

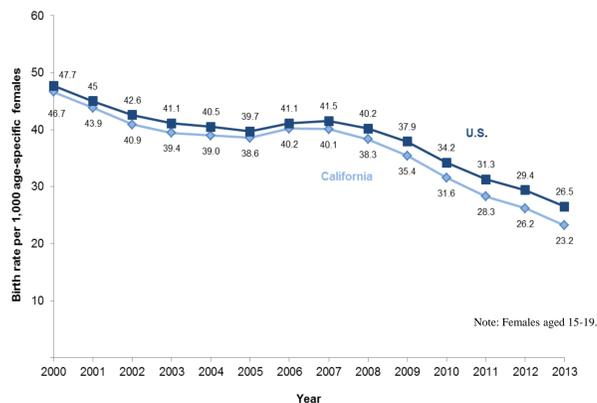
A Population Based Method of Program Targeting: Lessons Learned from California Adolescent Sexual Health Programs

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Background and Objectives

- The adolescent birth rate (ABR) in California has declined 50% since 2000¹ (Figure 1). However, ethnic, racial, and geographic disparities persist in rates of adolescent childbearing across CA.

Figure 1: Adolescent Birth Rate: California and U.S., 2000-2013¹

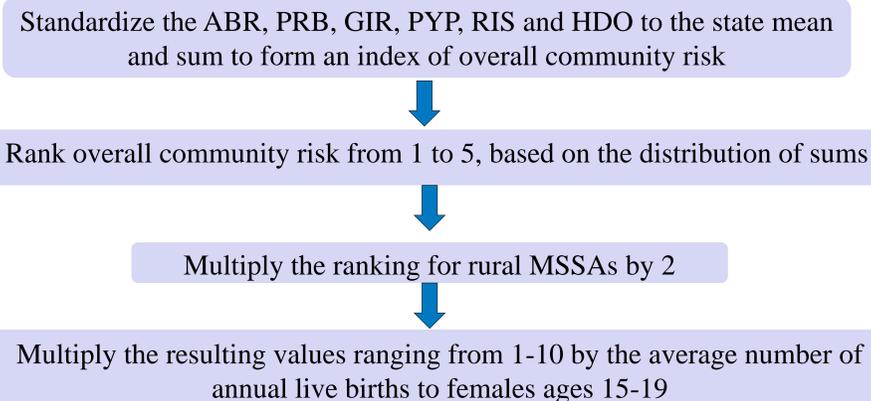


- Hispanics account for 74% of adolescent births and have the highest adolescent birth rate at 34.9.
- The county with the highest 3-year aggregated birth rate has a rate 6.1 times greater than the county with the lowest 3-year aggregated birth rate¹ and there are large within county differences in rates.
- To effectively target local areas in need of adolescent sexual health programming, the California Department of Public Health, Maternal Child Adolescent Health Branch (CDPH/MCAH) developed a method for creating the California Adolescent Sexual Health Index (CASHNI), by using publicly available quantitative data for program targeting.

Methods

- We utilized the factors below to calculate a needs-based score for program targeting:
 - Small-area geographical targeting²**
 - To address outcome variations within county, we used Medical Service Study Areas (MSSAs).³
 - Weighted incidence**
 - Number of births
 - Disparity Indicators²**
 - Adolescent Birth Rates (ABR)
 - Repeat Adolescent Births (PRB)
 - Gonorrhea Rate (GIR)
 - Rural and Urban Status (RUS)
 - High School Dropout Rate (HDO)
 - Concentrations of Poverty (PYP)
 - Racial Isolation (RIS)

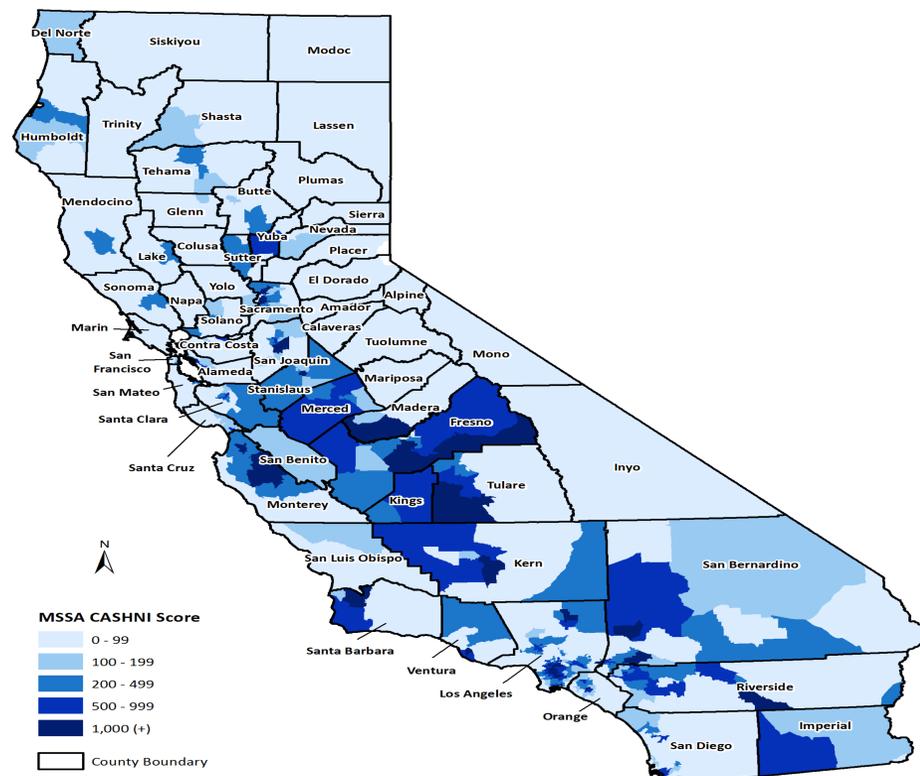
Calculation of CASHNI Scores at MSSA Level



Results

- There are 58 counties and 542 MSSAs in California. CASHNI scores ranged from 1 to 2728. Higher score indicated a greater community need for adolescent sexual and reproductive health services (Figure 2).

Figure 2. Map of CASHNI Scores Across California MSSAs¹

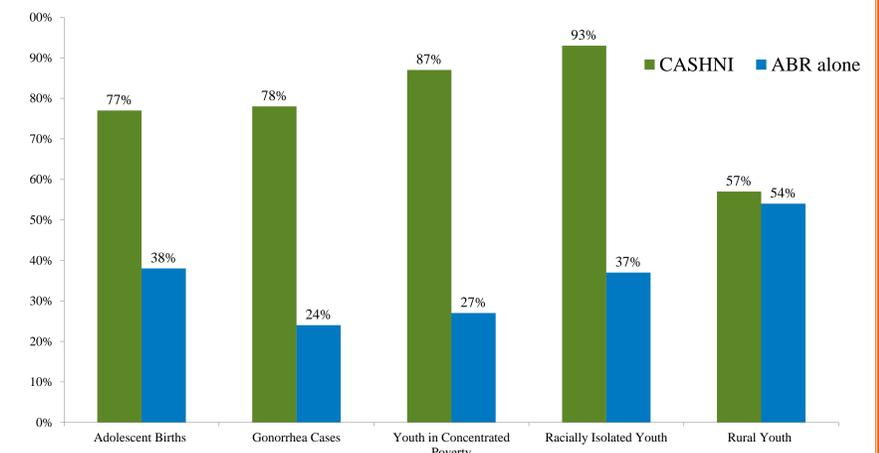


1. 2013 California Adolescent Birth Report. Sacramento: California Department of Public Health, Maternal, Child and Adolescent Health Program; 2015.
2. 2012 California Adolescent Sexual Needs Health Index (CASHNI). Sacramento: California Department of Public Health, Maternal, Child and Adolescent Health Program; 2014.
3. California's Office of Statewide Health Planning and Development, Medical Service Study Areas, retrieved from <http://www.oshpd.ca.gov/hwdd/MSSA/index.html>.

Results Continued

- To determine the effectiveness of the CASHNI, we compared the percent of need captured across five indicators when applying the CASHNI to target eligibility for a statewide sexual health program to the method used in the previous funding cycle of the same program where eligibility was determined by county ABRs alone.
- By using the CASHNI to target MSSAs eligible for funding for a statewide sexual health program, we were able to capture a higher percent of adolescent births, gonorrhea incidence, youth in concentrated poverty, and racially isolated youth in California compared with the eligible population from the previous cycle targeted using the ABR alone (Figure 3).
- A similar percentage of rural youth were eligible for services under both models.

Figure 3. Percent of Need Captured Across Funding Cycles Using CASHNI and ABR alone



Conclusion and Future Plans

- Information on methods for effective adolescent sexual health program targeting is limited.
- The method described here is a simple, yet effective way funders can improve their program targeting effectiveness and increase the likelihood of reaching youth with the greatest need for sexual health services.
- The CASHNI will be adjusted annually with the next report published in 2015; focus will be on improving the reach of rural youth.