Teenage Pregnancy, The Case for Prevention

2nd Edition

An Updated Analysis of Recent Trends & Federal Expenditures Associated with Teenage Pregnancy

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Advocates for Youth
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Advocates for Youth –
Helping young people make safe and responsible decisions about sex

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Advocates for Youth is dedicated to creating programs and promoting policies which help young people make safe and responsible decisions about their sexual and reproductive health. We provide information, training, and advocacy to youth-serving organizations, policy makers, and the media in the U.S. and internationally.

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Executive Summary

Teen pregnancy and birth rates have declined steadily in the United States in recent years. Experts attribute the declining rates to a substantial increase in contraceptive use by sexually active teens and to a decrease in sexual activity among adolescents.[1] Despite these declines, the United States continues to have the highest teen birth rate among all industrialized nations and a higher teen birth rate than over 50 developing nations.[2]

Teenage pregnancy and childbearing have considerable, long-term consequences for teenage parents and their children. For example, research shows that when younger adolescents give birth, they are less likely to complete high school and more likely during their lives to have a larger number of children than are non-parenting teens. Children born to younger teen mothers may also experience poorer health outcomes, lower educational attainment, and higher rates of adolescent childbearing themselves when compared to children born to older mothers.[3]

Americans commonly believe that educational, social, medical, and economic difficulties experienced by adolescent mothers and their children are the *consequences* of teenage childbearing. However, research demonstrates that economic and social disadvantage is among the *causes*, as well as consequences, of teenage childbearing.[4]

Teenage pregnancy and childbearing also have substantial economic consequences for society in the form of increased welfare costs. Advocates for Youth estimates that in federal fiscal year 1996 – the year for which the most recent data is available – the federal government spent over **$38.0 billion** to provide services and support to families that began with a birth to a teen. This includes families headed by adult females who were teenagers when they had their first child.

The federal government's financial support for teen pregnancy prevention initiatives pales when compared to this large expenditure. Advocates for Youth estimates that in federal fiscal year 1996, the federal government invested **$138.1 million** – less than one-seventh of one billion dollars to prevent teen pregnancy. That is more than 275 times *less* than the amount the federal government spent to support families begun with a birth to a teen.

Trends in adolescent sexual behavior are encouraging. However, pregnancy and birth rates among U.S. teens remain too high. Policy makers must *not* curtail support for families begun with a birth to a teen. However, to effectively reduce rates of unintended pregnancy and births among teens, the federal government should invest in teen pregnancy prevention initiatives. Moreover, these prevention funds *must* be invested in proven, scientifically evaluated programs which are effective in helping teens to delay the initiation of sexual intercourse and to practice safer sexual behaviors when they become sexually active. Such programs provide:

- Accurate, balanced, and realistic sexuality education
- Youth development
- Confidential and low-cost access to contraceptive services.

Sexuality Education

Research indicates that balanced, realistic sexuality education – which includes information on *both* abstinence *and* contraception – can delay teens' onset of sexual activity, increase the use of contraception by sexually active teens, and reduce the number of their sexual partners.[5] Moreover, an overwhelming majority of Americans support providing sexuality education in junior and senior high schools. In particular, most Americans want students to have information about protecting themselves against unplanned pregnancy and infection with sexually transmitted diseases (STDs).[6]

Youth Development

Research shows that youth development programs can reduce sexual risk behaviors and teenage pregnancy.[7] These programs are comprehensive and multifaceted. They build on the assets and strengths of young people and assist youth to define goals, complete school, and plan their futures. *Youth development seldom tackles isolated problems – such as sexual risk behaviors – but focuses instead on providing holistic support and opportunities for young people. Youth development is a strategy that attempts to meet the needs young people themselves identify: to have life skills, to be cared for and safe, to be valued and useful, and to be spiritually grounded. It meets these needs by building on young people's capacities, assisting them to cultivate their own talents and to increase their feelings of self-worth, and easing their transition to adulthood.*[8]

Access to Contraception

Making contraceptives available to youth also reduces adolescents' sexual risk behaviors. Confidential and low-cost contraceptive services ensure that sexually active teens have what they need to protect themselves and their partners from the risk of infection with HIV or STDs and unintended pregnancy. Research demonstrates that teenage women would experience an estimated 385,800 additional unintended pregnancies annually if publicly subsidized contraceptive services were not available. Therefore, publicly funded contraceptive services annually avert about 154,700 births, 183,300 abortions, and 47,800 miscarriages or spontaneous abortions among teens.[9]

Unfortunately, the limited funds that the federal government provides for teen pregnancy prevention are not always invested in scientifically evaluated strategies or programs that successfully reduce adolescent sexual risk behaviors and teenage pregnancy. Since 1981, the federal government has invested in the Adolescent Family Life Program which focuses on developing programs that promote abstinence as the ***only*** option to help young people avoid STDs, HIV, and teenage pregnancy. In 1996, the U.S. Congress enacted welfare reform legislation, Public Law 104-193, which funded a provision to support abstinence-only-until-marriage education that prohibits teaching about contraception beyond failure rates. [10]

The American public sees a strong distinction between abstinence and abstinence-only-until-marriage education. More than 90 percent of adults support abstinence being

included as a topic in sexuality education for high school students. However, 70 percent of American adults oppose provision of federal law that allocates over half a billion dollars for abstinence-only-until-marriage education but prohibits use of the funds for information on contraception for the prevention of disease and unintended pregnancy.[6]

No research indicates that abstinence-only – also known as abstinence-only-until-marriage programs – are effective at reducing rates of teen pregnancy or birth. In fact, a team of researchers reviewed the evaluation of federally funded abstinence-only programs for adolescents. The researchers reported, *We are not aware of any methodologically sound studies that demonstrate the effectiveness of curricula that teach abstinence as the only effective means of preventing teen pregnancy. … Additionally, there is mounting evidence suggesting that [abstinence-only] programs are generally ineffective*.[11 *]

In contrast, for every dollar spent to provide publicly funded contraceptive services, the government saves an average of three dollars in Medicaid costs for pregnancy-related health care and medical care for newborns.[9] If the $2.5 million invested in fiscal year 1996 through the federal Adolescent Family Life (AFL) Program had been invested instead in contraceptive services for sexually active teens, the accrued savings would have totaled over $7.6 million.

This report underscores the need for U.S. policy makers to take *pragmatic* action to prevent teen pregnancy. Adolescents deserve effective strategies to prevent teen pregnancy and programs that are based upon the best practices as determined by evaluation and research. The U.S. federal government could make a difference in young people's futures by increasing its investment in *effective* programs.

* The abstinence-only-until-marriage strategy was not in effect for federal fiscal year 1996, the fiscal year discussed in this report. Nevertheless, it is noteworthy that the $50 million allocated to abstinence-only-until-marriage programs in federal fiscal year 1998 would have consumed 36 percent of the federal government's total investment in prevention strategies if this initiative had been in effect in fiscal year 1996.

Trends in Teenage Pregnancy and Childbearing

Teen Birth Rates Decline

Following sharp increases in the late 1980's, teen birth rates in the United States have declined significantly from 1991 through 1997. In 1997, the overall teen birth rate was 52.9 births per 1,000 women ages 15 to19 and was 15 percent lower than in 1991. Moreover, the most dramatic decline – 21 percent from 1991 to 1996 – was in the birth rate among young women who already had one child.[12]

Research indicates that this trend in declining birth rates may be part of a larger trend among all U.S. teens, rather than one limited to a specific geographic region or to a specific age or racial/ethnic subgroup of teens.[12]

The teen birth rate declined in every state in the United States.
The decline in the birth rate was statistically significant in all but three states (Delaware, North Dakota, and Rhode Island).[12]

State birth rates varied considerably among females ages 15 to 19. In 1996, the District of Columbia had the highest teen birth rate – 102 births per 1,000 females. Arizona, Arkansas, Mississippi, New Mexico, and Texas had teen birth rates above 70 per 1,000. In contrast, several states – Maine, Massachusetts, Minnesota, New Hampshire, North Dakota, and Vermont – had teen birth rates at or below 32 births per 1,000.[12] [Appendix A provides a state-by-state ranking of the percentage change in states' teen birth rates between 1991 and 1996.]

The teen birth rate declined for all age groups.
The birth *rate* for teens ages 10 to 14 declined from 1.4 per 1,000 in 1991 to 1.2 per 1,000 in 1997, a 14 percent decrease. The *number* of births to teens in this age group dropped from over 12,000 in 1991 to less than 11,000 in 1997.[12]

The birth *rate* for teens ages 15 to 17 declined 16 percent from 38.7 per 1,000 in 1991 to 32.6 per 1,000 in 1997. Most of this decline occurred between 1995 and 1997. The *number* of births to teens ages 15 to 17 totaled 183,324 in 1997, down from 188,226 in 1991.[12]

The birth rate for teens ages 18 to 19 declined 11 percent from 94.4 per 1,000 in 1991 to 84.4 per 1,000 in 1997. The *number* of births to teens ages 18 to 19 also dropped during the same time period from 331,351 to 305,886.[12]

The birth rate declined for teens in all racial/ethnic groups.
Birth rates dropped sharply – by 23 percent – among African American teens between 1991 and 1997. The birth rate for Hispanic teens declined nine percent since 1991. The birth rate for white, Native American, and Asian/Pacific Islander teens declined by 16, 16, and 10 percent, respectively, since 1991.[12]

Birth rates for African American and Hispanic teens continue to be substantially higher than those for non-Hispanic white teens. The birth rate for white teens fell to 37.6 per 1,000 women ages 15 to 19. By comparison, the African American teen birth rate fell to 91.4 per 1,000 and the Hispanic, to 101.8 per 1,000.[12]

Nevertheless, because there are so many more white than African American or Hispanic teens, whites gave birth to more infants than did their African American and Hispanic peers (338,272; 128,539; and 118,122, respectively).[13]

Teen Abortion and Pregnancy Rates Decline

The teen abortion rate in the United States declined significantly from 1991 through 1995 – by 21 percent.[15] In the 1990's, an increasing proportion of teens chose to give birth rather than to terminate their pregnancies – possibly the result of changes in societal norms, teens' personal preferences, and/or teens' reduced ability to obtain abortion services.[15]

After rising for several decades, teen pregnancy rates[†] declined after 1991. From 1991 to 1995, teen pregnancy rates for females ages 15 to 19 declined 13 percent. The declining pregnancy rate reflects the declines in *both* teen abortion and teen birth rates. Another way to say this is that the decrease in the teen birth rate has been driven by declining pregnancy rates rather than by increasing abortion rates.[16]

Increasing Contraceptive Use and Declining Sexual Activity Rates Key to Declining Teen Birth and Pregnancy Rates

The Centers for Disease Control and Prevention (CDC) attributes recent declines in teen birth and pregnancy rates to a leveling off of sexual experience and activity and to increased condom use among sexually active youth.[1]

Experts attribute 80 percent of the decline in overall teenage pregnancy rates to improved use of highly effective, long acting contraceptives by sexually active teenagers.[17] More teen females, especially African Americans, are using injectable contraception (Depo-Provera) and contraceptive implants (Norplant) that were unavailable in the United States before 1992.[18] Additionally, teens' use of these newer, highly effective methods has been accompanied by increased condom use at most recent intercourse among both female and male sexually active adolescents. Among sexually active teens in 1995, nearly two-thirds (64 percent) of males and over one-third (36 percent) of females reported using a condom at most recent intercourse.[18]

The percentage of teenage females who used a method of contraception at *first voluntary* sexual intercourse increased from 65 percent in 1988 to 76 percent in 1995, largely due to increased condom use.[14] Condom use at first intercourse is an important measure of teens' ability to behave responsibly and plan as they initiate sexual activity.[18]

[†] The National Center for Health Statistics calculates pregnancy by combining data on live births with data on abortions. Data on abortions are not as current as data on births, and the most recent, complete estimates on abortion, and therefore pregnancy, are available only through 1995.[14] By comparison, the most recent data on teen birth rates is from 1997.

According to three separate national surveys conducted in the 1990's, the proportion of sexually experienced teens stabilized and then fell slightly, reversing the steady increases of the preceding decades.[19,20,21] About 20 percent of the decline in the overall teen pregnancy rate is attributable to this increased abstinence.[16] In fact, research shows that declining rates of sexual risk behaviors, increased abstinence, and increased use of effective methods of contraception can be attributed to the following strategies:

- Accurate sexuality education that includes information on *both* abstinence and contraception
- Youth development programs
- Access to confidential, low-cost contraceptive services.

Sexuality Education

Research indicates that balanced, realistic sexuality education – which includes information on *both* abstinence *and* contraception – can delay teens' onset of sexual activity, can increase the use of contraception by sexually active teens, and may reduce the number of their sexual partners.[5] Moreover, an overwhelming majority of Americans support providing sexuality education in junior and senior high schools. In particular, most Americans want students to have information to protect themselves against unplanned pregnancy and STDs and oppose the portion of the federal law that funds abstinence-only-until-marriage education.[6]

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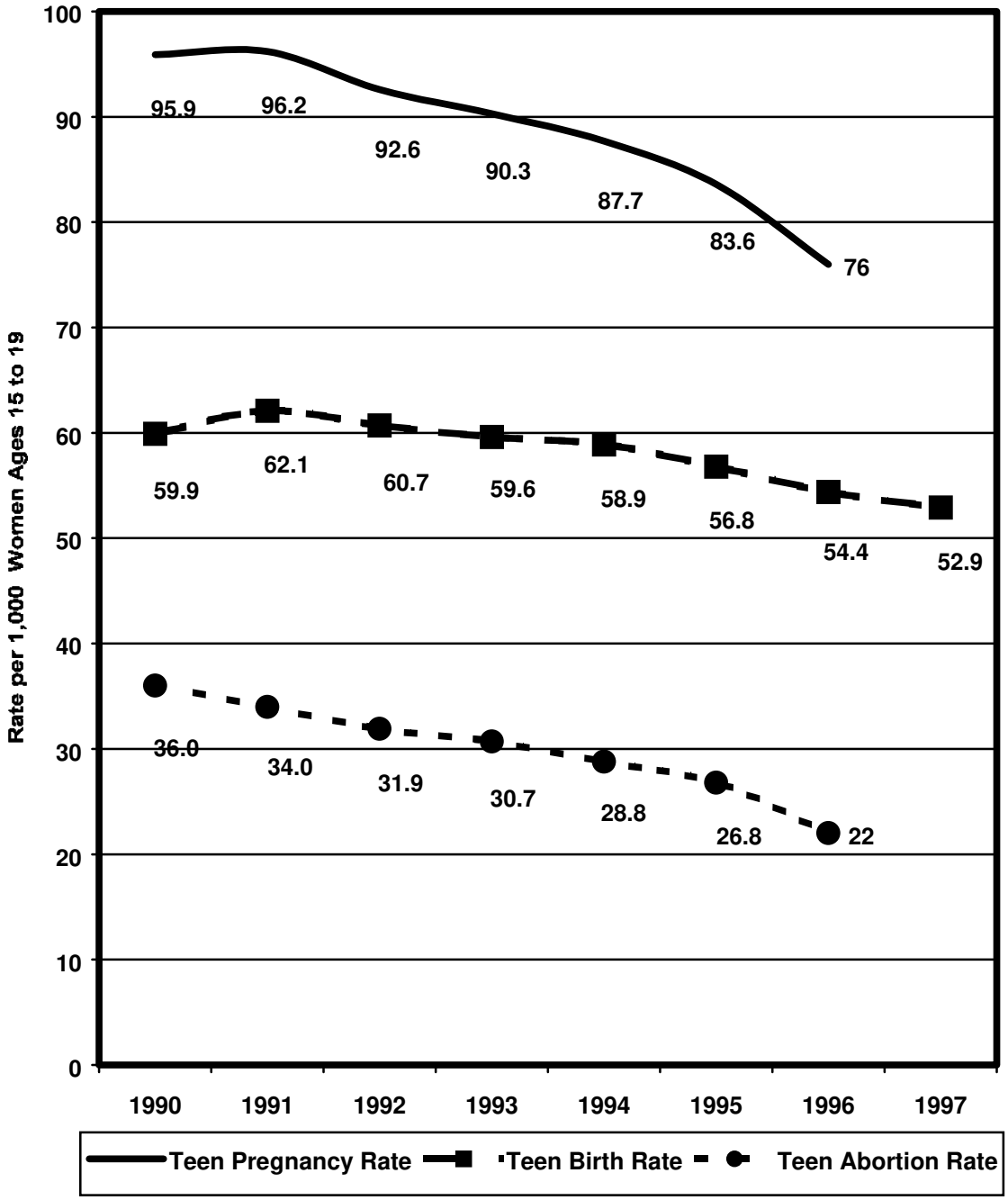
Figure 1. U.S. Teen Pregnancy, Birth, and Abortion Rates‡ per 1,000 Women Ages 15 to 19: 1990-1996[12,14,22]



‡ For 1996, the teen pregnancy and abortion rates are calculated based on data from 44 states and New York City. The abortion rate is calculated as the number of legal abortions obtained by women ages 15 to 19 per 1,000 women of this age group for the 44 states and New York City.

Methodology

A Historical Perspective

In 1986, Advocates for Youth began calculating single-year federal expenditures to support families in which the first birth occurred while the mother was a teenager. Advocates for Youth calculated these federal expenditures in order to highlight the public and societal costs of too-early childbearing. In 1993, some members of Congress used Advocates' figures to bolster their assertions that public assistance programs were too costly and should be eliminated. Such misguided arguments contributed to the establishment of a welfare reform policy which ignores the enormous costs – especially in health and education – incurred when the nation fails to assist young families and others in need. Advocates for Youth believes that the nation must *both* continue to support vulnerable young families and also make a corresponding financial investment in – and commitment to – preventing teenage pregnancy.

Therefore in 1998, in order to provide a context for federal expenditures to support young families, Advocates for Youth changed its methodology to additionally calculate the amount of money invested by the federal government in preventing teenage pregnancy. Advocates examines both expenditures and investments at the *national* level because the federal government is the largest funding source for prevention programs, sets national priorities by its funding decisions, and consistently supports the greatest number of prevention programs across the nation. *Teenage Pregnancy, The Case for Prevention*, also known as the "Cost Study," draws public attention to the need to invest more federal dollars in preventing teenage pregnancy in order to save federal expenditures to support future families.

The Cost Formula

In 1997, the Southern Regional Project on Infant Mortality, with the assistance of a Technical Advisory Group, updated the assumptions and revised Advocates' original cost formula. The Technical Advisory Group included other national experts as well as staff from Advocates for Youth. Revisions included the addition of data for costs of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and a more recent federal and state estimate on the percent of social service recipients who were teens at their first birth. The Technical Advisory Group determined that the appropriate national percentage of social service recipients whose families began with a birth to a teen is 47 percent. This percentage is derived from averaging the data from two reports – one by the U.S. General Accounting Office (GAO) and the other by the Urban Institute.[23,24] The Southern Regional Project on Infant Mortality used the new formula to calculate fiscal year 1995 public expenditures and investments – both state and federal funds – for 20 southern states and provides a state-by-state analysis of the findings.[25] [§]

[§] The methodology used for *Expenditures and Investments: Adolescent Pregnancy in the South, Vol. II* (1997) and the 1998 and 1999 editions of Advocates for Youth's *Teenage Pregnancy, the Case for Prevention* differs from methodologies used in Advocates' and the Project's previous publications. Estimates of expenditures and investments published before 1997, therefore, should not be compared with estimates published after 1997.

In 1998, Advocates for Youth published *Teenage Pregnancy: The Case for Prevention*, calculating the federal investments in pregnancy prevention and comparing them to federal expenditures to support families begun with a birth to a teen. Once again, Advocates revised the cost formula.

A 1996 analysis of the Survey of Income and Program Participation (SIPP) by a private research firm indicates that 55 percent of social service recipients were teens at the birth of their first child.[26] Congressional documents use this figure.[27] Therefore, Advocates for Youth used 55 percent as the estimated percentage of social service recipients who were teens at the birth of their first child in calculating costs associated with all but one of the federal programs. Advocates applied the 55 percent calculation to Medicaid, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Aid to Families with Dependent Children. However, Food Stamp Program recipient families are less likely to have begun with a birth to a teen. Therefore, Advocates for Youth's expenditures formula used 47 percent as the estimated percentage of Food Stamp Program recipients who were teens at the birth of their first child when calculating this federal program's expenditures.

Fiscal Year 1996

In this updated edition of *Teenage Pregnancy, The Case for Prevention*, Advocates for Youth examines the federal government's expenditures and investments related to adolescent pregnancy for the federal fiscal year 1996 (October 1, 1995 through September 30, 1996).

Estimating the annual expenditures and investments is not straightforward. Limited data exist to quantify the number of prevention and intervention programs that reach adolescents. Therefore, Advocates for Youth does *not* include programs for which information is not kept by age or childbearing status of recipients (such as Social Services Block Grant funds for family planning services). Moreover, no accurate picture exists of the individuals who use some programs, such job training, housing subsidies, subsidized school meals, special education, foster care, and day care programs. Therefore, Advocates excludes these programs from its analysis. Advocates for Youth's analysis of federal expenditures and investments includes only those federal programs that reach the greatest number of recipients. Moreover, the analysis is based on published data and estimates that have been provided by federal employees. It is, therefore, a conservative estimate of these costs.

After compiling the data for fiscal year 1996, Advocates for Youth calculated:

- Total **federal expenditures**[**] to provide services and support to families which began with a birth to a teen, including families now headed by adult females who were teenagers when they had their first child

[**] The terms, "expenditures" and "investments," are adapted from *Expenditures and Investments: Adolescent Pregnancy in the South* (1997). [25]

- Total **federal investments**[**] in the prevention of teenage pregnancy among youth ages 15 to19, including programs designed to prevent second (and higher order) pregnancies in teenage mothers. For programs serving a more generalized population, Advocates for Youth included only the percentage of their budgets that were dedicated to serving teens.

Four federal programs – Medicaid, Social Services Block Grant, Maternal and Child Health Services Block Grant, and the Adolescent Family Life Program – allocated funds both to provide services and support to families which began with a birth to a teen and to prevent teen pregnancy. Although 1.3 percent of Social Services Block Grant (SSBG) funds were used to provide family planning services in fiscal year 1996, Administration contacts could not estimate the percentage of family planning service recipients who were teens. Advocates for Youth, therefore, excluded the Social Services Block Grant from the investment calculation. The other three programs were included in both the expenditure and the investment calculations.

The expenditures formula includes federal costs associated with:

- Medicaid – Title XIX of the Social Security Act
- Aid to Families with Dependent Children (AFDC) – Title IV-A of the Social Security Act
- Food Stamp Program
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Social Services Block Grant (SSBG) – Title XX of the Social Security Act
- Maternal and Child Health Services Block Grant – Title V of the Social Security Act
- Adolescent Family Life (AFL) Program – Title XX of the Public Health Service Act.

The investments formula includes federal costs associated with:

- Medicaid – Title XIX of the Social Security Act
- Healthy Schools, Healthy Communities (HSHC)
- *Healthy People 2000* (Preventive Health and Health Services Block Grant)
- Community Health Center (CHC) Program
- Community Coalition Partnership Program for the Prevention of Teen Pregnancy (CCPPPTP)
- National Family Planning Program – Title X of the Public Health Service Act
- Maternal and Child Health Services Block Grant – Title V of the Social Security Act
- Adolescent Family Life (AFL) Program – Title XX of the Public Health Service Act.

Appendix B provides a more detailed explanation of the expenditures and investments cost formulas that Advocates for Youth used to calculate data for federal fiscal year 1996.

In fiscal year 1996, the federal government spent **$38.0 billion** to help families that began with a birth to a teenager, including families in which that teenager has since become an adult. At the same time, the federal government only **invested $138.1 million** to help adolescents delay or prevent pregnancy.

This disparity reflects the federal government's lack of commitment to preventing teenage pregnancy. Despite the enormous potential savings to be reaped by reducing teenage pregnancy and childbirth, the United States invests far too little to prevent pregnancy among the nation's young people.

Estimates of Federal Expenditures

Support and Services to Families Begun by a Birth to a Teen

Advocates for Youth calculated the federal expenditures in fiscal year 1996 by adding up the costs of resources allocated to provide support and services to families that began with a birth to a teen. Advocates for Youth included families headed by adult females who were teens when they had their first child. The various programs included in the expenditure calculation are discussed below.[††]

Fiscal Year 1996 Federal Expenditures to Support Families Begun with a Birth to a Teen	
Medicaid	$18.4 billion
Aid to Families with Dependent Children (AFDC)	$7.0 billion
Food Stamp Program	$10.6 billion
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	$2.0 billion
Social Services Block Grant (SSBG)	$11.9 million
Maternal and Child Health Services Block Grant	$2.5 million
Adolescent Family Life (AFL) Program	$5.2 million
Total Federal Expenditures	**$38.0 billion[‡‡]**

Medicaid — $18.4 billion

(A) Benefits — **$16.4 billion**
(B) Administration — **$2.0 billion**

In fiscal year 1996, the federal government spent nearly $18.4 billion ($18,388,027,095) on Medicaid to support families begun with a birth to a teen. More than $16.4 billion ($16,400,376,285) was for direct benefits to recipients and nearly $2 billion ($1,987,650,810) was for administrative costs. The annual number of adult Medicaid

[††] Administrative costs are broken out separately only for those for programs where benefits equal the monthly or annual allocation and do not include administrative costs.
[‡‡] Columns may not total due to rounding.

recipients, eligible based on AFDC status, was 7,126,807 with average annual Medicaid outlay of $1,722 per adult. The annual number of child Medicaid recipients, eligible based on AFDC status, was 16,738,800 with average annual Medicaid outlay of $1,048 per child. An estimated 55 percent of Medicaid recipients were teens when their first child was born.

Program Description. Title XIX of the Social Security Act (Medicaid) is an entitlement program that pays for medical assistance for vulnerable and needy individuals and families with low incomes and few resources. Medicaid is the largest source of funding for medical and health-related services for the United States' poorest people. In fiscal year 1996, Medicaid provided health care assistance to more than 36 million people.[28]

The Health Care Financing Administration (HCFA), established under the U.S. Department of Health and Human Services (HHS), administers grants to the states to manage Medicaid benefits. The Medicaid program allows the states considerable flexibility within their Medicaid plans. However, the federal government requires states to provide basic services – such as general health care, prenatal care, vaccines for children, and family planning services and devices – to categorically needy populations. Groups eligible to receive Medicaid coverage include: recipients of Aid to Families and Dependent Children and Supplemental Security Income (SSI) as well as pregnant women and children under age six whose family income is at or below 133 percent of the federal poverty level. By 2002 under the states' Child Health Insurance Program (CHIP), all children will be covered who are under age 19 in families with incomes at or below the federal poverty level.[28]

Aid to Families with Dependent Children (AFDC) — $7.0 billion

In fiscal year 1996, the federal government spent about $12.7 billion ($12,698,000,000) on Aid to Families with Dependent Children (AFDC). An estimated 55 percent of AFDC recipients were teens when their first child was born. The federal government, therefore, spent approximately $7 billion ($6,983,900,000) on AFDC to support families begun with a birth to a teen.

Program Description. Aid to Families with Dependent Children was established in 1935 as a matching grant program to enable states to aid needy children without fathers at home. AFDC was repealed 61 years later by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193). A block grant to the states for Temporary Assistance for Needy Families (TANF) replaced AFDC, effective July 1, 1997, by which time most states had already implemented TANF.[27]

Federal fiscal year 1998 was the first full year in which all states implemented TANF. Because federal fiscal year 1996 is October 1, 1995 through September 30, 1996, Advocates for Youth used figures associated with AFDC to calculate fiscal year 1996 expenditures and investments. Appendix C summarizes some major differences between the old (AFDC) and new (TANF) cash welfare programs for families with children.[27]

Before the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, AFDC provided transitional financial assistance to needy families. Federal and state governments shared the costs associated with AFDC. The Administration for Children and Families, Office of Family Assistance, U.S. Department of Health and Human Services administered the program, and the federal government provided broad guidelines and program requirements. States were responsible for program formulation, benefits determinations, and administration. Eligibility for benefits was based on the state's standard of need as well as the income and resources available to the recipient.[29]

Food Stamp Program — $10.6 billion

(A) Benefits **$9.7 billion**
(B) Administration **$0.9 billion**

In fiscal year 1996, the federal government spent over $10.6 billion ($10,614,904,072) through the Food Stamp Program to support families begun with a birth to a teen. Nearly $9.7 billion ($9,697,322,602) was in direct benefits and over $917 million ($917,581,470) was in administrative costs. The average monthly number of Food Stamp recipients was 26.9 million, and each recipient received an average monthly Food Stamp allocation of $73.30. About nine out of 10 AFDC recipients also received a Food Stamp allocation. Experts estimate that 47 percent of Food Stamp recipients were teens when their first child was born.

Program Description. The Food Stamp Program's purpose is to end hunger and improve nutrition and health. The program helps low-income households buy the food needed for a nutritionally adequate diet. State and local welfare offices operate the Food Stamp Program and the Food and Nutrition Service of the U.S. Department of Agriculture oversees the states' operations. The amount of benefits an eligible household receives depends on the number of people in the household and the amount of the household's income.[30]

Generally, recipients in the two primary cash welfare programs – AFDC and Supplemental Security Income (SSI) – are automatically eligible for food stamps if the household is composed entirely of AFDC or SSI beneficiaries.[27]

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) — $2.0 billion

In fiscal year 1996, the federal government spent over $3.6 billion ($3,688,200,000) on the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). An estimated 55 percent of WIC recipients were teens at the birth of their first child. The federal government, therefore, spent more than $2 billion ($2,028,510,000) through WIC to support families that began with a birth to a teen.

Program Description. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides food, nutrition counseling, and access to health services for low-income women, infants, and children. Established in 1974, WIC is administered at the federal level by the Food and Nutrition Service of the U.S. Department of Agriculture. Formerly known as the Special Supplemental *Food* Program for Women, Infants, and Children, WIC's name was changed in the mid 1990s to emphasize its role as a *nutrition* program.[31]

WIC is effective in improving the health of pregnant women, new mothers, and their infants. Women who participated in the program during their pregnancies have been shown to have lower Medicaid costs for themselves and their babies than did women who did not participate. WIC participation has also been linked with longer gestation periods, higher birth weights, and lower infant mortality.[31]

Social Services Block Grant (SSBG) — $11.9 million

In fiscal year 1996, the federal government spent over $11.9 million ($11,905,000) through the Social Services Block Grant to provide pregnancy and parenting services.

Program Description. Title XX of the Social Security Act, also referred to as the Social Services Block Grant (SSBG), is a capped entitlement program, which gives funds to states to help them achieve a wide range of social policy goals. States determine which services they will provide and the groups eligible for these services. The federal government, however, places some restrictions on the use of Title XX funds. States cannot use these funds to provide – among other services – medical care *except* family planning, drug rehabilitation, or detoxification services, and educational services that are generally provided by schools.

SSBG funds provide both family planning services and pregnancy and parenting services for teens. Advocates for Youth included the percentage of funds (0.5 percent) spent to provide services for pregnant and parenting teens in the calculation of expenditures.

Maternal and Child Health Services Block Grant — $2.5 million

In fiscal year 1996, the federal government spent nearly $2.5 million ($2,487,000) through the Maternal and Child Health Services Block Grant to provide pregnancy and parenting services.

Program Description. Title V of the Social Security Act establishes the Maternal and Child Health Services Block Grant, the basic authorizing legislation for the Maternal and Child Health Bureau (MCHB). Title V is a federal/state partnership that supports and develops community-based programs to improve the health of mothers and children, ensure quality health care for families, and create safe and healthy communities.[32] The fiscal year 1996 appropriation for the Maternal and Child Health Block Grant was over $678 million ($678,204,000).

Eighty-five percent of the block grant passes directly to the states and 15 percent is reserved for the Maternal and Child Health Bureau to operate federal projects, such as Special Projects of Regional and National Significance (SPRANS), Community Integrated Service System (CISS), and the Healthy Tomorrows Partnership for Children Program. MCHB jointly funded 147 demonstration projects with the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration under the Pregnant and Postpartum Women and their Infants initiative.

Special Projects of Regional and National Significance (SPRANS) is a set-aside federal program to which approximately 15 percent of the Title V funds are allocated. Five categories of projects fall under SPRANS: (1) applied research; (2) training; (3) genetic disease testing, counseling, and information dissemination; (4) hemophilia diagnostic and treatment centers; and (5) maternal and child health improvement projects (MCHIPs). MCHIPs cover a range of activities and support the demonstration of innovative services and new techniques for the delivery of services. Several SPRANS programs address teen pregnancy prevention and services for pregnant and parenting teens.[33]

The **Community Integrated Service System (CISS)** program seeks to reduce infant mortality and improve the health of mothers and children, including those living in rural areas and those with special health needs. CISS supports projects to develop and expand integrated services at the community level. These systems are public/private partnerships of health-related and other organizations and individuals. The partnerships collaborate in using community resources to address community-identified health problems.[34]

The CISS program was authorized by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) as a separate set-aside federal program of the Maternal and Child Health Services Block Grant (Title V of the Social Security Act). It did not

become operational, however, until fiscal year 1992 when the total MCH Services Block Grant appropriation exceeded $600 million for the first time. Under OBRA 89, 12 ¾ percent of the appropriated amount above $600 million is earmarked for CISS projects. CISS program funds may be used for programs to support pregnant and parenting teens.[34]

Healthy Tomorrows Partnership for Children Program (HTPCP) is a collaborative effort of the federal MCHB and the American Academy of Pediatrics. HTPCP aims to ensure access to quality health care for all children and pregnant women by promoting innovative, community-based child health care projects. Of the 54 HTPCP projects funded in fiscal year 1996, 14 focus on improving the health status of adolescents. Community projects may offer primary or secondary pregnancy prevention programs and/or provide services to support families begun with a birth to a teen.[35]

Center for Substance Abuse Prevention's (CSAP) mission is to provide leadership in the federal effort to prevent alcohol, tobacco, and illicit drug problems that are also linked to other national problems such as teen pregnancy. CSAP connects people and resources to innovative ideas and strategies and encourages efforts to reduce and eliminate alcohol, tobacco, and illicit drug use problems in the United States and internationally. In a joint initiative with the MCHB, CSAP funds 147 demonstration projects. Several CSAP programs target teen parents.[36]

Adolescent Family Life (AFL) Program — $5.2 million

In fiscal year 1996, two-thirds of the Adolescent Family Life Program's total budget ($7,698,000) was dedicated to programs that support families begun by a birth to a teen. Advocates for Youth calculated that the federal government spent nearly $5.2 million ($5,157,660) on the Adolescent Family Life Program to provide programs for pregnant and parenting teens.

Program Description. The Adolescent Family Life (AFL) Program was enacted in 1981 as Title XX of the Public Health Service Act. AFL is administered by the Office of Adolescent Pregnancy Prevention in the U.S. Department of Health and Human Services. Funding for AFL is divided between pregnancy prevention initiatives and care programs for pregnant and parenting teens. AFL programs focus on developing and promoting abstinence-only programs and helping teens avoid sexual intercourse. In fiscal year 1996, the AFL program funded 17 projects in 14 states. Advocates for Youth included only those programs that focus on providing care services for pregnant and parenting teens in the expenditure calculation.[37]

Estimates of Federal Investments

Teen Pregnancy Prevention

Advocates for Youth calculated the total fiscal year 1996 federal investments by adding up the costs of resources allocated to those pregnancy prevention programs that specifically include adolescents as a target audience. Both primary and secondary teenage pregnancy prevention programs were included in the investment calculation. The various programs included in the investment calculation are discussed below.

Fiscal Year 1996 Federal Investments to Prevent Teenage Pregnancy	
Medicaid	$71.1 million
Healthy Schools, Healthy Communities (HSHC)	$1.3 million
Healthy People 2000 **(Preventive Health and Health Services Block Grant)**	$0.9 million
Community Health Center (CHC) Program	$0.2 million
Community Coalition Partnership Program for the Prevention of Teen Pregnancy (CCPPPTP)	$3.3 million
National Family Planning Program	$57.8 million
Maternal and Child Health Services Block Grant	$1.0 million
Adolescent Family Life (AFL) Program	$2.5 million
Total Federal Investments	**$138.1 million**[§§]

Medicaid — $71.1 million

In fiscal year 1996, the federal government invested over $440 million ($440,140,498) of the total Medicaid appropriations to provide family planning services to women of reproductive age (15 to 44-years-old). Sixteen percent of clients for Medicaid family planning services are young people ages 15 to 20. The federal government, therefore, invested nearly $71.1 million ($71,083,971) to provide family planning services for young people.

[§§] Columns may not total due to rounding.

Program Description. Title XIX of the Social Security Act (Medicaid) is an entitlement program that pays for medical assistance for vulnerable and needy individuals and families with low incomes and few resources. Medicaid is the largest source of funding for medical and health-related services for the United States' poorest people. In fiscal year 1996, Medicaid provided health care assistance to more than 36 million people.[28]

The Health Care Financing Administration, established under the U.S. Department of Health and Human Services), administers grants to the states to administer Medicaid benefits. The Medicaid program allows the states considerable flexibility within their Medicaid plans. However, the federal government requires states to provide basic services – such as general health care, prenatal care, vaccines for children, and family planning services and devices – to categorically needy populations. Groups eligible to receive Medicaid coverage include: recipients of Aid to Families and Dependent Children and Supplemental Security Income as well as pregnant women and children under age six whose family income is at or below 133 percent of the federal poverty level. Under the states' Child Health Insurance Program (CHIP), by the year 2002 all children will be covered who are under age 19 in families with incomes at or below the federal poverty level.[28]

Healthy Schools, Healthy Communities (HSHC) $1.3 million

In fiscal year 1996, a portion of the Healthy Schools, Healthy Communities program's total budget of $4.25 million ($4,250,000) was dedicated to providing health education on topics such as communication and decision-making skills as well as pregnancy and STD prevention. Advocates for Youth included only funds dedicated to health education in the investment calculation. The federal government, therefore, invested approximately $1.3 million ($1,300,000), or about 30 percent, of the total Healthy Schools, Healthy Communities budget on teen pregnancy prevention initiatives.

Program Description. In 1994, Congress established Healthy Schools, Healthy Communities (HSHC), the first federal program that specifically mandates the creation of school-based health centers. HSHC is administered federally by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. HSHC provides school-based, family-centered, primary care services, including diagnosis and treatment of acute and chronic illnesses, preventive health, and dental and mental health services. In fiscal year 1996, HSHC funded 26 projects in 20 states and serving approximately 23,000 students. Each of the 26 sites was permitted to use as much as $60,000 of its funding to provide health education.[38]

Healthy People 2000 (Preventive Health and Health Services Block Grant) — $0.9 million

In fiscal year 1996, the federal government invested over $0.9 million ($921,945) to address Objective 5.1 of *Healthy People 2000*: to reduce pregnancies among females ages 17 and younger. The Preventive Health and Health Services Block Grant provided $359,479 in funds for Objective 5.1 while the remaining $562,466 in funds came from other sources.

Program Description. The Centers for Disease Control and Prevention (CDC) operates one major program specifically to reduce teen pregnancy, the Preventive Health and Health Services Block Grant (Public Law 102-051). The block grant is given to 61 projects to address the Health Status Objectives in *Healthy People 2000*, the federal government's blueprint for raising Americans' health status through an organized focus on prevention. Objective 5.1 of *Healthy People 2000* specifies reducing pregnancies among 15- to 17-year-old females to no more than 50 per 1,000.[39]

Community Health Center (CHC) Program — $0.2 million

In fiscal year 1996, the federal government invested $0.2 million ($200,000) in teen pregnancy prevention via the Community Health Center (CHC) Program. Five CHCs participated in the Guidelines for Adolescent Prevention Services (GAPS) program. They provided teen clients at 11 sites with health education and guidance on various issues, including teen pregnancy prevention. Federal funds for evaluation of the Community Health Centers' GAPS program are also included in the investment calculation.

Program Description. The Community Health Center (CHC) Program is a federal grant program funded under Section 330 of the Public Health Service Act to provide for primary and preventive health care services for medically under served people in rural and urban U.S. communities. In fiscal year 1996, the community and migrant health center appropriation was consolidated to include homeless and housing programs. Funding for CHCs was approximately 85 percent of the consolidated appropriations – $758.1 million – in fiscal year 1996. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population. While services in each CHC are tailored to the needs of the community, most seek to improve access to comprehensive services for migrant and seasonal farm workers, people infected with HIV/AIDS, the elderly, the homeless, and substance abusers.[40]

Under a three-year pilot project, five CHCs implemented Guidelines for Adolescent Preventive Services (GAPS) to increase teens' access to services and

to prevent teen pregnancy. GAPS is the American Medical Association's set of recommendations that describes the content and delivery of comprehensive clinical preventive services for people ages 11 to 21, a population which is traditionally hard to reach. GAPS is unique because it emphasizes health guidance, which encompasses health education, health counseling, and anticipatory guidance.[41]

Community Coalition Partnership Program for the Prevention of Teen Pregnancy — $3.3 million

In fiscal year 1996, the federal government invested nearly $3.3 million ($3,250,000) in the Community Coalition Partnership Program for the Prevention of Teen Pregnancy. Each of the 13 communities received a grant of approximately $250,000 to organize their resources to support effective and sustainable teen pregnancy prevention programs.

Program Description. The Community Coalition Partnership Program for the Prevention of Teen Pregnancy (CCPPPTP) is a competitive, five-year program federally administered by the Centers for Disease Control and Prevention (CDC). CDC launched the program in 1995 by awarding grants in 11 states to 13 communities with high rates of teen pregnancy. CDC awarded each community about $250,000 per year for the first two years. The funds were used to strengthen existing community-wide coalitions and to develop action plans. The second phase began in fiscal year 1997, with a total of $13.7 million to help the 13 community coalition partnership programs implement their action plans and later evaluate their impact.

National Family Planning Program — $57.8 million

In fiscal year 1996, the federal government invested nearly $0.2 billion ($192,592,000) in the National Family Planning Program (Title X). About 30 percent of the population served by Title X family planning clinics were under the age of 20. The federal government, therefore, invested over $57 million ($57,777,600) to provide family planning services for young people.

Program Description. The National Family Planning Program, created in 1970 as Title X of the Public Health Service Act, is a categorical grant program that provides funding for comprehensive family planning services. The program is administered by the Office of Family Planning within the Office of Population Affairs, U.S. Department of Health and Human Services.[42]

Title X family planning service funds are allocated to 10 regional offices of the Department of Health and Human Services which solicit applications, manage a competitive review process, award grants, and monitor program performance. Grantees include states, family planning councils, and Planned Parenthood affiliates, among others. Nearly two-thirds of Title X service funds are awarded to state health departments.[42]

Maternal and Child Health Services Block Grant — $1.0 million

In fiscal year 1996, the federal government invested slightly over $1.0 million ($1,012,500) via the Maternal and Child Health Services Block Grant to support teen pregnancy prevention initiatives.

Program Description. The Title V of the Social Security Act establishes the Maternal and Child Health Services Block Grant, the basic authorizing legislation for the Maternal and Child Health Bureau (MCHB). Title V is a federal/state partnership that supports and develops community-based programs to improve the health of mothers and children, ensure quality health care for families, and create safe and healthy communities.[32] The fiscal year 1996 appropriation for the Maternal and Child Health Block Grant was over $678 million ($678,204,000).

Eighty-five percent of the block grant passes directly to the states and 15 percent is reserved for the Maternal and Child Health Bureau to operate federal projects, such as Special Projects of Regional and National Significance (SPRANS), Community Integrated Service System (CISS), and Healthy Tomorrows Partnership for Children Program. MCHB jointly funded 147 demonstration projects with the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration, under the Pregnant and Postpartum Women and their Infants initiative.

Special Projects of Regional and National Significance (SPRANS) is a set-aside federal program to which approximately 15 percent of the Title V funds are allocated. Five categories of projects: (1) applied research; (2) training; (3) genetic disease testing, counseling, and information dissemination; (4) hemophilia diagnostic and treatment centers; and (5) maternal and child health improvement projects (MCHIPs). MCHIPs cover a range of activities and support the demonstration of innovative services and new techniques for the delivery of services. Several SPRANS programs address teen pregnancy prevention and services for pregnant and parenting teens.[33]

The **Community Integrated Service System (CISS)** program seeks to reduce infant mortality and improve the health of mothers and children, including those

living in rural areas and those with special health needs. CISS supports projects to develop and expand integrated services at the community level. These systems are public/private partnerships of health-related and other organizations and individuals. The partnerships collaborate in using community resources to address community-identified health problems.[34]

The CISS program was authorized by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) as a separate set-aside federal program of the Maternal and Child Health Services Block Grant (Title V of the Social Security Act). It did not become operational, however, until fiscal year 1992 when the total MCH Services Block Grant appropriation exceeded $600 million for the first time. Under OBRA 89, 12 ¾ percent of the appropriated amount above $600 million is earmarked for CISS projects. CISS program funds may be used to support teen pregnancy prevention programs.[34]

Healthy Tomorrows Partnership for Children Program (HTPCP) is a collaborative effort of the federal MCHB and the American Academy of Pediatrics. HTPCP aims to ensure access to quality health care for all children and pregnant women by promoting innovative, community-based, child health care projects. Of the 54 HTPCP projects funded in fiscal year 1996, 14 focus on improving the health status of adolescents. Community projects may offer primary or secondary pregnancy prevention programs and/or provide services to support families begun with a birth to a teen.[35]

Center for Substance Abuse Prevention's (CSAP) provides leadership in the federal effort to prevent alcohol, tobacco, and illicit drug use problems which are also linked to other national problems such as teen pregnancy. CSAP connects people and resources to innovative ideas and strategies and encourages efforts to reduce and eliminate alcohol, tobacco, and illicit drug use problems in the United States and internationally. In a joint initiative with the MCHB, CSAP funds 147 demonstration projects. Teen parents are the target populations of several CSAP/MCHB programs. Advocates for Youth includes the federal funds for CSAP/MCHB programs in the expenditure calculation.[36]

Adolescent Family Life (AFL) Program — $2.5 million

In fiscal year 1996, one-third of the Adolescent Family Life Program's total budget ($7,698,000) was dedicated to teen pregnancy prevention initiatives. Advocates for Youth calculated that the federal government invested over $2.5 million ($2,540,340) in teen pregnancy prevention through the Adolescent Family Life Program.

Program Description. The Adolescent Family Life (AFL) Program was enacted in 1981 as Title XX of the Public Health Service Act. AFL is administered by the Office of Adolescent Pregnancy Prevention in the U.S. Department of Health and

Human Services. Funding for AFL is divided between pregnancy prevention initiatives and care programs for pregnant and parenting teens. AFL programs focus on developing and promoting abstinence-only programs and helping teens avoid sexual intercourse. In fiscal year 1996, the AFL program funded 17 projects in 14 states. Advocates for Youth included only those programs that focus on teen pregnancy prevention initiatives in the investment calculation.[37]

Fiscal Year 1996 Federal Expenditures to Support Families Begun with a Birth to a Teen	
Medicaid	$18.4 billion
Aid to Families with Dependent Children (AFDC)	$7.0 billion
Food Stamp Program	$10.6 billion
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	$2.0 billion
Social Services Block Grant (SSBG)	$11.9 million
Maternal and Child Health Services Block Grant	$2.5 million
Adolescent Family Life (AFL) Program	$5.2 million
Total Federal Expenditures	**$38.0 billion**[***]

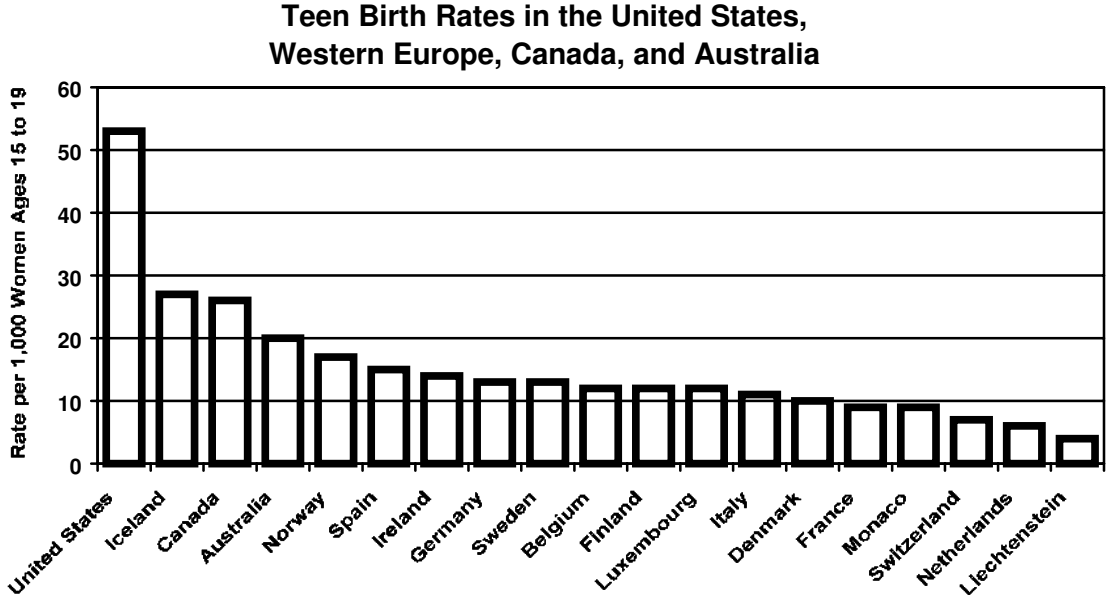
Fiscal Year 1996 Federal Investments to Prevent Teenage Pregnancy	
Medicaid	$71.1 million
Healthy Schools, Healthy Communities (HSHC)	$1.3 million
Healthy People 2000 **(Preventive Health and Health Services Block Grant)**	$0.9 million
Community Health Center (CHC) Program	$0.2 million
Community Coalition Partnership Program for the Prevention of Teen Pregnancy (CCPPPTP)	$3.3 million
National Family Planning Program	$57.8 million
Maternal and Child Health Services Block Grant	$1.0 million
Adolescent Family Life (AFL) Program	$2.5 million
Total Federal Investments	**$138.1 million**[***]

[***] Columns may not total due to rounding.

Conclusion and Recommendations

A comparison of federal expenditures and investments during fiscal years 1995 and 1996 indicates that the federal government *decreased* its expenditures to support families which began with a birth to a teen by $1.2 billion ($1,233,858527) actual dollars. This represents a three percent decrease. In constant 1996 dollars, the federal government decreased it expenditures to support families which began with a birth to a teen by $2.4 billion ($2,392,286,632) – a decrease of slightly more than six percent.[†††] Advocates for Youth calculates that between federal fiscal years 1995 and 1996, the federal government *increased* its investment in teen pregnancy prevention by about $7.5 million ($7,567,206) actual dollars – an increase of six percent. About $5 million of new investments in teen pregnancy prevention provided access to contraceptive services for sexually active teens. In constant 1996 dollars, the federal government increased its investment by $3.7 million ($3,716,891) – an increase of *less than three* percent.[†††]

Advocates for Youth applauds the increase in federal investments to prevent teenage pregnancy. However, Advocates cautions that current levels of funding are not enough to bring the United States' teen pregnancy and birth rates into line with those of other industrialized nations. The United States continues to have the highest teen pregnancy and birth rates in the industrialized world despite current reductions in teen pregnancy, birth, and abortion rates. The chart below compares recent birth rates in the United States, Western Europe, Canada, and Australia:[2,12]



The federal government should substantially increase its investment in *effective* teen pregnancy prevention programs. Investment in abstinence-only programs that exclude information about contraception wastes precious resources. To date, these programs have

[†††] Constant dollar adjustments were made using the overall Consumer Price Index for urban consumers (CPI-U).

been proven ineffective in delaying the initiation of sexual intercourse and/or in decreasing sexual risk-taking behaviors among sexually active youth.

Additionally, increased investments to prevent teen pregnancy should not be made at the expense of programs to help needy families. Indeed, since research clearly demonstrates that poverty and lack of opportunity are the *causes* as much as the consequences of teenage pregnancy, the long-term cost to individuals and society of inadequate funding to assist needy families is clear. Reductions in federal expenditures to support families in need may lead to spiraling rates of poverty, higher school dropout rates, and increased teenage birth rates.

Recommendations

- **Increase Federal Investments in Effective Programs**

This report underscores the clear need for increased public commitment to preventing teen pregnancy. In fiscal year 1996, the federal government spent over **$38.0 billion** to provide services and support to families that began with a birth to a teen and invested **$138.1 million** – *275 times less* – to prevent teen pregnancy. Increased federal investments in ***effective*** public health programs and strategies to reduce teen pregnancy could strengthen the welcome trends in lowered rates of adolescent pregnancy, abortion, and birth and could lessen the serious causes and consequences associated with too-early pregnancy and childbearing. Moreover, federal investments could reduce the percentage of teens requiring support in the future.

- **Focus on Effective Prevention Strategies**

Adolescents need teen pregnancy prevention strategies and programs that are based on the best, most effective practices as determined by evaluation and research. Effective prevention strategies include:

- Accurate, balanced, and realistic sexuality education
- Youth development
- Confidential, low-cost access to contraceptive services.

- **Continue Support for Needy Families**

While the federal government should increase its funding to prevent teenage pregnancy, the increased investments should not be achieved by cutting expenditures to support families in need. Because poverty and lack of hope for a productive future are the causes as much as the consequences of adolescent pregnancy, supporting families in need can also be a significant part of the effort to reduce teenage pregnancy and too-early childbearing.

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Appendix A: Percent Change in Teen Birth Rate per 1,000 Women Ages 15 to 19: 1991-1996, State-by-State Ranking

Rank	State	1991 Teen Birth Rate	1996 Teen Birth Rate	% Change
1	Alaska	65	46	-29
2	Maine	44	31	-28
3	Vermont	39	30	-23
4	Michigan	59	47	-21
5	Wyoming	54	44	-19
6	Hawaii	59	48	-18
7	Montana	47	39	-17
7	South Dakota	48	40	-17
7	Missouri	65	54	-17
7	Ohio	61	50	-17
11	Pennsylvania	47	39	-16
11	Washington	54	45	-16
11	California	75	63	-16
11	Wisconsin	44	37	-16
15	Maryland	54	46	-15
15	Virginia	54	46	-15
15	Colorado	58	50	-15
15	New Jersey	42	35	-15
15	Massachusetts	38	32	-15
20	Florida	69	59	-14
20	New Hampshire	33	29	-14
20	Minnesota	37	32	-14
20	South Carolina	73	63	-14
24	West Virginia	58	50	-13
*	**UNITED STATES**	**62**	**54**	**-12**
25	Idaho	54	47	-12
25	Louisiana	76	67	-12
25	Tennessee	75	66	-12
25	Oklahoma	72	63	-12
25	Illinois	65	57	-12
25	Mississippi	86	76	-12

Rank	State	1991 Teen Birth Rate	1996 Teen Birth Rate	% Change
31	Iowa	43	38	-11
31	Utah	48	43	-11
31	New Mexico	80	71	-11
31	District of Columbia	114	102	-11
31	Kentucky	69	62	-11
31	Georgia	76	68	-11
31	Kansas	55	50	-11
38	North Carolina	71	64	-10
39	North Dakota	36	32	-9‡‡‡
39	New York	46	42	-9
39	Nebraska	42	39	-9
42	Arizona	81	74	-8
42	Nevada	75	70	-8
42	Oregon	55	51	-8
45	Connecticut	40	37	-7
45	Indiana	61	56	-7
45	Delaware	61	57	-7‡‡‡
45	Texas	79	74	-7
49	Rhode Island	45	43	-6‡‡‡
49	Alabama	74	69	-6
49	Arkansas	80	75	-6

‡‡‡ Not significant at $p < .05$.

Ventura SJ, Mathews TJ, Curtin SC. Declines in teenage birth rates, 1991-1997: national and state patterns. *National Vital Statistics Report* 1998; 47(12):1-16.

Ranking system used in the chart is based on: Annie E. Casey Foundation. *When Teens Have Sex: Issues and Trends*. Baltimore, MD: The Foundation, 1998.

Appendix B: Expenditures and Investments Cost Formulas

Expenditures Cost Formula.[§§§] Advocates for Youth used the following cost formula to calculate the total fiscal year 1996 federal expenditures to support families in which the first birth occurred while the mother was a teenager.

Fiscal Year 1996 Expenditures		TOTAL
Medicaid	{[(Annual number of adult Medicaid recipients eligible based on AFDC status) x (Average annual Medicaid outlay per AFDC adult)] + [(Annual number of child Medicaid recipients eligible based on AFDC status) x (Average annual Medicaid outlay per AFDC child)]} x (55%[****])	**= A**
Medicaid (Administrative Costs)	(Medicaid total administrative costs) x (55%[****])	**= B**
Aid to Families with Dependent Children (AFDC)	(AFDC expenditures) x (55%[****])	**= C**
Food Stamp Program	(Average monthly number of Food Stamp recipients) x (Average monthly Food Stamp allocation) x (% of AFDC recipients also receiving Food Stamp Program) x (12 [months]) x (47%[****])	**= D**
Food Stamp Program (Administrative Costs)	(Food Stamp Program total administrative costs) x (47%[****])	**= E**
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	(Total WIC budget) x (55%[****])	**= F**
Social Services Block Grant (SSBG)	(Total SSBG funding level) x (% of SSBG funds dedicated to programs for pregnant and parenting teens)	**= G**
Maternal and Child Health Services Block Grant	(Total MCH budget) x (% of MCH budget dedicated to programs for pregnant and parenting teens)	**= H**
Adolescent Family Life (AFL) Program	(Total AFL budget) x (% of AFL budget dedicated to programs for pregnant and parenting teens)	**= I**

Total Expenditures = (A + B + C + D + E + F + G + H + I)

[§§§] The expenditures cost formula is adapted from *Expenditures and Investments: Adolescent Pregnancy in the South, Volume II* (1997).

[****] Estimated percent of recipients who were teens at the birth of their first child and/or children of families begun by a teenage birth.

Investments Cost Formula. Advocates for Youth used the following cost formula to calculate the total fiscal year 1996 federal investments in the prevention of teenage pregnancy.

Fiscal Year 1996 Investments		TOTAL
Medicaid	(Total Medicaid appropriations for family planning) x (% recipients of Medicaid family planning who are teens)	**= A**
Healthy Schools, Healthy Communities (HSHC)	(Total HSHC appropriations dedicated to health education in each site) x (Number of HSHC sites providing health education)	**= B**
Healthy People 2000 **(Preventive Health and Health Services Block Grant)**	(Total budget dedicated to Objective 5.1 of *Healthy People 2000*)	**= C**
Community Health Center (CHC) Program	(Total CHC budget dedicated to implement GAPS)	**= D**
Community Coalition Partnership Program for the Prevention of Teen Pregnancy (CCPPPTP)	(Total CCPPPTP grant awarded to each community) x (Number of CCPPPTP communities)	**= E**
National Family Planning Program	(Total Title X appropriations) x (% recipients of Title X services who are teens)	**= F**
Maternal and Child Health Services Block Grant	(Total MCH budget) x (% of MCH budget dedicated to teen pregnancy prevention)	**= G**
Adolescent Family Life (AFL) Program	(Total AFL budget) x (% of AFL budget dedicated to teen pregnancy prevention)	**= H**
Total Investments = (A + B + C + D + E + F + G + H)		

Appendix C: Key Differences Between AFDC and TANF[††††] [‡‡‡‡]

	AFDC/EA/JOBS (before 1997)	TANF (after 1997)
Federal Funding	• Unlimited for AFDC and EA • Capped entitlement for JOBS • Federal share of AFDC and JOBS costs varied inversely with state per capita income	• Fixed grant • Plus: (1) contingency fund and loans for states with high population growth and low welfare spending; (2) welfare-to-work grants (through FY 2003); and (3) bonuses to states that reduce the number of out-of-wedlock births and abortions
State Funding	• Matching required for each federal dollar	• States must spend 75 percent of "historic" level (100 percent for contingency funds) and must provide matching for contingency funds
Categories Eligibility	• Children with one parent or with an incapacitated or unemployed second parent	• Set by state
Income Limits	• Set by state	• Set by state
Benefit Levels	• Set by state	• Set by state
Entitlement	• States required to aid all families eligible under state income standards	• TANF expressly denies entitlement to some individuals
Work Requirement	• JOBS Program had participation requirements, but not work requirements	• By 2002, states must have 50 percent of their caseload in specified work activities
Exemptions from Work Requirement	• Parents (chiefly mothers) with a child under age three (under age one at state option)	• None, but states may exempt single parents caring for children under age 1
Work Trigger	• None	• Work (as defined by the state) required after a maximum of two years of benefits
Time Limit for Benefits	• None	• Five-year time limit (20 percent hardship exceptions allowed)

KEY	
AFDC	Aid to Families with Dependent Children
EA	Emergency Assistance for Needy Families
JOBS	Job Opportunities and Basic Skills Training
TANF	Temporary Assistance for Needy Families

[††††] Advocates for Youth used figures associated with AFDC to calculate fiscal year 1996 expenditures and investments because federal fiscal year 1998 was the first full year that all states implemented TANF, the new cash welfare program.

[‡‡‡‡] United States. House of Representatives, Committee on Ways and Means. *1998 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means.* Washington, DC: U.S. Govt. Printing Office, 1998.

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