different now? Why does the problem seem so much more difficult in this generation? . . . Have we really failed in our efforts to prevent pregnancies to unmarried teens? Or is it truer to say that we have abandoned them? Progressively over the last 25 years, we have, as a nation, decided that it is easier to give children pills than to teach them respect for sex and marriage.[11]

Kids are Going to Do It Anyway?

Flowing naturally from the myth of neutrality is the third flawed assumption which is that "kids are going to do it anyway, so we ought to at least protect them from the worst consequences of their behavior."

It is quite true that we will always have sexually active teenagers, and consequently, unintended premarital teenage pregnancies. It is equally true that

No responsible teacher, parent, school superintendent or counselor would take a 'neutral approach' to stealing, lying, cheating on exams, or violence. Yet, this is precisely what is being done in the area of sexual activity.

we will always have prostitutes, drug addicts, alcoholics, wife abusers, rapists, tax evaders and thieves. The fact that some individuals will engage in unhealthy behavior should not discourage society from promoting moral conduct.

The issue is not whether some teenagers will be sexually active, the issue is whether current pregnancy rates can be reduced by discouraging unmarried teenagers from engaging in sexual activity.

In spite of the strong natural desire and propensity toward sexual activity among adolescents, sexual activity can be controlled. When one states that there has been a dramatic increase in teenage sexual activity over the last fifteen years, he acknowledges that sexual promiscuity among teenagers was once much less common than it is today. Obviously, the desire for sexual activity among teenagers has always been great, but the recent increase in adolescent sexual activity has taken place because there is an unwillingness to state in unequivocal terms that sexual activity outside of marriage poses serious risks to one's physical, psychological, spiritual, and emotional well-being.

Teen sex is not inevitable. Indeed, a recent national study found that even today, nearly half of all 18 year-old females have never had premarital intercourse.[12] Moreover 20% of all sexually experienced teenagers aged 15-17 have had intercourse only once.[13]

Although teen sexual activity has shown a dramatic increase during the last two decades, it would be shortsighted to conclude that this is an irreversible trend. Trends can be reversed if society is willing to candidly re-evaluate existing programs and make much-needed changes.

Unfortunately, when current programs are evaluated and found to be ineffective, the proposed solutions are often an expansion and modification of existing concepts rather than a total change in direction. The recent emergence of school-based health clinics epitomizes such a phenomenon.

School-Based Clinics: An Overview

School-based health clinics have received a lot of attention recently, but the concept of offering family planning services in public schools is really not new. The first school-based clinic was opened in Dallas in 1970 by the University of Texas Health Science Center. Three years later, the Maternal and Infant Care Program of the St. Paul Ramsey Hospital opened a clinic in Mechanic Arts High School in St. Paul, Minnesota. Similar clinics in two other St. Paul schools soon followed, and the school-based concept spread to other communities throughout the country as well. Currently, there are at least 43 in-school clinics in operation and another 50 - 60 proposed clinics under consideration.

School-based health clinics vary in size and organizational structure. Some have been set up and managed by hospitals or public health departments, others by community health centers or nonprofit organizations. Almost all have been established in

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schools which are predominantly comprised of minority students.

A recent report issued by the Support Center for School-Based Clinics notes that "by definition all of the clinics are involved in family planning."[14] While this is no doubt their primary function, clinics also offer a variety of other health services, including athletic physicals, laboratory and diagnostic screenings, immunizations, nutrition and weight reduction programs, child care, and drug and alcohol abuse programs.

By providing a wide range of services, clinic organizers believe they can not only obtain greater student participation, but that they can achieve wider community support. Indeed, Joy Dryfoos of the Center for Population Options stated in a recent article that prospective clinics "can avoid local controversy by starting with primary health care and then adding family planning services."[15]

Regrettably, this underhanded approach to establishing in-school clinics is apparently quite common. A recent issue of *Family Planning Perspectives* identified ways in which comprehensive service providers have circumvented potential opposition:

The most common strategy adopted to avoid opposition was to maintain a low profile—generally by keeping programs out of sight, by avoiding potentially controversial preventive services, by staying clear of abortion services, by relying on word of mouth for recruitment and by giving names to programs that obscured their functions (Cyesis, Teen Awareness, Access, Services to Young Parents, Healthworks, and Continuing Education to Young Families are some examples).[16]

Moreover, the report states:

Program advocates and service providers are more or less obligated to exaggerate the potential benefits of services in order to secure political and material support. One popular ploy . . . revealed an incredible array of problems that allegedly would be solved by the provision of services for pregnant teenagers and adolescent parents. In claims reminiscent of those made for the patent medicine nostrums of the 19th century, it was argued that teenage pregnancy services would combat child abuse, crime, youth unemployment, sexual abuse, infant mortality, mental retardation, birth defects, drug abuse and welfare dependency.[17]

Evaluating Clinic Effectiveness

In supporting their claim that teen clinics are effective, clinic proponents often cite a study of the St. Paul schools which found that a drop in the number of teen births during the late 1970s coincided with an increase in female patronage of in-school clinics.[18]

But there is reason to question the validity of these findings. The Support Center for School-Based Clinics acknowledges:

Most of the evidence for the success of that program (St. Paul) is based upon the clinic's own records and the staff's knowledge of births among students. Thus the data undoubtedly do not include all births.[19]

Moreover, an analysis of the data conducted by Michael Schwartz of the Free Congress Foundation

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found that the total female enrollment of the two schools included in the study dropped from 1,268 in 1977 to 948 in 1979.[20] Therefore, the reduction in reported births could be attributable to an overall decline in the female population.

Furthermore, it is important to point out that the St. Paul study showed a drop in the teen *birth* rate rather than the teen *pregnancy* rate. Accordingly, it is quite likely that the reduction in the fertility rate was due at least in part to an increase in the number of abortions.

As Michael Schwartz noted in a recent article:

We still do not know whether the rate and/or number of pregnancies changed or how many students submitted to abortions.[21]

In addition to these problems, the St. Paul research design was not replicable and did not control for outside factors. Research analyst Marie Dietz noted:

Since its comparisons were done in a cross-sectional way between the school before and after clinic presence, other variables affecting birth rates could have been affecting all school populations. The suggested approach to show whether this occurred or not is to compare the clinic school with other schools or a school which is similar in school demographics (number of students, race of students, and socio-economic status of students) and to see if there is a significant difference between the birth/fertility rates of the school with a clinic and without a clinic. This was not done. Therefore, the widely publicized findings of the teenage contraceptive clinic which supposedly showed a drop in the birth rate are simply not supported by the data presented in the research report.[22]