

Introduction

THIS IS WHAT HAPPENS WHEN YOU
GET PREGNANT AS A TEENAGER

On a gray day in early winter, I parked my car outside the unassuming brick building that housed the Millerston Youth Center.¹ The bleak December sky mirrored the drab landscape of abandoned mills and boarded-up row housing. The youth center stood at the edge of Millerston's downtown, where health and human service organizations occupied many of the buildings, along with a scattering of storefront churches, bodegas, and discount stores. Across the canal from the youth center was the "Canals" neighborhood, crowded with the now-empty or repurposed factories that had made Millerston a vibrant city at the height of the manufacturing economy. Nowadays, the median income in the neighborhood was the lowest in the city, at only \$13,000.² Like most deindustrialized cities in the United States, Millerston's neighborhoods are racially and economically segregated; approximately 90% of the Canal's residents are Puerto Rican. The neighborhood has the highest teen birthrate in the city, at 154 births per 1,000 women ages fifteen to nineteen each year. In contrast, less than three miles away in the "Heights" neighborhood, the population is 89% white non-Hispanic, the median annual income is \$65,000, and the teen birthrate is 34 births per 1,000 young women ages fifteen to nineteen annually.

I was at the youth center to attend a meeting of the Millerston Adolescent Sexual Health Promotion Committee (MASHPC), a group composed of representatives from city government, health clinics, and social service organizations. MASHPC's mission was to develop multifaceted community-based approaches to decrease teen pregnancy and sexually transmitted infections (STIs) in Millerston. Millerston was well known in the region for its high teen pregnancy rate among Latinas, and I was interested in telling a different sort of story about teen pregnancy prevention and the lives of teen mothers. As I got out of my car, I greeted Hannah McNeil, a white former nurse in her sixties who served as commissioner of the Millerston Board of Health and the chair of MASHPC. Offering to help her unload meeting supplies from her luxury sports car, I found myself carrying cookies and fruit piled into a tote bag from an upscale athletic wear company whose \$100 yoga pants would represent 12.5 hours of labor for a worker making \$8 an hour, then the state minimum wage. We made small talk as we carried the items inside the building and found our way to the meeting room. Throughout my fieldwork, I spent many hours sitting in on meetings such as this one, where groups of mostly white, economically privileged, middle-age professional women lamented the "problem" of teen pregnancy in the city. They saw themselves engaged in a valiant battle against this problem.

Often in these meetings I felt as if I was in the Bill Murray movie *Groundhog Day*, where a time warp forces the main character to relive the same day over and over again. In MASHPC meetings, and in other coalitions and committees I observed during my research for this book, participants discussed the same issues, made identical critiques, and proposed similar strategies. Later, when my archival research turned up meeting minutes from earlier incarnations of the group, I learned that the focus of these efforts had changed little since the beginnings of Millerston's teen pregnancy prevention work in the 1990s. At this particular MASHPC meeting, members were celebrating the just-released data showing that the teen birthrate in the city had declined. They viewed the committee's work as having directly caused this declining rate, and discussed their next steps to ensure the rate would continue to go down. Hannah shared that this work had always been a "passion" of hers that she held "close to the heart." I scribbled in my notebook, "I don't even know what to say

about that.” As a white, economically privileged older woman who viewed the prevention of pregnancy among economically marginalized young women of color “close to her heart,” Hannah invoked a deep legacy of professional white women’s benevolence in managing racialized and economically marginalized women’s fertility and childrearing practices.³ She went on to tell the group that the city had “had a chance in the [19]90s” to get a handle on the teen birthrate. “We didn’t get it done then,” she lamented, “but we’re doing it now.” Moving to the next item on the meeting’s agenda, Hannah informed the group that the district superintendent had given them permission to hold a “National Day to Prevent Teen Pregnancy” rally at the Millerston high schools. Hannah hoped that the group could also organize a parade for teen pregnancy prevention in the city’s downtown. Beth Emmerson, a white nurse and researcher in her fifties, chimed in to share her thoughts on additional tactics the group could employ, such as hosting an event in which community members help clean up a city park to “promote change from within.” Along with other committee members, the majority of whom were white women in their forties and fifties, Beth lauded the importance of engaging Latinx parents as a strategy to prevent teen pregnancy.⁴ She argued, “We need community members to say to their kids, ‘You’re not going to have sex; you’re going to school!’”

Earlier that fall, I had joined students and staff for lunch in a small break room at the Towne House, a community-based school for pregnant and parenting young women in Millerston. We were participating in a multiday workshop in which students used storytelling to push back against the stigmatization of young mothers. A buffet of rice, beans, pork, yucca, and tostones from a local restaurant lined the middle of the table. As we ate, Tabitha, a Black 19-year-old mother to a 1-year-old who lived in a shelter for homeless teen mothers and their children, gazed out the windows at the large, weathered but elaborate Victorian homes lining the street. “If I stayed living in Millerston,” she remarked, “I’d want to live in one of those.” Emma, a 21-year-old Latina mother to a baby, disagreed with Tabitha’s remark, proclaiming that she wanted to move away from Millerston because “everywhere you look there’s girls with babies.” In response, Cristina, a 21-year-old Latina mother of a toddler, mentioned that she had heard that the teen pregnancy rate in Millerston was going down. Cristina thought that prenatal care providers in the city were

unhappy about this change because, she argued, “they are trying to make money off us.” Lourdes Colón Cruz, the Towne House’s education director, immediately jumped into the conversation. Lourdes was a Latina in her early fifties and had had her children in her late teens. “I’m just gonna say something,” she said, “I think a teen mom is like, 14, 15, 16 years old, not 18 or 19. When I was young, you got married right out of high school, you had a June wedding and a baby 9 months later. And nobody had any problem with that. It was normal.” The young mothers around the lunch table, most of them 18 to 22 years old, nodded in consensus. Before the group turned their conversation to the various side effects and downsides of contraception, Lourdes imparted a final bit of wisdom about inequality in Millerston. “Let me tell you something,” she said; “there are people in the world—there are rich people and there are poor people, and the rich people need the poor people to stay poor.”

The conversations at these two events demonstrate the divide in how privileged service providers and marginalized young people make sense of sexuality, reproduction, and power. Although the service providers, most of them privileged along the intersections of race and social class, were oblivious to the workings of disciplinary social power and their complicity in reproducing it, the young mothers at the Towne House had no choice but to negotiate their positions in a system of domination. The conversations at the MASHPC meeting relied on common tropes of young women of color as hyper-reproductive and of poor people as lazy; the conversations at the Towne House illustrated how multiply marginalized people make sense of the discourses that produce them.

In placing these vignettes side by side, I do not mean to imply that *Distributing Condoms and Hope* is a story about “good” professionals trying to do right by young people versus “bad” professionals intent on regulating young people’s sexuality and reproduction. The story of youth sexuality and reproduction in Millerston is much more complicated than such an easy dichotomy suggests. Instead, these vignettes provide a backdrop for understanding the politics of youth sexuality and reproduction in Millerston and frame the ways of thinking about and doing public health that I analyze in this book. *Distributing Condoms and Hope* demonstrates how discourses of race, reproduction, and science play out in the youth sexual health promotion efforts of this racially and economically stratified

small city in the northeastern United States. Health care providers and educators in Millerston acknowledge the social determinants of health, but privatize responsibility for race, class, and gender inequalities by advocating for individual-level solutions, such as distributing condoms and promoting “hope.” Since the early 2000s, teen pregnancy prevention campaigns based in shame and stigma have ignited conversations among scholars, service providers, and the public surrounding the politics of youth sexual health. Meanwhile, reproductive justice activists have worked to amplify the voices of pregnant and parenting youth.⁵ *Distributing Condoms and Hope* brings together the perspectives of these disparate groups. By making space for the stories of young mothers alongside an analysis of youth sexual health promotion, I aim to create a platform for affecting policy and practice. Moreover, I want us to imagine and theorize different kinds of futures, ones that neither use young mothers’ lives as the basis for disciplinary public policies nor romanticize their struggles.

This book makes visible the operation of power in youth sexual and reproductive health and reimagines what health promotion would look like through the lens of reproductive justice. Women of color feminist activists developed the concept of reproductive justice (RJ) in the mid-1990s as a framework, vision, and social movement. Reproductive justice refocuses individual-level debates about reproductive “rights” and “choice” so as to emphasize a broader analysis of racial, economic, and structural constraints on power.⁶ The approach expands a singular focus on white, economically privileged women’s access to contraception and abortion to include the right to have children and to parent them with dignity and support. In the RJ vision, reproductive freedom involves the ability to prevent or terminate a pregnancy alongside access to affordable child care and the ability to raise children without the threat of state violence.⁷ In Millerston, most professionals focused narrowly on promoting contraception and did not view expanding abortion access as part of their work. Rather than supporting teen mothers’ right to parent with dignity and resources, professional stakeholders considered their lives only in regard to their potential to serve as a “warning” about the dangers of teen pregnancy. Although they used “youth sexual health promotion” as an umbrella term to refer to their work, their efforts emphasized preventing pregnancy much more than promoting a holistic understanding of “sexual health.”⁸

Although I critique the absence of a reproductive justice framework in Millerston's youth sexual health promotion efforts, I have no doubt that the professionals in the city were sincere in their beliefs and conducted their work without explicit maliciousness. This sincerity, however, does not erase or diminish their complicity in structures of racial domination and the very real implications it has for racially and economically marginalized young people. Likewise, although I critique how the efforts pathologized teen pregnancy and parenting, I have no doubt that the teen parents I worked with experienced both joy and hardship. I call attention to how health promotion mobilizes discourses of race, reproduction, and science to justify intervention in the sexual and reproductive lives of marginalized young people. I also analyze how young parents negotiate the politics of teen pregnancy and make sense of the dominant understandings of their lives. By focusing on discourse, I am interested in how people in Millerston—public health professionals and young mothers alike—organize and create knowledge. I understand discourse in the Foucauldian sense, as composed of circulating forms of knowledge-power that produce and regulate language, bodies, populations, and so on. What makes power so useful, according to Foucault, is that it is not merely repressive but also “traverses and produces things, it induces pleasure, forms knowledge, [and] produces discourse.”⁹ Discourses of youth sexual health promotion produce particular ideas about race, class, gender, and sexuality—for example, that there is something about Latinx culture that leads to high rates of teen pregnancy in Millerston. Critiquing these discourses is more than a strategy by which to understand or eliminate health inequalities. It is a way to envision new ways of thinking about and doing public health, ways that center the people most impacted by interlocking systems of oppression.

“HOW DO YOU SUPPOSE YOU’RE GOING TO DO THAT?”

It is often difficult to locate the precise bounds of an ethnographic research project, or even identify when it began. To trace this project to its origins, I would have to return to my own unintended pregnancy at age 19. Shortly after I gave birth, a visiting nurse came to my father's house, where I lived

at the time, on a routine postpartum follow-up visit. Looking back, I don't know if she read me as just another Latina teen mom or a white girl who had made an unfortunate mistake. I do vividly recall the all too noticeable derision in her words when she asked what I planned to do now that I had a baby. I replied that I wanted to go to college. "Well," she snorted, "how do you suppose you're going to do that?" I can't recall what I said. Whatever it was, it was a lie, because I really had no idea. Now, looking back, it's almost as if I flouted her assumptions by going to college and never really leaving. I was a postsecondary student from the time my son was a toddler through the beginning of his teenage years; now I am a university professor. Like many of the young mothers in Millerston, and contrary to the dominant narrative, my "teen pregnancy" was not what ruined my life. It was what saved it. Yet I would be remiss if I let this anecdote pass without naming the considerable privilege and cultural capital that enabled me to become an academic who studies sexuality and reproduction, rather than a marginalized parent whom academics target to participate in their research projects. The path to academia is not equally open to all young people experiencing pregnancy while young, single, and poor, and it's not the result of a meritocratic system that allowed me to follow this path. In large part, it is my access to white-passing privilege that facilitated this path.

For now, it is sufficient to say that I got pregnant as a teenager and made a career out of it in the form of researching, writing, and teaching about the politics of sexuality and reproduction. I'm hardly the first scholar whose research topic chose them, and my professional connections to Millerston's public health circles made it a logical choice. Over the years I have frequently joked that I got knocked up as a teenager and now I'm stuck talking about teen pregnancy for the rest of my life. I have come to appreciate that, although the politics of teen pregnancy is not new to me, the social and political context of youth sexuality and reproduction is fertile ground for a feminist social scientist. Although teen pregnancy, and the moral panic surrounding it, is not a recent development, it remains a timely and deeply contested issue for communities, politicians, feminists, health and human service professionals, and cultural observers. Ultimately, however, *Distributing Condoms and Hope* is more an analysis of the politics of race, class, gender, and sexuality than a study of teen pregnancy and parenting per se.

PRODUCING YOUTH SEXUALITY AND REPRODUCTION
IN RESEARCH AND POLICY

A November 2014 *New York Times* op-ed by Nicholas Kristof exemplifies the dominant way of understanding teen sexuality and reproduction in the United States.¹⁰ In this editorial, Kristof invokes responsibility and greatly oversimplifies the social and political context of youth sexual health. To his credit, Kristof attempts to redirect the burden of responsibility toward the state and away from young people themselves. However, his argument elides the racial politics of sexuality, contraception, and family formation:

Here's a story of utter irresponsibility: About one-third of American girls become pregnant as teenagers.¹¹ But it's not just a story of heedless girls and boys who don't take precautions. This is also a tale of national irresponsibility and political irresponsibility—of us as a country failing our kids by refusing to invest in comprehensive sex education and birth control because we, too, don't plan ahead. I kind of understand how a teenage couple stuffed with hormones and enveloped in each other's arms could get carried away. But I'm just bewildered that American politicians, stuffed with sanctimony and enveloped in self-righteousness, don't adequately invest at home or abroad in birth-control programs that would save the government money, chip away at poverty, reduce abortions and empower young people.¹²

This brief piece touches on nearly all of the taken-for-granted “truths” that constitute commonsense understandings about teen sexuality and reproduction. By invoking “responsibility,” Kristof mobilizes a keyword that signals deeply held American cultural values of individualism, self-sufficiency, and personal responsibility.¹³ Whether intentional or not, invoking responsibility also reifies a well-worn trope in American politics: the irresponsible, nonwhite, promiscuous woman who keeps having babies in order to increase the value of her welfare check.

I encountered these assumptions over and over again both in my field research and in my analysis of policy documents, committee reports, and health promotion campaigns—as well as in my own life as a young parent. These “truths” include the assumptions that teen pregnancy is inherently problematic; that having children within a two-parent heterosexual middle-class marriage is the only legitimate family formation; that teens are

ignorant about their bodies and unable to make healthy decisions; that abortion is undesirable; that contraception is apolitical and uncomplicated; and that teen pregnancy causes poverty, rather than the other way around. Kristof also deploys another common strategy I encountered in my research, one that academics, activists, and professionals also use. He attempts to reframe teen pregnancy from an individual-level issue (blaming teens for being sexually irresponsible) to a structural-level issue (casting misguided public policies regarding sex education and contraception as irresponsible). Like many people involved in this work, however, Kristof is unsuccessful. Because he fails to acknowledge the influence of racial and sexual politics, he does little to address the structural inequalities that might promote sexual and reproductive justice and increase the well-being of vulnerable families.

Kristof is correct that young people in the United States are disproportionately likely to become pregnant as teenagers, at least in relation to our peer countries. The United States has one of the highest adolescent birthrates in the Global North, at approximately 22.3 births per 1,000 women ages 15–19 each year.¹⁴ In comparison, Western European countries such as France and the Netherlands have dramatically lower rates, at 6 and 5 births per 1,000 women under the age of 20, respectively.¹⁵ The rate of sexually transmitted infections among young people in the United States is also dramatically higher than in European countries. For example, the rate of syphilis among US teens is twice that of teens in the Netherlands, the rate of gonorrhea is 33 times higher, and the rate of chlamydia is 19 times higher.¹⁶ Both scientific and popular literature have tried to make sense of this discrepancy, mostly by placing the blame on poverty, lack of comprehensive sex education, and lack of access to contraceptive services.¹⁷

Teen pregnancy, abortion, and birthrates in the United States have been on the decline for several decades. This decline has occurred in most US states and among all racial and ethnic groups. The 2015 teen birthrate (22.3 births per 1,000 women ages 15–19) represents a 64% decline from its peak in 1991 (61.8 births per 1,000 ages women 15–19). In 2010, the US teen pregnancy rate reached its lowest point in over 30 years (57.4 per 1,000),¹⁸ a 51% decline from its apex in 1990 (116.9 per 1,000).¹⁹ The pregnancy rates for Hispanic/Latina and Black/African American teens remain about twice as high as their white, non-Hispanic

counterparts, though they have fallen 51% and 56%, respectively, since their peaks in the early 1990s.²⁰ The 2010 teen abortion rate was 14.7 abortions per 1,000 women ages 15–19, the lowest rate since *Roe v. Wade* legalized first-trimester abortion in 1973.²¹

The preoccupation with teen pregnancy as a social, economic, and public health issue is not on the decline, despite the fact that the teen birthrate continues to drop.²² Federal, state, and local governments, nongovernmental organizations, scholars, and the general public remain focused on determining the causes of teen pregnancy and what to do to prevent it. The 1981 Adolescent Family Life (AFL) program (Title XX of the Public Health Service Act) first brought preventing adolescent pregnancy under the purview of the federal government. This law authorized grants for programming that included prevention (in the form of promoting sexual health education and contraception) and supports for pregnant and parenting teens. However, with passage of the Personal Responsibility and Work Opportunity Reconciliation Act (commonly referred to as “welfare reform”) in 1996, the promotion of sexual abstinence became the primary strategy of most federal teen pregnancy prevention efforts. In 2010 the Obama administration shifted away from the focus on abstinence with the establishment of two programs that provided federal funding for “evidence-based” teen pregnancy prevention initiatives: Teen Pregnancy Prevention (TPP) and the Personal Responsibility Education Program (PREP). The TPP, funded in its first year at \$110 million, was a discretionary project that provided competitive grants to both public and private entities to fund “medically accurate and age appropriate” programs to reduce teen pregnancy. PREP, established through the Patient Protection and Affordable Care Act (ACA; also known as “Obamacare”), created a new state grant initiative that appropriated \$375 million over 5 years for broad-approach programs to educate young people on both abstinence and contraception.²³ President Obama’s fiscal year 2017 federal budget was the first since 1996 to eliminate all funding for abstinence-focused programs. Other federal programs related to teen pregnancy include the Title X family planning program, which provides preventive care and family planning services to low-income and uninsured individuals (\$286 million in fiscal year 2017)²⁴ and various public and private funding streams to support teen pregnancy prevention research. Teen pregnancy prevention therefore occurs throughout multiple sites and levels, including