FASTBACK 264

Teenage Parenthood: The School's Response

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Introduction

Adolescent parenthood is a major social problem today that demands a response from our schools. Schools with programs that provide young people with support, information, and decision-making skills can and do make a difference in the incidence of unplanned teenage pregnancies. What is important about these schools is that adolescents have somewhere to go for information, advice, and help from someone who cares. Your school can be such a place.

In this fastback we shall describe some of the innovative approaches developed by educators, health professionals, and others in the areas of pregnancy prevention and adolescent parenthood. Many of these approaches are controversial and are likely to arouse strong feelings in a community. But avoiding controversy will not make the problem go away.

The statistics on adolescent pregnancy can make us aware of the magnitude of the problem. But statistics alone cannot capture the human dimension of the problems of teenage pregnancy and adolescent parenthood. This fastback also will examine teenage pregnancy in terms of the consequences for the individuals involved and the implications for society in general. Our purpose is to provide a balanced perspective of the problem, with the goal of guiding those responsible for making policy decisions and for developing programs and services for young people.

The Dimensions of Adolescent Parenthood

More than one million American teenagers become pregnant each year. Nearly 500,000 of these teenagers will actually give birth. In each case there is, of course, a male involved, usually another teenager. He, too, will be affected by the pregnancy.

Adolescent pregnancy occurs in all ethnic and socioeconomic groups. It is not, as some think, just a "minority" problem. The teen pregnancy rate has doubled for white teenagers in the last several years, and 75% of all teenage abortions are performed on white adolescents. The Alan Guttmacher Institute (1981) reports that although the fertility rate among U.S. females 18 years and older has declined, it continues to rise for those 18 years and younger. And more than one-third of all teens who are sexually active before marriage have a premarital pregnancy before age 19.

Adolescent pregnancy in the black community also is a major problem. One in four black teenage girls will become pregnant by the time they are 18 years of age, and nearly a third of these will have a second pregnancy by the age of 20. The black adolescent pregnancy rate in the U.S. is the highest in the developed world.

The poor, which include a higher proportion of blacks, are more likely to carry their pregnancies to term; and they are more likely to keep their babies. These babies add to the economic, social, and psychological problems of teenagers already living in an impoverished environment. These young mothers are often the children of teenage

parents themselves and were raised in single-parent, female-headed households. Thus, their pregnancies perpetuate the cycle of poverty and resulting dependency that, apart from other social problems, cost the American taxpayer an estimated 16.5 billion dollars a year in welfare and Medicaid payments. Clearly, the financial and human costs associated with adolescent pregnancy have implications for our society that reach far beyond the individual teenager. The following sections will look at the implications of teenage pregnancy for our health, welfare, and education systems.

Implications for Health Care and Social Services

The cost of health care in the U.S. has increased at a much faster rate than inflation. A routine birth that cost $500 in 1960 now costs almost $5,000. Teenage parents usually do not have full-time employment where they are covered by group health insurance plans. Some might come from families where their parents' insurance covers the doctor and hospital costs; but teens from poor families, those with the highest birth rates, are less likely to have parents with health insurance. As a result, the costs of many teenage births need to be subsidized by outside sources. This is only the beginning.

Inadequate diet combined with lack of proper prenatal care – common conditions in adolescent pregnancies – often lead to premature delivery and accompanying low birth weight. These babies require special treatment and extended hospitalization often costing several thousand dollars a day. Planned Parenthood Federation of America has documented the health problems associated with teenage pregnancy: 1) The younger the mother is the more likely she will suffer from such complications of pregnancy as anemia, toxemia, and miscarriage. 2) The maternal mortality rate is higher for young mothers than for any other age group. 3) Younger mothers have much higher infant mortality and morbidity rates. 4) Children of teenage mothers have lower IQs and often have to repeat grades because of health problems and lack of care and attention.

When the teenager who is poor gives birth, social service agencies begin to provide various kinds of assistance, thus incurring even greater costs. More difficult to assess are the costs to our justice system as it copes with such legal matters as child custody and foster care. And the courts also must deal with problems of child neglect and abuse. These problems, already serious in our society, are exacerbated by teenage parents, who are immature and lacking in the parenting skills necessary to cope with child rearing.

Implications for Poverty and Crime

Children raised in single-parent homes, living at or near poverty levels, are much more likely to become involved in socially unacceptable behavior, including crime. While high teenage pregnancy rates do not automatically lead to crime, there is a correlation between poverty and criminal behavior. According to the FBI, teenagers commit more crime and in turn are the victims of more crime than any other age group. Thus, as teenage pregnancies perpetuate the cycle of poverty, we can expect a subsequent increase in the number of at-risk teenagers who are either perpetrators or victims of crime.

Implications for the Education System

In a recent Harris survey, nearly 60% of high school teachers surveyed rated teenage pregnancy as a serious problem in their schools. Even more disturbing, almost 40% of the junior high school teachers also rated the teenage pregnancy problem as "serious" in their schools. Acknowledging the problem is an important first step. Implementing programs to deal with the problem is a more difficult step, as we shall see. Nevertheless, most educators agree that the problem cannot be ignored.

In many schools the most obvious result of teenage pregnancy is a rising dropout rate. The one million teenage girls who become pregnant each year account for nearly half of all female dropouts. In some

urban schools in poverty areas, as many as one third of the girls drop out each year due to pregnancy. Many of the adolescent fathers also drop out, sometimes in order to find a job to support their new family. More than half of the teenage parents who drop out of school never return to earn a high school diploma. Without at least a high school diploma, few of these teenage parents are able to pursue a career that will provide them with enough income to support themselves and their family.

The problem is compounded as the children of adolescent parents enter the school system. We know that many of these children are at risk physically and psychologically. They are over-represented in classes for the learning disabled and emotionally disturbed. As the number of these children with learning problems increases, the per-pupil cost of education will rise. Demographers tell us that this will occur at approximately the time when the tax-paying population will be decreasing. The resulting financial problems for our schools could be catastrophic.

Some schools across the country have attempted to respond to the teenage pregnancy problem by providing information-based sex education programs. A few even have instituted school-based health clinics that dispense contraceptives. However, too many have chosen to ignore the problem. Much remains to be done. A few promising directions are described later in this fastback.

Teenage Pregnancy and Adolescent Development

As many parents will attest, adolescence is frequently a stormy period during which young people must come to terms with their changing body image, their emerging sexuality, their quest for independence, and their career decisions. All of these developmental tasks are interrelated with their expanding circle of interpersonal relationships and their sense of self-esteem. It is not an easy period in the life cycle.

Adolescence is a period when there is much emotional ambivalence in seeking the independence and autonomy associated with adulthood. It is a period of testing and trying out new experiences. It is a time of highs and lows in young people's lives; they frequently act and react impulsively. It is an unpredictable period for adolescents themselves, for their parents, and for their teachers.

Although adolescence marks the stage of physical maturation at which reproduction is possible, it is the emotional turmoil associated with the rapid physical changes that present the most problems. With changing body image come feelings of embarrassment. Doctors and nurses are most aware of this when conducting medical examinations. Often it is these same feelings of embarrassment about their bodies that deter sexually active teenagers from getting birth control.

With their emerging sexual feelings, adolescents' perceptions of themselves and of their relationships with peers take on a new dimension. While this is a natural part of achieving sexual identity, sometimes the emotional maturity necessary to deal with these over-

whelming sexual feelings is lacking when it comes to making appropriate decisions regarding sexual activity.

In a society such as ours, which bombards adolescents with sexual messages, it really is not surprising that many of them become involved in sexual relationships. Having sex is seen as one of the things you do to achieve an adult identity. What is unfortunate is that most teenagers have not yet developed the emotional maturity to understand the ramifications of their sexual decisions. They are faced with conflicting standards from family, school, church, peers, and the media. What they need is an opportunity to sort out these conflicts with the advice and guidance of an understanding adult, who may be a parent, teacher, counselor, pastor, or youth worker.

Becoming pregnant during adolescence only compounds this already difficult stage of development. Impending parenthood requires a rapid role transition that interrupts the normal developmental process. In fact, it usually precipitates a developmental crisis. How the adolescent handles this crisis depends largely on the family situation and the available support systems.

The potential and long-term problems associated with teenage pregnancy include:

1. Interruption of the normal process of adolescent development, thus curtailing the gradual transition to adulthood.
2. Perpetuation of the cycle of poverty in subcultures where keeping the baby is the norm.
3. Possible long-term psychological effects on the young woman and man who choose to terminate the pregnancy.
4. Fracture of relationships in families with few resources to deal with this crisis or with value systems that cause them to ostracize their pregnant teenagers.
5. Inability to cope with the demands of parenting, resulting in child abuse, substance abuse, and chronic depression.
6. Lack of acceptance, isolation, and alienation, resulting in lowered self-esteem and lowered expectations for life goals.

Impact of Teenage Pregnancy on Family Relationships

Each of the potential problems listed above also has significant ramifications for the families of the teenagers involved. In the best of scenarios, the families of the young woman and man involved in a teenage pregnancy can be and often are a source of great support. They provide financial aid, housing, child care, and emotional support. Such support can mitigate the crisis surrounding the pregnancy. And such support can be a critical factor in determining whether the teenagers finish high school.

Unfortunately, many families are unable to accept the pregnancy. They feel their moral and religious values have been violated, or they are embarrassed because of their status in the community. Some parents find it impossible to accept their daughter's or son's sexuality. Sometimes the hurt feelings persist, resulting in a permanent fracture in family relationships; more often the family becomes accepting of the situation and begins to deal realistically with decisions that have to be made. Often counselors in school or community agencies can help with these decisions.

Clearly, a teenage pregnancy creates a family crisis, requiring difficult decisions by both the teenagers and their parents. Should the couple get married? Should the mother and baby live with her family? Should alternative living arrangements be made such as living with friends or relatives or alone? Should the baby be put up for adoption? Should the pregnancy be terminated? This decision-making period is a stressful time for all concerned. Even when outside support is available in the form of counseling and health and welfare services, the family is still the major source of support for the pregnant teenager.

This brief overview of the statistical and human dimensions of teenage pregnancy provides some sense of the magnitude of the problem. The next chapter looks at some of the efforts to address the problem through education and health services.

Sex Education in the Home, School, and Community

Few would argue that sex education begins in the home. And there are some who state emphatically that that is where it should stay. It is probably more accurate to say that early sexual attitudes are influenced by family values. But by adolescence, they also are influenced heavily by peer values and the mass media. The picture is much less clear about how much sex information parents provide. Several studies show that, aside from some basic information about reproduction and menstruation for girls, parents provide limited sex information directly. There are several reasons that explain the reluctance of parents to provide explicit sex information.

First, our puritanical legacy inhibits open discussion of sex in the home. The most that many parents can bring themselves to say is, "Don't do it!" Second, many parents are fearful that they will say the wrong thing or give the wrong impression if they bring up the topic of sex. Third, many parents have difficulty accepting their teenagers' sexuality. Even though parents are aware of the sexual maturation of their offspring, they still tend to think of them and often treat them as children. Fourth, many parents feel they are powerless to control their adolescents' sexual behavior. This feeling is supported by a recent Louis Harris Poll conducted for Planned Parenthood Federation of America, which found that 64% of parents interviewed felt they had little or no control over their teenager's sexual activity. Also, 85% of those polled agreed "strongly" or "somewhat strongly" that sex education should be taught in the schools.

To what extent birth control information is provided in the home is difficult to answer; but given the high adolescent pregnancy rate in all cultural and socioeconomic groups, it seems likely that the information is insufficient or inaccurate. This raises the issue of whether it is realistic to expect parents to assume the role of sex educator. Many sex education teachers and counselors report that adolescents feel more comfortable receiving sex information from a professional on neutral ground where they can ask questions freely. And many parents are relieved to have a professional present this information, even though parents often give lip service to their role in sex education.

Sex Education in the Community

Many community agencies offer sex education programs, including mental health centers, youth centers, churches, family planning agencies, and the YMCA or YWCA, to name a few. These programs help to develop community awareness of teenage problems, provide young people with accurate sex and family life education, and assist teenagers in examining and clarifying their values in order to make intelligent decisions about their sexual behavior. Some programs have a broad focus such as personal growth and development; others focus on a specific goal such as pregnancy prevention. These programs are presented in a variety of formats but are usually short term and involve a lot of group discussion.

Sex education programs sponsored by religious institutions usually reflect values that are consistent with their doctrines, which is to be expected. This is important because it enables adolescents and their parents to have choices about where and on what terms they receive sex education. Whether one wants a program that emphasizes birth control methods, sexually transmitted diseases, sexual health and well being, issues of intimacy, or religious and moral dimensions of sexuality, there is likely to be an agency or institution in the community that provides such a program. These community-based programs sup-

port and supplement both sex education in the home and more formal instruction in the schools.

A more recent development is community programs designed specifically for parents. These programs help to build a comfort level with sexual subject matter so parents are able to discuss sex with their children in a relaxed and open manner. One such successful program is run by the Family Guidance Center in St. Joseph, Missouri. One course is offered to parents with children in their early teens and another to parents with children in their later teens.

Sex Education in the Schools

Some form of sex education in the schools is now widely accepted. Although sex education remains controversial in some communities, the issues now being debated are not whether sex education should be taught in the schools but rather how much and how explicit should the content be and at what age levels should it be taught. While no state prohibits the teaching of sex education, only three states mandate it. Course content ranges from a broad array of topics in family life courses to separate units on the anatomy and physiology of human reproduction in biology classes. Local school districts usually determine course content.

Sex education typically is taught as a unit in health and biology courses. Some schools offer a separate course. In some cases the program is little more than two or three lectures. The focus of many of these program is on acquiring factual information on such topics as physical and sexual maturation, reproductive anatomy and physiology, and fetal development. More controversial topics such as birth control methods, abortion, and homosexuality are less likely to be included in the curriculum.

Teaching methods used include lecture, discussion, and audiovisual presentations. Many excellent audiovisual resources are available for teaching factual information. Use of group-process techniques such

as values clarification tends to be a decision of the individual teacher rather than a part of the formal curriculum.

Most sex education teachers have credentials in health and physical education, home economics, or biological science. There has been some concern expressed about the lack of qualified personnel to teach sex education; in fact, many who are teaching it have not had formal preparation in the area. However, in recent years the situation has improved considerably with many universities offering both content and methods courses in sex education. Still, many teachers report discomfort in teaching sexual subject matter. This no doubt accounts for why they tend to restrict the content taught to factual information and to avoid the value issues and more controversial topics related to sexuality. Most sex educators would argue that information alone is not enough to influence sexual attitudes and behavior. Nevertheless, a school district with an information-based program can claim that it is meeting its responsibility of providing sex education.

The approach to sex education in family living courses taught in many high school home economics departments offers more opportunities for dealing with the interpersonal aspects of sexuality. These courses typically cover a wide variety of topics, ranging from personal relationships and self-understanding to such practical matters as balancing a checkbook and reading a contract. Sex education content in these courses can be integrated naturally around such topics as parenting, child development, family planning, and understanding self and others. Such courses also make extensive use of group discussion techniques where different points of view can be expressed and value issues can be examined. It is in this setting that values can be clarified and guidelines for behavior can be established.

An in-school program for teenagers who are already pregnant is another place for offering sex education. One immediate goal of such programs is the prevention of a second pregnancy. But there are other important goals as well, such as completing high school and thereby reducing the dropout rate, providing prenatal education to improve

the chances for a successful pregnancy, and fostering good health for both mother and baby. Several cities have such programs and report success in reducing the rate of second pregnancies, in lowering dropout rates, and in improving the health of mother and baby.

Another type of in-school program, although much less common, is for teenage fathers. In the great outpouring of concern over the teenage pregnancy problem, this group is frequently forgotten or ignored. The young father is viewed as the culprit and is labeled as irresponsible and uncaring, or as one writer described him, "the ultimate hit-and-run artist." Yet many young fathers report having very strong feelings about wanting to help support their child, but they either are not allowed to do so or they do not know how. Many of these teenage fathers drop out of school and attempt to find work in order to help support their child. But because they have few skills, they have difficulty finding a job that pays a living wage. This leads to further frustration and usually only compounds the problem.

In the few programs that do exist for teenage fathers (usually in cities where there is a high teenage pregnancy rate), the schools report they have little difficulty in attracting the young father to participate. The programs provide sex education, parenting skills, discussions about sexual responsibility, and in a few instances, actual job training. In two large programs run by the New York City Board of Education, it was felt that the overwhelming response of teenage fathers to the program was the promise of job training. As educators continue to develop programs for pregnant teenagers, clearly more attention must be given to the needs of the teenage father.

Health Clinics in School

The establishment of school-based health clinics is one way some communities are providing contraceptive counseling and related health services for adolescents. The Center for Population Options reports that there are more than 60 school-based health clinics currently in operation and many more are in the planning stages. School-based

clinics are sponsored by hospitals, medical centers, departments of public health, community health agencies, or the school system itself. Funding comes from a variety of sources, including Maternal and Child Health Block Grants and Title X funds. Some clinic directors prefer funding from several small local sources rather than a single large federal grant. This protects the clinic if certain funding sources are cut.

Reproductive health services and sex education are major programs at these clinics, but many provide a wide range of services including mental-health counseling, physical examinations, immunizations, and weight reduction programs. Of the existing clinics, the Center for Population Options reports that 52% of school-based clinics prescribe contraceptives, 28% dispense contraceptives, and 20% refer students to other agencies. All the school-based programs provide counseling and follow-up.

Staffing of the school-based clinics reflects the type of services offered. Usually there is a team of professionals that includes a social worker, nurse practitioner, pediatric nurse specialist or maternal-child nurse specialist, an obstetrician-gynecologist, nutritionist, health educator, and pediatrician. Not all of the professional staff will work full time in the clinic. Some come in only to provide special services or for consultation.

The establishment of school-based health clinics has not been without controversy. Some charge that, in those clinics that dispense contraceptives, the schools are tacitly endorsing promiscuity. Others counter that unless contraceptive education and contraceptives are easily accessible, the teenage pregnancy problem will escalate. Because of the controversy, some clinics provide only contraceptive counseling and refer students to local family planning agencies to obtain contraceptives. In some cases the clinics have had to confine their services to general health areas in order to be accepted in their community.

The overview of sex education in the home, school, and community presented in this chapter spotlights some of the programs and ser-

vices that can be used to deal with the problem of teenage pregnancy and teenage parenthood. However, given the magnitude of the problem, such programs and services must be expanded to reach every community. This calls for thoughtful and systematic program development on many fronts. The last chapter will provide educators and community leaders with guidelines for program development.

Guidelines for Program Development

Three sets of goals should guide the development of progams to deal with the multifaceted problem of teenage pregnancy and teenage parenthood. The first set deals with efforts to prevent or decrease adolescent pregnancies. The second set includes efforts aimed at minimizing the consequences of adolescent pregnancy. The third set includes efforts to provide resources and support to help adolescent parents assume their role as parents and to become productive citizens in their community.

Programs designed to prevent or decrease teenage pregnancy should reach out to adolescents at risk. They should provide a holistic approach to adolescent health and a comprehensive family life curriculum. Examples of these types of programs include parent-child education workshops, sex education courses in the school or community, family life courses in the school, and education and counseling services at school-based clinics.

Programs to minimize the consequences of adolescent pregnancy should provide for the early detection and resolution of the pregnancy, adequate prenatal care, emotional support, and good nutrition education. Examples of these types of programs are in-school programs for pregnant teenagers, adolescent fathers' programs, and prenatal services in school-based clinics.

Programs designed to provide psychological support and to foster good health for the mother and baby are usually under the jurisdic-

tion of community health and welfare agencies. Examples of such programs are prenatal classes, well-baby clinics, parenting classes, family planning counseling, and a variety of services from welfare agencies.

The schools carry the major responsibility for achieving the first set of goals dealing with pregnancy prevention. And more and more, the schools are initiating programs to achieve the second set of goals dealing with minimizing the consequences of pregnancy. The third set of goals dealing with support services for the young mother and baby usually are the responsibility of community agencies. However, the schools can play an important role by consulting with and advising community agencies that provide support services. The problems of teenage pregnancy and adolescent parenthood are concerns of the entire community. Solutions to the problems will require the coordinated efforts of many segments of the community.

Resources for Program Planning

As educators and community leaders begin to plan a coordinated effort to address the teenage pregnancy problem, there are several sets of data they will need in order to implement programs that are appropriate for a particular community. These data are important both for informing the community about the magnitude of the problem and for designing programs that will meet the needs of the community. Following are some of the kinds of data that should be collected:

Economic Data: unemployment rate, teenage unemployment rate, teenagers living in poverty, average family income.

Community Data: racial/ethnic demographics, age distribution demographics, teenage suicide rate, teenage crime rate, divorce rate, single-parent households, female-headed households.

Health Data: teenage pregnancy rate, teenage abortion rate, incidence of teenage drug and alcohol abuse, incidence of chronic health problems, incidence of mental health problems, infant mortality rate.

School Data: dropout rate, reasons for dropping out, suspension rate, absentee rate, student/counselor ratio, sex education content taught.

These data are available from national, state, and local sources. National sources provide benchmark data that can be used to compare with local data. Such comparisons are important in making the case to a community that programs and services are needed. Following is a list of national sources and the kinds of data they provide:

Alan Guttmacher Institute
111 Fifth Avenue
New York, NY 10003
(212)254-5656
Provides data on contraceptive use and related family planning issues.

Center For Population Options
Suite 1200
1012 14th Street, N.W.
Washington, DC 20005
(202)347-5700
Provides data on teenage pregnancy and sexuality.

Centers for Disease Control
1600 Clifton Road, N.E.
Atlanta, GA 30333
(404)329-3286
Provides data on communicable diseases, especially sexually transmitted diseases, and reproductive health.

Center for Vital Statistics
555 New Jersey Avenue, N.W.
Washington, DC 20208
(202)357-6651
Collects and disseminates a wide variety of statistical data on all aspects of life.

National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782
(202)436-8500
Maintains major data bases on natality, mortality, marriage, divorce, and family growth.

National Institutes of Health
9000 Rockville Pike
Bethesda, MD 20205
(301)496-4000
Serves as clearinghouse for information on alcohol, drugs, mental health, and health.

National Urban League, Inc.
500 East 62nd Street
New York, NY 10021
(212)310-9000
Provides data on urban and minority youth.

Population Reference Bureau
777 14th Street, N.W.
Washington, DC 20005
(202)639-8040
Provides data on population trends, fertility rates, infant mortality, including international comparisons.

Sex Information and Education Council of the U.S. (SIECUS)
New York University
32 Washington Place
New York, NY 10003
(211)673-3580
Provides publications and consultation to schools and other organizations interested in establishing sex education programs.

U.S. Department of Commerce
Bureau of the Census
Suitland, MD 20233
(202)763-4051
Provides the most comprehensive data on characteristics of U.S. population.

U.S. Department of Labor
Bureau of Labor Statistics
441 G Street
Washington, DC 20212
(202)523-1092
Provides data on employment and unemployment statistics, also data on teenagers in the work force.

Local sources provide data that are most relevant to the immediate community. Furthermore, the local people who compile and control the dissemination of these data are likely to be the very ones who can be of greatest assistance when the time comes to design and implement specific programs. Some of the local sources of data are: public health department, welfare department, social service agencies, family planning agencies, hospitals, mental health centers, law enforcement offices, county and city government offices, state employment office, chamber of commerce, religious institutions, and, of course, the school system.

Organizing a Task Force

A coordinated effort to deal with the problems of teenage pregnancy and teenage parenthood calls for a task force made up of representatives from many segments of the community. The schools can initiate efforts, but they cannot do the job alone. It will require cooperative community action on many fronts. The number of members on the task force may vary depending on the community; but it is important that the members selected represent a cross section of the communi-

ty. Representation from the following groups is recommended: schools, parent organizations, health service organizations, religious institutions, minority/ethnic groups, business, local government, student groups, juvenile justice, and community welfare agencies.

If the schools initiate the task force, the approval of the school board will be necessary; also, other members of the task force who officially represent their organizations may have to secure the approval of their governing boards. With such approval the task force can go to work. Its first task will be to gather data from the sources mentioned earlier in this chapter. With such data the task force becomes informed about the problem and all the ramifications it poses for the community. Using this information plus their knowledge of the constituency in the community they represent, the task force members become good spokespersons for convincing the community to support and fund programs and services to deal with the problem of teenage pregnancy and teenage parenthood.

When the task force is ready to report its findings and make its recommendations, it needs to solicit reactions and suggestions from the community. Open hearings are a useful way of doing this. Because many issues related to teenage pregnancy, such as sex education, contraception, and abortion, are controversial, the task force should be prepared to answer questions in a calm and reasoned manner. What is important is that community members have an opportunity to express their opinion. Open hearings can give the task force an indication of what the community is ready to accept in the way of programs and services.

In addition to open hearings, the task force also can reach out to the community by making presentations at the PTA, service clubs, church groups, and the city council. Other ways of informing the community are guest editorials in the local newspaper or a feature story on the work of the task force and its findings. Through these and other means, the task force can get across its message and invite community reaction.

Such community reaction could indicate pockets of resistance or certain programs or services that the community simply will not tolerate. For example, some communities may accept an expanded sex education curriculum in the schools but be unalterably opposed to school-based health clinics. Others may be willing to accept a school-based health clinic but object to its dispensing contraceptives. Each community is different and each will want its adolescent pregnancy program to serve what it feels are the community's specific needs. The challenge of the task force will be to determine, from among the available options, which programs the community will support.

This fastback has described some options. They may not be appropriate for all communities, but they each deserve serious consideration. The problem of teenage pregnancy will not go away, and is likely to increase, unless the schools and community agencies take direct and forceful action.

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