The State of Adolescent Sexual Health in Colorado 2014

a report by colorado youth matter

Introduction

The mission of Colorado Youth Matter is to actively engage Colorado communities to promote the healthy sexual development of all young people. This report provides a summary of relevant, up-to-date statistics on the sexual health of young people and a snapshot of how Colorado has progressed and measured up to national trends over time.

These data are intended to inform programs and policies that support the health and well-being of all Colorado youth. Colorado Youth Matter's recommendations following the data provide a framework that individual communities can tailor to support youth sexual health. For additional county-specific data on teen births and sexually transmitted infections (STIs), please visit Colorado Youth Matter's interactive map on our website: www.coloradoyouthmatter.org. Colorado Youth Matter staff is available to provide training, technical assistance and additional resources to meet community needs.

Report Highlights

- Among Colorado high school students who reported having sex in the past three months, 71% used a condom the last time they had sex.
- Less than 5% of teens are currently using the most effective and most cost-effective methods of contraception available, the IUD and the implant.
- The Colorado teen (15–19) birth rate has reached a historic low, declining 55% from 1990 to 2012.
- On average, 11 babies were born to Colorado teens every day in 2012 — or about one baby born every 126 minutes.
- Gonorrhea rates among Colorado teens have declined by 35% over the last five years.

Adolescent Sexual Behavior

Sexual Behavior and Influences

Although sexual activity among young teens is rare (only 1-5% of 12– and 13-year-olds and 5–10% of 14-year-olds have had sex), those who are younger are far less likely to use contraception than their older peers (only 52% of 12-year-olds, compared to 80–85% of 15–18-year-olds). Younger female teens were also more likely than their older peers to be coerced into having sex — 62% of 10-year-olds, 50% of 11-year-olds and 23% of 12-year-olds reported that their first sex was nonconsensual, compared with seven percent of female teens ages 13–14.[1]

Research shows that young people are less likely to have had sex (at every age group) than those born in the 1970s — that is, **more young people are delaying sexual initiation now than in the recent past**.[1] The current average age of first vaginal intercourse for both females and males is 17.1 years.[2]

In Colorado, 41% of high school students reported having had sexual intercourse at least once, with 61% of high school seniors reporting ever having sex.[3] Almost half of the students who reported recent sexual activity also reported binge drinking (45%) or using marijuana (49%) within the last month, and one quarter of students reported drinking or using drugs just prior to having sex.[3]

Contraceptive Use

U.S. high school students reported increased condom use at last sex from 46% in 1991 to 60% in 2011, and fewer teens reported using no method (from 17% to 13%).[4] **Among Colorado high school students who had sex within three months of being surveyed, 71% used a condom the last time they had sex**, and male-reported condom use increased from 67% in 2009 to 75% in 2011.[3]

A national survey of women ages 18-29 illuminates trends in contraceptive use and rationale for choosing certain types of contraception methods. Among those surveyed, 58% admitted to not using contraception every time they have sex and nearly a quarter (24%) were talked out of using contraception by a partner. Almost half (44%) had trusted their partner to use the withdrawal method effectively, and 30% had used emergency contraception at least once in their lifetime. Affordability, accessibility and efficacy were all priorities for these women when making contraceptive choices, and among this survey cohort the most widely used methods were condoms (92%) and the pill (74%).[5]

Less than 5% of teens are currently using the most effective and most cost-effective methods of contraception available, the IUD and the implant.[6] These methods, commonly referred to as long-acting reversible contraceptives (LARC), are now recommended by medical organizations as the first-line choice for adolescents who seek contraception. In addition to recommending LARC as the most effective form of contraception, health care providers should also advise youth to continue consistently using condoms to decrease the risk of sexually transmitted infections (STIs).[7] However, up to 70% of pediatricians report a need for more training on LARC,[8] and health educators, who are often on the front lines for providing contraceptive information to adolescents, are even less likely than clinicians to discuss LARC with patients.[9] Despite many myths and misperceptions that still persist among health professionals and the general public, LARC is safe for almost all teens to use and is 20–30 times more effective than commonly used methods like the pill and condoms.[10] Furthermore, when teens are educated about LARC and the additional barriers of cost and access removed, 70% percent of teens will choose a LARC method.[11]

Relationship Violence and Bullying

As previously mentioned, young people are far too often impacted by relationship violence. New research shows that **nationally more than one in three teens ages 14–20 have been involved in dating violence,**

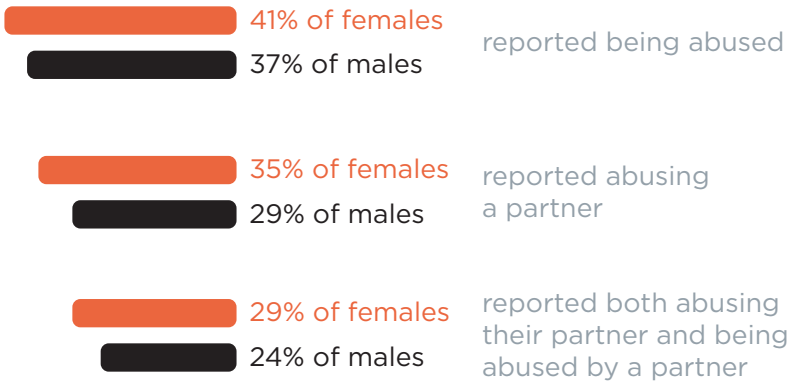
including physical, emotional and/or sexual abuse (Figure 1).[12]

This research also found that middle school students who verbally bullied their peers were seven times more likely to perpetrate physical abuse on a future partner compared with students who did not bully their peers.[12] Additional research shows that the most common age for initial sexual violence perpetration is 16.[13]

In 2011, seven percent of Colorado high school students reported being physically forced to have sex when they did not want to.[3]

Lesbian, gay, bisexual and transgender (LGBT) youth have reported high levels of bullying in school environments. A national survey showed that 82% of LGBT students reported being targeted for verbal harassment in the past year because of their sexual orientation and 64% because of their gender expression. Nearly 40% of students were physically harassed in the past year because of their sexual orientation and 27% because of their gender expression.[14]

Figure 1: Rates of physical, emotional and/or sexual abuse among females and males ages 14-20[12]



Teen Births and Abortions

When teen pregnancy occurs it is typically unplanned, as 91% of pregnancies among teens ages 15-17 are unintended compared to 77% of teens ages 18-19.[15]

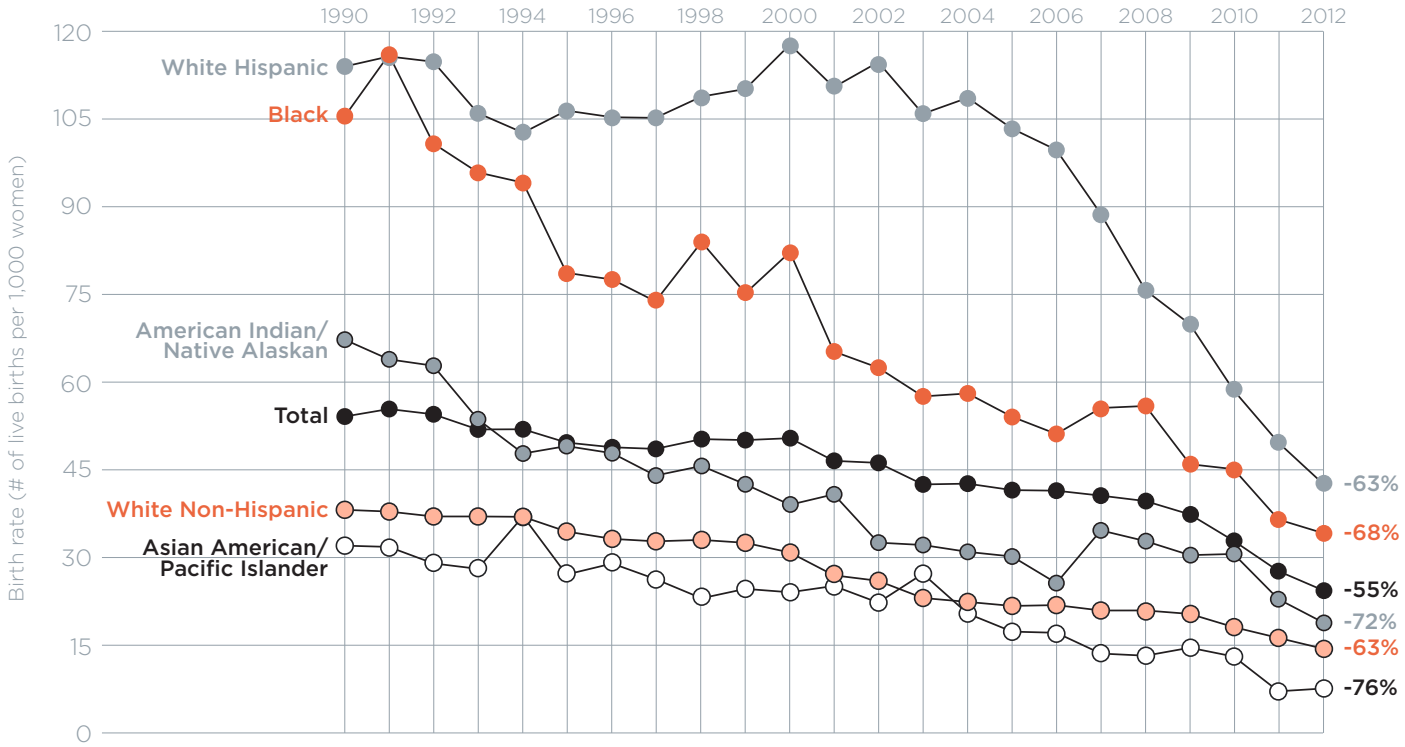
Despite the high rate of unintended pregnancy, **in 2012 the teen birth rate reached a historic low for the United States** — 29.4 births per 1,000 teens ages 15–19, a six percent decline from the previous year.[16] Colorado has also reached a historic low for teen birth rates, 24.3 births per 1,000 teens ages 15–19, which is a 55% decline between 1990 and 2012, and a 15% decline from 2011 to 2012 alone. In 2012, 4,152 females ages 10–19 gave birth in Colorado, almost 600 fewer births than the previous year. **On average, 11 babies were born to Colorado teens every day — or about one baby born every 126 minutes**.[17]

More and more counties are seeing overall decreases in teen birth rates each year. Of the 61 (of 64 total) Colorado counties with three or more births,** 95% have experienced declines in average teen birth rates since 1990, while only 5% have experienced increased teen birth rates.[17]

In 2012, the teen birth rates for all race/ethnicities declined to historic lows, both nationally and in Colorado. **Since 1990, the teen birth rates among Asian American/Pacific Islander and American Indian/Alaska Native 15–19 year old teens have declined more significantly than other race/ethnicities*.** In the last five years, Latina teens have also experienced the most dramatic decline in teen birth rates in the last five years in comparison with other racial/ethnic groups; however there are still significant disparities. Latina teens are three times more likely than White, non-Hispanic teens to experience a teen birth (Figure 2).[17]

The birth rate among teens ages 10–14 has declined even more dramatically. **Birth rates among young Colorado teens have declined 75% from 1990 to 2012**. When this trend is

Figure 2: Trends in birth rates of women (ages 15–19) in Colorado by race/ethnicity, 1990–2012[17]



**Colorado Youth Matter recognizes the great diversity that exists within each population group, especially within the Latino community. A deeper analysis is needed for an accurate depiction of the health disparities that exist among youth from diverse racial, gender, ethnic, cultural and socioeconomic backgrounds.*

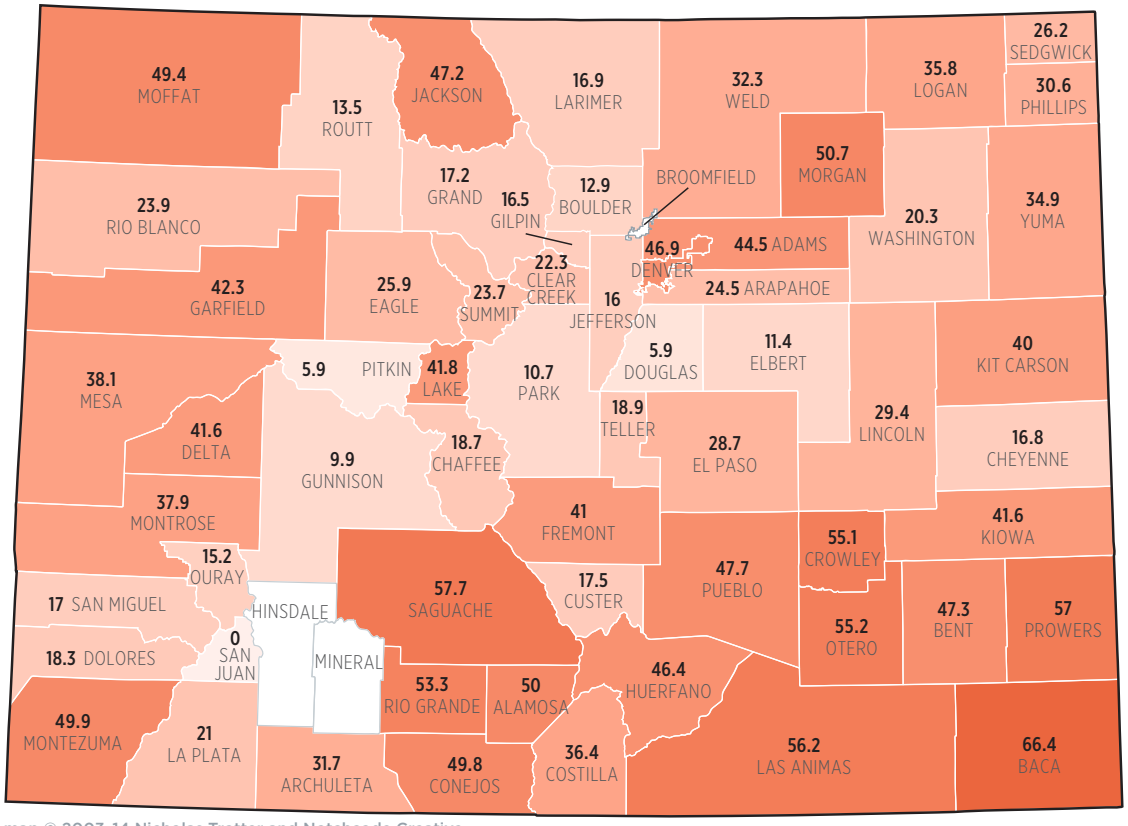
broken down by race and ethnicity, the racial disparity between different population groups is nearly eliminated.[17]

New data show that the U.S. abortion rate is the lowest it has ever been since 1973. The U.S. abortion rate for women of reproductive age (15-44) declined to 16.9 abortions per 1,000 women in 2011, a 13% decline from 2008. The estimated rate in Colorado has also dropped to 14.2 abortions per 1,000 women in 2011, a 10% decline from 2008. Approximately 88% of U.S. states have observed decreased abortion rates between 2008-2011.[18] Research suggests that restrictive laws and policies in various states, primarily in the Midwest and South, have likely not had an impact on lower abortion rates. Rather, it is posited that increased access to family planning services and increased use of long-acting reversible contraceptives (LARC), both of which have played a large role in reducing unintended pregnancies, have had more impact in reducing the abortion rate throughout the country.[18]

Currently, the state of Colorado has limited teen pregnancy, abortion and miscarriage data. If or when complete information is available, Colorado Youth Matter will include it in future reports.

For an interactive version of the county map on page 9 (Figure 3), visit our website at www.coloradoyouthmatter.org.

Figure 3: Birth rates of females ages 15–19, by Colorado county, 2010–2012 average[17]



Birth rate equals the number of births per thousand women. Darker areas indicate higher birth rates.

**Counties with fewer than three births are not included and indicated in white in order to protect privacy and confidentiality.

Pregnant and Parenting Teens

In Colorado, **teens ages 15-19 who gave birth,** in comparison with **women ages 20 or older,** were more likely to:[19]

68.2% vs. **34.3%**
live at 0-149% of the federal poverty line

...and

32.3% vs. **15.6%**
not begin pre-natal care as early as they wanted

Prenatal Care began later because they...

14.4% vs. **7%**
...couldn't get leave time from school or work

57.7% vs. **31.2%**
...didn't know they were pregnant

25.5% vs. **8.1%**
...kept the pregnancy a secret

Over the last five years, there were over 27,000 babies born to teens in Colorado. This means that, not accounting for repeat births, there may have been as many as 10,000 female teens currently parenting in Colorado in 2012.[20] In 2011, 19.4% of births to Colorado teens ages 15–19 were repeat births,[19] which is slightly higher than national repeat teen birth rates.[21] Repeat teen births can create additional challenges for teens in achieving the academic and economic opportunities they are striving for, as well as create health-related challenges for the mother and the infant, such as a higher likelihood of being preterm compared to first births (17.0% vs. 12.6%) and a higher likelihood of low birth weight (11% vs. 9%) compared to first births.[21]

Sexually Transmitted Infections (STIs)

Chlamydia

In 2012, 1.4 million cases of chlamydia were reported to the Centers for Disease Control and Prevention (CDC), which is the largest number of cases ever reported to the CDC for any condition. National chlamydia rates are highest among 15–24 year olds and, among women, rates are highest among 15–19 year olds.[22] While chlamydia rates among Colorado teens decreased slightly between 2011 and 2012, there has been very little overall change in rates over the last five years (Figure 4).[23] Following national trends, Colorado rates of chlamydia among teens are significantly higher for females than for males.[23] This trend may be due to the fact that chlamydia screening among women has become more widespread, diagnostic tests have become more sensitive to detecting infection and providers and laboratories have increased their reporting.[22]

Gonorrhea

National rates of gonorrhea in 2012 were highest among young people ages 15–24. Despite 15-19 year old teens having some of the highest rates of gonorrhea, national rates have been steadily decreasing over the last five years.[22] Similarly, **gonorrhea rates among Colorado teens have declined by 35% over the last five years** in spite of a small increase between 2011 and 2012 (Figure 4).[23] The CDC reports that inconsistent screening and the continual development of antibiotic-resistant strains make it difficult to fully understand the breadth of gonorrhea infections.[22]

Figure 4: Trends in U.S.[22] and Colorado[23] Chlamydia and Gonorrhea Rates among Adolescents Ages 15–19 (2008–2012)

	Chlamydia		Gonorrhea	
	U.S.	Colorado	U.S.	Colorado
2008	1947.7	1780.8	451.2	271.7
2009	1992.6	1837.4	403.9	216.5
2010	2002.4	1754.5	400.4	204.1
2011	2120.8	1891.5	407.2	159.8
2012	2001.7	1798.2	376.8	177.3
% change	+3%	+1%	-16%	-35%

Chlamydia and gonorrhea rates are given per 100,000 youth ages 15–19.

HIV/AIDS

Nationally among all new HIV diagnoses in 2010, one in four, or approximately 12,000, were youth ages 13–24.[24] HIV is much more widespread among young men than young women, as 80% of all new infections occur among males. Males become infected with HIV most often (87%) through male-to-male sex while 86% of females are most likely to become infected with HIV through heterosexual sex. An estimated 60% of youth with HIV do not know they are infected and thus are not receiving treatment, which can create adverse health outcomes for themselves in addition to unknowingly infecting others.[24]

Colorado HIV rates among teens ages 15–19 have slowly declined over the last five years, and there was no change in the rate between 2011 and 2012 — 1.8 infections per 100,000 youth.[23]

Human Papillomavirus (HPV)

The prevalence of the human papillomavirus (HPV), a principal cause of cervical cancer, has dropped in half from 7.2% in 2006 to 3.6% in 2010 among female teens in the United States.[25] However, only 33% of teen girls who are vaccinated received all three doses of the HPV vaccine series, and this rate decreased from 2011 to 2012 despite data that show the vaccine has contributed to the decreased prevalence of HPV.[26] Low vaccination rates may be due in part to doctors not offering the vaccination to teen patients during routine check-ups and/or parents not consenting to the vaccine. The top reasons parents have given for not vaccinating their daughters in the near future are because they feel it isn't needed, not recommended, concerned about safety, lack of knowledge about the availability of the vaccine or the belief that their daughter isn't sexually active. [26]

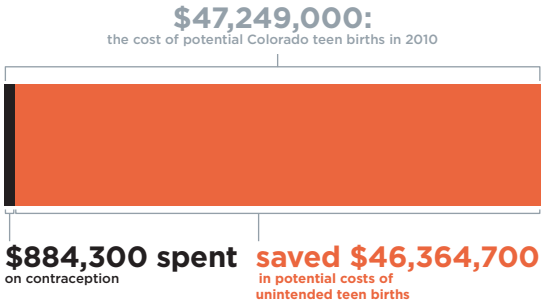
The CDC recommends that girls and boys receive the HPV vaccination around ages 11–12, as well as teens and 20-somethings that did not receive the vaccine series when they were younger.[26] While some believe this vaccine may encourage young teens to initiate sexual activity, new research confirms that receiving the HPV vaccine does not influence young women's initiation of sex and/or encourage them to engage in riskier sexual behaviors than they had prior to receiving the vaccine.[27]

Health Care Coverage and Services

The Affordable Care Act (ACA) is anticipated to have a large effect on not only the sexual and reproductive health of teens but overall health and well-being of entire families. An estimated 4.2 million uninsured youth ages 10–19 became eligible for health care coverage under the ACA in January 2014. The ACA also provides funding for teen pregnancy prevention education programs and school-based health centers.[28]

Funding for family planning services has been proven to yield substantial cost-savings nationally and in Colorado. Publicly funded clinics (such as public health departments, local health clinics, hospitals and other federally qualified health centers) provide free or reduced-fee contraceptive services to clients using Medicaid and/or Title X funds. **Nationally, publicly funded clinics have an enormous impact on preventing unintended pregnancies through investment in contraceptive services for women and teens, resulting in a net savings of $10.5 billion in 2010 alone**.[29]

Figure 5: Costs/savings in preventing unintended teen births through contraception, Colorado[29]



Among Colorado teens, an estimated 3,700 births were averted in 2010 as a result of contraceptive services offered at publicly funded family planning clinics.[29] The estimated cost of a Medicaid-covered birth (which includes prenatal care, delivery, post-partum care and infant care for one year) is $12,770. If those 3,700 births had not been averted, the total cost would amount to $47,249,000. The average cost of contraception provided at family planning clinics is $239 per client, meaning $884,300 was spent to prevent those 3,700 births. Colorado had significant cost savings by investing in contraception and thus preventing unintended teen births (Figure 5).[29]

Recommendations

These recommendations are intended to inform programs and policies that support the health and well-being of all Colorado youth. This framework supports youth sexual health and can be tailored to meet the needs of individual communities. For more information and resources, and to contact staff for technical assistance questions and needs, visit Colorado Youth Matter's website at www.coloradoyouthmatter.org.

Support all Colorado youth in achieving equitable access and educational opportunities. All students must be able to obtain the best, most relevant and developmentally appropriate education, resources and services available, regardless of socioeconomic status, geography, gender identity, race, ethnicity, sexual orientation, documentation status, ability and other demographic indicators.

Increase access to culturally-relevant and youth-friendly sexual health services, including but not limited to confidential STI testing and treatment, the most effective contraception available, safe and legal abortion, and accessible services for young families including early and quality prenatal care, child care and health care.

Increase access to safe relationships and environments that support health, equal responsibility and respect by advocating for safe and thriving communities that are free of racism, sexism, homophobia, poverty and other forms of marginalization.

Advocate for policies, programs, research and funding that promote sexual health and well-being. This includes a proactive approach to reducing the stigma and shame around youth sexuality and sexual decision making and recognizing sexual health as a holistic and integrated aspect of overall health.

Increase opportunities for youth decision-making and leadership within the family, school and healthcare systems by recognizing adolescents as consumers of their own care. Developing genuine partnerships between youth and adults is the most

effective strategy for leveraging the capacity of young people to make healthy decisions about their own lives.

Build the capacity of and promote the involvement of trusted adults, including but not limited to parents and families, who wish to work as advocates and allies in partnership with youth, to advance youth sexual health.

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Colorado Youth Matter Board of Directors, CREATE Youth Council and Staff

SASH Advisory Committee Members:

Kirk Bol, Director, Vital Statistics Unit, CDPHE

Eliza Buyers, MD, FACOG Pediatric and Adolescent Gynecology, Children's Hospital Colorado

Mary Jane Cassalia, Youth Health Specialist, CDPHE

Kelly Connor, CREATE Council Member, Colorado Youth Matter

Alexandra Eisler, Training and Technical Assistance Manager, Healthy Teen Network

Melanie Rogers, RN, BSN Public Health Nurse, Jefferson County Public Health

Jody Scanlon, Program Manager, GENESIS/GENESISTER Programs, Boulder County Public Health

Rickey Tolliver, Director, Health Surveys and Analysis Unit, CDPHE

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