BEYOND BORDERS

Bringing Abortion Law & Policy Experiences from Around the World to the United States

Regulation of Abortion Decision-Making Among Young People

SIX STATE INNOVATION EXCHANGE

O'NEILL INSTITUTE GEORGETOWN LAW

Legal Voice Toward Justice & Gender Liberation.

Quick Links to Accompanying Reports and Supplementary Materials:

Abortion as Health Care

Critiques of Abortion Criminalization

Regulation of Religious Refusals for Abortion Care

Executive Summary

Definitions

Policy Considerations

Acknowledgements:
This resource was prepared by the O'Neill Institute for National and Global Health Law, and the State Innovation Exchange (SiX), and Legal Voice. Support was provided in part by the Robert Wood Johnson Foundation. The views expressed do not necessarily reflect those of the Foundation.

Regulating of Abortion Decision-Making Among Young People

Table of Contents

1. Introduction

Patient autonomy is a core tenet of medical decision-making, including for young people.[a] The World Health Organization (WHO) has consistently grounded its approach to young people's medical decision-making in human rights, maintaining that young people have a right to participate in and express their views on decisions regarding their health.[1] In 2002, the WHO emphasized the need to "promot[e] autonomy so that adolescents can consent to their own [health] treatment and care."[2] In 2022, the WHO stressed the importance of recognizing children's and adolescents' capacities and abilities to engage in decisions that affect their lives.[3]

The law, however, has been slow to integrate these concepts into its regulation of young people's medical decision-making. International human rights law, as well as national laws, generally impose a "bright-line rule" dividing childhood and adulthood, most commonly drawn at the age of 18 years old.[b] [4] Strict age cutoffs determine when young people can exercise certain rights and engage in legal decision-making without adult involvement. In the medical decision-making context, the law presumes that many young people lack the capacity to consent and, as a result, require parental or other legal guardian consent[c] for medical care below a certain age.[5] Other actors, including government officials, courts, health providers, and educators, can play a role in young people's decision-making, particularly when a young person and their parents or other legal guardians disagree.

The presumption of young people's incapacity extends to decision-making around sexual and reproductive health services, particularly abortion.[d] Since the 1970s, most states in the United States have adopted laws requiring parental involvement in young people's abortion decision-making. In those states, young people who seek abortions without parental involvement must rely on the judicial bypass mechanism, which is discussed in **Parts 3** and **5**. In the wake of *Dobbs v. Jackson Women's Health Organization*, various states have passed additional laws that expand the scope of parental involvement in young people's decision-making related to sexual and reproductive health services. At least one state court (Florida) has ruled that *Dobbs* effectively overturned minors' independent right to abortion and invalidated the state's judicial bypass requirement.[6] In Connecticut, a never-enforced parental involvement requirement for abortion took effect in 2025 for the first time since its enactment in 1985.[7] While the Supreme Court declined to take up a case involving parental involvement requirements related to abortion during its 2025-2026 term, at least some of the justices have arguably expressed an interest in reviewing similar cases in the future.[e] [8]

Conversely, various countries have taken measures to limit parental involvement in young people's medical decision-making, particularly related to sexual and reproductive health services. The laws in some countries account for 18 being too high a cutoff, lowering the age of consent for abortion and other sexual and reproductive health services. Other countries — whether through statutes or case law — recognize young people's gradual attainment of capacity in medical decision-making, relying on concepts ranging from evolving capacities to progressive autonomy to mature minor.

a Concepts and definitions of "young people" can differ across cultures and jurisdictions. In this report, the term refers to those who are progressing toward independent decision-making capacity but remain below the legal age of adulthood, which is 18 years in many parts of the world. While "young people" is the authors' preferred term, the report also uses terms, such as minors, adolescents, and children, to mirror the language of the primary sources referenced throughout this report.

b However, the age of majority can vary across different areas of the law, even within a single legal system.

c Informed consent requires patients to have: 1) the capacity to consent; 2) an understanding of all information relevant to the decision; and 3) the ability to exercise a voluntary decision free from coercion or manipulation.

d While abortion care is the primary focus of this report, young people also face heightened barriers in decision-making surrounding contraception. As with abortion care, these barriers have increased since the Dobbs decision. For example, federal courts have undermined young people's confidential access to family planning services through the Title X program, relying on a state's existing parental involvement law. *Deanda v. Becerra*, 96 F.4th 750 (5th Cir. 2024).

e I.e., a different case that would ask the Supreme Court to decide "[w]hether a parent's fundamental right to direct the care and custody of his or her children includes a right to know and participate in decisions concerning their minor child's medical care, including a minor's decision to seek an abortion."

This report compiles and analyzes how international organizations and decision-makers in various countries have challenged the presumption that young people below a certain age are unable to engage in decision-making related to abortion without parental or other legal guardian involvement. While not intended to be comprehensive, this report seeks to bring greater visibility to many of the approaches taken and arguments relied upon by actors in other parts of the world.

Part 2 outlines the limitations and challenges associated with strict age cutoffs or age-based categorical exclusions in medical decision-making, according to experts from various disciplines.

Part 3 situates U.S. parental involvement laws in a global context, comparing them to corresponding laws in other countries.

Part 4 lays out the relevant human rights principles, describing how human rights bodies have assessed and provided recommendations related to young people's abortion decision-making.

Part 5 highlights the different approaches taken by various countries to recognize the gradual attainment of capacity in young people to make decisions related to abortion care.

Part 6 offers policy proposals and additional resources for advocates and decision-makers in the United States seeking to integrate these arguments and approaches into their local law and policy reform efforts.

2. Calls for Lowering or Eliminating Strict Age Cutoffs

According to international human rights law, the state has two important functions with respect to young people: protecting them from harm and supporting their healthy development.[9] Parents, however, have the primary responsibility for the care and upbringing of their children and, as a result, domestic law often reflects the traditional presumption that young people lack the capacity to make autonomous decisions and transfers decision-making authority to parents or other legal guardians.[10] Scholars from various disciplines have criticized the "bright-line rule" dividing childhood and adulthood through strict age cutoffs for various reasons, including the fact that it "fails both to recognize the full personhood of young people and account for the developing nature of childhood.[11]

Neuroscientists, bioethicists, social workers, and lawyers, among others, have begun to lay out some of the limitations associated with using age as a proxy for competence, maturity, or experience.

Research across disciplines underscores the limitations and challenges of setting 18 years of age as a strict cutoff for medical decision-making. First, decades of developmental science research demonstrate that 18 is an overly high age cutoff in this regard. According to this research, "by mid-adolescence, young people are comparable to adults in their ability to make deliberative decisions, including specific abilities in working memory, logical reasoning, weighing risks and benefits, and anticipating consequences of their actions."[12] Neuroscientists, moreover, distinguish "hot" decision-making, which involves short timelines, reactive processes, peer influences, and heightened emotions, from "cold" decision-making, which involves deliberative processes based on information and insight gathered over a period of time.[13] Medical decision-making, including decisions related to sexual and reproductive health care, is considered "cold" decision-making, with children often demonstrating the developmental capacity to consent by 12 years of age — which can be further aided by supportive factors.[14]

Second, various disciplines agree that factors beyond age are relevant to decision-making.[15] According to neuroscientists, brain development and the ability to make emotionally mature, long-term decisions can vary greatly from one young person to the next and from one context to the next, depending on the individual, their age, and environmental and other factors.[16] Even without brain imaging, health care professionals can assess relevant attributes (e.g., understanding, appreciation, reasoning, expression of choice) to determine a person's brain development for decision-making capacity.[17] The field of social work stresses that cultural and religious norms, community and family values, and personal life experiences can not only influence decisions, but also alter a young person's level of maturity and decision-making capacity. A young person's role within their own family and community can, moreover, differ enormously across cultures, contexts, and circumstances.

Third, strict age cutoffs can undermine core principles of bioethics and human rights, which prioritize the empowerment and centering of young people in the medical decision-making process. The principle of autonomy favors young people's involvement in decisions about their own health, with access to information about the consequences of those decisions.[18] The principles of beneficence and the best interests of the child support the course of treatment that is most aligned with the young person's well-being. Finally, the principle of non-malfeasance requires mitigating any risks of harm to the young person. Denying or delaying a young person's access to abortion care in favor of social norms, such as supporting parents' wishes, raises ethical issues because of the potential consequences[f] for their physical and mental health, well-being, and bodily autonomy.[19]

Parental involvement requirements can serve as major barriers to sexual and reproductive health services, given

f Forcing pregnancy on anyone who is denied abortion care is associated with numerous harms, including higher risk pregnancies, chronic pain, economic hardship and financial instability, and staying in a relationship with a violent partner. However, these harms are magnified when the person denied abortion care is a young person.

that parents or other legal guardians may be unaware of or uncomfortable with the fact that their child is sexually active.[g] While the majority of young people choose to involve a parent in their abortion decision, those who choose otherwise often do so out of fear of parental reactions (e.g., abuse, forced continuation of pregnancy, or kicking them out of the home), desire to preserve their own autonomy, or because they already have a difficult or estranged relationship with their parents.[20] In certain instances where a parent is deceased, incarcerated, or missing, the supportive adults present in a young person's life (e.g., grandparents, older siblings) may lack the documents to show legal guardianship, meaning they cannot provide consent even if they support the young person's medical decision. Research has shown, moreover, that parental involvement requirements affect young people's physical and mental health, given their associations with the inability of some minors to obtain their desired pregnancy outcome, delays in receiving wanted abortion care, and psychological harm.[21]

Accordingly, various international organizations and experts have stressed the need to eliminate parental involvement requirements from abortion laws. In its Abortion Care Guideline (2022), the WHO has explicitly noted that "[f]or adolescents, the authorization or consent of parents should not be required before the provision of abortion care," characterizing its recommendation against any third-party authorization as a human rights imperative.[22]

> "States are urged to consider the introduction of a legal presumption of competence that an adolescent seeking preventive or time-sensitive health goods and services, including for sexual and reproductive health, has the requisite capacity to access such goods and services. Where minimum ages of consent exist, as the Committee on the Rights of the Child has argued, any adolescent below that age and able to demonstrate sufficient understanding should be entitled to give or refuse consent. At a minimum, States should ensure a minimum age well below 18 years at which adolescents have the right to consent to or refuse services without mandatory authorization or notification of parent, guardian, spouse or intimate partner. The right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit."[23]
>
> *—UN Special Rapporteur on the Right to Health*

g While experts agree that trusted adult involvement in minors' medical decision-making is ideal, young people are far less likely to seek "sensitive" or stigmatized services if they are required to inform or receive permission from their parents or legal guardians. Rebecca Cook & Bernard M. Dickens, Recognizing Adolescents' 'Evolving Capacities' to Exercise Choice in Reproductive Healthcare, 70 Int'l J. Gynaecol. Obstet. 13 (2000).

3. United States Parental Involvement Laws in a Global Context

According to the WHO, 60 countries[h] around the world have clear and uniform parental consent requirements for young people below a certain age to access abortion care, including 22 in Europe and 21 in Asia.[24] In the 61 countries where abortion care is available on request, only 25 require young people to obtain parental consent.[25] In the **United States**, **38 states** require some degree of parental involvement in a young person's decision to have an abortion, ranging from written consent to notification.[26] Notably, parental involvement laws affect access to abortion care in jurisdictions with total or near-total bans under exceptions (e.g., to preserve the life or health of the pregnant person, or in cases of fetal anomaly, rape, or incest) and in jurisdictions that broadly permit abortion care.

Among countries with strict age cutoffs, age 18 remains the most common age of consent, though some countries have lowered the age of consent for sexual and reproductive health services, including abortion care. As of 2017, the vast majority of countries with clear and uniform age cutoffs for abortion care established 18 or 16 as the age of consent, while a handful established 15 or 14 as the age of consent.[27] Some countries establish a lower age of consent only for abortion care in cases of pregnancies that result from sexual violence, including Mexico, as discussed further below. In the **United States**, parental involvement requirements most often apply to young people under 18, but some statutes apply only to those under 17 (e.g., South Carolina) or 16 (e.g., Massachusetts, Montana).[28]

Some countries have adopted workarounds for cases where young people and their parents or other legal guardians disagree, such as judicial bypass, judicial waiver, or other medical authorization mechanisms. Up until now, **38 U.S. states** with parental involvement laws have included a judicial bypass or waiver alternative[i], as required by Supreme Court precedent.[29] Legal experts have documented the harms caused by judicial bypass or waiver mechanisms, including that they cause distress, delay care, and violate privacy and confidentiality standards.[30]

Further, in the wake of *Dobbs*, some decision-makers in the **United States** are seeking to invalidate judicial bypass mechanisms – which would leave young people with no alternative to parental involvement in abortion care.

U.S. States with Parental Involvement Laws

Alabama	**Maine**	**Oklahoma**
Arizona	**Maryland**	**Pennsylvania**
Arkansas	**Massachusetts**	**Rhode Island**
Colorado	**Michigan**	**South Carolina**
Delaware	**Mississippi**	**South Dakota**
Florida	**Missouri**	**Tennessee**
Georgia	**Montana**	**Texas**
Idaho	**Nebraska**	**Utah**
Indiana	**Nevada**	**Virginia**
Iowa	**New Hampshire**	**West Virginia**
Kansas	**North Carolina**	**Wisconsin**
Kentucky	**North Dakota**	**Wyoming**
Louisiana	**Ohio**	

h The database does not account for consent requirements of federal legal systems, given the possibility of varying ages of consent by state or province.

i In 1976, the Supreme Court considered early parental consent requirements for abortion and held that states cannot delegate to parents a veto power that states themselves do not have. Even when the Court later found that states have an interest in encouraging minors to involve their parents in abortion-related decisions, given their "inability to make critical decisions in an informed and mature manner," it reiterated that an absolute parental veto would be unconstitutional.

4. Young People's Abortion Decision-Making Under International Human Rights Law

International human rights law has sought to address the discrepancy between national legal systems' historical treatment of young people's decision-making capacity and more recent understandings of young people's mental and emotional development. Since the 1980s, various human rights bodies have acknowledged the gradual attainment of decision-making capacity among young people and, in some cases, called for countries to reform their laws requiring parental involvement in young people's abortion decision-making. This section examines the principles and rights most commonly referenced and relied upon by human rights bodies in the process — namely, evolving capacities of the child, progressive autonomy, and the right to privacy.

a. Evolving Capacities of the Child

The "evolving capacities of the child" principle first emerged in the 1989 United Nations Convention on the Rights of the Child (CRC). Before then, international human rights law afforded parents broad authority as the primary rights holders in the care and upbringing of their children and granted family units a protected status, leaving little room for government interference. The CRC departed from this approach, acknowledging children as distinct rights holders for the first time under international law, rather than merely "passive recipients of care."[31] The Committee on the Rights of the Child (CRC Committee) recognized that children's capacities evolve as they grow and develop, and directed parents to adapt their direction and guidance accordingly to enable their children to take on a greater role and responsibility in exercising their own rights as they move through childhood and adolescence into adulthood.

Article 5 of the CRC:

"States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention."[32]

The evolving capacities principle, moreover, is closely linked to CRC's four "general principles," namely non-discrimination, best interests of the child, the right to development, and the right to be heard. In fact, at the regional level, the African Committee of Experts on the Rights and Welfare of the Child (African Committee) has explained that the African Charter on the Rights and Welfare of the Child's (ACRWC)[33] right to development encompasses the evolving capacities principle:

"[T]he child's right to development entails a comprehensive process of realizing rights in order to allow them to grow up in a healthy and protected manner, free from fear and want, and to develop their personality, talents and mental and physical abilities to their fullest potential consistent with their evolving capacities."[34]

While the CRC itself provides little guidance regarding how the evolving capacities principle should be applied in practice, the CRC Committee has since commented on its meaning, interpretation, and implementation. As recently as October 2023, the CRC Committee issued a statement on Article 5 on striking the proper balance between the rights of the child and the responsibilities, rights, and duties of parents.[35] Regarding the gradual attainment of capacity, the CRC Committee noted that:

> "The more children know, have experienced and understand, the more the parent, legal guardian or other persons legally responsible for the children have to transform direction and guidance into reminders and advice and later to an exchange on an equal footing. This transformation will not take place at a fixed point in children's development but will steadily increase as children are encouraged to contribute their views, which should be given greater weight."[36]

The CRC Committee also stated that "[s]oliciting and hearing children's views are requirements both when providing direction and guidance, and when assessing and determining the child's best interests."[37] In other words, "one has to consider that the capacities of the child will evolve" as part of the best-interests assessment."[38]

The statement on Article 5 also established important limits on parents' ability to take actions that are not in their child's best interests. According to the CRC Committee, "[t]he evolving capacities should be seen as a positive and enabling process, not an excuse for authoritarian practices that restrict children's autonomy and self-expression, and which are often inaccurately justified by pointing to children's relative immaturity."[39] Similarly, in a 2021 general comment, the African Committee acknowledged that, "[o]rdinarily, parents and other caregivers act in the best interest of their children."[40] However, there can also "be a tension between the exercise of parental responsibility and the duty to guide children in their behaviour, and children's right to freedom of expression and to privacy, as well as their evolving capacity and need to engage increasingly with the adult world as they near the end of childhood."[41]

The CRC Committee also stressed that the "protection of the family" and references to culture or religion cannot be used to justify harmful laws, policies, or practices that violate girls' full and equal human rights.[42] Accordingly, "[s]tates are not required to respect the right of parents to provide direction and guidance when such direction and guidance would promote discrimination."[43]

The CRC Committee has applied the evolving capacities concept to various specific topics, including young people's medical decision-making in general and, in particular, related to sexual and reproductive health services. In 2013, the CRC Committee provided that States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception, and safe abortion care.[44] The CRC Committee also acknowledged that high pregnancy rates among adolescents globally (and the equally high risks of morbidity and mortality) demand that States ensure that "health systems and services are able to meet the specific sexual and reproductive health needs of adolescents," including family planning and safe abortion care."[j]

In 2016, the CRC Committee recommended a legal presumption that adolescents are competent to seek and access sexual and reproductive services, whether they are preventive or time-sensitive.[45] Relatedly, it stated that there should be no barriers to sexual and reproductive health services, explicitly referencing "requirements for third-party consent or authorization"[k] as an example of an impermissible barrier.[46] As part

j For purposes of data collection, the CRC Committee has considered adolescence to include "the period of childhood from 10 years until the 18th birthday." However, the CRC Committee has acknowledged that "adolescence is not easily defined, and that individual children reach maturity at different ages." *Id.* at ¶ 56

k "Third-party" has been interpreted broadly in international human rights law to include not only parents or legal guardians, but also spouses or judges.

of its call to States to ensure that young people can access safe abortion and post-abortion care, the CRC Committee urged States to review legislation to guarantee "the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions."[47] The CRC Committee has urged Russia[48], Djibouti[49], Palestine,[50] and Ireland[51] to take such actions in concluding observations from 2024, 2022, 2020, and 2016, respectively.

b. Progressive Autonomy

The Inter-American human rights system has developed its own principle to account for young people's gradual attainment of decision-making capacity, namely progressive autonomy. As early as 2005, the Inter-American Commission of Human Rights held that "children exercise their rights in a progressive manner as they develop a greater degree of independence and personal autonomy."[52]

In 2011, the Inter-American Court of Human Rights considered *Gelman v. Uruguay*, a case involving the forced disappearance of a pregnant student and the subsequent kidnapping of her child during Uruguay's military dictatorship.[53] In its decision, the Court established that children must be able to exercise their right to self-determination in a progressive manner. According to the Court:

> "While children are subject to human rights, this right implies the possibility of all human beings to self-determination and to freely choose the circumstances and options regarding their existence. In the case of children, they exercise this right in a progressive manner in the sense that the minor of age develops a greater level of personal autonomy with time [...]."[54]

Similarly, in *Furlan and Family v. Argentina*, the Court cited the CRC Committee in establishing that "children exercise their rights progressively as they develop a greater level of personal autonomy."[55]

In 2020, the Court recognized that young people could exercise other rights under the American Convention on Human Rights in a progressive manner. In *Paola Guzmán Albarracín v. Ecuador*, the Court held that the rights to personal integrity (Article 5) and to private life (Article 11) protect "sexual freedom and control over one's own body" and "may be exercised by adolescents in the measure that they develop the capacity and maturity to do so."[56] The Court also noted in a footnote that, according to the CRC Committee, levels of comprehension in children "are not uniformly linked to their biological age" and "that information, experience, social environment, cultural expectations and the level of support received contribute the development of the child's capacity to form an opinion."[57] Factors that influence the decision-making of children and adolescents must be taken into consideration "when trying to ensure a proper balance between respect for the progressive autonomy and appropriate levels of protection."[58]

c. Right to Privacy

The evolving capacities and progressive autonomy principles are grounded in various human rights, including the rights to development, participation, and non-discrimination. However, human rights bodies have also relied on other rights to call for the increased decision-making capacity for young people, particularly related to abortion care. Numerous human rights bodies have relied on the right to privacy to call for sexual and reproductive health information and services to be provided in a way that ensures confidentiality.[59] The CRC Committee and the Committee on Economic, Social and Cultural Rights have focused on States' obligations to ensure that adolescents have full access to appropriate information on sexual and reproductive health services, including abortion care, in a manner that ensures respect for privacy and confidentiality.[60] The CRC Committee, moreover, has linked privacy around health information and counseling with informed consent, requiring States to "enact laws or regulations to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent."[61] However, the Special Rapporteur on the Right to Health has gone further, recommending that all adolescents must be guaranteed access to confidential abortion care.[62]

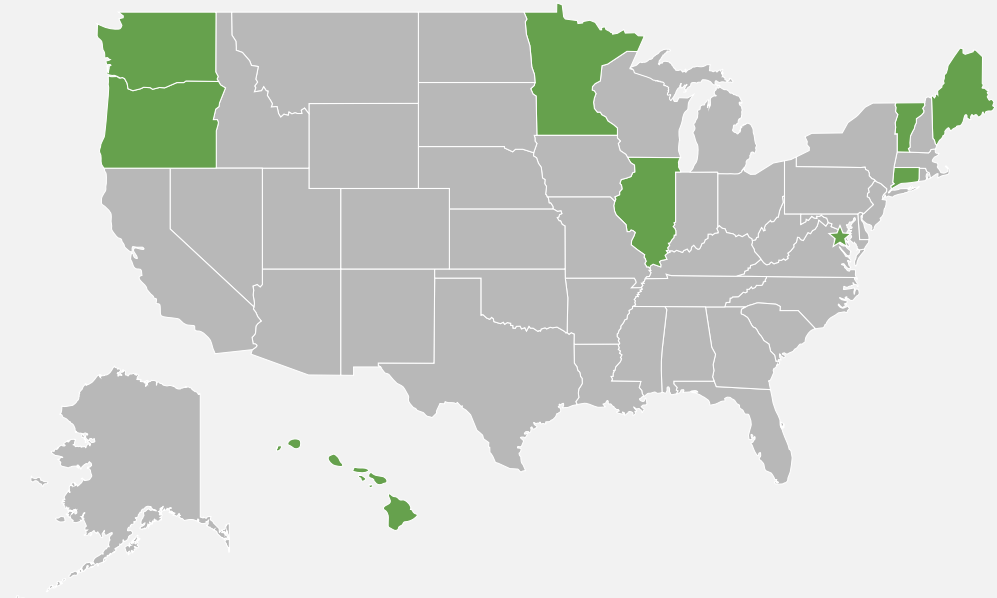
5. Approaches to Young People's Abortion Decision-Making in Comparative Law

Legal systems around the world have begun to recognize the limitations of strict age cutoffs in many contexts and, in turn, allow young people under 18 to exercise certain rights and make certain decisions without parental involvement. This section outlines three national-level approaches to regulating young people's access to abortion care in a way that acknowledges their gradual attainment of decision-making capacity — namely, removing the age of consent, lowering the age of consent, adopting age brackets, carving out exceptions to strict age cutoffs for "mature minors," and accounting for exceptions in abortion bans.

a. Removal of Age Cutoffs

Removing age cutoffs altogether is an approach that enables young people to seek abortion care without any age-based requirement for parental involvement in the decision-making process. It recognizes that any age cutoff is inherently arbitrary, given the gradual nature of young people's decision-making capacity. It aligns with international organizations and experts' calls for the elimination of parental authorization requirements for abortion care, among other sexual and reproductive health services. Importantly, in practice, this approach may still integrate mechanisms that encourage — but do not require — young people to consult with their parents or other legal guardians during the decision-making process.

In the **United States**, **nine states and D.C.** do not require parental or other third-party involvement in young people's abortion decisions.[63] In many of these states, courts struck down prior parental involvement requirements as unconstitutional.[64] For example, Washington's Supreme Court held that a state law affording parents an absolute veto over their minor child's abortion access was an unconstitutional violation of a minor's due process privacy and equal protection rights under both the U.S. and Washington constitutions.[65]



NO PARENTAL-INVOLVEMENT REQUIREMENTS FOR MINORS SEEKING ABORTION

Connecticut, Hawaii, Illinois, Maine, Minnesota, New York, Oregon, Vermont, Washington, and the District of Columbia

In **Colombia**, the Constitutional Court has relied on the constitutional rights to dignity, autonomy, and the free development of personality to remove its age cutoff for abortion decision-making. A series of cases decided in the late 1990s and early 2000s held that restrictions on young people's right to free development of personality must be based on the person's degree of maturity. The Court has stressed that age is not a purely objective criterion for legal capacity and autonomy to make decisions, even though it can serve as a guide in assessing a minor's intellectual and emotional maturity.[66] Minors of identical age may "show different capacities for self-determination and, therefore, may enjoy different protections of the right to the free development of the individual."[67] The legal protection afforded to the right to free development of personality increases "as the ability of self-determination of the minor increases"[68] and, as a result, "the higher the degree of intellectual capacity, the lesser the legitimacy of interventions into the decisions of the minor."[69]

In February 2025, the Colombian Ministry of Health passed a resolution on measures aimed at guaranteeing "access, autonomy, and informed consent for girls, boys, and adolescents in healthcare."[70] The resolution seeks to integrate the principles of evolving capacities and progressive autonomy established by both the CRC Committee and Colombia's Constitutional Court into healthcare settings. Notably, the resolution introduces six rules to guide the "intensity of support" provided by adults to children and adolescents related to medical decision-making, addressing factors, such as the level of risk of the procedure or treatment, disagreement between minors and legal representatives, and situations where it is not possible to determine the minor's decision.[71]

The Colombian Constitutional Court has applied the removal of the strict age of consent specifically to the abortion context. When decriminalizing abortion care under three circumstances in 2006, the Court also reviewed a provision of the law that criminalized any abortion "performed on a woman of less than 14 years of age" by categorically presuming that a person under age 14 was incapable of consenting to abortion care. The Court ultimately ruled that this presumption was unconstitutional, given its disregard for human dignity, the free development of personality, and the autonomy of pregnant minors under 14.[72] The Court held that while the Colombian legislature could "establish rules in the future regarding representation of minors or the assertion of minors' rights," those rules cannot invalidate the consent of a minor under 14 years of age.[73]

In 2009, the Court explicitly named parental consent an impermissible requirement for obtaining abortion care, characterizing "preventing girls under 14 from providing informed consent when their parents disagree" as an unconstitutional barrier to legal abortion care.[74] The Court reiterated this approach in 2016, stressing that only the minor's "consent is required to undergo a voluntary termination of pregnancy."[75] Similarly, in 2018, the Court stated:

> **"Minors are full holders of the right to free development of personality and to that extent enjoy full capacity to consent to treatments and interventions on their bodies that affect their sexual and reproductive development, including voluntary termination of pregnancy. Obstacles or additional barriers should not be imposed when their parents or legal representatives do not agree with the consent given for this purpose."[76]**

Colombia adopted and then updated a resolution regulating the provision of abortion care in 2018 and 2023, respectively.[l] The resolution (No. 051/2023) includes provisions that integrate the standards adopted by the Constitutional Court related to the ability of all young people, regardless of age, to consent to and access abortion care without parental involvement.[77] It states that "[g]irls under 14 years old can exercise their right to VTP [voluntary termination of pregnancy] autonomously. Their wish to terminate or continue with the pregnancy takes precedence over the wishes of their parents or legal representatives, even if they do not agree with their decision."[78] The resolution references the concept of "substitute consent" but stresses that, in cases involving abortion care, it is not decisive and that only the minor's decision is valid.[79]

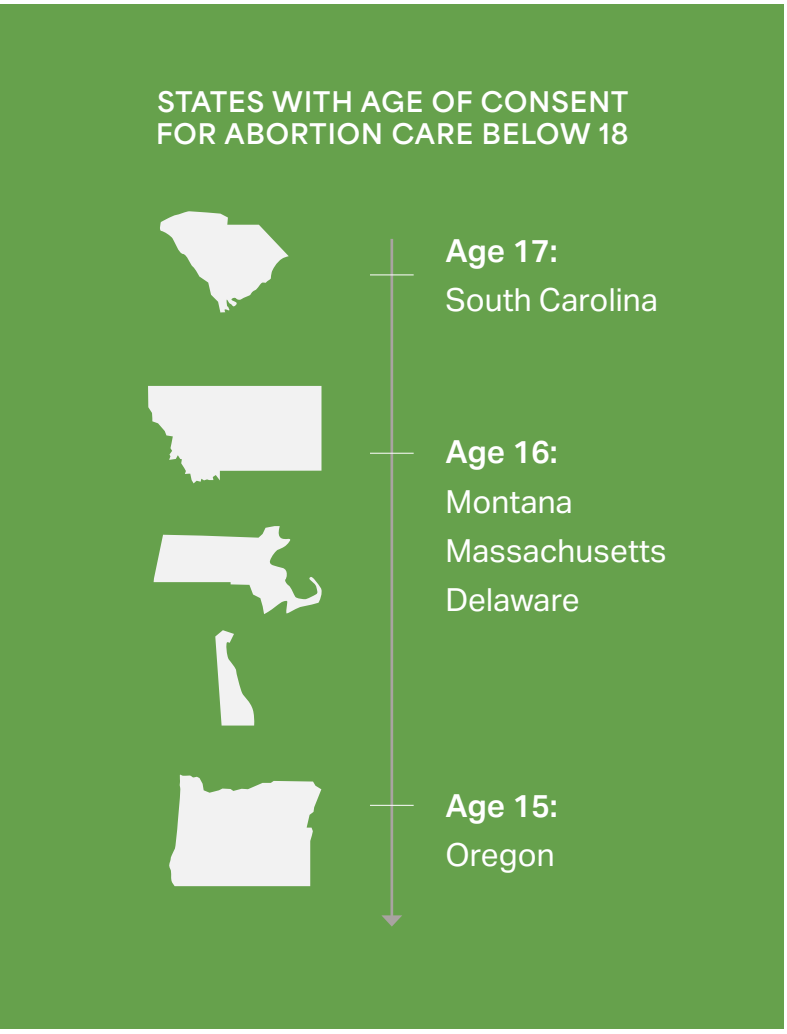
In practice, health professionals in Colombia typically involve the parents or caregivers of young people under the age of 14 in medical decision-making involving abortion care. However, in cases of disagreement, they comply with the law's requirement that the young person's decision take precedence.

l This resolution references not only "progressive autonomy," but also "contextual autonomy."

b. Lowering of Age Cutoffs

An alternative approach to removing an age cutoff altogether has been to lower it to a specific age under 18, either for all abortion care or abortion care under certain circumstances. Lowering the age cutoff for abortion care acknowledges that 18 years of age is too high and that at least some young people below that age are capable of consenting to abortion care. Even lowering the age of consent for abortion care to 16 years of age can result in improved access to care for young people, as demonstrated by research in Massachusetts following the 2020 reforms to its parental consent requirement.[m] [80]

In the **United States**, **five states** have lowered the age of consent for abortion care to below 18. The age of consent for abortion care is 17 in **one state** (South Carolina), 16 in **three states** (Delaware, Massachusetts, and Montana), and 15 in **one state** (Oregon).[81]



In **Mexico**, while the age of consent for most abortions remains 18 years of age, the government reformed federal regulation in 2016 to lower the age of consent to 12 years for girls who are survivors of sexual violence.[82] That same year, the Aguascalientes legislature challenged the reform, arguing that it encroached on the state's jurisdiction to legislate on parental authority and its effects on minors, citing various provisions of the state's civil code.[83]

In 2022, the Supreme Court upheld the law, relying on international human rights standards, particularly the CRC's evolving capacities principle and its protection of the right to health.[84] The Court underscored the link between the evolving capacities principle and the right to health, stressing the need to recognize that children's ability to assume responsibilities and make decisions affecting their lives, including regarding medical treatments and interventions, gradually increases.[85] Citing its previous caselaw, the Court characterized childhood as:

> "The stages of a child's development are cumulative; each one impacts subsequent stages, influencing the child's health, potential, risks, and opportunities. Understanding their life trajectory is crucial for safeguarding their right to the highest possible standard of physical and mental health."[86]

The Court also reflected on Mexico's approach to parental authority, which is grounded in a careful balancing of the need to protect young people and recognize their progressive autonomy.[87] According to the Court, while "[c]omprehensive protection of minors is a constitutional mandate imposed on both parents and public authorities," minors must also "be recognized as persons and rights holders with progressively increasing capacity to exercise those rights as they mature."[88] Allowing for young people aged 12 to 18 who are survivors of sexual violence to access abortion care without parental consent is crucial for protecting the best interests of the child and in line with authorities' obligations to protect survivors and "take special measures aimed at reducing the direct and indirect effects of traumatic experiences and ensuring the healthy and harmonious development of their personality in the future."[89] Importantly, according to the Court, the federal constitution's best interests of the child principle (Article 4) can be used to limit the scope of parental rights:[90]

m After Massachusetts removed its parental consent requirement for pregnant minors seeking abortion care who were 16 and 17 years old in 2020, one study found that minors in the state who accessed abortion under the reformed law did so earlier in their pregnancies, indicating that the reform effectively eased a barrier to care.

> [J]udicial authorities must move beyond the old conception of parental authority as absolute parental power. Today, parental authority is not a right of the parents, but a function entrusted to them for the benefit of the children, directed at their protection, education, and comprehensive development, with the child's best interests always prevailing in the parent-child relationship. Public authorities are increasingly vigilant in ensuring this principle.[91]

In 2022, the Ministry of Health issued Technical Guidelines on Safe Abortion Care, which establish that young people who are 12 years of age or older can request and consent to abortion care without parental involvement in cases of pregnancies resulting from sexual violence.[92] Young people under 12 years of age are required to request abortion care "through" a parent or guardian. If no such person is available, a representative of the child protection authority may make the request in accordance with the child's best interests.

In August 2025, **Rwanda** passed a law that lowered the age of consent for sexual and reproductive health services from 18 to 15.[n] [93] Abortion care is legal in Rwanda on several grounds, including where the pregnant person is a child.[94] The law had previously required all people under 18 to obtain parental consent for abortion care, though the law indicated that the child's wish should prevail in cases where the child and parent disagreed. By lowering the age of consent to 15, Rwanda aimed to remove practical and legal barriers to sexual and reproductive health care, better align with the country's constitutional right to health (including reproductive health), and comply with international human rights standards and WHO guidelines.[95]

c. Age Ranges

The adoption of "age ranges" also represents a departure from the "bright-line" approach to dividing childhood and adulthood in the abortion decision-making context. Different age ranges are associated with varying levels of decision-making capacity, recognizing the gradual attainment of abortion decision-making capacity among young people. The approach builds on pediatric medicine's "rule of sevens,"[o] which has historically been used to assess children's decision-making capacity.[96]

In 2015, **Argentina** adopted this approach when its legislature reformed its Civil and Commercial Code to align the country with its obligations under international human rights law, including the CRC's approach to young people's decision-making capacity. In doing so, Article 26 of the Code uses a series of age ranges to govern young people's consent for different types of medical treatment based on the level of risk. The provision states that:

> "Regarding consent to medical treatment, it is presumed that adolescents between 13-16 have the capacity to decide for themselves regarding treatments that are non-invasive, do not compromise health, or carry a serious risk to life or physical integrity. If treatments are invasive or do compromise health or life, the adolescent age 13-16 must give consent with the assistance of their parents. Conflicts are resolved based on the medical opinion of the provider, based on the minor's best interest. From age 16, the adolescent is considered an adult for decisions related to the care of their own body."[97]

Another relevant provision in the Code, Article 639, establishes general principles related to parental responsibility, including the best interests of the child, progressive autonomy, and the right to be heard and have one's opinion taken into account, according to age and level of maturity.[98] Even before the 2015 reforms, Argentina's 2009 Patient Rights Act integrated the principle of progressive autonomy into its provision on freedom of choice, stating that children and adolescents have the right to "intervene for the purposes of making decisions about medical or biological therapies or procedures that involve their life or health."[99]

n This was part of a broader reform of Rwanda's Law Regulating Healthcare Services that sought to expand access to sexual and reproductive health services and establish guidelines for assisted reproductive technologies.

o The rule of sevens establishes that: children under seven do not have decision-making capacity; children from 7–14 are presumed not to have decision-making capacity until proven otherwise; and children over 14 are presumed to have decision-making capacity.

In 2015, Argentina's legislature passed a resolution[100] that applied its approach to progressive autonomy in young people's medical decision-making to sexual and reproductive health services. Section 2.3 of the resolution established 13 as the age of consent for sexual and reproductive services, including contraception, HIV testing, and pregnancy testing, given that they are "non-invasive" and do not pose a grave threat to life or physical integrity.[101]

Argentina also integrated the principle of progressive autonomy into its 2019[102] and 2022[103] abortion care protocols[p], which directly applied Article 26 of the Civil and Commercial Code to abortion care. As a result, in Argentina, young people 16 and older are considered adults for the purposes of consenting to abortion care and can do so without parental involvement.[104] Young people who are between 13 and 16 years of age can consent to abortion care as long as the abortion does not pose a grave threat to their life or health.[105] In cases where the abortion poses such a threat, parental involvement is required.[q] Young people under age 13 should participate in a shared decision-making process with their parents or guardians, "in line with the principle of progressive autonomy."[106]

When parental involvement is required and parents, guardians, or caregivers refuse to support a young person's decision, the patient may provide consent with the support of another family member. If this is not an option, the health team must resolve the conflict between the patient and their parents, guardians, or caregivers, taking into account the child's best interests, the rule of "non-substitution of consent," and the child's decision-making capacity based on the development of their progressive autonomy.[107]

Anecdotally, health professionals in Argentina are more likely to rely on the principle of progressive autonomy to determine capacity in cases involving young people under 13.

d. Exceptions to Age Cutoffs

The most common and enduring approach to recognizing the gradual attainment of young people's abortion decision-making capacity is through exceptions or carveouts to strict age cutoffs based on an individual young person's demonstrated maturity. In common law countries, such as **Australia**, **Canada**, the **United Kingdom**, and the **United States**, these carveouts are known as the "mature minor" doctrine or rule.[r] Since the doctrine first emerged in the 1960s, courts around the world and human rights experts have explicitly connected it to the principles of evolving capacities of the child and the best interests of the child, as well as other related rights. Judicial bypass mechanisms arguably also rely on a similar assessment of the young person's maturity. As a result, depending on the nature of the specific provision at issue, the mature minor doctrine can guide either health providers or judges in their assessment of a young person's decision-making capacity.

In the **United States**, at least **eight states** have adopted the mature minor rule through judicial decisions or attorney general opinions, and at least **six** others have incorporated it into statutes.[108] While the breadth and application of the doctrine vary by state, they all acknowledge to some extent that certain young people under 18 are capable of providing informed consent for certain health services.[109] Maryland's abortion law explicitly incorporates the mature minor rule, providing that "[t]he physician may perform the abortion, without notice to a parent or guardian of a minor if, in the professional judgment of the physician … [t]he minor is mature and capable of giving informed consent to an abortion."[110]

To the extent that the mature minor rule generally applies to health services, it does not necessarily override specific statutory requirements for obtaining parental consent for abortion care in particular. However, the majority of U.S. states' parental involvement laws include judicial bypass mechanisms that often rely on standards aligned with the mature minor doctrine to guide judges' determinations in specific cases. In Alabama, for example, the judicial bypass provision provides that the court can waive the state's parental consent requirement upon a finding that "[t]hat the minor is mature and well-informed enough to make the abortion decision on her own."[111] Judicial bypass, however, affords judges the wide discretion to assess young people's maturity and best interests, which can lead to highly subjective rulings, sometimes based on a judge's personal beliefs rather than objective factors.[112] In effect, the mechanism merely allows judges to substitute their consent for parental consent.

In the **United Kingdom**, the mature minor doctrine emerged from the 1985 case, *Gillick v. West Norfolk and Wisbech Health Authority*, which established that children under 16 can receive information about and access contraception without parental consent. In that case, the UK House of Lords held that children

p The 2019 and 2022 protocols regulated the law decriminalizing abortion under three circumstances, and the law decriminalizing abortion through 14 weeks of pregnancy, respectively.

q Abortion rarely poses such a threat because it is very safe, and much safer than the alternative of pregnancy and/or childbirth.

r The doctrine first emerged in the U.S. in the 1960s, and the United Kingdom, Australia and Canada adopted it through caselaw in the 1980s, 1990s, and 2000s, respectively.

under 16 years of age can consent to treatment if they demonstrate "sufficient understanding and intelligence to understand fully what is proposed."[113] The court explained that "parental rights yield to a child's right to make decisions, when a child reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."[114]

The court also established the "Fraser Guidelines"[115] in *Gillick*, which health providers in the UK commonly rely on to determine whether a minor under 16 can access a range of sexual and reproductive health services (e.g., contraception, abortion care, STI care).[116]

In 2004, the UK Department of Health issued guidance that codified Gillick's mature minor standard and Fraser Guidelines,[117] allowing mature minors under the age of 16 to receive confidential information about and access to contraception, STI care, and abortion care without parental consent. When a parent subsequently challenged the guidelines on the grounds that the failure to inform parents constituted a violation of the European Convention on Human Rights' right to privacy and family life (Article 8), the court rejected that argument, holding that physicians could lawfully provide such advice or treatment to a girl under the age of 16 without the consent of her parents if the physician was satisfied that the girl had sufficient maturity to understand what is involved.[118]

The Court stated that, "although family factors are significant and cogent, they should not override the duty of confidentiality owed to the child."[119] It held that limiting a young person's right to confidentiality would infringe on various articles of the CRC[s] and would likely deter young people from seeking advice on and treatment involving contraception, STIs, and abortion care.[120] Further, the Court noted that any infringement on parental rights could be justified where the infringement would be "in accordance with the law" and "necessary in a democratic society…for the protection of health…or for the protection of the rights…of others."[121]

THE FIVE CONSIDERATIONS OF THE UK'S *FRASER GUIDELINES*

1. The young person understands all aspects of the advice and its implications
2. The physician cannot persuade the young person to tell their parents or to allow you to tell them
3. In relation to contraception and STIs, the young person is very likely to have sex with or without such treatment
4. The young person's physical or mental health is likely to suffer unless they receive such advice or treatment
5. It is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent[122]

s Article 12 assures "to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child"; Article 16(1) establishes children's right to privacy; and Article 18(1) establishes the "best interests of the child" as parents' "basic concern." **Convention on the Rights of the Child,** ***supra*** **note 34, arts. 12, 16.**

In **Australia**, the High Court adopted the Gillick standard in the 1992 case commonly known as "Marion's Case."[t] According to the Court, a minor is capable of consenting to medical treatment if they achieve a "sufficient understanding and intelligence to enable them to understand fully what is proposed."[123] The Court also weighed in on who is able to consent to medical treatments on behalf of a young person who lacks Gillick competence, holding that parents may do so in a "wide range of circumstances."[124] However, in some cases, court authority has been required before a minor deemed incompetent can receive medical care.[125] Australia's Family Law Act of 1975 allows the courts to issue a decision in the best interests of the child.[126]

Regarding young people's access to abortion care, most Australian states and territories rely on the mature minor doctrine. For example, in **Western Australia**, as of 2023, a young person under the age of 18 can obtain abortion care without involving a parent or guardian if their health practitioner determines that they have sufficient understanding and intelligence to consent to their own medical treatment.[127] If a young person is deemed not to have such understanding and intelligence, the young person can either allow their health practitioner to defer to parental or guardian consent or require the health practitioner to seek court approval for abortion care.[128]

In **Canada**, the Court of Appeal for the province of Alberta first adopted the Gillick standard in 1986 in the case *J.S.C. v. Wren*.[129] The Court found that a 16-year-old girl could provide consent without parental involvement, determining that she had "sufficient intelligence and understanding to make up her own mind and did so. At her age and level of understanding, the law is that she is to be permitted to do so."[130]

In 2009, Canada's Supreme Court later adopted the Gillick standard in the case *A.C. v. Manitoba*, holding that the "mature minor" standard governs the participation of children under the age of 16 in their own medical decisions.[131] The best interests of the child principle informed the Supreme Court's application of the mature minor standard to medical decision-making, with the Court noting the importance of striking a "constitutional balance" between an individual's fundamental right to autonomous decision-making in connection with their body and the law's attempt to protect vulnerable children from harm.[132] In the case of adolescents, in particular, the Court noted that:

> "[T]he 'best interests' standard must be interpreted in a way that reflects and addresses an adolescent's evolving capacities for autonomous decision making. It is not only an option for the court to treat the child's views as an increasingly determinative factor as his or her maturity increases, it is, by definition, in a child's best interests to respect and promote his or her autonomy to the extent that his or her maturity dictates."[133]

The Gillick standard continues to inform the practice of medicine, including abortion care, in most parts of Canada, though the age of majority for medical decision-making varies by provincial jurisdiction (ranging from 14 to 19 years of age), as do presumptions about legal capacity below that age.[134]

e. Exceptions to Abortion Bans

A handful of countries have adopted exceptions to abortion bans that account for the uniquely burdensome effects that the lack of access to abortion care has on young people and the disproportionate barriers (e.g., legal, financial, logistical, social) that young people face when accessing abortion care. Some countries, for example, have waived or eased requirements associated with accessing abortion care under certain exceptions for young people in particular. While not explicitly grounded in the notion that young people gradually attain decision-making capacity, these approaches do account for the need for young people to be involved in decisions that profoundly affect their lives, health, and well-being.

In 2023, the CRC Committee underscored the critical nature of ensuring access to abortion care in cases of child pregnancy based on the unique health and human rights concerns that pregnant minors must face. That year, the CRC Committee issued a decision in its first individual complaint related to abortion care.[135] The case involved a 13-year-old rape victim's inability to access legal abortion care in Peru, where abortion care is permitted only when the life or health of the pregnant person is threatened by the pregnancy.

t This case involved a 14-year-old child with a disability who lacked Gillick competence. Marion's parents sought a court order authorizing a hysterectomy and ovariectomy for their daughter. *Secretary, Department of Health & Community Services. v. J.W.B. & S.M.B.*, 175 C.L.R. 218 (1992) (Austl.).

The CRC Committee found that Peru's failure to ensure access to safe abortion care resulted in a violation of various human rights, including the rights to life, health, information, freedom from cruel, inhuman, and degrading treatment, and freedom from discrimination.[136] In particular, the CRC Committee found that "the failure to take account of the author's repeated requests to terminate her pregnancy violated the obligation to give her views due weight in a matter that affected her as directly as pregnancy" constituted a violation of her right to be heard.[137] Importantly, the CRC Committee stressed that:

> "[I]n the case of pregnant girls, consideration should be given to the special and differential physical and mental health impacts of child pregnancy, the particularly significant risk that pregnancy poses to the lives of girls because of possible complications during pregnancy and childbirth, and the potentially serious impact that it can have on their development and their future."[138]

Accordingly, the CRC Committee called upon Peru "to decriminalize abortion in all cases involving child pregnancy," as well as to "ensure access to safe abortion services and post-abortion care for pregnant girls."[139]

A handful of countries link exceptions to abortion bans with minority. **Ethiopia** and **Rwanda** both explicitly include an exception to their respective abortion bans based on minority (among other grounds).[140] There is no explicit requirement that minors obtain parental consent for abortion care in Ethiopia[141], and Rwanda does not require parental consent for children over the age of 15.[142] **Zambia**, similarly, has a health exception that allows health providers to take minority into account. Its abortion law states that in determining whether a patient is eligible to obtain abortion care based on risks to the patient's life or physical or mental health, the health practitioner can consider the "pregnant woman's [...] age."[143]

Various countries, like **Chile**, have rape exceptions to abortion bans with extended gestational limits for young people. In the **United States**, the gestational limit for West Virginia's rape exception is eight weeks for adults and 14 weeks for minors.[144] In the **United States**, some states explicitly waive parental involvement requirements under specific circumstances. In Alabama, which has a total ban on abortion, the parental consent requirement is not meant to apply in cases where, "in the best clinical judgment of the attending physician on the facts of the case before him, a medical emergency exists that so compromises the health, safety, or well-being of the mother as to require an immediate abortion."[145] Wisconsin goes further, allowing an abortion provider to waiver parental consent in certain cases where the minor is experiencing a medical emergency; the pregnancy is the result of sexual assault; the minor is likely to commit suicide if required to seek parental consent; the pregnancy is the result of sexual intercourse with a caregiver; or if a parent, other family member, or guardian is inflicting abuse on the minor.[146]

6. Toolkit for Supporting Young People's Medical Decision-Making in the United States

Since the *Dobbs* decision, various states have expanded the scope of parental involvement in young people's decision-making around sexual and reproductive health services. Conversely, other countries are increasingly adopting laws and policies that account for young people's gradual attainment of capacity to make decisions related to abortion care. As state lawmakers in the United States explore opportunities to support and advance young people's autonomy in abortion decision-making, they can look to the diverse approaches taken by many of these countries, as well as the global standards established by human rights bodies and international organizations.

a. Policy Proposals

1. Adopt **affirmative laws**[u] that allow young people to consent to abortion care.
2. Eliminate or lower **strict age cutoffs** for young people seeking abortion care.
3. Adopt **age ranges** for abortion decision-making capacity among young people reflecting their gradual attainment of the capacity to consent.
4. Incorporate the principles of **evolving capacities and progressive autonomy** into guidelines for assessing young people's individual decision-making capacity.

b. Additional Resources

New Brunswick Office of the Child and Youth Advocate, *ON BALANCE, CHOOSE KINDNESS: The Advocate's Review of Changes to Policy 713 and Recommendations for a Fair and Compassionate Policy* (2023).

Committee on the Rights of the Child, Statement on Article 5 of the Convention on the Rights of the Child, U.N. Doc. CRC/C/GC/5 (2003).

Jonathan Todres, *Confronting Categorical Exclusions Based on Age: The Rights of Children and Youth*, 36 Harv. Hum. Rts. J. 283 (2021).

Sheila Varadan, *The Principle of Evolving Capacities Under the UN Convention on the Rights of the Child*, 27 Int'l J. Children's Rts. 306 (2019).

J. Shoshanna Ehrlich & MaryRose Mazzola, *Minor Abortion Access Research and Advocacy Project*, Planned Parenthood League of Mass. ASPIRE Ctr. (2024).

Human Rights Watch & If/When/How, *Whose Abortion Is It? The Harms of State-Mandated Parental Notification for Abortion and Judicial Bypass in the United States* (2025).

u For example, in 2025, Connecticut enacted a law that codifies minors' right to consent to "services, examination or treatment related to pregnancy and pregnancy prevention without the consent or notification of the minor child's parent or guardian." *An Act Concerning Access to Reproductive Health Care*, 2025 Conn. Pub. Acts 25-28 (Reg. Sess.).

Endnotes

1 World Health Organization, *Assessing and Supporting Adolescents' Capacity for Autonomous Decision-Making in Health Care Settings: A Tool for Health-Care Providers* (2021), https://www.who.int/publications/i/item/9789240039568.

2 Peter McIntyre et al, *Adolescent Friendly Health Services — An Agenda for Change*, World Health Organization (2002), https://iris.who.int/bitstream/handle/10665/67923/WHO_FCH_CAH_02.14.pdf?sequence=1.

3 World Health Organization, Abortion Care Guideline (2022), https://www.who.int/publications/i/item/9789240039483.

4 Jonathan Todres, *Confronting Categorical Exclusions Based on Age: The Rights of Children and Youth*, 36 Harv. Hum. Rts. J. 283, 285 (2021), https://journals.law.harvard.edu/hrj/wp-content/uploads/sites/83/2023/12/36HHRJ283-Todres.pdf.

5 Deborah Grace Robertson, *Adolescent Consent in Reproductive and Sexual Health Decision-Making: Should There Be an Arbitrary Age of Consent or Should It Be Based on the 'Evolving Capacities of the Child'?*, 21 J. Pediatr. Adolesc. Gynecol. 47 (2008).

6 *Doe v. Uthmeier*, No. 5D2025-1363 (Fla. Ct. App. 5th Dist. May 14, 2025).

7 *Planned Parenthood Monte Mar, Inc. v. Ford*, No. 3:85-cv-00331-ART-CSD. (D. Nev. Apr. 25, 2025).

8 *Montana et al. v. Planned Parenthood of Montana et al*, 606 U. S. (2025).

9 Jonathan Todres, *supra* note 4, at 285.

10 Katherine Romero & Rebecca Reingold, *Advancing Adolescent Capacity to Consent to Transgender-Related Health Care in Colombia and the USA*, 21 Reprod. Health Matters 186, 186 (2013), https://www.tandfonline.com/doi/epdf/10.1016/S0968-8080%2813%2941695-6?needAccess=true.

11 Jonathan Todres, *supra* note 4.

12 Julie Maslowsky, Laura Lindberg & Emily S. Mann, *Adolescence Post-Dobbs: A Policy-Driven Research Agenda for Minor Adolescents and Abortion*, 11 (2024), Youth Reproductive Equity, https://dx.doi.org/10.7302/22808.

13 C.A. Hartley & L.H. Somerville, *The Neuroscience of Adolescent Decision-Making*, 5 Curr. Opin. Behav. Sci. 108 (2015).

14 P. Grootens-Wiegers, I.M. Hein & J.M. van den Broek, *Medical Decision-Making in Children and Adolescents: Developmental and Neuroscientific Aspects*, 17 BMC Pediatrics 120 (2017), https://doi.org/10.1186/s12887-017-0869-x.

15 C.A. Hartley & L.H. Somerville, *supra* note 13; O. Ravindranath et al, *Adolescent Neurocognitive Development and Decision-Making Abilities Regarding Gender-Affirming Care*, 67 Dev. Cogn. Neurosci. (2024); D.S. Diekema, *Adolescent Brain Development and Medical Decision-Making*, 146 Pediatrics S18 (2020).

16 P. Grootens-Wiegers, supra *note* 14.

17 *Id.*

18 P.A. Michaud et al, *How to Approach and Take Care of Minor Adolescents Whose Situations Raise Ethical Dilemmas? A Position Paper of the European Academy of Pediatrics*, 11 Front. Pediatr. 1120324 (2023).

19 University of California San Francisco, Advancing New Standards in Reproductive Health, *The Turnaway Study*. https://www.ansirh.org/research/ongoing/turnaway-study; ChildUSA Research Report. *The Impact of Restrictive Abortion Policies on Children: How Dobbs v. Jackson Women's Health Organization Decision Negatively Affects Youth* (2023), https://childusa.org/wp-content/uploads/2023/02/Impact-of-Abortion-Bans-FINAL.pdf.

20 Human Rights Watch & If/When/How, *Whose Abortion Is It? The Harms of State-Mandated Parental Notification for Abortion and Judicial Bypass in the United States* (2025), https://ifwhenhow.org/wp-content/uploads/2025/10/us_abortion1025-web.pdf.

21 Julie Maslowsky, Laura Lindberg & Emily S. Mann, *supra* note 12, at 10.

22 World Health Organization, *supra* note 3.

23 UN Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. A/HRC/32/32, ¶ 60 (2016).

24 World Health Organization, Global Abortion Policies Database, https://abortion-policies.srhr.org/.

25 Susheela Singh et al, *Abortion Worldwide 2017: Uneven Progress and Unequal Access*, Guttmacher Institute (Mar. 2018), https://www.guttmacher.org/report/abortion-worldwide-2017.

26 Guttmacher Institute, Minors' Access to Abortion Care (Nov. 2025), https://www.guttmacher.org/state-policy/explore/minors-access-abortion-care.

27 UN Department of Economic and Social Affairs, Abortion Laws and Policies (2017), https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd_2017_abortion_laws_policies_country_profiles.pdf.

28 Sarah Horvath & Susan Frietsche, *Judicial Bypass for Minors Post-Dobbs*, 19 Women's Health (London) 17455057231219601 (2023), https://doi.org/10.1177/17455057231219601.

29 *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (recognizing that "[m]inors, as well as adults, are protected by the Constitution and possess constitutional rights."); *Bellotti v. Baird*, 443 U.S. 622 (1979).

30 Human Rights Watch & If/When/How, *supra* note 20.

31 Sheila Varadan, *The Principle of Evolving Capacities under the UN Convention on the Rights of the Child*, 27 Int'l J. Children's Rts. 306 (2019).

32 Convention on the Rights of the Child, art. 5, Nov. 20, 1989, U.N. Doc. 1577 U.N.T.S. 3.

33 African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990).

34 African Committee of Experts on the Rights and Welfare of the Child, General Comment on Article 30 of the African Charter on the Rights and Welfare of the Child, ACERWC/GC/01, ¶ 25 (2013).

35 Committee on the Rights of the Child, Statement on Article 5 of the Convention on the Rights of the Child, U.N. Doc. CRC/C/GC/5 (2003).

36 *Id.* at ¶ 11.

37 *Id.* at ¶ 8.

38 Committee on the Rights of the Child, General Comment No. 14: On the Right of the Child to Have His or Her Best Interests Taken as a Primary Consideration, U.N. Doc. CRC/C/GC/14 (2013).

39 Committee on the Rights of the Child, *supra* note 35, at ¶ 10.

40 African Committee of Experts on the Rights and Welfare of the Child, General Comment No. 7 on Article 27 of the African Charter on the Rights and Welfare of the Child: Sexual Exploitation (2021).

41 *Id.*

42 Committee on the Rights of the Child, *supra* note 35, at ¶ 13.

43 *Id.*

44 Committee on the Rights of the Child, General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24), U.N. Doc. CRC/C/GC/15, ¶ 31 (2013) .

45 Committee on the Rights of the Child, General Comment No. 20 on the Implementation of the Rights of the Child During Adolescence, U.N. Doc. CRC/C/GC/20, ¶ 39 (2016).

46 *Id.* at ¶ 60.

47 *Id.*

48 Committee on the Rights of the Child, Concluding Observations on the Combined Sixth and Seventh Periodic Reports of the Russian Federation, U.N. Doc. CRC/C/RUS/CO/6-7, ¶ 36(c) (2024).

49 Committee on the Rights of the Child, Concluding Observations on the Combined Third to Fifth Periodic Reports of Djibouti, U.N. Doc. CRC/C/DJI/CO/3-5, ¶ 34(d) (2022).

50 Committee on the Rights of the Child, Concluding Observations on the Initial Report of the State of Palestine, U.N. Doc. CRC/C/PSE/CO/1, ¶ 53(a) (2020).

51 Committee on the Rights of the Child, Concluding Observations on the Combined Third and Fourth Periodic Reports of Ireland, U.N. Doc. CRC/C/IRL/CO/3-4, ¶ 58(a) (2016).

52 *Atala Riffo & Daughters v. Chile*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 239, ¶ 68 (2012).

53 *Gelman v. Uruguay*, Inter-Am. Ct. H.R. (ser. C) No. 221 (2011).

54 *Id.* at ¶ 29.

55 *Furlan and Family v. Argentina*, Inter-Am. Ct. H.R. (ser. C) No. 400, ¶ 230 (2021); Committee on the Rights of the Child, Genenral Comment No. 7 (2005): Implementing Child Rights in Early Childhood, U.N. Doc. CRC/C/GC/7/Rev.1, ¶ 17 (2005).

56 *Paola Guzmán Albarracín v. Ecuador*, Inter-Am. Ct. H.R. (ser. C) No. 395 (2021).

57 *Id.* at fn. 136.

58 *Id.*

59 UN Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. A/HRC/32/32 (2016).

60 Committee on the Rights of the Child, General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, U.N. Doc. CRC/GC/2003/4, ¶ 7 (2003); Committee on the Rights of the Child, *supra* note 44, at ¶ 31; Committee on Economic, Social & Cultural Rights, General Comment No. 22: The Right to Sexual and Reproductive Health, U.N. Doc. E/C.12/GC/22, ¶ 44 (2016).

61 Committee on the Rights of the Child, *supra* note 60, at ¶ 33.

62 UN Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. A/HRC/32/32, ¶ 90 (2016).

63 Kaiser Family Foundation, Parental Consent/Notification Requirements for Minors Seeking Abortions (2024), https://www.kff.org/womens-health-policy/state-indicator/parental-consentnotification/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

64 *Id.*

65 *State v. Koome*, 84 Wn.2d 901 (1975).

66 Corte Constitucional [C.C.] [Constitutional Court], Sentencia SU-337, May 12, 1999, ¶ 14 (Colom.).

67 *Id.* at ¶ 26.

68 *Id.*; Corte Constitucional [C.C] [Constitutional Court], Sentencia SU-642, November 5, 1998, ¶ 3 (Colom).

69 Corte Constitucional, *supra* note 66, at ¶ 26; Corte Constitucional, *supra* note 68, at ¶ 6.

70 Ministerio de Salud y Protección Social, *Resolución 309 de 2025: Por la cual se adoptan las medidas para garantizar el acceso, autonomía y consentimiento informado de niñas, niños y adolescentes en la atención en salud,* Feb. 20, 2025 (Colom.).

71 *Id.* at 5.

72 Corte Constitucional [C.C.] [Constitutional Court], Sentencia C-355/06, May 10, 2006 (Col.).

73 *Id.*

74 Corte Constitucional [C.C.] [Constitutional Court], Sentencia T-388, May 28, 2009, ¶ 4.4 (Colom.).

75 Corte Constitucional [C.C] [Constitutional Court], Sentencia T-697, December 13, 2016, ¶ 14. (Colom.).

76 Corte Constitucional [C.C] [Constitutional Court], Sentencia SU-096, October 17, 2018, ¶79. (Colom.)

77 Ministerio de Salud y Protección Social, *Resolución 051 de 2023: Por medio del cual se adopta la regulación única para la atención integral en salud frente a la Interrupción Voluntaria del Embarazo (IVE) y se modifica el numeral 4.2 del Lineamiento Técnico y Operativo de la Ruta Integral de Atención en Salud Materno Perinatal adoptado mediante la Resolución 3280 de 2018*, Jan. 12, 2023 (Colom.).

78 *Id.* at 21.

79 *Id.* at 20.

80 Isabel Fulcher et al, *Changes to Parental Consent Requirements for Abortion in Massachusetts and Impact on Timeliness of Care for Adolescents Aged 16 to 17 Years*, American Journal of Public Health 115, 397_402, https://doi.org/10.2105/AJPH.2024.307918.

81 Mabel Felix, Laurie Sobel & Alina Salganicoff, *Minors' Ability to Consent to Contraception and Abortion Services*, Kaiser Family Foundation (August 7, 2025), https://www.kff.org/womens-health-policy/minors-ability-to-consent-to-contraception-and-abortion-services/.

82 NOM-046-SSA2-2005, *Violencia familiar, sexual y contra las mujeres. Criterios para la prevención y atención*, art. 6.4.2.7, Diario Oficial de la Federación [DOF], 16 de abril de 1996, modificada el 24 de marzo de 2016 (Mex.).

83 Código Civil del Estado de Aguascalientes [Cód. Civ.], arts. 435, 436 and 436, 7 de diciembre de 1947, modificada 25 de noviembre de 2024 (Mex.).

84 Controversia Constitucional 54/2016 [CC 54/2016], Suprema Corte de Justicia de la Nación [SCJN], mayo de 2022 (Mex.).

85 *Id.* at ¶ 201.

86 *Id.* at ¶ 212.

87 *Id.* at ¶ 216.

88 *Id.* at ¶ 79.

89 *Id.* at ¶ 221.

90 Controversia Constitucional 45/2016 [CC 45/2016], Suprema Corte de Justicia de la Nación [SCJN], mayo de 2022, (Mex.).

91 *Id.* at ¶ 217.

92 Lineamiento técnico para la atención del aborto seguro en México (2022) (Mex.).

93 Republic of Rwanda, Official Gazette No. Special of 18 September 2025 (Rwanda).

94 Center for Reproductive Rights, Rwanda's Abortion Provisions, https://reproductiverights.org/maps/provision/rwandas-abortion-provisions/.

95 Stabit Advocates Legal News, *Rwanda 2025 Healthcare Law Reform: Single-Statute Reform That Redraws Risk, Rights & Revenue Lines. A Stabit Opinion* (Sept. 2025), https://stabitadvocates.com/legal-news/rwanda-2025-healthcare-law-reform/.

96 Hannah Oliason, *Designer Minor: Creating a Better Legal Regime for Pediatric Cosmetic Procedures*, 106 Minn. L. Rev. (2022), https://scholarship.law.umn.edu/minnlrev/vol106/iss4/7.

97 Código Civil y Comercial de la Nación [Cód. Civ. y Com.] [Civil and Commercial Code], art. 26 (Buenos Aires, 2015) (Arg.).

98 *Id.* at art. 639.

99 Law 26.529, art. 2 (e), 21 de octobre de 2009 (Arg.).

100 Resolución 65/2015, 9 de diciembre de 2015 (Arg.).

101 *Id.* at § 2.3.

102 Protocolo para la atención integral de las personas con derecho a la interrupción voluntaria y legal del embarazo, actualización (2019) (Arg.).

103 Protocolo para la atención integral de las personas con derecho a la interrupción voluntaria y legal del embarazo, actualización (2022) (Arg.).

104 Código Civil y Comercial, *supra* note 97, at art. 26 .

105 Protocolo para la atención integral, *supra* note 103, at § 4.1.

106 *Id.*

107 *Id.*

108 National Center for Youth Law, *Minor Consent and Confidentiality: A Compendium of State and Federal Law*, Annex N (August 2024), https://static1.squarespace.com/static/66421681d90ded764d1347e8/t/671c0a19325b0b69be2e3b94/1729890846941/NCYLMinorConsentCompendium2024-AppendixN.pdf.

109 Doraine Lambelet Coleman & Philip M. Rosoff, *The legal authority of mature minors to consent to general medical treatment*, 131(4) Pediatrics 786 (2013), https://pubmed.ncbi.nlm.nih.gov/23530175/.

110 Md. Health–Gen, § 20-103**.**

111 Ala. Code, § 26-21-4 (2024).

112 Abbey Marr, *Judicial Bypass Procedures Undue Burdens for Young People Seeking Safe Abortion Care*, Advocates for Youth (2015), https://www.advocatesforyouth.org/wp-content/uploads/storage/advfy/documents/Factsheets/judicial%20bypass%20procedures.pdf.

113 *Gillick v. West Norfolk and Wisbech Health Auth.,* [1985] 1 All E.R. 224 (Eng.).

114 *Id.*

115 *Id.*

116 General Medical Council, Contraception, Abortion and Sexually Transmitted Infections (STIs), https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/0-18-years/contraception-abortion-and-sexually-transmitted-infections-stis.

117 *Id.*

118 *R (Axon) v. Secretary of State for Health,* EWHC 37 (2006) (Eng.).

119 *Id.* at ¶ 109, citing Committee on the Rights of the Child, *supra* note 44, at ¶ 24.

120 *R (Axon) v. Secretary of State for Health, supra* note 119, ¶ 72.

121 *Id.* at ¶¶ 118-19.

122 *Id.*

123 *Secretary, Department of Health & Community Services. v. J.W.B. & S.M.B.,* 175 C.L.R. 218 (1992) (Austl.).

124 *Id.* at ¶ 26.

125 *Id*. at ¶ 33.

126 *Id.*

127 Health Western Australia, Abortion, https://www.health.wa.gov.au/articles/a_e/abortion#:~:text=Under%20the%20new%20legislation%2C%20a,weeks%20(23%2B0).

128 *Id.*

129 *J.S.C. v. Wre*n, 76 A.R. 115 (Alta. C.A. 1986) (Can.).

130 *Id.*

131 *A.C. v. Manitoba*, 2 S.C.R. 181 (2009) (Can.).

132 *Id.* at headnote.

133 *Id.* at ¶ 88.

134 Kevin W. Coughlin, *Medical Decision-Making in Paediatrics: Infancy to Adolescence*, Canadian Paediatric Society (Apr. 12, 2018), https://cps.ca/documents/position/medical-decision-making-in-paediatrics-infancy-to-adolescence#table%201.

135 *Camila v. Peru*, Inter-Am. Ct. H.R. (ser. C) No. 417 (2023).

136 *Id*. at ¶¶ 8.1–8.18.

137 *Id*. at ¶ 8.7.

138 *Id*. at ¶ 8.5.

139 *Camila v. Peru*, *supra* note 135.

140 Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No. 414/2004, art. 551 **(**2004) (Ethiop.); Republic of Rwanda, *supra* note 93.

141 Godfrey Kangaude et al, *Adolescent sexual and reproductive health and universal health coverage: a comparative policy and legal analysis of Ethiopia, Malawi and Zambia*, 28(2) Sexual and Reproductive Health Matters 1832291 (2020), https://pubmed.ncbi.nlm.nih.gov/33121392/.

142 Center for Reproductive Rights, *supra* note 94; Republic of Rwanda, *supra* note 93.

143 Zambian Termination of Pregnancy Act, Chapter 304(3)(2) (1972) (Zambia).

144 Code of West Virginia, §16-2R-3.

145 Ala. Code, § 26-21-5 (2024).

146 Wisconsin Rev. Stat. 48.375.