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Winning Campaign: California's Concerted Effort To Reduce Its Teen Pregnancy Rate

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In 1992, California's teen pregnancy rate was the highest in the nation: For every 1,000 women aged 15–19 in the state, 157 became pregnant that year. By 2005, the rate had essentially been cut in half—to an all-time low of 75 per 1,000. California's teen pregnancy rate decline was the steepest for any state, and it was far above the national decline of 37% over the same period.

Although the causes of teen pregnancy are complex, public health experts in California credit teen pregnancy prevention efforts dating back to the 1990s for the state's record declines. California—the only state that never accepted federal abstinence-only dollars—has made teen pregnancy prevention a high public policy priority, with a strong emphasis on providing teens with comprehensive sex education and on fostering their access to the information and health care services they need to prevent pregnancy and protect their health. This concerted, statewide effort, which is still ongoing, has spanned the administrations of three governors—two Republicans and one Democrat—and is notable for having garnered significant private-sector support as well (see chart). A closer look at this effort shows just how remarkable it is.

Moving to Comprehensive Sex Education

California's sex education policies in the early 1990s reflected the push-pull of the times. On the one hand, the state's legislature—confronted with the growing AIDS crisis—acted in 1991 to require that schools provide HIV/AIDS prevention education that includes a discussion of both abstinence and condom use. On the other hand, and at about the same time, the state was experimenting with an abstinence-only initiative to address teen pregnancy. Launched with great fanfare in the Governor's Council Room at the California State Capitol in 1992, the $15 million, three-year Education Now and Babies Later (ENABL) program was, at the time, the largest statewide teen pregnancy prevention effort ever initiated in the United States. It involved 187,000 adolescents aged 12–14 in more than 30 counties across the state, and its core was a five-session abstinence-only curriculum accompanied by a set of a community-wide activities and a media campaign.

According to data collected at the time, the ENABL campaign was widely popular among parents and teens. But in December 1995—in the middle of the fiscal year—the state's Republican governor abruptly canceled his own initiative when an extensive evaluation of the curriculum found no impact on young teenagers' initiation of sex. In a stunning announcement, then-governor Pete Wilson said simply, "I have concluded that we need a much more comprehensive strategy to deal with out-of-wedlock pregnancy."

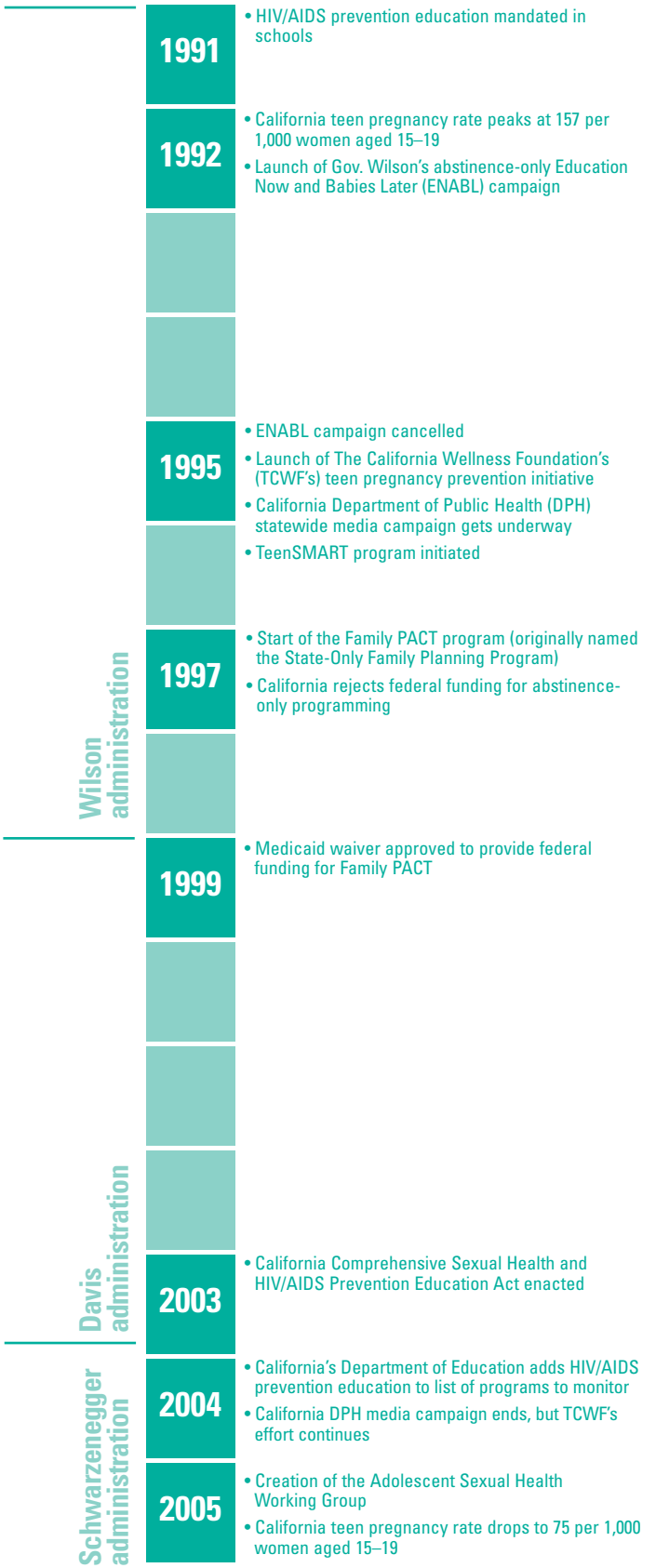
California's experience with ENABL set the stage for its decision a few years later to turn down federal funding for abstinence-only-until-marriage programming. In 1996, as part of a massive overhaul of the nation's welfare system, Congress had established an entitlement program—under Title V of the Social Security Act—that guaranteed $50 million per year in grants to states for abstinence-only education. (Funding for the Title V abstinence-only program continued until June 2009, when the program lapsed for a

few months, only to be revived for another five years beginning in FY 2010 in the context of federal health care reform legislation.) To be eligible for their allocation, however, states were required to ensure that programs they funded would comply with an extremely narrow eight-point definition of abstinence-only education, including a prohibition on discussing contraceptive methods or safer-sex practices, other than to emphasize their shortcomings, and a requirement to teach that "sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects."

Although 21 other states and the District of Columbia eventually rejected the money as well (many of them not until much later), California is the only state to have never applied for its Title V grant. Evidence-based advocacy played a key role in this decision, according to Margie Fites Seigle, president and CEO of the California Family Health Council, the organization that manages the distribution of federal Title X family planning funds throughout California. "Advocates who had organized in the late 1980s in support of family planning took it upon themselves to educate the Wilson administration about the negative public health impact of abstinence-only programming—and they found strong support from within the governor's office and the Department of Health Services," said Seigle. These advocates came together again in 1999 in support of legislation that required sex education to be medically accurate and objective, and in 2003 they persuaded legislators to defeat an attempt to require California to participate in the Title V abstinence-only program.

In a final repudiation of the abstinence-only approach, then-governor Gray Davis (D) signed the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act into law in 2003 to consolidate and coordinate state policies on sex and HIV/AIDS education. Under the measure, school-based education programs must be medically accurate, age-appropriate and comprehensive. Classes may "not teach or promote religious doctrine nor reflect or promote bias against any person." Moreover, from seventh grade on, all instruction must include informa-

KEY EVENTS IN CALIFORNIA



tion about abstinence, "while also providing medically accurate information on other methods of preventing pregnancy and STDs." This instruction must "provide information on the effectiveness and safety of all [Food and Drug Administration–approved] contraceptive methods including, but not limited to, emergency contraception."

One indication of how seriously California takes its sex and HIV/AIDS education programs are efforts by the Department of Education to ensure that school districts understand and are in compliance with the law. Even though schools are not required to teach sex education, HIV/AIDS prevention education is mandated, and both types of instruction are widely taught in California. According to a survey of school districts, conducted by PB Consulting and published by the American Civil Liberties Union of Northern California in 2003, 94% provide HIV/AIDS prevention education and 96% provide sex education. Since 2004, the Department of Education has included HIV/AIDS prevention education on its list of "categorical programs" that the agency monitors for compliance. As a result, state staff visit school districts every four years to interview parents, students and teachers, observe classroom instruction and review documents, to make sure sex and HIV/AIDS education are being provided in accordance with the law.

Increasing Access to Contraceptive Services

Even as California was moving to provide young people with more comprehensive sex and HIV/AIDS education, the state was also working to increase their access to family planning services. In 1997, California took a dramatic step by launching the Family Planning, Access, Care, and Treatment (Family PACT) program. Family PACT provides a package of contraceptive and related reproductive health services at no cost to Californians—adolescents and adults, males and females—with incomes up to 200% of the federal poverty level. The program was operated entirely with state dollars until 1999, when the state decided to seek federal reimbursement for part of the costs and filed an application with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) to waive the normal eligibility rules under Medicaid. This Medicaid family planning "waiver" was approved later that year and allows the state to claim federal reimbursement for 90% of the costs of specifically identified services.

California's Family PACT program is notable for being the largest family planning waiver program in the nation. Moreover, it has four central features that make it particularly well-suited to address the needs of adolescents, especially those who are most vulnerable. First, teens can enroll in the program based on their own income—not their family's income—and are able to access a range of services confidentially, including contraceptive services and methods, cervical cancer screening, HIV testing, treatment for STIs and other related reproductive health care. Second, California has a process for on-site enrollment, which allows clients to both enroll and receive services on the same day at the point of service. Specially trained personnel help walk a teen through the program application and, during the visit, the state's computer system is able to determine and issue a decision on whether the teen is eligible. Eligible teens leave with an enrollment card in hand that they can use for future clinic visits or at a pharmacy for contraceptives (including condoms).

Third, the delivery system under Family PACT includes private physicians in addition to family planning centers. Although the large majority of adolescents (80%) are served by public-sector providers, Family PACT gives teens the option of seeing a private physician as a means of increasing access to services, because in a state as large as California, the distance between clinics can be considerable. According to Seigle, expanding to private physicians also helped build a base of support for Family PACT. "Support for the continuation of Family PACT is widespread among private doctors as well as pharmacists and laboratories—and this has proven to be critical politically," she said.

Finally, Family PACT provides services to all low-income teens, regardless of their immigration

status. Adolescents who do not qualify for federal reimbursement are served with state dollars. According to an evaluation of Family PACT—conducted by the University of California, San Francisco (UCSF) for California's Office of Family Planning and published in 2005—keeping program enrollment and service utilization as unrestricted as possible has been key to preventing unintended pregnancy among those at high risk. Almost half (45%) of Hispanic teen births and 41% of Asian or Pacific Islander teen births are to those born outside the United States.

Moreover, the UCSF research team found that Family PACT has dramatically expanded teens' access to family planning services over time. The number of adolescents participating in the program doubled between 1997 and 2008, with the largest growth taking place in the first few years of the family planning waiver. Today, roughly 20% of Family PACT clients are younger than 20. The program has been especially successful in reaching out to Hispanic youth, who have higher teen pregnancy rates than their white counterparts. Whereas Latinos make up 41% of California's adolescent population, Latinos account for 52% of Family PACT's teen clients.

Involving the Private Sector

A hallmark of California's teen pregnancy prevention effort is that for many years it has been a collective endeavor involving both the public and private sectors. Private foundations have played an especially important complementary role, both by directly funding state and community organizations and by providing the essential infrastructure support for the state's teen pregnancy prevention efforts.

A number of private foundations in the state have invested in teen pregnancy prevention efforts over the last decade, notably the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, Wallace Alexander Gerbode Foundation and the Women's Foundation of California. But the major investor, in terms of both money and time, has been The California Wellness Foundation. Created in 1992 as a private, independent foundation, The California Wellness Foundation's mission is to improve the health of the people of California by making grants for health promotion, wellness education and disease prevention. In 1995, the foundation established a 10-year teen pregnancy prevention initiative, under which it has provided nearly $60 million in grants for research, public education and policy advocacy programs, community outreach efforts and professional development programs. One of the major legacies of the foundation's initiative is the "hot spot" analysis—research to identify regions of the state where birthrates among teens are the highest. This analysis helped guide the foundation in determining where it would focus its efforts, says Gary Yates, president and CEO of The California Wellness Foundation. "Rather than scattering money across the state, the foundation decided to concentrate on areas with the greatest need." For example, the foundation supported the Hollywood Teen Community Project, which worked with area high schools to implement comprehensive sex education programs and with clinics to provide teen-friendly reproductive health services. To this day, the hot spot analysis continues to shape funding by California's Office of Family Planning, with the analyses now being conducted by state epidemiologists.

Another prominent aspect of The California Wellness Foundation's initiative was a $16 million media campaign designed to create public support for the types of state and local policies that encourage and fund effective sex education, contraceptive services and youth development activities. The "Get Real About Teen Pregnancy" campaign team developed messages for print, television and radio ads, including outreach to specific ethnic communities, which resulted in a large number of news stories devoted to the topic. Playing a complementary role in the late 1990s, the state of California also sponsored a media campaign to raise public awareness of the consequences of teen pregnancy. There was a good deal of coordination behind the scenes between the two campaigns. Although with a much smaller budget, the "Get Real" campaign was credited by observers (including state officials) with having the freedom and courage to tackle tough messages. Later, when the state's funding ended, the "Get Real" campaign was

able to continue to keep the issue of teen pregnancy prevention alive before decision makers.

The foundation also supported the California Family Health Council to provide specialized trainings to health care workers, social service providers and educators, to better support teens in making healthy decisions. Seigle says these trainings have helped establish a group of experienced professionals across the state dedicated to providing adolescent-centered care. "Enhanced services for youth is now expected across clinics. They recognize that outreach to youth is vital. It's the norm, part of the conversation."

Private- and public-sector involvement has unleashed tremendous creativity in the state's network of family planning centers. One program notable for leveraging funding is the Teen SMART outreach program. Initiated as a three-year demonstration project in 1995, Teen SMART is now an established component of Family PACT. The program encourages family planning centers and other providers—with funding from California's Office of Family Planning as well as grants from private foundations—to find innovative ways of reaching teens in their communities. Over the years, Teen SMART–supported clinics have reached thousands of adolescents—through group presentations in schools, social networking Web sites, street outreach and teen-led clinic tours—to promote awareness of teen pregnancy and introduce teens to clinic services in a nonthreatening environment. And the program appears to be working: During the first half of FY 2005/2006, nearly 30,000 teens visited Teen SMART–supported clinics for the purpose of receiving contraceptive or related reproductive health services, and approximately 35% of their visits were first-time visits.

Defying the Demographic Odds

The California experience demonstrates what can happen when there is long-term bipartisan support for a concerted, statewide effort, involving various actors from both the public and private sectors, all working in the same direction. This is not to say that there ever was a centrally coordinated, top-down effort; instead, it was a collective one on the part of government officials, family planning advocates and private foundations, who took it upon themselves to become actively involved in reducing teen pregnancy. In California, the whole of the effort clearly added up to more than the sum of its parts.

One of the features of this winning campaign was that it was and remains a long-term strategy. "We understood that we had to stick with the issue, not only to help keep the issue alive, but also to keep funding consistent, so organizations can continue to do their work," says The California Wellness Foundation's Yates. "This is not the sort of issue that the government or foundations can throw themselves into and then stop. Teen pregnancy prevention is a long-term, chronic issue that requires a long-term focus."

Moreover, the case study shows that policies do matter. Policy decisions in California had a significant impact on the resources available to support programs and services; they also influenced the types of information and services available. According to a 2006 analysis conducted by the Guttmacher Institute, California ranked first among states in overall efforts to help women avoid unintended pregnancy. (The analysis was not limited to state efforts to avoid teen pregnancy.) The state ranked consistently high on service availability, laws and policies to facilitate access to contraceptive information and services, and public funding.

California's progress may be especially remarkable given the characteristics of its population. Stemming from broader, persistent economic and social inequities, there are large and long-standing racial, ethnic and income disparities in the state, and a primary driver of any state's teen pregnancy rate is its demographic makeup. Nationally, for example, about 13% of black teens and 13% of Hispanic teens become pregnant each year, compared with 4% of whites. Similarly, women living in poverty are almost four times more likely to become pregnant unintentionally than women of greater means.

It would be expected, then, that teen pregnancies would be substantially more common in

Teen Pregnancy in the Southern States: A Different Picture

A look at teen pregnancy rate trends in the nation's Southern states yields a very different picture than that of California. These states made much less progress than the rest of the nation in declines in teen pregnancy between 1992 and 2005. Six of the 16 states considered by the U.S. Census Bureau to be in the South had declines near the national average of 37%, whereas nine states had declines that were somewhat or markedly lower than the national average (24–33%). Just one Southern state, Maryland, did substantially better than the national average, with its 45% decline in teen pregnancy. California, on the other hand, ranks first in the nation: The state's teen pregnancy rate declined 52% between the 1992 peak and 2005.*

To be sure, the Southern states, like California, have a diverse geography of urban and rural areas and large populations of black and Latino teens—groups with disproportionately high rates of teen pregnancy. The South also has a large number of residents who are living in poverty. But the Southern states do not seem to have been able to overcome these demographic challenges the way California has.

One factor may be the South's approach to public policy. The Southern states as a whole have far more conservative sexual and reproductive health policies than California. This is especially striking with respect to their education policies. According to a nationally representative survey of school districts conducted by the Guttmacher Institute and published in the November/December 1999 issue of Family Planning Perspectives, *among all U.S. districts with a district-wide policy, Southern districts were much more likely than those in the West (or any other part of the nation) to have a policy that teaches abstinence as the only option for unmarried adolescents. This exclusive focus on abstinence promotion is also evident in states' decisions to participate in the Title V abstinence-only program: Since the program got underway in 1997, 14 of 16 states in the South accepted the annual abstinence-only education allocation set aside for them each year. In addition, these states' abortion policies are far more conservative than California's. Thirteen Southern states follow the restrictive federal standard and provide abortions for poor women enrolled in Medicaid only in cases of life endangerment, rape and incest. In addition, 15 states in the South require parental involvement in a minor's decision to have an abortion: Nine require parental consent only, four parental notification only and two require both. Finally, although many Southern states have stepped up and expanded eligibility for Medicaid coverage of family planning services, eligibility levels for health care generally remain low: Nine Southern states limit Medicaid eligibility for adult parents to less than 50% of the federal poverty line (in 2009, $18,310 for a family of three), and the three states that rank the lowest in the nation in eligibility levels are all in the South: Arkansas (17% of poverty), Alabama (24%) and Louisiana (25%).*

Little wonder, then, that a 2006 assessment of states on their efforts to help women avoid unintended pregnancy conducted by the Guttmacher Institute found that many states in the South ranked among the lowest in the nation in terms of their laws and policies. Altogether, eight Southern states—Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Tennessee and Texas—ranked in the bottom third in laws and policies, and, by the most recent statistics, these states have some of the highest teen pregnancy rates in the nation.

**According to the U.S. Census Bureau, the states in the South are Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.*

California than in the nation as a whole—as, indeed, they were in 1992. But by 2005, California had achieved a rate only slightly above the national average (75 vs. 70 per 1,000 women aged 15–19). Moreover, between 1992 and 2005 the state made more headway in reducing teen pregnancy within its borders than did any other state. And this decline in the total teen pregnancy rate consisted of declines in both the teen birthrate and the teen abortion rate: Teen births dropped 47% between 1992 and 2005, and teen abortions declined a whopping 66% from their peak in 1988 to 2005 (from 76 to 26 per 1,000). (It is worth noting that these declines took place in a state known for its progressive abortion policies. California is one of 17 states that use

their own funds to subsidize abortions under Medicaid. Moreover, voters in California have repeatedly rejected attempts to require parental notification for teens seeking an abortion.) Indeed, California's experience stands in sharp contrast to that of other areas of the country with similarly challenging demographics, but very different laws and policies (see box, page 23).

Forging Ahead in a Tough Environment

Notwithstanding their significant successes to date, California's teen pregnancy prevention advocates—public and private sector alike—are hardly resting on their laurels. "While the continuing decline in the teen birthrate is encouraging and welcome news, teen pregnancy remains a public health challenge," says Mark Horton, director of the California Department of Public Health.

For their part, a group of government and nongovernmental organizations that came together in 2005 as the Adolescent Sexual Health Working Group—including the California Department of Education, the Office of AIDS, the Office of Family Planning, the Maternal, Child and Adolescent Health Program, the California Family Health Council, the California Adolescent Health Collaborative and others—continues its efforts to turn policy into practice. "There is a critical difference between knowing what the policies are and having the skill-set to be an effective educator or counselor," says Sharla Smith, HIV/STD prevention education consultant with the California Department of Education. "What we try to do is ensure that those working in the area of sexual health have what they need to deliver effective behavioral interventions consistent with California's policies."

Meanwhile, major private foundations are also staying in the game. The Hewlett Foundation, for example, is currently providing grants to expand services in California's Central Valley, a fast-growing region with high teen birthrates. And the Ford Foundation is supporting the California School Boards Association, along with the California Healthy Kids Resource Center and the California School Health Centers Association, to build awareness among school boards of the importance of comprehensive sex education and its links to improving student learning and achievement.

Still, California's progress could be as fragile as it has been remarkable. The current economic recession and historic state budget deficit have put teen pregnancy prevention programs in jeopardy and present significant challenges for the future of this work. The California Wellness Foundation's Yates suggests the greater danger may be that teen pregnancy prevention will become less of a priority as the numbers get better. "Positive changes are evident in the teen pregnancy arena. Our collective actions are having an effect," says Yates. "But if we want to continue to see progress, we must continue to make sure our young people have the information and health services they need to prevent unwanted pregnancies and to become sexually healthy adults." **www.guttmacher.org**

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