

**Social Determinants and Teen Pregnancy Webinar**  
**May 15, 2013**  
**12:00 pm CT**

Coordinator: Welcome and thank you for standing by. At this time all participants in today's call will have a listen-only line.

However if you'd like to ask a question during our Q&A session you may do so by pressing star 1 on your screen.

The call is being recorded. If you have any objections you may disconnect. Also today's presentation on the PowerPoint may be downloaded.

To do this in the bottom right-hand of the screen you'll see where it says Fit to page. If you go two icons over you'll see a printer. Click that and it'll give you the option to print.

I would now like to - one moment please. I would now like to turn the call over to Ms. Taleria Fuller. You may begin ma'am.

Taleria Fuller: Thank you (Chuck). Good afternoon and welcome to the Webinar on Exploring the Influence of Social Determinates on Teen Pregnancies.

I'm Taleria Fuller with the CDC Division of Reproductive Health. I am a Project Officer with the Teen Pregnancy Prevention Project.

This Webinar is a collaboration between the Office of Adolescent Health within the Office of the Assistant Secretary of Health in the Family and Youth Services Bureau within Administration of Children and Families and the Division of Reproductive Health within the Centers for Disease Control and Prevention.

My disclaimer, the purpose of this Webinar is to explore the link between social determinants and teen pregnancies by highlighting recent research on socioeconomic disadvantage and teen childbearing and discussing the importance of key community partnerships.

I will provide brief introductions and a little background on the CDC Teen Pregnancy Prevention Project. You will then hear from Dr. Anna Penman Aguilar who will discuss her recent article Socioeconomic Disadvantage as a Social Determinant of Teen Birth.

This article is very timely since there is limited research in this area and her work demonstrates a clear link between socioeconomics and teen births.

Currently Dr. Penman Aguilar is the Associate Director for Science of CDC's Office of Minority Health and Health Equity where she provides leadership and consultation in science, research, evaluation and practice issues that advance the elimination of health disparities and achievement of health equity.

She has 15 years of experience working in public health research domestically and abroad.

Dr. Penman Aguilar received her MPH. in International Health from Tulane University School of Public Health and Tropical Medicine and a PhD in Epidemiology from the University of Alabama at Birmingham.

After Dr. Penman Aguilar presents you will hear two examples from the CDC Teen Pregnancy Prevention Communitywide Initiative, Michelle Reese from the Adolescent Pregnancy Prevention Campaign of North Carolina and Carmen Chiparro from Harvard Health and Human Services.

They will talk about how they are working to highlight the link between teen pregnancy and social determinants in their community.

Michelle Reese is a Public Health Educator serving as the Community Integration Coordinator and Clinical Coordinator on the Gaston Youth Connected Initiative which is part of CDC's funded project through the Adolescent Pregnancy Prevention Campaign of North Carolina.

Michelle has worked in public health education for 16 years and received her Bachelors of Science in Health Promotion from the University of North Carolina at Charlotte.

Carmen Chiparro is the Project Coordinator for the city of Harvard's Health Department and Human - for the Hartford Department of Health and Human Services Teen Pregnancy Prevention Initiative also funded through the CDC.

Previously Ms. Chiparro was the Coordinator of a health equity grant where she assisted in developing the health equity action training for the health department staff.

She has eight years of elementary and preschool teaching experience and holds a BS in Elementary Education and Psychology from Guilford College in Greensboro, North Carolina and a MS in organizational psychology from the University of Hartford.

After their presentations we will open the lines to questions and answers.

To provide a little context of the presentation especially to the community examples, I will briefly share some background on the CDC communitywide initiative.

The purpose of this project is to test the effectiveness of the innovative multi-component communitywide initiative targeting or excuse me, are designed to reduce rates of teen pregnancies and birth in communities with the highest rates.

This has a special emphasis on African-American and Latino youth 15 to 19 in communities with the highest rates of teen pregnancies and births.

This also includes youths otherwise at increased risk such as those in foster care and the juvenile justice system. We fund nine state and local grantees and five national grantees.

There are five components to this project -- community mobilization evidence based programs, evidence based programs, clinical services stakeholder education and working with diverse communities.

It is with in this last component, the working with diverse communities where the work on social determinants fits in our initiative.

This component supports the other components and focuses on reaching youth with culturally and (implicitly) appropriate evidence based programs in reproductive health services and exploring the link between social determinants and teen pregnancy.

This component is led by our national grantee JSI Research and Training. They provide specialized training and technical assistance to our grantees across the reproductive health equity in our funded communities.

I've also provided information on the JSI Web sites specifically designed for the working and diverse community component.

On this site you can access information as well as tools and resources related to our topic.

So we are really excited to have Dr. Penman Aguilar join us today since her work not only contributes to the literature but also complements the local efforts in our funded communities. I will now turn it over to Dr. (Anna) Penman Aguilar.

Dr. Penman Aguilar: Thank you so much for the introduction. Today I will discuss the role of socioeconomic disadvantage as a social determinant of teen births.

My objectives today are to define common terms used in health equity work, present results of a literature review on socioeconomic determinants of teen births and discuss implications for intervening to reduce teen birth rates in disadvantaged communities.

And I'm going to start out with some interest - some definitions so that we're all on the same page. Health equity has been defined variously with the

common theme of universal opportunity to be healthy and to make healthy choices.

Here is the HHS definition of health equity. It clarifies that although the aspiration is for all to be healthy achieving health equity requires persistent rigorous attention to health disparities that are associated with historical and contemporary injustices such as racism, stigma against people with disabilities, ageism, and hetero sexism.

The CDC Health Disparities and Inequalities Report is the first CDC report to broadly consider disparities across a wide range as health outcomes and determinants.

And that report uses this definition of health disparities. It defines health disparities as differences in health outcomes and their determinants between segments of the population as defined by social demographic environmental and geographic attributes.

You may notice that the previous definition or the one I just read to you to defines - would define the difference between upper income and lower income people and binge drinking in which higher income people drink more as a health disparity even though it does not affect a socially disadvantaged group.

In contrast this definition of health disparities discusses socioeconomic and environmental disadvantaged. And this is the HHS and Healthy People 2020 definition.

It says that health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on racial or ethnic

group, religion, socioeconomic status and several other factors including other characteristics historically linked to discrimination or exclusion.

Here is the definition of health inequities is based on the important work of Dr. Paula Braveman. A health inequity is a health disparity that is systematic, avoidable and unfair. CDC's Office of Minority Health and Health Equity prioritizes these health disparities for action.

Finally as most of you are aware social determinants of health reflects social factors in the physical conditions in the environment in which people are born, live, learn, play, work and age.

Also known as social and physical determinants of health they have an impact on a wide range of health functioning and quality of life outcomes.

Teen pregnancy and birth are public health issues. Because you are all familiar with this information the importance of teen pregnancy and birth as a public health issue I won't spend much time here.

But I would like to point out that the overall birthrate among 15 to 19 year old females reached a record low in 2011, however the number of teen births remains high and there are consequences for teens and their infants.

I would like to take a moment to discuss disparities. So non-Hispanic black youths, Hispanic and Latino youth and American Indian Alaska native youth experience the highest rates of teen pregnancy and childbirths.

Together black and Hispanic youth comprise 57% of US teen births in 2011.

Here you see the decline in teen birth rates since 2000. Although birth to Hispanic teens are declining at the fastest rate the gap between Hispanic teens and non-Hispanic white teens remain substantial.

Non-Hispanic black rates are declining but the rate of decline does not appear much different than that among non-Hispanic whites and it does not appear that the gap between non-Hispanic black teens and non-Hispanic white teens is narrowing substantially.

This chart does not show American Indian and Alaska native births but as I noted earlier there is statistically significant disparities. If they were a line here you would see a large gap.

So now I like to transition to the research studies that I will discuss with you today. This is a literature review that my co-authors and I completed. Briefly the methods were focusing on individual family school and community level socio and economic influences.

We used an electronic search of several databases. We looked at peer reviewed articles published between 1995 and 2011 that addressed socioeconomic factors as determinants of teen births.

First birth among females age less than 19 years in the US, original quantitative analysis and data aggregated at county level or lower.

To be more specific about the socioeconomic economic factors we considered they are listed here. Educational attainment as a teen or her parents, family members, income wealth or occupation and community level financial or material resources.

Here you see the variety of racial ethnic populations that were included in the studies we reviewed. Interestingly we were not able to identify any study of teen births among American Indian or Alaska natives, Asian-American, or native Hawaiian or other Pacific Islander that addressed socioeconomic determinants of teen births.

The study that looked at only non-Hispanic white was focused on teens living in rural settings in Appalachia.

A total of 12 studies were identified that looked at socioeconomic factors as determinants of teen births.

Three considered only family level socioeconomic influences. In these studies less parental education and lower family level socioeconomic status met more teen births.

Two studies identified parental education as important and one identified family level socioeconomic status as important.

Eight studies looked at community level influences. Here you see the first four Gold et al and (Bickel) et al looked at counties.

Gold found that lower per capita income was associated with higher teen birth rates. Gold also used a measure of income inequality and found that the higher the income inequality in a county the higher the teen birth rate was.

(Bickle) found that lower average wage and higher unemployment were associated with higher teen birth rates.

(Kirby) et al and (Blake) and (Ben Tov) looked at geographic areas defined by ZIP Codes. (Kirby) found that fewer college graduates and greater poverty were important.

(Blake) and (Ben Tov) found that fewer years of education fewer high school graduates, lower income and greater receipt of public assistance were associated with more teen births.

In red you see one of only two associates of two associations that went in the opposite direction than we had expected.

So of all these studies only two findings went in the direction that would not support socioeconomic status as a determinant of teen births.

(Kirby) found that male employment was higher in ZIP Codes that had a higher birth rates but this is not totally surprising because greater employment can lead to reduced parental monitoring.

Here are the other four studies that looked at community level influences. I won't go through these line by line but I would like to point out a few things.

(Way) et al took an inventive approach. They looked at 82 neighborhoods in Pittsburgh Pennsylvania and they used a neighborhood physical disorder index that included things such as the presence of graffiti, beer or alcohol containers, litter and abandoned vehicles. And they found that greater physical disorder was associated with higher teen birth rate.

(Sukoff) and (Upchurch) looked at individual level data that linked to census data on poverty of the census tracked level.

(Massey) and (Saboya) took a similar approach and found that high male joblessness and a low income to needs ratio were both associated with teen births.

Finally (Salf) and (Boehmer) did the same thing with a different data set and found that higher neighborhood disadvantage and lower neighborhood advantage were associated with teen births.

In a study that looked at individual family and school level measures of socioeconomic factors attending public school was associated with teen birth among black teens but so was higher family level SES. You will see this stated in the right-hand column.

Attending a less resourced school was associated with teen births among white teens. School dropout was associated with teen births among white and Hispanic teens and lower family socioeconomic status was associated with teen births among Hispanic teens.

So this leads to the undeniable conclusion the social determinants of health in this case socioeconomic factors are important to consider.

We observed a consistent pattern of socioeconomic factors being important across the populations represented in this review.

There is a pressing need to examine the role of socioeconomic factors in teen births in various populations, for example among populations that are not represented in this review.

Whether socioeconomic factors matter may not vary from population to population but which ones matter and how they matter may vary substantially.

It is critically important to locate prevention within its cultural context. Qualitative research and research that mixes qualitative and quantitative methods are necessary to unravel how socioeconomic factors operate in communities. I don't think I could ever repeat this enough. It is vitally important.

There are some measurement issues to contend with. Individual peer, family, community school and policy level factors jointly influence health outcomes.

And it is important to measure socioeconomic factors at multiple levels whenever possible. In fact Dr. Paula Braveman put out a paper describing the need for that.

Many data sets do not allow for analysis at multiple levels. However one solution is linking individual data sets to census or American community survey data and that's what a few of the studies in this review did.

Other conclusions to be drawn are access to high quality clinical services is critical including contraceptive counseling and affordable contraception.

Yet as we know from decades of experience access to services is generally not sufficient for eliminating health disparities.

Targeted efforts that are culturally and linguistically appropriate are necessary. A couple of examples are the (Sele) intervention and the (Quidate) interventions that are described on the OAH Web site.

Because individual community policy level and other factors jointly influence health outcomes, multilevel approaches to prevention may be well positioned to succeed.

For each of these bullets I have listed examples from the Teen Pregnancy Prevention Resource Center which is maintained by the HHS Office of Adolescent Health and you can find this on the OAH Web site.

The next bullet reflects the youth development approaches can help teens envision successful lives for themselves in the future and give them tools to make this a reality. This approach may lessen the influence of negative socioeconomic factors.

Finally multi-sector collaboration is key. We can only accomplish our goals together by collaborating with other sectors such as education, justice and housing.

To sum up health inequities are health differences are disparities that are systematic, unfair and avoidable.

Social economic disadvantage is linked to high teen birth rates, data related challenges exist, access to high quality services critical, cultural linguistic - cultural and linguistic appropriateness of intervention is also important.

And there has been a recent shift away from the talk of cultural and linguistic appropriateness to cultural humility.

Access to multi-level interventions is important and multi-sector collaboration is key.

This is where you can find the article on which the presentation is based. I'd like to acknowledge my co-authors on the article Dr. (Marion Carter), Dr. (Christine Snead), and Dr. (Athena Curtis). And this is my favorite closing slide. Thank you all for your attention.

Taleria Fuller: We'll now turn it over to Michelle Reese.

Michelle Reese: Thank you Taleria. Thank you everyone for your attention. My name is Michelle Reese. I am the Community Integration and Clinical Coordinator for the Gaston Youth Connected project in North Carolina.

(Unintelligible). Right there is my disclaimer.

Just a little bit about our project. Our project is called Gaston Youth Connected. We are a CDC funded project to reduce teen pregnancy rates in Gaston County by 10% by 2015.

And our staff is very small. We are a staff of five people. We have four staff members and one part time staff person that provides technical assistance.

Gaston County is a very small bedroom community that is right outside of Charlotte, North Carolina. And it's most formally known as an old mill town and its chief industries were yarn and farming.

And it's very unique in the sense that it has 13 unique municipalities that we've tried to reach throughout the county.

The target population for our project is to reach African American and Latino youths. The specific target populations include the following but are not

limited to 18 and 19 year olds, youth living in poverty, individuals that are in foster care, youth in the juvenile justice system and homeless youth.

African-American and Latino youth make up about 28% of the adolescent population in Gaston County. And the birth rates for African-American and Hispanic and Latino teens are approximately higher than Gaston white and Caucasian teens.

Data that we found from 2006 shows us that the Hispanic and Latino teen birthrate was 140% - 154% higher and the African-American teen birthrate was 43% higher than white and Caucasian, than the white and Caucasian birthrate.

Older teens are particularly at risk in our community. There's slightly more than 2/3 of Gaston teen births in 2009 or to females 18 to 19 year olds. And 1/4 of the teen births were to females 16 to 17.

So that really created a lot of conversation in our community all about the age range of individuals that needed to be targeted through our project.

Approximately 75% of Gaston teens teen births in 2009 were to white and Caucasian females. And so that was another point of conversation that came up as we were discovering information about our populations.

What you're seeing here is a map. It takes our 2009 teen birth rates for Gaston County. Since 2003 Gaston's teen pregnancy and birth rates have not changed significantly however they have consistently remained above the state and national rates.

And this map is a cross tab of the county itself with the school zone for the county that show our high and middle school zones.

And we use this map to determine where are the most at risk areas that we need to reach, do outreaches for as evidence based programs and increasing access to clinical services in the community.

A little snapshot of our community so that you can kind of get a sense of the data that connects on the teens birth rate outcomes as far as social determinants of health that (Anna) has just spoken about.

Prior to the project entering the community we discovered there were a few organizations that addressed social determinants of health.

We did know that there was a healthcare commission prior to the project but addressing social determinants of health was not their main focus. They were focusing on other things.

However they did stop for a poverty simulation just before our project entered into the community which was primarily for organization executives, elected officials, sort of high powered individuals in the community to participate in that event.

The health department was also a part of that event. And from that they did express some interest in working in the area of addressing social determinants of health.

But there was no fiscal support for that work. And so there really has not been or was not an organizational champion addressing those issues.

Most importantly after a thorough needs assessment of the community we discovered there was much value in highlighting some of the P&E data that affects teen pregnancy outcomes and birth outcomes.

And we did so by getting out there in the community. And I will definitely share some of the activities that we've done in just a moment.

Also in 2010 the percent of persons aged 25 and older who are high school graduates was 71% lower compared to 78.1% for the states. And the percentage of persons aged 25 and older who possessed a Bachelor's degree or higher was 14.2 compared to 22.5 for the state. And that's based on our census data.

And in 2008 the median household income was a little over 46,000. And that's slightly below the state median of 46.5.

And in 2008 15.4% of all persons in the county lived below the federal poverty level which was compared to 14.6% for the state.

So we definitely took the time to use this data to support some of the reasons why we should address social determinants.

Some other quick snapshots is that there was a sharp rise in unemployment from 2007 to 2009. And the top importers in the community like most small communities in America would be a Wal-Mart or like a hospital or public health or Department of Social Services but mainly lots of manufacturing opportunities in the community as well.

The child birth rate for 2007 we did find for children birth to 17 that 12.9% of those individuals did not have health insurance. So that definitely was something for us to focus on and bring awareness about to the community.

And we also found that in 2010 138 young people ages 13 to 18 were in custody of DSS and receiving those types of services.

Another snapshot that we did find that was important to us was that 41% of youth aged 15 to 19 live in single-parent households. And that was a really big issue for a lot of the community members that they felt that needed to be addressed and so we wanted to find that data for them to substantiate their concerns.

So given the data available it became more apparent to our team and our community volunteers and leaders that there was an opportunity to address the determinants that are affecting the entire community and specifically around teen pregnancies.

And we felt that by raising awareness and providing opportunities to communicate about the issues and supporting substantial activities that could potentially create a community that actively supports teen pregnancy prevention past the life of the project.

Some of our awareness activities during the first implementation year which was we had an opportunity to work with JSI to conduct a root cause analysis with the members of our three leadership teams. Those three leadership teams are comprised of individuals that are organizational leaders around working with youth in various capacities.

We also have a community mobilization team. Those are primarily individuals who live and work in the community that have a general interest in teen pregnancy prevention and a youth action team which are made up of high school students from all of the high schools within the community.

From this opportunity working with JSI the leaders did prioritize determinants that they felt were most likely to affect teen pregnancy outcomes in the community.

And they felt that there were a lack of transportation opportunities. And the transportation and the community, public transportation did not have late hours.

And so a lot of times the clinic would have late hours but the bus would not be running or there would be problems getting access to like what we call the transportation services that are provided at CPSS.

They also felt that it wasn't issue with high youth unemployment rates. There were very few opportunities for youth to have places to work and youth were not in - a high percentage of youth were not enrolled in school.

There were also mentions of having very selective and inequitable job training. And so there seemed to be a disconnect between children of color, African American and Latino youth having job opportunity training versus those who are not.

And also there was an issue around marginalized Latino population very much not engaged in the community prior to the project.

After conducting the analysis and working with JSI the leadership team facilitated - it kind of facilitated a collective process for identifying determinants rather than our staff determining what those determinants were and what we were going to work on. So it created by in from the beginning and they created those priorities for working with diverse communities.

And also it also allowed leadership teams to develop a shared vision around these priorities as they are the representatives of the community and becoming the thought leaders on the subject of teen pregnancy.

Gaston Youth Connected staff and volunteers leaders conducted over 139 presentations and individual meetings with elected officials, Rotary clubs, civic organizations, historically black fraternities and sororities and the business community.

And through those we reached 1822 individuals. Most - some of them have been a part of repeat presentations but those are the individuals that we were able to reach in that case.

From all these presentations we were able to connect with the United Way representatives who expressed extreme concern for race, education economic development issues within the county and had gone on to really go on to raise awareness among local officials and business leaders among his network to help raise awareness and bring about other leaders to come on to our project.

He's also been instrumental in creating a think tank to improve the quality of life for individuals 21 to 45 within the community. And this is being done - these conversations are happening with the hopes of addressing education and economic development within Gaston County.

We've also had a city councilman come on board is a very active member and leader on our project just from being at a presentation and hearing about the information we got for the community assessment and they felt we needed to have more information that affects all adolescents in the community and wanted to know why we were only focusing on African-American Latinos youths.

But by presenting the data and the things that I stated earlier we were able to show the disparities and the adverse effects for African-American and Latino youth.

We've also done presentations from the fraternities and sororities. And many of them have given us leaders and representatives on our leadership teams to be very active in addressing their goal of providing prevention services in the community and youth development activities.

And so they've been very supportive and have come on to be very vocal and very strong advocates for our projects.

Another activity that we've had on the project is we've conducted assistance changing workshops for our community mobilization team members, our tech - our teen advisory council members and copilot team members.

This workshop is an adaptation of the ongoing racism community work - community organizing workshop that was developed by the People's Institute for Survival and Beyond.

The main focus of this intense workshop is to create understanding about what racism is, where it came from, how it functions, why it persists and how it can be undone.

So our adaptation workshop was conducted during the implementation year as an awareness raising activities. And the goal was to identify underlying social, economic and political systems that affect the community specifically in Gaston and disproportionately privileged subgroup and also while disadvantaging others.

The participants of our workshop have discussed concerns about the systems that were addressed on a local level and how it impacts those health outcomes and actually identified the following system as those that were vulnerable in the community for disadvantaging several populations.

And those would include public health, law enforcement, the Department of Social Services, elected officials including the county commissioners and board of education, our housing Authority, the educational system as well as the faith community. And those became individuals that we targeted to engage in our projects.

Some outcomes that are projects that we've had since the inception in Gaston County is that our teen birth rates for 15 to 19-year-olds decreased by 19% from 2010 to 2011.

We've also made major strides with our school system. They were a very conservative school system. And they have allowed the teen outreach program to be implemented after school on campus.

We've also seen a dropout rate decrease from 2010 to 2012 since the inception of the project. And we've also increased the evidence-based programs in the community drastically. And we've increased locations for teens to receive the health services from one location to over five.

Some of the lessons that we've learned through raising awareness in this small community is that you should definitely consistently share your messages about your work with key stakeholders in the community and remain prepared to keep them engaged.

Consistent engagement eventually leads to increased support. You just have to keep revisiting it no matter what oppositions you have.

In small rural communities relationship building is critical to opening the doors of opportunities to address awareness around social determinants of health.

A lot of times with addressing reproductive health issues the - it's a very emotional topic for some people and it can be very layered and controversial. And you really need someone who is trusted in the community to endorse your credibility so that others can trust you to raise these issues and to bring them along the journey.

We've also found ways to work with the dissonance between acknowledging social determinants and actively addressing them.

Many people came to our presentations in the beginning and are planning year. They heard what we had to say. They were willing to identify social determinants but they weren't necessarily willing to be the one to actually do something about it.

And so we learned that we have to keep revisiting that and be comfortable with that process.

Next steps for our project are to continue the conversation within the community by supporting and by supporting and collaborating with the health department in their effort efforts around social determinants of health.

We don't want to re-create the will but support the efforts that they're doing because that definitely has a much more sustainable model. And our project will be withdrawing from the community in 2015 and we want see their work continue.

We will continue to be at the table to provide expertise and guidance on keeping teen pregnancy prevention as an issue and make sure that we're able to guide that process and not necessarily take over that process and that there are advocates at the table that we've been able to increase their skills and their ability to speak out and be thought leaders around pregnancy prevention.

And also the next thing we'd also want to make sure that we're doing that we're building a sustainability plan over the next two years in collaboration with our community leaders that have been engaged with the project so the efforts that have started will continue throughout the life of the project.

And so that is it for what we've done in Gaston County as it relates to social determinants.

Taleria Fuller: We'll now turn it over to Carmen Chiparro.

Carmen Chiparro: Thank you. Good afternoon everyone. Thank you for joining this afternoon. My name is Carmen Chiparro and I'm the Project Coordinator for the Hartford Teen Pregnancy Prevention Initiative here in the Hartford Health and Human Services Department.

And my slides are not advancing. Okay. So here's our disclaimer.

So the Hartford Teen Pregnancy Prevention Initiative is a project of the Hartford Health and Human Services Department in partnership with multiple community agencies.

And we're focusing specifically on five Hartford neighborhoods where the highest teen birth rates exist and where socioeconomic conditions and health outcomes are least favorable.

Hartford is a small city. It's packed into nearly 18 square miles. And there are 17 distinct neighborhoods throughout the city.

Hartford's one of the poorest cities in the nation with about three out of every ten families living below the federal poverty level.

Hartford's - closer to about 125,000 people live here in Hartford. We're racially and ethnically diverse. About 40% of our population identifies as Latino and about 38% is black with about 17.8% identifying white.

About, you know, 74.3% of children living in children Hartford that are younger than 18 years of age are living in families headed by a single parent. And 42% of children younger than 18 years of age are living below the federal poverty level which I mentioned before.

And it's significant. I'm sure many of you have heard that, you know, Connecticut is both the richest and the poorest state in the nation and that holds true. We see, you know, I've given you the Hartford statistics but in general there's a huge disproportionate rate of all of these things between Hartford and the state in general.

In 2008 the Department of Health and Human Services through a grant made possible by the Kellogg Foundation was one of three Connecticut health departments that funded - was funded to pilot and explore the Health Equity Index.

The Health Equity Index is a community-based tool that can be used to identify social, political, economic and environmental conditions that are most strongly correlated with specific health outcomes.

In Hartford we've used this tool to demonstrate that teen pregnancy is not a health concern that stands alone but rather one that is affected by many other conditions.

We've used the Health Equity Index and have done some data triangulation techniques to inform decisions and program implementation, geographical distribution and target populations.

So those five neighborhoods that I mentioned earlier were really pulled from our work with the Health Equity Index.

Data monitoring and evaluation processes continue to inform our future strategic planning and implementation for sustainable efforts.

The highest teen birth rate exists in neighborhoods where socioeconomic conditions and health outcomes are the least favorable. And this relatively high teen birth rate coupled with both economic and social disparities drive the need to address precursors to teen pregnancy in the context of social determinants of health.

So connecting the dots, a high birth rate coupled with health economic and social disparities drives the need to address precursors to teen pregnancy in the context of the social determinants of health.

So creating conditions for youth to achieve economic security while educating them to make informed decisions about their reproductive sexual health is key for a community like ours.

Capital Workforce Partners, we've really - we're fortunate to have Capital Workforce Partners right here in our city with us. There the state's regional workforce investment board that coordinates programs and initiatives to develop a skilled educated and vital workforce that promotes and invests in youth in future workforce development solutions.

This board consists of 22 members from various sectors.

Through both summer youth employment and year round programming CWP serves more than 1500 youth annually. As an essential partner in economic development for the region Capital Workforce Partners promotes and invests in you in future workforce development solutions that identifies and supports development of sustainable career paths for adult workers.

It assists employers and targeted industries helping them grow and remain competitive. And the board, the Workforce Investment Board consists of private business owners, education personnel, organized labor personnel, community-based organization personnel and folks from the economic development and one-stop partners from throughout our greater Hartford region.

So why this partnership? So we have - in Dr. Aguilar's research she noted that interventions that address socioeconomic influences at multiple levels could positively affect large numbers of teens and contribute to the elimination of disparities and teen childbearing.

So evidence-based implementation sites play a key role in reaching out to high risk populations.

In Hartford we currently have 15 sites who are implementing a number of evidence-based interventions.

The nontraditional sites such as Capital Workforce Partners will first provide the opportunity for long-term vision and sustainable results and then provide access to a greater number of youth and adults who work with them.

Such nontraditional sites are more capable of addressing the social determinants commonly associated with teen pregnancy.

So by creating conditions for youths to achieve economic security while educating them to make informed decisions about their reproductive sexual health we will have a greater impact on reducing teen pregnancy rates STI and HIV in Hartford.

So our partnership, it's been a long partnership with Capital Workforce Partners we can say to steal some language from our national partners. We've been courting Capital Workforce Partners for quite a while.

In 2011 about 360 Capital Workforce Partner youth who were enrolled in summer youth employment programs completed a youth risk behavior survey for us.

And about six months later we were able to invite CWP back to the table for a conversation about the survey results and next steps.

That about a year later in 2012 we were able to pilot the implementation of Be Proud Be Responsible with two Capital Workforce Partner funded agencies. And we were able to serve 123 youth through that process.

And since then we've continued to engage CWP in conversations resulting in the development of a crosswalk between the evidence-based interventions that we've been using in Hartford and from the - from OAH's approved list with Capital Workforce Partners career competencies.

That was really important because any agency that's funded through Capital Workforce Partners is expected to meet all of the goals on their career competencies which in a five to six week, you know, summer youth employment program is exciting but can also be challenging.

So we wanted to be sure that through the engagement of Capital Workforce Partners funded sites we didn't want them to feel like they were taking on this huge responsibility which they are. But we really wanted to show them how this could really fit and work really nicely with their career competencies.

And as a result in summer 2013 we will be partnering with three of their, what they call tier one summer youth employment agencies with access to 270 youth.

And our goal is to train staff both permanent and temporary summer staff through human sexuality training as well as curriculum training and in July be

ready to jump into it and have them implementing to these 270 youth that they're serving.

So our lessons learned. Relationships take a really long time. The process has been lengthy. And the energy has always been present and been very exciting to work with Capital Workforce Partners. And that's really what's kept us motivated.

We feel it was when we took the opportunity to really do the crosswalk between the evidence-based interventions and the career competencies that we began to really kind of glue the pieces together for, you know, for all of us. It was a benefit to all of us.

And it was then that it became tangible and easier to explain to leadership in Hartford and to, you know, both our agencies and for us as a municipal department to our City Hall as well and our mayor.

So and also, you know, having done the YRBS with CWP also gave us the opportunity to present specific data about, you know, "their teens."

We have some agencies who, you know, oh our teams aren't, you know, aren't doing that or our teens don't feel a certain way. So it was really nice to have really good specific data to bring back to CWP to show them what was happening.

You know, we approached CWP strategically and really on their terms and we're really trying to speak their language.

So and as you can tell with our timeline we've been really patient and they've been really patient with us as we really tried to make this work.

And as a sustainable effort that's really our goal is to derive something that's going to be of benefit not just to our agencies but to the thousands of kids that CWP serves on an annual basis. So that's it. Thank you.

Taleria Fuller: Thank you to Anna, Michelle and Carmen for your great presentations.

We do have a few minutes and I think (Chuck) we can take a couple of questions.

Coordinator: Certainly. If you'd like to ask a question at this time please press star 1 on your phone. You'll be prompted to record your name. Please do so clearly.

One moment. Our first question today is coming from the line of (Melissa Blake). Your line is now open.

(Melissa Blake): Hi. Good afternoon. My question was for the first presenter. She used the term teen birth instead of teen pregnancy. And I was wondering if there was a particular reason for that?

Dr. Penman Aguilar: Yes because the review focused on teen births. There were other articles that discussed teen pregnancy. But the review was focused on teen births.

(Melissa Blake): May I respond to that?

Dr. Penman Aguilar: Oh yes of course.

(Melissa Blake): Okay am sorry. Is - do you find that there's a difference between the social determinants or can you even speak on that 14 birth as opposed to teen pregnancy?

I was wondering if maybe socioeconomic influences yield more births in some cases than others or if there was another background reason why the studies may not have looked at teen pregnancy?

Dr. Penman Aguilar: No. I think the background reason is simple which is that was the research question we were seeking to answer. But I would say that the social determinants are the same.

There may be - I think it's kind of the same thing that I was saying about different populations, which ones matter and how they matter may differ between the two outcomes.

But I think it's safe to say from the literature that socioeconomic status, socioeconomic factors such as these underlie teen pregnancy as well as teen birth.

(Melissa Blake): Thank you.

Coordinator: One moment for our next question.

Our next question is coming from (Marquis). Your line is now open.

(Marquis): Good afternoon. Thank you for all three presenters. Just a simple question, is there any way that I can get a copy of the slides that we saw today?

Taleria Fuller: Yes. (Chuck) I think she can print them out correct?

Coordinator: That is correct. If you look down on the bottom right-hand corner of your screen you'll see where it says Fit to Page. If you go two icons over you will see a printer. You can just click that.

(Marquis): Awesome. Okay. That's all.

Coordinator: We have no more questions at this time.

Taleria Fuller: Okay. I just want to thank again all of presenters for their great presentations. As we heard that Dr. Penman Aguilar highlighted the significance of having multilevel interventions that address the various sectors of a community.

And so we know we can all do a better job at designing targeted interventions and prevention efforts and activities that are able to successfully address the unique needs of youth.

I think that the community examples really highlight and demonstrate how communities really are willing to examine the larger context of teen pregnancy and birth and also take into consideration those factors that may impact the outcomes such as SES.

And also with all of the work that we're doing especially in our project we hope that in the end to strengthen our delivery of evidence-based programs as well as reproductive healthcare once we have a better understanding of the context in which is live, work and play.

So I just like to thank you all again for attending the Webinar. And you can go to the OAH Web site where it will be archived as well as the CDC teen pregnancy site. Thank you.

Coordinator: Thank you. That does conclude today's call. You may disconnect at this time.

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