United States General Accounting Office

GAO

Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate

November 1998

TEEN PREGNANCY

State and Federal Efforts to Implement Prevention Programs and Measure Their Effectiveness

GAO/HEHS-99-4

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-277558

November 30, 1998

The Honorable James M. Jeffords
Chairman, Committee on Labor
and Human Resources
United States Senate

Dear Mr. Chairman:

In 1996, about 1 million teenage girls in the United States became pregnant and over half of them gave birth. Among births to teens aged 15 to 17, 84 percent occurred outside of marriage. Although the teen birth rate has been declining steadily in recent years, the United States has the highest teen birth rate of all industrialized nations—about 54 per 1,000 teens aged 15 to 19 as of 1996,[1] nearly twice as high as the next nation, the United Kingdom. Families started by teenagers received an estimated $39 billion in federal assistance in 1995 from programs such as Medicaid; Aid to Families With Dependent Children[2]; and the Special Supplemental Food Program for Women, Infants, and Children.[3]

Teenage pregnancy and parenthood have unfortunate consequences for society, teenage mothers, and the children born to them. Teen mothers frequently do not complete high school, have poor earnings, and have increased dependency on the welfare system. A child born to a teen mother is more likely to have a low birthweight and health problems, suffer abuse, live in an inferior home environment, be poor, and be less likely to succeed in school. Moreover, a child born to a teen is more likely to become a teenage parent.

In an effort to prevent teen pregnancy, the federal government and states have taken a number of actions. For example, the Congress recently enacted welfare reform legislation that contains provisions directed at reducing out-of-wedlock childbearing and welfare dependency and promoting sexual abstinence education, especially to teenagers.[4] The Department of Health and Human Services (HHS) is developing a national

[1]National Center for Health Statistics, Monthly Vital Statistics Report (Washington, D.C.: Centers for Disease Control and Prevention, June 30, 1998).

[2]Replaced in 1996 by the Temporary Assistance for Needy Families (TANF) program.

[3]Advocates for Youth, Teen Pregnancy, the Case for Prevention: An Analysis of Recent Trends in Federal Expenditures Associated With Teenage Pregnancy (Washington, D.C.: Apr. 1998).

[4]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, Aug. 22, 1996).

strategy to prevent teen pregnancy, while states and local governments and private entities are implementing strategies for addressing the problem of teenage pregnancy and childbearing.

Because of your interest in efforts to prevent teen pregnancy, you asked us to provide information on (1) state strategies to reduce teen pregnancy and how states fund these efforts, (2) how welfare reform affected states' strategies, (3) the extent to which programs that are part of states' prevention strategies are evaluated, and (4) what teen pregnancy prevention activities the federal government supports.

For this review, we focused on eight states that had longstanding teen pregnancy prevention (TPP) strategies in place: California, Georgia, Illinois, Louisiana, Maine, Maryland, Oregon, and Vermont. The teen birth rates in these states vary; some had experienced recent declines, and some had more stable rates. These states also employed a variety of strategies to prevent teen pregnancy, but the strategies are not necessarily representative of the nation. During our state visits, we interviewed officials from multiple state agencies—health, social services, education, and justice—who were responsible for implementing their states' TPP strategies. We also held discussions with local officials who were responsible for implementing the state strategies and some of the teens involved in the programs. We obtained information on state TPP strategies and programs, including state and federal financial assistance, and state efforts to evaluate them. Although we collected information on state strategies and programs, we did not evaluate them.

To determine the federal role in preventing teen pregnancy, we met with HHS officials who were knowledgeable about TPP activities. We also obtained written responses to questions on programs, funding, surveillance, monitoring, and evaluation from HHS and other federal agencies that HHS identified as having a role related to teen pregnancy prevention.[5] To learn more about teen pregnancy prevention, demographics, research, programs, and other issues, we met with and obtained information from experts in academia and relevant organizations. (See app. I for a detailed description of our scope and methodology.) We conducted our work between April 1997 and November 1998 in accordance with generally accepted government auditing standards.

[5]The other federal agencies identified were the Departments of Agriculture, Defense, Education, Housing and Urban Development, Justice, and Labor; the Office of National Drug Control Policy; and the Corporation for National Service.

Results in Brief

The eight states in our review have, over time, developed TPP strategies involving numerous programs that fall into six areas: sex education, family planning services, teen subsequent pregnancy prevention, male involvement, youth development, and public awareness. In general, these states targeted high-risk populations and communities and tailored programs to three different groups of teens—those not sexually active, those sexually active, and those who are already parents. While strategies were applicable statewide, states typically relied on local communities to select and implement specific programs from an array of alternatives. States generally gave localities the flexibility to choose the type and mix of programs they wanted to put in place. Some communities chose not to implement programs that the state strategy encouraged. For example, even though some state strategies encouraged sex education in the schools, some communities chose not to have sex education in school-based settings. As a result, programs implemented within and across the states varied. All of the states we visited relied on federal funding to support their strategies, and in many of the states, federal funding exceeded state funding for teen pregnancy prevention.

The 1996 federal welfare reform legislation had a limited effect overall on these states' TPP strategies, in part, because the states in our review already required that teen parents live at home and stay in school to receive assistance—two key provisions now mandatory under federal welfare reform. Currently, only one of the eight states plans to compete for the bonus provided by the law to states that show the greatest success in reducing out-of-wedlock births. The other states are unlikely to compete because they lack the data needed to show reductions or because their prevention efforts focus on teens who account for a relatively small proportion of out-of-wedlock births. Although the eight states initially had concerns about the prescriptive nature and administrative requirements of the new law's grant program for sexual abstinence education, the eight states applied for the grants, received funding, and plan to either initiate new abstinence education programs or expand programs that they had already included as part of their strategies to prevent teen pregnancy.

Although all eight states are tracking changes in teen births, few are evaluating the effect of their TPP programs on teen pregnancy. Only four states—California, Georgia, Illinois, and Maryland—are attempting to link some of their TPP efforts to changes in teen pregnancies, births, or other closely related outcomes, such as sexual and contraceptive behavior. Georgia and Maryland plan to continue some evaluations for several years to gauge long-term program effects. In Louisiana, Maine, Oregon, and

Vermont, most program evaluations focus on outcomes, such as knowledge gains and attitude changes, rather than behavior changes, even though research studies have shown knowledge or attitude changes to be moderate or weak predictors of teen pregnancy. All states are evaluating program processes to ensure that programs are operating as intended; however, these provide little information on whether such programs really make a difference.

For fiscal year 1997, HHS identified at least $164 million in funding specifically for TPP programs or services—more than two-thirds of which comes from Medicaid and title X (of the Public Health Service Act) family planning programs. In fiscal year 1998, the Congress authorized an additional $50 million for abstinence education. In addition, block grants, such as Maternal and Child Health and TANF, are used by states to fund teen pregnancy prevention; other HHS and federal agency programs could be used to support activities related to teen pregnancy—a total of 27 HHS programs and funding streams and various programs within 8 other federal agencies. However, funding specifically for TPP activities through these streams could not be isolated at the federal level, primarily because of the flexibility on spending decisions given to states. HHS also supports research and surveillance that provide information on teen births and their causes. To date, HHS has undertaken very few evaluations to determine whether and how these programs affect teen birth rates and the behavioral outcomes related to teen pregnancy. However, HHS has recently begun program evaluations for two TPP programs that will measure program effects on behavior outcomes closely related to teen pregnancy.

Background

Nationally, teen birth rates have declined steadily in the last several years. From 1991 to 1997, the number of teens having engaged in sexual activity has also decreased; for sexually active teens, the rate of condom use has increased. However, the teen birth rate in the United States is high at about 54 per 1,000 girls aged 15 to 19. Teen birth rates vary greatly by state, ranging in 1996 from 30 per 1,000 girls aged 15 to 19 in Vermont to 76 per 1,000 in Mississippi.

Research shows that four risk factors consistently predict teen pregnancy: poverty, early school failure, early behavior problems, and family problems and dysfunction.[6] Risk factors for teen pregnancy are common to other problem youth behavior, such as delinquency and substance

[6]K. A. Moore and others, Adolescent Sex, Contraception, and Childbearing: A Review of Recent Research (Washington, D.C.: 1995).

abuse. Research has also identified several factors that can help protect against teen pregnancy, including positive relationships with parents and positive connections to a school community. Recent reviews of program evaluation results concluded that certain approaches are more promising than others, but too few programs have been rigorously evaluated to assess their effect on teen pregnancy.[7]

Numerous federal, state, and local agencies as well as private citizens and organizations have had a role in TPP activities. For decades, the federal government has supported efforts to prevent teen pregnancy. As part of HHS' Healthy People 2000 initiative, each state sets goals to reduce teen pregnancy.[8] To help meet these goals, the federal government provides funding to states and local communities for teen pregnancy prevention through a variety of grants and programs administered primarily by HHS. HHS also supports research and data collection and surveillance on the magnitude, trends, and causes of teen pregnancies and births. The 1996 welfare reform legislation also includes provisions aimed at reducing teen pregnancy. For example, the new law provides funding for abstinence-only education—sex education programs that emphasize abstinence from all sexual activity until marriage and exclude instruction on contraception—and allows states to use their TANF block grants for other TPP activities. In addition, the legislation requires states to set goals for decreasing out-of-wedlock births and will financially reward states with bonuses for the largest decreases in all out-of-wedlock births. The legislation also requires teen parents receiving assistance to stay in school and live at home or in another approved setting. States must also indicate how they intend to address the problem of statutory rape, and the government is required to study the link between teen pregnancy and statutory rape. Finally, the new law requires HHS to develop a national strategy to prevent out-of-wedlock teen pregnancy.

States in our review have designed strategies for reducing teen pregnancy and have implemented and overseen programs that support their strategies. Generally, state health departments lead state TPP efforts. However, because of the crosscutting nature of teen pregnancy prevention, coordination is necessary with other state agencies whose

[7]Douglas Kirby, No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy (Washington, D.C.: Mar. 1997), and K. A. Moore and others, Adolescent Pregnancy Prevention Programs: Interventions and Evaluations (Washington, D.C.: Child Trends, 1995).

[8]Healthy People 2000: National Health Promotion and Disease Prevention Objectives, released by HHS in 1990, sets national goals on numerous health indicators, including reducing teen pregnancy. Most states have emulated the national objectives but have tailored them to their specific needs. HHS tracks progress against objectives and periodically reports progress. HHS is in the process of finalizing national health objectives for 2010.

programs and activities can affect efforts to prevent teen pregnancy, such as departments of social services, justice, and education. Governors' offices, special commissions, and task forces can also play a central role in designing and implementing strategies and programs at the state level. States generally administer statewide programs, but most of the responsibility for implementing programs is delegated to local communities. States also encourage building coalitions among community groups and organizations involved in teen pregnancy prevention. State strategies must operate within the context of statutes, local policies, and other activities in the state.

At the local level, public institutions, like schools and health departments as well as community-based and other organizations, often implement TPP programs or otherwise influence how TPP programs are implemented. Finally, some private organizations at the national, state, or local level may support public efforts or, in some cases, run independent initiatives.

States' Teen Pregnancy Prevention Strategies Target Different Groups and Are Implemented at the Local Level

In their efforts to address the problem of teen pregnancy, the states that we visited developed prevention strategies with multiple components that included a variety of programs and services. But in all cases, a key objective of these states' strategies was to target high-risk groups, such as teens living under impoverished conditions. Within the context of their broad strategies, states generally gave localities the flexibility to administer programs to meet local needs and preferences. States identified the federal government as a major contributor of funds that support their TPP strategies.

State Strategies Have Multiple Components

Since the early 1980s, the TPP strategies in the eight states that we visited have evolved from focusing on services for teen parents to an array of programs with increased emphasis on prevention, while still providing programs and services for pregnant and parenting teens. The TPP strategies of all the states we visited contained six basic components: sex education, family planning services, teen subsequent pregnancy prevention programs, male involvement, comprehensive youth development, and public awareness. (See table 1.) Although each state generally had all of these components in their TPP strategies,[9] the emphasis placed on the components and the types of services and programs included in their strategies varied.

[9]At the time of our review, Louisiana did not have a public awareness component in its strategy, but the state is in the process of developing one.

Table 1: Six Components of the Eight States' TPP Strategies

Component	Description
Sex education	Includes several approaches: those that provide education only about sexual abstinence (often called "abstinence-only" programs), those that provide education about abstinence and about contraceptive use for teens and preteens who are or soon may become sexually active (sometimes called "abstinence-based" programs), and those that provide education about a broad range of topics on human sexuality (sometimes called "sexuality education"). Sexuality education often addresses topics broader than reproductive health and may address marriage and families, dating, and gender psychology. Sex education may be provided in the context of comprehensive health curricula or family life education and may be provided in schools, clinics, community settings, or at home.
Family planning services	Family planning services include counseling on abstinence, contraception, sexually transmitted diseases, HIV, birth options, and other sexual health issues. These services may also include testing for pregnancy, sexually transmitted diseases, and HIV as well as dispensing various forms of contraception, such as condoms, birth control pills, and implanted and injectable birth control. Family planning services may be offered in the context of primary care or targeted health care and may be provided by family planning clinics, health clinics, school-based health centers, and private physicians.
Teen subsequent pregnancy prevention	This component aims to keep pregnant or parenting teens from becoming pregnant again. Services and programs in this component help teens finish school; obtain job training, parenting education, and day care; gain access to family planning; and ensure consistent and effective methods and use of contraception.
Male involvement	States have recently begun to adopt this strategy to encourage young males to assume a stronger role in preventing teen pregnancy. These programs teach young males primary prevention skills and provide them motivation for choosing to be sexually responsible through a variety of settings and activities, such as mentoring, sex education and contraception, counseling services, tutoring, and sports activities.
Youth development	These programs—while not focusing specifically on teen pregnancy prevention—often contain multiple components aimed at reducing risky behaviors among teens, such as sexual activity and drug and alcohol abuse. Youth development activities include general skills building to promote self-esteem, social skills, and negotiation tactics; academic tutoring and vocational training; career counseling; sex education, which may include an emphasis on abstinence or delay of initiation of sexual activity or sexuality and contraception education; youth and adult mentoring; and recreational activities. These activities are intended to motivate teenagers to continue in school and become self-sufficient.
Public awareness	Many states used television, radio, and print to disseminate key messages. These and other public awareness initiatives aim to increase knowledge and influence public opinion or behavior related to teen pregnancy prevention. They typically target teens, parents, adult males, or the general public.

Two of these components—male involvement and youth development—are beginning to play prominent roles in states' TPP strategies. Traditionally, pregnancy prevention efforts almost exclusively targeted young women. More recently, strategies have begun to focus on young men's role in decisions to have sex and to use contraception. In 1995, 68 percent of males surveyed by the National Survey of Adolescent

Males[10] reported having had intercourse by age 18. The survey also observed that one of the biggest shifts in teen reproductive behavior is the improvement in teenage males' use of contraception. These shifts suggest that male teens can be encouraged to delay sex or use contraception if they have begun having sex.

All the states we visited included a male involvement component in their TPP strategies in an effort to change male behavior and produce more promising results. For example, California's male involvement program—a 3-year, $8 million grant program established in 1995—funds 23 projects across the state to improve teen males' motivation for being sexually responsible through peer education, mentoring, youth conferences, and other activities. California also supports prevention and parenting programs for incarcerated young men and has increased enforcement of statutory rape laws to increase the prosecution and conviction of adult men who have unlawful sex with minors. In addition, one of the state's public awareness campaigns specifically targets males. Georgia's male involvement effort aims to establish community-based programs that focus on male responsibility for pregnancy prevention, responsible fatherhood, and motivation for academic achievement and economic self-sufficiency. In 1996, Georgia used $265,500 from the Medicaid Indigent Care Trust Fund (ICTF) to sponsor 17 projects across the state. Grant recipients included health departments, community centers, and various chapters of Alpha Phi Alpha Fraternity, Inc.[11] In 1997, Georgia used $200,000 from ICTF to award 23 grants that focused specifically on pregnancy prevention programs from a male perspective.

All of the states we visited also included youth development—another nontraditional component—in their TPP strategies. Although many of these programs do not focus specifically on teen pregnancy prevention, states and some experts believe they can reduce teen pregnancy by improving teens' belief in their future and improving their education and career opportunities. Youth development activities often include mentoring, after-school homework assistance and tutoring, peer leadership, self-esteem building, social and recreational activities, and sex education. For example, Illinois' Teen REACH (Responsibility, Education, Achievement, Caring, and Hope)—an $8.4-million annual after-school program—aims to decrease teen pregnancies, arrests, alcohol and drug

[10]Funded by the National Institute of Child Health and Human Development and HHS' Office of Population Affairs, the survey combines longitudinal data collection and individual research.

[11]Since 1980, Chapters of Alpha Phi Alpha Fraternity, Inc., and the March of Dimes Birth Defects Foundation have collaboratively conducted "Project Alpha"—a longstanding national program to provide men with information about teen pregnancy.

use and increase school attendance and completion and work or work-related activities. The program targets girls and boys aged 10 to 17 at 41 sites across the state and will link participants to other state and community-based programs and services.

Table 2 summarizes the activities and services in the various components that the eight states used to implement their TPP strategies.

Table 2: TPP Programs and Services in Each of the Eight States, by Component

State goal and strategy	Sex education	Family planning services
California		
California's goal is to reduce teen pregnancy for ages 17 and under to no more than 50 per 1,000. Its TPP strategy uses numerous prevention and intervention programs. Programs are based on research indicating that teen pregnancy and subsequent births among teens are associated with many negative education, economic, health, and social outcomes. The programs provide education, information, counseling, clinical services, and community outreach to serve abstaining teens, sexually active teens, and teen parents. The programs are administered both statewide and through local community grant programs.	— Teen information and education services are comprised of 31 youth intervention projects targeting at-risk and foster care youth to enhance knowledge, attitudes, and skills of boys and girls to make responsible decisions about abstinence and sexual behavior. — Department of Education grant programs, administered by 37 grantees, provide abstinence-based education in 450 elementary and secondary schools. — Most Community Challenge grants (112) offer family life programs that include sex education and programs to help parents develop effective communication skills when talking to adolescents and children about sex and pregnancy prevention.	— State-funded family planning program for low-income men and women provides services through 2,200 clinics, hospitals, universities, and private practice providers. — Teen Smart clinics (56 state-funded and administered) aim to reduce teen pregnancy and sexually transmitted diseases and provide enhanced counseling for teens. — Federally funded title X family planning clinics (over 230) administered by the California Family Health Council, a nonprofit corporation, serve about 150,000 teens annually. Special teen services include a Teen Reproductive helpline and a Teen Family Planning Retention program.
Georgia		
Georgia's goal is to reduce the pregnancy rate for girls aged 15 to 19 by 15 percent by 2002, reduce the rate of sexual activity among teens, increase effective contraception use for sexually active teens, and increase high school completion rates among teen parents to reduce repeat pregnancies and increase employment opportunities. Its strategy, Teen Plus, includes programs and clinical services to improve health and social outcomes for teens, systems to collect and disseminate data on teen well-being, measures to strengthen state laws to protect and support teens, and assisting families and communities to ensure the well-being of teens and their families. Georgia's Family Connection program encourages community coalitions to improve youth and family outcomes, including reducing teen pregnancy. Of the 76 Family Connection communities, 60 have selected teen pregnancy prevention as a priority.	— Abstinence-based education in schools supplements state-mandated kindergarten through grade 12 comprehensive sex education and HIV prevention instruction. — Grants provide training for trainers in abstinence-plus curricula in 10 health districts.	— Teen Plus centers in 27 sites provide multiple services to promote health and well-being, including abstinence education, counseling, health education, contraceptive services, as well as educational and recreational programs designed to involve teens in positive activities after school. — Nontraditional family planning clinics aim to improve access to contraceptive services for low-income women, including teens, who are at high risk for unintended pregnancies. — Community outreach by Medicaid staff encourages at-risk teens and others to use family planning and preventive services in the Teen Plus centers and nontraditional clinics.

Teen subsequent pregnancy prevention	Male responsibility	Youth development	Public awareness
— Adolescent and Family Life program, a case management program, aims to prevent second pregnancy and prevent teen pregnancy among siblings. — Cal-Learn and Department of Education programs aim to keep pregnant and parenting teens in school.	— Male involvement program at 23 grantees across the state aims to promote the involvement of teen males to reduce teen pregnancy by promoting primary prevention skills and motivation for choosing to be sexually responsible. — Young Men as Fathers program targets male teens in all state juvenile detention facilities and emphasizes pregnancy prevention and fathering skills for teen fathers. — Statutory Rape Vertical Prosecution program aims to increase prosecutions statewide.	— Statewide mentoring program aims to recruit 250,000 adult mentors to be matched with 1 million at-risk youth. — Community Challenge grants to 112 grantees in high-risk areas include abstinence education, life-skills training, decisionmaking skills, academic and employment skill development, sex and contraception education, and parent-child communication.	— Statewide media campaign aims to promote sexual abstinence; enhance male involvement in teen pregnancy prevention and responsible fatherhood; heighten public awareness of legal, social, health, and economic consequences of teen pregnancy; and heighten public commitment.
— Resource mothers work with pregnant and parenting teens in 15 communities to provide parenting education and education to delay a subsequent pregnancy.	— Grants for 23 community-based programs focus on male responsibility for pregnancy prevention, responsible fatherhood, and academic achievement and economic self-sufficiency.	— Micro Enterprise programs teach skills to prevent high-risk behavior, including teen pregnancy. — Peer counseling programs in 23 communities aim to prevent pregnancy, sexually transmitted diseases, and substance abuse. — Teen Plus community involvement grants to 17 communities support community-based, nonclinical services.	— Statewide media campaign aims to increase awareness of consequences of teen pregnancies.

(continued)

State goal and strategy	Sex education	Family planning services
Illinois		
Illinois' goal is to reduce the birth rate among girls aged 14 and younger to no more than 2.5 per 1,000 and among girls aged 15 to 17 to no more than 28 per 1,000 by the year 2000. Its multifaceted strategy includes a variety of prevention programs and services implemented at the state and local level as well as services for teen parents to encourage school completion and delay of second pregnancy.	— Many of the 42 adolescent health programs implemented at the local level include sex education.	— Title X clinics (60 across the state) develop teen action plans for outreach, community education, postponing sex, and access to counseling and contraception. Clinics are required to adjust hours to accommodate teens. — Twenty-two school-based health centers throughout the state provide abstinence education and family planning counseling. Distribution of contraception is a local decision. — Medicaid expansion allows for family planning coverage for postpartum women, including teens.
Louisiana		
Louisiana's goal is to reduce the rate of unwed teen pregnancy by at least 1 percent statewide and by 2 percent in 1998 in the pilot area. Its strategy is to implement community- and school-based programs whose goals are to delay the start of sexual activity; reduce the incidence of teen pregnancy, repeat teen pregnancies, and all out-of-wedlock births; and increase the number of parenting teens who complete high school, improving the employability of parenting teens and other at-risk youth.	— Abstinence-based curriculum is provided to public and private schools in pilot area. — Abstinence program aims to simulate the demands of parenting in pilot area (3 middle schools). — Sex education is encouraged in middle and high schools in pilot area. (In the rest of the state, sex education is prohibited before and under local control after grade 7.)	— Family planning services for teens are not specifically included in the strategy but counseling, sex education, and contraceptive services are available to teens through the state health department family planning program, funded in part with title X funding. — School-based health centers have a strong abstinence focus and are prohibited from providing family planning counseling and services but can refer for these services (31 sites).

Teen subsequent pregnancy prevention	Male responsibility	Youth development	Public awareness
— Parents Too Soon provides intervention services for pregnant and parenting teens, including prevention of second pregnancy at 25 sites across the state. — Projects at 10 sites across state use home visits and peer support to help teen mothers finish school and effectively and consistently use birth control to avoid another pregnancy. — Teen Parent Services—a TANF case management statewide program—helps teen parents finish school and obtain job training, parenting education, day care, and family planning education.	— Two family planning clinics have male responsibility projects. — Ten of the 42 adolescent health programs include male responsibility components.	— Adolescent health programs in 42 of Illinois' 102 counties include abstinence and sexuality education; self-esteem training; alcohol, tobacco, drug, and violence prevention; teen and parent communications; peer relationships; and male responsibility activities. — Parents Too Soon (20 sites) for at-risk and foster teens focuses on education achievement and nonviolent and future-oriented decisionmaking. — Teen REACH, an after-school program (41 locations), includes a variety of services to prevent multiple teen risks, including risk for teen pregnancy.	— Help Me Grow helpline includes information on family planning, sexuality, and sexually transmitted diseases.
— Clinics for pregnant and parenting teens and their babies provide primary and preventive care, with a goal of preventing subsequent pregnancies.	— Community-based programs are offered in the pilot area (4 sites). — Adolescent male project trains two students as peer counselors in reproductive health, sexually transmitted disease prevention, and drug prevention (1 site).	— Community-based youth development programs in pilot area include teen pregnancy prevention, tutoring, mentoring, and other after-school activities (3 sites).	— No media campaign is currently in place, but statewide media campaigns are being planned: one as part of the new abstinence education plan, and one as part of the state's overall TPP strategy. — Cable TV talk show in pilot area discusses teen issues, including teen sexuality.

(continued)

State goal and strategy	Sex education	Family planning services
Maine		
Maine's goals are to eliminate pregnancy among 10- to 14-year-olds, reduce the rate among 15- to 17-year-olds to 20 per 1,000 and among 18- to 19-year-olds to 80 per 1,000, and reduce the rate of repeat teen pregnancy and sexually transmitted diseases in teens. Its strategy encourages and supports community coalitions—through the Governor's Children's Cabinet and Communities for Children program—to assess risks, develop action plans to address teen pregnancy, and develop partnerships with the state. It also advocates comprehensive health education in the schools, makes family planning accessible, supports broad prevention efforts, and provides services to teen mothers.	— Strategy advocates comprehensive health education in the schools and funds health educators to assist schools in curricula development and instruction. — Family life educators are available to schools to develop comprehensive health and sexuality education curricula, train teachers, and do classroom instruction.	— Title X and state-funded family planning clinics (34 statewide) conduct outreach and education programs for teens and provide family planning counseling and contraceptive services for teens. — Eleven school-based health centers provide family planning counseling; three distribute contraception. — Teen Access to Contraception toll-free hotline provides contraception and counseling services.
Maryland		
Maryland's goal is to reduce teen births to no more than 30 per 1,000 for teens aged 15 to 17. Its strategy provides comprehensive and multidimensional programs that encourage delaying the start of sexual activity, promote parents as the primary sex educators, and support positive outcomes for pregnant and parenting teens. In addition to increasing family planning services for sexually active teens, the state involves communities in prevention and parenting efforts by funding local coalitions and offering grants to local communities.	— Statewide media campaign promotes abstinence and encourages parents to be their children's primary sex educators; campaign materials approved for use in all school districts. — Adult and Children Talking program encourages parent and adult-child communication on sexuality. State provides training to Interagency Committees on Adolescent Pregnancy Prevention and Parenting at the local level for parents and community members on communication and sexuality issues. — Comprehensive health education, including family life and sexuality, in kindergarten through grade 12 is mandated. Local jurisdictions select curricula.	— Three Teen Outreach clinics are in areas with high rates of teen birth and sexually transmitted diseases. — Title X family planning clinics (98 statewide) served about 23,000 teens in 1997. — Three for Free, a condom distribution program, implemented at 200 sites across state. — Medicaid expansion allows for family planning coverage for postpartum women, including teens. — Minors over age 13 can consent to reproductive health services with parental notification at the provider's discretion.

Teen subsequent pregnancy prevention	Male responsibility	Youth development	Public awareness
— Pregnant and parenting program in each of Maine's 16 counties provides social, education, medical, and support services, including prevention of subsequent pregnancies among teens.	— Child support enforcement education directed at young males aims to help them understand the economic impacts of teen pregnancy.	— Peer Leader program is offered at 130 sites. — Local prevention programs in two communities for teens at high risk for early pregnancy include self-esteem building and support groups for middle school boys and girls.	— TV campaign provides information on parent-child communication on sexuality issues, life aspirations, and refusal skills.
— Five community incentive grantees focus on parenting teens to prevent repeat pregnancies. — TANF-funded home visiting program for unwed mothers and fathers 16 and over provides services, including family planning to prevent repeat teen pregnancies and out-of-wedlock pregnancies.	— Two community incentive grants fund male responsibility programs. — Male Involvement Task Force advises the Governor's Council on Adolescent Pregnancy on strategies and policies to promote responsible behavior. — Young Fathers, Responsible Fathers, a statewide program, provides services to unwed, expectant, and noncustodial fathers. — Maryland Regional Practitioners Network maintains a statewide representation of advocates concerned with issues facing men and fathers and hosts an annual male involvement conference.	— Several of the 15 community incentive grants fund multiservice youth programs, including abstinence programs and prevention programs for siblings of pregnant teens. — After-school programs funded by the Governor's Office of Crime Control and Prevention aim to prevent crime and substance abuse and to reduce delinquency in 35 areas with high crime.	— Statewide media campaign established in 1987 promotes delaying the start of sexual activity and abstinence; encouraging responsible behaviors among teens; and increasing parent-child communications about sex, values, and pregnancy prevention. — State-supported Interagency Committees on Adolescent Pregnancy Prevention and Parenting provides communities information on teen pregnancy and prevention. — Over 600 school, health care, and community professionals attend an annual statewide TPP conference to receive information on planning, implementing, and evaluating programs and services.

(continued)

State goal and strategy	Sex education	Family planning services
Oregon		
Oregon's goal is to reduce teen pregnancy to 15 per 1,000 females aged 10 to 17 by the year 2000—an official state benchmark. Its strategy is to address the causes of teen pregnancy through coalitions sensitive to local needs, character, and attitudes and through statewide efforts to provide leadership, data, technical aid, policy development, and resources to support local efforts. Local coalitions have autonomy to develop their own plans but are encouraged to integrate their efforts with statewide public awareness efforts.	— STARS (Students Today Aren't Ready for Sex), a teen-taught abstinence curriculum with resistance skills, has been taught to 45 percent of the state's sixth- and seventh-graders. — Comprehensive sex education is encouraged in grades 5 through 12, but local school districts make final decision. — School-based health centers reinforce abstinence goals and sex education through counseling services and provide preventive services in high-risk areas to improve access to reproductive health information and service intervention.	— Preliminary approval for Medicaid expansion to allow coverage of family planning services up to 185 percent of the federal poverty level. — Medicaid expansion covers family planning services, including vasectomies. — Title X family planning clinics served about 17,700 teens in 1997. — School-based health centers (39 currently, 14 state-funded), if locally permitted, provide high-risk teens family planning counseling and services. — Skills-for-Life program provides family planning instruction for youth whose families come in contact with state welfare system.
Vermont		
Vermont's goal is to reduce teen pregnancies among girls aged 17 and younger to no more than 25 per 1,000 and to delay parenthood until couples are emotionally and financially stable. Its strategy includes health, education, and social services programs offered through a statewide network of integrated services—services provider by parent-child centers, public home health visiting programs, family planning clinics, and school-based education. Community-state partnerships promote healthy behaviors and self-reliance among Vermont children and families.	— Comprehensive health education in the schools requires instruction in age-appropriate sexual development, HIV and sexually transmitted disease prevention, and drug and alcohol abuse. — Health educators provide technical assistance to schools. — Information on resources is available to youth, sexual harassment policies in schools are mandated, and sex education for children in foster care is provided. — Family planning clinic providers are available to work with schools to provide training for teachers and review curricula and to present classes on topics such as sexual violence.	— Title X family planning clinics (13 sites) have special teen initiatives, including special hours and walk-in appointments. — Expanded Medicaid eligibility to 225 percent of poverty increases access to family planning services, which are available out-of-plan so that a referral from a primary care provider is not required.

Teen subsequent pregnancy prevention	Male responsibility	Youth development	Public awareness
— Case management for teen parents in state welfare system includes family planning. — Local coalitions may target teen parents for subsequent pregnancy prevention activities.	— Initiative under way to study the role of older men's involvement in teen pregnancy. — Public awareness program and local coalition activity includes efforts to inform males about teen pregnancy prevention and to involve them in these efforts.	— Skills-for-Life instructional program with youth development approach aims to prevent teen pregnancy and other youth problems.	— Statewide public awareness campaign supported by local community efforts delivers state strategy messages regarding sexual abstinence, sexual postponement, access to contraceptives for sexually active teens, male responsibility, family communication, and parental involvement. — Statewide private media campaign targeting teens and their parents is planned.
— Support services for pregnant and parenting teens—including parenting classes, family planning to prevent a second pregnancy, and assistance to complete school—are available. — Public education for pregnant teens is state-mandated.	— Programs offered are determined by local need through state network of parent-child centers.	— Network of 16 parent-child centers statewide offers integrated health, education, and social services, including, parenting education, child abuse and neglect prevention, early child development programs, mentoring, male responsibility, teen mother panels who visit schools to speak about the realities of pregnancy and parenting at a young age, school success programs, and mental health services.	— Statewide primary prevention plan guides how state resources are to be used to help local communities alter conditions that contribute to problem behaviors, such as teen pregnancy. — Media campaign targets parents to help them address with their middle-school-aged children the relationship between drug and alcohol use and sexual activity.

Targeting High-Risk Groups Is a Key Objective of States' Strategies

A key objective of all the states' strategies is to target their TPP efforts to groups or communities at higher risk of teen pregnancy. California, for example, targeted TPP efforts to communities and neighborhoods with high rates of teen births, high poverty and unemployment rates, and low education levels. The states' strategies also focused on meeting the needs of three different groups of teens: those who were not yet sexually active, those who were sexually active, and those who were already pregnant or were parenting. Louisiana is targeting 12 zip codes in the New Orleans area with the highest teen birth rates in the city. Oregon offers special life-skills training for teens whose parents receive public assistance because they are at increased risk of becoming teen parents. California, Illinois, and Vermont developed programs aimed at youth in foster care or

with foster parents because research has shown that these youth are at a greater risk for unsafe sexual behavior and teen pregnancy. Other state strategies target high-risk groups such as incarcerated males and siblings of teen mothers.

The states we visited were using different types of data to target TPP efforts to high-risk communities and youth. For example, all of the states in our review use teen birth data, frequently broken down by zip code, to identify and target high-risk areas. Illinois uses data from a sexually transmitted disease reporting project sponsored by HHS' Centers for Disease Control and Prevention (CDC) to help target TPP initiatives. In addition, the states that participated in the federal Youth Risk Behavioral Survey (YRBS)[12] use this data in developing their strategies and programs. For example, to improve access to and use of contraception, Oregon uses YRBS data to target sexually active teens who report not using contraception.

Program Implementation Varied at the Local Level

While TPP strategies were applicable statewide, the states we visited typically gave communities flexibility in selecting and implementing programs to meet local needs and preferences. States generally offered localities a choice among certain state-approved programs or programs that used promising approaches. Communities selected programs that they found most consistent with local policy and values. According to state officials, this resulted in a mix of programs, approaches, and services that varied among communities within a state. Some communities, for example, have chosen programs that encourage abstinence, while others chose a more comprehensive approach that includes abstinence-based sex education as well as access to family planning services, including contraceptive services. Still other communities emphasized youth development programs that focus not on teen pregnancy but on general skill building aimed at improving youth life options. In particular, family planning and sex education programs varied considerably among communities because of local preferences and policies, particularly in schools.

[12]YRBS is a school-based survey undertaken by CDC that collects data on often interrelated adolescent health risk behaviors, such as sexual activity, substance abuse, behaviors that result in intentional and unintentional injuries, diet, and physical activity. In 1997, five of the eight states we visited participated in YRBS—California, Georgia, Maine, Oregon, and Vermont. Illinois, Louisiana, and Maryland did not participate in the most recent survey because of the controversy surrounding the questions on sexual activity or they lacked the resources needed to conduct the survey, according to state officials.

Providing sex education and access to family planning services, particularly in school-based settings, varied considerably among communities because they adopted approaches consistent with their preferences and values. Even though each state we visited encouraged or mandated sex education in the schools, local policies dictated the content of such programs in school settings. In some cases, states offer these programs in settings other than schools; in others, state strategies tried to encourage a school-based approach.

For example, Maine and Vermont provide funding for health educators who work with schools to provide technical assistance, develop curricula, and train teachers in sex education. But officials in these states said that not all schools offer sex education and in those that do, the curricula vary. Oregon's strategy encourages the use of a specific abstinence education program for sixth- and seventh-graders and encourages comprehensive sex education in grades 5 through 12. Oregon officials report that 45 percent of the state's sixth- and seventh-graders received the prescribed abstinence curricula but said that only a few schools are providing comprehensive sex education in the higher grades. Louisiana's strategy encourages sex education in schools but only within a targeted area with high birth rates. Illinois' strategy encourages sex education in community or home settings and funds community-based sex education programs. Maryland's strategy includes a media campaign and outreach program that encourages parents to be the primary sex educators of their children as well as encouraging comprehensive health education in the schools. Two states, Oregon and Maine, are beginning to implement systems that are intended to encourage schools to teach sex education.

Although not a part of the states' strategies, all eight states received federal funding from CDC to support school HIV prevention education programs. The purposes of these programs are similar to those of some TPP programs—to increase the percentage of high school students who do not engage in intercourse and to increase the percentage of sexually active teens who correctly and consistently use condoms. Officials in some of the states we visited cited HIV prevention education as one reason for the decline in teen pregnancy in their states.

Illinois, Maine, and Oregon encouraged access to family planning in school-based health centers. However, local policies and statutes control the types of school-based family planning services—primarily contraceptives and information on abortion—that may be made available in these centers. Some communities permitted school health centers to

dispense contraception—including condoms, birth control pills, and implantable and injectable birth control—while other communities only allowed school health centers to refer students to other facilities for these services. In some states, such as Georgia, laws restrict referrals and providing family planning information in schools. Louisiana state laws prohibit school-based health centers from providing any family planning services, but the law allows schools to refer students elsewhere for these services. Even though California and Maryland did not include school-based health centers in their strategies, these states had some school-based health centers that provided referrals and access to family planning where permitted by local communities.

To improve teen access to family planning services, some states included in their strategies access to family planning in other settings. For example, California's strategy includes over 2,200 state-funded community, hospital, university, and private practice providers that serve low-income males and females, with 56 of these clinics offering enhanced counseling for teens. Georgia provides similar services along with other youth services and activities in 27 community-based youth centers. Also, strategies in Georgia, Illinois, Maine, Maryland, Oregon, and Vermont included collaboration with the federal Title X Family Planning Program to overcome barriers to teen access by opening teen-only clinics, having clinics open at hours convenient for teens, and doing outreach to inform teens about available services. Although the Title X Family Planning Program serves teens in the remaining states, these states do not include title X programs in their TPP strategies. Some states also included Medicaid expansions to improve access to family planning. Other states' Medicaid managed care programs also allow enrollees to obtain family planning services from other health care providers.

Most States Report That Federal Funding Is a Major Source of Support for Their TPP Programs

Federal, state, and local governments and private entities fund state TPP activities. In the six states where data were available, the federal government provided a large share of the funds states use and distribute to local communities for teen pregnancy prevention. (See table 3.) In the six states that provided funding data, the federal share of total TPP funding ranged from 74 percent in Georgia to 12 percent in California. The primary mechanisms by which states receive federal funds for TPP efforts include block grants, entitlement programs, and categorical programs. Because federal funds provided through many of these programs are not designated specifically for teen pregnancy prevention, states have some flexibility in deciding what activities to support with federal funding and how much to

devote to TPP efforts. The federal government also provides grants directly to local communities to fund TPP initiatives. Officials in the states we visited said that they do not keep track of funds communities receive directly from the federal and local governments or from private contributions.

Table 3: Key Funding Sources States Use to Support Teen Pregnancy Prevention Initiatives, Fiscal Year 1997

	California	Georgia[a]	Illinois	Maine	Maryland	Vermont
Federal funding (total)	$11,806,397	$11,151,769	$11,581,137	$2,465,119	$2,984,133	$433,239
Medicaid[b]	7,405,397	5,089,878[c]	1,830,887	595,749	1,395,080	110,392
Title V Maternal and Child Health Services Block Grant	[d]	1,123,604[e]	2,644,300	625,970	598,528	130,432
Title X Family Planning	4,401,000	1,638,287	1,914,000	920,000	990,525	161,646
Social Service Block Grant	0	0	5,191,950	273,400	0	30,759
TANF	[f]	3,300,000	[f]	[f]	[f]	[f]
Preventive Health and Health Services Block Grant	0	0	0	50,000	0	0
State funding	84,310,000	3,866,993	6,635,290	1,806,541	3,543,000	193,786
Total federal and state funding	**$96,116,397**	**$15,018,762**	**$18,216,427**	**$4,271,660**	**$6,527,133**	**$627,015**

Note: State fiscal years vary.

[a]Funding is for fiscal year 1998.

[b]Medicaid costs for family planning for ages 19 and under.

[c]Total is Medicaid funds for family planning for ages 19 and under and ICTF funds used to support the TPP strategy.

[d]Unable to isolate. Total block grant was $7.5 million.

[e]Includes carryover for fiscal year 1997.

[f]Could not isolate TANF funds for services to teen parents, which could include services relating to the prevention of a subsequent pregnancy or prevention counseling to nonparent teens in the household.

Source: State-reported data, except for Medicaid funding obtained from the Health Care Financing Administration. Louisiana and Oregon did not report financial data by funding source.

Federal Welfare Reform Had a Limited Effect on Eight States' TPP Strategies

Federal welfare reform legislation contained several provisions related to teen pregnancy prevention, but the law did not require major changes to the TPP strategies of the states we reviewed. Before federal welfare reform, the eight states were already requiring teen mothers to live at home and stay in school in order to continue receiving welfare benefits—key welfare reform provisions. However, at the time of our review, state officials had mixed reactions to other welfare reform provisions intended to reduce teen pregnancy. Only one of the eight states currently plans to apply for an out-of-wedlock bonus, and all states were concerned about the prescriptive requirements surrounding federal grants for abstinence education, although each applied for and received funding.

States Began Requiring Teen Parents to Stay in School and Live at Home Before Federal Welfare Reform

The eight states in our review had already begun requiring teen parents receiving welfare to live at home or in supervised living arrangements and stay in school or job training to receive assistance—requirements that were subsequently included in federal welfare reform. Officials in some states said they believe that these provisions may deter teens from having any more children until they finish school and become self-sufficient and discourage other teens from having their first child. In addition, all the states' TPP strategies included a teen subsequent pregnancy prevention component that emphasized school completion and prevention of another pregnancy, and some states included activities to inform teens of the welfare requirements. For example, for more than 10 years, California's Adolescent Family Life and Cal-Learn programs have encouraged pregnant and parenting teens to complete school as well as provided these teens case management and health and social services. Officials and teenagers in two of the states we visited said that they believe the states' requirements related to school and living arrangements played a part in preventing some teens from getting pregnant.

Not All Study States Plan to Seek Bonus for Reducing Out-of-Wedlock Births

Federal welfare reform legislation provides a financial incentive for reducing the ratio of out-of-wedlock births to all births within the state. According to the proposed regulations for the "Bonus to Reward Decrease in Illegitimacy" provision, states can receive a total award of up to $100 million annually for 4 fiscal years starting in fiscal year 1999 for reducing the ratio of out-of-wedlock births without increasing the abortion rate.[13] Each eligible state can receive up to $25 million a year. As proposed, the bonus would be based on a calculation of birth and abortion

[13]HHS will determine the rates of abortions for the most recent calendar year compared to 1995—the base year.

rates for a state's population as a whole; bonuses would not be based on reductions for specific populations, such as teenagers. The five states that demonstrate the largest proportionate decrease in their out-of-wedlock birth ratios between the most recent 2 years and the prior 2-year period will be potentially eligible for a bonus award.[14]

Among the eight states we reviewed, state officials had mixed views about their chances to successfully compete for the bonus. Some say they will likely not be competitive for the bonus because they are focusing their prevention efforts on teens rather than adult women, who have most out-of-wedlock births; other states say they may not be eligible to compete because they do not have available the abortion data needed to compete. For example, California does not have an abortion reporting system for the data required under the proposed rules and, therefore, is unsure of its ability to compete. Illinois and Maryland had concerns about their abortion data being overstated because of current limitations in capturing information on marital status and residency. Oregon's state law prohibits marriage under the age of 17 and, because the bonus encourages marriage, state officials do not believe the state will be competitive. Georgia, Maine, and Vermont will continue to focus their prevention efforts on teens, but since most out-of-wedlock births in these states occur among women 20 or older, these states believe they will not be competitive. Conversely, Louisiana—with its high teen birth rate—is very interested in getting any financial assistance available to support its TPP efforts and, thus, plans to compete for the bonus.

Some States Concerned About the Prescriptive Nature of Abstinence-Only Education Programs

Welfare reform also included a provision to enhance efforts to provide sexual abstinence education and authorized $50 million annually for 5 years in grants to states that choose to develop programs for this purpose. States must match 3 state dollars for every 4 federal dollars spent. States, local governments, and private sources often provide such funds in the form of cash or in-kind contributions, such as building space, equipment, or services. The funding can be used for abstinence-only education or mentoring, counseling, and adult supervision programs to promote abstinence until marriage and cannot be incorporated with programs that provide information on both abstinence and contraception.

[14]The amount of the award will depend on the number of recipients. HHS is expected to issue the final rules no later than January 1999. Guam, American Samoa, and the Virgin Islands are also potentially eligible for the bonus if they have a decrease in their out-of-wedlock ratios that is comparable to that of the top five states. While these territories face similar eligibility criteria, their eligibility is determined separately (that is, they could be potentially eligible in addition to the five states) and the amount of their bonus is less.

States had some concerns about the restrictive nature of the abstinence programs. One concern was that implementing education programs that stressed only abstinence would interfere with their efforts to develop and continue comprehensive programming. Maine, for example, encourages comprehensive sex education in the schools and felt that abstinence-only programs were not consistent with the state's attempts to provide education that addresses both abstinence and contraception. Some states were also concerned that the research on abstinence-only education was limited. Moreover, they noted that the data that were available suggested that such programs have little or no effect on the initiation of sex, while research results on programs that provide information on both abstinence and contraception show that these types of programs do have some effect. Officials in seven of the eight states were also concerned about how to come up with the required matching funds without affecting the comprehensive programs they already had in place. Despite these concerns, all the states we visited applied for and received the federal funding to either initiate new programs or expand existing abstinence efforts.[15] Fiscal year 1998 federal grants to the states for various abstinence-only initiatives ranged from $69,855 for Vermont to $5,764,199 for California. (See table 4.)

[15]As of June 1998, all 50 states and the territories had applied for and received federal funding. New Hampshire returned its federal funds because state agencies were unable to come to an agreement on the best program for the state.

Table 4: State Initiatives for Abstinence-Only Education

State	Type of program	Federal funds	Amount and source of matching funds
California	Local community programs targeted to youth aged 17 and under to motivate them to avoid sexual activity and to resist media, peer, and partner pressure.	$5,764,199	$4,323,149 (state, local, and in-kind)
Georgia	Grants to local coalitions for various programs for 10- to 19-year-olds and their parents, including mentoring, parent involvement, after-school programs, and media campaigns.	1,450,083	1,087,562 (local grantees)
Illinois	Programs for at-risk communities to form coalitions to link existing abstinence-only programs targeted at 9- to 14-year-olds.	2,095,116	161,416 (state) 1,467,191 (local grantees)
Louisiana	Multifaceted approach, including community projects, pilot project, public awareness campaigns, and a state clearinghouse on abstinence programs.	1,627,850	1,220,867 (state, local, and in-kind)
Maine	TV campaign targeted to children 14 and under to improve parent and child communication on issues of sexuality, life aspirations, and refusal skills.	172,468	129,351 (in-kind)
Maryland	Funds 16 after-school abstinence-only programs for 9- to 18-year-olds (2 focus on male involvement) and expanded TV campaign.	535,712	410,784 (state, local, and private)
Oregon	Expand abstinence curricula for sixth and seventh grades throughout the state.	460,076	345,657 (state and private)
Vermont	Media campaign targeted at parents to address with their middle-school-aged children the relationship between drug and alcohol use and sexual activity.	69,855	52,698 (state)

As of June 1998, six of the eight states we visited had begun to implement their abstinence-only initiatives. In California, the state legislature did not approve the Governor's proposal to implement the abstinence program, thereby preventing the use of federal funds. California has until September 1999 to approve a program and use the federal funds. Although Louisiana had received HHS approval on the basis of its initial application, the state withdrew the proposal in light of state pressure to implement a stronger abstinence program. HHS is currently reviewing the state's revised plan.

Few State Assessments of TPP Programs Adequately Measure Their Effect on Teen Pregnancy

All of the states we visited had a variety of efforts under way to assess state TPP programs, including monitoring birth rates and conducting program evaluations. However, few of the evaluations measure program effect on the number of teens who become pregnant or on outcomes closely related to teen pregnancy, such as sexual and contraceptive behavior or high school achievement. Most of the state's evaluations are measuring other outcomes, such as changes in knowledge, attitude, and behavioral intentions—outcomes that have been shown to be only moderate or weak predictors of teen pregnancy—or are monitoring program processes to determine whether certain aspects of programs were operating as intended, such as whether procedures and protocols were being followed. Some states are using performance measurement systems intended to assess their progress towards achieving TPP goals and improve accountability, but these alone will provide little information on program effectiveness.

Program Effects on Teen Pregnancy Not Generally Captured by Current Program Evaluations

At the time of our review, all eight states were tracking the number of teen births and conducting evaluations of program operations, known as process evaluations. These data and evaluations enable states to know, for example, the number of program participants and whether or not programs were following procedures; however, they do not provide information on whether or not the program has had an effect on particular outcomes. While all states had begun evaluations that measure program effect on outcomes, most of the outcomes evaluated were of the type that research shows to be moderate or weak predictors of teen pregnancy.[16] (See table 5.) Four states—California, Georgia, Illinois, and Maryland—had evaluations under way for some of their programs that would measure program effect on outcomes that research results have shown to be closely related to teen pregnancy, such as changes in sexual or contraceptive behavior or school achievement.[17] However, most of the states' outcome evaluations tended to measure program effects on knowledge, attitudes, and behavioral intention. Although evaluations of these indicators are useful, they do not necessarily show the long-term effects of the program or, more importantly, the effect the program has on teen pregnancy.

[16]Douglas Kirby, No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy, commissioned by the National Campaign to Prevent Teen Pregnancy Task Force on Effective Programs and Research (Washington, D.C.: Mar. 1997).

[17]"National Campaign to Prevent Teen Pregnancy," memo to HHS from the Task Force on Effective Programs and Research (Washington, D.C.: Jan. 14, 1998), and K. A. Moore and others, Adolescent Pregnancy Prevention Programs: Interventions and Evaluations.

Table 5: Evaluations of the Various Activities in the Eight States' Strategies

	Type of program evaluation			
			Outcome	
State and activity	None	Process	Moderate or weak relation	Strong relation
California				
Adolescent and Family Life program (statewide)		x		
Community Challenge grants (112 sites)		x	x	x
Education Department TPP grants (37 programs)		x	x	x
Information and education services for teens (31 sites)		x	x	
Male involvement (23 projects)		x	x	
Media campaign (statewide)		x	x	
Mentoring (statewide)	x			
Teen Smart (56 clinics)		x	x	x
Georgia				
Abstinence education				x
Comprehensive family life education	x			
Family connection collaboration		x		
Male responsibility program (23 sites)		x		
Media campaign (statewide)		x		
Micro Enterprise program	x			
Nontraditional clinics		x		
Peer counseling program (23 sites)	x			
Postponing sexual involvement[a]		x		
Resource mothers	x			
Teen Plus (27 centers)		x	x	x
Teen Plus nonclinical (17 sites)		x		
Illinois				
Abstinence-only program			x	x
Adolescent health program (42 sites)		x		
Family planning program (60 clinics)		x		
Help-Me-Grow helpline (statewide)	x			
Parents Too Soon (20 prevention sites; 45 teen mother sites)		x	x	x
School-based health (22 centers)		x	x	x
Subsequent pregnancy project (10 sites)		x		x
Teen parent services (statewide)	x			
Teen REACH after-school program (13 sites)		x	x	x
Louisiana				
Abstinence-based curriculum	x			

(continued)

State and activity	Type of program evaluation			
			Outcome	
	None	Process	Moderate or weak relation	Strong relation
Pilot area programs[b] — Abstinence-based, simulating demands of parenthood (3 programs) — Sex education in pilot area schools — Cable TV teen talk show — Male involvement program (4 sites) — Community-based youth development program (3 sites)				
Pregnant and parenting teens (2 clinics)		x		
School-based health (31 centers)		x		
Teen male peer counseling program	x			
Maine				
Abstinence education media campaign (statewide)		x		
Family life education program		x	x	
Family planning (34 clinics)		x		
Peer leader program (130 sites)	x			
Primary prevention (2 programs)		x	x	
School-based health (11 centers)		x	x	
Teen pregnancy and parenting services (every county)		x	x	
Maryland				
Abstinence-only after-school program		x		x
Community incentive grants[c] (15 programs)		x	x	x
Family planning (98 clinics)		x		
Media campaign (statewide)			x	
Teen outreach (3 clinics)		x		
Oregon				
Contraceptive access—title X clinics		x		
Public awareness program (statewide)	x			
Responsible sex education in schools		x		
School-based health (33 centers)		x		
Sex education in school-based health center preventive services		x		
Skills-for-Life program	x			
STARS abstinence education curricula[e]		x	x	
Vermont				
Abstinence education media campaign (statewide)		x	x	
Family planning (13 clinics)		x		
Parent-child (16 centers)	x			
School-based health (4 centers)		x		

(Table notes on next page)

[a]Although only process evaluation is required, Georgia expanded this program after a privately funded outcome evaluation showed positive effects on outcomes closely related to teen pregnancy. A follow-up showed that these gains diminished by grade 12.

[b]According to Louisiana officials, the evaluation plan for activities in the pilot area is not yet complete.

[c]Evaluation requirements vary by grantee.

[d]Outcome evaluation of program effect on attitudes and behavior is planned for the 1998-99 school year.

The process evaluations being conducted in the eight states typically measured the number of clients served, types of services received, client responses to certain activities, and procedures and protocols followed. States use this information to monitor, evaluate, and modify program operations. In Maine and Vermont, for example, teens who used family planning clinics were surveyed to evaluate their satisfaction with the hours and locations of clinics, the types of services provided, and the overall appearance of the facility. The results were used to improve the delivery of teen-oriented services. States also used birth rates to track overall progress. Vermont officials told us that rather than conducting evaluations on each component in its strategy, the state's oversight efforts focus on teen birth and pregnancy rates and responses to the state's YRBS. These officials further believe that the availability of many TPP programs is responsible for the state's low teen birth rate.

Four states—California, Georgia, Illinois, and Maryland—are evaluating key programs in their TPP strategies that will likely give state officials some insight into the impact these programs are having on outcome measures closely related to teen pregnancy. At least three of these evaluations will use more rigorous designs and include comparison groups and follow-up. Georgia has awarded a contract for a 4-year evaluation that will determine the effect of its key program—Teen Plus—on contraceptive use as well as on teen pregnancies and births. The results of this evaluation will give state policymakers insight into whether the presence of the clinical services offered at the centers improved teen-pregnancy-related outcomes. California's Community Challenge Grant Program is evaluating program effect on delay of sexual activity, contraceptive use, and school and job achievement and comparing results of its program participants with a group of nonprogram participants after 1 year. Illinois plans to evaluate the effect of its after-school program by assessing high school drop-out rates, graduation rates, and births to teens under age 18 and comparing these results with those for similar communities that did not participate in

the program. Maryland plans to track over 5 years participants in its after-school programs to assess program effect on teen pregnancy.

Two states we visited have used the results of previous outcome evaluations to modify their strategies. For example, when evaluation results of Illinois' teen subsequent pregnancy prevention program showed an increased rate of school completion and a lower rate of subsequent pregnancy among participants, the state expanded the program to other communities. When an outcome evaluation of a California education program that focused on postponing sexual activity of 12- to 14-year-olds showed some improvement in knowledge gain but no delay of sexual intercourse, improved use of birth control, or reduced teen pregnancy, the state discontinued the program and implemented a more comprehensive TPP program.

Officials in most states we visited expressed interest in knowing the effect of their programs on teen pregnancy. However, state officials said that available funding and resources limited their ability to conduct rigorous and long-term outcome evaluations, which research indicates may be necessary to evaluate and measure program effectiveness.[18] Also, some program staff are reluctant to spend program dollars on evaluations.

Some States Are Implementing Performance Measurement Systems to Assess Progress Towards TPP Goals

Four states we visited—Illinois, Maine, Maryland, and Oregon—were implementing performance measurement systems. Performance measurement—the ongoing monitoring and reporting of program accomplishments, particularly toward preestablished goals—is intended to improve program accountability and performance by requiring programs to establish and meet agreed-upon performance goals. In assessing their progress, states can use process, output, outcome measures, or some combination of these.

To measure progress toward its goal of reducing teen pregnancy, Oregon plans to compare program performance measures—including the number of students remaining abstinent, the percent of sexually active teens using contraception, and the percent of teen mothers with no subsequent births—with established goals. Oregon has adopted an official statewide benchmark for the pregnancy rate among girls aged 10 through 17: The state has set a goal of reducing this rate to 15 by the year 2000 and to 10 by the year 2010. Maine requires all state health service contracts to be

[18]National Research Council, Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing (Washington, D.C.: 1987), and Douglas Kirby, No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy.

performance based and has established specific goals and objectives against which teen pregnancy programs are to be measured. The state plans to use assessment results in budgeting decisions. Maryland's Partnership for Children and Families performance management system will measure teen birth rates, among other indicators. Illinois, which is in the early stages of developing its program performance measurement system, plans to use performance measurement in all program and service contracts, including teen pregnancy prevention.

HHS Provides Key Federal Support for TPP Initiatives

The federal government funds numerous TPP programs and supports research and data collection and surveillance on indicators related to teen pregnancy. Although a number of federal agencies provide funding, HHS has the primary federal role in supporting programs to reduce teen pregnancy. Together, 27 different HHS programs are available to states and local communities to support teen pregnancy prevention. Some of the funds are solely for teen pregnancy prevention; but others, such as the Maternal and Child Health Block Grant, allow states to fund various activities that improve the health of women, infants, and children. Although HHS could not isolate all of the funding specifically for TPP efforts, it was able to identify at least $164 million in fiscal year 1997. HHS also supports research, data collection, and surveillance related to teen pregnancy prevention and, in some cases, evaluates programs and demonstration projects related to teen pregnancy prevention at the state and local levels.

HHS has evaluated very few of its programs to determine whether and how these programs affect teen pregnancies, births, or closely related behavioral outcomes. HHS recently began program evaluation efforts for two of its TPP programs—the multisite Community Coalition Partnership Program and the new Abstinence Education Program—that will measure the programs' effects on behavior outcomes closely related to teen pregnancy. Also, in its strategic plan required by the Government Performance and Results Act of 1993,[19] HHS established performance measures against which the performance of HHS-funded activities will be assessed.

[19]Under the Results Act, federal agencies are required to set goals, measure performance, and report on the degree to which the goals are met. The legislation was enacted to increase program effectiveness and public accountability by having federal agencies focus on results and service quality.

Multiple Federal Programs Support State Efforts

Nine federal agencies support programs that could be used to support TPP efforts: HHS; the Departments of Agriculture, Defense, Education, Housing and Urban Development, Justice, and Labor; the Corporation for National Service; and the Office of National Drug Control Policy. (See app. II for a list of these agencies' programs related to teen pregnancy prevention.)

HHS has the primary federal leadership role in teen pregnancy prevention. In fiscal year 1997, the agency provided at least $164 million in federal support to reduce teen pregnancy. About $126 million of this total was from Medicaid and the Title X Family Planning Program. Another $28 million was for two of the three federal programs whose primary goal is teen pregnancy prevention—the Adolescent Family Life (AFL) Program and the Community Coalition Partnership Program for the Prevention of Teen Pregnancy (CCPPPTP). The remaining $10 million is from the Preventive Health and Health Services Block Grant and several broad youth programs that were able to isolate specific funds for teen pregnancy prevention. Beginning fiscal year 1998, HHS provided states with $50 million in funding for the new Abstinence Education Program (AEP). AFL and CCPPPTP are funded directly to local communities and may not be included in a state's strategy, whereas funding for AEP goes directly to states.

Many other TPP initiatives are funded through block grants, but HHS could not isolate the amount of additional funding. Because of the nature of block grant programs, funds are not specifically allocated to teen pregnancy at the federal level and states have some flexibility in deciding how to use them. The states we visited said they relied on programs such as the Maternal and Child Health Block Grant, the Social Services Block Grant, and TANF to support their TPP strategies. Other funding streams that support programs addressing other issues may include teen pregnancy prevention as one of the objectives. For example, the Community Services Block Grant funds programs that address poverty in communities, but the programs can include teen-pregnancy-related initiatives, such as family planning, substance abuse prevention, and job counseling. Table 6 shows fiscal year 1997 funding available through HHS that could be used to support teen pregnancy prevention.

Table 6: HHS Programs and Funding Streams That Support Teen Pregnancy Prevention

Program or funding stream	Description	Fiscal year 1997 funding	Administering agency
TPP-specific programs			
Adolescent Family Life Demonstration and Research Program	Directly funds local abstinence-based programs that emphasize abstinence but include information on reproductive health; beginning fiscal year 1997, provides funding for abstinence-only programs following the welfare law's abstinence definition.	$14.2 million through Office of Secretary (up to $8 million may be awarded to state or local grantees, with the remainder awarded to localities)	Office of Population Affairs (OPA)
Community Coalition Partnership Program for the Prevention of Teen Pregnancy	CDC's 5-year program (now in its third year) funds 13 communities to demonstrate that they can mobilize community resources to support comprehensive prevention programs. CDC also provides support for national nongovernmental education organizations to help schools implement TPP programs. This effort is just beginning.	$13.7 million	CDC
Abstinence Education Program	Legislated under welfare reform, awards grants to states for abstinence-only programs. The legislation prescribes the parameters of acceptable abstinence-only programming. There is a required match of 3 nonfederal dollars for every 4 federal dollars awarded.	$50 million a year for 5 years, beginning fiscal year 1998 ($250 million total); additional $6 million for evaluation	Health Resources and Services Administration (HRSA)
Block grant funding			
Maternal and Child Health Services Block Grant	Funding to monitor and improve the health status of women, infants, children, and teens. States receive funding directly from the federal government to fund various programs, including TPP programs.	$681 million total (could not isolate TPP)	HRSA
Social Services Block Grant	Funding directly to states for social services. Up to 10% of the grant may be transferred to other block grant programs, including those that support health services.	$2.5 billion total (could not isolate TPP)	Administration for Children and Families (ACF)
Preventive Health and Health Services Block Grant	Funds state activities to meet Healthy People 2000 goals. States can use the funds for programs to reduce teen pregnancy for ages 15 to 17 and to reduce unintended pregnancies. In 1997, 9 states funded teen pregnancy prevention.	$148 million total, with $2.8 million used for TPP	CDC
Community Services Block Grant	Funding for states to address poverty. Teen pregnancy prevention is not a specific activity, but programs can fund family planning, job counseling, substance abuse treatment, and general equivalency diploma education.	$487 million total (could not isolate TPP)	ACF
TANF	Funding directly to states to serve needy families and children (replaces Aid to Families With Dependent Children). Funds can be used for preventing out-of-wedlock births, especially to teens.	$13 billion total (could not isolate TPP)	ACF

(continued)

Program or funding stream	Description	Fiscal year 1997 funding	Administering agency
Key categorical and entitlement programs			
Title X Family Planning Program	Family planning education, counseling, and clinical services, with priority given to ensuring services are available to individuals up to 250 percent of the federal poverty level. The prevention of unintended pregnancy is a major program goal. About 30% of clients are under age 20, and clinics can have programs that target teens.	$198 million total through HRSA, with an estimated $59 million for teens[a]	OPA
Male research grants	Grants awarded to 10 local organizations in 8 states to support male-oriented organizations in developing, implementing, and testing approaches to involve young men in family planning and reproductive health programs.	$1.8 million through HRSA (fiscal year 1998)	OPA
Medicaid	Provides medical assistance for low-income individuals, and requires states to provide family planning services to eligible individuals of childbearing age (including sexually active minors).	$67,181,220 (family planning for ages 19 and under)	Health Care Financing Administration
Other programs or funding sources related to TPP			
Health education in schools	Provides funding to all states, 19 of the nation's largest cities, and relevant national nongovernmental organizations to support schools and other agencies that serve youth to provide HIV prevention education, including training teachers and developing and distributing educational materials. The goal is to prevent HIV, but sexual risk behaviors that also put teens at risk of unintended pregnancy are targeted.	$38 million total (could not isolate TPP)	CDC
Healthy Schools, Healthy Communities	Grants to local communities to establish school-based health centers that provide comprehensive primary health care services to at-risk youth. Reproductive health services could be included.	$5.1 million for 26 centers in 20 states (could not isolate TPP)	HRSA
Community Schools Program	Funds after-school programs in communities with high poverty and delinquency to help youth aged 5 to 18 achieve academic and employment success.	$13 million total (could not isolate TPP)	ACF
Girl Neighborhood Power	Targets girls aged 10 to 14 to promote successful futures; teaches prevention for multiple risks, including pregnancy. Nationally, there are 4 projects in low-income neighborhoods.	$1 million total through the Maternal and Child Health Services Block Grant (could not isolate TPP)	HRSA
Direct health care services for American Indian and Alaskan Natives	Provides direct care to native American Indians and Alaskans, including teen pregnancy prevention and family planning services.	$5.6 million estimated for TPP and family planning services	Indian Health Service
High-Risk Youth Program	Supports 117 projects focusing on female teen drug prevention. Teen pregnancy is a risk factor associated with drug use; teen pregnancy prevention is a goal of some of the projects.	$15 million total, with $750,000 for TPP	Substance Abuse and Mental Health Services Administration (SAMHSA)
Pregnant and Postpartum Substance Abuse Prevention	Program for pregnant and postpartum women also provides services for girls and women of childbearing age to prevent unwanted pregnancies that could result in a drug-exposed infant.	$883,000 total, with $45,000 for TPP	SAMHSA

(continued)

Program or funding stream	Description	Fiscal year 1997 funding	Administering agency
Independent Living Initiatives Program	Assists teens in transitioning from foster care to independent living. Pregnancy prevention is not specifically addressed in the legislation, but some programs fund teen pregnancy prevention.	$70 million total (could not isolate TPP)	ACF
Healthy Start	Demonstration to reduce infant mortality. Teen pregnancy contributes to higher rates of infant mortality, so projects have developed approaches to prevent teen pregnancy.	$96 million total (could not isolate TPP)	HRSA
Community health centers	Provide health services (including family planning) to low-income individuals in medically underserved areas. Teen pregnancy prevention is not an explicit goal.	$645 million total (could not isolate TPP)	HRSA
Migrant health centers	Provide medical and support services to migrant farmworkers and their families in about 400 clinics, including family planning services.	$69 million total (could not isolate TPP)	HRSA
National Youth Sports Program	National Collegiate Athletic Association sports program for 70,000 low-income youth aged 10 to 16.	$12 million total (could not isolate TPP)	ACF
Basic Center Program for Runaway and Homeless Youths	Supports local agencies that provide crisis intervention services and social and health services to runaway and homeless youth outside the traditional juvenile justice and law enforcement systems.	$43.7 million total (could not isolate TPP)	ACF
Street Outreach Program	Sexual abuse and exploitation prevention program for runaway, homeless, and street youth.	$8 million total (could not isolate TPP)	ACF
Transitional Living for Older Homeless Youth	Provides services for homeless youth aged 16 to 21 to transition to self-sufficiency.	$14.9 million total (could not isolate TPP)	ACF
Empowerment Zone/Enterprise Community Initiative	Federal governmentwide effort to enable the self-revitalization and growth of distressed urban and rural areas; 105 designated communities receive enhanced federal funds through Social Services Block Grant funds, tax incentives, special consideration for competitive federal grants, and technical assistance.	$1 billion total in Social Services Block Grant funds; $2.5 billion in tax incentives (could not isolate TPP)	HHS and other federal agencies, with the Departments of Agriculture and Housing and Urban Development as lead program managers

[a]Estimate based on the proportion of title X clients under age 20.

To complement the activities summarized in table 6, HHS is developing a TPP strategy at the federal level. In 1997, HHS released the National Strategy to Prevent Teen Pregnancy, a departmentwide effort to prevent out-of-wedlock teen pregnancy and support and encourage teens to remain abstinent. As part of the strategy, HHS has reported that it is strengthening its efforts to improve data collection, research and evaluation, and the dissemination of information. In addition, HHS said it will strengthen its support for promising research-based approaches that are tailored to the unique needs of individual communities.

In addition to its funding for programs, HHS supports data collection, surveillance, and research related to teen pregnancy prevention through broader public health activities and research on issues such as adolescent health. Within HHS, CDC has the primary role of monitoring teen pregnancy and births by collecting data on pregnancies, live births, fertility, contraception, and teen sexual behavior and collaborating with state vital statistics offices to develop data on the incidence and trends of teen pregnancies and births. CDC also monitors sexual risk behaviors among high school students at national and state levels and monitors TPP policies and programs implemented by the nation's state education agencies, school districts, and schools. The National Institutes of Health (NIH) supports research on the causes of and risks associated with teen pregnancy. (See table 7.)

Table 7: HHS Surveillance and Research Related to Teen Pregnancy

CDC		NIH[a]
National Center for Health Statistics	**National Center for Chronic Disease Prevention and Health Promotion**	**National Institute of Child Health and Human Development**
— Generates national teen pregnancy rates by combining data on legal induced abortion and fetal loss with live birth data. — Collects national data on incidence and trends in teen pregnancies and births. Collects state data on trends and variations in teenage births. — Collects state-by-state and national data on trends and variations in births to unmarried teens. — Conducts National Survey of Family Growth, with other HHS agencies. The 1995 survey was released in 1997. It provides national data on sexual activity, characteristics of partners, fertility, contraception, marriage and cohabitation, infertility, adoption, maternity leave, and other factors that affect teenage and adult women and the health and well-being of their children.	— Generates state-by-state teen pregnancy rates by combining data on legal induced abortion and fetal loss with live birth data. — Collects state-by-state and national data on incidence, trends, and causes of teen pregnancy. — Youth Risk Behavior Surveillance System—national, state, and local school-based surveys (YRBS) of representative samples of ninth- to twelfth-grade students and a national household-based survey of 12- to 21-year-olds—provides information on sexual behavior, contraceptive use, substance abuse, and pregnancy and HIV education. — School Health Policy and Program Study provides national data on TPP policies and programs implemented by states' departments of education, school districts, and schools. It provides information about state requirements, training provided, and percentage of teachers who taught the subject. — Pregnancy Risk Assessment Monitoring System—an ongoing, state-specific (16 states), population-based surveillance system—generates state-specific data for assessing preconception, prenatal and postpartum health status, including information on pregnancy intention and family planning.	— National Longitudinal Study of Adolescent Health (Add Health) combines longitudinal data collection efforts and individual investigator-initiated research using these data. The survey is designed to measure the effects of various influences on health behaviors, such as sexual activity and drug and alcohol use, offering insight into the basis for changes in teen birth rates over time. — National Survey of Adolescent Males (with OPA) combines longitudinal data collection and individual research.

[a]NIH funds a range of research examining intervention programs for young people to help them abstain from early sex or unprotected sex. The focus at the NIH level is on theoretically grounded programs with rigorous evaluation components. Some interventions are for HIV prevention, and some are for pregnancy prevention. In fiscal year 1997, the National Institute of Child Health and Human Development's Demographic and Behavioral Sciences Branch was examining eight such interventions and a number of smaller programs for pregnancy prevention.

Few HHS Evaluations Will Show the Effect Programs Have on Teen Pregnancy

HHS has conducted very few evaluations to determine whether and how programs that it supports actually affect teen pregnancies, births, or the behavioral outcomes closely related to teen pregnancy. Because block grants—a source of funding used by the eight states to support their TPP strategies—give states flexibility in using funds, specific program

evaluations are not typically required. Other programs that can support TPP activities do not evaluate their effect on teen pregnancy because teen pregnancy prevention is not their primary goal. HHS does require evaluations of three HHS programs whose primary goal is teen pregnancy prevention. Two of these program evaluations will measure program effects on teen sexual behavior, use of contraceptives, and teen births.

AFL, one of three TPP programs, provides local and state grantees with funding for abstinence programs. The enabling legislation requires annual evaluations and are supposed to be funded by not less than 1 percent and not more than 5 percent of program funds. According to HHS officials, evaluations of AFL programs have shown positive short-term results in increased knowledge and changed attitudes but have not examined program effects on teen pregnancy. CDC's Community Partnership Program requires all grantees to evaluate program processes and allocates about 20 percent of program funds to evaluations. All 13 of these communities will collect similar data, including behavioral data that are closely related to teen pregnancy, so that comparisons across sites can be made. Six of the 13 communities are participating in enhanced evaluations that will include a special focus on certain program components. CDC is providing supplementary funding and technical assistance to the communities participating in the enhanced evaluation.

Although there is no evaluation requirement for states participating in AEP to evaluate their abstinence-only programs, the Balanced Budget Act of 1997 authorized HHS to use up to $6 million in fiscal years 1998 and 1999 to evaluate AEP. In May 1998, HHS issued a request for proposals to evaluate the effectiveness of selected AEP programs. The evaluation's goal is to determine the effects of the abstinence education programs in achieving key outcomes, including reduced rates of sexual activity, teen pregnancies and births, and sexually transmitted diseases. In August 1998, HHS awarded the contract to Mathematica Policy Research, Inc. In addition to these evaluations, HHS is currently evaluating or has recently completed evaluating two multisite teen parent programs that measure TPP outcomes, including teen subsequent pregnancies and births, sexual activity, contraceptive practices, as well as other measures related to education attainment, employment, welfare dependency, and child well-being.

According to HHS officials, HHS plans to direct additional funds toward evaluation of the specific TPP programs the agency funds. As part of a national strategy, HHS announced in May 1998 the availability of $300,000 to enhance ongoing state, local, or private evaluations. HHS officials said

they recognize that even more program evaluations need to be done. According to some experts, higher quality evaluation is also needed. These evaluations should measure program effects on the behavioral goals of the program and risk factors associated with teen pregnancy; they should also follow program participants to learn about long-term effects. HHS officials also suggested that evaluation dollars be used selectively on promising programs and not be spread too thinly.

As required under the Results Act, HHS recently began implementing performance goals and measures for all of its programs, including those intended to prevent teen pregnancy. In 1997, the Maternal and Child Health Bureau worked with states and other stakeholders to pilot test the new Results Act requirements on the Maternal and Child Health Services Block Grant Program. For this program, state grantees must set numeric goals for each performance measure and are required to report progress in achieving these goals. The Bureau and its eight pilot states—including Maine, a state in our review—collaborated to pretest the new reporting requirements, such as those related to reducing the birth rate among teens aged 15 to 17—one of the 18 national core performance measures.[20] According to an HHS official, the pilot resulted in the automated reporting of more uniform data and a much more streamlined process, making it easier for Bureau officials to assess program performance against goals. The official stated that the piloted process has the potential to improve state accountability for progress toward state goals.

Officials in Maine said that the experience they gained from participating in the pilot prompted them to reexamine priorities and focus on current needs of its Maternal and Child Health Services Block Grant population. In developing its 1998 plan, Maine added a state-initiated performance measure of lowering the number of unintended births among women under age 24. Maine officials also reported that the new application and reporting process helped them make resource decisions that were more consistent with agreed-upon state and federal priorities.

Conclusions

The federal government provides millions of dollars to support TPP efforts. Although the states in our review relied on research findings in developing certain aspects of their strategies, too few programs are systematically evaluated to guide TPP program efforts. Some programs within the state strategies are being evaluated, but most do not measure the known risks

[20]In addition, states may select state-initiated performance measures against which program performance will be assessed.

or outcomes that are linked to teen pregnancy, such as school achievement, delay of sexual initiation, and contraceptive and sexual behavior. Furthermore, most do not allow for sufficient follow-up to determine long-term program effects. Evaluation efforts at the federal level have also been limited. However, HHS is beginning two major evaluations of TPP programs that will look at their long-term impact on outcomes known to be related to teen pregnancy prevention. The results of evaluations that focus on outcomes related to teen pregnancy should help states, the federal government, and others in choosing the programs or approaches most likely to be effective in preventing teen pregnancy.

Four of the states we visited and the federal government are establishing performance measures systems to allow for assessments of program performance toward achieving established TPP goals and to help improve accountability. Although performance measurement alone will not provide the information necessary to understand the link between the programs and their effects on reducing teen pregnancy, the Results Act encourages a complementary role for performance measurement results and program evaluation findings. Performance measurement combined with program evaluations of outcome measures that are predictors of teen pregnancy is more likely to yield results that can be used to improve the overall effectiveness of states' TPP efforts.

Agency and State Comments

We obtained comments on a draft of this report from HHS; the eight states we visited; the Director of the Center for Reproductive Health Policy Research, University of California; and the Director of the National Campaign to Prevent Teen Pregnancy. The reviewers generally agreed with the findings and conclusions in the report. HHS felt that the Department's commitment to evaluating TPP programs described in the report could be expanded to include other efforts that evaluate how teen parent programs affect teen births and behavioral outcomes related to teen pregnancy. We added the information HHS provided. Each reviewer provided additional information and clarification and suggested technical changes, which we incorporated where appropriate.

We plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to the Secretary of HHS, officials of the states included in our review, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request.

Please contact me on (202) 512-7119 if you or your staff have any questions about this report. Other major contributors to this report were James O. McClyde, Assistant Director; Martha Elbaum; and Karyn Papineau.

Sincerely yours,

Marsha Lillie-Blanton
Associate Director
Health Services Quality and
Public Health Issues

Contents

Tables

Abbreviations

ACF	Administration for Children and Families
AEP	Abstinence Education Program
AFL	Adolescent Family Life
CCPPPTP	Community Coalition Partnership Program for the Prevention of Teen Pregnancy
CDC	Centers for Disease Control and Prevention
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
ICTF	Indigent Care Trust Fund
NIH	National Institutes of Health
OPA	Office of Population Affairs
SAMHSA	Substance Abuse and Mental Health Services Administration
TANF	Temporary Assistance for Needy Families
TPP	teen pregnancy prevention
YRBS	Youth Risk Behavioral Survey

Objectives, Scope, and Methodology

In response to congressional concern about teen pregnancy, we were asked to identify the strategies states have been implementing to prevent teen pregnancy and how states fund these strategies, determine if federal welfare reform had an effect on these strategies, identify these states' efforts to evaluate their pregnancy prevention efforts, and describe the federal government role in supporting state efforts to prevent teen pregnancy.

To accomplish these objectives, we first contacted HHS and experts from the National Campaign to Prevent Teen Pregnancy, the Urban Institute, the National Governor's Association, the Annie E. Casey Foundation, and the Henry J. Kaiser Family Foundation to learn about states that had strategies or were embarking on interesting approaches. Complementing this information, we used HHS' teen birth rate data by state from 1991 to 1994, the most current data available at the time, to determine which states had high, low, and moderate birth rates. Subsequent to our review of state-level data in April 1997, the National Center for Health Statistics published state-level teen birth rates for 1995 and 1996. The variations among states in 1995 and 1996 were not markedly different from those reported for 1994. Using this information and the 1994 data, we selected eight states for review: California, Georgia, Illinois, Louisiana, Maine, Maryland, Oregon, and Vermont. All had their TPP strategies in place or had initiatives or reorganization under way. The teen birth rates in these states were high, low, or stable. (See table I.1.) These states provided a cross section of approaches to teen pregnancy prevention, but the results of our work cannot be generalized nationally—particularly since we chose states that had strategies under way.

Table I.1: Changes in Birth Rates Per 1,000 Teens Aged 15 to 19 in the Eight Selected States, 1991, 1994, and 1996

Year	Calif.	Ga.	Ill.	La.	Md.	Maine	Oreg.	Vt.
1991	75	76	65	76	54	44	55	39
1994	71	72	63	75	50	36	51	33
1996	63	68	57	67	46	31	51	30

Source: HHS, National Center for Health Statistics.

To learn about each state's TPP strategy, we interviewed state officials within the lead agencies responsible for TPP efforts, along with officials from other state agencies that had a supporting role in the strategy, as shown in table I.2.

Table I.2: State Agencies Contacted in Each of the Eight States

State	Agency
California	Department of Health Services Department of Social Services Department of Education Department of Alcohol and Drug Programs Department of Youth Authority Department of Criminal Justice Planning
Georgia	Department of Human Resources Department of Family and Children Services Family Connection Initiative Department of Juvenile Justice
Illinois	Department of Human Services Department of Public Health State Board of Education
Louisiana	Department of Health and Hospitals Office of Public Health Department of Social Services Department of Education
Maine	Department of Human Services Department of Education Department of Mental Health, Mental Retardation, and Substance Abuse Office of Data Research and Vital Statistics
Maryland	Governor's Office for Children, Youth, and Families Governor's Council on Adolescent Pregnancy Department of Health and Mental Hygiene Department of Human Services Department of Education
Oregon	Oregon Health Division Department of Human Resources STARS Program Governor's Office
Vermont	Department of Health Department of Social Welfare Department of Education Department of Social and Rehabilitative Services Department of Mental Health and Mental Retardation

To describe state strategies and programs and the effect welfare reform may have had on these efforts, we obtained and analyzed program documents and data in each of the case study states and obtained descriptions of applicable laws. We also interviewed local program officials from county governments, local health departments, and community organizations responsible for implementing TPP programs. In the states where Title X Family Planning Program funding does not go directly to the state, we interviewed officials in the nonprofit corporations who administer the program. In the states where major private TPP programs were operating independent of the state strategy, we

interviewed relevant officials to determine their involvement with the states.

To determine how states evaluate their strategies and programs, we reviewed and analyzed completed evaluations and discussed with officials plans to conduct additional evaluations. We also reviewed the literature on the current status of evaluating TPP programs and conducted interviews with program evaluators.

To determine how much states spend on teen pregnancy prevention, we asked each state to provide financial information for their fiscal year 1997 programs. We asked the states to provide us the dollar amount and sources of federal and state funding for programs to prevent teen pregnancy. Some states were able to identify the amount of money from various federal sources, but some states were unable to break out TPP spending from the various block grants used to fund the effort. Federal requirements do not mandate that funding for TPP efforts be separated from more broad categories, such as the Maternal and Child Health Block Grant, and block grants offer states discretion in the use of funds. We did not verify the funding information the states provided.

To obtain information on the federal role in supporting state efforts to reduce teen pregnancy, we met with HHS officials, who identified all agencies within HHS that administer TPP programs along with other federal agencies that fund TPP efforts. Through HHS, we asked each HHS agency and the other federal agencies to provide us information on the programs they administer that can impact teen pregnancy. We also asked them to provide information on the programs' total funding and the amount of the funding directly for teen pregnancy. Many of the programs could not isolate funding for teen pregnancy prevention because it was not an explicit focus of their programs. We did not verify the funding data provided.

We performed our work between April 1997 and November 1998 in accordance with generally accepted government auditing standards.

Selected Federal Agencies With Programs That May Impact Teen Pregnancy Prevention

Table II.1: Federal Agencies and Their TPP-Related Programs

Agency	TPP-Related Programs
Department of Agriculture	The Cooperative State Research, Education, and Extension Service links education resources and Department of Agriculture programs and works with land grant universities and other educational institutions. A systemwide initiative on children, youth, and families at risk has highlighted programs and research related to teen pregnancy prevention. In addition, the service reaches 5.6 million youth through 4-H programs managed by state land grant partners. Programs vary from state to state; state land grant institutions typically do not have a budget line item for teen pregnancy prevention.
Department of Defense	Supports youth programs that offer no specific efforts to prevent teen pregnancy. Most Department of Defense youth program staff can refer youth to appropriate education or health programs, and many youth programs provide curricula geared to informing teens about pregnancy prevention services offered by military medical treatment facilities. Some educational activities at U.S. installations have prevention education for teens and preteens.
Department of Education	Programs are not authorized to allocate money for TPP activities, but some of the money distributed to states in the form of grants may be used for that purpose.
Department of Housing and Urban Development	No specific programs for teen pregnancy prevention; however, the Department does have some grant programs that local grantees may use for broad purposes, such as youth development programs with more specific teen pregnancy prevention goals.
Department of Justice	Administers programs focused on at-risk youth and designed to reduce juvenile delinquency, which may have a tangential impact on teen pregnancy.
Department of Labor	Youth programs that target poor areas and at-risk youth and seek to ameliorate youth problems by providing services and education, training, and work opportunities. Programs may include education, counseling, and services related to teen pregnancy prevention.
Corporation for National Service	Volunteers through the Corporation's volunteer program work with communities on various activities, some of which may be TPP activities or youth development programs.
Office of National Drug Control Policy	Does not provide direct programming on teen pregnancy prevention. The Office coordinates substance abuse prevention focus of other federal agencies, with a focus on youth.

Source: HHS and the federal agencies listed.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

PRINTED ON  RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested