The State of Adolescent Sexual Health in Colorado

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A report by

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and

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Foreword

In December 2017, Colorado Youth Matter (CYM), the state's leading nonprofit organization committed to improving youth sexual health, announced it would be closing its doors. As a result, Trailhead Institute was selected to receive CYM's assets in January 2018. During the summer of 2018, Trailhead conducted an environmental scan with stakeholders across the state to identify the gaps and priorities of youth sexual health.[1]

The State of Adolescent Sexual Health (SASH) Report was one critical resource whose absence was identified as a gap. This year's report was assembled through a partnership between the Colorado Department of Public Health and Environment (CDPHE) and Trailhead Institute. This effort is not meant to re-invent the report but rather to continue its legacy, and through improvements, reflect the issues of the current adolescent sexual health landscape.

This report provides a summary of up-to-date statistics on the sexual health of young people and a brief snapshot of how Colorado's progress compares to national trends over time. These data are intended to inform programs and policies across the state that support the health and well-being of all Colorado youth. The recommendations at the end of this report provide a framework that communities can adapt to support youth sexual health.

While data presented in this report are vital to improving the sexual health of young people, it is equally important to reflect on these data through a health equity lens. Because nearly 80 percent of our health is determined by where we live, work, learn, and play, it is necessary to address the environmental, social, and economic factors that have set the foundation of the social norms and systems that have left communities behind.[2] **Health Equity** acknowledges the advantages and barriers experienced by many and recognizes that individuals and communities are not to blame for the disparities they face. A principle of health equity is that all Coloradans should have equitable access and opportunity to thrive and reach their full health potential.[3]

Executive Summary

The 2018–2019 State of Adolescent Sexual Health (SASH) Report presents local and national findings and recommendations based on the current adolescent sexual landscape within a shared risk and protective factor framework. The report offers up-to-date statistics related to adolescent sexual health in Colorado, including adolescent sexual behavior, birth rates, STI transmission, interrelated health outcomes, and health care accessibility. Within these categories, it explores health outcome disparities associated with sexual orientation, gender identity, race/ethnicity, and geography. This report acknowledges that individuals and communities are not to blame for the disparities they face as these are the result of various underlying environmental, social, and economic factors that have set the foundation of the social norms and systems that have left communities behind.

Key Findings

- **In 2017, more than half (52.6 percent) of young people in Colorado became sexually active by the 12th grade.**
- **Colorado continues to be a national leader** in the number of youth using a Long Acting Reversible Contraceptive (LARC) method for contraception: 10.3 percent of sexually active youth reported using a LARC method. However, there has also been a 7.5 percent decline in youth condom use since 2013, putting young people at a greater risk of STIs.
- From 2007 to 2017, Colorado experienced a **61 percent decrease in birth rates** among young people ages 15-19. **Challenges remain, however.**
    - Of all births among young people, the majority (72.9 percent) were unintended pregnancies.
    - Hispanic and black youth were almost three times more likely to experience a birth at a young age compared to their white peers. Significant structural barriers such as stigma, discrimination, low socio-economic status, high unemployment rates, high poverty rates, misinformation, lack of health care coverage, and limited access to services disproportionately affect youth of color.
    - Birth rates among young people in rural counties continue to be notably higher than in urban counties and are decreasing at a much lower rate. Compared to their urban peers, youth in rural counties experience fewer economic and educational opportunities and face increased barriers to accessing health care services, including transportation challenges and a scarcity of health care professionals.
- **Reported STIs have increased significantly** among youth ages 15-19 between 2016 and 2017. Gonorrhea rates increased 30.4 percent, HIV rates increased 23.3 percent, and chlamydia rates increased 7.2 percent.
- **In 2017, more than one in three transgender youth and one in ten female youth reported experiencing sexual violence in their lifetime.**
- **Youth who felt connected to a trusted adult and to school were more likely to delay sexual initiation and use condoms.** These connected youth were less likely to be bullied on school property or electronically, less likely to experience sexual violence, and less likely to have attempted suicide.

Recommendations

Based on report findings, current research, and experts in the field, the following recommendations were identified to address current trends and improve adolescent sexual health across the state:

1. Reduce barriers and ensure equitable access to health care for all Coloradans.

2. Strengthen educational systems to provide critical knowledge and skills that ensure young people can make autonomous and informed sexual health decisions

3. Build protective and supportive environments for young people so they can thrive and reach their full potential.

4. Address underlying structural drivers that lead to adverse health outcomes among youth through policies, practices, and organizational systems. Ensure special emphasis on those drivers that lead to disparities based on sexual orientation, gender identity, race/ethnicity, and geography.

Detailed recommendations can be found on pages 19-20 of the full report.

Shared Risk and Protective Factor Framework

In order to gain a deeper understanding of adolescent sexual and reproductive health behaviors it is necessary to address the inter-related and underlying factors influencing these behaviors. This report acknowledges that adverse adolescent sexual health outcomes are interconnected to multiple other health outcomes including sexual violence, suicide, and bullying. These behaviors share many of the same underlying causes, including: stigma; discrimination; high unemployment rate and diminished economic opportunities; insufficient health care coverage and access to services; and weak health, educational, economic, and social policies or laws. Addressing these shared factors through policies, practices, and organizational systems broadens the impact of primary prevention strategies and can improve opportunities for all youth in Colorado.[4]

The field of adolescent health has historically focused on addressing and minimizing risk factors, things that increase the likelihood of experiencing adverse health outcomes. Equally important is the promotion of protective factors, things that increase resilience in youth or make them less likely to experience adverse health outcomes.[5] Research shows that adolescents' sense of connectedness to caring adults, school or community is protective against a wide range of adverse health-related outcomes.[6] Youth who feel connected are more likely to engage in healthy behaviors and excel academically. Therefore, promoting shared protective factors, such as youth connectedness, have important implications for youths' overall health and well-being.

Based on the most recent Healthy Kids Colorado Survey (HKCS) data, the majority of youth reported having strong trusted adult relationships and positive perceptions about the importance of school. In 2017, 73.5 percent of Colorado youth reported having an adult to go to for help with a serious problem and 97.5 percent reported it was important to finish high school.[7]

While existing approaches that focus on individual-level behavior change are an important component of prevention efforts, modifying individual behavior in an environment that continues to facilitate or support these behaviors is extremely challenging.[8] As a result, implementing community-level strategies that modify the characteristics of neighborhoods, school systems, workplaces, and other organizational settings rather than the individuals within the community, is critical for multi-level prevention efforts and significant population-level reductions in adverse health outcomes among youth.[9]

In 2017, 73.5 percent of Colorado youth reported having an adult to go to for help with a serious problem and 97.5 percent reported it was important to finish high school.[7]

Adolescent Sexual Behavior

Adolescence is a stage of significant transition and development in which youth become increasingly independent, self-reliant, and capable of making autonomous decisions. This requires programs, practices, and policies to promote the development of critical skills through strengths-based approaches and to provide opportunities for youth to foster connections and build positive relationships with prosocial peers and caring adults.[10]

Sexual health is an integral part of one's own overall health and wellness and adolescence is a critical time to learn about oneself, one's body, intimate partners, and relationships while simultaneously mitigating risk and developing positive sexual health behaviors.[11] In 2017, 40.0 percent of U.S. high school students reported ever having sex compared to 32.7 percent of Colorado high school students.[12,13] In Colorado, male students were slightly more likely to report ever having sex, 35.0 percent compared to 30.3 percent of female students. Among Colorado high school age youth, 22.9 percent reported being currently sexually active (had sex with one or more people during the past three months before being surveyed).[14]

Access to a trusted adult and a sense of connectedness to school were important protective factors for youth's sexual behavior.

Older students were more likely to report engaging in sexual activity. In Colorado, more than half (52.6 percent) of 12th grade students have had sex, while 13.7 percent of 9th grade students have done so.[15] The most common age of sexual initiation was 15 years old and only 2.5 percent of youth reported having sex for the first time prior to the age 13.[16] It is important to note that this data does not discern between consensual sex and sexual abuse.

With more than half of young people becoming sexually active in high school, it is essential for youth to have access to comprehensive sexuality education (CSE), positive relationships with the adults in their lives, and health care coverage and services to support their sexual and reproductive decision-making early in adolescence.[17]

According to 2017 HKCS data, access to a trusted adult and a sense of connectedness to school were important protective factors for youth's sexual behavior. Youth who reported having a trusted adult, those who reported enjoying being at school, and those who believed it was important to finish high school were more likely to delay sexual initiation, have fewer sex partners, and were less likely to use alcohol or drugs the last time they had sex (Table 1).[18]

Figure 1: Proportion of Colorado Students Who Ever Had Sexual Intercourse by Grade.[15]

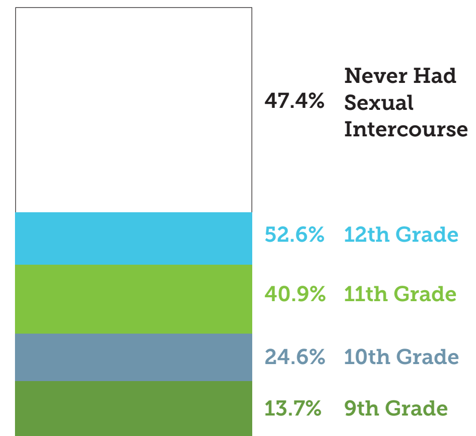


Table 1: Presence of Trusted Adults, School Connectedness and Youth Sexual Behaviors, Colorado, 2017[18]

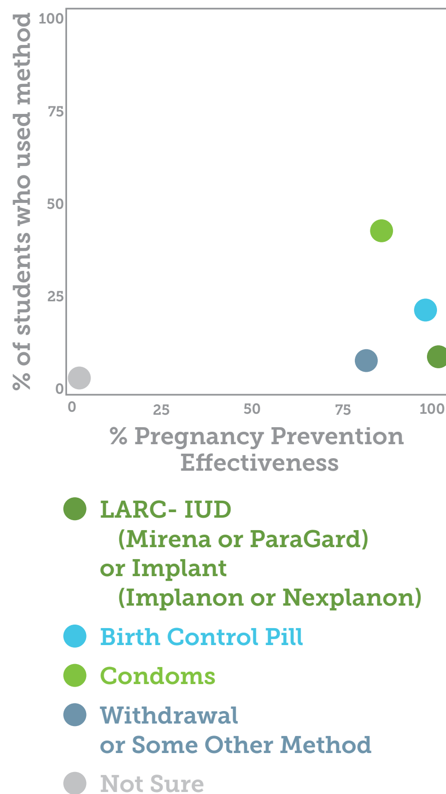
Percent of students who…	Trusted Adult		School Connectedness			
	…had an adult to go to for help with a serious problem	…did not have an adult to go to with a serious problem	…enjoyed being in school	…did not enjoy being in school	…think it's important to finish high school	…don't think it's important to finish high school
…had sex before 13	1.8	6.3	1.0	2.9	1.9	21.6
…have had sex with 4 or more people in their lifetime	7.0	13.6	4.3	9.3	7.1	32.3
…used alcohol/ drugs during their last sexual intercourse	16.3	29.8	11.6	20.1	16.9	50.8
…used a condom the last time they had sex	60.9	51.0	65.6	54.7	58.0	41.2

Darker shades indicate a higher degree of safe sexual behavior.

Contraceptive Use

Colorado youth were more likely than their national peers to use birth control the last time they had sexual intercourse. Nine out of ten Colorado youth reported they used birth control the last time they had sex.[19] Consistent with past trends, older students were more likely to use contraception. Among sexually active youth ages 16 and older, 80.0 percent used a method of contraception compared to 73.0 percent of youth 15 years and younger.[20]

Figure 2: Most Common Contraceptive Methods Used for Birth Control Among Sexually Active Youth, Colorado, 2017[34,35]



Despite the majority of youth using birth control, youth face significant barriers to contraceptive use, including stigma, lack of sexual health information, lack of health care coverage, limited access to effective methods of contraception, and confidentiality concerns.[21,22] For example, between 2011 and 2013, only 50 percent of U.S. female students and 58 percent of male students ages 15-19, received formal instruction about condom use as part of their sexual health education in school and about half of all adolescents received no formal instruction on any form of contraception.[23] The cost of contraception is also a significant barrier; for example, long-acting reversible contraceptives (LARC) such as IUDs and implants, can cost up to $1,300 including a medical exam, implant/IUD, insertion of the device, and follow-up visits.[24]

The Colorado Family Planning Initiative (CFPI) has been critical in reducing barriers of cost and access to effective contraception among young, low-income women across the state. Between 2009 and 2016, CFPI provided more than 43,000 no-cost or low-cost IUDs to Colorado women.[25] Because of the CFPI along with many other family planning clinics and champions, Colorado continues to be a national leader in the number of youth using a LARC method for contraception. In 2017, 10.3 percent of Colorado youth reported using a LARC methodcompared to only 5.3 percent of their national peers.[26,27]

Nationally, there has been a significant increase in youth using highly effective hormonal methods (greater than 90 percent effective) like IUD, implant, injectable, patch, ring or pill. In 2017, 34.6 percent of U.S. female students reported using a hormonal method compared to 29.8 percent in 2013.[28] While highly effective for pregnancy prevention, these methods do not provide protection against sexually transmitted infections.

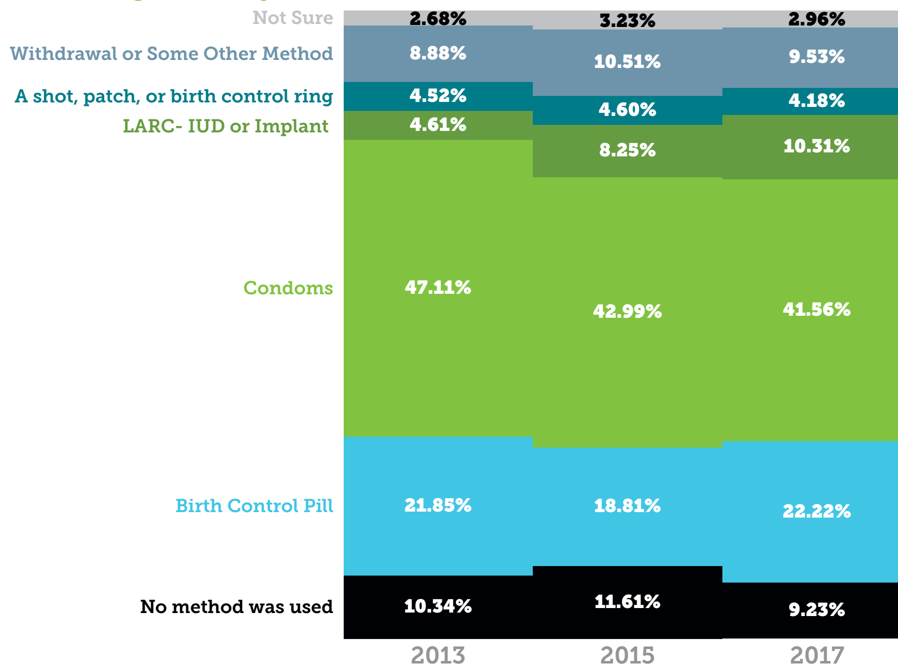
With correct and consistent use, barrier methods such as condoms are considered the most effective method for STI and HIV prevention.[29] Although sexually active youth in Colorado report higher condom use than their national peers, the percentage of Colorado high school students who used a condom the last time they had sex has been significantly decreasing over the years. In 2013, 63.6 percent of Colorado youth used a condom the last time they had sex, but in 2017, 58.9 percent of Colorado youth had done so.[30,31] A similar 10-year trend was reported among high school students nationally.[32]

Among sexually active youth, those who reported having a trusted adult and those who reported it was important to finish high school were more likely to report condom use the last time they had sex (Figure 1).[33]

Figures 2 and 3 depict contraceptive use when used intentionally for birth control. This is valuable trend data but does not reflect when multiple contraceptive methods are used or capture all contraceptive use, such as condoms when used for STI protection.

The Colorado Family Planning Initiative (CFPI) has been critical in reducing barriers of cost and access to effective contraception among young, low-income women across the state.

Figure 3: Trends in Contraceptive Methods Used for Birth Control Among Sexually Active Youth, Colorado, 2013–2017[34,35]



Births Among Young People

Teen pregnancy prevention efforts often unfairly depict young parents in a negative and biased manner. These shame-based approaches blame young parents for the systemic inequities they face and are not only ineffective, but also perpetuate discrimination among young parents and families.[36] When youth have access to a full range of sexual and reproductive health care information, resources, and services, young people are fully capable of considering alternatives and making informed decisions for themselves, including decisions about pregnancy and parenting.[37]

Despite declines in births among young people across all racial/ethnic groups, disparities continue to persist.

Rates of young people carrying pregnancies to term have reached historic lows. The 2017 U.S. birth rate among females ages 15-19 was 18.8 births per 1,000, a 55 percent decline from 2007.[38] During the same time period, Colorado experienced a 61 percent decrease in births among young people. Colorado's 2017 birth rate among young people ages 15-19 was 15.5 births per 1,000.[39] There was also a drastic decline in Colorado repeat births (two or more live births before the age of 20) among youth of this age range. Since 2007, Colorado repeat births decreased 72.3 percent, from 1,317 repeat births in 2007 to 365 in 2017.[40] While this data is encouraging, it is important to note that of all births among young people, the majority (72.9 percent) were unintended pregnancies.[41]

Despite declines in births among young people across all racial/ethnic groups, disparities continue to persist. Hispanic and Black youth were almost three times more likely to experience a birth at a young age compared to their White female peers (Figure 4).[42] Significant structural barriers such as stigma, discrimination, low socio-economic status, high unemployment rates, high poverty, lack of health care coverage, limited access to services, and misinformation disproportionately affect youth of color.[43,44]

For instance, as a result of redlining practices by the Federal Housing Administration, families of color in Denver were forced to live in "undesirable" neighborhoods- ones that were not improved by policies related to affordable housing or access to schools, grocery stores, and parks.[45] Due to redlining and predatory lending practices, communities of color have been, and continue to be excluded from equal opportunities to build wealth. These communities experience disproportionately high levels of poverty, and children of parents and grandparents who lived in redlined neighborhoods are more likely to live in these same neighborhoods today.[46] Further compounding the systemically induced cycle of poverty among communities of color, Hispanic communities have the highest rates of uninsured individuals. Although Hispanic communities make up only 21.2 percent of the total population in the state, they account for the highest uninsured rates (34.0 percent).[47] These systemic challenges make it more difficult for young people to access preventive health information and services.

Although birth rates among young people have decreased across the state, rates in rural counties continue to be notably higher and are decreasing at a much lower rate (Figure 5).[48] Compared to urban youth, youth in rural counties experience fewer economic and educational opportunities, and face increased barriers to accessing health care services due to a scarcity of health care professionals, and transportation challenges.[49] For instance, rural counties have three percent fewer physicians compared to urban counties, and two counties reported no practicing physicians.[50] Also, of Colorado's 47 rural counties, eleven do not have a hospital and two do not have either a clinic or hospital.[51] Given the unique challenges rural communities face, it is important to recognize that the implementation of programs, policies, and systems that may be effective in urban areas may not be viable solutions for rural communities.

Figure 4: Birth Rates of Women (ages 15-19) in Colorado by Race/Ethnicity, 2000-2017[42]

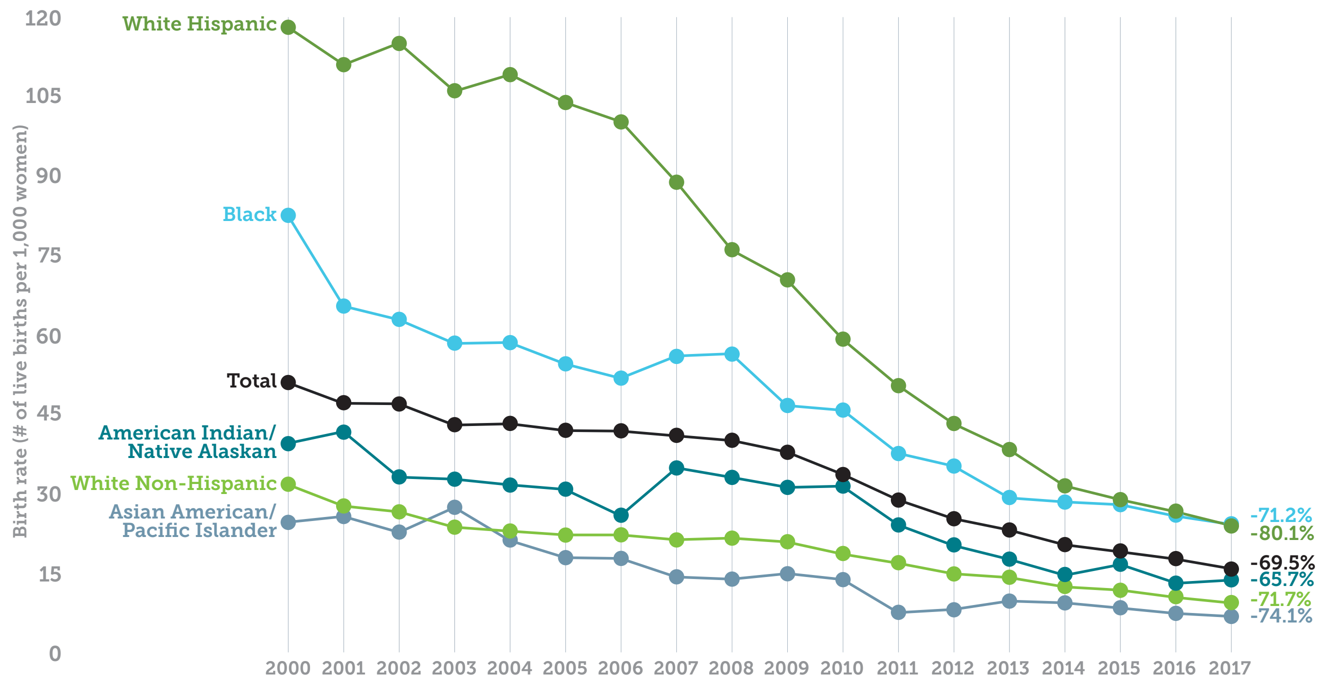
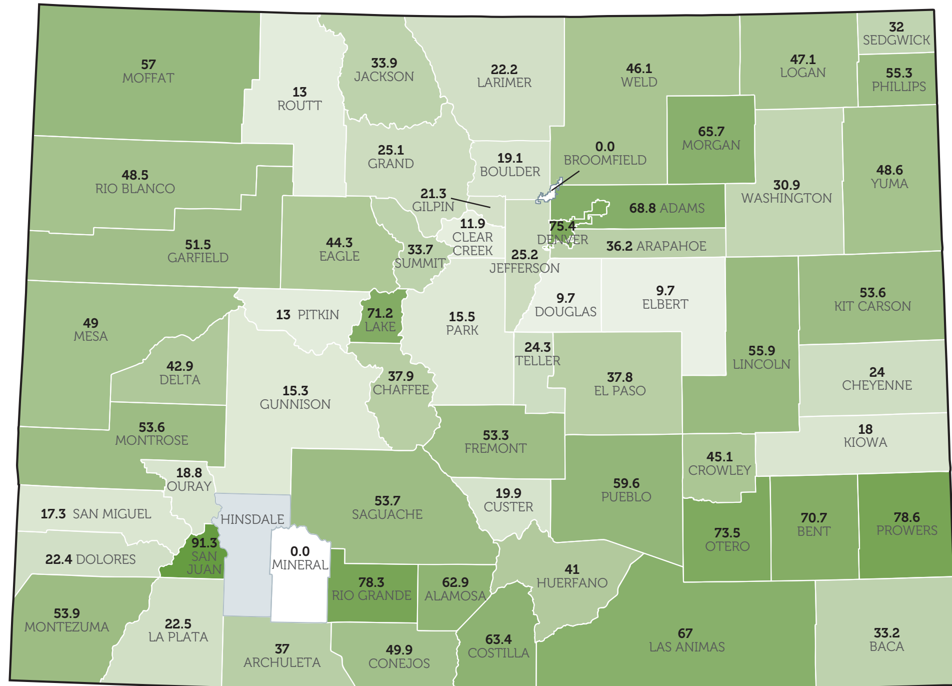
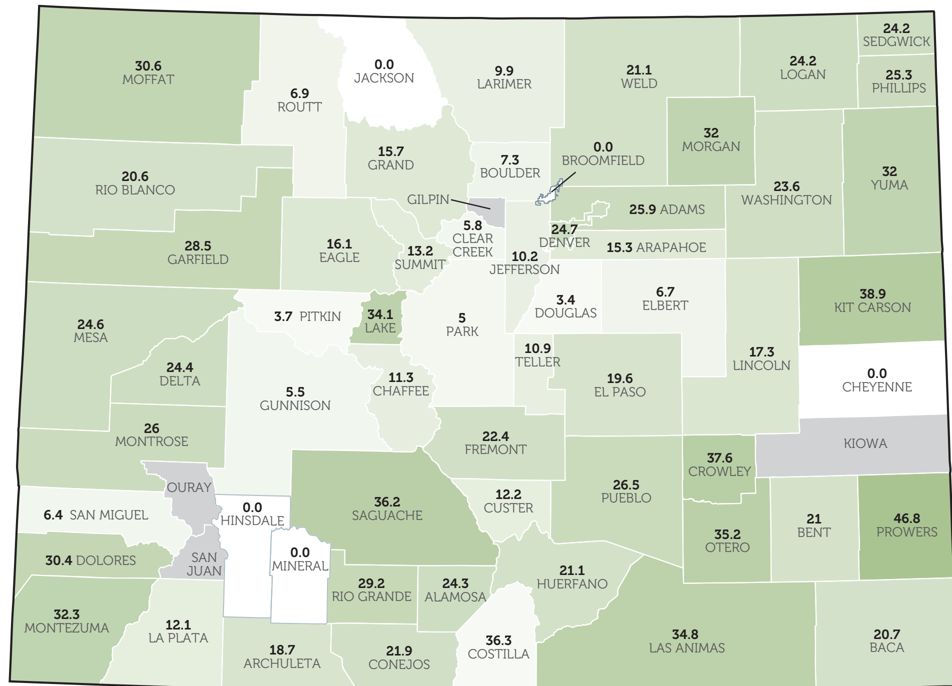


Figure 5: Average Colorado Birth Rates of Young Women Ages 15-19 by County[48]

2005–07 average



2015–17 average



map ©2003–19 Nicholas Trotter and Notchcode Creative. **Birth rate equals the number of births per thousand females in that age group. Darker areas indicate higher birth rates.** Counties with fewer than three births are not included and indicated in gray in order to protect privacy and confidentiality.

Abortion

Abortions are often considered an important indicator of unintended pregnancy and access to contraception has been identified as a key predictor of abortions.[52] In 2017, there were 7,851 reported abortions in Colorado. Of these, only one in ten (9.5 percent) was among youth ages 15-19.[53] Abortions among Colorado adolescents decreased 64.6 percent between 2007 and 2016, with much of this decline attributed to the significant increase in LARC use among youth with the Colorado Family Planning Initiative and other Colorado family planning providers.[54,55] While abortions among youth continue to decrease, access to safe and legal abortions remain a critical component of high-quality sexual and reproductive health care services.[56] Many women continue to experience significant barriers in accessing services, including stigma, legislative restrictions, health care coverage restrictions, reduced public funding for services, and a limited number of abortion providers.[57] Based on the most recent data available, 78.0 percent of Colorado counties had abortion-providing clinics, and between 2011 and 2014 there was a 13.0 percent decline in the number of clinics providing abortions.[58]

Sexually Transmitted Infections (STIs)

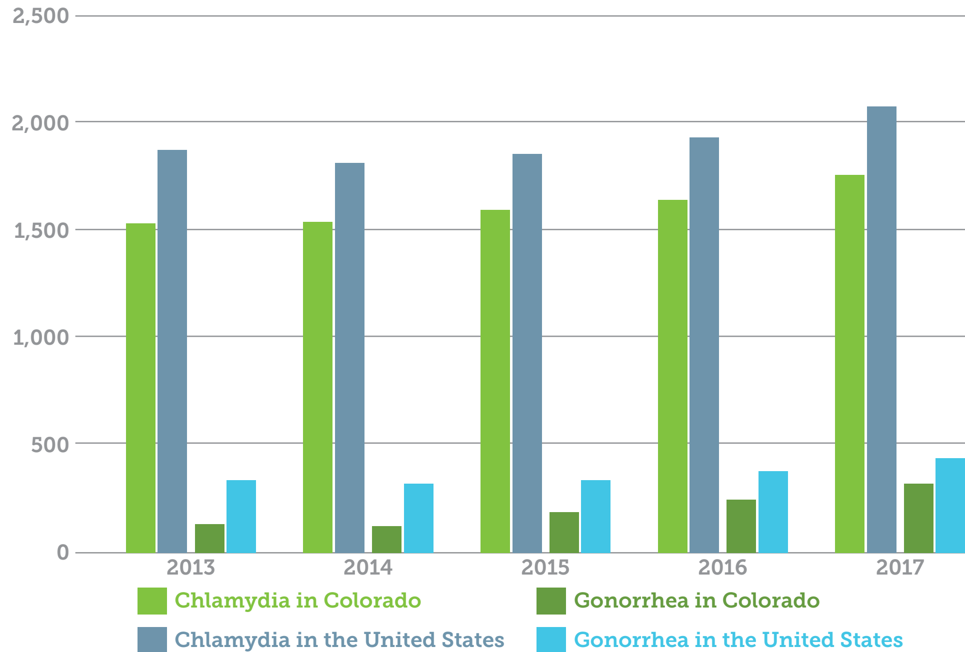
Compared to adults, young people are at an especially high risk of acquiring STIs due to multiple barriers in accessing STI prevention and management services, including social norms and stigma, lack of sexual health education, limited access to contraception, limited accessibility of services, lack of transportation, and concerns about confidentiality.[59,60] For example, between 2013 and 2015, lack of confidentiality deterred 7.4 percent of U.S. young people from seeking sexual and reproductive health services due to concerns about their parents finding out.[61]

Comprehensive sexuality education (CSE) is critical in providing young people human sexuality instruction that is medically accurate, age-appropriate, culturally sensitive, inclusive of all gender identities and sexual orientations, and uses a positive youth development framework. Research indicates that CSE is effective in reducing teen pregnancy and STIs.[62] Yet, only 33 percent of Colorado school districts had CSE policies in place as of 2016, leaving youth without critical sexual and reproductive health information.[63]

Youth of color experience an array of additional barriers to sexual and reproductive health services. Structural barriers such as living in high poverty neighborhoods, limited access to sexual and reproductive health services, cultural beliefs, and fear and distrust of the health care system as a result of actual or perceived discrimination and provider bias contribute to higher rates of STIs among Black and Hispanic youth.[64,65,66] These barriers are often due to or made worse by systemic inequities that occur outside an individual's control. It is critical to recognize these external forces at play when assigning meaning to STI data.

Research indicates that comprehensive sexuality education (CSE) is effective in reducing teen pregnancy and STIs.[62] Yet only 33 percent of Colorado school districts had CSE policies in place as of 2016.[63]

Figure 6. Chlamydia and Gonorrhea Rates Among Youth Ages 15-19, US and Colorado, 2013-2017.[67,68]



Chlamydia

In 2017, of all nationally reported chlamydia cases, 62.6 percent were among youth ages 15-24.[67] Chlamydia remains the most commonly reported STI in the state and rates among youth ages 15-19 increased 7.2 percent since 2016 (Figure 6).[68] Disparities among racial/ethnic groups are also important to underscore; rates of diagnoses were higher among Colorado Black and Hispanic youth, 2,962 and 1,208 cases per 100,000, respectively, compared to 590 cases per 100,000 among White youth.[69]

Gonorrhea

Colorado gonorrhea rates of diagnosis among youth ages 15-19 have increased by 30.4 percent since 2016 (Figure 6).[70] Of all reported gonorrhea cases in the state (8,478 cases), 14.1 percent were among youth ages 15-19.[71] Hispanic youth were over three times more likely to be diagnosed with gonorrhea and Black youth were thirteen times more likely to be diagnosed compared to White youth.[72]

HIV

From 2016 to 2017, Colorado HIV rates of diagnosis among young people ages 15-19 increased 23.3 percent, to 4.06 cases per 100,000.[73] Of all reported cases among youth of this age range (15 cases), eighty percent were among men who have sex with men (MSM).[74] Based on the most recent data from the Center for Disease Control (CDC), 51 percent of youth ages 13-24 with HIV do

not know they have it.[75] Screening for HIV is critical to reduce the likelihood and transmission as it is the only way to determine if an individual has HIV.

Pre-exposure prophylaxis (PrEP) is a daily pill that can help prevent HIV. Studies have shown PrEP reduces the risk of acquiring HIV by 92 percent when used as prescribed.[76] PrEP may benefit individuals who are HIV-negative, those who have an HIV-positive partner, or multiple partners whose HIV status is unknown and who don't always use a condom, or those who inject drugs and share needles with individuals who may have HIV.[77] Yet, only a small percentage of individuals who could benefit from PrEP have been prescribed the medication. Nationally, Black and Hispanic receive the smallest percentage of prescriptions. Approximately 500,000 Black individuals could benefit from PrEP, but only one percent were prescribed the medication. Likewise, of the 300,000 Hispanic individuals who could benefit from PrEP, only three percent were prescribed PrEP.[78] Suggesting that more equitable implementation of PrEP recommendations by health care providers is needed especially among communities of color.[79]

As a result of stigma, homophobia, and discrimination, young gay and bisexual men of all races/ethnicities are at higher risk of acquiring HIV due to lack of high-quality health care services, including HIV prevention, testing, and treatment services.[80] A national survey found that young gay and bisexual men were two times less likely to have been tested for HIV compared to older gay and bisexual men.[81] Further, 30 percent weren't comfortable discussing their sexual behaviors with their provider.[82]

In 2016, 17.2 percent of all new HIV diagnoses nationally were among young gay and bisexual men; in Colorado, 80 percent of all HIV diagnoses among youth (15-19) in 2017 were attributed to male-to-male sexual contact.[83,84]

Human Papillomavirus (HPV)

The HPV vaccine provides safe, effective, and long-term protection against cancers caused by the HPV infection. As of October 2016, the CDC updated the HPV vaccination dose schedule recommendation and now recommends two doses of HPV vaccine for both female and male youth ages 11 or 12.[85]

Nationally, HPV vaccination rates have increased by five percent every year since 2013. In 2017, 49 percent of adolescents ages 13-17 were up to date on the HPV vaccine and 66 percent had received at least one dose vaccine.[86] Simultaneously 51 percent of youth have not yet completed the vaccine series and are, therefore, not fully protected from HPV.[87] The HPV vaccination recommendation for females began in 2006 but did not include males until 2011. As a result, notable differences across gender exists in vaccination rates. Nationally, more female youth were up-to-date on the vaccine series, 65.1 percent compared to 56.0 percent of male youth.[88]

Colorado's HPV vaccination rates have been higher than the national average. As of 2017, 72.1 percent of Colorado adolescents ages 13-17 received at least one dose of the HPV vaccine, a 13.5 percent increase from 2016, and 53.4 percent were up to date on the series.[89] As with HPV vaccination nationally, rates among female youth were also notably higher than among male youth.[90]

Based on the most recent data from the Center for Disease Control (CDC), 51 percent of youth ages 13-24 with HIV do not know they have it.[75]

Sexual and Teen Dating Violence

National studies indicate that youth who experience sexual violence (SV) and teen dating violence (TDV) are less likely to use contraception and are at higher risk of unintended pregnancies and STIs.[91,92] Skills such as trust, respect, communication and boundaries are crucial for the development of healthy sexual and nonsexual relationships among youth. Promoting the importance of building healthy relationships is a vital component of adolescent development and an integral element of comprehensive sexuality education. School-based CSE promoting refusal skills has been associated with a decreased risk of sexual assault victimization.[93]

Youth who reported having a trusted adult were half as likely to experience both sexual violence and dating violence compared to youth without a trusted adult.[105]

In 2017, 9.7 percent of high school students in the US and 6.3 percent of Colorado high school students reported being physically forced to have sex against their wishes.[94,95] SV was more common among Colorado female youth than male youth, with one in ten (9.6 percent) female students having reported experiencing SV compared to one in thirty (3.0 percent) male students.[96] Colorado transgender youth were even more likely to experience SV. More than one in three (40.0 percent) transgender youth reported experiencing SV.[97] Female and transgender youth were also more likely to experience dating violence. Among Colorado female and transgender high school students who had dated someone within a year of being surveyed, 11.1 percent of female students and 44.2 percent of transgender students were physically hurt on purpose by the person they were dating.[98,99]

Similar to national trends, LGB youth in Colorado are at greater risk of SV and TDV.[100]

Compared to heterosexual youth, LGB youth were four times more likely to have experienced SV (18.5 percent versus 4.5 percent) and over two times more likely to have experienced TDV (18.2 percent versus 7.5 percent).[101] Nationally, many LGBTQ+ youth are left without critical sexual health information to inform their sexual and reproductive health decisions.[102] Among LGBTQ+ youth who received some form of sexual health education in schools, more than half (55.8 percent) reported the curricula was not inclusive of LGBTQ+ topics.[103] Furthermore, as of 2017, seven states prohibit educators from discussing LGBTQ+ topics or require that such topics be presented in a negative way but Colorado is not one of them.[104]

According to HKCS data, youth who reported having a trusted adult were half as likely to experience both sexual violence (5.2 percent versus 9.6 percent) and dating violence (7.3 percent versus 14.2 percent) compared to youth without a trusted adult.[105] Similarly, youth who reported that it was important to finish high school were over three times less likely to experience SV and almost four times less likely to experience TDV compared to youth who did not think it was important to finish high school.[106]

Mental Health and Bullying

Schools play a vital role in ensuring students feel socially, emotionally, and physically safe and supported. In Colorado 82 percent of school districts have adopted explicit anti-bullying policies[107] and, according to HKCS data, nine out of every ten youth reported feeling safe at school.[108] However, many female and LGBTQ+ youth continue to feel unsafe, often as a result of bullying.

Bullying has serious implications for youth's academic, psychological, and health outcomes. Bullying has been associated with increased absenteeism, lower grades, and decreased likelihood of pursuing post-secondary education.[109] Additionally, students who have been victimized are less likely to use contraception, are at increased risk of STIs, and more likely to experience unintended pregnancies.[110,111] Victimized youth are also are more likely to experience high levels of depression, suicidal ideation, and are at higher risk of sexual violence perpetration.[112,113] Research demonstrates that creating a safe and supportive environment and implementing CSE prevents bullying in schools by helping youth understand sexual orientation, gender identity, and promoting respect for all youth.[114]

Among Colorado young people, female youth were more likely to be bullied compared to male youth. Approximately one in five female youth reported being bullied either on school property or electronically (through text, Instagram, Facebook or other social media).[115] Transgender youth were significantly more likely to be bullied both on school property and electronically compared to cisgender youth. Transgender youth were three times more likely (53.2 percent versus 17.9 percent) to have been bullied on school property and twice as likely (41.0 percent versus 14.3percent) to have been electronically bullied compared to cisgender youth.[116] Similarly, Colorado LGB youth were twice as likely to have been bullied on school property and electronically.[117]

Studies demonstrate that LGBTQ+ youth who have access to LGBTQ+ school resources such as Gay Straight Alliances/Gender and Sexuality Alliances (GSAs), inclusive educational curricula, inclusive and supportive school policies, and supportive educators report better school experiences and academic outcomes.[117] More than half (53 percent) of all LGBTQ+ students nationally reported having a GSA at their school; these students were less likely to miss school due to safety concerns, reported lower levels of victimization due to their sexual orientation and gender identity, and performed better academically.[118]

Further, youth with a trusted adult were less likely to report being bullied either on school property or electronically. Only 15.9 percent of youth with a trusted adult reported being bullied at school and 12.7 percent reported being electronically bullied compared to 27.3 percent and 22.0 percent of youth without a trusted adult, respectively.[119] Youths' perceived importance of and connectedness to school were also strongly correlated with the likelihood of experiencing bullying and attempting suicide. Youth who enjoyed being in school were almost two times less likely to be bullied at school (14.0 percent versus 20.7 percent) and students who reported it was important to finish school were five times less likely to have attempted suicide compared to students who did not think it was important to finish high school (6.3 percent versus 32.5 percent).[120]

Students who have been bullied are less likely to use contraception, are at increased risk of STIs, and more likely to experience unintended pregnancies.[110,111]

Health Care Coverage and Services

Health care coverage has the potential to improve access, utilization, health status, and may reduce the likelihood of adverse health outcomes. With the implementation of the Affordable Care Act (ACA) coverage provisions in 2014, state Medicaid expansion now covers individuals at or below 138 percent of the Federal Poverty Level and tax credits are available for individuals with incomes up to 400 percent of the Federal Poverty Level.[121] As a result of these major coverage reforms, uninsured rates have reached historic lows both nationally and in Colorado. In 2017, 93.5 percent of Coloradans had health insurance coverage and among young people, the rate of uninsured adolescents ages 13-17 continues to decline.[122] In 2016, 8.5 percent of adolescents ages 13-17 were uninsured compared to 14.6 percent in 2008.[123]

While health care coverage significantly improves an individual's opportunity to access health care services; coverage alone does not guarantee adequate or timely care. Many families continue to face challenges with accessing care because of multiple barriers including out-of-pocket expenses, time constraints, possible lost wages, inadequate or unavailable childcare, lack of transportation, inadequate supply of providers accepting certain insurance plans, and actual or perceived prejudice (on the basis of race/ethnicity, sexual orientation, gender identity, or income).[124]

School-based health centers (SBHCs) address many of the barriers youth experience when it comes to health care access, especially among low income, uninsured, and rural communities. As of 2016, Colorado had 58 SBHCs, 48 were concentrated in urban schools and 17 in rural schools of the state.[125] SBHCs are integrated into schools and communities and ensure young people have access to timely care. SBHCs offer comprehensive health care services including providing youth access to sexual and reproductive health services such as contraception and STI testing and management services. The majority of SBHC users are covered by public health insurance such as Medicaid; in urban settings for example, 63.4 of youth patients are covered by Medicaid.[126] Efforts to repeal the Affordable Care Act (ACA), cuts to Medicaid, and potential increased state control over health care policy could significantly impact SBHCs.[127]

School-based health centers (SBHCs) address many of the barriers youth experience when it comes to health care access, especially among low income, uninsured, and rural communities.

While great uncertainty remains in federal priorities for Title X Family Planning services, it is critical to underscore the impact of Title X funding for young women all across the country.

In 2015, Title X supported approximately 3,700 sites to deliver low-cost, confidential family planning and preventive health services to 3.8 million women and helped prevent over 822,000 unintended pregnancies, 278,000 abortions, and 188,700 unintended adolescent pregnancies.[128] CDPHE has provided funding to service sites since 1970, and currently supports 77 Title Family Planning clinics across the state.[129] These clinics provide services to everyone regardless of race/ethnicity, age, sexual orientation, residency status, or income, and patients are never turned away due to their inability to pay for services.[130]

Recommendations

Adolescent sexual and reproductive health behaviors and outcomes are significantly influenced by inter-related social, environmental, and economic factors. The individual choices adolescents have and the decisions they make about their bodies and their lives are shaped by the policies, practices, social norms, and systems within their communities. The data presented throughout this report underscores the importance of addressing the underlying causes of these various factors through primary prevention approaches. Modifying the communities where youth live, increasing access to resources, and changing policies, societal norms, and systems that influence youth's behavior are all critical for preventing unwanted health outcomes in a comprehensive way.

These recommendations are intended to inform programs and policies that support the health and well-being of all Colorado youth. The following is a broad framework that recognizes the shared root causes of multiple youth outcomes related to sexual health, bullying, violence, etc., and aims to address systemic inequities that drive disparities across Colorado communities.

The data presented throughout this report underscores the importance of addressing the underlying causes of these various factors through primary prevention approaches.

Reduce health care access barriers and ensure equitable access for all Coloradans.

1. Advocate for continued funding and political support of clinics providing vital health care services to youth, such as School-Based Health Centers, Title X Family Planning Clinics, Federally Qualified Nonprofit Clinics, and Planned Parenthood Clinics.

2. Support a holistic approach to youth sexual health and well-being by ensuring linkage, accessibility, and coordination of resources and communication between schools, health care providers, and communities.

3. Develop a resource list of local health providers experienced with serving LGBTQ+ youth in order to refer students to appropriate, supportive, and youth friendly health care services upon request.

Strengthen educational systems to provide critical knowledge and skills that ensure young people can make autonomous and informed sexual health decisions for themselves.

1. Advocate for statewide and/or district-wide, implementation of K-12 comprehensive health education inclusive of sexual health and LGTBQ+ topics that covers a range of content including safe relationships, consent, STI prevention, family planning, decision-making and goal-setting using medically accurate information and a trauma informed approach.

2. Require the completion of comprehensive health education, inclusive of sexual health, as a graduation requirement across the state to promote standardization, equity, and institutionalization.

3. Improve educational systems such as universities to provide health education training for school-professionals, such as health educator certification programs and ensure a sustained mechanism to train all health educators.

Build protective and supportive environments for young people so they can thrive and reach their full potential.

1. Promote meaningful youth development across all aspects of adolescent health work. Base policies, programs, and practices on a positive youth development framework that supports youth's strengths and encourages positive connections with caring adults and schools.

2. Support the implementation, oversight, and accountability of explicit and comprehensive school policies regarding all types of sexual harassment and bullying to ensure all students, including LGBTQ+ youth, have access to safe and supportive school environments.

3. Provide educators and administrators with LGBTQ+-related professional development, trainings, and resources in order to help support a more inclusive school environment for all students. Sustainable professional development and trainings should be written into long-term budgets and policies to ensure consistent access and prioritization.

4. Explore alternative disciplinary measures such as restorative justice.

5. Support and promote opportunities to help caregivers and parents build their skills in having difficult conversations with the young people in their lives such as Askable Adult trainings.

6. Modify and strengthen the physical and social environments of neighborhoods to ensure spaces where young people live, work, and play are safe and healthy. Examples include: the inclusion of SBHCs on school premises; safe routes to schools; and increased public transport.

Address underlying structural drivers that lead to adverse health outcomes among youth through policies, practices, and organizational systems. Ensure special emphasis on those drivers that lead to disparities based on sexual orientation, gender identity, race/ethnicity, and geography.

1. Unemployment and neighborhood poverty are key barriers that contribute to and drive adverse health outcomes. Strategies known to reduce these and ultimately build economic stability and supports should be promoted and strengthened statewide including: the development and enforcement of policies that ensure comparable salaries across genders, work supports such as quality affordable childcare and paid family and medical leave, increased access to assistance programs such as The Supplemental Nutrition Program for Women, Infants, and Children (WIC), The Supplemental Nutrition Assistance Program (SNAP), and The Colorado Child Care Assistance Program (CCCAP), and the adoption of family friendly business practices.

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Glossary

Sexual Orientation: A person's physical, sexual, romantic, emotional, and/or spiritual attraction to another person.

Gender Identity: A person's internal perception of being male, female, neither of these, both, or another gender(s).

Gender Expression: The external display of a person's gender identity through clothing, hairstyle, voice, body shape, etc.

Sex Assigned at Birth: The assignment and classification of people as male, female, intersex, or another sex based on a combination of anatomy, hormones, and chromosomes.

Cisgender: A person whose gender identity and gender expression align with their assigned sex at birth.

Transgender: A person whose gender identity and gender expression is different from their assigned sex at birth.

Heterosexual: A person primarily, physically, sexually, romantically, emotionally/spiritually attracted to a person of the opposite sex.

Lesbian: Women (transgender or cisgender) who are attracted to other (transgender/cisgender) women.

Gay: Men (transgender or cisgender) who are attracted to other (transgender/cisgender) men.

Bisexual: A person who is physically, sexually, romantically, emotionally/spiritually to males/men and female/women.

Redlining: Practice used by the Federal Housing Administration (FHA) beginning in 1934 which consisted of drawing red lines on maps between neighborhoods to separate and designate as risky neighborhoods for home builders to develop, these were the same neighborhoods where families of color lived.[131]

Interpersonal Violence: Refers to violence between individuals and can be divided into family/partner violence (Intimate partner violence) and community violence. It encompasses the use of physical force or power to act against another person, group, or community that can result in physical, sexual, psychological harm, deprivation or neglect.[132]

Intimate Partner Violence (Dating Violence): Violence committed by a current or former partner, spouse, girlfriend, or boyfriend and can occur among heterosexual or same-sex couples.[133]

Sexual Violence (SV): SV involves a range of acts including attempted or completed forced or alcohol/drug facilitated penetration (i.e., rape), being made to penetrate someone else, verbal (non-physical) pressure that results in unwanted penetration (i.e., sexual coercion), unwanted sexual contact (e.g., fondling), and non-contact unwanted sexual experiences (e.g., verbal harassment, voyeurism).[134]

Comprehensive Sexuality Education (CSE): CSE curricula are medically accurate, evidence-based, age-appropriate, culturally sensitive and should discuss benefits of delaying sexual initiation while providing information about normal reproductive development, contraception, unintended pregnancies, and use barrier methods for the protection against STIs. CSE should also emphasize human rights and values or all individuals (inclusive of gender equality and sexual and gender diversity). Includes information on healthy relationships, consent and decision-making, and intimate partner violence.[135]

Title X Family Planning Program: the national family planning program administered by the U.S. Department of Health and Human Services and is the only federally funded program dedicated to the provision of family planning resources and services with special emphasis on low-income families. The program is implemented through grants awarded to state and local public health departments, community health, family planning, and other non-profit agencies. Title X funded sites provide contraceptive education and services, breast and cervical cancer screening. STI and HIV testing, referral and prevention education, pregnancy diagnosis and counseling.[136]

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