cials will not concede even that much. When residents point to blood lead levels well within the normal range, agents such as Frank Peters reply that blood lead levels are "irrelevant." He explained the agency's stance thus: "We don't have to prove a present [lead] risk, just a potential risk."

Triumph, Idaho, is part of Sun Valley, which my road atlas of America classes as among the nation's "Regal Resorts." It tells me that Averell Harriman, as chairman of Union Pacific in the mid 1930s, founded it as a ski resort to build business for his railroad. By the 1940s, "such luminaries as Ernest Hemingway and Gary Cooper graced the lodge." On the southern edge of national forests that stretch uninterrupted four hundred miles through Montana up into Canada, Sun Valley has developed into "one of the nation's most beautiful holiday complexes"—64 ski runs, 4 golf courses, horse riding, and more. It is a place of great natural beauty and bountiful good health, says the atlas. But the EPA has ranked adjacent Triumph among the most dangerous Superfund sites in the nation—90.3 on its Hazard Ranking System, on a scale where Times Beach, Missouri, even at the height of the since discredited dioxin scare, ranked below 60.

No matter that Pat McGavran, a toxicologist with the state health department, found an average blood-lead reading of 4 µg/dl in a test of 38 longtime Triumph residents.

Says Donna Rose, a local businesswoman: "The EPA people in their L. L. Bean clothing aren't going to want to go to inner-city areas where there are real lead problems, but no money. It's much more fun for them to come to Sun Valley and save us white people who live in rich areas. The EPA attorney says they are searching the records for PRPs. Meanwhile there are thousands of people who are political prisoners of the EPA, people whose lives are on hold because of the financial freeze on our properties."

Chris Field, the EPA's on-the-scene coordinator, is unimpressed. When the local blood-lead levels were pointed out to him, he replied that he works for the Environmental *Protection* Agency, not the environmental reaction agency. "We don't wait to act until a problem has arisen. We act when we believe the potential for a problem exists." □

Norplant v. Abortion

A MORAL CHOICE

Would Norplant simply stop unwanted pregnancies —or increase destructive teen sex?

DOUGLAS J. BESHAROV

SINCE its approval by the FDA in December 1990, Norplant, the implantable contraceptive, has been both lauded and vilified. As a nearly infallible birth-control device, Norplant is seen by many as an important new tool to prevent unwanted pregnancy, and they have pressed to make it available in various settings—including high-school clinics.

Others, however, are concerned that the easy availability of Norplant, particularly in school-based clinics, will lead to increased sexual activity among teenagers. Writing in these pages, for example, Richard John Neuhaus said that such programs lend tacit approval to premarital teen sex. He argues that, by promoting the use of contraceptives like Norplant, public officials are sending the message that teen sex is commonplace and chastity is abnormal. According to Neuhaus, the only proper way to reduce teen pregnancy is to promote abstinence ["The Wrong Way to Go," Feb. 1].

Like Fr. Neuhaus, we should all be disturbed by the high level of sexual activity among teenagers. Every year, more teenagers are having more sex, with increasing frequency, and at younger ages. This trend started in the 1960s and continued well into the late 1980s. Rates of sexual experience increased about 80 per cent between 1970 and 1988, according to the National Survey of Family Growth (NSFG), a national in-person survey of women ages 15 to 44 conducted in 1982 and again in 1988. Although rates have now apparently leveled off, today over half of all unmarried teenage females report engaging in sexual intercourse at least once.

With this increase in sexual activity have come large increases in teen abortions, out-of-wedlock births, welfare dependency, and sexually transmitted diseases. So worries about teen sex go beyond nostalgia for the past.

Condoning Teen Sex?

NEUHAUS is also right to warn us about "solutions" that might make the problem worse. As he points out, the level of teen sexuality is easily exaggerated. If half of all teenage girls have had sex, half have not. Moreover, this is half of all teens ages 15 to 19. Eighteen- and 19-year-olds, most of whom have graduated from high school, many of whom are in college, and some of whom are married (surveys are not limited to unmarried teens), are much more likely to be sexually active than are 15-year-olds (70 per cent compared to 25 per cent). Even these statistics are deceptive. Many teens, particularly younger ones, have sex sporadically. Sexually active teen males, for example, report that they go without sex an average of six months each year.

Thus, there is substantial room for yet higher levels of sexual activity among teens. Easier access to a more effective contraceptive, such as Norplant, would probably lead some already sexually active teens to have more sex. That's what happened when the pill appeared in the 1960s. But would Norplant lead more young people to *start* having sex?

Even more than the birth-control pill, Norplant is really only suitable for females who have sex regularly. A

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teenage girl cannot simply stop at the drugstore on the way to a date to pick up Norplant, "just in case." She must have a physician implant the device, which is expensive—between $500 and $750. Moreover, since the device is usually visible, at least faintly, she is unlikely to want the implant unless her sexual activity is already known, particularly to her parents.

That is why the first (and thus far the sole) school to make Norplant available was the Laurence Paquin School in Baltimore, a special facility for pregnant and parenting teens. Not only are these teenagers obviously sexually active, but they have also demonstrated that they need help in controlling their fertility.

Nevertheless, it's possible that the easy availability of Norplant would heighten the atmosphere of sexuality that already permeates the teen subculture. If that were the only consideration, one might conclude Norplant should be discouraged. But there is an important element left out of this calculation: Norplant's impact on abortions and out-of-wedlock births.

"I'm declaring a war on poverty—all of you who make under $6,000 a year are under arrrest."

Abortion and Illegitimacy

EACH YEAR, there are about one million pregnancies among teenagers. About 40 per cent end in abortions and 10 per cent end in miscarriages. Some 60 per cent of those that go to term (that is, 30 per cent of all teen pregnancies) result in a baby being born out of wedlock—the first step toward welfare dependency.

Abortion. About 1.6 million abortions are performed each year. Over 400,000—or a quarter of the total—are on teenagers. Teenagers as a whole have higher abortion rates than older women, with older teens reporting the highest rate of any age group. In 1988, the abortion rate for 18- to 19-year-olds was 62 per thousand women of that age group, compared to 27 per thousand among all women ages 15 to 44. The rate for 15- to 17-year-olds, at 31 per thousand, was half that of older teens but still higher than the rate for all women of childbearing age.

In the 11 years between 1973 and 1984, the teenage abortion rate almost doubled, from about 24 to about 44 per thousand females ages 15 to 19, according to the Alan Guttmacher Institute (AGI). (Between 1984 and 1988, the rate stablized.)

Out-of-wedlock births. Over one million children are born out of wedlock each year. That is about 27 per cent of all births. Although the proportion of black children born out of wedlock is three times that of whites, the white rate has steadily increased over the last thirty years, so that there are now more white babies born out of wedlock than black ones.

Over 300,000 babies were born to unwed teenagers in 1988. That's three-fifths of all births to teenagers. Although the total number of births to teenagers declined between 1970 and 1988, the percentage born out of wedlock more than doubled (from 29 per cent to 65 per cent), and the teenage out-of-wedlock birth rate increased by two-thirds (from about 22 per thousand to 37 per thousand). Over 10,000 babies were born to children under 15 years old.

Arguments about Murphy Brown notwithstanding, the plain fact is that having a baby out of wedlock as a teenager is the surest road to long-term welfare dependency. About 50 per cent of all teen mothers are on welfare within one year of the birth of their first child; 77 per cent are on within five years, according to the Congressional Budget Office. Nick Zill of Child Trends, Inc., calculates that 43 per cent of long-term welfare recipients (on the rolls for ten years or more) started their families as unwed teens.

While many women want to have the babies they have, many do not—as witnessed by those high abortion rates. In fact, many abortion patients report that they were trying to prevent pregnancy at the time they conceived. A 1987 AGI study of abortion patients found that more than half were practicing birth control during the month in which they got pregnant. Only 9 per cent reported that they never used a contraceptive.

Many people see the disproportionate number of out-of-wedlock pregnancies among the poor as a sign that they live by different moral standards. But while middle-class teens are still somewhat less sexually active (though the gap is narrowing), the real difference is that they are better contraceptors.

Poor women of all races report higher overall levels of contraceptive failure. In 1988, 27 per cent of poor teens reported a condom failure while 13 per cent reported a pill failure, compared to 13 per cent and 6 per cent, respectively, for non-poor teens. Similar patterns hold for older women.

By now, the many ways that condoms can fail, through nonuse as well as misuse, should be well known. But people may not understand how so many women who claim to be on the pill become pregnant. In fact, the modern pill contains much lower dosages of estrogen and progesterone than did those of the 1960s and 1970s. While these newer pills cause significantly fewer side effects than earlier versions, they also require more precise use. Missing just one day puts a woman at risk of pregnancy. Missing more days is an invitation to pregnancy, as Patty Aleman, a nurse practitioner at the Capital Women's Center relates. "One college freshman came in for an abortion and said she was taking the pill. When I pressed her about it, she said, 'Well, I did miss three days.'"

The life circumstances of many women are not consistent with maintaining this kind of daily routine. Virginia Cartoof, a former social worker in inner-city Boston, found that many of her teenage clients lived in crowded households where pills got lost. Often, there was no money to replace them

immediately. Others did not always spend the night in the same place, and would forget to take their pills along.

Norplant avoids all these problems. With Norplant, there is no need for women to remember a daily pill or a barrier method at each act of intercourse. They need not go to a doctor to get a prescription when they initiate a new relationship. And they cannot easily discontinue use. Susan Davis, a contraception counselor at a Washington, D.C., Planned Parenthood clinic, agrees. "The biggest market for Norplant is former pill users," she says. "A former pill user told me, 'I had an abortion and I really don't want to get pregnant again.' She is now using Norplant."

The association between poverty and poor life prospects on the one side, and too early sex and unwise childbearing on the other, is too obvious to ignore. Elijah Anderson notes, "Most middle-class youths take a stronger interest in their future and know what a pregnancy can do to derail it. In contrast, many [inner-city] adolescents see no future to derail—hence they see little to lose by having a child out of wedlock." Because those young people who have the most to look forward to are the most responsible about their sexual practices (and are least likely to be sexually active), it is not too much of an exaggeration to say that good education and real opportunities in life are the best contraceptives. But until those ideals are achieved, Norplant is an important option.

It is true that, for younger teens especially, abstinence is the best goal of social policy. But the harsh fact is that we have neither the social will nor the practical tools to achieve it. Meanwhile, each year teenagers have another 400,000 abortions and 300,000 babies out of wedlock.

Where does all this bring us? Norplant's very effectiveness would lead to a marginal increase in sexual activity among teens, and thus to a concomitant increase in sexually transmitted diseases (which Norplant does not prevent). But on the other side of the social ledger, widespread use of Norplant would sharply reduce the number of abortions and babies born out of wedlock. This is the tradeoff that Norplant offers.

Neuhaus criticized this choice as "moral defeatism." Perhaps he is right. But sometimes the moral life requires one to swallow hard and choose the lesser of two evils. Which is worse: the possibility of a marginal increase in sexual activity? Or losing the opportunity to reduce abortions and out-of-wedlock births by 10, 20, or even 30 per cent? To ask the question is to answer it. □

A BETTER CHOICE

RICHARD JOHN NEUHAUS

MR. BESHAROV asks us, "Which is worse: the possibility of a marginal increase in sexual activity? Or losing the opportunity to reduce abortions and out-of-wedlock births by 10, 20, or even 30 per cent? To ask the question is to answer it." I have asked the question, and it is by no means answered. The alternatives he poses are misleading.

Given the figure of a million teenage pregnancies, a 10 per cent reduction by the use of Norplant would require 100,000 implantations. In either case, it's an ambitious program. Presumably the program is voluntary and hundreds of thousands of teenage girls (the proposal does put all the responsibility on the girls) would want to have a minor surgical procedure that would contraceptively equip them for sexual intercourse. Presumably also, the parents would have some say in this and would agree to having their daughters thus equipped. Presumably yet further, one result would be "the possibility of a marginal increase in sexual activity."

I suggest that the result would be the near certainty of a *substantial* increase in sexual intercourse among teenagers. If so, that would mean also an increase in abortions and single-parent children. The problems that the proposal intends to resolve would be greatly exacerbated.

Of course we do not know for sure until it is tried. There are many perilous things that should not be tried. We should not under public auspices try implanting Norplant in teenage girls. To do so would be to try something that possibly no society has tried before: to state publicly that there are no social standards or sanctions with respect to the sexual activity of young people. It might be objected that we are already making that statement by distributing condoms in public schools. Just so. Which is why condom distribution is a dumb idea, and far from settled policy in most schools.

Mr. Besharov says that abstinence is the best goal "for younger teens especially." (At 15 you can't do it but at 16 you can?) He adds, "But the harsh fact is that we have neither the social will nor the practical tools to achieve [the goal of abstinence]." I do not know what he means by "practical tools," but presumably we do have means of discouraging and encouraging certain behaviors among young people. Parents have never succeeded in controlling totally the behavior of their children, which is just as well. But if Mr. Besharov is suggesting that parents—and churches and schools—should give up on discouraging sexual promiscuity and encouraging abstinence, his is even more of a counsel of despair than I had at first thought.

The critical reference is to "social will." To whom, one may ask, belong the wills that make up this social will? Teenagers, parents, brothers, sisters, pastors, teachers, school boards, aunts, and uncles—each, one by one, can have a will with respect to teenage sexuality. Or perhaps the suggestion is that most people who are in a position to influence teenagers really do not care about what they do sexually. The survey research data do not support that suggestion. But even if most people did not care, that does not mean that we should adopt public policies premised upon not caring. Mr. Besharov cares. He obviously cares about abortion and out-of-wedlock children, and by implication he cares

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