Q. What information is presented in *Adolescent Births in California*? Why do these numbers matter?

A. *Adolescent Births in California* is an annual release of data about live births among California females under age 20 completed by the California Department of Public Health (CDPH), Maternal, Child and Adolescent Health (MCAH) Division. While most of the data included in the report focuses on young women between the ages of 15-19, some data is presented for births to women under the age of 15. Early childbearing remains a public health issue and monitoring birth data among adolescents helps state and local efforts to identify areas of greatest need for support and program services. The data helps to understand trends over time, demonstrate successes and identify challenges that need to be addressed.

Q. How are the adolescent birth rate (ABR) and percentage of repeat births (PRB) calculated? Why are these numbers different from other sources (e.g., National Center for Health Statistics)?

The ABR is calculated as the number of live births to females aged 15-19 divided by the female population aged 15-19, multiplied by 1,000.

The PRB is calculated as the number of live births to females with a previous live birth divided by the total number of live births among females aged 15-19, multiplied by 100; the percentage of repeat births excludes births where birth order is unknown or the number of previous live births is greater than 6 (less than 1% of births excluded).

The data needed to calculate the ABR and PBR come from the California Department of Public Health, Center for Health Statistics *Birth Statistical Master File* and the California Department of Finance *Population Projections*. CDPH calculates these numbers statewide, by county, by race and Hispanic ethnicity, and by age group. These numbers may differ from rates published for California by other sources due to differences in the data used and/or methods of calculation.

Birth rates for racial and ethnic groups are reported for seven standard race/ethnic categories that match the California Department of Finance (CDOF) population racial categories: Hispanic, non-Hispanic White, non-Hispanic Black, non-Hispanic Asian, non-Hispanic Pacific Islander, non-Hispanic American Indian, and non-Hispanic Multiple Race.

To calculate the ABR, CDPH uses the most up-to-date population files from the CDOF, which serves as the single official source of demographic data for state planning and budgeting. Because the CDOF regularly updates their population projections based on new information, rates published in prior years’ press releases may not be the same as the rates currently published.
Q. **What does it mean for a county ABR or PRB to be higher or lower than the state rate?**

The county ABR and PRB are calculated by combining three years of data. The county data is compared to the state’s ABR and PRB recalculated to exclude the comparison county. County ABR and PRB are indicated as ‘lower’ or ‘higher’ if the differences are large enough that the 95% confidence intervals do not overlap with that of the recalculated state rate; otherwise they are listed as ‘no statistical difference’ (for details on calculation of statistical significance, see Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. *Births: Final Data for 2003. NVSR 54(2).* Hyattsville, MD: National Center for Health Statistics, 2005). Non-overlapping intervals indicates confidence that the differences in numbers reflect a true difference in the population values.

Q. **What does it mean that the data are suppressed? What is a Relative Standard Error (RSE)?**

A. CDPH applies data suppression and reliability rules to protect the confidentiality of adolescents and ensure the integrity of the data presented. ABRs were suppressed if the denominator is less than 50 and the numerator is between 1-5. PRBs were suppressed if the denominator is less than 20 and the numerator is between 1-5. Relative Standard Errors (RSE), a tool to measure the variability of the estimate compared with the magnitude of the estimate, were calculated for ABRs and PRBs. Rates and percentages with an RSE of 30% or higher are denoted with the ‘□’ symbol. Use caution in interpreting data with an RSE of 30% or higher as these estimates are unstable due to small counts of birth or population. Rates and percentages with an RSE of 50% or higher were considered unreliable and therefore suppressed.

Q. **Why does the ABR continue to decline? Why is California successful?**

A. Adolescent childbearing is a complex issue, which is influenced by social, economic, and individual factors. On a national level, evidence suggests that birth rates are declining largely because more youth are using contraception, including long-acting reversible contraception, known as LARC methods. Examples of LARC methods are the Mirena® and ParaGard® intrauterine devices (IUDs) and the contraceptive implant (brand names include Nexplanon® and Implanon®). Youth also appear to be delaying sexual intercourse, although this accounts for much less of the decline. Public health prevention, evidence-based education and support programs along with increased outreach around rights and improved access for youth to reproductive health clinical services have contributed to these successes. Other contributing factors include declines in fertility rates during the recession (across all age groups except for women aged 40 and above) and innovative public health messaging.
California’s innovative sexual health policies create a multi-pronged approach for promoting adolescent sexual health and are consistent with the link between contraceptive use and reductions in early childbearing. Key components of this approach include:

- Laws that support comprehensive sexual health education, including:
  - The California Healthy Youth Act (Education Code sections 51930-51939)
  - The Sexual Health Education Accountability Act (Health and Safety Code sections 15100-151003)
  - The Health Education Content Standards for California Public Schools, K-12 (currently undergoing revision).

- Providing accessible, no or low cost, youth-friendly family planning services through the Title X provider network and the Family PACT (Planning, Access, Care and Treatment) Program administered by the California Department of Health Care Services (DHCS);

- Utilizing adolescent sexual health prevention programs that are evidence-based or evidence-informed, skill-focused, and culturally and linguistically appropriate; and,

- Integrating positive youth development (PYD) and healthy relationship development into primary and secondary pregnancy prevention programs.
  - PYD is a strengths-based approach that emphasizes and promotes protective factors (e.g., caring relationship and meaningful opportunities for youth) that help build resiliency, which results in positive health outcomes.
  - Supporting youth in building healthy relationships can also affect their decisions related to educational attainment, reproductive life planning, and health.⁴

In sum, California has a long history of providing services that help young people make informed sexual and reproductive health choices. The State has made the prevention of adolescent childbearing a high public health priority spanning the administration of four governors, two Republicans and two Democrats. Additionally, a number of major private and non-profit organizations contribute by providing independent grants to local agencies to help young people delay childbearing and improve student achievement.⁵

Q. How confident should we feel in a continued decline? Do we still need to worry about this issue?

A. California has had great success in reducing the number of births to females under age 20. However, much work around the issues of adolescent sexual and reproductive health remains, particularly in addressing health disparities. There are substantial racial, ethnic, and geographic inequalities in adolescent childbearing across California. Vulnerable youth populations such youth in foster care, homeless youth, and youth who identify as lesbian, gay, or bisexual, have higher rates of early pregnancy, childbearing, and/or STIs including HIV than other adolescents.⁶

In 2015 alone, over 6,500 children were born to California mothers under age 18. Moreover, nearly 1 in 5 births to mothers ages 18 – 19 was a repeat birth. CDPH has a sustained
Q. Why do some areas still have such high birth rates compared to others? What can we learn from areas where the birth rates are dropping?

A. Adolescent health, including adolescent sexual health, often mirrors the social and economic status of communities as a whole. In communities where there are high birth rates among youth, often there are also high levels of poverty and limited employment and educational opportunities. Interviews with California youth and adults in communities with high and low ABRs found that youth in areas with lower rates report better communication about reproductive health with parents than youth in areas where birth rates remain high. Research has also found that the birth rate is lower in areas of California where youth are more likely to access state-funded family planning services than in areas of lower access.

Q. How does early childbearing affect the life course options of young parents?

A. While early childbearing is associated with a number of negative life course outcomes, such as poverty and lower educational attainment, research suggests that much of the negative effects are not directly caused by childbearing but rather result from other background factors. For example, youth who become parents are more likely to come from economically disadvantaged backgrounds than their peers. This can affect their life course trajectory separately from the challenges of becoming an adolescent parent. While parenting as a young person brings unique challenges, we also know that it can become a motivating factor in the lives of young women and men who pursue opportunities to be able to better support and care for their children. Working as a community to provide California’s youth with equal access to quality schools, community mentoring, job-training and clear paths to higher education can effectively reduce the negative effects of early parenthood and improve life course options for California families.

Q. How much does adolescent childbearing cost California taxpayers?

A. Estimations of costs of adolescent childbearing are published by the Public Health Institute Center for Research on Adolescent Health and Development and the National Campaign to Prevent Teen and Unplanned Pregnancy. Note: The views and opinions of authors expressed on these sites does not necessarily reflect those of the State of California.

Q. What programs does the Maternal, Child, and Adolescent Health Division (MCAH) provide to support adolescent pregnancy prevention? What programs are available in different counties?

A. CDPH/MCAH awards federal and State General Funds to local agencies, including Local Health Jurisdictions, community-based organizations, and school districts to implement three adolescent sexual and reproductive health programs.
The three MCAH-funded programs during Fiscal Year 17-18 are:

1) The Adolescent Family Life Program (AFLP), which addresses the social, health, educational and economic challenges of adolescent pregnancy by providing strengths-based comprehensive case management services for expectant and parenting youth (EPY) under 19 years old. The goals of the program are to increase access to and utilization of needed services; increase educational attainment; improve pregnancy planning and spacing; increase social and emotional support and build resilience.

2) The California Personal Responsibility Education Program (CA PREP), which provides sexual health education to high-need youth populations (10-21 years old) in California through implementation of evidence-based programs in diverse settings including foster care, homeless shelters, and schools. The goals of the program are to reduce rates of adolescent birth and sexually transmitted infection through skill-based instruction. The program also promotes linkages to local sexual and reproductive health services and community engagement around supporting adolescent health.

3) The Information & Education (I&E) Program, which educates high-need young people (12-19 years old) about sexual and reproductive health through evidence-based or evidence-informed curricula, provides information on eligibility and access to reproductive health care services, and engages local communities to promote adolescent health. The program aims to reduce rates of adolescent birth and sexually transmitted infection through community-informed interventions.

In recognition of the profound impacts health disparities have on expectant and parenting youth and the geographic variation in disparities, MCAH developed the California Adolescent Sexual Health Needs Index (CASHNI) to target programs to areas in the state with the greatest need. In 2014, countywide CASHNI scores ranged from less than 5 to 25764 across CA. The 31 highest scoring counties capture 95.6 percent of 2014 CA statewide births to adolescent females aged 15-19 and are designated as high-need counties for program targeting.

For more information about MCAH adolescent sexual health programming, including listings of local funded programs, please visit: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Adolescent-Health.aspx

Q. What other adolescent sexual health programs are available throughout the state?

A. There are several statewide initiatives to support adolescent sexual and reproductive health such as the CDPH Sexual Transmitted Diseases Control Branch programs; Department of Health Care Services Family PACT program and the Department of Social Services Cal-LEARN program. There are various additional privately and publically funded local initiatives throughout California.
Q. What is California doing to support young men/fathers?

A. MCAH recognizes that optimizing adolescent sexual and reproductive health outcomes in California requires inclusion of all California youth – male and female. MCAH includes male youth in both primary and secondary prevention programming. In the MCAH primary sexual health education programs about half of participants are young men along with about 10 percent of youth enrolled in secondary prevention programs. In addition, all males are eligible to obtain contraceptive methods and other related reproductive health care services from the state family planning program (Family PACT).

Q. How much does MCAH spend on adolescent pregnancy prevention programs? In the last ten years, how did this funding change? What changes might occur in the future?

A. Between the 2007-2008 and 2011-2012 fiscal years, state-level funding to support adolescent sexual and reproductive health in California was dramatically reduced. In 2008, five adolescent reproductive and sexual health programs were administered through CDPH with total funding of $46.4 million, including $11 million in State General Funds (SGF). During the budget cuts that occurred between 2008 and 2012, spending on these programs was cut by 72% (FY 07-08 compared to FY 11-12) resulting in the elimination of three programs (Community Challenge Grants, Male Involvement Program, and Teen SMART Outreach) and reduced scope of the remaining two (AFLP and the I&E program). Currently (FY 17-18) MCAH administers approximately $16 million in local assistance funding for three adolescent reproductive and sexual health programs (AFLP, I&E and CA PREP), of which $1.5 million is SGF and $14.5 is Federal funding. Given recent changes in Federal funding priorities, there is uncertainty about the continuation of Federal funding to support adolescent pregnancy prevention and comprehensive sexual health education.

Q. Why is funding for adolescent sexual health programming important?

While the ABR is declining, the number of youth, families, and communities impacted by early and unintended childbearing remains high. Moreover, racial, ethnic and geographical disparities persist in adolescent sexual and reproductive health in California, including sexually transmitted disease (STD) rates, which are increasing across age groups. After several years of declining chlamydia rates among adolescent females ages 15-19 years old, 2016 is the second year of increases, higher by 2% compared with 2015. Wide disparity in gonorrhea incidence rates by race/ethnicity in the same age group persist, showing African American females have rates 9 times higher than White females.14

Providing youth with the knowledge and motivation to make informed decisions around their sexual and reproductive health is an important tool in assisting them in becoming healthy and successful adults.

Notes and References

1 State of California, Department of Finance, State and County Population Projections by Race/Ethnicity, Sex, and Age 2010-2060, Sacramento, California, December 2014.


13 Examples of other community initiatives are: Community Action Partnership of San Luis Obispo County, Inc.; Contra Costa Health Services

14 Sexually Transmitted Diseases Control Branch, 2016 STD Surveillance Report available at [https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx)