AN EQUAL PROTECTION ANALYSIS OF UNITED STATES REPRODUCTIVE HEALTH POLICY: GENDER, RACE, AGE, AND CLASS

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I. INTRODUCTION

The purpose of this Essay is to bring an "anti-essentialist" and "reproductive health" perspective to the public policy debate concerning pregnancy-related regulations, including, but not limited to, abortion regulations. It will attempt to create a gender-based equal protection framework that is attentive to the ways in which U.S. reproductive health policies impact on one particular subgroup of women—adolescents.

My desire to describe the possibilities within contemporary equal protection doctrine is, in part, a personal desire to respond to some of my critics. In previous articles, I have suggested that we need to turn to equal protection arguments to make persuasive pro-choice arguments rather than privacy arguments[1] to gain the higher moral ground on the

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Despite the rules of *A Uniform System of Citation,* I have retained the first name of the authors that I cite in this Essay because those names often gender-identify the authors, and I believe that the author's gender is relevant to her perspective. In addition, where the author retains her birth name as a middle name, I also try to include her birth name. I follow this practice out of respect for women's desire to increase control over their own naming, although I recognize the fact that a woman's birth name often becomes her middle name, upon marriage, is itself a reflection of women's lack of control over their naming. I also have provided the first names of authors of both books and articles, not wanting to prioritize books over articles (as is conventional under *A Uniform System of Citation*).

1. I do not object to us making a privacy argument in the alternative, as long as it is also accompanied by an equal protection argument, because I do recognize that certain aspects of the abortion decision are compatible with a privacy perspective. For example, arguments concerning the right of women to have access to the contraceptive RU 486 could be grounded in an individually-based liberty/privacy argument as well as an equal protection argument. A liberty/privacy argument would emphasize the right of each individual to make informed decisions about appropriate

abortion issue. I have been criticized for not fully sketching out that equal protection framework.[2] This Essay will respond to those criticisms by showing how feminists can make a persuasive equal protection argument concerning reproductive issues that is respectful of life in all of its various forms.

In this Introduction, Part I, I define what I mean by an "anti-essentialist" and "reproductive health perspective" and briefly discuss how these perspectives would enhance the discussion of pregnancy-related regulations. In Part II, I summarize the magnitude of the problem of unintended pregnancies and early childbirth in the United States, focusing on female adolescents. Because I do not believe it is possible to talk readily about the problem of unintended pregnancies as if it is experienced by all women in the same way, I focus my attention on one subclass of women—adolescents. And because I realize that even the women in this sub-class do not form a monolithic unit, I try to describe how their lives are affected by the variables of race and class. I then examine how our social and legislative policies respond to reproductive health issues by discussing: (1) contraception and sex education; (2) prenatal care; (3) abortion; and (4) adoption. I argne that, at each stage, our social policies act coercively on the lives of adolescent females in a way that is detrimental to their health, as well as the health of their fetus and future children. Based on this empirical discussion, I then conclude that our legislatures have consistently demonstrated an appalling disrespect for the value of the lives of pregnant adolescent females. I argue that this evidence demonstrates how important it is for the courts to examine reproductive health legislative policies with the utmost scrutiny to insure that we protect the health and well-being of adolescent females who often do not have the power to vote to influence political decisions.

In Part III of this Essay, I apply the previous discussion to law by describing my proposed equal protection framework for challenging reproductive health policies that hurt female adolescents. One issue in the constitutional debate over abortion has been a controversy concerning

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medical treatment. An equal protection framework would emphasize that women are not simply being treated as individuals, whose liberty interests are being disregarded by being denied access to RU 486, but women also are being denied protection of their liberty interest in a group-based way. Women as a class are denied access to RU 486 (and other contraceptive technology that is available in Europe) as part of their systematic disrespectful treatment by society in relation to their reproductive capacity. Thus, the argument can be expressed in privacy or in equal protection terms, but I believe that the equal protection argument more fully captures the significance of the denial of access to contraceptive technology.

2. *See* Sarah Burns, *Notes From the Field: A Reply to Professor Colker,* 13 HARV. WOMEN'S L.J. 189, 201 (1990) ("Professor Colker raises the equality issue as if it were a new idea not explored by other feminists.").

the appropriate level of scrutiny that the court should apply in assessing the constitutionality of these kinds of legislative policies. The Supreme Court appears to be moving toward a heightened rationality standard, under privacy doctrine, that is less rigorous than the standard used in *Roe v. Wade*[3] and that is also less rigorous than the standard employed under equal protection analysis for sex-based classifications.[4] I hope that this Essay will help persuade some people that reproductive health legislation that affects female adolescents deserves the highest level of scrutiny, and that scrutiny should not be limited to parental consent or notification statutes that target adolescents. All of our reproductive health policies dramatically affect female adolescents, irrespective of whether the legislature focused on adolescents when it enacted the legislation.

A. *Anti-Essentialism*

Gender essentialism is "the notion that a unitary, 'essential' women's experience can be isolated and described independently of race, class, sexual orientation, and other realities of experience."[5] It is exemplified in the work of many feminist academicians,[6] who, when we are allegedly talking about an issue's impact on "women," have, in fact, been talking about its impact on white, middle-class women.[7] Through footnotes or parentheticals, we have often noted the impact on poor, adolescent, women of color. An anti-essentialist perspective, however, points out that the parentheticals and footnotes only made it clear that women, unmodified, in fact meant white, middle-class, able-bodied, heterosexual,

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3. 410 U.S. 113, 164-66 (1973).

4. *See, e.g.*, Craig v. Boren, 429 U.S. 190, 197 (1976) (asking whether the classification serves "important governmental objectives and [is] substantially related to achievement of those objectives").

5. Angela Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 585 (1990).

6. The feminists who are often cited as fitting into this category include Catharine MacKinnon and Robin West. However, I would include some of my own work in this category. *See, e.g.*, Ruth Colker, *Anti-Subordination Above All: Sex, Race, and Equal Protection*, 61 N.Y.U. L. REV. 1003 (1986) (attempting to describe women's subordination in universal terms). Thus, I use the pronoun "we" in discussing feminists to whom the anti-essentialism critique applies.

7. *See generally* ELIZABETH SPELMAN, INESSENTIAL WOMAN: PROBLEMS OF EXCLUSION IN FEMINIST THOUGHT ix (1988) ("[Western feminist thought] expresses and reinforces the privilege of white middle-class women"); Nitya Duclos, *Lessons of Difference: Feminist Theory on Cultural Diversity*, 38 BUFFALO L. REV. 325, 374 (1990) (referring to "renegotiated feminism"); Nitya Duclos, *Same Sex Marriage: Complicating the Question*, 1 LAW & SEXUALITY: REV. LESBIAN & GAY LEGAL ISSUES (forthcoming 1991) (referring to the "anti-essentialist" stance); Angela Harris, *supra* note 5, at 608-16 (referring to "post-essentialism"); Maria C. Lugones & Elizabeth V. Spelman, *Have We Got a Theory for You! Feminist Theory, Cultural Imperialism and the Demand for 'The Woman's Voice,'* 6 WOMEN'S STUD. INT. F. 573 (1983) (suggesting non-ethnocentric theories).

adult women. As Angela Harris has noted, this tendency did not make all feminists who wrote from an essentialist perspective "racist."[8] Our awareness of the need to observe the impact of policies specifically on women of color, for example, was based on an appropriate race-conscious sensitivity. Nevertheless, our general discussions of "women" with parentheticals concerning African-American or Hispanic women did not go far enough toward race-conscious sensitivity. An anti-essentialist perspeetive would be more careful in describing "women," embracing the important differences that exist among women.

The anti-essentialism critique is not directed only at feminist academicians. Many academic and political discussions of various issues suffer from the problem of essentialism. For example, the abortion debate, as reflected in both pro-choice and pro-life writings, has often been overly superficial and general in its description of how women are affected by various reproductive choices,[9] thereby suffering from a problem of essentialism. The variables of race, age, sexual orientation, handicap, religion, and social class affect how various reproductive decisions influence women's lives. Nevertheless, the abortion debate tends to focus on all "women" as if they are a monolithic category. Recently, it has become fashionable to discuss the "problem of teenage pregnancy," but even this more focused discussion is unsatisfactory because it fails to reflect that pregnancy does not affect all adolescents[10] in the same way. Finally, the popularity of the abortion debate is a reflection of the problem of essentialism because this debate chooses one issue for debate—abortion—and generally ignores the larger and more complex problems relating to reproductive health issues, of which pregnancy is only one part.

One source to help us move beyond the problem of essentialism in the abortion debate is the empirical literature on reproductive health issues that concerns adolescents ranging from contraception to post-natal

8. Angela Harris, *supra* note 5, at 585.

9. *See, e.g.*, MARY ANN GLENDON, ABORTION AND DIVORCE IN WESTERN LAW (1987) (disagreeing with *Roe* decision); CHRISTINE OVERALL, ETHICS AND HUMAN REPRODUCTION (1987) (pro-choice); John Hart Ely, *The Wages of Crying Wolf: A Comment on* Roe v. Wade, 82 YALE L.J. 920 (1973) (disagreeing with *Roe* decision). A somewhat more sensitive account of the abortion issue is provided by Rosalind Petchesky. *See* ROSALIND POLLACK PETCHESKY, ABORTION AND WOMAN'S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM (1984) (discussing history, practice, and politics). However, Petchesky does not discuss adolescents until page 200, and then does so only in universal terms—describing teenagers as if they are a monolithic group.

10. I use the phrase "adolescent pregnancy" rather than "teenage pregnancy" in this Essay to emphasize that some girls become pregnant before arriving at their teenage years. I also do not use the phrase "juvenile pregnancy" because that phrase sounds derogatory. The phrase "adolescent pregnancy" seems to have the fewest negative connotations of the various phrases that I have heard to describe this phenomenon; it is the phrase most commonly used in the reproductive health literature.

care. Because of the rigorous nature of this literature and the broad range of its considerations, it can help us break down some of the universalist categories about women that are prevalent in abortion and pregnancy-related discussions. I therefore turn to explaining what I mean by a "reproductive health perspective" and how it can help us to better understand the phenomenon of adolescent pregnancy and abortion.

B. *Reproductive Health Perspective*

The abortion debate has not represented a reproductive health perspective. In the cases and literature, it often sounds as though women find themselves pregnant without ever engaging in sexual behavior or using contraceptives.[11] Moreover, the consequences of carrying a fetus to term or aborting it are largely absent from the debate.[12] Both the pro-choice and anti-abortion scholarship reflect an ignorance of the larger socioeconomic circumstances surrounding pregnancy. For example, in *Hodgson v. Minnesota*,[13] a case involving the constitutionality of a two-parent notification requirement for adolescents, both the majority and dissenting Justices ignored the socioeconomic conditions under which adolescents find themselves pregnant, including, for example, coercive sexual experiences and inaccessible contraceptives. The primary focus of all of the opinions is how a parental notification requirement affects the existing family unit—parents and pregnant teenager—and largely fails to consider how such a requirement affects the pregnant teenager's life, as well as the lives of her future offspring and family unit.[14]

Thus, some commentators (and Justices) seem to believe that we can resolve the abortion debate by making moral arguments that are largely inattentive to the empirical literature that concerns the lives of women and their children.[15] Of course, abortion is a moral issue. But more im-

11. "Because contraceptives and their uses are not perfect, the 38 million sexually active women and their partners using contraceptives account for 1.5 million unintended pregnancies, 43% of all unintended pregnancies in the United States." RACHEL BENSON GOLD, ABORTION AND WOMEN'S HEALTH: A TURNING POINT FOR AMERICA? 12 (1990).

12. For an especially insensitive account of the impact of reproductive decisions on women's lives, see Robert Araujo, *Fetal Jurisprudence—A Debate in the Abstract*, 33 CATHOLIC LAW. 203 (1990). When I saw the title of this article, I thought it was a spoof because I couldn't imagine anyone *deliberately* creating an entirely abstract argument which considers fetuses but not pregnant women. However, as far as I can tell, the author is quite serious in trying to hide himself behind a veil of ignorance.

13. 110 S. Ct. 2926 (1990).

14. *See id.* at 2941-44 (identifying issues considered by the court in the case).

15. *See, e.g.*, ABORTION & CATHOLICISM: THE AMERICAN DEBATE (Patricia Beattie Jung & Thomas Shannon eds. 1988) (containing both pro-choice and anti-abortion articles, none of which refers to the empirical, reproductive health literature); Robert Araujo, *supra* note 12 (attempting to resolve the abortion issue by considering the rights of fetuses entirely in the abstract, without considering the empirical literature about women's well-being).

portantly, abortion is an issue about the quality of the lives of women and their children. If we want to demonstrate our moral concern about life—the basis of the moral arguments made by both pro-choice and anti-abortion advocates—then we need to be attentive to the empirical literature about those lives.[16]

A reproductive health perspective,[17] by contrast, considers the full consequences of a woman's reproductive capacity and sexual behavior. In other words, a reproductive health perspective would discuss the nature of sexual activity (e.g., whether it is consensual), the use and availability of contraceptives, the availability of pre- and post-natal care, the socioeconomic and physical consequences of motherhood, the socioeconomic status and physical health of the child that is born, the availability of adoption, as well as the availability and consequences of abortion. Although the feminist slogan of "pro-choice" attempts to emphasize the importance of the choice to bear children as well as the choice not to bear children, the public debate often focuses only on the choice of abortion.

In addition, a reproductive health perspective can provide substantial insight into the real nature of the problem of adolescent pregnancy. The emerging discussion of the "problem of teenage pregnancy" assumes that the underlying problems are the pregnancy and the young age at which it occurs.[18] However, the pregnancy becomes problematic because of the inadequate social resources devoted to facilitating the pregnancy. In addition, youth is not necessarily the problem for all subgroups of women. For example, the negative socioeconomic consequences of childbirth are problematic for Hispanic women, on average, irrespective of the age that they give birth.[19] The underlying problem may be class-based, rather than determined by age or race, meaning that we need to spend dollars to alleviate the conditions of poverty rather than blame adolescents for engaging in sexual activity, or African-American or Hispanic women for having too many children. The anti-essentialism critique reminds us not to assume that the essential factors that determine problem-

16. Justice Marshall referred to this empirical literature with approval in *Hodgson,* 110 S. Ct. at 2952-57 (Marshall, J., concurring in part, dissenting in part). However, I believe that even Justice Marshall's discussion was insufficient because he ignored the socioeconomic conditions that cause adolescents to face unintended pregnancies.

17. The group most responsible for articulating a reproductive health perspective is the Alan Guttmacher Institute with its publication *Family Planning Perspectives.* Although family planning issues are only a subset of reproductive health issues, *Family Planning Perspectives* publishes extensive material on all reproductive health issnes. Fortunately, the ideas and information this organization provides received attention by Justices Marshall, Brennan, and Blackmun in *Hodgson. See id.* at 2951-60.

18. That assumption is pervasive in Petchesky's discussion of adolescent reproductive issues. *See* ROSALIND PETCHESKY, supra note 9.

19. *See infra* Part II and text accompanying notes 32-33.

atic pregnancies and childcare responsibilities are age or race; it suggests that we examine other variables to understand fully why certain subgroups of women face more serious negative consequences from pregnancies.

Finally, a reproductive health perspective can provide a useful distinction between the supposed problems of adolescent pregnancy and adolescent sexual activity. Some commentators assume that the "teenage pregnancy" problem is related to the "problem of teenage sexual activity."[20] But sexual activity, in itself, is not necessarily a problem. The problem is the lack of access to and use of *effective contraceptives* during sexual activity that creates unintended pregnancy and early childbirth, and *inadequate prenatal care* that makes the pregnancies harmful to the pregnant woman and fetus. Only as a consequence of our failure in these other areas of reproductive health does abortion become a problem. Somehow, the public debate always seems to focus on the wrong variables.

Nonetheless, I do not want to suggest that the reproductive health literature is unproblematic. This literature is accustomed to placing people into categories—Hispanic, African-American, poor, female, etc. These categories themselves are riddled with assumptions. How do we define who is "African-American?" How poor is "poor?" In addition, this literature selects only *certain* categories to examine. For example, I was able to find substantial amounts of literature on African-American women, some literature on Hispanic women, and virtually no literature on other racial subgroups. Very little literature discusses the special problems faced by adolescent women who are handicapped, lesbian,[21] or victims of incest. The importance of being able to define which catego-

20. This assumption is pervasive in the anti-abortion movement, which is also anti-sex (outside the context of marriage and procreation). James Trussell, a reproductive health practitioner, does an excellent job distinguishing between the issues of sexual activity and pregnancy. *See* James Trussell, *Teenage Pregnancy in the United States*, 20 FAM. PLAN. PERSP. 262 (1988) (low contraceptive use is a contributing factor to teenage pregnancy rates).

21. One reader of a draft of this Essay inquired as to why I listed lesbians, since they would not appear to need information on either birth control or abortion. In fact, many lesbians do choose to utilize artificial insemination in order to bear children, and therefore need both family planning information as well as assistance from the health care community. In addition, a lesbian, like any other woman who gets pregnant, may find that she needs to consider the option of abortion during the course of her pregnancy. An initially intended pregnancy can become an unwanted pregnancy due to various social, economic, and physical conditions. The societal disapproval of lesbians getting pregnant often makes it difficult for them to receive the reproductive health services that they desire. *See generally* Barbara Kritchevsky, *The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family*, 4 HARV. WOMEN'S L.J. 1 (1981).

ries are important then gets emphasized in later research, such as mine, which builds on those primary sources.[22]

In the analysis that follows, I try to document quantitatively and qualitatively the various ways that pregnancies disadvantage the lives of adolescents and their children. This data should support Justice Stevens' concurrence (joined by Justice Brennan) in *Hodgson* in which he concluded that, on the facts presented, it was constitutionally impermissible for a state to promote childbirth over abortion for adolescents.[23] In addition, I show how U.S. reproductive health policy, ranging from sex education to abortion to adoption, systematically compounds rather than relieves these problems. This entire picture, I believe, should be used to persuade courts to examine U.S. family planning policy with the utmost scrutiny in terms of its impact on female adolescents.

II. THE MAGNITUDE OF THE PROBLEM OF UNINTENDED PREGNANCIES AND EARLY CHILDBIRTH

A. *Introduction*

"One out of every ten women 15-19 years old becomes pregnant each year in the United States, a proportion that has changed little in the last fifteen years."[24] It was estimated in 1981 that more than five million women fifteen to nineteen years old were at risk of unintended pregnancy.[25] Although forty-three percent of unintended pregnancies occur among women using contraceptives,[26] three-fourths of all unintended adolescent pregnancies occur to those who do not practice contraception.[27]

22. Feminists have done an excellent job criticizing many of the subjective and unexamined biases of so-called objective science. *See, e.g.*, BIOLOGICAL WOMAN—THE CONVENIENT MYTH: A COLLECTION OF FEMINIST ESSAYS AND A COMPREHENSIVE BIBLIOGRAPHY (Ruth Hubbard, Mary Sue Henefin & Barbara Fried eds. 1982). I do not believe, however, that their critique requires us to abandon the use of empirical literature entirely, especially when that literature tries to reflect women's needs and concerns. Thus, I have chosen to use empirical literature in this Essay, which I believe is respectful of women's well-being while acknowledging that this literature is far from perfect. My choice to utilize empirical literature is not intended to denigrate the importance and usefulness of other kinds of information concerning women. Ideally, we should combine this empirical evidence with other kinds of information collected by feminists, such as experiential literature. In previous works, I have tried to examine some of that other literature. *See* Ruth Colker, *Feminism, Theology, and Abortion: Toward Love, Compassion, and Wisdom*, 77 CALIF. L. REV. 1011, 1064-67 (1989). In this Essay, however, I am largely limiting myself to the empirical literature. The task of interweaving empirical and experiential literature must be left until later.

23. Hodgson v. Minnesota, 110 S. Ct. 2926, 2937 (1990) (Stevens, J., concurring).

24. James Trussell, *supra* note 20, at 262.

25. Margaret Terry Orr, *Private Physicians and the Provision of Contraceptives to Adolescents*, 16 FAM. PLAN. PERSP. 83 (1984).

26. *See supra* note 11.

27. James Trussell, *supra* note 20, at 262.

The U.S. teenage birthrate is much higher than that of other developed countries, with the maximum relative difference occurring for adolescents under the age of fifteen. Moreover, this disparity continues to grow.[28] Since 1973, although the proportion of wanted births has risen for women age twenty-five to thirty-nine, the proportion of births that were considered "mistimed" for never-married adolescents increased by thirty-seven percent.[29] Unwanted[30] childbearing is more common among unmarried African-Americans than among their white counterparts (thirty percent versus eighteen percent), but varies little among unmarried African-American women according to the mother's current age. By contrast, the rate of unwanted childbearing among single white women is almost cut in half after the age of twenty-four. White and African-American women appear to be similarly situated after age thirty-three with respect to unwanted childbirth, but quite dissimilarly situated under age twenty-four.[31]

Statistics for Hispanics are often not reported separately. However, one study indicated that in 1985, about 39,000 Hispanics age fifteen to nineteen obtained abortions, for an abortion rate of fifty per 1000 births. "The abortion rate was about thirty-two percent higher than the abortion rate for whites of the same age, but almost thirty percent lower than that of nonwhites."[32] Hispanics age fifteen to nineteen had approximately 65,000 births in 1985 for a birthrate of eighty-five per 1000, which was close to the non-white rate of ninety.[33] In other words, Hispanic women, age fifteen to nineteen, are about as likely as non-white women to give birth but less likely to have an abortion.

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28. Elise Jones, Jacqueline Darroch Forrest, Noreen Goldman, Stanley Henshaw, Richard Lincoln, Jeannie Rosoff, Charles Westoff & Deirdre Wulf, *Teenage Pregnancy in Developed Countries: Determinants and Policy Implications*, 17 FAM. PLAN. PERSP. 53, 55 (1985).

29. *Unwanted Childbearing in United States Declines, But Levels Still High Among Blacks, Singles*, 17 FAM. PLAN. PERSP. 274 (1985) (digest section reporting on recent study) [hereinafter *Unwanted Childbearing*].

30. I refer to "unwanted" childbearing in order to be respectful to the reproductive desires of women. A high birthrate is only problematic when the women who are pregnant do not desire the births.

31. *Unwanted Childbearing*, *supra* note 29 (citing W.C. Pratt and M.C. Horn, *Wanted and Unwanted Childbearing United States, 1973-1982, Advance Data from Vital and Health Statistics*, No. 108 (1985)).

The 1985 statistics confirm the relatively high fertility rate for teenagers. Per 1000 women, the pregnancy rate for females was 16.6 for females under age 15 and 109.8 for females age 15 to 19. (For older women, the comparable statistics are around 10%.) For non-white females, these figures are much higher: 50.8 for females under age 15 and 185.8 for females age 15 to 19. Stanley Henshaw & Jennifer Van Vort, *Teenage Abortion, Birth and Pregnancy Statistics: An Update*, 21 FAM. PLAN. PERSP. 85 (1989).

32. Stanley Henshaw & Jennifer Van Vort, *supra* note 31, at 86.

33. *Id.*

In 1979, forty-seven percent of white metropolitan women age fifteen to nineteen were sexually active, as were sixty-six percent of their African-American counterparts.[34] Although African-American adolescents are more likely to be sexually active than white adolescents, they also are less likely to use contraceptives. Forty percent of African-American adolescents, as contrasted with twenty-four percent of whites, reported never having used a contraceptive during intercourse.[35] These statistics yield the not-surprising result that, in 1979, thirty percent of African-American teenage women in metropolitan areas had had a premarital pregnancy, as compared to fourteen percent of whites.

In understanding these statistics, however, it is important to control for social class. Within the group of African-American teenage women, for example, dramatic differences in contraceptive use exist depending upon social class. One study found that forty-four percent of African-American teenage women who were of high social class, had intact families, and resided in a non-ghetto neighborhood, used a contraceptive at first intercourse, as compared with only twelve percent of those who were of low social class, did not have intact families, and resided in a ghetto neighborhood.[36] The statistics for these "higher class" African-American women appear to be similar to a comparable group of white women, thus demonstrating the importance of social class and race in understanding the problem of adolescent pregnancy. This finding about contraceptive use at first intercourse is important because other studies demonstrate that those who use contraceptives at first intercourse are more consistent users thereafter.[37]

Thus, the problem of unintended pregnancies is dramatic for all groups of adolescents. Thirty percent of unmarried, African-American adolescents who live in metropolitan areas face an unintended pregnancy, as do fourteen percent of similarly situated white adolescents. Each year, more than five million sexually-active female adolescents face a possible unintended pregnancy, which is compounded by the fact that three-fourths of them do not practice contraception. One million of them become pregnant each year, with 470,000 giving birth to a child.[38] These statistics demonstrate that the phenomenon of large numbers of unwanted births is primarily class based. Poor, adolescent women do not

34. Dennis Hogan, Nan Marie Astone & Evelyn Kitagawa, *Social and Environmental Factors Influencing Contraceptive Use Among Black Adolescents*, 17 FAM. PLAN. PERSP. 165 (1985).

35. *Id.*

36. *Id.* at 168.

37. *Id.* at 168-69.

38. Comment, *Risking the Future: A Symposium on the National Academy of Sciences Report on Teenage Pregnancy*, 19 FAM. PLAN. PERSP. 119 (1987).

have the opportunity to choose the conditions under which they become pregnant to the same extent as middle-class women.

Because the problem of unwanted pregnancies is a class-based problem, which disproportionately affects female adolescents, the expenditure of public funds targeted at adolescents could make a real difference in the lives of women. Nevertheless, as I discuss, we have an entirely ineffective public program for limiting unwanted adolescent pregnancies. In fact, our public policy encourages childbirth over contraception or abortion; we facilitate the problem rather than solve it.

B. *Consequences of Early Childbirth for the Mother*

To understand the magnitude of the problem of unintended pregnancies for adolescents, we need to understand the impact on the physical health of the mother, as well as the socioeconomic consequences stemming from early childbirth. Female adolescents face substantial negative consequences from early childbirth, although the source of these problems may often be socioeconomic rather than age-related. Early childbirth, in itself, need not cause negative physical and socioeconomic consequences. It does, however, because adolescent mothers are disproportionately poor. In addition, they often are without effective assistance from state-funded or other health care providers during their pregnancies and after their children are born.

1. *Physical Health.* "[A]dolescent mothers between the ages of fifteen and nineteen years are twice as likely to die from hemorrhage and miscarriage than mothers over twenty years of age."[39] The maternal mortality and morbidity rate is sixty percent higher for this group than for older women.[40] Adolescent mothers are "23 percent more likely to experience a premature birth with complications such as anemia, prolonged labor and nutritional deficiency," and ninety-two percent more likely to experience anemia than older mothers.[41] The risk of health

39. Alva Barnett, *Factors that Adversely Affect the Health and Well-Being of African-American Adolescent Mothers and Their Infants,* in TEENAGE PREGNANCY: DEVELOPING STRATEGIES FOR CHANGE IN THE TWENTY-FIRST CENTURY 101, 105 (Dionne Jones & Stanley Battle eds. 1990) (citing Klerman, *Adolescent Pregnancy: A New Look at a Continuing Problem,* 70 AM. J. PUB. HEALTH 776, 776-78 (1980)).

40. *Id.*

41. *Id.* at 106. Another study found that anemia occurs more frequently among teenagers than among older women. Carolyn Makinson, *The Health Consequences of Teenage Fertility,* 17 FAM. PLAN. PERSP. 132, 133 (1985). Four other studies found a significant difference in toxemia in adolescence. *Id.* A Canadian study of teenage pregnancy and health complications found that teenagers had a higher incidence of eclampsia and anemia than older women. *Id.*

One study reported that in France and the United States teenagers had a higher mortality rate than older women, whereas in England and Wales they did not. *Id.* at 134. The actual statistics

problems and medical complications are even higher for African-American adolescents because of the inequitable distribution of resources in society.[42]

Socioeconomic factors, rather than age, seem to contribute substantially to adverse health consequences from teenage pregnancy.[43] Recent research in the United States has shown that many of the adverse health consequences of adolescent childbearing documented by earlier studies were overstated because of a lack of adequate controls for socioeconomic status.[44] Several studies suggest that pregnancy outcomes among adolescents who receive good prenatal care are no different from, or are better than, those of older women.[45] Thus, the underlying problem is one of poverty. As we will see, our Medicaid policies do little to assist women and their children during pregnancy.

In countries where adverse health consequences were not found for adolescents, an excellent prenatal care system was in place.[46] Thus, it is not the age or race of the adolescents that cause their pregnancy to coincide with adverse health consequences, but it is the lack of access to adequate prenatal care that causes these adverse health consequences. In fact, some authors seem to believe that adolescents would have healthier pregnancies than older women if they received adequate prenatal care.[47]

2. *Education.* Education is a very important variable because it strongly correlates with socioeconomic status.[48] Because no literature that I have been able to find actually traces the relative earning power of

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suggest, however, that this statement is inaccurate. The maternal mortality rate for black women, under the age of 15, is 43.7 per 100,000 live births and, for white women, is 23 per 100,000 live births. These rates are higher than the rate for African-American women until age 25 and for white women until age 35. However, the maternal mortality rate for teenagers, age 15-19, is lower for African-American and white women than for older women. Thus, maternal mortality appears to increase with age, except for teenagers under the age of 15, who have a disproportionately high mortality rate. The marked difference in maternal mortality is actually based more on race than age. The maternal mortality rate for African-American women, of any age group, is at least twice and sometimes four times as high, as the rate for white women. African-American women, age 40-44, for example, face a maternal mortality rate of 236.8 deaths per 100,000 live births. In other words, more than .02% of African-American women, age 40-44, die during their pregnancy. *Id.*

42. Alva Barnett, *supra* note 39, at 106.

43. Carolyn Makinson, *supra* note 41, at 132. For example, one U.S. study found that African-American teenagers in urban clinics had a high rate of pregnancy-induced hypertension, anemia, prematurity and perinatal mortality, but that teenagers from more economically advantaged backgrounds did not have more health complications than older women. *Id.* at 133.

44. James Trussell, *supra* note 20, at 268.

45. *Id.*

46. Makinson, *supra* note 41, at 133 (reporting Swedish experience).

47. *See supra* notes 41 & 43.

48. Conversation with sociology professor Rosemary Gartner, University of Toronto, Department of Sociology (Summer 1990).

pregnant and nonpregnant adolescents, the literature on educational attainment comes closest to predicting the earning power of pregnant adolescents versus nonpregnant adolescents.

High school graduation rates are affected markedly for women age twenty-one to twenty-nine, by age at first birth. As of 1986, African-American women who delay their first birth until age twenty have a better than ninety-two percent chance of graduating from high school.[49] By contrast, African-American women who have their first child under the age of seventeen have only a sixty percent chance of high school graduation, and African-American women who have their first birth at the age of eighteen to nineteen have only a seventy-five percent chance of high school graduation.[50] For white women the statistics are comparable, except that white women who have their first child under the age of seventeen have only a fifty-four percent chance of high school graduation.[51] Thus, both African-American and white women who bear children while under the age of twenty have a significantly greater chance of not graduating from high school than women who delay childbirth until after age twenty.

Another study found that in 1983, ninety-five percent of white women, ninety-three percent of African-American women, and eighty-seven percent of Hispanic women who had not borne children had received a high school diploma or GED certificate.[52] For African-American and white women, roughly sixty percent of them completed high school if they had a child within seven months after leaving school.[53] Hispanic women, however, had only a thirty-three percent chance of completing school if they conceived a child while in high school but gave birth after leaving school, and had a fifty-nine percent chance of completing high school if they both conceived and gave birth before leaving school.[54] The latter statistic is about ten percentage points lower than the comparable group of African-American and white women; however, the former statistic is more than twenty percentage points lower than the comparable group of African-American and white women. Thus, early childbearing has a dramatic influence in the educational lives of Hispanic women, and a very significant influence in the educational lives of white and African-American women.

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49. Dawn Upchurch & James McCarthy, *Adolescent Childbearing and High School Completion in the 1980s: Have Things Changed?*, 21 FAM. PLAN. PERSP. 199, 200 (1989).

50. *Id.*

51. *Id.* at 199.

52. Frank Mott & William Marsiglio, *Early Childbearing and Completion of High School*, 17 FAM. PLAN. PERSP. 234, 235 (1985).

53. *Id.*

54. *Id.*

Although the impact of early childbearing may be more significant for Hispanic women than for African-American or white women, it is interesting to note that Hispanic women are much less likely to bear children before leaving school than are African-American women. Nineteen percent of African-American women gave birth before leaving school in 1983, whereas only seven percent of Hispanic women gave birth before leaving school.[55] (The figure for white women was four percent.) Thus, if we encourage African-American and Hispanic women to use contraception during high school if they are sexually active, their pregnancies more likely will be intentional rather than unwanted or mistimed. The reasons for targeting them are somewhat different. African-American women are at a greater risk of giving birth before leaving school than Hispanic women, but Hispanic women are more likely to face serious consequences when they do give birth before leaving school.

More adolescent mothers are now graduating from high school than ever before.[56] However, graduation rates did not increase equally among all racial and socioeconomic groups, and the increases did not occur in the same periods for all groups.[57] Ironically, African-American adolescents made the greatest progress in graduating from high school, despite their pregnancy, *before* federal law made it illegal for schools receiving federal funds to expel students because of pregnancy or childbirth.[58] The statistics also make clear that race, rather than socioeconomic status, are important predictors of high school graduation among pregnant adolescents. For example, the increase in the graduation rate from 1975 to 1986 among white mothers from disadvantaged backgrounds was over 200% as compared with eighty-seven percent for similar African-American mothers.[59]

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55. *Id.* at 237.

56. Dawn Upchurch & James McCarthy, *supra* note 49, at 199.

57. *Id.*

58. *Id.* (reporting that African-American teenagers made the greatest progress between 1958 and 1975, whereas Title IX of the Education Amendments of 1972, Pub. L. No. 92-318, 86 Stat. 235, 373-75 (codified as amended at 20 U.S.C. §§ 1681-1685 (1988)), did not become effective until 1975). The author of this study is not exactly accurate in her description of Title IX of the Education Amendments of 1972. That law prohibited sex-based discrimination in educational programs or activities receiving federal financial assistance. The regulations accompanying the statute interpreted the law to forbid pregnancy-based discrimination. The Supreme Court's subsequent conclusion in General Electric Co. v. Gilbert, 429 U.S. 125 (1976), that sex-based discrimination under Title VII of the Civil Rights Act of 1964, Pub. L. No. 88-352, 778 Stat. 241, 253-66 (codified as amended at 42 U.S.C. § 2000e (1988)), does not include pregnancy-based discrimination, would also seem to apply to Title IX. Thus, the regulations to Title IX may have applied to pregnancy-based distinctions. It is questionable, however, whether those regulations are valid.

59. Dawn Upchurch & James McCarthy, *supra* note 49, at 202 (also reporting that one needs to view statistics about improvements in gaining high school diplomas with caution because other

This evidence suggests that we need to modify our strategy for adolescents to encourage them to stay in school during and after their pregnancies. Federal law that prohibits pregnancy-related discrimination in education does not appear to help African-American adolescents. But it also seems clear that it is inappropriate to focus on early childbirth as the crucial factor in explaining the socioeconomic future of African-American and Hispanic adolescents. Their upward economic mobility appears to be limited irrespective of whether they bear children while they are adolescents; our social policies need to assist their lives more holistically rather than to focus exclusively on early childbearing.

C. *Consequences of Early Childbirth to the Child*

Children born to adolescents do not fare well. Despite the media's focus on the race and age of mothers affecting the children's health, socioeconomic factors, rather than the age of the mother, seem to be the most important determinant of both prematurity and low birth weight.[60] Inadequate prenatal care has been singled out as an important determinant.[61] The mother's age affects the long-term future consequences for the child more than her age affects the child's immediate situation. Although studies show association of socioeconomic status with neonatal, postnatal, and sudden infant death, they also show an association of age with the cognitive, social, and economic development of the child.[62]

The gap between the rates for African-American and white low birth weight (LBW) and very low birth weight (VLBW) infants has been increasing in recent years. The risk for African-American infants, as compared with white infants, of being LBW increased from 2.1 in 1975 to 2.2 in 1985, where it has remained.[63] The relative risk of VLBW infants also increased (from 2.6 in 1975 to 2.9 in 1987) for African-American infants as compared with white infants.[64] Within each high risk subgroup (unmarried, under twenty years of age, less than twelve years of education, inadequate prenatal care) African-American mothers are twice as likely to have LBW infants and two to three times as likely to have VLBW infants.[65] These statistics are disappointing because LBW is considered to be an important indicator of infant morbidity and mortal-

studies indicate that adolescents who become mothers are less likely to continue their education in college, which is not discussed in studies of high school completion).

60. Carolyn Makinson, *supra* note 41, at 135-36.

61. *Id.* at 135.

62. *Id.* at 137-38.

63. *Low Birthweight—United States, 1975-1987,* 39 MORBIDITY & MORTALITY WEEKLY REP. 148, 150 (1990).

64. *Id.*

65. *Id.*

ity. In quantitative terms, one author concluded that almost 20,000 African-American infants who died during the first year of life over the last five years would have lived had their access to health care been equal to that of white infants.[66]

It is important, however, not to focus entirely on low birth rate as a problem contributing to infant mortality. Recent studies have found that normal and optimal birth-weight babies, born to African-American mothers, have a poorer survival rate than normal and optimal birth-weight babies born to white mothers.[67] Thus, even if we succeed in creating social policies that will raise the birth weight of African-American babies, we also need to create social policies that will assist these babies, after birth, when they have achieved normal or optimal birth weights. Interestingly, the variables of early pregnancy and low birth weight are more significant in the lives of white females than African-American females. In other words, as a child or as an adult, the hardships of being African-American are significant even when obvious problems such as low birth weight or early pregnancy have been avoided. An emphasis on the problem of low birth weight may be more reflective of the experience of white women and their children than of African-American women and their children.

Some studies have shown that inadequate or no prenatal care is an important factor in predicting infant mortality. For both African-American and white infants, the risk of mortality is approximately double if prenatal care is absent or if care is not obtained until the third trimester.[68] Among Hispanic infants, however, the odds of infant mortality remain quite low, regardless of when prenatal care is obtained.[69] This result is puzzling since Hispanics tend to be of low socioeconomic status; the anomaly deserves further attention.

Children born to adolescents are more likely to be involved in accidents during the first five years of life, and more likely to be admitted to a hospital because of accidents and gastrointestinal infections, than are children born to older women.[70] This relationship exists after adjustment for the effects of socioeconomic and biological factors.

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66. Alva Barnett, *supra* note 39, at 106-07.

67. *Way to Lower Black Neonatal Mortality Not Simple, Study Finds,* 17 FAM. PLAN. PERSP. 129 (1985) (reporting N.J. Binkin, R.L. Williams, C.J.R. Hogue & P.M. Chen, *Reducing Black Neonatal Mortality: Will Improvement in Birth Weight be Enough?,* 253 J. A.M.A. 372 (1985)).

68. Jeanette Johnson, *U.S. Differentials in Infant Mortality: Why Do They Persist?,* 19 FAM. PLAN. PERSP. 227, 231-32 (1987).

69. *Id.* at 232.

70. *Children Born to Teens More Likely to Be Injured or Hospitalized by Age 5,* 16 FAM. PLAN. PERSP. 238 (1984).

One needs to be careful not to overgeneralize concerning the relationship between maternal age and the well-being of children. One study, conducted entirely on African-American and Hispanic women who had given birth to their first children on the wards of a New York City hospital in 1975, found that there was no relationship between maternal age and the well-being of children.[71] This study suggests that previous studies may not have appropriately controlled for socioeconomic and racial status. If one controlled for socioeconomic and racial status, age would not be a significant factor in predicting the health of infants—at least for poor Hispanic and African-American women.[72]

In sum, poverty again seems to be the key factor in explaining the health and well-being of children. By failing to provide effective welfare programs to assure these children basic food, education, and housing, we are helping to perpetuate a gruesome cycle of poverty. Early childbirth is only a problem because of its correlation with poverty; we need to attack the poverty rather than simply the early childbirth.

D. *Contraception and Sex Education*

One way to avoid the problems of early childbirth is to use contraception to avoid pregnancy. Nevertheless, as compared with other western countries, U.S. social policy is entirely ineffectual in preventing early childbirth for poor adolescents through contraception. In 1978, the United States Congress passed the Adolescent Health, Services, and Pregnancy Prevention and Care Act,[73] which promoted the distribution of contraceptives and abortion counseling or referral. In 1981, Congress folded the Adolescent Health Services and Pregnancy Prevention and Care Act into the Maternal and Child Health block grant to the states, and enacted the Adolescent Family Life Act (AFLA).[74] The AFLA is fundamentally different from the 1978 Adolescent Pregnancy Prevention Act in that it supports "chastity" and adoption, but not contraception or abortion. Although the 1978 Act required grantees to offer counseling and referral about abortion, the 1981 Act forbids such counseling or referral.[75]

71. Katherine Darabi, Elizabeth Graham, Pearila Namerow, Susan Philliber & Phyllis Varga, *The Effect of Maternal Age on the Well-being of Children*, 46 J. MARRIAGE & FAM. 933 (1984).

72. *Id.* at 934.

73. Health Services and Centers Amendments of 1978, Pub. L. No. 95-626, §§ 601-08, 92 Stat. 3551, 3595-601 (codified as amended at 42 U.S.C. §§ 300a-21 to -28; repealed by Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 955, 95 Stat. 357, 578-92 (codified as amended at 42 U.S.C. § 300z (1988)).

74. 42 U.S.C. § 300z (1988).

75. *See* Patricia Donovan, *The Adolescent Family Life Act And the Promotion of Religious Doctrine*, 16 FAM. PLAN. PERSP. 222-23 (1984).

The rationale behind this approach is the assumption that sex education and the availability of contraceptives and abortions promotes sexual behavior and unintended pregnancies.[76] Proponents consider the message of abstinence to be the most effeetive way to limit teenage sexual activity and thus unintended pregnancies. However, empirical surveys suggest the opposite. Studies of teenage pregnancy in developed countries slıow tlıat countries with more liberal attitudes toward talking about sex have the lowest birthrates.[77] In addition, one study found that exposure to contraceptive education liad no consistent effect on tlie probability that a woman, who had not previously experienced intercourse, would subsequently initiate intercourse.[78] A study of predominantly poor, inner-city African-American adolescents in Baltimore found tliat a program that combined sex education, counseling, and contraceptive services, witli an emphasis on the development of personal responsibility, goal setting, and communication with parents, reduced pregnancy rates substantially and contributed to delaying the onset of sexual activity.[79] Thus, increased sex education may actually delay the onset of sexual activity as well as reduce the pregnancy rate.[80]

The U.S. policy on family planning, as compared to other developed countries, differs in one important respect. In the United States, policy analysts are not sure whether they should advocate tlie prevention of teenage sexual activity or unwanted teenage pregnancy; in other developed countries, national policy is squarely behind preventing unwanted teenage pregnancy irrespective of the prevalence of sexual activity among adolescents.[81] Thus, easily accessible and relatively free contraceptives,

76. In the only legal argument that I have been able to find that defends this program, the author does not explain the rationale behind this policy choice. He simply repeatedly asserts that the government is entitled to choose childbirth over abortion, without explaining why that choice would be prudent for teenagers. Theodore Hirt, *Commentary: Why the Government is Not Required to Subsidize Abortion Counseling and Referral,* 101 HARV. L. REV. 1895, 1896 (1988) (author was the Assistant Branch Director in the Federal Programs branch of the Civil Division of the Department of Justice).

77. Elise Jones et al., *supra* note 28, at 54.

78. Jaines Trussell, *supra* note 20, at 267.

79. *Id.* However, Trussell cautions the reader that the delay in intercourse was mitigated by other factors, so that one needs to read that result with caution.

80. One assumption that often seems to accompany discussions of the usefulness of sex education programs is that it is necessarily bad if such programs serve to encourage sexual activity among adolescents. Jaines Trussell observes that the prevalence of sexual activity should not be so relevant to the discussion about these programs. Instead, he argues that preventing preguancy should be judged the most important factor, irrespective of the rates of teenage sexual activity. *Id.* at 269. As long as sexual activity is consensual, our primary focus should be on the prevention of uuintended pregnancies. In fact, I would even go further and say that our focus should be on preventing unintended *childbirth* and *childcare* rather than pregnancy, unless studies demonstrate that abortion or adoption have negative consequences for preguant adolescents.

81. Elise Jones et al., *supra* note 28, at 60-61.

which are made available in most developed countries and which substantially help to lower the rate of unintended teenage pregnancy, are not part of the U.S. national family planning policy. Due to a lack of sex education or public discussion about contraception, adolescents are more likely to hear about abortion than about how to prevent pregnancy through contraception.[82] As one group of commentators has observed, U.S. adolescents "seem to have inherited the worst of all possible worlds regarding their exposure to messages about sex."[83]

Another important aspect of an effective contraceptive policy would be to have a wide range of inexpensive contraceptive services available to adolescents. American adolescents, however, do not have many services readily available to them. Most adolescents obtain contraceptives (if they obtain them at all) at family planning clinics rather than from private physicians.[84] Only seven out of ten clinics, and five out of ten private physicians, accept Medicaid payment for contraceptive services. Thus, poor adolescents may have no affordable way to obtain the contraceptive pill, which is generally considered to be the most appropriate birth control option for adolescent females. In addition, many private physicians will not serve an unmarried minor without parental consent.[85] We know the difficulties of parental consent and notification statutes from the abortion cases. If a pregnant teenager feels uncomfortable telling her parents that she is pregnant in order to be able to obtain an abortion, then she would likely also feel uncomfortable in telling her parents that she is sexually active in order to get their Medicaid card to see a doctor for the contraceptive pill.

Even when sex education does exist, it is often not adequate or effective. For example, one study found that of those adolescents who did have sex education, thirty-four percent could not correctly identify the time during the menstrual cycle when conception is most likely to occur.[86] In addition, ninety percent of the sex education that schools provide about contraceptives and where to get them occurs after ninth grade, despite evidence that adolescents initiate sexual activity in their

82. *Id.*

83. *Id.* at 61.

84. Margaret Orr, *Private Physicians and the Provision of Contraceptives to Adolescents*, 16 FAM. PLAN. PERSP. 83, 86 (1984); *see also* William Mosher, *Use of Family Planning Services in the United States: 1982 and 1988*, 184 ADVANCE DATA 1 (April 11, 1990) (reporting that black women, poor women, and teenagers were more likely to rely on clinics for their reproductive health services than were white, higher-income, and older women).

85. Margaret Orr, *supra* note 84, at 86.

86. James Trussell, *supra* note 20, at 267.

early teens.[87] Thus, it is not sufficient for sex education to exist; it must be comprehensive both in its coverage and in its audience.

The only good news in the family planning area is that the United States Congress has modified Medicaid so that women who do not meet the income and family structure criteria for cash assistance are eligible for Medicaid as long as they meet certain income criteria. By July 1990, states had to extend Medicaid coverage to infants and pregnant women with incomes up to the federal poverty level, and had the option of covering infants and pregnant women with incomes up to 185% of the poverty level. As of July 1988, forty states have opted to expand their Medicaid programs to cover infants and pregnant women with incomes of 100% of the poverty level.[88] It is too soon to assess whether that money is actually reaching poor, pregnant adolescents.

Finally, it is important to recognize that effective sex education programs will not prevent unintended pregnancies as long as only current contraceptive technology is available. For example, fifty-one percent of all abortion patients in a 1987 study reported that they were practicing contraception during the month in which they conceived.[89] Of those who had stopped practicing contraception, about fifteen percent had ceased using the pill within one month of becoming pregnant, forty-four percent had ceased using the pill within three months of becoming pregnant.[90] These former pill users were probably not using contraceptives because they mistakenly believed that after a woman stops using the pill that she has a several month "grace" period during which she will not become pregnant.[91] Only nine percent of women obtaining abortions had had no prior contraceptive experience.[92] Thus, it is simply not true that women who have abortions are ignorant of the importance of practicing contraception or unwilling to make an effort to avoid pregnancy. The evidence strongly suggests that women experience problems in successfully using even the most effective methods of contraception.[93] Rather than place all the blame on women, it is important to recognize that

87. *Id.*

88. Rachel Benson Gold & Sandra Guardado, *Public Funding of Family Planning, Sterilization and Abortion Services, 1987,* 20 FAM. PLAN. PERSP. 228, 228 (1988).

89. Stanley Henshaw & Jane Silverman, *The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients,* 20 FAM. PLAN. PERSP. 158, 165 (1988).

90. *Id.*

91. *Id.*

92. *Id.* at 167.

93. *Id.* at 168.

contraceptive technology itself has inherent limitations which result in many unintended pregnancies.[94]

In sum, U.S. contraception and sex education policy is entirely ineffective in preventing unintended teenage pregnancy. Our policies send a confused and ineffectual message to adolescents and cause the United States to have the least effective contraception and sex education program in the western world. In addition, we have failed to devote adequate resources to developing safe, cheap, and effective contraceptives. Legislative policy is inept; the poor, pregnant adolescents disproportionately pay the heavy price for this incompetence.

E. *Prenatal Care*

Another way to avoid some of the negative consequences of early childbirth, especially for the child, is to have available an excellent system of prenatal care. The importance of adequate prenatal care cannot be overstated. Six in ten women, in general, are treated for some pregnancy-related medical problems.[95] Three in ten women are reported to have had major complications from pregnancy.[96] Women who do not obtain adequate prenatal care are much more likely than those who do to have a low birth-weight baby, to gain too little weight during pregnancy, or to have a premature birth.[97] Because nearly half of all women under the age of twenty receive inadequate prenatal care,[98] these women are at high risk of having pregnancy-related complications. By not preventing these complications early in the pregnancy, we raise the ultimate cost of the medical complications associated with the pregnancy and place the mother's and child's health at risk.

Despite the importance of effective and accessible prenatal care, it is no more available to poor adolescents after pregnancy than were contraceptives and sex education prior to pregnancy. Although much controversy exists concerning appropriate contraceptive policy, no controversy exists concerning the importance of adequate prenatal care for pregnant women. In 1980, the United States Surgeon General called for an in-

94. I have not even discussed the lack of contraceptive research in the United States, as compared with Europe. Although only a minority of people who oppose abortion also oppose contraception, that small fringe of the pro-life movement has managed to curtail contraception research in the United States. Although RU 486 is not, in most cases, a contraceptive, the total stalemate in the United States concerning this drug reflects the lack of progress being made in the United States with regard to contraceptives.

95. Rachel Benson Gold, Asta Kenney & Susheela Singh, *Paying for Maternity Care in the United States*, 19 FAM. PLAN. PERSP. 190, 192 (1987).

96. *Id.*

97. *Id.* at 193.

98. *Id.* at 192.

crease, by 1990, of at least ninety percent in the proportion of women in each racial and ethnic group who receive care in the first trimester of pregnancy.[99] The United States has made progress in reaching this goal for married, white, adult, non-poor women, but has made no progress in reaching this goal for adolescents of all racial subgroups. In fact, the proportion of non-white women who received first-trimester care between 1980 and 1982 actually *declined.*[100] Some commentators attribute this decline to tightened eligibility for Medicaid coverage and cutbacks in funding of maternal health services for the poor.[101] The unavailability of publicly-funded prenatal care becomes especially troubling when one realizes that 32.1% of the babies born are born into families with a yearly income of 150% or less of the poverty line.[102] Not surprisingly, only 65.6% of this group receives first-trimester pre-natal care as contrasted with about eighty-three percent for the rest of the popnlation.[103] Females under the age of eighteen, however, receive the least amount of prenatal care; 48.5% receive first-trimester prenatal care; 12.7% receive third-trimester care only; and some receive no care.[104] In addition, the percentage of female adolescents who receive third-trimester only or no care is substantially higher for African-American and Hispanic adolescents than for white adolescents.[105]

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99. Susheela Singh, Aida Torres & Jacqueline Darroch Forrest, *The Need for Prenatal Care in the United States: Evidence from the 1980 National Natality Survey,* 17 FAM. PLAN. PERSP. 118, 118 (1985).

100. *Id.* at 119.

101. *Id.*

102. *Id.* at 120.

103. *Id.*

104. *Id.*

105. *Id.* at 121. One study estimates that 8.3% of white mothers receive third trimester-only care or none whatsoever, whereas the statistic is 12.8% for African-American mothers and 11.9% for Hispanic mothers. *Id.*

Nevertheless, it is important not to overstate the significance of age for Hispanic women. Among Hispanic mothers, the incidence of inadequate care is nearly as high among 20-24 year-olds (11%) as among adolescents (12%). (Inadequate care is defined as third trimester-only care, or none at all.) For African-American women, however, there was a more marked difference between inadequate prenatal care for adolescents (12.8%) as compared with 20-24 year-olds (6.4%). For Hispanic mothers, then, the problem of inadequate prenatal care is prevalent irrespective of whether they bear a child as adolescents or in their early 20s. There is no reason to single out pregnant, Hispanic adolescents for special attention in terms of prenatal care; all pregnant, Hispanic women under the age of 25 need to be targeted. We may have grown accustomed to talking about the special problem of teenage pregnancy without understanding that, for some groups, age is not a relevant variable. Not surprisingly, age is a significant variable for white women where the incidence of inadequate prenatal care is 8.3% for adolescents and only 3.9% for 20-24 year olds. Finally, we have to be careful not to talk about "women of color" generally with respect to prenatal care. The only racial subgroups that are monitored closely are African-American and Hispanic women and, for those two groups, the relationship between age and prenatal care differs. The evidence available for other racial subgroups is lacking. *Id.*

The structure of the federal Medicaid program explains the unavailability of prenatal care for certain groups in society. Eligibility for Medicaid is based on poverty and family structure. As of 1985, only one state, Vermont, had an eligibility level that exceeded the federal poverty level and twenty-three states had income limits that were *less than half* of the federal poverty level.[106] If the new Medicaid rules are successful,[107] these figures should improve. In addition, prenatal care, delivery, and postpartum care are not mandated under the Medicaid program. Two states do not cover prescription drugs, five states do not cover clinics (which are a major source of health care for poor women), twenty-seven states do not cover diagnostic services, thirty-one states do not cover screening services such as amniocentesis or ultrasound, and ten states limit the number of outpatient visits below the number recommended for an uncomplicated pregnancy.[108] Only twelve states provide all of the services under Medicaid that are considered part of an "adequate" prenatal health care system.[109] Pregnant adolescents can have special problems receiving Medicaid coverage because they often need to present their parent's Medicaid card at the doctor's office to receive treatment.[110] Finally, it can be difficult to find a doctor who will accept Medicaid payment; a 1983 study indicated that only forty-six percent of obstetrician-gynecologists in private practice accept Medicaid for a delivery.[111]

In sum, our prenatal care policies substantially harm the health and well-being of fetuses, and poor, pregnant, teenage women. Unfortunately, for poor, Hispanic women, escaping their teen years does not make this problem diminish. We have consistently failed to spend sufficient federal money to ensure a minimally healthy life for these women and their children.

F. *Abortion*

Another way to avoid early childbirth stemming from unwanted pregnancies is to have accessible abortion—especially at the early stages of pregnancy when it is safest. But the Supreme Court has long supported restraints on abortions for adolescents. Moreover, the restrictions

106. Rachel Benson Gold & Asta Kenney, *Paying for Maternity Care,* 17 FAM. PLAN. PERSP. 103, 107 (1985).

107. *See supra* text accompanying note 88.

108. Rachel Benson Gold & Asta Kenney, *supra* note 106, at 108-09.

109. *Id.* at 109.

110. *Id.*

111. *Id. See* Margaret Terry Orr & Jacqueline Darroch Forrest, *The Availability of Reproductive Health Services from U.S. Private Physicians,* 17 FAM. PLAN. PERSP. 63, 67-68 (1985) ("substantial proportions of physicians who provide reproductive health service are inaccessible to the poor, because they will not accept medicaid reimbursements.").

approved in *Webster v. Reproductive Health Services*[112] that increased the costs of second trimester abortion and that made abortions unavailable in hospitals on public property will have a dramatic effect on adolescents, because they are disproportionately affected by these measures. Although adolescents manage to have abortions in relatively large numbers, they do so by overcoming substantial burdens that are placed in their way. The consequence is that adolescents have disproportionately late-term abortions, thereby increasing the health risks of the procedure and raising its cost.[113]

Despite parental consent laws and the unavailability of Medicaid for abortions, about six percent of eighteen to nineteen year-olds had abortions in 1981, the highest rate of any age group.[114] Female adolescents are the second most likely group to face a pregnancy, and the most likely group to terminate it by abortion, despite the relative difficulty for many of them to obtain an abortion.[115]

The rate of abortions per 1000 women was much higher in 1981 for non-white adolescents as compared to white adolescents (59.7 compared with 33.5). However, the ratio of abortions per 100 abortions plus live births was higher for white adolescents than non-white adolescents (41.8 compared with 39.6). These statistics reflect a much higher pregnancy rate in the non-white community than the white community. Thus, in absolute terms, non-white adolescents experienced many more abortions *and* births than white adolescents, and were, overall, less likely to terminate a pregnancy through abortion. Non-white adolescents are therefore in much greater need of all reproductive health services than white adolescents.

Adolescent females are disproportionately likely to have abortions in the second trimester. In 1981, between six and eight percent of the abortions performed on women over the age of twenty-five took place at thirteen or more weeks gestation.[116] In the same year for women under the age of twenty, between ten and twenty-three percent of the abortions performed took place at thirteen or more weeks' gestation, with the high-

112. 492 U.S. 490 (1989). For further discussion of the impact of this decision on female adolescents, see Ruth Colker, *Feminist Litigation: An Oxymoron?—A Study of the Briefs Filed in* William L. Webster v. Reproductive Health Services, 13 HARV. WOMEN'S L.J. 137, 175-78 (1990).

113. *See* Hodgson v. Minnesota, 110 S. Ct. 2926, 2953-54 (1990) (Marshall, J., concurring in part and dissenting in part).

114. Stanley Henshaw, Nancy Binkin, Ellen Blaine & Jack Smith, *A Portrait of American Women Who Obtain Abortions*, 17 FAM. PLAN. PERSP. 90 (1985).

115. *Id.*

116. David Grimes, *Second-Trimester Abortions in the United States*, 16 FAM. PLAN. PERSP. 260, 262 (1984).

est statistic for women under the age of fourteen.[117] There appears to be an inverse, geometric relationship between age and second trimester abortions for women under the age of twenty. Thus, when adolescent females do face unintended pregnancies and decide to have an abortion, they disproportionately face the high health risks of second trimester abortions.[118] Our silence about contraception and abortion may cause them to risk their lives and health in order to obtain an abortion.

More recent statistics depict a similar trend, although the overall number of abortions may be declining. In 1984, 1,333,521 legal abortions were performed; five percent more than the number reported for the previous year.[119] In 1985, the number decreased to 1,328,570, a reduction of less than one percent.[120] The abortion ratio was highest for women under fifteen years of age and second highest for fifteen to nineteen years of age.[121] In 1984 and 1985, adolescents had twenty-six percent of all legal abortions. Of the abortions performed at sixteen to twenty weeks gestation, 37.1% were performed on fifteen to nineteen year-olds in 1985, although that group generally comprised only twenty-five percent of all abortions. For abortions past twenty-one weeks, the same trend continues. Of all post-twenty-one-week abortions, 36.7% were performed on fifteen to nineteen year-olds.[122] Other than females under the age of fifteen, who have only one percent of all abortions, no other group disproportionately had post-sixteen-week abortions.[123] Even women over the age of thirty-five who might discover that their fetus was handicapped late in the pregnancy were most likely to have abortions in the first ten weeks of pregnancy.[124] Non-white women also were disproportionately likely to have post-eleven week abortions. For example, although they generally comprised 32.7% of the women having abortions, they comprised 44.7% and 41.3% of the women having sixteen-to-twenty-week and post-twenty-one-week abortions, respectively.[125]

Abortion mortality statistics show a steady decline since abortion was legalized. In 1972, ninety women died as a result of abortion, with forty-three percent of those deaths (thirty-nine women) dying as a result

117. *Id.*

118. *Id.* at 262-63.

119. *Abortion Surveillance: Preliminary Analysis—United States, 1986 and 1987,* 38 MORBIDITY & MORTALITY WEEKLY REP. 662, 663 (1989).

120. *Id.*

121. *Id.* (The abortion ratio is defined as the number of abortions per 1000 live births.).

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.* Preliminary statistics for 1986 and 1987 show a similar pattern of abortions by race, age, and gestation. *Id.*

of an illegal abortion. By contrast, in 1984, eighteen women died as a result of an abortion, eleven of which died from a legally induced abortion, six from a spontaneous abortion.[126]

All of the previously cited abortion studies indicate how many adolescents procure abortions and mortality rates from abortions. Only one study that I have found, however, analyzes the short-term and long-term consequences for adolescents who procure abortions as compared with pregnant adolescents who bear the child and care for it or relinquish it for adoption. One study sought to determine if the young women (360 African-American teenage women of similar socioeconomic backgrounds who sought pregnancy tests from two Baltimore reproductive health providers) who terminated their pregnancies fared differently than the women who carried their pregnancies to term.[127] In terms of educational status, the study found that the women who carried their pregnancies to term attained significantly less education. Interestingly, the difference became more significant over the two year period of the study.[128] This negative change in their educational experience was not consistent with their educational expectations, as expressed during interviews. As for economic well-being, the abortion group's economic status improved over the two year period, while at the same time the child bearer's economic well-being deteriorated. Even when the effect of the presence of the baby was removed from the calculation of household income, the abortion group performed significantly better than the child bearing group.[129] An investigation of the psychological profiles of the abortion and childbearing groups showed no significant differences; the only significant factor that was found was a relationship between self-esteem and educational expectations.[130] Finally, no significant results were found in contraception use or subsequent pregnancy based on whether the women aborted or carried their pregnancies to term. A somewhat higher percentage of the women who had an abortion (76.9% as compared with 68.2%) reported using contraceptives always or most of the time, but a somewhat higher percentage of the women who had an abortion (57.5% as compared with 54.5%) had a subsequent pregnancy within two years of the first pregnancy.[131] In interpreting these statistics, however, one has to remember that the women who carried the pregnancy to term

126. *Id.*

127. Laurie Schwab Zabin, Marilyn Hirsch & Mark Emerson, *When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy,* 21 FAM. PLAN. PERSP. 248, 248 (1989).

128. *Id.* at 250.

129. *Id.* at 251.

130. *Id.* at 252.

131. *Id.* at 253 (Table 6).

were at risk of pregnancy for a much smaller portion of the two years of the study than the women who had abortions.

This study confirms my initial thesis: Pregnancy, in itself, need not be a problem for adolescents. The pregnancy becomes problematic due to the socially created, negative life consequences of carrying the pregnancy to term and the high possibility of another unintended pregnancy, which also may be carried to term. Adolescent women who procure an abortion will, on average, fare better than their peers who bear the child. However, both sets of adolescents remain at high risk of undergoing another unintended pregnancy with subsequent child care responsibilities. By putting substantial obstacles in the path of adolescents who want abortions, we cause them to delay their abortion and thereby undergo significant health risks. In contrast, by facilitating their ability to procure an abortion, we may improve the quality of their lives as well as the lives of their future children.

G. *Adoption*

Another way to avoid the consequences of early childbirth is to make adoption an easily-available option. Adoption, however, is not considered to be an acceptable alternative by most pregnant women, and especially by pregnant African-American or Hispanic women.

1. *Frequency of Adoption by Race.* Information on adoption is limited[132] and the statistics that do exist are difficult to understand. The federal government stopped compiling national adoption statistics in 1975.[133] Statistics from the 1980s suggest that despite the public emphasis on the adoptability of all children, adoptions may have declined during the mid-1980s.[134] Most of the decline in adoption appears to have taken place among white women. For adoptions of unrelated children, the white rate fell from 1.9% in 1982 to 1.4% in 1987; the rate for African-American women fell from 0.9% in 1982 to 0.8% in 1987; the rate for Hispanic women *increased* from 0.2% in 1982 to 0.4% in 1987.[135] Although the rate of adoption among Hispanic women is not declining

132. Christine Bachrach, Patricia Adams, Soledad Sambrano & Kathryn London, *Adoption in the 1980's*, 181 ADVANCE DATA 1 (January 5, 1990) (reporting that the federal government only began collecting information, and then only on a voluntary basis, in 1982).

133. *Unmarried White Women Are Those Most Likely to Place Children for Adoption, NSFG Data Show*, 19 FAM. PLAN. PERSP. 29 (1987) (data obtained from Christine Bachrach, *Adoption Plans, Adopted Children, and Adoptive Mothers*, 48 J. MARRIAGE FAM. 246 (1986)) [hereinafter *Unmarried White Women*].

134. Christine Bachrach et al., *supra* note 132, at 1-3 (declining from 2.2% of all ever-married women 20-44 years of age in 1982 to 1.7% in 1987; declining for adopting an unrelated child from 1.7% in 1982 to 1.3% in 1987).

135. *Id.* at 3.

and the African-American level is relatively constant, the absolute numbers of African-American and Hispanic women who adopt unrelated children is much lower than the rate for white women. Because interracial adoptions constitute only about eight percent of all adoptions and those adoptions consist primarily of the adoption of children of races other than African-American or white by white adoptive mothers,[136] African-American and Hispanic children have a much lower likelihood of being adopted than do white children. In 1987, eighty-seven percent of the mothers who adopted were white, seven percent were African-American, and about two percent were Hispanic. The adoptive mother and child are of the same race 92.4% of the time.[137] Given that the pregnancy rate among African-American and Hispanic women is higher than that among white women, one could infer that adoption is not a viable option, other than with relatives, in the African-American and Hispanic communities. Unfortunately, there are no statistics on the number of unadoptable African-American and Hispanic children.

The women who place their children for adoption are not the most disadvantaged women in society. "Babies born to single white women were much more likely to have been placed for adoption (12 percent) than were those born to single [African-American] women (less than one percent) in 1982."[138] Of the white women who did place their child for adoption, they were three times more likely to have had fathers who had some college education than women who kept their babies.[139] Single women who had placed their children for adoption were less likely to be receiving public assistance, less likely to be poor, and more likely to have completed high school than were single women who kept their babies.[140] Thus, adoption is not a realistic solution to pregnancy for the most disadvantaged, pregnant, single women.[141]

2. *Consequences of Adoption.* The Antiabortion movement considers adoption to be the panacea for the need for abortion.[142] Few studies, however, compare the consequences for adolescents based on whether they abort, raise the child themselves, or relinquish the child for

136. *Id.* at 1-2.

137. *Id.* at 5.

138. *Unmarried White Women, supra* note 133, at 29.

139. *Id.*

140. *Id.*

141. Eleanor Smeal, President of the Feminist Majority, has suggested to me that society deliberately limits abortions for adolescents so that some white adolescents will "choose" to relinquish their children for adoption rather than obtain an abortion. The fact that both abortion and adoption are relatively unavailable for non-white women is of little concern to people who profit from adoptions.

142. *See, e.g.,* Newsday, Jan. 1990, at 5 (President Bush noting "the self-evident moral superiority of adoption over abortion").

adoption. One study has compared these latter two alternatives, but has not compared either of these two groups to women who abort an unintended pregnancy.[143] Despite the fact that women who relinquish their children for adoption would seem to face fewer financial, emotional, and child-care demands than those who raise their children, previous studies had suggested that there are significant negative psychological consequences stemming from the relinquishment decision.[144] Nevertheless, one recent study found that relinquishers are generally more successful than child rearers in terms of completing vocational training, delaying marriage, avoiding a rapid subsequent pregnancy, working following the birth of the child, and living in a higher income household.[145] As compared with adolescents who do not bear a child, however, both relinquishers and child rearers attain lower socioeconomic status.[146] These authors were not able to confirm that relinquishers suffer deleterious social or psychological consequences as compared with nonrelinquishers. However, their findings do not provide much evidence as to how relinquishers compare with women who choose abortion.

H. *Conclusion*

Early childbirth has substantial negative health effects on adolescent mothers, including a higher mortality and morbidity rate than for older women. The cause of these adverse health effects appears to be inadequate prenatal care, because there is no physical reason why women between the ages of fifteen and nineteen should face more difficult pregnancies than older women. Countries that have instituted a successful state-funded prenatal care system have been able to avoid these adverse health consequences.

Early childbirth also impacts substantially on a woman's educational opportunities. African-American and Hispanic women are generally less likely to graduate from high school than white women; early childbirth compounds this problem. Federal policy appears to have assisted white pregnant women to stay in school. However, it appears to

143. Steven McLaughlin, Diane Manninen & Linda Winges, *Do Adolescents Who Relinquish Their Children Fare Better or Worse Than Those Who Raise Them?*, 20 FAM. PLAN. PERSP. 25 (1988) (study group consisted of 123 adolescents who kept their child and 146 who relinquished their child).

144. *Id.* at 25.

145. *Id.* at 32.

146. *Id.* The study is imprecise on this point. At one point, it compares these two groups with their "never-pregnant peers" and at another point compares them with adolescents who "avoid a birth." *Id.* Clearly, adolescents who have an abortion have been pregnant but have not given birth to child. I have assumed for this discussion that they meant to refer to adolescents who have not had a child rather than adolescents who have never been pregnant.

have been rather ineffectual in assisting African-American and Hispanic women to stay in school. In monitoring our progress in this area, it is not sufficient to look at the overall statistics for adolescents and be satisfied; we need to examine each subgroup and see that virtually no progress has occurred for African-American and Hispanic adolescents even if the general statistics have improved due to the large numbers of white women.

In addition, early childbirth dramatically impacts on the well-being of the child born. Inadequate prenatal care is a major factor causing both prematurity and low birth weight. Race correlates with low birth weight. The relative risk of low birth weight for African-American children is more than twice as high as for a comparable group of white children, with the difference increasing over time. African-American children, unfortunately, appear to have a disproportionately higher mortality rate even when they have normal birth weights, meaning that we really need to target the health care needs of African-American children. In quantitative terms, nearly 20,000 African-American infants died in the first year of life over the last five years who would not have died had their chances for health care been equal to that of white infants. It also appears to be the case that avoiding teenage pregnancies is not going to solve the health problems for African-American children. It appears that the problems of low birth weight and high mortality exist among all African-American children irrespective of the age of their mothers.

Despite the clear need for effective sex education, contraception, availability of abortion, prenatal care, and adoption services, Congress and many of the states do very little to achieve these goals. They continue to promote childbirth by curtailing contraception, sex education, and abortion services for adolescents and by *not* improving the quality of prenatal care. They speak in the negative—limiting access to certain reproductive health services—but do not take any affirmative steps to encourage real family planning among adolescents. The results are the high rates of unintended teenage pregnancies that have been described above. In the next section, I discuss legal strategies to make Congress and the states act more responsibly with respect to reproductive health issues.

III. EQUAL PROTECTION FRAMEWORK

A. *Introduction*

The previous sections have demonstrated that our reproductive health policies act coercively in the lives of adolescent females in a way that is detrimental to their health and well-being, as well as to the health

and well-being of their fetus and future children. In this section, I argue that such appalling disrespect for the lives and well-being of adolescent females and their future offspring violates the equal protection clause. Unfortunately, in recent years the courts have consistently ruled that such actions do not violate either the equal protection or due process clauses.

The recent case of *Hodgson v. Minnesota*[147] highlights the need to protect female adolescents from coercive state policies, as well as the difficulty of obtaining such protection under contemporary legal doctrine. In that case, Minnesota largely succeeded in creating a public policy that favors childbirth over abortion through a two-parent notification requirement with judicial bypass, ignoring entirely the dramatic negative consequences of such a policy on the lives of female adolescents and their future offspring.[148] The primary interests that the Minnesota claimed to be considering by enacting the law were the interests of the parents of the pregnant adolescent and the family unit comprised of the pregnant adolescent and her parents—Minnesota did not maintain that the adolescent's self-perceived best interests should control.[149] Although the federal district court had concluded that one major motivation behind the parental notification statute had been to favor childbirth over abortion, the state did not even attempt to argue in favor of this policy before the Supreme Court because it understood that such a policy choice did not further the well-being of the preguant adolescent.[150] My argument, under the equal protection clause, is that states should be required to

147. 110 S. Ct. 2926 (1990).

148. The Supreme Court held that the two-parent notification requirement was constitutional as long as a judicial bypass procedure existed. *Id.* at 2950-51, 2969-71. Female adolescents are therefore burdened by notifying both parents or undergoing a court procedure—both forms of intrusion will cause many adolescents to delay or to refrain from obtaining an abortion, despite the fact that the pregnancy is unintended and unwanted. What I find puzzling about the Court's ruling is that the Court apparently ruled that a judicial bypass—which itself is burdensome, stressful, and not guaranteed to yield a positive result for the petitioner—can undo the unconstitutionality of the two-parent notification requirement. Five members of the Court (Stevens, Blackmun, Brennan, O'Connor, and Marshall) concluded that a two-parent notification requirement infringed adolescents' liberty interests and served no legitimate public purpose, but somehow, five members of the Court (Kennedy, Scalia, O'Connor, White, and Rehnquist) ruled that the availability of a judicial bypass procedure could justify the two-parent notification requirement. *Id.* at 2945-47, 2950-51, 2969-71. Such an illogical result is possible, I would argue, under a judicial framework that largely disregards the well-being of pregnant adolescents when rendering its decisions. (For example, I would like to see a study presented to the Court that documents the negative health consequences to pregnant adolescents of undergoing the highly stressful experience of appearing before a judge or notifying an abusive, absent parent. It is hard to believe that such extreme stress could be healthy for the adolescent's pregnancy or subsequent abortion.)

149. *Id.* at 2941-44.

150. *Id.* at 2937 (noting that the state "affirmatively disavow[ed] . . . state interest as a basis for upholding the law").

consider the impact of their policies on the lives and well-being of pregnant adolescents. They should not be allowed to assert alternative, weak considerations about the supposed well-being of others without first accounting for the impact of their policies on pregnant adolescents (i.e., the people upon whom the law has the most direct and drastic impact). The states should be forced to justify how they could favor coerced childbirth over abortion given the enormous negative implications of that coerced childbirth in the lives of the pregnant woman, the fetus she currently carries, and her present and future offspring.

Although Justice Stevens, speaking for the majority in *Hodgson,* did conclude that the two-parent notification without judicial bypass was unconstitutional, he did so without serious consideration of the impact of coerced pregnancies on the lives of pregnant adolescents and the children born to them. He simply refuted the state's assertions about the parents' interests being served by the forced two-parent notification procedure. He did not find fault with the state for admittedly not making the well-being of adolescents a prime consideration. Under my proposed analysis, the impact on the pregnant adolescents would be the focus of the analysis under heightened scrutiny rather than a side issue that is easily ignored while "parents rights" (without responsibilities) are discussed.[151] As I discuss, this proposed analysis conflicts with several of the Supreme Court's major holdings; I therefore suggest arguments to modify those decisions.

B. *Doctrinal Advantages of Equal Protection Doctrine*

Traditionally, the courts have used a privacy framework to resolve abortion cases. (That is the framework used in *Hodgson.*) In *Roe v. Wade,*[152] the Supreme Court found that the right of privacy was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[153] The Court did not find an absolute right of privacy, but rather held that the right of privacy should be "considered against important state interests in regulation."[154] In the fifteen years that fol-

151. Ironically, pregnant adolescents are themselves potential parents but receive no respect by the state for that potential parenthood (although the state does prefer to refer to the pregnant adolescent as a "mother" during the course of her pregnancy). If the state really viewed the fetus inside the pregnant woman as a child then it would have had to give the pregnant adolescent as much respect, as a parent, as it gave the parents of the pregnant adolescent.

152. 410 U.S. 113 (1973).

153. *Id.* at 153.

154. *Id.* at 154. In other cases, the Court has required the state to present "compelling" reasons for abortion restrictions. *See* Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 427 (1983) ("restrictive state regulation of the right to choose on abortion . . . must be supported by a compelling state interest").

lowed, the Court applied this framework to invalidate nearly all restrictions against abortion except: (1) Congressional and state limitations on Medicaid that made it very difficult for poor people to obtain government-funded abortions,[155] and (2) parental consent and notification statutes that made it difficult for adolescents to preserve their privacy and obtain expeditious abortions.[156] Many feminists criticized the Court's privacy approach, because it could not protect the most disadvantaged women from coercive anti-abortion regulations. Concurrently, they have credited the privacy framework as being more rigorous than the intermediate scrutiny standard applied to sex-based equal protection claims.[157]

In addition, feminist pro-choice litigators have continued to use the privacy approach because of doctrinal problems with the equal protection approach. The Supreme Court has rejected the view that discrimination against pregnant women constitutes *per se* sex-based intentional discrimination.[158] An argument that a pregnancy-related distinction constituted intentional sex-based discrimination would therefore have to meet the difficult standard of proof for intentional discrimination as set forth in *Personnel Administrator v. Feeney.*[159] In *Feeney,* the Supreme Court held that the discriminatory purpose test, which applies to facially neutral policies that produce a disparate impact on the basis of gender, requires that the institution "selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group."[160] This test has proved almost impossible to meet; thus, attempts to meet this standard in cases involving abortion-related restrictions have failed.[161]

Nevertheless, the privacy approach is no longer superior to the equal protection approach. Although the Supreme Court denies that it has modified the *Roe* framework, it has watered down the privacy stan-

155. *See* Harris v. McRae, 448 U.S. 297 (1980) (a woman's freedom of choice does not include an entitlement to the financial resources necessary to exercise that choice; thus, the Hyde Amendment limitation on the subsidization of certain medically necessary abortion is constitutional).

156. *See* Bellotti v. Baird, 443 U.S. 622, 640 (1979) ("parental notice and consent typically may be imposed by the state on a minor's right to make important decisions," including abortion).

157. *See, e.g.,* Sarah Burns, *supra* note 2, at 200-01 (recognizing the distinction between the intermediate scrutiny standard and the strict scrutiny standard that is applied in the fundamental rights context, which includes privacy).

158. *See* Geduldig v. Aiello, 417 U.S. 484, 494-95 (1974) (state's decision to exclude pregnancy from coverage under its disability insurance program is not an invidious discrimination violation of the Equal Protection clause).

159. 442 U.S. 256 (1979).

160. *Id.* at 279.

161. *See, e.g.,* Harris v. McRae, 448 U.S. 297, 322-27 (1980) (failed attempt to prove a violation of equal protection rights of poor women). For an excellent critique of the *Feeney* standard, see Note, *Discriminatory Purpose and Disproportionate Impact: An Assessment After Feeney,* 79 COLUM. L. REV. 1376 (1979).

dard by suggesting that the state need assert only a "legitimate" interest to sustain an abortion-related restriction.[162] This standard is less rigorous than the "compelling" state interest standard used under *Roe* as well as the "important" state interest standard required under intermediate scrutiny for sex-based equal protection cases. Given the controversial nature of privacy doctrine, the development of equal protection doctrine might be politically and legally advantageous.

C. *A Proposed Equal Protection Framework*

There are two major doctrinal difficulties in trying to apply current equal protection doctrine to reproductive health issues: (1) the *Geduldig v. Aiello*[163] holding that pregnancy is not a sex-based condition, and (2) the *Personnel Administrator v. Feeney*[164] holding that purposeful discrimination must be established by proving that a legislature acted "because of" its desire to harm women rather than "in spite of" this desire. Although these doctrinal difficulties are enormous, they can be overcome without revolutionizing equal protection doctrine.

Proof of gender-based discrimination can take two forms. A plaintiff can establish that a defendant has instituted a policy that facially creates a gender-based distinction. In such a case, the Court presumes that the action was intentional and therefore concludes that the plaintiff has established a prima facie case of gender-based discrimination.[165] The case then goes to the justificatory stage in which the Court assesses the importance of the state's objective and the relationship between the means chosen and that objective. Alternatively, a plaintiff can establish that a defendant has instituted a gender-neutral policy that creates a disparate impact based on sex. In such a case, she can only establish a prima facie case of discrimination if she *also* demonstrates that the defendant intentionally discriminated on the basis of sex.[166] Thus, when a female plaintiff desires to challenge a state's reproductive health policies, she has the option of (1) establishing that the policy is explicitly sex-based and therefore is a presumptive example of intentional sex-based discrimination, or (2) that the policy is gender-neutral but creates a disparate impact on the basis of sex that can be categorized as "intentional."

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162. Webster v. Reproductive Health Servs., 492 U.S. 490, 520 (1989).

163. 417 U.S. 484, 496-97 (1974).

164. 442 U.S. 256, 279 (1979).

165. *See, e.g.*, Frontiero v. Richardson, 411 U.S. 677, 682-84 (1973) (striking down a statutory presumption that female spouses of military personnel are dependents whereas male spouses are not).

166. *See, e.g., Feeney*, 442 U.S. at 279-80 (upholding statute that created a sex-based disparate impact because no proof of intentional discrimination was established).

The stumbling block to the first strategy is *Geduldig.* In *Geduldig,* the Court found that pregnancy is not a sex-based condition and therefore did not apply heightened scrutiny to a case involving a pregnancy-based exclusion from disability insurance.[167] Because, in the Court's opinion, the case did not present an example of sex discrimination (or any other suspect class of discrimination), it considered minimal rational basis scrutiny to be appropriate.[168] Under this lenient standard, the Court held that the state's economic arguments for excluding pregnancy from its disability insurance were a sufficient justification.[169]

The stumbling block for the second strategy is *Feeney.* In *Feeney,* the Court clarified that the intent standard could only be met with evidence that the legislature enacted its policy because it desired to harm women rather than in spite of such a desire.[170] Thus, the fact that the Massachusetts Legislature precluded ninety-eight percent of women from obtaining civil service jobs through its veteran's preference statute was not sufficient evidence to warrant heightened scrutiny because that action was not instituted for the purpose of harming women; the legislature did not seriously contemplate the impact on women when it passed and maintained its veteran's preference.[171]

Feminist critiques of the Court's decisions concerning reproductive health have largely focused on *Geduldig* rather than *Feeney.* They have criticized *Geduldig* by focusing on the absurdity of the Court's conclusion that pregnancy is not a sex-based condition.[172] They have argued that it is ridiculous to suggest that a legislature is unaware that pregnancy-related restrictions adversely affect women, and not men, because everyone knows that only women can become pregnant.

These critiques of *Geduldig* have been unsuccessful, in part, because they misunderstand the Court's reluctance to extend heightened scrutiny to pregnancy-related distinctions. I understand the Court to be saying that pregnancy-related restrictions are not first-order sex-based equal protection problems because they are based on a real physical difference between men and women. Consistent with that view, the Court has been reluctant to use heightened scrutiny in cases relating to women's "rapability" or ability to become pregnant during teenage sex.[173] In the

167. *Geduldig,* 417 U.S. at 496-97.

168. *Id.* at 494-95.

169. *Id.* at 496.

170. *Feeney,* 442 U.S. at 276.

171. *Id.* at 279-81.

172. *See generally* Sylvia Law, *Rethinking Sex and the Constitution,* 132 U. PA. L. REV. 955, 983 (1984) (describing the numerous criticisms of *Geduldig* as a "cottage industry").

173. *See* Michael M. v. Superior Court, 450 U.S. 464, 470-73 (1981) (upholding state statutory rape law in which only the male participant in the sexual act is criminally liable, because the statute

Court's view, these kinds of distinctions are less problematic than nonbiological restrictions on women and therefore deserve lower scrutiny. The Court's persistent use of a low level of scrutiny in biologically-based equal protection claims is consistent with its movement toward a low level of scrutiny in pregnancy-related privacy cases. The Court simply does not see those biologically-based restrictions as, in Justice O'Connor's words, "unduly burden[ing]" women's lives.[174]

I propose two strategies to overcome this trend. First, feminists should attack the *Feeney* test for how to prove purposeful discrimination rather than the *Geduldig* holding itself. If we can meet the standard set forth in *Feeney* (or a modified version of it), we would not have to win under *Geduldig*. Second, feminists should present the record of the systematic disadvantage of women through increased use of the reproductive health literature. We may not ultimately persuade the Court that *all* pregnancy-related restrictions disadvantage women's lives in a dramatic way; however, by focusing on the literature concerning female adolescents, we may be able to make the Court see that many of these restrictions dramatically disadvantage female adolescents. Under privacy doctrine, female adolescents have received a lower level of scrutiny than adult women because of the courts' deference to parents under privacy doctrine.[175] I believe that an equal protection approach can demonstrate that pregnant female adolescents are, in fact, the group *most* in need of heightened scrutiny because the sphere of family-related privacy, coupled with legislative insensitivity, has caused them to be a highly disadvantaged and politically powerless group.

Turning to the first strategy, the facts in *Feeney* exemplify the unsatisfactory nature of the "but for" causation requirement. *Feeney* involved the constitutionality of a lifetime veteran's preference statute. Because the statute was written in terms of "veterans" and "nonveterans," the Court considered it to be gender neutral. Nevertheless, the facially neutral statute produced a disparate gender-based impact. Thus, the Court inquired as to whether the impact was "intentional." The veteran's preference was enacted before women were eligible for most civil service

is designed to prevent illegitimate adolescent pregnancies); Dothard v. Rawlinson, 433 U.S. 321, 332-37 (1977) (upholding a state regulation explicitly preventing women from serving as guards in "contact" positions in state penitentiaries, as "[t]he likelihood that inmates would assault a woman because she was a woman would pose a real threat . . . [to the] control of the penitentiary").

174. Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416, 453 (1983) (O'Connor, J., dissenting).

175. *See* Bellotti v. Baird, 443 U.S. 622, 640-41 (1979) (permitting state to require parental consultation in the abortion decision). As Justice O'Connor has explained, the Court has extended the liberty interest to choose an abortion to adolescents but with some "important limitations." Hodgson v. Minnesota, 110 S. Ct. 2926, 2949 (O'Connor, J. concurring).

jobs.[176] The Massachusetts legislature did not enact the veteran's preference statute to harm women because its original enactment had little to do with women. Thus, showing a discriminatory intent was impossible. The original enactment gave one group of men preference over another group of men, because job classifications were generally sex-segregated. The preference, however, was maintained in the early 1970s, after civil service jobs were no longer officially sex-segregated. Since ninety-eight percent of veterans were men, the preference served to exclude women from nearly all jobs open to the preference on a lifetime basis, even after the sex-segregation rules were lifted.[177]

The fact that the legislature never consciously considered how the classification would affect women, once women became eligible to compete against men for most civil service employment, should not be an acceptable defense. We should insist that legislatures wrestle with a statute's impact on women. Thus, the appropriate doctrinal question should be whether a legislature would have been willing to impose these kinds of burdens on women if it fully considered their well-being. Would it be willing to exclude all men from civil service jobs to benefit a subcategory of women?[178]

By formulating a narrow intent test, the Court failed to ask the questions that are likely to go to the core of women's equal protection problems. Legislatures are more likely to act on the basis of patronizing stereotypes about white, middle-class, adult women's[179] best interests than on the basis of an intention to discriminate against women. Alternatively, legislatures are likely to ignore all women's interests altogether and thereby act to preserve the status quo of unequal opportunity be-

176. *See Feeney*, 442 U.S. at 256 (noting that single-sex hiring was explicitly authorized under the 1884 Civil Service statute, which predated the Veteran's Preference statute). This practice was apparently not officially eliminated until 1971, when Massachusetts required that single-sex examinations receive the prior approval of the Massachusetts Commission Against Discrimination. *Id.* at 266 n.14.

177. *See Feeney*, 442 U.S. at 270 (noting that only 1.8% of women who were hired by Civil Service were veterans).

178. I find it ironic that the Court can uphold a lifetime veteran's preference for men in *Feeney* while overturning limited preferences for African-Americans and women in other cases. The fact that the Court will rarely approve affirmative action for women, and then only when it is of a limited duration, suggests that society is not willing to place the kinds of burdens on men that it is willing to place on women. Women are asked to give up all hopes of procuring decent civil service jobs, whereas men are not asked to step aside for even a brief period of time to help women advance in the workplace. *See generally* City of Richmond v. J.A. Croson Co., 488 U.S. 469, 498-508 (1989) (creating very rigid rules for affirmative action plans).

179. I say "white, middle-class, adult women" because I think that this is the group of women considered by legislators, if they consider women at all. Legislators have rarely had positive or patronizing stereotypes of African-American or poor women.

tween men and women.[180] An *unthinking* attitude can be as harmful to women as direct animus, because it serves to keep women's interests in society invisible. The "but for" causation requirement of *Feeney* gives a legislature the incentive to say nothing about women's interests when enacting legislation, making it all but impossible to prove discriminatory intent. Such silence, however, should not be the goal of the equal protection clause. A full and considered legislative debate should be the goal of the equal protection clause. The intent test encourages legislatures to be *unthinking* with reference to women's liberty interests.

Thus, I suggests that the Court continue to insist that discriminatory intent be established when a state develops a facially neutral statute that disproportionately impacts women. However, the definition of "intent" does not have to be the narrow definition utilized in *Feeney.* A legislature, for example, could be considered to have an unconstitutional state of mind (or "intent") when it entirely *ignores* a statute's impact on women, and imposes burdens on women that it would not be willing to impose on men. If equal protection doctrine is truly designed to "protect" women and men equally then the Court should not tolerate conscious blindness to women's needs, interests, and well-being. Clearly, the definition of intent that I suggest is not the one currently used by the Court; however, careful consideration of how it is that legislatures are most likely to discriminate against women makes such a test appropriate. Permitting legislatures to burden women through legislative oversight should not be tolerated, yet that kind of oversight is exactly what *Feeney* encourages.

Returning to the thesis of this Essay—the example of female adolescents—I believe that it should be sufficient to present the following two-step analysis in order to show a gender-based violation of equal protection. First, using the empirical evidence that I have described above, we would show that our current reproductive health policies have a dispa-

180. Feminists provide a twofold description of women's subordinate status. First, feminists argue that women's needs and burdens are not fully understood; women are often silent, not heard, or not considered. *See generally* TILLIE OLSEN, SILENCES (1978); ADRIENNE RICH, ON LIES SECRETS AND SILENCE (1979). Second, feminists argue that when men observe women they often do not see women as whole persons; they do not respect women. This is often called a problem of "sexual objectification." *See generally* CATHERINE MACKINNON, FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW (1987). Men may love women yet may treat women as sexual objects for their sexual pleasure. Men may value women's ability to bear children yet may use that biological ability as a reason to preclude women from a range of work outside the home. As Justice Brennan once commented, the pedestal can be a cage. Frontiero v. Richardson, 411 U.S. 677, 684 (1973). Justice Brennan was probably thinking of white, middle-class women because, for poor women, there is only a cage. For all women, however, to varying degrees, it is a cage of limited opportunity where women's needs are not fully understood and women are not given the opportunity to achieve their full potential.

rate impact against female adolescents. Because all of the individuals in that category are female, we would argue that we had shown that a facially neutral policy produced a gender-based disparate impact. Second, using my modified *Feeney* test, we would argue that a legislature that respected the well-being of female adolescents would not have passed the legislation in question. Because female adolescents are often poor and do not necessarily have the right to vote, they are especially deserving of the Court's protection.[181] It is difficult to imagine that legislatures would deliberately want to harm female adolescents; however, if their blindness to the effects of their policies on this group is causing enormous disadvantages for this group, then the equal protection clause mandates that the Court intercede.[182]

Having described the best equal protection argument that I can make on behalf of female adolescents, I also would like to note one theoretical difficulty with this approach. The empirical literature that I have presented shows that our reproductive health policies impact female adolescents differently depending upon their class and race. Our adoption policies, for example, may disfavor African-American and Hispanic women while favoring some poor Caucasian women and disfavoring other poor Caucasian women. Our prenatal policies may disfavor all poor female adolescents, but they especially disfavor poor, African-American women. Equal protection doctrine, however, forces us to generalize to

181. Persons under the age of 18 do not have the right to vote. Although 46% of the population eligible to vote did so in 1986, only 18.6% of persons, age 18-20, did vote. REGIONAL DIFFERENCES IN AMERICA: A STATISTICAL SOURCEBOOK 189 (A. Garwood ed. 1988).

182. This view is similar to the general perspective articulated by John Hart Ely. *See* JOHN HART ELY, DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW 135-70 (1980) (courts should protect constitutional rights irrespective of why they are denied, and should also strive to protect politically weak minorities where legislative action is harmful to such minorities).

Unfortunately, even if I could persuade the Court to modify the *Feeney* test, as I have suggested, one major doctrinal problem might remain. In equal protection analysis, we are accustomed to talking about the impact of a policy on one particular subgroup that receives close scrutiny by the courts such as African-Americans or women. The Supreme Court has refused to use close scrutiny in analyzing the impact of restrictive abortion policies on a subgroup of women—poor, minority women. *See* Harris v. McRae, 448 U.S. 297, 322-26 (1980) (applying a rational relationship test, as there was no suspect classification, and rejecting an equal protection claim by poor, minority women). In the Title VII context, some courts have recognized that it is unlawful to have combined categories, such as African-American women, face different treatment; nevertheless, the courts have never defined a subclass on the basis of class, race, and sex terms. *See, e.g.*, Jefferies v. Harris County Community Action Ass'n, 615 F.2d 1025, 1032 (5th Cir. 1980) (recognizing the Title VII forbids race or sex discrimination, which includes discrimination based on a combination of those categories). Moreover, the recognition that African-American women constitute a protected class has not been broadly utilized under Title VII, nor has it been introduced into equal protection doctrine. It is important for this concept of combined categories to be introduced into equal protection doctrine in order for legal doctrine to be sensitive to the essentialism critique. For further discussion of the importance of recognizing combined categories, see Note, *Invisible Man: Black and Male Under Title VII,* 104 HARV. L. REV. 749 (1991).

categories that are recognized as suspect classes such as gender or race and forces us to ignore categories that are not recognized as suspect such as class. Thus, I could have easily described the impact of our reproductive health policies in class terms as in gender terms, but our equal protection doctrine requires me to choose the latter rather than the former. More importantly, however, equal protection doctrine forces us to generalize into broad categories such as gender rather than specify the range of difference within each category.

Nevertheless, I do not believe that the essentialism critique forces us to dispense with all group-based legal arguments. The fact that the impact of our reproductive health policies differs on the basis of race and class does not take away from the fact that every individual who is directly impacted by these policies is also female. The essentialism critique does not make feminism meaningless by eliminating our ability to talk about gender. It simply makes feminism more *complicated* by insisting that we understand the diversity of experiences within the category of female. Thus, in this Essay, I have tried to focus on adolescent females—a group that is generally ignored in our discussions of reproductive health policies. Rather than have white, middle-class, adult women be the paradigm when reproductive health policies are discussed, I have tried to bring poor female adolescents to the forefront and to propose an equal protection doctrine that is sensitive to *their* experiences. That goal, I believe, is central to the anti-essentialism project even if it must retain some elements of essentialism to satisfy the courts.

IV. CONCLUSION

In this Essay, I have argued that pregnant adolescents deserve the highest level of judicial protection when the federal government or states create reproductive health policies that favor childbirth over sex education, contraception, abortion, or adoption. Because of the extensive record of society coercing pregnant adolescents to undergo childbirth, despite the dramatic negative consequences of such childbirth on the lives of the pregnant adolescents as well as her future offspring, this group is deserving of treatment as a "suspect class." Moreover, their political powerlessness, as evidenced by their legal inability to vote and their low voting turnout when they can vote, contributes to their entitlement to suspect class treatment.

A legislature's ignorance of the impact of its policies should be no defense to an equal protection challenge; rather, we should insist that legislatures protect the most disadvantaged groups in society by being aware of the impact of their policies on them. If legislatures would open their eyes to the impact of their reproductive health policies on female

adolescents, they would see that nearly ten percent of female adolescents face unintended pregnancies and that three-fourths of those women do not have access to contraceptives. Overall, one million female adolescents become pregnant each year; although more than three-fourths of those pregnancies were unintended, nearly half of those pregnancies result in the birth of a child. Thus, approximately one million female adolescents need to be reached through effective reproductive health policies so that their pregnancies can be intended and wanted.

The courts should monitor Congress and the states closely to ensure that the legislatures reverse their despicable record on reproductive health issues. The legislatures need to be made aware of the kinds of statistics I have cited in this Essay and urged to take positive, responsible steps rather than blindly encouraging childbirth among the group that can ill afford unintended and unwanted pregnancies. It should no longer be possible for legislatures to say blithely that they favor childbirth over contraception, sex education, and abortion, or to ignore entirely the impact of their policies on pregnant adolescents to favor restrictive reproductive health practices. They must be made to account for the ways that their irresponsible attitudes dramatically harm pregnant, female adolescents and their offspring.