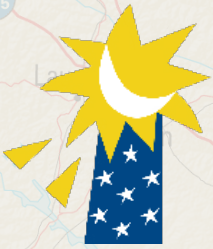

SOUTH CAROLINA CAMPAIGN to PREVENT TEEN PREGNANCY

Accelerating Progress

A road map for achieving further reductions in teen pregnancy

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THANK YOU
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Foreword & Acknowledgments

South Carolina has made unbelievable progress reducing teen pregnancy and teen birth rates. In fact, as this publication goes to print, the South Carolina Campaign to Prevent Teen Pregnancy (SC Campaign) will be announcing a 54% decline in the state's teen birth rate since 1992. Such progress was likely unthinkable to the group of individuals that started this statewide effort more than 20 years ago. What has happened along the way is extraordinary and reflects the tireless effort of so many who care passionately about the youth of our state. While important to celebrate and reflect on the successes of the last two decades, it is equally important that we take this opportunity to craft a new path forward – a path that builds on successes; a path that identifies 'what works' and strives to do more of it; a path that aims to accelerate progress and invest more thoughtfully and strategically in our state's most valuable resource... young people.

In 2012, the SC Campaign received funding from The Duke Endowment to further define this path. At the time, most of the news on the teen pregnancy prevention front was positive – rates were declining, the federal government had just made a substantial investment in teen pregnancy prevention, numerous state and local funders had taken on the issue as one of interest – yet the thoughtful staff and leadership at The Duke Endowment recognized there was more to the story. Despite impressive declines, South Carolina still has the 12th highest teen birth rate in the nation, over 4,700 young women under the age of 20 became mothers in our state just last year, and the economic impact of children having children is estimated to be over $166 million annually. Progress, yes. Success, not quite.

An innovative investment from The Duke Endowment allowed our team to take a more deliberate and thoughtful look at the issue of teen pregnancy – past, present, and future – than we had ever done before, which ultimately resulted in this publication. For their willingness to be a strong partner in the process, to show patience with deadlines, and provide guidance along the way we are forever grateful. Throughout the process, we were fortunate to be assisted by many individuals from across the state who contributed in a variety of ways to our understanding of the issue and the path forward, including participation in focus groups, discussion groups and interviews, each of whom deserve our thanks.

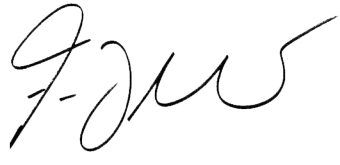
A key component of the funding received from The Duke Endowment was resources to hire a post-doctoral fellow to lead the data collection effort. Dr. India Rose joined our team in summer 2012 on a two-year fellowship and contributed beyond measure to the completion of this project. In addition, a leadership team was formed who provided insight, guidance, and critical thinking along the way. Members of the Leadership Team are listed on the inside front

cover of this publication. Leadership Team discussions were facilitated by Charles Weathers whose expertise allowed us to move conversations forward in a productive way. We were also fortunate to have a group of dedicated professionals volunteer their time to participate in the Data Management and Medical Services Advisory workgroups. Their insights and recommendations are included throughout this publication.

We must also thank Dr. Heather Brandt (University of South Carolina), Stephanie Derr (SC Department of Health and Environmental Control), Dr. Nathan Hale (University of South Carolina), Erika Kirby (BlueCross BlueShield of SC Foundation), Jeremy VanderKnyff (SC Department of Health and Environmental Control), and Tamika Williams (The Duke Endowment) each of whom took the time to read various iterations of this publication – some more than once – and suggest numerous improvements along the way. In addition to these content experts, a special thanks to Gwen Baker and Kemi Ogunji, both part of the SC Campaign team, who took the time to edit the document and make it more clear and reader friendly.

Extending my personal privilege as the CEO at the SC Campaign, I would also like to express my deepest gratitude to some members of our team who made this effort possible. Mary Prince and Doug Taylor took on the lion's share of the writing and editing, and spent countless hours reviewing, improving, and revising this document from beginning to end. India Rose and Erin Johnson also made substantial contributions in the writing process. Cayci Banks single-handedly designed this entire publication from cover to cover and was exceptionally thoughtful along the way suggesting improvements that allowed information to be more clear and concise. A special thanks to Jen Duffy, Sarah Kershner and Nell Fuller for going above and beyond in responding to last minute requests to ensure all of the data in the report was accurate and up-to-date. Finally, thank you to the entire team at the SC Campaign. While not all directly authors, each staff member has contributed to our understanding of the issue through their efforts and daily work.

What has resulted from all of this input is a final product that each of us can be proud of. As a reader, I encourage you to take the time to become familiar with the publication and use it to improve our collective efforts preventing teen pregnancy in South Carolina. While certainly not the final word on this topic, what you will find on the following pages is a recommended path forward for each of us to follow. Together we can – and will – accelerate the progress that has been made reducing teen pregnancy and teen birth rates in our state. As we continue to learn more, we look forward to sharing it with you, but for now, enjoy!



Forrest L. Alton
SC Campaign, CEO
September 2014

Navigating the Prospectus

Introduction

Chapter 1
Setting the Stage

Chapter 2
Assessing Needs & Assets

Chapter 3
Identifying Greatest Need

Chapter 4
Recommending a Direction for the Future

SOUTH CAROLINA CAMPAIGN to PREVENT TEEN PREGNANCY

CHAPTER SUMMARY

A two-year research and exploratory project funded by the Duke Endowment allowed the South Carolina Campaign to Prevent Teen Pregnancy to engage more than a dozen agencies and hundreds of stakeholders in a process informed by the Collective Impact model to examine teen pregnancy prevention efforts and to identify strategies to accelerate the path of progress in reducing teen birth rates.

This document serves as a guide and resource to help funders and policy makers understand **WHAT** strategies should be used to decrease teen birth rates and **WHERE** these strategies should be implemented to have the greatest return on future investments.

Presented in this chapter is background information about the issue of teen pregnancy and a discussion of how the "Six Components Necessary for Effective Public Health Programs" and Collective Impact can jointly provide a framework for how funders and influencers should think about the funding, implementation, evaluation, and sustainability of teen pregnancy prevention efforts.

Introduction

Despite significant decreases in teen pregnancy and teen birth rates over the last two decades, rates remain far too high in South Carolina. While the collection of efforts that have taken place during this time period have resulted in extraordinary progress, too often federal dollars, state dollars, and private/local prevention dollars have been invested without any connection to each other, without any uniform measurement, without much coordination and synchronization, and with very little attention paid to sustainability. In order to continue positive trends and accelerate decreases in the state's teen pregnancy and birth rates, a new investment strategy is needed.

For a period of nearly two years, the South Carolina Campaign to Prevent Teen Pregnancy (SC Campaign) has taken the leadership on a significant, first-of-its-kind research project, with funding from The Duke Endowment (The Endowment), to identify a path forward for teen pregnancy prevention efforts that would maximize resources and target communities most in need. Organizational leadership from more than a dozen agencies - state organizations, funders, and nonprofits from around South Carolina - whose mission or scope of work included teen pregnancy prevention initiatives, met regularly to share strategies, measures of performance, and programmatic areas of interest. Each of the organizations had a statewide focus and came together to form a Leadership Team with the goal of building and designing a document that explores next steps in teen pregnancy prevention; one that funders, philanthropists, community leaders, and decision makers interested in making further progress in reducing rates of teen pregnancy would find useful. From the beginning, a main focus of this group was on helping funders and philanthropists recognize opportunities where their investments would have the greatest return.

In order to better understand the degree of effort being extended in South Carolina, where interventions are taking place, and what common challenges are encountered in the field, the organizations participated in a process informed by the collective impact model.[1] Agency representatives discussed what a state plan to prevent teen pregnancy should look like, what it should include, and how it would advance the field of teen pregnancy prevention in South Carolina. In addition, a number of data collection and information gathering strategies were employed to create the most comprehensive picture of the current state and future direction as possible.

As the organizing force or backbone agency of the collective impact process, the SC Campaign assumed the role of capturing the input of these

[1]Collective impact is defined as "the commitment of a group of important actors from different sectors to a common agenda for solving a specific problem." Kania J & Kramer M. Nonprofit management: Collective impact. Stanford Social Innovation Review, Winter 2011.

organizations and research efforts and summarizing them into what has been proposed as the "state plan" for preventing teen pregnancy in South Carolina. Our working hypothesis is this: in order to truly accelerate progress in reducing still too high rates of teen births in our state, the "same old" approach just won't do. Formulating a new investment strategy required a more deliberate and sophisticated examination of the issue of teen pregnancy than what had previously been available. A complex methodology was used to gather, analyze and synthesize data. What has resulted is a collection of information, recommendations, and investment strategies showcased as a "prospectus." Readers of this document should understand that our intent is not to provide the *HOW* (to prevent teen pregnancy) but rather to present *WHAT* prevention strategies should be considered by funders and philanthropists and *WHY* these interventions are appropriate given the contextual characteristics of the current landscape. Equally important, this document is an attempt to create a mechanism that can establish a uniform direction for future prevention efforts.

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1. a document describing the major features of a proposed project, etc., in enough detail so that prospective investors, participants, or buyers may evaluate it.

To develop such a document, multiple sources of information were required, including: thoughtful exploration of the current prevention landscape, insightful feedback from a collection of content experts, and a careful review of existing literature. This process was possible due to an innovative commitment from a funder who provided the necessary resources and allowed enough time for the project to come to fruition. By definition, funding from The Endowment allowed the SC Campaign to ***make long-term, sustainable changes to existing structures and put into place collective impact strategies that will accelerate the path of progress in reducing teen pregnancy.***

The principles and conditions of the collective impact approach informed much of the initial project's direction and effort. While the scope and intensity of this effort has not been, and (given available time and resources) was never intended to be a complete replication of the collective impact approach, several conditions of collective impact were met and/or prepped for future implementation. The collective impact group identified a *backbone agency*[2] (SC Campaign) and established a *common agenda*. Also, the assembled parties discussed the reality of *shared measurement* and the need to be engaged in *mutually reinforcing activities* by establishing a mechanism for *continuous communication*.

While the collective impact model

[2]A backbone agency is defined as an organization with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies in Understanding the Value of Backbone Organizations in Collective Impact, http://www.ssireview.org/blog/entry/understanding_the_value_of_backbone_organizations_in_collective_impact_1, accessed on 08/02/14.

influenced this work, the writings of Dr. Thomas Frieden, Director, Centers for Disease Control and Prevention, also guided the preparation and roll out of this report. In 2011, Dr. Frieden named teen pregnancy prevention as one of seven *winnable battles* based on the magnitude of the problem and the nation's ability to make significant progress in improving outcomes (www.cdc.gov/winnablebattles/focusareas.html). Additionally, in a 2013 piece published in the *American Journal of Public Health*, Frieden suggested six key components of successful public health programs.[3] These components overlap well with the conditions of collective impact and provided us an extended, yet reinforcing view for direction and next steps.

It is our belief that in order to accelerate progress reducing teen birth rates, those interested in investing in prevention programs must begin working from a shared set of assumptions and guidelines. This document begins with a vision crafted from the tenets of collective impact; is mindful of the "Six Components Necessary for Public Health Programs;" and ultimately **aims to create a paradigm shift among funders and influencers that will have long-term implications for how teen pregnancy prevention efforts will be funded, implemented, evaluated and sustained**.

Thus calling this document a prospectus – defined as *"a document describing the major features of a proposed project, etc., in enough detail so that prospective investors, participants, or buyers may evaluate it"* – was not by chance. It was a purposeful selection of title to illustrate the importance of being clear, thoughtful and detailed about the steps forward. As explained in the methods section, the suggested investment options presented in this chapter did not come about by chance. They were explored, vetted, researched and reviewed at great length.

Six Components Necessary for Effective Public Health Programs

1. Innovation exists to develop the evidence base for action.
2. A limited number of high priority, evidence-based interventions are packaged together.
3. Effective performance management exists including real time evaluation.
4. Partnerships between public and private sector organizations.
5. Timely communication to stakeholders and decision makers.
6. Commitment to resources and support.

[3]Frieden T. (2013). Six Components Necessary for Effective Public Health Program Implementation. *American Journal of Public Health: 104*(1): 17-22.

Many steps were taken to create this prospectus. Many questions were asked and explored. By no means is this document complete – we all learn more every day and updates will be necessary as a result – but it represents the most comprehensive and up-to-date view of what we know at this moment. Much of the data presented is specific to South Carolina, but our belief is that the premise will hold anywhere, and at a minimum, the methodology will be useful to those in other locations looking to conduct a similar assessment.

With an intended audience of funders, philanthropists and investors, our ultimate hope is that this publication will serve as a guide for future investments; a "road map" for those communities, organizations, foundations, and government agencies who share a desire to invest in teen pregnancy prevention efforts in this state or elsewhere. It is time that such investments become more pragmatic, more strategic, more committed to evidence and more willing to collect uniform performance measures that will allow for determination of a collective impact.

TAKE NOTE...

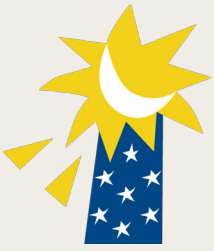
This is a comprehensive document and for many, reading it from start to finish may not be feasible. For ease of reading, tabs have been created delineating each of the various sections. Although the information presented is sequential, it may not be necessary to read every page in order. Instead, readers may consider one of the following:

- Readers who are interested in understanding the decline of teen births in South Carolina and the scope of current prevention efforts should focus on **Chapter 1**.

- Those interested in understanding all of the various methods used to inform the creation of this state plan/prospectus, see **Chapter 2**.

- Further still, to gain a more detailed understanding of the formula used to determine what areas in South Carolina are in greatest need of investment, see **Chapter 3**.

- If you are interested in reading and exploring only the proposed investment options, skip to **Chapter 4**.



SOUTH CAROLINA CAMPAIGN to PREVENT TEEN PREGNANCY

CHAPTER SUMMARY

Over the past 21 years, South Carolina's teen birth rate among 15-19 year old females has decreased 54%. Significant decreases have occurred among all age groups and among all races. Reductions in teen sexual risk taking behavior have contributed to these declines.

During this time, several South Carolina state agencies along with statewide nonprofits like the South Carolina Campaign to Prevent Teen Pregnancy have taken leadership on implementing programs, policies, and funding for teen pregnancy prevention initiatives across the state. In addition, since 2010, South Carolina has received significant levels of federal funding through a variety of mechanisms to implement a variety of evidence-based programs to reach youth at risk for pregnancy.

Despite impressive declines, South Carolina still has the 12th highest teen birth rate in the US. Further reductions will require a more coordinated funding effort and a uniform approach to prevention efforts including targeting areas and populations of greatest need and a more uniform implementation and scaling of evidence-based prevention strategies.

Chapter 1: Setting the Stage

Continued Declines

Twenty years ago in South Carolina, more than 8,500 girls under the age of 20 gave birth annually. This is a staggering number and one that undoubtedly contributed to the state's high rates of poverty and numbers of children living in single parent homes; high rates of premature and low-birthweight births; substandard graduation rates; and huge societal and economic consequences for our entire state.

Fast forward to 2014. South Carolina is still a state that is at or near the bottom of nearly every public health indicator and yet teen pregnancy and birth rates have decreased dramatically. A 54% decline in the teen birth rate since 1992 ranks as one of our state's most notable public health achievements. In one generation's time, leadership across the state invested resources and maintained a sustained commitment to tackling an issue that many once thought to be intractable.

There is no doubt that the progress South Carolina has made reducing the rate of teen pregnancy over the past two decades should be celebrated. Had teen birth rates not decreased over the last 20 years, it is estimated an additional 20,000 children would have been born to teen mothers. Further, the estimated cost savings to South Carolina taxpayers as a result of the decline exceeds $172 million annually.[4] Between 1992 and 2013, teen birth rates in South Carolina have declined significantly among all age groups and among all races as shown in **Table 1** below and **Figures 1 and 2** on the following page.

Table 1. Changes in South Carolina Teen Birth Rate* by Race and Age

	1992	2013	% change
15-19 White	49.7	28.1	-43%
15-19 AA**/other	98.0	37.6	-62%
TOTAL 15-19	68.3	31.6	-54%
15-17 White	27.1	11.9	-56%
15-17 AA/other	68.8	17.5	**-75%**
TOTAL 15-17	43.2	14.0	-68%
18-19 White	83.6	52.3	**-37%**
18-19 AA/other	141.8	67.9	-52%
TOTAL 18-19	106.0	58.1	-45%

**Rate is calculated per 1,000 births* ***African American*

[4] *Counting It Up: The Public Costs of Teen Childbearing in South Carolina in 2010*. The National Campaign to Prevent Teen and Unplanned Pregnancy. http://thenationalcampaign.org/sites/default/files/resource-primary-download/fact-sheet-south-carolina.pdf

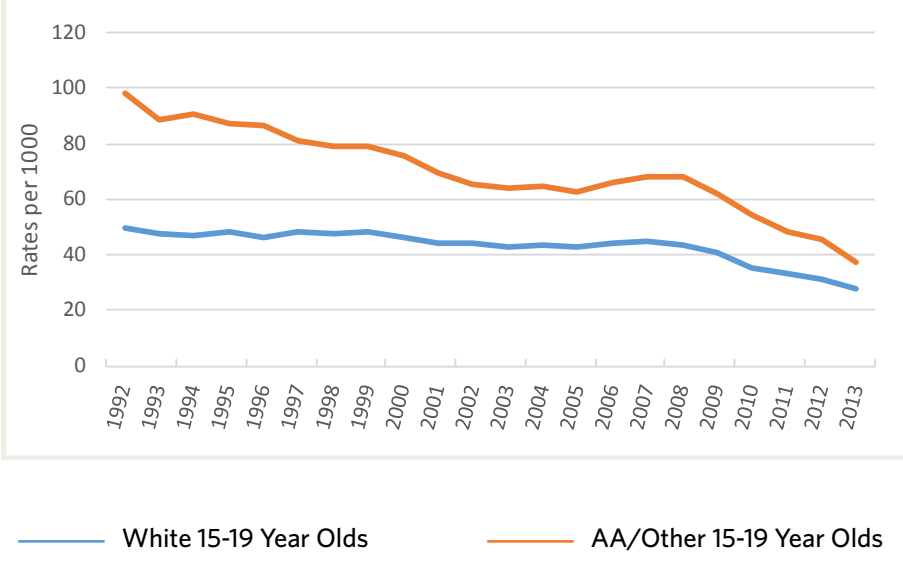
The most recent 15-19 year old birth rate (of 31.6 per 1,000) is the lowest in recorded history.

Decreases in the state's teen birth rate differ significantly by race and age, which is very similar to trends seen nationally.[5] Rates of birth for African American teens aged 15-19 have decreased 62% compared to a 43% drop among similar aged white teens. Broken out further by age, teen birth rates for African Americans aged 15–17 have decreased a staggering 75% compared to a 56% decline among 15–17 year old white teens. These declines far exceed those among older youth who continue to shoulder the burden of teen pregnancy and teen births. Among 18-19 year old African American teens, the birth rate decreased 52% while among White teens ages 18-19 the decrease was only 37%, the smallest decrease among any of the age/race subgroups.

While racial differences in the teen birth rate have been reduced significantly, they are still very much present, especially among older teens. It is instructive that decreases have been so different across age and race categories and something that must be explored further to gain a clearer picture of "what works" in the prevention of teen pregnancy.

It is well documented that a number of individual, societal and environmental factors contribute to rates of teen pregnancy and teen births. To understand the

Figure 1. SC Birth Rates by Age & Maternal Race

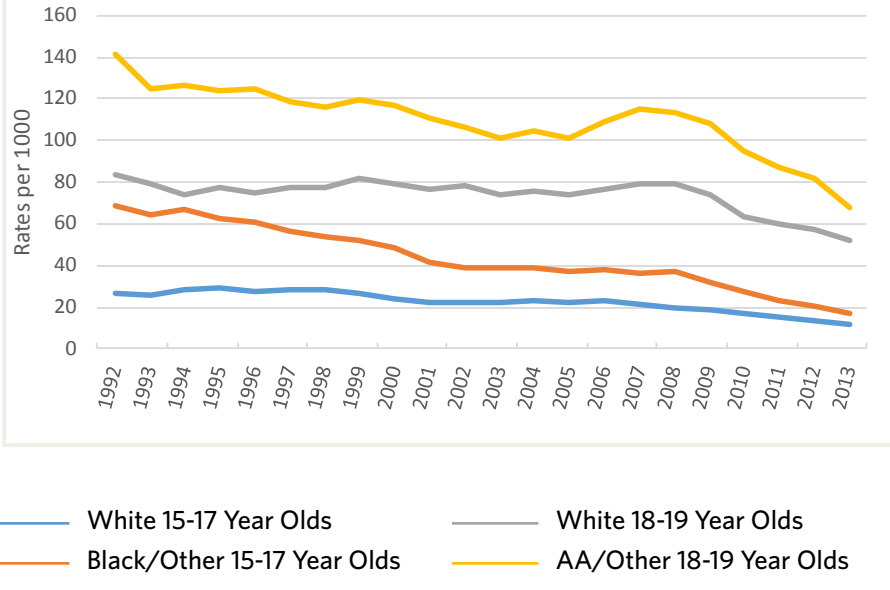


[5]OAH website http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.html#

complexity of recent declines, we must recognize that combinations of risk and protective factors are at work including individual factors (biological and behavioral), community factors, family factors and more globally the environment in which young people live.

Recently there have been attempts at the national level to explain trends in teen childbearing, citing facts such as the Great Recession; fewer kids of teen moms, which can begin to change the cultural norms around teen childbearing; and shows like MTV's *Sixteen and Pregnant* that appear to deter teen pregnancy.[6] At the most basic level, decreases in the number of youth who have had sex, decreases in the number of sexual partners, and increases in the number of youth who used condoms and contraception at last intercourse are ultimately the reasons for such improvements in the teen birth rate. **Figures 3 and 4** on the following page show that this trend is certainly true in South Carolina. However, these changes did not occur in a vacuum. Improvements in education, overall access to information, an increased awareness of the issue of teen pregnancy and improved access to clinical services have influenced these healthy changes in behavior in a significant way.

Figure 2. SC Birth Rates by Age & Maternal Race



[6]The National Campaign to Prevent Teen and Unplanned Pregnancy at http://thenationalcampaign.org/press-release/teen-pregnancy-rate-reaches-another-historic-low, accessed 08/02/14.

Figure 3. SC High School Students Who Have Had Sex[7]

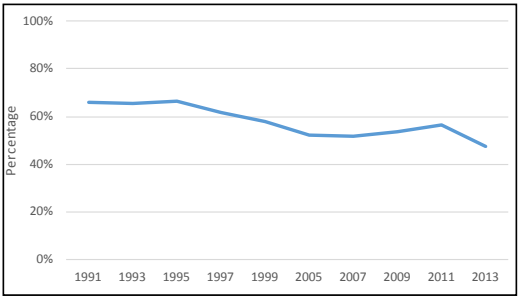
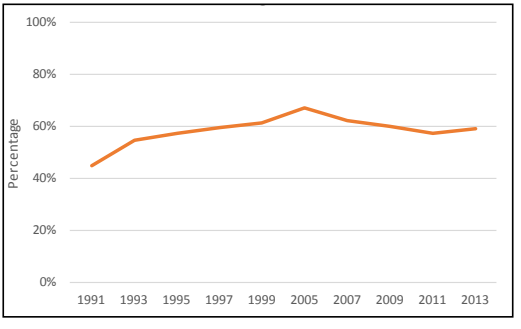


Figure 4. Used a Condom at Last Sex Among SC High School Students[7]



In South Carolina over the past 20 years, numerous programs and policies have been enacted to help shape an environment designed to reduce the number of teen pregnancies and teen births in the state, and to generally help support healthy sexual behaviors among young people. Although there has been no impact research on the effect of these efforts, it is probably safe to say, based on research of similar programs and policies, there is a correlation between these innovations and the decline of teen pregnancy in South Carolina. These programs and policies are briefly described below.

Statewide Initiatives to Prevent Teen Pregnancy

1. Policy and Education. Initial reproductive health education efforts date back to 1988 when the state's Comprehensive Health Education Act (CHEA) was adopted to ensure South Carolina students received age-appropriate, comprehensive education programs developed with a strong emphasis on local control of content. While one might assume a law requiring the delivery of sex education would result in universal implementation, uptake has been slow and anything but uniform across the state. The state's Department of Education has attempted to bring uniformity to implementation through teacher training and district-specific technical assistance, but with scarce resources to provide such assistance these efforts have been limited. That said, in 2012, 78% of high schools taught nine key pregnancy, HIV, or other STD prevention topics in a required course. And, despite not having a requirement to teach pregnancy

prevention specifically, 60% of middle school students report being taught about HIV and STD prevention.[7] Eighty-eight percent of high school students report being taught how to access valid and reliable health information, products, or services related to HIV, other STDs, and pregnancy. While it is troubling that these numbers are not 100%, the percent of youth receiving prevention education in a school setting over the past two decades is still significant and important.

2. State level support and capacity building. In 1994, the SC Campaign was founded in response to increasingly high rates of teen pregnancy, and since that time, has been the only organization in South Carolina that provides training and capacity building to organizations in each of the state's 46 counties with a steadfast dedication to this single issue. Over the past 20 years, the SC Campaign has used science and research to guide its practice; leveraged funds at the state and national level; and become a leader in the conversation about preventing teen pregnancy, not just in South Carolina, but across the country. The SC Campaign's effort has included providing training and technical assistance to thousands of professionals working with youth; working with middle and high schools, technical colleges, and four-year institutions to provide medically accurate and age-appropriate classes on teen pregnancy prevention; advocating for teen health policies at the State House and within state-based agencies; helping clinics become more teen friendly; and ensuring access to affordable, effective contraception for sexually active young people.

3. Statewide funding mechanism. In July 1998, the SC General Assembly appropriated $10.3 million to be distributed over a three-year period to fund Community Adolescent Pregnancy Prevention (CAPP) initiatives in all 46 counties. Temporary Assistance for Needy Families (TANF) funding was used to support the program. For the first time, every county had resources to dedicate to teen pregnancy prevention. After the initial three-year period, funding was extended in the Department of Social Service's state line-item budget for another eight years until the program was ultimately eliminated in 2009. To ensure accountability for the use of the funds, the legislation required all initiatives to: 1) emphasize premarital sexual abstinence and male responsibility, 2) include a plan of action for prevention of adolescent pregnancy that extended for at least five years, and 3) provide evidence that linked proposed project activities to the reduction of teen pregnancies. Numbers of youth served were in the thousands, primarily ages 11-14, over the course of the program. Unfortunately, many of the county initiatives were unable to continue after funding was eliminated.

By in large, most of the teen pregnancy prevention effort(s) in South Carolina over the past 20 years or so have focused on preventing pregnancies among teens ages 17 and younger, and not older

[7] 2013 Youth Risk Behavior Survey at www.cdc.gov/yrbs accessed on 08/02/14

teens, even though the 18-19 year old age group accounts for 74% of teen births in South Carolina. The reason for this is simple; younger teens are easier to reach as most of them are still in school and can be engaged in school classes and after-school programs. Hence programs that have been funded either to reach youth directly in schools (Department of Education) or with an intention of reaching large numbers of youth (Department of Social Services) have focused on this age group. Once youth have exited the school system, it is difficult to design interventions that can be implemented to reach large numbers. As such, populations of out-of-school youth and older youth have not received much attention to date. In fairness, some state agencies - i.e. Department of Health and Environmental Control (DHEC), Health and Human Services (HHS) - have been steadfast in their offering of services to all youth, including access to affordable contraception. In many ways these types of safety net programs are all that exist for older teens who are sexually active.

Department of Health and Environmental Control administers the Federal Title X funding throughout South Carolina with the aim of providing high quality and cost-effective family planning and related preventive health services for low-income women and men. DHEC has worked closely with HHS over the years to expand access to Medicaid through the Family Planning Waiver and more recently the State Plan Amendment (SPA). The SPA gives women and men who fall within 100% and 194% of the federal poverty level access to services provided by DHEC and other health care providers that accept Medicaid clients. DHEC has established several teen specific clinics, called The Point, that provide ease of scheduling appointments, ensure confidentially and provide high quality services that meet the unique needs of teens - all of which are designed to improve their overall experience.

Department of Health and Human Services is responsible for administering the Medicaid Adolescent Pregnancy Prevention Services (MAPPS) program, which serves youth between 10-19 years old who are Medicaid-eligible and have at least one of the following: parent(s) were teen parents, sibling is pregnant and/or a teen parent, is sexually active, has a history of sexual abuse, and/or identifies peer pressure to engage in sexual activity as a problem. MAPPS provides each teen client with three reimbursable services: an annual Individualized Case Plan, one-on-one family planning counseling sessions and evidence-based programs in a group setting.

As previously noted, HHS also administers the Family Planning Program, which provides reimbursement for family planning services for women and men whose income is below 194% of the federal poverty level. In addition, beginning March 1, 2012, HHS changed its policy to allow long-acting reversible contraception (LARC) to be reimbursed outside of the Diagnosis Related Group (DRG) when inserted inpatient post-delivery. Prior to this action, most hospitals weren't willing to stock LARC methods due to the cost. Physicians had

to rely on the patient scheduling an outpatient clinic/office visit to receive contraception. This proved to be challenging since Medicaid beneficiaries often missed their post-partum appointment, increasing the likelihood of a rapid repeat teen pregnancy. The new policy has been praised by the OB/GYN community as a continuing commitment by HHS to remove obstacles to treatment and to help reduce the number of unwanted and unplanned pregnancies.

Additionally, a wide variety of public organizations including schools, government entities, nonprofits, faith-based organizations and health service centers have been involved in prevention efforts in a variety of ways. And, despite widely publicized budget cuts across state agencies and shrinking coffers among private funders, there are, still today, significant investments being made throughout the state specific to the prevention of teen pregnancy. State agencies, private foundations (BlueCross BlueShield of SC Foundation, New Morning Foundation, Mary Black Foundation), hospital systems (Palmetto Health, Spartanburg Regional), United Ways (Anderson County, Piedmont, Midlands) and others are actively funding teen pregnancy prevention programs and interventions.

Federal Initiatives to Prevent Teen Pregnancy

In addition to state and local level resources, a change in the political landscape and funding strategy at the federal level in 2010 created an expanded opportunity for states to secure federal dollars for the replication of research-proven teen pregnancy prevention programs and strategies. Prior to this time, most federal dollars had been earmarked for the implementation of abstinence-only-until-marriage programs with little evidence of effectiveness. However, beginning in 2010, multiple federal agencies including Health Resources and Services Administration (HRSA), the Office of Adolescent Health (OAH), and the Centers for Disease Control and Prevention (CDC)

Table 2. Distribution of Grants in SC

FUNDING AGENCY	AMOUNT FEDS DISTRIBUTED	SC GRANTEE	ANNUAL AMOUNT RECEIVED	EXPECTED END DATE
Office of Adolescent Health (Tier 1)[8]	$75 million	SC Campaign	$1.48 million	September 2015
Office of Adolescent Health (CDC)[8]	$25 million	SC Campaign	$1.46 million	September 2015
PREP (ACYF)[9]	$50 million	SC DHEC	$760,906	September 2017
MIECHV[10]/Home Visitation (ACF[10], HRSA[10])	$124 million (Formula) (Competitive)	Children's Trust of SC	$1.4 million $4.8 million	September 2016 September 2016
Office of Adolescent Health (PAF[11])	$23 million	Children's Trust of SC	$1.5 million	July 2017

Note: Table 2 does not include Title V Abstinence-Only funding from ACYF totaling $50 million nationally. South Carolina's annual distribution is $821,923 through September 2017. The table also does not account for $5,539,000 Title X dollars coming into the state annually, which support family planning and preventive health service delivery to low-income women and men.

[8] http://www.hhs.gov/ash/oah-initiatives/tpp

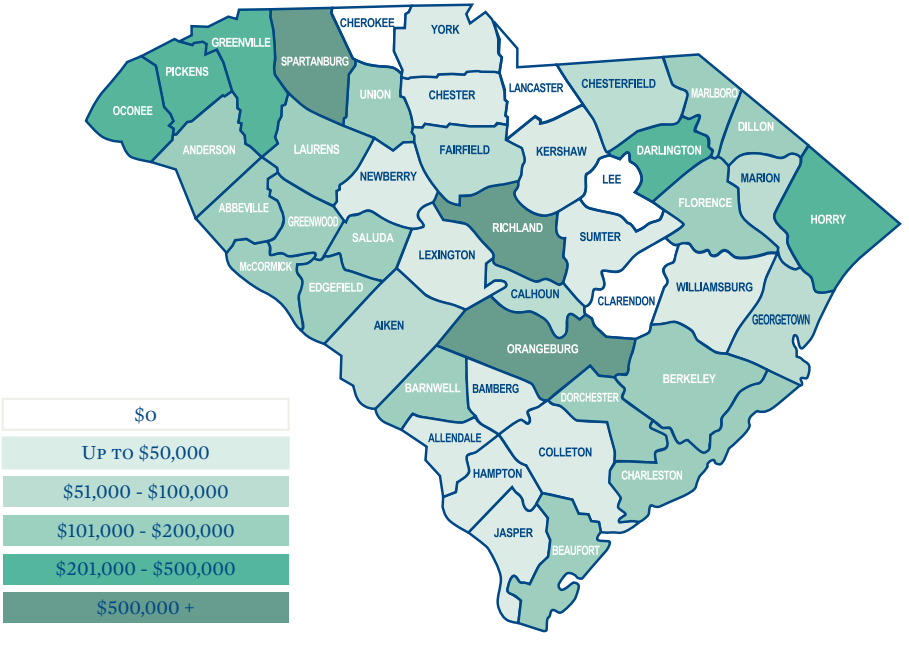
[9] http://www.acf.hhs.gov/programs/fysb/programs/adolescent-pregnancy-prevention/programs/state-prep

[10] http://mchb.hrsa.gov/programs.homevisiting

[11] http://www.hhs.gov/ash/oah/oah-initiatives/paf/home.html

released competitive applications to state and private organizations to compete for funding. Capitalizing on these investments, the SC Campaign and other statewide partners have brought in approximately $11.5 million annually to South Carolina, which either in whole, or in part, is being used for teen pregnancy prevention programming. **Table 2** on page 19 outlines the federal agency responsible for disbursing these funds and the agency in South Carolina who has received the dollars. **Figure 5** provides a more detailed geographical illustration of where these federal investments in teen pregnancy prevention are impacting the state. While this record of securing federal funds is impressive, each funding opportunity was independent of one another, therefore no statewide, cross-agency, coordinated effort was used to identify counties in greatest need of resources and interventions. In some cases there were counties, such as Spartanburg and Horry, which were selected as sites for more than one grant because of their high teen birth rates and higher population of teens. On the other hand, some high need counties such as Lee and Chester have received limited resources. Chapter 3 describes a unique process to identify counties that could be considered for future funding.

Figure 5. Federal Funding Allocation by County



Need for Sustained Investment

The story so far is overwhelmingly positive: teen birth rates have been cut nearly in half; investments are being made at the federal, state and local level. Why change anything? Better yet, why continue investing if we have made such progress? Herein lies one of the great challenges faced by those in the social service sector – the juxtaposition of celebrating progress while emphasizing the need for further investment.

A more nuanced inspection of the progress that has been made indeed reveals the work that remains. Despite declines, South Carolina still has the 12th highest teen birth rate in the nation, and the United States has one of the highest rates of teen births in the industrialized world. For instance, the US teen birth rate is eight times higher than the teen birth rate in the Netherlands. In our state, more than 4,700 young women under the age of 20 become mothers every year. That is 13 new teen mothers in South Carolina every day!

Teen mothers are less likely to finish high school - only 38% ever will and only between 2-3% of teen mothers will have earned a four-year college degree by the age of 30.[12] Children of teen mothers are more likely to be born at a low birth weight, live in a single-parent household, grow up in poverty, and are less prepared to enter school ready to learn. In economic terms, teen pregnancy costs South Carolina taxpayers more than $166 million annually to cover costs associated with teen childbearing.[12]

Despite significant declines in the teen birth rate, overall child well-being indicators for South Carolina remain poor. According to KIDS COUNT, South Carolina ranks 45th nationally in overall child well-being with rankings on key indicators of economic well-being (44th), educational achievement (41st), and overall health (44th) falling near the bottom of national comparisons.[13]

These data are compelling and underscore the need to continue prevention efforts; a more direct answer to the question "why continue investing in this issue?" can be surmised from two key observations about the current landscape of teen pregnancy prevention efforts in South Carolina.

1. Large declines at the state level have masked the fact that teen birth rates remain too high in certain communities and among certain populations.

Despite impressive declines, there are still significant disparities in teen birth rates among ethnic/racial minority groups. African American youth have a teen birth rate higher than their White peers – 37.6 and 28.1 per 1,000 respectively - although it is notable that this disparity has decreased significantly over time (see **Figure 1**) especially among younger teens. African American (Non-Hispanic) females make up 33% of the teenage female population, but account for 42% of the teen births. Similarly, while Hispanic teens make up a small percentage of the population of teens (just over 5%) in South Carolina, they account for 8% of all teen births.

Even within these data the story is not complete. A 2013 report from the SC Campaign found that among a sample of Medicaid eligible youth, rates of pregnancy by race are nearly identical[14] implying that controlling

[12]Hoffman, S. (2006). *By the Numbers: The Public Costs of Teen Childbearing*. National Campaign to Prevent Teen and Unplanned Pregnancy; https://thenationalcampaign.org/sites/default/files/resource-primary-download/btn_national_report.pdf

[13]*Kids Count Data Book 2014*/Children's Trust; http://www.aecf.org/resources/the-2014-kids-count-data-book/

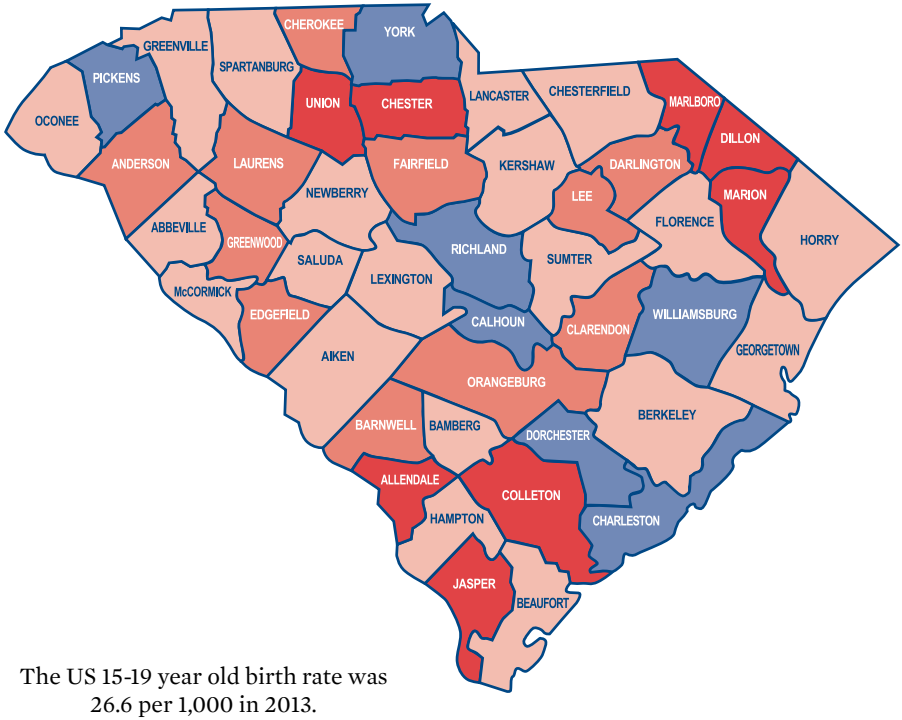
[14]South Carolina Campaign to Prevent Teen Pregnancy (2013). *Patterns of family planning services, contraceptive use, and pregnancy among 15-19 year olds enrolled in South Carolina Medicaid*. Columbia, SC: Shannon Flynn and Jennifer Duffy.

for poverty may in fact diminish, if not eliminate, differences in teen birth rates by race. In either case, whether by race or poverty, disturbing differences exist in teen birth rates.

Nearly three out of every four teen births in South Carolina are to 18-19 year olds; older teens in South Carolina have a much higher birth rate (58.1 per 1,000) compared to their younger peers (14.0 per 1,000) and these birth rates have decreased more slowly over time; and, the issue of repeat births must be accounted for. Almost 25% of all teen births in South Carolina are repeat births, and among teens age 18-19 the rate approaches 30% highlighting the need for increased education and contraceptive access for young moms.

Stark geographical differences also exist throughout South Carolina specific to teen birth rates. Rates continue to be higher in rural counties (42.7 births per 1,000 girls) than in urban communities (29.7 births per 1,000 girls). While it is true that there have been declines across all 46 counties over the last 20 years, **Figure 6** illustrates that compared to national averages the picture for

Figure 6. Birth rates for 15 – 19 year old teens compared to national rate



The US 15-19 year old birth rate was 26.6 per 1,000 in 2013.

EQUAL TO OR LOWER THAN THE US RATE

BETWEEN 1% AND 49% HIGHER THAN THE US RATE

BETWEEN 50% AND 99% HIGHER THAN THE US RATE

MORE THAN DOUBLE THE US RATE

Table 3. Percent of Teen Births (ages 15-19) that are Repeat by County			
County	Number of births	Number of Repeat births	% of births that are repeat
Counties with highest percentage of repeat teen births			
Lee	20	10	50%
Chester	52	19	37%
Chesterfield	53	19	36%
Georgetown	54	19	35%
Darlington	100	34	34%
Counties with lowest percentage of repeat teen births			
Jasper	15	7	16%
Kershaw	57	8	14%
Beaufort	143	19	13%
Hampton	25	*	n/a
Calhoun	10	*	n/a

Note: McCormick County excluded from chart given values too small to register. ** indicates a value less than 3*

many South Carolina counties is less than stellar. Only eight counties have rates at or below the national rate of 26.6 per 1,000 girls. However, there are areas even within these counties that have extremely high birth rates (data not shown). Rates of repeat teen births also vary widely by county as shown in **Table 3** and present an especially troubling picture in small rural counties with exceptionally high rates of repeat births.

2. Current prevention efforts are numerous, but are disconnected, difficult to measure collectively, hard to sustain over time, and rarely taken to full scale.

Within the current economic landscape of our state and nation, funding and resources must be maximized. As isolated entities, organizations implementing teen pregnancy prevention programs are oftentimes not equipped with sufficient resources to make systemic changes to reduce teen pregnancy on a larger scale. Adding to these challenges is the difficult process of taking state level policies that have the potential to reach large numbers of youth with prevention education and services to scale. The contributions of agencies such as SC DOE, SC DHEC, and SC HHS have been discussed previously. Each of these agencies has had its own experience, wrought with challenges, trying to channel new policies and procedures through their large bureaucratic systems down to local level implementation. Correctly interpreting and consistently implementing policies and programs at the regional and local levels requires resources for coordinated training, oversight, coaching and monitoring of performance including a continuous quality improvement loop. Ignoring or minimizing these important actions

will reduce the likelihood that the policies/programs will be fully implemented with high rates of fidelity.

As federal, state and private dollars continue to be invested to prevent teen pregnancy in South Carolina, developing shared performance measures across programs and agencies that reach similar populations with similar goals should be considered an essential next step. An increased understanding of the how and why funds are being invested can assist with reducing duplication, increasing collaboration, and expanding evaluation results. As part of the two-year collective impact process, a common set of performance measures was drafted to monitor the implementation and reach of evidence-based programs (EBP) and clinical outcomes related to the use of contraceptives. Further explanation of these measures can be found in Chapter 4.

While great progress has been made on this issue, the path forward will require more strategic, planned and collaborative investments. As presented in the remainder of this publication, this path forward must include developing a uniform approach to targeting those areas and populations of greatest need, understanding the importance of ensuring all relevant stakeholders are at the table communicating, planning and sharing with one another, and recognizing the need for investments and programs to be sustainable over time. While the prospect of additional resources being dedicated to this issue is promising and encouraging, now is the time to ensure those investments are coordinated, synchronized, and thoughtful.

Gaffney
Greer
Spartanburg
Rock Hill
Greenville
Union
Chester
Lancaster
Broad
Catawba River
Laurens
Clinton
Saluda R
Newberry
Camden
Hartsville
Greenwood
Lake Murray
River
St Andrews
Columbia
Sumter
J Strom Thurmond Lake
Lake Marion
Aiken
Orangeburg
Savannah
Bamberg
Edisto
Summerville
Allendale
Walterboro
Charleston
Beaufort
St Helena Sou
Hilton Head Island
26
385
77
20
95

SOUTH CAROLINA CAMPAIGN to PREVENT TEEN PREGNANCY

CHAPTER SUMMARY

Presented in this chapter are the methods used by the South Carolina Campaign to Prevent Teen Pregnancy to collect and analyze information to generate an understanding of "what we know" and "where we need to go" specific to teen pregnancy prevention efforts in South Carolina.

Information from multiple stakeholders representing a variety of professional occupations and from all four regions of the state provided an in-depth understanding of how the issue of teen pregnancy is being addressed. These stakeholders, along with SC Campaign staff, participated in several topic-specific discussions to share their insights and recommendations on what is working well and strategies funders should consider when undertaking prevention efforts with communities. Recommendations from federal agencies directly involved in winning the battle of teen pregnancy, like the Office of Adolescent Health, are included.

A number of strategies and approaches including the delivery of evidence-based programs with fidelity; access to low-cost, highly effective contraception; and engaging parents appeared frequently in these discussions, no matter the source.

Chapter 2: Assessing Needs & Assets

Multiple methods, including both quantitative and qualitative strategies, were used to provide insight into the current state of teen pregnancy prevention in South Carolina and to identify a clear and innovative path for future interventions. Multiple types of data were collected and analyzed over the course of two years to generate an understanding of "what we know" and "where we need to go." The methods and findings are briefly explained on the following pages. Given the variety and volume of responses, it proved impractical to explicitly list every recommendation offered as an "investment option" in Chapter 4; however, for many of the data collection efforts mentioned, a complete summary report – and in some cases a more sophisticated publication - was produced and will be available at www.teenpregnancysc.org. Multiple journal articles have also been produced based on data presented in this chapter, which are in various stages of review and publication.

Methods and Findings

Leadership Team

From the onset of the project, one of the more valuable processes was the ongoing convening of a leadership team[15] consisting of organization leadership from public and private entities that 1) have a statewide focus, 2) actively fund teen pregnancy prevention activities in statewide or regional settings, and/or 3) receive federal dollars to prevent teen pregnancy. The identified organizations met multiple times (six) over the 24 month project and brought together, for the first time in more than a decade, an audience of leadership groups in South Carolina to specifically discuss teen pregnancy prevention. The members of the leadership team were selected strategically based on their ability to leverage resources, implement systems level change, and mobilize communities. The collective knowledge of the leadership team, their motivation to explore the current landscape of teen pregnancy prevention in order to make thoughtful recommendations to this report, and the overall process proved invaluable. This team, based on their collective wisdom, was charged with outlining a vision for future teen pregnancy prevention efforts. First, the leadership team worked together to identify a uniform definition of teen pregnancy prevention.

teen pregnancy prevention

"...the collaboration of community sectors to increase knowledge, skills, support, and access to resources to empower young people to make healthier decisions and prevent unplanned pregnancy."

[15]Members of the leadership team are listed on the inside front cover of this publication.

Through numerous conversations and activities, the leadership team also prioritized the following services as essential:

1. Clinic-based services;
2. School-based services that include evidenced-based health and sex education programs and clinical services;
3. Condom availability programs; and
4. Parent-child communication and connectedness.

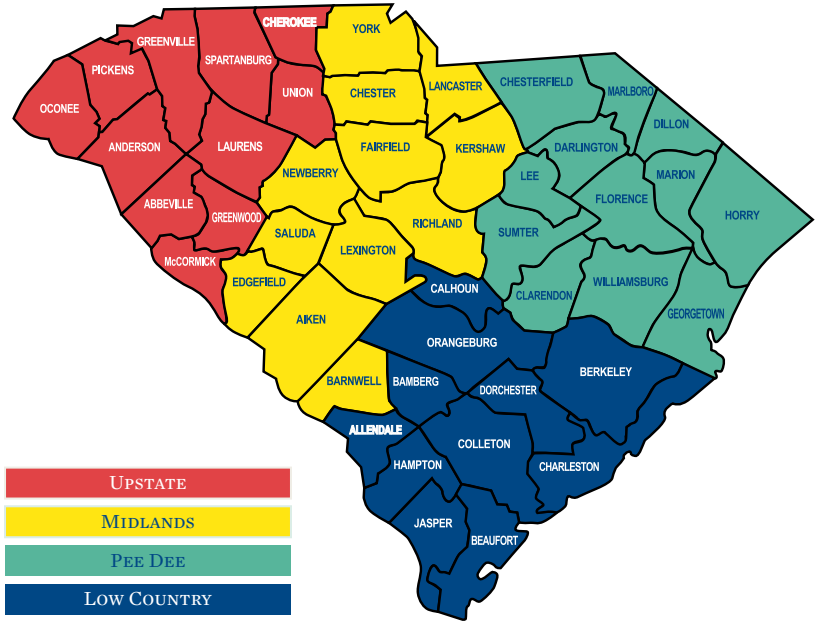
Interviews and Focus Groups

A series of interviews and focus groups were conducted with a number of audiences important in the conversation about preventing teen pregnancy. Physicians, school leaders, and parents were specifically targeted to ensure their input in any future recommendations was accounted for. In all of the examples that follow, focus group discussions and interviews were audio-recorded, transcribed verbatim, and thematically coded. Data were then analyzed and reported. Only brief summaries and key points ("what we learned") are included in this document.

Regional Discussions

In fall 2013, four regional discussions were held in the Midlands, Upstate, Pee Dee, and Low Country regions of South Carolina (see **Figure 7**) to get input from local communities on programs and strategies needed to prevent teen

Figure 7. Regions of South Carolina



pregnancy. A total of 56 community leaders from 30 counties participated, including representatives from DHEC, DSS, United Way, community-based organizations, health care agencies, faith-based groups, and the education community. The purpose of these meetings was to gather ideas on how best to prevent teen pregnancies in South Carolina.

What we learned: Groups were challenged with the question "where would you invest your first $1 million to achieve further reductions in the state's teen birth rate?" A total of six recommendations for investing in teen pregnancy prevention emerged from the discussions. They are listed below.

1. Hire additional clinical staff who are able to prescribe, dispense, or insert (same-day) a contraceptive method.
2. Design and construct a mobile family planning clinic specifically to serve rural communities where transportation is a barrier.
3. Invest more in outreach and training that targets parents and caring adults.
4. Consider building teen wellness centers to provide reproductive health care.
5. Assist school districts in implementing evidence-based, comprehensive sexuality education programs in public schools.
6. Engage young men in prevention efforts in a more meaningful way.

To gain further insight on the nuances of these recommended strategies, SC Campaign staff conducted an assortment of follow up interviews and focus/discussion groups with health professionals, school leadership, and parents as outlined below.

Physician Interviews

Interviews were conducted in 2013 by the University of South Carolina's Center for Health Services and Policy Research (CHSPR) with both public and private providers in South Carolina. CHSPR identified interviewees based on their delivery setting, by geographic region, and by the age of youth to whom they provide Medicaid family planning services. In total, 15 interviews were conducted with providers from three clinical settings: SC DHEC (Title X provider), Federally Qualified Health Centers (FQHC), and private practices. Open-ended, semi-structured questions guided the interviews. CHSPR, with input from the SC Campaign and members of the project's Medical Services Advisory Committee, developed the protocols and interview questions.

What we learned: Providers cited compliance and cost/reimbursement as the most important factors in determining the most appropriate method of birth control for teen patients. Providers believed that long-acting reversible

contraception (LARC) were the best choice for adherence to contraception, however, concerns were raised about young patients who received LARC who came back into the office after a short period of time to have them removed.

Most providers were aware that Medicaid reimbursement for LARC methods had increased in 2011 and were prescribing them again due to the increase. Physicians focused on cost reimbursement issues for contraceptives from Medicaid HMOs or private insurance. Several physicians raised the concern that Medicaid HMOs were not reimbursing for Depo-Provera. Many physicians prescribed only contraceptives that would be covered by insurance or Medicaid in order to reduce or eliminate the cost to the practice and the patient. Some providers responded that sexual risk behavior was a factor in considering the best option for birth control. Sexual risk behaviors mentioned included whether a patient was sexually active, and/or in a monogamous relationship, or had multiple partners. Although providers believed LARC for sexually active patients was important, a greater concern centered on patients not using other forms of birth control such as condoms to reduce the risk of sexually transmitted diseases.

School Leader Interviews

In order to reduce teen birth rates, prevention programs must be consistently available to large numbers of youth. However, prevention efforts in schools have been historically conducted with little emphasis on ensuring program sustainability. This set of interviews with middle school principals focused specifically on the needs and barriers to sustaining teen pregnancy prevention programming in schools long term. Eleven qualitative interviews were conducted between June and September 2012 with middle school leaders currently involved in a grant-funded, evidence-based teen pregnancy prevention program (EBP) (*It's Your Game, Keep It Real*) in South Carolina.

What we learned. Common barriers to program sustainability included: lack of resources (e.g., computer equipment, curriculum), insufficient funding (at the school and district level), lack of support; parental opposition; and/or other school/district priorities. School leaders also identified several facilitating factors to continue TPP programming including: continued funding; training for staff; outcome/effectiveness data to support the program; and regularly updated curricula.

Parent Focus Groups

To examine South Carolina parents' perceptions of school-based teen pregnancy prevention programs, seven focus groups were conducted in fall 2012 in school districts located across South Carolina's Midlands, Upstate, Pee Dee and Low Country regions. Seventy-two parents who currently have children enrolled in *It's Your Game, Keep It Real* participated.

What We Learned. The findings from the parent focus groups reminded us once again that parents are overwhelmingly supportive

of public schools providing sex education and believe that information about abstinence and condoms and contraceptives should be taught even in middle school. A particular concern of parents was the quality of instruction and the training teachers received to teach this sensitive topic. This is an important finding and consistent with other research on this topic.

Internal Staff Discussions at SC Campaign

In an attempt to capture the institutional knowledge of staff at the SC Campaign, a series of topic-specific discussions were held. Staff, and in some cases external consultants with topic-specific expertise in working with community-based organizations (CBOs) and school-based programs, and/or knowledge of clinic best practices, were invited to participate. Each of the discussions was audio-recorded, transcribed verbatim and thematically coded.

Community Based Organizations

What we learned. The number of CBOs that focus exclusively on teen pregnancy prevention and/or have the topic as an identified focus area has decreased substantially in recent years. There continues to be a need for CBOs that often have the flexibility to truly meet the needs of their target community like no other organization can. CBOs often do the work and serve the populations that others find uncomfortable, or don't have the capacity to serve, like youth in the Department of Juvenile Justice, foster care, and older teens. CBOs tend to be more grassroots and connected to the community, and the community feels connected to them. However, capacity and skills issues exist in CBOs too, who often do not have the resources for adequate training and skill development for staff. This can be more of a problem in rural areas and in small organizations. Nonetheless, it is essential that the field continues to work with CBOs to build their capacity to implement EBPs and other pregnancy prevention strategies effectively.

Engaging Parents and Other Caring Adults

What we learned. Parents and trusted adults play a key role in shaping and influencing teen behavior and as such should be considered an important group to work with to increase their knowledge and skills to effectively communicate their values around love, sex, and relationships. It is also important to gain their support for EBPs in schools and clinics that meet the health care needs of teens.

Providing Clinical Services to Teens

What we learned. To improve access to LARC methods, health care providers from DHEC and FQHCs need knowledge and motivation to use the latest recommendations from the American Congress of Obstetricians and Gynecologists (ACOG), the Centers for Disease Control (CDC), and the Office of Population Affairs (OPA), which clearly state LARC methods such as implants and IUDs are first-line methods for preventing teen pregnancy and rapid repeat pregnancies. These methods are safe for teen use and do not increase risk of infertility. It is necessary for all providers in South Carolina to be trained and able to counsel

about these methods during all clinical visits with sexually active teens. Interventions must recognize and address the myriad barriers present – regardless of setting – for adolescents interested in obtaining contraception. These include limited appointment availability; shortage of staff with sufficient knowledge and training on LARC methods; limited numbers of LARC ready and available for same-day insertion; facilities that are not teen-friendly; and, an overall lack of knowledge on the benefits of LARC among providers and patients. Finally, it is important that effort is given to ensuring that previously mentioned policy changes instituted by HHS are implemented widely, accompanied by appropriate training and messaging.

Implementing Evidence-Based Programs (EBPs) in Schools

What we learned. Schools are undoubtedly the best setting for any programs aiming to reach large numbers of youth. Despite obstacles, implementing a curriculum or program with fidelity is possible but does require intensive training, technical assistance and oversight. In many schools, sex education is seen as an extra-curricular activity; it is not fully integrated into the school curriculum because it is often not seen as a priority. This does not necessarily mean that administrators do not support sex education, and as such, effort must be paid to ensure schools do not see implementation of EBP as "something extra" but rather as a necessity for the health and well-being of their students. It is also important to recognize there are competing forces at work. Every special interest wants their own part of the school day - obesity, drug/alcohol prevention, smoking cessation, etc. – because, as stated above, schools provide access to large numbers of youth. Programs may consider how to work with schools on the implementation of a more comprehensive, integrated approach to health and sexuality education. A shortage of health teachers has created a scenario where significant training and technical assistance is required to ensure that EBPs are being taught in the classroom with fidelity. That said, program implementers must be cautious of becoming the "fidelity police" who are constantly looking over teachers/schools shoulders. This may cause curriculum implementers to become frustrated and just add to a belief that sex education "doesn't fit" in the school setting. Despite challenges, staff believe it is essential that the field continue to work with schools to build their capacity to implement EBPs effectively and efficiently.

It's Your Game, Keep It Real Process Evaluations

What we learned. Over the course of this five-year curriculum implementation project, SC Campaign staff have conducted multiple process evaluations to collect data on fidelity, student satisfaction, teacher satisfaction and school support. Data, which is analyzed annually, show the curriculum has been implemented with 97% observed fidelity over time; 100% of teachers surveyed agreed that implementing a medically accurate, evidence-based teen pregnancy prevention program in their middle school has effectively influenced their

students to make healthier choices; and 91% of middle school students agreed they will use the information and skills learned in the program lessons.

A National Call to Action

While a 54% decrease in the state's teen birth rate since 1992 is impressive, and certainly in part the result of work happening on the ground, it is important to remember that teen birth rates are decreasing at similar rates nationally and in many other states. Much attention is being paid to the issue nationally, not just in South Carolina. Given current federal investments in teen pregnancy prevention (see Chapter 1), a call to action issued in 2014 by leaders from the Administration for Children and Families (ACF) Family and Youth Services Bureau, the CDC, OAH, and OPA proved to be particularly informative. Despite significant declines, this call to action recognized there was still work to do by "encouraging communities to continue working to prevent teen pregnancy and improve outcomes for expectant and parenting teens." Specifically, leadership encouraged communities to:[16]

1. Implement evidence-based or evidence-informed teen pregnancy prevention programs.
2. Engage youth, parents and community stakeholders in events and activities related to teen pregnancy prevention.
3. Build partnerships with organizations who share the goal of reducing teen pregnancy and improving youth outcomes in communities.
4. Ensure sexual and reproductive health services are teen-friendly, culturally competent and readily available.
5. Share information on the importance of preventing teen pregnancy through social media.

Identifying Local Success Stories

A critical part of the data gathering and assessment process was identifying local examples, in South Carolina communities, where things are going well. In doing so, lessons learned emerged that informed the writing of this prospectus. Two case studies were completed by two external consultants (Dr. Charlotte Galloway and Dr. Lauren Workman respectively), which ultimately were summarized for this report on the following two pages and also independently submitted for publication in peer reviewed journals.

1. A description of a successful teen clinic: The Point at Tobias, located in Spartanburg, SC.
2. The successful adoption and implementation of an EBP in a large school district: Beaufort County School District located in Beaufort, SC.

[16] http://www.acf.hhs.gov/blog/2014/05/hhs-leaders-charge-communities-to-continue-critical-efforts-to-prevent-teen-pregnancy

Case Study: The Point at Tobias

This case study was conducted to explore the administrative and clinical practices related to high utilization rates of long-acting reversible contraception (LARC) by teens who received services at SC DHEC's The Point Teen Health Center at Tobias (Tobias) in Spartanburg, SC. The current LARC utilization rate at Tobias is 40%, compared to the 7% average utilization rate found at other DHEC sites across the state, and compared to 4.5% nationally. To better understand the success at Tobias, 12 in-depth interviews were completed in spring 2014 with SC DHEC Central Office Family Planning management, regional leadership, and the administrative and clinical staff at Tobias. Interviews were audio-recorded, transcribed verbatim and thematically coded.

What we learned. Several key themes associated with high LARC utilization rates were identified, including:

BOLD LEADERSHIP by the Regional Health Director to improve customer service for teen clients in order for teens to have a positive experience during their visit, which made them more likely to tell friends and family about the clinic;

EFFECTIVE OUTREACH strategies to potential clients that were currently not using Tobias' services;

MOTIVATED CLINIC STAFF who recommended and made available the best contraceptive options to their teen clients, which in many cases, was a LARC method;

PROACTIVELY COUNSELING teen clients about potential side effects of the selected method and stressing the importance of a call or return to the clinic if they experienced problems;

FUNDING ensured an Advanced Practice Registered Nurse (APRN) was scheduled and available during clinic hours and allowed for LARC methods to be continuously stocked. This combination allowed for same-day insertion of LARC;

RENOVATIONS to the clinic improved its appearance making it more teen-friendly, expanded the number of exam rooms to allow for more appointments and walk-ins, and created more privacy for clients.

Case Study: Beaufort County School District

Across South Carolina's 81 school districts there is great variability in size (i.e. number of schools, number of students). Historically, smaller districts in the state have been more successful taking evidence-based teen pregnancy prevention programs (EBP) to scale. Working with larger school districts that have high numbers of middle and high schools, and therefore multiple layers of administration and decision making, has been more challenging. All the more reason to highlight a successful large school district currently involved in the SC Campaign's *It's Your Game, Keep It Real* project. The Beaufort County School District has emerged as a true success story, with six middle schools involved in the project – initially with three intervention and three control sites, now with all six schools implementing the program – all participating with high levels of fidelity. To understand the factors associated with this success, 17 in-depth interviews were conducted in spring 2014 with school district staff, administration, comprehensive health education advisory committee members, community stakeholders, and SC Campaign staff involved with the project.

What we learned. Six components characterizing the project were associated with the successful adoption of a multi-session EBP in schools:

- Existing partnerships between Beaufort schools and community-based teen pregnancy prevention advocates;
- A commitment by Beaufort County School District to provide a consistent message about teen pregnancy prevention across all schools;
- A district-wide, comprehensive approval process sought buy-in from multiple stakeholders;
- Increased community awareness of teen pregnancy and the SC Comprehensive Health Education Act through newspaper articles;
- An active Comprehensive Health Education Committee (responsible for curriculum review) that contained the right people;
- Ongoing support, guidance, and training from a third party expert (in this case, the SC Campaign).

Conclusion

This chapter summarizes an incredible amount of time and effort and most likely presents the most comprehensive set of data and information on the topic of preventing teen pregnancy in South Carolina that is available to date. What began as an exploration of the current landscape of teen pregnancy prevention in South Carolina uncovered trends, themes and input that will undoubtedly create a path forward. Interestingly enough, some trends emerged; to the input of the leadership team, to regional discussion groups, to case studies and interviews with experts, the same priorities/strategies for reducing teen pregnancy and teen births keep appearing. Strategies and approaches like access to low-cost, highly effective contraception, delivery of EBPs with fidelity, and engaging parents appeared frequently no matter the data collection source or mechanism.

But, we already knew that. So, does this mean this prospectus is putting forward the same old approaches? Not quite. Since these strategies have been achieving results, it would be easy to stay the course, but in truth we know that in order to achieve accelerated declines in the state's teen pregnancy and birth rate will require a more thoughtful and nuanced approach. The basic tenants remain important, but the conversation we aim to start in the following chapters will change the way efforts are funded, implemented and evaluated moving forward.

At a minimum, taking interventions that have proven to be successful to scale across the state should be challenging to us all, but as you will discover throughout Chapters 3 and 4, we propose to raise the bar even further. We propose a challenge to everyone in the arena of teen pregnancy prevention: it is time to move out of our comfort zone, to take what works and implement it in the communities that need us most, to build partnerships, and tackle unintended teen pregnancies with a complete package of proven strategies bundled together and supported by sufficient funding. In doing so, not only will our state continue to see extraordinary decreases in the teen pregnancy and birth rates, but will also begin to achieve secondary, yet equally important and related results of increased graduation rates, a viable workforce of young people, fewer single parent households, and fewer children being raised and growing up in poverty.

Gaffney
Greer
Spartanburg
Rock Hill
Greenville
Union
Chester
Lancaster
Broad
Catawba River
Laurens
Clinton
Saluda R
Newberry
Camden
Hartsville
Greenwood
Lake Murray
River
St Andrews
Columbia
Sumter
J Strom Thurmond Lake
Lake Marion
Aiken
Orangeburg
Savannah
Bamberg
Edisto
Summerville
Allendale
Walterboro
Charleston
Beaufort
St Helena Sou
Hilton Head Island
26
385
77
20
95

SOUTH CAROLINA CAMPAIGN to PREVENT TEEN PREGNANCY

CHAPTER SUMMARY

This chapter explores which areas of South Carolina should be considered to have the "greatest need." Simply taking into account where the highest number of teen births occur or which counties have the highest birth rates does not adequately answer the question. For example, the 10 counties with the highest teen birth rates only account for 11% of all teen births in South Carolina. While one can make the case for "high need" within this group of counties, the direct return on such an investment intended to reduce the overall, state teen birth rate is not high.

Taking into consideration a combination of high teen birth rates; high numbers of teen births; and associated risk factors like poverty, infant mortality, and school dropout rates; the SC Campaign created a new cohort of priority counties that fall into two distinct categories, **"high volume"** and **"high burden."** Trying to delineate the differences in the return on investment in a high volume versus high burden situation is complicated, but necessary. And, in any case, taking a measured approach to targeting investments in this issue will have a greater return than failing to do so.

Other decision points for funders include the ability to take a proven strategy/intervention to scale statewide, or if this is not an option, then strategically selecting a subset of counties to target.

Chapter 3: Identifying Greatest Need

Mr. Cave is right! But identifying "the worst" – that is the areas in South Carolina with the greatest need – is a bit more complex than it may seem. It is well documented that teen pregnancy and birth rates remain too high in certain areas of South Carolina. Funders and decision makers commonly inquire as to where the problem is the worst. On the surface an easy question, but in reality a bit tricky to answer. Consider for example, if the question is ***"where do the highest number of teen births occur?"*** The answer would include population-heavy and often resource-rich counties, such as Greenville, Richland, Spartanburg, Charleston, York, and Horry. Instead, if the question is ***"where are the highest rates of teen birth?,"*** the size of the population must now be considered (in the calculation of a rate) and the answer shifts to counties with smaller populations that are often resource-poor, such as Dillon, Chester, Marlboro, Cherokee, and Allendale.

Areas of Greatest Need

The answer to the "which is worst" question otherwise known as "where is the greatest need" heretofore has differed based on one's lens and preference. For example, Allendale County has one of the highest teen birth rates in the state (76.9 births per 1,000 teens 15-19) yet there were only 18 teen births in the county in 2013.

"My feeling is... if South Carolina is going to change, we have to change the worst."[17]

– Wilbur Cave
Executive Director, Allendale Alive

Conversely, Richland County has one of the lowest teen birth rates in the state (19.5 per 1,000) yet there were 310 live births in the county in 2013. Which county has the greatest need?

Before venturing too far into the question of ***"what?"*** strategies and interventions should be invested in, there is great benefit in discussing briefly the equally important, and perhaps even more complex question of ***"where?"*** such strategies should take place. That is the geographical location – the zip codes, communities, counties and regions of greatest interest. In order to define the areas of greatest interest, one must have a better understanding of how need is defined. While true that all counties – and most communities – within the state have at least some level of need, and depending on the unit of measure most counties would qualify as high need and/or high risk, determining where to target efforts is a critically important issue that must be addressed to see further progress.

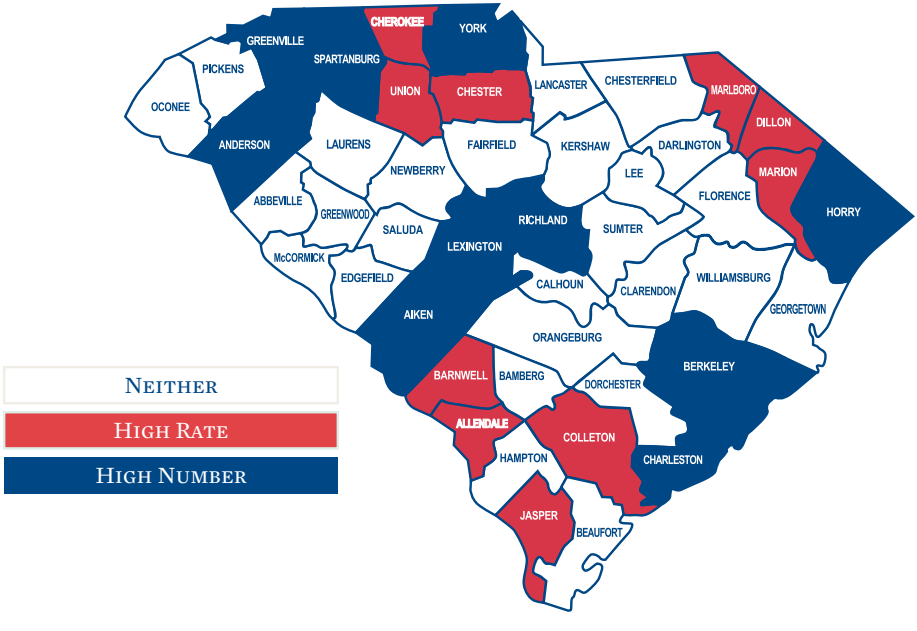
[17]As quoted in The Soul of the South by Paul Theroux. *Smithsonian Magazine*, July 2014.

Table 4 presents a quick visual of the number versus rate comparison as it presents in South Carolina. On the left are the 10 counties with the highest number of teen births in 2013. **These 10 counties account for a staggering 54% of all teen births in South Carolina.** Alternatively, on the right side of the chart are the 10 counties with the highest teen birth rates in the same year, which in turn represent a very small percentage of the teen births in the state (11%). None of the 46 counties in the state appear on both charts. Of particular note are clusters of high rate counties that appear in the Upstate, Pee Dee and Low Country (see page 26 for regional descriptions). Not surprisingly, high number counties track consistently with population centers.

Table 4. 2013 Birth Data: High Number Counties vs. High Rate Counties

HIGH NUMBER			HIGH RATE		
COUNTY	NUMBER	RATE/1000	COUNTY	NUMBER	RATE/1000
Greenville	411	27.0	Allendale	18	76.9
Spartanburg	319	32.9	Jasper	45	63.2
Richland	310	19.5	Dillon	64	62.6
Horry	282	36.9	Marlboro	44	57.8
Lexington	251	30.6	Union	45	57.0
Anderson	249	41.5	Chester	52	56.1
Charleston	218	20.8	Colleton	64	56.0
York	215	26	Marion	52	55.3
Aiken	158	32.1	Barnwell	35	50.8
Berkeley	156	27.5	Cherokee	91	50.2
TOTAL	**2,569**		**TOTAL**	**510**	
% of Total Births	**54%**		**% of Total Births**	**11%**	

Figure 8. 2013 Teen Birth Data: High Number vs. High Rate

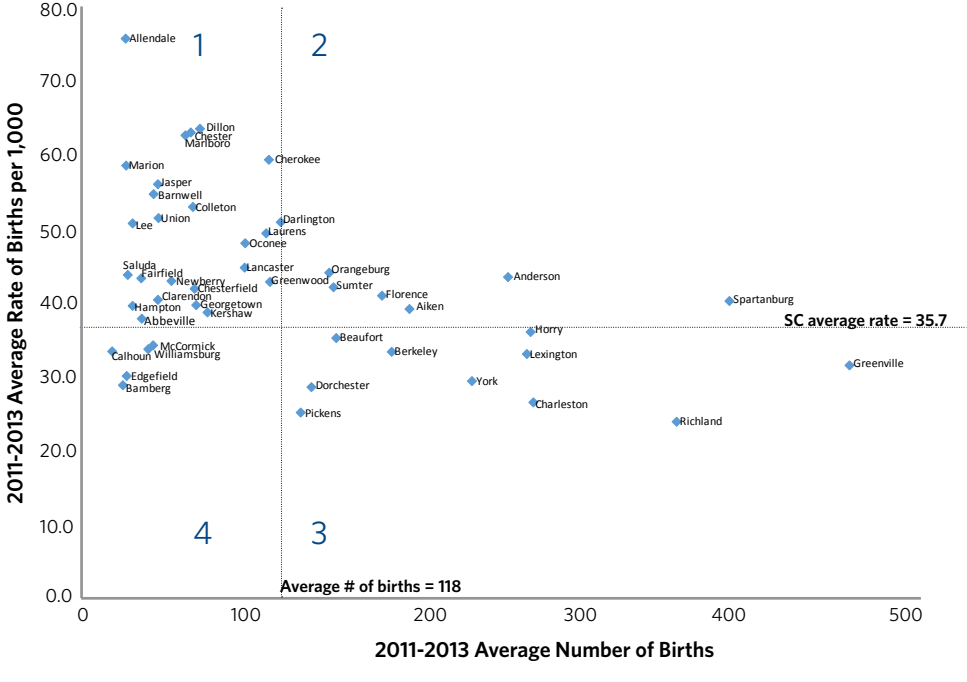


Knowing this information, if you were designing a program to target 10 counties, would you rather invest in those with the highest number or those with the highest rate? Fair to say there is no wrong answer to this question, but it is also important to note that more information is needed to make an informed choice.

VOLUME CALCULATION

Any meaningful definition of need in this context must move beyond a simple comparison of numbers and rates. A more comprehensive comparison should account for numbers and rates, and therefore include some combination of a county's absolute number of births as a function of its birth rate. This intersection of number versus rate is shown more clearly in **Figure 9** with counties who have both high numbers of births and a high rate compared to state averages being referred to moving forward as "high volume." In the visual, each of South Carolina's 46 counties are plotted on a single graph with the y-axis representing a county's *rate* of teen birth and the x-axis representing the *number* of teen births. Dotted lines form the intersection of the state's rate of teen births and the average or expected number of births per county, thus forming four quadrants in the figure. Counties appearing in "quadrant 2" (top right) can be said to have both high numbers and high rates - by this measure, quadrant 2 would be considered a high volume quadrant. Many of the high rate (low number) counties from **Table 4** are found in quadrant 1, and many of the high number (low rate) counties are found in quadrant 3.

Figure 9. SC 15-19 Year Old 2011-2013 Average Birth Rates & Average Incidence by County



NOTE: Teen birth data can fluctuate greatly from one year to the next – especially teen birth rates in smaller counties with small populations. In order to control for this fluctuation, Figure 9 (volume calculation) used three-year averages for the state and counties' birth rate and number of births, 2011-2013.

Counties that appear in quadrant 2 - Aiken, Anderson, Darlington, Florence, Orangeburg, Spartanburg, and Sumter - all exhibit both higher than average rates of teen births and higher numbers than other counties and therefore can be said to have a HIGH VOLUME. This combination makes each of these counties a prime intervention location for those interested in addressing this issue from a volume perspective. That said, this volume calculation is not intended to be an absolute, just a guide, so counties with exceptionally high numbers (i.e. Richland, Greenville); exceptionally high rates (i.e. Allendale); or that are very close to grid lines (Cherokee, Horry) should not be ignored.

BURDEN

With a volume measurement in place, it is also necessary to attempt to understand the ***burden*** placed on a county when a teen birth occurs. Recognizing that teen pregnancy impacts a community and its residents in different ways, multiple indicators should be considered to determine this measure. Based on a county's overall health and stability, some have more capacity and ability to "absorb" a teen birth while others have very little infrastructure in place to do so. Some other factors that may impact a county and its residents' burden level include poverty levels, school dropout rates, and overall community health. By including indicators like poverty and dropout in the discussion, we can begin to explore the overall ***burden*** that teen births may place on the county in a more comprehensive way. In order to tease out this concept, a simple "burden level" index was created. A county's ***"burden level"***

Table 5. Burden Level by County

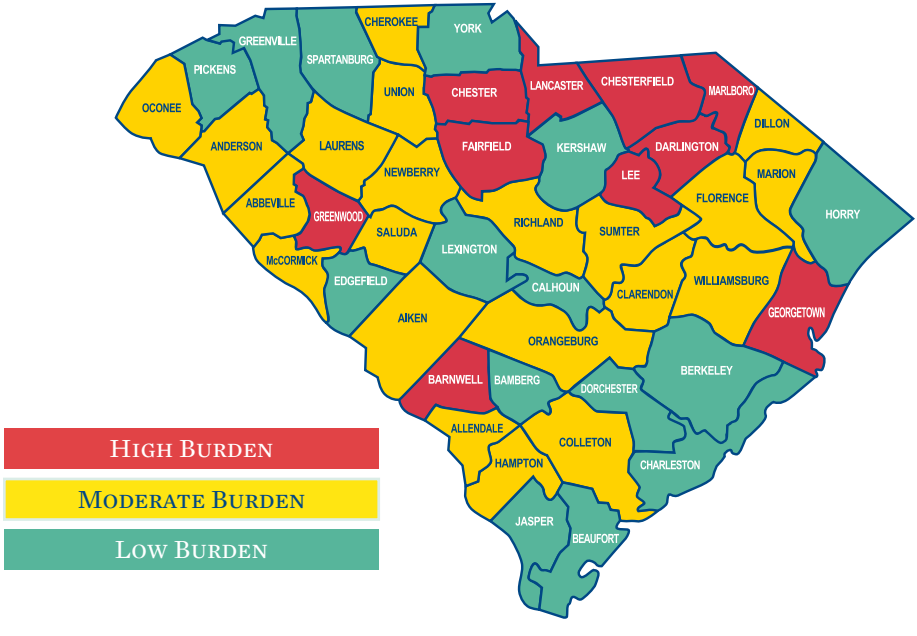
High Burden Level	Moderate Burden	Low Burden
Scoring 6-7	Scoring 4-5	Scoring <4
Barnwell	***Abbeville***	***Bamberg***
Chester	Aiken	***Beaufort***
Chesterfield	***Allendale***	Berkley
Darlington	Anderson	Calhoun
Fairfield	***Cherokee***	Charleston
Georgetown	***Clarendon***	Dorchester
Greenwood	***Colleton***	Edgefield
Lancaster	***Dillon***	Greenville
Lee	Florence	Horry
Marlboro	***Hampton***	***Jasper***
	Laurens	Kershaw
	Marion	Lexington
	McCormick	Pickens
	Newberry	Spartanburg
	Oconee	York
	Orangeburg	
	Richland	
	Saluda	
	Sumter	
	Union	
	Williamsburg	

BOLD Italics indicates a rural county[18]

was determined by comparing the county's rate of teen births, percentage of teen births that were repeat, number of children living in poverty, high school dropout rates, and rates of infant mortality with state averages. Similar to the calculation of volume, where possible, three-year averages were used for each measure to account for year-to-year fluctuations. Averages were used for each variable with the exception of the percentage of teen births that were repeat, which is a measure that has proven to remain relatively constant over time.

To calculate ***burden level*** for each county, a county received a score of one (+1) if they had rates higher than state rates for poverty, dropout, and infant mortality measured by KIDS Count indicators[13]; counties received a score of two (+2) if they had teen birth rates higher than the state rate, and (+2) if their percentage of repeat teen births exceeded the state average. The latter two outcomes were given more weight since they are the outcome of interest. After scoring, counties were grouped into high, moderate, and low levels of burden based on their composite risk score with the highest possible score being seven (7). High burden counties scored six-seven (6-7), moderate four – five (4-5), and low less than four (4). **Table 5** and **Figure 10** visually depict the distribution of counties across burden level. Barnwell, Chester, Chesterfield, Darlington,

Figure 10. Burden Levels

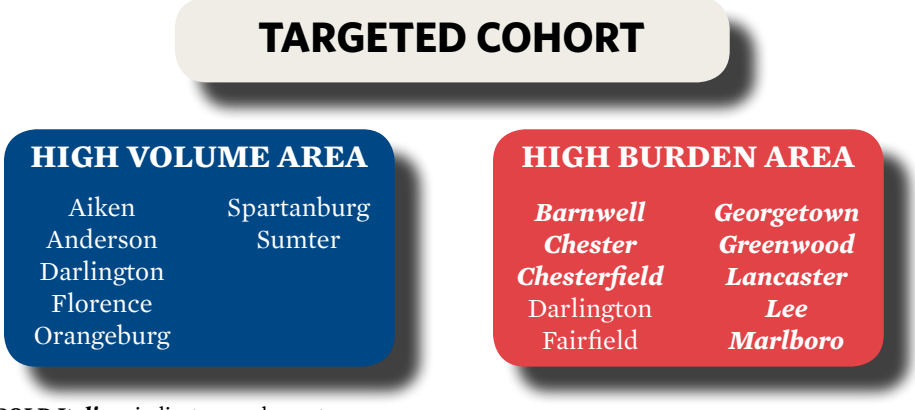


[18]Definition of Rural: There is not a universal definition for the term "rural." The South Carolina Office of Rural Health uses Non-Metropolitan Statistical Area (Non-MSA) and Urban Influence Codes to determine the rurality of South Carolina counties. According to the South Carolina Office of Rural Health, "a metropolitan statistical area is defined as an area of at least 50,000 people." http://www.ruralcenter.org/sites/default/files/webform/Compiled%20SC%20Rural%20Health%20Plan%20082508version.pdf

Fairfield, Georgetown, Greenwood, Lancaster, Lee, and Marlboro all emerge as HIGH BURDEN counties based on this measure. By no means is this index perfect, but it does provide a more detailed look at counties that may be deemed "in need" or "at risk" than a simple calculation of birth rate would. As mentioned earlier in the discussion of volume, by no means is this presentation meant to suggest counties with moderate or low burden levels should be ignored completely, but it is informative to know how a county compares to others in the state.

Funders and others interested in implementing teen pregnancy prevention programs where they will have the greatest impact are presented a clear decision – invest where the volume is highest or invest where the predicted burden is greatest. Within each decision there are, of course, pros and cons to be explored and understood. **Figure 11** displays each option in an easy to read visual. As a reminder, the volume and burden counties presented are based on data averages for 2011-2013. Over time, it may be necessary to recalculate a county's position as new data become available.

Figure 11. Targeting Volume vs. Burden



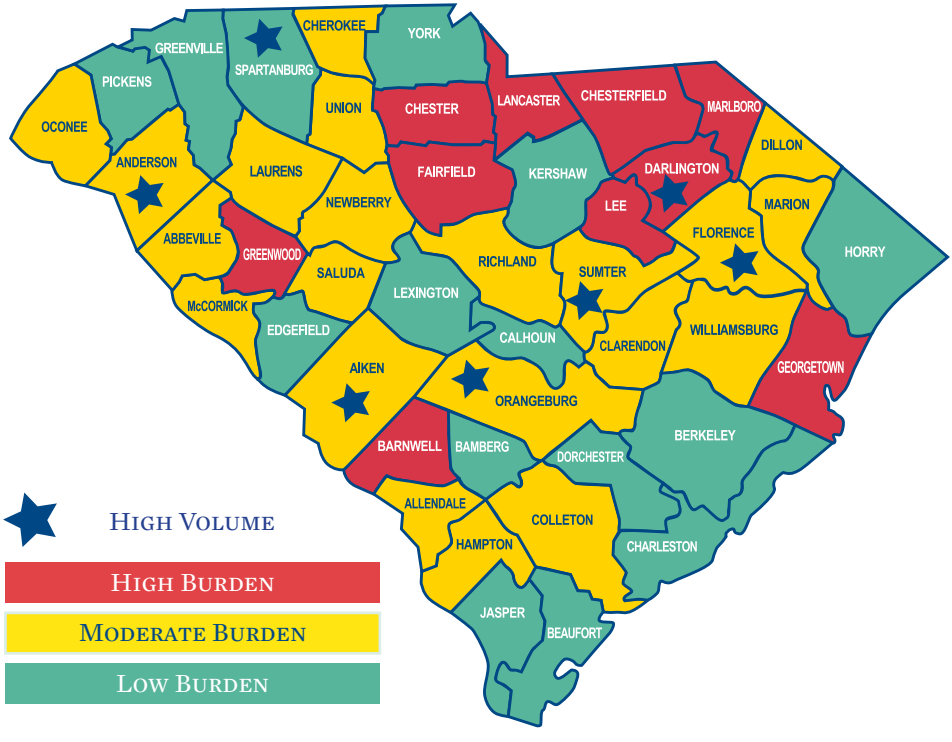
BOLD Italics - indicates rural county

The purpose of this discussion is not to present the selection of volume or burden as either right or wrong, rather to be sure that those investing in prevention efforts understand there is a difference – and more importantly that there is benefit to choosing one or the other. Much of the narrative nationally has been about the differences in teen pregnancy and birth rates in urban versus rural settings.[19] In reality, here in South Carolina, a state that on the whole is quite rural by definition, the conversation is much more complex. Urban/rural distinctions are important, but what emerges here as a more critical and nuanced discussion is one that considers a variety of factors,

[19] *Science Says #47: Teen Childbearing in Rural America* (January 2013). The National Campaign to Prevent Teen and Unplanned Pregnancy. http://thenationalcampaign.org/sites/default/files/resource-primary-download/ss47_teenchildbearinginruralamerica.pdf

which collectively determine the burden that is placed on a county when teen birth occurs. Ultimately, trying to delineate the differences in the return on investment in a high volume versus high burden situation is complicated. What is more important is to remember that in either case (volume or burden), targeting efforts will produce a significantly greater return than the "scattershot approach" of locating and positioning interventions. It is also informative to see where each of the *high volume* counties falls in terms of *burden level*. This overlay is presented in **Figure 12**.

Figure 12. Burden Levels of High Volume Counties



Of particular interest, in high volume situations, it is quite likely that a larger number of youth will be reached with chosen interventions. Choosing to work in high volume counties requires sufficient funding to take programs to scale, ensuring sufficient reach. It is also common – although not universally true – that one will find better access to other resources, partners and infrastructure in high volume areas, perhaps making an increased reach more feasible. On the other hand, in high burden areas youth are, on the whole, likely at greater risk and/or have greater needs, and by definition the burden of a teen birth is higher on the individual and the community, so an intervention's impact may actually be more profound. However, the potential to reach high numbers of youth in high burden counties is virtually nonexistent, and these counties are often

saddled with other risk factors, such as poverty, unemployment, lack of resources and infrastructure that may adversely impact a program's ability to be implemented fully and successfully. Implementing interventions in high burden counties almost assuredly require more time and resources dedicated to building capacity and infrastructure.

Implications for Future Funding

Readers should note that the rationale and descriptions of volume versus burden described can also be translated to individual communities, systems, school districts, and even populations of young people. While not exactly synonymous, the overall theory holds.

For example, African-American youth have higher rates of teen birth than their White peers, but in many counties the number of births to White youth is significantly higher. Similarly, research tells us that youth in the foster care and juvenile justice systems have much higher rates of teen births than their peers, yet the burden of system-level change is expensive, time consuming, and ultimately reaches youth in small numbers. Older youth and those youth who are already parents are two additional groups with higher rates of teen births than the general population, but in both cases are significantly harder to reach in large numbers. Reaching youth 17 and younger *en masse* is more commonplace; yet the "burden" or rate of teen pregnancy and teen births among this group is much lower. Therefore, the direct and immediate return on investment may be less.

Of course, the entirety of this chapter assumes that funding streams and the resulting interventions will actually be targeted towards an identified group of counties, communities, or individuals. The conversation to this point also assumes that every county and every community is equally "ready" to receive an intervention. Neither of these things are universally true.

Consider the funding proposal that suggests serving 10 communities with "x" intervention or 10 school districts with an evidence-based program. As noted previously, such a proposal without further commentary about how locations will be selected, can produce great variability in terms of numbers served and ultimate impact. A return on investment will vary considerably depending on where the interventions are ultimately located. Yet, by default, funding streams often end up supporting those counties and/or communities that are most ready or able to implement an intervention rather than those with the highest volume or the highest burden. Often priority is given to those communities and organizations who can start implementation right away (i.e. have high levels of readiness) in order to see immediate results.

This is not to dismiss the concept of readiness. Much has been written about readiness - at both the organizational[20] and community[21]

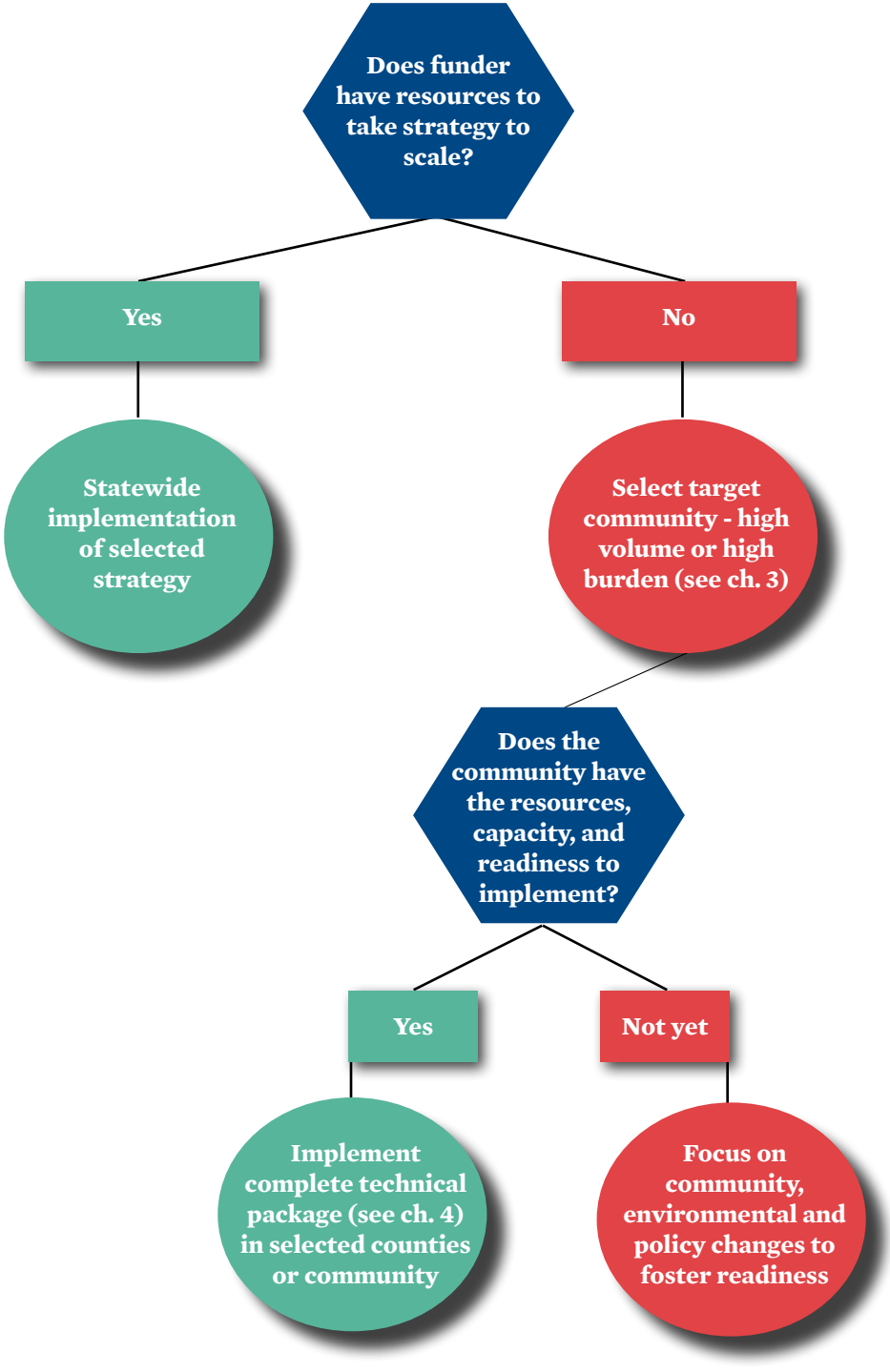
[20]ASPE Issue Brief on readiness. *Willing, Able, and Ready: Basics and Policy Implications of Readiness as a Key component for Implementation of Evidence-based Interventions*. September 2014. Washington, DC.
[21]Community Tool Box http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/community-readiness/main

level – and the importance of ensuring a community is ready and willing to receive an intervention. Providing the resources necessary – both time and money – to build capacity, readiness, and motivation in a community or within an organization is a necessary precursor to successful implementation, especially when funding decisions are being made in consideration of volume and/or burden and not influenced solely by the need to begin programming immediately. Undoubtedly, some counties who are considered high volume or high burden are simply not "ready" to address this issue and funders should proceed with caution in these instances. Readiness is particularly important related to the topic of teen pregnancy prevention as a community's readiness is often issue-specific (i.e. a community may be ready to address overall health, but not ready to talk about sex), and also can vary across segments of the community (i.e. in the same community, a clinic may be willing to improve delivery of LARC, but a school is not willing to implement an evidence-based program).

Funders and philanthropists must understand all of these factors to make the most impactful funding decisions. The first decision point is to identify whether resources are available to take an intervention or program to full scale that results in universal implementation across the state. While this may be the preference, resources – both time and money – often prevent such an approach from being the reality. It is unlikely, for example, that a single funder would be able to provide the resources necessary to implement an evidence-based program in every high school in South Carolina. What remains is the decision to work solely with those who are most ready without consideration of any other factors (not recommended), or spending the time and purposefully targeting a specific cohort or group of counties. As discussed, the former is much more expeditious and may represent the path of least resistance, however, the content of this chapter would suggest that if we are truly interested in accelerating the rate of progress made already in reducing the teen birth rate in our state, it is time to take another look at how efforts are targeted.

The path forward cannot continue to exclude counties where the greatest volume and/or burden exist – whether intentional or not – as it limits our ability to have the desired, statewide impacts and outcomes. Funders must realize that in order to move past working solely with those who are currently ready and motivated, a certain level of patience and willingness to invest in community organizing to build capacity and infrastructure may be needed. Taking an integrated approach, which considers both the importance of a community's readiness AND the level of impact that can be expected based on its volume and burden of teen births, would seem to be the most logical and thoughtful approach moving forward. **Figure 13** presents a more complete decision-making matrix that may prove helpful moving forward for those interested in funding and investing in teen pregnancy prevention efforts.

Figure 13. Investment Decision Tree



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Spartanburg
Rock Hill
Greenville
Union
Chester
Lancaster
Broad
Catawba River
Laurens
Clinton
Saluda R
Newberry
Camden
Hartsville
Greenwood
Lake Murray
River
St Andrews
Columbia
Sumter
J Strom Thurmond Lake
Lake Marion
Aiken
Orangeburg
Savannah
Bamberg
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Walterboro
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SOUTH CAROLINA CAMPAIGN to PREVENT TEEN PREGNANCY

CHAPTER SUMMARY

Successful public health campaigns all have a number of common components. Notably, success requires the implementation of a select group of high priority, evidence-based interventions that, implemented together, will achieve and sustain substantial improvements in a specific risk factor or outcome - this set of interventions is defined as a "technical package."

The technical package for teen pregnancy prevention being suggested in this chapter consists of four overarching strategies: 1) widespread implementation of evidence-based teen pregnancy prevention programs in schools, communities and clinics; 2) expanded availability of quality, teen friendly family planning services for sexually active young people, including the delivery of long-acting reversible contraception (LARC); 3) increased messaging and education centered on a dual-method approach including increasing condom use; and 4) increasing parent-child communication about sex.

Other popular strategies like youth development and mentoring programs, engaging the faith community, and broad community-wide media campaigns aimed at changing social norms may also be incorporated into comprehensive teen pregnancy prevention efforts to complement, but should not take the place of, those recommended in the technical package.

Chapter 4: Recommending a Direction for the Future

"In the financial sector, it is assumed that investors should conduct painstaking due diligence, research and engage in recurrent monitoring and measurement to ensure that their investments achieve desired results… the idea is that first they should contemplate and hypothesize, then research, then assess the knowable risks against the reward potential, then invest, and then pay very close attention all along the way…"[22]

This quote from the "Guide to Social Investing" sums up our thought process when this project was in the conceptual phase. The hypothesis was that if we, in the field of teen pregnancy prevention, could move forward with the same 'painstaking due diligence,' with the same interest in research, and the same interest in measurement as the financial (and other) sectors, we could indeed put forward a plan that would accelerate progress reducing teen birth rates and build on the progress of the last two decades.

Some of the greatest successes in public health have been the result of widespread, specific, highly effective campaigns (i.e. small pox and polio eradication, smoking cessation to name a few).[3] They target individual and community behavior, policy, and environmental systems using a variety of proven technologies in education, media and social media. They apply up-to-the-minute, research-proven innovations to achieve big impacts. They don't tolerate approaches that fail to produce expected outcomes simply because they are "comfortable" and "what we're used to doing." And, they don't throw a variety of programs at a community and hope "something sticks."

As referenced earlier, successful public health campaigns all have a common component that is referred to as a "technical package" defined as *a selected group of high priority, evidence-based interventions that, implemented **together**, will achieve and sustain substantial improvements in a specific risk factor or outcome.*[3] This is not a shopping cart where

[22]Hunter, D.E.K., Butz, S. *Guide to Effective Social Investing.* http://www.alleffective.org/uploads/Guide_to_Effective_Social_Investing.pdf

funders, investors, or communities pick from among a list of priorities which strategies they are interested in funding. Quite the opposite. By definition, technical packages include putting into play for a selected county or community, all proposed strategies, not just one or two. An acceptable exception to this approach may involve a funder selecting a single intervention from the technical package and taking that intervention to full scale, statewide. Resources and/or environments may be such that full scale implementation of a single intervention, nor full intervention of the technical package in a single location are possible. In these cases there should be a detailed plan showing how policy and environmental changes will be made to make such implementation possible over time.

Technical packages also distinguish themselves from other approaches in that they take to scale only research-proven strategies. The technical package approach would not have been a viable choice for teen pregnancy prevention interventions until just a few years ago as the field lacked a strong inventory of research-proven strategies that could scale up and achieve significant impact within a population. But these interventions now exist, and building on federal investments made since 2010, it is time to introduce a technical package to regional, state and local funders interested in reducing too-high rates of teen pregnancy.

TAKE NOTE...

Readers of this Chapter will recognize that there are numerous moving parts, and suggestions are being offered simultaneously to accelerate progress reducing teen births in our state. So as not to be overwhelmed with all of the information included, it is our belief that after processing the information within, decision makers, funders and investors should make a decision to proceed down one of the following paths:

1. Select the intervention(s) from the technical package that are of greatest interest and **commit resources to taking the intervention(s) to full scale - that is, statewide;**

2. If resources are not available to do #1, funders should focus on a selected number of counties/communities, preferably identified through some process similar to what is presented in Chapter 3, and **implement with fidelity the entirety of the technical package presented in this chapter;**

3. **When neither of the above are possible**, a funder may also choose to focus on community, policy and environmental changes that can have local and statewide impact, and result in conditions that make implementing this technical package easier and more feasible in the future.

The Technical Package for Preventing Teen Pregnancy

What emerged from this project - through the multiple data collection and information gathering methods presented in Chapter 2 - are four research-proven interventions that, collectively, will have a significant and measurable impact in reducing teen birth rates in selected communities. The interventions included in this technical package target three behaviors strongly associated with unintended pregnancy in teens: abstinence, contraceptive use and condom use if sexually active.

The technical package for teen pregnancy prevention being suggested here consists of four overarching goals: 1) implementing evidence-based sexual and reproductive health programs in schools, communities and clinics; 2) providing reliable contraception, including long-acting reversible contraception, to teens in clinics and to teen moms post partum in hospitals; 3) increasing condom access points and male involvement; and 4) increasing parent-child communication about sex. Pages 48-49 provide a quick, visual summary of these four strategies, followed by more in-depth discussion of each strategy individually. Other interventions continue to show promise and importance, but without the depth of evaluation data, cannot be included as part of a technical package and therefore should be thought of as complimentary strategies for now. As mentioned in Chapter 1, how these strategies will be accomplished is outside the scope of this document, and in reality, will be county-specific.

What does not explicitly emerge in this range of interventions is the absolute necessity of focusing on "special" populations such as foster care, Department of Juvenile Justice and most importantly 18-19 year old teens - the group that accounts for 70% of the teen births in the state! But, of course, providing effective sexual and reproductive health services to older teens and other high risk groups continues to be a top priority. At the same time, we must recognize the importance of members of the leadership team, decision makers and the funding community continuing to work collaboratively to determine how policy can expedite and reinforce proposed activities from the state and policy level. These will be reviewed and shared at the end of this chapter.

STRATEGIES

1

Achieve widespread implementation with fidelity of evidence-based teen pregnancy prevention programs in schools, community-based organizations, clinics and via online mechanisms. Implementation should be supported by appropriate policy change and be accompanied by thorough education/training programs, monitoring, personalized technical assistance and continuous quality improvement strategies.

2

Expand the availability of quality, teen friendly family planning services for adolescents that includes prescription of long-acting reversible contraception (LARC) and other highly reliable family planning methods. Expansion should include comprehensive training, education, monitoring, technical assistance and continuous quality improvement.

3

Within a high-level, coordinated messaging and education strategy, interventions should seek to both increase public awareness of dual method protection and increase the number of young men seeking reproductive health services. **As part of this effort, increase the number and utilization of teen friendly condom access points in communities.**

4

Improve educational and informational offerings for parents to increase parent-child communication about love, sex and relationships; and, ultimately increase the quality and quantity of interactions between young people and their parents.

INDICATORS

1. Number of youth who participate in an evidence-based program by age, gender and race.
2. Percent of youth who complete at least 75% of evidence-based program.
3. Percent of activities within the evidence-based program implemented with fidelity.

1. Number of females ages 12-19 enrolled in Medicaid who received a reproductive health service.
2. Number of females ages 12-19 who received a contraceptive method as part of a reproductive health service.
3. Percent of females ages 12-19 who received a LARC as their contraceptive method.
4. Percent of females ages 12-19 who report still using their LARC method at one-year follow up.

1. Number of condom distribution points in community.
2. Number of condoms distributed.
3. Percentage of sexually active adolescent males who report using a condom during last sexual intercourse.
4. Number of adolescent males who received a reproductive health service.

1. Number of programs addressing parent-child communication offered in a community (both in person and virtually).
2. Number of parents reached through educational and informational programs.

Strategy 1

Achieve widespread implementation with fidelity of evidence-based teen pregnancy prevention programs in schools, community-based organizations, clinics and via online mechanisms. Implementation should be supported by appropriate policy change and be accompanied by thorough education/training programs, monitoring, personalized technical assistance and continuous quality improvement strategies.

Research has shown evidence-based programs and curricula (EBPs) that stress abstinence-first and are age-appropriate, medically accurate, and based on behavior change theory can be effective in increasing knowledge and building skills necessary to reduce behaviors associated with high risk of unintended pregnancy such as early initiation of sex and engaging in unprotected sex. EBPs expose young people to information about puberty, anatomy, and, for older teens, information about contraception as well as help young people build their skills to negotiate with a partner, refuse sex, establish boundaries in a relationship, and use contraception consistently and correctly.

Some of the most comprehensive and informative reviews on "what works" specific to EBPs and the prevention of teen pregnancy have been authored by Dr. Douglas Kirby. Most recently in 2007, Dr. Kirby published *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*[23] in which he summarized a growing knowledge base about program effectiveness. This informed a substantial federal investment in EBP replication beginning in 2010. In that year, the Office of Adolescent Health (OAH) allocated $75 million to support a five-year nationwide replication project to increase the saturation of programs that work and to continue testing and learning about their implementation in "real world" settings. As part of this effort, OAH conducted "an independent, systematic review of the teen pregnancy prevention literature to identify programs with evidence of effectiveness..." and (as of August 2014) identified 35 programs as evidence-based, suitable for replication.[24] The entire, searchable OAH evidence-based programs database can be accessed via http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/tpp-searchable.html.

[23]Kirby, D. (2007). Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy
[24]Office of Adolescent Health website http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/index.html

Why are these programs needed?
The 2013 Youth Risk Behavior Survey[7] showed that 61% of South Carolina's high school students have engaged in sexual intercourse before graduating. Thirty-two percent (32%) of high school students reported having sex in the last three months and of these students, only 59% used a condom. Among sexually active females in high school, just over one-third (36%) report using some form of birth control. Unfortunately, 14% of students used no method of birth control at last intercourse.

South Carolina's Comprehensive Health Education Act (CHEA) mandates that, by law, schools provide a minimum of 750 minutes of sexual health instruction that includes discussions on abstinence as well as condoms and contraception. While 80% of high school students report having received a lesson on the benefits of not having sex to reduce the risk of an unintended pregnancy or infection such as HIV, only 56% of 9th graders and 65% of 12th graders report ever receiving instruction on birth control. As discussed in Chapter 1, the CHEA has played a role in helping to reduce the teen birth rate in South Carolina over the last two decades; however, a 2012 report showed a majority of school districts in SC aren't following the state-mandated guidelines for sexual health education.[25] The mandate is unfunded and generally speaking lacks oversight, direction, and resources for implementation. There is no reason that less than 100% of the state's young people receive information on pregnancy/disease prevention. And, therefore greater saturation of sexuality education is needed in our schools which, in turn, is supplemented and reinforced by alternative delivery sites such as community and clinic-based programs, and even Internet-delivered EBP.

School-based EBPs

Despite the current level of uptake in South Carolina, schools have been shown to be an appropriate setting for implementing EBPs and other sexuality education programs and are, by far, the most efficient way to reach large numbers of youth. Nearly one-third of the programs in the OAH evidence-based programs database have been evaluated in an in-school setting. Further, despite what is perceived as controversy, the vast majority of South Carolinians support school-based sex education, which includes information on both abstinence and contraception.[26]

There are bright spots around the state demonstrating that success is possible. A case study was presented earlier in this chapter that is part of a larger five-year federally funded project to replicate an EBP (*It's Your Game, Keep It Real*), as part of a randomized control trial, in 24 middle schools across the state. Lessons learned from this research will help provide insight on how to take EBP in schools to scale. One thing is abundantly clear already – intensive planning, training and follow up technical assistance is necessary to help guide schools through the implementation process. Especially in situations where a district or

[25]New Morning Foundation http://www.tellthemsc.org/new/docs/TellThem_CHEA-report.pdf"www.tellthemsc.org/new/docs/TellThem_CHEA-report.pdf
[26]See http://teenpregnancysc.org/UserFiles/teenpregsc/Documents/Its%20OK%20to%20talk%20about%20Sex.pdf

community may not be ready (see Chapter 3), this process can be intensive, time consuming, and costly.

Community-based EBPs

Community-based organizations (CBOs) have traditionally existed to address gaps in services present in conventional delivery systems. Implementation of EBPs in CBOs is designed to reach smaller, targeted populations, and often those at a higher risk of teen pregnancy. In short, *"they do the work that other people find uncomfortable or don't want to do."*[27] There are more than a dozen community-based EBPs included in the OAH database. While community-based implementation of EBPs may not yield the same high numbers served that school-based implementation does, using CBOs as a delivery system has three inherent advantages.

First, school-based sex education is wrought with controversy and political posturing while CBOs traditionally operate under much less scrutiny and can provide programming that meets the community's needs. Second, CBOs play an active and important role in teen pregnancy prevention by reaching out to those young people who are traditionally harder to reach; youth who have been disenfranchised in their community due to poverty, crime, family violence or other circumstances; and/or youth who are disengaged or completely absent from school. Finally, CBOs are usually staffed with people from within the target community and therefore are regarded as trusted sources of information.

System-based EBPs

Also working in the community, but distinct from CBOs are local government agencies, which provide services to youth who also are regarded as "higher risk" populations such as Department of Juvenile Justice and foster care youth. Several EBPs and promising programs have been developed for youth whose needs may not be addressed by more traditional interventions and such efforts should be increased in communities.

Clinic-based EBPs

There are seven EBPs designed for clinic settings that have shown positive evaluation results. Most programs use strategies such as DVDs, individual or group sessions, vouchers, etc. and are often short interventions delivered onsite at a clinic as part of a reproductive health visit.

Online EBPs

While there is currently a research gap relative to the effectiveness of online EBPs, it stands to reason that the field must account for technology trends moving forward. The ability to provide EBPs digitally would allow for uncompromised, 24-7 access. Ensuring information remains medically accurate and age-appropriate is a paramount concern. Providing content in this way may help to lessen cultural and political conflicts over content, and done correctly will certainly reduce the amount of resources (both time and money) dedicated to teacher/facilitator training.[28]

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[27]From recorded and transcribed focus group discussion with SC Campaign staff working with CBOs as part of the Collective Knowledge Project, March 27, 2014.

[28]Strasburger, V., Brown, S. (2014). Sex Education in the 21st Century. *Journal of the American Medical Association*. Volume 312, Number 2.

INTERVENTION(S):

Individual level:
Ensure that all young people in a community have the opportunity to be exposed to sexuality education and information – via schools, community-based organizations, clinics, and online mechanisms.

Community level:
Engage community based organizations and systems level entities (DJJ, foster care) in the process of delivering EBP such that the burden does not rest solely on schools. Funders must recognize the high level of training needed across each of these delivery systems.

Policy level:
Increase the monitoring and oversight of the state's Comprehensive Health Education Act to ensure uniform implementation of programs across the state's 81 school districts. In addition, policy changes may be required at other state level agencies (i.e. DJJ) to fully support the implementation of EBP within their systems.

Environmental level:
Create an environment in the community that diffuses controversy and supports the implementation of EBP in a variety of settings by engaging school staff, parents, community leaders, faith leaders, and youth to ensure curricula, programs and interventions meet both the needs of young people and community values.

INDICATORS:

1. Number of youth who participate in an evidence-based program by age, gender and race.
2. Percent of youth that complete at least 75% of an evidence-based program.
3. Percent of activities within the evidence-based program implemented with fidelity.

REAL WORLD MEDIATORS:

As funders begin to think about investing in the widespread implementation of EBPs, it is important to be aware of contextual differences that may exist between high, medium, and low burden counties, which need to be considered prior to funding an intervention. For example, the per student cost associated with implementing an EBP – training of teachers, classroom materials, fidelity tracking system, ongoing technical assistance – can vary widely depending on the size of a community/school district and also based on the curriculum selected. The ability to implement with high levels of fidelity is also influenced by a district/organization's readiness and buy-in from administration so careful attention must be paid to ensure this happens prior to initiating any implementation.

Strategy 2

Expand the availability of quality, teen friendly family planning services for adolescents that includes prescription of long-acting reversible contraception (LARC) and other highly reliable family planning methods. Expansion should include comprehensive training, education, monitoring, technical assistance and continuous quality improvement.

Recent data from the Guttmacher Institute underscore the need for women of all ages, but especially sexually active teens, to have increased access to affordable, effective birth control methods. More than half (52%) of unintended pregnancies in the United States can be attributed to partners using no contraception; another 43% of unintended pregnancies can be attributed to incorrect or inconsistent use. In sum, an astounding 95% of unplanned pregnancies (among women of all ages) are the result of non-use or incorrect use of contraception![29] Barriers for contraceptive use among teens include access to family planning services, cost of contraceptive methods, and lack of knowledge about contraceptive options.[30]

Why are these programs needed?

In a state where 32% of high school aged teens report having sex in the last three months, and only 26% report using some form of hormonal birth control, and 14% used no method of protection at all, these data are especially troubling.[7] Data for older teens, ages 18-19, are not much more encouraging. Nationally, this group is more sexually active than their younger peers, but do not appear, on the whole, to be more consistent or effective users of contraception.[31]

There is a growing unmet need for contraceptive services appropriate to the unique needs of teens. Step one in this process would seem to be ensuring that highly functioning clinics exist, at a minimum, in every county. The National Campaign identifies a successful teen clinic as one that provides: 1) longer appointment times (to allow for client-centered contraceptive counseling), 2) a wide range of confidential services, 3) onsite

[29]Guttmacher Institute. *Contraception works – and Publically funded Family Planning Programs are Essential to Reduce Unintended Pregnancy and Abortion*. https://guttmacher.org/media/inthenews/2011/03/09/index.html
[30]Welsh MJ, Stanback J, Shelton J. (2006). Access to Modern Contraception: Best Practice and Research. *Clinical Obstetrics and Gynecology:20*(3):323-338
[31]Suellentrop, K. (2010). *The Odyssey Years: Preventing Teen Pregnancy Among Older Teens.* Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

availability of contraceptives, 4) free or low cost services, 5) convenient services, 6) flexible medical protocols, 7) educational programs including education about reproductive health skills (such as how to use a condom), 8) referrals and outreach.[32] Other leading national organizations would also include 9) respectful treatment by well-trained, culturally competent staff, 10) promotion of parent-child communication, and 11) services for young men.[33] The sheer number of criteria for success demonstrates the complexity of helping clinics modify and improve existing policies and procedures as well as their physical structures.

Step two is ensuring that when teens do access reproductive health services, they are provided with the best care and most effective contraceptive options available. Changes in technology and overall medical advances have resulted in significantly more effective and reliable birth control methods for women of all ages (see **Table 6)**. In 2012, the American Congress of Obstetricians and Gynecologists[34] approved the use of long acting reversible contraception (LARC) for teens, and LARC could prove to be a major part of the solution to the problem of unintended pregnancies in teens.[35] Ninety-eight percent (98%) of pregnancies among 15-17 year olds and 75% of pregnancies among 18-19 year olds are unintended and a movement towards more highly effective LARC methods (bottom three rows of **Table 6**) could be a game changer. The risk of a contraceptive failure from the pill, patch or vaginal ring is 20 times higher than the risk of unintended pregnancy with a LARC method.[36] Similarly, while condoms are 98% effective at preventing a pregnancy and the only contraceptive method that protects against sexually transmitted diseases (see Strategy 3), incorrect use drops their typical efficacy related to prevention of pregnancy to 85%.

Table 6. Contraceptive Effectiveness of Short-Acting and Long-Acting Methods and Continuation Rate after One Year (Office of Population Affairs, 2013)

	PERFECT USE	TYPICAL USE	CONTINUED USE AT 1 YEAR
Oral contraceptives	99.7%	92%	68%
Condoms	98%	85%	53%
Paragard	99.2%	99.4%	78%
Mirena	99.8%	99.8%	80%
Nexplanon	99%	99%	84%

[32] National Campaign to Prevent Teen and Unplanned Pregnancy. *What Helps in Providing Contraceptive Services to Teens*. http://thenationalcampaign.org/sites/default/files/resource-primary-download/what_helps_2011_2012_final.pdf

[33] Advocates for Youth. *Best Practices for Youth-Friendly Clinical Services*. http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services

[34] ACOG Committee Opinion (2012) http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception accessed on 08/06/14

[35] LARC methods including the subdermal implant Nexplanon and two intrauterine devices Paragard (copper T) and Mirena. These methods provide uninterrupted protection against an unintended pregnancy for at least three years (Nexplanon and Mirena) and up to 10 years (copper T).

[36] Hillard P. (2013) What is LARC? And why does it matter for adolescents and young adults? *Journal of Adolescent Health*:52, pp. S1 – S5.

Yet, making LARC accessible to sexually active teens is wrought with challenges beyond the barriers described at the beginning of this section. They include limited knowledge of long acting reversible contraceptives (LARC) among providers, physician indifference, lack of awareness of LARC as a top tier method, and the cost of LARC to providers and ultimately consumers. Teen awareness of LARC methods is also low to modest. Few can describe the different methods of LARC or know about LARC effectiveness. In a 2009 study, 94% of older teens reported they had heard of the pill, 69% had heard of the IUD and 38% had heard of the contraceptive implant.[37]

Recent studies nationally have demonstrated the far-reaching effects of LARC. In both studies a major barrier to access was removed – cost! Both showed significant and promising drops in births and pregnancies. In St. Louis, an 80% reduction in teen births was reported,[38] and researchers in Colorado reported a 29% drop in pregnancy rates among 15-19 year olds.[39] Closer to home, interventions and policy changes in South Carolina are demonstrating very positive results and are ready to be taken to scale. For example, a major policy change instituted in 2012 at the SC Department of Health and Human Services (SC DHHS) allowed for LARC to be reimbursed outside of the Diagnosis Related Group, which allowed hospitals to bill for LARC when inserted in a mother immediately post-partum. This change has been hailed by the medical community as a show of commitment to removing obstacles that can inhibit the use of LARC, but, knowledge of or adherence to the policies is inconsistent and requires constant monitoring and education. On the intervention side, The Point at Tobias was highlighted previously in this report (see p. 32) as a model clinic intervention. Through intensive training, dedicated outreach and clinical staff, leadership buy-in and community support, a clinic located in the upstate of South Carolina has LARC utilization rates that approach 40%. Both the policy changes and success of The Point at Tobias deserve more attention and the opportunity to be taken to full scale.

In order to reach full saturation of this strategy, improvements to clinical settings and wide scale promotion of LARC will be necessary across four major systems in the state: 1) Department of Health and Environmental Control (DHEC) / Title X provider; 2) Federally qualified health centers (FQHCs); 3) private practices and affiliated providers; and, 4) hospitals that provide labor and delivery services.

[37]Kaye K, Sullentroup K, Sloup C. (2009). *The Fog Zone: How Misperceptions, Magical Thinking, and Ambivalence Put Young Adults at Risk for Unplanned Pregnancy*. Washington DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
[38]Secura G et. al. (2010). The Contraceptive CHOICE Project: Reducing barriers to long-acting reversible contraception. *American Journal of Obstetrics and Gynecology*: 203(2), 115-e1 – 115e7
[39]Ricketts S. et.al. (2014) Game change in Colorado: Widespread use of long-acting reversible contraceptives and rapid decline in births among young low-income women. *Perspectives on Sexual and Reproductive Health:46(3)*, (not yet in print)

INTERVENTION(S):

Individual level: Ensure teens have access to medically accurate information about highly reliable contraceptive methods through schools, community based organizations, health care settings and on-line resources like NotRightNowSC.org.

Community level: Engage youth serving agencies and systems of care to ensure young people know where they can access free or low cost quality reproductive health services. Create a referral network system within the community that provides teens assistance with accessing these services.

Policy level: Promote existing state and federal policies that reduce barriers for young people to receive highly reliable contraceptives and ensure implementation across health centers and hospitals.

Environmental level: Evaluate capacity of the existing health care system to provide confidential/timely services to teens. Engage parents and community leaders to gain support and to advocate for these services.

INDICATORS:

1. Number of unduplicated females ages 12-19 enrolled in Medicaid who received a reproductive health service.
2. Number of unduplicated females ages 12-19 who received a contraceptive method as part of reproductive health service.
3. Percent of unduplicated females ages 12-19 who received a LARC.
4. Percent of unduplicated females ages 12-19 who report still using their LARC method at one-year follow up.

REAL WORLD MEDIATORS:

There are contextual differences that exist between high, medium, and low burden counties when related to access and availability of LARC. In high burden counties, staffing may prohibit same day insertion of LARC in health centers. Staffing and infrastructure issues must have top priority. Identifying and/or creating other access points and delivery mechanism for reproductive health services within the community may be necessary.

Funders investing in LARC as a top-line prevention strategy must also recognize that such work comes with a cautionary tale.[40] Disproportionate rates of child bearing in the US among women of color and the poor has, in the past, made them the target of forced sterilization and other discriminatory actions around family planning. Reproductive coercion especially of young women of color could become an unintended outcome of LARC. Clinicians and policy makers need to be aware and sensitive to this reality.

[40]Gomez, M., Fuentes, L., Allina, A. (2014). Women or LARC First? Reproductive Autonomy and the Promotion of Long-Active Reversible Contraceptive Methods. *Perspectives on Sexual and Reproductive Health (46)3*. ViewPoint.

Strategy 3

Within a high-level, coordinated messaging and education strategy, interventions should seek to both increase public awareness of dual method protection and increase the number of young men seeking reproductive health services. **As part of this effort, increase the number and utilization of teen friendly condom access points in communities.**

It is common misperception that family planning services and teen pregnancy prevention programs are only for females. Perhaps this can be blamed on the recent, intense promotion of LARC as a front-line teen pregnancy prevention strategy. Perhaps it is a deeper-rooted issue attributable to the belief that pregnancy is a "girls problem." In either case, the result is that providers, clinicians, parents and teens themselves are left to ask, "what about the boys?" The absence of young men in the prevention conversation is brought to light through the most recent Youth Risk Behavior Survey (YRBS) data in South Carolina. Only 59.1% of sexually active high school students used a condom at last intercourse, and significantly fewer (10.7%) report using both a condom and a hormonal method of birth control.[7] Among older teens (18-19), while contraceptive use increases slightly, still 25% admit to inconsistent use of their method and 24% use no method at all.[41]

A dual-method approach to prevention will help to ensure the greatest impact on teen pregnancy and birth rates. Such education and awareness must include continued promotion and education on LARC – to both genders – and a greater focus on the use of condoms. Approaches seeking to engage young men must include conversations of responsibility and general sexual health information, but more to the point they should ensure young men have high access to reproductive clinical services (refer to Strategy 2), including access to condoms. Parents of males should also make it abundantly clear through consistent communication that they have the same, high expectations of their sons as they do of their daughters.

Why are these programs needed?

Research has shown that increasing the availability of condoms is associated with significant reductions in HIV risk.[41] Equally as important, it is clear from decades of research that

[41]Cohen, D.A., Farley, T.A., Bedimo-Etame J.R., et al. (1999). Implementation of condom social marketing in Louisiana, 1993 to 1996. *American Journal of Public Health*: 89:204-8.

making condoms available to young people does not hasten the onset of sexual intercourse.[22] Youth Risk Behavior Survey data in South Carolina and nationally consistently show that condoms remain the most commonly used method of pregnancy and disease prevention among youth.[7] The Centers for Disease Control recommends that practitioners "counsel sexually active teens on the importance of always using dual methods—such as an IUD or hormonal method and a condom to prevent pregnancy, and STDs."[42] Perhaps most notably, the American Academy of Pediatrics released a policy statement in 2013 indicating that "restrictions and barriers to condom availability should be removed...beyond retail distribution of condoms, sexually active adolescents should have ready access to condoms at free or low cost where possible."[43]

All signs point to increasing the number of interventions and messaging campaigns focused on young men, specifically removing the barriers of cost and stigma of condom use, as a critical part of teen pregnancy prevention efforts moving forward. To get communities to this place will require a commitment to implement strong, thoughtful dual-method messaging campaigns, and a commitment to implement clinical best practices, which include ensuring low/no cost readily available reproductive health services for all adolescents. Among other things, this includes providing males with access to condoms, emergency contraception, and screening for HIV, chlamydia and gonorrhea. It should be made clear to both males and females that when used consistently and correctly, latex condoms are highly effective at preventing pregnancy and the sexual transmission of diseases. To this end, practitioners and educators should consistently remind young people that even with the use of LARC or other forms of hormonal contraception, there is no protection from sexually transmitted diseases without the use of condoms – a dual method message.

To facilitate greater use of condoms, and be sure that males take an increased responsibility in negotiating contraceptive use with their partners, young people need to 1) be educated about condom effectiveness, 2) improve condom use and negotiation skills, and 3) have unfettered access to condoms. While true that under typical use condoms are not as effective as other more highly reliable methods at preventing pregnancy, they are the only method that offers a level of protection from sexually transmitted diseases. Continuing to emphasize that both males and females have a responsibility when it comes to contraception is a necessary precursor to improving utilization rates for all forms of contraception, including condoms.

Research has shown that public awareness/ education messages, along with many evidence-based programs, which attempt to normalize condom use and lessen barriers to consistent use (i.e. condoms don't feel good, don't fit, or are expensive) can be

[42] http://www.cdc.gov/teenpregnancy/healthcareproviders.htm
[43] Condom Use by Adolescents. Committe on Adolescents. Pediatrics. http://pediatrics.aappublications.org/content/132/5/973.full.pdf+html

effective. Making condoms available at a variety of locations, beyond medical practices, is also an important part of this strategy. A 2010 "secret shopper" campaign in two South Carolina communities found that 14% of drug/convenience stores did not have any condoms in stock and an additional 30% had only one brand of condom available. Nearly half of the drug/convenience stores (42%) displayed condoms behind a counter or locked cabinet, which required asking for assistance from a staff member prior to purchase.[44]

[44]*Shopping List: Milk, Bread & Condoms. An Assessment of Adolescents' Experience Purchasing Condoms.* South Carolina Campaign to Prevent Teen Pregnancy. December 2010.

INTERVENTION(S):

Individual level: Increase the educational and outreach efforts targeting young men specific to condom use for those who are sexually active. Programs and strategies should aim to address specific determinants such as knowledge, perception of risk and self-efficacy, all of which are tied directly to condom use.

Community level: Create identifiable, non-judgmental condom access points throughout a community including, but not limited to: medical practices, retail stores, pharmacies, and other locations frequented by young men in particular.

Policy level: Through partnerships with local youth serving agencies and medical providers, promote policies that allow eligible males to receive reproductive health services through the Family Planning Program. In addition, DHEC clinics, FQHCs and private medical practices ensure condoms are available at each of their sites. Finally, other statewide entities (including the Department of Juvenile Justice, Department of Social Services) may consider revising or instituting policies that allow for greater condom access for those they serve.

Environmental level: Reduce stigma present in communities around sexually active young people accessing and obtaining condoms. In addition, create and distribute mass media messaging campaigns focused on a dual-method approach to teen pregnancy prevention.

INDICATORS:

1. Number of condom distribution points in community.
2. Number of condoms distributed.
3. Percentage of sexually active adolescent males who report using a condom during last sexual intercourse.
4. Number of adolescent males who received a reproductive health service.

REAL WORLD MEDIATORS:

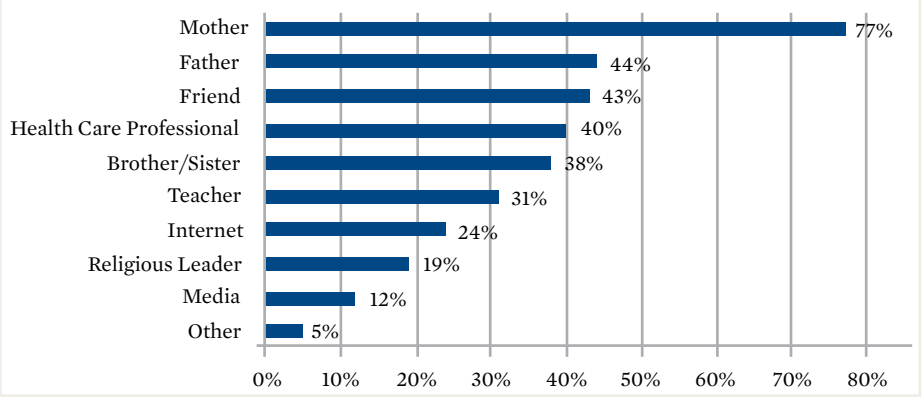
Despite the volume of evidence to the contrary, funders and program implementers may find it difficult to identify (non-medical or retail) locations willing to distribute condoms. Strong messaging campaigns and efforts to build community support and acceptance will likely be necessary prior to implementation. Programmers and funders should also note that increasing condom access and associated messaging can be especially important for older teens and those teens engaged in systems (i.e. DJJ, foster care) who may not have high levels of access to education programs/EBPs.

Strategy 4

Improve educational and informational offerings for parents to increase parent-child communication about love, sex and relationships; and, ultimately increase the quality and quantity of interactions between young people and their parents.

Time and again, teens say parents wield the most influence on their sexual-risk taking behaviors. Contrary to popular belief, teens prefer to get information about love, sex and relationships from their parents over any other source, including friends, school, doctors or the Internet.

Figure 14. Where Teens Would Prefer to Receive Information about Sex or Birth Control[45]



It is important to note that this strategy, despite its title, refers not only to parents, but other trusted adults in young peoples' lives. While most of the collected and published research on the topic refers to parents specifically, reality suggests that not all young people are fortunate to have two, or even one, parent(s) in their lives. In fact, in South Carolina, more than one-third of all children live in mother-only households (34%) and an additional 7% live in father-only households.[46] Nonetheless, it is important to note that parents can have a strong impact on their children's behavior, especially sexual behavior, specifically through communicating their beliefs, values,

[45]Philliber Research Associates. *The Voices of Teens.* SC Campaign to Prevent Teen Pregnancy. March 2011.
[46]Kirby, D., Coyle, K., Alton, F., Rolleri, L., Robin, L. (2011). *Reducing Adolescent Sexual Risk. A Theoretical Guide for Developing and Adapting Curriculum Based Programs.*

and expectations. Parent-child communication about sex refers to communicating (preferably prior to their teen initiating sex) these family values and beliefs, which can help to 1) discourage sexual initiation before their teens have sex and 2) support contraceptive use when sexually active. This includes both verbal communication and nonverbal modeling of relationships and sexual behavior. Effective parent-child communication is typically accompanied by parent-child connectedness and supervision and results in more sexually healthy youth. In addition, communication about love, sex and relationships should be started at a young age, be developmentally appropriate and occur throughout a child's life, not just as a single conversation.

Why are these programs needed?

While the research is a bit unclear on parent-child connectedness and the initiation of sexual activity (largely due to methodological challenges), it is clear that sexually active teens are more likely to use contraception when parents accept and support contraceptive use and encourage their teens to use contraception.[47] No studies have found a negative effect of parental support and acceptance of teen condom/contraception use. And, teens who reported having a 'good talk' with their parents in the last year about sex and birth control were twice as likely to use condoms at last sex than teens who did not talk with their parents.[48] In addition, teens were three times more likely to use condoms when their mothers discussed condom use *before* they initiated sex. This is critical because teens who use condoms the first time they have sex are 20 times more likely to use condoms regularly. Specific to contraception, consistent users report more frequent conversations with their parents than inconsistent users.[48]

Given all of this, it seems logical that engaging parents at a higher level in prevention efforts would be paramount to future success. However, the task is more difficult than it may seem as parents admittedly struggle with these conversations and too often are not having them at all. Even when parents think they are talking with their children about sexual health they often overestimate the quantity and quality of the communication; while parents are thinking they've had effective conversations, their children are saying they haven't.

A large scale random digit dial survey of parents and adults conducted in 2011 in two South Carolina communities found that parents openly admit they need help,[36] specifically around the following topics:

- How to talk with their child about sex
- Healthy relationships
- Puberty
- Additional resources and local support

[47]Kirby, D., Coyle, K., Alton, F., Rolleri, L., Robin, L. (2011). *Reducing Adolescent Sexual Risk. A Theoretical Guide for Developing and Adapting Curriculum Based Programs.*
[48]Advocates for Youth. http://www.advocatesforyouth.org/the-facts-parent-child-communication.

Relative to the final topic, many parents did not know where to send their teen for free/low cost birth control and were operating off of myths and misinformation related to the prevention of pregnancy and sexually transmitted diseases.

The SC Campaign has also conducted several focus groups with parents (see Chapter 2) that support the assertion that parents want to talk more with their children about love, sex and relationships, but are unsure how to start the conversation, what to say, and how to say it.

In-depth research into this topic has identified a number of factors that can influence the level of impact parent-child communication can have on young people.[47] These include the characteristics of the parents (i.e. their parenting style and cultural norms), the closeness of the relationship between parents and their children, the content and accuracy of the ideas being communicated, and the characteristics of the communication process (i.e. monologue vs dialogue).

Reflecting back to Strategy One presented earlier in this Chapter, one of the most common arguments against mandated, school based sexual health education is the belief that discussions of such a sensitive topic should occur at home. Parents are the ideal people to impart their values, beliefs and customs, while infusing religious beliefs and expectations as appropriate; and, they should be the primary sexuality educators of their children. These ideas are not mutually exclusive. In light of this, interventions that educate parents to increase their knowledge, comfort and intentions as well as create safe, structured environments for parents and children to begin these conversations are needed, and would offer a perfect complement to other strategies discussed in this chapter.

INTERVENTION(S):

Individual level: Increase the quality and quantity of messages, information and educational offerings available to parents in the community. Activities must be numerous, culturally competent and diverse (i.e. in-person and virtual). The content of such efforts should focus on those areas which parents indicate they need the most help – general reproductive health information, age-appropriate messaging, and accessing resources in the community.

Community level: Engage community agencies and service providers, such as pediatricians, child development and faith centers and schools, to encourage parents to have ongoing communication with their children about love, sex and relationships throughout their child's development. The community should also provide safe spaces for parents to seek help from trained professionals and support from peers.

Policy level: Consider requiring all schools to include information about parent-child communication at parent orientations, and ensure that parents are represented on each school district's Comprehensive Health Education Advisory Committee (as required by law). Among medical professionals, follow American Academy of Pediatrics policy that "encourages parents to discuss sex-related issues that are appropriate for adolescents' developmental level."

Environmental level: Assess local resources available to parents and the capacity of those resources to meet the existing needs of parents. Develop public awareness, education and social norms messaging in communities designed to increase parent-child communication and an increased number of opportunities for parents to build their capacity and comfort level.

INDICATORS:

1. Number of programs addressing parent-child communication offered in a community (both in person and virtually).
2. Number of parents reached through educational and informational programs.

REAL WORLD MEDIATORS:

Many parents are challenged in having talks with their children about love, sex and relationships. Finding opportunities for parents and trusted adults to learn more about this sensitive subject in an ever increasingly demanding work/school/home environment can be challenging. On the other hand, parents continue to admit that these conversations are challenging and that they need help. Creating a bridge between these two realities is essential. Parents/guardians from high burden communities are especially challenged as they may be faced with additional barriers related to a lack of available resources including poorer performing schools and less access to health care facilities that can be supportive networks for these discussions.

Beyond the Technical Package

At the moment, the science of teen pregnancy prevention is of national interest. The current climate at the federal level supports the implementation of programs with a proven track record of effectiveness, but also encourages continued research and development, which will continue to add to the growing body of evidence and understanding of what works in preventing teen pregnancy.

This is important for two reasons. First, teen pregnancy is a complex issue and the prevention science is equally as complex and dynamic. New products and programs will continue to emerge and must be assessed for their potential contribution to reducing teen pregnancy in this state, and elsewhere. Second, it is quite possible that there are effective programs and strategies that already exist but have not had the opportunity to be carefully evaluated and studied.

Ensuring that the current funding climate at the national, state, and regional level, continues to support such research and evaluation is a critical piece of moving the entire field forward. While our focus in this chapter was on those interventions with a strong body of existing evidence and worthy of inclusion in the technical package, by no means should anyone, especially funders, dismiss the need to continue supporting this culture of research and innovation.

As an example, just recently (July 2014) the Office of Adolescent Health added four new programs to their list of evidence-based programs that are designed to reach very specific subsets of the teen population that are traditionally underserved, including, 1) a program aimed at reducing sexual risk behavior in early adolescents by intervening with the adolescent's mother; 2) a four-session intervention aimed at reducing sexual risk behaviors in low income, urban, sexually active females; 3) a cognitive behavioral intervention to reduce STDs among ethnic minority adolescent females with a history of sexual or physical abuse; and, 4) a family-based intervention aimed to reduce sexual risk behaviors, substance abuse, and delinquency among runaway youth.

In addition to effective curriculum-based programs, there are other commonly implemented strategies that aim to prevent teen pregnancy by targeting more distal, nonsexual risk factors. Programs like youth development and mentoring, engaging the faith community, substance abuse prevention, job training and preparedness, and early child development programs all have been associated with more broad scale teen pregnancy prevention efforts. Again, the importance of these programs should not be diminished, however, implementing them in the absence of those interventions offered as part of the technical package will likely yield less of an impact. Addressing

nonsexual issues is important in the course of improving health and wellness more generally, but will only have a minimal impact on teen pregnancy and teen birth rates unless programs and communities take this issue head on and address the sexual risk and protective factors most closely associated with teen sexual behavior through those interventions presented in the technical package.

Finally, it should be acknowledged that the world young people live in is ever changing. The impacts of technology, popular culture, and larger social values indeed have an impact on the learning and decision making of the average young person. It would be impossible to have far-reaching impacts on teen pregnancy and teen birth rates in a state or community without attempting to mitigate such factors. While the implementation of programs, increased availability of condoms and other forms of contraception, and improved parent- child communication will all make a difference, it stands to reason that some larger, broad community-wide campaigns aimed at addressing social norms are also necessary. Some combination of direct prevention interventions and broader social norms messaging would seem most appropriate.

The impact of technology on adolescents is likely underrepresented in this publication. As a field, it is important that we continue to learn more about the impacts of traditional media and social media – both positively and negatively. In order to have the greatest reach, we must reach teens where they are, and undoubtedly they are spending most of their time in a digital environment. This type of continued effort may, over time, include continuing to learn more about the implementation of evidence-based programs online (see Strategy 1), educating young people about contraceptive methods (see Strategy 2) through website and social media, and offering increased educational options for parents digitally (see Strategy 4).

As the field continues to learn more about "what works" in preventing teen pregnancy, we look forward to being able to update this publication. For now, we believe that this technical package – and the entire prospectus – represents an appropriate path forward for those interested in reducing teen pregnancy and teen birth rates in South Carolina. A path forward that, with our collective commitment, will accelerate the progress being made in our state and ensure future investments in the issue come with high returns.

SOUTH CAROLINA CAMPAIGN TO PREVENT TEEN PREGNANCY

About the SC Campaign

The South Carolina Campaign to Prevent Teen Pregnancy was founded in 1994 to combat increasingly high rates of teen pregnancy. Since that time, it has been the only organization in South Carolina that works in all of the state's 46 counties exclusively focused on the reduction of teen pregnancy. Through mission based focus areas of training & technical assistance, public awareness & advocacy and research & evaluation; the organization strives to build the capacity of local communities to address teen pregnancy within their own neighborhoods.

About this Project

Two years ago amidst recognition that South Carolina is squarely positioned at the forefront of a national movement to prevent teen pregnancy, a project to explore how to continue and accelerate reductions in the state's teen pregnancy and birth rates began. In June 2012, the SC Campaign received funding from The Duke Endowment to increase the collective understanding of all that is currently happening throughout the state – both in schools and communities – relative to teen pregnancy prevention, develop a strategy to increase the collective impact of such efforts, and increase attention paid to long-term sustainability. One of the key outcomes of this work was the production and dissemination of this document – a "road map for achieving further reductions in teen pregnancy" – that can be used by funders, philanthropists and decision makers who aim to make more strategic investment and programmatic decisions relating to the prevention of teen pregnancy.

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