# Health and Human Services Funding for Sexual Risk Avoidance, Education for Teen Pregnancy and HIV/STD Prevention, and Other Programs that Address Adolescent Sexual Activity

This funding report was prepared by the HHS Office of the Assistant Secretary for Planning and Evaluation.

Rates of teenage sex, pregnancy, births, and abortions have generally declined since the 1990's, yet concerns persist about teen sexual activity and the associated rates of teenage pregnancy and sexually transmitted diseases (STDs) among young people. The national teen pregnancy rate continues to be higher than the rates in other Western industrialized nations.[1] The consequences of teenage sexual activity in terms of non-marital childbearing and sexually transmitted diseases (STDs) are many and serious for teens, their families, their communities, and society. The U.S. Department of Health and Human Services (HHS) administers a variety of federal programs aimed at delaying sexual activity among teens, increasing use of effective contraception, and preventing STDs.

HHS funds programs that address adolescent sexual activity directly (e.g., Sexual Risk Avoidance Education). Other funded programs (e.g., Temporary Assistance to Needy Families, known as TANF) address adolescent sexuality as part of a broader focus, but the amount of funding addressing adolescent sexuality can be estimated. This report describes those programs and presents estimates of federal funding within HHS from FY 2007 through FY 2018. This report provides a better understanding of how much federal funding is available for programs that address adolescent sexual activity.

## Trends in Teen Sexual Behavior, Pregnancy and STDs

The mission of HHS is to enhance and protect the health and well-being of all Americans. HHS fulfills that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services. These programs include activities that support adolescent reproductive health, including education and awareness programs and family planning services to delay sexual activity and prevent teenage pregnancy and sexually transmitted diseases. The trends for adolescent sexual activity and its consequences are generally going in the right direction, as detailed in the sections below. Fewer teens are having sex and when they do, they are using more effective contraception. Teen birth rates have dropped significantly in the last 25 years, including large drops in the last decade alone. However, youth report that they are less likely to use condoms than they were a decade ago and this has corresponded with a recent uptick in reported STDs.

[1] Sedgh, G., Finer, L.B., Bankole, A., Eilers, M.A., Singh, S, (2015). Adolescent pregnancy, birth, and abortion rates across countries: Levels and recent trends. Journal of Adolescent Health, 56(2). 223-230.

*Trends in Teen Sexual Activity*

The trends in adolescent sexual activity are going in the right direction, with teens delaying sexual activity longer. During the period between 1991 and 2017, a significant decrease occurred overall in the prevalence of youth having ever had sexual intercourse, from 54.1% of youth in ninth through twelfth grade in 1991 reporting they had ever had sexual intercourse to 39.5% of youth in high school reporting they had ever had sexual intercourse in 2017.[2] From 1991 to 2007, the percentage of ninth through twelfth grade students who reported having had sexual intercourse during their lifetime declined from 54.1% to 47.8% (a 12% decrease).[3] In the 10 years between 2007 and 2017, the percent who reported having had sexual intercourse dropped nearly 20% more from 47.8% to 39.5%.

Between 1991 and 2017, the percentage of very young adolescents (under age 13) having sexual intercourse was cut by one-third from 10% of youth reporting that they had sexual intercourse in 1991 to 3.4% of youth under age 13 reporting they had had sex in 2017.[4] Between 1991 and 2017, the percentage of high school students who reported having had sex with four or more partners fell almost in half, from 18.7% to 9.7%. Between 1991 and 2017 there was a nearly one-quarter decline (37.5% to 28.7%) in the overall prevalence of being currently sexually active, which is defined as having had sexual intercourse with at least one person during the three months before the survey.[5]

*Trends in Teen Contraceptive Use*

In 2017, among the 28.7% of currently sexually active high school students nationwide, 56.9% reported that either they or their partner had used a condom during last sexual intercourse. Between 1991 and 2017 a significant increase (16.5%) occurred in the prevalence of having used a condom during last sexual intercourse, from 46.2% of high school youth reporting condom use at last sex in 1991 to 53.8% in 2017. However, a closer look at the trends during this period indicates that condom use increased from 1991 to 2005 and then decreased from 2005 to 2017 (62.8% reporting used a condom at last sex in 2005 vs. 53.8% in 2017).[6] Among the currently sexually active students nationwide in 2017, 20.7% reported that either they or their partner had used birth control pills and 4.1% reported that they or their partner had used an IUD or implant to prevent pregnancy before last sexual intercourse. High school youth increased their use of birth control pills before last sex almost 20% between 1995 (17.4%) and 2017 (20.7%). The prevalence of having used an IUD or implant before last sexual intercourse was only measured beginning in 2013 and there was a significant increase (150%) in use between 2013 (1.6%) and

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[2] Kann, L., McManus, T., Harris, W.A., et al, (2018). Youth Risk Behavior Surveillance—United States, 2017. *MMWR Survillance Summaries* 2018;67(8). https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf

[3] Centers for Disease Control and Prevention, *Trends in the Prevalence of Sexual Behaviors: National YRBS 1991-2007:* Available at http://www.cdc.gov/HealthyYouth/yrbs/pdf/yrbs07_us_sexual_behaviors_trend.pdf

[4] Kann, L., McManus, T., Harris, W.A., et al, (2018). Youth Risk Behavior Surveillance—United States, 2017. *MMWR Survillance Summaries* 2018;67(8). https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf

[5] Kann, L., McManus, T., Harris, W.A., et al, (2018). Youth Risk Behavior Surveillance—United States, 2017. *MMWR Survillance Summaries* 2018;67(8). https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf

[6] Trends in the Prevalence of Sexual Behaviors and HIV Testing National YRBS: 1991—2017. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trends/2017_sexual_trend_yrbs.pdf

2017 (4.1%).[7] However, 70.6% did not use one of the more effective birth control methods (i.e. birth control pills; an IUD or implant; or a shot, patch, or birth control ring to prevent pregnancy before last sexual intercourse).

*Trends in Teen Births*

The teen birth rate has decreased dramatically since 1991 and it hit a record low in 2017, the last year for which data are available.[8] Since 2009, the teen birth rate has fallen to a new low each year. The birth rate for teens aged 15 to 19 years old in the United States decreased 9% between 2015 and 2016 from 22.3 births per 1,000 women to 20.3 births. The teen birth rate declined another 7% between 2016 and 2017, to 18.8 births per 1,000 females aged 15–19.[9] Rates fell for nearly all race and Hispanic-origin groups.

Although the direction of causality is not always clear, being a teenage mother is associated with a number of adverse conditions. Over three-fifths of teen mothers live in poverty at the time of their child's birth, and over four-fifths eventually live below poverty.[10] There are substantial disparities in the educational attainment of teen mothers compared to young women who delay child-bearing.[11] Compared with children born to mothers who delay childbearing until age 21 or older, children of teen mothers are more likely to grow up in homes that are not emotionally supportive or cognitively stimulating, to suffer from abuse and neglect, to repeat a grade in school, and to drop out of high school.[12]

*Trends in Sexually Transmitted Diseases (STDs)*

Another major concern about teen sexual activity is the transmission of STDs. Compared to older adults, sexually-active adolescents 10 to 19 years of age and young adults 20 to 24 years of age are at higher risk for acquiring STDs because of a combination of behavioral, biological, and cultural reasons.[13] It is estimated that there are 20 million new STDs in the U.S. each year.[14]

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[7] Trends in the Prevalence of Sexual Behaviors and HIV Testing National YRBS: 1991—2017. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trends/2017_sexual_trend_yrbs.pdf

[8] Martin, J.A., Hamilton, B.E., Osterman, M.J.K, Driscoll, A.K., Drake, P. (2018). Births: Final data for 2016. *National Vital Statistics Reports; 67* (1). Hyattsville, MD: National Center for Health Statistics. 2018. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf

[9] Martin J.A., Hamilton B.E., Osterman, M.J.K. (2018). Births in the United States, 2017. *NCHS Data Brief, no 318.* Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db318.htm

[10]Maynard, Rebecca (ed.) *Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing.* New York: The Robin Hood Foundation, 1996.

[11]Hotz at al. 'The Impacts of Teenage Childbearing On the Mothers And The Consequences of Those Impacts for Government." In *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy,* edited by Rebecca Maynard. Washington, DC. The Urban Institute Press, 1997. pp. 59.

[12] Maynard, Rebecca (ed.) *Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing.* New York: The Robin Hood Foundation, 1996.

55[13] Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2006*. Atlanta, GA: U.S. Department of Health and Human Services, November 2007.

[14] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2016. Atlanta: U.S. Department of Health and Human Services; 2017. https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf

Approximately half of all new STDs occur in teens and young adults (ages 15-24) each year.[15] The human and monetary costs of STDs are very high. STDs can cause lifelong health complications. Approximately 10 to 20% of women with gonorrhea and chlamydia develop pelvic inflammatory disease (PID), which can lead to complications, such as infertility and potentially fatal ectopic pregnancies.[16] Many sexually transmitted diseases can cause adverse pregnancy outcomes, including, but not limited to, miscarriages, stillbirths, intrauterine growth restriction, and perinatal (mother-to-infant) infections.[17] Estimates indicate that the economic burden of the nine million new cases of STDs that occurred among 15-24 year-olds in 2000 was $6.6 billion (in year 2000 dollars).[18]

Rates of chlamydia infections are at record highs (since records began in 1984) and chlamydia rates are highest among adolescent and young adult females.[19] Rates of gonorrhea peaked in 1975 at 464.1 cases per 100,000 people and reached a low of 98.1 case per 100,000 people in 2009. Gonorrhea rates are highest among adolescents and young adults ages 15 to 24 years old. In 2017 the rate was 171.9 cases per 100,000, an increase of 18.6% from 2016 in which there were 145.0 cases per 100,000 people. Rates of primary or secondary syphilis reached record lows in 2000 and 2001, since records began in 1941. However, the rates have steadily increased every year since the low of 2.1 per 100,000 individuals (any age) to 9.5 per 100,000 individuals in 2017.[20] There was a nearly 10% increase in the rate of primary or secondary syphilis between 2016 and 2017 for teens ages 15 to 19 years old, from 6.1 per 100,000 to 6.7 per 100,000 people). Syphilis rates are much higher for older age groups from age 20 to age 44 years old.

## HHS Funding for Programs that Address Adolescent Sexual Activity

The Department funds three categories of programs that address adolescent sexual activity. While these categories are explained in more detail below, the following is a brief summary:

- Sexual Risk Avoidance (previously referred to as Abstinence Education);
- Education or awareness about pregnancy and/or STD/HIV prevention programs; and
- Family planning services.

In 2008, the Department conducted a review of its funding streams to make the best possible estimate of the federal funding levels for programs in these three categories of programs,

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[15] Weinstock, H., Berman, S., and Cates, W. "Sexually Transmitted Diseases Among American Youth: Incidence and Prevalence Estimates, 2000." *Perspectives on Sexual and Reproductive Health*, 2004, 36(1): 6-10.
[16]Center for Disease Control, *Tracking the Hidden Epidemics: Trends in STDs in the United States 2000,* pp. 3. Available at http://www.cdc.gov/nchstp/dstd/Stats_Trends/Trends2000.pdf
[17]National Institute of Allergy and Infectious Diseases, National Institutes of Health, Department of Health and Human Services, *Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention,* July 2001. pp. 1. Available at http://www.niaid.nih.gov/dmid/stds/condomreport.pdf
[18] Chesson et al. "The Estimated Direct Medical Cost of Sexually Transmitted Disease Among American Youth, 2000," Perspectives on Sexual and Reproductive Health, Vol 36:1, January/February 2004. Available at http://www.agi-usa.org/pubs/journals/3601104.html
[19] Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. (2018). Atlanta: U.S. Department of Health and Human Services. https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf
[20] https://www.cdc.gov/std/stats16/tables/1.htm

covering fiscal years 2007 and 2008, and released a report in December 2008. The goal of the current report is to update this review for the period between FY 2008 and FY 2018.

In the 2008 report, the first category of programs, abstinence education, was defined as programs that were defined by Title V, Section 510(b)(2) (A-H) of the Social Security Act (SSA) (see Appendix A). For the current report, the name and definition of this class of programs has changed to reflect the current terminology and legislative changes. The current report reflects the change in name of such programs from Abstinence Education to Sexual Risk Avoidance (SRA) education programs.

In both reports, the review of activities to address the prevention of sexual risk behaviors among adolescents focused only on domestic programs and included:

- federal efforts that specifically target the prevention of sexual risk behavior; and
- federal efforts that indirectly fund activities aimed at preventing sexual risk behavior (e.g., where some funds are used to provide such services even if the program is not targeted this way).

## Methodology

To identify the full range of activities that HHS supports, Operating Divisions within HHS were asked to provide information on programs they administered aimed at preventing sexual risk behaviors among adolescents. HHS Operating Divisions identified programs using the following three mutually exclusive categories of program activities:

1. **Sexual Risk Avoidance** (previously referred to as Abstinence Education): Programs for which the legislation indicates the primary or only intent is to fund abstinence programs including, but not limited, to the Title V, Section 510 State Abstinence Education program and the Sexual Risk Avoidance Education (SRAE) program.

2. **Education or Awareness about Pregnancy and/or STD/HIV Prevention**: Programs that include a component addressing sexual activity among adolescents, including, but not limited to:
   - Sexual risk avoidance (abstinence education) funded through federal programs that are not legislatively required to fund primarily abstinence education, but rather, can fund a broader range of interventions [such as the Teen Pregnancy Prevention (TPP) program or Personal Responsibility Education Program (PREP)];[21]
   - Pregnancy prevention and awareness activities, such as education about contraception use;
   - STD and/or HIV prevention and awareness activities, such as education about the importance of prevention, early identification, and treatment of sexually transmitted diseases; and

[21] Note: This group of programs excludes sexual risk avoidance programs in category #1 and family planning services in category #3.

- Clinical services, outreach services, media campaigns, training programs, research and evaluation activities, and technical assistance.

3. **Family Planning Services**: Programs that provide family planning services to adults and adolescents including, but not limited to, Title X Family Planning Clinics, Medicaid Family Planning waivers and enhanced match services, Health Resources and Services Administration (HRSA) health centers, TANF, and others.

Although the term "adolescent" has been used to refer to children and teenagers anywhere between the ages of 10 and 24 years old, for the purposes of this exercise, Operating Divisions were asked to define adolescents as youth aged 19 and younger. Operating Divisions were asked to use this definition even if the program uses a different definition or does not have a specific definition of adolescent. Programs that use an alternative definition for youth are identified within the program descriptions below.

Operating Divisions were asked to use a table to provide funding levels for activities addressing the prevention of sexual risk behavior for adolescents for domestic programs only. For programs that support the prevention of sexual risk behavior as part of a broader mission, funding was included if the amount used for the prevention of sexual risk behavior could reasonably be estimated.

In addition, Operating Divisions were asked to provide a program narrative using a template with the following information, if available:

- Program description and the kinds of activities funded;
- Target population for the program or services;
- The number of adolescents served per year;
- Alternative definitions of adolescent if the program routinely uses a different definition of adolescent other than "any youth aged 19 and younger;"
- Funding mechanism (e.g., block grant, individual grants, cooperative agreement, or contracts) and the grant recipients, in addition to the methodology used to estimate funding levels (if applicable).
- Supplemental budget information about the kinds of activities funded for each program.

## Analysis of Federal Funding Levels

In order to estimate federal funding levels for programs that address adolescent sexual activity between the 2008 report and the current updated report, the Department collected up to 10 fiscal years of federal funding data from HHS operating divisions (FY 2009 through FY 2018 funding levels). FY 2018 funding information was only available for some of the programs since the data were being collected during the same fiscal year. Therefore, the narrative below uses FY 2017 funding to estimate federal funding levels. More details are presented in charts and tables, as well as in the appendices. Appendix B includes the program narratives describing the programs that appear in the report tables. Appendix C provides more detailed budget information for some of the programs; not all of the programs were able to breakdown program costs further and therefore do not appear in the appendix.

In FY 2017, that were 17 programs administered by HHS that fell within the three categories of programming to address adolescent sexual activity: two programs provide sexual risk avoidance education; eight programs include education or awareness about pregnancy and/or STD/HIV prevention; and seven programs provide family planning services. During the twelve year period between FY 2007 and FY 2018, some programs were discontinued and new programs were authorized.

The sections below present an analysis of federal funding and the current HHS estimate for the total level of funding. This funding is also broken out by the three categories for addressing sexual activity among adolescents. This report documents the federal funding levels for these programs within HHS, briefly describes the methodology used to determine these estimates, briefly describes the programs, and discusses the analysis in detail.

Based on the estimates collected within HHS, in FY 2017 the Department estimates that the HHS federal funding levels for programs addressing sexual activity among adolescents was $800.2 million. Estimated funding levels, broken down by category are:

*FY 2017 Funding for Adolescents*

- Sexual Risk Avoidance Education = $ 90.0 million
- Pregnancy/STD/HIV prevention and education programs = $ 364.7 million[22]
- Family Planning services = $ 345.5 million

In FY 2017, 11% of federal funding for adolescents went to programs for which the exclusive purpose of the legislation is to fund sexual risk avoidance education, 46% went to pregnancy and STD/HIV education and awareness activities[23], and 43% went to family planning.

Total HHS federal funding[24] on these activities at any age was $2.78 billion in FY 2017, which is a 15% increase from the amount of money spent on these programs in FY 2008 ($2.41 billion). Of the total sum spent on these activities for any age in FY 2017, $90 million was spent on sexual risk avoidance education; $368.1 million was spent on pregnancy and STD/HIV education and awareness; and $2.33 billion was spent on family planning services. The total federal funding estimates did not include funding for pregnancy and STD/HIV education and awareness programs that do not serve any adolescents.

*Historical FY 2008 Funding for Adolescents*

[22] This funding total includes FY 2017 TANF funding for out of wedlock pregnancies even though funding can't be estimated for adolescents ages 10 to 19 years old. Excluding TANF funding, the total money spent on adolescents was $219.9 million.

[23] This category includes programs that fund a range of education and awareness activities, including sexual risk avoidance education.

[24] The total HHS federal funding at any age includes funding for all three categories of programs for both adults and adolescents.

- Sexual Risk Avoidance Education (formerly Abstinence Education) = $176.5 million
- Pregnancy/STD/HIV prevention and education programs = $300.2 million
- Family Planning services = $319.4 million[25]

In FY 2008, the total federal funding spent on adolescents was $796.1 million, of which 22% went to abstinence education activities as defined by Title V, Section 510(b)(2) (A-H) of the SSA, 38% went to STD/HIV education and awareness activities, and 40% went to family planning.

Total federal funding at any age for these activities in FY 2008 was $2.46 billion, of which $176.5 million was for abstinence education; $310.6 million was for pregnancy and STD/HIV education and awareness; and $1.97 billion was for family planning services.[26]

The following sections describe the federal funding levels for each of the three categories.

## Sexual Risk Avoidance Education

*FY 2017 Funding*

Under the Sexual Risk Avoidance Education category (formerly known as abstinence education), there were two programs targeted at adolescents in FY 2017. Both programs were administered by the Administration for Children and Families: the discretionary Sexual Risk Avoidance Education (SRAE) program and the mandatory Title V, Section 510 State Abstinence Education Grant program.[27] As shown in Table 1, the FY 2017 federal funding level for the two programs was $90 million.

The FY 2008 federal funding level for all three abstinence education programs was $176.5 million. The FY 2017 funding of $90 million in sexual risk avoidance education represents a decrease of $86.5 million (a 49% decline) in funding from the FY 2008 level. Table 1 indicates that, in FY 2018, funding for the discretionary Sexual Risk Avoidance Education program increased by $10 million to $25 million bringing the total funding for sexual risk avoidance to $100 million.

[25] The 2008 report did not include estimates for two family planning programs: the HRSA Health Center Program or the State Children's Health Insurance Program (SCHIP). During the current update, HRSA and the Centers for Medicare and Medicaid Services (CMS) were able to retroactively provide estimates for their respective programs. In FY 2008, Health Center Program expenditures for adolescent family planning was $5 million and SCHIP expenditures on adolescent family planning was $5.3 million for a total of $319.4 million spent on family planning. The 2008 report stated that the total family planning funding was $309.1 million without these two programs.
[26] The total reported for FY 2008 reflect the additional funding reported in the current report for the HRSA Health Center Program and the State Children's Health Insurance Program (SCHIP) that was not reported in the 2008 report.

[27] The Bipartisan Budget Act of 2018 (P.L. 115-123) changed the name and authorizing legislation for the Title V, Sec 510 State Abstinence Education program. The program is now entitled the Title V Sexual Risk Avoidance Education program and it continues to target youth ages 10 to 19, emphasizing that youth should refrain from sexual activity before marriage.

*Changes in Funding from FY 2008 to FY 2017*

In the 2008 report, abstinence education programs were defined by Title V, Section 510(b)(2) (A-H) of the Social Security Act (SSA). Three HHS programs were identified, including one that continued to be funded in FY 2017: the Title V, Section 510 State Abstinence Education Grant program. Two of the programs were in the Administration for Children and Families and the third was administered by the Office of Population Affairs within the Office of the Assistant Secretary for Health.

The Title V, Section 510 State Abstinence Education Grant program was funded at $50 million per year until it expired on June 30, 2009. The program was reauthorized in FY 2010 through the Patient Protection and Affordable Care Act (ACA).[28] The program continued to be funded at the previous annual level of $50 million for each of the years FY 2010 through FY 2014 ($250 million over five years). In FY 2016[29] Congress increased the funding level to $75 million, to be on par with the Personal Responsibility Education Program (PREP), which is a pregnancy prevention education program detailed in the next section. The Bipartisan Budget Act of 2018 changed the name and authorizing legislation for the Title V, Section 510 State Abstinence Education Grant program. It is now the Title V Sexual Risk Avoidance Education program and it no longer adheres to the Title V, Section 510(b)(2) (A-H) of the Social Security Act (SSA), but rather, uses the new definition of sexual risk avoidance laid out in the updated legislation.

Congress created and funded the Community-Based Abstinence Education Program (CBAE) beginning in FY 2001 with an appropriation of $20 million. The funding increased each year until it reached $113.4 million in FY 2007 and FY 2008. In FY 2009 the funding declined approximately $18 million from $113.4 million to $94.7 million and the program was eliminated in FY 2010.

The Adolescent Family Life program was also eliminated in FY 2010. This program consisted of both a sexual risk avoidance education component (Prevention demonstrations) and a program for pregnant and parenting teens (CARE demonstrations). The Prevention demonstrations were annually funded at $13.1 million between FY 2007 and FY 2009.

A new sexual risk avoidance program, the Competitive Abstinence Education program, was created in annual appropriations in FY 2012. It was funded at $5 million per year for four years until FY 2016 when the Sexual Risk Avoidance Education (SRAE) program was created, replacing the Competitive Abstinence Education program. Both programs were discretionary competitive grant programs administered by ACF. The SRAE program funds programs to educate youth on how to voluntarily refrain from non-marital sexual activity and prevent other youth risk behaviors. It was first funded in FY 2016 at $10 million and its funding has increased each subsequent year to $15 million in FY 2017 and $25 million in FY 2018.

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[28] P.L. 111-148

[29] Funding for the Title V Abstinence Education grant program expired on June 30, 2009 meaning that federal funding for the program for FY 2009 was $37.5 million (i.e., a rate of $50 million per year for three-quarters of the fiscal year). Solomon-Fears, C. (2016). Teenage Pregnancy Prevention: Statistics and Programs. *Congressional Research Service Report*. https://fas.org/sgp/crs/misc/RS20301.pdf

**Table 1. Federal Programs Addressing Sexual Activity among Adolescents: Sexual Risk Avoidance Education**

| Program | Fiscal Year (FY) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sexual Risk Avoidance Education** | FY 2007 | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 |
| **Administration for Children and Families (ACF)** | | | | | | | | | | | | |
| **Title V, Section 510 State Abstinence Education Grant Program** | 50.0 | 50.0 | 37.5 | 50.0 | 50.0 | 50.0 | 50.0 | 50.0 | 75.0 | 75.0 | 75.0 | - |
| **Title V, Section 510 Sexual Risk Avoidance Education Program**[30] | - | - | - | - | - | - | - | - | - | - | - | 75.0 |
| **Community Based Abstinence Education** | 113.4 | 113.4 | 94.7 | - | - | - | - | - | - | - | - | - |
| *PHS Evaluation Funding (non add)* | *4.5* | *4.5* | *4.5* | - | - | - | - | - | - | - | - | - |
| **Competitive Abstinence Education program**[31] | - | - | - | - | - | 5.0 | 5.0 | 5.0 | 5.0 | - | - | - |
| **Sexual Risk Avoidance Education (SRAE) Program**[32] | - | - | - | - | - | - | - | - | - | 10.0 | 15.0 | 25.0 |
| **Office of the Assistant Secretary for Health (OASH)** | | | | | | | | | | | | |
| **Adolescent Family Life: Prevention Demonstrations** | 13.1 | 13.1 | 13.1 | - | - | - | - | - | - | - | - | - |
| **Subtotal, Sexual Risk Avoidance Education** | **176.5** | **176.5** | **145.3** | **50.0** | **50.0** | **55.0** | **55.0** | **55.0** | **80.0** | **85.0** | **90.0** | **100.0** |

[30] The Bipartisan Budget Act of 2018 (P.L. 115-123) changed the name and authorizing legislation for the Title V, Sec 510 State Abstinence Education program. The program is now entitled the Title V Sexual Risk Avoidance Education program and it continues to target youth ages 10 to 19, emphasizing that youth should refrain from sexual activity before marriage.

[31] The abstinence education program is a discretionary, competitive grant program created in annual appropriations in FY 2012. The program provided abstinence education as defined by Title V, Section 510(b)(2) (A-H) (see Appendix A).

[32] In FY 2016, the discretionary abstinence education program was replaced by the Sexual Risk Avoidance Education (SRAE) program and redefined in terms of program requirements.

## Education and Awareness about Pregnancy and/or STD/HIV Prevention Programs

*FY 2017 Funding*

In FY 2017 there were eight programs identified that were categorized as education and awareness about pregnancy and/or STD/HIV prevention.[33] In FY 2017, HHS estimates that $364.7 million was provided for education and awareness about pregnancy and/or STD/HIV prevention targeted to adolescents, as Table 2 below shows. The funding for adolescents for education and awareness about pregnancy and/or STD/HIV prevention increased between FY 2008 and FY 2017 from $300.2 million to $364.7 million, a 21.5% increase.

*Changes in Funding from FY 2008 to FY 2017*

There were multiple changes in programming within the Office of the Assistant Secretary for Health (OASH) between FY 2008 and FY 2017. The Adolescent Family Life program, which was administered by the Office of Population Affairs in OASH, was eliminated in FY 2010. This program consisted of both a sexual risk avoidance education component (Prevention demonstrations) and a program for pregnant and parenting teens (CARE demonstrations). The CARE demonstrations were funded at $11 million annually between FY 2007 and FY 2009. In FY 2010 a new program for pregnant and parenting teens was authorized by Congress: the Pregnancy Assistance Fund (PAF), which is administered by the Office of Adolescent Health in OASH. In FY 2010 it was funded at $25 million and this decreased slightly to $23.3 million by FY 2017.

The Teen Pregnancy Prevention Program, administered by the Office of Adolescent Health in OASH was also created in FY 2010. The purpose of the program is to replicate evidence-based teen pregnancy prevention programs and to support research and demonstration grants to test new models and innovative strategies. The Teen Pregnancy Prevention program was originally funded at $110 million in FY 2010, although funding decreased slightly over time. In FY 2017 it was funded at $101 million.

A third program was created in FY 2010: the Personal Responsibility Education Program (PREP), administered by the Family and Youth Services Bureau within ACF. This program has been consistently funded at $75 million annually. The purpose of the PREP program is to educate youth on both abstinence and contraception for the prevention of pregnancy and sexually transmitted disease infections. PREP consists of four funding streams: state block grants, competitive grants to tribal entities, competitively awarded grants to implement evidence-based

[33] This category represents programs that include education and awareness activities about pregnancy, STDs, contraception and other aspects of adolescent sexual activity. While this category historically provides funding for risk reduction approaches, some programs may also include funding for sexual risk avoidance education. Federal programs funded under this category are usually not legislatively required to fund one particular approach, but rather, can fund a broader range of interventions [e.g., the Teen Pregnancy Prevention (TPP) Program; Personal Responsibility Education Program (PREP); TANF).

programs and Innovative Strategies grants to implement and evaluate new and untested programs.

In 2008, the Centers for Disease Control and Prevention (CDC) ran three education and awareness programs in this category. In FY 2017, two of those three programs still existed, although at significantly reduced funding. The CDC's School Based Programs to Promote Delay of Sexual Debut program ended after 2008. It was a small program funded at $2.3 million in FY 2008. The CDC's Safe Motherhood program was funded at $6.9 million for adolescents in 2008; in FY 2017 the funding was $3.4 million. The CDC's Health Promotion: School Based HIV Prevention Education program was funded at $40 million for adolescents in 2008; in FY 2017 the funding was $15.9 million. The decline in funding for the school-based program observed in FY 2012 reflects the impact of a reorganization that split previously comprehensive school programs into two budget lines: one for chronic disease related programs and one for HIV/STD and pregnancy prevention programs. At the same time, the School Health HIV budget was cut by $10 million. These cuts resulted in scaling back activities throughout the nation to funding only a portion of state and local jurisdiction.

In addition to the PREP program, ACF administers the Temporary Aid for Needy Families (TANF) program. The TANF program is designed to help needy families achieve self-sufficiency. One of the four purposes of TANF is to prevent and reduce the incidence of out-of-wedlock pregnancies among people of any age. ACF does not require states to report the ages of individuals served and therefore cannot estimate what percentage of TANF funds serves only adolescents. Furthermore, estimates of funding spent on such activities cannot be compared from the time period before FY 2015 and after because the program changed the way in which the funding was reported. Beginning in FY 2015, states used a revised financial reporting form, which clarified and expanded the list of expenditure categories and improved the accounting methodology. Prior to FY 2015, some states had counted activities such as pre-kindergarten and college scholarships in the category of preventing out-of-wedlock pregnancies, with the rationale that these activities might reduce non-marital pregnancies and births. However, the connection was indirect, so starting in FY 2015 the expenditure categories were refined to link spending directly to a program's primary purpose. For example, pre-kindergarten is now included in "Early Care and Education" and college scholarships are reported in "Education and Training." As a result, any analysis of TANF spending trends over time should be done carefully, particularly with spending on the prevention of out-of-wedlock pregnancies. Because TANF expenditures for out-of-wedlock pregnancies can't be estimated for youth ages 10 to 19 and because of the changes in financial reporting, Table 2 includes two subtotal lines: one including TANF expenditures and one excluding TANF expenditures.

In FY 2008, the Indian Health Service (IHS) reported funding approximately $1.8 million in education and awareness activities to adolescents through its Clinical Services, Prevention, and Urban Health program. IHS did not report further funding for these activities after FY 2008. Beginning in FY 2010, IHS has administered two small education and awareness projects through the Secretary's Minority AIDS Initiative (SMAIF) contract. Funds have been used to support projects such as the HIV Youth Media (Project Red Talon) and Disseminating Effective Adolescent Health Interventions in AI/AN Communities. FY 2017 funding for adolescents was approximately $1 million. Activities from these projects include developing and enhancing an

online, multimedia health resource and promoting HIV prevention services within existing tribal systems of care. In FY 2017 IHS also spent $300,000 for programming for High Risk and Infected Persons who are at risk for HIV infection. Specifically, the Retention and ReEngagement in Care program covers high risk and infected youth and has the largest HIV programs in the U.S. Southwest, where about 60% of known HIV patients in Indian Country reside.

**Table 2. Federal Programs Addressing Sexual Activity among Adolescents: Education or Awareness about Pregnancy or STD/HIV Prevention**

| Program | Fiscal Year (FY) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Education or Awareness about Pregnancy or STD/HIV Prevention** | **FY 2007** | **FY 2008** | **FY 2009** | **FY 2010** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** |
| **Administration for Children and Families (ACF)** | | | | | | | | | | | | |
| **Personal Responsibility Education Program (PREP)[34]** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | -- | -- | -- | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 |
| Services or Activities provided to adolescents | -- | -- | -- | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 | 75.0 |
| **Temporary Assistance for Needy Families (TANF)** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 238.0 | 238.0 | 724.2 | 511.6 | 418.5 | 557.4 | 1,088.1 | 845.6 | 129.3[35] | 136.4 | 144.8 | N/A |
| Services or Activities provided to adolescents | 238.0 | 238.0 | -- | -- | -- | -- | -- | -- | -- | -- | -- | |
| **Centers for Disease Control and Prevention (CDC)** | | | | | | | | | | | | |
| **Promoting Adolescent Health Through School-Based HIV/STD Prevention Education** | 40.9 | 40.2 | 39.2 | 34.7 | 33.5 | 18.0 | 18.9 | 20.8 | 17.2 | 16.0 | 15.9 | 16.9 |
| Services or Activities provided to any age ... | 40.9 | 40.2 | 39.2 | 34.7 | 33.5 | 18.0 | 18.9 | 20.8 | 17.2 | 16.0 | 15.9 | 16.9 |
| Services or Activities provided to adolescents | | | | | | | | | | | | |

[34] The Personal Responsibility Education Program (PREP) can fund a range of program approaches, including sexual risk avoidance education.

[35] FY 2015 was the first year that states used a revised financial reporting form, which clarified and expanded the list of expenditure categories and improved the accounting methodology. In FY 2015 the expenditure categories were refined to link spending directly to a program's primary purpose. As a result, any analysis of TANF spending trends over time should be done carefully, particularly with spending on the prevention of out-of-wedlock pregnancies.

| Program | Fiscal Year (FY) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Education or Awareness about Pregnancy or STD/HIV Prevention** | **FY 2007** | **FY 2008** | **FY 2009** | **FY 2010** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** |
| **Safe Motherhood**[36] | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 11.0 | 13.8 | 8.9 | 6.0 | 5.7 | 5.7 | 6.2 | 6.4 | 12.2 | 7.2 | 4.1 | 1.9 |
| Services or Activities provided to adolescents | 5.5 | 6.9 | 8.9 | 6.0 | 5.7 | 5.7 | 6.2 | 6.4 | 5.2 | 4.9 | 3.4 | 1.9 |

[36] Between FY 2010 and FY 2014, CDC received $1.7 million to $9.8 million in additional funds from the OAH Teen Pregnancy Prevention program to administer research and demonstration grants (reported in the OAH TPP funding).

| Program | Fiscal Year (FY) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Education or Awareness about Pregnancy or STD/HIV Prevention** | **FY 2007** | **FY 2008** | **FY 2009** | **FY 2010** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** |
| **Centers for Disease Control and Prevention (CDC)** (continued from previous page) | | | | | | | | | | | | |
| **School Based Programs to Promote Delay of Sexual Debut** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 2.3 | 2.3 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Services or Activities provided to adolescents | 2.3 | 2.3 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Indian Health Service (IHS)** | | | | | | | | | | | | |
| **Clinical Services, Prevention, and Urban Health** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 4.4 | 4.6 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Services or Activities provided to adolescents | 1.7 | 1.8 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Information and Education Prevention Services)** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | -- | -- | 2.7 | 2.8 | 2.8 | 2.8 | 2.8 | 2.8 | 2.9 | 3.0 | 3.1 | 3.1 |
| Services or Activities provided to adolescents | -- | -- | 1.0 | 1.1 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.1 | 1.0 | 1.0 |
| **High Risk or Infected Persons** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | -- | -- | .8 | .8 | .8 | .8 | .8 | .8 | .9 | .9 | .9 | .9 |
| Services or Activities provided to adolescents | -- | -- | .3 | .3 | .3 | .3 | .3 | .3 | .3 | .3 | .3 | .3 |
| **Program** | **Fiscal Year (FY)** | | | | | | | | | | | |
| **Education or Awareness about Pregnancy or STD/HIV Prevention** | **FY 2007** | **FY 2008** | **FY 2009** | **FY 2010** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** |
| **Office of the Assistant Secretary for Health (OASH)** | | | | | | | | | | | | |
| **Adolescent Family Life: CARE** | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Demonstrations** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 11.0 | 11.0 | 11.0 | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Services or Activities provided to adolescents | 11.0 | 11.0 | 11.0 | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **Teen Pregnancy Prevention Program[37]** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | -- | -- | -- | 110.0 | 104.8 | 104.8 | 98.4 | 101.0 | 101.0 | 101.0 | 101.0 | 101.0 |
| Services or Activities provided to adolescents | -- | -- | -- | 110.0 | 104.8 | 104.8 | 98.4 | 101.0 | 101.0 | 101.0 | 101.0 | 101.0 |
| **Pregnancy Assistance Fund** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | -- | -- | -- | 25.0 | 25.0 | 25.0 | 23.7 | 23.2 | 23.2 | 23.3 | 23.3 | 23.4 |
| Services or Activities provided to adolescents | -- | -- | -- | 25.0 | 25.0 | 25.0 | 23.7 | 23.2 | 23.2 | 23.3 | 23.3 | 23.4 |
| **Subtotal, Education and Awareness Activities, EXCLUDING TANF** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | **69.6** | **71.9** | **62.6** | **254.3** | **247.6** | **232.1** | **225.8** | **230.0** | **232.4** | **226.4** | **223.3** | **N/A** |
| Services or Activities provided to adolescents | **61.4** | **62.2** | **60.4** | **252.1** | **245.3** | **229.8** | **223.5** | **227.7** | **222.9** | **221.6** | **219.9** | **N/A** |
| **Subtotal, Education and Awareness Activities, INCLUDING TANF** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | **307.6** | **309.9** | **786.8** | **765.9** | **666.1** | **789.5** | **1,313.9** | **1,075.6** | **361.7** | **362.8** | **368.1** | **N/A** |
| Services or Activities provided to adolescents | **299.4** | **300.2** | **784.6** | **763.7** | **663.8** | **787.2** | **1,311.6** | **1,073.3** | **352.2[38]** | **358.0** | **364.7[39]** | **N/A** |

[37] The Teen Pregnancy Prevention program can fund a range of program approaches, including sexual risk avoidance education.

[38] FY 2015 was the first year that states used a revised financial reporting form, which clarified and expanded the list of expenditure categories and improved the accounting methodology. In FY 2015 the expenditure categories were refined to link spending directly to a program's primary purpose. As a result, any analysis of TANF spending trends over time should be done carefully, particularly with spending on the prevention of out-of-wedlock pregnancies.

[39] The subtotal for services provided to adolescents includes TANF funding, even though these funds can serve people of any age and are not limited to adolescents. The goal is for the funds to be used to prevent and reduce the incidence of out-of-wedlock pregnancy.

## Family Planning Services

*FY 2017*

HHS provides significant funding for family planning, including family planning services specifically targeted to adolescents. In FY 2017, HHS spent approximately $2.32 billion on family planning services for people of any age, of which we estimate that $345.5 million was spent on adolescents.

As shown in Table 3, Medicaid is the largest program providing family planning services, with $1.5 billion provided to individuals at any age in FY 2017. States report their Medicaid data to the Centers for Medicare and Medicaid Services (CMS) in the aggregate without an age breakdown. Therefore, CMS does not have a way to break out funding for Medicaid services provided to adolescents. In 2008, using expenditure data and utilization rates, the CMS Office of the Actuary estimated the portion of Medicaid family planning expenditures that are directed towards adolescents to be 10% of all family planning expenditures. The current report uses the same 10% estimate. Therefore, we estimate that $153 million of the $1.5 billion in family planning services was spent on adolescents in FY 2017.

The Title X program is another well-known source of federal funding for family planning, with $286.5 million provided to individuals of any age and an estimated $51.6 million provided to adolescents. The Title X Family Planning grants are administered by the Office of Population Affairs (OPA) within the Office of the Assistant Secretary for Health (OASH), although the appropriations account is through the Health Resources and Services Administration (HRSA).

HRSA estimates that in FY 2017 approximately $116 million was spent on family planning services through the Health Center Program, of which it was estimated that $11.6 million goes to serve adolescents. The Health Center Program funding for adolescent family planning is based on estimates because HRSA does not administer grant programs or provide targeted funding specifically for this activity and it doesn't collect data that allows accurate reporting or analysis. HRSA estimated that 2.5% of health center visits involved the reduction of sexual risk behavior (contraception management) and that adolescents make up approximately 10% of the total patients served by health centers.

The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives, including family planning services. In FY 2017, approximately $117 million was spent on family planning services for adolescents receiving health care through the Indian Health Service.

CMS administers two additional programs that provide smaller amounts of funding for family planning services for adolescents: the Children's Health Insurance Program (CHIP) and Medicaid 1115 family planning demonstrations. CHIP funding provides health coverage, including family planning services, for targeted low-income children. In FY 2017, approximately $3.4 million was spent on adolescent family planning services through CHIP. Medicaid 1115 experimental or pilot demonstration projects can include family planning demonstrations, which permit states flexibility to provide a targeted benefit of family planning services to women and men who do not qualify for full Medicaid benefits. The objective of these demonstrations is to

reduce unintended pregnancies that would likely be paid for by Medicaid or the Children's Health Insurance Program. This report includes the five states that currently implement family planning demonstrations that serve low-income women and men of reproductive age, including adolescents under age 19: Florida, Georgia, Mississippi, Oregon, and Washington. In FY 2017 approximately $6.8 million was spent on family planning services for adolescents through 1115 demonstrations in these states.

A small amount of family planning services are funded through ACF's Social Services Block Grant (SSBG) program. SSBG is a $1.7 billion program that funds a wide variety of services through flexible funding to states to target populations that might not otherwise be eligible for services people need to remain self-sufficient and economically independent. FY 2015 is the last year for which there are calculations of the amount of SSBG dollars spent on family planning for people of any age. ACF is not able to provide estimates of the funding spent on adolescents aged 10 to 19, although they can report funding for children, typically defined by states as under age 18. In FY 2015, $7.7 million in SSBG funds was spent on family planning for people of any age and approximately 2% of clients served were identified as children (7,249 children out of 365,540 people served). This would mean that approximately $154,000 was spent on family planning for children, which is a negligible amount of the overall family planning funding for adolescents. Using the same $154,000 estimate for 2017 would increase the total funding spent on family planning services for adolescent from $345.5 million to $345.65 million.

*Changes in Funding from FY 2008 through FY 2017*

In FY 2008, estimated federal funding levels for domestic family planning services provided through HHS programs totaled $1.97 billion, of which $319.4 million was estimated to be provided to adolescents. The 2008 report did not include estimates for two family planning programs because estimates were not available: the Health Resources and Services Administration (HRSA) Health Center Program or the State Children's Health Insurance Program (SCHIP). During the current update, HRSA and the Centers for Medicare and Medicaid Services (CMS) were able to retroactively provide estimates for their respective programs. In FY 2008, Health Center Program expenditures for adolescent family planning was $5 million and SCHIP expenditures on adolescent family planning was $5.3 million. Using these estimates, the total funding for FY 2008 on family planning was $319.4 million.

Overall the total funding for family planning services for adolescents has increased 8% between FY 2008 ($319.4 million) and FY 2017 ($345.5 million). There have also been changes in funding within programs during this period, with some programs experiencing an increase in funding and others experiencing a decline.

In FY 2010, the Health Center program was expanded as part of the Affordable Care Act, which corresponded to an estimated increase in family planning services after FY 2010. Medicaid expenditures on family planning services increased an estimated 10% between FY 2008 and FY 2017 from $140 million to $153.5 million. The Indian Health Service reported a 30% increase in funding from $89.5 million in FY 2008 to $116.9 million in FY 2017.

Funding for the overall Title X Family Planning program has decreased from $300 million in FY 2008 to $286.5 million in FY 2017. Similarly, the funding spent on adolescents has declined from $75 million in FY 2008 to $51.6 million in FY 2017. There was a similar decrease in funding for family planning services through SSBG from FY 2007 to FY 2015, the last year for which there is data for this program. SSBG reports funding levels across eight High Level Service Areas, including the Health and Wellbeing Category that contains family planning services. Between FY 2011 and FY 2015, total SSBG expenditures for the Health and Wellbeing category, which includes family planning services, decreased by $30 million (17%).[40] The largest negative percent change in total SSBG expenditures for the Health and Wellbeing category was for family planning services, which decreased by $23 million (75%) between FY 2011 and FY 2015. However, the total SSBG expenditures for all services combined remained relatively stable over the five year period between FY 2011 and FY 2015, increasing less than one percent.

Funding for family planning services through IHS was $89.5 million in FY 2008 and $116.9 million in FY 2017, a nearly 31% increase. Reflecting the increase in overall spending for family planning, reimbursements for family planning services through Medicaid also increased over time for adolescents, from an estimated $140.0 million in FY 2008 to an estimated $153.5 million in FY 2017, a nearly 10% increase.

[40] Social Services Block Grant Fiscal Year 2015 Annual Report. https://www.acf.hhs.gov/sites/default/files/ocs/rpt_ssbg_annual_report_fy2015.pdf

**Table 3. Federal Programs Addressing Sexual Activity among Adolescents: Family Planning**

| Program | Fiscal Year (FY) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Family Planning** | **FY 2007** | **FY 2008** | **FY 2009** | **FY 2010** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** |
| **Administration for Children and Families (ACF)** | | | | | | | | | | | | |
| **Social Services Block Grant (SSBG)** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 37.6 | 37.6 | 33.7 | 31.4 | 31.0 | 11.6 | 7.7 | 6.4 | 7.7 | N/A[41] | N/A | N/A |
| Services or Activities provided to adolescents | 4.6 | 4.6 | -- | -- | -- | -- | -- | -- | -- | | | |
| **Centers for Medicare and Medicaid Services (CMS)** | | | | | | | | | | | | |
| **Medicaid[42]** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 1,250.0 | 1,350.0 | 1,384.6 | 1,635.8 | 1,732.4 | 1,617.4 | 1,638.2 | 1,635.0 | 1,513.0 | 1,550.5 | 1,525.3 | N/A |
| Services or Activities provided to adolescents | 130.0 | 140.0 | 138.5[43] | 163.6 | 173.2 | 161.7 | 163.8 | 163.5 | 151.3 | 155.1 | 153.5 | |
| **Children's Health Insurance Program (CHIP) – federal share** | | | | | | | | | | | | |
| Medicaid- Expansion CHIP (M-CHIP) | -- | -- | -- | 0.3 | 0.7 | 0.8 | 0.1 | 1.0 | 1.1 | 1.6 | 1.7 | N/A |
| CHIP (federal funding) | 4.6 | 5.3 | 3.1 | 2.2 | 1.9 | 4.2 | 3.3 | 2.7 | 2.1 | 3.4 | 3.4 | N/A |
| **1115 Waiver Program[44]** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | | | | | 27.2 | 59.5 | 59.8 | 45.5 | 28.5 | 28.3 | 27.6 | |
| Services or Activities provided to adolescents | | | | | 5.9 | 17.8 | 15.6 | 8.5 | 4.9 | 5.5 | 6.8 | |

[41] Funding estimates for SSBG funded family planning were not available between FY 2016 and FY 2018, although SSBG could still fund these services.

[42] Funding amounts for family planning services provided to adolescents through Medicaid are based on estimates.

[43] States report their Medicaid data to CMS as an aggregate without an age breakdown. We estimate spending on services for adolescents based on the same estimate provided in 2008, which is that approximately 10% of Medicaid family planning funds are spent on adolescents.

[44] In FY 2011 there were three states with approved family planning demonstration projects that could serve adolescents: Georgia, Mississippi, and Oregon. In FY 2012 and FY 2013 there were four states with approved family planning demonstration projects that could serve adolescents: Georgia, Mississippi, Oregon, and Washington. In FY 2014 through FY 2017 there were five states with approved family planning demonstration projects that could serve adolescents: Florida, Georgia, Mississippi, Oregon, and Washington.

| Program | Fiscal Year (FY) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Family Planning** | **FY 2007** | **FY 2008** | **FY 2009** | **FY 2010** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** |
| **Health Resources and Services Agency (HRSA)** | | | | | | | | | | | | |
| **Title X Family Planning**[45] | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 238.1 | 300.0 | 307.5 | 316.3 | 300.2 | 294.6 | 278.3 | 284.2 | 286.5 | 286.5 | 286.5 | N/A |
| Services or Activities provided to adolescents | 70.8 | 75.0 | 55.3 | 56.9 | 54.0 | 53.0 | 50.1 | 51.2 | 51.6 | 51.6 | 51.6 | N/A |
| **Health Center Program**[46] | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 48.0 | 50.0 | 53.0 | 50.0 | 55.0 | 60.0 | 65.0 | 80.0 | 105.0 | 110.0 | 116.0 | 123.0 |
| Services or Activities provided to adolescents | 4.8 | 5.0 | 5.3 | 5.0 | 5.5 | 6.0 | 6.5 | 8.0 | 10.5 | 11.0 | 11.6 | 12.3 |
| **Indian Health Service** | | | | | | | | | | | | |
| **Family Planning Services**[a] | | | | | | | | | | | | |
| Services or Activities provided to any age ... | 223.3 | 231.8 | 225.0 | 236.1 | 262.3 | 293.6 | 308.4 | 324.0 | 340.4 | 357.6 | 365.3 | 362.8 |
| Services or Activities provided to adolescents | 86.2 | 89.5 | 84.4 | 88.6 | 84.3 | 104.2 | 109.5 | 112.4 | 117.8 | 123.7 | 116.9 | 116.1 |
| **Subtotal, Family Planning** | | | | | | | | | | | | |
| Services or Activities provided to any age ... | **1801.6** | **1974.7** | **2,006.9** | **2,272.1** | **2,410.7** | **2,341.7** | **2,360.8** | **2,378.8** | **2,284.3** | **2,337.9** | **2,325.8** | **N/A** |
| Services or Activities provided to adolescents | **301.0** | **319.4** | **286.6** | **316.6** | **325.5** | **347.7** | **348.9** | **347.3** | **339.3** | **351.9** | **345.5** | **N/A** |

[45] The Title X program is administered by OASH's Office of Population Affairs although the appropriations account is through HRSA

[46] Funding amounts for family planning services provided to people of any age and to adolescents is based on estimates.

## Conclusion

As this report shows, the Department of Health and Human Services has a wide array of programs that address adolescent sexual activity and its consequences. The programs can be classified into three categories: sexual risk avoidance education; programs on education and awareness about pregnancy and/or STD/HIV prevention; and family planning services to adolescents. In FY 2017, the HHS funding level was an estimated $800.2 million for programs addressing sexual activity among adolescents. This includes $90 million for Sexual Risk Avoidance Education, $364.7 million for Pregnancy/STD/HIV prevention and education programs, and $345.5 million for Family Planning services.

Total HHS federal funding for all of these services for people of any age was $2.46 billion in FY 2008 and $2.78 billion in FY 2017, a 13% increase in funding. Federal funding for adolescents was $796.1 million in FY 2008 and $800.2 in FY 2017, a less than one percent increase. However, there was more variation within categories over time: there was a 49% decrease in funding for sexual risk avoidance between FY 2007 and FY 2017[47] a 21.5% increase in funding for education and awareness to prevent pregnancy and STD; and an 8% increase in family planning spending.

[47] Funding for sexual risk avoidance education increased from $90 million in FY 2017 to $100 million in FY 2018; the decrease in spending between FY 2008 and FY 2018 was 43%.

## Appendix A

### Social Security Act Definition of Abstinence Education

Sec. 510. [42 U.S.C. 710] (a) For the purpose described in subsection (b), the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

(1) The amount appropriated in subsection (d) for the fiscal year; and

(2) The percentage determined for the State under section 502(c)(1)(B)(ii).

(b)(1) The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

(2) For purposes of this section, the term "abstinence education" means an educational or motivational program which—

(A) Has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

(C) Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

(D) Teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

(E) Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

(F) Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

(G) Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

(H) Teaches the importance of attaining self-sufficiency before engaging in sexual activity.

**Appendix B**
**Program Descriptions**

# Sexual Risk Avoidance Education Programs

## Administration for Children and Families – Title V, Section 510 State Abstinence Education*

*Program Description:* This program was first authorized by Congress in 1996, as part of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. Funds first became available to states in 1998. The stated purpose of this funding is "to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity…." For that reason, states must fund abstinence education as defined by section 510(b)(2) of the Social Security Act (42 U.S.C. § 710(b)) and may include services that provide mentoring, counseling, and adult supervision as a means of promoting abstinence from sexual activity. All programs incorporated by a state must ensure that abstinence from sexual activity is an expected outcome and that all elements of the section 510(b)(2) definition is incorporated in the program.

The Bipartisan Budget Act of 2018 changed the name and authorizing legislation for the Title V, Section 510 State Abstinence Education Grant program. It is now the Title V Sexual Risk Avoidance Education program and it no longer adheres to the Title V, Section 510(b)(2) (A-H) of the Social Security Act (SSA), but rather, uses the new definition of sexual risk avoidance laid out in the updated legislation.

*Target Population:* Grants focus on those groups most likely to bear children out of wedlock, including youth who are homeless, in foster care, live in rural areas or geographic areas with high teen birth rates, or come from racial or ethnic minority groups.

*Funding Mechanism:* The Title V State Abstinence Education Grant Program (AEGP) was re-authorized through FY 2014 under the Affordable Care Act and extended through FY 2017 under the Medicare Access and Chip Reauthorization Act (MACRA). All fifty states, the District of Columbia, Puerto Rico, Virgin Islands, Guam, American Samoa, Northern Mariana Islands, the Federated States of Micronesia, the Marshall Islands, and Palau are eligible to receive AEGP funding. In fiscal years 2014 and 2015 the $50 million of AEGP allocations funded 39 states and territories.

Total Number of Adolescents Served in the Title V Abstinence Education Grant Program:
*(Estimated number of adolescents served as formal reporting platforms were developed in FY2013)*

FY 2010: 72,799
FY 2011: 270,094
FY 2012: 320,472

* This program uses an alternative definition for adolescents other than youth younger than 19 years of age.

FY 2013: 324,179
FY 2014: 319,570
FY 2015: 399,272

*Program Activities:*
_X_ Multi-dimensional programs and interventions
_X_ Curriculum-based programs
___ Clinical services
___ Media campaigns
___ Technical assistance
___ Support services
___ Training programs
___ Research and evaluation
___ Other, please describe _____

**Administration for Children and Families – Community Based Abstinence Education (no longer funded)**

The Administration for Children and Families also operated the Community Based Abstinence Education (CBAE) program. The CBAE program supported programs that were designed to promote abstinence-until-marriage education, as defined by Section 510(b)(2)(A-H) in Title V of the Social Security Act, for adolescents aged 12 through 18. The focus of the program was to educate young people and create an environment within communities that supports teen decisions to postpone sexual activity until marriage. Activities funded through this program included multi-dimensional programs and interventions, curriculum-based programs, clinical services, media campaigns, technical assistance, support services, training programs, and research and evaluation. The population targeted was 12 to 18 year old adolescents.

CBAE programs were discretionary grants competitively awarded to county health departments, school districts, community based organizations, faith-based organizations and others. Organizations that were eligible to apply included state or local governments, school districts, institutions of higher education, Indian/Native American tribal governments, non-profits, for-profit organizations and small businesses.

**Administration for Children and Families – Competitive Abstinence Education program (no longer funded)**

In FY 2012 through 2015, Congress provided $5 million each year to be used to award competitive abstinence education grants. The purpose of the Competitive Abstinence Education program was to provide organizations with funding to address the rates of teen pregnancy through abstinence education by targeting adolescents who were most likely to bear children out of wedlock. The implementation of abstinence education for this program was defined by Section 510(b)(2)(A)-(H) of the Social Security Act, 42 U.S.C. § 710(b)(2).

*Total Number of Adolescents Served:*
FY 2014: 13,000 adolescents
FY 2015: 14,642 adolescents

**Administration for Children and Families – Sexual Risk Avoidance Education (SRAE)**

*Program Description:* In FY 2016, Congress replaced the Competitive Abstinence Education program that had been funded from FY 2012 through FY 2015 with the Sexual Risk Avoidance Education (SRAE) program, which was funded at $10 million in FY 2016. In FY 2017 and FY 2018, Congress increased funding for SRAE to $15 million and $25 million respectively.

The purpose of the SRAE program is to provide organizations with funding to educate youth on how to voluntarily refrain from non-marital sexual activity and prevent other youth risk behaviors. Successful applicants are expected to submit program plans that agree to use medically accurate information referenced in peer-reviewed publications by educational, scientific, governmental, or health organizations; implement an evidence-based approach integrating research findings with practical implementation that aligns with the needs and desired outcomes for the intended audience; and teach the benefits associated with self-regulation, success sequencing for poverty prevention, healthy relationships, goal setting, resisting sexual coercion, dating violence, and other youth risk behaviors such as underage drinking or illicit drug use without normalizing teen sexual activity.

*Target Population:* SRAE programs target all youth populations and youth who are most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in or aging out of foster care, runaway and homeless youth, culturally underrepresented youth, and sexual minority youth.

*Funding Mechanism:* Competitive awards are made to entities to implement SRAE projects.

*Total Number of Adolescents Served:*
FY 2016: 21,302 adolescents

*Program Activities:*
_x__ Multi-dimensional programs and interventions
_x__ Curriculum-based programs
____ Clinical services
____ Media campaigns
_x__ Technical assistance
_x__ Support services
___ Training programs
___ Research and evaluation
___ Other, please describe _____

**Office of the Assistant Secretary for Health – Adolescent Family Life Prevention Demonstrations (no longer funded)**

Until the program ended in FY 2010, the Office of Population Affairs operated the Adolescent Family Life Prevention Demonstration Projects. The Adolescent Family Life (AFL) program, authorized in 1981 under Title XX of the Public Health Service Act, was administered and directed by the Office of Adolescent Pregnancy Programs (OAPP) in the Office of Population Affairs (OPA). The AFL prevention programs established innovative and integrated approaches to implement abstinence education, as defined by section 510(b)(2) (A)-(H) of Title V of the Social Security Act.

AFL prevention programs developed and tested curricula, educational materials and youth development or developmental assets approaches designed to encourage adolescents to postpone sexual activity until marriage. These programs implemented and evaluated abstinence education services and activities targeting adolescents before they become sexually active. The target population was adolescents under the age of 19 and their families. Prevention demonstration programs were funded through competitive grants. Grant recipients included public or private nonprofit agency or organizations, i.e., faith-based, community-based, school districts, hospitals, and tribal organizations. The Title XX statute also required an independent evaluation of all funded demonstration projects and authorized research grants in the area of adolescent family life.

# Education or Awareness about Pregnancy and/or STD/HIV Prevention Programs

## Administration for Children and Families – Personal Responsibility Education Program (PREP)

*Program Description:* The purpose of this program is to educate youth on both abstinence and contraception for the prevention of pregnancy and sexually transmitted disease infections, including HIV/AIDS.

The state, tribal, competitive Personal Responsibility Education Program (PREP), and PREP Innovative Strategies grantees take a holistic approach to educating youth on pregnancy prevention by implementing evidence-based effective programs or substantially incorporating elements of effective programs, rigorous evaluations of innovative models, adulthood preparation subjects, and other youth development programming that supports healthy transitions to adulthood while addressing risky behaviors. These PREP projects provide adulthood preparation programming that promotes behavioral health and social-emotional well-being of vulnerable youth with a trauma-informed approach. Grantees are statutorily mandated to address at least three of the adulthood preparation subjects: healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills.

*Target Population:* PREP grantees are required to target youth populations between the ages of 10 and 19 that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, runaway and homeless youth, youth living with HIV/AIDS, pregnant and/or parenting youth who are under 21 years of age, and youth residing in areas with high birth rates.

*Funding Mechanism:* The PREP program consists of four funding streams:

- State PREP: All fifty states, the District of Columbia, Puerto Rico, Virgin Islands, Guam, American Samoa, Northern Mariana Islands, the Federated States of Micronesia, the Marshall Islands, and Palau are eligible to receive a portion of $55.25 million allotted to implement PREP. Individual state awards for each fiscal year are based on the proportion of the number of youth between the ages of 10 and 19 in a state to the total number of youth between those ages in all of the states and U.S. territories. There were 49 State PREP grantee awards in FY 2016 and 51 awards in FY 2017, with a minimum grant award of $250,000 annually.

- Competitive PREP: If a state or territory did not submit an application in FY 2016 or FY 2017, the state or territory was deemed ineligible to apply for PREP funds from the amounts allotted to the state or territory for each of the fiscal years 2018 through 2020. Funds that would have gone to those jurisdictions for fiscal years 2010 through 2017 were used to award the FY 2013 and FY 2016 cohort of competitive three-year grants to local organizations and entities for the same purpose and in the same geographic regions.

The second cohort of Competitive PREP grants were awarded to 21 applicants ranging from $250,000 to $794,000 in September 2015. Throughout the three-year project period, $11 million was available annually for grant awards. The FY 2018 cohort of Competitive PREP grants will be available to entities in 8 jurisdictions: Florida, Indiana, Kansas, North Dakota, Texas, Virginia, American Samoa, Marshall Islands,

- Tribal PREP: In addition to grants to states and territories, $3.25 million is available annually for providing grants to tribes and tribal organizations to implement PREP. Tribal PREP supports grantees and projects that include a planning year as well as three implementation years. Programs have the first 6 to 9 months of their initial award year to conduct a needs assessment, plan, and develop strategies for capacity building followed by subsequent years for program implementation. Programs are encouraged to use models (or elements of models) that have demonstrated through scientific research that they are effective in changing behavior. A funding opportunity announcement to award the second cohort of Tribal PREP resulted in eight grants ranging from $327,876 to $638,410.

- PREIS: The PREIS program is funded at $10 million for competitive grants to entities to implement innovative pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in or aging out of foster care, homeless youth, youth with HIV/AIDS, pregnant and parenting women who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. A funding opportunity announcement for the second cohort of PREIS resulted in the award of 13 applicants in FY 2016, with grants ranging from $548,060 to $975,000. Throughout the five-year project period, there will be approximately $10 million for awards based upon the availability of funds.

- Finally, $6.5 million is reserved for providing training, technical assistance, and evaluation activities.

*Total Number of Adolescents Served:*

| Program | FY 2010 | FY2011 | FY 2012 | FY2013 | FY 2014 | FY2015 | FY2016 |
|---|---|---|---|---|---|---|---|
| **SPREP** | | 80,000* | 80,000* | 80,000* | 84,699 | 98,520 | 94,019 |
| **CPREP** | | 20,000* | 20,000* | 20,000* | 23,439 | 32,225 | |
| **TPREP** | | 2,000* | 2,000* | 2,000* | 2,316 | 2,951 | Planning Year |
| **PREIS** | | Planning Year | 856 | 1,382 | 3,982 | 370 | Planning Year |

**Estimated number of adolescents served as formal reporting platforms were developed in FY2013*

*Program Activities:*
_x_ Multi-dimensional programs and interventions
_x_ Curriculum-based programs
___ Clinical services
___ Media campaigns
___ Coalition-building for the purpose of increasing services to teens
___ Education
Is the focus of the education risk avoidance? ___ yes ___ no
Is the focus of the education risk reduction? ___ yes ___ no
_x_ Technical assistance
_x_ Support services
___ Training programs
_x_ Research and evaluation
___ Other, please describe _____

**Administration for Children and Families – Temporary Assistance for Needy Families (TANF) Program**

*Program Description:* The TANF program provides a fixed block grant of about $16.5 billion to states, territories, and Washington, D.C. In addition, federally-recognized American Indian tribes and Alaska Native organizations may elect to operate their own TANF programs. The TANF program provides state flexibility in operating programs designed to help low-income families with children achieve economic self-sufficiency. TANF funds monthly cash assistance payments to low-income families with children, as well as a wide range of services that are reasonably calculated to address the program's four broad purposes, which are to:
(1) provide assistance to needy families so that children may be cared for in their own homes or the homes of relatives;
(2) end dependence of needy parents by promoting job preparation, work, and marriage;
(3) prevent and reduce the incidence of out-of-wedlock pregnancies; and
(4) encourage the formation and maintenance of two-parent families.

States have wide flexibility under TANF to determine their own eligibility criteria, benefit levels, and the type of services and benefits available to TANF recipients. Each state receiving federal TANF funds must spend an applicable percentage of its own money (known as the maintenance-of-effort requirement) to help eligible families in ways that are consistent with the purpose of the TANF program.

This report presents how states used federal TANF funds for "prevention of out-of-wedlock pregnancies," defined in the state TANF quarterly financial reporting form (ACF 196R) as "programs that provide sex education or abstinence education and family planning services to individuals, couples, and families in an effort to reduce out-of-wedlock pregnancies. Includes expenditures related to comprehensive sex education or abstinence programs for teens and pre-teens. Other benefits or services that a state provides under TANF purpose 3

(to prevent and reduce the instances of out-of-wedlock pregnancies), should be reported under a more appropriate subcategory, e.g., Services for Children and Youth."

FY 2015 was the first year that states used a revised financial reporting form (the ACF-196R), which clarified and expanded the list of expenditure categories (including the definition above) and also improved the accounting methodology. Prior to FY 2015, some states had counted activities such as pre-Kindergarten and college scholarships in that category, with that rationale that these activities might reduce non-marital pregnancies and births (the third purpose of TANF). However, the connection was indirect, so starting in FY 2015 the expenditure categories were refined to link spending directly to a program's primary purpose. Thus, pre-Kindergarten was included in "Early Care and Education" and college scholarships were to be reported in "Education and Training." As a result, any analysis of TANF spending trends over time should be done carefully, particularly with spending on the prevention of out-of-wedlock pregnancies.

*Target Population:* The target population is not limited to adolescents; states have wide flexibility as long as the activities address one of the four purposes. Each state has its own definition of adolescent, meaning states do not necessarily use the definition of "any youth age 19 and younger." ACF does not collect data on the number of individuals served by programs funded with the TANF block grant, beyond those receiving basic assistance.

**Centers for Disease Control and Prevention – Promoting Adolescent Health Through School-Based HIV/STD Prevention**

*Program Description:* CDC funds national nongovernmental organizations, state education agencies, and local education agencies, to carry out the following programmatic activities:

- Implement school-based programs and practices designed to reduce HIV infection and other STDs among adolescents; and
- Reduce disparities in HIV infection and other STDs among specific adolescent populations.
- Increase communication and dissemination of effective approaches to school-based programs to create healthier adolescents with reduced rates of HIV and STD infection

FY 2010 and FY 2011 funding levels include programmatic support for school-based HIV/STD prevention as well as school-based chronic disease prevention programs. The decline observed in 2012 reflects the impact of a reorganization that split previously comprehensive school programs into 2 budget lines - one for chronic disease related programs and one for HIV/STD and pregnancy prevention programs. At the same time, the School Health HIV budget was cut by $10 million. These cuts resulted in activities scaling back from national reach to only funding a portion of state and local jurisdictions. FY 2010, FY 2011, and FY 2012 include funding levels for surveillance as well as school-based HIV/STD prevention. Surveillance funding to grantees was not tracked separately until FY2013. All budget years include extramural and related intramural costs associated with school-based HIV prevention program implementation.

*Target Population:* The target population is adolescents in middle schools and high schools

*Total Number of Adolescents Served:* Agencies receiving CDC funding for this program reach 1.8 million students.

*Funding Mechanism:* CDC supports national nongovernmental organizations, state education agencies, local education agencies, and territorial education agencies through cooperative agreements.

***Program Activities:***
___ Multi-dimensional programs and interventions
___ Curriculum-based programs
___ Clinical services
___ Media campaigns
_X_ Coalition-building for the purpose of increasing services to teens
_X_ Education
_X_ Technical assistance
___ Support services
_X_ Training programs
_X_ Research and evaluation
_X_ Other, please describe: CDC facilitates local decision-making by making available evidence-based tools such as the Health Education Curriculum Analysis Tool (HECAT). However, it is up to localities to determine what curricula is implemented, and whether its focus is risk avoidance or risk reduction. That decision is not dictated by CDC.

**Centers for Disease Control and Prevention – Safe Motherhood/Preventing Teen Pregnancy: Promoting Science-based Approaches to Teen Pregnancy Prevention, HIV and STIs**

*Program Description:* CDC works with partners to improve surveillance and evidenced-based approaches to understand and prevent teen pregnancy. CDC also developed and maintains clinical practice recommendations.

From 2010 to 2015, CDC, the HHS Office of Adolescent Health, and the Office of Population Affairs collaborated to demonstrate the effectiveness of innovative, multicomponent, communitywide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates, with a focus on reaching African American and Latino or Hispanic young people aged 15 to 19 years.

*Target Population:* The target populations for CDC's teen pregnancy prevention efforts are young people aged 15-19 years.

*Total Number of Adolescents Served:*

2012 through 2015: Grantees served a total of 54,149 youth (15-19 years old) with evidence-based interventions; about 33% of these youth (17,846) were served by curriculum that was exclusively sexual risk avoidance and the remaining two-thirds (36,303) were served by curriculum that included sexual risk avoidance as a component, based on local decisions for their community's needs.

2011 through 2015: Health center partners served an average of 48,000 youth (15-19 years old) per year.

*Funding Mechanism:* CDC awards cooperative agreement grants to governmental agencies and non-governmental organizations, and state and local health departments and awards contracts to universities, hospitals, and commercial databases

*Program Activities:*

_X__ Multi-dimensional programs and interventions
_X__ Curriculum-based programs
___ Clinical services
___ Media campaigns
_X__ Coalition-building for the purpose of increasing services to teens
_X__ Education
Is the focus of the education risk avoidance? ___ yes ___ no
Is the focus of the education risk reduction? ___ yes ___ no
_X__ Technical assistance
_X__ Support services
_X__ Training programs
_X__ Research and evaluation
___ Other, please describe _____

**Centers for Disease Control and Prevention – School Based Programs to Promote Delay of Sexual Debut (no longer funded)**

This program funded state and territorial education agencies and national organizations to help adolescents avoid early sexual debut, unintended pregnancies, and STDs including HIV/AIDS. The activities that were funded include curriculum-based programs, technical assistance, research and evaluation, and capacity building. These activities were funded through cooperative agreements. The target population served was adolescents in middle schools and high schools and youth in out-of-school institutions such as homeless shelters, juvenile detention centers, etc.

**Indian Health Service – Clinical Services, Prevention, and Urban Health HIV/AIDS Prevention Program (no longer funded)**

The HIV Program within the Office of Clinical and Preventive Services in the Division of Clinical and Community Services of the Indian Health Services (IHS) was implemented at national, regional and local levels with many collaborators both internal and external to the agency. Activities of this program included advocacy and awareness, capacity building, treatment and care, monitoring and evaluation, and prevention. This program provided anticipatory guidance[48] to children and adolescents and their parents in traditional clinical settings as well as during school-linked and school-based encounters. Patient education during sexually transmitted disease screening and reproductive health care visits was standard practice at facilities.

Funding shown is for specific HIV/AIDS prevention activities. Funding does not include HIV/AIDS treatment or HIV/AIDS prevention provided as part of a broader context (e.g., in a physician visit when many health messages are provided). In order to estimate the funding spent on adolescent services, the total estimated cost was multiplied by the FY 2006 user population aged 19 and under (38.6%).

**Indian Health Service – Information and Education Prevention**

*Program Description:* The Indian Health Service has administered two small education and awareness projects through the Secretary's Minority AIDS Initiative (SMAIF) Contract. From FY 2010 through FY 2018, $130,000 to $200,000 in annual funds have supported *Project Red Talon,* operated by the Northwest Portland Area Indian Health Board. From FY 2015 through FY 2018, $200,000 in annual funds have supported the project, *Disseminating Effective Adolescent Health Interventions in American Indian and Alaska Native (AI/AN) Communities*, to promote HIV prevention services (Native It's Your Game, Native VOICES and Safe in the Village) within existing systems of care.

[48] Anticipatory Guidance is information that helps families prepare for expected physical and behavioral changes during their child's or teen's current and approaching stage of development.

***Indian Health Service Information and Education Prevention: HIV Youth Media (Project Red Talon)***

*Program Description:* From FY 2010 through FY 2018, $130,000 to $200,000 in annual funds have supported *Project Red Talon,* operated by the Northwest Portland Area Indian Health Board. The project used data and community-based participatory research (CBPR) recommendations to design and disseminate online HIV/STD/Hepatitis information and skill-building tools targeting American Indian and Alaska Native (AI/AN) youth 13-21 years old. Funds have been used to develop and enhance *We R Native*, which is an online, multimedia health resource for Native teens and young adults. The Indian Health Service estimates that approximately half of the funds support sexual risk avoidance education and half supported other types of education programs. As described in more detail below, there were three different project periods with varying goals.

*FY 2010-FY 2012*
Funds support *Project Red Talon* to use data and community-based participatory research (CBPR) recommendations to design and disseminate online HIV/STD/Hepatitis information and skill-building tools targeting American Indian and Alaska Native (AI/AN) youth, that were reinforced by social networking and text messaging channels. Funds were used to develop We R Native, which is a multimedia health resource for Native teens and young adults. We R Native includes content on social, emotional, physical, sexual, and spiritual health. The website (www.WeRNative.org ) contains accurate, age- and gender-appropriate content. Multimedia strategies were used to promote active learning and disseminate medically accurate information (discussion boards, text messaging services, polls, quizzes, hyperlinks, and "ask an expert" features). The resulting interventions incorporated multimodal educational strategies informed by communication and information processing theories that reflect traditional AI/AN teaching and learning practices, including storytelling (i.e., role model stories, digital storytelling, videos, animation); personal reflection (i.e., journaling, blogging, virtual discussions); and experiential learning (i.e., practice, social service).

*FY 2013-FY 2015*
Funds supported the design and dissemination of HIV/STD/Hep information and skill-building tools targeting American Indian and Alaska Native (AI/AN) youth nationwide. This included efforts to integrate and collaborate with external tribal and community programs and with federal partners (AIDS.gov, IHS HIV, etc.). The project's multimedia strategies included maintenance and enhancements to: 1) www.WeRNative.org, the We R Native text messaging service, the We R Native Facebook page, the We R Native YouTube channel, and the We R Native Twitter feed, and 2) ongoing marketing efforts to increase use of these services by AI/AN youth.

*Stigma Reduction Project*: The project trained and funded ten (n=10) AI/AN tribes and tribal organizations located throughout Indian Country to create local social marketing and social media campaigns that: 1) Expand testing and the importance of early diagnosis, inclusive of the lesbian, gay, bisexual, transgender, queer, and two spirit (LGBTQ2S) community; 2) Re-engage clients in HIV care and adherence to treatment with culturally appropriate messages;

and/or 3) Reduce stigma around testing, homophobia and transphobia. Training and technical assistance were provided to the sites throughout the year-long project. Each site developed a *Media Design Plan* based on their community's priorities and readiness levels, and tracked the dissemination of their campaign.

*Advocacy*: The project strengthened HIV knowledge and skills among tribal leaders using the *Tribal STD/HIV Advocacy Kit and Policy Guide* as a resource, and collaborated frequently with regional and national partners, including: the Indian Health Service, the United States Department of Health and Human Services, the National Indian Health Board, the Office of Minority Health, and the National Native American HIV/AIDS Prevention Center. Digital copies of the kit were also distributed at the International AIDS Society meeting of *AIDS 2012: Turning the Tide Together*.

*FY 2016 – FY 2018*
The project's primary goal was to reduce new HIV infections among American Indian and American Indian (AI/AN) teens and young adults, particularly LGBTQ2S youth. Social marketing, multimedia projects, and youth engagement activities were launched or extended to meet the prevention needs of this population. We R Native designed and disseminated social marketing campaigns (Native. Tested. Proud.), and other evidence-based interventions (GYT, the Native VOICES video, Texting 4 Sexual Health messages, etc.) to reduce STD/HIV disparities and promote HIV testing among AI/AN teens and young adults across the U.S.

*Target Population:* AI/AN youth 13 to 21-years old

*Funding Mechanism:* Secretary's Minority AIDS Initiative Fund (SMAIF) Contract

*Total Number of Adolescents Served:*
2010: 750 AI/AN youth 13 to 21-years old
2011: 3,500 AI/AN youth 13 to 21-years old
2012: 20,000 AI/AN youth 13 to 21-years old
2013: 25,000 AI/AN youth 13 to 21-years old
2014: 100,000 AI/AN youth 13 to 21-years old
2015: 300,000 AI/AN youth 13 to 21-years old
2016: 300,000 AI/AN youth 13 to 21-years old
2017: 300,000 AI/AN youth 13 to 21-years old

*Program Activities:*
_X_ Multi-dimensional programs and interventions
_X_ Curriculum-based programs
___ Clinical services
_X_ Media campaigns
_X_ Coalition-building for the purpose of increasing services to teens
_X_ Education
Is the focus of the education risk avoidance? _X_ yes ___ no
Is the focus of the education risk reduction? _X_ yes ___ no

_X_ Technical assistance
___ Support services
___ Training programs
___ Research and evaluation
___ Other, please describe _____

***Indian Health Service Information and Education Prevention: Disseminating Effective Adolescent Health Interventions in American Indian and Alaska Native (AI/AN) Communities***

From FY 2015 through FY 2018, $200,000 in annual funds have supported the project, Disseminating Effective Adolescent Health Interventions in American Indian and Alaska Native (AI/AN) Communities, to promote HIV prevention services (Native It's Your Game, Native VOICES and Safe in the Village) within existing systems of care, including Indian Health Service, Tribal, and Urban clinics, tribal health departments, and Bureau of Indian Education schools across the United States. The funds supported development of a website (www.healthynativeyouth.org) that houses culturally-relevant sexual health curricula, and provides training and technical assistance to interested sites to increase the capacity of clinical and non-clinical community based organizations to implement effective prevention strategies for a high-risk racial and ethnic minority population: American Indian and Alaska Native (AI/AN) teens and young adults. The Indian Health Service estimates that approximately half of the funds support sexual risk avoidance education and half supported other types of education programs. The Northwest Portland Area Indian Health Board works closely with the Alaska Native Tribal Health Consortium, the Intertribal Council of Arizona, and the University of Texas Center for Health Promotion and Prevention Research.

*Target Population:* The target audience is teachers, health educators, and clinicians who work with AI/AN youth 12 to 24-years old.

*Funding Mechanism:* Secretary's Minority AIDS Initiative Fund (SMAIF) Contract

*Total Number of Adolescents Served*:
2015: 300 adults who work with AI/AN youth
2016: 4,800 adults who work with AI/AN youth
2017: 7,000 adults who work with AI/AN youth

*Program Activities:*
___ Multi-dimensional programs and interventions
___ Curriculum-based programs
_X_ Clinical services
___ Media campaigns
___ Coalition-building for the purpose of increasing services to teens
_X__ Education
Is the focus of the education risk avoidance? _X__ yes ___ no
Is the focus of the education risk reduction? _X__ yes ___ no

_X_ Technical assistance
___ Support services
___ Training programs
___ Research and evaluation
___ Other, please describe _____

**Indian Health Service – High Risk and Infected Persons**

The IHS has programming for High Risk and Infected Persons who are at risk for HIV infection. Specifically, the Retention and ReEngagement in Care program covers high risk and infected youth and has the largest HIV programs in the U.S. Southwest, where about 60% of known HIV patients in Indian Country reside. Each setting uses its own approach for maximizing adherence, which requires intense case management especially for those with substance abuse issues. These key Southwest facilities have proven to be our early adopters for Pre-Exposure Prophylaxis (PrEP) implementation. The retention programs are showing strong indicators of success, and effectively improving the results for American Indians and Alaska Native youth. Our largest HIV treatment programs, with their strong case management and outreach, deliver strong HIV cascade of care outcomes for hard-to-reach populations. IHS documents best practices for linkage to care and adherence, PrEP implementation in remote settings, and screening in emergency care settings in Indian Country.

**Office of the Assistant Secretary for Health – Adolescent Family Life CARE Demonstrations (no longer funded)**

In addition to the Adolescent Family Life Prevention (abstinence education) demonstrations, the Office of Population Affairs also administered CARE demonstrations through the Adolescent Family Life program. The CARE demonstration projects developed and tested interventions with pregnant and parenting teens in an effort to ameliorate the negative effects of too-early-childbearing on teen parents, their babies and their families. Preventing repeat pregnancies was one of the major program goals. CARE demonstrations targeted youth aged 19 and younger. Similar to the AFL Prevention demonstrations, community-based, community supported, faith-based, and school-based applicants were encouraged to apply for grants.

**Office of the Assistant Secretary for Health – Teen Pregnancy Prevention (TPP) Program**

*Program Description:* The Teen Pregnancy Prevention (TPP) program, managed within the Office of Adolescent Health, Office the Assistant Secretary for Health (OASH), is a discretionary grant program to replicate evidence-based teen pregnancy prevention programs and to support research and demonstration grants to test new models and innovative strategies. The program targets youth ages 10 to 19 years old. Grants are awarded in the form of cooperative agreements to public and private entities.

*Target Population:* The target population is youth between the ages of 10 and 19.

*Funding Mechanism:* Grants are awarded in the form of cooperative agreements to public and private entities, and research and evaluation activities are also funded through contracts.

*Program Activities:*
_X_ Multi-dimensional programs and interventions
_X_ Curriculum-based programs
____Clinical services
____Media campaigns
_X_ Technical assistance
_X_ Support services
___ Training programs
_X_ Research and evaluation
___ Other, please describe_____

**Office of the Assistant Secretary for Health – Pregnancy Assistance Fund**

*Program Description:* The Affordable Care Act provides $25 million for each of fiscal years 2010 through 2019 and authorizes the Secretary of HHS, in collaboration and coordination with the Secretary of Education to establish and administer a Pregnancy Assistance Fund. The Office of Adolescent Health (OAH) within the Office of the Assistant Secretary for Health (OASH) is responsible for administering this program. The program is a competitive state grant program that serves pregnant and parenting teens and women. In FY 2018, OAH awarded a new cohort of competitive grants to States and Tribes for a two-year project period. FY 2019 funds will support the second and final year of these new FY 2018 grants.

States and Tribes use these grant funds to carry out any or all of the following activities:
- Support for pregnant and parenting student services at institutions of higher education;
- Support for pregnant and parenting teens at high schools and community service centers;
- Improving services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking; and
- Increasing public awareness and education.

This competitive grant program provides pregnant and parenting teens and women a seamless network of supportive services to help them complete high school or postsecondary degrees and gain access to health care, child care, family housing, and other critical support. In addition, States can use the funds to combat violence against pregnant women. This program provides much needed financial assistance for states and tribes to provide supports for pregnant and parenting teens and women.

*Target Population:* The program serves pregnant and parenting teens and women.

*Funding Mechanism:* Competitive State grant program.

*Program Activities:*
_X_ Multi-dimensional programs and interventions
_X_ Curriculum-based programs
___ Clinical services
___ Media campaigns
_X_ Technical assistance
___ Support services
_X_ Training programs
___ Research and evaluation
___ Other, please describe _____

# Family Planning Services

## Administration for Children and Families – Social Services Block Grant

The Social Services Block Grant (SSBG) is designed to reduce or eliminate dependency; achieve or maintain self-sufficiency for families; help prevent neglect, abuse or exploitation of children and adults; prevent or reduce inappropriate institutional care; and secure admission or referral for institutional care when other forms of care are not appropriate. SSBG serves low-income children and families, the disabled, and elderly with well-documented need. SSBG is a $1.7 billion federal grant program that provides state and local flexibility in allocating federal funds and enables states to target populations that might not otherwise be eligible for services needed to remain self-sufficient and economically independent.

SSBG funds "Family Planning Services" which are defined as " those educational, comprehensive medical or social services or activities that enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved. These services and activities include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods (including natural family planning and abstinence), and the management of infertility (including referral to adoption). Specific component services and activities may include preconceptional counseling, education, and general reproductive health care, including diagnosis and treatment of infections that threaten reproductive capability. Family planning services do not include pregnancy care (including obstetric or prenatal care).[49]

*Target Population:* The target population includes, but is not limited to, children and adolescents, individuals with low incomes, older adults, and individuals with disabilities. Individuals and families receive services based on a formula Block Grant program that is highly flexible and can include TANF transfer funds. The age of child recipients is defined by each State, but usually refers to individuals younger than 18 years of age.[50]

*Number of Adolescents Served:* In FY 2015, the latest year for which published data are available, 11.4 million children were served by the Social Services Block Grant, for any type of services. In FY 2015, 365,540 individuals of any age received family planning services.[51]

States submit their data using several age categories that include children, adults and adults of unknown age. The age of child recipients is defined by each State, but usually refers to individuals younger than 18 years of age. As seen in the table below, children represented approximately 2% of those receiving family planning services in FY 2015.

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[49] Social Services Block Grant Fiscal Year 2015 Annual Report. https://www.acf.hhs.gov/sites/default/files/ocs/rpt_ssbg_annual_report_fy2015.pdf
[50] Social Services Block Grant Fiscal Year 2015 Annual Report. https://www.acf.hhs.gov/sites/default/files/ocs/rpt_ssbg_annual_report_fy2015.pdf
[51] Social Services Block Grant Fiscal Year 2015 Annual Report. https://www.acf.hhs.gov/sites/default/files/ocs/rpt_ssbg_annual_report_fy2015.pdf

| Number of Clients Receiving Family Planning Services through SSBG in FY 2015 | | | | | | |
|---|---|---|---|---|---|---|
| **SSBG Service Category** | Children | Adults Age 59 Years and Younger | Adults Age 60 Years and Older | Adults of Unknown Age | Total Adults | Total Recipients |
| Family Planning Services | 7,249 | 292,487 | 1,038 | 64,766 | 358,291 | 365,540 |

*Funding Mechanism:* The SSBG Block Grant is distributed to States and Territories by formula, who then distribute the funds to social service agencies to tailor social service programming to their population's needs.

*Program Activities:*
Using the checklist below, please check all types of activities funded:
_X_Multi-dimensional programs and interventions
_X_ Curriculum-based programs
_X_Clinical services
___ Media campaigns
_X__ Coalition-building for the purpose of increasing services to teens
_X__ Education
Is the focus of the education risk avoidance? ___ yes ___ no
Is the focus of the education risk reduction? ___ yes ___ no
__X_ Technical assistance
__X_ Support services
__X_ Training programs
__X_ Research and evaluation
___ Other, please describe _____

## Centers for Medicare and Medicaid Services (CMS) – Medicaid

*Program Description:* Medicaid is a program jointly funded by the federal and state governments to provide medical care to various low-income populations. Medicaid is an entitlement program, meaning that federal law guarantees reimbursement for services provided to everyone enrolled under federal and state eligibility criteria. The mandatory family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, a medical visit to change the method of contraception, and (at the state's option) infertility treatment. By federal law, the federal government pays for 90% of each state's Medicaid expenditures for family planning services and supplies. Although federal law requires that each State Medicaid program cover family planning services, states have leeway in deciding what exactly is included. CMS is not able to breakout funding specifically for adolescent family planning services. In 2008, using expenditure data and utilization rates, the CMS Office of the Actuary estimated the portion of Medicaid family planning expenditures that are directed towards adolescents to be 10% of all family planning expenditures. The current report uses the same 10% estimate.

**Centers for Medicare and Medicaid Services (CMS) – Children's Health Insurance Program**

*Program Description:* The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. CHIP funding is generally for child health assistance (defined as coverage that meets the requirements of section 2103 of the Social Security Act) to targeted low-income children. States are also allowed to use CHIP administrative funding (up to 10% of their annual funding) for Health Services Initiatives (HSIs), which are activities that protect the public health, protect the health of individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children (including targeted low-income children and other low-income children).

*Target Population:* The Children's Health Insurance Program (CHIP) serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid. States have broad discretion in setting their income eligibility standards, and eligibility varies across states.

*Total Number of Adolescents Served*: In FY 2017, there were 3,615,202 unduplicated children ages 13 through 18 enrolled in separate CHIP and Medicaid Expansion CHIP in FY 2017. Separate CHIP accounts for 1,330,655 of these children, while the other 2,284,547 children in this age group are enrolled in a Medicaid expansion program.

*Funding mechanism*: CHIP is a capped program, meaning each state is provided an annual CHIP allotment. Every fiscal year, the Centers for Medicare & Medicaid Services (CMS) determines the share of program funding they will pay that year. States must provide matching funds to get their federal funding allotment.

*Program Activities:*
___ Multi-dimensional programs and interventions
___ Curriculum-based programs
_X_ Clinical services
___ Media campaigns
___ Coalition-building for the purpose of increasing services to teens
__ Education
Is the focus of the education risk avoidance? ___ yes ___ no
Is the focus of the education risk reduction? ___ yes ___ no
___ Technical assistance
___ Support services
___ Training programs
___ Research and evaluation
___ Other, please describe _____

**Centers for Medicare and Medicaid Services (CMS) – Family Planning Section 1115 Medicaid Demonstrations**

*Program Description:* Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental or pilot demonstration projects that are found to be likely to assist in promoting the objectives of the Medicaid program. "Family planning" demonstrations are one type of section 1115 demonstration approved to permit state flexibility with providing a targeted benefit of family planning services to women and men who do not qualify for full Medicaid benefits. The objective of these demonstrations is to reduce unintended pregnancies that would likely be paid for by Medicaid or the Children's Health Insurance Program. States have broad flexibility in designing the eligibility for and scope of coverage under family planning demonstration programs. For the purposes of this report, we focus only on the currently approved five targeted family planning demonstrations that serve a combination of low-income women and men of reproductive age, including adolescents under age 19: Florida, Georgia, Mississippi, Oregon, and Washington.

*Target Population:*

Florida: Women of childbearing age losing Medicaid pregnancy coverage or full Medicaid coverage, who have family income at or below 191% of the federal poverty level (FPL), and who are not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services.

Georgia: Women, ages 18-44, with a family income at or below 200% of the federal poverty level, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP) and do not have any other health insurance

Mississippi: Women and men, ages 13 through 44, with income at or below 194% of the federal poverty level who are not enrolled in Medicaid, Medicare, the Children's Health Insurance Program, or other credible health insurance coverage that includes family planning services.

Oregon: Men and women of childbearing age who are otherwise not eligible for Medicaid or the Children's Health Insurance Program and whose household income is at or below 250% of the federal poverty level.

Washington: Uninsured women and men capable of producing children with income at or below 260% of the federal poverty level; women losing Medicaid pregnancy coverage at the conclusion of the 60-day postpartum period; and teens and domestic violence victims who need confidential family planning services and have individual income at or below 260% of the FPL.

*Total Number of Adolescents Served:*
FY 2011: 28,480 (in three states – GA, MS, and OR)
FY 2012: 62,988 (in four states – GA, MS, OR, and WA)
FY 2013: 54,089 (in four states – GA, MS, OR, and WA)

FY 2014: 33,178 (in five states – FL, GA, MS, OR, WA)
FY 2015: 20,541 (in five states – FL, GA, MS, OR, WA)
FY 2016: 19,375 (in five states – FL, GA, MS, OR, WA)
FY 2017: 33,057 (in five states – FL, GA, MS, OR, WA)

**Health Resources Services Administration (HRSA) – Title X Family Planning (Administered by the Office of the Assistant Secretary for Health)**

Enacted in 1970, the Title X Family Planning program is the only Federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. The Title X program is designed to provide access to contraceptive services, supplies and information to all want and need them. By law, priority is given to persons from low-income families, including adolescents. Services are delivered through a network of community-based clinics, including State and local health departments, hospitals, university health centers, independent clinics and public and private nonprofit agencies. The family planning programs provide a broad range of effective and acceptable family planning methods and related preventive health services, including counseling and education on sexual risks and promoting preventive health practices. The Title X Family Planning program is appropriated to HRSA and administered by the Office of Population Affairs (OPA) within the Office of the Assistant Secretary for Health.

*Target Population:* The Title X Family Planning Program targets females and males of child-bearing age, with a priority given to persons from low-income families. While adolescents are not specifically targeted, they are offered and provided the range of services available at Title X family planning centers. These services include, physical exams, preventive screenings, including STD testing and treatment, HIV testing, related education and counseling on contraceptive methods, and a range of other preventive health and sexual and reproductive health topics. All Title X clients are provided confidential services.

*Funding Mechanism:* Funding is via discretionary, competitive grants made available to public and private non-profit entities such as community-based clinics, state and local health departments, hospitals, university health centers, and independent clinics. Currently, there are approximately 90 grantees that receive Title X services funds and services are provided through a network of approximately 4,000 Title X-funded centers.

*Program Activities:*
_X__ Multi-dimensional programs and interventions
_X__ Curriculum-based programs
_X__ Clinical services
___ Media campaigns
_X__ Technical assistance
_X__ Support services
_X__ Training programs
_X__ Research and evaluation
___ Other, please describe _____

**Health Resources Services Administration (HRSA) – Health Center Program**

*Program Description:* For more than 50 years, health centers have delivered affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, behavioral, and patient services. Today, nearly 1,400 health centers operate more than 11,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

In 2016, health centers served 25.9 million patients, one in every twelve people living in the United States, providing approximately 104 million patient visits, at an average cost of $890 per patient (including Federal and non-Federal sources of funding). In 2016, nearly half of all health centers served rural areas providing care to 8.6 million patients, about one in 6 people living in rural areas. Patient services are supported through Federal Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party payments, self-pay collections, other Federal grants, and State/local/other resources.

The Health Center Program funding for adolescent family planning is based on estimates. HRSA does not administer grant programs or provide targeted funding specifically for this activity. Additionally, it does not collect data that allows accurate reporting or analysis for this specific activity. The following methodology is provided as the best rough estimate of Health Center Program grant funding spent by grantees on preventive sexual risk behavior for adolescents.

- The percentage of health center visits that included the prevention of sexual risk behavior (contraception management) was calculated at approximately 2.5%.
- The percentage of adolescents served by health centers is approximately 10% of total patients.

Total grant dollars awarded in each respective fiscal year were multiplied by 2.5% to compute estimated annual grant dollars for preventive sexual risk behavior, which were then multiplied by 10% to compute estimated grant dollars spent on preventive sexual risk behavior for adolescents.

*Target Population:* Health centers serve people of all ages. Approximately 31\% of patients in 2016 were children (age 17 and younger); over 8% were 65 or older. Health centers serve people with and without health insurance; about one in 4 patients served are without health insurance. Those patients that are insured are covered by Medicaid, Medicare, other public insurance, or private insurance. Health centers serve a significant number of special population patients. Some health centers receive specific funding to focus on certain special populations including agricultural workers, individuals and families experiencing homelessness, those living in public housing, and Native Hawaiians. In 2016 health centers served more than 1.2 million individuals experiencing homelessness, over 950,000 agricultural workers and their families, almost 2.7 million residents of public housing and nearly 14,000 Native Hawaiians.

The Health Center Program tracks patients by age, but does not have a routine definition for the term "adolescent." For this activity, the total number of patients in age groups 13-19 was used. In 2016, the total number of adolescents served was 2.73 million (ages 13-19).

*Funding Mechanism*: Competitive grants to community based health center organizations.

*Program Activities:*
Using the checklist below, please check all types of activities funded:
___ Multi-dimensional programs and interventions
___ Curriculum-based programs
_X_ Clinical services
___ Media campaigns
___ Coalition-building for the purpose of increasing services to teens
___ Education
Is the focus of the education risk avoidance? ___ yes ___ no
Is the focus of the education risk reduction? ___ yes ___ no
_X_ Technical assistance
_X_ Support services
_X_ Training programs
___ Research and evaluation
___ Other, please describe _____

**Indian Health Service – Family Planning Services**

*Program Description:* The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level.

The Division of Nursing Services (DNS) leads in developing and managing clinical and public health nursing services, such as acute care, ambulatory care, women's health, public health nursing, emergency care services, and the HIV/AIDS program. The DNS aids in nursing recruitment and funding scholarships, as well as providing guidance with management information systems to benefit documentation and data collection by and for registered nurses, public health nurses and advanced practice registered nurse health care providers. The DNS provides clinical services in either the inpatient or ambulatory care settings. Public health nurses provide education for family planning to adolescents.

*Target Population:* The DNS provides nursing services to all age groups including adolescents.

*Total Number of Adolescents Served:* In FY 2017, IHS served 124,849 adolescents aged 11 to 19 years old.

*Funding Mechanism:* The DNS budget is allocated by Congress and IHS funds family planning services through direct services funding.

*Program Activities:*

Using the checklist below, please check all types of activities funded:
___ Multi-dimensional programs and interventions
___ Curriculum-based programs
_X_ Clinical services
___ Media campaigns
___ Coalition-building for the purpose of increasing services to teens
___ Education
Is the focus of the education risk avoidance? ___ yes ___ no
Is the focus of the education risk reduction? ___ yes ___ no
___ Technical assistance
___ Support services
___ Training programs
___ Research and evaluation
___ Other, please describe _____

# Appendix C

## Supplemental Budget Tables

## Sexual Risk Avoidance Education

Table 4. Sexual Risk Avoidance Education funded by the Administration for Children and Families

| | FY 2009 | FY 2010 | FY2011 | FY 2012 | FY2013 | FY 2014 | FY2015 | FY 2016 | FY 2017 |
|---|---|---|---|---|---|---|---|---|---|
| *Direct Services (Formula & Discretionary)* | AEGP: $22,949,425 | AEGP: $33,434,552 | AEGP: $33,434,552 | AEGP: $33,434,552<br><br>CAE: $4,732,173 | AEGP: $36,862,525<br><br>CAE: $4,259,810 | AEGP: $35,841,891<br><br>CAE: $4,485,864 | AEGP: $46,218,984<br><br>CAE: $4,554,816 | AEGP: $66,683,508<br><br>GDM SRAE: $8,981,973 | AEGP: $63,372,499<br><br>GDM SRAE: $13,447,039 |
| Training and Technical Assistance | | | | CAE: $108,753 | CAE: $70,950 | CAE: $71,400 | CAE: $72,471 | GDM SRAE: $300,000 | GDM SRAE: $580,610 |
| Research and Evaluation Funds (all Funds | | | | | | | | GDM SRAE: $295,954 | GDM SRAE: $444,965 |
| Funding specifically for an Impact Evaluation | | | | | | | | | |
| Other *(Program Support -Staff Salaries and Benefits/Logistical Contracts/Inter-agency Agreements)* | | | | | | | | GDM SRAE: $417,715 | GDM SRAE: $501,927 |

AEGP = Title V, Section 510 Abstinence Education Grant Program (AEGP)
CAE = Community Abstinence Education Program
GDM SRAE = Discretionary, Competitive Sexual Risk Avoidance Education (SRAE) Program

## Education and Awareness about Pregnancy and/or STD/HIV Prevention Programs

Table 5. Personal Responsibility Education Program (PREP) Administered by the Administration for Children and Families

| | FY 2009 | FY 2010 | FY2011 | FY 2012 | FY2013 | FY 2014 | FY2015 | FY 2016 | FY 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Direct Services *(Formula & Discretionary)* | | PREP: $44,168,860 | PREP: $43,823,273 | PREP: $66,038,864 | PREP: $63,364,868 | PREP: $61,657,135 | PREP: $57,885,071 | PREP: $69,110,829 | PREP: $63,941,283 |
| Training and Technical Assistance | | | PREP: $1,799,493 | PREP: $2,927,071 | PREP: $2,542,708 | PREP: $2,276,569 | PREP: $1,431,548 | PREP: $1,940,626 | PREP: $1,264,377 |
| Research and Evaluation Funds *(all funds)* | | | PREP: $5,500,000 | PREP: $3,248,000 | PREP: $2,170,830 | PREP: $2,017,903 | PREP: $2,199,972 | PREP: $2,795,730 | PREP: $2,125,677 |
| Funding specifically for an Impact Evaluation | | $225,000 (PREIS) | $185,000 (PREIS)<br><br>$ 1,539,687 (PREP Impact Study) | $410,000 (PREIS)<br><br>$ 1,539,687 (PREP Impact Study) | $292,680 (PREIS)<br><br>$1,538,687 (PREP Impact Study) | $202,624 (PREIS)<br><br>$1,538,687 (PREP Impact Study) | $1,538,687 (PREP Impact Study) | $496,688 (PREIS)<br><br>$1,538,687 (PREP Impact Study) | |
| Other *(Program Support -Staff Salaries and Benefits/Logistical Contracts/Inter-agency Agreements)* | | PREP: $1,657,476 | PREP: $1,942,643 | PREP: $1,993,401 | PREP: $1,833,197 | PREP: $1,933,401 | PREP: $1,657,476 | PREP: $2,462,507 | PREP: $2,387,005 |

PREIS= Personal Responsibility Education – Innovative Strategies (a subset of the PREP funding)

## Education and Awareness about Pregnancy and/or STD/HIV Prevention Programs

Table 6. CDC Safe Motherhood – Teen Pregnancy Prevention Program (funding in millions)

| | FY 2009 | FY 2010 | FY2011 | FY 2012 | FY2013 | FY 2014 | FY2015 | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|---|---|---|---|---|---|---|
| *Direct Services* | | - | - | - | - | - | - | - | | |
| Training and Technical Assistance | | $2.0 | $2.0 | $2.0 | $2.0 | $2.0 | $0.7 | $2.0 | 0.0 | |
| Research and Evaluation Funds *(all funds)* | | $1.5 | $1.5 | $1.5 | $1.5 | $1.5 | $3.0 | $3.7 | $2.2 | |
| Funding specifically for an Impact Evaluation | | $9.8 | $9.5 | $9.5 | $9.5 | $9.5 | $2.0 | $2.0 | $1.9 | $1.9 |
| Other* *(please list activities)* Grant Awards-Surveillance | | $0.5 | $0.5 | $0.5 | $0.5 | $0.5 | $4.8 | $7.8 | 0.0 | |
| Other* *(please list activities)* Intramural | | $2.0 | $2.0 | $2.0 | $2.0 | $2.0 | $1.7 | $1.7 | 0.0 | |
| **Total** | | $15.8 | $15.5 | $15.5 | $15.5 | $15.5 | $12.2 | $17.2 | $4.1 | $1.9 |

** Other (please provide amount of funding that goes to other types of activities funded in this category and list the activities; one activity per line)*

## Education and Awareness about Pregnancy and/or STD/HIV Prevention Programs

Table 7. CDC Promoting Adolescent Health Through School-Based HIV/STD Prevention

| | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 | FY 2014 | FY2015 | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|---|---|---|---|---|---|---|
| Direct Services | | - | - | - | - | - | - | - | | |
| Training and Technical Assistance | | 5.990 | 5.035 | | 2.460 | 2.196 | 2.042 | 2.085 | 2.073 | |
| Research and Evaluation Funds *(all funds)* | | | | | 0.550 | 0.499 | 0.499 | 0.499 | 0.499 | |
| Funding specifically for an Impact Evaluation | | | | | | | | | | |
| Other* *(please list activities)* Grant Awards | | 25.985 | 24.585 | 16.318 | 13.419 | 15.410 | 11.999 | 10.674 | 10.530 | |
| Other* *(please list activities)* Intramural | | 2.696 | 3.862 | 1.657 | 2.425 | 2.658 | 2.662 | 2.704 | 2.774 | |
| **Total** | | 34.671 | 33.482 | 17.975 | 18.854 | 20.763 | 17.202 | 15.962 | 15.876 | |

## Education and Awareness about Pregnancy and/or STD/HIV Prevention Programs

Table 8. Indian Health Service's *HIV Youth Media (Project Red Talon)*

| | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|---|---|---|---|---|---|---|
| Direct Services | | | | | | | | | | |
| Training and Technical Assistance | | $50,000 | $50,000 | $50,000 | $40,000 | $40,000 | $40,000 | $50,000 | $50,000 | |
| Research and Evaluation Funds *(all funds)* | | | | | | | | | | |
| Funding specifically for an Impact Evaluation | | | | | | | | | | |
| Other* *(please list activities)* Social Marketing | | $50,000 | $50,000 | $50,000 | $40,000 | $40,000 | $40,000 | $75,000 | $75,000 | |
| Other* *(please list activities)* Website | | $50,000 | $50,000 | $50,000 | $53,000 | $53,500 | $53,500 | $75,000 | $75,000 | |
| **Total** | | $150,000 | $150,000 | $150,000 | $133,000 | $133,000 | $133,000 | $200,000 | $200,000 | |

## Education and Awareness about Pregnancy and/or STD/HIV Prevention Programs

Table 9. Indian Health Service's *Disseminating Effective Adolescent Health Interventions in American Indian and Alaska Native (AI/AN) Communities*

| | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|---|---|---|---|---|---|---|
| Direct Services | | | | | | | | | | |
| Training and Technical Assistance | | | | | | | $100,000 | $100,000 | $100,000 | |
| Research and Evaluation Funds *(all funds)* | | | | | | | | | | |
| Funding specifically for an Impact Evaluation | | | | | | | | | | |
| Other* *(please list activities)*<br><br>Website | | | | | | | $100,000 | $100,000 | $100,000 | |
| **Total** | | | | | | | $200,000 | $200,000 | $200,000 | |