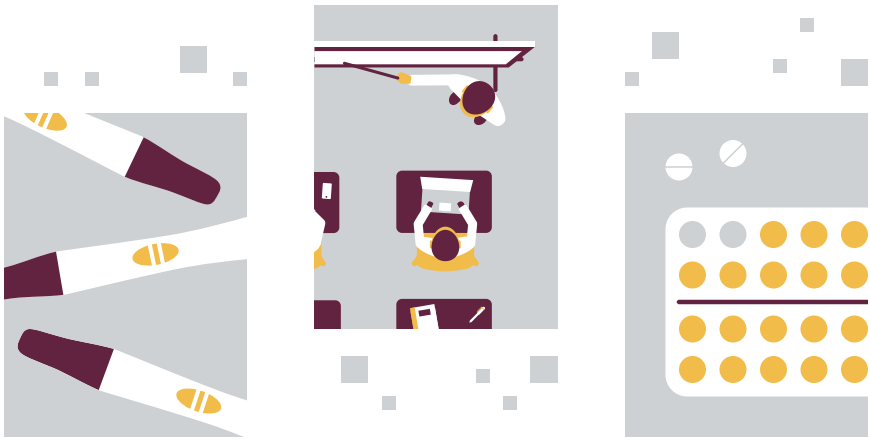
17. TEEN PREGNANCY PREVENTION PROGRAMS

A Tale of Persistence

Andrea Kane is the vice president for policy and strategic partnerships at Power to Decide.

Rachel Fey is the policy director at Power to Decide.

G. William Hoagland is a senior vice president for the Bipartisan Policy Center. He is currently a council member at Power to Decide and previously worked as the Republican director of the Senate Budget Committee.



Teen pregnancy can have a wide range of health, social, educational, and economic consequences for young people. Policymakers long ago decided that reducing these preventable consequences for adolescents was a priority. But despite considerable progress, teen pregnancy and birth rates in the United States remain higher than most other developed countries, and racial/ethnic, geographic, and socioeconomic disparities persist within the United States, suggesting there is room for more progress.[1,2,3]

Beginning in 2009, federal policymakers began a new evidence-backed effort to invest in educational programs related to teen pregnancy prevention. The federal government created two complementary programs: the Teen Pregnancy Prevention (TPP) Program and the Personal Responsibility Education Program (PREP).[4] The programs have a shared goal—to reduce teen pregnancies—but operate with different grant-making structures and strategic coordination to achieve public-policy objectives. Creating the programs was a major milestone. Previously, the only dedicated federal funding for reducing teen pregnancy was not based on criteria about effectiveness; it was based exclusively on content, namely abstinence-only approaches.

While Congress has introduced bipartisan legislation since 1999 to fund evidence-based programs and build knowledge about effective strategies, TPP and PREP were the first to gain traction.[5] They were propelled by the broader movement toward evidence-based policymaking.

Nearly a decade after the launch of TPP and PREP, these two programs provide vital information and skills to some of the most marginalized youth in the country. They also contribute to producing knowledge about effective teen pregnancy prevention efforts. These programs offer important lessons both for the power of using evidence to inform policymaking and the potential obstacles that can derail these programs and others informed by evidence.

ISSUE BACKGROUND

Both TPP and PREP are examples of tiered evidence-based programs. Tiered evidence is a framework typically applied to grant-making where policymakers allot a share of program funds to replicate models based on evidence of effectiveness in past studies. Policymakers allocate other funds to further strengthen evidence about other potentially effective models (to distinguish from the overall TPP and PREP programs or funding streams, we use "model" to refer to a specific curricula or educational program that has been or can be evaluated to assess impacts). As a result, most funding supports replication of successful models, while the broader program continues to build the overall evidence base through high-quality evaluation, continuous improvement, and innovation.

Teen Pregnancy Prevention Program

TPP is administered by the U.S. Department of Health and Human Services (HHS) Office of Adolescent Health. In TPP's first year, the program received a $110 million appropriation. In the subsequent nine years, Congress appropriated between $98 million and $101 million for the program.

In order to support strong TPP implementation and assessment, up to 10 percent of program funding can be used for training and technical assistance, evaluation, and program support. Of the remaining funds, 75 percent is available for "replicating programs that have been proven effective through rigorous evaluation" to reduce teenage pregnancy and other relevant behavioral risk factors. This funding is awarded competitively to what are called "Tier 1 grants." Tier 1 grantees can select from a broad array of previously evaluated models that best meet the needs of their communities. As part of the selection process, some grantees choose models with a focus on abstinence, others choose models that teach about both abstinence and contraception. Still others focus on youth development, parent-teen communication, or healthy relationships. What these have in common is an objective, high standard of evidence.

Recognizing the continued need for innovation as the characteristics and behaviors of adolescents change over time, an additional 25 percent of TPP funding supports competitive grants to develop, replicate, refine, and test additional strategies (called "Tier 2 grants").[6] A wide variety of organizations, including universities, local health departments, faith-based organizations, and community organizations, administer both the Tier 1 and Tier 2 competitive grants.

Personal Responsibility Education Program

The HHS Administration on Children, Youth, and Families administers PREP. The program receives $75 million annually to educate adolescents on both abstinence and contraception—with the goal of preventing pregnancy and sexually transmitted infections. The program also supports activities that prepare adolescents for adulthood, including topics such as maintaining healthy relationships, communicating with parents, and developing financial literacy.[7]

PREP focuses on youth at greatest risk of teen pregnancy (including foster youth, homeless youth, youth with HIV/AIDS, youth who are victims of human trafficking, and youth under 21 years of age who are pregnant or parenting) and geographic areas with high teen birth rates.[8] Most funding is formulaically allocated to states to replicate programs with existing research proving they are effective at changing behaviors (that is, delaying sexual activity, improving use of birth control, or reducing pregnancies). While the evidence criteria for PREP is slightly more flexible than for TPP, states take the commitment to evidence seriously, and they dedicated over 90 percent of their grant funding for models from the HHS evidence review.

Consistent with a tiered framework, in order to support innovation, HHS awards $10 million for organizations to compete to develop and test innovative strategies (PREP's version of Tier 2).[9] In addition, HHS sets aside $3.5 million annually for grants to Indian tribes or tribal organizations. Similar to TPP, PREP reserves 10 percent of its funding for training and technical assistance, evaluation, research, and dissemination of promising practices to reduce teen pregnancy.[10]

Together, the complementary TPP Program and PREP—with a combined investment of $185 million—serve nearly 350,000 youth annually.[11,12] The programs strengthen the capacity of states, tribes, and communities to replicate, implement, and evaluate evidence-based programs. Importantly, the programs generate useful results about what works to reduce teen pregnancy for different youth and in different settings.

Given the nature of these programs, and a historical focus on abstinence-only approaches, policymakers sometimes view these activities with an ideological perspective, rather than predominantly through a lens of funding the most effective approaches.

EVIDENCE AVAILABILITY

Before 2010, Congress did not appropriate federal funding to evidence-based approaches to reduce teen pregnancy. Evidence building began with private, philanthropic, and academic commitments.

Systematic reviews

In 1997, the National Campaign to Prevent Teen Pregnancy (now Power to Decide) commissioned an evidence review of effective strategies for preventing teen pregnancy.[13] The review found that, with a few exceptions, most studies assessing the impact of programs to reduce teen sexual risk-taking failed either to measure or to find sustained long-term impacts on behavior. A subsequent research review in 2001 identified additional research about programs that sustained positive behavioral effects.[14] The review offered stakeholders a few identified effective strategies; but finding funding for such programs was a challenge. By 2007, 15 strategies demonstrated evidence of positive and meaningful impacts on reducing adolescent sexual behavior, pregnancy, or sexually transmitted disease (STD).[15]

To support implementation of TPP and PREP, HHS commissioned an independent, systematic, and rigorous review of evaluation studies to establish the HHS Teen Pregnancy

Prevention Evidence Review.[16] The initial HHS effort in 2010 reviewed hundreds of studies of individual models and identified 28 that changed teens' sexual behavior or teen pregnancy. Because the HHS Evidence Review identified the models, they were eligible for use by grantees as part of TPP's Tier 1.

HHS regularly updates the Evidence Review to incorporate new research, including from TPP and PREP grantees as well as from other sources. The menu of effective models continues to grow and reached 48 in April 2018.[17] This expanding menu gives communities more options to best meet the needs of particular young people and implementation sites. For example, some communities want to provide longer-term strategies, while others are looking for relatively quick interventions. Communities may need models that are developmentally appropriate for youth in middle school, high school, or out of school. Or, they may want to focus on underserved or high-risk populations, such as youth in foster care or the juvenile justice system.[18] To assist program grantees and others in the field to select appropriate models that fit their needs, HHS offers a searchable database that categorizes models by populations, settings, and other characteristics, along with training and technical assistance for grantees, including online resources.[19,20]

Changing human behavior is hard, and so is conducting rigorous evaluation that detects such changes. Against this backdrop, the evidence generated from TPP and PREP to date is impressive in its scope, process, and results. In 2017, the bipartisan U.S. Commission on Evidence-Based Policymaking highlighted TPP as an example of a federal program developing increasingly rigorous portfolios of evidence.[21]

Evidence generated by TPP and PREP grantees

It is ambitious and can even be risky for a government-funded social program to make research about its effectiveness publicly available. Releasing the results of what worked, and what did not, then using that knowledge to inform current projects could lead to perceptions about program failure, as well as concern among program developers and grantees about exposing their efforts to rigorous evaluation when evaluations do not produce the expected results. These programs illustrate both the benefits and risks, especially in an environment where ideological views about program content run strong, despite the focus on evidence.

Grantees conducted the first round of 41 grantee evaluations of 32 individual models from 2010 through 2015. All of the evaluations used experimental research designs to determine program impacts. HHS released the final results in 2016. Of the models evaluated, one-third were part of TPP's Tier 1. Through Tier 1 evaluations, evidence-based teen pregnancy prevention models could be replicated and evaluated in different settings or with different populations than prior evaluations. Four of the 10 models positively impacted behavior in Tier 1.

Grantees rigorously tested another 22 models as part of TPP's and PREP's Tier 2 grants, including evaluating new and innovative approaches.[22] Eight of the 22 models tested in Tier 2 were effective. As a result of the number of evaluations, several academic journals dedicated volumes to discussing both TPP and PREP. These included articles about program results as well as implementation and evaluation lessons.[23,24,25]

These conclusions must also be met with caution about how effective grantees were overall. Of all the models evaluated as part of the first-round research, 12 out of 32 (38 percent) showed positive impacts. This is well above the 10 to 20 percent of rigorous evaluations (typically experimental evaluations with random assignment) that experts say typically demonstrate positive results. In addition, 13 of the 41 individual studies were inconclusive because of implementation challenges or methodological limitations (note: Grantees evaluated some of the 32 models in more than one place, which is why there were 41 studies of 32 models).[26] This illustrates a challenge for conducting impact evaluations, especially with smaller or underserved populations, such as rural or Native American teens, where getting adequate sample sizes can be difficult. But the grantees collectively contributed to developing a robust new body of research and evaluation to support future implementation of the tiered evidence framework in TPP and PREP.

EVIDENCE USE

In keeping with the tiered evidence framework for the programs, lessons and insights gained from existing evaluations immediately began to feed back into the future cycles of funding for TPP and PREP. HHS uses evidence as a criterion to award funding, and in turn, HHS expects the programs to continue generating new evidence. After completing the grantee evaluations, HHS shared the results and the Office of Adolescent Health actively encouraged the second round of TPP Tier 1 grantees awarded in 2015 to shift toward replicating the most effective models based on the latest knowledge about what works best in different contexts. Grantees adjusted their plans, which resulted in a stronger mix of models than grantees used in the first round.[27] In addition, the Tier 2 evaluations from the first round contributed to eight new models that met Tier 1 standards, and current Tier 1 grantees are now replicating some of those models.

The misuse of the evidence

Despite longstanding bipartisan support for TPP and PREP and recognition by experts that these programs are strong examples of a tiered evidence framework that have contributed to evidence building, the Donald Trump administration has tried to make dramatic changes to TPP. While they have had mixed success in doing so, an unfortunate theme in the administration's actions is a misuse of evidence—including mischaracterizing results, using evidence as a weapon rather than a tool, and using lower standards of evidence than Congress intended. First, the administration proposed cutting the program funding, though Congress did not agree and continued to fund the program. Second, HHS abruptly cut short the final two years of the second round of five-year grants, without providing grantees notice or explanation. The reaction from Congress and program advocates was swift, raising questions about the rationale for the decision.[28] In addition, four federal judges ruled that shortening the grants was illegal and funding was ultimately restored for the last two years of the grants.[29] Third, HHS took steps through a new funding opportunity announcement to redirect TPP funding to grants with lower standards of evidence and evaluation than Congress intended and that the past administration had used. This too raised objections from some members of Congress, and two courts found the Tier 1 funding opportunity announcement illegal.[30]

In trying to justify shortening the second round of grants, the Trump administration responded by citing results from the first round of grantee evaluations, claiming that TPP failed or may have even harmed young people. In fact, the decisions had been based on longstanding pressure from advocates in outside groups—some of whom ended up in the administration—who called for defunding TPP and instead funding what was previously called abstinence-only programs, now rebranded as "sexual risk avoidance," or SRA (typically described in statutes as programs that urge young people to "refrain from non-marital sexual activity").[31]

Stakeholders noted that the Trump administration mischaracterized the results and lacked context for what researchers typically expect to find when replicating rigorous evaluations.[32] So while "using" some of the existing evidence in their assertions, the uses did not reflect widely accepted stakeholder and evidence experts' perspectives of the overall TPP success or design to improve and expand use of effective models. Moreover, they misused results from individual evaluations to claim the overall TPP Program failed, when in fact learning what does and does not work is part of an evidence-based program's goal. In addition, they misused results from prior evaluations as a weapon to justify cutting current grants that had been strengthened by learning from those results and were in the process of generating new evidence.

Meanwhile, PREP has not faced the same kind of challenges. In contrast to TPP, the administration supports continued funding,[33] and Congress continues to fund it as part of a package that includes parallel funding for abstinence or SRA grants to states. So far, the administration has not made visible efforts to redirect the program focus or use of evidence.

LESSONS

- ***Incorporating evidence early on can deter partisanship.*** The fact that funding levels and legislative language governing both TPP and PREP remained fundamentally consistent for nine years, with bipartisan support in Congress—and continued despite efforts to undermine TPP—is a testament to the power of an approach that incorporates evidence into the policymaking and practices of grantees. At the same time, TPP offers a cautionary tale of how ideology can potentially derail efforts to use evidence during program implementation and how evidence can be misused in the pursuit of ideological objectives.
- ***Programs cannot let the fear of potential findings stop them from evaluating in the first place.*** A commitment to rigorous evidence standards and evaluation is hard and involves risk for programs, model developers, and researchers. If those involved fear that the result of any rigorous evaluation that does not demonstrate a positive impact will be weaponized against that model or even an entire program, they will be far less likely to subject their models and programs to this rigorous evaluation in the first place. The evidence-based policy movement has more work to do to

manage expectations and put results in context—even before evaluations begin. Doing so will help to build a safe space for evidence and evaluation. TPP was the first of the federal tiered-evidence programs to do a large-scale release of evaluation results. Experts and advocates had to work hard to put the results in context after completing the evaluations. Managing expectations from the start about the meaning of the results might have mitigated some of the misuses of available evidence. Policymakers, the press, and the public do not always understand that a lack of positive impact is common in rigorous evaluations and that what appears to be failure can actually be part of a success story. Indeed, people frequently misconstrue the difference between null results (no statistically significant positive or negative impact) and negative results. In the case of TPP, several studies had null results, but only a handful had negative results. Evidence-based policymaking is about learning from what does and does not work, and then using that data to inform the focus of future efforts, again and again. It is an iterative process. Similarly, it is important to clearly differentiate between the success of overall programs such as TPP and PREP—which are clearly examples of high-quality, evidence-based policymaking—and individual models that are evaluated within these programs.

- ***Instilling a culture of continuous learning.*** A steadfast commitment to continuous improvement and learning from results is essential if the American public is to see the full benefit of evidence-based policymaking. It requires patience on the part of policymakers and other stakeholders to ensure programs have the time and sustained investments to learn from results and build on them, rather than cutting off research midstream or declaring programs a failure before results from ongoing replications and research are available. For example, the past Tier 2 grants have already yielded impressive new evidence to help meet the changing needs of young people, and those underway have the potential to yield even more evidence if program disruptions do not compromise the research.

- ***Building evidence is not cheap, but it can be worth it.*** Supporting and scaling a tiered evidence program such as TPP or PREP in multiple sites and with a diverse array of grantees with different levels of evaluation expertise cannot be done on the cheap. It requires an investment in training, technical assistance, and capacity building; it also benefits from opportunities for grantees to share best practices and to learn from each other.

- ***Evidence can solve problems but not change beliefs.*** Even evidence-based programs are affected by ideology and values in political decision-making processes. When a favorite model is subjected to rigorous evaluation, you might not like the results. For example, some popular models that teach both abstinence and contraception to young people did not replicate the strong results shown in earlier evaluations. Asking those tough questions, and not always liking the results, is critically important. The stakeholders of the program have to continually support the process of learning and adjust accordingly. Keeping the focus on evidence and results, rather

than on a particular ideology or approach to content, helped broaden political buy-in for TPP. For example, some conservative policymakers found it extremely helpful to know that some programs that taught about both abstinence and contraception helped young people wait longer to have sex. In other words, abstinence was a behavioral result of programs that were not abstinence-only. Even if both sides do not love everything about the program, when it is framed as an evidence-based program rather than one defined by content, policymakers on both sides of the aisle have more cover to support the program—or to at least take a neutral stance.

- ***Teaching evidence-based policymaking is just as important as doing it.*** Educating key audiences about what evidence-based policymaking is and what it means—everyone from policymakers, press, and the public—helps explain a program's story and impact better. TPP and PREP grantees had to learn how to explain the "what" of their work and tell that story to policymakers, the press, and the public in a credible way. ■

1 U.S. Centers for Disease Control and Prevention. "Reproductive Health: Social Determinants and Eliminating Disparities in Teen Pregnancy." Last reviewed January 28, 2019. Available at: https://www.cdc.gov/teenpregnancy/about/social-determinants-disparities-teen-pregnancy.htm.

2 International Comparisons. "International Teen Pregnancy Statistics." Available at: http://internationalcomparisons.org/social/teen-pregnancy.html.

3 United Nations Statistics Division. *Demographic Yearbook 2003* (New York: United Nations, 2015), 331-353.

4 Adrienne L. Fernandes-Alcantara. *Teen Pregnancy: Federal Prevention Programs*. U.S. Library of Congress. Congressional Research Service, R45183, 2018. Available at: https://fas.org/sgp/crs/misc/R45183.pdf.

5 *See for example:* Teenage Pregnancy Reduction Act of 1999 (H.R. 1636) in the 106th Congress; Preventing Teen Pregnancy Act (H.R. 3581) in the 110th Congress; and Putting Prevention First Act (S. 2336 and H.R. 4192) in the 108th Congress.

6 *Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019*. Public Law 115-245, 2019.

7 Personal Responsibility Education, U.S. Code 42 §§ 713, and *Bipartisan Budget Act of 2018*. Public Law 115-123, 2018.

8 While TPP funding announcements and guidance also focus on high need populations and communities, the PREP statute specifically mentions these groups.

9 Administration for Children and Families. "Personal Responsibility Education Innovative Strategies Program (PREIS)." Family & Youth Services Bureau. Available at: https://www.acf.hhs.gov/fysb/programs/adolescent-pregnancy-prevention/programs/preis.

10 For a thorough review of the history of TPP Program and PREP, see CRS report below as well as the funding for abstinence and sexual-risk avoidance programs. Adrienne L. Fernandes-Alcantara. *Teen Pregnancy: Federal Prevention Programs*. U.S. Library of Congress, Congressional Research Service, R45183, 2018.

11 For the latest numbers from TPP, see: U.S. Department of Health and Human Services. "Performance Measures Snapshot: The Teen Pregnancy Prevention Program: Performance in Fiscal Year 2017 (Year 2)." Office of Adolescent Health, October 2017. Available at: https://www.hhs.gov/ash/oah/sites/default/files/tpp-performance-measures-year-2-brief.pdf.

12 For the latest numbers from PREP, see: Adrienne L. Fernandes-Alcantara. *Teen Pregnancy: Federal Prevention Programs*. U.S. Library of Congress, Congressional Research Service, R45183, 2018, 26.

13 Doug Kirby. *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy*. National Campaign to Prevent Teen and Unplanned Pregnancy, 1997.

14 Doug Kirby. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*. National Campaign to Prevent Teen Pregnancy, 2001.

15 Doug Kirby. *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. National Campaign to Prevent Teen and Unplanned Pregnancy, 2007.

16 U.S. Department of Health and Human Services. "Welcome to the Teen Pregnancy Prevention Evidence Review." Available at: https://tppevidencereview.aspe.hhs.gov/. The Office of the Assistant Secretary for Planning and Evaluation manages this evidence review; it is consistent with best practices in the evidence field and is included in the Pew-MacArthur Results First Clearinghouse Database.

17 Julieta Lugo-Gil, et al. *Updated Findings from the HHS Teen Pregnancy Prevention Evidence Review: August 2015 through October 2016*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2018.
Available at: https://tppevidencereview.aspe.hhs.gov/pdfs/Summary_of_findings_2016-2017.pdf.

18 The profiles of grantees published by the Office of Adolescent Health reflects the diversity of approaches. *See*: U.S. Department of Health and Human Services. "TPP Successful Strategies." Office of Adolescent Health. Last reviewed December 15, 2016. Available at: https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/successful-strategies.

19 U.S. Department of Health and Human Services. "Teen Pregnancy Prevention Evidence Review: Programs." Available at: https://tppevidencereview.aspe.hhs.gov/EvidencePrograms.aspx.

20 U.S. Department of Health and Human Services. "Using Evidence-based Programs." Available at: https://www.hhs.gov/ash/oah/resources-and-training/tpp-and-paf-resources/using-evidence-based-programs/index.html.

21 U.S. Commission on Evidence-Based Policymaking. *The Promise of Evidence-Based Policymaking*. U.S. Commission on Evidence-Based Policymaking, 2017.
Available at: http://cep.gov/content/dam/cep/report/cep-final-report.pdf.

22 Amy Feldman Farb and Amy L. Margolis. "The Teen Pregnancy Prevention Program (2010-2015): Synthesis of Impact Findings." *American Journal of Public Health*, 106(S1): S9-S15, 2016.

23 Ibid.

24 Andrea Kane. "Adolescent Pregnancy Prevention in Undeserved Populations: The Way Forward." *American Journal of Public Health*, February 27, 2018. Available at: https://ajph.aphapublications.org/toc/ajph/108/S1.

25 Evelyn Kappeler. "Building the Evidence to Prevent Adolescent Pregnancy." *American Journal of Public Health*, 106(S1), September 2016.

26 Ron Haskins and Andrea Kane. *The Trump Administration Deals a Blow to Evidence-Based Policy*. Evidence-Based Policymaking Collaborative, October 2018.

27 Ibid, 7-8, 15-16. The mix of programs shifted in three ways. First, one model (the Teen Outreach Program), which the first cohort widely replicated without successfully replicating results in most new settings, was used only on a very limited basis in the second cohort. Second, the evidence review added a number of new models based on emerging evidence from Tier 2 evaluations in the first cohort that were then selected for replication as Tier 1 projects in the second cohort. (For example, at least nine TPP sites are replicating a new Tier 1 healthy relationship model called Love Notes.) Third, OAH disallowed replication in the second cohort of one model (Cuidate) that had produced negative results in the first cohort and allowed one other (It's Your Game: Keep It Real) to be replicated only under narrow circumstances that were different than the first cohort evaluation.

28 Ibid.

29 Megan Uzzell and Charisma Troiano. "One Year of Successful Battles to Protect the TPP Program Against Trump Administration Unlawful Actions; Fights Remain as Administration Continues its Assault on Evidence." *Democracy Forward*, April 11, 2019. Available at: https://democracyforward.org/press/trump-administration-continues-unlawful-effort-to-dismantle-the-evidence-based-teen-pregnancy-prevention-program/.

30 Ibid. While the government dropped its appeals in two of the Tier 1 funding opportunity announcement (FOA) cases, two legal appeals are still pending—one challenging both the Tier 1 and Tier 2 FOAs, and another challenging Tier 2.

31 Heidi Pryzbyla. "Notes, Emails Reveal Trump Appointees' War to End HHS Teen Pregnancy Program." *NBC News*, March 20, 2018. Available at: https://www.nbcnews.com/politics/politics-news/notes-emails-reveal-trump-appointees-war-end-hhs-teen-pregnancy-n857686.

32 Robert Gordon and Ron Haskins. "Trump Team Doesn't Understand Evidence-based Policies Regarding Social Problems." *The Hill: Pundit's Blog*, July 26, 2017. Available at: https://thehill.com/blogs/pundits-blog/the-administration/343908-trump-team-doesnt-understand-evidence-based-policies.

33 The president's fiscal year 2020 budget proposes one year of funding; Congress most recently extended it for two years, through fiscal year 2019, in the *Bipartisan Budget Act*. Public Law 115-123.