

Q. What is the ABR press release? Why do these numbers matter?

- A. The adolescent birth rate (ABR) and percentage of repeat births (PRB) press release 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. Early childbearing remains a public health issue and monitoring the birth data among adolescents aids in State and local surveillance to support program planning efforts.

Q. How is the ABR calculated? How is the PRB calculated? Why are these numbers different from other sources (e.g., National Center for Health Statistics)?

- A. The ABR and the percentage of repeat births are calculated as follows:
- The ABR is the number of live births to females aged 15-19 divided by the female population aged 15-19, multiplied by 1,000.
 - Percentage of repeat births is 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; excludes births where birth order is unknown or the number of previous live births is greater than 6 (less than 1% of births excluded).

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.

Consistent with State mandate, CDPH uses the most up-to-date population files from the CDOF¹ to calculate the ABR. 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 aggregating three years of data and compared to the state's ABR and PRB that excluded the county being compared. County ABR and PRB are indicated as 'lower' or 'higher' if the differences were large enough that the 95% confidence intervals do not overlap with that of the 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).

Q. What do you mean the data are suppressed? What is an 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 involves the cumulative effect of social and economic disparities and sexual developments prior to pregnancy and childbearing. On a national level, evidence suggests that birth rates are declining largely because more youth are using contraception, in particular improved access to LARC among teens seeking contraception at Title X service sites.² Youth also appear to be delaying sexual intercourse, although this accounts for much less of the decline. California will now be in a position to examine statewide, representative data on sexual activity and contraceptive use from the 2015 Youth Risk Behavior Survey, available for the first time, which overtime can help us better understand the patterns of adolescent childbearing in our state³. California's innovative sexual health policies are consistent with the link between contraceptive use and reductions in early childbearing. California's success likely relates to a multi-pronged approach for promoting adolescent sexual health. Key components of this approach include:
- The California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act (*Education Code [EC] sections 51930-51939*) requiring school-based and other state-funded sexuality education to be comprehensive, medically accurate, and age and culturally appropriate; this legislation, now called The California Healthy Youth Act, was expanded and updated effective January 1, 2016 to include requirements to provide information around healthy relationships, pregnancy options, LGBTQ inclusivity among other topics. The text of the amended law is available here: https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB329
 - Providing accessible, no cost, youth-friendly family planning services through the Family PACT (Planning, Access, Care and Treatment) Program administered by the California Department of Health Care Services (DHCS);
 - Addressing social determinants by utilizing adolescent sexual health prevention programs that are evidence-based, skill-focused, and culturally and linguistically appropriate; and,

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- Integrating positive youth development (PYD) and healthy relationship development into primary and secondary pregnancy prevention programs.
 - PYD is a strengths-based construct that emphasizes and promotes youth protective factors (e.g., resiliency) that can lead to positive health outcomes.
 - Supporting youth in building healthy relationships can also affect their decisions related to educational attainment, family planning, and health⁴.

In sum, California has a long history of providing services that help young people make informed reproductive 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 grants to help young people delay childbearing and improve student achievement.

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. In 2014 alone, over 8,500 children were born to California mothers under age 17. Moreover, nearly 1 in 5 births to mothers ages 18 – 19 were repeat births. Additionally, there are substantial racial, ethnic, and geographic inequalities in adolescent childbearing across the State. By 2020, there will be over 5 million adolescents in California - supporting the health and well-being of these individuals is a cause CDPH will continue to champion.

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 health and attitudes 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 opportunities⁵. Moreover, 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 high⁶. 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 access⁷.

Q. How does early childbearing affect the life course options of male and female youth?

- A. All California youth deserve access to high-quality education and opportunities for job training and success. Evidence suggests that youth who do not complete high school and/or post-secondary education are less successful in the job market and earn less money over their lifetimes⁸. Adolescent childbearing is one factor that may affect a youth's ability to successfully complete schooling⁹. Other factors include family poverty, school violence, and systemic racial

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Q. How much does adolescent childbearing cost California taxpayers?

- A. Estimations of costs of adolescent childbearing are published by the Public Health Institute (<http://teenbirths.phi.org/>) and the National Campaign (<http://www.thenationalcampaign.org/costs/>). **Note:** The views and opinions of authors expressed on these sites does not necessarily state or 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 receives federal and State General Funds to support the capacity of Local Health Jurisdictions and community based organizations. These stakeholders implement primary and secondary prevention programs that focus on informed decisions about sexual and reproductive behavior, healthy relationships, positive youth development, and educational attainment. For more information about MCAH adolescent sexual health programming, including listings of local programs, please visit: <http://www.cdph.ca.gov/programs/MCAH/Pages/default.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 (www.cdph.ca.gov/programs/std/Pages/default.aspx); Department of Health Care Services Family PACT program (www.familypact.org) and the Department of Social Services Cal-LEARN program (www.cdss.ca.gov/cdssweb/PG84.htm). 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. Consistent with federal guidelines, MCAH includes male youth in both primary and secondary prevention programming. In addition, all males are eligible to obtain contraceptive methods and other related reproductive health care services from the state family planning program.

Q. How much does MCAH spend on adolescent pregnancy prevention programs? In the last five years, how did this funding change?

- A. Between the 2007-2008 and 2011-2012 fiscal years, funding to support adolescent's sexual and reproductive health in California was dramatically reduced, resulting in the elimination of three programs entirely (Community Challenge Grants, Male Involvement Program, and Teen SMART Outreach). In Fiscal Year 2014-2015, MCAH spent approximately \$13.3M in State and Federal funds on three statewide youth sexual health programs including \$6.0M on the Personal Responsibility and Education Program, \$1.9M on the Information and Education Program, and \$5.4M on the Adolescent Family Life Program¹¹. This was a slight \$0.1M increase from the previous fiscal year.

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

- A. 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. 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. Adolescent sexual and reproductive health programs funded by MCAH include information and skill-based training on adolescent development, sexual decision making and contraceptive use, as well as information about developing healthy relationships with caring adults and peers, and goals for balancing educational and reproductive outcomes.

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Notes and References

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

²Santelli JS, Lindberg LD, Finer LB, Singh S. Explaining recent declines in adolescent pregnancy in the United States: The contribution of abstinence and improved contraceptive use. *American Journal of Public Health*: January 2007, Vol. 97, pp. 150-156. doi: 10.2105/AJPH.2006.089169; Romero, et al. Trends in use of long-acting reversible contraception among teens aged 15-19 years seeking contraceptive services – United States, 2005-2013. *MMWR*: 2015, Vol. 64(13), pp363-369.

³California participated in the Centers for Disease Control and Prevention biennial Youth Risk Behavior Survey (YRBS) from 1991 to 1999 and again from 2009 to 2013. In each of these years, the State was unable to collect data from enough schools and/or enough youth to generate data that is weighted to, and representative of, the State's youth population. For the first time, in 2016, California will receive state-weighted 2015 survey data. MCAH is currently in the process of obtaining the data, which will be analyzed and results shared with MCAH partners and stakeholders. For more information about YRBS visit: <http://www.cdc.gov/healthyouth/data/yrbs/index.htm>.

⁴Markham CM, Lormand D, Gloppen KM, et al. Connectedness as a predictor of sexual and reproductive health outcomes for youth. *Journal of Adolescent Health*: March 2010, Vol. 46, pp. S23-41.

⁵Gold R, Kennedy B, Connell F, Kawachi I. Teen births, income inequality, and social capital: Developing an understanding of the causal pathway, *Health & Place*, Vol. 8(2), June 2002, pp. 77-83.

⁶Promising and struggling communities: A qualitative assessment of adolescent pregnancy in California: preliminary results. University of California, San Francisco, 2013.

⁷Chabot M, Navarro S, Swann D, Darney P, Thiel de Bocanegra, H. Association of access to publicly funded family planning services with adolescent birthrates in California counties. *American Journal of Public Health*, February 2014, Vol. 104(S1), pp. e1-e6.

⁸Levin H. The economic payoff to investing in educational justice, *Educational Researcher*, Vol. 38(1), pp. 5–206.

⁹Kane JB, Morgan SP, Harris KM, Guilkey DK. The educational consequences of teen childbearing. *Demography*, September 2013, pp. 1 – 22.

¹⁰Wodtke, GT, Harding DJ, Elwert F. Neighborhood effects in temporal perspective: The impact of long-term exposure to concentrated disadvantage on high school graduation, *American Sociological Review*, Vol. 76, October 2011, pp. 713-736.

¹¹California Department of Public Health, Maternal, Child & Adolescent Health Division, Contracts and Grants Unit.

