



# 2019 MINNESOTA ADOLESCENT SEXUAL HEALTH REPORT

**This report details the sexual health of Minnesota’s youth. Teen pregnancy and birth rates are at historic lows. From 1990 to 2017, the teen pregnancy rate among 15 to 19 year-olds decreased 72%. The teen birth rate decreased nearly 67% in that same period. Young people should be commended for making wise and safe choices about their sexual health. However, despite the improvements, many challenges remain. Sexually transmitted infections are at an all-time high. Disparities by geography, race/ethnicity, and experiences with the juvenile corrections system and homelessness persist. In response to the data outlined in this report, the following are recommendations from University of Minnesota Healthy Youth Development • Prevention Research Center (PRC).**

## RECOMMENDATIONS

- Adolescent sexual health comprises much more than the absence of pregnancy, early childbearing, or infection. To fully support young people’s health, we need to address their physical, social, emotional, and cognitive development, and give them skills and supports to navigate their teen years.
- Sexual health disparities persist. We must assure that programs and services meet the unique needs of youth from underserved populations, including those who are LGBTQ, gender diverse, adolescent parents, from rural areas, homeless/runaway, in foster care, in juvenile justice settings, and/or from populations of color.
- Fostering young people’s health, including their sexual health, requires addressing social determinants of health including education, employment, income, housing, community safety and vitality, discrimination, family and social supports, and access to quality health care services.
- The systems that serve young people are not providing the supports needed to ensure overall health, including sexual health. Schools, community-based programs, clinics, and faith communities must be better prepared to have open and nonjudgmental conversations with youth.
- Families need to be supported in their role as sexuality educators. Honest, accurate and developmentally appropriate information from parents, grandparents, and other adult caregivers is the first step toward raising children who make safe and healthy decisions about sex, sexuality, and relationships.
- STI rates are at an all-time high. Current resources for STI prevention and treatment are inadequate to address this priority public health issue. Increased federal and state funding is needed to build public health education campaigns and make testing and treatment more accessible.
- Clinicians and educators must stress the importance of barrier methods, including with youth who use IUDs and implants. Widespread adoption of innovations in screening — such as universal testing in schools, street outreach, and home-based screening — together with expanded access to treatment, including expedited partner therapy, can address rising rates of STIs.
- Minnesota’s most vulnerable youth — including those who are runaway, homeless and in juvenile corrections facilities — require increased resources and targeted interventions. The systems that serve these youth have a unique opportunity to address their sexual and reproductive health care needs, and everyone has a role to play to ensure these youth have a successful transition to adulthood.



# PREGNANCY & BIRTH

Every day in 2017, approximately 8 adolescents became pregnant and 6 gave birth in Minnesota.<sup>1</sup>

## Trends in Pregnancy and Birth

Overall, the pregnancy rate among adolescents aged 15–19 decreased 4.4% from 2016 to 2017. The birth rate decreased 4.1%. Both pregnancy and birth rates are at historic lows. Since 1990, the pregnancy rate has declined 72% and the birth rate has declined 67%. From 2016 to 2017, the number of pregnancies among adolescents 15 and younger decreased 39% and the number of births decreased 20%. This change is magnified because there were so few adolescents in this age group who became pregnant and/or gave birth in 2016 and 2017.

**FIGURE 1. MINNESOTA ADOLESCENT PREGNANCY STATISTICS, 1990–2017**

NUMBER OF PREGNANCIES	1990	2000	2010	2015	2016	2017	CHANGE SINCE 1990	CHANGE SINCE 2016
Under 15	159	150	89	38	41	25	-84.3%	-39%
15–17 years	2803	2411	1479	809	755	700	-75%	-7.3%
18–19 years	5833	5164	3872	2352	2249	2177	-62.7%	-3.2%
15–19 years	8636	7575	5351	3161	3004	2877	-66.7%	-4.2%
PREGNANCY RATES PER 1,000	1990	2000	2010	2015	2016	2017	CHANGE SINCE 1990	CHANGE SINCE 2016
15–17 years	33.8	21.9	13.8	7.7	7.2	6.6	-80.3%	-7.7%
18–19 years	92.2	70.9	53.9	33.8	32.5	31.3	-66.1%	-3.8%
15–19 years	59	41.4	29.9	18.1	17.2	16.4	-72.1%	-4.4%

**FIGURE 2. MINNESOTA ADOLESCENT BIRTH STATISTICS, 1990–2017**

NUMBER OF BIRTHS	1990	2000	2010	2015	2016	2017	CHANGE SINCE 1990	CHANGE SINCE 2016
Under 15	94	87	47	22	15	12	-87.2%	-20%
15–17 years	1648	1710	1072	594	512	475	-71.2%	-7.2%
18–19 years	3688	3686	2951	1790	1689	1638	-55.6%	-3%
15–19 years	5336	5396	4023	2384	2201	2113	-60.4%	-4%
BIRTH RATES PER 1,000	1990	2000	2010	2015	2016	2017	CHANGE SINCE 1990	CHANGE SINCE 2016
15–17 years	19.9	15.5	10	5.7	4.9	4.5	-77.3%	-8%
18–19 years	58.3	50.6	41.1	25.7	24.4	23.5	-59.7%	-3.6%
15–19 years	36.5	29.5	22.4	13.7	12.6	12.1	-66.9%	-4.1%

## National Comparison

From 1991 to 2017, the birth rate among adolescents aged 15–19 in the United States dropped 70%, reaching a record low of 18.8 births per 1,000.<sup>2</sup> The decline in the adolescent birth rate over the past two decades is due to a combination of improved contraceptive use and delayed initiation of sexual activity.<sup>3</sup> More recent declines have mainly been driven by increased use of highly effective contraceptive methods (IUDs and implants) and dual methods.<sup>4,5</sup>



Despite reaching historic lows in 2017, the United States continues to have among the highest adolescent pregnancy and birth rates among developed nations.<sup>6</sup> The U.S. adolescent birth rate is five times higher than Japan, Denmark and the Netherlands, six times higher than Switzerland, and nearly ten times higher than South Korea.

## Subsequent Births

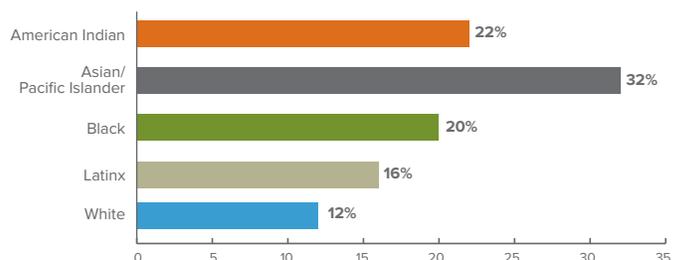
(Additional births to adolescent mothers)<sup>7</sup>:

- Nationally, 16% of births to adolescents are subsequent births.
- In Minnesota, 16% of births to adolescents are subsequent births, which is a 45% increase from 2016.

Pregnancy prevention among teen parents is a complex issue. Adolescents who experience a subsequent birth are more likely to be younger at first sex and first birth, have lower educational expectations and attainment, have intended their first birth, be living with a partner, and have not been employed or in school after their first birth.<sup>7</sup>

In Minnesota, teens with the highest percent of subsequent births are from communities of color (Figure 3).

**FIGURE 3. SUBSEQUENT ADOLESCENT BIRTHS BY RACE/ETHNICITY IN MINNESOTA, 2017**



# GEOGRAPHIC DISPARITIES<sup>8,9</sup>

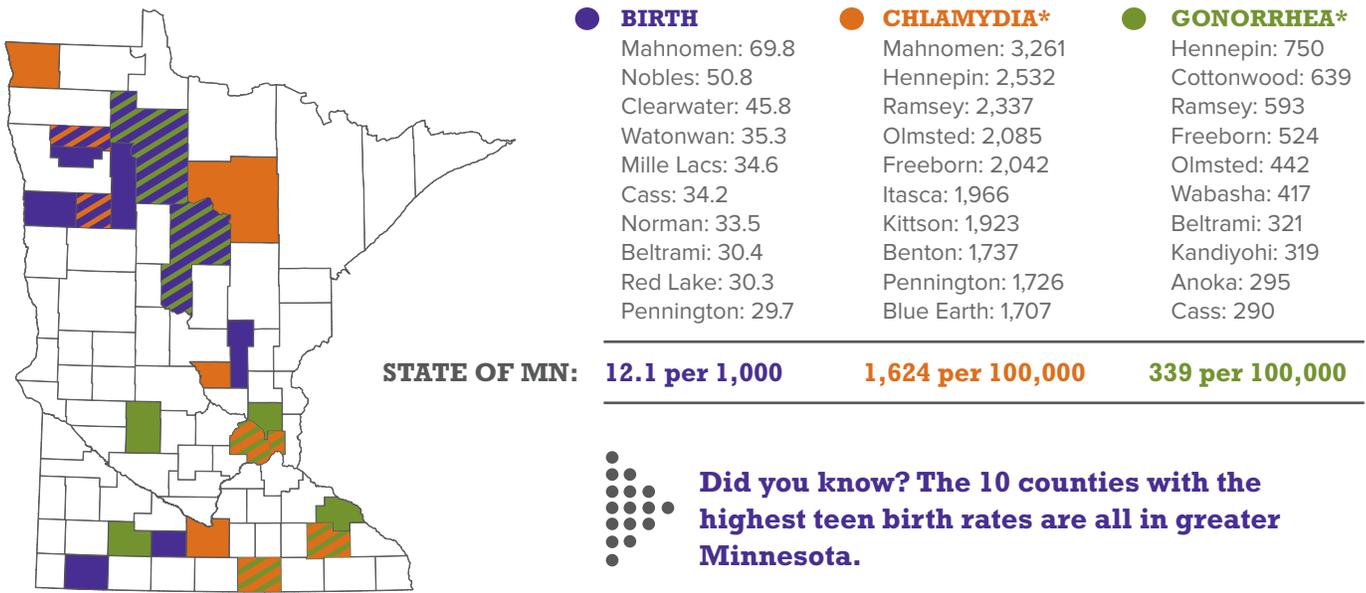
## Pregnancy and birth disproportionately impact greater Minnesota counties while STIs are widespread throughout the state.

Although the number of pregnancies and births are larger in the metropolitan area, the rates of pregnancies and births are higher in greater Minnesota. STIs are widespread throughout the state (Figure 4).

In rural areas, access to confidential, affordable, youth-friendly health care may be limited. There are large geographic disparities in sexual health clinics' hours of availability and distance to services. For example, there are 18 sexual health clinics in Hennepin and Ramsey Counties with services available five days per week.<sup>10</sup> In contrast, 47.5% of rural counties in Minnesota have no sexual health clinic.<sup>10</sup>

*\*Rural sexual health clinic access statistics are based on the Minnesota Department of Health directory of Family Planning Special Projects and Title X family planning services. Statistics may not include hospitals and primary care clinics that also provide sexual health services.*

**FIGURE 4. MINNESOTA COUNTIES WITH HIGHEST BIRTH, CHLAMYDIA AND GONORRHEA RATES AMONG YOUTH AGED 15–19**



**Did you know? The 10 counties with the highest teen birth rates are all in greater Minnesota.**

\*Chlamydia and gonorrhea rates not calculated for counties with fewer than five cases. To view county-specific adolescent sexual health reports, please visit [www.prc.umn.edu](http://www.prc.umn.edu).

# SEXUALLY TRANSMITTED INFECTIONS

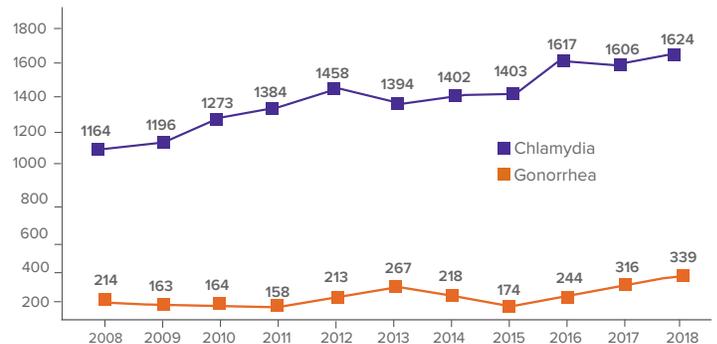
## Although they account for only 7% of the population in Minnesota, adolescents aged 15–19 accounted for 25% of chlamydia and 17% of gonorrhea cases in Minnesota in 2018.<sup>9,11</sup>

Adolescents experience a disproportionately high rate of sexually transmitted infections. This is likely due to a combination of biological, behavioral, and cultural factors, barriers to health services such as transportation, cost, concerns about confidentiality, and peer and media influences.<sup>12</sup>

### Chlamydia and gonorrhea are at an all-time high among Minnesota youth (Figure 5).

There were 8 new cases of HIV among 15–19 year olds in Minnesota in 2018. There are currently 47 adolescents (aged 15–19) living with HIV in Minnesota.<sup>9</sup>

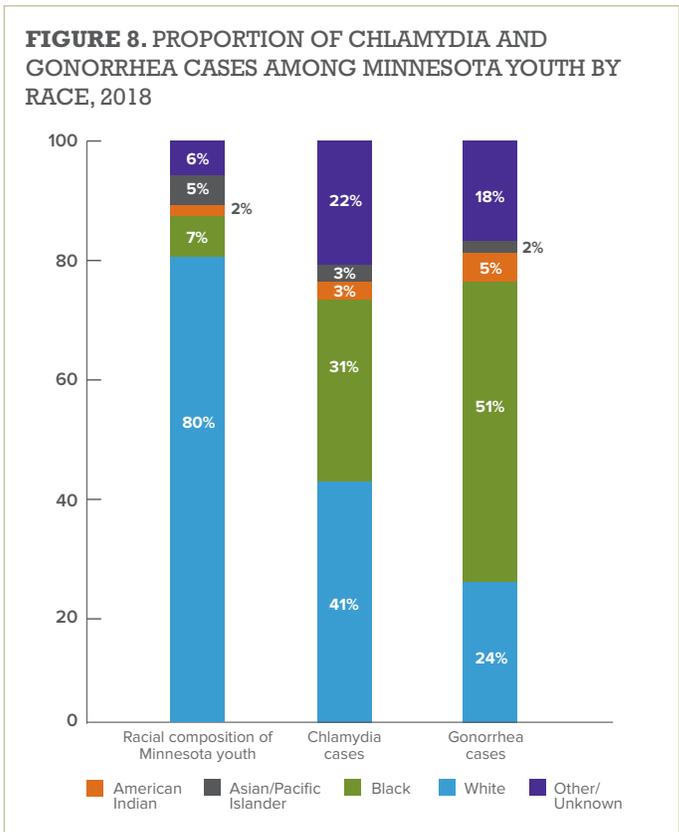
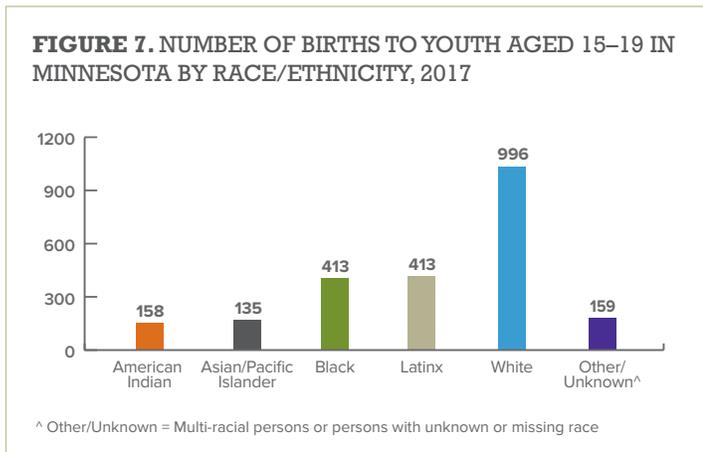
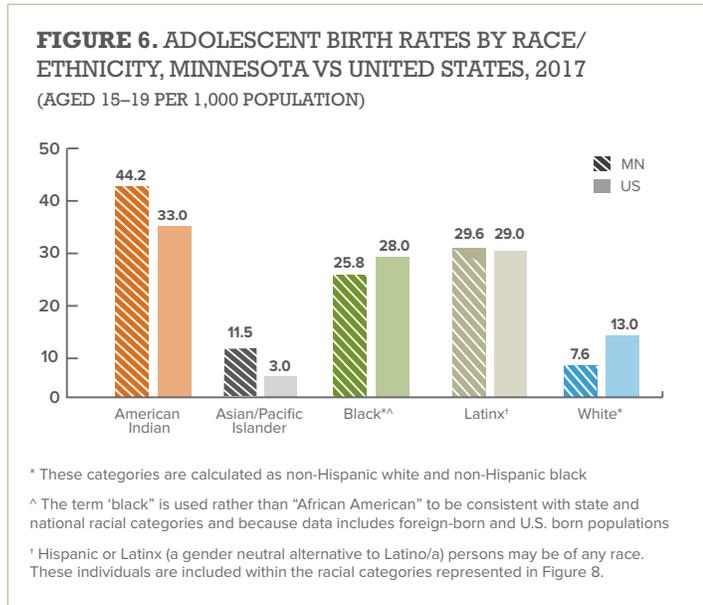
**FIGURE 5. CHLAMYDIA AND GONORRHEA RATES IN MINNESOTA, 2008–2018 (AGED 15–19 PER 100,000 POPULATION)**



# RACIAL/ETHNIC DISPARITIES<sup>8,9</sup>

The birth rate for American Indian youth is nearly six times greater than that of white youth. Birth rates for black and Latinx youth are more than three times greater than that of white youth (Figure 6).

From 2016 to 2017, birth rates decreased among adolescents who identify as white, Asian/Pacific Islander or Latinx. Birth rates increased among adolescents who identify as black or American Indian. The birth rate fell most markedly among Asian/Pacific Islander adolescents, with a decline of 24%.



## Sexually Transmitted Infections

STI rates are disproportionately high in communities of color in Minnesota (Figure 8).<sup>9</sup> The rates of chlamydia and gonorrhea were highest among black and American Indian youth. The gonorrhea rate is nearly 25 times higher and the chlamydia rate is nearly 9 times higher among black youth compared to white youth, who have the lowest STI rates of all racial/ethnic groups.

Although adolescent pregnancy and birth rates are highest among populations of color, the largest number of adolescent births in Minnesota is among white youth (Figure 7).

## Improving adolescent sexual health outcomes starts where we live, learn, work and play.

Pregnancy, birth and STI rates among Minnesota’s adolescents continue to vary across racial and ethnic groups, socioeconomic status and geography. While many programs and services focus on changing individual behaviors that lead to pregnancy, increasing attention is being paid to the social determinants that contribute to poor health outcomes through systematic lack of access to resources, power and opportunity.<sup>13</sup> Higher rates

of adolescent pregnancy have been linked with concentrated poverty, residential segregation, unemployment, and lack of access to health care and education.<sup>14-18</sup> Strategies to eliminate these persistent disparities must address the social determinants of health which disproportionately affect young people in communities of color.<sup>19</sup>

# A FOCUS ON YOUTH WHO ARE RUNAWAY, HOMELESS, AND IN JUVENILE CORRECTIONS FACILITIES

## Runaway/Homeless Youth

Compared to youth with stable housing, youth who have experienced homelessness and/or have run away from home have significantly higher rates of sexual activity, involvement in a pregnancy, substance use before last sex, no condom use at last sex, and suicide attempts (Figure 9).

**5.4% of Minnesota youth report having run away from home in the past 12 months.**



**FACT: Youth experience homelessness and/or run away from home at the same rates in both rural and urban areas of Minnesota.**

**1.1% of Minnesota youth report having stayed in a shelter or somewhere not intended for habitation in the past 12 months.**

## Youth in Juvenile Correctional Facilities (JCF)

JCF youth are almost four times more likely to be sexually active and five times more likely to have been involved in a pregnancy than non-JCF youth. JCF youth are nearly three times more likely to use drugs/alcohol at last sex, and are six times more likely to have had a suicide attempt in the past year (Figure 10).<sup>21,22</sup>

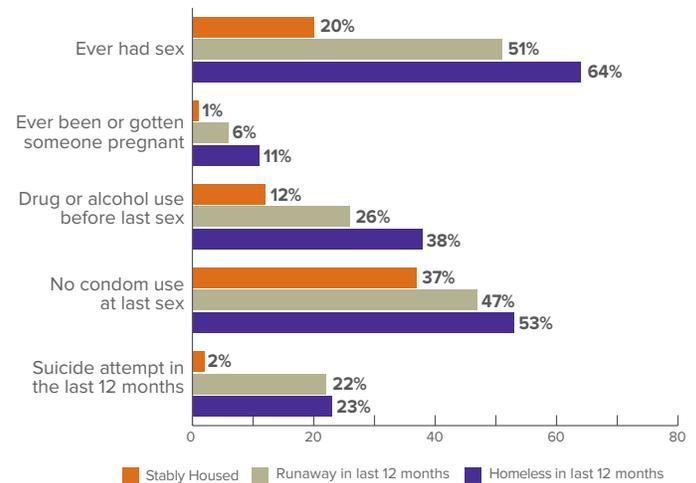
**FACT: 47% of females in JCF aged 15–19 in Minnesota have experienced sexual abuse by a non-family member.<sup>20</sup>**



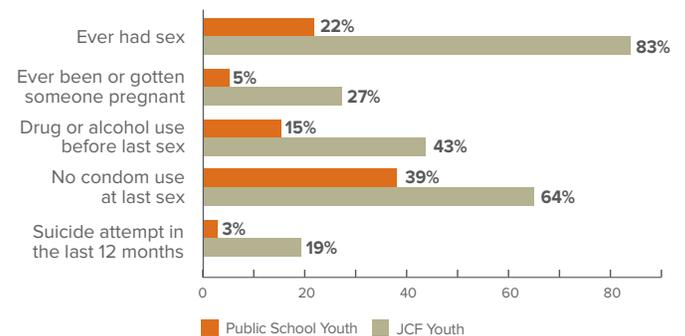
**Compared to youth in public schools, youth in JCFs are slightly older, more likely to be male, and significantly more likely to be experiencing poverty.<sup>21</sup>**

**FACT: 31% of JCF youth have experienced homelessness in the past 12 months.<sup>22</sup>**

**FIGURE 9. HOUSING STABILITY AND HEALTH INDICATORS AMONG MINNESOTA YOUTH, 2016<sup>20</sup>**



**FIGURE 10. HEALTH INDICATORS AMONG MINNESOTA YOUTH IN JUVENILE CORRECTIONAL FACILITIES (JCF) VS. PUBLIC SCHOOL YOUTH, 2016<sup>20</sup>**



## What Can We Do?

Minnesota's most vulnerable youth represent unique populations that would benefit from increased resources and targeted prevention strategies. Addressing the health outcomes of these youth requires acknowledging the cumulative impacts of limited resources, power and opportunity, while building on resilience and assets that these youth possess. Recommendations and strategies include:

- Understand the long-term health risks associated with homelessness, running away, and involvement in the juvenile justice system
- Implement strategies to improve access to stable housing and decrease juvenile justice involvement
- Identify and intervene with youth who are homeless and/or have run away
- Provide high-quality sexual health education and healthcare for systems-involved youth, and ensure continuity of care as youth transition back to the community
- Build capacity for policy, systems and environmental change to promote stable housing for all youth

Special thanks to Annie-Laurie McRee, DrPH, Janna Gewirtz O'Brien, MD, Rebecca Schlafer, PhD, MPH and Virginia Pendleton, MPH for their assistance with these data.

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Suggested citation: **Farris, J., Delehanty, E. (2019). 2019 Adolescent Sexual Health Report. Minneapolis, MN: University of Minnesota Healthy Youth Development - Prevention Research Center.**

# PRC

Healthy Youth Development  
Prevention Research Center

For over 30 years, the Centers for Disease Control and Prevention have worked to eliminate health disparities and create healthy communities by funding Prevention Research Centers (PRCs) throughout the United States.

The Healthy Youth Development • Prevention Research Center (HYD•PRC), housed at the University of Minnesota, Department of Pediatrics, is one in a network of 26 academic centers whose main objective — as a PRC — is to link science to practice and advance the fields of health promotion and prevention.

The HYD•PRC collaborates with state and local organizations and communities to conduct research, provide training, and disseminate actionable knowledge and best practices that promote healthy development and health equity for all youth.

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*Thanks to the Ripley Memorial Foundation and the  
Minnesota Department of Health for their financial support  
of this report.*

 Ripley Memorial Foundation  
A FUND OF THE WOMEN'S FOUNDATION OF MINNESOTA

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Department of Health