Abortion care is extremely stigmatized in the United States. The lack of open and honest conversations surrounding abortion care can contribute to misconceptions around care among

those seeking an abortion (Foster et al., 2013; Kavanaugh et al., 2019). Furthermore, stigma against abortion will continue to discourage abortion patients from asking for and receiving support from their communities (Biggs et al., 2020). While abortion for adults is more commonly discussed in scientific literature, in comparison, abortion care for young people specifically may be overlooked. As attitudes and self-perception of clinical personnel's support for young people patients are understudied, this thesis sought to explore clinical personnel's own perspectives of their roles in providing person-centered care for young people seeking an abortion. More specifically, this thesis sought to answer the question: how do clinical personnel's self-perceived roles, responsibilities, and interactions facilitate person-centered reproductive health equity for young people under the age of 18 seeking an abortion in the Southeastern United States? In this study, I explored this question using in-depth interviews with abortion providers from Southeastern states.

Chapter II. Literature Review

Current literature on young abortion patients, particularly people under the age of 18, is extremely disaggregated and limited our understanding of this population. First, the current demographic data on young abortion patients is insufficient and lack insight into nuances in identities due to blanket categories for race, ethnicity, and other socioeconomic characteristics. Second, the variability in age group categorization among different studies contributes to the difficulty of generalizing patterns to minors. In this literature review, young people are defined as people under the age of 20 to include relevant literature that used broader age groups.

Abortion Trends in the United States

Since 1980, abortion rates among people in the United States have slowly declined. In 1980, the abortion rate among people capable of pregnancy in the United States was 29.3 per 1,000 people (Maddow-Zimet & Kost, 2021). By 2018, the abortion rate had reached 13.5 per 1,000 people. Looking at the total number of abortions per year, the number of individuals who received an abortion went down from 1,553,890 in 1980 to 862,320 in 2017 (Maddow-Zimet & Kost, 2021). Over the years, the abortion rate has consistently been the highest among people aged 25-29 (23.5 per 1,000 people), with lower rates for people in younger and older age ranges (Jones & Kavanaugh, 2011; Maddow-Zimet & Kost, 2021). In 2017, the abortion rate among people under 18 and over 40 ranged between 1.0 and 3.7 per 1,000 people (Jones & Kavanaugh, 2011). Across all age groups, the abortion rate for young people has seen the largest reduction (Jones & Jerman, 2017b). Between 2008 and 2014, the abortion rate for young people aged 15-17 declined by 56%, from 11.8 to 5.2 abortions per individual. By 2014, people aged 15-17 comprised 3.4% of all abortion patients in the United States, the second lowest group after people above 40 years old (Jerman et al., 2016; Jones & Jerman, 2017b).

While abortion rates among young people are declining, wider gaps between needs and availability of abortion services in the South suggest lack of accessibility of abortion care in this region. The discrepancy between abortion rates among young people and number of abortion clinics varies by state. Florida has one of the highest abortion rates among people aged 15-19 (9.1 per 1,000 people), but the state also lost six abortion clinics (dropping from 71 to 65 clinics) since 2014 (Jones, Witwer, & Jerman, 2019; Maddow-Zimet & Kost, 2021). Other states in the Southeast such as Georgia and North Carolina also reported relatively high abortion rates among the same population, along with two abortion clinics closing since 2014 (Jones et al., 2019; Maddow-Zimet & Kost, 2021). North Carolina, specifically, lost 30% of abortion providers between 2014 and 2017 (Jones et al., 2019).

Demographic Characteristics of People Receiving Abortions

Patients who receive abortions in the United States differ by demographic characteristics, notably race and ethnicity. For example, in 2014, non-Hispanic Black people aged 15-44 had the highest abortion rates in the United States, whereas non-Hispanic white people had the lowest abortion rates; furthermore, the abortion rate among non-Hispanic Black people was more than two times the rate among non-Hispanic white people (Jones & Jerman, 2017b). The racial disparity was more extreme among young people aged 15-19, where the abortion rate among non-Hispanic Black people was almost four times the rate among non-Hispanic white people in 2013 (Kost, Maddow-Zimet, & Arpaia, 2017). While the gap had narrowed in the past decade, the racial disparity in abortion care persists.

Abortion rates also vary drastically by patients' economic status. In the United States, 24% of U.S. residents aged 15-49 are uninsured, but 75% of abortion patients are low-income (Jerman et al., 2016; Sonfield, 2021). In the Southeast, the financial disparity is also similar; 87%

of abortion patients needing financial support from an abortion fund (mostly created by local grassroots organizations to support various needs related to logistical arrangements for abortions) have public insurance or are uninsured (Rice, Labgold, Peterson, Higdon, & Njoku, 2021). The intersection between race/ethnicity and income is also significant among people who received abortions. In 2008, the abortion rate was highest among non-Hispanic Black people with low-income (Jerman et al., 2016; Jones & Jerman, 2017b). Funding support in the Southeast also showed a consistent pattern, with over 80% patients identifying as non-Hispanic Black (Rice et al., 2021).

The racial and economic disparity in abortion care is consistent with disparities in other reproductive health indicators, suggesting that racism and social inequities play a larger role in this differential pattern (Prather, Fuller, Marshall, & Jeffries, 2016). Dehlendorf, Harris, and Weitz (2013) argue, as discrimination stemming from racism consistently contributes to various negative health outcomes across multiple populations, discrimination as an expression of racism at the societal level also explains the disparities in abortion rates (Williams & Mohammed, 2009). Furthermore, Dehlendorf et al. (2013) also highlight the deprivation in neighborhood resources as an additional factor that contributes to the disparate pattern in abortion rates. In addition to community-level determinants, policy could also accentuate abortion disparities in the United States. For example, Georgia's House Bill 954 that shortened gestational limit to 22 weeks in 2012 disproportionality impacted Black people as the abortion rate at or after 22 weeks dropped from 7.09 abortions per 1,000 births in 2007 to nearly zero in 2017, compared to the abortion rate for white people that dropped from 4.07 to also nearly zero during the same time period (Hall et al., 2020; Mosley et al., 2022).

Reasons for Abortion

Individuals who choose to terminate their pregnancies may come to this conclusion based on various considerations. First, many people may not be able to adjust their current lifestyles to become a parent, especially when education is still a significant priority for many in younger age groups (Biggs, Gould, & Foster, 2013; Coleman-Minahan, Stevenson, Obront, & Hays, 2020; Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005). Having a child can create barriers for young people to continue school, which can influence their career plans and future opportunities.

Becoming a parent also creates financial burdens for most individuals, especially relevant for young people who may not be financially independent. In one study, young women expressed their desire to become a parent only when they can provide for a child; participants recognized that financial stability is a key component to achieving that goal (Coleman-Minahan et al., 2020).

Abortion patients also express lack of social support as a reason for choosing an abortion. Young people who are still dependent on their families may not feel ready to parent on their own, particularly if they also lack support from a partner (Coleman-Minahan et al., 2020; Finer et al., 2005). Furthermore, young people may fear damaging their relationships with their families, specifically parents (Coleman-Minahan et al., 2020). Some young people also wish not to raise a child in the same unhealthy domestic environment that they grew up in (Coleman-Minahan et al., 2020; Hasselbacher, Dekleva, Tristan, & Gilliam, 2014). Overall, the decision to have an abortion is often a thoughtful and mature one made by young people to maintain stability in their lives.

Abortion Care Journey

Seeking an abortion is often an unfamiliar process, especially for young people. Out of young people aged 15-17, around 93% were seeking abortion care for the first time (Jones & Jerman, 2017b). Young people are likely to learn about their pregnancy status later, which can contribute to longer waiting periods before seeking abortion services. The average amount of time to pregnancy discovery for young people under the age of 18 is 54 days since their last period, which is 10 more days compared to the average for most abortion patients (Finer et al., 2006). One of the reasons for delayed pregnancy awareness is because young people often commonly mistake their early pregnancy symptoms with irregular menstrual cycles (Foster, Heather, & Biggs, 2021; Upadhyay et al., 2014). For example, some would misidentify spotting from an early pregnancy as a light period (Foster et al., 2021). A small number of people may also experience delayed confirmation of pregnancy status because they are in denial of being pregnant (Foster et al., 2021). Delay in pregnancy awareness imposes barriers to accessing abortion services for young people, especially in states that prohibit abortion after a shorter length of pregnancy.

After learning about their pregnancy, young people often include people from their support network to navigate the care pathway together. In general, young people are more willing to disclose their pregnancy with people who they know will be unconditionally supportive (Coleman-Minahan et al., 2020; Hasselbacher et al., 2014). Most young people prefer to involve their parents if they feel that it will not severely damage their relationships (Hasselbacher et al., 2014). If parents are not perceived as supportive, patients often still seek consult from other trusted adults such as partners or other family members (Friedman, Hendrix, Haberman, & Jain, 2015; Hasselbacher et al., 2014). Most young people, especially older

adolescents, will also include a partner in the process (Hasselbacher et al., 2014; Ralph, Gould, Baker, & Foster, 2014). On the other hand, younger patients will more often involve only their parents and not a partner (Ralph et al., 2014).

Parental involvement in young people's abortion decision may compromise patient-led decision-making. Studies indicate that roughly one or two out of ten young patients may experience pressure from their mothers to seek an abortion (Henshaw & Kost, 1992; Ralph et al., 2014). According to a study focusing on minor abortion patients, more parents favored young people to seek an abortion, around 15% of parents expressed preference for young people to not seek an abortion (Henshaw & Kost, 1992). Furthermore, not all individuals to whom young people disclose pregnancy are supportive, and unsupportive parental involvement may contribute to worse emotional wellbeing. Young patients who did not receive support from mothers are more likely to feel sad or ashamed about their decision to get an abortion than those who did not receive negative parental reactions (Ralph et al., 2014). A small number of young patients also recalled receiving unsupportive attitudes in healthcare settings. When recalling her experience receiving an abortion at 15 years old, one adult interviewee from a qualitative study described insensitive comments made by her abortion provider that left her feeling "judged" (Altshuler, Ojanen-Goldsmith, Blumenthal, & Freedman, 2017).

Overall, young people may go through a complex journey to arrive at the decision to get an abortion (Finer et al., 2006; Ralph et al., 2014). A little over a quarter of young patients find this to be a difficult decision that takes time to process (Finer et al., 2006). Although this is a difficult choice to make for people at a young age, most patients feel a strong sense of relief after getting an abortion (Ralph et al., 2014). Around 36% of young people will feel some sadness, but the sense of relief is much stronger as they know it is the right decision (Ralph et al., 2014).

Barriers to Seeking Abortion Care

The physical and social environment imposes many barriers to successfully seeking abortion care. One common challenge that abortion patients may experience is the absence of correct and widely available information on abortion. A recent study assessing the quality of abortion pill information found that only the most-searched page online, created by Planned Parenthood, meets expectations for educational content and user experience (Pleasants et al., 2021). All other popular sources presented much lower quality information and even misinformation on abortion options (Pleasants et al., 2021). Lack of helpful resources online can be more harmful to people who live in states with more restrictive abortion laws. A study found more online searches for information on abortion and the abortion pill from states with more abortion restrictions such as Mississippi (Guendelman et al., 2020). Higher rates of self-searching for abortion information suggest that abortion restrictions do not stop people from seeking care options; instead, it may provide more opportunities for misinformation. When abortion information is not widely available, people of all ages often need to learn the process as they go, prolonging the care-seeking journey (Finer et al., 2006; Kavanaugh et al., 2019; Upadhyay et al., 2014).

Abortion patients, especially young people, may also find it difficult to reach an abortion facility due to logistical and financial burdens. Over half of all young people under the age of 18 mention logistical difficulties as a barrier to seeking abortion care (Finer et al., 2006). First, the accessibility of abortion facilities is extremely limited in most counties in the country, especially in the South and the Southeast. The median distance to abortion services in Southern states ranges from 15 to 89 miles, compared to the Northeast and the West, where the median distance is mostly under 15 miles (Bearak et al., 2017). Higher proportions of people from the South are

also living in a county without an abortion provider. In the United States, 34% of people aged 15-44 live in a county without an abortion provider. On the other hand, 91% of people aged 15-44 in Mississippi and 62% in Tennessee live in counties without an abortion provider (Frost, Frohwirth, & Zolna, 2016).

Second, high abortion fees, coupled with restrictive state laws on abortion funding, can contribute to delayed care. A national study found cost as a significant reason for which an abortion patient would receive care in the second trimester or be turned away due to gestational age limit (Upadhyay et al., 2014). The financial burden disproportionally impacts low-income abortion patients. Abortion patients below 200% of the federal poverty level took longer to make arrangements, including securing funds, for their abortion appointments (Finer et al., 2006).

Logistical burdens (such as document requirements, procedural costs, and arrangements for visiting abortion facilities) can be a critical factor that deters people from seeking abortion services. A study focusing on people living in rural communities found that some people decide to continue their pregnancy when they think seeking abortion services is not a feasible option (O'Donnell, Goldberg, Lieberman, & Betancourt, 2018). Another study focusing on young people also found that different rates of unintended pregnancies ended in abortion by urbanicity. While 16% of unintended pregnancies ended in abortion for young people living in urban areas, only 7% of the same group ended in abortion for those living in rural areas (Sutton, Lichter, & Sassler, 2019). Logistical and financial burdens not only deter people from seeking abortion care but also negatively impact people’s mental health. A study found that stress levels are higher for abortion patients seeking care later in pregnancy, suggesting an association between logistical burden and negative emotional outcomes (L. F. Harris, Roberts, Biggs, Rocca, & Foster, 2014).

In addition to common barriers on the abortion care-seeking pathway, young patients under the age of 18 may also face additional challenges when trying to fulfill parental involvement law requirements. For those seeking judicial bypass to waive parental involvement requirements, process can be complex and burdensome to navigate. Young people may need to find time off from school to attend court hearings and other preparation sessions. Furthermore, the process can be unpredictable and lack transparency in steps and outcomes (Coleman-Minahan et al., 2019).

Abortion Stigma

Abortion stigma can be defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar, Hessini, & Mitchell, 2009). Patients seeking abortion regularly experience abortion stigma from their communities (Kavanaugh et al., 2019). A little over half of abortion patients expect that people close to them as well as those from their community would look down on them had they known about their abortion (Biggs et al., 2020). In addition to stigma from familiar community members, patients also expect to experience stigma in the care pathway. Before entering abortion facilities, patients often encounter protesters that may be present outside of abortion clinics (Biggs et al., 2020; Foster et al., 2013). The level of engagement with protesters can influence the degree of individual-level (also known as self- or intrapersonal) abortion stigma experienced by patients; people who are stopped by protesters report significantly higher self-perceived stigma than those who did not interact with protestors (Biggs et al., 2020). People's experience of stigma can also differ by culture, and specifically by religion. Those living in abortion-unfriendly regions or with people of strong Protestant or Catholic identities experienced stronger perceived stigma (Biggs et al., 2020).

Perceived abortion stigma also differs by racial identity. In general, non-Hispanic white women had higher perception of abortion stigma than non-Hispanic Black and Hispanic women. The disparity is larger by abortion status, with higher perceived stigma among people who reported having had an abortion (Bommaraju, Kavanaugh, Hou, & Bessett, 2016). It is important information for health care professionals to acknowledge these disparities when interacting with people with different lived experiences.

Abortion stigma also negatively influences abortion patients' psychological well-being. Patients who experience high levels of perceived abortion stigma are almost four times more likely to experience psychological distress than patients not experiencing stigma (Biggs et al., 2020). Another study found that regardless of abortion patients' age, around half of the people who saw, heard, or were stopped by protesters expressed some level of upset feelings (Foster et al., 2013). In general, perceived abortion stigma exacerbates negative emotions, specifically sadness, during abortion care pathway in the short term (Rocca et al., 2020).

Perceived abortion stigma is frequently stronger for young people compared to adult abortion patients (Biggs et al., 2020). For instance, young patients may be more likely to get stopped by protesters when entering the abortion clinic building (Foster et al., 2013). Considering geographical differences, young people in the South may be more at risk for experiencing abortion stigma; protesters in the South have been perceived as more aggressive than ones in other regions of the country (Biggs et al., 2020; Foster et al., 2013). Young people seeking judicial bypass also often experience abortion stigma at court. When presenting their case, some young people feel that judges are judgmental and discredit their maturity (Coleman-Minahan et al., 2019). Overall, the process can be perceived as a form of punishment that shames young people seeking abortions (Coleman-Minahan et al., 2019).

Long-existing abortion stigma in the United States may also deter people from speaking up about their experience after receiving an abortion. When abortion patients are asked for an interview, only 40% of them agreed to face-to-face interview compared to computer-assisted interview, which is more private (Maddow-Zimet, Lindberg, & Castle, 2021). The preference to not disclose one's abortion status may be due to social expectation that people who become pregnant should raise the child. When asking about the perception of unintended pregnancy and abortion, many young people from the South agreed that there is social judgement for those who choosing abortion or adoption instead of parenting (Smith et al., 2016).

Abortion Care Environment

Abortion care quality is assessed considering various components, including but not limited to restrictive laws, accessibility by distance, and perceived support in the clinical provision of care. Restrictive regulations around abortion care can perpetuate stigma and influence abortion care quality. For example, abortion clinics in states with more restrictive regulations around abortion face more difficulty obtaining Medicaid reimbursements for abortion patients (Dennis & Blanchard, 2013). Continuous delays in reimbursement can affect the sustainability of providing abortion services at these clinics. Restrictive policies can also directly impact abortion patients' timing to receive care. When a shorter gestational age limit is implemented, the number of second-trimester abortions significantly decreased, suggesting that a larger proportion of people wishing to seek care failed to do so (Hall et al., 2020; White, Baum, Hopkins, Potter, & Grossman, 2019).

Abortion care quality is also determined by physical accessibility. First, the availability of abortion services varies drastically by state. States hostile to abortion have half the number of facilities compared to places with less restrictive laws; however, over half of all abortions in the

U.S. are performed in hostile states (Jones, Ingerick, & Jerman, 2018). The disparity in accessibility by distance is also more common in the South. The number of abortion facilities in the United States decreased by 13% between 2011 and 2014, and 93% of counties in the South do not have an operating abortion clinic (Jones & Jerman, 2017a). More concerning, there is only one abortion clinic operating for all 82 counties in Mississippi (Jones & Jerman, 2017a). The imbalance between service and needs may present a difficulty in securing a timely abortion appointment in restrictive states. When the number of facilities go down, the number of abortions at later gestational ages may increase due to more delayed care (White et al., 2019). Challenges related to abortion access disproportionally hurt low-income individuals. In the Southeast, 38% of abortion patients in need of fund support are at least 50 miles away from an abortion facility (Rice et al., 2021).

In addition to challenges in reaching an abortion facility, perceived support for reaching abortion services from the general healthcare professional community is somewhat inconsistent. Overall, providers may consider patients' reasons for abortion before deciding whether to provide abortion services, and the decision could be influenced by providers' personal beliefs (L. H. Harris, Cooper, Rasinski, Curlin, & Lyerly, 2011). For example, a female provider may be less likely to deny abortion care and more likely to provide abortion care even when they disagreed with patient's abortion decision, compared to male counterparts (L. H. Harris et al., 2011). Healthcare providers' attitudes towards abortion also differ by region. Providers in the Northeast and West are more willing to administer abortion services than those in the Midwest and South. Specifically, only 3% of obstetrician-gynecologists in private practices performed abortion in the South (Desai, Jones, & Castle, 2018). Even in hospital settings, some clinical staff refuse to support abortion procedures due to personal beliefs on abortion (Bennett et al., 2020; L.

H. Harris et al., 2011). Hesitancy to provide abortion services by the general healthcare community is often picked up on by patients. A qualitative study found that abortion patients perceive the healthcare community to be an unhelpful source of support during their care-seeking pathway, especially when providers refuse to provide the service (Kavanaugh et al., 2019).

Among healthcare professionals willing to provide abortion services, the literature documents tailored care as supporting patients navigating the care pathway. Since patients may not have correct information about abortion, phone counseling scripts with accurate information can help decrease endorsement of abortion myths by patients (Berglas et al., 2017). Healthcare professionals expressing respect for abortion patients can also help foster emotional comfort during the care-seeking process (Altshuler et al., 2017). These empathetic actions show the positive influence of patient-centeredness on patients' overall experience with abortion care.

Further research is needed to systematically assess how abortion care aligns with patient-centered frameworks, particularly in the South and Southeast. Using the Institute of Medicine's healthcare quality framework, White et al. (2021) assessed the role of abortion regulations, specifically parental involvement laws, on abortion clinic staff's experience providing abortion services to young patients. The qualitative study found that providers face logistical burdens in fulfilling extensive documentation requirements, which could diminish their efforts in the provision of care that is effective, patient-centered, timely, and equitable. As patient-centeredness for patients under the age of 18 is understudied and potentially compromised due to the current political environment, this thesis aimed to further explore data from this qualitative study to identify abortion clinical personnel's self-perceived roles and responsibilities in facilitating person-centered abortion care in the Southeast.

Chapter III. Student Contribution

My contribution to this thesis project began in April 2021 when I approached Dr. Whitney Rice, the Thesis Committee Chair, about supporting my thesis and brainstorming proposed topics. In discussion with Dr. Rice and Thesis Committee Members, Sophie A. Hartwig and Dr. Subasri Narasimhan, I finalized the thesis topic and identified a research question, as well as secondary qualitative data, that would inform the results of this project.

I conceptualized the project topic based on my interest in reproductive health and social determinants of reproductive health and decided to use data from the Center for Reproductive Health Research in the Southeast's (RISE) Confidentiality and Parental Involvement Processes for Minors Seeking Reproductive Health Services (CPI) project. Data from the CPI project include in-depth interviews with abortion facility personnel, in-depth interviews with minors seeking abortion care, data from mystery calls to county courts to collect information provided to young people on parental involvement processes, and medical record data on minors who obtained abortion care in three Southeastern states in the United States (White et al., 2021). With insights from Thesis Committee Members, I identified a gap in abortion care research and the unique contribution this project could provide.

An agreement was signed between CPI project team and I to protect the privacy, confidentiality, rights, and interests of study participants and the facilities from which data were obtained. I was also added as a member the study team under the project's approved protocol with Emory University's Institutional Review Board (IRB). Additionally, I agreed to share findings from the analysis with Dr. Kari White (Co-Investigator of the CPI project) for review, interpretation, discussion, and feedback prior to public dissemination of the results.

I acquired qualitative interview transcripts from the CPI project team and began reading through the data in June 2021. During data exploration, I also added memos for reflection and brainstorming of the codebook structure. I developed a codebook with eight deductive codes reflecting each domain of the reproductive health framework after data exploration.

During the first cycle of coding on five transcripts, I added inductive parent codes and subcodes informed by memos and pattern coding to the codebook. For example, a new parent code describing limitations of current abortion care was created to document participants' opinion about what could be improved in abortion care. For parent codes that represent domains of the original framework, I added subcodes to describe various strategies clinical personnel used to facilitate person-centered care.

I coded in isolation and discussed the coding processes with the thesis committee on a bi-weekly basis. To assess coding strategies, I discussed my code descriptions and example quotes with the thesis committee. To improve validity of data analysis procedures, I also reviewed the codebook with the thesis committee to refine and align on definitions and example quotes used to guide my coding process. I also engaged in reflexivity by continuing to memo about personal reflections and salient quotes during the coding process.

During codebook revision, I reviewed the subcodes with fewer frequencies to assess their relevance to the research question. Similar subcodes across different parent codes were also re-evaluated to re-assign under the same parent code. After reviewing five transcripts, the codebook was revised to consist of ten parent codes – eight from framework domains (e.g., dignity, autonomy, privacy/confidentiality, communication, etc.), one on job responsibilities, and one on policy limitations. Each framework domain represents a parent code, and each subcode represent a different property for the respective domain. The finalized codebook consisted of detailed

description and example quotes for me to refer to when coding the remaining 29, with minor revisions regarding codebook organization along the way. I compared framework domains across individual cases to identify similar or different expressions of person-centered care.

I drafted and revised all five chapters of this thesis based on feedback from the thesis committee between September 2021 and April 2022. With the support from the thesis committee, I also prepared and presented my thesis defense on Zoom at 10 AM EST on March 31, 2022.

Positionality Statement

I conducted my thesis to understand reproductive health care using currently available frameworks. I hoped to understand better abortion care as a product of historical and social context through this thesis project. I acknowledge that knowledge gained from this research would be subjective, as the data described clinical personnel's perceptions of abortion care.

My special interest in abortion care as the topic for this thesis project stemmed from my social identity as a cisgender woman. My lack of knowledge in sexual and reproductive health from school and social settings also contributed to my curiosity about people's lived experiences with abortion care. Although some of my social identities relate closely with participants in the project, I identify as an outsider in relation to the project perspective due to our differences in culture, as well as my position as a researcher trainee in reproductive health topics. My identity as an international Asian individual in the United States isolates my position from clinical personnel with a stronger root in the Southeastern region of the country.

As an outsider, I hope to bring a less proximal lens to this project when analyzing interview data of clinical personnel working in abortion clinics in the Southeast. Nevertheless, I acknowledge my lack of proficiency in Southern cultural nuances as a major limitation to this

project. To mitigate this limitation, I worked closely with my thesis committee who have strong knowledge of this community and/or prior experience with the data as members of the original research team.

Chapter IV. Journal Article

Title Page for Manuscript

Prepared in accordance with Instructions for Authors for Sexual and Reproductive Health Matters (Instructions for Authors).

Examining clinical personnel's roles in facilitating person-centered abortion care for minors in the Southeastern United States

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Abstract

Abortion care is extremely stigmatized in the United States. While abortion for adults is more commonly discussed in scientific literature, in comparison, abortion care for young people specifically may be overlooked. As clinical personnel play an important role in supporting young patients, this thesis sought to explore clinical personnel's perspectives on their roles in providing person-centered care for young people seeking an abortion. More specifically, this thesis used secondary qualitative data on abortion providers' narratives to answer the question: how do clinical personnel's self-perceived roles, responsibilities, and interactions facilitate person-centered reproductive health equity for young people under the age of 18 seeking an abortion in the Southeastern United States? Findings highlight four key themes of person-centeredness that are facilitated by abortion providers: dignity/autonomy, privacy/confidentiality, communication, and support. Abortion providers play mediatory roles between young patients and parents to ensure that decisions are patient-led and free of coercion. Abortion providers also facilitate privacy for young patients by periodically separating patients and parents at the clinic. To ensure young patients can receive the care they desire, providers spend much of their time explaining parental involvement laws and providing logistical support so patients fulfill the requirements. This thesis argues that parental involvement laws impose challenges for person-centeredness in abortion care for both patients and providers and explores recommendations for facilitating person-centered care under the current political environment.

Keywords: abortion, person-centered care, minor, U.S. Southeast

Manuscript

Introduction

Southern states have been identified as more hostile to abortion rights than other regions of the country (Nash, 2020). The widening gap in abortion policies by region also sheds light on the polarized lived experiences in United States. As of 2021, a total of 1,338 abortion restrictions have been enacted since *Roe v. Wade* in 1973; among all the restrictions, 44% were enacted in the past year (Nash, 2021b). One of the most hostile regulations introduced in 2021 was Texas' six-week abortion ban, which the Supreme Court has since refused to block.

Young people are a small but important group that requires abortion services. Across all age groups, the abortion rate for young people has the largest reduction over time (Jones & Jerman, 2017b). Between 2008 and 2014, the abortion rate for young people aged 15-17 declined by 56%, from 11.8 to 5.2 abortions per individual. By 2014, people aged 15-17 only comprised 3.4% of all abortion patients in the United States, the second lowest group after people above 40 years old (Jerman et al., 2016; Jones & Jerman, 2017b). Given their age, legal status, and stage of emotional development, young people may face unique barriers when seeking an abortion. For example, as young patients take on average seven weeks to learn of their pregnancy, early gestational age limits often simulate a total ban on abortion (Finer et al., 2006). Therefore, it is important to better understand young people's experiences in the current abortion care seeking pathway and provide appropriate support to young patients.

Young people's perceived barriers to obtaining an abortion are frequently documented in literature. First, the logistical requirements young people must comply with (such as document requirements, procedural costs, and arrangements for visiting abortion facilities) are one of the most reported barriers (Bearak et al., 2017; Coleman-Minahan et al., 2019; Finer et al., 2006;

Guendelman et al., 2020; Kavanaugh et al., 2019; Pleasants et al., 2021; Upadhyay et al., 2014). Second, the lack of perceived support from family, community members, and the judicial system is also a common reason that makes the abortion-seeking process even more daunting for young people (Biggs et al., 2020; Foster et al., 2013; Kavanaugh et al., 2019; Rocca et al., 2020).

Clinical personnel play an important role as advocates for young abortion patients, with the ability to mediate these potentially adverse experiences. Previous studies have thoroughly examined abortion-seeking experience from the patient's perspective, but less is known about how abortion clinical personnel perceive their roles when supporting young patients. Examining clinical personnel's self-perceived roles and responsibilities in abortion care could help further assess abortion care quality for young people and explore potential unmet needs in the United States.

According to the Institute of Medicine's healthcare quality framework, there are six domains that characterize quality care in clinical settings: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (Institute of Medicine, 2001). Using this model, White et al. (2021) assessed the role of abortion regulations, specifically parental involvement laws, on abortion clinic staff's experience providing abortion services to young patients. The study found that providers face logistical burdens in fulfilling extensive documentation requirements, which could diminish their efforts in the provision of care that is effective, patient-centered, timely, and equitable. Further research is needed to systematically assess how abortion care aligns with patient-centered frameworks, particularly in the South and Southeast. As patient-centeredness for patients under the age of 18 is understudied and potentially compromised due to the current political environment, this study aimed to revisit data from this qualitative study to

identify abortion clinical personnel's self-perceived roles and responsibilities in facilitating person-centered abortion care in the Southeast.

The conceptual framework of this study is informed by the Person-Centered Care Framework for Reproductive Health Equity by Sudhinaraset et al. (2017). This is a relatively new framework that describes multilevel factors that all contribute to one's reproductive health outcomes. This framework incorporates and redefines WHO's Quality of Care for maternal and newborn health (Tunçalp et al., 2015) under the context of reproductive health to highlight the influential role of abortion clinics in facilitating person-centered health outcomes. While the eight domains for person-centered care are not mutually exclusive, each identifies an important aspect of care that should be present. While most person-centered reproductive care frameworks were initially developed for maternal health care in low- and middle-income countries, the authors anticipated this framework could be applied in other reproductive contexts such as family planning and abortion care.

Abortion care is extremely stigmatized in the United States. Lack of open and honest conversations surrounding abortion care can contribute to misconceptions around care among those seeking an abortion. While abortion for adults is more commonly discussed in the scientific literature, abortion care for young people, especially people under the age of 18 (i.e., minors), may be overlooked. As attitudes and self-perception of clinical personnel's support for minor patients are understudied, this thesis sought to explore clinical personnel's own perspectives on their roles in providing person-centered care for minors seeking an abortion. More specifically, this study sought to answer the question: how do clinical personnel's self-perceived roles, responsibilities, and interactions facilitate person-centered reproductive health equity for young people under the age of 18 seeking abortion in the Southeastern United States?

In this study, I explored this question using in-depth interviews with abortion providers from Southeastern states.

Methods

Study Design

The current study is embedded within the RISE Center study titled Confidentiality and Parental Involvement Processes for Minors Seeking Reproductive Health Services (CPI). All study procedures were conducted with the approval of the Institutional Review Boards at the University of Alabama at Birmingham and Emory University. See the original paper for detailed description of research procedures (White et al., 2021).

Sampling and Recruitment

The eligibility criteria for this sub-study included clinical personnel 1) currently employed at one of the participating abortion clinics, and 2) involved with clinic's judicial bypass/parental notification procedures. The study team worked with clinic administrators who acted as gatekeepers to identify and connect with clinical personnel working in abortion facilities. The researchers first contacted administrators or directors of 12 (out of 15) abortion facilities in three Southeastern states by email or telephone to publicize the study and ask to discuss the study with clinical personnel who might be willing to participate. All participating clinics signed a letter of support, which was included in the Institutional Review Board (IRB) submission. Within each participating clinic, personnel interested in participating in the study were invited to sign up for eligibility screening. The researchers assessed each clinical personnel's eligibility for the study and contacted eligible individuals to invite them to participate. In addition to oral consent, the study team obtained a Certificate of Confidentiality (CoC) from National Institute of Health as an extra layer of protection for participants.

Data Collection

Between May 2018 and September 2019, the study team conducted 34 semi-structured, in-depth interviews with clinical personnel working in nine clinics in three Southeastern states. Interviews lasted between 28 to 78 minutes, with a median duration of 49 minutes. All interviewers received graduate-level training in qualitative research methods and had knowledge of abortion policy in specific states the interviewees worked in. Before beginning the interviews, participants were informed of the purpose of the study, asked for oral consent, and reminded of options to opt-out of any questions and/or end at any time without penalty. Participants were also asked to give permission for the researchers to audio-record the interviews for transcription purposes. To reinforce confidentiality for study participants, researchers did not document specific states the participants worked in because of the low number of abortion facilities in the region.

One interview guide was developed by the study team and reviewed by clinicians (experienced in abortion policy and abortion care in the Southeast but not involved in the study as participants). At the beginning of interviews, researchers asked participants to describe their roles and responsibilities to identify questions more relevant to their experience in abortion care and gauge their involvement with scheduling appointments. Different sets of questions with skip patterns were also developed depending on the context of abortion policy, and specifically the type of required parental involvement, for each Southeastern state. All participants were also asked about their knowledge of and experiences with judicial bypass.

Data Analysis

The mythological focus of this study was reconceptualizing the data informed by a different framework that focuses on person-centeredness in reproductive health. I was added as a

member the study team under the project's approved protocol with Emory University's IRB and began reading through the data in June 2021. During data exploration, I added memos for reflection and brainstorming of the codebook structure. I also developed a codebook with eight deductive codes reflecting each domain of the reproductive health framework after data exploration. After codebook development, I began the first cycle of coding on five transcripts and added inductive parent codes and subcodes informed by memos and pattern coding to the codebook. For example, a new parent code describing limitations of current abortion care was created to document participants' opinion about what could be improved in abortion care. For parent codes that represent domains of the original framework, subcodes were added to describe various strategies clinical personnel used to facilitate person-centered care.

I coded in isolation and discussed the coding processes with the research team on a bi-weekly basis. To assess coding strategies, I discussed code descriptions and example quotes with the thesis committee. To improve validity of data analysis procedures, I reviewed the codebook with the research team to refine and align on definitions and example quotes used to guide the coding process. I also engaged in reflexivity by continuing to memo about personal reflections and salient quotes during the coding process.

During codebook revision, subcodes with fewer frequencies were reviewed to assess their relevance to the research question. Similar subcodes across different parent codes were also re-evaluated so that they were assigned under the same parent code. After reviewing five transcripts, the codebook was revised to consist of ten parent codes – eight from framework domains (e.g., dignity, autonomy, privacy/confidentiality, communication, etc.), one on job responsibilities, and one on policy limitations. Each framework domain represents a parent code, and each subcodes represent a different property for the respective domain. The finalized

codebook consisted of detailed description and example quotes for the student to refer to when coding the remaining 29 transcripts, with minor revisions regarding codebook organization along the way. Original framework domains across individual cases were compared to identify similar or different expressions of person-centered care.

Results

Sample Description

Nine (of 12 contacted) abortion facilities from three Southeastern states agreed to participate in the study. Most participating facilities specialized in abortion care. The majority of participating clinics' patients were adult women of color who resided in the same state as the facility. Less than 10% of clinic patients were under 18 years of age (White et al., 2021).

Thirty-four clinical personnel (i.e., providers) from the participating clinics completed in-depth interviews. Out of all participants, eighteen individuals worked in supporting roles, which included call center staff, counselors, and health educators. Seven individuals work in clinical or patient care roles such as registered nurse, and nine served as directors or administrators for the clinic. The average participant age was 47 years old, and the average length of time worked in abortion care was 15 years. A full description of sample characteristics can be found in Table 4.

I drew from the person-centered care framework (Figure 3) as the foundation for analysis, and four key themes emerged from the data: dignity and autonomy, privacy/confidentiality, communication, and support (Figure 4). The two themes of dignity/autonomy and support each had two to three unique sub-themes demonstrating how the theme was discussed by participants. In this study, specific domains from original framework blended together based on providers' experiences and perceptions (e.g., dignity/autonomy and social support/supportive care). Thus, I describe them as combined rather than distinct domains. Facility environment and patients'

perceived trust were not observed in the data, perhaps in part because the in-depth interviews focused on providers' narrative on navigating parental involvement laws.

Dignity and Autonomy

Dignity refers to the ability of patients to receive care in a respectful and caring setting, and autonomy indicates that providers respect patients' decisions and support patients in making informed choices. Dignity and autonomy were difficult to differentiate in this study because respecting patients' wishes and decisions was at the heart of creating a respectful environment in the clinic. This combined theme describes providers' effort in creating supportive environment that is patient-led and free of coercion.

The majority of providers expressed their intent to respect minors' decisions, irrespective of their age, because, as providers, they are "obliged to advocate for the patient." When asked about their views on parental involvement, a few participants noted that people should respect what minors want because "it's their body" (Clinical/patient care roles, 3.5 years in abortion care). Providers also acknowledged that it is often minors first time seeking abortion, so staff, especially phone advocates, get "really involved when it comes down to the minors" (Support staff, 13 years in abortion care). To provide dignified care and a respectful environment for minors, providers made sure to 1) involve patients in decision-making and 2) ensure consented care throughout the entire process.

Patient-led decision-making. To foster minors' autonomy in abortion care, one important practice is to involve patients in decision-making processes. After identifying minor patients, providers request both patients and parents be on the call. With parental involvement legal requirements, as with other aspects of abortion care, providers would ensure that patients are participating in the decision-making process.

> Some parents call just thinking they would like to schedule [the abortion appointment] for their children, and we have to tell them, like, oh, we actually have to have the minor on the phone and get their consent and read them this state-mandated information. Sometimes they're [the parent] upset about that, because they think they should just be able to schedule their daughter's appointment. – *Director/administrator, 16 years in abortion care*

As minors continue with the decision-making process of obtaining an abortion, providers give appropriate support to help minors decide whether to get an abortion and how to satisfy parental involvement laws. Providers often work closely with minors to help make informed decisions without parental input. One way providers do this is to conduct decision assessments with patients to assess their needs. One participant stated, "We do a decision assessment on all people, especially young people… [minors are] usually pretty straightforward [in their decision]. Sometimes they might be ambivalent…" (Support staff, 12 years in abortion care). Occasionally, minors may contact an abortion clinic with their mind set on getting an abortion, and in those situations, providers would simply provide support for whichever option the patient has chosen for parental involvement laws. Overall, providers follow patients' lead on decision-making and provide flexible support depending on each patient's situation. As another participant stated,

> What we try to close each conversation with is [the message] that this is your decision. We can help you as much as you keep us involved. If at any point where you don't feel we're helping you or anything like that, you don't have to call us and let us know what's going on with your life. We're here if you need us, period. – *Support staff, 1 year in abortion care*

Freedom from coercion. All clinic providers emphasized the importance of ensuring minors consent to receiving an abortion. Providers generally confirm consent at two time points during the continuum of care: once during the scheduling process and again during private consultation, separate from a parent, before the procedure. All providers ensured consent with minor patients, but sometimes providers adapted their approach based on the relationship between minors and parents.

The majority of participants described encounters in which minors and parents do not agree on the abortion decision; when that happens, providers would act protectively to ensure that patients are not coerced into an abortion procedure. When providers sense tension or disagreements between patients and parents during scheduling, the provider would pause the process and ask patients to come back when they are certain about their decision to avoid coercion. As one participant stated, "If there's both a parent and the child on the phone, you know, we would clarify, 'Do you want to make—schedule this appointment?' Each circumstance is different. If that minor patient says no, at that point we tell the parent, 'Look, she says "no" and we cannot force her'" (Support staff, 13 years in abortion care). Mediation could also occur at the clinic, any time before the procedure happens. As another participant explained, "We have a situation sometime where I have to ask the minor to, not really step out the [counseling] room, but let me talk to the mom in private. I leave the minor there, and I bring the mom and talk to her in here. If I got the minor up there, vice versa. I say, 'Well, it's her decision. You can't force her to have an abortion if she doesn't want to have one'" (Clinical/patient roles, 25 years in abortion care).

Participants discussed the role of mediators between minors and parents could negatively impact providers' mental health as well as their allocation of clinic resources. One provider

stated, “It’s burdensome. It sometimes puts us in really awkward places. Sometimes it kind of sets up the staff to have to safeguard minors from parents. And we have to take our time and energy and financial resources to comply with the laws” (Director/administrator, 16 years in abortion care). Overall, providers described immense efforts to facilitate person-centered care through respectful for minors’ decisions and efforts to create a caring setting, even when that requires additional effort and time on their part.

Privacy / Confidentiality

This domain relates to discretion in the environment in which abortion care is provided, and the concept of privileged communication and confidentiality of information shared between patients and providers. According to the American Medical Association, minor patients are entitled to confidentiality except when parental involvement is necessary to avert serious harms to the patient (American Medical Association, 2001a). However, state-mandated regulations specific to minor abortion patients impose challenges for maintaining privacy from legal guardians under all circumstances.

At abortion clinics, minors have the choice of inviting parents throughout the process up to the procedure. Providers begin counseling alone with minors first to ask if they want to invite parents into the space. If so, providers would go ahead and bring parents in. As one participant stated, “We always want to speak with [minors] alone at first… because sometimes they’re a little more forthcoming if someone else is not around. So, we definitely get them by themselves initially, and then we can include the parent afterwards, once we get that initial talk out of the way. Then we can bring the parent in” (Clinical/patient roles, 5 years in abortion care). Providers sometimes have to explain to parents why minors have the right to alone time with the medical team if requested, which could take up extra time and effort. As one participant stated,

> Trying to keep confidentiality the way it needs to be, like yes, a parent's here to provide their – that they've been notified, but then the parent may want a lot of information and access that we can't provide because of HIPAA, trying to maintain the patient's privacy, trying to just get that alone time with the patient when the parent is still here and wants to be a part of every single thing, is kind of hard to explain to parents sometimes. – *Director/administrator, 16 years in abortion care*

The majority of providers noted parental involvement laws for abortion as interfering with minor patients' right to privacy. Although minors have the right to privacy at abortion clinics, parental involvement laws enforced by states require legal guardians to be informed about minors' health information, regardless of patients' health status. One provider stated, "To me, it violates [minors'] privacy. I mean, I don't know of any other specific thing other than I think women should always have that right to privacy" (Support staff, 8 years in abortion care). In addition to parental involvement laws, providers also noted how judicial bypass intrudes on minor patients' privacy because the law requires minors to share their health information to more parties.

> I just think [judicial bypass is] one more hurdle for [minors] to have to overcome. It's one more person that you're having to let into your business what's going on with you. Depends on how many people are there. If they end up giving the fetus an attorney and all that, then it drags that out even further. I just think it's more people that are involved in a woman's reproductive decision. – *Clinical/patient care roles, 18 years in abortion care*

Providers expressed challenges of regulating parental involvement given the wide range of family circumstances and needs. Specifically, these regulations may create additional barriers

to care for minors unable to easily involve a legal guardian in their life. One provider described a situation when, "Maybe the parent, like I said, isn't available… Basically, you're looking at forced parenting" (Director/administrator, 17.5 years in abortion care). When minors are uncomfortable with including parents in the care-seeking process, parental involvement laws could delay care and increase the abortion cost, causing more burden for some patients. "When we're telling [minors] what they need. Only when they don't have a clue—they're shocked. They go away and I don't know if they come back. We don't know if they ever call back for the actual process—to go through the actual process" (Clinical/patient care roles, 24 years in abortion care). At least half of the respondents described similar situations when minors would pause during the scheduling stage because they cannot include their parents in the process.

> I feel in my experience that a lot of the minors are a lot more ahead in gestation because… when maybe they call us initially, they might be a lot earlier on, but then, when we tell them they have to have their parent involved – or a letter of notification scares them… It's like, you know, very invasive and intimidating for a minor, let alone an adult… I think it definitely proves to deter minors from getting the abortion care they might need a lot earlier. – *Support staff, 2 years in abortion care*

Communication

Communication refers to providers clearly explaining to patients their gestational age, details of abortion services, and available options. As participants in this study described, communication begins on the phone when patients first engage with providers for abortion care. After the first contact, providers working in the call center and in other counseling and support roles continue to inform patients as they navigate the steps in obtaining an abortion. Two key points were emphasized by providers as important to convey to minors early in the process, first,

their parental involvement options and second, how to prepare for parental involvement requirements prior to attending the appointment.

To begin the conversation about parental involvement laws, providers would obtain the date of birth to calculate the age of the patient. Upon identifying that the patient is a minor, phone advocates would first introduce requirements of state-mandated parental involvement. Taking into account minors' situations, providers would address their concerns and work through ways to satisfy the state-mandated requirements. While the communication process is nearly the same across clinics, starting from establishment of age to introducing parental involvement requirements, the level of information providers would share on alternative pathways may vary depending on patients' situation and inquiry. For example, in the event that minors express difficulty including their parents or legal guardians in the process, phone advocates may provide alternative options tailored to their needs. One provider explained, "So, once they initially call and we identify that they are a minor, I gather all kind of information, and give them the most helpful information that I can give them based off their situation" (Support staff, 21 years in abortion care). If patients show willingness to inform parents after learning that it is required by law, providers may not mention judicial bypass as an option. "If they're really not pressing the issue, I really don't bring it up 'cause that just tells me, you can feel 'em out and see, okay, they're gonna tell their parents" (Support staff, 1 year in abortion care).

For minors who decide not to include parents in the abortion process, providers may provide additional information about navigating judicial bypass to their best ability. While most clinics do not engage directly with legal stakeholders for judicial bypass, many may have referral resources such as a list of phone numbers for patients to contact themselves. Providers may also ask additional questions to understand minors' situations better and provide tailored

recommendations on how to obtain a judicial bypass. Some phone advocates may also encourage patients to come into the clinic for a "mini counseling session" or specialized decision counseling to prepare patients for questions regarding their decision to get an abortion without parental involvement (Clinical/patient care roles, 18 years in abortion care). One provider stated, "I tell them they need to do their homework. They need to make sure this is what they want to do. They need to look at everything" (Director/administrator, 40 years in abortion care).

In addition to discussing ways to involve parents and meet mandated requirements, providers also spend a large amount of time communicating with minors about how to prepare for the abortion appointment, including how to satisfy parental involvement requirements. As patients all have unique situations, conversations are often tailored during this stage. For example, clarifications on which documents patients need to provide depend on the parental involvement law option they chose to fulfill. For patients seeking a judicial bypass, providers would closely describe steps to take before arriving at the courthouse. For example, one participant described in detail the assistance they provided regarding finding a courthouse, preparing documents, and how to prepare the conversations at the courthouse.

Explaining document requirements was most frequently noted as a topic that took up a long time, especially when speaking to a parent. Some states require clinics to keep patients' original birth certificates because it has the official seal along with names of parents as proof of legal guardianship. Overall, providers emphasized their effort to summarize and remind patients and their parents about the document requirements before they showed up at the clinic because without the appropriate documents, they would be turned away. As another participant stated,

> We try to lay everything out as simply as possible and as directly as possible… We just try to make sure everybody's informed and knows what they need to do, that way we

> don't have to hit too many hurdles. Because usually misinformation is where we hit gaps… If we can get everything laid out as much as possible over the phone so we can get them here, it makes the process a lot easier. But it's a bit more to do, you know, because the minor is involved. But it has to be done because it is the law. – *Support staff, 3.25 years in abortion care*

Overall, providers recognized that each minor may face different challenges and considerations, so they try to stay flexible and provide the best feasible option according to patients' unique needs. One participant stated, "You just have to work with, as I said, whatever the cards you're dealt. I would work with that patient, no matter what… I would make sure she knew what her choices were from a legal standpoint. Even if we weren't doing the abortion, even if I'm referring, is she from—there's so many things I have to think about" (Director/administrator, 40 years in abortion care). Providers also recognized their role as knowledge expert in abortion care and emphasized their responsibility to inform minors about their options so they could receive the care they wanted.

> Well, the wonderful thing about it is because we're informed, I think that helps a lot. No one's really intimidated by the legislation. We know what can and cannot be done, so we're confident in that we're still able to service the population base that may not be as informed. But they're not really required to be informed. It's up to us to inform them, 'cause that's what we do. – *Support staff, 1 year in abortion care*

Support

Support refers to how providers provide abortion care in a timely, compassionate, and caring manner. It also refers to care that is responsive to minors' needs. All participants described efforts to help address minors' concerns and needs during the abortion experience, and

three types of emerged from the data: 1) provision of logistical support, 2) provision of emotional support, and 3) navigation of parental involvement.

Logistical support. One of the most common ways of assisting minors is providing logistical support, which may take many forms, depending on minors' needs and situation. Some common logistical support includes triangulation of multiple identity documents to fulfill mandated requirements or referral to abortion funds to help with financial hardship.

Participants acknowledged that providing proof of the parent-child relationship plus photo ID can be difficult for minors, especially those who wish to not include parents in the process. As one participant stated, "I know that can be hard for some of these kids. That becomes a sticky thing when you can't get access to one of your parents" (Support staff, 12 years in abortion care). When minors and/or their parents cannot provide typical documents to prove their identities, providers may find solutions to help fulfill the requirement. As another participant explained, "If they have a social security card with – maybe they don't have a student ID, but they have a print out of their schedule with their name and that kind of information on it, you know, we can combine those two" (Support staff, 2 years in abortion care).

Another type of logistical support that providers may facilitate is financial assistance. All providers acknowledged that abortion care can be costly, sometimes beyond the means of a minor, and that not all patients would have the ability to gather all the funds in time for their abortion procedure. Respondents also described ways of helping patients alleviate these financial burdens. For example, one provider described their clinic waiving the ultrasound fee for a minor who needed sonograms for their judicial bypass procedure, because minors are "kind of struggling" (Support staff, 13 years in abortion care). Participants would also refer minors to organizations such as abortion funds so the cost would not hinder them from receiving care.

> So, because abortion's expensive… we try to help them with funding any way we can, and we do give them additional numbers… But, you know, we try to help them out as much as we can. We ask for exceptions with NNAF [National Network of Abortion Funds] ... if they need help, because it's expensive. It's hard, you know? – *Support staff, 3.25 years in abortion care*

Emotional support. Another way providers described support given to minors is by addressing their emotional needs when deciding whether to have an abortion or not. In situations when minors and parents disagree, minors may worry about damaging familial relationships or, in extreme cases, their safety. During care, providers recounted comforting minors to help them work through emotional challenges. Again, the level of involvement in providing emotional support from providers can vary depending on the need of each patient. If minors demonstrate extreme emotional stress, providers may become more involved. This was mentioned more frequently for minors seeking a judicial bypass because they were more likely to lack a supportive adult. One participant recalled, "The patient called me in tears on the courthouse steps saying, '[The court clerk] won't give me my paperwork.' And she was 18 weeks along, and I am – oh, it makes me want to cry" (Support staff, 3.25 years in abortion care). For minors with additional needs (e.g., those who do not speak English or are seeking a judicial bypass), providers also try to assign the same staff so that patients can form a "relationship of comfort where they don't have to be sidetracked with somebody [else]" (Support staff, 2 years in abortion care).

Supporting and navigating parental involvement law and process. Most providers acknowledged both the benefits and complications of requiring parents or legal guardians'

involvement in minors' abortion care. As every parent–child relationship differs, providers often provided tailored support to help minors navigate parental involvement.

Providers noted that it could be "priceless" when parents are supportive of minors' decisions (Clinical/patient care roles, 5 years in abortion care). When parents and patients "can see eye to eye and understand that this needs to be done, and mutual respect for the person who's actually pregnant, it can really strengthen a relationship" (Support staff, 3.25 years in abortion care). One provider described a time when a non-guardian parent visited the abortion clinic with a child who pursued a judicial bypass just to show support for their decision. More commonly, participants described how parents would "reluctantly go with [minors], because they understand where their kid is coming from" (Support staff, 3.25 years in abortion care). When supportive parents are involved in the process, providers would also rely on the parent to obtain the medical history information needed for the procedure and reiterate medically related information. As one participant explained, "A lot of times the child doesn't know that much about their medical history in order to complete that part of it or understand what anesthesia is and what they need to prepare for. You need someone that understands" (Support staff, 12 years in abortion care). As some parents may have strong influences in minors' lives, providers may encourage minors to have open dialogues with their parents, while being centered on the young person, to facilitate supportive involvement by parents. "I'm obligated to advocate for the patient. I'm not obligated to advocate for the parent; although, they're a family unit, so I'd like to bring them together so that they—you know, they can at least talk to each other" (Director/administrator, 40 years in abortion care).

Providers also acknowledged drawbacks of parental involvement because "half the time [the relationship is] great, and half of the time it's not so great" (Clinical/patient care roles, 5

years in abortion care). When parents are unavailable or unwilling to provide support, minors may face additional challenges associated with seeking a judicial bypass at the courthouse. In addition, parental involvement may damage parent–child relationships and potentially threaten minors' safety. For example, providers observed situations when parents are "shaming or guilting their daughters" or "making them feel really bad about the decision that they've made" (Director/administrator, 16 years in abortion care; support staff, 2 years in abortion care). When encountering these dynamics, a few providers had pulled parents aside to ask them to be supportive of their children, again pointing to the role of provider as mediator. As one participant put it,

> Of course, those who have a good relationship with mom and dad don't mind it [involvement] and they feel supported by it. But if it's an issue where mom or dad is not available or mom and dad are not supportive then that puts them at odds I would imagine. It makes it difficult for them. – *Director/administrator, 16 years in abortion care*

Discussion

Abortion care in the U.S. Southeast can be extremely limited and difficult to navigate, especially for young people under 18 years of age due to parental involvement laws. Using the Institute of Medicine's healthcare quality framework, the original paper from the data analyzed in this current study found shortcomings in person-centeredness as a care quality domain for young people's abortion care (White et al., 2021). Specifically, regulations enforced by parental involvement laws may compromise young patients' decision-making power when seeking abortion care. This study aimed to explore patient-centeredness more deeply, examining clinical personnel's self-perceived roles, responsibilities, and interactions with patients to facilitate person-centered reproductive health equity for young people under the age of 18 seeking

abortion in the U.S. Southeast. In-depth interviews with providers working in abortion care facilities highlighted three key tasks providers emphasize to ensure person-centered care for minor patients: 1) ensuring privacy/confidentiality, 2) facilitating dignity and autonomy, and 3) tailoring communication and support for minor patients.

State-mandated regulations such as parental involvement laws could compromise minor patients' right to confidential care. Providers are legally required to follow regulations imposed by the state, even when they may contradict public health principles such as patient-centeredness. In this study, providers often noted abortion care's unique situation that requires minor patients to involve additional parties even when it may not be in their best interest. Moreover, regulations specific to minor abortion patients often do not translate to other adolescent sexual and reproductive health services. Almost all Southeastern U.S. states explicitly permit all or some young people to consent to contraception, prenatal care, adoption, and other services without parental involvement (Table 5). To better support young patients seeking abortion services, legal institutions should reconsider the necessity and feasibility of current mandate requirements, as they may hinder minor patients from reaching abortion services. Furthermore, the role of parental involvement should also be reassessed to ensure that young patients can make coercion-free decisions about their own bodies.

In addition to ensuring private and confidential care, providers play a crucial role in supporting minor patients' decision-making power in abortion care. Minor patients in many U.S. states are required by law to include legal guardians in the abortion process, and they may face pressure from parents to receive or not receive an abortion. Providers described many instances where parents may intrude with the patient-led decision-making process and consent to abortion

procedures. To facilitate minor-centered care, providers may need to intervene between minors and parents to advocate for patients' wishes and decisions about their bodies.

The literature shows consistent findings that young patients face challenges in maintaining their decision-making power in abortion care (Ralph et al., 2014). The lack of autonomy underscores the need for the healthcare system to better support young people in abortion care. Under a hostile social and political environment for young abortion patients, providers may benefit from preparing to play the mediator role between young patients and parents. Mediator trainings for abortion providers may allow clinic staff to intervene more effectively and better maintain dignity/autonomy for young people when conflicts or disagreements arise between two parties (Parsons, 1991; Walton, 2015).

Finally, abortion providers focus heavily on supporting minor patients and their families with logistical needs such as providing identity documents and fulfilling mandated requirements. As it is often minor patients' first time going through the process, providers need to deliver clear and consistent communication about the abortion care process, document requirements, and parental involvement laws. Depending on minor patients' situations, providers also offer support tailored to address patients' unmet needs. For example, clinics may waive fees if minor patients could not afford the ultrasound but needed a sonogram for a judicial bypass.

Consistent with the literature, logistical barriers are one of the key factors that delay people from seeking care (Finer et al., 2006; Upadhyay et al., 2014). In addition to arranging transportation, cost, and document requirements before their appointment date, young patients who wish to not include a parent must obtain a judicial bypass through the court, which could further delay their timing of care. The lack of accurate, high-quality abortion resources online also complicates the care-seeking process, especially if it misinforms young patients (Pleasants

et al., 2021). To minimize the amount of logistical support that abortion providers have to deliver, online educational platforms should provide accurate and tailored resources for young people so that patients are informed and prepared before arriving at abortion facilities.

Although the study was grounded in an established conceptual framework, there are three limitations that need to be addressed. First, the study used secondary qualitative data from the CPI study, which was guided by a different conceptual framework. Some responses were not able to provide robust insights into this study's research question due to differences in the original intention of the interviews. Second, the study was only able to interpret the perspectives of abortion providers. While clinical personnel's contribution to person-centered care is crucial to understand, patients' experience of their interactions with providers may help strengthen the validity of the proposed findings from this study. Finally, I did not have a second coder to address the validation of coding strategies; however, I provided detailed descriptions for each code and discussed my coding strategies extensively with the study team to ensure that the results could accurately describe participants' meanings.

This study contributes to the limited knowledge about providers' delivery of quality abortion care to young patients in region of the United States that is traditionally more hostile toward abortion care. Findings from this study help expand on prior literature examining abortion care experience for young people in the U.S. Southeast.

Chapter V. Public Health Implications

Person-Centered Abortion Care

The Person-Centered Care Framework for Reproductive Health Equity, informed by WHO's Quality of Care and the Cultural Health Capital theory, highlights the impact of multilevel determinants on people's experience of care (Dubbin et al., 2013; Sudhinaraset et al., 2017; Tunçalp et al., 2015). In the U.S. Southeast, young people under 18 face unique regulations that impede their opportunities to receive person-centered abortion care. In this study, abortion providers in the U.S. Southeast emphasized providing logistical support and ensuring young patients' right to private, respectful, and autonomous care when seeking an abortion.

To promote person-centered care for young abortion patients in the U.S. Southeast, state-mandated regulations should be reconsidered for their necessity and impact on young patients' privacy. Although the majority of young people voluntarily include a parent in their care-seeking process, parental involvement laws force some to disclose their pregnancy when they otherwise would not. Parental involvement laws also create an additional burden on young people who live in nontraditional family structures, such as when children do not live with their biological parents. Policies should aim to support every young person seeking an abortion and reconsider their implications on diverse family structures in the United States.

Under the current political environment and abortion regulations, and given the unlikelihood of widespread policy change, abortion providers may benefit from mediator training as part of their education to better facilitate person-centered care when young patients and parents disagree on the abortion decision. Power dynamics between children and their parents can be extremely unbalanced, especially when children live with parents. When young people are affected by tension with parents or other individuals, providers may wish to intervene to

ensure that patients can receive the care they desire. In abortion care, providers play an important role in ensuring young patients' wishes are heard and honored. Formal mediator training may allow abortion providers to address conflict more effectively and improve care efficiency and person-centeredness for young patients (Parsons, 1991; Walton, 2015).

In addition to policy changes and interpersonal intervention to enhance person-centeredness in abortion care, accurate and high-quality abortion information needs to be more accessible for young people to improve their literacy about abortion care. As young people have a longer average start time in care-seeking, abortion resources are critical in reducing the delay and quickly connecting patients to an abortion facility (Finer et al., 2006). In addition to online platforms, schools should incorporate abortion into their sex education curriculum to further demystify abortion care for young people and their families. Inclusion of abortion in sex education materials may allow young people to reach desired services more quickly and reduce abortion providers' tasks that fall outside of their responsibilities (Guendelman et al., 2020; Stanger-Hall & Hall, 2011).

Abortion Care and Sexual and Reproductive Health Care

Sexual and reproductive health (SRH) includes abortion, yet the requirements for young people receiving abortion services vary drastically from those related to accessing other SRH services such as contraception. In the U.S. Southeast, almost all young people have the right to consent to contraception, STI services, prenatal care, adoption, and medical care for their child without a parent's presence (Table 5). However, young people's right to SRH services excludes abortion care, and all 11 Southeastern U.S. states still require parental involvement (Table 2; Table 5).

The unique requirements for abortion among adolescent SRH services raise questions regarding the necessity of parental involvement policies and whether they support young patients in receiving better abortion care. Parental involvement laws ensure parents are involved in the abortion process, but many young people voluntarily include parents regardless of the law (Ralph et al., 2014). Furthermore, parental involvement laws do not inherently promote social support for young patients; for some young people, they may delay care (Davis & Beasley, 2009).

Mandated regulations targeting young people seeking abortion care also hinder their rights to private and confidential care. The U.S. Supreme Court confirmed that young people have the constitutional right to receive abortions, but complex regulations such as parental involvement and judicial bypass create harmful barriers that may deter young people from seeking abortion care ("Bellotti v. Baird," 1979). Many medical organizations such as the American Medical Association, the American Academy of Pediatrics, and the American Public Health Association emphasize young people's right to confidential care, including abortion (American Medical Association, 2001b; American Public Health Association, 2011; Braverman et al., 2017). Recent shifts in policy in other regions of the U.S. also reflect the recognition that young people should possess the same rights as adult patients ("Youth Health and Safety Act," 2021).

In addition to parental involvement laws specific to minors seeking an abortion, abortion facilities also face targeted regulations that implement higher standards than other SRH care facilities. Besides strict evidence-based regulations (e.g., licensing requirements, medical ethics, etc.), targeted regulations of abortion provider (TRAP) laws are additional regulations that go beyond what is necessary to ensure patient safety. For example, most TRAP laws require abortion clinics to meet the same standards as ambulatory surgical centers, although the risk of

experiencing complications from abortion is rare (Upadhyay et al., 2015). In addition to the burden on abortion providers, TRAP laws also limit young people's access to abortion services. For example, in 2013, Texas passed House Bill 2 (HB2), which required abortion providers to have admitting privileges within 30 miles of the abortion clinic ("HB 2," 2013). This unnecessary requirement contributed to abundant closures of abortion clinics; by 2014, only 6 out of 41 abortion clinics remained open (Grossman et al., 2014). Arkansas also introduced similar laws to Texas' HB2 that required abortion providers to have a transfer agreement with a hospital ("Act 740," 2021). Furthermore, Arkansas and Louisiana also now require abortion facilities to meet the same standards as ambulatory surgical centers (Guttmacher Institute, 2022d). These laws burden abortion providers and continue to limit abortion access for individuals living in the U.S. Southeast.

New Direction for Minor Abortion Laws

The disparity between other SRH services and abortion regulations underscores the need for policy change to ensure autonomy and confidentiality in all SRH services. While all Southeastern states in the U.S. still require parental involvement for minors seeking an abortion, states from other regions are introducing repeal bills to honor minors' fundamental rights to make coercion-free decisions. For example, in December 2021, Illinois Governor Pritzker signed the Youth Health and Safety Act to repeal the parental notice requirement for young people seeking an abortion ("Youth Health and Safety Act," 2021). The law will go into effect in June 2022; future research can observe the impacts of this bill and speak to implications for young people seeking abortion care in other contexts.

Parental involvement laws compromise young people's rights to receive abortions as part of their reproductive rights. Furthermore, new restrictions in the U.S. South are directly

challenging reproductive rights since *Roe v. Wade*. In 2021, Texas Governor Abbott signed legislation SB8, also known as the Texas Heartbeat Act, to ban abortion at six weeks of gestation, which is before the average time it takes young people to learn about their pregnancy (Finer et al., 2006; "SB 8," 2021). The Texas-style ban, without direct opposition from the Supreme Court, would encourage further expansion of the hostile environment in the U.S. Southeast. For example, the case *Dobbs v. Jackson Women's Health Organization* set a historic record where the Court may consider the overturn of *Roe v. Wade* (Center for Reproductive Rights). Depending on the ruling of this case, five more U.S. Southeastern states (Arkansas, Kentucky, Louisiana, Mississippi, and Tennessee) may ban abortion care due to abortion restrictions designed to be "triggered" and take effect automatically if Roe is overturned (Nash, 2021a). Instead of creating a more hostile environment for people seeking an abortion, Southeastern states should learn from other states to promote a more equitable environment so young people can access all SRH services without compromising their right to autonomous and confidential care.

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Tables

Table 1. Southeastern U.S. states abortion laws

Adapted from Guttmacher Institute (2022a).

State	Must be performed by a licensed physician	Prohibited (except in cases of life/health endangerment) at	Providers may refuse to participate	Funding limited to life endangerment, rape, and incest	Mandated counseling on:	Waiting period after counseling
Alabama	X	20 weeks*	--	X	--	48 hours
Arkansas	X	20 weeks†	Individual & institution	X	Fetal pain$^{\Phi}$	72 hours
Florida	X	24 weeks	Individual & institution	X		
Georgia	X	20 weeks*	Individual & institution	X	Fetal pain	24 hours
Kentucky	X	20 weeks*	Individual & institution	X		24 hours
Louisiana	X	20 weeks*	Individual & institution	X	Fetal pain & negative psychological effects	24 hours
Mississippi	Only OB/GYNs	20 weeks*, €	Individual & institution	X$^{\Omega}$	Breast cancer link	24 hours
North Carolina	X	Viability*	Individual & institution	X	Negative psychological effects	72 hours
South Carolina	X	20 weeks*	Individual & private institution	X	--	24 hours
Tennessee	X	Viability*	Individual & institution	X	--	--
Virginia		3rd trimester	Individual & institution	X$^{\Omega}$	--	--
Total in SE U.S. (Total nationwide)	**11 (36)**	**11 (43)**	**10 (45)**	**11 (34)**	**5 (13)**	**8 (25)**

* Exception in case of threat to the patient's physical health.
† Exception in case of rape or incest.
€ A court has temporarily blocked enforcement of a Mississippi law that would have banned abortion at 15 weeks after the patient's last menstrual period.
Ω Exception in case of fetal abnormality.
Φ Fetal pain information is given only to patients with a pregnancy at or after 20 weeks' gestation.

Table 2. Southeastern U.S. states minor's abortion laws

Adapted from Guttmacher Institute (2022c).

State	Parental involvement	Other relatives allowed to consent	Parent must provide:	Judicial bypass	Judicial bypass decision criteria	Exceptions
Alabama	Consent	--	ID & proof of parenthood	X	--	Medical emergency
Arkansas	Consent	--	ID*	X	Specific criteria & "clear and convincing evidence" standard	Medical emergency & abuse, assault, incest, or neglect
Florida	Consent & notice	--	ID	X	Specific criteria & "clear and convincing evidence" standard	Medical emergency
Georgia	Notification	--	ID	X		Medical emergency
Kentucky	Consent	--	--	X	Specific criteria	Medical emergency
Louisiana	Consent	--	ID* & proof of parenthood	X	"Clear and convincing evidence" standard	Medical emergency
Mississippi	Consent from both parents	--	--	X	"Clear and convincing evidence" standard	Medical emergency
North Carolina	Consent	X	--	X	--	Medical emergency
South Carolina	Consent†	X	--	X‡	--	Medical emergency & abuse, assault, incest, or neglect
Tennessee	Consent	--	Proof of parenthood	X	--	Medical emergency & abuse, assault, incest, or neglect
Virginia	Consent & notice	X	ID*	X	--	Medical emergency & abuse, assault, incest, or neglect
Total in SE U.S. (Total nationwide)	**11 (45)**	**3 (6)**	**8 (12)**	**11 (36)**	**5 (16)**	**11 (35)**

* Parental consent documentation must be notarized, which requires the parent to provide government-issued identification. In Louisiana, the parent must also provide identification to the abortion provider.
† Allows specified health professionals to waive parental involvement in limited circumstances.
‡ In South Carolina, applies to those younger than 17.
-- No explicit policy or relevant case law.

Table 3. Person-centered abortion care domains and definitions for young people

Adapted from Sudhinaraset et al. (2017).

Domains	Definitions
Dignity	Dignity refers to the ability of young people to receive care in a respectful and caring setting. It captures the mis/treatment of young people seeking abortion, as well as less subtle acts during patient-provider encounters that make young people feel dis/respected.
Autonomy	Autonomy implies that clinical personnel respect young people's views of what is appropriate and support patients and their companion of choice to make informed choices.
Privacy/Confidentiality	This relates to privacy in the environment in which care is provided, and the concept of privileged communication and confidentiality of medical records. An example is whether young people feel others who are not involved in their care could hear information about their care or could see them during physical examinations, even if they are their legal guardians.
Communication	This domain refers to clinical personnel clearly explaining to young people and family the nature of their pregnancy, details of the abortion process, and all available abortion options. An example is whether clinical personnel clearly explain to patients their abortion options and whether patients understand those explanations.
Social Support	This domain reflects the extent to which young people have access to their companion of choice when receiving care.
Supportive Care	This refers to clinical personnel providing care in a timely, compassionate, and caring manner, as well as integration of care in a way that is responsive to patient needs. It also captures abandonment or denial of care, protection from harm and unnecessary procedures, and patient safety.
Trust	This captures how young people assess their care at abortion clinic. Here, measures include whether patients feel providers tell them the truth about their care, their health, their situation, and whether they have confidence in the good intention of their providers.
Abortion facility environment	This captures the quality of the facility and providing a fully enabled environment, including the commodities and equipment, but also referral system, communication and transportation, environment where staff are respected and valued and that is clean, and the extent to which a health facility offers a welcoming and pleasant environment. Examples include clean surroundings and enough space in waiting rooms and wards.

Table 4. Characteristics of study participants in percentage or average (N=34)

Characteristics	Count	Percentage
Race & Ethnicity		
Black or African American	21	62%
White	8	24%
Hispanic/Latinx	3	9%
Other	2	6%
Education		
Some college	8	24%
College degree	13	38%
Professional/graduate degree	11	32%
Other	2	6%
Role in abortion care		
Director/administrator	9	26%
Support staff	18	53%
Clinical/patient care roles	7	21%
	Average (Range)	
Age	47 (24-71)	
Years worked in abortion care	15 (1-40)	

Table 5. Southeastern U.S. states consent to sexual and reproductive health services for young people

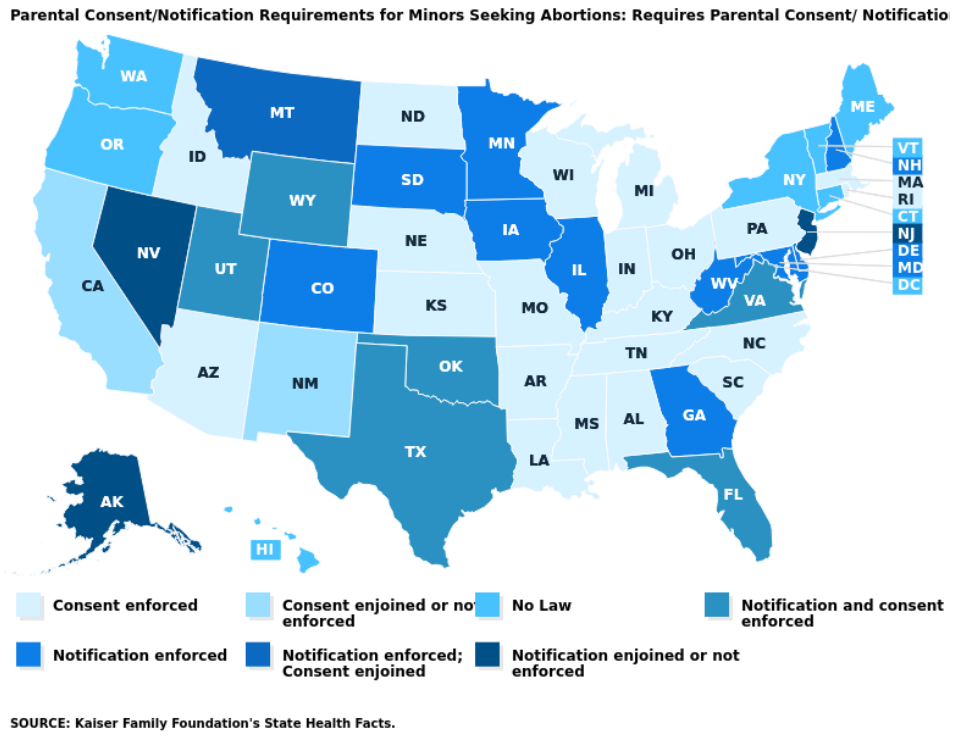
Adapted from Guttmacher Institute (2022b).

State	Contraceptive Services	STI Services	Prenatal Care	Adoption	Medical Care for Minor's Child	Abortion
Alabama	All	All*	All	All	All	Parental consent
Arkansas	All	All*	All	--	All	Parental consent
Florida	Some	All	All	--	All	Parental consent & notice
Georgia	All	All*	All	All	All	Parental notice
Kentucky	All*	All*	All*	Legal counsel	All	Parental consent
Louisiana	Some	All*	--	Parental consent	All	Parental consent
Mississippi	Some	All	All	All	All	Parental consent
North Carolina	All	All	All	--	--	Parental consent
South Carolina	All	All	All	All	All	Parental consent‡
Tennessee	All	All	All	All	All	Parental consent
Virginia	All	All	All	All	All	Parental consent & notice
Total in SE U.S. (Total nationwide)	**11 (27)**	**11 (50)**	**10 (33)**	**6 (28)**	**10 (30)**	**0 (2)**

* Physicians may, but are not required to, inform the young person's parents.
‡ The abortion law in South Carolina applies to those younger than 17.
-- No explicit policy or relevant case law.

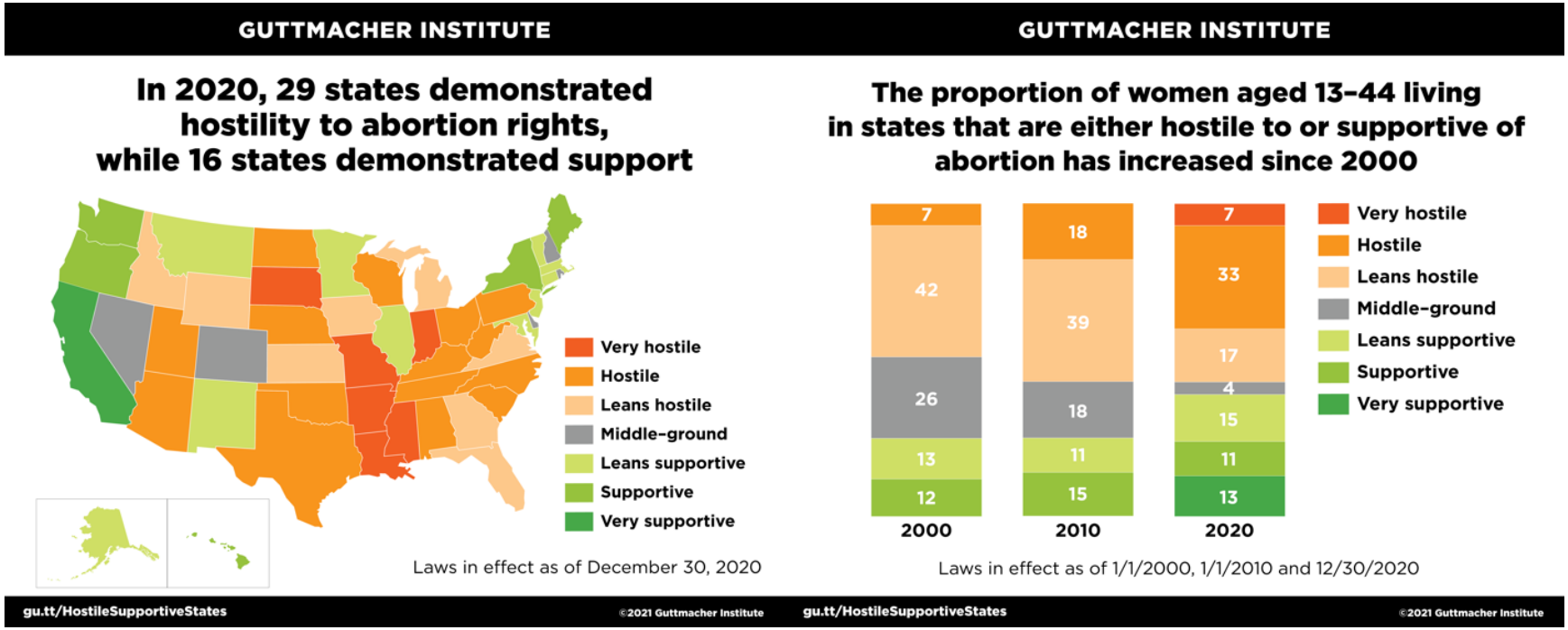
Figures

Figure 1. Parental involvement laws by U.S. state



Retrieved from Kaiser Family Foundation (2021). Adapted from Guttmacher Institute (2022c).

Figure 2. Abortion hostility by U.S. state



Retrieved from Nash (2020).

Figure 3. Person-centered care in reproductive health

Adapted from Person-Centered Care Framework for Reproductive Health Equity by Sudhinaraset et al. (2017).

Figure 4. Person-centered care for provider-minor engagement in abortion care