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Teenage Pregnancy Prevention: Statistics and Programs

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Summary

In 2015, U.S. teen births accounted for 5.8% of all births and 12.9% of all nonmarital births. The birth rate for U.S. teenagers (ages 15 through 19) increased in 2006 and 2007 after a steady decline since 1991. However, in each of 2008 through 2015, the teen birth rate dropped below the 2006 teen birth rate, reversing the two-year upward trend. Although the birth rate for U.S. teens has dropped in 22 of the past 24 years, it remains higher than the teen birth rate of most industrialized nations. Preventing teen pregnancy is generally considered a priority among policymakers and the public because of its high economic, social, and health costs for teen parents and their families.

The Adolescent Family Life (AFL) program, created in 1981 (Title XX of the Public Health Service Act), was the first federal program to focus on pregnancy among adolescents. It was created to support demonstration projects that provide comprehensive and innovative health, education, and social services to pregnant and parenting adolescents, their infants, male partners, and their families. From 1998 to 2009, federal teen pregnancy prevention efforts in the AFL program and in general relied heavily on using abstinence-only education as their primary tool. The appropriation for the AFL program was $16.7 million in FY2010 and $12.4 million for FY2011. The AFL program has not received any funding since FY2011.

P.L. 111-117 (Consolidated Appropriations Act, 2010) included a new discretionary Teen Pregnancy Prevention (TPP) program, funded at $110 million for FY2010, which provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy. Since FY2010, funding for the TPP program has fluctuated from a high of $109 million in FY2011 to a low of $98.4 million in FY2013 (post-sequester). P.L. 113-76 (the Consolidated Appropriations Act, 2014) provided $101 million for the TPP program (and $8.5 million for program evaluation) for FY2014. P.L. 113-235 (the Consolidated and Further Continuing Appropriations Act, 2015) funded the TPP program at $101 million for FY2015 (plus $6.8 million for program evaluation). Pursuant to P.L. 114-53 (the Continuing Appropriations Act, 2016; enacted September 30, 2015), the TPP was funded for FY2016 at the FY2015 rate of $101 million (plus $6.8 million for program evaluation) minus an across-the-board rescission of 0.2108%, through December 11, 2015, or enactment of applicable appropriations legislation. Pursuant to P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015), the TPP was funded for FY2016 at $101 million (plus $6.8 million for program evaluation). Pursuant to P.L. 114-223 (the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act; enacted September 29, 2016), the TPP is funded for FY2017 at the FY2016 rate of $101 million annually (prorated) plus $6.8 million for program evaluation, minus an across-the-board reduction of 0.496%, through December 9, 2016, or enactment of applicable appropriations legislation.

P.L. 111-148 (the Patient Protection and Affordable Care Act-ACA) established a new state formula grant program and appropriated $375 million, at $75 million per year for five years (FY2010-FY2014), to enable states to operate a new Personal Responsibility Education Program (PREP), which is a broad approach to teen pregnancy prevention that educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted diseases. PREP also provides youth with information on several adulthood preparation subjects (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills). P.L. 113-93 (the Protecting Access to Medicare Act of 2014), which was enacted on April 1, 2014, extended PREP ($75 million per year) through FY2015 (i.e., September 30, 2015). P.L. 114-10 (the Medicare Access and CHIP

Reauthorization Act of 2015) extended PREP ($75 million per year) through FY2017 (i.e., September 30, 2017).

The Title V Abstinence Education Block Grant to states was authorized under P.L. 104-193 (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996). The Title V Abstinence Education program is a formula grant program, specifically for abstinence-only education, funded by mandatory spending. The program's funding expired on June 30, 2009, but P.L. 111-148 reauthorized the program and restored funding at the previous annual level of $50 million for each of FY2010-FY2014. P.L. 113-93 extended the Title V Abstinence Education block grant ($50 million per year) through FY2015. P.L. 114-10 increased the Title V Abstinence Education block grant to $75 million per year for FY2016 and FY2017.

Several appropriation laws included an additional $5 million for *competitive grants* for abstinence-only education for each of FY2012, FY2013, FY2014, and FY2015 (P.L. 112-74, P.L. 113-6, P.L. 113-76, and P.L. 113-164/P.L. 113-235). P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015) included funding of $10 million for competitive grants which exclusively implement education in sexual risk avoidance (defined as refraining from nonmarital sexual activity) for FY2016. Pursuant to P.L. 114-223 (the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act; enacted September 29, 2016), the competitive sexual risk avoidance grant program (also referred to as abstinence education) is funded for FY2017 at the FY2016 rate of $10 million (annually, prorated) minus an across-the-board reduction of 0.496%, through December 9, 2016, or enactment of applicable appropriations legislation.

This report briefly examines some of the data collected by the National Center for Health Statistics on teenage childbearing, offers potential reasons for high teen pregnancy and birth rates, and provides basic information on federal programs whose purpose is primarily to delay sexual activity among teenagers and to reduce teen pregnancy. **Appendix A** provides a funding history of the teen pregnancy prevention programs discussed in this report.

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Introduction

In 2011, an estimated 552,640 U.S. teenagers (ages 15-19) became pregnant, approximately 80,220 had miscarriages, and 142,650 had legal abortions (latest available data).[1] The result was that there were 329,772 births to teenagers in that year. In 2015, 5.8% of all U.S. births were to teens, and 12.9% of all nonmarital births were to teens.

According to a 2010 report:

> Teen childbearing is associated with adverse health and social outcomes for teen mothers and their children, although these outcomes often reflect preexisting social deficits. Compared with women who delay childbearing until their 20s, teen mothers are more likely to drop out of school and have low educational attainment; to face unemployment, poverty, and welfare dependency; to experience more rapid repeat pregnancy; to become single mothers; and to experience divorce, if they marry. Infants of teen mothers are more likely to be premature and experience infant mortality. The children of teenage mothers do less well on indicators of health and social wellbeing than do children of older mothers.[2]

In recognition of the negative, long-term consequences associated with teenage pregnancy and births, the prevention of out-of-wedlock pregnancies[3] is a major goal of this nation. Reducing nonmarital childbearing is one of the explicit goals that were stipulated in the 1996 welfare reform law.[4] Although the birth rate for U.S. teens has dropped in 22 of the last 24 years, it remains higher than the teenage birth rate of most industrialized nations.[5]

Teenage Births in the United States

National Trends

In 1950, the number of births to U.S. females under age 20 was 438,000; by 1960, births to teens had increased nearly 36% to 593,746; and by 1970 they had increased another 11% to 656,460. Since then, the number of births to teens has generally declined, with some upward fluctuations.

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[1] Kathryn Kost and Isaac Maddow-Zimet, *U.S. Teenage Pregnancies, Births and Abortions, 2011: National Trends by Age, Race and Ethnicity*, Guttmacher Institute, April 2016, p. 8.

[2] John S. Santelli and Andrea J. Melnikas, "Teen Fertility in Transition: Recent and Historic Trends in the United States," *Annual Review of Public Health 2010*, vol. 31, pp. 371-383.

[3] As noted later, 89% of births to females under age 20 were nonmarital births (i.e., births to unmarried women) in 2015. Note that although P.L. 104-193 uses pregnancies as the policy variable, in practice births have become the indicator because birth data are more current and reliable than pregnancy data.

[4] Pursuant to P.L. 104-193 (the 1996 welfare reform law), states may use Temporary Assistance for Needy Families (TANF) funds in any manner "reasonably calculated" to achieve the four goals set forth in TANF statute. These four goals are (1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families. The bulk of federal TANF funding is in a basic block grant totaling $16.5 billion for the 50 states and the District of Columbia.

[5] For further information on a comparison of U.S. teen birth rates with those of other countries, see "Teen Pregnancy Rates Declined In Many Countries Between The Mid-1990s and 2011—United States Lags Behind Many Other Developed Nations," at https://www.guttmacher.org/news-release/2015/teen-pregnancy-rates-declined-many-countries-between-mid-1990s-and-2011. Also see Gilda Sedgh, Lawrence B. Finer, Akinrinola Bankole, Michelle A. Eilers, and Susheela Singh, "Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends," *Journal of Adolescent Health*, vol. 56, issue 2, February 2015, pp. 223-230.

Births to teenagers declined nearly 65% from 1970 to 2015; 59% from 1980 to 2015; 56% from 1990 to 2015; 51% from 2000 to 2015; and 38% from 2010 to 2015. In 2015, the number of births to teens was 232,391 (of which 2,503 births were to girls under age 15).[6]

As shown in **Figure 1**,[7] the peak birth rate for U.S. teenagers occurred in 1957, with 96.3 births per 1,000 women ages 15-19. The 2015 teenage birth rate of 22.3 per 1,000 women ages 15-19 is almost 8% lower than the 2014 teenage birth rate. Teenage birth rates increased during the late 1940s (i.e., the "baby boom" years after World War II) and 1950s, decreased during the 1960s and early 1970s, remained relatively stable between 1975 and 1988, increased sharply during the late 1980s, declined every year from 1991 through 2005, and then increased in 2006 and 2007. The 2015 teen birth rate (22.3 births per 1,000 teens ages 15-19) is currently the lowest teen birth rate recorded. Although the *number* of births to females under age 20 decreased 56% from 1991 to 2015, the *birth rate* of teens ages 15 through 19 declined by nearly 64% in the same period.[8] The smaller decline in the number of births to teens compared with the teen birth rate is due to an increase in the number of teenage females in the 1990s.

In 2015, the birth rate for teenagers ages 15-17 was 9.9 per 1,000 teens ages 15-17, down 74% from 1991. For teens ages 18-19, the birth rate was 40.7 per 1,000 teens ages 18-19, down nearly 57% from 1991.[9]

In 2015, of the 232,391 births to females under age 20, 89% (206,530 births) were to unmarried teenagers.[10] With fewer teens entering into marriage, the proportion of births to unmarried teens has increased dramatically (89% in 2015 versus 29% in 1970).

[6] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, "Births: Preliminary Data for 2015," *National Vital Statistics Reports*, vol. 65, no. 3, June 2, 2016, Table 1.

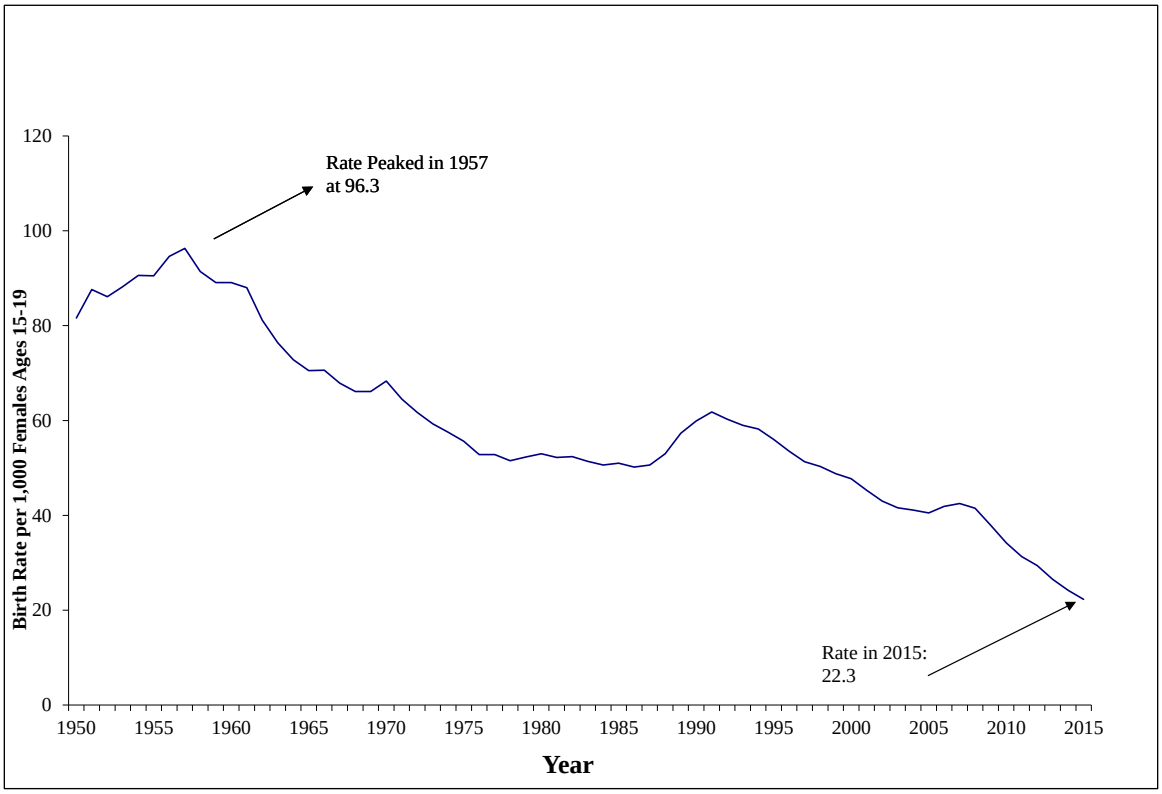
[7] **Table B-1** shows the underlying data for **Figure 1**.

[8] According to the Center for Disease Control and Prevention (CDC), if the 1991 birth rates had prevailed, there would have been an estimated 3.4 million additional births to teenagers from 1992 through 2010. (Source: Brady E. Hamilton and Stephanie J. Ventura, "Birth Rates for U.S. Teenagers Reach Historic Lows for All Age and Ethnic Groups," *NCHS Data Brief*, no. 89, April 2012, p. 3.)

[9] Although this report focuses on teenagers, young adults ages 20-24 also have high birth rates. In 2015, for young adults ages 20-24, the birth rate was 76.9 per 1,000 young adults ages 20-24; down 33% from 1991.

[10] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, "Births: Preliminary Data for 2015," *National Vital Statistics Reports*, vol. 65, no. 3, June 2, 2016, Table 1.

Figure 1. Teen Birth Rates (Ages 15-19), 1950-2015



Source: Chart prepared by the Congressional Research Service (CRS), based on data from the National Center for Health Statistics, Department of Health and Human Services (HHS).

State Data/Trends

Teen birth rates vary considerably from state to state. In 2014, the state with the lowest reported rate was Massachusetts, at 10.6 births per 1,000 women (ages 15-19); the state with the highest reported rate was Arkansas, at 39.5 births per 1,000 women (ages 15-19).[11] From 2013 to 2014, the birth rate of teens (ages 15-19) decreased or did not change significantly in all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, American Samoa, and the Northern Mariana Islands.[12]

Some Demographic Features and Trends

After having declined for all racial and ethnic groups during the period from 1991 to 2005, the teen birth rate increased for white, black, and American Indian/Alaska Native women ages 15 through 19 from 2005 to 2007.[13] The teen birth rates for women ages 15 through 19 decreased for all racial and ethnic groups during the period 2007 to 2015.[14] From 2007 to 2015, teen birth rates (for women ages 15 through 19) fell 54% for Hispanic teens, 53% for Asian/Pacific Islander

[11] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, Sally C. Curtin, and T.J. Mathews, "Births: Final Data for 2014," *National Vital Statistics Reports*, vol. 64, no. 12, December 23, 2015, Table 12 and p. 6.

[12] Ibid.

[13] Joyce A. Martin, Brady E. Hamilton, Stephanie J. Ventura, Michelle J.K. Osterman, and T.J. Mathews, "Births: Final Data for 2011," *National Vital Statistics Reports*, vol. 62, no. 1, June 28, 2013, Table A.

[14] Brady E. Hamilton and T.J. Mathews, "Continued Decline in Teen Births in the United States, 2015," National Center for Health Statistics, *NCHS Data Brief*, no. 259, September 2016, p. 2.

teens, 49% for black teens, 48% for American Indian/Alaska Native teens, and 41% for white teens. However, birth rates for Hispanic, black, and American Indian/Alaska Native teenagers continue to be much higher than that of other racial/ethnic groups. In 2015, Hispanic teens (ages 15-19) gave birth at a rate of 34.9 per 1,000 Hispanic teens. Black teens gave birth at a rate of 31.8 per 1,000 black teens. American Indian/Alaska Native teens gave birth at a rate of 25.7 per 1,000 American Indian/Alaska Native teens. In contrast, white teens gave birth at a rate of 16.0 per 1,000 white teens, and Asian/Pacific Islander teens gave birth at the lowest rate, 6.9 per 1,000 Asian/Pacific Islanders teens.[15]

Also noteworthy is the decline in subsequent births among teens. In 1951, 28% of all teen births were second or higher-order births, compared to 17% in 2014.[16]

Financial and Social Costs of Teen Births

Preventing teen pregnancy is generally considered a priority among policymakers and the public because of its high economic, social, and health costs for teen parents and their families. Teenage mothers and fathers tend to have less education and are more likely to live in poverty than their peers who are not teen parents. Children of teenage mothers are more likely than children of older mothers to have chronic medical conditions, rely heavily on provided health care, do poorly in school, give birth during their teen years (continuing the cycle of teen pregnancy), spend some time in a juvenile detention facility or jail, and be unemployed or underemployed as a young adult.[17]

Other data indicate that 30% of teen girls who have dropped out of high school cite pregnancy or parenthood as a reason, 67% of teen mothers who moved out of their own family's household live below the poverty level, 63% of teen mothers receive some type of public benefits within the first year after their children are born, less than 25% of teen mothers receive any child support payments, and children born to mothers under age 18 score significantly worse on measures of school readiness including math and reading tests.[18]

Teen childbearing in the United States cost taxpayers (federal, state, and local) about $9.4 billion in 2010, according to an analysis by The National Campaign to Prevent Teen and Unplanned Pregnancy.[19] According to the report, most of the costs of teen childbearing are associated with negative consequences for the children of teen mothers, including increased costs for health care, child welfare, incarceration, and lost tax revenue. The study looks only at the increase in these costs that is associated with having a child before age 20 versus having a child at age 20 or 21. That is, they are net costs and not gross costs.[20]

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[15] Ibid.

[16] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, Sally C. Curtin, and T.J. Mathews, "Births: Final Data for 2014," *National Vital Statistics Reports*, vol. 64, no. 12, December 23, 2015, Table 2.

[17] Emily Holcombe, Kristen Peterson, and Jennifer Manlove, *Ten Reasons to Still Keep the Focus on Teen Childbearing*, Child Trends, March 2009. See also: Urban Institute, *Kids Having Kids: Costs and Social Consequences of Teen Pregnancy*, edited by Saul D. Hoffman and Rebecca A. Maynard, 2008 (second edition).

[18] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Why It Matters: Teen Childbearing, Education, and Economic Wellbeing*, July 2012.

[19] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Counting It Up—The Public Cost of Teen Childbearing: Key Data*, December 2013. (This analysis updates research originally conducted by Saul Hoffman, of the University of Delaware, and released by the National Campaign to Prevent Teen Pregnancy in 2006.)

[20] The costs discussed by the study include those associated with all children in a given year who had been born to a teen mother—this includes very young children as well as those who are currently adolescents or young adults.

The December 2013 study by the National Campaign to Prevent Teen Pregnancy estimated that in 2010, adolescent childbearing cost U.S. taxpayers about $9.4 billion per year: $3.1 billion in child welfare benefits; $2.1 billion in public sector health care expenses; $2.0 billion in spending on incarceration (for the sons of women who had children as adolescents); and $2.2 billion in lost tax revenue because of lower earnings of children of teen mothers over their own adult lifetimes. Research indicates that teens who give birth are less likely to complete high school and go on to college, thereby reducing their potential for economic self-sufficiency. The research also indicates that the children of teens are more likely than children of older parents to experience problems in school and drop out of high school, and as adults are more likely to repeat the cycle of teenage pregnancy and poverty. The 2013 report contends that if the teen birth rate had not declined between 1991 and 2010, the annual costs associated with teen childbearing would have been about $21 billion (instead of $9.4 billion).[21]

Reasons for High Pregnancy and Birth Rates Among Teens

In 2015, 24.1% of 9th graders reported having experienced sexual intercourse. The corresponding statistics for older teens were 35.7% for 10th graders, 49.6% for 11th graders, and 58.1% for 12th graders.[22]

The high volume of pregnancies and birth rates among teenagers is associated with earlier sexual activity among teen girls. Also, beginning in about 2004, the use of contraception (which was never as high as the use in other developed countries) started waning.[23] The academic and professional communities also maintain that teen parenthood is one of the negative consequences of growing up without a father.[24] The president of the Alan Guttmacher Institute, commenting on a study about adolescent pregnancy and childbearing in "developed" countries, stated: "In the United States, poverty and inequity clearly are behind much of our high rates of pregnancy, birth and abortion. But lack of sensitive, confidential, low-cost contraceptive services and the denial of accurate and frank information about sex, are equally to blame."[25] Other commentators argue that

> teen childbearing is so high in the United States because of underlying social and economic problems. It reflects a decision among a set of girls to "drop-out" of the economic mainstream; they choose non-marital motherhood at a young age instead of investing in their own economic progress because they feel they have little chance of advancement.[26]

[21] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Counting It Up—The Public Cost of Teen Childbearing: Key Data*, December 2013.

[22] Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance—United States, 2015," *MMWR*, vol. 65, no.6, June 10, 2016, p. 119 (Table 69).

[23] John S. Santelli and Andrea J. Melnikas, "Teen Fertility in Transition: Recent and Historic Trends in the United States," *Annual Review of Public Health 2010*, vol. 31, pp. 375-376.

[24] Wendy Sigle-Rushton and Sara McLanahan, *Father Absence and Child Well-Being: A Critical Review*, Princeton University, Center for Research on Child Wellbeing (Working Paper #02-20), November 2002.

[25] Alan Guttmacher Institute, *United States and the Russian Federation Lead the Developed World in Teenage Pregnancy Rates*, News Release, February 24, 2000, p. 2.

[26] Kearney and Levine, "Why is the teen birth rate in the United States so high and why does it matter?" *Journal of Economic Perspectives*, Spring: 26(2), 2012, pp. 141-166.

Decline in Pregnancy/Birth Rates

One reason given for the historical decline (1991-2005) in teen pregnancies and births is that sexually active female teenagers had significantly increased their use of contraceptives, particularly condoms. Abstinence campaigns, aimed at younger teens, were also seen as having a positive effect on pregnancy prevention. Moreover, casual sex, which may increase the risk of sexually transmitted diseases (STDs) and may prove to be fatal given the presence of HIV/AIDS, is viewed in an increasingly negative light by many teenagers.

In 2006 and 2007, the decline in the teen birth rate was interrupted by a small increase. According to a 2008 report:

> A dearth of research examining the factors responsible for previous trends undermines our ability to understand what may be occurring at present. Hypotheses abound, including changes in the economy, attitudes, anxiety, schooling, public policy, programs and services, families, and media messages. In addition, prevention fatigue and the need for new strategies to reach teens who have not been reached by existing approaches have also been suggested.[27]

Some observers attribute the return to the long-term downward trend in teen birth rates (after the two-year increase in 2006 and 2007) to the severe recession that began in 2008. They contend that the decrease in teen births—like the decrease in overall births—is, in part, because teenagers are being more careful as they witness the economic difficulties faced by their families.[28]

According to the Center for Disease Control and Prevention (CDC):

> The impact of strong pregnancy prevention messages directed to teenagers has been credited with the birth rate declines. Recently released data from the National Survey of Family Growth, conducted by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS), have shown increased use of contraception at first initiation of sex and use of dual methods of contraception (that is, condoms and hormonal methods) among sexually active female and male teenagers. These trends may have contributed to the recent birth rate declines.[29]

According to several commentators, several factors have been discussed among researchers as reasons underlying the falling teen birth rate during the period since 2007. Some of these factors include (1) the recession that started in late 2007 and ended in the middle of 2009; (2) the slight increase in IUD use; (3) the popular MTV show that deglamorized teen pregnancy; (4) the use of the Plan B "morning after" pill; and (5) increased use of the Internet via iPhones which allow teenagers immediate access to information they may have been too embarrassed to ask parents or other adults.[30] There is not agreement among researchers regarding which of and to what extent the aforementioned factors contributed to the 46% reduction in teen births since 2007.

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[27] The National Campaign to Prevent Teen and Unplanned Pregnancy and Child Trends, *Teen Births: Examining the Recent Increase*, by Kristin Anderson Moore, October 2008, p. 1.

[28] Rob Stein, "Birthrate Among Teens Hits Record Low," *Washington Post*, December 22, 2010, A02.

[29] Brady E. Hamilton and Stephanie J. Ventura, "Birth Rates for U.S. Teenagers Reach Historic Lows for All Age and Ethnic Groups," *NCHS Data Brief*, no. 89, April 2012, p. 5.

[30] Sarah Kliff, The mystery of the falling teen birth rate, September 22, 2014 (updated January 21), http://www.vox.com/2014/8/20/5987845/the-mystery-of-the-falling-teen-birth-rate. See also: Pew Research Center, Why is the teen birth rate falling?, by Eileen Patten and Gretchen Livingston, April 29, 2016. See also: Heather D. Boonstra, "What is Behind the Declines in Teen Pregnancy Rates?" *Guttmacher Policy Review*, vol. 17, issue 3, September 3, 2014.

Other interested parties maintain that "with improved economic opportunities, reduced poverty, and improved prospects for other adult outcomes, teen pregnancy would also decline."[31] They assert that public policies targeted directly at teen pregnancy prevention such as sex education, improved access to contraception, and abstinence counseling are not likely to improve outcomes much for disadvantaged young women.[32]

Federal Strategies to Reduce Teen Pregnancy

Reducing nonmarital pregnancies is one of the explicit goals that were stipulated in the 1996 welfare reform law (P.L. 104-193). The 1996 welfare reform law also provided funding for and spearheaded the abstinence-only approach for preventing and reducing teen pregnancy.

Although the pregnancy rate, birth rate, and abortion rate for teens have all dropped in recent years, the teen birth rate in the United States is still far above that of most industrialized countries.[33] The U.S. teen birth rate was 1.4 times that of the United Kingdom and eight times that of Switzerland.[34] According to the United Nations Demographic Yearbook for 2014, teen birth rates were 3.0 births per 1,000 teens ages 15-19 in Switzerland; 4.3 births per 1,000 teens ages 15-19 in Denmark; 4.4 births per 1,000 teens ages 15-19 in Japan, 7.8 per 1,000 in Germany; 14.1 per 1,000 in Canada (2009 data); 17.3 per 1,000 in the United Kingdom; and 24.2 per 1,000 in the United States.[35]

Until recently, there was a great divide in the teen pregnancy prevention arena with one group maintaining that "abstinence-only education" programs (sometimes referred to as sexual risk avoidance programs) are the best and healthiest strategy to prevent unintended teen pregnancies and sexually transmitted infections among teenagers[36] (see "1996-2009: Abstinence Only" section below for additional arguments). The other group claims a comprehensive approach to sex education provides today's youth with the information and decisionmaking skills needed to make realistic, practical decisions about whether to engage in sexual activities. They contend that such an approach allows young people to make informed decisions regarding abstinence, gives them the information they need to set relationship limits and to resist peer pressure, and also provides them with information on the use of contraceptives and the prevention of sexually transmitted diseases.[37] Given that 47.4% (2011 data) of high school students have experienced sexual intercourse, advocates argue that abstinence-only messages provide no protection against the risks of pregnancy and disease for these youth. They further point out that according to one study, teens

[31] Melissa S. Kearney and Phillip B. Levine, "Why is the Teen Birth Rate in the United States So High and Why Does It Matter?," *Journal of Economic Perspectives*, vol. 26, no. 2 (Spring 2012), p. 163.

[32] Ibid.

[33] Guttmacher Institute, news release, "Teen Pregnancy Rates Declined In Many Countries Between The Mid-1990s and 2011—United States Lags Behind Many Other Developed Nations," January 23, 2015.

[34] The Guttmacher news release indicated that Switzerland has long-standing sex education programs, free family planning services, low-cost emergency contraceptives, and that sexually active teen are expected to use contraceptives.

[35] United Nations Statistics Division, "Demographic Yearbook 2014," see http://unstats.un.org/unsd/demographic/products/dyb/dyb2014.htm, Table 10. See also "Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries," by Susheela Singh and Jacqueline E. Darroch, *Family Planning Perspectives*, Alan Guttmacher Institute, vol. 3, no. 1, January/February 2000, pp. 14-23.

[36] U.S. House of Representatives, Committee on Energy and Commerce, *The Policy Paper Series: Transforming Ideas Into Solutions, vol. 1, issue 2*, "A Better Approach to Teenage Pregnancy Prevention-Sexual Risk Avoidance," prepared by the Energy and Commerce Committee Majority Staff, July 2012.

[37] Some contend that the abstinence-only approach leads to a substitution of other risky behaviors such as oral sex. They cite data that indicate that about 25% of virgin teens ages 15 through 19 have engaged in oral sex; Child Trends Data Bank, "New Indicator on Oral Sex," September 15, 2005, at http://www.childtrendsdatabank.org/whatsNew.cfm.

who break their virginity pledges were less likely to use contraception the first time than teens who had never made such a promise.[38] In addition, the high number of females under age 25 with sexually transmitted infections (STIs)[39] has re-energized efforts to persuade girls and young women to abstain from sexual activity or to use condoms (along with other forms of contraceptives) to prevent or reduce pregnancy and reduce their risk of getting STIs.[40]

A nationally representative survey conducted in 2012 found that (1) 93% of adults and 87% of teens agree that young people should get a strong message that they should not have sex until they are at least out of high school, and (2) a majority of adults (74%) and many teens (49%) want teens to get more information about both abstinence and contraception. Specifically with regard to federally funded programs, 62% of parents of teens indicated that teens should be provided with information about both postponing sex and about birth control or protection.[41] The American public—both adults and teens—support encouraging teens to delay sexual activity *and* providing young people with information about contraception.[42] They see encouraging teens to delay sex and providing teens with information about contraception as complementary, not contradictory strategies.

In 2010, HHS Secretary Kathleen Sebelius stated: "Teen pregnancy is a serious national problem and we need to use the best science of what works to address it. This investment will help bring evidence-based initiatives to more communities across the country while also testing new approaches so we can expand our toolkit of effective interventions."[43]

The CDC has identified teen pregnancy prevention as a winnable battle. According to the CDC:

> Through our experience, we know that we can prevent teen pregnancies by promoting teen-friendly interventions aimed at both increasing the number of teens who abstain from or delay sexual activity, and increasing the number of sexually active teens who consistently and correctly use effective contraceptive methods. This can be accomplished by involving more teens in evidence-based programs and linking prevention programs to clinical services.[44]

The following section examines federal strategies to reduce teen pregnancy by focusing on three time periods: 1981-1996, 1996-2009, and 2009 to the present.

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[38] Peter S. Bearman and Hannah Bruckner, "Promising the Future: Virginity Pledges as They Affect the Transition to First Intercourse," *American Journal of Sociology*, January 2001.

[39] This report uses the term sexually transmitted diseases (STDs) and sexually transmitted infections (STIs) interchangeably.

[40] A Centers for Disease Control and Prevention (CDC) report indicated that approximately 19 million new sexually transmitted infections occur each year, almost half of them among young people ages 15 to 24; "Trends in Reportable Sexually Transmitted Disease in the United States, 2007," January 5, 2009.

[41] Bill Albert, *With One Voice 2012—America's Adults and Teens Sound Off About Teen Pregnancy*, National Campaign to Prevent Teen Pregnancy and Unplanned Parenthood, August 2012, pp. 17-19, http://thenationalcampaign.org/sites/default/files/resource-primary-download/wov_2012.pdf.

[42] There appears to be significant public support for the involvement of religious groups in preventing teen pregnancy. In the survey associated with the "With One Voice report," adults (73%) and teens (75%) agreed that religious leaders and groups should be doing more to help prevent teen pregnancy. (Source: Bill Albert, *With One Voice 2012—America's Adults and Teens Sound Off About Teen Pregnancy*, National Campaign to Prevent Teen Pregnancy and Unplanned Parenthood, August 2012, p. 38, http://thenationalcampaign.org/sites/default/files/resource-primary-download/wov_2012.pdf.)

[43] U.S. Department of Health and Human Services, *HHS awards evidence-based teen pregnancy prevention grants*, news release, September 30, 2010.

[44] Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Dear Colleague Letter by Thomas R. Frieden, Director, Centers for Disease Control and Prevention, January 14, 2011.

1981-1996: Reducing Pregnancies and Helping Adolescent Mothers

The Adolescent Family Life (AFL) program (Title XX of the Public Health Service Act), created in 1981, was the first federal program to focus on adolescents. From 1981 to 1996, the AFL program was the only federal program that was required to use all of its funding directly (and exclusively) on the issues of adolescent sexuality, pregnancy, and parenting.

The AFL program authorized grants for three types of demonstrations: (1) projects that provide "care" services only (i.e., health, sex education information, including information about contraceptive methods, and social services to pregnant adolescents, adolescent parents, and their infants, families, and male partners);[45] (2) projects that provide "prevention" services only (i.e., services to promote abstinence from premarital sexual relations, including abstinence-only-focused educational information, for pre-teens, teens, and their families); and (3) projects that provide a combination of care and prevention services.

It is important to note that until 1998, the "prevention" services component of the AFL program offered a wide range of interventions, including contraception services, to help young people avoid pregnancy. It was only after implementation of the Title V Abstinence Education block grant to states (discussed later) that Congress mandated that AFL "prevention" demonstration grants were only to be awarded for programs that used an abstinence-only model (that adhered to the abstinence definition used by the Title V Abstinence Education program).

The AFL program also provided funding for research grants dealing with various aspects of adolescent sexuality, pregnancy, and parenting. Through its research component, the AFL program attempted to increase understanding of how to prevent adolescent pregnancies and their adverse consequences. Research projects have included studies that examined the causes and consequences of adolescent sexual relations, the use of contraceptives, the impact of pregnancy on adolescents, and child-rearing practices of adolescents. (The AFL program is described in greater detail later in this report.)

1996-2009: Abstinence Only

When the idea of abstinence-only education was being discussed during the 1994-1996 welfare reform debate, it was in the context of providing funding for abstinence education that was equal to amounts provided then for programs which, among other things, provided information about contraception and sexually transmitted diseases and sometimes referrals or access to contraception services to teenagers.

From 1996 through 2009, federal teen pregnancy prevention efforts relied heavily on using abstinence-only education as the primary tool.

Many commentators argued then (and now) that sexual activity in and of itself is wrong if the individuals are not married. Advocates of the abstinence education approach argue that teenagers need to hear a single, unambiguous message that sex outside of marriage is wrong and harmful to their physical and emotional health. These advocates contend that youth can and should be empowered to say no to sex. They argue that supporting both abstinence and birth control is hypocritical and undermines the strength of an abstinence-only message. They also cite research

[45] These care services projects are synonymous to what is now generally referred to as comprehensive sex education. Comprehensive sex education programs generally include one or more of the following components: (1) information about the benefits of abstinence, (2) information on the use of condoms and other contraceptive devices or methods for those who are sexually active, (3) information on the importance of early identification and treatment of sexually transmitted diseases, (4) information on how to resist negative peer pressure, and (5) information on how to improve communication skills (e.g., how to say no).

that indicates that teens who take virginity pledges to refrain from sex until marriage appear to delay having sex longer than those teens who do not make such a commitment. (One study found that teens who publicly promise to postpone sex until marriage refrain from intercourse for about a year and a half longer than teens who did not make such a pledge.)[46] They further argue that abstinence is the most effective means (i.e., 100%) of preventing unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS.[47]

Until FY2010, three federal programs included funding that was exclusively for abstinence education: the Title V Abstinence Education Block Grant to states, the Community-Based Abstinence Education (CBAE) program, and the "prevention" component of the Adolescent Family Life (AFL) demonstration program. All of these programs were carried out by HHS and are discussed in detail, later in this report.

2009-Present: Evidence-Based

Until legislation passed in 2010 (P.L. 111-117 and P.L. 111-148), there was no federal funding stream exclusively for teen pregnancy prevention initiatives that included an array of intervention approaches including both abstinence-only and contraception information/services. The following two programs, established in the 111th Congress, provide federal funding for evidence-based teen pregnancy prevention initiatives: (1) the discretionary spending Teen Pregnancy Prevention (TPP) program and (2) the mandatory spending Personal Responsibility Education Program (PREP). These programs and their funding levels are discussed in detail in a later section of this report.

It appears that a consensus is now growing around the viewpoint that success in the teen pregnancy prevention arena does not necessarily have to be an "either-or" proposition in which "abstinence-only education" programs (sometimes referred to as sexual risk avoidance programs) are pitted against "comprehensive sex education" programs (sometimes referred to as sexual risk reduction programs).

The Obama Administration has indicated that it will use evidence-based approaches to expand programs that work and eliminate programs that do not work. The Obama Administration is supportive of using rigorous evaluation (i.e., a scientific method using experimental and control groups) to determine whether untested innovative programs are effective.[48] As discussed later, the Department of Health and Human Services (HHS) has compiled a list of 37 evidence-based program models that it has found to be effective in delaying sexual activity, increasing condom or contraception use for sexually active youth, or reducing teen pregnancy.[49] This list includes many programs designed to educate youth on both abstinence and contraception for the purpose of preventing teen pregnancy. It also includes a couple of programs that many would consider abstinence-only education programs.[50] The evidence-based approach to teen pregnancy

[46] Peter S. Bearman and Hannah Bruckner, "Promising the Future: Virginity Pledges as They Affect the Transition to First Intercourse," *American Journal of Sociology*, January 2001.

[47] Those opposed to the abstinence-only education approach generally favor a comprehensive sex education approach, but also claim that abstinence-only programs often use medically inaccurate information regarding STDs, condoms, and other contraceptive devices. The Department of Health and Human Services (HHS) now requires grantees of abstinence education programs to sign written assurances in grant applications that the material/data they use are medically accurate.

[48] Ron Haskins and Jon Baron, *Part 6: The Obama Administration's Evidence-Based Social Policy Initiatives: An Overview*, Coalition for Evidence-Based Policy http://www.brookings.edu/~/media/Files/rc/articles/2011/04_obama_social_policy_haskins/04_obama_social_policy_haskins.pdf.

[49] See http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/tpp-searchable.html.

[50] The list of 37 evidence-based models includes several programs that are considered abstinence-only interventions: (1) Heritage Keepers Abstinence; (2) Making a Difference!; and (3) Promoting Health Among Teens! Abstinence-Only Intervention.

prevention holds the view that whatever services or program components that are proven to be effective should be replicated or expanded upon by entities seeking federal dollars to prevent pregnancy among young people.

Evidence-based teen pregnancy prevention programs are varied and approach the problem from different frameworks. Some teen pregnancy prevention programs seek to delay the first time teens have sex. Others have an underlying goal of trying to decipher the root reasons behind teen pregnancy and childbearing. Is it loneliness or trying to find love or a sense of family? Is it carelessness (not bothering with birth control or using it improperly), or shame (not wanting to go to the doctor to ask about birth control or not wanting to be seen in a pharmacy purchasing birth control)? Is it a need to meet the sexual expectations of a partner? Is it trying to find individual independence or is it defiance (a mentality of "you can't boss me or control me—I'm grown")? Is it trying to validate and/or provide purpose to one's life? Is it realistically facing the probability that the entry-level job she can get at the age of 18 is the same or similar to the one she will likely have when she is 30, thus why should she wait to have a child?

In addition, the purpose of several teen pregnancy prevention programs is to prevent second or additional births to teens. The more successful of such programs recognize that a different approach is often needed to prevent secondary births as compared to first births. Research has indicated that teen pregnancy prevention programs that include mentoring components, enhanced case management, home visits by trained nurses and/or program personnel, and parenting classes have been effective in reducing subsequent childbearing by teens.[51]

According to The National Campaign to Prevent Teen and Unplanned Pregnancy:

> Most researchers agree that evidence-based teen pregnancy prevention programs share some common characteristics:
>
> • They have a strong theoretical underpinning that has both guided program development and informed the evaluation. Using theory helps program developers focus on specific risk and protective factors, which in turn strengthens their chances of changing behavior related to teen pregnancy.
>
> • They have been rigorously evaluated (that is, the evaluation tracked both implementation and outcomes, was based on randomized controlled trials or quasi-experimental methods, included adequate sample size and follow-up, addressed issues of retention/attrition, and used appropriate statistical analyses to control for confounding factors; some would add replication in multiple sites).
>
> • They change behavior—outcomes typically include delaying sex, increasing contraceptive use among sexually active teens, reducing the number of sexual partners, or reducing teen pregnancy itself. While positive changes in knowledge, attitudes, and behavioral intent are also encouraging, these outcomes are not as strongly tied to preventing teen pregnancy.
>
> • The evaluation results have been published in peer reviewed journals.[52]

The National Campaign to Prevent Teen and Unplanned Pregnancy also has stated the following:

> In the ongoing debate over teen pregnancy prevention, some of these characteristics have been called into question. We believe that it is important to clarify that different programmatic approaches can be grounded in different theories of behavior change. That

[51] Erin Schelar, Kerry Franzetta, and Jennifer Manlove, "Repeat Teen Childbearing: Differences Across States and by Race and Ethnicity," *Child Trends, Research Brief no. 2007-23*, October 2007.

[52] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Policy Brief: Key Points About Teen Pregnancy Prevention*, December 2012, p. 3.

> is, there is no single valid theory. To suggest that a program is not theory-based because one does not agree with the theory or the approach is simply inaccurate. It is also inaccurate to suggest that one approach is more effective because of its underlying theory—effectiveness is an empirical question that needs to be tested by looking at the results of the program. Similarly, it is not valid to compare a theory to a proven intervention.[53]

Federal Teen Pregnancy Prevention Programs[54]

Teen Pregnancy Prevention (TPP) Program

P.L. 111-117, the Consolidated Appropriations Act, FY2010, provided funding for a new discretionary TPP program that provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy and for the federal costs associated with administering and evaluating such grants and contracts. The TPP program is administered by the Office of Adolescent Health in the Office Assistant Secretary for Health in the Department of Health and Human Services (HHS).

The following types of entities are eligible to apply for TPP program funding: nonprofit organizations, for-profit organizations, universities/colleges, research institutions, hospitals, community-based organizations, faith-based organizations, Indian tribes and tribal organizations, state/local governments, and small businesses.

Of the $110 million appropriated for the TPP program for FY2010, $75 million was for "Tier 1" grants to replicate programs that had been proven through rigorous evaluation to be effective in reducing teenage pregnancy, behavioral factors underlying teen pregnancy, or other related risk factors;[55] $25 million was for "Tier 2" grants for research and demonstration projects; and $10 million was for training and technical assistance, outreach, and other program support. P.L. 111-117 also provided a separate $4.5 million for FY2010 (within the Public Health Service Act program evaluation funding) to carry out evaluations of TPP program approaches.

Within the TPP program, "Tier 1" grants are available on a competitive basis for two broad program types: (1) curriculum-based programs that seek to educate young people about topics such as responsible behavior, relationships, and pregnancy prevention; and (2) youth development programs that seek to reduce teenage pregnancy and a variety of risky behaviors through a broad range of approaches. Youth development programs usually incorporate multiple components, such as service learning, academic support, or opportunities to participate in sports or the arts. They also collaborate with multiple networks and/or provide youth with development-focused activities. In both cases, funding under this announcement can only be provided to applicants who seek to replicate evidence-based programs that have been shown to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors.[56] In most

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[53] Ibid.

[54] See **Appendix A** for a funding history of the programs discussed in this section of the report. Also see The National Campaign to Prevent Teen and Unplanned Pregnancy, *Federal Funding Streams for Teen Pregnancy Prevention*, March 2014.

[55] Under a contract with HHS, Mathematica Policy Research conducted an independent, systematic review of the evidence base. This review defined the criteria for the quality of an evaluation study and the strength of evidence for a particular intervention. Based on these criteria, HHS has defined a set of rigorous standards an evaluation must meet in order for a program to be considered effective. HHS has compiled a list of 31 evidence-based program models that it has deemed to have met those standards. (The 31 evidence-based programs can be found at http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs.html.

[56] U.S. Department of Health and Human Services (HHS), Office of Public Health and Science, Office of Adolescent Health, *Teenage Pregnancy Prevention: Replication of Evidence-based Programs*, Funding Opportunity

cases the Tier 1 grants must replicate an evidence-based program model that has been deemed by HHS to be effective.[57]

"Tier 2" grants are available on a competitive basis for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy.[58]

Since its inception in FY2010, TPP program funding has ranged from a high of $110 million in FY2010 to a post-sequester[59] low of $98.4 million in FY2013. Funding for TPP program evaluation was $4.5 million in FY2010 and $4.4 million in FY2011, it was increased to $8.5 million for each of FY2012 through FY2014, and was decreased to $6.8 million in FY2015 and FY2016. (See **Appendix A** for a funding history of the TPP program.)

P.L. 113-76 (the Consolidated Appropriations Act, 2014; enacted January 17, 2014) included funding of $101 million for the TPP program for FY2014. It also included funding of $8.5 million for program evaluation for FY2014.[60]

Pursuant to P.L. 113-164 (the Continuing Appropriations Resolution, 2015; enacted September 19, 2014), for FY2015 the TPP program was funded at the FY2014 rate of $101 million (plus $8.5 million for program evaluation) through December 11, 2014, or enactment of applicable appropriations legislation.

Pursuant to P.L. 113-235 (the Consolidated and Further Continuing Appropriations Act, 2015; enacted December 16, 2014), the TPP program was funded at $101 million for FY2015 (plus $6.8 million for program evaluation). On July 6, 2015, HHS announced that it had awarded $86.5 million in TPP grants to 81 nonprofit organizations, school districts, universities, and others.

Pursuant to P.L. 114-53 (the Continuing Appropriations Act, 2016; enacted September 30, 2015) the TPP was funded for FY2016 at the FY2015 rate of $101 million (plus $6.8 million for program evaluation) minus an across-the-board rescission of 0.2108%, through December 11, 2015, or enactment of applicable appropriations legislation.

Pursuant to P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015), the TPP was funded for FY2016 at $101 million (plus $6.8 million for program evaluation).

Pursuant to P.L. 114-223 (the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act; enacted September 29, 2016), the TPP is funded for FY2017 at the FY2016 rate of $101 million annually (prorated) plus $6.8 million for program evaluation, minus an across-the-board

Announcement and Application Instructions, 2010.

[57] If an applicant for a Tier 1 TPP program grant wants to apply to replicate a program model that is not on the HHS list of 31 evidence-based models, it may do so only if it is able to meet stringent specified criteria. Such applicants may be more successful if they submit applications for the Tier 2 TPP program for the teen pregnancy prevention research and demonstration grants.

[58] U.S. Department of Health and Human Services (HHS), Office of Public Health and Science, Office of Adolescent Health & Administration for Children and Families, Administration on Children, Youth and Families, *Teenage Pregnancy Prevention (TPP): Research and Demonstration Programs and Personal Responsibility Education Program (PREP)*, Funding Opportunity Announcement and Application Instructions, 2010.

[59] The American Taxpayer Relief Act (ATRA, P.L. 112-240), enacted on January 2, 2013, made a number of significant changes to the procedures in the Budget Control Act of 2011 (BCA, P.L. 112-25). BCA, which included sequestration of most programs, projects, and activities included in the budget, was implemented on March 1, 2013. The sequestration of funds was ultimately applied at the program, project, and activity level within each account.

[60] For additional information on the TPP program, see the following webpage: http://thenationalcampaign.org/sites/default/files/resource-primary-download/overview_fedfunding.pdf.

reduction of 0.496%, through December 9, 2016, or enactment of applicable appropriations legislation.

In July 2015, HHS awarded 81 new TPP program grants amounting to $86 million to nonprofit organizations, school districts, universities, and others.[61]

Personal Responsibility Education Program

P.L. 111-148 (the Patient Protection and Affordable Care Act, ACA) established a new state formula grant program and appropriated $375 million at $75 million per year (mandatory spending) for five years (FY2010 through FY2014)[62] to enable states to operate a new Personal Responsibility Education Program (PREP), which is a broad approach to teen pregnancy prevention that educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted diseases. It also provides youth with information on several adulthood preparation subjects (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills). P.L. 113-93 (the Protecting Access to Medicare Act of 2014), which was enacted on April 1, 2014, extended PREP ($75 million per year) through FY2015 (i.e., September 30, 2015). P.L. 114-10 (the Medicare Access and CHIP Reauthorization Act of 2015) extended PREP ($75 million per year) through FY2017 (i.e., September 30, 2017).

A total of 59 jurisdictions are eligible for PREP. Eligible entities include all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Federated States of Micronesia, the Marshall Islands, and Palau. PREP funds do not require a state match. PREP is administered by the Administration on Children, Youth and Families' (ACYF) Family and Youth Services Bureau (FYSB) in HHS.

PREP contains five components: (1) state PREP formula grants, (2) competitive PREP grants, (3) Tribal PREP, (4) PREP–Innovative Strategies (PREIS), and (5) funding for training, technical assistance, and evaluation.[63]

Most of the PREP appropriation (about $55.250 million annually) goes to states/territories (via a formula grant based on youth population). The formula for determining the PREP allocation to states and territories is derived by calculating the proportion of the number of youth between the ages of 10 and 19 of a state to the total number of youth between the ages of 10 and 19 in all of the states and territories. A state/territory's application for PREP funding must include a description of the state's plan for using the allotment to achieve stipulated goals especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under age 21, mothers who are under age 21, and youth residing in areas with high birth rates for youth.[64]

Currently 45 states, the District of Columbia, Puerto Rico, the Virgin Islands, and the Federated States of Micronesia receive PREP formula grant funds.[65]

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[61] See http://www.hhs.gov/about/news/2015/07/06/hhs-awards-teen-pregnancy-prevention-program-grants.

[62] PREP also was subject to sequestration. The FY2013 post-sequester operating level for PREP was $71.2 million in FY2013. The FY2014 post-sequester operating level for PREP is $69.6 million in FY2014.

[63] U.S. Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, HHS, Administration for Children and Families, FY2015*, pp. 339-340.

[64] For a list of the grantees, see http://www.acf.hhs.gov/programs/fysb/resource/2014-state-prep-awards.

[65] Florida, Indiana, North Dakota, Texas, and Virginia and the territories of American Samoa, Guam, the Marshall

If a state or territory failed to submit an application in FY2010 or FY2011, the state/territory was ineligible to apply for funds from the amounts allotted to the state or territory for each of FY2012, FY2013, and FY2014. Funds that would have gone to those jurisdictions for fiscal years 2010 through 2014 were used to award competitive three-year grants to local organizations and entities for the same purpose and in the same geographic regions.[66] An organization or entity awarded such a grant must agree to participate in a rigorous federal evaluation.

The first two components of PREP mentioned above (i.e., the state formula grant and the state competitive grant) are defined as programs designed to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, and at least three of the six stipulated adulthood preparation subjects. These two components of PREP also are required by law to replicate effective evidence-based programs or substantially incorporate elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth. They also are required to be medically accurate and age-appropriate. As mentioned earlier, HHS established, through a systematic review, a list of 31 program models that are considered evidence-based programs that have been found to be effective in achieving one of the behavioral outcomes: delaying sexual activity, increasing condom or contraception use for sexually active youth, or reducing pregnancy among youth. These evidence-based models are examples of programs that are eligible for replication and the programs from which states can incorporate significant elements. States are required to assure that their program (1) addresses both abstinence and contraception, and (2) incorporates at least three of the adult preparation subjects.

Tribal PREP (funded at $3.250 million annually) provides grants to tribes and tribal organizations to implement PREP. It supports 16 grantees and projects. Programs are encouraged to use models (or elements of models) of existing teen pregnancy prevention programs that have been proven by scientific research to be effective in changing behavior.

Of the funding not awarded to states/territories, the HHS Secretary is required to annually reserve $10 million for competitive discretionary PREIS grants to organizations/entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in, and aging out of, foster care; homeless youth; youth with HIV/AIDS; pregnant and parenting women who are under 21 years of age and their partners; and youth residing in areas with high birth rates for youth.[67] An entity that is awarded a PREIS grant is required to conduct a rigorous evaluation of their program and/or to agree, if selected, to participate in a rigorous federal evaluation of the activities funded by the grant.

In addition, the HHS Secretary is required to reserve $6.5 million annually for expenditures by the Secretary to (1) provide (directly or through a competitive grant process) research, training,

Islands, the Northern Mariana Islands, and Palau chose not to take state PREP funding (FY2015 data).

[66] If the state government opted not to apply after two years, the funding allotted to that state became available on a competitive basis to other organizations in the state. For the five states and three territories that opted not to take the PREP funding in FY2010 and FY2011, 37 Competitive Personal Responsibility Education Program grants totaling approximately $19 million were awarded for FY2012 to entities in those states and territories on a competitive basis. (These are three year grants, with the funding level listed being the FY2012 amount. FY2013 amounts were subject to sequestration. For a list of the grantees, see https://www.acf.hhs.gov/programs/fysb/resource/2012-cprep-awards).

[67] For a list of the grantees, see http://www.acf.hhs.gov/programs/fysb/resource/preis-summaries.

and technical assistance for the programs and activities funded by PREP allotments or grants; and (2) evaluate the program and activities funded by PREP allotments or grants.[68]

Title V Abstinence Education

The Title V Abstinence Education Block Grant to states was authorized under P.L. 104-193 (the 1996 welfare reform law). The law provided $50 million per year for five years (FY1998-FY2002) in federal funds specifically for the abstinence education program. Subsequently, the block grant was funded through June 30, 2009, by various legislative extensions. The Title V Abstinence Education program is considered a mandatory program and is funded by mandatory spending. It is a formula grant program. State funding is based on the proportion of low-income children in the state compared to the national total. Funds must be requested by states when they solicit Title V Maternal and Child Health (MCH) block grant funds.

To ensure that the abstinence-only message is not diluted, the law (P.L. 104-193, §510 of the Social Security Act) stipulated that the term "abstinence education" means an educational or motivational program that (1) has as its exclusive purpose, teaching the social, psychological, and health gains of abstaining from sexual activity; (2) teaches abstinence from sexual activity outside of marriage as the expected standard for all school-age children; (3) teaches that abstinence is the only certain way to avoid out-of-wedlock pregnancy, STDs, and associated health problems; (4) teaches that a mutually faithful monogamous relationship within marriage is the expected standard of human sexual activity; (5) teaches that sexual activity outside of marriage is likely to have harmful psychological and physical effects; (6) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society; (7) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and (8) teaches the importance of attaining self-sufficiency before engaging in sex.

The Title V Abstinence Education program must be used exclusively for teaching abstinence and may not be utilized in conjunction with, or for any other purpose. Title V Abstinence Education programs must be medically accurate. To receive federal funds, a state must match every $4 in federal funds with $3 in state funds.[69] This means that full funding (from states and the federal government) for abstinence education must total at least $87.5 million annually. In FY2009, 27 states and Puerto Rico chose to sponsor a Title V Abstinence Education program.

The program's funding expired on June 30, 2009,[70] but P.L. 111-148, the Patient Protection and Affordable Care Act (ACA), reauthorized the program and restored funding to the Title V Abstinence Education formula block grant to states at the previous annual level of $50 million for each of the years FY2010 through FY2014 ($250 million over five years).[71] P.L. 113-93 (the

[68] For additional information on PREP, see Personal Responsibility Education Program (PREP) Evaluation, OPRE Report #2014-27, FYSB Report #2014-1, *How States are Implementing Evidence-Based Teen Pregnancy Prevention Programs Through the Personal Responsibility Education Program*, by Susan Zief, Rachel Shapiro, and Debra Strong (Mathematica Policy Research), April 2014 http://www.acf.hhs.gov/sites/default/files/opre/prep_dis_brief_032814_edited.pdf.

[69] States use a variety of methods to meet the federal matching requirement, such as state funds, private or foundation funds, matching funds from community-based grantees, and in-kind services (e.g., volunteer staffing and public service announcements).

[70] As mentioned above, since its inception, the Title V Abstinence Education Block Grant has been funded at a rate of $50 million per year. Funding for the program expired on June 30, 2009. Therefore, federal funding for the program for FY2009 was $37.5 million (i.e., a rate of $50 million per year for three-quarters of the fiscal year).

[71] The Title V Abstinence Education block grant also was subject to sequestration. The FY2013 post-sequester operating level for the Title V Abstinence Education block grant was $47.5 million in FY2013. The FY2014 post-

Protecting Access to Medicare Act of 2014) which was enacted on April 1, 2014, extended the Title V Abstinence Education block grant ($50 million per year) through FY2015 (i.e., September 30, 2015). P.L. 114-10, the Medicare Access and CHIP Reauthorization Act of 2015, increased the Title V Abstinence Education block grant to $75 million per year for FY2016 and FY2017.

In FY2016, all 50 states, the District of Columbia, and 8 territories (American Samoa, Guam, the Marshall Islands, the Northern Mariana Islands, Palau, Puerto Rico, the Virgin Islands, and the Federated States of Micronesia) chose to sponsor a Title V Abstinence Education program.[72]

Adolescent Family Life Program

The Adolescent Family Life (AFL) program was enacted as Title XX of the Public Health Service Act (P.L. 97-35) in 1981. It is administered by the Office of Adolescent Pregnancy programs in the Department of Health and Human Services (HHS). The AFL program has two basic components, the "care" component and the "prevention" component. AFL care demonstration projects are required to provide comprehensive health, education, and social services (including life and career planning, job training, safe housing, decisionmaking and social skills), either directly or through partnerships with other community agencies, and to evaluate new approaches for implementing these services. AFL care projects are based within a variety of settings such as universities, hospitals, schools, public health departments, or community agencies. Many provide home visiting services and all have partnerships with diverse community agencies. The AFL program supports care demonstration projects to develop, test, and evaluate interventions with pregnant and parenting teens, their infants, male partners, and family members in an effort to ameliorate the effects of too-early childbearing for teen parents, their babies, and their families. Care services to parenting adolescents include pre- and post-natal care, nutrition counseling, continuing education, and vocational services.

From 1998 to 2009, the AFL appropriation was expended primarily on the prevention component of the AFL program (i.e., services for pre-teens, teens, and their families to promote abstinence from premarital sexual relations) to develop, test, and evaluate pregnancy prevention interventions designed to encourage adolescents to postpone sexual activity and reduce their risks for teenage pregnancy and sexually transmitted diseases. AFL prevention demonstration projects were required to develop, test, and use curricula that provide education and activities designed to encourage adolescents to postpone sexual activity until marriage. Since 1998, the prevention component of the AFL demonstration program was used to exclusively fund abstinence-only education projects that conformed to the definition of abstinence education defined in the Title V Abstinence Education Block Grant to states. Most of the AFL prevention projects tried to reach students between the ages of 9 and 14 in public schools, community settings, or family households; all involved significant interaction with parents to strengthen the abstinence message.

Any public or private nonprofit organization or agency was eligible to apply for an AFL demonstration grant. AFL projects could be funded for up to five years; all grantees were required to reapply each year of their continuing grant. Every program that received AFL grant funds was required to include an independent evaluation component.

The prevention component of the AFL demonstration program was funded at $9.0 million in FY1998 and FY1999; $9.1 million in FY2000 and FY2001; $10.2 million in each of the fiscal

sequester operating level for the Title V Abstinence Education block grant is $46.4 million in FY2014.

[72] U.S. Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, HHS, Administration for Children and Families, FY2017*, pp. 429-430. For information on the grantees, see http://www.acf.hhs.gov/fysb/resource/aegp-fact-sheet.

years FY2002 through FY2004; and $13.1 million in each of the fiscal years FY2005 through FY2009. No funding has been provided for the prevention component of the AFL program since FY2009.[73]

The FY2010 appropriation for the care component of the AFL program was $16.7 million. P.L. 111-117 stipulated that none of the AFL funds were to be used for "prevention" services or projects.

Similarly, the FY2011 appropriation for the AFL program (P.L. 112-10) specified that the AFL funding was not to be used for AFL prevention services or projects. P.L. 112-10 included funding of $12.4 million for the AFL program for FY2011.[74] No funding has been provided for the program since FY2011.[75]

Community-Based Abstinence Education (CBAE) Program

Abstinence-only education funding (discretionary funding) provided through the Community-Based Abstinence Education (CBAE) program was included in annual appropriations legislation, from FY2001 through FY2009. Note that the CBAE program was known as the Special Projects for Regional and National Significance (SPRANS) until FY2005. The CBAE program was funded through Section 1110 of the Social Security Act for discretionary grants. P.L. 106-246 appropriated $20 million for abstinence education to HHS under the SPRANS program for FY2001 to bolster the abstinence-only message for adolescents ages 12 to 18. CBAE program competitive grants provided support to public and private entities for the development and implementation of abstinence-only education programs (that conform to the definition of abstinence education defined in the Title V Abstinence Education Block Grant to states) for adolescents ages 12 through 18 in communities nationwide. Funding for the CBAE program increased incrementally, from $20 million in FY2001 to $108.9 million in FY2008; in FY2009 CBAE funding dropped to $94.7 million. No CBAE funding has been appropriated since FY2009.

Competitive Abstinence-Only Grants

Several appropriation laws included an additional $5 million for *competitive grants* for abstinence-only education for each of FY2012, FY2013, FY2014, and FY2015. The most recent laws, P.L. 113-235/P.L. 113-164, included funding of $5 million for competitive grants for abstinence-only education for FY2015.[76]

[73] According to HHS, in 2010-2011 the AFL program was supporting 27 care demonstration projects across the country. AFL care projects are programs primarily for pregnant or parenting adolescents.

[74] Note that the $12.4 million figure accounts for the 0.2% across-the-board rescission that was also included in P.L. 112-10.

[75] The Obama Administration's budget request for FY2012 did not include funding for the AFL program for FY2012. FY2012 budget document commentary stated: "Mandatory funding for the Pregnancy Assistance Fund was included in the Patient Protection and Affordable Care Act. This new program directs resources to similar populations and activities-making the AFL program duplicative. Therefore HHS has not provided funding to continue the AFL program"; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf, p. 123.

[76] P.L. 113-164, the Continuing Appropriations Resolution, 2015 (enacted September 19, 2014) funded the competitive abstinence-only grants for FY2015 at the FY2014 rate of $5 million through December 11, 2014, or enactment of applicable appropriations legislation. Pursuant to P.L. 113-235, the Consolidated and Further Continuing Appropriations Act, 2015 (enacted December 16, 2014), the competitive abstinence-only grants are funded at $5 million for FY2015.

P.L. 113-76, the Consolidated Appropriations Act, 2014 (enacted January 17, 2014), included funding of $5 million for competitive grants for abstinence-only education for FY2014.[77] P.L. 113-6, the Consolidated and Further Continuing Appropriations Act, 2013 (enacted March 26, 2013), included pre-sequester funding of $5 million for competitive grants for abstinence-only education for FY2013. The post-sequester amount of funding for the competitive grants for abstinence-only education was $4.7 million in FY2013. P.L. 112-74, the Consolidated Appropriations Act, 2012 (enacted December 23, 2011), included funding of $5 million for *competitive grants* for abstinence-only education for FY2012.

P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015) included funding of $10 million for competitive grants that exclusively implement education in sexual risk avoidance (defined as refraining from nonmarital sexual activity) for FY2016.

Pursuant to P.L. 114-223 (the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act; enacted September 29, 2016), the competitive sexual risk avoidance grant program (also referred to as abstinence education) is funded for FY2017 at the FY2016 rate of $10 million (annually, prorated) minus an across-the-board reduction of 0.496%, through December 9, 2016, or enactment of applicable appropriations legislation.

Other Federal Programs

Although there are several federally funded programs that have a pregnancy prevention component and thereby may use their funds to provide pregnancy prevention information and/or contraception services to teenagers, they are not mandated by federal law to use any of their funds for teenagers. These programs include Medicaid Family Planning (Title XIX of the Social Security Act), Title X Family Planning, the Maternal and Child Health block grant (Title V of the Social Security Act), the Temporary Assistance for Needy Families (TANF) block grant (Title IV-A of the Social Security Act), the Title XX Social Services block grant, and several other HHS programs. As implied above, the services provided by these programs are primarily targeted to adult women rather than teenagers, and the programs themselves make no attempt to isolate program expenditures for information and/or contraception services provided to teens.[78]

As part of President Obama's Teen Pregnancy Prevention Initiative (TPPI), the Center for Disease Control and Prevention (CDC) is partnering with the federal Office of the Assistant Secretary for Health (OASH) "to reduce teenage pregnancy and address disparities in teen pregnancy and birth rates. The OASH Office of Adolescent Health (OAH) is supporting public and private entities to fund medically accurate and age appropriate evidence-based or innovative program models to reduce teen pregnancy. The purpose of the program is to demonstrate the effectiveness of innovative, multicomponent, communitywide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates, with a focus on reaching African American and Latino/Hispanic youth aged 15–19 years."[79]

In addition, the mission of the CDC's Division of Adolescent and School Health (DASH) is to prevent the most serious health risks among children, adolescents, and young adults. Such health risks include preventing unintended pregnancies among children, teens, and young adults.

[77] For information on the grantees, see http://www.acf.hhs.gov/programs/fysb/resource/2013-caegp-awards.

[78] U.S. General Accounting Office, "Teen Pregnancy: State and Federal Efforts to Implement Prevention Programs and Measure Their Effectiveness," GAO/HEHS-99-4, November 1998. (GAO is now known as the Government Accountability Office.)

[79] For more information, see http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/about/communitywide.html.

Evaluation of Teen Pregnancy Prevention Programs

There is a growing body of literature on effective interventions for reducing teen pregnancy. These evidence-based programs have demonstrated impacts on sexual activity (including delaying initiation of sexual activity), contraceptive use, STDs/STIs, and pregnancy or births.

Many analysts and researchers agree that effective teen pregnancy prevention programs (1) convince teens that not having sex or that using contraception consistently and carefully is the right thing to do; (2) last a sufficient length of time (i.e., more than a few weeks); (3) are operated by leaders who believe in their programs and who are adequately trained; (4) actively engage participants and personalize the program information; (5) address peer pressure issues; (6) teach communication skills; and (7) reflect the age, sexual experience, and culture of young persons in the programs.[80] Others indicate that effective teen pregnancy prevention programs are often developed in cooperation with teens and experts, help clarify the teen's values and develop the coping skills of teens, provide medically accurate information, have clear goals, focus on specific health behaviors, address psychological risk and protective factors, use trained educators, and provide ongoing support.[81]

The Office of Adolescent Health (OAH), established within HHS in FY2010, coordinates adolescent health programs and initiatives across HHS related to adolescent health promotion and disease prevention. The OAH supports multi-disciplinary projects focused on improving adolescent health, collects and disseminates information on adolescent health to health professionals and the general public, and works in partnership with other HHS agencies to support evidence-based approaches to improving the health of adolescents. OAH provides a list of 41 programs/initiatives/interventions that it deems to be effective and suitable for replication.[82]

The list of 41 evidence-based models showcases a wide range of programs, including those that are curriculum-based (aimed at educating teens on responsible behaviors) and those that are clinic-based (aimed at teens seeking contraceptive services), in several types of settings (e.g., schools, community centers). The evidence-based programs vary in the types of program models used and the populations targeted (e.g., African American youth, Hispanic youth, persons in the juvenile justice system). They include programs that focus on abstinence as a way to prevent teen pregnancy and sexually transmitted infections and programs that focus on improving contraceptive use among sexually active teens.[83] The evidence-based approach to teen pregnancy prevention is based on the principle that services or programs that work (i.e., are proven to be effective) should be replicated or expanded upon by entities seeking federal dollars to prevent pregnancy among young people.

The list of 41 includes three abstinence-only education programs.[84] Prior to those three programs, which were found to be effective, it was widely held that the abstinence-only approach was

[80] Katy Suellentrop, *What Works 2011-2012: Curriculum-Based Programs That Help Prevent Teen Pregnancy*, The National Campaign to Prevent Teen Pregnancy, p. 5.

[81] Kristen Anderson Moore (Child Trends), *What If We took Research Seriously: What Would Teen Pregnancy Programs Look Like?*, Presentation to the Healthy Teen Network, October 27, 2010.

[82] The list of the 41 programs can be found at http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/tpp-searchable.html.

[83] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Types of Programs Funded Through the Office of Adolescent Health Funding Announcement*, April 2010.

[84] The following are considered abstinence-only education programs: (1) Heritage Keepers Abstinence Education; (2) Making a Difference!; and (3) Promoting Health Among Teens! Abstinence Only Intervention.

ineffective.[85] Moreover, another study of the abstinence-only strategy, not counted in the 41, also found positive results. The scientifically based study assigned African American students in the 6th and 7th grades to (1) an 8-hour abstinence-only intervention to reduce sexual intercourse; (2) an 8-hour safer sex intervention to increase condom use; (3) 8-hour and 12-hour comprehensive interventions to reduce sexual intercourse and/or increase condom use; or (4) a control group wherein an 8-hour health promotion intervention was used to improve healthy behaviors unrelated to sexual behavior (i.e., informed students about behaviors associated with heart disease, hypertension, stroke, diabetes, and certain cancers). The study found that only about 34% of the student participants in the abstinence-only intervention said that they had engaged in sexual intercourse,[86] whereas about 49% of the students in the control group reported (during the two-year follow-up interview) that they had engaged in sexual intercourse.[87] The authors also reported that among the participants in the abstinence-only intervention who had engaged in sexual activity during the demonstration, there was no significant difference between the abstinence-only intervention participants and the control group participants regarding consistent condom use.[88] The authors further noted that none of the interventions had significant effects on consistent condom use.[89]

The teen pregnancy prevention arena has grown substantially with respect to program evaluation. There is a growing evidence base of activities and services that have been shown to be effective in reducing teen pregnancy, delaying sexual activity among young people, and reducing sexually transmitted infections. Moreover, the number of evaluations/studies that have used a scientific approach with experimental and control groups (an approach that most analysts agree provides more reliable, valid, and objective information than other types of evaluations) have also increased.[90]

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[85] This viewpoint was in large part based on the 2007 Mathematica Policy Research, Inc., report that presented the final results from a multi-year, experimentally based impact study on several abstinence-only block grant programs. The report focused on four selected Title V abstinence education programs for elementary and middle school students. Based on follow-up data collected from youth (ages 10 to 14) four to six years after study enrollment, the report, among other things, presented the estimated program impacts on sexual abstinence and risks of pregnancy and STDs. The report found that program participants had just as many sexual partners as non-participants, had sex at the same median age as non-participants, and were just as likely to use contraception as non-participants; Christopher Trenholm, Barbara Devaney, Ken Fortson, Lisa Quay, Justin Wheeler, and Melissa Clark, "Impacts of Four Title V, Section 510 Abstinence Education Programs (final report)," Mathematica Policy Research, Inc., April 2007, http://aspe.hhs.gov/hsp/abstinence07/.

[86] The participants were interviewed two years after the intervention.

[87] John B Jemmott III, Loretta S. Jemmott, and Geoffrey T. Fong, "Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months," *Archives of Pediatrics and Adolescent Medicine*, v. 164, no. 2, February 2010, pp. 152-159. (Note: The authors remarked that the abstinence-only intervention studied would not meet the federal criteria for an abstinence-only program. One difference between the abstinence-only intervention studied and the Title V Abstinence Education block grant program was that the target behavior of the intervention was to abstain from any form of sexual intercourse (vaginal, anal, or oral) until a time later in life when the adolescent is more prepared to handle the consequences of sex, whereas one of the necessary components of the federal abstinence-only education programs was to teach school-age children that they were expected to abstain from sexual activity until they got married.)

[88] According to the study, 76% of the abstinence-only participants who had engaged in sexual activity had used condoms consistently during intercourse in the past three months, whereas 78% of the control group participants had used condoms consistently.

[89] John B Jemmott III, Loretta S. Jemmott, and Geoffrey T. Fong, "Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months," *Archives of Pediatrics and Adolescent Medicine*, v. 164, no. 2, February 2010, p. 157.

[90] Ron Haskins and Greg Margolis, *Show Me the Evidence: Obama's Fight for Rigor and Results in Social Policy*, Brookings Institution Press, Washington, DC, 2014. Also see Heather Fish, Jennifer Manlove, Kristin Anderson Moore, and Elizabeth Mass, Child Trends, What Works for Adolescent Sexual and Reproductive Health: Lessons From Experimental Evaluations of Programs and Interventions, Publication no. 2014-64,, December 2014.

A recent report states:

> The movement to shift public and philanthropic funding to support "what works" has made real gains in the last few years. Government and philanthropy are seeking to identify high-impact programs that have been tested in rigorous trials and found to deliver superior results for society. However, it is not enough to identify what works—we also have to identify how it works so that other organizations can replicate the implementation of the program and get similar results.[91]

The teen pregnancy prevention programs (i.e., Tier 1 TPP and state formula and competitive PREP) are federally mandated to replicate evidence-based programs. Tier 2 TPP and PREIS are mandated to implement innovative strategies to prevent teen pregnancy and STIs. Both the TPP program and PREP provide funding for evaluation. Replication of programs and evaluation of new programs will add to the evidence base regarding what works and what does not work with regard to teen pregnancy prevention.[92]

OAH supports several evaluation activities to continue to build the evidence base for what works to prevent teenage pregnancy. OAH currently provides funding to 41 Teen Pregnancy Prevention (TPP) grantees to conduct an independent, rigorous evaluation of their programs; 19 grantees are evaluating their efforts to replicate evidence-based programs and 22 grantees are evaluating new and innovative teen pregnancy prevention programs. In addition, OAH funds two large multi-site federal evaluations focused on teen pregnancy prevention.[93]

According to an Office of Adolescent Health (OAH, HHS) announcement,

> On September 30, 2016, the American Journal of Public Health released a special supplement which focuses on findings from the Teen Pregnancy Prevention (TPP) Program… The supplement, funded by OAH, reports on the results of more than half of the studies conducted in the first cohort of OAH TPP Program grantees..The TPP Program rigorously evaluated evidence-based and promising teen pregnancy prevention programs to learn more about what works, for whom, and under what conditions…. The journal supplement highlights findings from a subset of grantees of the OAH Teen Pregnancy Program's 41 studies…. A number of editorials discuss the Teen Pregnancy Prevention Program, lessons learned, and expert commentary.[94]

For detailed information on findings from the first cohort of OAH TPP grantees, see the September 30, 2016, special supplement to the American Journal of Public Health.[95]

Upon authorizing the PREP program, Congress required that it be evaluated. The evaluation will help the federal government, states, tribes and tribal communities, and local service providers learn more about program design, implementation, and outcomes. The Administration for Children and Families (ACF) within HHS contracted with Mathematica Policy Research (and its subcontractors—Child Trends, Twin Peaks Partners, Decision Information Resources, Public Strategies, and Chapin Hall) to document and assess this large-scale replication effort. The

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[91] The Bridgespan Group, *What Does It Take to Implement Evidence-Based Practices? A Teen Pregnancy Prevention Program Shows the Way*, by Daniel Stid, Alex Neuhoff, Laura Burkhauser, and Bradley Seeman, November 11, 2013, p. 2.

[92] U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, *Evidence-Based Initiatives: Opportunities and Challenges*, by Barbara Broman (Associate Deputy Assistant Secretary for Human Services Policy).

[93] See the following webpage: http://www.hhs.gov/ash/oah/oah-initiatives/for-grantees/evaluation/.

[94] U.S. Department of Health and Human Services, Office of Adolescent Health, "Announcement—American Journal of Public Health Supplement: Building the Evidence Base to Prevent Teen Pregnancy," October 3, 2016.

[95] See http://ajph.aphapublications.org/action/doSearch?AllField= Supplement+on+Building+the+Evidence+to+Prevent+Teen+Pregnancy.

evaluation will study PREP programs nationwide, collecting data from all grantees, and will also conduct an in-depth examination of a few selected PREP sites.[96]

[96] See http://www.prepeval.com/. Also see Personal Responsibility Education Program (PREP) Evaluation, OPRE Report #2014-27, FYSB Report #2014-1, *How States are Implementing Evidence-Based Teen Pregnancy Prevention Programs Through the Personal Responsibility Education Program*, by Susan Zief, Rachel Shapiro, and Debra Strong (Mathematica Policy Research), April 2014. Note: The first product of the PREP multi-component evaluation, led by Mathematica Policy Research, was published in October 2013 and is entitled "PREP: Launching a Nationwide Adolescent Pregnancy Prevention Effort" (OPRE Report 2013-37).

Appendix A. Federal Teen Pregnancy Prevention Program Funding: FY1998-FY2016

Table A-1. Federal Teen Pregnancy Prevention Program Funding, FY1998-FY2017

(millions of dollars)

	Teen Pregnancy Prevention (TPP) Program	Evaluation Funds for TPP Program	Personal Responsibility Education Program (PREP)	Title V Abstinence Education Block Grant	Community-Based Abstinence Education (CBAE) Program	Evaluation Funds for CBAE Program	Competitive Abstinence-Only Grants	Adolescent Family Life (AFL) Program—"Care" Component	Adolescent Family Life (AFL) Program—"Prevention" Component
FY1998	—	—	—	$50.0	—	—	—	$7.7	$9.0
FY1999	—	—	—	50.0	—	—	—	8.7	9.0
FY2000	—	—	—	50.0	—	—	—	10.2	9.1
FY2001	—	—	—	50.0	$20.0	—	—	15.3	9.1
FY2002	—	—	—	50.0	40.0	—	—	18.7	10.2
FY2003	—	—	—	50.0	54.6	—	—	20.7	10.2
FY2004	—	—	—	50.0	70.0	$4.5	—	20.5	10.2
FY2005	—	—	—	50.0	99.2	4.5	—	17.6	13.1
FY2006	—	—	—	50.0	108.8	4.5	—	17.6	13.1
FY2007	—	—	—	50.0	108.9	4.5	—	17.6	13.1
FY2008	—	—	—	50.0	108.9	4.5	—	16.7	13.1
FY2009	—	—	—	37.5	94.7	4.5	—	16.7	13.1
FY2010	$110.0	$4.5	$75.0	50.0	0.0	0.0	—	16.7	0.0
FY2011	104.8	4.4	75.0	50.0	0.0	0.0	—	12.4	0.0

	Teen Pregnancy Prevention (TPP) Program	Evaluation Funds for TPP Program	Personal Responsibility Education Program (PREP)	Title V Abstinence Education Block Grant	Community-Based Abstinence Education (CBAE) Program	Evaluation Funds for CBAE Program	Competitive Abstinence-Only Grants	Adolescent Family Life (AFL) Program—"Care" Component	Adolescent Family Life (AFL) Program—"Prevention" Component
FY2012	104.8	8.5	75.0	50.0	0.0	0.0	$5.0	0.0	0.0
FY2013	98.4	8.5	71.2	47.5	0.0	0.0	4.7	0.0	0.0
FY2014	101.0	8.5	69.6	46.4	0.0	0.0	5.0	0.0	0.0
FY2015	101.0	6.8	75.0	50.0	0.0	0.0	5.0	0.0	0.0
FY2016	101.0	6.8	75.0	75.0	0.0	0.0	10.0	0.0	0.0
FY2017	101.0	6.8	75.0	75.0	0.0	0.0	10.0	0.0	0.0
Total	**$822.0**	**$54.8**	**$590.8**	**$1,031.4**	**$705.1**	**$27.0**	**$39.7**	**$217.1**	**$132.3**

Source: Table prepared by the Congressional Research Service based on data from the Department of Health and Human Services (HHS).

Notes: For FY2013 and FY2014, these data reflect appropriations after all rescissions and post-sequester. Dashes indicate that program was not yet authorized. For FY2017, the TPP Program and the Competitive Abstinence grants are funded at the FY2016 annual rate (prorated) for their respective programs minus an across-the-board reduction of 0.496%, through December 9, 2016, or enactment of applicable appropriations legislation.

Appendix B. Teen Birth Rates for Females Ages 15 Through 19

Table B-1. Teen Birth Rates for Females Ages 15-19, 1950-2015

Year	Birth Rate	Year	Birth Rate	Year	Birth Rate	Year	Birth Rate
1950	81.6	1967	67.9	1984	50.6	2001	45.3
1951	87.6	1968	66.1	1985	51.0	2002	43.0
1952	86.1	1969	66.1	1986	50.2	2003	41.6
1953	88.2	1970	68.3	1987	50.6	2004	41.1
1954	90.6	1971	64.5	1988	53.0	2005	40.5
1955	90.5	1972	61.7	1989	57.3	2006	41.9
1956	94.6	1973	59.3	1990	59.9	2007	42.5
1957	96.3	1974	57.5	1991	61.8	2008	41.5
1958	91.4	1975	55.6	1992	60.3	2009	37.9
1959	89.1	1976	52.8	1993	59.0	2010	34.2
1960	89.1	1977	52.8	1994	58.2	2011	31.3
1961	88.0	1978	51.5	1995	56.0	2012	29.4
1962	81.2	1979	52.3	1996	53.5	2013	26.5
1963	76.4	1980	53.0	1997	51.3	2014	24.2
1964	72.8	1981	52.2	1998	50.3	2015	22.3
1965	70.5	1982	52.4	1999	48.8		
1966	70.6	1983	51.4	2000	47.7		

Source: Table prepared by the Congressional Research Service (CRS) based on data from the Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).

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