

THE POLITICS OF TEEN WOMEN'S SEXUALITY: PUBLIC POLICY AND THE ADOLESCENT FEMALE BODY

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INTRODUCTION

Teen women's sexual and reproductive lives are shaped by laws and public policies that expand or constrict their educational and health supports. Most adolescents depend substantially on the public sector to help support their healthy sexual development and to protect them from sexual violence, disease, and pregnancy. Thus, it is critical to examine the ways in which public policies concerning young women's sexualities have been forged within religious and "moralizing" discourses. The explicit pairing of law and religious ideology has transformed the role of law and public policy in young women's lives from a supportive function to one that censures young women for their sexual behavior. As educational, social service, and health supports for youth are scaled back in the name of small government or neoliberal reform, the adverse consequences of sexual behavior are described as if they are natural. As a consequence, the etiology of these consequences is erased. Young women, especially young women of color and poor women, end up shouldering a heavy burden for engaging in sexual activity—activity that they engaged in by choice or by coercion.

In this Article, we argue that contemporary public policies on adolescent sexuality are being designed in ways that

- significantly limit young women's access to information and health care regarding sexual behaviors and sexual desire;
- diminish the supports available to young women, including those who have experienced sexual violence, risk, and/or danger;
- limit the professional license of educators and health workers who typically support teens in their sexual and reproductive decision making; and
- circumscribe the options available to young women who experience sexual desire or sexual violence in the name of protecting the young.

We analyze how certain groups of already marginalized young women, such as young women of color, those with disabilities, lesbians, and young women in poverty, suffer more severely as the public sphere shifts away from offering support and instead toward punishment for sexual activity.

To investigate our thesis, we analyze three specific public policies: (1) the federally funded proliferation of abstinence-only-until-marriage education in

schools and communities, discussed in Part II.A; (2) the refusal to grant young women over-the-counter access to emergency contraception, discussed in Part II.B; and (3) requirements of parental consent or notification for an abortion, discussed in Part II.C. These three public policies affect young women in the core institutional contexts of their lives: their families, schools, and health care settings. In this Article we include a brief history of each policy, the current implementation of the policy, and the consequences of each policy for women under eighteen, with particular attention to how these consequences are unequally distributed among young women based on their race or class or both.

To forecast our argument, we review a recent case in Kansas in which educators, therapists, and health care practitioners resisted a mandatory requirement to report all sexual activity of youth under sixteen as sexual abuse. In this case, it is possible to see the simultaneous withdrawal of public supports for youth and the moral framework imposed on all forms of teen sexuality in the name of state protection.

I. TEEN SEXUAL ACTIVITY AS SEXUAL ABUSE: WHEN LAWS AND IDEOLOGY INTERSECT

In 2003, Kansas Attorney General Phillip Kline released an opinion that cast a wide net that ensnared all adults who interact with minors—including teachers, physicians, nurses, and therapists—and described them as legally required to report any sexual activity involving minors less than sixteen years of age.¹ Kline's opinion was an interpretation of the 1982 Kansas law criminalizing all sexual intercourse, *consensual or nonconsensual*, with a person younger than sixteen.² Kline's opinion of the law was important because it included a broad interpretation of sexual activity—for example, a young woman seeking birth control—as grounds for the mandatory reporting requirement to be triggered.³

While current Kansas policies might seem extreme in their vigilance over teenage sexuality, they provide a prototype of national policies in which we are

¹ See Op. Kan. Att'y Gen. 2003-17 (2003), 2003 WL 21492493 (citing KAN. STAT. ANN. § 38-1522 (2003), which lists mandatory reporters).

² As the court noted in *Aid for Women v. Foulston*, "Kansas law defines 'sexual abuse' as 'any act committed with a child, described in article 35, chapter 21 of the Kansas Statutes Annotated.'" 427 F. Supp. 2d 1093, 1098 (D. Kan. 2006). The referenced chapter criminalizes a range of sexual activities involving a minor under the age of sixteen. See § 21-3503.

³ See Op. Kan. Att'y Gen., *supra* note 1.

able to observe four specific trends: (1) all teen sex is considered a form of sexual abuse; (2) the state is asserted, in response, as the ultimate protector of young women; (3) adult educators and health professionals are repositioned as mandatory reporters for the state, effectively eliminating “zones of privacy”⁴ and the availability of supportive adults who were once available to teens; and (4) marriage is proffered as the *only* context that legitimates sexual activity for teens or adults. Even though the District Court of Kansas permanently blocked enforcement of Attorney General Kline’s legal opinion in April 2006, the spirit of Kline’s opinion nevertheless highlights current trends in legislating the sexuality of minors.⁵ The Kansas case allows us to observe the increasingly dangerous confusion between making laws to protect young people and making religious, “moral,” and punishing judgments concerning their sexual activity.

Adolescent sexual activity as sexual abuse. Kline’s interpretation of the 1982 Kansas statute positioned young women, the State of Kansas, and supervisory adults in very specific relationships to one another. One important consequence of the 1982 statute was that it was no longer possible for teenagers under sixteen to have voluntary and consensual sex. Instead, Attorney General Kline reframed “intercourse, in any fashion, with children [as] inherently harmful to the child.”⁶ As a result, even consensual and developmentally appropriate sexual activity between peers under sixteen years of age became equated with sexual abuse. Through this legal maneuver, the state positioned itself as the prosecutor and protector of all teenage sexual activity. While state laws and policies are necessarily concerned with stopping all forms of sexual abuse, Kansas law deliberately conflated consensual and nonconsensual sex and removed the potential for the expression of sexuality from all young people.

State as sole protector of young women. While the potential for consensual sexual activity for minors was removed by the Kansas legislature in 1982, Kline’s interpretation of the 1982 statute took an important step towards removing *any* supports for young people who did become sexually active.

⁴ The court in *Aid for Women* noted that “[a]lthough the United States Constitution does not explicitly recognize a right to privacy, the Supreme Court has found certain ‘zones of privacy’ in the amendments to the Constitution.” 427 F. Supp. 2d at 1105 (citing *Union Pac. R.R. Co. v. Botsford*, 141 U.S. 250 (1891); *Roe v. Wade*, 410 U.S. 113, 152–53 (1973)). *Botsford* found a zone of privacy based on common law, not a constitutional right. See 141 U.S. at 251.

⁵ See *Aid for Women*, 427 F. Supp. 2d at 1116.

⁶ See Op. Kan. Att’y Gen., *supra* note 1.

According to Kline, educators and health care professionals were incapable of differentiating sexual activity from sexual abuse because they were ill equipped to make the assessments that are required to distinguish developmentally normative activity and sexual abuse. In contrast, Kline's opinion described the state and its institutional infrastructure as fundamentally able to protect young women from harm. He stated that the Kansas Department of Social and Rehabilitation Services (SRS) should review *all* cases of sexual activity, even if there was "no force or coercion or power differential apparent or at least perceived by the partner"—a distinction that he noted would be relevant in the decision of whether to prosecute the alleged offender.⁷ This subtle, but important, move to transfer the review of all sexual activity between minors to the state had the potential to cast an enormous shadow of state-level surveillance over adolescents and professionals alike.

Educators and health professionals become mandatory reporters. An important aspect of the Kline opinion was an attempt to reinscribe the role of adults who interact with minors. Kline's intention to turn professionals who work with adolescents, including teachers, nurses, and therapists, into mandatory reporters for the state created a legally sanctioned form of adolescent sexual surveillance and drained adults of their ability to serve as sources of information, support, or advice for young people looking for help. This included adults who provided supports such as birth control, STD treatment, and pregnancy testing, as well as information about sexual development. Kline's interpretation of the statute would have required these adults to report a young person as sexually abused upon hearing evidence of a sexual relationship.

While Kansas is one of 12 states in which sex under a certain age—16, 17, or 18—is always presumed illegal, regardless of consent or the age difference between the partners, Kline's written interpretation of Kansas' reporting law [would have made] it the only state requiring that doctors, nurses, counselors, and all other care providers report—as abuse—*any* sexual interaction between teens under 16 Under Kline's view, professionals [would have been required to] report the crime, even when the sex is consensual, committed with partners their age, and where there is no suspicion of injury.⁸

⁷ Transcript of Bench Trial at 590, *Aid for Women*, 427 F. Supp. 2d 1093 (No. 03-1353-JTM).

⁸ Dhalia Lithwick, *Smells Like Teen Snogging: Kansas Wacky Attorney General Smells Sex Everywhere*, SLATE, Feb. 2, 2006, <http://www.slate.com/id/2135328>.

Marriage legitimates sexual activity for teens. While sexual contact has long been considered illegal for those less than sixteen years old in Kansas, there has been an important exception to this law—when the minor is married.⁹ The State of Kansas “allow[s] twelve-year-old females and fourteen-year-old males to marry with parental or judicial consent.”¹⁰ According to Kansas law, while nonmarital sexual activity with a fifteen-year-old girl is considered “sexual abuse,” this same activity—within the confines of a marriage—is viewed as normal. This distinction, even if the use of this exception is unusual today, is not unusual given recent trends towards insisting on marriage as the only *lawful* space for sexual activity. As will be evident later in this discussion, the current policy environment places enormous weight on the significance and sanctity of heterosexual marriage, making it the *only* context in which sexual behaviors are appropriate and presumed safe.¹¹

These four trends in Kansas legal policy serve as a lens through which to view emerging national policies that concern the sexuality of young women. We turn now to three examples of U.S. legal and policy discourses in which young women's bodies are used as a way of creating “moral” standards for all, using specific criteria for what is considered moral (and by extension, lawful) behavior and doling out punishments for those who do not fit within these narrow confines. Important questions to ask of these legal discourses are: Whose behavior is the law aimed at changing? Who gains “protection” and who loses support? And finally, who is punished for being sexual, even when this includes having been sexually victimized?

II. CONTEMPORARY POLICIES

Recent shifts in public policy systematically narrow the sexual and reproductive rights of young women within their families, schools, and health care settings. Young women engage in sexual activity with diminished access to sexual and reproductive education, decreased support from adults, and constricted zones of privacy. As a result, young women are increasingly without good information about their own sexual health, hindered in their access to contraception, and limited in access to abortion without parental consent or notification. This policy environment artificially naturalizes the

⁹ See *Aid for Women*, 427 F. Supp. 2d at 1098.

¹⁰ *Id.*

¹¹ See David B. Cruz, *Heterosexual Reproductive Imperatives*, 56 EMORY L.J. 1157 (2007), for further discussion of the legal support of heterosexual marriage.

progression from adolescent sexual intercourse to pregnancy, sexually transmitted diseases, motherhood, and adoption or abortion. This progression, as we will demonstrate, is not natural but highly organized by the laws and policies surrounding young women's sexuality.

Before we begin the policy analysis, it is important to put U.S. policies in context alongside nations where the state assumes responsibility to support healthy sexual development *and* reduce negative potential consequences of teen sexuality. If there is any doubt that national policies matter, consider one data pattern: Teens in the United States, on average, begin having heterosexual intercourse at 17.4 years of age; in France, the age is 18; Germany 17.4, and the Netherlands 17.7.¹² Yet young women in the United States are *nine* times more likely to become pregnant than young women in the Netherlands.¹³ The U.S. teen pregnancy rate is almost twice that of Great Britain, four times that of France, and five times that of Germany.¹⁴ A study of the Netherlands, France, and Germany found that adolescent sexuality was presented not as a political or religious issue, but as a health issue, with healthy sexual development the desired outcome of sexuality education.¹⁵ In these countries, adolescents receive positive information about sexuality, sexual desire, development and relationships, contraception, abortion, and varied sexualities; indeed, youth are educated as responsible agents in their own sexual development.¹⁶

In contrast, in the United States, we witness public policy drafted in punitive tones, directed toward reduction of supports and the affirmation of sex-negative information about adolescent sexual development. Indeed, in 1999, then-future President George W. Bush made explicit his aim to guide young people through the use of morality and state-sponsored discipline:

Some people think it's inappropriate to draw a moral line. Not me. For our children to have the lives we want for them, they must learn to say yes to responsibility, yes to family, yes to honesty and work What can be done? . . . We must say to our children, "We

¹² See AMMIE N. FEJOO, ADVOCATES FOR YOUTH, ADOLESCENT SEXUAL HEALTH IN EUROPE AND THE U.S.—WHY THE DIFFERENCE? 3 (2001), <http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsest.pdf>.

¹³ See *id.* at 1.

¹⁴ *Id.*; see also Jacqueline E. Darroch et al., *Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use*, 33 FAM. PLAN. PERSP. 244, 246 (2001).

¹⁵ FEJOO, *supra* note 12, at 4.

¹⁶ *Id.*

love you, but discipline and love go hand in hand, and there will be *bad consequences for bad behavior.*"¹⁷

We live in a nation where public policy is interpreted as the vehicle to ensure that bad outcomes follow "bad behaviors." Our task in this Article is to rescue an analysis that recognizes these "bad" outcomes as political, not biological, products—as social and mutable, not natural and inevitable.

Below we assess the abstinence-only-until-marriage education campaign, the FDA refusal to deregulate emergency contraception for teen women, and the rapid proliferation of parental consent and notification mandates for teen abortion. We identify how each public policy constricts the supports available to young women, how differentially positioned teens are affected, how professional discretion has been curtailed, and where movements of resistance are mobilizing.

A. *Abstinence-Only-Until-Marriage Education*

How do young women and men get information about healthy sexual relationships? Turning to the issue of young women and their schooling, we consider the role of abstinence-only-until marriage (AOUM) curricula in schools and communities, limiting young women and men's access to comprehensive sexuality education.

In the 1980s and early 1990s, as HIV infection became an increasing threat, there was a push to broaden sexuality education to include information on disease prevention and contraception, especially condoms; this type of curricula is often referred to as "comprehensive sex education."¹⁸ Starting in the 1980s, the boundaries of what could and could not be taught in a sex education class became the interest of policymakers at state and federal levels.¹⁹ This interest translated into a shift from teaching about sexuality comprehensively (i.e., various forms of age-appropriate sexual expression, contraception, disease prevention, and healthy sexual development), to teaching about abstinence from all sexual activity until marriage. Importantly, comprehensive sex education, like abstinence education, teaches that abstinence is the most effective method of preventing unintended pregnancy

¹⁷ Governor George W. Bush, Address in Cedar Rapids, Iowa (June 12, 1999), <http://www.gwu.edu/~action/bushann.html> (emphasis added).

¹⁸ Rebekah Saul, *Sexuality Education Advocates Lament Loss of Virginia's Mandate . . . or Do They?*, GUTTMACHER REP. ON PUB. POL'Y, June 1998, at 3, 3.

¹⁹ *See id.*

and sexually transmitted diseases.²⁰ Comprehensive sex education does not, however, place restrictions on what young people are allowed to learn about in class. This distinguishes it from the strict federal requirements that govern what can and cannot be taught in AOUM classrooms.

1. Federal Requirements Concerning Funding of Sex Education

The 1981 passage of the Adolescent Family Life Act (AFLA)²¹ marked the first federal law expressly funding sex education “to promote self discipline and other prudent approaches.”²² In 1996, with the Congressional passage of the Personal Responsibility and Work Opportunity Reconciliation Act,²³ AOUM education funds gained an additional funding source through the approval of Title V of the Social Security Act: “Under Title V, the U.S. Department of Health and Human Services allocates \$50 million in federal funds each year to the states.”²⁴ Since 1982, when funding was first earmarked for AOUM education, over \$1 billion has been spent through federally sponsored programs (including AFLA, Title V, and CBAE).²⁵ In the 2007 budget alone, President Bush advocated for and was granted \$204 million in AOUM funding, and according to the U.S. Office of Management and Budget, the federal budget “supports increasing funding for abstinence-only education programs to \$270 million by 2009.”²⁶

Federally funded abstinence programming must adhere to a series of eight principles called “A to H.”²⁷ The eight central tenets of abstinence-only

²⁰ See Advocates for Youth, Sex Education Programs: Definitions & Point-by-Point Comparison, <http://www.advocatesforyouth.org/rrr/definitions.htm> (last visited Jan. 18, 2007).

²¹ Pub. L. No. 97-35, 95 Stat. 578 (1981); see SEXUALITY INFO. & EDUC. COUNCIL OF THE U.S., A BRIEF HISTORY OF FEDERAL ABSTINENCE-ONLY-UNTIL-MARRIAGE FUNDING 1 (2005), <http://www.siecus.org/policy/states/2005/Explanation.pdf>.

²² 42 U.S.C. § 300z(b)(1) (2000).

²³ Pub. L. No. 104-193, 110 Stat. 2105 (1996).

²⁴ SEXUALITY INFO. & EDUC. COUNCIL OF THE U.S., *supra* note 21, at 1.

²⁵ See SEXUALITY INFO. & EDUC. COUNCIL OF THE U.S., FEDERAL SPENDING FOR ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS (1982–2006) (2005), <http://www.siecus.org/policy/states/2004/Federal%20Graph.pdf>.

²⁶ OFFICE OF MGMT. & BUDGET, EXECUTIVE OFFICE OF THE PRESIDENT, BUDGET OF THE U.S., FISCAL YEAR BUDGET 2007, at 115 (2006), <http://www.whitehouse.gov/omb/budget/fy2007/pdf/budget/hhs.pdf>.

²⁷ 42 U.S.C. § 710(b)(2) reads:

For purposes of this section, the term “abstinence education” means an educational or motivational program which—

(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

education impose a strict set of criteria on educators who are looking to educate young people about their sexuality. These central beliefs emphasize various aspects of the abstinence philosophy, including the “harmful psychological” effects of nonmarital sexual activity and that children born “out-of-wedlock” pose a threat to society. While the Clinton administration’s program guidance for Title V in 1996 noted that states “need not ‘place equal emphasis on each element of the eight-point definition,’” the Bush administration worded its March 2005 guidance differently: “[W]e strongly encourage each state to develop programs that place equal emphasis on each element of the abstinence education definition.”²⁸

“Virtually all the growth in funding” since 2001 has come from the Community Based Abstinence Education (CBAE) program.²⁹ “CBAE funding is typically granted to community and local organizations, but states themselves are eligible to apply” and many states use this funding stream to bolster their existing AOUM school programming that relies on federal Title V monies.³⁰ Programs funded under CBAE are explicitly restricted from providing young people information about contraception or safer-sex practices³¹; this includes even those organizations that might use nonfederal funds to do so.³² This restriction has not only resulted in a silence around the

(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;

(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

²⁸ Cynthia Dailard, *Administration Tightens Rules for Abstinence Education Grants*, 8 GUTTMACHER REP. ON PUB. POL’Y, Nov. 2005, at 13, 13 (internal brackets and emphasis omitted).

²⁹ John Santelli et al., *Abstinence and Abstinence-Only Education: A Review of U.S. Policies and Programs*, 38 J. ADOLESCENT HEALTH 72, 75 (2006).

³⁰ SEXUALITY INFO. & EDUC. COUNCIL OF THE U.S., SEXUALITY EDUCATION AND ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS IN THE STATES: AN OVERVIEW 5 (2005), <http://www.siecus.org/policy/states/2004/Analysis.pdf>.

³¹ Notice of Correction for Community-Based Abstinence Education Program Announcement, 70 Fed. Reg. 32343 (June 2, 2005).

³² “Sex education programs that promote the use of contraceptives are not eligible for funding under this announcement.” DEP’T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN & FAMILIES, FUNDING

subject of contraception, but has also included educating teenagers about the failure rates of contraception, most notably, the “failure” of condoms to provide protection from sexually transmitted diseases.³³

For schools and communities in impoverished areas, the promise of federal dollars often pushes them into accepting these curricular restrictions in order to fill funding gaps. Students who are in the most educational and health need—poor urban and rural students—are also the most likely to be miseducated through these curricula.³⁴ The distribution of AOUM curricula explicitly favors communities with high levels of teen sexual activity and teen pregnancy and, importantly, imposes religious and moralizing curricula more strongly on youth who have already been sexual and who need information about how to avoid pregnancy and sexually transmitted diseases.³⁵ For example, former Massachusetts Governor Mitt Romney’s administration shifted the object of federal AOUM funding from media campaigns to classroom programming.³⁶ Importantly, this classroom programming was specifically aimed at students ages twelve to fourteen in schools in African American and Hispanic

OPPORTUNITY TITLE: COMMUNITY BASED ABSTINENCE EDUCATION PROGRAM 1 (2006), <http://158.71.31.30/grants/pdf/HHS-2006-ACF-ACYF-AE-0099.pdf> (internal quotations omitted).

³³ One example is the Scott & White “Worth the Wait” program. Their Frequently Asked Questions section warns, under the heading, “Don’t condoms prevent pregnancy and STDs?”:

Condoms are not 100% effective in preventing pregnancy and STDs. Condom failure rates are higher for adolescents than adults. “Failing” refers to leaks, breaks, and incorrect or inconsistent use. Condoms are greatly effective in preventing HIV/AIDS when used correctly and consistently but provide little or no protection from genital herpes, chlamydia, and human papillomavirus (HPV). The only way to be 100% protected from unwanted pregnancy and STDs is for both partners to abstain from sexual activity until you’re in a committed lifelong adult relationship.

Scott & White Worth the Wait Program, <http://www.worththewait.org/teens/faq.html#4> (last visited Nov. 12, 2006).

³⁴ Laura Duberstein Lindberg et al., *Changes in Formal Sex Education: 1995–2002*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 182, 187 (2006), available at <http://www.guttmacher.org/pubs/journals/3818206.pdf> (“In 2002, fewer than 60% of black males, males living below 200% poverty and males living in nonmetropolitan areas had received any formal instruction about birth control methods. Among sexually experienced males in these groups, no more than half had received instruction about birth control prior to first sex.”).

³⁵ Only one out of three sexually experienced black males and fewer than one in two sexually experienced black females had received instruction about birth control methods prior to first sex, as compared with two-thirds of their white peers; proportions among Hispanic teenagers were also significantly lower than those for white teenagers. For both males and females in both [1995 and 2001], those living below 200% of poverty were less likely to have received birth control education before first sex than were their higher income peers.

Id. at 186.

³⁶ Scott Helman, *State to Push Abstinence in Schools*, BOSTON GLOBE, Dec. 21, 2005, at A1.

communities throughout the state.³⁷ This example reflects the trend toward state-sponsored distribution of religious fundamentalism among communities where more information and resources—not moral surveillance—are needed.

In early 2006, the federal guidelines for funding abstinence education underwent substantial revisions.³⁸ The new guidelines explicitly endorsed the federal government's support of abstinence. However, instead of encouraging adolescents to avoid sexual intercourse, the new definition cast a much wider net around what counts as "sexual activity": "Sexual activity refers to any type of genital contact or sexual stimulation between two persons including, but not limited to sexual intercourse."³⁹ This updated version creeps into the territory of all things sexually "stimulating." Most importantly, this broad definition of abstinence removes any possibility for sex education curricula to include mention of how teens might engage in nonintercourse behaviors *even in an effort to remain abstinent*. Educators who may want to take a pro-abstinence position and teach teenagers to abstain from sexual intercourse in order to reduce pregnancy or STD rates are unable to do so under the scope of the new federal guidelines.

2. *Lessons About Sex*

In 2004, Representative Henry A. Waxman, then-ranking minority member on the Government Reform Committee, undertook a systematic review of the abstinence-only curricula.⁴⁰ The Committee released a report evaluating the scientific and medical accuracy of thirteen of the most commonly used abstinence-only curricula.⁴¹ This investigation found that two thirds of the programs contained basic scientific errors,⁴² relied on curricula that distorted information about the effectiveness of contraceptives,⁴³ blurred religion and

³⁷ *Id.*

³⁸ See generally DEP'T OF HEALTH & HUMAN SERVS., *supra* note 32 (discussing funding opportunities for CBAE programs).

³⁹ *Id.* at 5.

⁴⁰ U.S. HOUSE OF REPRESENTATIVES, COMM. ON GOV'T REFORM, THE CONTENT OF FEDERALLY FUNDED ABSTINENCE-ONLY EDUCATION PROGRAMS 5 (2004), available at <http://reform.democrats.house.gov/Documents/20041201102153-50247.pdf>.

⁴¹ *Id.*

⁴² According to the report, the WAIT Training program "erroneously includes 'tears' and 'sweat' in a column titled 'At risk' for HIV transmission." *Id.* at 22.

⁴³ According to the report, the "Why kNOw" program describes condoms as failing approximately 31% of the time. *Id.* at 9.

science,⁴⁴ and reinforced stereotypes about girls and boys as scientific facts.⁴⁵ Other researchers have noted that the curricula include scare tactics, such as the “No Second Chance” video, where a student says to a school nurse, “What if I want to have sex before I get married?,” to which the nurse replies, “Well, I guess you’ll just have to be prepared to die.”⁴⁶

Throughout these curricula, sex-role stereotypes for males and females are untroubled, normalized as if true. The Rhode Island ACLU pointed out that, for instance, the curriculum developed by Heritage of Rhode Island, Right Time, Right Place, taught students that “girls have a responsibility to wear modest clothing that doesn’t invite lustful thoughts.”⁴⁷ “Similarly, in describing ‘what makes a man’ and ‘what makes a woman,’ the manual describes men as being ‘strong,’ ‘respectful,’ ‘courageous,’ and ‘protect[ive].’ By contrast, a ‘real woman’ is, among other traits, ‘caring’ and someone who ‘sends a clear message’ by choosing her ‘clothes, expression and gestures carefully.’”⁴⁸

In addition to reifying gender stereotypes, heterosexual marriage is presumed as the only “appropriate” and “safe” arrangement for sexual behavior.⁴⁹ The contraception mandate and the pro-marriage language of the abstinence-only-until-marriage curricula were tightened as of fiscal year 2005.⁵⁰ The press for marriage in the abstinence-only-until-marriage curricula ignores the substantial evidence that young marriages often have high levels of violence, young mothers who marry are far more likely to have a second child in a short period than those who do not, and teen women who marry and then divorce have worse economic outcomes than teen mothers who never marry.⁵¹ Teen marriage significantly reduces the likelihood that a young woman—especially a young mother—will return to school.⁵² In fact, in a study of

⁴⁴ According to the report, the Middle School FACTS program presents as fact that life begins with conception: “Conception, also known as fertilization, occurs when one sperm unites with one egg in the upper third of the fallopian tube. This is when life begins.” *Id.* at 15.

⁴⁵ *Id.* at 16.

⁴⁶ JUDITH LEVINE, HARMFUL TO MINORS: THE PERILS OF PROTECTING CHILDREN FROM SEX 106 (2002) (quoting PEOPLE OF THE AM. WAY, TEACHING FEAR: THE RELIGIOUS RIGHT’S CAMPAIGN AGAINST SEXUALITY EDUCATION 6 (1996), http://www.pfaw.org/pfaw/dfiles/file_160.pdf (internal emphasis omitted)).

⁴⁷ Letter from Steven Brown, Executive Dir., R.I. ACLU, to Peter McWalters, Comm’r, R.I. Dep’t of Educ. (Sept. 21, 2005), available at http://www.riaclu.org/documents/sex_ed_letter.pdf.

⁴⁸ *Id.*

⁴⁹ *See id.*

⁵⁰ Dailard, *supra* note 28, at 13.

⁵¹ NAOMI SEILER, CTR. FOR LAW & SOC. POL’Y, IS TEEN MARRIAGE A SOLUTION? 8–9 (2002).

⁵² *Id.*

African-American teen mothers, 56.4% returned to school within six months of having a baby if they did not marry, but only 14.9% returned to school if they did marry.⁵³

For lesbian, gay, bisexual, and transgender (LGBT) youth, the AOUM curricula not only fail to address their very real educational needs and concerns, but—more significantly—the AOUM curricula collude in the homophobic harassment already known to infect public school settings at an extraordinarily high rate.⁵⁴ In fact, this lack of support can be observed across various levels throughout the school setting for LGBT youth. A 2005 report released by the Gay, Lesbian and Straight Education Network (GLSEN) found that nearly half of the LGBT youth surveyed reported that their school followed an AOUM curriculum and that these youth experienced very different school environments than their peers in non-AOUM schools.⁵⁵ For example, GLSEN found that AOUM curricula were related to poorer educational and personal outcomes for LGBT students.⁵⁶ These outcomes included missing school because of feelings of insecurity, higher levels of harassment based on sexual orientation, higher levels of relational aggression (i.e., being the target of rumors or lies), and higher levels of religion-based harassment.⁵⁷ In addition, LGBT students attending school with an AOUM curriculum reported feeling less comfortable talking one-on-one with school personnel, most profoundly with principals, school nurses, and librarians.⁵⁸ These outcomes and loss of adult relationships in young people's lives are not insignificant. They are the result of educational programming that singles out LGBT youth as abnormal, pathological, or simply invisible. AOUM curricula explicitly deny that LGBT youth deserve any sexuality education since the abstinence model is predicated on waiting until marriage for sexual expression, and marriage is not an option for these youth. These decisions at the policymaking

⁵³ *Id.* at 9.

⁵⁴ JOSEPH G. KOSCIW, GAY, LESBIAN & STRAIGHT EDUC. NETWORK, THE 2003 NATIONAL SCHOOL CLIMATE SURVEY (2004), http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/300-3.PDF; *see also* STEVE BROWN & BILL TAVERNER, STREETWISE TO SEX-WISE: SEXUALITY EDUCATION FOR HIGH-RISK YOUTH 16 (2d ed. 2001). LGBT teens are about four times more likely to have attempted suicide than straight students; 40% of gay, lesbian, and bisexual students report a suicide attempt compared to 10% of heterosexual students. *Id.*

⁵⁵ JOSEPH G. KOSCIW & ELIZABETH M. DIAZ, GAY, LESBIAN & STRAIGHT EDUC. NETWORK, THE 2005 NATIONAL SCHOOL CLIMATE SURVEY 87 (2006).

⁵⁶ *Id.* at 87–89.

⁵⁷ *Id.* at 87–88.

⁵⁸ *Id.* at 89.

and school levels have significant consequences for youth who desire or engage in same-sex sexual relationships.

3. *Health Consequences of Abstinence-Only Education*

The teaching of AOUM is worrisome because there are real, researchable questions about how abstinence education affects adolescent (and later, adult) sexual health. These include: how long “abstaining” youth remain abstinent, what choices they make when they decide to have sex (including sexual behaviors and contraception use), and the long-term consequences of learning exclusively about the dangers of sexuality.

One way of answering the question of what choices young people make when they decide to stop being abstinent is to measure STD rates in young people who take “virginity pledges,” an exercise that exists within some AOUM programming.⁵⁹ Brückner and Bearman in 2005 found that “pledgers,” compared to “nonpledgers,” typically deferred their first heterosexual intercourse⁶⁰ and had fewer partners than those adolescents who did not take a virginity pledge.⁶¹ However, they also found that pledgers were significantly less likely to use a condom at first intercourse.⁶² Pledgers were also found to engage solely in nonintercourse behaviors, such as oral and anal sex, at higher rates than nonpledgers.⁶³ An interesting finding in the Brückner and Bearman study is that both pledgers and nonpledgers were found to have comparable rates of sexually transmitted diseases.⁶⁴ The authors speculate that this finding may be due to less frequent use of condoms by pledgers.⁶⁵ A number of parallel findings put these data into stark relief: Pledgers were less likely to be aware of their STD status and were less likely to have sought medical testing or treatment once they became sexually active.⁶⁶

Other adolescent health researchers have studied the “user-failure” rates for abstinence; in other words, the rates of failure for those who promise to be

⁵⁹ Hannah Brückner & Peter Bearman, *After the Promise: The STD Consequences of Adolescent Virginity Pledges*, 36 J. ADOLESCENT HEALTH 271, 271 (2005). “In 1993, ‘True Love Waits’ initiated a movement to encourage adolescents to pledge to abstain from sex until marriage. By 1995, an estimated 2.2 million adolescents (12% of all adolescents) in the United States had taken such pledges.” *Id.*

⁶⁰ *Id.* at 275.

⁶¹ *Id.* at 276–77.

⁶² *Id.* at 276.

⁶³ *Id.*

⁶⁴ *Id.* at 274.

⁶⁵ *Id.* at 276.

⁶⁶ *Id.* at 277.

abstinent until marriage but have premarital sex.⁶⁷ For example, Haignere et al. reviewed the research on the user-failure rates of abstinence and found that much like condom failure rates, there is a difference between “perfect” use and “actual” use of the abstinence ideal. For condom failure rates, this entails collecting information on the rates at which condoms break, are not used correctly or consistently. Using this as a model, Haignere and her colleagues found that abstinence had a user-failure rate between 26 and 86%.⁶⁸ This rate is higher than the condom user-failure rate, which is between 12 and 70%.⁶⁹ These findings highlight the ephemeral quality of virginity pledges and nonsustainability of intentions to abstain. This would not be cause for alarm except for the fact that these youth who have been instructed using AOUM curricula and who have pledged to remain abstinent are becoming sexual with no information about how to do so successfully and are without adult and institutional support.

These findings bring the health consequences of abstinence-only-until-marriage education into sharp focus. In fact, John Santelli and his colleagues have argued that abstinence-only education and the current federal approach to sexuality education raise serious ethical and human rights concerns.⁷⁰ They argue that complete and accurate sexual health information is a basic human right and that the current federal funding requirements, by restricting the content of AOUM curricula, place adolescent sexual health in jeopardy.⁷¹

4. Summary

While most adults hope that teenagers will wait to engage in sexual activity until they are in a position to guarantee that the sex they have is pleasurable and safe, we cannot ensure that teens will wait. Even adults who want young people to remain abstinent until marriage recognize that this is unlikely. For example, in a recent national poll, of those parents who stated that they thought girls should wait “until they are married” to have sexual intercourse, 89% also

⁶⁷ Clara S. Haignere et al., *Adolescent Abstinence and Condom Use: Are We Sure We Are Really Teaching What Is Safe?*, 26 HEALTH EDUC. & BEHAV. 43 (1999); see also Steven D. Pinkerton, *A Relative Risk-Based, Disease-Specific Definition of Abstinence Failure Rates*, 28 HEALTH EDUC. & BEHAV. 10, 11 (2001).

⁶⁸ Haignere et al., *supra* note 67, at 47–48.

⁶⁹ *Id.* at 46–47.

⁷⁰ See John Santelli et al., *Abstinence and Abstinence-Only Education: A Review of U.S. Policies and Programs*, 38 J. ADOLESCENT HEALTH 72, 76–79 (2006).

⁷¹ *Id.* at 78–79.

said they thought that “most girls will have intercourse earlier [than that].”⁷² It is clear that sexuality education must serve all youth equally. This means not turning our back to those youth who are sexually active (by choice or by force). Sexuality education must provide information, support, and resources that allow young people to make decisions about their bodies and their sexual health.⁷³ By insisting that a pledge of abstinence is enough to guarantee subsequent sexual development and decision making—thereby ignoring any education concerning the mechanisms of adolescent sexual exploration and sexual development, as well as the forms of contraception that make this development healthy and safe—educators, policymakers, and families are placing young people at substantial risk.

B. Regulating Emergency Contraception

As abstinence-only-until-marriage education limits information about sexuality and reproduction, the controversy over emergency contraception (EC) reminds us that young women also confront obstacles when they seek help post-intercourse. Plan B, a form of emergency contraception, has been marketed as a safe way to avoid ovum release, fertilization, and implantation, and thus reducing pregnancies and abortions.⁷⁴ Given that the government is interested in reducing teen pregnancy and abortion, it would seem reasonable to assume that this same government would support young women’s access to emergency contraception to reduce unwanted or unintended pregnancies. Guess again.

Plan B is a pharmaceutical product. The drug primarily works by blocking or delaying ovulation after unprotected sex and dramatically reduces the likelihood of getting pregnant after vaginal intercourse.⁷⁵ It contains a high dose of a synthetic form of progestin, which has been used in birth control pills for more than three decades.⁷⁶ The drug is meant to be taken within seventy-

⁷² NAT’L PUB. RADIO, KAISER FAM. FOUND. & KENNEDY SCH. OF GOV’T, SEX EDUCATION IN AMERICA: GENERAL PUBLIC/PARENTS SURVEY 19 (2004), <http://www.npr.org/programs/morning/features/2004/jan/kaiserpoll/publicfinal.pdf>.

⁷³ For a full discussion of the content of AOUM curricula, see Michelle Fine & Sara I. McClelland, *Sexuality Education and Desire: Still Missing After All These Years*, 76 HARV. EDUC. REV. 297 (2006).

⁷⁴ Plan B, Plan B: Safe and Effective, <http://www.go2planb.com/ForConsumers/AboutPlanB/SafeAndEffective.aspx> (last visited Nov. 28, 2006).

⁷⁵ Plan B, How Plan B Works, <http://www.go2planb.com/ForConsumers/AboutPlanB/HowItWorks.aspx> (last visited Nov. 28, 2006).

⁷⁶ U.S. Food and Drug Administration, FDA’s Decision Regarding Plan B: Questions and Answers, <http://www.fda.gov/cder/drug/infopage/planB/planBQandA.htm> (last visited Nov. 28, 2006).

two hours of unprotected sex for it to be most effective.⁷⁷ Due to the limited time frame of the drug, women's health advocates have argued that requiring women to wait for a physician's prescription not only needlessly delays the process, but keeps the drug out of the hands of women who have no immediate or affordable access to a physician.⁷⁸ The Guttmacher Institute estimates that emergency contraception prevented more than 100,000 unintended pregnancies and around 51,000 abortions in 2000—at which point EC was available only through prescription.⁷⁹

In 2003, the FDA advisory committee argued that Plan B should be made broadly available through over-the-counter (OTC) sale to adult women.⁸⁰ However, in May 2004, the FDA rejected Barr Pharmaceuticals' application for Plan B to be sold OTC.⁸¹ The controversy about this pharmaceutical product centers around two main fears. The first is that OTC availability of emergency contraception will increase the frequency of unprotected sex.⁸² The second is that the mechanism of Plan B is an abortifacient.⁸³ The first fear has been discredited in recent research,⁸⁴ and the second fear is due to a misunderstanding of the difference between preventing an ovum from being released, fertilized, or implanted on the uterine wall (i.e., contraception) and removing an ovum once it has been fertilized (i.e., abortion)—both of which are *legal* procedures in the United States.

1. *The FDA Decision*

In 2004, twenty-two of the twenty-eight FDA Advisory Committee experts reviewing the application to make Plan B available OTC recommended *not*

⁷⁷ Plan B, What is Plan B?, <http://www.go2planb.com/ForConsumers/AboutPlanB/WhatisPlanB.aspx> (last visited Nov. 28, 2006).

⁷⁸ Press Release, Nat'l Org. for Women, FDA Decision Is a Victory for Millions of Adult Women, But Leaves Young Women Vulnerable (Aug. 24, 2006), <http://www.now.org/press/08-06/08-24.html>.

⁷⁹ Guttmacher Institute, Plan B Decision by FDA a Victory for Common Sense (Aug. 24, 2006), http://www.guttmacher.org/listserv/agi_update/20060824.html.

⁸⁰ FDC Reports, Barr Plan B Emergency Contraceptive OTC CARE Program Adequate, Cmte. Says (Dec. 16, 2003), http://www.thepinksheet.com/FDC/AdvisoryCommittee/Committees/Nonprescription+Drugs/121603_PlanB/121603_EmergConR.htm.

⁸¹ Cynthia C. Harper et al., *The Effect of Increased Access to Emergency Contraception Among Young Adults*, 106 OBSTETRICS & GYNECOLOGY 483, 483 (2005).

⁸² *Id.* at 484.

⁸³ See Deborah Friedman et al., *Refusal Clauses: A Threat to Reproductive Rights*, FACT SHEET (Planned Parenthood, New York, N.Y.), Dec. 17, 2004, <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/birth-control-access-prevention/refusal-clauses-6544.htm>.

⁸⁴ See Harper et al., *supra* note 81, at 490.

placing *any* limitations, *age-related or otherwise*, on access to Plan B.⁸⁵ However, on May 7, 2004, the FDA responded to Barr's application with a not approvable letter⁸⁶ denying OTC access for women of any age. Soon after the letter was made public, W. David Hager, a Bush appointee to the Advisory Committee for Reproductive Health Drugs in the Food and Drug Administration, delivered a speech at Kentucky's Asbury College, an evangelical Christian school, explaining his role in the FDA not approvable letter:

The opinion I wrote was not from an evangelical Christian perspective I argued it from a scientific perspective, and God took that information and he used it through this minority report to influence the decision. You don't have to wave your Bible to have an effect as a Christian in the public realm. We serve the greatest Scientist. We serve the Creator of all life. We serve the Author of all truth. All we're required to do is to proclaim that truth.⁸⁷

Evident in Hager's comment is the problematic relationship—publicly and proudly asserted—between science, religion, and public health. This relationship has already shown itself to be a powerful force in public health decisions. Young women have been the first to feel their rights constricted in the wake of these three institutions becoming intertwined.

In July 2004, Barr Pharmaceuticals submitted a revised application to the FDA that supported the marketing of Plan B as a prescription-only product for women fifteen years of age and younger and a nonprescription product for women sixteen years of age and older.⁸⁸ With endorsements from major medical associations,⁸⁹ an editorial in the *New England Journal of Medicine*,⁹⁰ and a study in *Obstetrics and Gynecology*⁹¹ reporting on a randomized,

⁸⁵ FDC Reports, *supra* note 80.

⁸⁶ Press Release, U.S. Food & Drug Admin., FDA Issues Not Approvable Letter to Barr Labs; Outlines Pathway for Future Approval (May 7, 2004), <http://www.fda.gov/bbs/topics/news/2004/NEW01064.html>.

⁸⁷ CHRIS MOONEY, THE REPUBLICAN WAR ON SCIENCE 218–19 (2005).

⁸⁸ See Alastair J.J. Wood et al., *A Sad Day for Science at the FDA*, 353 NEW ENG. J. MED. 1197, 1198 (2005).

⁸⁹ Policy Statement, *Emergency Contraception*, 116 PEDIATRICS 1038, 1044 (2005). The American Academy of Pediatrics "continues to support improved availability of emergency contraception to teens and young adults." *Id.*

⁹⁰ Wood et al., *supra* note 88.

⁹¹ Harper et al., *supra* note 81. The authors concluded that "[a]dolescents aged younger than sixteen years behaved no differently in response to increased access to emergency contraception (EC) from the other age groups." *Id.* at 483. In addition, young adolescents (those under sixteen years of age) with access to Plan B did not increase their sexual risk behavior. *Id.*

controlled trial of 2,117 women (including 964 adolescents, 90 of whom were younger than sixteen) who were given access to Plan B, the consensus regarding EC was that young women were no different than older women in their ability to understand directions and take the pills correctly. Results have consistently indicated no safety concerns, no effect on STDs, and no changes in risky sexual behavior.⁹² Nevertheless, the FDA rejected the OTC application based on concerns about young women's access to EC and instead opened the process to a sixty-day period for public comment.⁹³

Organizations such as the Concerned Women for America, a conservative group committed to bringing "Biblical principles into all levels of public policy,"⁹⁴ published a call for letters of public concern on their web site,⁹⁵ as well as their own thirty-seven page letter to the FDA, which outlined their concerns about OTC access to EC.⁹⁶ Their argument rested on the position that young girls might become more promiscuous with Plan B.⁹⁷ In fact, they cited as one of their major concerns that "[s]ome females come to rely upon the morning-after pill on a regular basis, with every case being an 'emergency.'"⁹⁸

Susan Wood, director of the FDA's Office of Women's Health, resigned upon hearing that the application had been rejected.⁹⁹ Later, she commented, "If this drug had nothing to do with sex, this wouldn't have happened. This decision was not based on science and clinical evidence. This threatens the FDA's credibility, and it threatens the faith the public has in the FDA for

⁹² January W. Page, *Is Plan B Unsafe?*, WASH. POST, Sept. 6, 2005, at F1.

⁹³ Wood et al., *supra* note 88, at 1198.

⁹⁴ Concerned Women of America, <http://www.cwfa.org/about.asp> (last visited Nov. 12, 2006).

⁹⁵ Wendy Wright, Concerned Women for Am., FDA Seeks Your Input on Morning-After Pill (Sept. 30, 2005), <http://www.cwfa.org/articledisplay.asp?id=8951&department=CWA&categoryid=life>.

⁹⁶ Wendy Wright, Concerned Women for Am., CWA Files Response to Plan B Scheme (Aug. 25, 2006), <http://www.cwfa.org/articles/9437/CWA/life/index.htm>.

⁹⁷ Wright, *supra* note 95. For additional background on fears of repeated use of EC by young women, see also WENDY WRIGHT ET AL., *THE MORNING-AFTER PILL 6-7* (2005), <http://www.cwfa.org/images/content/mapalec.pdf>.

⁹⁸ Wright, *supra* note 95.

⁹⁹ See Wood et al., *supra* note 88, at 1199. Frank Davidoff, M.D., also resigned his post as a consultant to the FDA in light of the recent Plan B announcement. Dr. Davidoff was a member of the FDA's Nonprescription Drugs Advisory Committee when it voted to approve Plan B for OTC sales. His decision to resign was based on his observation of the loss of the firewall between science and politics. Davidoff commented, "There wasn't any observable scientific or procedural reason for them to first decline and then further delay the decision [It] seemed to me that [this] was unacceptable." *Consultant, Former Member of FDA Advisory Panel Resigns over Handling of Plan B Application*, DAILY WOMEN'S HEALTH POL'Y REP. (Henry J. Kaiser Family Found., Wash., D.C.), Oct. 7, 2005, http://www.kaisernet.org/daily_reports/rep_index.cfm?DR_ID=32989.

making sure products are safe and effective.”¹⁰⁰ The *New England Journal of Medicine* (NEJM) agreed and came out strongly against the use of political and religious pressure to influence science and public health.¹⁰¹ In their 2005 editorial, the editors of the *NEJM* wrote,

The recent actions of the FDA leadership have made a mockery of the process of evaluating scientific evidence, disillusioned many of the participating scientists both inside and outside the agency, squandered the public trust, and tarnished the agency’s image. American women and the dedicated professionals at the FDA deserve better.¹⁰²

The once solid reputation of the U.S. agency and the science it produces has come to be regarded with suspicion due to the crumbling of the divide between science, politics, and religious ideology.¹⁰³

In August 2006, the FDA finally approved the sale of Plan B to women over age 18.¹⁰⁴ For young women aged 17 and younger, however, Plan B remains available only with a prescription from a physician.¹⁰⁵ In their decision, FDA officials concluded they had too little safety data to approve the drug for women younger than 18.¹⁰⁶ While this acknowledgement of adult women’s reproductive rights signals an important victory, the continued restrictions of young women’s access highlights one of the important ways that young women are held solely responsible for the consequences of sexual activity. With the new FDA decision, a young woman who experiences unplanned or forced sexual intercourse must first see a doctor (at her own cost) to obtain a prescription during the 72-hour window when emergency contraception is most effective; second, she must find a pharmacist who is willing to fill the prescription; and third, she must pay for the drug (again, at

¹⁰⁰ Brian Alexander, *The New Lies About Women’s Health*, GLAMOUR, May 2006, at 296, 298.

¹⁰¹ Wood et al., *supra* note 88, at 1199.

¹⁰² *Id.*

¹⁰³ Medical professionals have been explicit in their loss of confidence of health information put out by the U.S. government. For example, Dr. Ruth Shaber, Kaiser Permanente’s director of women’s health services for Northern California and head of Kaiser’s Women’s Health Research Institute has stated, “As a physician, I can no longer trust government sources I no longer trust FDA decisions or materials generated [by the government]. Ten years ago, I would not have had to scrutinize government information. Now I don’t feel comfortable giving it to my patients.” Alexander, *supra* note 100, at 297.

¹⁰⁴ Press Release, U.S. Food & Drug Admin., FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older; Prescription Remains Required for Those 17 and Under (Aug. 24, 2006), <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html>.

¹⁰⁵ *Id.*

¹⁰⁶ Memorandum from Andrew C. Von Eschenbach, Acting Comm’r, U.S. Food & Drug Admin. (Aug. 23, 2006), <http://www.fda.gov/cder/drug/infopage/planB/avememo.pdf>.

her own cost). In addition, the age restriction has two important consequences for women of *all* ages: Because adult women must prove they are 18 years or older in order to purchase the pills, pharmacists will keep the drugs behind the counter. Secondly, pills will not be sold at gas stations, convenience stores, or other outlets that do not have pharmacists.¹⁰⁷ Both of these limitations mean that the pills are not truly available “over the counter,” as is usually implied with other pharmaceutical products, like aspirin. EC joins the ranks of tobacco products and cough-cold products like pseudoephedrine—products that are restricted to consumers 18 and over.¹⁰⁸ Ultimately, this means that women of all ages will continue to face pharmacies and pharmacists who have the power to limit their access to these drugs by not stocking the products, through personal intimidation or shame, and finally, through refusing to fill a prescription.

2. *Pharmacists' Refusal and Claims of Moral Choice*

The question of access to EC for *all* women, particularly young women and those who live in poverty, continues to be vexing on many fronts. The so-called “right to refuse” has been gaining momentum for pharmacists and pharmacies that choose not to provide EC. As reproductive freedom for young women is shrinking, freedom for pharmacists is growing. Forty-six states have a religious or moral “refusal clause” concerning the provision of abortion services.¹⁰⁹ Fourteen states have proposed refusal clauses specifically for contraceptives.¹¹⁰ As of January 2006, only seven states required hospitals to dispense EC to sexual assault survivors,¹¹¹ and a series of Catholic and private hospitals are refusing to administer emergency contraception even in these cases.¹¹²

Wal-Mart, until early 2006, had been determined not to sell EC, except where local regulations forced them to do so. In March 2006, after the national

¹⁰⁷ Rob Stein, *FDA Approves Plan B's Over-the-Counter Sale*, WASH. POST, Aug. 25, 2006, at A4.

¹⁰⁸ Memorandum from Andrew C. Von Eschenbach, *supra* note 106.

¹⁰⁹ GUTTMACHER INST., STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES (2006), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.

¹¹⁰ CTR. FOR REPROD. RIGHTS, 2006 MID-YEAR REPORT, http://www.reproductiverights.org/st_leg_summ_midyear_06.html. “So far this session sixteen bills in eight states proposed to give ‘conscience protection’ to health care providers who refuse to provide a variety of reproductive-health related services. Moreover, twenty-nine bills in fourteen states have sought to allow pharmacists or pharmacies to refuse to fill valid prescriptions for contraceptives.” *Id.*

¹¹¹ Center for Reproductive Rights, Emergency Contraception (EC) for Sexual Assault Survivors in the Emergency Room, http://www.reproductiverights.org/pub_fac_ecintheer.html (last visited Feb. 6, 2007).

¹¹² Friedman et al., *supra* note 83.

chain was sued for not carrying EC and from pressure brought on by the Massachusetts pharmacy board, Wal-Mart began stocking the prescription drug in its pharmacies across the country.¹¹³ However, it remains to be seen whether EC will actually be available at Wal-Mart pharmacies. The company says it will allow pharmacists who object to the pills for personal reasons to refuse to dispense them.¹¹⁴ This policy, except where prohibited by law, allows any Wal-Mart or Sam's Club pharmacy associate who does not feel comfortable dispensing a prescription to refer customers to another pharmacist or pharmacy.¹¹⁵ In some parts of the country, and for some women, this referral is not a matter of simply going down the street. In rural and underserved areas, there may be limited locations or personnel who are willing to fill a prescription within a reasonable timeframe and for a reasonable cost.¹¹⁶ Wal-Mart's decision signals a clear choice to favor pharmacists' right to "choose" over women whose right to choose is sacrificed. If the local pharmacy won't help a young woman get emergency contraception, or her hospital refuses to dispense it, she has no options but pregnancy and then abortion, adoption, or early unwanted motherhood.

3. Summary

If a woman has had unprotected sexual intercourse due to sexual coercion or violence, faulty contraception, or no contraception, she faces a number of obstacles before she is able to reduce the likelihood of pregnancy. The FDA decision to restrict access to Plan B for women under 18 has enormous consequences. Young women must access medical care, get a prescription from a physician, and find a pharmacist who is willing to fill the prescription—all within the seventy-two hour window that emergency contraception needs to be taken in order to be effective. These obstacles represent serious constrictions on the reproductive freedom of those young women who have considerably less access to medical care, physicians, and pharmacies. The decision to let pharmacists decide what they will and will not dispense and to whom has wider consequences in rural areas where there may be no other pharmacy or pharmacist willing to dispense the medication. This decision restricts access to legal pharmaceuticals for women of *all* ages.

¹¹³ ConsumerAffairs.com, Wal-Mart to Begin Dispensing "Morning After" Pill This Week (Mar. 19, 2006), http://www.consumeraffairs.com/news04/2006/03/walmart_planb.html.

¹¹⁴ *Id.*

¹¹⁵ *See id.*

¹¹⁶ Julie Cantor & Ken Baum, *The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW ENG. J. MED. 2008, 2010 (2004).

While young female bodies will continue to bear the brunt of the FDA's decision, we must still contend with how the decision was made, in whose interest it was made, and on what basis U.S. government agencies continue to make decisions concerning public health. In fact, in November 2005, the U.S. Government Accountability Office (GAO), an independent, nonpartisan agency that works for Congress, issued a report investigating the FDA's first Plan B rejection.¹¹⁷ The GAO study found four atypical aspects of the May 7, 2004 FDA decision: (1) the directors of the offices that reviewed the application, including the Director of the Office of New Drugs who would normally sign a not approvable letter, did not sign the Plan B letter because they disagreed with the decision; (2) the FDA's high-level management was more involved in this decision than in those of other OTC switch applications; (3) there was conflict over whether the decision was made before the reviews were completed; and (4) the decision's rationale was novel.¹¹⁸

The story of Plan B is one where a national public health agency took a specific stance concerning women's sexual and reproductive freedom. While the FDA's not approvable letter notes that the application did not provide "adequate data to support use of Plan B by young adolescent women without the intervention of a physician,"¹¹⁹ it is not clear why the decision was initially made to restrict access for women under sixteen years old. What seems evident from the FDA decision is that public ambivalence about young women's sexuality was used as a way of restricting the reproductive choices for all women. This is not a small point. It signals how young women are increasingly being used to reinscribe female sexual behavior as inappropriate and dangerous at the same time as access to contraception is being curtailed.¹²⁰ Young women were used as a lightning rod in constructing the story of how Plan B would "increase promiscuity" or affect sexual risk taking, thereby limiting access to a form of contraception that has been proven safe and effective. The example of Plan B should serve to illustrate how young women's sexuality is increasingly described as dangerous and their sexual and

¹¹⁷ GOV'T ACCOUNTABILITY OFFICE, DECISION PROCESS TO DENY INITIAL APPLICATION FOR OVER-THE-COUNTER MARKETING OF THE EMERGENCY CONTRACEPTIVE DRUG PLAN B WAS UNUSUAL, GAO-06-109 (2005), <http://www.gao.gov/new.items/d06109.pdf>.

¹¹⁸ *Id.* at 19–22; see also Gillian E. Metzger, *Abortion, Equality, and Administrative Regulation*, 56 EMORY L.J. 865 (2007). FDA review officials "noted that the agency had not considered behavioral implications resulting from differences in cognitive development in prior OTC switch decisions." *Id.* at 22.

¹¹⁹ Press Release, U.S. Food & Drug Admin., FDA Issues Not Approvable Letter to Barr Labs; Outlines Pathway for Future Approval, May 7, 2004, <http://www.fda.gov/bbs/topics/news/2004/NEW01064.html>.

¹²⁰ Russell Shorto, *Contra-Contraception*, N.Y. TIMES, May 7, 2006, § 6 (Magazine), at 48, 50.

reproductive freedoms constricted. Young women's rights should serve as a warning to all women; the same arguments that are used today to circumscribe the sexual rights of adolescents can (and have already been) used to circumscribe the rights of all women tomorrow.

C. *Parental Consent for Minors' Access to Abortion*

Finally, we come to the young woman who is pregnant and seeks an abortion. In addition to the fact that only 17 states provide Medicaid funding for her abortion,¹²¹ 34 states require the pregnant minor to confront a requirement for parental consent or notification.¹²²

1. *State Regulations*

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the U.S. Supreme Court held that states could encourage parental participation in minors' abortion decisions.¹²³ In May 2006, the number of states with some requirement for parental involvement totaled 34, with 13 requiring notice and 22 requiring consent.¹²⁴ Of the 34, all but Utah required an alternative process for minors seeking an abortion, usually in the form of a judicial bypass.¹²⁵ Six states also permitted a minor to obtain an abortion if a grandparent or adult relative was involved in the decision.¹²⁶

¹²¹ GUTTMACHER INST., STATE FUNDING OF ABORTION UNDER MEDICAID (2006), http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf.

¹²² GUTTMACHER INST., STATE POLICIES IN BRIEF: PARENTAL INVOLVEMENT IN MINORS' ABORTIONS (2006), http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf.

¹²³ See 505 U.S. 833, 878–79 (1992).

¹²⁴ GUTTMACHER INST., *supra* note 109.

¹²⁵ *Id.*

¹²⁶ *Id.* As of early 2006, nine states introduced additional reporting requirements for minors seeking abortion. For example,

[T]he K[ansas] House passed a measure that would amend the state's abortion laws concerning minors' access to abortion. Current law requires someone over the age of 21 to accompany a minor to her abortion counseling session. The measure would require that person to show valid identification, state their relationship to the minor and provide any information available as to the identity of the father of the fetus. The minor would need to present valid identification proving state of residence. In addition, the measure would prohibit abortion clinic staff from aiding a minor during the course of a judicial bypass of parental notice and institute reporting requirements when a judicial bypass is obtained.

Guttmacher Institute, State Center, Monthly State Update: Major Developments in 2006, Minors Reporting Requirements, <http://www.guttmacher.org/statecenter/updates/index.html#MinorReportingRequirement> (last visited Nov. 28, 2006).

In the process of establishing laws that demand parental involvement, the state *appears* to relinquish all decisions concerning young women to the privatized realm of family decision making. But what is accomplished, instead, is the insertion of the state into the family, asserting itself in the role of protector—above and beyond that of the family. As the state legislates familial communication, it establishes itself as both part of the family and overseer of the family dynamic—the new “Dad.”¹²⁷

On the face of it, the argument to involve the minor's family in her decision to maintain or terminate a pregnancy makes sense. Young women need adult support in good and bad times, and families are often the first place they seek such support. Yet, it is clear that families, with this legal strategy, are only supposed to point a young woman toward parenthood, adoption, or early marriage—not abortion. Unlike the predictions, sometimes parents of minors who find out about the pregnancy pressure their daughters to have an abortion.¹²⁸

To set the empirical context straight, it is important to know that most young women *already* involve their mothers or a close relative in decisions about sexuality and reproduction.¹²⁹ Even in states with no parental involvement laws, 61% of the young women voluntarily involve at least one parent, with 26% saying their father knew about the abortion, although apparently 57% of mothers who knew did not tell the father of the young woman.¹³⁰ For younger teens, aged fourteen and below, 90% indicate that at least one parent knows and most indicate that the parents who know support their daughters' actions.¹³¹ Further, African-American teens are far more likely to discuss sexuality with their mothers than other groups; even those

¹²⁷ See Brief of New Hampshire Legislators as Amicus Curiae in Support of Petitioner at 1–2, *Ayotte v. Planned Parenthood*, 126 S. Ct. 961 (2006) (No. 04-1144). Professor Collett laid out the argument for the State's position on the benefits of parental consent:

Parents can provide or help obtain the necessary resources for early and comprehensive prenatal care. They can assist their daughters in evaluating the options of single parenthood, adoption or early marriage They can provide the love and support that is found in many healthy families of the United States.

Legal Affairs Debate Club, *Parent Free Abortion?* (Mar. 13, 2006), http://www.legalaffairs.org/webexclusive/debateclub_parental-notification0306.msp (statement of Teresa S. Collett).

¹²⁸ Stanley K. Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions*, 24 FAM. PLAN. PERSP. 196, 196 (1992).

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.* at 200.

who sought judicial bypasses did so after telling their mothers about the pregnancy.¹³²

2. Families and Violence

While involving families may be a form of support for some young women, there is a group of young women who do not have a parent or guardian to whom they can safely turn; many of these women have been sexually or physically abused at home.¹³³ Research in this area has highlighted the untenable position that young women are pushed into in states that mandate parental involvement in their reproductive decisions. Henshaw and Kost found that of those who could not or would not tell parents about their pregnancy, 30% indicated they had experienced violence in their families, 30% feared more violence, and 18% feared pressure to leave home.¹³⁴ Ehrlich interviewed 490 minors who sought judicial waivers in Massachusetts between 1998 and 1999 and found that almost a third of young women feared a “severe adverse reaction, such as being kicked out of the house, physical harm, or others kinds of abuse,” with rates varied by living arrangements: 30% living with both parents, 29% living with mother only, and 39% living with father only.¹³⁵

The complex trajectories that link sexual violence and abuse in the family with heightened rates of teen pregnancy and teen refusal to seek parental consent for abortion have been documented by numerous researchers.¹³⁶ Boyer and Fine found that 68% of teenage mothers have been sexually abused.¹³⁷ Getshenson et al. found that 62% of 445 teen mothers reported

¹³² Robert Wm. Blum, Michael Resnick & Trisha Stark, *Factors Associated with the Use of Court Bypass by Minors to Obtain Abortions*, 22 FAM. PLAN. PERSP. 158, 160 (1990); Caroline A. Placey, *Of Judicial Bypass Procedures, Moral Recusal, and Protected Political Speech: Throwing Pregnant Minors Under the Campaign Bus*, 56 EMORY L.J. 693 (2006).

¹³³ Twenty-five percent of adolescent girls said they wanted to leave home at some point because of family violence; 58% of abused versus 18% of nonabused girls say they wanted to leave home. CATHY SCHOEN ET AL., *THE COMMONWEALTH FUND SURVEY OF THE HEALTH OF ADOLESCENT GIRLS* 11 (1997).

¹³⁴ Henshaw & Kost, *supra* note 128, at 196, 203.

¹³⁵ J. Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Made the Abortion Decision Without Their Parents*, 18 BERKELEY WOMEN'S L.J. 61, 94 (1992). Ehrlich further found that 12% said their parents would have pressured them to keep the baby or marry. *Id.* at 95.

¹³⁶ See, e.g., Debra Boyer & David Fine, *Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment*, 24 FAM. PLAN. PERSP. 4 (1992).

¹³⁷ *Id.* at 8; see also Janice R. Butler & Linda M. Burton, *Rethinking Teenage Childbearing: Is Sexual Abuse a Missing Link?*, 39 FAM. REL. 73, 74 (1990) (stating that 60% of teenage mothers were sexually abused).

coercive sexual experiences, 33% at the hands of a family member.¹³⁸ Dietz et al. found that abused women were far more likely to have had an unintended pregnancy than those not abused.¹³⁹ Finally, Rainey et al. found that sexually abused women reported a desire to conceive three times more frequently than nonabused females.¹⁴⁰

Early abuse seems to increase the likelihood of teen pregnancy, the desire to conceive, the rates of unwanted or unintended pregnancy, and the rates of untrusting parents or physicians.¹⁴¹ These young women have had more sexual partners and more unprotected sex than their peers who have not experienced such abuse.¹⁴² A study of 13 to 19 year olds, living in rural counties, found that “sexual risk takers”—measured by number of partners and nonuse of contraception—were more likely to have been sexually or physically abused at home than their peers.¹⁴³ A Guttmacher Institute study of young women found that 74% of young women who had intercourse prior to age 14, and 60% of those before age 15, reported that the sex was not voluntary.¹⁴⁴ In sum, the trajectory from abuse at home to early pregnancy is too common to assume that families of young women are necessarily safe or protective of them. Parental consent laws ignore these data and force young women to return to their homes in order to negotiate their unwanted pregnancies.

Girls and young women who run away or are removed from their families of origin because of physical, emotional, or sexual abuse are often referred to foster care or the juvenile justice system or both, where general and reproductive health care range from uneven to nonexistent.¹⁴⁵ The sexual and reproductive consequences of family trauma and the absence of state support

¹³⁸ Harold H. Getshenson et al., *The Prevalence of Coercive Sexual Experience Among Teenage Mothers*, 4 J. INTERPERSONAL VIOLENCE 209–14 (1989).

¹³⁹ Patricia M. Dietz et al., *Unintended Pregnancy Among Adult Women Exposed to Abuse or Household Dysfunction During Their Childhood*, 282 J. AM. MED. ASS'N 1359, 1359 (1999).

¹⁴⁰ David Rainey et al., *Are Adolescents Who Report Prior Sexual Abuse at Higher Risk for Pregnancy?*, 19 CHILD ABUSE & NEGLECT 1283, 1285–86 (1995).

¹⁴¹ See Evvie Becker-Laussen & Annette U. Rickel, *Integration of Teen Pregnancy and Child Abuse Research: Identifying Mediator Variables for Pregnancy Outcome*, 16 J. PRIMARY PREVENTION 39, 42–47 (1995); Cynthia Franklin & Jacqueline Corcoran, *Preventing Adolescent Pregnancy: A Review of Programs and Practices*, 45 SOC. WORK 49–50 (2000).

¹⁴² Tom Luster & Stephen A. Small, *Factors Associated with Sexual Risk Taking Behaviors Among Adolescents*, 56 J. MARRIAGE & FAM. 622, 628 (1994).

¹⁴³ PLANNED PARENTHOOD, *ADOLESCENT SEXUALITY* 11 (2001), <http://www4.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/teensexualhealth/white-adolescent-sexuality-01.pdf>.

¹⁴⁴ GUTTMACHER INST., *SEX AND AMERICA'S TEENAGERS* 19–31 (1994).

¹⁴⁵ ANNIE E. CASEY FOUND., *2004 KIDS COUNT DATA BOOK: MOVING YOUTH FROM RISK TO OPPORTUNITY* 1, 6–9 (2004), http://www.aecf.org/kidscount/databook/pdfs_e/kc2004_e.pdf.

for families converge to produce an enormous fallout for young women, particularly poor working class teens of color, who are more likely than males to be removed from homes with any suspicion of abuse or neglect and referred to foster care or criminal justice systems or both—only to be betrayed again.¹⁴⁶

3. *Legal Obstacles Instead of Legal Support*

Proponents argue that parental involvement laws reduce the number of abortions in the state.¹⁴⁷ However, there is sufficient evidence to suggest that a number of other factors affect abortion rates in individual states, such as variations in access, limitations, and Medicaid funding.¹⁴⁸ At present, access to abortion services is extremely limited.¹⁴⁹ From 1996 to 2000, the number of abortion providers dropped by 11%.¹⁵⁰ A full 87% of all counties in the United States do not have abortion services; these counties are home to 34% of women.¹⁵¹ Further, the abortion rate for any one state is affected by neighboring states that have different laws.¹⁵² Researchers have calculated interstate travel costs incurred by minors seeking abortions outside of states where there are parental consent laws and to states with fewer requirements.¹⁵³ Substantial evidence suggests that parental notification or consent laws simply relocate the bulk of abortions from in state to out of state.¹⁵⁴ Cartoof and Klerman found that 40% of Massachusetts minors traveled to surrounding states for abortions once they realized that Massachusetts had a parental

¹⁴⁶ *Id.* In 2000, 555,000 children were in publicly supported foster care, 16% between ages 16 and 18. Forty percent were African Americans, who are more likely to be in resident or group care than family. They stay in care longer and are least likely to be reunited with families. *Id.*

¹⁴⁷ See, e.g., MICHAEL J. NEW, CAL. CATHOLIC CONF., ANALYZING THE EFFECT OF PRO-LIFE LEGISLATION 4 (2005), <http://www.catholic.org/docsppr/AbortionStudy2005.pdf>; Michael J. New, Heritage Found., A Lesson in Data and Analysis for the New York Times (Mar. 7, 2006), <http://www.heritage.org/Research/Family/wm1009.cfm>.

¹⁴⁸ HEATHER D. BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES 34–37 (2006), <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf>.

¹⁴⁹ *Id.* at 21.

¹⁵⁰ Lawrence B. Finer & Stanley K. Henshaw, *Abortion Incidence and Services in the United States in 2000*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 6, 6 (2003).

¹⁵¹ BOONSTRA ET AL., *supra* note 148, at 36.

¹⁵² See Virginia G. Cartoof & Lorraine V. Klerman, *Parental Consent for Abortion: The Impact of the Massachusetts Law*, 76 AM. J. PUB. HEALTH 397, 399–400 (1986).

¹⁵³ See *id.* at 399.

¹⁵⁴ See *id.* at 399–400; Stanley K. Henshaw, *The Impact of Requirements for Parental Consent on Minors' Abortions in Mississippi*, 27 FAM. PLAN. PERSP. 120, 121 (1995).

involvement law.¹⁵⁵ Similar trends have been documented for minors seeking abortions in Minnesota, Missouri, and Indiana.¹⁵⁶

In states with parental consent or notification provisions, the law requires that young women who are unable or unwilling to seek parental consent or notification must have an option for judicial bypass.¹⁵⁷ While these, on the surface, would seem to provide for a sufficient set of supports for a young woman seeking an abortion, the judicial bypass does not always provide the support it promises and, in fact, the process of gaining the bypass often puts the young woman in a more vulnerable position.¹⁵⁸ Political scientist Helena Silverstein undertook a series of “gap studies” to document the space between law and practice in which she examined the institutional and personal obstacles that young women faced while pursuing judicial bypasses in Alabama, Pennsylvania, and Tennessee.¹⁵⁹ Silverstein documented wide variation in access to the waivers—measured by the burden of multiple phone calls, ill-prepared clerks, the costs of travel for young women,¹⁶⁰ and the extent to which judges recused themselves from these cases because of “moral considerations.”¹⁶¹ She found, for instance, that four judges in three counties in Alabama tell young women that they must attend pro-life counseling sessions from a crisis pregnancy center called Sav-A-Life in order to qualify for the judicial waiver process.¹⁶² In a few instances, judges have required the

¹⁵⁵ See Cartoof & Klerman, *supra* note 152, at 398.

¹⁵⁶ See Charlotte Ellertson, *Mandatory Parental Involvement in Minors' Abortions: Effects of the Laws in Minnesota, Missouri, and Indiana*, 87 AM. J. PUB. HEALTH 1367, 1367 (1997). *But see* James Rogers, Robert F. Boruch & George B. Stoms, *Impact of the Minnesota Parental Notification Law on Abortion and Birth*, 81 AM. J. PUB. HEALTH 294, 294 (1991) (challenging Ellertson's findings).

¹⁵⁷ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 899 (1992).

¹⁵⁸ See Sherry F. Colb, *The Minor Issue of Abortion: Priscilla Owen's Confirmation Battle*, FINDLAW, July 31, 2002, <http://writ.news.findlaw.com/colb/20020731.html> (quoting Professor Sanger's description of the judicial bypass process as a “ritual of humiliation”); *see also* Sherry F. Colb, *Virginity Tests in South Africa and Judicial Bypass in the U.S.: Ritually Scrutinizing the Virtue of Girls*, FINDLAW, Jan. 11, 2006, <http://writ.news.findlaw.com/colb/20060111.html> (likening the judicial bypass process to the practice of virginity testing in South Africa: “[J]udges will sometimes ask [the young woman] how she came to be pregnant and whether she is sorry for what she did.”).

¹⁵⁹ Helena Silverstein, *In the Matter of Anonymous, a Minor: Fetal Representation in Hearings to Waive Parental Consent for Abortion*, 11 CORNELL J.L. & PUB. POL'Y 69 (2001) [hereinafter Silverstein, *In the Matter of Anonymous*]; Helena Silverstein, *Road Closed: Evaluating the Judicial Bypass Provision of the Pennsylvania Abortion Control Act*, 24 LAW & SOC. INQUIRY 73 (1999) [hereinafter Silverstein, *Road Closed*]; Helena Silverstein et al., *Judicial Waivers of Parental Consent for Abortion: Tennessee's Troubles Putting Policy into Practice*, 27 LAW & POL'Y 399 (2005).

¹⁶⁰ Silverstein, *Road Closed*, *supra* note 159, at 91–92.

¹⁶¹ Silverstein, *In the Matter of Anonymous*, *supra* note 159, at 102.

¹⁶² Helena Silverstein & Kathryn Alessi, *Religious Establishment in Hearings to Waive Parental Consent for Abortion*, 7 U. PA. J. CONST. L. 473, 475 (2004).

presence of a guardian ad litem to provide legal representation for the fetus.¹⁶³ Laying to rest the fantasy of the simple judicial bypass option, Silverstein has documented the substantial burdens young women must overcome on their journey to bypassing parental involvement.¹⁶⁴

4. *Health Consequences of Parental Involvement Requirements*

Women who have experienced physical or sexual abuse in childhood are often the very young women who find themselves circling the maze of judicial bypass in search of reproductive health care or abortion services. When judges say no or extend the time of their decision, there is a risk of locking these young women into abusive homes of origin or encouraging them to create “new” potentially abusive homes of marriage and motherhood.¹⁶⁵ Out of public view, these young women are clearly not safe, and neither are their children.

Obstacles created by consent requirements have critical implications for access and timing of pregnant minors seeking abortion or prenatal health care. Griffin-Carlson and Schwanenflugle found that 32% of young women who were required by law to attain parental consent waited longer than two weeks after they were aware of their pregnancies to inform their parents.¹⁶⁶ We, of course, do not know how many women are simply discouraged and move forward with the pregnancy and we do not know if they receive prenatal care in a system that has so alienated them. Others have found that parental involvement laws may delay young women’s abortions into the second trimester of pregnancy¹⁶⁷ and that mandated parental involvement, in combination with mandatory waiting periods, are associated with a rise in later-term abortions.¹⁶⁸

¹⁶³ Silverstein, *In the Matter of Anonymous*, *supra* note 159, at 70.

¹⁶⁴ See generally Helena Silverstein & Leanne Speitel, “Honey I have no idea”: *Court Readiness to Handle Petitions to Waive Parental Consent for Abortion*, 88 IOWA L. REV. 75 (2002).

¹⁶⁵ See Emily A. Impett & Letitia Peplau, *Sexual Compliance: Gender, Motivational and Relationship Perspectives*, 40 J. SEX RES. 87, 94 (2003).

¹⁶⁶ Mary S. Griffin-Carlson & Paula Schwanenflugel, *Adolescent Abortion and Parental Notification: Evidence for the Importance of Family Functioning on the Perceived Quality of Parental Involvement in U.S. Families*, 39 J. CHILD PSYCHOL. & PSYCHIATRY & ALLIED DISCIPLINES 543, 546 (1998).

¹⁶⁷ Ellertson, *supra* note 156, at 1372.

¹⁶⁸ Marianne Bitler & Madeline Zavodny, *The Effect of Abortion Restrictions on the Timing of Abortions*, J. HEALTH ECON. 1011, 1030 (2001).

5. *Summary*

Examining the available empirical data, we see that parental consent legislation encumbers young women's sexual and reproductive freedoms and aggravates health risks for the young woman and—if they carry to term—their babies. The state requirement for minors to notify their parents is often redundant; most young women already involve someone in their families (but not necessarily one or both parents) in their decision. However, for those young women living in abusive households, requiring notification only puts them at greater risk for abuse. The logic of state “protection” does not hold in these cases. In fact, parental involvement mandates remove any hope of protection for these young women. These laws wrap themselves in pro-family rhetoric under the guise of protecting young women and encouraging familial support. However, parental involvement laws end up simply legislating familial communication and undermining a young woman's decision as to whether she is able to safely notify her family of her decision to get a *legal* abortion. Young women who are required to make reproductive decisions within these legal contexts are forced to interact with state and legal structures that claim to be supporting them. What we see upon closer examination are a set of moral judgments that are imposed on young women who have become pregnant. These judgments only serve to punish the young woman (and not the father of this same fetus) by placing her in harm's way—by possibly forcing her to interact with an abusive family in order to gain permission, by delaying the abortion through increasing the number of legal obstacles she must pass, or by sustaining an unwanted pregnancy.

III. CONSEQUENCES OF LEGAL RESTRICTIONS

While it may be tempting to blame the constriction of teen sexuality rights on the current political environment, the early seeds of the movement toward federal restrictions on adolescent sexual freedoms can be traced to the Personal Responsibility and Work Opportunity Reconciliation Act signed into law by President Clinton in 1996.¹⁶⁹ Nevertheless, we find ourselves today at a strategic historic moment when social policy, educational practice, and federally funded research work together to promote abstinence until heterosexual marriage.¹⁷⁰ These same policies align *against* teen sex, abortion,

¹⁶⁹ Pub. L. No. 104-193, 110 Stat. 2105 (1996).

¹⁷⁰ Sara I. McClelland & Michelle Fine, *Embedded Science: The Production of Consensus in Evaluation of Abstinence-Only Curricula*, 13 QUALITATIVE INQUIRY (forthcoming 2007).

contraception, and gay and lesbian relationships, thereby threatening the possibility of open and educational conversations about sexual desires and dangers. In this political environment, we witness public education about health censored in many classrooms and clinics. The language of public policy is increasingly fraught with discourses that consider any form of nonmarital sex dangerous, while marital heterosexuality is considered inherently safe. At the same time, current policies strip away resources that could assist young women who do experience sexual risk and danger (e.g., access to comprehensive sex education, access to emergency contraception, and access to legal abortions).

While the three state and federal strategies discussed above could be considered in isolation and described as unrelated to one another, we view them as dynamically interrelated. They each have grave implications for young women's educational, economic, civic, and health outcomes. Abstinence-only-until-marriage education, the retreat from over-the-counter access to Plan B, and parental consent for abortion are all strategies that are meant to curtail the sexual freedoms of young women and place the burden of sexuality on them—in the guise of protecting them. Analyzing these three strategies next to one another allows us to see the qualities they share—specifically their language, their intentions, and their consequences. The juxtaposition of the three allows us to deconstruct how these state-sponsored policies have rendered young women vulnerable to political whims, particularly those young women with the least political power by virtue of social class, race or ethnicity, immigration status, disability, and sexual orientation. These are not young women for whom privacy and liberty, alone, will suffice. They need and deserve what we consider *enabling contexts* for their economic, educational, health, and sexual well-being.

A. *Young Women's Dependence on the State*

Unlike adult women, who may (if privileged) entertain the fantasy of full autonomy, all young women depend on state and federal resources and institutions to varying degrees, be it in the form of public education, health care, libraries, relations with police, juvenile justice, foster care, publicly subsidized family supports, Pell grants, public child care, antidiscrimination politics for LGBT students, or Medicaid-funded abortions. With such a heavy dependence on state and federal policies and practices, young women's bodies curve at the dangerous intersection of neoliberalism and "soft" fundamentalism. The neoliberal shift to the right has hollowed public

responsibility for social well-being, deporting needs to the marketplace, insisting on individualism, and ideologically justifying this social betrayal in the name of freedom and privacy. Critical theorist Wendy Brown cites Thomas Lemke, who has argued that the state leads and controls subjects without being responsible for them.¹⁷¹ She argues that “subjects are controlled through their freedom . . . and neo-liberalism’s *moralization* of the consequences of this freedom.”¹⁷²

When considering the issue of reproductive rights, there is often an interest in maintaining a focus on a woman’s legal right to make private decisions about her body, with her physician, but without interference from the state. While this commitment to privacy and autonomy *may* be sufficient for some adult women, adolescents are among those who are never free from state interests. In fact, adolescent women *need* the state to support their sexual development—not abandon, discipline, or punish them for their sexualities. In particular, those young women growing up in rural and urban poverty depend on the political whims of the state without alternative.

1. *Differential Impact by Race, Ethnicity, and Class*

All young women, due to their age, interact with state institutions to a greater degree than adult women, and young women of color and those who are poor rely on the state to a much greater extent. On the one hand, they require the state to play a role in their lives. On the other hand, this dependence has the potential to strip them of their rights in a way that men of all ages and women over eighteen do not experience. This interrelationship deeply impacts the ways that these young women come to know and experience their sexual and reproductive possibilities.

For these young women, we witness two concurrent moves in current legal and policy development: First, the neoliberal state has narrowed the full range of education and health care available; access to comprehensive sex education, contraception, health care insurance, and abortions has been severely curtailed. Second, the state has aggressively restricted young women’s access to information, education, conversation, adult supports, and opportunity in ways explicitly aligned with a right-wing religious agenda. Those most dependent

¹⁷¹ See Wendy Brown, *Neo-Liberalism and the End of Liberal Democracy*, 7 THEORY & EVENT 1 (2003) (citing Thomas Lemke, ‘*The Birth of Bio-Politics*’: Michel Foucault’s Lecture at the College de France on *Neo-Liberal Governmentality*, 30 ECON. & SOC’Y 190, 201 (2001)).

¹⁷² *Id.*

on the state are, of course, most likely to be targeted by the current religious agenda in U.S. domestic policy and least likely to have the education or health care to challenge it. For example, unintended pregnancy rates among poor women increased by 29% between 1994 and 2001, while rates among higher-income women decreased by 20% in this same period; a poor woman is four times as likely to experience an unplanned pregnancy as a higher-income woman.¹⁷³ In sum, it is a matter of age, as well as a matter of race and class, that positions young women in terms of state laws, policies, and funding strategies.

In a nation that has walked away from the needs of poor children and their families, we hear a muscular assertion of the need for state protection even as the most vulnerable young women—by virtue of disability,¹⁷⁴ sexual identity,¹⁷⁵ poverty,¹⁷⁶ or racism,¹⁷⁷—are made more vulnerable by the cocktail of neoliberalism and fundamentalism. They are the most likely to experience structural and interpersonal violence, to be recruited into the military,¹⁷⁸ or to go to prison;¹⁷⁹ they are also least likely to have access to good schools, comprehensive sexuality education, quality health care, adequate health

¹⁷³ Lawrence B. Finer & Stanley K. Henshaw, *Disparities in the Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 90, 94 (2006), available at <http://www.guttmacher.org/pubs/journals/3809006.pdf>.

¹⁷⁴ HARILYN ROUSSO, STRONG, PROUD SISTERS: GIRLS AND YOUNG WOMEN WITH DISABILITIES (2001), <http://www.centerwomenpolicy.org/pdfs/DIS3.pdf>.

¹⁷⁵ See generally AMBER L. HOLLIBAUGH, MY DANGEROUS DESIRES: A QUEER GIRL DREAMING HER WAY HOME (2000).

¹⁷⁶ See generally JONATHAN KOZOL, THE SHAME OF THE NATION (2005).

¹⁷⁷ See generally TRICIA ROSE, LONGING TO TELL: BLACK WOMEN TALK ABOUT SEXUALITY AND INTIMACY (2003).

¹⁷⁸ Sixty-three percent of women in the Army are women of color, compared to 32% in the general population. David R. Segal & Mady Wechsler Segal, *America's Military Population*, 59 POPULATION BULL. 3, 30 (2004). In JROTC, 54% of high school students are “minority” and from 1993–1994, 40% were women. African American female students participate at rates greater than white females and African American men. *Id.* The Segals argue that many black women see the military as providing greater opportunities and benefits than the civilian labor market, and black women are better represented in the military than black men. *Id.* at 30. Further, black women are better represented than white women among noncommissioned officers, in part reflecting their longer stays in the service. *Id.* at 20.

¹⁷⁹ While black juveniles constitute 15% of U.S. population ages 10–17, they account for 45% of delinquency cases involving detention, 40% of those placed in residential placement, and 46% of cases judicially waived to criminal court. See HEIDI M. HSIA ET AL., OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, U.S. DEP'T OF JUSTICE, DISPROPORTIONATE MINORITY CONFINEMENT: 2002 UPDATE 2 (2002), <http://www.ncjrs.gov/pdffiles1/ojjdp/201240.pdf>.

insurance, alternatives to violent homes and schools, or the enabling conditions to help them reinvent the possibilities tomorrow.¹⁸⁰

When public institutions refuse to support and protect young women, the state, by default, naturalizes adverse outcomes. A strong, supportive welfare state acts like a barrier method—severing the automatic relationship between heterosexual intercourse and pregnancy, disease, and teen motherhood. Sex need not result in any of these consequences, and, even though some groups of young women find themselves faced with these consequences, such consequences must not be treated as “natural.” Indeed, these consequences are political and can be changed with the implementation of public policies that support young women—even (and especially) when they have engaged in sexual activity that has resulted in pregnancy or disease. Today, particularly within poor communities, we find that between teen sexuality and teen pregnancy lie aggressively punitive public policies, such as abstinence-only education and limited access to medical care, which increase the probability of teen pregnancy, STDs, teen births, and teen abortions. With these policies in place, the government actively facilitates teen births, sexually transmitted diseases and abortions, with sharply differential consequence according to race, ethnicity, and class.

The gendered, raced, and classed burden of teen sexuality is neither natural nor simply a question of biological destiny or “culture.” Teen women are forced to carry the burden of sexuality when the state continually describes them as “at fault” *and* when the state, because of this attribution of guilt, refuses to support them. In the sphere of adolescent sexuality, the neoliberal withdrawal of public supports for sexual and reproductive health is joined by an aggressive and punitive penetration of the presumably private realm of body. Fundamentalism insists on invading the body—specifically young women’s bodies—just as neoliberalism retreats from public support.

¹⁸⁰ Teen pregnancy and drop out rates are highly correlated, usually *not* because pregnant teens decide to drop out, but rather because young women who stop going to school are more likely to become (and stay) pregnant than those in school. *See generally* MICHELLE FINE, FRAMING DROPOUTS: NOTES ON THE POLITICS OF AN URBAN PUBLIC HIGH SCHOOL (1991). Thirty-eight percent of all teens who dropped out between eighth and twelfth grade had subsequent pregnancy and birth, versus 11% of teens who did not drop out. Jennifer Manlove, *The Influence of High School Dropout and School Disengagement on the Risk of School-Age Pregnancy*, 8 J. RES. ON ADOLESCENCE, 187, 200 (1998).

B. *Loss of Supportive Adults: Censorship and Criminalization*

While we have primarily addressed the loss of institutional supports in the form of resources and access to health care, there is another important loss happening in young women's lives. This is the loss of adults working in the public sector who are free to aid and support women in attaining sexual education and access to reproductive services, including abortion. An important component of the emerging legal and policy environment concerns those adults who would otherwise step forward to help young women—to educate, to provide contraception, to help them find an abortion even if across state lines—who are now being positioned by lawmakers as interfering with state interests in “protecting young people.” These adults are becoming “enemies” of the state.

In 2005, Wade Horn, Assistant Secretary for Children and Families at the U.S. Department of Health and Human Services, addressed the National Conference on Abstinence Education Research by distinguishing those who “protect” children from those who “hurt” children: “Our *enemies* want 13-year-old girls to be able to have sex, smoke, [and] drink”¹⁸¹ In this case, Horn threw a wide net around “enemies” including those parents, health care professionals, and educators who support comprehensive sexuality education. Disagreement about the best ways to educate adolescents about their own sexuality has bifurcated into two choices: side with the state or risk being an “enemy” of the state. A wide range of professionals and advocates have been exiled into the “enemies” category or threatened with such deportation.

1. *Educators Are Censored*

In the field of public education, many teachers and health care practitioners continue to teach the comprehensive sexuality curriculum. Nevertheless, available evidence suggests that educators are experiencing a “chill” in what they can and cannot teach, despite parents' desires for comprehensive sexuality education.¹⁸² It is estimated that 35% of all public schools now offer

¹⁸¹ Wade Horn, Luncheon Keynote Address at the Department of Health and Human Services Conference: Strengthening Abstinence Education Programs through Scientific Evaluation (Nov. 3, 2005).

¹⁸² NAT'L PUB. RADIO ET AL., *supra* note 72. The national poll data are based on a nationwide telephone survey of the general public conducted among a random nationally representative sample of 1,759 respondents, including a subsample of 1,001 parents of children in grades 7 to 12. Results were weighted to be representative of public middle, junior, and senior high school in the United States based on geographic region and type of residential area (urban, suburban, nonmetropolitan).

abstinence-only or abstinence-only-until-marriage curricula.¹⁸³ There have been significant changes in how educators think about their own freedom to teach comprehensive education in classrooms. In 1999, 24% of sexuality education teachers reported that they were prohibited from teaching about contraception.¹⁸⁴ The chill of censorship in the classroom extends to the specifics of what is taught; for example, in 2000 only 21% of junior high teachers reported that they taught the correct use of condoms.¹⁸⁵ Censorship, including active withholding of critical health information from youth, undermines the professionalism of educators.

2. *Providing Access to Legal Abortion Is Criminalized*

Like educators who teach comprehensive sexuality education despite the press for abstinence only, there are youth advocates, health care providers, educators, family, and friends who continue to help young women find contraception and abortion providers. In this vein, the newest threat to young women's access to abortion comes through the Child Interstate Abortion Notification Act (H.R. 748),¹⁸⁶ which would mandate that parents must be notified if a young woman seeks abortion services in a state where she does not reside.¹⁸⁷ The bill would legislate a set of provisions that make it a federal crime for someone other than a parent to assist a teen as she crosses state lines for an abortion unless the young woman had already satisfied her home state requirements.¹⁸⁸

At present, access to abortion services is extremely limited. From 1996 to 2000, the number of abortion providers dropped by 11%. A full 87% of all counties in the U.S. do not have abortion services; home to 34% of all women.¹⁸⁹ And yet according to H.R. 748, before performing an abortion on an out-of-state minor, doctors, under the threat of federal criminal prosecution, would be required to notify the out-of-state parents of their intention to

¹⁸³ Katy Kelly, *Just Don't Do It!*, U.S. NEWS & WORLD REP., Oct. 17, 2005, at 46.

¹⁸⁴ Jacqueline E. Darroch, David J. Landry & Susheela Singh, *Changing Emphases in Sexuality Education in U.S. Public Secondary Schools, 1988–1999*, 32 FAM. PLAN. PERSP. 204, 209 (2000).

¹⁸⁵ Centers for Disease Control and Prevention, *School Health Policies and Programs Study 2000*, Fact Sheet: Sexually Transmitted Disease (STD) Prevention, <http://www.cdc.gov/HealthyYouth/shpps/factsheets/pdf/stdprev.pdf>.

¹⁸⁶ See Child Interstate Abortion Notification Act, H.R. 748, 109th Cong. (1st Sess. 2005).

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

¹⁸⁹ BOONSTRA ET AL., *supra* note 148.

perform an abortion.¹⁹⁰ In other words, teens would have to comply with up to two states' restrictions (including, for instance, college students) and may have to secure judicial waivers in two states. Further, "under the threat of civil and criminal penalties, the bill requires doctors to make 'reasonable' efforts to provide in-person, written notice to an out-of-state teens' parents."¹⁹¹ Approved by a House Judiciary subcommittee in April 2005, the bill would make it a crime for a person other than a parent—including a grandmother, aunt, or adult sibling—to aid a teen to cross state lines. Two federal crimes would be established, each with a \$100,000 fine, one year in jail or both, first for the person who transports the minor over state lines and second for the abortion provider, justified as vital to "parental rights" and to "recognition of parental authority."¹⁹²

3. *Resistance*

Despite the alignment of state policy and funding, we offer a few images here of the resistance mobilized by educators, health care providers, scholars, activists, and youth on behalf of healthy teen sexual development. In the spirit of democratic access to education and public health, many are arguing for comprehensive sexuality education. In response to the well-funded and chilling campaign launched at the state and federal levels, in 2005, Representative Barbara Lee (D-Calif.) and Senator Frank Lautenberg (D-N.J.) introduced the REAL Act in Congress.¹⁹³ The Responsible Education About Life (REAL) Act (formerly known as the Family Life Education Act, 2001) would allocate \$206 million to states for medically accurate, age appropriate, comprehensive sex education in schools, including information about both abstinence and contraception.¹⁹⁴ This legislation spells out a few important differences that would be included in federal sexuality education requirements: curricula must "not teach or promote religion," "stress[] the value of abstinence while not ignoring those young people who have had or are having sexual intercourse," and provide information "about the health benefits and

¹⁹⁰ Letter from Laura W. Murphy, Dir., ACLU & Gregory T. Nojeim, Assoc. Dir. & Chief Legislative Counsel, to Members of the House of Representatives (Apr. 26, 2005), <http://www.aclu.org/reproductiverights/abortion/12600leg20050426.html>.

¹⁹¹ Memorandum from ACLU, Wash. Nat'l Office to Interested Persons (Apr. 2, 2005), <http://www.aclu.org/reproductiverights/abortion/12617leg20050402.html>.

¹⁹² Mike Allen, *Bush Backs Abortion Measure*, WASH. POST., Apr. 25, 2005, at A4.

¹⁹³ See Responsible Education About Life Act, H.R. 2553, 109th Cong. (1st Sess. 2005); see also Responsible Education About Life Act, S. 368, 109th Cong. (1st Sess. 2005).

¹⁹⁴ H.R. 2553.

side effects of all contraceptives and barrier methods” to young people.¹⁹⁵ To date, over 100 organizations including the American Medical Association, American Public Health Association, and the American Psychological Association have come out to publicly support this legislation.¹⁹⁶

Moving from the national to the local level, we see communities organizing to resist the pressures and strings that come with federal funding. In Texas, scientists and educators have joined to create *texscience.org*, where they can post informed protests against textbook censorship in their communities. The Colorado Council of Black Nurses returned \$16,000 in abstinence-only funding because they believed that the dollars interfered with responsible health education.¹⁹⁷ Due to intensive organizational collaboration and protests by adolescent health advocates and a group of high school students, the Board of Education of the Chicago Public Schools voted in 2006 to require its schools to offer comprehensive sexual education in grades 6–12, including information about contraception.¹⁹⁸

Finally, there are a number of comprehensive sexuality education resources being distributed and applied within and outside of school settings.¹⁹⁹ Community-based organizations, the Unitarian Church, and other youth-serving settings are stepping up to the challenge and offering courses, seminars, and workshops on healthy sexual development.²⁰⁰ Seeds of resistance and mobilization can be found in every sector of the nation,

¹⁹⁵ *Id.* § 3(b); S. 368.

¹⁹⁶ Heather Boonstra, *Legislators Craft Alternative Vision of Sex Education to Counter Abstinence-Only Drive*, 5 GUTTERMACHER REP. ON SOC. POL'Y 1, 2 (2002).

¹⁹⁷ See PLANNED PARENTHOOD, ABSTINENCE-ONLY PROGRAMS (2006), <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/teen-pregnancy-sex-education/abstinence-6236.htm>.

¹⁹⁸ David Mendell, *Sex Ed to Cover Birth Control: Abstinence Will Be City Classes' Focus*, CHI. TRIB., Apr. 27, 2006, at 1.

¹⁹⁹ There are, of course, rich sexual education curricula available through SEICUS. See generally NAT'L GUIDELINES TASK FORCE, GUIDELINES FOR COMPREHENSIVE SEXUALITY EDUCATION: KINDERGARTEN–12TH GRADE (3d ed. 2004), <http://www.siecus.org/pubs/guidelines/guidelines.pdf>. In addition, there are a variety of publications on comprehensive sexuality education, including ELIZABETH M. CASPARIAN & EVA S. GOLDFARB, *OUR WHOLE LIVES: SEXUALITY EDUCATION FOR GRADES 4–6* (2000); Laina Y. Bay-Cheng, *The Trouble of Teen Sex: The Construction of Adolescent Sexuality Through School-Based Sexuality Education*, 3 SEX EDUC. 61 (2003); and Debbie Mabray & Bill J. LaBauve, *A Multidimensional Approach to Sexual Education*, 2 SEX EDUC. 31 (2002). The Center for Family Life Education, Planned Parenthood of Greater Northern New Jersey, has published a series of extremely useful training materials, including PEGGY BRICK & BILL TAVERNER, *EDUCATING ABOUT ABORTION* (2d ed. 2003); BROWN & TAVERNER, *supra* note 54; BILL TAVERNER & SUE MONTFORT, *MAKING SENSE OF ABSTINENCE: LESSONS FOR COMPREHENSIVE SEX EDUCATION* (2005); SEXUALITY INFO. & EDUC. COUNCIL OF THE UNITED STATES, *FILLING THE GAPS: HARD TO TEACH TOPICS IN SEXUALITY EDUCATION* (1998), http://www.siecus.org/pubs/filling_the_gaps.pdf.

²⁰⁰ For example, see CASPARIAN & GOLDFARB, *supra* note 199.

dedicated toward comprehensive youth development, education, health care, and human rights campaigns for teens, regardless of their age or sexual orientation.

IV. DISCUSSION

A. The Imprint of Law and Public Policy on the Lives of Young People

Sexual and reproductive freedom requires offering young people enabling conditions for their healthy sexual development. These conditions provide for more information than abstinence education and even more than comprehensive information about pregnancy and disease prevention. Creating facilitating conditions means that the state recognizes the agency and sexual development of young people as it simultaneously recognizes the need for public supports for young women in the form of education, subsidized and safe reproductive health care, and protection from violence. Support and protection must not be confused with surveillance, control, and punishment. State- and federal-sponsored supports must be joined with—and not given in place of—privacy.

While the body of the minor has never been totally private by law, we are concerned about the increasingly public and punished nature of the young female body. What is the fallout from this public scrutiny for young women? How can public policies insist that young women comply with mandates but restrict their interactions with educators and health care practitioners? Which aspects of young women's sexual health are compromised when policies consider their sexual desires to be dangerous, in need of containment and regulation, not conversation and support? Where do young women in sexual danger turn?

1. An Argument for Legal Support of "Thick Desire"

If we are to adequately address sexual and reproductive freedoms for young women, there must be an analysis of the institutions and environments that threaten the existence of these complex yearnings for quality education. Elsewhere, we have argued that young women (and men) have "thick desire,"²⁰¹ a deep and complex yearning for quality education, lives of economic self-sufficiency and meaning, safe conversations with supportive

²⁰¹ See Fine & McClelland, *supra* note 73, at 300–01.

adults, relationships free from violence, and sexual lives of pleasure, not danger. By “thick desire” we suggest that young women and men want and deserve to be engaged with institutions, communities, relationships, and opportunities in which responsible economic, educational, healthy, and sexual lives can be lead, crafted in dialogue with caring and responsible adults, mindful of the privacy and complexity of adolescent lives.

Thick desire places sexual activity for all people (regardless of age or gender) within a larger context, which includes the social and interpersonal structures that enable a person to engage in the political act of *wanting*.²⁰² Wanting can be interpreted in any number of ways, but it necessarily positions the person as feeling entitled to that which comes in the future. It includes wanting to engage in pleasurable (and safe, and age appropriate, and protected) sexual experiences. It includes wanting to have unhindered access to those structural and institutional supports, such as education and health care. With wanting securely in place and thick desire as an organizing frame, it is possible to theorize young women's sexual and reproductive freedoms not merely from a perspective of minimal loss, but from a perspective that sees them as entitled to desire in all of its forms.

The organizing framework of thick desire recognizes the conditions that are necessary to make safe, agentic, responsible sexuality possible. Sexual desire sits within a set of conditions that aid or impede a person's ability to want and feel entitled to resources, schooling, relationships, and sexual pleasure for themselves. Young women are particularly vulnerable to having these conditions blocked, so that their sexual desire and reproductive freedoms are not only impeded, but even punished with adverse consequences to self and professionals who seek to assist.

Thick desire for young women, as we theorize it here, is nourished in public conditions where there are opportunities to (1) develop intellectually, emotionally, economically, and culturally; (2) imagine themselves as sexual beings, capable of pleasure and cautious about danger without carrying the undue burden of social, medical, and reproductive consequences; (3) access information and health care resources; (4) be protected from structural and intimate violence and abuse; and (5) be a part of a social safety net of public resources to absorb the domestic and emotional labors that young women perform (unpaid and unreciprocated) for peers, family, and community. Thick

²⁰² Sara I. McClelland & Michelle Fine, *Rescuing a Theory of Adolescent Sexual Excess: Young Women and Wanting*, in *THE POST-FEMINIST, POST-SUBCULTURE READER* (Anita Harris ed., forthcoming 2007).

desire explicitly connects sexual well-being with structural contexts that enable economic, educational, social, and psychological health. When we interrogate thick desire, then, we seek to understand for whom law, policies, and public institutions serve as the soil that nourishes, or fails to nourish, young women's sense of economic, social, and sexual possibility.²⁰³

Finally, thick desire requires the support of the state. This means that the state and its laws must be attuned to the needs of young people, while not taking decision making out of young people's hands (and handing it over to the state). Institutions, policies, and laws that educate young women about pleasure and danger are essential; these structures must not unfairly distribute blame for sexual activity to young women; and finally, fundamentalist religious ideology must not continue to play a role in shaping U.S. laws concerning adolescent sexual behavior.

B. Policy and Collaboration Recommendations

We view this historic moment as one in which lawyers, youth advocates, educators, and social researchers have the opportunity and, we would argue, obligation to collaborate on a vision of sexual and reproductive freedoms for young women, to create movements for enabling contexts for thick desire for all kinds of teens and to agitate for supports for those who have been victimized by family, peers, strangers, or political arrangements. We identify below a series of issues upon which feminist researchers and lawyers might collaborate.

1. Policies that Support Sexual and Reproductive Freedoms for Young Women

It seems crucial to begin to identify all the ways in which the neoliberal social policy environment is undermining young women's educational, economic, health, sexual, and reproductive trajectories. Young women's lives are intimately wedded to educational and economic opportunities, particularly young women of poverty or of color. Feminist and critical race scholars, working with lawyers, can begin to piece together the empirical puzzles that link cuts in educational budgets, school-based health clinics, sexuality

²⁰³ Arjun Appadurai, *The Capacity to Aspire: Culture and the Terms of Recognition*, in *CULTURE AND PUBLIC ACTION* 59, (Vijayendra Rao & Michael Walton eds., 2004); Martha C. Nussbaum, *Women's Education: A Global Challenge*, 29 *SIGNS* 325 (2004).

education, and tuition assistance for higher education to reproductive outcomes.

In concert with public health researchers, we can begin to clarify the educational and health conditions necessary for young women to develop into sexually healthy adults and the public health costs of being denied quality education and health care. What educational materials, experiences, and health care supports do young women need to develop a healthy sense of sexual and reproductive efficacy sufficient to limit their exposure to danger, and enable their pursuit of pleasure? Conversely, what forms of educational materials and health care render a young woman more vulnerable to danger and less likely to be sexually healthy? What does it cost young women, their children, health care systems, taxpayers, community well-being, and foster care *not* to provide for young women's healthy sexual development and desires?

2. Policies That Protect Educators and Health Care Providers

Not only are these conditions critical for young women, but the professional conditions for those who work with young women are threatened as well. Educators and youth workers' freedoms of speech and professional responsibility are under attack. This is an issue upon which unions, lawyers, and civil rights activists must come together because the building blocks of democratic practice are in jeopardy. It is most important to document threats and to protect educators and health care providers' right to speak, prescribe, and deliver education and health services as needed for young women's healthy development.

3. Policies that Attend to Various Forms of Sexual Discrimination

A number of potential sex discrimination claims should be investigated within the field of adolescent sexuality policy and practice—both in schools and in community settings. To name a few:

- Sex-role stereotypes and scientific misinformation about gender are woven into the abstinence-only curricula;
- Young women and men enjoy distinct and gender-specific access to OTC contraception, e.g., access to condoms over the counter and emergency contraception by prescription only;
- Parental consent or notification mandates are in place in many states for young women, placing an undue and unhealthy burden on young pregnant women (but not the fathers of the fetuses);

- Young women and men in juvenile facilities, foster care, and the military have differential access to reproductive and sexual health care and protections from sexualized violence;
- Young women with disabilities are far more likely to be pregnant or parenting than young men with disabilities and far less likely to have had access to quality sexuality education or health care; and
- Significant anecdotal evidence suggests that pregnant and parenting teens are among the growing group of high school push outs who are being illegally “discharged” because of high stakes testing pressures, disproportionately showing up underage in GED programs.

CONCLUSION

The assaults on young women’s sexual and reproductive freedoms are so fundamental and so coordinated that it is difficult at times to notice how religious and moralizing punishment has taken the place of education and support. Concerted analysis of this blurred boundary between punishment and protection is needed as the federal government walks away, leaving young women in need—and thick desire—in its shadow.

Today is a propitious moment for critical scholars and researchers, youth advocates, and lawyers to join forces to interrogate and challenge the gendered consequences of contemporary adolescent sexuality policy in the United States. This may be a moment to seed litigation and policy change, critical research, and social movements so that opportunities to experience *thick desire*—not merely privacy and liberty—can be available to all young women, who have been betrayed by the state, ironically, in the name of “protection.”