



# Teenage Pregnancy Prevention: Statistics and Programs

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## Summary

In 2009, U.S. teen births accounted for 10.1% of all births and 21.4% 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 2008 and 2009 the teen birth rate dropped below the 2007 teen birth rate, reversing the two-year upward trend. Although the birth rate for U.S. teens has dropped in 16 of the last 18 years, it remains higher than the teenage birth rate of most industrialized nations. In recognition of the negative, long-term consequences associated with teenage pregnancy and births, the prevention of teenage and out-of-wedlock childbearing is a major goal of this nation.

The Adolescent Family Life (AFL) program, created in 1981 (Title XX of the Public Health Services Act), was the first federal program to focus on 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.

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 are pitted against comprehensive sex education programs. P.L. 111-117 (the Consolidated Appropriations for FY2010) 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.

P.L. 111-148 (the health care reform law) 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 comprehensive 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).

The Title V Abstinence Education Block Grant to states was authorized under P.L. 104-193 (the 1996 welfare reform law). The Title V Abstinence Education program is 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 to it at the previous annual level of \$50 million for each of FY2010-FY2014.

There are many other federal programs that can provide pregnancy prevention information and/or services to teens. They include Title X Family Planning, Medicaid family planning, the Maternal and Child Health block grant, the Title XX Social Services block grant, the TANF block grant, and several other Department of Health and Human Services (HHS) programs. 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, in whole or part, is to prevent teen pregnancy and reduce teen births.

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## Introduction

In 2006, an estimated 743,000 U.S. teenagers became pregnant, approximately 107,000 had miscarriages, and 200,000 had legal abortions (latest available data).<sup>1</sup> The result was that there were 435,000 births to teenagers in 2006. In 2009, 10.1% of all U.S. births were to teens, and 21.4% of all nonmarital births were to teens. In recognition of the negative, long-term consequences associated with teenage pregnancy and births, the prevention of teenage and out-of-wedlock childbearing is a major goal of this nation. Although the birth rate for U.S. teens has dropped in 16 of the last 18 years, it remains higher than the teenage birth rate of most industrialized nations.

## 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. Births to teenagers declined 37% from 1970 to 2009; 26% from 1980 to 2009; 22% from 1990 to 2009, and 13% from 2000 to 2009. In 2009, the number of births to teens was 414,870 (of which 5,030 births were to girls under age 15).<sup>2</sup>

As shown in **Figure 1**, the peak birth rate for U.S. teenagers occurred in 1957, with 96.3 births per 1,000 women ages 15-19. The 2009 teenage birth rate of 39.1 per 1,000 women ages 15-19 is 6% lower than the 2008 teenage birth rate (22% below the 1986 low of 50.2 births per 1,000 female teens). 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 2009 teen birth rate (39.1 births per 1,000 teens ages 15-19) was below the previous all-time low teen birth rate (40.5 births per 1,000 teens in 2005). In 1950, teens (ages 15-19) gave birth at the rate of 81.6 per 1,000 teens, compared to 61.8 per 1,000 teens in 1991, 40.5 per 1,000 teens in 2005, 41.9 per 1,000 teens in 2006, 42.5 per 1,000 teens in 2007, 41.5 per 1,000 teens in 2008, and 39.1 per 1,000 teens in 2009. Although the *number* of births to females under age 20 decreased 22% from 1991 to 2009, the *birth rate* of teens ages 15 through 19 declined by 37% in the same period. 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.

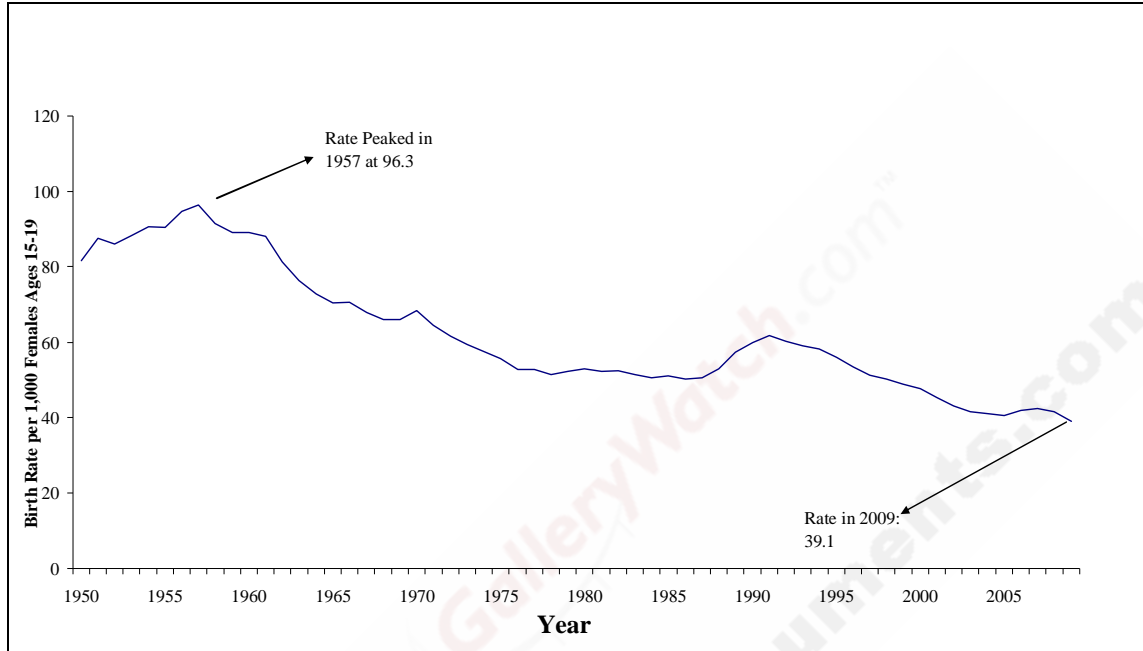
In 2009, the birth rate for teenagers ages 15-17 was down 48% from 1991. For teens ages 18 and 19, the birth rate dropped by 30% from 1991 to 2009. In 2009, of the 414,870 births to females under age 20, 87% (362,490 births) were to unmarried teenagers. With fewer teens entering into

<sup>1</sup> Guttmacher Institute, “U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity,” updated January 2010, p. 7.

<sup>2</sup> Brady E. Hamilton, Joyce A. Martin, and Stephanie J. Ventura, “Births: Preliminary Data for 2009,” *National Vital Statistics Reports*, vol. 59, no. 3, December 21, 2010. Hereafter referred to as “Births: Preliminary 2009 Data.”

marriage, the proportion of births to unmarried teens has increased dramatically (87% in 2009 versus 29% in 1970).

**Figure 1. Teen Birth Rates (Ages 15-19), 1950-2009**



**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. The birth rate of teens (ages 15-19) decreased in 14 states (and 1 jurisdiction) from 2007 to 2008; increased in 1 state (Montana); and remained virtually unchanged in 35 states (and 5 jurisdictions). Nonetheless, during the period 1991-2005, a reduction in the rate of births among teens ages 15-19 was observed in all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, American Samoa, and the Northern Mariana Islands. In 2008, the lowest reported rate was in New Hampshire, at 19.8 births per 1,000 women (ages 15-19), and the highest reported rate was in Mississippi, at 65.7 births per 1,000 women (ages 15-19).<sup>3</sup>

## 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.<sup>4</sup> In 2008, the teen birth rates for women ages 15 through 19

<sup>3</sup> Joyce A. Martin, Brady E. Hamilton, Paul D. Sutton, Stephanie J. Ventura, T.J. Mathews, and Michelle J. K. Osterman, "Births: Final Data for 2008," *National Vital Statistics Reports*, vol. 59, no. 1, December 2010, Table B. (Hereafter referred to as "Births: Final 2008 Data.")

<sup>4</sup> "Births: Preliminary 2009 Data," Table 5.

dropped below their respective 2007 levels for all racial and ethnic groups. Similarly, in 2009 the teen birth rates for women ages 15 through 19 dropped below their respective 2008 levels for all racial and ethnic groups. Between 2007 and 2009, teen birth rates fell 14.3% for Hispanic teens, 13.6% for Asian/Pacific Islander teens, 8.1% for black teens, 6.4% for American Indian/Alaska Native teens, and 5.9% for white teens. However, birth rates for Hispanic and black teenagers continue to be much higher than that of other racial/ethnic groups. In 2009, Hispanic teens (ages 15-19) gave birth at a rate of 70.1 per 1,000 Hispanic teens. Non-Hispanic black teens gave birth at a rate of 59.0 per 1,000 non-Hispanic black teens. In contrast, American Indian/Alaska Native teenagers gave birth at a rate of 55.5 per 1,000 American Indian/Alaska Native teens, non-Hispanic white teens gave birth at a rate of 25.6 per 1,000 non-Hispanic white teens, and Asian/Pacific Islander teens gave birth at the lowest rate, 14.6 per 1,000 Asian/Pacific Islanders teens.<sup>5</sup>

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 19% in 2009.<sup>6</sup>

## **Age of Fathers**

According to one study, about one in five births to unmarried, teenage girls is attributed to men at least five years older than the mother.<sup>7</sup> The information on fathers' age has fueled legislative action at the state and local level. Statutory rape laws are viewed by several states as a deterrent to teen pregnancy and birth—the premise being that older men will avoid sexual relations with an adolescent if criminal charges are likely to be brought. According to the 2002 National Survey of Family Growth, among unmarried men ages 25-29, 8% had a female partner in the past 12 months who was 7 or more years younger than himself.<sup>8</sup>

## **Financial and Social Costs of Teen Births**

An October 2006 study by the National Campaign to Prevent Teen Pregnancy estimated that, in 2004, adolescent childbearing cost U.S. taxpayers about \$9 billion per year: in child welfare benefits, \$2.3 billion; in health care expenses, \$1.9 billion; in spending on incarceration (for the sons of women who had children as adolescents), \$2.1 billion; in lost tax revenue because of lower earnings of the mothers, fathers, and children (when they were adults), \$6.3 billion; and in offsetting public assistance savings (younger teens receive less annually over a 15-year period than those who give birth at age 20-21), \$3.6 billion. 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 2006 report

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<sup>5</sup> "Births: Preliminary 2009 Data," Table 5.

<sup>6</sup> "Births: Preliminary 2009 Data," Table 3.

<sup>7</sup> "How Old Are U.S. Fathers?" by David J. Landry and Jacqueline D. Forrest, *Family Planning Perspectives*, vol. 27, no. 4, 1995.

<sup>8</sup> Centers for Disease Control and Prevention. Fertility, Contraception, and Fatherhood: Data on Men and Women from Cycle 6 (2002) of the National Survey of Family Growth, by Gladys M. Martinez, Anjani Chandra, Joyce C. Abma, Jo Jones, and William D. Mosher. National Center for Health Statistics, Series 23, No. 26. 2006.



contends that if the teen birth rate had not declined between 1991 and 2004, the annual costs associated with teen childbearing would have been almost \$16 billion (instead of \$9 billion).<sup>9</sup>

## **Reasons for High Pregnancy and Birth Rates Among Teens**

The high volume of pregnancies and birth rates among teenage and never-married women is often attributed to a liberal view of sexual activity.<sup>10</sup> Some analysts also contend that contraceptive advancements have afforded women a false sense of security, thereby contributing to increased sexual activity and more pregnancies. The academic and professional communities also maintain that teen parenthood is one of the negative consequences of growing up without a father.<sup>11</sup> Moreover, policymakers suggest that, prior to reform, “welfare” was seen as a guaranteed source of income for unmarried teenage mothers with grim marriage and job prospects. 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.”<sup>12</sup>

### **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 have significantly increased their use of contraceptives, particularly condoms. The more effective and consistent use of contraception has been facilitated by long-lasting injectable (Depo Provera) and implanted (Norplant) devices that are readily available to female teens. Abstinence campaigns, aimed at younger teens, are 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.

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.<sup>13</sup>

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<sup>9</sup> The National Campaign to Prevent Teen Pregnancy, *By the Numbers: The Public Cost of Teen Childbearing*, by Saul D. Hoffman. October 2006.

<sup>10</sup> U.S. Congress, House Ways and Means, Subcommittee on Human Resources, Testimony of Dr. Isabel V. Sawhill on Nonmarital Births and Child Poverty in the United States, June 29, 1999.

<sup>11</sup> General Accounting Office, *Teen Pregnancy: State and Federal Efforts to Implement Prevention Programs and Measure Their Effectiveness*, GAO/HEHS-99-4, November 1998.

<sup>12</sup> Alan Guttmacher Institute, *United States and the Russian Federation Lead the Developed World in Teenage Pregnancy Rates*, News Release, February 24, 2000, p. 2.

<sup>13</sup> Rob Stein, “Birthrate Among Teens Hits Record Low,” *Washington Post*, December 22, 2010, A02.

## Federal Strategies to Reduce Teen Pregnancy

In recognition of the negative, long-term consequences of teen pregnancy and births, the prevention of teenage and nonmarital childbearing is a major goal of this nation. 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. The U.S. teen birth rate was one and one-half times that of the United Kingdom and 11 times that of the Netherlands. In 2006, teen birth rates were 4 births per 1,000 teens ages 15-19 in the Netherlands; 5 per 1,000 in Japan; 10 per 1,000 in Germany; 13 per 1,000 in Canada; 27 per 1,000 in the United Kingdom; and 42 per 1,000 in the United States.<sup>14</sup>

When the idea of abstinence-only education was being discussed during the 1994-1996 welfare reform debate it was in the context of providing equal funding for abstinence education as was then provided for teen sexual education programs that included information about contraception and sexually transmitted diseases. 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 are pitted against comprehensive sex education programs. This section discusses three approaches to reducing teen pregnancy: comprehensive sex education, abstinence-only education, and youth programs that address teen pregnancy.

### Comprehensive Sex Education

Advocates of a comprehensive approach to sex education argue that today’s youth need information and decision-making skills 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.<sup>15</sup> Given that about 50% of high school students have experienced sexual intercourse,<sup>16</sup> 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 who break their virginity pledges were less likely to use contraception the first time than teens who had never made such a promise.<sup>17</sup> In addition, the high number of females under age 25 with sexually transmitted diseases (STDs)<sup>18</sup>

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<sup>14</sup> United Nations Statistics Division, “Demographic Yearbook 2006,” [http://www.thenationalcampaign.org/resources/pdf/TBR\\_InternationalComparison2006.pdf](http://www.thenationalcampaign.org/resources/pdf/TBR_InternationalComparison2006.pdf). 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.

<sup>15</sup> 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. Source: Child Trends Data Bank, “New Indicator on Oral Sex,” September 15, 2005, at <http://www.childtrendsdatbank.org/whatsNew.cfm>.

<sup>16</sup> For more information on sexual activity of high school students, see Congressional Research Service, CRS Report RS20873, *Reducing Teen Pregnancy: Adolescent Family Life and Abstinence Education Programs*, by Carmen Solomon-Fears.

<sup>17</sup> 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.



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 as well as reduce their risk of getting STDs.<sup>19</sup>

Comprehensive sexuality 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).

Until recent legislation (P.L. 111-117 and P.L. 111-148), there was no federal funding stream that was exclusively for comprehensive sex education in schools. In other words, there was no federal appropriation specifically for comprehensive sex education. The following two programs, established in the 111<sup>th</sup> Congress, provide exclusive funding for comprehensive teen pregnancy prevention initiatives: (1) the Teen Pregnancy Prevention (TPP) program (funded at \$110 million in FY2010) and (2) the Personal Responsibility Education Program (PREP; funded at \$75 million in FY2010).

### **Teen Pregnancy Prevention Program**

P.L. 111-117, the Consolidated Appropriations for FY2010, included 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. Of the \$110 million appropriated for the TPP program for FY2010, \$75 million is for replicating programs that are proven through rigorous evaluation to be effective in reducing teenage pregnancy, behavioral factors underlying teen pregnancy, or other related risk factors; and \$25 million is for research and demonstration grants. The TPP program is administered by the new Office of Adolescent Health within HHS. P.L. 111-117 also provides a separate \$4.5 million (within the Public Health Service Act program evaluation funding) to carry out evaluations of teenage pregnancy prevention approaches.

### **Personal Responsibility Education Program**

P.L. 111-148 (the Patient Protection and Affordable Care Act, PPACA) 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, which is a comprehensive 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). The new Personal Responsibility

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(...continued)

<sup>18</sup> This report uses the term sexually transmitted diseases (STDs) rather than sexually transmitted infections (STIs). In the literature the terms are often used interchangeably.

<sup>19</sup> The Centers for Disease Control and Prevention (CDC) estimates that approximately 19 million new infections occur each year, almost half of them among young people ages 15 to 24. Source: “Trends in Reportable Sexually Transmitted Disease in the United States, 2006,” November 13, 2007.

Education program is mandated to provide programs that are evidence-based, medically accurate, and age-appropriate.

Also, the Adolescent Family Life (AFL) program, which has been in existence since 1981, was funded at \$16.7 million. The FY2010 appropriation for the AFL program (P.L. 111-117) stipulated that the funds were to be exclusively used for comprehensive sex education-type programs.

## **Evaluation of Comprehensive Sex Education Programs**

There have been numerous evaluations of comprehensive sex education programs, but most of them did not use 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.<sup>20</sup> A recent report by the National Campaign to Prevent Teen Pregnancy, however, highlighted five teen pregnancy prevention programs that were subjected to a random assignment, experimentally designed study.<sup>21</sup> These five comprehensive sex education programs were found to be effective in delaying sexual activity, improving contraceptive use among sexually active teenagers, or preventing teen pregnancy.

Many analysts and researchers agree that effective 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.<sup>22</sup>

The new Office of Adolescent Health (OAH) within the Department of Health and Human Services (HHS) coordinates adolescent health programs and initiatives across HHS related to adolescent health promotion and disease prevention. The new OAH (established in FY2010) 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 28 programs/initiatives/interventions that it deems to be effective and suitable for replication.<sup>23</sup>

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<sup>20</sup> Note that there also are many reasons why programs are not considered successful. For example, in some cases the evaluation studies are limited by methodological problems or constraints because the approach taken is so multilayered that researchers have had difficulty disentangling the effects of multiple components of a program. In other cases, the approach may have worked for boys but not for girls, or vice versa. In some cases, the programs are very small, and thereby it is harder to obtain significant results. In other cases, different personnel may affect the outcomes of similar programs.

<sup>21</sup> The National Campaign to Prevent Teen Pregnancy, “Putting What Works To Work: Curriculum-Based Programs That Prevent Teen Pregnancy,” 2007. (The report only examined studies that had been published in 2000 or later.)

<sup>22</sup> *Ibid.*

<sup>23</sup> The list of the 28 programs can be found at <http://www.hhs.gov/ash/oah/prevention/research/programs/index.html>.

## Abstinence Education

Many argue 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 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.)<sup>24</sup> They further argue that abstinence is the most effective (100%) means of preventing unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS.<sup>25</sup>

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.<sup>26</sup> All of these programs were carried out by HHS. For FY2009, federal abstinence education funding totals \$149.8 million: \$37.5 million for the Title V Abstinence Education Block Grant to states; \$94.7 million for the CBAE program (up to \$10 million of which could be used for a national abstinence education campaign) and \$4.5 million for an evaluation of the CBAE program; and \$13.1 million for AFL abstinence education “prevention” demonstration projects.<sup>27</sup>

### 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; funded through June 30, 2009, by various legislative extensions) in federal funds specifically for the abstinence education program.<sup>28</sup> 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 and must be used exclusively for teaching abstinence (pursuant to P.L. 104-193) and may not be utilized in conjunction with, or for any other purpose.

<sup>24</sup> 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.

<sup>25</sup> 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.

<sup>26</sup> For more information on these abstinence education programs, see CRS Report RS20873, *Reducing Teen Pregnancy: Adolescent Family Life and Abstinence Education Programs*, by Carmen Solomon-Fears.

<sup>27</sup> Abstinence education funding totaled \$79 million in FY2001, \$100 million in FY2002, \$115 million in FY2003, \$135 million in FY2004, \$168 million in FY2005, and \$177 million in each of FY2006 through FY2008.

<sup>28</sup> The Title V Abstinence Education Block Grant is a mandatory formula grant program (i.e., its funding is considered mandatory funding as opposed to discretionary funding).

To receive federal funds, a state must match every \$4 in federal funds with \$3 in state funds.<sup>29</sup> This means that full funding (from states and the federal government) for abstinence education must total at least \$87.5 million annually. In FY2008, 23 states and several territories chose not to sponsor a Title V Abstinence Education program. As mentioned above, the Title V Abstinence Education program was continued through a series of funding extensions.

The program's funding expired on June 30, 2009,<sup>30</sup> but P.L. 111-148, the Patient Protection and Affordable Care Act (PPACA; enacted March 23, 2010), 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).

### **Community-Based Abstinence Education<sup>31</sup>**

Additional abstinence-only education funding (discretionary funding), for the CBAE program, had been included in annual appropriations legislation. P.L. 106-246 appropriated an additional \$20 million for abstinence education to HHS under the special projects of regional and national significance (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.<sup>32</sup> No abstinence education funding was appropriated for FY2010 through the annual appropriations process (i.e., the CBAE program was not funded in FY2010).<sup>33</sup>

Moreover, from FY2004 through FY2009, \$4.5 million annually (in discretionary funding) was set aside from the Public Health Service for evaluation of the CBAE program.<sup>34</sup>

### **Adolescent Family Life Program—“Prevention” Component**

The AFL demonstration program was enacted in 1981 as Title XX of the Public Health Service Act (P.L. 97-35). It is administered by the Office of Adolescent Pregnancy Programs at HHS. The purpose of the AFL program is to evaluate innovative and integrated approaches to the delivery of

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<sup>29</sup> 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).

<sup>30</sup> 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. Thereby, federal funding for the program for FY2009 was \$37.5 billion (i.e., a rate of \$50 million per year for three-quarters of the fiscal year).

<sup>31</sup> 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.

<sup>32</sup> In the intervening years, the CBAE program was funded at \$40 million in FY2002, 54.6 million in FY2003, \$70 million in FY2004, \$99.2 million in FY2005, \$108.8 million in FY2006, and \$108.9 million in FY2007.

<sup>33</sup> Instead, P.L. 111-117, the Consolidated Appropriations for FY2010, includes a \$110 million new discretionary teenage pregnancy prevention program for FY2010.

<sup>34</sup> In FY2010, \$4.5 million annually (in discretionary funding) was set aside from the Public Health Service for evaluation of the TPP program.

comprehensive services to pregnant and parenting adolescents, and provide and evaluate teenage pregnancy prevention services that promote abstinence from sexual activity for adolescents. The AFL program provides services to pre-adolescents, adolescents, families, infants of parenting teens, and teen fathers. Any public or private nonprofit organization or agency is eligible to apply for a demonstration grant. AFL projects can be funded for up to five years; all grantees are required to reapply each year of their continuing grant.

Since 1998, the “prevention” component of the AFL demonstration program<sup>35</sup> has been used to exclusively fund abstinence-only education projects that conform to the definition of abstinence education defined in the Title V Abstinence Education Block Grant to states. 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 years FY2002 through FY2004; and \$13.1 million in each of the fiscal years FY2005 through FY2009. In FY2010, no funding was provided for the “prevention” component of the AFL program.

### **Evaluation of Abstinence Education Programs**

A report by Mathematica Policy Research, Inc. (released in April 2007) presented the final results from a multi-year, experimentally based impact study on several abstinence-only block grant programs.<sup>36</sup> 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. According to the report

Findings indicate that youth in the program group were no more likely than control group youth to have abstained from sex and, among those who reported having had sex, they had similar numbers of sexual partners and had initiated sex at the same mean age.... Program and control group youth did not differ in their rates of unprotected sex, either at first intercourse or over the last 12 months.... Overall, the programs improved identification of STDs but had no overall impact on knowledge of unprotected sex risks and the consequences of STDs. Both program and control group youth had a good understanding of the risks of pregnancy but a less clear understanding of STDs and their health consequences.<sup>37</sup>

In response to the report, HHS (under the Bush Administration) stated that the Mathematica study showcased programs that were among the first funded by the 1996 welfare reform law. It stated that its recent directives to states encouraged states to focus abstinence-only education programs

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<sup>35</sup> The AFL program authorizes grants for two types of demonstrations: (1) projects which provide “care” services (i.e., health, education, and social services to pregnant adolescents, adolescent parents, their infants, families, and male partners) to develop, test, and evaluate interventions with pregnant and parenting teens, in an effort to lessen the negative effects of childbearing on teen parents, their infants, and their families; and (2) projects which provide “prevention” services (i.e., services 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 STDs. The AFL demonstration program also has a basic and applied research component, the purpose of which is to report on the causes and consequences of adolescent premarital sexual relations, adolescent pregnancy, and adolescent parenting.

<sup>36</sup> CRS Report RS22656, *Scientific Evaluations of Approaches to Prevent Teen Pregnancy*, by Carmen Solomon-Fears.

<sup>37</sup> 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/>.



on youth most likely to bear children outside of marriage (i.e., high school students) rather than elementary or middle-school students. It also mentioned that programs need to extend the peer support for abstinence from the pre-teen years through the high school years.<sup>38</sup>

In contrast, a recently released study of the abstinence-only strategy found positive results. The scientifically based study assigned African-American students in the 6<sup>th</sup> and 7<sup>th</sup> grades to (1) an eight-hour abstinence-only intervention to reduce sexual intercourse; (2) an eight-hour safer sex intervention to increase condom use; (3) eight-hour and 12-hour comprehensive intervention to reduce sexual intercourse and/or increase condom use; or (4) a control group wherein an eight-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,<sup>39</sup> 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.<sup>40</sup> 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.<sup>41</sup> The authors further noted that none of the interventions had significant effects on consistent condom use.<sup>42</sup>

## Youth Programs

Youth programs incorporate elements of the other two approaches, and generally include one or more of the following components to address teen sexual activity: sex education, mentoring and counseling, health care, academic support, career counseling, crisis intervention, sports and arts activities, and community volunteer experiences. Youth programs receive funding from a wide array of sources, including the federal government, state and local governments, community organizations, private agencies, nonprofit organizations, and faith-based organizations.

The sex education component of many youth programs usually includes an abstinence message (which is intended to enable teens to avoid pregnancy) along with discussions about the correct and consistent use of contraception (which is intended to reduce the risk of pregnancy for

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<sup>38</sup> U.S. Department of Health and Human Services (HHS), "Report Released on Four Title V Abstinence Education Programs," HHS Press Office, April 13, 2007, <http://aspe.hhs.gov/hsp/abstinence07/factsheet.shtml>.

<sup>39</sup> The participants were interviewed two years after the intervention.

<sup>40</sup> 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.)

<sup>41</sup> 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.

<sup>42</sup> 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.



sexually active teens). There is a significant difference between abstinence as a *message* and abstinence-only *interventions*. While some child advocates continue to support an abstinence-only program intervention (with some modifications), others argue that an abstinence message integrated into a comprehensive sex education program that includes information on the use of contraceptives and that enhances decision-making skills is a more effective method to prevent teen pregnancy. A recent nationally representative survey found that 90% of adults and 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 that a majority of adults (73%) and teens (56%) want teens to get more information about both abstinence and contraception.<sup>43</sup> The American public—both adults and teens—supports encouraging teens to delay sexual activity *and* providing young people with information about contraception.<sup>44</sup>

Some youth 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, many youth programs also want to prevent second or additional births to teens and they realize that a different approach may be needed to prevent secondary births as compared to first births. Research has indicated that youth 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.<sup>45</sup>

## Evaluation of Youth Programs

A study that evaluated youth programs that sought to delay the first time teens have sex partly summarized the research by highlighting some characteristics or activities associated with teenagers who delayed sexual activity. The study reported that (1) teens who do well in school and attend religious services are more likely to delay sexual initiation; (2) girls who participate in sports also delay sex longer than those who do not; and (3) teens whose friends have high educational aspirations, who avoid such risky behavior as drinking or using drugs, and who

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<sup>43</sup> Bill Albert, "With One Voice 2007—America's Adults and Teens Sound Off About Teen Pregnancy," National Campaign to Prevent Teen Pregnancy, February 2007, p. 2., [http://www.teenpregnancy.org/resources/data/pdf/WOV2007\\_fulltext.pdf](http://www.teenpregnancy.org/resources/data/pdf/WOV2007_fulltext.pdf).

<sup>44</sup> There appears to be significant public support for the involvement of religious groups in preventing teen pregnancy. When asked what organizations could do the best job of providing teen pregnancy prevention services, 39% said religious groups, 42% said non-religious community groups, and 12% said government. (Source: The National Campaign to Prevent Teen Pregnancy, *Keeping the Faith: The Role of Religion and Faith Communities in Preventing Teen Pregnancy*, by Barbara Dafoe Whitehead, Brian L. Wilcox, and Sharon Scales Rostosky. September 2001.)

<sup>45</sup> 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.

perform well in school are less likely to have sex at an early age than teens whose friends do not.<sup>46</sup>

## **Other Federal Programs to Reduce Teen Pregnancy**

Although there was not a federal comprehensive sex education program per se for teens until 2010, there were many federal programs that provided information about contraceptives, and provided referral and counseling services related to reproductive health. These programs still provide such services, they include the Title XX Adolescent Family Life “care” demonstration grants, Title X Family Planning, and Medicaid Family Planning. Also, funds from the Maternal and Child Health block grant, the Title XX Social Services block grant, the TANF block grant, and several other Department of Health and Human Services (HHS) programs<sup>47</sup> can be used to provide contraceptive services to teens.<sup>48</sup>

### **The Adolescent Family Life (AFL) Program: Title XX of the Public Health Services Act**

The Adolescent Family Life (AFL) program, created in 1981 (Title XX of the Public Health Services Act), was the first federal program to focus on adolescents. The AFL Program was created in 1981 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. The AFL program is authorized to provide comprehensive sex education information, including information about contraceptive methods (sometimes referred to as the AFL “care” component) as well as abstinence-only-focused educational information (sometimes referred to as the AFL “prevention” component). The AFL program also seeks to prevent subsequent births among teens. Although there are many federally funded programs that provide pregnancy prevention information and/or services to teens,<sup>49</sup> from 1981 to 1996, the Adolescent Family Life (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. From 1998 to 2009, federal teen pregnancy prevention efforts relied heavily on using abstinence-only education as its primary tool. The federal appropriation for the AFL program for FY2010 stipulated that none of the funds were to be used to fund abstinence-only type projects.

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<sup>46</sup> Jennifer Manlove, Angela Romano Papillio, and Erum Ikramullah, “Not Yet: Program To Delay First Sex Among Teens,” *The National Campaign to Prevent Teen Pregnancy and Child Trends*, September 2004, p. 4.

<sup>47</sup> For example, 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.

<sup>48</sup> 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.)

<sup>49</sup> These programs include the Adolescent Family Life (AFL) program, Medicaid Family Planning, Title X Family Planning, the Maternal and Child Health block grant, the Temporary Assistance for Needy Families (TANF) block grant, the Title XX Social Services block grant, and a couple of teen pregnancy prevention programs administered by the Centers for Disease Control and Prevention.

## **Reproductive Health and Family Planning Services: Title X of the Public Health Services Act**

The National Family Planning Program, created in 1970 as Title X of the Public Health Services Act, is administered through the Office of Population Affairs/Office of Public Health and Science, Department of Health and Human Services (HHS). It provides grants to public and private non-profit agencies to provide voluntary family planning services for individuals who are otherwise ineligible for medical services. Family planning programs provide basic reproductive health services: contraceptive and infertility services, gynecological care, screening for breast and cervical cancers, STDs, reproductive health counseling/education and referrals.

## **Maternal and Child Health (MCH) Block Grant: Title V of the Social Security Act**

These funds support a variety of health services for women and children, including adolescent pregnancy prevention activities. Activities include adolescent pregnancy prevention programs; state adolescent health coordinators; state prenatal hotlines; family planning; technical assistance and other prevention services. Through the block grants, approximately 610 school-based and school-linked centers are supported.

## **Medicaid: Title XIX of the Social Security Act**

Medicaid is a jointly funded federal-state health insurance program for certain low-income people. The federal government pays 90% of state expenditures for Medicaid family planning services. The enhanced match encourages states to fund family planning programs that provide patient counseling and education on pregnancy prevention and reproductive health.

## **Social Services Block Grant: Title XX of the Social Security Act**

The Social Services Block Grant is a flexible source of federal funds that states may use to support a range of social services, which may include family planning services and pregnancy prevention and parenting programs.

## **Temporary Assistance for Needy Families (TANF): Title IV-A of the Social Security Act**

One of the four goals of the 1996 welfare reform law (P.L. 104-193) is to prevent and reduce out-of-wedlock pregnancies.<sup>50</sup> To receive assistance under TANF, unmarried minor parents are required to live at home or in an adult-supervised setting and to attend school if they lack a high school diploma. HHS also awarded a bonus of \$20 million for each of the years FY1999-FY2006 to up to five states that showed the largest decrease in nonmarital births, while simultaneously maintaining abortion rates at or lower than FY1995 levels. P.L. 109-171 eliminated this bonus.

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<sup>50</sup> 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.

## **The National Strategy to Prevent Out-of-Wedlock Teen Pregnancies**

In January 1997, HHS announced the National Strategy to Prevent Out-of-Wedlock Teen Pregnancies in January 1997. The purpose of the National Strategy is to ensure that at least 25% of communities in the United States have pregnancy prevention programs. (Annual reports were published for 1997-1999.) An alternative initiative, which is part of the Strategy, encourages states to create Second Chance Homes with TANF and other funding. These homes are expected to provide teen parents, who might be at risk of abuse if they stayed at home, with guidance in parenting, child development, budgeting, health and nutrition; these skills are seen as a way to prevent repeat pregnancies.

P.L. 104-193 contained some comprehensive child support enforcement measures. Because strict child support enforcement is thought to deter nonmarital childbearing, the child support provisions were seen by Congress as another method of attempting to reduce nonmarital pregnancies. Child support enforcement measures include streamlined efforts to name the father in every case; employer reporting of new hires (to locate noncustodial parents quicker); uniform interstate child support laws; computerized statewide collections to expedite payment; and stringent penalties, such as the revocation of a drivers' license in cases in which noncustodial parents owe past-due child support.

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