

How the Teen Pregnancy Prevention Program Impacted Teen Pregnancy Rates in GA
Counties: A Quantitative Study

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ABSTRACT

This quantitative correlational study examined whether participation in the federally funded Morehouse School of Medicine Teen Pregnancy Prevention Initiative (TPPI) affected teen birth rates in selected counties compared to demographically matched comparison counties. This research was guided by the Public Health Model, with a focus on the following three research questions: What has been the impact of the federally funded Teen Pregnancy Prevention (TPP) Program on teen pregnancy rates in targeted Georgia counties?, What other contributing factors or social determinants of health influence teen pregnancy rates in targeted counties in Georgia?, and How does the political climate impact the programs and services available to address teen pregnancy? To effectively address these questions, secondary data were obtained from the Georgia Department of Public Health's OASIS system and U.S. Census QuickFacts. For reliable and statistically sound analyses, both descriptive statistics and chi-square tests of association were conducted. The analyses showed that teen birth rates declined across all counties from 2010 to 2024. Although TPPI counties began with higher baseline rates, they experienced steeper declines during program implementation and sustained reductions afterward. Education, socioeconomic status, and race were all significant predictors of teen birth rates, and political affiliation patterns differed between TPPI and comparison counties. These findings have important implications for the allocation of fiscal and human resources, the design of programs and services, and the development of policies aimed at reducing teen pregnancy and improving adolescent health.

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DEDICATION

This work is dedicated to my Daddy, Earl Mitchell Flowers.
I was his angel in life, now he's my heavenly angel watching over me always.
Daddy, I did it.
Love you always-
Forever your baby girl

Chapter I

Introduction to the Study

Teen pregnancy is a social problem in the United States. United Nations Children's Fund, formerly the United Nations International Children's Emergency Fund (UNICEF, 2021), reported a birth rate of 13.7 live births per 1,000 adolescent girls aged 10-19 in 2022. This varies drastically from other developed countries such as the United Kingdom, Canada, and Japan, which report birth rates of 8.6, 4.5, and 1.7 per 1,000 adolescent girls, respectively (UNICEF Data Warehouse, 2021). The Centers for Disease Control and Prevention (CDC, 2024) reported that teen birth rates have been on a steady decline in the United States since the early 1990s, with 2022 birth rates decreasing by 2% to 13.6 births per 1,000 for teen girls ages 15-19 years from the previous year, with a rate of 13.9 births per 1,000 teens. Osterman et al. (2024) reported the following birth rates in 2022 for the various age ranges of female adolescents: 10-14 was unchanged from the 2021 rate of 0.2 births per 1,000 females, 15-17 was unchanged at 5.6 births per 1,000 females, while the 18-19 rate of 25.8 births was a 3% decrease from 2021. Additionally, the 2022 National Vital Statistics Report on birth data also detailed a decline in teen births among various races, indicating that birth rates decreased 7% for Black and American Indian and Alaska Native females, and 3% for White females, but increased 1% for Hispanic females (Osterman et al., 2024).

The problem of teen pregnancy persists despite policies and practices such as abstinence-only and comprehensive sexual education services. These programs have demonstrated a slight decrease in pregnancy rates; however, the decrease has not been enough to counter the public health costs. To continue this consistent decline, it is essential to address teen pregnancy prevention due to substantial costs both socially and economically to the teens, their children, and their communities. Teen pregnancy affects individuals, their families, and all of society in a myriad of ways. Some individuals may experience disruptions in their educational goals, social lives, and mental well-being. Jakubowski et al. (2023) found that more than half of women aged 20 with a history of adolescent pregnancy dropped out of high school and/or received financial assistance in comparison to their counterparts who did not experience an adolescent pregnancy. Families of adolescent parents endure hardships that are equally challenging. Teen pregnancy can be indicative of poverty and poor health (Mann et al., 2020), which plagues the family unit and creates additional difficulties such as financial consequences, emotional costs, and changes in the overall family structure. In addition to the personal and familial consequences, teen pregnancy results in societal concerns, such as extreme economic costs, increased adverse medical outcomes, and influences on public policy (Akella & Jordan, 2015). Teen pregnancy impacts various facets of society and has become a public health issue that needs to be addressed.

Since the 1990s and early 2000s, teen pregnancy rates have consistently declined in the United States. The reasons for the decline are not exact, but the Teen Pregnancy Prevention (TPP) Program, funded in 2010 under the Obama Administration, influenced this decline in the later years. The funding of the TPP Program was one of many

impactful legislative efforts for the Obama administration. As detailed by Kappeler and Farb (2014), the TPP Program was the Obama administration's chance to meaningfully influence public health issues related to teen pregnancy, risky behaviors, and consequences that could result from engaging in sexual activity. It aimed to ultimately improve overall adolescent health and the U.S. government's response to the public health concerns. This was accomplished through rigorous evaluation and by creating social policies and initiatives that were rooted in evidence-based practices that aimed to improve programmatic outcomes. The TPP Program was a transition from abstinence-only until marriage education programs to programs that were identified as promising practice or evidence-based programs (Kappeler & Farb, 2014). It was an all-inclusive approach to teen pregnancy with various programs, such as sex education, youth development, abstinence education, and programs for vulnerable populations (Farb & Margolis, 2016). This Congressionally funded project was the beginning of a new approach to addressing teen pregnancy.

Teen Pregnancy Prevention (TPP) Program Background

The Department of Health and Human Services' (HHS) Office of Adolescent Health, which in 2019 merged with the Office of Population Affairs (OPA, 2023), implemented the bipartisan Congressionally funded multi-tiered TPP Program. OPA is the agency that would administer the TPP Program, which would include a two-tiered funding system: (a) Tier 1 focused on implementing medically informed, age-appropriate programs, verified effective through an evaluation to prevent teen pregnancy and/or associated sexual risk behaviors, and (b) Tier 2 focused on developing and testing additional models and innovative strategies for preventing teen pregnancy (Margolis &

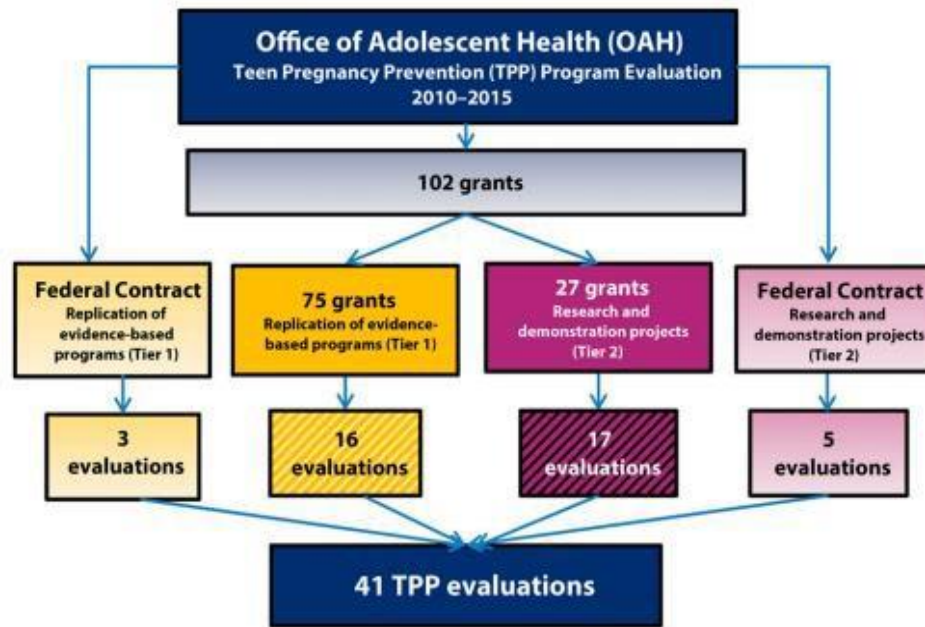
Roper, 2014). After a competitive and demanding grant process, the organizations were identified for the first TPP Program cohort. Tier 1 would be allocated \$75 million of the total budget, and Tier 2 would receive \$25 million (Margolis & Roper, 2014). To utilize the remaining budgeted funds, an agency was contracted to provide thorough training and technical assistance for the funded grantees of both tiers. These contractors were tasked with ensuring that the projects were designed, implemented, analyzed, and reported on in accordance with HHS-established policies and procedures (Farb & Margolis, 2016). Overall, the inaugural 2010-2015 cohort of the TPP Program was expansive, as the project funded 75 individual Tier 1 organizations that implemented one or more of 28 existing evidence-based interventions, and 27 Tier 2 organizations that would work to create new interventions for teen pregnancy prevention (Farb & Margolis, 2016). The first TPP cohort demonstrated an achievement with “a total of 41 program evaluations, including 19 evaluations of evidence-based programs and 22 evaluations of new or innovative approaches” (Farb & Margolis, 2016, p. S10), as depicted below in Figure 1.

The TPP Program, as a federal funding source, has been essential in affecting teen pregnancy rates in the United States. After its positive first cohort, OPA (2023) elected to release another funding opportunity announcement for a second cohort, which was funded from 2015 to 2020. After its successful first cohort, OPA (2023) elected to release another funding opportunity announcement for a second cohort, which was funded from 2015 to 2020. The projects it was tasked with achieving were diverse: (a) support replication of evidence-based teen pregnancy prevention programs in those communities with the greatest need; (b) increase the communities’ capacity to serve vulnerable youth, including homeless youth, parenting youth, and those in juvenile detention and foster

care; (c) fill gaps in the knowledge of what interventions work to prevent teen pregnancy; and (d) test new, innovative approaches to combating teen pregnancy (OPA, 2023).

Figure 1

Flow of Teen Pregnancy Prevention Program Grants and Contracts into Evaluations



Note. Adapted from “The Teen Pregnancy Prevention Program (2010-2015): Synthesis of Impact Findings ,” by A. F. Farb and A. L. Margolis, 2016, *American Journal of Public Health*, 106(S1), p. S9-15 (<https://doi.org/10.2105/ajph.2016.303367>)

The TPP Program allowed states to proactively address teen pregnancy. The Health Promotion Resource Center at Morehouse School of Medicine recognized the need for funding in Georgia to address the public health issue of teen pregnancy. A grant application was submitted and awarded to the Health Promotion Resource Center at Morehouse School of Medicine to be a part of the second TPP Program cohort. The Morehouse School of Medicine (MSM) Teen Pregnancy Prevention Initiative (TPPI) would be a multi-faceted project that would use evidence-based program curricula paired

with Youth Leadership Councils and Community Advisory Boards to implement the program and ensure it met the requirements of a TPP Tier 1 Project (Langley & Laster, 2014). The TPPI was to be implemented in different Georgia counties with teen pregnancy rates higher than the state average, as reported by the Georgia Department of Public Health's (2023) data collection tool, Online Analytical Statistical Information System (OASIS) (Langley & Laster, 2014). The counties included in the TPPI program were diverse, classifying as rural or urban, as determined by their population number according to U.S. Census Bureau data. In addition to high teen pregnancy birth rates, the counties were chosen because they had high repeat birth rates within a two-year period, high areas of poverty, and higher rates of youth sexually transmitted infections (Langley & Laster, 2014). The selected counties were ideal for the TPPI Program because they were all affected by these social determinants of health and would benefit from participation. MSM's TPPI Program included the following counties: DeKalb, Dougherty, Douglas, Lamar, and Thomas (Langley & Laster, 2014).

The TPPI Program would implement several evidence-based programs to serve middle and high-school-aged youth in the identified counties. The interventions were chosen through targeted community needs and resource assessments, which identified the programs and services the community members considered to have the most potential to be effective in handling teenage pregnancy prevention and high-risk behaviors among the youth (Langley & Laster, 2014). This process ensured that the evidence-based programs were specific to the community in which implementation would occur. Five program options were allowed for TPPI Program counties: "1) Making a Difference–Abstinence Education; 2) Be Proud! Be Responsible! –Sexuality Education; 3) Be Proud! Be

Responsible! Be Protective! –Program for Pregnant and Parenting Girls; 4) Teen Outreach Program–Youth Development; and 5) 17 Days–Clinic-based” (Langley & Laster, 2014, p. 11). Implementing a diverse selection of evidence-based programs would ensure the MSM TPPI Program effectively met the needs of the youth participants and communities being served by the project and simultaneously impacted the teen pregnancy rates.

Statement of the Problem

Teen pregnancy is a public health issue with effects beyond the parenting teen and their child. In Georgia, teen pregnancy is a costly public health issue with direct and indirect impacts on everyone. Existing studies have looked at how specific curricula, programs, services, and other contributing factors address teen pregnancy. For example, various studies have indicated that abstinence-only education programs are ineffective in preventing teen pregnancy (Bruggink, 2007; Saul, 1999; Stanger-Hall & Hall, 2011). This supports the need for a data-driven and evidence-based program to address teen pregnancy and the reason for the existence of the TPP Program. Despite the apparent need for the TPP Program and the multitude of ways in which teen pregnancy affects people, there has been limited research on how the federally funded program has impacted teen pregnancy rates. Thus, this study is relevant because it is important to know if there is any impact on teen birth rates in Georgia due to the TPP Program.

Purpose of the Study

The purpose of this quantitative study was to determine the impact of the federally funded TPP Program on teen pregnancy rates in select Georgia counties. Additionally, the study examined other contributing factors, such as socioeconomic status

(SES), race, and education, which may impact teen pregnancy rates in Georgia counties. This in-depth exploration of various factors that may impact the public health issue of teen pregnancy is essential to fully understanding the necessity for teen pregnancy prevention and a holistic approach to teen pregnancy.

Research Questions

This study reviewed and explored data from multiple Georgia counties to determine if there was an impact on teen pregnancy rates due to the presence of the federally funded teen pregnancy prevention program. The study compared data from counties served by teen pregnancy prevention organizations to data from counties of similar size and demographics that did not receive services from a teen pregnancy prevention organization. The following counties were used as comparison counties: Bibb, Cobb, Glynn, Greene, and Laurens Counties. These counties were selected because they mirrored the MSM Project counties in size, population demographics, and geographic designation as determined by the U.S. Census Bureau data (USCB, 2023). Additionally, these counties were chosen because they were not a grantee or sub-awardee of the second cohort for the TPP Program. Using data collected on these 10 counties, the study endeavored to answer several research questions. The study addressed one primary research question:

RQ1. What has been the impact of the federally funded Teen Pregnancy Prevention (TPP) Program on teen pregnancy rates in targeted Georgia counties?

This study also explored the following sub-questions:

RQ1a. What other contributing factors or social determinants of health influence teen pregnancy rates in targeted counties in Georgia?

RQ1b. How does the political climate impact the programs and services available to address teen pregnancy?

Hypothesis

The research hypothesis for this study was that Georgia counties funded by the TPP Program would have significantly lower teen birth rates than the counties that were not funded by the federal TPP Program. Statistical tests were conducted to either accept or reject this hypothesis.

Theoretical Framework

The theoretical framework that guided this study was the Public Health Model (PHM), which focuses on the health, safety, and well-being of populations, with the overarching desired outcome of providing the greatest benefit for the maximum number of people (CDC, 2024). The PHM uses a four-phase methodology to address an issue and achieve change in health behavior:

1. Define and monitor the problem.
2. Identify risk and protective factors.
3. Develop and test prevention strategies.
4. Assure widespread adoption (CDC, 2024).

PHM was employed to implement the TPPI, and it also informed this study because teen pregnancy is a public health issue. Applying PHM created a framework for this study that explored all contributing factors that impact teen pregnancy. Additionally, it can aid in identifying social determinants of health as well as risks and protective factors that influence teen pregnancy.

Significance of the Study

This study is relevant because it aims to provide an understanding of how teen pregnancy affects the teen parent as an individual, the impact of teen pregnancy on the family unit, and how it contributes to high economic burdens on society. This includes related issues such as high drop-out rates, increased involvement in the criminal justice system, and increased poverty rates of adolescent parents that can be outcomes of teen pregnancy. This study could also be integral in identifying any gaps in the field of teen pregnancy prevention, which could assist in curtailing the problem. Additionally, this study's results may influence future legislative policies and budget allocations for programs serving youth in Georgia and across the nation. Should this level of adoption occur, it would align with the fourth phase in the Public Health Model, which is widespread adoption and result in healthier populations throughout Georgia as the use of evidence-based programs and services would be commonplace and readily available to youth.

Assumptions, Delimitations, and Limitations

Assumptions

This study made certain assumptions that must be true to form the foundation for methodological integrity and the validity of the study's findings. For this quantitative study, examining the impact of the federal prevention initiative on teen pregnancy rates in selected Georgia counties, several key assumptions grounded the research design and analysis, including the following:

Accuracy and Reliability of Secondary Data Sources. It was assumed that all secondary data obtained from reputable sources such as the Georgia Department of

Public Health's Online Analytical Statistical Information System, the Centers for Disease Control and Prevention, and the U.S. Census Bureau were correct, reliable, and up to date. This assumption was necessary given that the study's analyses and any additional inferences relied on the integrity and completeness of these publicly accessible data sets.

Consistency of Data Collection Across Counties. It was assumed that all counties, both those participating in the TPP Program and those used for comparison, adhered to consistent data reporting standards concerning vital statistics, population estimates, and sociodemographic indicators. The consistency in data collection should ensure comparability and validity across counties.

Implementation Fidelity of the Teen Pregnancy Prevention Program. The study assumed that the TPP program was implemented in each funded county in accordance with federally approved guidelines and with reasonable fidelity to the evidence-based program model. Variations in program delivery can be expected, but it was assumed that the variations in implementation quality or duration would not significantly alter the results or the relationship between program exposure and teen pregnancy outcomes.

Influence of Social Determinants of Health. It was assumed that social determinants of health (SDOH), such as socioeconomic vulnerability, educational attainment, and race, had an influence on teen pregnancy rates and that these influences could be sufficiently analyzed using secondary data.

Independence of County-Level Factors. It was assumed that each county operated as an independent unit of analysis, so that local policies, community norms, and

resource distributions were distinct, allowing valid intercounty comparisons without significant cross-contamination of programmatic outcomes.

Delimitations

The delimitations of this study were indicative of deliberate boundaries established to clearly define and narrow the scope and focus of the study. These decisions were made to help clarify what the study did and did not intend to address and to enhance the manageability and organizational aspects of the study. The delimitations for the study are detailed below:

Geographic Boundaries. This study was delimited to selected counties in the state of Georgia, particularly those that received TPP funding through the MSM Project and the five comparison counties of Bibb, Cobb, Glynn, Greene, and Laurens. These counties were strategically selected based on demographic and geographic similarities to create noteworthy comparisons, not generalized conclusions for other states.

Programmatic Focus. The research was delimited to evaluating the impact of the TPP Program in Georgia counties. Other local, state, or privately funded initiatives aimed at the prevention of teen pregnancy were beyond the scope of this study and analysis.

Population Considerations. The population of interest was adolescents aged 10 to 19 years, consistent with standard public health definitions of teen pregnancy. Individuals outside this age range were excluded from analysis in this study.

Methodology Constraints. The study employed a quantitative research design utilizing secondary statistical data analysis. Qualitative factors, such as perceptions of program participants, facilitator experience, or community engagement, were beyond the scope of this study and were not considered.

Selection of Comparison Counties. The strategic selection of Bibb, Cobb, Glynn, Greene, and Laurens counties as non-funded comparison sites was a delimitation based on demographic information, geographic likeness, and availability of data. These delimitations were essential to maintaining the comparability of the counties while also controlling population and SES variables. Additionally, this delimitation improves validity by maintaining homogeneity of information in the study.

Limitations

Limitations refer to inherent factors in the research design that are beyond the control of the researcher but may affect the generalizability of the study outcomes. Acknowledging the limitations of the study, improves comprehensibility and supports the academic fortitude of the study. The limitations include the following:

Study Design. As a quantitative comparative study that uses secondary data, this research is non-experimental. Incidentally, the design can only infer associations, trends, and potential impact. The study design cannot establish causal relationships between TPP program implementation and teen pregnancy rates.

Data Availability and Quality. The study was limited by the integrity and quality of secondary data sources. Discrepancies in reporting practices, missing data, or changes in measurement criteria across counties or years could affect the outcomes. Additionally, many of the federal websites, such as CDC and USCB, had either altered the content or shut down, which is another limitation for the study.

Time Frame of Study Analysis. The analysis was confined to data collected during the period of TPP funding and implementation. This may have resulted in delayed

effects of the program or long-term trends that extend beyond the funding cycle not being captured in this study.

Variability in Program Implementation. Differences in program administration, resource allocation, and curriculum delivery across funded counties have the potential to impact program outcomes. These variances in program execution could affect teen pregnancy rates, making it difficult to determine if an influence on teen birth outcomes was exclusively due to the presence of the TPP Program.

Unmeasured Confounding Variables. The study accounted for several social determinants of health; however, it is possible that other unmeasured confounding factors, such as cultural norms, parental involvement, access to contraceptive services, community attitudes toward teen sexuality, and the influence of media or faith-based organizations, could also have affected teen pregnancy rates. These factors may not be fully captured within the secondary data sets utilized for the study.

Political and Policy Considerations. Changes in local, state, or national political leadership and climate can influence policy priorities, funding concerns, or educational mandates. This had the potential to shape program implementation and communal attitudes toward sexual education, which could have had an indirect effect on teen pregnancy rates.

Generalizability of Results. The study's findings were specific to the data collected and methodological design employed and may not be generalized to other states, regions, or populations. Focusing on select Georgia counties ensured validity but limited the external application of the results.

Definitions

Adolescence is the stage of life between childhood and adulthood, from ages 10 to 19. It is the phase of human development during which the foundations of good health are established. Youth are individuals in the 15-24-year age group. Young People are individuals in the 10-24-year age group (World Health Organization [WHO], 2025).

Birth Rate is expressed as the number of live births per 1,000 population. The rate may be restricted to births to women of specific age, race, marital status, or geographic location (specific rate), or it may be for the entire population (crude rate) (National Center for Health Statistics, 2022). For the purposes of this study, the age range is 10-19 years old.

Protective Factors are any attribute, characteristic, or exposure that decreases the likelihood of negative outcomes or buffers against risk (CDC, 2024).

Public Health Model emphasizes input from diverse sectors, including health, education, social services, justice, policy, and the private sector. Collectively, these key collaborators work to address community problems, with the intention to provide the maximum benefit for the largest number of people. The public health approach is a four-step process, which is as follows: (a) define and monitor the problem, (b) identify risk and protective factors, (c) develop and test prevention strategies, and (d) assure widespread adoption of effective approaches (CDC, 2024).

Risk Factors are characteristics that increase the likelihood of a negative outcome (CDC, 2024).

Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of

health, functioning, and quality-of-life outcomes and risks. SDOH are divided amongst the following five categories: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context (Office of Disease Prevention and Health Promotion, 2020).

Socioeconomic Vulnerability refers to the experience of individuals struggling with the negative impacts of challenging economic circumstances. These individuals often do not have access to institutional support to cope with these difficulties (Gómez-Quintero et al., 2020).

Teen Pregnancy is defined by the American Pregnancy Association (2017) as a pregnancy that occurs for a woman under the age of 20, and though not officially a teenager, a young pregnant woman 12 or under falls into this definition of teenage pregnancy as well. For this study, the terms early childbearing and adolescent pregnancy are used interchangeably with teen pregnancy.

Teen Pregnancy Prevention (TPP) Program is a program administered by HHS OPA as a national, evidence-based grant program funding diverse organizations to prevent teen pregnancy across the United States. OPA (2023) allocates funds for the implementation of effective TPP programs to develop and evaluate new and innovative programs and services to prevent teen pregnancy, prevent sexually transmitted infections (STIs), and promote healthy behavior and youth development.

Chapter Summary

This chapter provided a background for the study and created a foundation on which to build the study when considering the TPP Program and its impact on teen pregnancy rates in select counties in Georgia, as well as various factors that influence

teen pregnancy. The next chapter is the literature review, which examines existing literature related to teen pregnancy and shows the gap in the literature that creates a necessity for the study, as there has been little done to explore the impact of the TPP Program on teen pregnancy rates at the local level in Georgia. The literature review is followed by an explanation of the study's methodology chapter, which includes elaborate details about the different counties and variables of the study, as well as the reasoning for the statistical tests conducted in this study. This is followed by the findings chapter that describes the outcomes of the statistical tests detailed and performed in the previous chapter, including information about statistical significance and acceptance or rejection of the hypothesis. The final chapter explores discussion and implications, summarizes the study, includes inferences drawn from the study, acknowledges gaps that exist, and details future research that could be explored. Subsequently, if the public health issue of teen pregnancy is appropriately addressed, the outcomes could equate to significant economic savings in Georgia and nationwide, as well as improved well-being and overall health for Georgia's youth. This study aimed to serve as a tool to assist in that task.

Chapter II

Literature Review

The literature review employs a comprehensive approach that includes a historical perspective on teen pregnancy, provides an overview of teen pregnancy in Georgia, explores several recurring themes from the literature that were identified to increase the likelihood of teen pregnancy or serve as an outcome of experiencing teen pregnancy, and examines teen pregnancy as a public health issue, including the interventions taken to address teen pregnancy. Researching these varied contributing factors to teen pregnancy is essential for a thorough literature review that garners a comprehensive understanding of the issue. Additionally, by synthesizing the existing research, this literature review provides an inclusive overview of the relationship between teen pregnancy and the federally funded TPP Program in Georgia counties.

The literature review created a foundational understanding of teen pregnancy on which to build this study. The historical context of the review provided background on how teen pregnancy evolved into the public health issue it is presently. Moreover, the reviewed literature further established connections between early parenthood, decreased educational attainment, and greater likelihood of poverty (Patel & Sen, 2012). The literature also supports the idea that teen-motherhood can result in outcomes such as inferior education and fewer employment and career opportunities (Brindis, 2006). Additionally, the research evaluated the notion that teen pregnancy should be addressed

with data-driven interventions and an all-inclusive program that engages the teens, their families, and the communities in which they reside. For example, Rabbitte and Enriquez (2019) found that abstinence-only education (AOE) programs are largely ineffective in reducing sexual risk-taking among youth; while in contrast, comprehensive sex education (CSE) programs, those that are medically accurate, age-appropriate, and inclusive of information on both abstinence and contraception, are appreciably more effective. These inclusive programs also address the psychosocial, emotional, physical, and mental dimensions of sexuality, contributing to healthier decision-making among adolescents (Rabbitte & Enriquez, 2019). Overall, this literature review supports the need to study the TPP Program, specifically in the state of Georgia, and its impact on the public health issue of teen pregnancy. This quantitative study aimed to evaluate the effects of the TPP program on teen pregnancy rates in selected Georgia counties. It also examined additional contributing factors such as poverty, mental health, and education that may influence these rates.

Historical Review of Teen Pregnancy

Late 19th Century/Early 20th Century

Teen pregnancy was not always considered a public health issue in this country. In the 19th century and the early part of the 20th century, there were a couple of explanations about why teen pregnancy was not identified as a public health issue. The first was that it was largely due to marriage at an early age being expected and culturally acceptable, such that “failure to marry before age 20 was seen as a problem rather than having married too young” (Vinovskis, 2003, p. 401). As conception and pregnancy occurred within a marriage, teen pregnancy was not considered problematic. Another

suggestion to understand why teen pregnancy was not deemed a public health priority during this period was that young girls may have been incapable of bearing children, due to the late age at which their menstrual cycles began because of poorer nutrition during that time (Vinovskis, 2003). Gluckman and Hanson (2006) further detail this by suggesting that stress experienced in childhood and insufficient dietary intake can delay the onset of puberty and ultimately menarche. The researchers further detail that the evolution of puberty over time influenced the expression of secondary sexual traits and readiness for reproductive competence, both of which would have an effect on teen pregnancy (Gluckman & Hanson, 2006). Subsequently, the biological phenomena of late menarche and pubertal evolution may better account for the reasons why teen pregnancy was not identified as an issue during this time period.

Beyond these possible explanations, there was a strong societal aversion to people engaging in premarital and extramarital sex, so much so that unmarried women were condemned and reproached for engaging in premarital sex and having children without being married (Daguerre & Nativel, 2006; Neiterman, 2012). Unplanned pregnancies outside of marriage often led women to seek unsafe, illegal abortions (Vinovskis, 2003). When pregnancies were carried to term, teens were frequently relocated to discreet facilities to give birth and place their children for adoption (Neiterman, 2012). These varied cultural, biological, and societal practices contributed to the low reported rates of teen pregnancy during that period, preventing it from being recognized as a public health concern.

Mid-20th Century

As time progressed, changes occurred both socially and politically, which led to the declaration of teen pregnancy as a public health concern. In the 1950s, Furstenberg (2007) explained that the rates of early childbearing reached levels that sparked societal concern. Also, during this time, the emerging norm of this country was deferred childbearing, which resulted in teen pregnancy being depicted as socially deviant behavior (Daguerre & Nativel, 2006), prompting greater public concern about teen pregnancy as an issue to be addressed. Neiterman (2012) argued that societal factors such as limited access to sexual education, inadequate contraceptive availability, and challenging social conditions also contributed to the rise in teen pregnancy. Additionally, major social movements of the 1960s, like the Civil Rights and Women's Liberation Movements, coupled with the landmark political decision of the 1973 nationwide legalization of abortion through the passing of *Roe v. Wade* (Levine et al., 1999), contributed to increased concern regarding teen pregnancy. With the rising interest in teen pregnancy as a societal issue, additional issues arose, such as an increase in unwed teen parents and a higher prevalence of premarital sex. These issues positioned teen pregnancy as a significant public health concern requiring targeted interventions.

The literature provided specifics regarding teen pregnancy, indicating that the late 1970s saw a two-thirds increase in the number of young women, aged 15-19, who reported that they had premarital sexual intercourse (Mecklenburg & Thompson, 1983), further supporting the necessity of declaring teen pregnancy a public health concern. Vinovskis (2003) referenced a study that indicated approximately 30% of all first births were premaritally conceived, indicating a societal behavioral change. The identification

of teen pregnancy as a public health issue was substantiated by Finkel's (1995) work, which suggested that teen pregnancy became the focus of concern primarily for three reasons:

1. "Sexual activity has increased sharply among the youngest teenagers (<15 years)
2. Out-of-wedlock childbearing rose appreciably among all teenagers
3. The issue of welfare" (Finkel, 1995, p. 501).

For a multitude of reasons, which included increased incidence of premarital sex, added political and societal awareness of early age pregnancy, and the economic impact of caring for the children of unmarried teens, teen pregnancy soon became identified as a public health concern.

Late 20th Century

In the five-year time frame between 1973 and 1978, teen pregnancies among women aged 15-19 rose from a total of 980,000 to 1,113,000, which translates to an increase from 96.8 to 107.3 pregnancies per 1,000 women (Mecklenburg & Thompson, 1983). According to Finkel (1995), "By the late 1980s and early 1990s, data show that the youngest teenagers (<15 years) were engaging in sexual intercourse in increasing proportions" (p. 501). These factors and more impacted teen pregnancy and were catalysts for it being identified as a public health issue, which in turn, brought it to the attention of political figures. Gorry (2022) explained that elected officials identified teen pregnancy as a public health issue in the United States and abroad. Additionally, teen pregnancy was such an issue that in the 1995 State of the Union address, President Clinton deemed teen pregnancy a major social problem (Furstenberg, 2007).

Another reason for the change in designation was the increasing number of births out of wedlock, which was not an acceptable social or moral norm at that time (Dutton et al., 2025). The literature supports this as Finkel (1995) wrote that “by the mid-1990s, among all age groups and among all ethnic groups, the majority of teenage births occurred out-of-wedlock” (p. 503). Additionally, the literature indicated that the designation as a public health issue was compounded by the secondary outcomes of teen pregnancy and parenting that made it into the controversial, multifaceted, and complex public health matter (Dutton et al., 2025). These outcomes, which were repeated throughout the literature (de la Calle et al., 2021; Diabelková et al., 2023; Neiterman, 2012), included the following:

- Economically, teen mothers come from low-income families and are often in need of state assistance.
- Educationally, teen pregnancy leads to poor educational attainment for young mothers and a high likelihood of poverty.
- Healthwise, direct health outcomes may be premature birth and low birth weight and indirect health outcomes like poor social conditions in which the infants are raised with a lack of responsiveness to medical advice on the part of young mothers.

Classifying teen pregnancy as a public health issue was an appropriate designation because it established reach beyond the parenting teens and their children, to also include societal, economic, and political influences.

21st Century

Due to the complexity of teen pregnancy, it is widely regarded as a significant public health and societal challenge of the 21st century (Garba et al., 2016). Existing research attributed shifts in its prevalence to broader sociocultural changes, including evolving attitudes toward sexuality, marriage, and early childbearing (Sevareid et al., 2023). These transformations, coupled with more permissive social norms, have reduced stigma and contributed to the normalization of adolescent pregnancy (Finkel, 1995) within contemporary society. Research indicates that teen pregnancy arises from multifaceted and interrelated factors and is often rooted in complex sociocultural and psychological factors rather than mere behavioral or economic motives. Finkel (1995) argued that many adolescents perceived early childbearing as an appropriate life choice, associating it with responsibility and identity formation. For some, parenthood provided a sense of purpose and emotional fulfillment, while others viewed it as a means of securing affection and stability. Similarly, Brezeanu et al. (2023) emphasize the influence of family history, adverse social environments, and cultural norms in shaping these attitudes, suggesting that early motherhood can be understood as both a coping mechanism and a response to structural inequalities. Finkel (1995) observed that early pregnancy among adolescent females was now prevalent, while adolescent males frequently regarded early fatherhood as a marker of pride and personal fulfillment. This attitudinal shift signified a substantial departure from previously established societal norms.

Despite the fast-changing societal norms that increased the acceptance of teen pregnancy, teen pregnancy rates have consistently declined in recent years. The April 2025 *Vital Statistics Rapid Release Report* reports a 2024 birth rate of 12.7 per 1,000

females aged 15-19—a 3% decrease from 2023 (Hamilton et al., 2025). This decrease reflects years of implementing various comprehensive public health strategies and programs to address teen pregnancy, as well as improvements in contraceptive options and access (Boonstra, 2014; Finkel, 1995; Klein & Committee on Adolescence, 2005). These efforts mark significant advancement and progressive moves in the right direction toward the decline of teen pregnancy. However, the issue remains a pressing public health concern nationally and within Georgia.

Teen Pregnancy in Georgia

Historical Context

The State of Georgia is not excluded from the public health issue of teen pregnancy. Georgia experienced trends like those in other parts of the nation regarding increased unwed births to teens 15-19 years of age and an overall increase in teen pregnancies over the decades. The Georgia Department of Human Resources' (GADHR) 2006 factsheet indicated births to unwed teens during the 1980s were 51%, 75% in 1994, and 80% in 2004. Furthermore, it showed that in 1994 the birth rate for teens aged 15-19 was a startling 70.6 births per 1,000 girls, decreasing to 53.3 births per 1,000 girls in 2004. Despite a 58.2% decline in adolescent births between 2004 and 2022, teen pregnancy remains a concern in Georgia (Georgia Department of Public Health [GADPH], 2023).

In 2006, nearly 28% of pregnancies among Georgia teens were repeat pregnancies, and over 80% of teen mothers were unmarried (GADHR, 2008). Teen pregnancy is such a concern that the GADHR (2006) declared that the high number of births among 10-14-year-olds, coupled with the fact that 84% of pregnant teens' healthcare costs were covered by Medicaid, was a major public health matter. Prior research demonstrates that adolescent childbearing exerts both immediate and sustained repercussions across health,

social, and economic domains, which include compromised health trajectories, destabilized family structures, strained community resources, and negative economic implications for Georgia (GADHR, 2008). Sonfield et al. (2011) report that Georgia incurred an average cost of \$13,128 for each state-funded birth, while unintended pregnancies, a substantial proportion of which occurred among teenagers, cost the state approximately \$274.1 million. Therefore, much like the nation, Georgia's experience of the teen pregnancy issue is costly and widespread, with consequences that extend beyond individual adolescents to their families, communities, and the state system. Georgia's teen pregnancy issue reflects a national trend; like the nation, the teen pregnancy crisis is widespread, imposes significant costs, and influences family, community, and state systems.

During the period from 1994 to 2004, the State of Georgia invested in targeted programs for high-risk mothers and their children, encompassing expenditures for neonatal care of premature infants as well as essential health and living costs (GADHR, 2006). The State's investments were critical in addressing adolescent pregnancy, a multidimensional public health concern associated with SES disadvantage, lower educational attainment, recurrent teenage pregnancies, and adverse developmental outcomes for children (Brace et al., 2008; Sprague, 2023). As these associated challenges range from poverty to government dependency, they reflect a broader recognition of the need for comprehensive strategies that address the structural and social determinants contributing to adolescent pregnancy. Collectively, the literature emphasizes that

sustained public investment in multi-level, culturally responsive strategies is essential for mitigating the educational, health, and economic disparities associated with adolescent pregnancy.

Georgia Prevention Efforts

In 1997, the State of Georgia implemented a comprehensive teen pregnancy prevention initiative, allocating \$9 million in combined state and federal resources (GADHR, 2006). This initiative established the Office of Adolescent Health and Youth Development (AHYD) with the objectives of reducing welfare dependency, enhancing economic opportunities, and promoting responsible parenting. AHYD programs employ a public health framework to address high-risk behaviors, including unprotected sexual activity and substance use (GADHR, 2006; GADPH, 2023). More than two decades later, AHYD remains the foremost state agency for teen pregnancy prevention efforts. The Office of Adolescent Health and Youth Development employs a multipronged approach to helping youth and creating resiliency by (a) building on the strengths or “assets” of individual youth, their families, and communities, (b) promoting positivity about the future for the youth served, and (c) providing youth with important skills and tools to effectively resist peer pressure and make positive life choices (GADHR, 2006).

The leadership in Georgia was an early adopter of addressing teen pregnancy as a public health issue and understood that there was not a singular methodology that would be suitably and effectively transformative for teen pregnancy (GADHR, 2006). In 1995, then First Lady Mary Perdue co-founded the Georgia Campaign for Adolescent Power & Potential (GCAPP, n.d.), a statewide adolescent health organization that works with schools and other youth-serving organizations to provide young people with the

resources, knowledge, and motivation needed to make healthy lifestyle choices that maximize their potential. GCAPP (n.d.) implements programs and services using a public health approach with five focus areas: CSE, parent engagement, teen pregnancy prevention, youth empowerment, and physical activity and nutrition. AHYD programs align with GCAPP's comprehensive strategy, which research shows reduces teen pregnancy and other high-risk adolescent behaviors (GADPH, 2023). The combined efforts of these organizations have been an important factor in addressing teen pregnancy.

Teen Pregnancy Interventions

Recognizing the effectiveness of a diverse and inclusive approach to the problem, the State of Georgia readily participated in federally funded programs that focused on the public health issue of teen pregnancy. These programs included the Title V Sexual Risk Avoidance Education (SRAE), the Personal Responsibility Education Program (PREP), and the TPP Program (Hulsey et al., 2023; OPA, 2023; Trenholm et al., 2007). Each program targets adolescents to impact teen pregnancy and other behavioral health activities, but varies significantly in scope, approach, and effectiveness.

The Title V SRAE Program of 1998 is an AOE curriculum that teaches abstaining until marriage as the standard of practice. It does not include information regarding safe sex or contraception usage (Trenholm et al., 2007). The PREP Program, which was established in 2010, targets the general population of youth aged 10-19, but also vulnerable populations (youth in foster care, homeless, or justice-involved) (Hulsey et al., 2023). PREP provides youth with a knowledge base on the topics of abstinence and contraception education, healthy relationships, and adolescent development (Georgia Department of Human Services, n.d.). The third program implemented in Georgia was

the 2010 TPP Program. This program was developed to provide grant opportunities that supported replication of evidence-based programs and innovation projects in high-need areas across Georgia and the nation to prevent teen pregnancy, prevent sexually transmitted infections (STIs) among adolescents, and promote positive youth development (OPA, n.d.). Table 1 provides a comparative overview of the various federally funded programs in Georgia (Hulsey et al., 2023; OPA, 2023; Trenholm et al., 2007).

Table 1

Comparison of Federally Funded Teen Pregnancy Prevention Programs

PROGRAM	PROGRAM FOCUS	ALLOCATED FUNDING	TARGET POPULATION	EFFECTIVENESS
Title V Sexual Risk Avoidance Education (SRAE)	AOE until marriage; excludes contraception	\$50M annually; 75% state match	Adolescents	No significant effect on delaying sexual initiation or reducing risky behaviors (Trenholm et al., 2007)
Personal Responsibility Education Program (PREP)	CSE: abstinence safe sex practices	\$75M annually (mandatory)	Youth ages 10-19; high-risk groups (foster care, homeless, justice involved)	Associated with improved contraceptive use and reduced sexual risk behaviors; modest reductions in teen pregnancy rates (Hulsey et al., 2023)

Teen Pregnancy Prevention (TPP) Program	Evidence-based and innovative strategies to reduce teen pregnancy	\$101M annually (discretionary)	General adolescent population	Demonstrated reductions in teen birth rates and sexual risk behaviors; strong evidence for effectiveness (OPA, 2023)
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The TPP Program proved beneficial to the state’s efforts to address teen pregnancy, as multiple youth-serving organizations, which included universities, nonprofit organizations, health departments, and community-based organizations throughout Georgia, were successfully funded through the TPP Program. The agencies funded by the TPP Program in the 2015 Cohort were as follows: Augusta Partnership for Children, Inc., Georgia Alliance of Boys and Girls Clubs, Inc., Georgia Campaign for Adolescent Power & Potential, Fulton County Board of Health, and Morehouse School of Medicine (OPA, 2023). The funding organization recognized that these agencies understood the complexities of the issue of teen pregnancy and the necessity to address it in a comprehensive manner.

To achieve meaningful outcomes, interventions operate at multiple levels, engaging pregnant and parenting adolescents, their families, and the broader community. Research consistently highlights that multicomponent strategies combining education, healthcare access, and psychosocial support (Brace et al., 2008; Mickler & Tollestrup, 2024; Sprague, 2023) are most effective in reducing teen pregnancy rates and improving outcomes for young parents and their children. In Georgia, multiple organizations exemplify this model by integrating evidence-based education, family engagement, and

community partnerships to promote adolescent well-being and reduce teen birth rates statewide (GADHR, 2006; GCAPP, n.d.).

Recurring Themes of Teen Pregnancy

Teen pregnancy remains a persistent public health issue with complex and far-reaching implications that require continued monitoring. Existing research consistently identifies recurring themes that shape both the causes and consequences of adolescent childbearing. These include the disruption of educational attainment for parenting teens, long-term health risks experienced by both mother and child, and the substantial social and economic costs borne by families, communities, and state systems (GADPH, 2023; Mickler et al., 2011; Sprague, 2023). Additionally, politics, inclusive of shifting policies, funding priorities, and ideological thought processes play a prevailing role in determining the availability and effectiveness of prevention strategies. Together, these themes underscore the multifaceted public health issue of teen pregnancy.

Impact of Teen Pregnancy on Education

In 1972, under Title IX, an education amendment was passed that mandated that public schools provide equivalent educational opportunities to pregnant and parenting students (Pillow, 2006). This law would allow teen parents to be educated in a manner equal to their non-parenting peers. Despite the existence of this mandate, many pregnant and parenting teens often experience educational disruptions. The literature reveals that teen girls who experience teen pregnancy have lower levels of education than their counterparts and delay childbearing until age 20 (Maslowsky et al., 2022). This equates to a three-year reduction in schooling for White, Black, and Hispanic women (Ferre et al., 2013), per a 12-year longitudinal study of 2,975 women in the United States.

Furthermore, the data indicate that 59% of girls who become mothers before the age of 18 drop out of high school, meaning that only 41% complete high school diploma requirements (Ducker, 2007). While some teen mothers pursue a GED, the combined diploma/GED attainment rate for parenting teens (70%) remains considerably lower than that of non-parenting peers (94%) (Maslowsky et al., 2022). Barnett et al. (2004) suggest that, in addition to decreased education years, teen mothers experience exacerbated social and economic disadvantages for the individual, their family, and the broader community.

The research specifies that teen pregnancy disrupts academic achievement, which leads to markedly less schooling in comparison to women who delay childbirth until their thirties (Basch, 2011; Otegbayo et al., 2023). Basch (2011) further expounds upon the idea that decreased education creates other challenges, such as increased likelihood to live in impoverishment, a greater chance of the teens' children becoming teen parents too, and the decreased possibility of pursuing higher education opportunities. Research highlights that these challenges perpetuate cycles of poverty and limit access to employment opportunities (Otegbayo et al., 2023). Teen pregnancy has a profound influence on educational attainment and often serves as a key determinant of school attrition. The research indicates that adolescent mothers are notably less likely to complete high school, which hinders their economic opportunities and increases reliance on public assistance (Jakubowski et al., 2023). This disruption in education not only impedes individual self-sufficiency but also deters women from maximizing their human capital, creating impoverished homes, which "limits freedom, opportunities, and resources and creates conditions for powerlessness, exclusion and vulnerabilities" (Mohr et al., 2019, p. 20), all of which have long-term consequences for the life of the teen.

Long-Term Consequences Associated with Teen Pregnancy

The long-term impacts of adolescent childbearing are multifaceted, spanning education, economic stability, health, and intergenerational effects. Literature regularly associates early motherhood with a litany of long-term consequences such as reduced educational attainment, limited occupational opportunities, higher marital instability, and increased poverty (Card, 1981; Massallay & Gogra, 2025; Otegbayo et al., 2023).

Additionally, other impactful long-term outcomes of teen pregnancy, such as poverty and repeated births, were frequently found in the reviewed literature. A known predictor of adolescent motherhood is lower family-level SES status, with parenting teens experiencing an enhanced vulnerability to poverty and residence in low-income households (Basch, 2011; Jakubowski et al., 2023; Penman-Aguilar et al., 2013; Ruedinger & Cox, 2012). Teens who experience teen pregnancy are more apt to have unstable housing accommodations and to be dependent on social welfare programs and services (Mann et al., 2020), all of which are challenges with the potential to considerably impede the teen mother's ability to adequately provide for their child. Because teenage parents have a higher likelihood of becoming impoverished and working low-wage jobs, overcoming poverty entails navigating multifaceted SES barriers, facts which expound exponentially for the teen mothers who become pregnant a second time within two years of their first pregnancy (Ducker, 2007; Maslowsky et al., 2022). These outcomes often perpetuate cycles of challenges and hardships that extend beyond the teen years of the mother well into young adulthood.

Teen pregnancy is a prevailing public health issue, and its many long-term outcomes have a transformative impact, which requires a comprehensive approach

(Lesinskienė et al., 2025). Thus, understanding these outcomes is essential to effectively address the issue. The literature further details that teen-motherhood is correlated with adverse outcomes, such as lower intellectual skillsets and abilities when compared to non-parenting teens, naiveté about intimate relationships, and underemployment (Patel & Sen, 2012). Moreover, teen pregnancy is associated with a higher risk of postpartum depressive disorder, higher stress levels, and increased anxiety (Lesinskienė et al., 2025). These outcomes are compounded when coupled with social stigma and lack of support, which exacerbate the long-term educational and economic disadvantages experienced by parenting teens (Patel & Sen, 2012). Additionally, mental illness, substance use/misuse, and STIs are added complications that a teen may encounter (Mann et al., 2020), which create more challenges in the life of a teen parent.

Teen pregnancy can also have a transgenerational influence, impacting not only the teens but also their child and family. The children of teens have a propensity to endure adverse physical conditions and growth-related outcomes (Rowlands et al., 2021). Also, many teen mothers have mothers who also experienced early pregnancy, resulting in generational transference of complications associated with adolescent pregnancy, which include social costs, poor health issues for mother and child, and mental illness, to name a few (Akella & Jordan, 2015; Paranjothy et al., 2009; Rowlands et al., 2021). Thus, teen pregnancy has recurrent effects that oftentimes result in disproportionate life challenges and hardships for the parenting teen, the child of the teen, the family, and the community. The breadth of outcomes of teen pregnancy, especially those with long-term consequences, makes it a public health issue that affects teens well into adulthood. Since teen pregnancy has potentially long-term consequences and an unfavorable impact that

intersects the areas of health, education, and economics for teens, their families, and the community at large, this complex issue is likely best addressed with an all-inclusive approach.

Broad Social and Economic Costs of Teen Pregnancy

Many teen parents endure a multitude of obstacles and adversities that make it difficult to earn a viable living wage; thus, they often require government assistance and programs. These services amount to substantial economic costs for the community and society as a whole. With multiple thousands of teen births annually, this cost rises exponentially and becomes an important component of any literature review regarding teen pregnancy. In 2006, 10% of all live births in the United States were born to teenagers, which resulted in considerable government spending towards public aid to assist teen mothers (Patel & Sen, 2012). According to Winger et al. (2025), the average national cost of medical care, to include prenatal, delivery, and postpartum service and the first year of infancy, is in excess of \$20,000 per birth, a great portion of which can be attributed to teen births. Specifically, regarding teen pregnancy, taking into consideration public assistance, child welfare, and lost tax revenue, the broader societal cost of teen childbearing is approximately \$9.4 billion annually in the United States (Power to Decide, 2013). In the timeframe of 2001-2010, 70% of the costs associated with childbirth for teen mothers were paid by Medicaid (Ronen et al., 2018), a cost covered by taxpayers. These costs are substantial and underscore the extensive economic implications of adolescent pregnancy for local, state, and federal systems, but there are also social, physical, mental, and emotional costs that are just as far-reaching.

Teen pregnancy also has societal effects, such that “when individuals cannot

realize their full educational and occupational potential, society loses their economic contributions” (Hofferth, 1987, p. 140). Unfortunately, teen mothers are frequently criticized and condemned as being major contributors to adult poverty, which can have lasting effects on their psyche and self-esteem (Patel & Sen, 2012). This sense of inadequacy is compounded because oftentimes those who experience teen pregnancy have unstable social support systems (Mann et al., 2020), which present challenges for them and their children throughout their lifetime (Rowlands et al., 2021). As giving birth is a transformative experience, teens can experience physical, emotional, and personality changes (Akella & Jordan, 2015). These internal changes can have external expressions that affect their ability to provide for their families and engage in society. Additionally, not only is the parenting teen affected, but children born to teen parents have an increased likelihood to endure the societal ills of “community violence, gang membership involvement, alcohol and substance abuse and a high incidence of illiteracy” (Akella & Jordan, 2015, p. 42). Overall, a comprehensive review of the complex economic and social consequences of teen pregnancy is vital to framing it as a public health phenomenon and an essential component of this study’s literature review.

Effects of Policy & Politics on Teen Pregnancy

Political decisions play a crucial role in shaping teen pregnancy prevention efforts. The 2022 Supreme Court decision of *Dobbs, State Health Officer of the Mississippi Department of Health v. Jackson Women’s Health Organization* repeal of 1973 *Roe v. Wade* abortion drastically affected reproductive rights and access to abortion services in many states (*Dobbs v. Jackson Women’s Health Organization*, 2022). In Georgia, a restrictive six-week abortion ban was implemented, titled the Living Infants

Fairness and Equality (LIFE) Act, which enforces a six-week abortion ban (LIFE Act, 2019). The LIFE Act has a few exceptions when an abortion procedure can be performed, including extenuating circumstances such as a medical emergency that may pose considerable risk to the mother's life or conception resulting from rape or incest (LIFE Act, 2019). Consequently, policies such as the LIFE Act can lead to increased teen births due to the lack of access to abortion care and adversely impact reproductive health options (Bell et al., 2025; Treder et al., 2023). Additionally, these policies have the likelihood of influencing access to contraception, sexual health education curricula and resources, and exacerbate existing systemic barriers (Treder et al., 2023), particularly among disadvantaged populations who disproportionately suffer from scarcity.

In addition to the repeal of *Roe v. Wade*, federal and state budget crises, combined with restrictive policies, have affected progress that has been made in addressing the public health issue of teen pregnancy (Brindis, 2006). From a historical perspective, Brindis (2006) adds to the literature and validates the effect of policy on teen pregnancy by explaining how political decisions have a wide-range of outcomes for parenting teens, including the following:

- An increase or decrease in resources supporting programs and services
- Determination of types of services available and recipients of said services
- Availability of birth control and family planning services
- Policies on sex education in public schools and public media campaigns
- Implementation of laws restricting abortion

A specific policy example is Title X of the Public Health Service Act of 1970, which created a “comprehensive federal program devoted entirely to the provision of

family planning service” (Saul, 1999, para. 8). Essentially, the law established an environment for women to seek confidential health and reproductive health services without regard to age or marital status, and since it went into effect, multitudes of teens have turned to the clinics for reproductive healthcare services, disease testing and treatment, and other health screenings and care (Saul, 1999). Schapiro (2020) reported that the confidentiality components of the law have remained intact since its enactment and have been sustained through subsequent renewals and legislative initiatives. Title X created an environment that allowed for increased contraception access and use, which resulted in “historically low teen birth rates” (Schapiro, 2020, p. 175). Therefore, the implementation of the Title X Law ultimately served as an impetus to the decline in teen pregnancy rates.

One of Title X’s mandates requiring strict confidentiality created a space of less inhibition for teens to receive health care services. Saul (1999) provided details that prior to the law and establishment of Title X clinics, 64% of high school girls indicated they would not seek care for fear of their parents learning of their health situation. Additionally, the confidentiality requirement led to increased use of health care providers in clinical settings, such that 38.1% of adolescents aged 15 - 17 years spent time with a provider without a parent or guardian present for overall health, while 40.5% of females in the same age group received sexual or reproductive health services (Schapiro, 2020). Thus, the Title X law made it possible for teen girls to have their health needs met under the most discreet conditions.

Unfortunately, Title X and other laws that support women’s reproductive health and rights are consistently under attack in political arenas. For example, in 2019, under

the Trump Administration, the Compliance With Statutory Program Integrity Requirements was announced, which was a final rule that established precedence and administration for the Title X law (Schapiro, 2020). Subsequently, Schapiro (2020) detailed how the implementation of the Compliance With Statutory Program Integrity Requirements resulted in changes to funding allocation for adolescent reproductive health service providers, reduced limits for counseling for pregnant teens, and a significant exodus of many service providers from participating in the Title X program. With these changes to this important mandate and the ever-evolving political landscape, it is essential to understand how enacted policies addressing reproductive health can have far-reaching effects and that efforts to address teen pregnancy must be implemented in a strategic manner that is reasonable and aligns with the needs of people today, especially the vulnerable population of parenting teens.

Addressing Teen Pregnancy as a Public Health Issue

Per the literature, public health is an ever-evolving field that monitors “outbreaks of new diseases, as well as changing patterns of population growth, economic development, and lifestyle trends that may threaten the health of the public at large and require a public health response” (Rothstein, 2002, p. 144). Teen pregnancy aligns with this definition, such that it is a multifactorial issue that intersects with and impacts various aspects of society. Teen pregnancy is not simply an individual behavioral issue, as historically believed, but a complex situation influenced by SDOH such as poverty, access to healthcare, systemic barriers, politics, and insufficient sexual education and services (Berlan et al., 2025; Dutton et al., 2025). The themes detailed in the previous section are all potential effects of teen pregnancy with an impact on the lives of the

pregnant and parenting teens. As the outcomes of teen pregnancy can vary, a strategic public health approach is necessary to best control the issue.

Why a Public Health Approach to Teen Pregnancy

The CDC (2024) explained that the public health approach considers various facets of an issue, including health, education, social services, economics, and policy. As it relates to teen pregnancy and adolescent reproductive health, the approach must be a holistic and collaborative effort of policymakers, public health practitioners, families, community members and other key stakeholders that focuses on comprehensive policies, cultural factors, and underlying causes such as lack of access, inequity, and poverty (Raya-Diez et al., 2024). OPA (2023), the leading federal agency tasked with addressing teen pregnancy and adolescent health, advocates for public health strategies that are comprehensive, evidence-based programs that integrate sexual health education, contraception access, and community engagement to effectively address the underlying factors of teen pregnancy. Brindis (2006) suggested that reducing teen pregnancy requires behavioral change among adolescents alongside shifts in attitudes and beliefs within their social networks. The literature further implied the integration of policies and programs as essential to sustain declines in teen pregnancy rates (Saul, 1999).

Despite years of research, enduring gaps persist in informing on the effectiveness of a strategic and comprehensive public health method geared toward the prevention of teen pregnancy. However, the limited literature that does exist highlights the development of evidence-based programs that contributed to declines in teen birth rates (Berlan et al., 2025). Also, many of the evidence-based programs focused on urban populations, neglecting rural and underserved populations and thereby missing the opportunity to

adopt a holistic perspective (Berlan et al., 2025; Ott et al., 2020). The use of evidence-based programs increases knowledge and skills, but as a singular methodology, they do not effectively address the underlying root causes of teen pregnancy. The literature reveals that the best public health-focused preventive strategy for addressing teen pregnancy must include the following:

- Increased ability to obtain contraceptives and reproductive health information through community-based teen clinics
- An inclusive target group (adolescent girls and boys, parents, and community leaders)
- Informative sex education courses (AOE and CSE)
- A focus on contextual factors (social norms, empowerment, skill training and personal development) (Mohamed et al., 2023; Sprague, 2023; Vincent & Dod, 1989).

With the inclusion of the components detailed above, there is an increased likelihood of successfully impacting the public health issue of teen pregnancy thoroughly. As a public health issue, teen pregnancy is intricately linked to educational disruptions, intergenerational challenges, significant SES costs, and the prevailing political landscape (Maslowsky et al., 2022; Mohamed et al., 2023). Addressing this concern through a comprehensive public health lens not only mitigates adolescent reproductive health risks but also contributes to broader societal goals, including reducing social determinants of health and promoting positive youth development. This study aimed to deepen understanding of teen pregnancy as a public health issue and explore how to address it in a manner that best serves the affected teens, their families, and society.

Interventions for Teen Pregnancy

Historically, adolescent pregnancy was not considered a public health concern; however, its extensive social, economic, health, and political implications have prompted its recognition as a crucial public health issue over time. Addressing this complicated phenomenon requires comprehensive, evidence-based interventions that extend beyond individual behavior modification to include systemic, communal, and policy-level strategies (Berlan et al., 2025). Consequently, a thorough understanding of the varied interventions is necessary to best mitigate adolescent pregnancy, improve adolescent reproductive health outcomes, and reduce health disparities (OPA, 2023). Being knowledgeable about teen pregnancy interventions is necessary for this study, as they are a core component of the federally funded TPP Program, which is under review for this study.

About Teen Pregnancy Prevention Interventions

As a complex matter, teen pregnancy affects families of teens, teachers, governing bodies, and the overall community (Klein & Committee on Adolescence, 2005). Due to the variety of intersecting contributing factors of teen pregnancy, there has not been an individual determinant identified as the cause of teen pregnancy (Finkel, 1995). A singular, factor-specific intervening approach is inadequate; effective teen pregnancy prevention requires multifaceted, comprehensive prevention strategies (Mecklenburg & Thompson, 1983; Mohamed et al., 2023; Raya-Diez et al., 2024). An early attempt at this came in the latter part of the century in 1980, when the Adolescent Family Life (AFL) Program, which succeeded the Adolescent Pregnancy Program (APP) of 1978, was formed as the initial effort of the government to address teen pregnancy and parenting

(Mecklenburg & Thompson, 1983).

The AFL identified two levels of prevention for teen pregnancy: “1) primary prevention-prevention of adolescent pregnancies and 2) secondary prevention-alleviation of the negative consequences of pregnancy for the adolescent parent and offspring”

(Mecklenburg & Thompson, 1983, p. 25) and intertwined in both prevention levels is family. Mecklenburg and Thompson (1983) describe the operationalization of the 1980 AFL Program under the core services listed below:

- Pregnancy Testing and Maternity Counseling
- Family Planning Services
- Primary and Preventive Health Services (including pre/postnatal care)
- Nutrition Information and Counseling
- Screening and Treatment of Venereal Disease
- Educational Services in Sexuality and Family Life
- Educational and Vocational Services
- Adoption counseling
- Pediatric care
- Transportation and Other Health Services
- Referral to Licensed Residential Care or Maternity Home Services
- Mental Health Services

The AFL Program differed from its predecessor, the APP, in the types of projects funded. Through the AFL’s funded demonstration-evaluation projects, new information was presented regarding what primary and secondary prevention strategies were effective to avoid adolescent pregnancy and identify adverse consequences (Mecklenburg & Thompson, 1983). The projects that evolved from the AFL Program were then referred to local and state organizations for implementation to employ a novel approach to the public health issue of teen pregnancy. The AFL Program was an innovative program for the

time period. It enlisted a comprehensive approach to address the complex public health issue of teen pregnancy (Mecklenburg & Thompson, 1983). The AFL Program created a foundation upon which future programs and services could be established and move prevention efforts to be more comprehensive (Mecklenburg & Thompson, 1983). One such contemporary program is the TPP Program. The TPP Program created a communal effort to effectively intervene in the issue of teen pregnancy by engaging youth, parents, caregivers, and key stakeholders in all aspects of the program (OPA, 2023). In addition, the multi-faceted public health approach of the TPP Program also advocated for active collaboration with a network of partners to increase awareness and access to adolescent-friendly health services (OPA, 2023) to address all areas impacted by the far-reaching issue of teen pregnancy nationwide and in Georgia.

Gaps in Literature

Although extensive research addresses the causes, consequences, and prevention of teen pregnancy, a critical gap remains in evaluating the impact of federally funded TPP Programs at the county level. Existing studies primarily examine national trends or program-wide outcomes, overlooking local variations in effectiveness. Without county-level assessments, policymakers and program administrators lack the evidence needed to adapt interventions and allocate resources effectively. Furthermore, national and state analyses do not account for community-specific contributing factors such as SES disparities, educational attainment, and politics that influence program success (Brindis, 2006; Penman-Aguilar et al., 2013). This absence of local data limits the identification of high-need areas and the development of strategies addressing determinants of health (Berlan et al., 2025; Mohamed et al., 2023). Closing this gap is essential for informed

resource allocation, equity-focused policy decisions, and adapting interventions to meet the unique needs of high-risk communities.

Chapter Summary

The literature overwhelmingly confirms that teen pregnancy remains a considerable public health issue with broad implications that extend well beyond the individual level to encompass educational, economic, and sociopolitical domains.

Historically, the prevalence of teen pregnancy was shaped by shifting societal norms, economic realities, and political agendas, with public health interventions progressing in response to changing needs and available evidence. The recurring themes throughout the research emphasize the lasting impact of teen pregnancy on education, with many adolescent parents facing disruptions to academic attainment, constrained career trajectories, and decreased lifetime earning potential. Additionally, the educational barriers often contribute to long-term SES disparities, perpetuating cycles of poverty that influence not only the young parents but also their children, families, and communities. Furthermore, the broad social and economic burdens associated with teen pregnancy include increased reliance on public assistance, elevated healthcare expenditures, and diminished tax contributions, which reinforces its designation as a multifaceted societal and public health challenge. The literature consistently emphasizes that teen pregnancy is not an isolated issue but rather a complex matter that is best addressed with effective prevention and intervention strategies, which are comprehensive and evidence based.

From early campaigns to comprehensive, evidence-based programs, efforts to address teen pregnancy acknowledged the interconnectedness of social, educational, and economic determinants that influence adolescent reproductive health outcomes. The

research reinforces the concept that any efficacious prevention and intervention efforts will require an all-inclusive, evidence-based approach that addresses the underlying determinants of health, advances educational and economic opportunity, and ensures equitable access to reproductive healthcare. Additionally, delving into the various themes that impact teen pregnancy was essential to understanding why the TPP Program exists and why it funds programs and services throughout Georgia, the state under study here. Presently, the TPP Program is an innovative and integrative approach that aligns with public health principles through its emphasis on multi-level engagement, making it valuable to study and relevant for addressing the issue of teen pregnancy through a public health lens. This research sought to contribute to the discourse on effective public health strategies and to inform future policies and programmatic efforts to address teen pregnancy. The lack of literature detailing how the presence of a comprehensive program, such as the TPP Program, affects teen pregnancy rates underscores the need for this study.

Chapter III

Methodology

The TPP Program, a federally funded initiative, has been implemented in Georgia since 2015 by Morehouse School of Medicine's Health Promotion Resource Center and named the Teenage Pregnancy Prevention Initiative. Despite the longevity of the TPP Program in Georgia, it has not been evaluated for its impact on the counties, including DeKalb, Dougherty, Douglas, Lamar, and Thomas, that are served by the project and that are the sample this study used. The MSM TPPI Program served diverse communities representing various parts of the state. This chapter details the methodological framework of the study, to include information about the research design, the population, procedures, and data analysis employed to assess whether participation in TPPI, which was federally funded by the TPP Program had an impact on targeted Georgia counties.

Study Purpose

The purpose of this quantitative study was to evaluate the extent of impact of the federally funded TPP Program on teen pregnancy rates in select Georgia counties that were participants in the MSM TPPI. In addition to assessing program impact, the study also aimed to determine whether social determinants of health, such as poverty, politics, and education, could account for variation in teen pregnancy outcomes across identified Georgia counties. An in-depth understanding of these factors is fundamentally necessary to be knowledgeable about teen pregnancy prevention and comprehensive approaches to

effectively address the issue. This study also sought to identify any disparities associated with teen pregnancy prevention efforts that could aid in creating lasting change that informs long-term public health strategies. Finally, the results of this study may support future political and legislative programs that lead to the allocation of funds toward teen pregnancy prevention, programs, and services that affect contributing factors of teen pregnancy.

Research Questions

The study addressed one primary research question:

RQ1. What has been the impact of the federally funded Teen Pregnancy Prevention (TPP) Program on teen pregnancy rates in targeted Georgia counties?

This study also explored the following sub-questions:

RQ1a. What other contributing factors or social determinants of health influence teen pregnancy rates in targeted counties in Georgia?

RQ1b. How does the political climate impact the programs and services available to address teen pregnancy?

Research Design

This study employed a quantitative research approach, which was selected based on the type and quantity of available data. Using a quantitative design was appropriate for this study to assess whether an association existed between participation in the MSM TPPI and teen pregnancy rates across selected counties in Georgia. A quantitative approach also allowed examination of a substantial data set, enabled rigorous analysis, facilitated identification of relationships within the data, and minimized potential bias (Creswell, 2015). Additionally, this study used a specific subset of a quantitative study

known as a correlational study, which enables the exploration of statistical relationships using observational, population-level data without manipulating variables (Creswell, 2015). While qualitative methods could have provided additional insight into the public health issue of teen pregnancy, they are not suitable for identifying statistical relationships or trends based on large-scale numerical data.

Furthermore, Lau (2017) details that a correlational study design is the best fit for a study such as this, as the goal is to determine whether differences in outcomes were associated with exposure to a specific intervention. Also, the quantitative correlational design is useful for identifying trends, recognizing relationships, and providing insight into program effectiveness; however, this design does not establish causation (Price & Lovell, 2018). Although causality cannot be inferred from this study, the quantitative correlational design enabled the study to evaluate patterns and associations between program participation and teen pregnancy outcomes, while also providing insight into the contributing factors influencing teen pregnancy rates across Georgia counties.

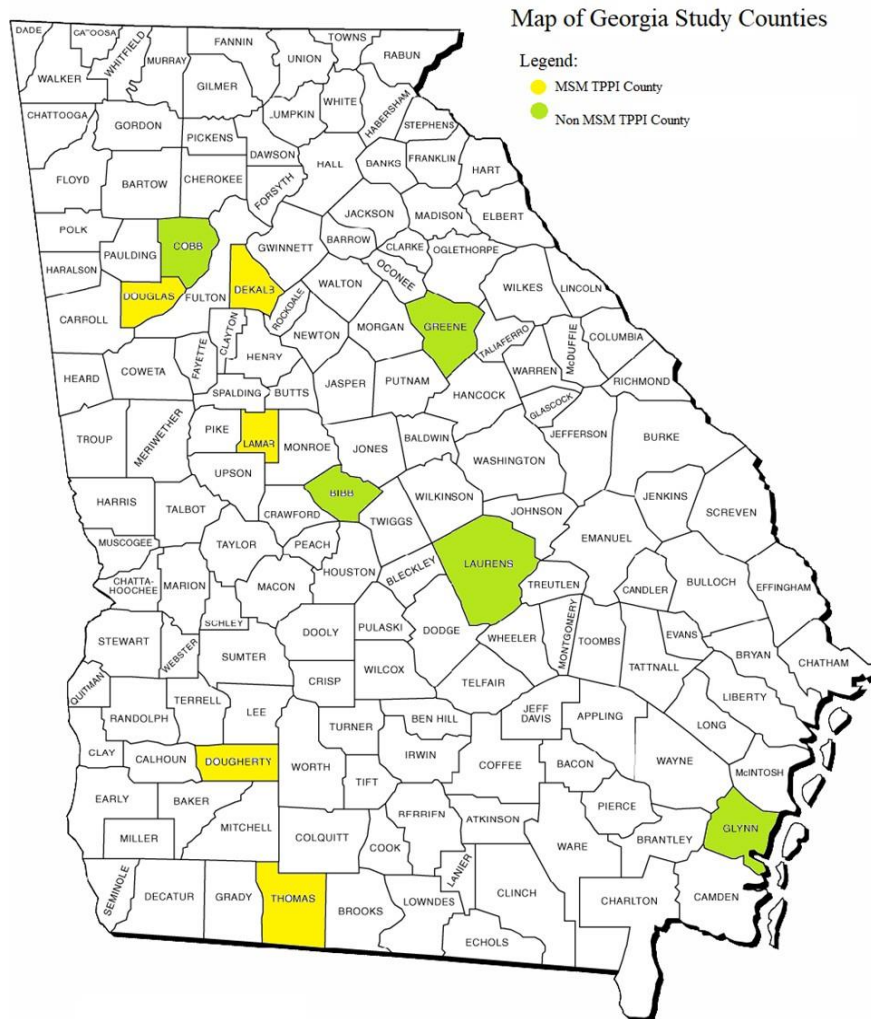
Population of Study

The study focused on DeKalb, Dougherty, Douglas, Lamar, and Thomas counties, all of which participated in the MSM TPPI (see Figure 2). These counties are compared with similar counties that were not a part of the MSM project, which include Cobb, Glynn, Bibb, Greene, and Laurens counties. Comparative counties were identified using the USCB's (2023) QuickFacts tool, which allowed for a comparison of variables such as population, sex, and race. Counties were also paired based on their geographic classification as either urban or rural, defined by the 2020 Census. Areas with at least 5,000 residents (an increase from the previous requirement of 2,500 people) or 2,000

housing units are classified as urban, while all others are considered rural (USCB, 2022).

Figure 2

Map of Georgia Study Counties



Note. Adapted from “Regions of Georgia,” by Georgia Department of Economic Development, 2025. (<https://georgia.org/regions>).

Table 2 presents the information used to select and pair counties for comparison. Counties are organized first according to participation in the TPPI Program, then aligned with their demographic counterparts. Additional considerations included total population, racial breakdown, birth rates, and political affiliation. This matching process ensured that

comparison counties resembled TPPI counties on key structural factors that might otherwise confound statistical comparison.

A subset of the broader population, youth ages 10-19 residing in the identified Georgia counties, was analyzed. WHO (2025) defines this developmental period as adolescence and describes it as critical for shaping young people's health behaviors and decision-making patterns. OPA, which funds the TPP Program, recognized the importance of this pivotal time in a young person's life and has dedicated fiscal, human, and infrastructural resources to effectively address the public health issue of teen pregnancy (OPA, n.d.). Given that the OPA prioritizes addressing teen pregnancy during this developmental stage, youth ages 10-19 represent the appropriate target population for this study.

The counties outside of the identified comparison group were excluded from this study due to differences with the experimental groups on key demographic and structural characteristics. Georgia has 159 counties (Georgia Department of Economic Development, 2025); thus, many of the counties differed in population size, racial makeup, geographic designation, and birth rate patterns, making them incompatible for comparison with the experimental counties. Additionally, a review of public federal records and documentation confirmed the selected counties were not participants in the TPP Program during the study period. Inclusion of these counties without adequate comparable information could potentially introduce bias to the study. Therefore, only counties meeting criteria for demographic indicators and not involved in OPA's TPP Program were selected as controls, ensuring a more unbiased and methodologically reliable comparative analysis for this study.

Table 2*County Selection Demographics*

	MSM TPPI Counties						Non-MSM TPPI Counties				Georgia
County	Dekalb	Dougherty	Douglas	Lamar	Thomas	Cobb	Glynn	Bibb	Greene	Laurens	
2024 Population Count**	762,820	82,966	147,316	19,467	45,561	771,952	85,079	156,197	20,139	49,660	10,912,876
2024 Population Count** (target population)	93,861	11,961	22,615	2,796	6,131	103,421	10,205	21,666	2,024	7,033	1,511,1778
2024 Percent target population by Race (W = White, B = Black, O = all other races)**	W 34.6%	16.4%	36.0%	60.5%	55.6%	58.3%	59.5%	29.1%	52.8%	53.5%	54.2%
	B 54.1%	78.8%	56.6%	34.0%	40.0%	30.1%	33.1%	65.1%	39.1%	41.7%	35.5%
	O 11.3%	4.9%	7.3%	5.4%	4.4%	11.6%	7.4%	5.8%	7.8%	4.8%	10.4%
Geographic Designation	Urban	Urban	Urban	Rural	Rural	Urban	Urban	Urban	Rural	Rural	
2024 Presidential Political Affiliation~	Dem	Dem	Dem	Rep	Rep	Dem	Rep	Dem	Rep	Rep	Rep
Percent of Population in Poverty *	14.5%	26.1%	12.8%	14.1%	19.1%	9.6%	16.5%	24.5%	14.0%	21.9%	12.7%
2024 Birth Rate (10-19yo)**	8.2	14.9	6.9	7.9	16.1	5.2	12.1	13.7	6.2	17.2	8.3

Note. This table was constructed using data from three sources: *: “Quick Facts: Georgia,” by the U.S. Census Bureau, 2024. (<https://www.census.gov/quickfacts/fact/table/GA/PST045222>); **: “Maternal Child Health—Birth Web Query,” by Online Analytical Statistical Information System, n.d. (<https://oasis.state.ga.us/oasis/webquery/qryBirth.aspx>); ! “Donald Trump Flips Georgia,” by Z. Montellaro, 2025. (<https://www.politico.com/2024-election/results/georgia>)

Data Collection

After identifying comparative counties, secondary data were collected from the OASIS, the GADPH (n.d.) online statistical database. OASIS is a tool that provides extensive health statistics and indicators from various sources, and the information can be presented in different formats as needed, enabling users to generate customized reports (GADPH, n.d.). For this study, OASIS was the primary source for the population, birth rate, and demographic information collected for the study. Because the research involved analysis of publicly available, de-identified secondary data and did not include interaction with human subjects, the study met the requirements for Institutional Review Board (IRB) exemption (see Appendix A) under federal guidelines.

Data were collected for the years 2010 through 2024, which represent pre-program years; 2015-2020 represent the MSM TPPI Program implementation years; and 2021-2024 represent post-program years. For each year, data were collected for all 10 counties in the study stratified by age groups of 10-14, 15-17, and 18-19. Statistics were downloaded from OASIS and collated into a Microsoft Excel file to provide data sets for analysis. The variables extracted from OASIS included overall teen birth rates and counts for teens aged 10-19 from 2010-2024, stratified for each county. The teen birth rates for

the target population and timeframe were also obtained based on educational attainment, race, and socioeconomic vulnerability status. Additionally, political data was gathered for each county on party affiliation for the past five presidential elections. Data on these variables were collected to effectively address the study's research questions and test the hypothesis that Georgia counties funded by the federal project will have lower teen birth rates than the counties that were not funded by the federal TPP Program. After adequate data analysis, the hypothesis can be accepted or rejected based on the outcomes.

Data Analysis

This study explored the relationship between the TPPI Program and other contributing factors of teen births. Both descriptive and inferential analyses were utilized to explore data that illustrated the association between teen birth rates and the independent variables. The OASIS database provided statistics on teen birth rates during the target timeframe for teens aged 10-19, stratified by several variables. However, for some variables, statistics were not available for teens aged 10-19 who did not give birth during this timeframe. As such, inferential comparisons could not be reliable for those variables, and descriptive statistics were used instead. Descriptive analyses were conducted to examine the birth rates among the target population stratified by education less than 12th grade, race, and socioeconomic vulnerability, where the lower the socioeconomic vulnerability, the higher the SES.

Inferential statistics were used to examine the relationship of teen birth rates with the presence of TPPI in the county, as well as race. To analyze the data related to RQ1 and RQ1a, chi-square tests of association were used to identify the association between the teen birth rates and the presence of the TPPI in the county, race, education, and

socioeconomic vulnerability. Analyses were conducted using IBM SPSS, a software platform for inferential statistics and trend prediction (IBM, 2024). The dependent variable was county-level teen birth rates for the respective timeframe (before the program, 2010-2014; during the program, 2015-2020; or after the program, 2021-2024). The independent variable was the presence of the TPPI program (yes/no).

The chi-square test of association was chosen because it was the best for the data available on teen birth rates in Georgia stratified by whether TPPI was in place. Chi-square tests of association examine relationships between categorical variables (Kremelberg, 2011; Shih & Fay, 2017). Importantly, the analyses can be conducted using a case-weighted approach where count data for various groupings is available (Green & Salkind, 2013). In this study, the count of teen births was available for various groups (teen birth counts in TPPI and non-TPPI counties, among racial groups, educational status groups, and socioeconomic vulnerability groups); however, the individual-level data for each teen in Georgia were not available. As such, other analyses that examine changes over time using individual-level data, such as repeated measures ANOVA or regression analysis, could not be used. The grouping nature of teen birth rates with count data made available by OASIS provided a means for examining the association of teen birth rates and the desired independent variables using a chi-square test of association.

Several assumptions are made when conducting a chi-square test of association, including independence of the data and a sufficiently large sample size to yield a normally distributed test statistic (Green & Salkind, 2013). The sample size requirement is met when each cell has more than five observations (Green & Salkind, 2013). The assumption of independence was met by analyzing data from the three time periods

separately. Given that the population data is based on the geographic location of the teens, it was considered reasonable to assume that the majority of the teens were repeated in the data over the time periods that were the same, with the exceptions being those that aged into or out of the age criteria (10-19 years or age) or relocated. The data from the three time periods were not considered independent and were analyzed separately.

To address sample size, descriptive statistics were reviewed prior to analyses to ensure that all levels of the independent variables provided a minimum of five observations. When examining race, several categories failed to meet this requirement. These included the race categories of American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, and Unknown. These groups were not included in the analysis, resulting in three racial groups being compared: Black or African American, Multiracial, and White.

For RQ1, three chi-square tests were conducted to test the association between the dependent variable and the independent variable. First, a chi-square test was conducted to examine the association for the time period before the TPPI program (2010-2014). Second, a chi-square test was conducted to examine the association for the time period during the TPPI Program (2015-2020). Finally, a chi-square test was conducted to examine the association for the time period after the TPPI program (2021-2024). For RQ1a, chi-square tests were run to examine the association between teen birth rate and race. Race served as the independent variable and included three levels: Black or African American, Multiracial, and White. Three chi-square analyses were run to examine the association during the three time points (see Table 3).

Table 3*Summary of Chi-Square Tests of Association Conducted to Answer RQ1 and RQ1a*

Research Question	Test	Timeframe	Dependent Variable	Independent Variable
RQ1: TPPI vs. Non-TPPI	1	2010–2014	Teen birth rate	TPPI vs. no TPPI
	2	2015–2020	Teen birth rate	TPPI vs. no TPPI
	3	2021–2024	Teen birth rate	TPPI vs. no TPPI
RQ1a: Other contributing factors	4	2010–2014	Teen birth rate	Race
	5	2015–2020	Teen birth rate	Race
	6	2021–2024	Teen birth rate	Race

RQ1b sought to understand the influence of politics on issue of teen pregnancy.

As mentioned in the literature review, politics has a considerable influence on the services and programs offered. For example, the repeal of *Roe v. Wade* via the *Dobbs v. Jackson Women's Health Organization* Supreme Court decision will impede access to and availability of reproductive healthcare services and programs (Treder et al., 2023). Table 4 details the election results for each of the study counties for the various Presidential elections from inception of the TPP Program to the present. This covers the pre-, during, and post-program years of this study. A descriptive analysis of the information in this table was conducted to identify any trends.

Table 4*Presidential Election Outcomes*

County	Year	2008*	2012*	2016*	2020*	2024
	TPP/NTPP	Winning Political Party				
Bibb	0	D	D	D	D	D
Cobb	0	R	R	D	D	D
Glynn	0	R	R	R	R	R
Laurens	0	R	R	R	R	R
Greene	0	R	R	R	R	R
Dekalb	1	D	D	D	D	D
Dougherty	1	D	D	D	D	D
Douglas	1	D	D	D	D	D
Lamar	1	R	R	R	R	R
Thomas	1	R	R	R	R	R

Note. This table used data from “Maps: Compare How Georgia Counties Voted for President in 2008-2020,” by E. M. DiRico, 2020.

(<https://www.ajc.com/politics/election/maps-compare-how-georgia-counties-voted-for-president-in-2008-2020/W3HHBQHUN5GMVPO6A6PMOD6PNY>).

Legend: D = Democrat; R = Republican; 1 = non-TPP-participating county ; 0 = TPP participating county

Chapter Summary

This methodology provided a strategic approach for evaluating the impact of the federally funded TPP Program on teen birth rates in Georgia counties that participated in the program compared to those that did not. Through the utilization of a quantitative correlational design and secondary data from sources such as OASIS and USCB (2024) QuickFacts, the study underwent a methodical approach to examine associations between program participation and teen pregnancy outcomes. Additionally, to ensure a comprehensive analysis, both descriptive and inferential analyses were conducted, allowing for the identification of statistical relationships and trends.

Chi-square tests were performed for pre-program, implementation, and post-program years to identify if an association existed between the variables of TPPI Program

participation and race. This methodology presented a reliable and thorough research approach to measure the effectiveness of participation in the TPP Program in identified counties throughout Georgia. While the inferential statistics tested association between variables, the descriptive statistics provided understanding into demographic patterns, SES status, and educational attainment. Furthermore, selecting comparable counties and stratifying by contributing factors strengthened the reliability of the study's results. Although causality cannot be inferred using these types of analyses, this approach offered a thorough lens that assessed programmatic impact on teen pregnancy and contributing social determinants. It is a strategically sound and comprehensive analysis that used dependable data sources, making this study a potentially noteworthy contributor to the field of adolescent health and the public health issue of teen pregnancy. The next chapter details the results of the analyses described in this methodology chapter.

Chapter IV

Findings

Overview of the Sample

This chapter presents the results of the analysis examining the influence of the federally funded TPP Program on adolescent birth rates across selected counties in Georgia from 2010 to 2024. The study addressed one primary research question:

RQ1. What has been the impact of the federally funded Teen Pregnancy Prevention (TPP) Program on teen pregnancy rates in targeted Georgia counties?

This study also explored the following sub-questions:

RQ1a. What other contributing factors or social determinants of health influence teen pregnancy rates in targeted counties in Georgia?

RQ1b. How does the political climate impact the programs and services available to address teen pregnancy?

To effectively address the study's research questions, data were collected from OASIS, the state health database, and analyzed using descriptive and inferential statistics to identify trends and relationships. This chapter includes tables and graphs to illustrate patterns and highlight focus areas for further investigation. Overall, the results provide an understanding of the association (if any) between the counties that participated in the TPPI Program and birth rates, identify disparities among subgroups, and potential

implications for policy that impacts programs and services directed at reducing teen pregnancy.

Demographics

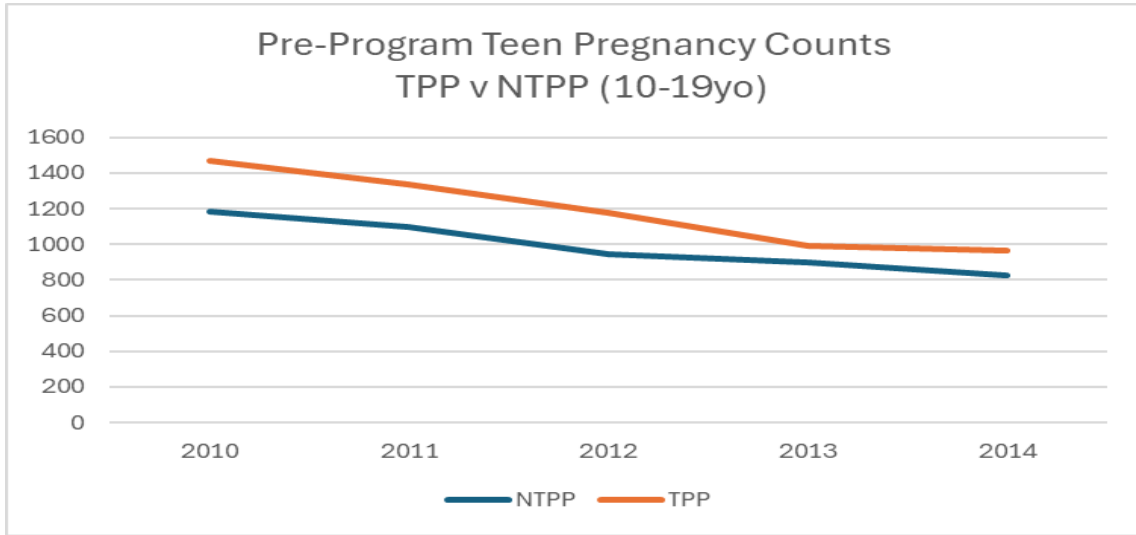
The demographic characteristics of the study population provide important insights into patterns in teen birth outcomes across the selected Georgia counties. Demographic data were derived from the Georgia Department of Public Health's OASIS database and include information on education level, socioeconomic vulnerability, and race among adolescents aged 10-19 residing in the 10 counties included in the study. The analysis for this study examined these variables over three time periods, including pre-program, during, and post-program, which created a more robust and reliable study.

Additionally, the study combined both descriptive and inferential statistics, which are depicted using tables and graphical representations to provide a comprehensive understanding of teen pregnancy trends in Georgia.

Analysis of Research Questions

To initiate the analysis, line graphs were created in Microsoft Excel to visually depict teen pregnancy across the three time periods reviewed in the study. The data used to construct the line graphs in this chapter can be viewed in their raw form, as tables for the three time periods, in Appendix B. They demonstrate a consistent decline in teen births across both TPP and non-TPP counties before, during, and after program implementation. Although TPP counties exhibited higher teen birth levels throughout the study period, the data show a narrowing gap between county groups over time. As the data analysis to create the figures was conducted, it was noted that in Figure 3, TPP counties reported 1,471 teen births in 2010, while non-TPP counties reported 1,184.

Figure 3
Pre-Program Teen Pregnancy Counts TPP-v-NTPP



Additionally, between 2015 and 2018, teen births in TPP counties declined from 889 to 801, while non-TPP counties declined from 732 to 583, as seen in Figure 4 , which also shows that teen births decreased in both county groups, but the rate of decline was more pronounced in TPP counties. The steeper slope observed for TPP counties suggests that programmatic interventions may have contributed to declines during the implementation period, and teen birth levels remained lower than pre-program levels

Figure 5 depicts post-program trends from 2021 through 2024, where teen births stabilized at lower levels in both county groups following program completion. By 2024, these totals had declined to 607 and 534, for TPP and NTPP respectively. TPP counties reported a modest increase between 2023 and 2024, while non-TPP counties remained stable. Despite these differences, Figure 5 shows that teen birth levels remained noticeably lower than pre-program levels, reinforcing the durability of the overall downward trend. This phenomenon of narrowing indicates decreasing differences in teen births across periods, which potentially suggests a possible programmatic influence. This

downward trajectory in the reduction in adolescent births is consistent with national trends. during the post-program time period.

Figure 4

Program Implementation Teen Pregnancy Counts TPP-v-NTPP

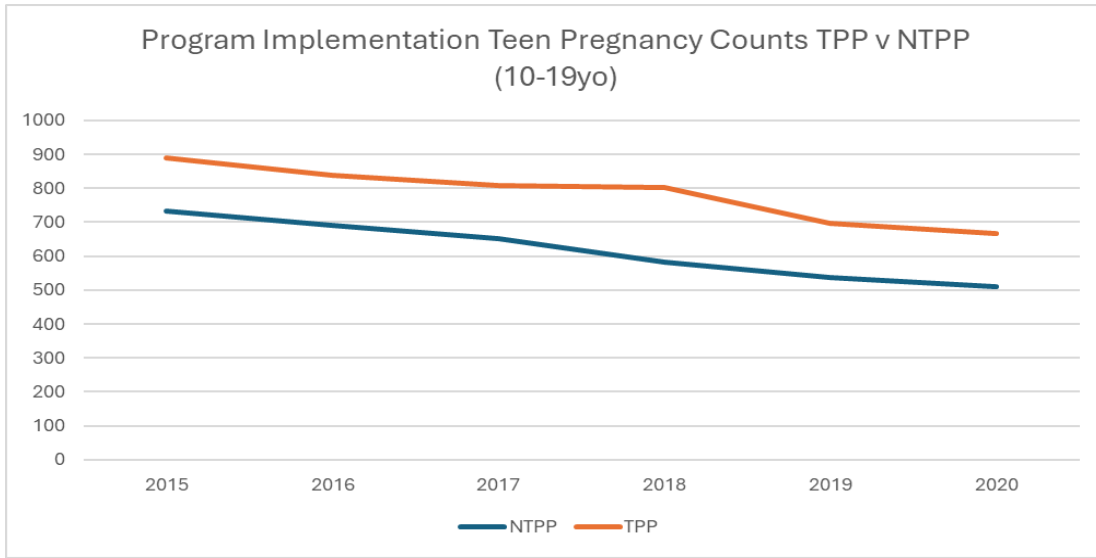
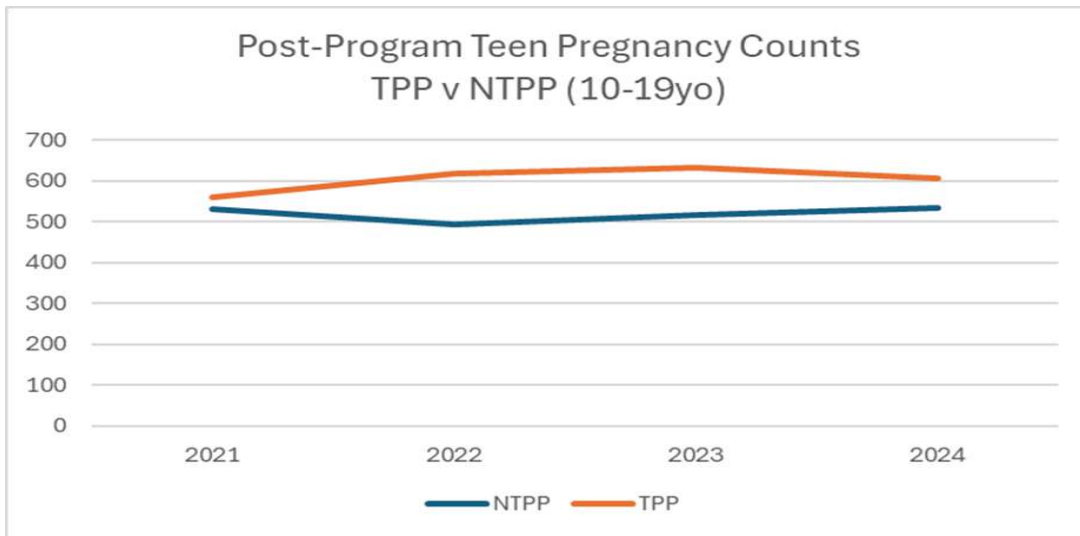


Figure 5

Post-Program Teen Pregnancy Counts TPP-v-NTPP



Tables to summarize the teen birth rate statistics based on race, high school education level, and socioeconomic vulnerability obtained from the OASIS database were organized per RQ in a data table that was used to extrapolate the following results (see Appendix C). To avoid potential dependence on the data, the statistics were separated into before, during, and after time periods for the TPPI Program. Below are details about the analytics associated with each of the research questions for the study.

RQ1

Three chi-square tests of association were conducted to examine the teen birth rate between counties with the TPPI Program and counties without the TPPI Program over the three time periods. The percentage of teen births before the program was 0.92% for TPPI counties and 0.71% for non-TPPI counties (see Table 5). The chi-square test was significant, $\chi^2(1, N = 1,344,846) = 172.26, p < .001$. There was a significantly higher percentage of teen births for the TPPI counties prior to the program beginning.

The second chi-square test examined the association between the teen birth rate and TPPI program involvement from 2015-2020, the timeframe during which the program operated. The percentage of teen births during this period was 0.59% in TPPI counties and 0.43% in non-TPPI counties. The chi-square test was significant, $\chi^2(1, N = 1,650,951) = 198.46, p < .001$. This indicated that there was a significantly higher percentage of teen births for the TPPI counties while the programming was in place.

The third chi-square test examined the association of teen birth rate to TPPI Program involvement after the program was completed (2021-2024). The percentage of teen births during this period was 0.45% in TPPI counties and 0.36% in non-TPPI counties. The chi-square test was significant, $\chi^2(1, N = 1,121,006) = 54.46, p < .001$. This

showed that the TPPI counties had a significantly higher percentage of teen births after the program was completed.

Overall, the birth rate in TPPI counties decreased over time. Before the program, the percentage of teen births was 0.92%, which decreased to 0.59% during and 0.45% after the program. However, a similar trend was noted among the non-TPPI counties, with the percentage of teen births starting at 0.71% before the program and decreasing to 0.43% and 0.36% during and after the program, respectively. Of note is that the difference in birth rate between the TPPI counties and non-TPPI counties became smaller over time. Prior to the program, the percentage of teen births was 0.20% higher in the TPPI counties compared to non-TPPI counties. During the program, the TPPI counties had a teen birth rate that was 0.16% higher than that of non-TPPI counties, and after the program, this gap closed to only 0.09%. While this suggests the potential for a positive impact of the program on teen birth rates, the data available for this study were restricted to chi-square analysis and therefore could not statistically analyze this trend.

RQ1a

RQ1a sought to understand the relationship between birth rates and other contributing factors, such as race, education, and socioeconomic vulnerability. To that end, a chi-square test of association was used to examine the role of race in teen birth rates. Race included three levels: Black or African American, Multiracial, and White. Three chi-square analyses were run to examine this association before, during, and after the TPPI Program. The percentage of teen births before the program was 1.02% for Black and African American teens, 1.48% for Multiracial teens, and 0.55% for White teens. The chi-square test was significant, $\chi^2(1, N = 1,289,579) = 1026.03, p < .001$. Follow-up

paired comparisons were conducted to identify which racial groups differed significantly. The results showed that all groups differed significantly from each other. The percentage of births to Black and African American teens (1.02%) was significantly lower than the percentage for Multiracial teens (1.48%; $\chi^2(1, N = 707,270) = 75.59, p < .001$) but significantly higher than the percentage for White teens (0.55%; $\chi^2(1, N = 1,250,542) = 835.15, p < .001$). The percentage of Multiracial teen births was also significantly higher than the percentage for White teens, $\chi^2(1, N = 621,346) = 510.52, p < .001$.

Table 5

Percentage of Teen Births between Counties with and without the TPPI Program

	Total Teens	Teens with Live Birth	Percentage of Teen Births
Before TPPI (2010–2014)			
TPPI counties	651,452	5,977	0.92%
Non-TPPI counties	693,394	4,952	0.71%
During TPPI (2015-2020)			
TPPI counties	799,197	4,724	0.59%
Non-TPPI counties	851,754	3,703	0.43%
After TPPI (2021-2024)			
TPP counties	544,410	2,428	0.45%
Non-TPPI counties	576,596	2,077	0.36%

The percentage of teen births during the program was 0.64% for Black and African American teens, 0.40% for Multiracial teens, and 0.40% for White teens. The chi-square test was significant, $\chi^2(1, N = 1,572,095) = 435.55, p < .001$. Follow-up paired comparisons were conducted to identify which racial groups differed significantly. The results showed that the percentage of births to Black and African American teens (0.64%)

was significantly higher than the percentage for Multiracial teens (0.40%; $\chi^2(1, N = 845,346) = 51.75, p < .001$) and significantly higher than the percentage for White teens (0.40%; $\chi^2(1, N = 1,513,131) = 414.18, p < .001$). The percentages of births for Multiracial and White teens were not significantly different during the program, $p = .93$.

The percentage of teen births after the program was 0.48% for Black and African American teens, 0.35% for Multiracial teens, and 0.36% for White teens. The chi-square test was significant, $\chi^2(1, N = 1,064,202) = 87.52, p < .001$). Follow-up paired comparisons were conducted to identify which racial groups differed significantly. The results showed that the percentage of births to Black and African American teens (0.48%) was significantly higher than the percentage for Multiracial teens (0.35%; $\chi^2(1, N = 56,642) = 14.41, p < .001$) and significantly higher than the percentage for White teens (0.36%; $\chi^2(1, N = 1,015,744) = 82.10, p < .001$). The percentages of births for Multiracial and White teens were not significantly different after the program, $p = .81$.

While not the focus of RQ1a, a longitudinal pattern was observed in the data related to race and teen birth rate. As illustrated in Table 6, the percentage of teen births changed over time for all three racial groups. Between 2010 and 2024, the percentage of teen births decreased by 53% for Black and African American teens, 76% for Multiracial teens, and 35% for White teens. This aligns with the pattern of decreasing birth rates discussed with respect to RQ1. However, the difference in decline across the three racial groups suggests a potential interaction: not all racial groups have observed the same rate of decline in birth rates.

Table 6

Percentage of Teen Births by Race

Before TPPI (2010-2014)	Total Teens	Teens with Live Birth	Percentage of Teen Births
Black or African American	668,233	6,789	1.02%
Multiracial	39,037	576	1.48%
White	582,309	3,227	0.55%
During TPPI (2015-2020)			
Black or African American	786,382	5,052	0.64%
Multiracial	58,964	236	0.40%
White	726,749	2,926	0.40%
2021-2024			
After TPPI (2021-2024)			
Black or African American	518,081	2,476	0.48%
Multiracial	48,461	172	0.35%
White	497,663	1,799	0.36%

Before the program, the number of teen births among 10-19-year-olds in the selected 10 counties with less than a high school education was 5,182. This accounted for 47.42% of all teen births in this population, a figure similar both during (48.02%) and after (45.19%) the TPPI Program, suggesting a possible relationship between educational status and the teen birth rate.

Socioeconomic vulnerability status was provided on three levels: very low, average, and very high. A consistent trend was observed across the three time points. When considering only these three categories, low socioeconomic vulnerability teens contributed the least to the percentage of births, ranging between 6.11% and 6.85% of all teen births among 10-19-year-olds in the 10 counties. Teens in the average socioeconomic vulnerability category accounted for 14.20% to 15.27% of live births in the 10-19-year-old population in these counties. Teens in the high socioeconomic vulnerability category contributed the largest percentage among the three socioeconomic

vulnerability categories analyzed. Their contribution to the percentage of teen births ranged between 43.90% and 45.50%. This suggests that higher socioeconomic vulnerability may be a strong contributor to teen birth rates (see Table 7).

Table 7

Teens Live Births and Percentage Contributing to All Teen Births by Education and SES

Status

	Teens with Live Birth	Percentage of Teen Births
Before TPPI (2010–2014)		
Total Teen Births	10,929	100%
Education Status		
Less than High School Education	5,182	47.42%
Socioeconomic Vulnerability Status		
Very Low	749	6.85%
Average	1,669	15.27%
Very High	4,798	43.90%
During TPPI (2015–2020)		
Total Teen Births	8,427	100%
Education Status		
Less than High School Education	4,047	48.02%
Socioeconomic Vulnerability Status		
Very Low	515	6.11%
Average	1,197	14.20%
Very High	3,828	45.43%
After TPPI (2021–2024)		

Total Teen Births	4,505	100%
Education Status		
Less than High School Education	2,036	45.19%
Socioeconomic Vulnerability Status		
Very Low	299	6.64%
Average	644	14.30%
Very High	2,050	45.50%

RQ1b

RQ1b examined political forces’ role in teen birth rates by reviewing the presidential election data that overlapped with the study timeframe (see Table 4). The political party for the majority vote was recorded for each year by county to compare the counties that participated in the TPPI program and those that did not. Of the five counties with the TPPI program, 15 of 25 election results were Democratic. Of the five counties without the TPPI program, 17 of 25 election results were Republican, with a change occurring in the 2016 election cycle.

Data were collated in a table to compare 2008-2024 Republican versus Democratic presidential vote totals across two county groupings (see Appendix D). This data were used to visually represent the trends (see Figure 6). The groups are coded as NTPP for counties that did not participate in the TPPI Program and as TPP for counties that did. In the NTPP counties (Bibb, Cobb, Glynn, Laurens, Greene), the Republican Party led in 2008 and 2012, but this pattern changed when Cobb County transitioned to the Democratic majority in 2016. This shift was a major reason the NTPP group experienced an increase in Democratic votes in later years. The TPP counties (DeKalb, Dougherty, Douglas, Lamar, Thomas) predominantly trended toward the Democratic

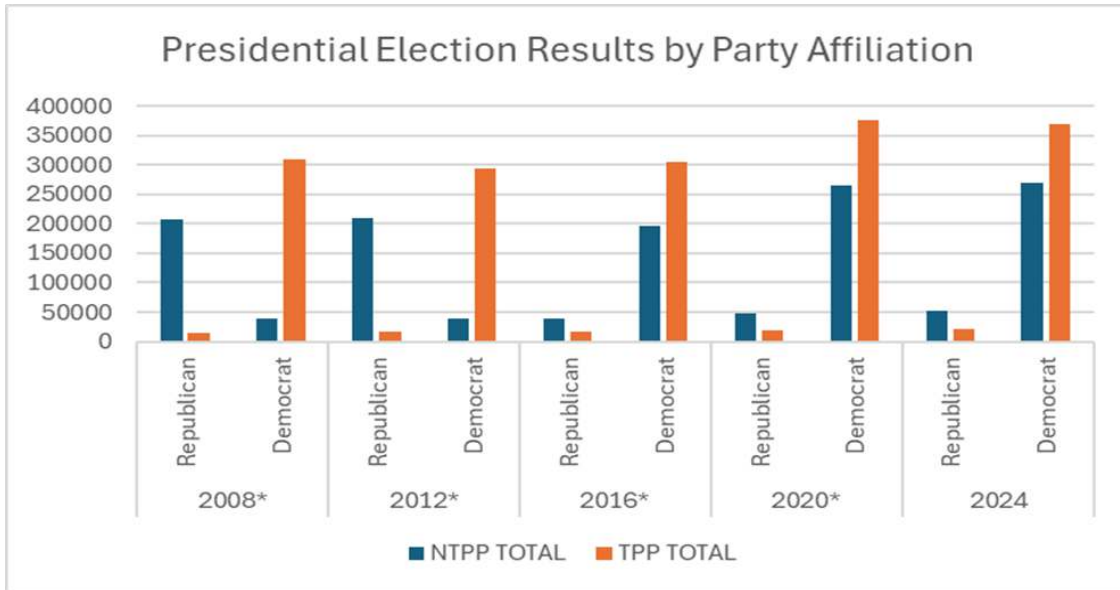
Party all the years identified in the study. This is important because it informs that TPP counties had Democratic strength, while NTPP counties shifted to Democrat in recent years after being Republican led for an extended time. This is also noteworthy because the political administration in office has a great influence over the availability of and types of teen pregnancy prevention services and programs for implementation (Treder et al., 2023).

Hypothesis Outcomes

The hypothesis for this study proposed that Georgia counties funded by the federal TPPI Program would have lower teen birth rates than counties that were not funded. After the analyses were conducted, the results consistently showed that TPPI counties had significantly higher teen birth rates than non-TPPI counties across all time periods in the study. In each period, chi-square tests indicated that these differences were statistically significant ($p < .001$), demonstrating that teen birth rates were not lower in funded counties. In summary, the hypothesis is rejected because the federally funded TPP counties did not have lower teen birth rates than NTPP-funded counties. However, supporting evidence indicates that the TPPI Program may have had an encouraging impact by accelerating declines and reducing disparities, rather than by producing lower overall rates compared to non-TPPI counties.

Figure 6

Presidential Election Results by Party Affiliation



Chapter Summary

This chapter examined the impact of the federally funded TPP Program on adolescent birth rates in 10 selected Georgia counties from 2010 to 2024. Using data from the Georgia Department of Public Health’s OASIS database, the chapter addressed three research questions related to program impact, SDOH, and political context. To best answer these questions, a series of descriptive and inferential statistical analyses was employed to examine trends across pre-program, program implementation, and post-program periods. Overall, the analysis revealed trends and program impact of consistent declines in teen birth rates across all counties during the study period, paralleling national trends. Declines in birth rates occurred in TPP and NTPP counties throughout the study period. The counties that participated in the TPPI Program exhibited a noticeable decline during the program years (2015-2020), potentially inferring programmatic influence. The pattern of declining birth rates was present in both descriptive trend analyses and chi-square tests of association, further suggesting an influence from the TPPI program.

The chi-square tests proved that there were significant differences in teen birth rates between TPP and non-TPP counties across all timeframes. Before the program, TPP counties had a teen birth rate of 0.92% compared to 0.71% in non-TPP counties. During the program, birth rates declined to 0.59% and 0.43%, respectively, and after the program, to 0.45% and 0.36%. Statistical significance does not lead to a conclusion of causality, but significance substantiates the likelihood of impact from participation in TPPI.

The statistical analysis of contributing factors stressed the role of SDOH, especially education level, SES, and race. SES findings revealed a pattern across time, with teens categorized as having very high socioeconomic vulnerability contributing the largest proportion of teen births among the socioeconomic vulnerability categories analyzed. Racial disparities were also evident, with Black or African American and Multiracial teens experiencing higher teen birth rates than White teens across all periods, although all racial groups demonstrated substantial declines over time. These results indicate that while overall teen birth rates are decreasing, inequities among demographic subgroups persist.

Finally, the findings linked to political climate suggested that TPPI counties were more consistently aligned with Democratic presidential voting patterns, whereas some non-TPPI counties showed a shift from Republican to increased Democratic trends. This contextual information is relevant given the influence of political leadership on public health funding priorities and the availability of programs and services offered to address teen pregnancy.

Overall, the findings presented in this chapter provide an understanding of teen pregnancy trends in Georgia and clarification on various factors that influence teen pregnancy rates and can potentially lead to future research on effective ways to address the public health issue. Chapter V discusses how these findings validate the existing literature by confirming that teen pregnancy is a multifaceted public health issue shaped by social determinants and that prevention programs function within broader societal systems, reinforcing the study's credibility. Additionally, the study's findings imply that TPP contributed to changes over time, aligning with the literature supporting comprehensive, evidence-based interventions as the most effective approach to this public health issue.

Chapter V

Discussions and Implications

Summary of Study

This quantitative, correlational study examined whether Georgia counties that participated in the MSM TPPI, funded under the federal TPP Program, experienced different teen birth outcomes than demographically similar counties that did not participate. This study was guided by the Public Health Model and investigated three research questions. The study first addressed one primary research question:

RQ1. What has been the impact of the federally funded Teen Pregnancy Prevention (TPP) Program on teen pregnancy rates in targeted Georgia counties?

This study then explored the following sub-questions:

RQ1a. What other contributing factors or social determinants of health influence teen pregnancy rates in targeted counties in Georgia?

RQ1b. How does the political climate impact the programs and services available to address teen pregnancy?

To ensure the study was comprehensive with reliable results, secondary data were drawn from the Georgia Department of Public Health's OASIS System and USCB's (2024) QuickFacts, with analyses comprising descriptive statistics and chi-square tests of association.

The study population consisted of 10 comparable counties, five of which were included in the MSM TPPI Program and five that did not participate in the program. Both study groups saw a consistent decline in teen births for the entire timeframe of the study, consistent with national trends. Throughout the study, the TPP counties exhibited higher baseline teen birth rates than their matched counterparts but demonstrated sharper declines during the program years and sustained reductions thereafter. The contributing factors of education level, socioeconomic vulnerability, and race were each associated with teen birth outcomes. As it relates to the political factors, the presidential vote patterns suggested contextual differences between TPPI and non-TPPI county groupings relevant to policy and funding environments. An in-depth discussion of the findings allows for an understanding of the impact of the TPP Program in Georgia.

Major Findings

The major finding of this study was that teen birth rates declined in all counties over time, with narrowing gaps between TPPI and non-TPPI counties during and after the program implementation period. Incidentally, the teen pregnancy birth rates for counties in the TPPI Program were not significantly lower than those in non-TPPI counties, which resulted in rejecting the hypothesis for the study. Additional noteworthy findings detailed below explain the associations between teen pregnancy rates and various contributing factors that can influence them.

Teen Pregnancy Rates

Initially, TPPI counties had higher birth rate percentage (0.92%) compared to non-TPPI counties (0.71%). By the post-program period, these rates dropped to 0.45% and 0.36%, respectively, reducing the absolute gap from 0.20 percentage points to 0.09. This

trend suggests that TPPI counties experienced accelerated declines during and after program implementation. Overall, teen birth rates declined across all counties over time, with the gap between TPPI and non-TPPI counties narrowing significantly.

Race

Race was significantly associated with teen birth rates at all time points, with notable disparities between groups and unequal declines among racial groups. Before the program (2010-2014), Black/African American and Multiracial teens had higher birth percentages than White teens. By 2024, all groups saw declines, but the magnitude varied, with percentages of 53% for Black/African American teens, 76% for Multiracial teens, and 35% for White teens. Additionally, this variable presented significant differences between both Black/African American and Multiracial racial groups and their White counterparts.

The research is encouraging in that all groups declined in teen births; however, the uneven distribution in decline implies that gaps exist in areas of distribution and access to resources, programs, and services (Raya-Diez et al., 2024). This study shows that the federally funded TPP Program, as well as any state-funded programs, should be designed in a manner that is equity centered to more effectively reduce gaps and improve access for all races.

Education

Educational status was a strong predictor of teen births throughout the study period. Teens with less than a high school education consistently accounted for approximately 45% - 48% of all teen births. This is a strong indication of a stable and meaningful association between lower educational attainment and increased teen birth

outcomes. Lower educational attainment and teen births are so closely linked that it is important to advocate for and invest in a comprehensive approach that includes school engagement and supportive academic policies for pregnant/parenting youth to evoke change in this area (GADHR, 2006; GCAPP, n.d.; GADPH, 2023). As discussed in the literature review, Title IX protections are necessary but should be coupled with supportive services that can improve retention and completion rates (Saul, 1999; Stanger-Hall & Hall, 2011). The holistic approach of the federal teen pregnancy initiative to improve retention among adolescent mothers is a strong foundation for addressing this factor.

Socioeconomic Status

Three SES categories (very low, average, and very high) were used in this study. The very high socioeconomic vulnerability group accounted for the largest share of teen births (44% - 46%), followed by the average (14% - 15%) and very low (6% - 7%) socioeconomic vulnerability groups. These results align with what is generally accepted as fact regarding the influence of SES and teen pregnancy (Basch, 2011; Jakubowski et al., 2023; Penman-Aguilar et al., 2013; Ruedinger & Cox, 2012).

Political Climate

Political context differed across county groupings and shifted over time. TPPI counties consistently supported Democratic presidential candidates. While non-TPPI counties initially were more Republican, with Cobb County trending Democratic in later election cycles. The political dynamics provide important context for understanding funding stability, curriculum flexibility, and access to reproductive health services.

The availability and types of programs and services that can be implemented are strongly linked to the political affiliation and ideology of the reigning party, as detailed in the literature review (Treder et al., 2023). Unfortunately, this can have a lasting impact on the public health issue of teen pregnancy in local counties, the state of Georgia, and nationwide. This study underscores the need for program planners to recognize how a community's political landscape shapes the types of teen pregnancy prevention services that can be implemented.

Discussion

Program Impact

The study results found that the presence of the TPP Program in a community did not ensure lower birth rates. This outcome was expected because the program was introduced in counties that had much higher-need settings and baseline teen birth burdens, meaning parity with comparison counties was unlikely over such a brief timeframe. However, the findings of this study suggested that the presence of the program did have a meaningful influence, such that faster declines in birth rates and reduced disparities, resulting in narrowing gaps over time, were noted during program implementation years (Rabbitte & Enriquez, 2019).

The MSM TPPI Program was a multi-tiered design, which combined evidence-based curricula, youth development, and community advisory structures, aligning with PHM phases (defining/monitoring, risk/protection, testing strategies, assuring adoption) (CDC, 2024). The observed narrowing of the gap between county groups across periods suggests that scaling up evidence-based programming in high-burden communities can accelerate declines, despite the inability to establish causality. These improvements

support the need for continued investment in adolescent health interventions paired with robust evaluation to confirm effects.

Limitations to the Study

This study has several limitations that could have impacted the outcomes of the study. It is crucial to recognize these limitations to build credibility, provide context for findings, and guide future studies by highlighting gaps. The limitations of this study are detailed below to ensure the study is of integrity.

Non-Experimental Design and Causal Inference. Study design is a limitation because of the use of secondary data. Causality could not be inferred because chi-square tests cannot prove causality. Also, given the sensitive subject matter, it would have strengthened the research to have interacted with individuals with lived experience. A mixed methods design could have potentially strengthened this study's findings.

Sample Size. The sample size of this study was a limitation and could have also been a confounding factor. The small sample size impeded the use of several statistical tests that would have allowed stronger inferences. A larger sample size could have been derived had all the Georgia TPP Program grantees serving other counties been included in the study. This may be a possibility for future research.

Recommendations for Future Research

Teen pregnancy is a public health issue with a wide-reaching impact; as such, more research is needed to facilitate innovative approaches for effectively addressing the issue. This study has several areas for improvement. For example, this study used a quantitative design, but future research could employ a mixed method research design. Future research could include individuals with lived experience, which creates an

opportunity to obtain multilevel determinants of teen pregnancy outcomes and enable a more intricate understanding of pathways from program exposure to behavioral and health outcomes.

This study indicated that there was an association between teen pregnancy rates in various Georgia counties when the TPP Program's services and resources were present. This information could serve as the basis for more research. The future research could lead to the development of best practices for developing and implementing evidence-based programs in much-needed communities nationwide, thereby reducing teen pregnancy rates. Additionally, this study implied that politics influence programming content and implementation, which presents another consideration for future research. A future study could interview individuals, families, and community stakeholders regarding their input on legislation related to adolescent health. These recommendations reinforce the need for thorough, context-sensitive research strategies to inform policy and practice, while also advocating for and advancing adolescent reproductive health initiatives.

Contributions to the Field of Public Administration

This study has the potential to add to the field of public administration, as the information gained has both practical and applicable usefulness at local, state, and national levels. This study can provide information on how the federally funded TPP Program, which was signed into law in 2010 under the Obama Administration, has affected teen pregnancy rates in Georgia. As public administration is a complex field of study, inclusive of political, legal, managerial, and occupational implications (Shafritz et al., 2013), this study could make an impression in those fields by adding to the knowledge base of those who make decisions related to the public health issue of teen

pregnancy. This study also reinforces the need for greater federal investment in teen pregnancy prevention programs, given the significant associations identified between teen pregnancy and SES, race, and education. Thus, the public administration implications for this study are long-reaching and could result in positive lasting change for one of the country's most vulnerable populations, the youth.

Summary and Conclusions

This study contributes to the knowledge base in Georgia, informing on the impact of the federally funded teen pregnancy prevention program at the county level. The study showed a consistent decline in teen birth rates across both TPPI and non-TPPI counties from 2010 to 2024. The birth rates for TPP counties were not lower than those of NTPP counties, which led to the hypothesis being rejected for the study. Additionally, although the birth rates were not lower, there were considerable declines in the rates, which may be attributed to the programmatic influence of the TPP Program. This study could serve as a catalyst for future research in Georgia so that the vulnerable adolescent population can have their overall health and reproductive needs met in a dignified manner. Furthermore, this study offers a foundation for future researchers and a roadmap for public health practitioners, policymakers, and public administration professionals to strengthen and expand the resources needed to address teen pregnancy more holistically.

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Appendix A:
IRB Exemption

Appendix A: IRB Exemption

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Institutional Review Board (IRB) For the Protection of Human Research Participants

Protocol Exemption Report

Protocol Number: 04467-2023

Responsible Researcher(s): Trese Flowers

Supervising Faculty: Dr. A.J. Ramirez

Project Title: *Is There an Impact? Teen Pregnancy Prevention Program of Georgia Counties: A Quantitative Study.*

INSTITUTIONAL REVIEW BOARD DETERMINATION:

This research protocol is exempt from Institutional Review Board (IRB) oversight under 45 CFR 46.101(b) of the federal regulations, category 4. If the nature of the research changes such that exemption criteria no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research study.

ADDITIONAL COMMENTS:

- *Upon completion of the research study collected data must be securely maintained and only accessible by the researcher(s) for a minimum of 3-years. At the end of the required time, collected data must be permanently destroyed.*

If this box is checked, please submit any documents you revise to the IRB Administrator at tmwright@valdosta.edu to ensure an updated record of your exemption.

Elizabeth Ann Olphie *10.27.2023*
Elizabeth Ann Olphie, IRB Administrator

Thank you for submitting an IRB application.
Please direct questions to irb@valdosta.edu or 229-253-2947.

Revised: 06.02.16

Appendix B:
Data Tables for Pre, During, and Post-Program

Pre-Program Teen Birth Count Data, 2019-2014

Year	NTPP	TPP
2010	1184	1471
2011	1100	1339
2012	944	1179
2013	826	963

Program Implementation Teen Birth Count Data, 2015-2020

Year	NTPP	TPP
2015	732	889
2016	690	838
2017	651	807
2018	583	963
2019	536	698
2020	511	666

Post-Program Teen Birth Count Data, 2020-2024

Year	NTPP	TPP
2021	1184	1471
2022	1100	1339
2023	944	1179
2024	826	963

Appendix C:
Research Questions Data Charts

RQ1 Data Table						
2010-2014	Teens without live birth	Teens with live birth	Total Teens	% teen births	Difference between groups	
TPP counties	645475	5977	651452	0.92%		
Non-TPP counties	688442	4952	693394	0.71%	0.20%	
2015-2020						
TPP counties	794473	4724	799197	0.59%		
Non-TPP counties	848051	3703	851754	0.43%	0.16%	
2021-2024						
TPP counties	541982	2428	544410	0.45%		
Non-TPP counties	574519	2077	576596	0.36%	0.09%	
SPSS data set (weighted cases by before, during, and after)						
2010-2014	TPP	Birth	Count	X2	df	p-value
	Yes	No	645475	172.262	1	<.001
	Yes	Yes	5977			
	No	No	688442			
	No	Yes	4952			
2015-2020						
	TPP	Birth	Count			
	Yes	No	794473	198.462	1	<.001
	Yes	Yes	4724			
	No	No	848051			
	No	Yes	3703			
2021-2024						
	TPP	Birth	Count			
	Yes	No	541982	51.466	1	<.001
	Yes	Yes	2428			
	No	No	574519			
	No	Yes	2077			

RQ 1a Data Table					
Race					
		Teens without live birth	Teens with live birth	Total Teens	% teen births
2010-2014					
Black or African American		661,444	6,789	668,233	1.02%
Multiracial		38,461	576	39,037	1.48%
White		579,082	3,227	582,309	0.55%
2015-2020					
Black or African American		781,330	5,052	786,382	0.64%
Multiracial		58,728	236	58,964	0.40%
White		723,823	2,926	726,749	0.40%

2021-2024					
Black or African American		515,605	2,476	518,081	0.48%
Multiracial		48,289	172	48,461	0.35%
White		495,864	1,799	497,663	0.36%
SPSS Data set (weighted cases by before, during or after)					
Race	Birth	Before	During	After	
Black or African American	No Birth	661,444	781,330	515,605	
Multiracial	No Birth	38,461	58,728	48,289	
White	No Birth	579,082	723,823	495,864	
Black or African American	Birth	6,789	5,052	2,476	
Multiracial	Birth	576	236	172	
White	Birth	3,227	2,926	1,799	
Overall association		X2	df	N	p-value
<i>Overall association</i>	<i>Before program</i>	<i>1026.06</i>	<i>2</i>	<i>1289579</i>	<i><.001</i>
follow-up	AAB vs. Multi	75.59	1	707270	<.001
follow-up	AAB vs. White	835.15	1	1250542	<.001
follow-up	Multi vs. White	510.528	1	621346	<.001
<i>Overall association</i>	<i>During program</i>	<i>435.55</i>	<i>2</i>	<i>1572095</i>	<i><.001</i>
follow-up	AAB vs. Multi	51.75	1	845346	<.001
follow-up	AAB vs. White	414.18	1	1513131	<.001
follow-up	Multi vs. White	0.008	1	785713	0.93
<i>Overall association</i>	<i>After program</i>	<i>87.52</i>	<i>2</i>	<i>1064202</i>	<i><.001</i>
follow-up	AAB vs. Multi	14.41	1	56642	<.001
follow-up	AAB vs. White	82.1	1	1015744	<.001
follow-up	Multi vs. White	0.053	1	546124	0.81

RQ1b Data Table				
	Total Teens	Teens with Live Birth	Percentage of Teen Births	Difference between groups
Before TPPI (2010-2014)				
TPPI counties	651,452	5,977	0.92%	
Non-TPPI counties	693,394	4,952	0.71%	0.20%
During TPPI (2015-2020)				
TPPI counties	799,197	4,724	0.59%	
Non-TPPI counties	851,754	3,703	0.43%	0.16%
After TPPI (2021-2024)				
TPPI counties	544,410	2,428	0.45%	
Non-TPPI counties	576,596	2,077	0.36%	0.09%
	Total Teens	Teens with Live Birth	Percentage of Teen Births	
Before TPPI (2010-2014)				
Black or African American	668,233	6,789	1.02%	
Multiracial	39,037	576	1.48%	
White	582,309	3,227	0.55%	
2015-2020				
During TPPI (2015-2020)				
Multiracial	58,964	236	0.40%	
White	726,749	2,926	0.40%	
2021-2024				
After TPPI (2021-2024)				
Multiracial	48,461	172	0.35%	
White	497,663	1,799	0.36%	
	Teens with Live Birth	Percentage of Teen Births		
Before TPPI (2010-2014)				
Total Teen Births	10,929	100%		
Education Status				
Less than High School Education	5,182	47.42%		
Socioeconomic Vulnerability Status				
Very Low	749	6.85%		
Average	1,669	15.27%		
Very High	4,798	43.90%		
During TPPI (2015-2020)				
Total Teen Births	8,427	100%		
Education Status				
Less than High School Education	4,047	48.02%		

Socioeconomic Vulnerability		
Status		
Very Low	515	6.11%
Average	1,197	14.20%
Very High	3,828	45.43%
After TPPI (2021-2024)		
Total Teen Births	4,505	100%
Education Status		
Less than High School	2,036	45.19%
Socioeconomic Vulnerability		
Status		
Very Low	299	6.64%
Average	644	14.30%
Very High	2,050	45.50%

Appendix D:
Presidential Vote Totals Across County Groupings

		NTPP Total	TPP Total
2008*	Republican	208,020	15,515
	Democrat	38,987	308,554
2012*	Republican	209,636	16,055
	Democrat	38,585	292,960
2016*	Republican	39,413	16,418
	Democrat	196,908	305,686
2020*	Republican	47,177	18,924
	Democrat	265,314	375,372
2024*	Republican	51,233	21,245
	Democrat	270,576	369,701