

fetus as separate entities, often with adverse interests. And although the development of reproductive technology was spurred by the desire of infertile couples for children, there are fears that children procured through this technology will be wanted for the wrong reasons, as market goods whose characteristics may be selected in advance, rather than as uniquely valuable persons.

In order to guard against such harms, we may decide that reproductive technology ought to be more strictly regulated. The challenge we face is to avoid the two extremes described by Will Kymlicka: on the one hand, "a Hobbesian world of markets in bodies and services," and, on the other, "an Orwellian world of parental licenses and judicial restrictions." If we respond successfully, the role of reproductive technologies in facilitating alternative parenting arrangements may prove to be healthy and liberating. The flourishing of families will depend on the capacity of our legal and social order to accommodate new forms of parenting, and on the capacity of the nuclear family to survive and flourish without a legal monopoly.

— David Wasserman and Robert Wachbroit

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Thinking About Teenage Childbearing

Last December, the Baltimore city health department announced a pilot program designed to make the long-term contraceptive Norplant available to sexually active teenage women who could not otherwise afford it. The new program, funded by a private foundation, began in a public high school for pregnant teenagers and young mothers, and during the first four months, nine students received the contraceptive implant. In August the city health commissioner proposed extending the program to five additional school-based clinics which already offer an array of birth control methods.

Consisting of five small capsules inserted into the inner side of the upper forearm, Norplant achieves its

contraceptive effect by releasing a hormone (levonorgestrel) gradually over a period of five years. Reported side effects include weight gain and irregular bleeding. Because Norplant contains no estrogen, it does not present many of the health risks associated with oral contraceptives. If a woman decides to have the capsules removed, fertility is restored more quickly than with other hormonal methods. According to the Population Council, which sponsored the research leading to the development of Norplant, 1.8 million women have used the method worldwide, and clinical trials involving 30,000 volunteers have been conducted in 44 countries.

Baltimore is the first city in the nation to provide

Norplant in school-based clinics, and its program has become the center of a national debate focusing renewed attention on the problem of teenage childbearing. During this debate, people with a wide variety of political views and policy orientations have made themselves heard, longtime alliances have splintered apart, and new coalitions have sprung up between disparate constituencies. In this context, it is worth asking why teenage childbearing is such a persistent source of controversy, and how the Norplant debate in Baltimore illuminates the issues that surround it.

Interpreting the Numbers

Since 1960, the *teenage birth rate* in the United States — that is, the percentage of teenage women who bear a child — has declined substantially, although there has been a slight reversal in this downward trend since 1985. This means that even as concern about teenage childbearing has intensified during the past three decades, the probability that a teenage woman from virtually any racial, ethnic, or economic category will become a mother has actually diminished. How can we account for the discrepancy between levels of concern and the actual demographic trend?

We might start by noting that there are other indicators, apart from the teenage birth rate, to suggest how large a problem teenage childbearing might be. For example, the teenagers of the 1960s and early 70s were members of the baby boom generation, and this group was so enormous in size that, even with a smaller percentage becoming mothers, the *absolute number of babies born to teenagers* went up. This made teenage childbearing more visible than it had been before. At the same time, birth rates among older women were declining, and doing so more quickly than the birth rates among teenagers. As a result, births to teenagers began to comprise a larger *percentage of total babies born* than in the past. The pregnancy rate for teenagers has also risen steadily over the past three decades — a trend almost wholly attributable to the sharp increase in sexual activity among young people. The main reason that the teenage birth rate has not kept pace with the rising pregnancy rate is that teenagers as a group are having a great many abortions. According to one estimate, the proportion of teenage pregnancies ended by abortion increased from 20 percent in 1972 to 40 percent in 1987.

Even as the teenage birth rate has proven to be an incomplete measure of the problem of teenage childbearing, the nature and meaning of the problem have changed over these past thirty years. In the first place, teenage childbearing is increasingly concentrated among the inner-city poor. The various indicators I have cited are often twice as high among urban residents as they are in the population as a whole.

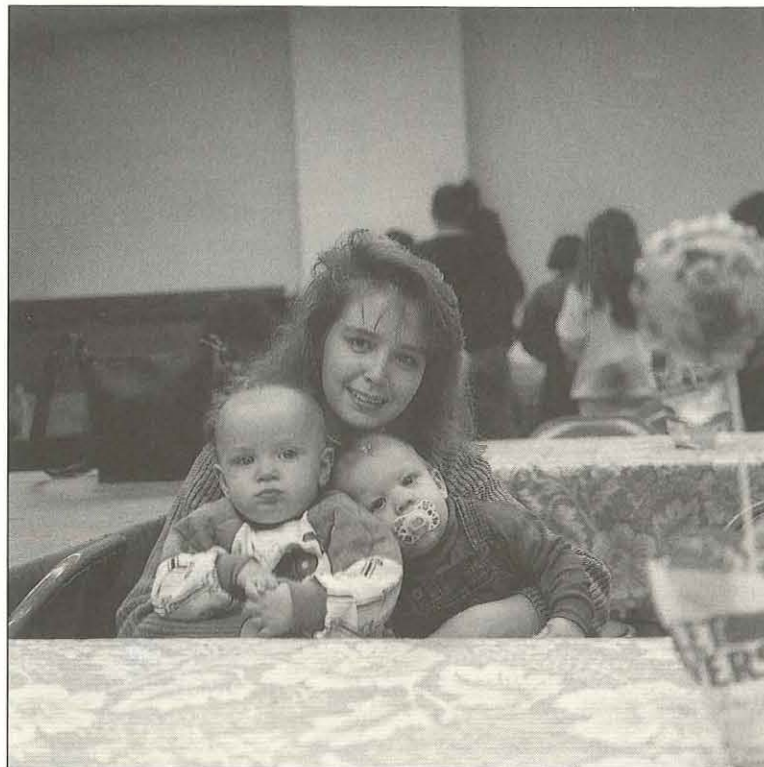
Moreover, the likelihood that a teenage mother is also a single mother has increased dramatically over this same period. Non-marital childbearing is a major factor contributing to the increase in the number of people — especially children — who live in households headed by unmarried women, and who for this reason are more likely to live in poverty. Moreover, the educational deficits which have always been associated with teenage childbearing have become more troubling than they once were, in view of increased expectations that women will enter the labor force to support or help support their families.

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As teenage childbearing has come to be seen as a social problem, various schools of thought have arisen among those who are trying to find a solution. Although many individuals may not feel entirely at home in any one of these schools, and will blend ideas from one or more of them in devising their own response, we may nonetheless identify four different perspectives, which I will present as characteristic of conservative traditionalists, public health practitioners, critics of welfare dependency, and liberal activists. Each school is distinguished by a particular world view concerning the fundamental nature of human beings and what motivates their behavior. These world views lead their proponents to adopt widely divergent ideas about why teenagers have babies and what, if anything, to do about it.

Conservative Traditionalists

Conservative traditionalists believe that teenage childbearing is part of a larger failure, both moral and cultural, that has undermined the stability of American society. They link the increase in sexual activity among teenagers to the prevalence of sexually explicit images in the popular media; they lament the breakdown of once-powerful taboos against sexual relationships outside of marriage; and they argue that the bonds of sexual attraction have taken precedence over those between parent and child and among kin and community. In addition, conservative traditionalists criticize what they see as the family's loss of privacy and autonomy before the encroachments of the state. Thus they oppose sex education in public



schools, arguing that their right to transmit moral values to their children is undermined by programs that aspire to be "morally neutral."

Many conservative traditionalists wish to establish a social and moral consensus about the formation and conduct of families, so that religious teachings, the civil code, and the content of school curricula would be virtually identical with respect to ideas about family life. For others, the primary goal is to return to an earlier understanding of gender roles. If only implicitly, they favor a return to the "separate spheres" for men and women that were characteristic of Victorian society, and they object to changes in social and familial arrangements that they associate with contemporary feminism. Kristin Luker, in her study of pro-life and pro-choice activists, points out that many women among the conservative traditionalists are homemakers who feel that their roles *as* homemakers, as community builders, and especially as mothers have been unfairly denigrated since the 1960s; their decision not to seek self-validation in the workplace has made them marginal figures in the new society.

The social criticism offered by the conservative traditionalists has won a hearing even among people who do not share their religious views or their ideological commitments. In particular, a growing number of "outsiders" to this perspective concede that the pursuit of individual happiness as a primary goal has weakened the sense of commitment necessary to sustain families. But these outsiders are also quick to point out that conservative traditionalists are not in the forefront of efforts to enact legal and political reforms on behalf of children and troubled families. Wary of

government intervention, and intent upon maintaining conventional lines of authority within the family, conservative traditionalists tend to favor the rights of parents over the rights of children, or indeed to deny that children *have* rights. This is one reason why the issue of parental notification emerges in debates such as the one in Baltimore over the provision of Norplant. Instead of making family planning services more widely available, conservative traditionalists favor drastic restrictions on access to contraception and the outlawing of abortion.

Public Health Practitioners

The world view of public health practitioners begins with faith in the possibility of human flourishing, and with optimism about each person's ability to overcome both harmful inclinations and unfavorable circumstances. This world view developed at the turn of the century when, fresh from the technological achievements of the Industrial Revolution, Western nations set out to reduce the incidence of infectious disease among their citizens. Remarkable success in this endeavor led to new efforts on two fronts: an attempt to repeat the performance in less developed countries, where infectious disease was still the major cause of death; and a new focus on degenerative diseases, which had taken the place of infectious diseases as the major killers in Europe and among the overseas European populations.

It was in connection with this second effort that public health practitioners first began to think seriously about behavioral change as a component of public

health intervention. This idea was all the more influential by mid-century, when the focus of public health efforts had expanded yet again to include not only the prevention of degenerative diseases (such as lung cancer), but also a reduction in other causes of death and injury (such as automobile accidents). Such efforts required interventions that would motivate people to adjust their *habitual* behavior — to quit smoking, for example, or to use seat belts. The techniques adopted for this purpose included mass communications and one-on-one interactions targeted to members of specific groups. Public health practitioners had, of course, advocated and promoted behavioral change in the past. But in former times, the needed changes were more often made at the collective level — as when a town decided to install a proper drainage system— or else they involved isolated actions, such as having a child vaccinated, rather than habitual ones.

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Public health practitioners take two assumptions for granted in their approach. First, they assume that people often act against their own best interest — out of habit, ignorance, addiction, or insufficient motivation to change. Second, they assume that technical experts, be they doctors, epidemiologists, or social scientists, are in a position to know what is good or bad for people and to promote certain behaviors over others. The latter assumption clearly reflects the fact that public health practice was forged in order to conquer disease, a complex phenomenon that most lay people do not pretend to understand.

Public health practitioners tend to believe that they should respond to teenage childbearing much as they have responded to automobile fatalities and lung cancer. That is, they believe that the solution is to provide interventions modeled on those they have used to prevent disease or injury. In order to change the habitual behavior of sexually active teenagers, they would provide sex education and access to effective contraception. They also favor, as a backup measure, making abortion services available to teenage women.

Welfare Reformers and Liberal Activists

Though they belong to different schools of thought, critics of welfare dependency (hereafter referred to as “welfare reformers”) and liberal activists share a fun-

damental conviction about human nature: they believe that the majority of people perceive their own best interest, and act in accordance with it, most of the time. In this respect, they might justly claim to be even more optimistic than public health practitioners (though welfare reformers, as proponents of the “dismal science,” are seldom perceived that way). Members of both these groups argue that the problem of teenage childbearing is rooted in an economic and normative social context which provides too few incentives to delay parenthood until after marriage (and therefore until adulthood), and too few disincentives to avoid early childbearing.

The key differences between welfare reformers and liberal activists emerge when we consider their intellectual influences and the policies they recommend. Though both groups may include scholars, politicians, and what have come to be known as “policy wonks,” welfare reformers tend to affirm middle-class values and the free market, whereas liberal activists are usually motivated by a commitment to a liberation movement, such as feminism or civil rights. In their policy agenda, welfare reformers usually advocate *disincentive* measures: making eligibility for Aid to Families with Dependent Children (AFDC) contingent upon contraceptive use, for example, or eliminating the increase in benefits which now occurs when a woman on AFDC bears a child conceived after benefits have begun. Those who favor such measures have been largely responsible for the recent tightening of paternal child support enforcement. In contrast, liberal activists more often focus on *incentive* programs, as when feminists propose increases in women’s wages, or anti-poverty activists support jobs programs, job training, and better schools.

On the issue of teenage childbearing, welfare reformers and liberal activists tend to agree on two things. First, they believe that the restricted access to contraception and abortion favored by conservative traditionalists would result in an increase in the teenage birth rate. Second, they agree that efforts to change the behavior of individual young women are misguided if they occur in the absence of structural changes in the young women’s social and economic circumstances. But whereas the welfare reformers view the efforts of public health practitioners as well-meaning but ineffective, the liberal activists are more likely to see them as paternalistic, or even (in the absence of structural change) immoral. “Of what use is it to persuade young women to succeed in school, when even women’s jobs that require high levels of education pay so poorly?” asks the feminist. “Why set up a clinic in a school when most young women who bear children as adolescents drop out of school more than nine months before the birth?” asks the anti-poverty activist.

The Norplant Controversy in Baltimore

With this background, we can begin to understand the controversy over the Norplant program for school-based clinics in Baltimore. The distribution of contraceptives in such clinics is a prototypical public health intervention. Opposition to such programs is now coming mainly from conservative traditionalists, who regard the provision of contraceptives in schools as a signal to students that sexual activity is condoned by school authorities. However, as we shall see, there is also opposition from a coalition of liberal activists.

Public health practitioners respond to the conservative challenge by arguing that the provision of contraceptives is primarily a health issue, and not a moral or political one. This response is entirely in keeping with the belief underlying the public health approach: that teenage childbearing should be addressed as if it were a disease. From a public health standpoint, a program that makes contraceptives available in schools is morally neutral, just as a program distributing clean needles to heroin addicts in order to prevent the spread of AIDS is morally neutral. But conservative traditionalists insist that such interventions are not morally neutral at all — and some liberal activists agree with them.

In fact, the voices of liberal activists have been especially prominent in the Norplant debate. Many feminists, who generally support efforts to expand access to contraception, are uneasy about providing Norplant in school-based clinics. Specifically, they question whether earlier Norplant safety studies are applicable to inner-city teenagers, many of whom smoke, are in poor health, and have limited access to health care. African-American community leaders have similar concerns — which should come as no surprise since African-Americans, like women, have a history of being used as guinea pigs by the medical establishment. In addition, some African-American leaders have accused the city health department of “targeting” their community for fertility reduction out of racist or “genocidal” motives. Others have pointed to studies and statistics challenging the view that teenage childbearing diminishes the life prospects of poor African-American women; given the risk factors that these women already confront, some research suggests that early parenthood does not appreciably worsen their condition.

There is also a broader political context which helps to explain the liberal activist opposition to Baltimore’s Norplant program. Shortly after city health officials announced their plans last December, the governor of Maryland suggested that he was willing to consider targeting certain groups, such as prisoners and women on public assistance, for long-term contraceptives and sterilization as part of a comprehensive agenda of welfare reform and crime prevention. The governor

specifically mentioned Norplant in his State of the State address to the General Assembly in January. The measures he proposed for consideration are strikingly similar to those that feminists and other activists have judged to be coercive when adopted by family planning programs in less developed countries. Such measures also fall squarely into the category of disincentive approaches typically favored by welfare reformers. In opposing the Norplant program in Baltimore, liberal activists were also taking a stand against what they see as a broader attempt to control the reproductive lives of the minority poor. It is certain that the prominence of Norplant in the governor’s remarks had an impact on the debate about providing the contraceptive to teenage women in Baltimore’s school-based clinics.

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Implications

What are the implications of this widely noted debate for government policy regarding teenage childbearing — or family policy generally — in the 1990s?

First, the results of the 1992 election signaled the end of sweeping federal support for the agenda of the conservative traditionalists. Among those who hold other views, the neutralization of a common adversary is likely to cause a series of ruptures and realignments. Welfare reformers and liberal activists will differ more sharply on the question of whether incentives or disincentives are the best way to cultivate civic virtue and personal responsibility. More important, liberal activists will intensify their criticism of public health initiatives that they deem to be paternalistic or implicitly racist. They may not hesitate to form alliances with conservative traditionalists in opposing these programs, especially if they believe that the programs are vulnerable to cooptation by welfare reformers. In the African-American community, where Christian and Muslim clergy and activist leaders often have closer ties than in other settings, new alliances of this kind are especially likely to develop.

The political debate in this country over how to address social problems, including teenage childbearing and other objects of family policy, has been largely suppressed, at least at the national level, for more than a decade. As long as conservative traditionalists dom-

inated policymaking in the Reagan and Bush administrations, the enormous diversity of opinion that continues to exist in such matters was easily obscured. The reason was not so much the nature of conservative traditionalism itself, but rather the fact that those outside the traditionalist camp were reluctant to disagree openly, lest they strengthen the advantage that the conservative traditionalists already had. At the time, many observers assumed that when the reign of conservative traditionalism ended, the unified coalition that had emerged in opposition to it would remain to formulate a coherent policy. But in trying to imagine what that policy might be, they tended to envision something in accordance with their own world view.

In fact, given the enduring range of values and beliefs among those outside the conservative traditionalist camp, it was always unlikely that a new policy could actually be fashioned without a struggle. But if it is no longer the case that one point of view holds bureaucratic sway in excess of its popular support, a real debate — with the possibility of a balanced resolution — is possible at last.

The Norplant controversy in Baltimore, then, is a harbinger of both bad and good news: Finding a solution to the problem of teenage childbearing will not be easy or pleasant, but there now exists an opportunity to forge a policy based on open and honest debate of the issues.

— Nan Marie Astone

Nan Marie Astone is assistant professor of population dynamics at The Johns Hopkins School of Hygiene and Public Health. Nicholas Burbank, Andrew Cherlin, Katherine McFate, Constance Nathanson, Geri Peak, and Laurie Zabin provided helpful comments on an earlier draft. Other sources: *The Baltimore Sun* (Dec. 3, 1992, Jan. 29 and Aug. 29, 1993); *The New York Times* (March 7, 1993); *The Washington Post*, Dec. 4, 1992; S. Henshaw et al., "Teenage Pregnancy in the United States: The Scope of the Problem and State Responses" (Alan Guttmacher Institute, 1989); *Overview of Entitlement Programs*, 1992 Green Book, Committee on Ways and Means, U.S. House of Representatives (U.S. Government Printing Office, 1992); Kristin Luker, *Abortion and the Politics of Motherhood* (University of California Press, 1984); Constance Nathanson, *Dangerous Passage: The Social Control of Sexuality in Women's Adolescence* (Temple University Press, 1991); Frank F. Furstenberg and Andrew J. Cherlin, *Divided Families: What Happens to Children When Parents Part* (Harvard University Press, 1991); Janet B. Hardy and Laurie S. Zabin, *Adolescent Childbearing in an Urban Environment* (Urban and Schwarzenberg, 1991).

Feminism, Race, and the Politics of Family Values

When social critics lament the state of the American family, they sometimes assert that the feminist movement has done much to undermine the values that once held families together and protected the interests of children. With its emphasis on individual fulfillment and its denigration of women's traditional role, feminism, these critics say, has ruptured patterns of family life and caregiving for which there are, in the nature of things, no substitute.

As it is usually formulated, this argument includes two invariable features: a fixed image of what constitutes a family, and an equally static view of what femi-

nism is. In her essay "Dan Quayle Was Right" in the April issue of the *Atlantic*, Barbara Dafoe Whitehead provides a characteristic example. With regard to family structure, she writes, "The social arrangement that has proved most successful in ensuring the physical survival and promoting the social development of the child is the family unit of the biological mother and father," and to judge from the context this claim is presumed to hold true "across time and across cultures." As for feminism, Ms. Whitehead represents it exclusively as a movement which sought greater equality for women by steering them into "the world of work