This report details the sexual health of Minnesota's youth. Teen pregnancy and birth rates are at historic lows, with the teen pregnancy rate among 15-19 year olds having declined nearly 71% from 1990 to 2016 and the teen birth rate having declined 65% in that same time period. Rates have decreased most among youth from communities of color. Young people should be commended for making wise and healthy choices about their sexual health. However, many challenges remain. Sexually transmitted infections continue to increase, youth are experiencing sexual violence and harassment, and disparities – by geography, sexual orientation, race/ethnicity, and gender identity – persist. The following recommendations are the University of Minnesota Healthy Youth Development • Prevention Research Center’s (PRC) response to the issues outlined in this report.

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.

• Fostering young people’s health, including their sexual health, requires that we address social determinants of health like 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, out-of-school time 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.

• Sexual health disparities persist. We need to 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, in foster care, in juvenile justice settings, and/or from populations of color.

• STI rates have been on the rise for a decade, even while birth rates decline. Clinicians must stress the importance of barrier methods, including with youth who use IUDs and implants. Widespread adoption of screening innovations – such as universal testing in schools, street outreach, and home-based screening – and expedited partner therapy can address rising rates of STIs.

• Sexual harassment, dating violence, and sexual abuse are pervasive among Minnesota’s youth. Educators, clinicians and advocates all have a role to play in changing social norms and educating young people about healthy relationships and consent.
PREGNANCY & BIRTH

Every day in 2016, approximately 8 adolescents became pregnant and 6 gave birth in Minnesota.¹

Trends in Pregnancy and Birth

Overall, the birth rate among adolescents age 15-19 in Minnesota decreased 8% from 2015 to 2016. Pregnancy rates decreased by 5%. Both pregnancy and birth rates are at historic lows, having declined 70.8% for pregnancy and 65.5% for births since 1990. Mirroring national trends, the declines are driven by dramatic decreases in rates among Minnesota’s adolescent populations of color.²

The number of pregnancies for adolescents 15 and younger increased by 7.9% and the number of births for this age group decreased by 31.8% from 2015 to 2016. This change is magnified because there are so few adolescents in this age group who become pregnant and/or give birth each year.

FIGURE 1. MINNESOTA ADOLESCENT PREGNANCY STATISTICS, 1990-2016

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<tr>
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<tbody>
<tr>
<td>Under 15 years</td>
<td>159</td>
<td>154</td>
<td>150</td>
<td>53</td>
<td>38</td>
<td>41</td>
<td>-74.2%</td>
<td>7.9%</td>
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<tr>
<td>15–17 years</td>
<td>2803</td>
<td>2782</td>
<td>2411</td>
<td>951</td>
<td>809</td>
<td>755</td>
<td>-73.1%</td>
<td>-6.7%</td>
</tr>
<tr>
<td>18–19 years</td>
<td>5833</td>
<td>4664</td>
<td>5164</td>
<td>2610</td>
<td>2352</td>
<td>2249</td>
<td>-61.4%</td>
<td>-4.4%</td>
</tr>
<tr>
<td>15–19 years</td>
<td>8636</td>
<td>7446</td>
<td>7575</td>
<td>3561</td>
<td>3161</td>
<td>3004</td>
<td>-65.2%</td>
<td>-5.0%</td>
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</thead>
<tbody>
<tr>
<td>15–17 years</td>
<td>33.8</td>
<td>31.2</td>
<td>21.9</td>
<td>9.1</td>
<td>7.7</td>
<td>7.2</td>
<td>-78.7%</td>
<td>-6.5%</td>
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<tr>
<td>18–19 years</td>
<td>92.2</td>
<td>68.5</td>
<td>70.9</td>
<td>37.0</td>
<td>33.8</td>
<td>32.5</td>
<td>-64.8%</td>
<td>-3.8%</td>
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<tr>
<td>15–19 years</td>
<td>59</td>
<td>47.3</td>
<td>41.4</td>
<td>20.4</td>
<td>18.1</td>
<td>17.2</td>
<td>-70.8%</td>
<td>-5.0%</td>
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FIGURE 2. MINNESOTA ADOLESCENT BIRTH STATISTICS, 1990-2016

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<tbody>
<tr>
<td>Under 15 years</td>
<td>94</td>
<td>84</td>
<td>87</td>
<td>23</td>
<td>22</td>
<td>15</td>
<td>-84.0%</td>
<td>-31.8%</td>
</tr>
<tr>
<td>15–17 years</td>
<td>1648</td>
<td>1939</td>
<td>1710</td>
<td>708</td>
<td>594</td>
<td>512</td>
<td>-68.9%</td>
<td>-13.8%</td>
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<tr>
<td>18–19 years</td>
<td>3688</td>
<td>3273</td>
<td>3686</td>
<td>2002</td>
<td>1790</td>
<td>1689</td>
<td>-54.2%</td>
<td>-5.6%</td>
</tr>
<tr>
<td>15–19 years</td>
<td>5336</td>
<td>5212</td>
<td>5396</td>
<td>2710</td>
<td>2384</td>
<td>2201</td>
<td>-58.8%</td>
<td>-7.7%</td>
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<tbody>
<tr>
<td>15–17 years</td>
<td>19.9</td>
<td>21.7</td>
<td>15.5</td>
<td>6.8</td>
<td>5.7</td>
<td>4.9</td>
<td>-75.4%</td>
<td>-14.0%</td>
</tr>
<tr>
<td>18–19 years</td>
<td>58.3</td>
<td>48.1</td>
<td>50.6</td>
<td>28.4</td>
<td>25.7</td>
<td>24.4</td>
<td>-58.1%</td>
<td>-5.1%</td>
</tr>
<tr>
<td>15–19 years</td>
<td>36.5</td>
<td>33.1</td>
<td>29.5</td>
<td>15.5</td>
<td>13.7</td>
<td>12.6</td>
<td>-65.5%</td>
<td>-8.0%</td>
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National Comparison

From 1991 to 2016, the birth rate for youth aged 15–19 in the US dropped 67%, reaching a record low of 20.3 births per 1,000 in 2016.³ While the overall decline in the adolescent birth rate over the past two decades is likely due to a combination of improved contraceptive use as well as delayed initiation of sexual activity, declines in the past decade have mainly been driven by increased use of highly effective contraceptive methods (IUDs and implants) and dual methods.⁴⁵⁶

Despite reaching historic lows in 2016, the United States continues to have among the highest adolescent pregnancy and birth rates among developed nations. The U.S. adolescent birth rate is five times higher than Denmark, Japan and the Netherlands, nearly seven times higher than Switzerland and ten times higher than South Korea.⁷

Subsequent Births (Additional births to adolescent mothers):³
- Nationally, 16% of births to adolescents are subsequent births.
- In Minnesota, 11% of births to adolescents are subsequent births.

Pregnancy prevention among adolescent mothers 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 to not have been employed or in school after their first birth.⁸ In Minnesota, teens with the highest percent of subsequent births are from communities of color. Over 30% of births to Asian/Pacific Islander youth, 22% of births to American Indian youth and 20% of births to Latinx youth are subsequent births compared to 11% of births to white adolescents.³
GEOGRAPHIC DISPARITIES\textsuperscript{9,10}

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

Although the numbers of pregnancies, births and STIs are larger in the metropolitan area, these issues also affect greater Minnesota (Figures 3 and 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 throughout Hennepin County with services available 5 days per week.\textsuperscript{11} In contrast, 47.5% of rural Minnesota counties have no sexual health clinic.\textsuperscript{11}

Youth in rural counties may have to travel an hour or more to access services; sexual health clinics may be open only a few days a month. Additionally, rural youth seeking sexual health care may have heightened privacy and confidentiality concerns due to visibility and interconnected social networks in small communities and personal relationships with health care providers.\textsuperscript{12} Improving adolescent sexual health in Minnesota requires a heightened focus on rural areas.

*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 clinics that also provide sexual health services.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure3.png}
\caption{Minnesota Counties with highest birth, Chlamydia and Gonorrhea rates among youth aged 15-19}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure4.png}
\caption{Chlamydia and Gonorrhea cases among youth aged 15-19 by geographic location, 2017}
\end{figure}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
Proportion of the population & \% & \% & \% \\
\hline
Chlamydia cases & 47.6 & 18.2 & 34.2 \\
\hline
Gonorrhea cases & 68.6 & 13.1 & 18.3 \\
\hline
\end{tabular}
\end{table}

*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.
Racial/Ethnic Disparities

The birth rate for American Indian youth is nearly five times greater than that of white youth and the birth rates for black and Latinx youth are three times greater than that of white youth (Figure 5). Although adolescent pregnancy and birth rates are highest among Minnesota populations of color, the largest number of adolescent births is among white youth (Figure 6).

From 2015 to 2016, birth rates decreased among adolescents in every racial group except American Indian youth, which increased by 5.9%. The birth rate fell most markedly among Asian/Pacific Islander youth, which saw declines of 14.3%.

Sexually Transmitted Infections:
STI rates are disproportionately high for communities of color in Minnesota (Figure 7). The rates for both chlamydia and gonorrhea were highest among black youth, followed by Latinx and American Indian youth. The gonorrhea rate is 33 times higher for black youth and the chlamydia rate is over 9 times higher for black youth compared to the rate for white youth.

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

Pregnancy, birth and STI rates among Minnesota youth 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. Higher rates of adolescent pregnancy have been linked with concentrated poverty, residential segregation, unemployment, and lack of access to health care and education. Strategies to eliminate these persistent disparities must address the social determinants of health which disproportionately affect young people in communities of color.
**SEXUALLY TRANSMITTED INFECTIONS**

Even though they account for only 7% of the population in Minnesota, adolescents ages 15-19 accounted for 25% of chlamydia and 18% of gonorrhea cases in 2017.\(^{20,10}\)

Adolescents and young adults experience a disproportionately high rate of sexually transmitted infections. This is likely due to a combination of biological, behavioral and cultural factors, including young women’s increased anatomical vulnerability to infection, barriers to health services such as transportation, cost, concerns about confidentiality, and peer and media influences.\(^{21}\)

After a 15% spike in 2016, the chlamydia rate decreased very slightly by 0.7% in 2017.\(^9\) While the gonorrhea rate among 15-19 year olds fell to a low of 174 cases per 100,000 in 2015, in the past two years rates have increased by 82% to 316 cases per 100,000. This is the highest figure in over 10 years (Figure 8).\(^{10}\)

There were 8 new cases of HIV among adolescents aged 15-19 in Minnesota in 2017, which is a decrease of 47% from 2016 when 15 new cases were diagnosed in this age group. There are currently 56 adolescents (aged 15-19) living with HIV in Minnesota.

**A FOCUS ON SEXUAL MINORITY, TRANSGENDER AND GENDER DIVERSE YOUTH**

Sexual minority, transgender and gender diverse (TGD) youth experience substantial health disparities compared to heterosexual, cisgender adolescents.

Over 1.5 times more gay, lesbian and bisexual youth report having ever had sex compared to their heterosexual or questioning peers. Over five times more bisexual youth report ever being pregnant compared to their heterosexual and lesbian peers.

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**FIGURE 9. RISK BEHAVIORS AMONG MINNESOTA STUDENTS BY GENDER IDENTITY, 2016**

- Ever had sex
  - Cisgender: 22%
  - Transgender and gender diverse: 30%
- No condom at last sex
  - Cisgender: 38%
  - Transgender and gender diverse: 51%
- Depressive symptoms
  - Cisgender: 21%
  - Transgender and gender diverse: 58%
- Suicide attempt (ever)
  - Cisgender: 7%
  - Transgender and gender diverse: 31%
- Bullied because of gender
  - Cisgender: 15%
  - Transgender and gender diverse: 47%

Sexual minority and TGD youth are more likely to report risk behaviors than their heterosexual and cisgender peers (Figures 9 and 10).\(^{22,23}\) Sexual minority and TGD youths’ experiences of individual, interpersonal and structural stigma (such as internalized homophobia or transphobia, prejudice and discrimination, and exclusionary policies) may contribute to psychological distress, increased risk behaviors and adverse health outcomes.\(^{24}\) These disparities demonstrate the need for health professionals, school staff, community organizations, and policy makers to recognize, support and protect these vulnerable youth.\(^{21}\)

2.7% of youth in Minnesota identified as TGD, which is comparable to the proportion of youth with autism spectrum disorders (1.5%), food allergies (3.9%) and developmental delays (3.7%).\(^{21}\)
RELATIONSHIP VIOLENCE AND SEXUAL ABUSE AMONG MINNESOTA YOUTH

Overall, nearly 14% of Minnesota youth reported violence in their dating relationships.

Note: These findings are preliminary and do not consider co-occurring factors.

Sexual Harassment: Overall, 19.3% of students in Minnesota report experiencing sexual harassment victimization (sexual jokes, comments or gestures) by other students in the past 30 days. Students who experience sexual harassment at school are more likely to report skipping school, feeling like their friends and school staff don’t care about them, and feeling unsafe at school (Figure 1).

Intimate Partner Violence: Overall, 10.3% of 9th graders and 17.2% of 11th graders report experiencing some form of intimate partner violence (IPV), with many students experiencing multiple forms of violence (verbal, physical and/or sexual) in their dating relationships (Figures 12 and 13). Females report experiencing IPV twice as often as males, and female 11th graders report sexual violence more than three times as often as their male peers. Youth experiencing violence in dating relationships are less likely to report using a condom the last time they had sex.

Sexual Abuse: Students with a history of sexual abuse were three to four times more likely to report suicidal ideation than students without a history of sexual abuse. Females with a history of sexual abuse were five times more likely to report a suicide attempt, and males were eight times more likely to report a suicide attempt (Figure 14). Students with a history of sexual abuse were twice as likely to report having ever had sex, three times as likely to have had multiple partners in the past year, and nine times more likely to have been involved in a pregnancy (Figure 15).
**What Can We Do?**

There is a high prevalence of sexual violence throughout the state. Minnesota is addressing sexual violence by:

- Conducting prevention strategies to reduce first-time perpetration
- Building capacity for policy, systems, and environment change, including local and organizational level policies and practices, in order to change harmful social-cultural norms
- Promoting healthy and equitable relationships
- Centering health equity approaches and working against systems of oppression
- Addressing sexual violence as an integrally connected issue with sexual health, chronic disease, mental illness, substance misuse, and other health issues

Much more can be done. Communities facing oppression and health disparities experience sexual violence at higher rates. Organizations serving these communities require more prevention resources and support. They have deep understandings of the communities they reflect and serve, are leaders in prevention, and know the best solutions for themselves. We must support community-driven research to inform sexual violence prevention programs, policies, and practices.

Everyone has a role in creating a healthy world for our youth to thrive. We can accomplish this by building on aforementioned strengths, as well as:

- Partnering with organizations that reflect and serve populations experiencing disparities
- Focusing on racial and gender equity in school policy improvements, including discipline protocols that contribute to the school-to-prison pipeline, culturally responsive teaching and curriculum, and training school staff to interrupt sexualized, racialized or gendered comments
- Teaching the histories, resiliencies and social movements of girls, women, transgender and gender diverse youth and providing leadership opportunities to these groups
- Providing comprehensive, medically accurate and age-appropriate sexuality education that includes healthy relationships, gender and sexual orientation
- Increasing availability of mental health services, with particular strategies for boys and young men, and creating trauma-informed environments for youth with adverse childhood experiences

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**Sexual Exploitation:** In 2011, Minnesota passed the Safe Harbor Law, which decriminalized and increased legal protections for sexually exploited youth. Between July 2015 and June 2016, Safe Harbor providers served 826 sexually exploited youth in Minnesota. The youth who received services were on average 15 years old, 85% female, and were referred to services from 55 different Minnesota counties.

Note: This data does not represent all youth who were sexually exploited in Minnesota, but rather only those that received services.

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**Fourteen percent of homeless youth in Minnesota report being sexual with someone only for the purpose of getting shelter, clothing or food. Lesbian, gay and bisexual (LGB) youth are over twice as likely to engage in “survival sex” as non-LGB homeless youth.**
REFERENCES

1 Minnesota Department of Health (MDH), Center for Health Statistics. Minnesota Health Statistics Annual Summary, 2016.