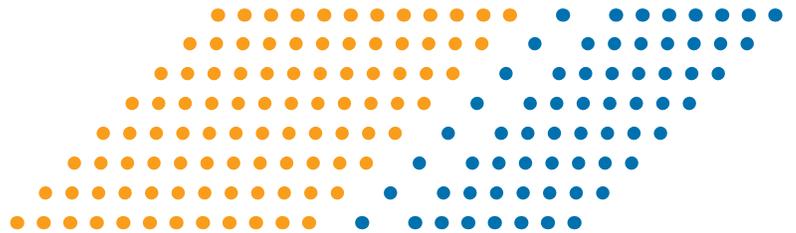
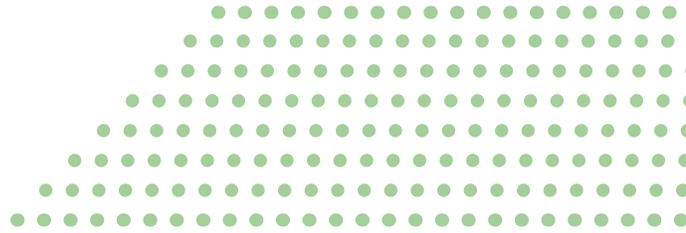


OREGON Youth
Sexual
HEALTH
PLAN **5** YEAR
UPDATE



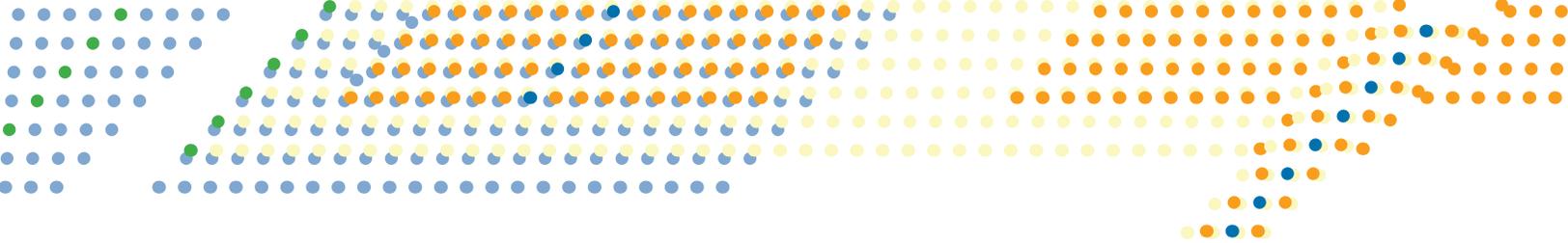
Oregon's Progress in Youth Sexual Health

In 2009, a group of state agency and private partners presently known as the Oregon Youth Sexual Health Partnership (OYSHP) released the Oregon Youth Sexual Health Plan (YSH Plan). The partnership developed the YSH Plan to address teen pregnancy prevention in a more holistic manner — shifting youth sexual health from a risk-focused paradigm to a youth-development model of sexual health and well-being. Working collaboratively, the partnership engaged young people, garnered community input and used evidence-based recommendations to develop the YSH Plan. This report looks at the progress Oregon has made in promoting youth sexual health from 2008, just before the plan was released, through 2014. This report also looks at improvements in youth sexual health policy, partnerships, programming and outcomes made across the state.

GOALS

OREGON YOUTH SEXUAL HEALTH PLAN

1. Youth use accurate information and well-developed skills to make thoughtful choices about relationships and sexual health.
2. Rates of unintended pregnancy are reduced.
3. Rates of sexually-transmitted infections are reduced.
4. Non-consensual sexual behaviors are reduced.
5. Sexual health inequities are eliminated.



GOAL ONE

Youth use accurate information and well-developed skills to make thoughtful choices about relationships and sexual health.



⋮ **A key to meeting this goal is that organizations throughout Oregon advance policies and support programs so youth have access to information and skill-building opportunities. Comprehensive sexual health education is an effective way to promote positive behavior change and help youth make healthy decisions regarding sexual behaviors.(1,2) Oregon has had several successes in the area of sexuality education.**

Oregon's Human Sexuality Education Law, passed in 2009, is among the most comprehensive in the United States.(3) This state law requires school districts to provide medically-accurate, culturally-appropriate, unbiased human sexuality education. In 2012 and 2013, Oregon Health Education Standards and Benchmarks and administrative rules for sexuality education were strengthened to closely align with National Sexuality Education Standards and updated Oregon laws.(4) In the 2012 Oregon School Health Profiles Survey (SHPS), 92% of lead 9–12th grade health education teachers reported teaching their students how to access valid and reliable health information and services related to sexual health.(5)

Oregon Youth Sexual Health Partnership members collaborated on a private foundation grant to support comprehensive sexuality education in schools. Since 2009, Working to Institutionalize Sexuality Education (WISE) has supported teacher training, school health advisory council training and engagement activities in comprehensive sexuality education for young people in 14 Oregon school districts.

In Figure 1, less than half of 11th grade youth report ever having sex between 2008 and 2013. This rate has been relatively stable over time. Among the youth who have had sex, 85% reported using some form of contraception (e.g. condoms, birth control pills, intrauterine devices) at last intercourse, as seen in Figure 2.

(REFERENCE CHARTS ON FOLLOWING PAGE)

FIGURE 1

Ever had sexual intercourse among 11th grade youth in Oregon by gender, 2008–2013*

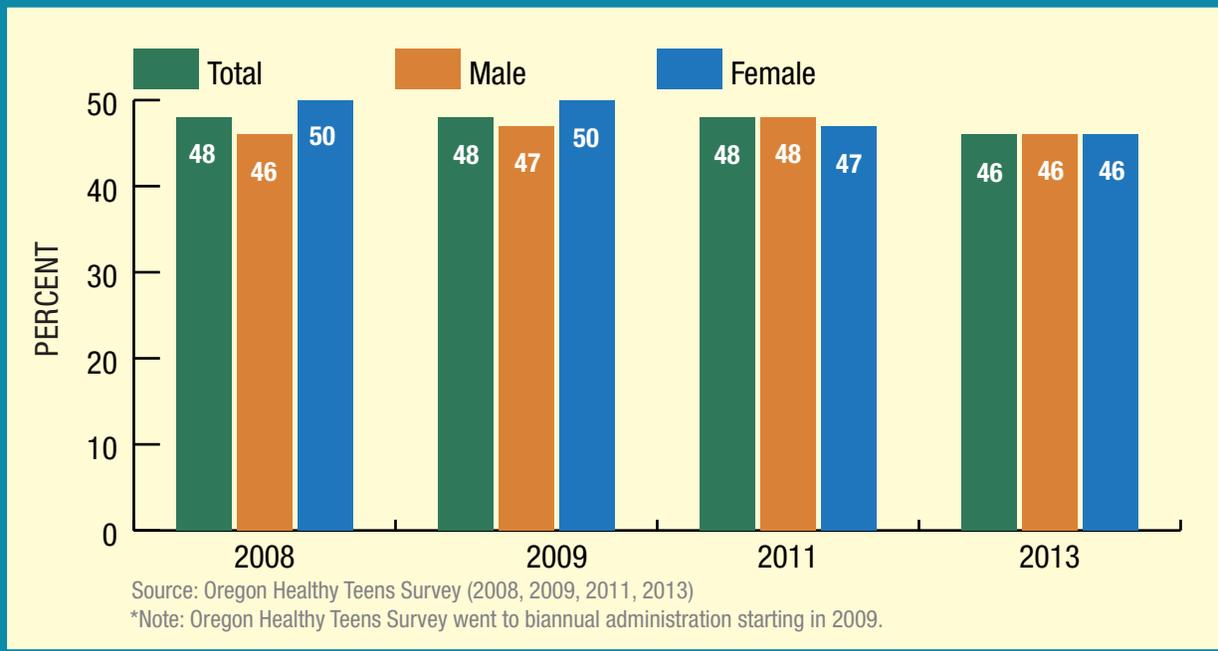


FIGURE 2

Contraceptive use at last intercourse among 11th grade youth who have had sex in Oregon by gender, 2008–2013*

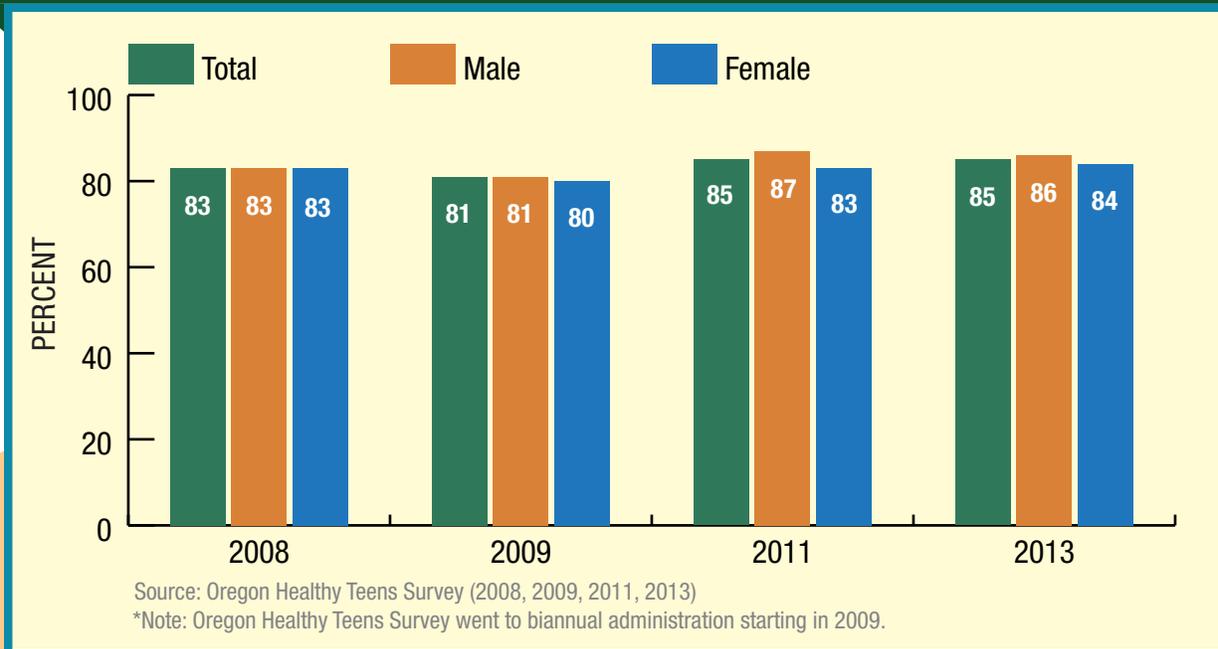


FIGURE 3

Pregnancy Rates among Females 15-19 Years in Oregon, 2008-2012

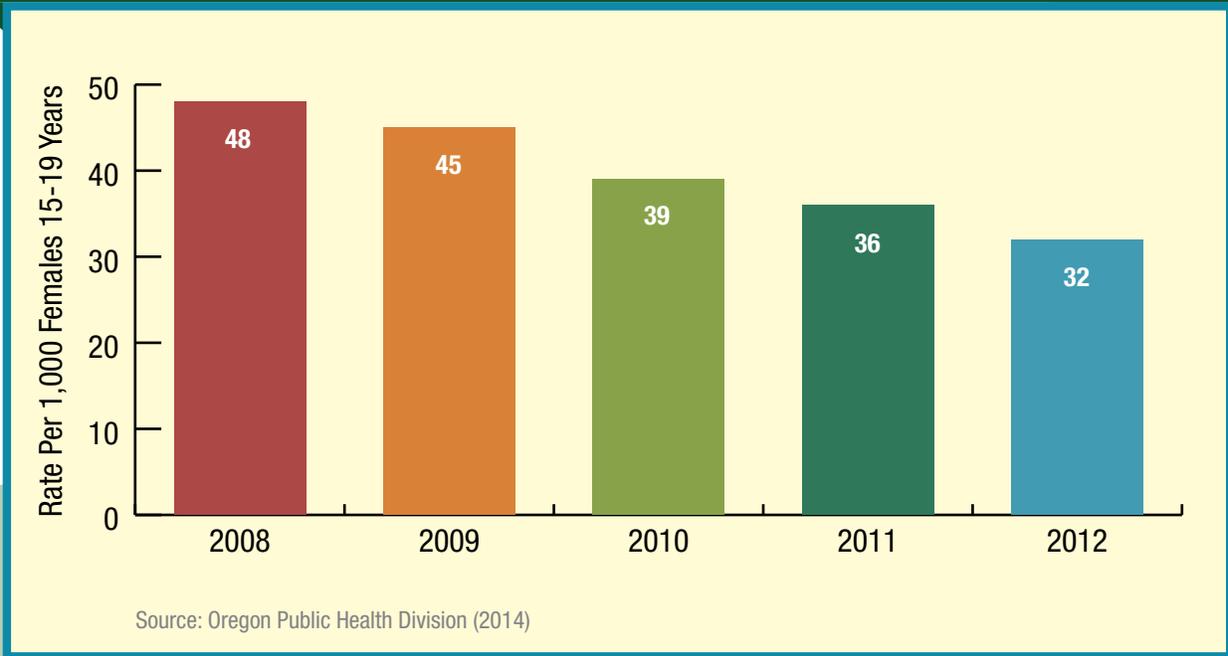


FIGURE 4

Methods of Contraceptives Dispensed at Reproductive Health Clinics in Oregon, 2012

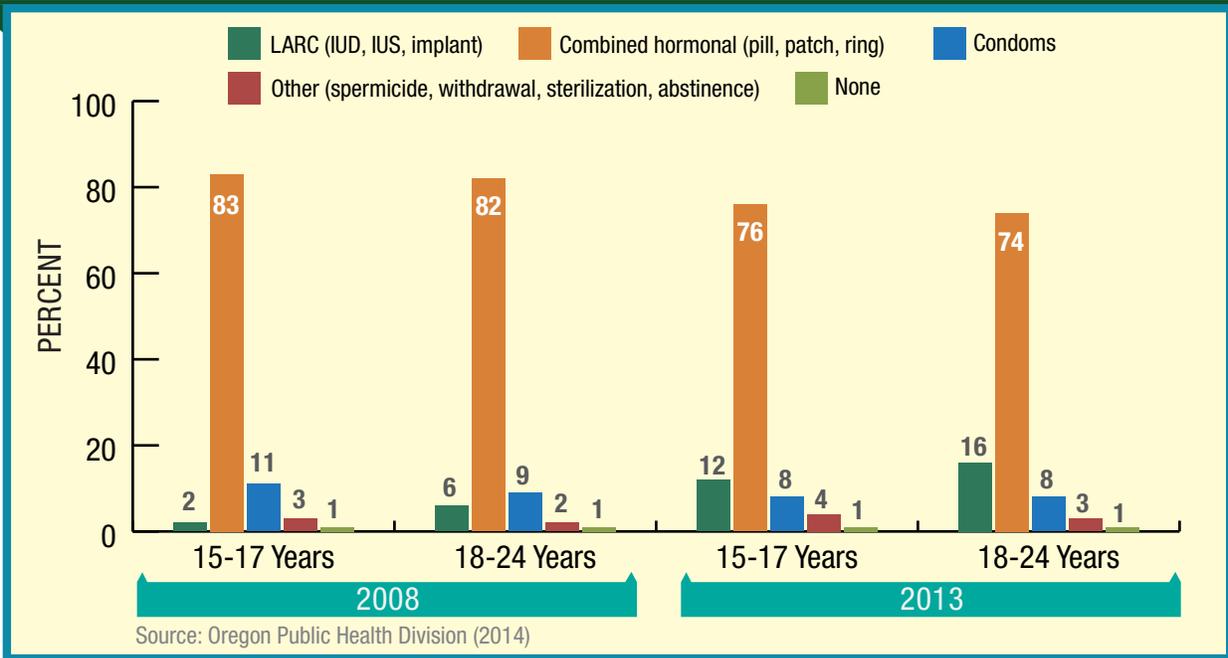
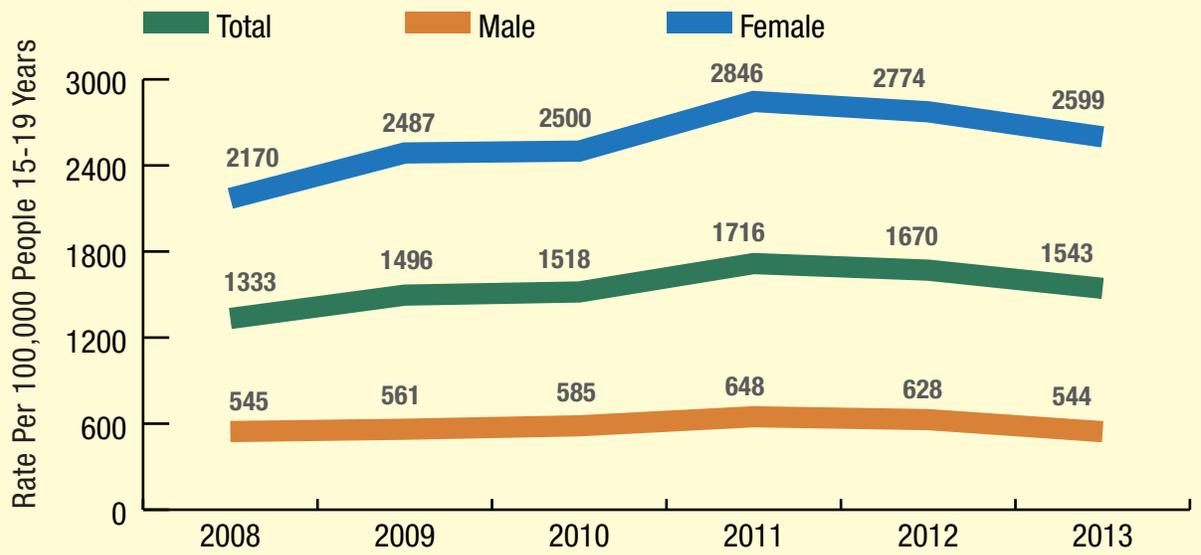


FIGURE 5

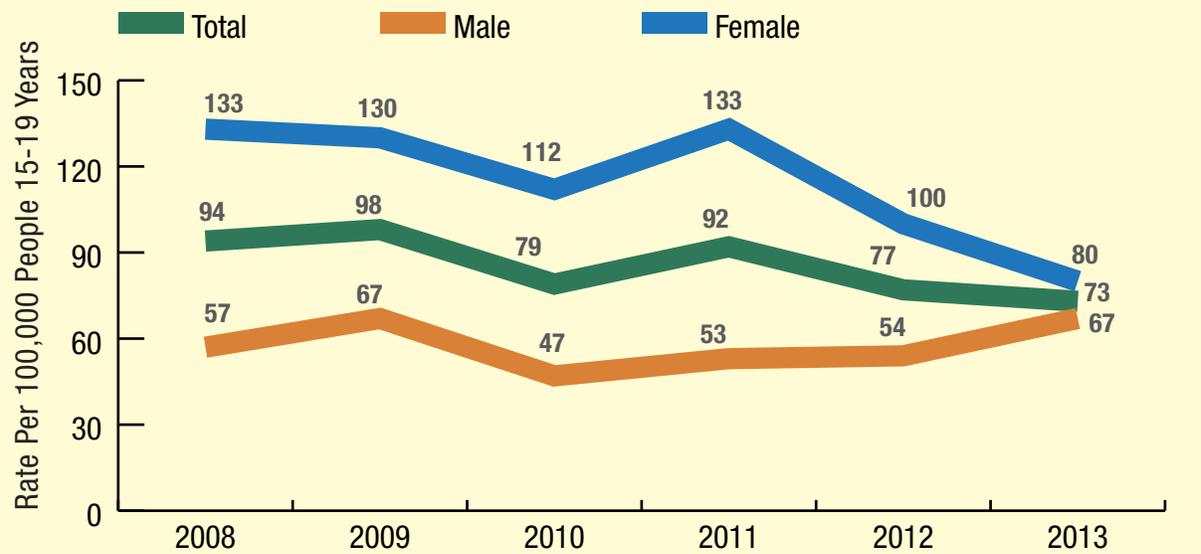
Chlamydia rates among 15–19 year olds in Oregon by sex, 2013



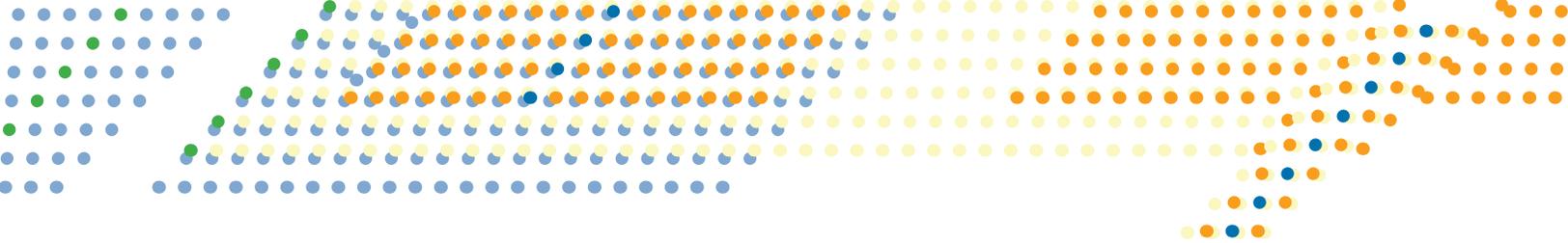
Source: Oregon Public Health Division (2014)

FIGURE 6

Gonorrhea rates among 15–19 year olds in Oregon by sex, 2008–2013



Source: Oregon Public Health Division (2014)



GOAL FOUR

Non-consensual sexual behaviors are reduced.

.....
: **Reducing non-consensual sexual behaviors requires continuous effort. As part of the development of the Oregon Youth Sexual Health Plan, Youth Action Researchers worked in three counties in Oregon (Deschutes, Jackson and Multnomah) to better understand what their peers thought about youth sexual health. The researchers concluded that youth want more information about relationships, rather than just the mechanics of sex and sexuality.**

Oregon’s Human Sexuality Education Law requires “course material to include information and skill building on reducing non-consensual sexual behaviors and physical, emotional and sexual harm.”(3) The Healthy Teen Relationship Act addresses all forms of relationship violence, including non-consensual sexual behaviors. The Act “encourages and supports services, programs and curricula to educate and inform students about teen dating violence, to provide assistance to victims and to prevent and reduce the incidence of teen dating violence.”(13)

With Oregon law as a strong backbone, many agencies work together to ensure youth have information about healthy relationships and resources to assist them if they are in an unhealthy relationship. These efforts have been concentrated in schools around the state. In the 2012 Oregon School Health Profiles Report, 96% of lead 9–12th grade health education teachers reported they taught their students how to create and sustain healthy and respectful relationships.(5) The Oregon Coalition Against Domestic and Sexual Violence developed two Healthy Teen Relationship Act Toolkits* to support domestic and sexual violence prevention advocates working with local school districts to reduce violence in teen relationships. Additionally, the statewide Sexual Health Work Group (SHWG), supported by the Oregon Sexual Assault Task Force, explores, identifies, and highlights the connections between sexual health promotion and sexual violence prevention.

In 2008, 11th grade females were four times more likely to report being pressured to have sexual intercourse as compared to males. Since 2009, there have been notable declines in the percentage of females who report pressure to have sexual intercourse while the percentage of males has declined slightly, as illustrated in Figure 7. Figure 8 shows the percentage of youth who reported being physically forced to have sex has remained stable since 2008.

Collaboration among agencies to implement the Healthy Teen Relationship Act by addressing the root causes of sexual violence, providing youth with the skills they need to promote healthy relationships and prevent sexual violence, can support continuing decreases across both indicators.

(REFERENCE CHARTS ON FOLLOWING PAGE)

* Healthy Teen Relationship Act Toolkits
<http://ocadsv.org/resources/htra-advocate-toolkit> and <http://ocadsv.org/resources/htra-local-school-districts-toolkit>

FIGURE 7

Pressured to have sexual intercourse among 11th grade youth, 2008–2013

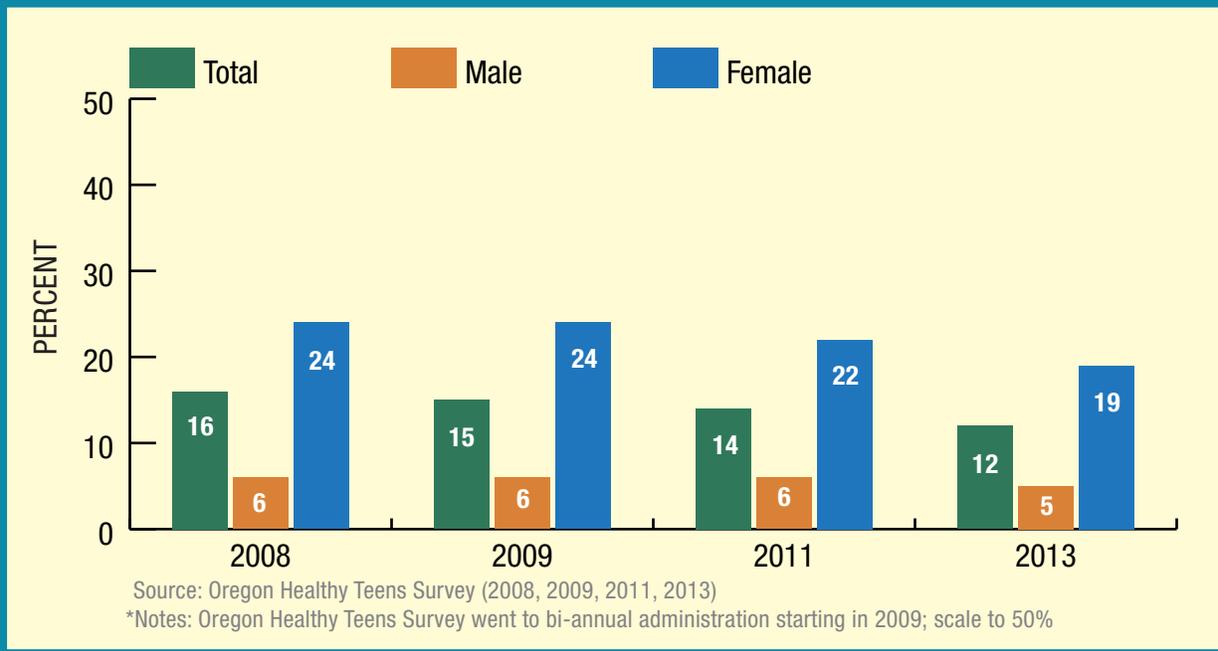
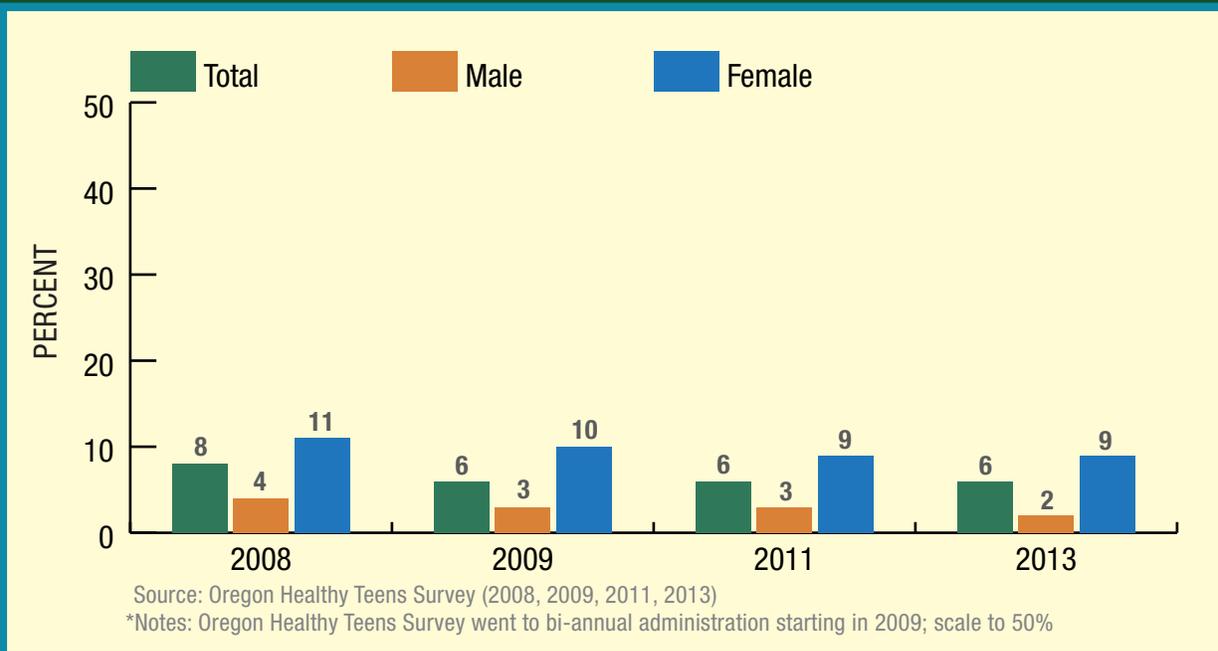
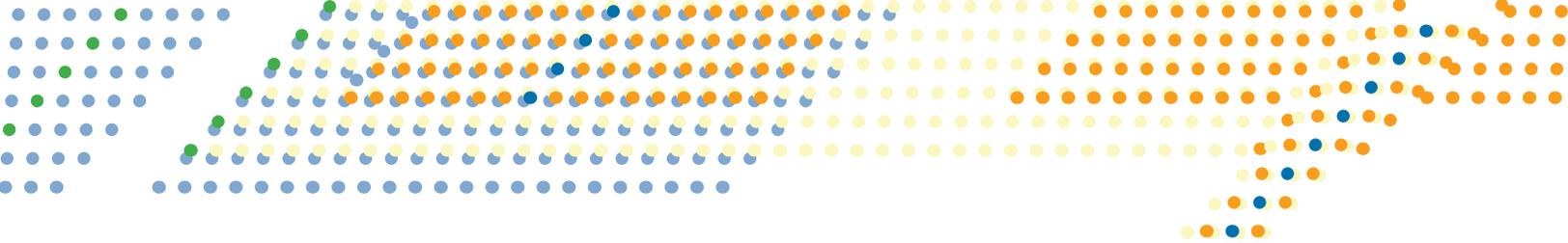


FIGURE 8

Physically forced to have sexual intercourse among 11th grade youth, 2008–2013





GOAL FIVE

Sexual health inequities are eliminated.

To eliminate disparate rates of unplanned pregnancy and sexually transmitted infection, policies and programs must address underlying inequities. Family income, age, race, gender identity, ability, sex, immigration status, sexual orientation, ethnicity and geography all affect health outcomes.

Achieving equity requires agencies to understand historical and institutional practices that perpetuate disparities. Beyond understanding these practices, achieving equity requires that agencies commit time and resources to better understand these dynamics and make changes that remove barriers for clients and improve the health of diverse communities. This is especially important because the demographics of Oregon's youth are changing. Figure 9 shows the percentage breakdown of 15–19 year olds in Oregon by race and ethnicity between 2008 and 2013. Between these years, there was an almost 20% increase in “Hispanic or Latino” youth, and a 15% increase in the percentage of youth who are “two or more races.” The percentage of “White” 15–19 year olds decreased about 12% over the same time period.

OYSHP collaborations ensure programming in communities that serve racial and ethnic groups with the highest disparities. ¡Cuidate!, a culturally specific HIV and pregnancy prevention curriculum for Latino youth is being implemented in six Oregon counties. The Teen Outreach Program, shown to be effective in reducing incidence of pregnancy and high school dropout, is implemented in largely African-American and Hispanic communities. The Confederated Tribes of the Grand Ronde is implementing “It’s Your Game,” a computer-based teen pregnancy prevention program shown to delay the onset of sexual activity, with youth in their community.

Disparities in sexual health outcomes are also seen in youth who are marginalized. Youth in corrections; with developmental disabilities; in foster care; who are homeless; who identify as lesbian, gay, bisexual, transgender and questioning (LGBTQ); with mental health conditions and who have experienced sexual abuse, all experience higher rates of pregnancy involvement, sexual abuse and STIs.(14) Recognizing the unique needs of this population, the OHA Public Health Division and the Pathways Research and Training Center at Portland State University partnered to publish “Sexual Health Disparities Among Disenfranchised Youth.” This publication breaks down the challenges associated by disparity in a specific area (e.g. youth who are homeless) and presents ways that are appropriate and effective for reaching that population.

While disparities still exist in the sexual and reproductive health of young persons in Oregon, the teen pregnancy rate has been decreasing among all races/ethnicities. Of note, the Hispanic/Latino teen pregnancy rate has decreased 45% since 2008, and is a contributing factor for the overall rate reduction. Rates among racial and ethnic groups between 2008 and 2012 are seen in Figure 10.

To reach the goal of eliminating sexual health inequities, partners throughout Oregon need to acknowledge and address the impact of structural racism in their communities, recognize and leverage community assets, and implement data collection plans that will further support targeted education and health care interventions to improve sexual health outcomes for all youth.

(REFERENCE CHARTS ON FOLLOWING PAGE)

FIGURE 9

Percentage of people 15–19 years by race/ethnicity in Oregon, 2008–2013

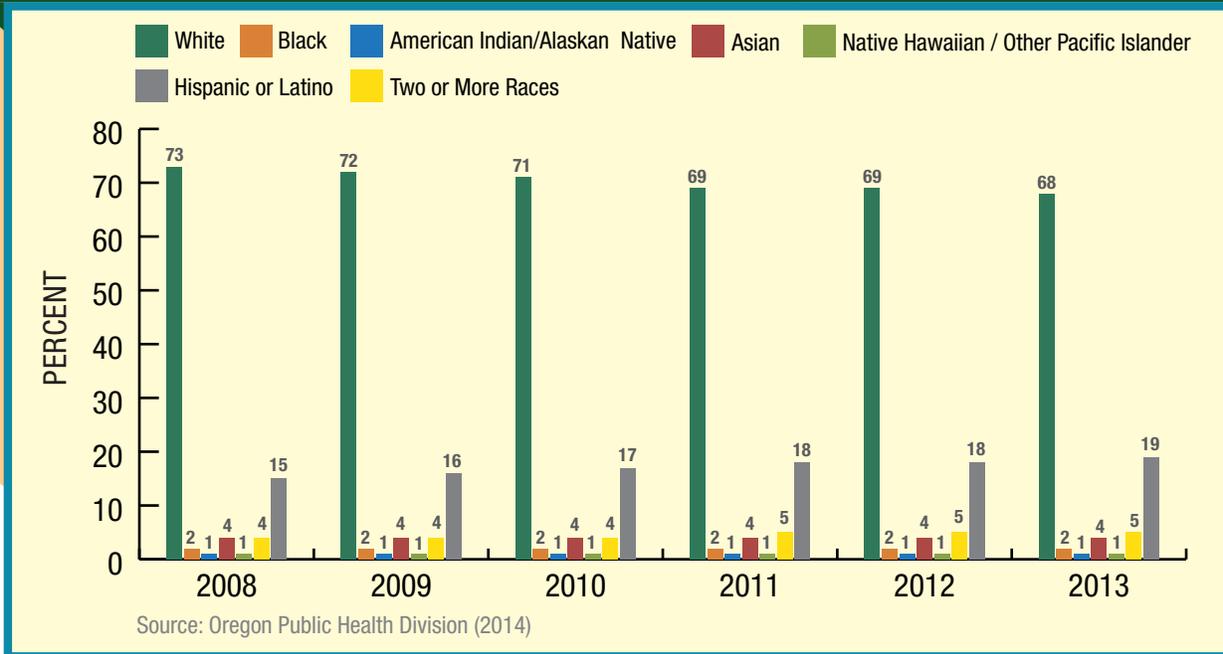
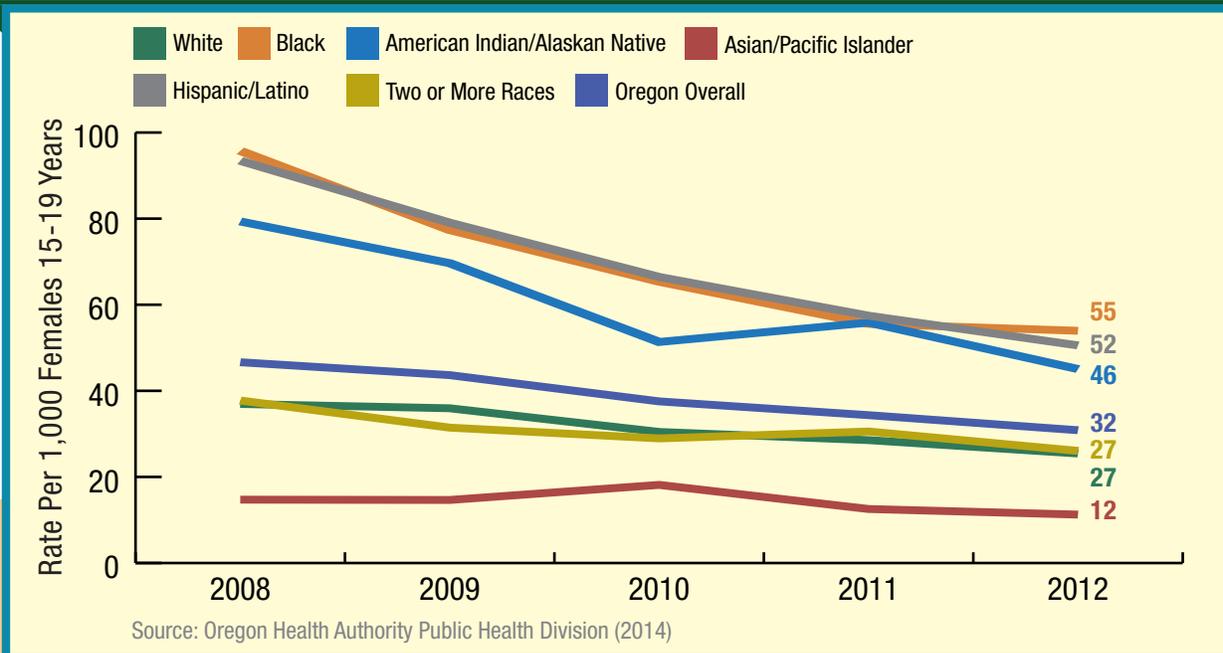


FIGURE 10

Pregnancy Rates among Females 15-19 Years by Ethnicity, 2008-2012



Recommendations

This progress report is a brief snapshot of the current state of youth sexual health in Oregon since the release of the Youth Sexual Health Plan. To meet the YSH Plan goals and improve the indicators at the state and local levels, it is vital that all sectors of Oregon communities — policy makers, funders, educators, health professionals, families and advocates — take steps to provide youth with opportunities and information to continue to make healthy decisions.

A long-term investment in programs will provide youth opportunities to fulfill their dreams and aspirations, reduce negative outcomes and support positive lifetime sexual health. In moving forward, below is a list of recommendations that address one or more of the goals of the YSH Plan. These recommendations can guide activities, programs and health care services towards positive youth sexual health outcomes.

Health care

1. Implement a comprehensive campaign promoting sexual health care services for youth to inform the public of the range of sexual health services recommended and covered for youth; to normalize sexual health services as a standard component of health care; and create norms of accessing sexual health care for preventive services as well as when experiencing symptoms or illness.
2. Support low or no-cost confidential reproductive health care for young people.
3. Support and implement routine human papillomavirus (HPV) 3-dose vaccination series of males and females at the recommended 11 or 12 years of age.*

Education and programming

1. Support schools to implement comprehensive sexuality education as outlined in Oregon Human Sexuality Education Law (ORS 336.455), Human Sexuality Education Administrative Rule (OAR 581-022-1440) and Oregon Health Education Standards and Benchmarks for sexual health.
2. Provide professional development to individuals, programs and organizations on youth sexual health evidence-based practices and curricula.
3. Support programs that educate and empower young people as peer educators and advocates.
4. Support implementation of the Healthy Teen Relationship Act (HB4077) in each school district to reduce teen dating violence.

Policy and assurance

1. Ensure the capacity to support evidence-based strategies that reflect a positive approach to youth sexual health.
2. Increase access to care for youth. Support School Based Health Centers (SHBCs) in providing comprehensive services that reduce barriers to preventative services and ultimately decrease unintended pregnancies and STIs.
3. Identify and support implementation of policies that guarantee access to sexual health care for all youth regardless of documentation status or income.

* Centers for Disease Control and Prevention. Human Papillomavirus (HPV) ACIP Vaccine Recommendations. Morbidity and Mortality Weekly Reports (MMWR)



Social justice and equity

1. Require that youth-serving programs are guided by meaningful input from underserved and underrepresented communities (e.g. communities of color, immigrant communities, youth in foster care, LGBTQ youth).
2. Collaborate with stakeholders to eliminate systemic social inequities related to employment, housing opportunities, education and poverty that intersect with youth sexual health.
3. Increase the support for funding opportunities to conduct culturally-sensitive research and evaluation focused on identifying and addressing the needs and assets of diverse populations.
4. Ensure youth programming is inclusive, culturally appropriate and reaches underserved populations.

Acknowledgments

To all those who contributed to the 2009 Oregon Youth Sexual Health Plan, this YSH Progress Report and to all who work to promote youth sexual health — thank you.

Cascade AIDS Project

Oregon Coalition Against Domestic & Sexual Violence

Oregon Department of Education

Oregon Department of Human Services

Oregon Health Authority/Public Health Division

Oregon Teen Pregnancy Task Force

Oregon Youth Sexual Health Partnership

Planned Parenthood Columbia Willamette

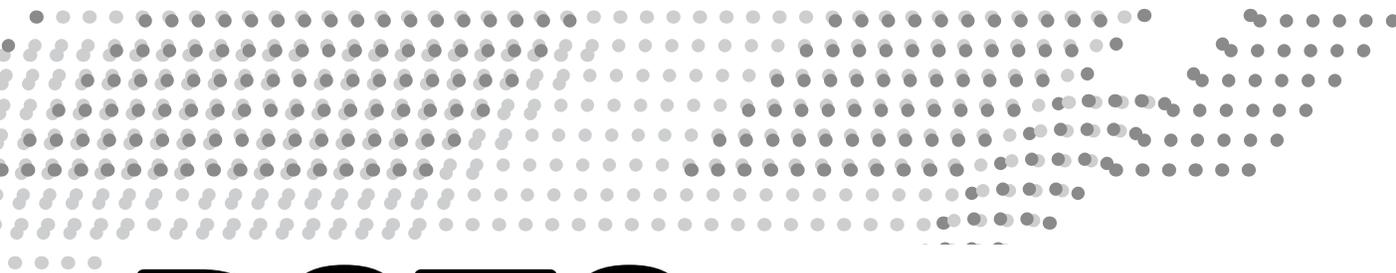
Planned Parenthood Southwestern Oregon

Oregon Attorney General's Sexual Assault Task Force

Oregon Local County Health Departments

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About this data appendix

The data appendix is intended to supplement and expand upon the data presented in the Youth Sexual Health Plan Five Year Update.

The data in this appendix is broken down by indicators, such as pregnancy, birth, abortion, chlamydia rates and sexual behaviors.

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Data sources

Oregon Health Authority Public Health Division (OHA PHD) is Oregon's home for statewide data on health behaviors, diseases and injuries, vital statistics such as pregnancy, birth and death rates and an array of other indicators that contributes to policies to improve the health and well-being of all Oregonians. Other data and indicators that are collected and analyzed by the OHA PHD include:

- STI/STD and HIV rates
- Maternal and child health data
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Adolescent Suicide Attempt Data System (ASADS)

OHA PHD data is used to assess the need for public health services, measure health outcomes against state and national benchmarks such as Healthy People 2020.

For more information about the OHA PHD, please visit <https://public.health.oregon.gov/DataStatistics/Pages/index.aspx>.

Oregon Healthy Teens Survey (OHT) has been Oregon's effort to monitor the health and well-being of adolescents since 2001. The anonymous survey was administered to 8th and 11th grade students annually until 2009 and then it went to every other year beginning in 2011. The OHT Survey combines two youth-focused surveys that preceded it, the Youth Risk Behavior Survey (YRBS) and the Student Drug Use Survey. Topics assessed on the OHT Survey include:

- Tobacco, alcohol and other drug use
- Personal safety behaviors and perceptions
- Sexual activity and HIV/AIDS knowledge
- Positive youth development
- Health conditions and access to care
- Nutrition and physical activity

OHT Survey data is used to help evaluate the effectiveness of projects and programs that promote healthy adolescence in Oregon. The indicators included in the OHT Survey are a key source of data when assessing progress for state and national benchmarks, including those in Healthy People 2020.

For more information about the OHT Survey, please visit <https://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx>.

National Center for Health Statistics (NCHS) is an expansive website of national health statistics critical to public health surveillance and used to influence health policies. Data collection systems housed in the NCHS include:

- National Health and Nutrition Examination Survey (NHANES)
- National Vital Statistics Systems (NVSS)
- National Health Care Survey

The NCHS health statistics help to identify disparities in health statistics and use of health care by race, ethnicity, region, etc., and provide information for making changes or evaluating public policies and programs.

For more information about NCHS, please visit www.cdc.gov/nchs/index.htm.



School Health Profiles Survey (SHPS) is a system of surveys assessing school health policies and practices in states, large urban school districts, territories and tribal governments. SHPS are conducted every other year by education and health agencies among middle and high school principals and lead health education teachers. Some of the topics that SHPS monitors are:

- School health education requirements and content
- Physical education and physical activity
- School health policies related to HIV infection/AIDS, tobacco-use prevention and nutrition
- School health coordination

SHPS data is used by education and health professionals to identify professional development needs, describe school health policies and practices, monitor current programs and plan for future needs.

For more information about SHPS, please visit www.cdc.gov/healthyyouth/profiles/index.htm.

Youth Risk Behavior Survey (YRBS) is a national school-based survey conducted by the Centers for Disease Control and Prevention. The survey is administered to middle and high school students across the United States every other year in odd years. Topics assessed on the survey include:

- Alcohol, tobacco and drug use
- Sexual behaviors
- Nutrition and physical activity
- Bullying
- Injury and suicide

The YRBS is used to inform the overall Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health-risk behaviors and the prevalence of obesity and asthma among the nation's adolescents. YRBSS data are used to measure progress toward achieving national health objectives such as Healthy People 2020, assess trends in priority behaviors among high school youth, and evaluate and plan interventions at the national, state and local levels.

For more information about the YRBS, please visit: www.cdc.gov/healthyyouth/yrbs/brief.htm.



Sexual behavior among 11th grade youth

As seen in Figure 1, nationwide a higher percentage of 11th grade youth reported having sexual intercourse compared to their Oregon counterparts across all years. In Oregon, the percentage of 11th grade youth reported ever having sex has remained stable since 2008.

Figure 1. Ever had sexual intercourse among 11th grade youth, Oregon and United States, 2008-2013

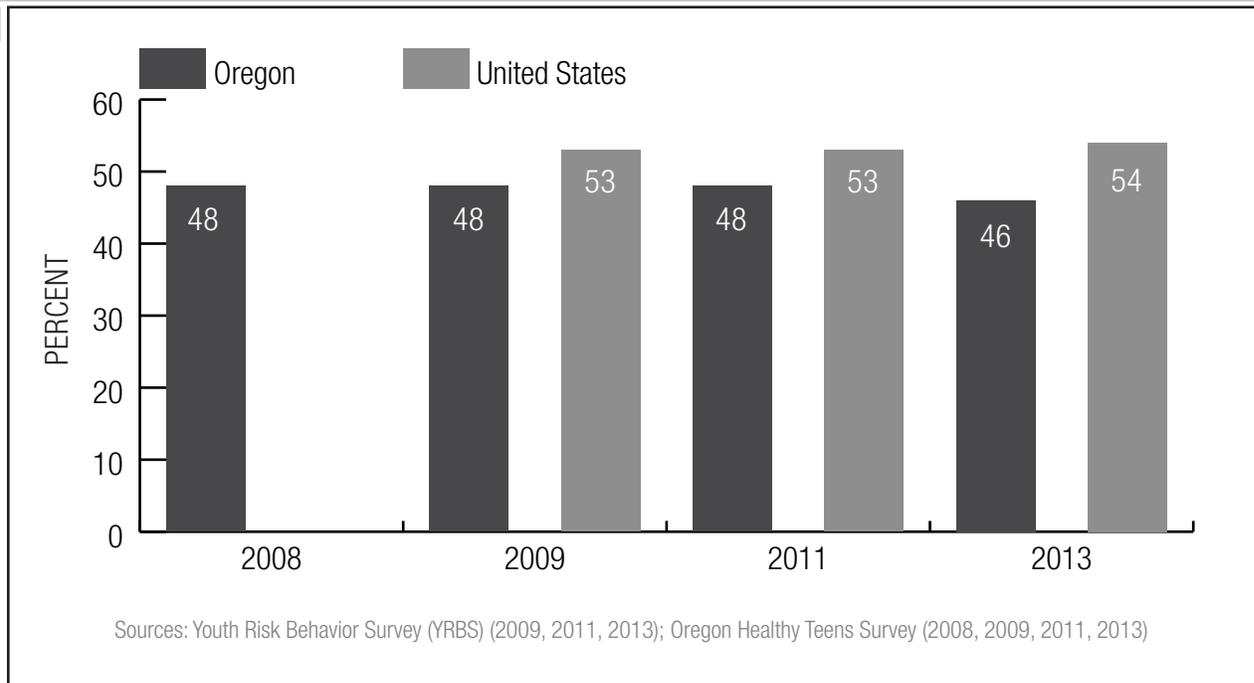


Figure 2 shows the percentage of 11th grade males and females in Oregon and nationwide who have ever had sexual intercourse. Across all years and both genders, nationwide averages are higher than in Oregon, with just under 50% of Oregon 11th grade youth reporting they have ever had sex.

Figure 2. Ever had sexual intercourse among 11th grade youth, Oregon and United States by gender, 2008-2013

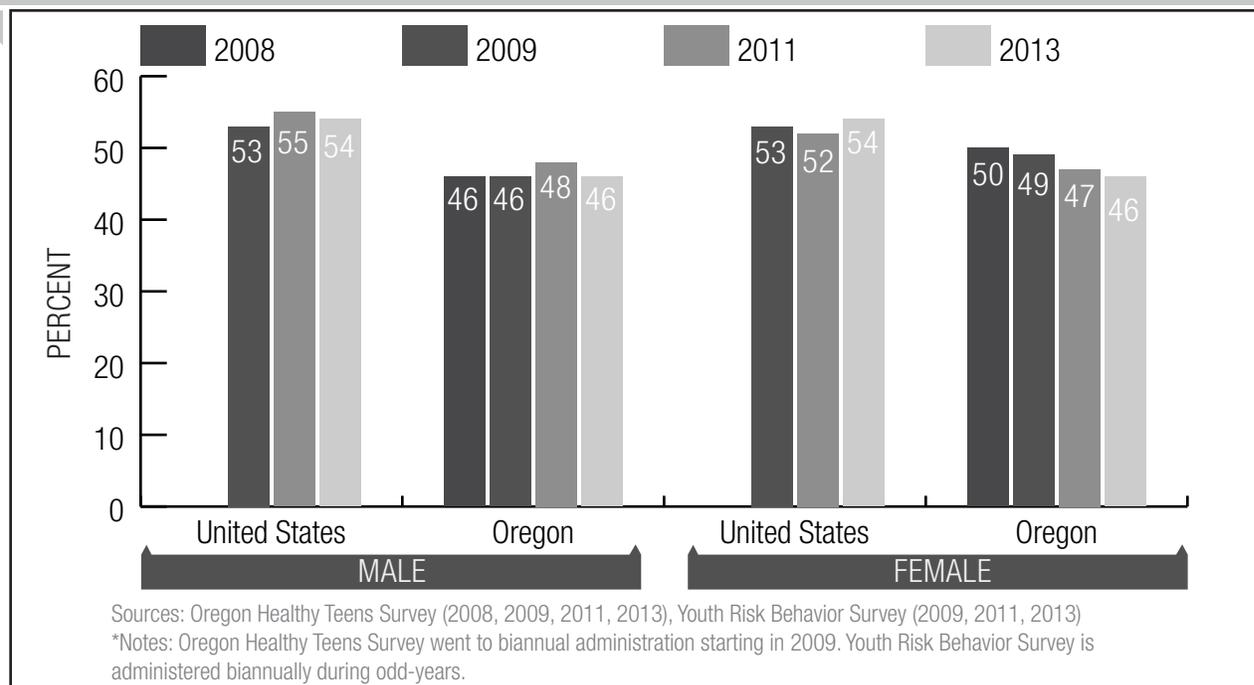
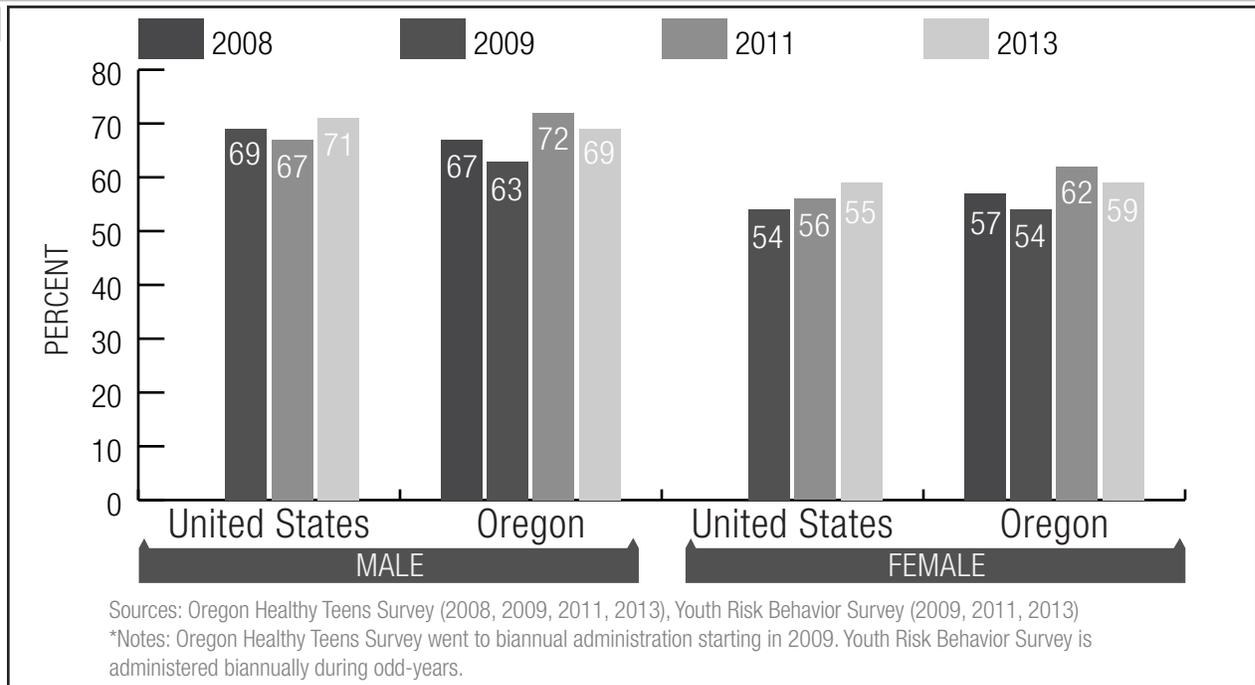


Figure 3 shows condom use at last intercourse among 11th grade youth. With regard to national and statewide data, males report higher percentages of condom use than females. Condom use at last intercourse has declined slightly in Oregon among both genders from 2011 to 2013.

Figure 3. Used a condom at last sexual intercourse among sexually-experienced 11th grade youth, Oregon and United States by gender, 2008-2013



Contraceptive use at last sexual intercourse among 11th grade youth is depicted in Figure 4. Across all years and both genders, Oregon's contraceptive use is slightly lower than the national average. Since 2008, both genders have reported slight upticks in the percentages of contraceptive use in Oregon.

Figure 4. Used contraception at last intercourse among sexually-experienced 11th grade youth, Oregon and United States by gender, 2008-2013

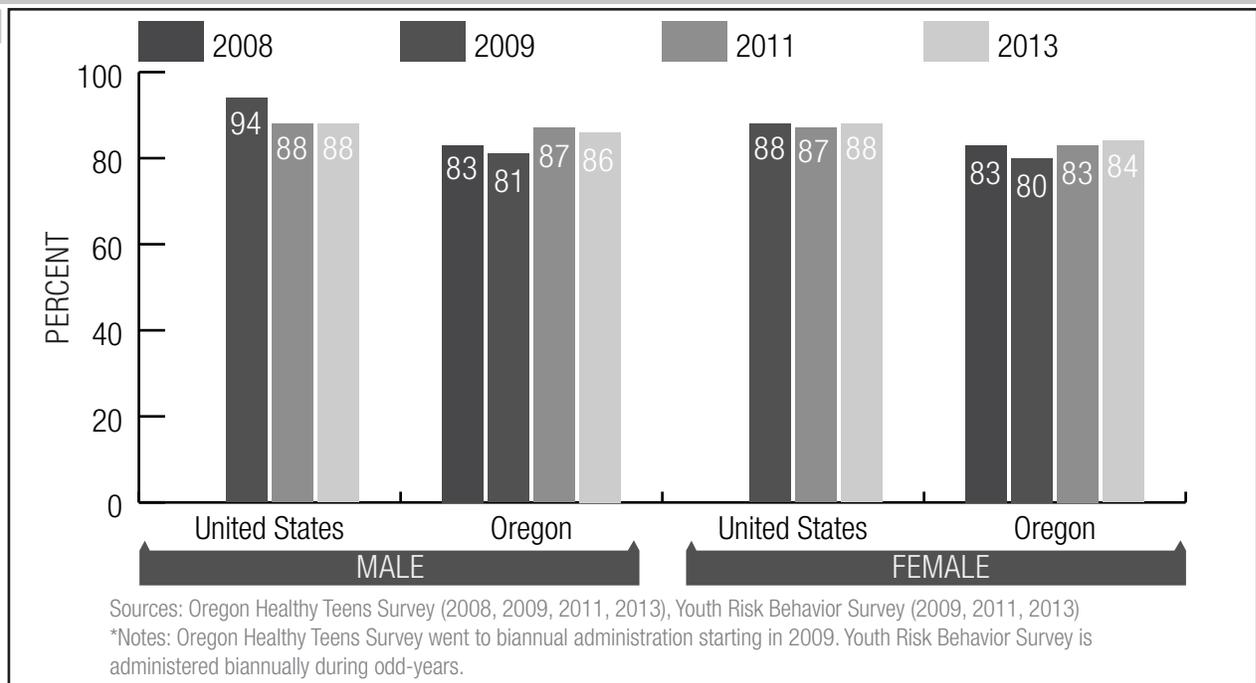


Figure 5 depicts age at first intercourse among sexually-experienced 11th grade youth in Oregon. Since 2008, the highest percentage of males and females reported they had intercourse for the first time at age “16 years,” followed closely by “15 years.” Less than 5% of females across all years reported having sexual intercourse for the first time at “11 years or younger” or “12 years.”

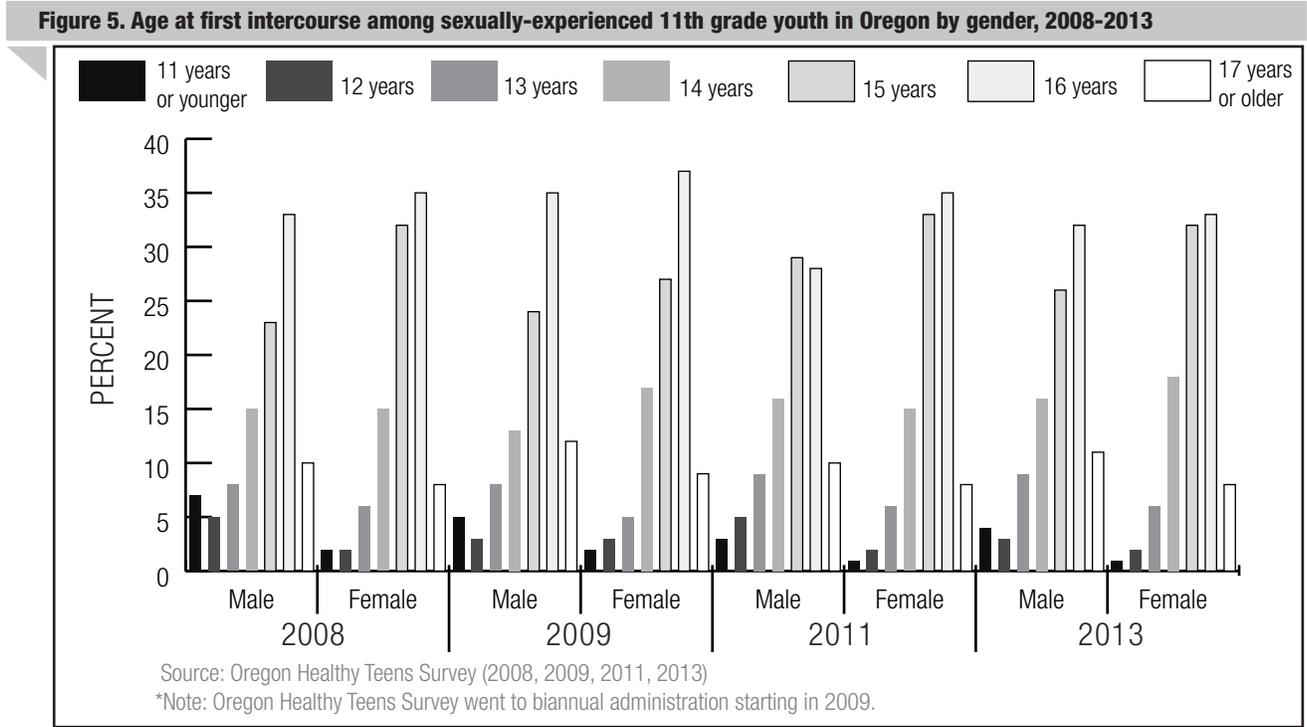
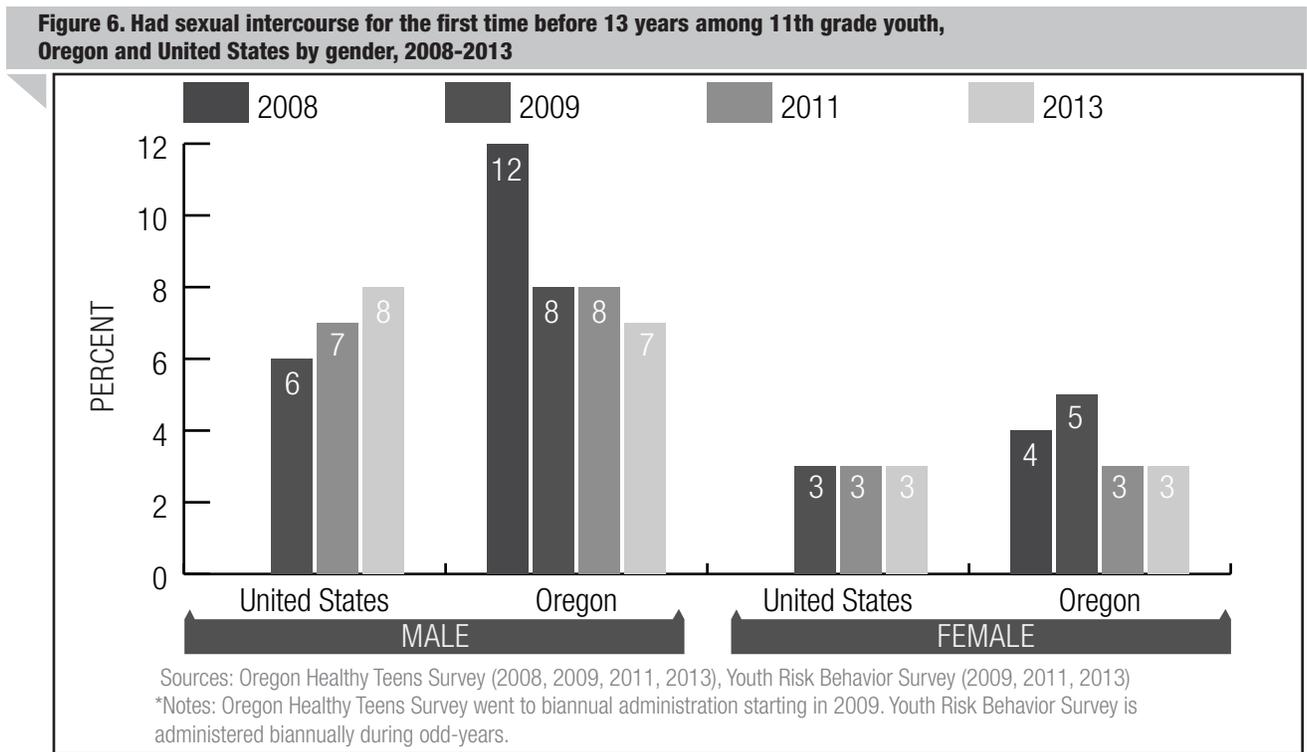


Figure 6 indicates the percentage of 11th grade youth who reported they had sexual intercourse before 13 years of age. Nationally and in Oregon, males report higher percentages of having sex before 13 years of age than females. Additionally, there is very little variance in the percentages of 11th grade youth who report early sexual debut within genders and across years.



Pregnancy rates among females 15–19 years

Figure 7 shows the pregnancy rates among 15–19 year old females in Oregon and nationwide since 2002. Oregon's pregnancy rates — while following the national trend — have been consistently lower than the national average. There has been a 40% decrease in pregnancy rates among 15–19 year old females in Oregon between 2002 and 2012.

Figure 7. Pregnancy rates among females 15–19 years, Oregon and United States, 2002–2012

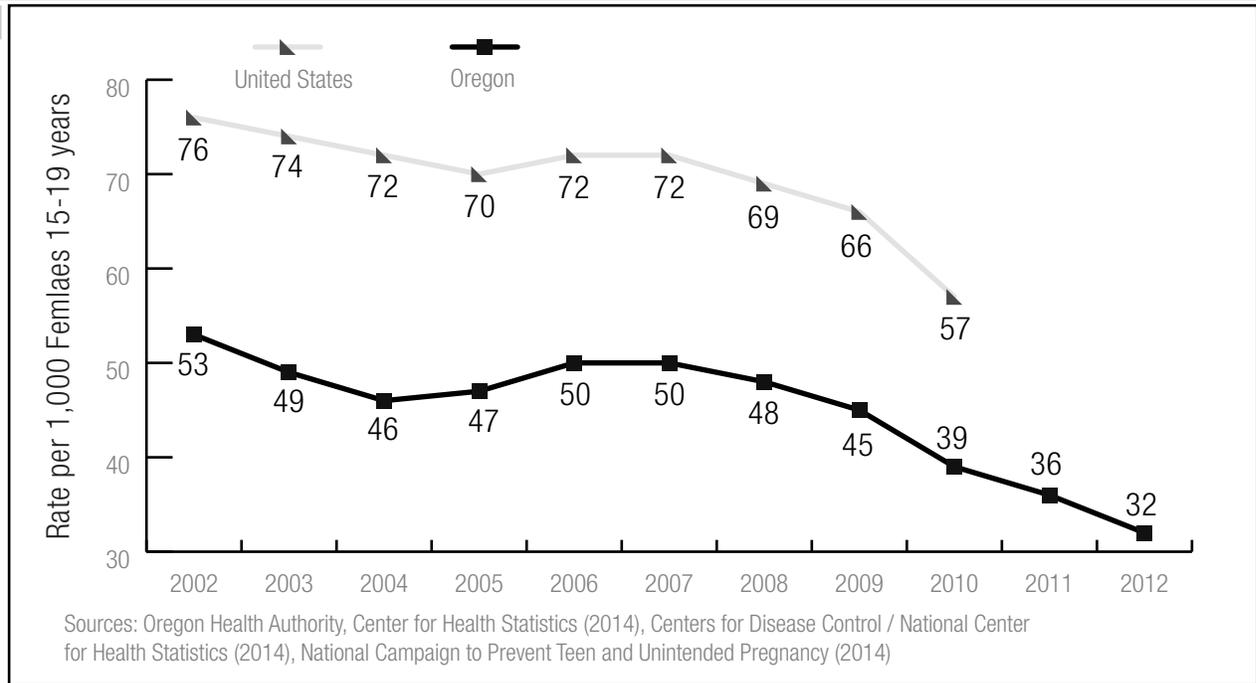
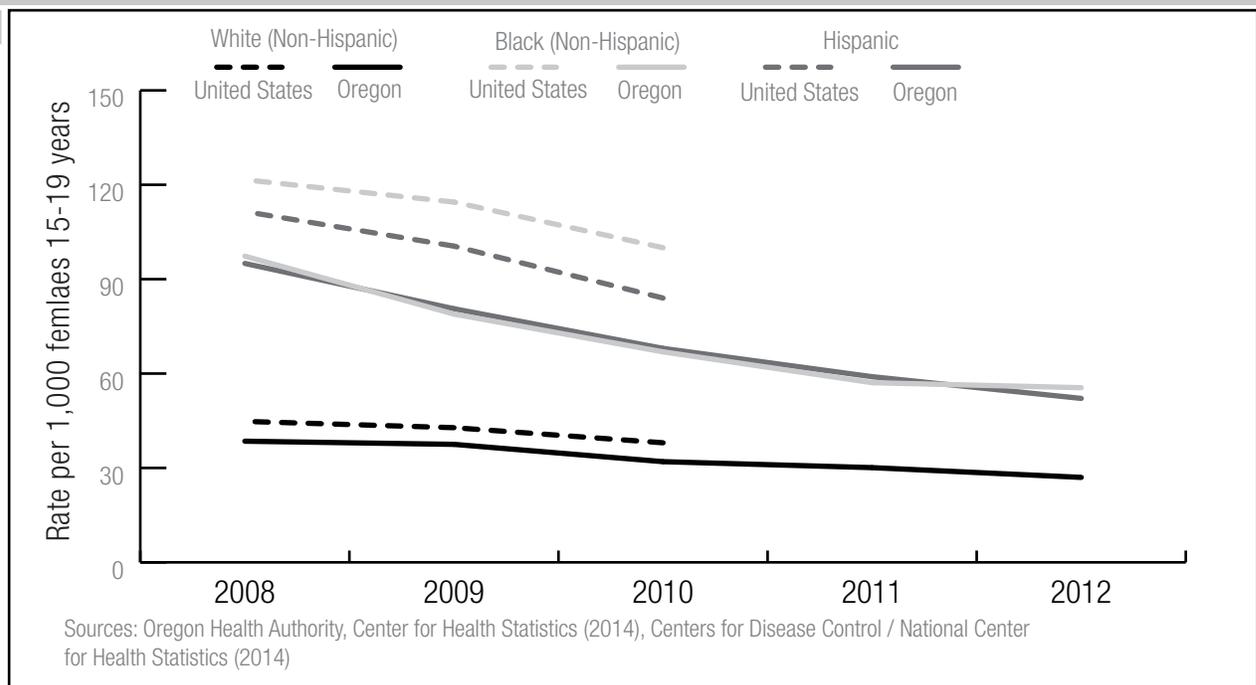


Figure 8 shows that across all years, Oregon's rates of pregnancy by selected race and ethnicities are lower than the national rates. Between 2008 and 2012, rates in Oregon followed the national trend and declined across all races and ethnicities.

Figure 8. Pregnancy rates among females 15–19 years, Oregon and United States by race/ethnicity, 2008–2012



Birth rates among females 15–19 years

Figure 9 shows that birth rates among 15–19 year old females in Oregon have been steadily declining since the uptick in 2008, which is similar to the national trend. From 2008 to 2011, there was a 28% decrease in birth rates among Oregon females aged 15–19.

Figure 9. Birth rates among females 15–19 years in Oregon and United States, 2008–2012

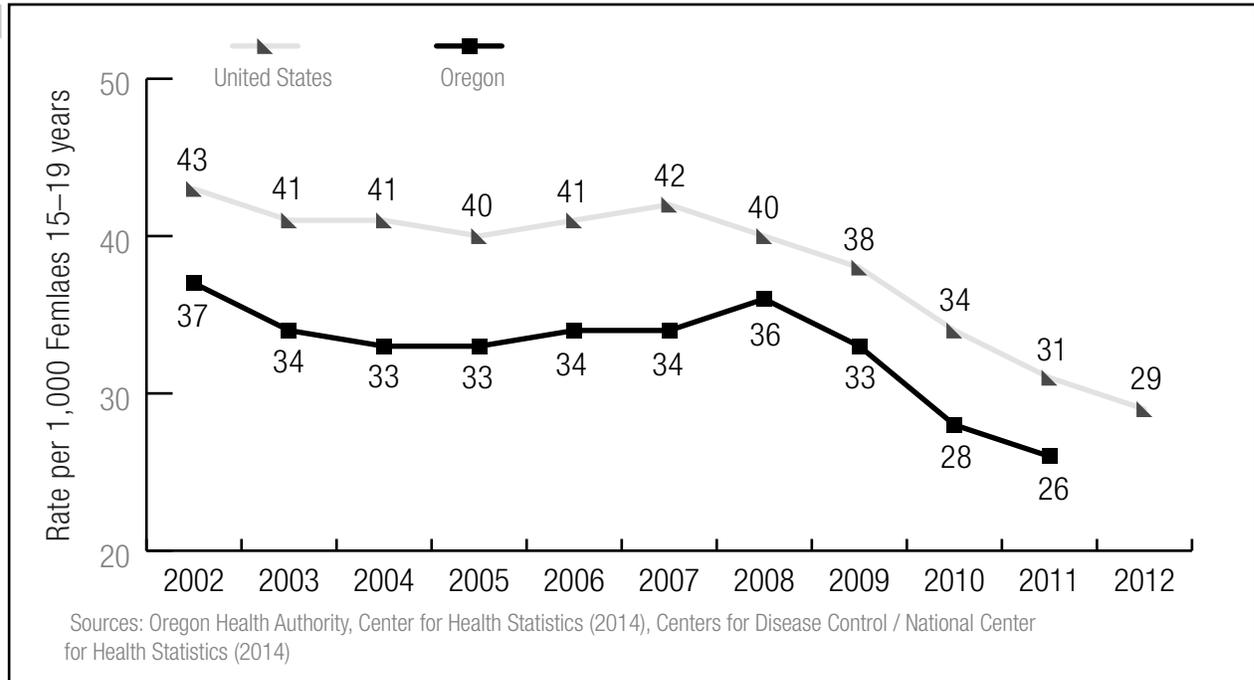
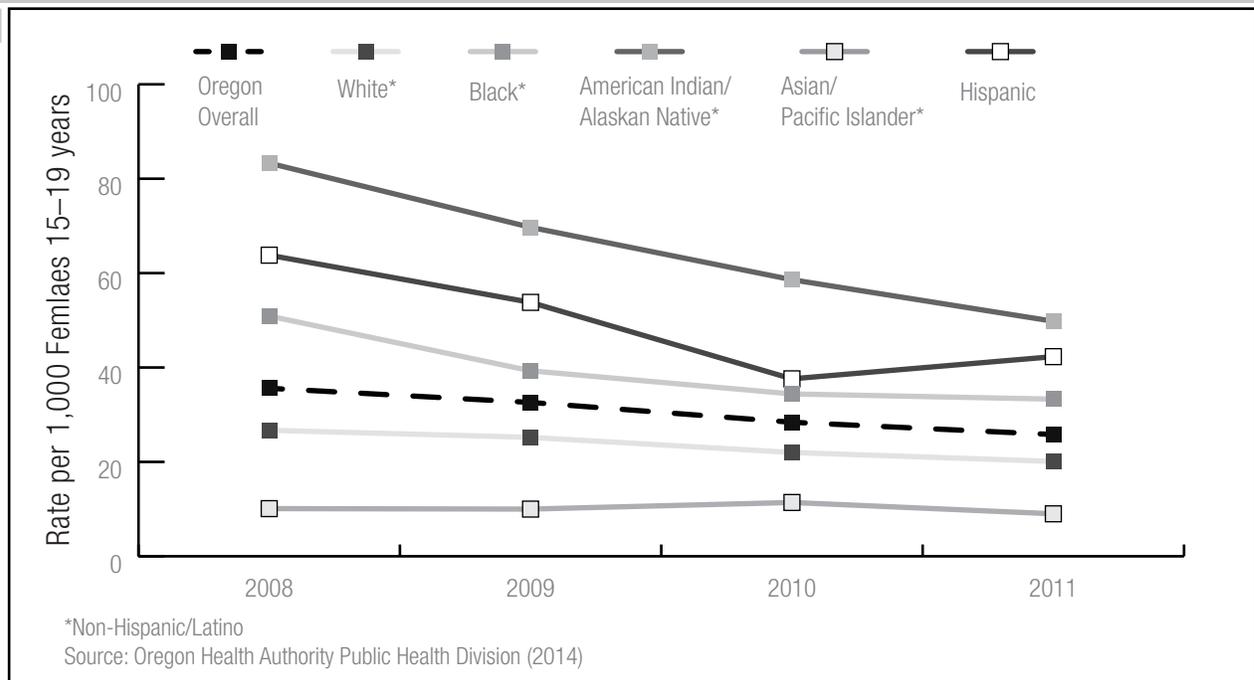


Figure 10 shows birth rates among 15–19 year olds in Oregon across all races and ethnicities. Except for “Hispanic/Latina” females, all have been in decline since 2008, with the biggest decrease among “American Indian/Alaskan Native” females. Despite these declines, non-Hispanic “American Indian/Alaskan Native” and “Black” and “Hispanic/Latina” females aged 15–19 years were much more likely to give birth than their “Asian/Pacific Islander” and “White” peers.

Figure 10. Birth rates among females 15–19 years by race/ethnicity in Oregon, 2008–2011



Abortion rates among females 15–19 years

As seen in Figure 11, abortion rates in Oregon among females 15–19 years have declined 47% between 2002 and 2012. There was a slight uptick in abortion rates in Oregon in 2006 and 2007, but rates have been continuously declining since 2008, reaching a record low rate of 9 per 1,000 abortions in 2012. Abortion rates in Oregon have consistently been lower than the national average.

Figure 11. Abortion rates among females 15–19 years in Oregon and the United States, 2008–2012

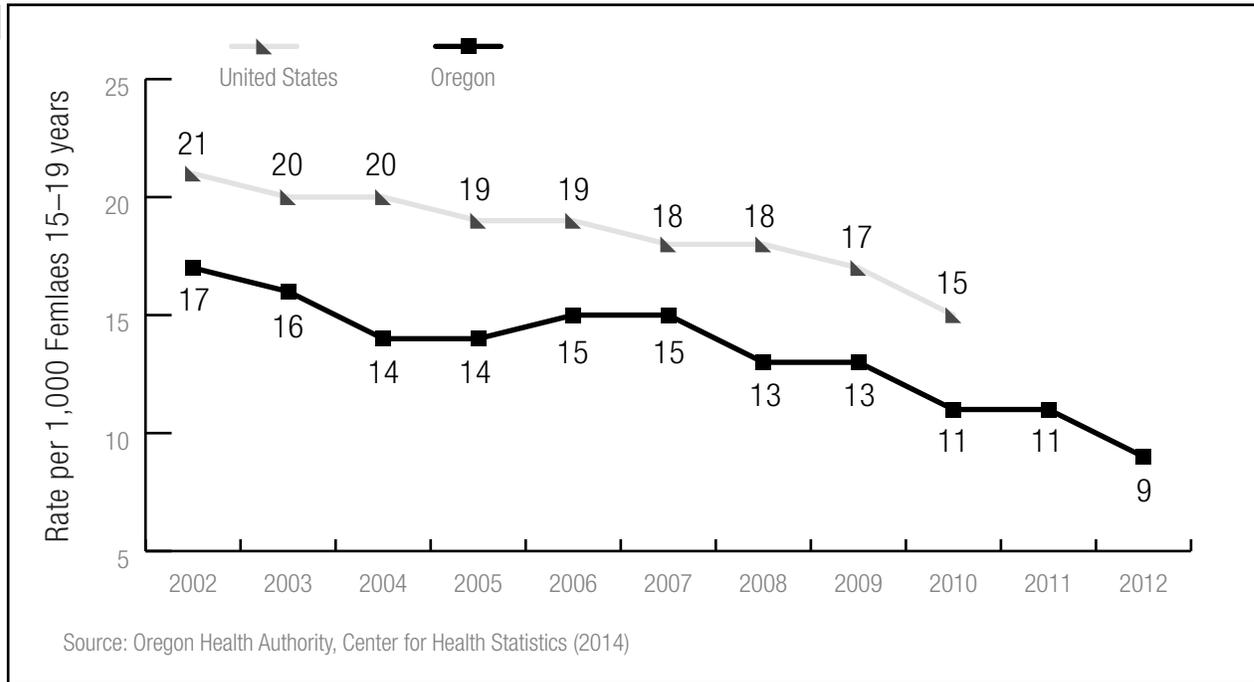
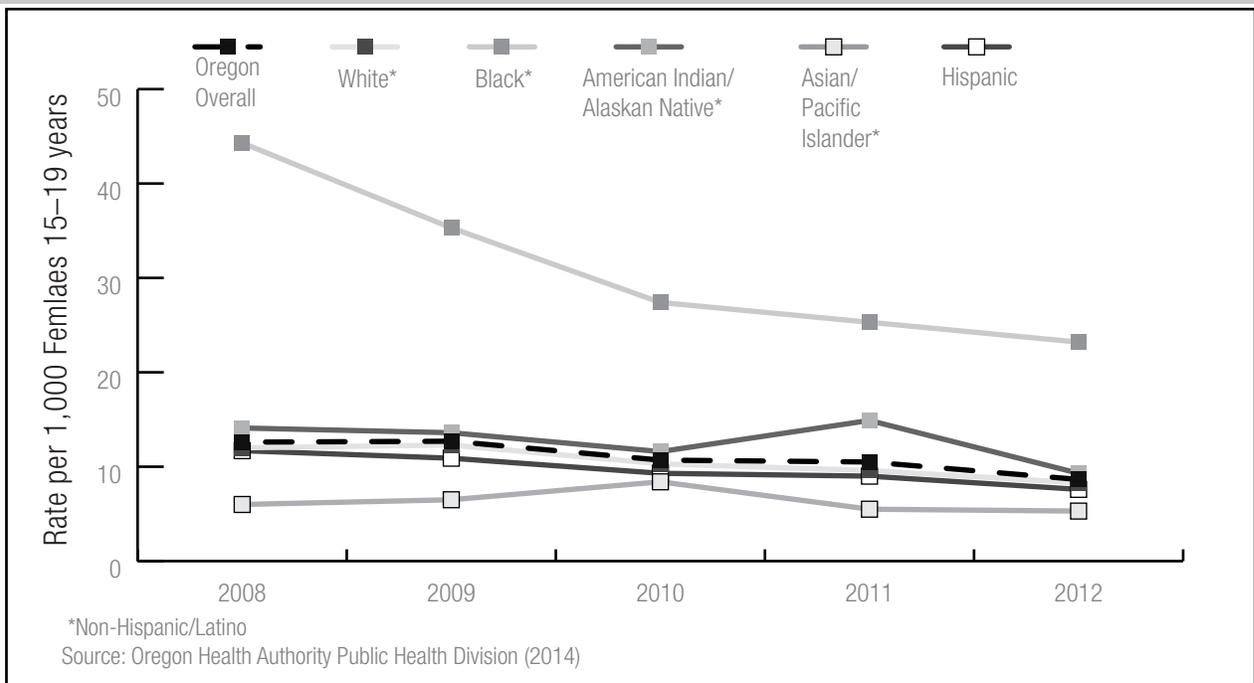


Figure 12 illustrates abortion rates in Oregon by race/ethnicity from 2008 to 2012. “Black” females had the highest rate of abortions across all years, followed by “American Indian/Alaskan Native” females. “White,” “Hispanic/Latina” and “Asian/Pacific Islander” females had rates that were right at or below the state average across all years. Across all races, abortion rates were lower in 2012 than they were in 2008.

Figure 12. Abortion rates among females 15–19 years in Oregon by race/ethnicity, 2008–2012

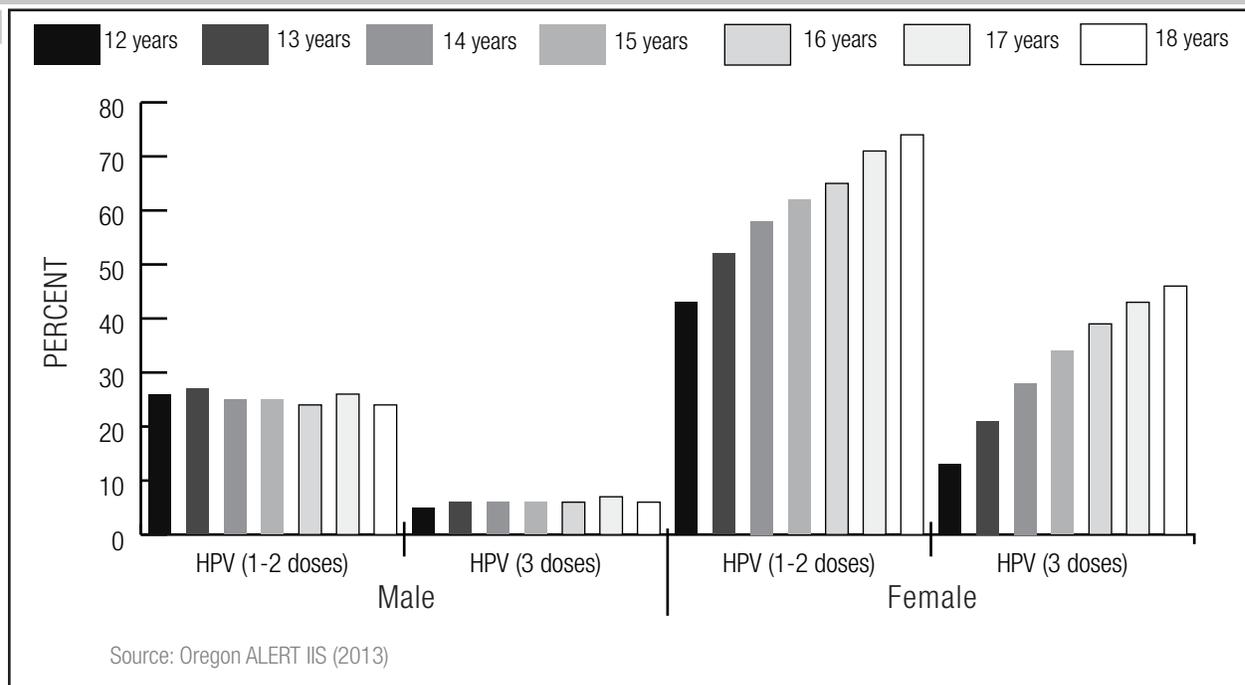


Human papillomavirus vaccination immunization rates

Figure 13 shows the percentage of Oregon youth who have received the human papillomavirus (HPV) immunization by age. The Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC) recommends routine three-dose vaccination series for males and females at 11 or 12 years of age. HPV vaccination can be administered to individuals between the ages 9–26 years. Healthy People 2020 has set the target of 80% of females 13 to 15 years receive the three recommended doses of the HPV vaccine. Overall, just 28% of Oregon females aged 13 to 15 years have finished the recommended three dose HPV series.

For females, percentage of receiving either 1-2 doses or 3 doses increases with age, with 46% of 18 year old females receiving the three recommended dosages compared with 13% and 21% of females aged 12 and 13 years, respectively. Only 6% of males in Oregon across all ages have received the recommended three doses.

Figure 13. HPV immunization rates by age in Oregon, 2013



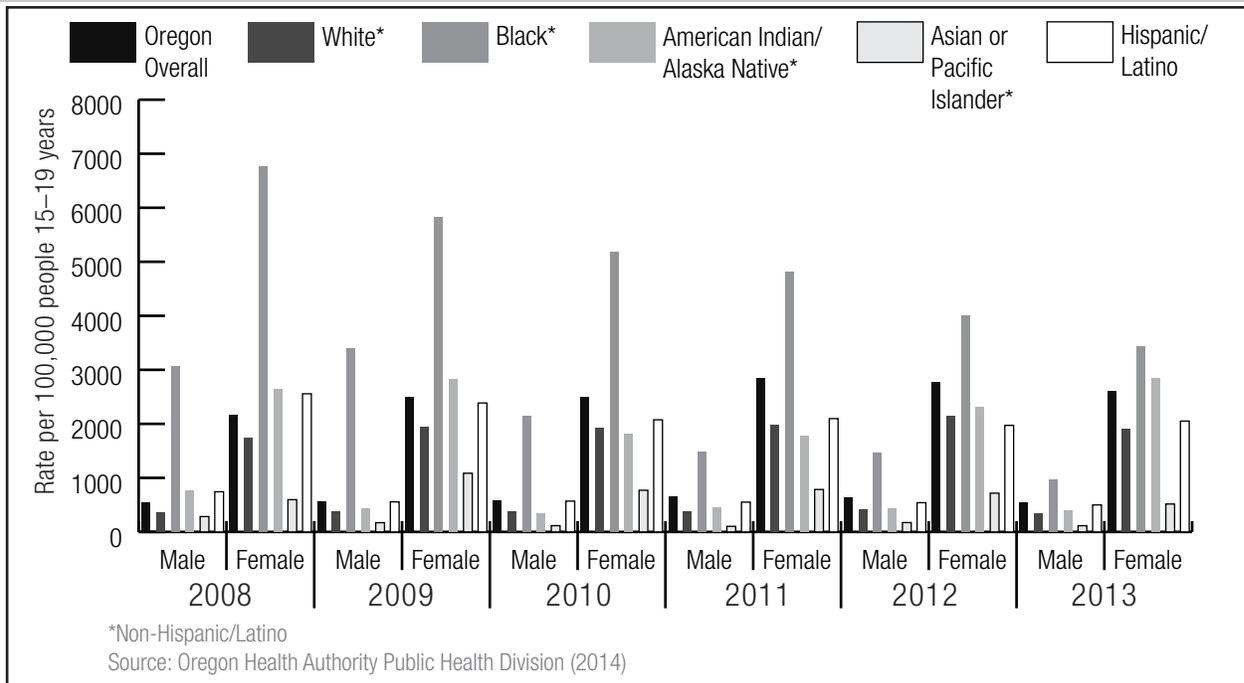
Chlamydia rates among youth 15–19 years

As seen in Figure 14, “Black” females in Oregon have the highest rates of chlamydia across both genders and all races. Since 2008, however, rates among “Black” females’ rates have fallen. Among males, blacks have the highest percentage across all races and ethnicities, but their rates have followed the “Black” females’ trend and have fallen since 2008. There has been an increase in the rates of “American Indian/ Alaska Native” females diagnosed with chlamydia since 2011.

Changes in chlamydia rates can be affected by other factors including:

- Resources for outreach, testing and partner follow up
- Type of screening test administered and testing sensitivity
- Actual increase/decrease in disease prevalence

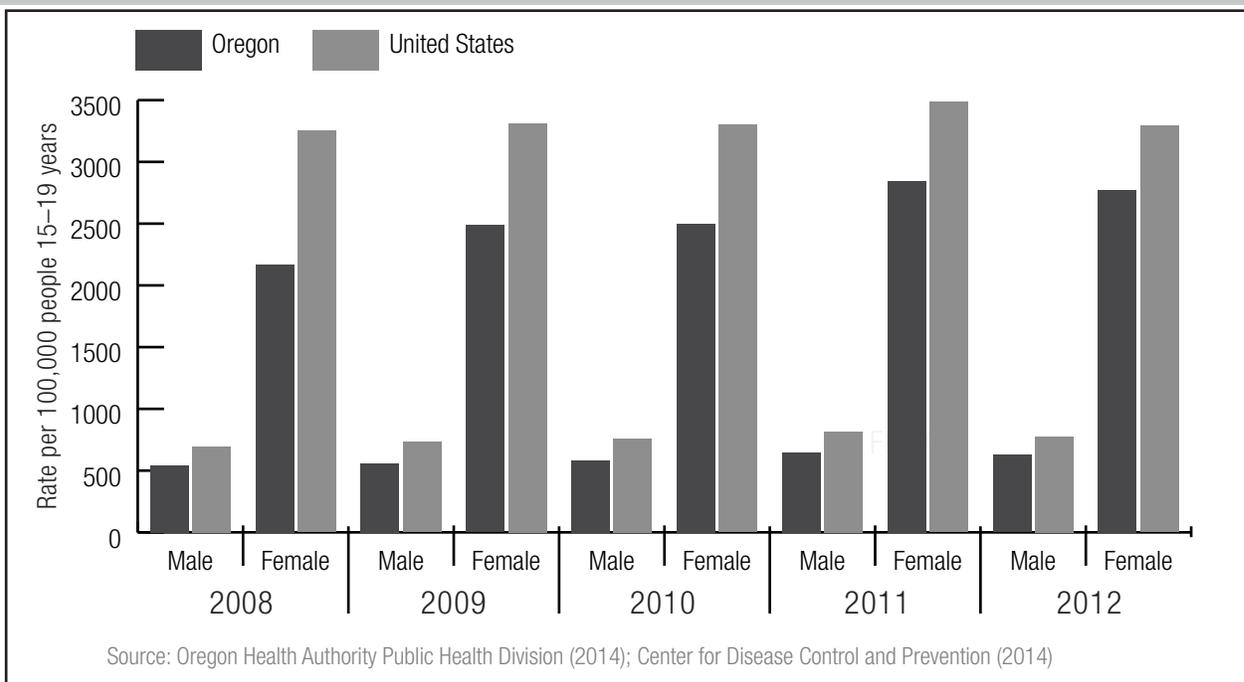
Figure 14. Chlamydia rates among youth 15–19 years in Oregon by race/ethnicity, 2008-2013



Chlamydia rates in Oregon and nationwide averages are seen in Figure 15. Across all years and both genders, Oregon has lower rates of chlamydia than the nationwide averages. Females have higher rates than males in both Oregon and nationwide. Reasoning for the disparity in rates between males and females include: (1, 2)

- Increased screening efforts among females
- Anatomical differences
- Lack of symptoms in females

Figure 15. Chlamydia rates among youth 15–19 years in Oregon and the United States, 2008-2012



Gonorrhea rates among youth 15–19 years

Figure 16 depicts gonorrhea rates by race and ethnicity in Oregon. “Black” females have the highest rates of any gender and racial/ethnic group in the state across all years, with a rate hike occurring in 2011. Over the course of five years, the rates have fallen dramatically from 850 per 100,000 to just under 400 per 100,000. “Black” males have the second highest rates in the state.

Figure 16. Gonorrhea rates among youth 15–19 years in Oregon by race/ethnicity, 2008-2013

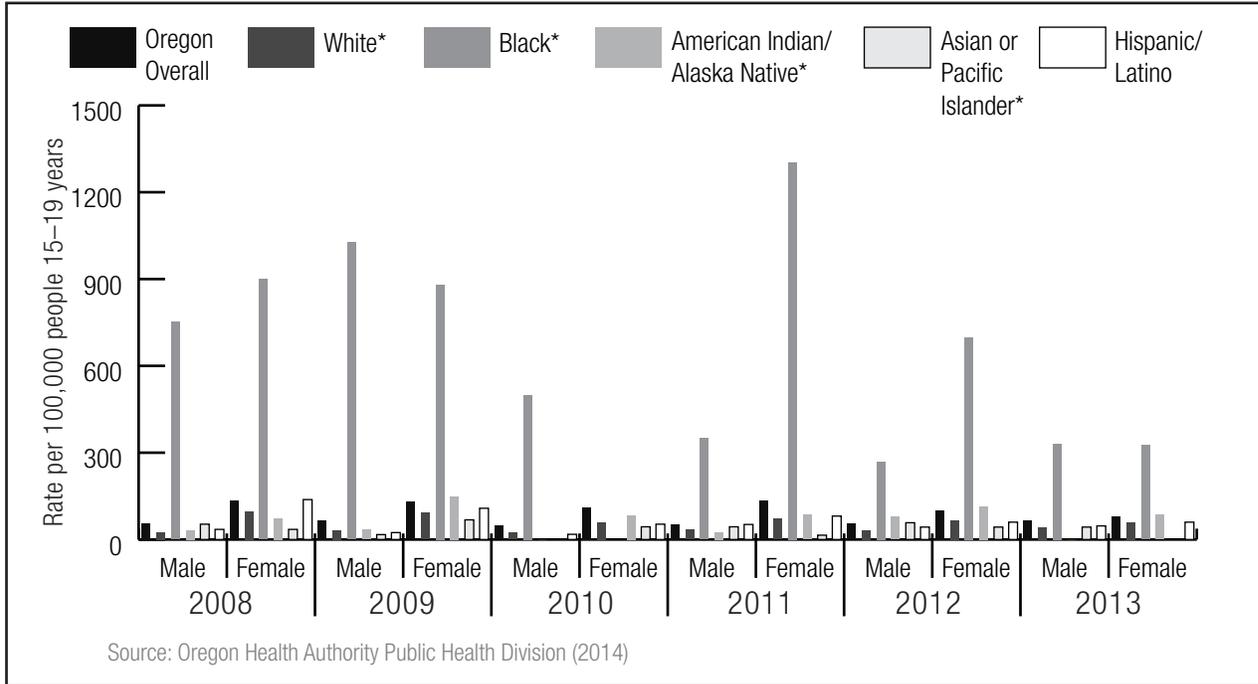
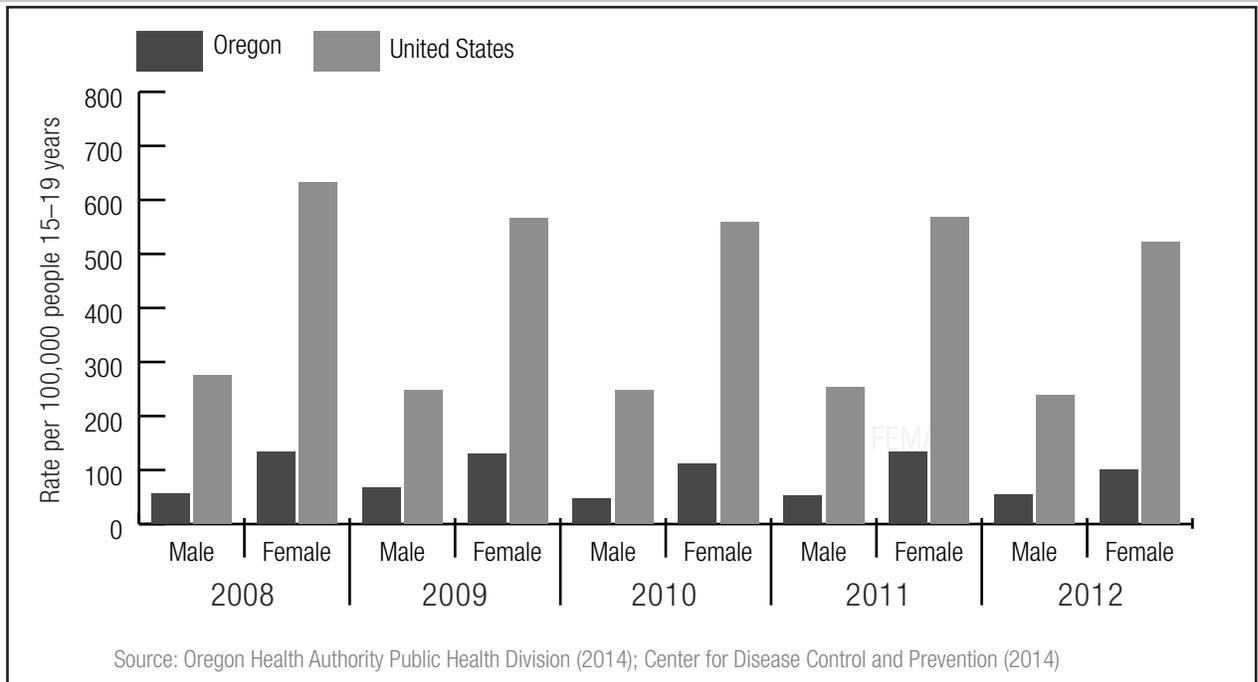


Figure 17 shows gonorrhea rates in Oregon and the United States. From 2008 to 2012, Oregon is well below the national averages for both males and females diagnosed with chlamydia. In 2012, Oregon had a rate of 100 per 100,000 females and 50 per 100,000 males, compared to the nationwide averages of over 500 per 100,000 females and 225 per 100,000 males.

Figure 17. Gonorrhea rates among youth 15–19 years in Oregon and the United States, 2008-2012



Sexual health education in Oregon

Figure 18 shows the percentage of health teachers who reported teaching their students about accessing valid information, products and services to enhance health during health classes across Oregon in 2012. An average of 85% of teachers reported this, with the highest percentage of teachers reporting this at the high school level.

Figure 18. Health teachers who taught about accessing valid information, products and services to enhance health in Oregon, 2012

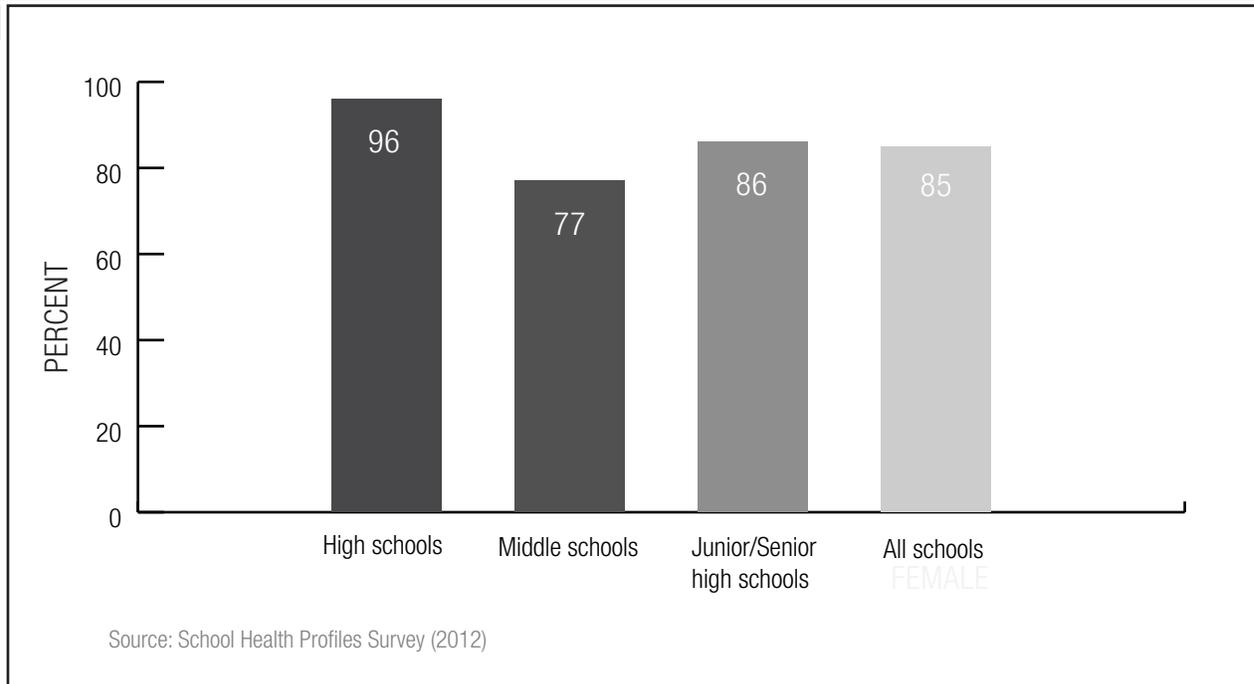
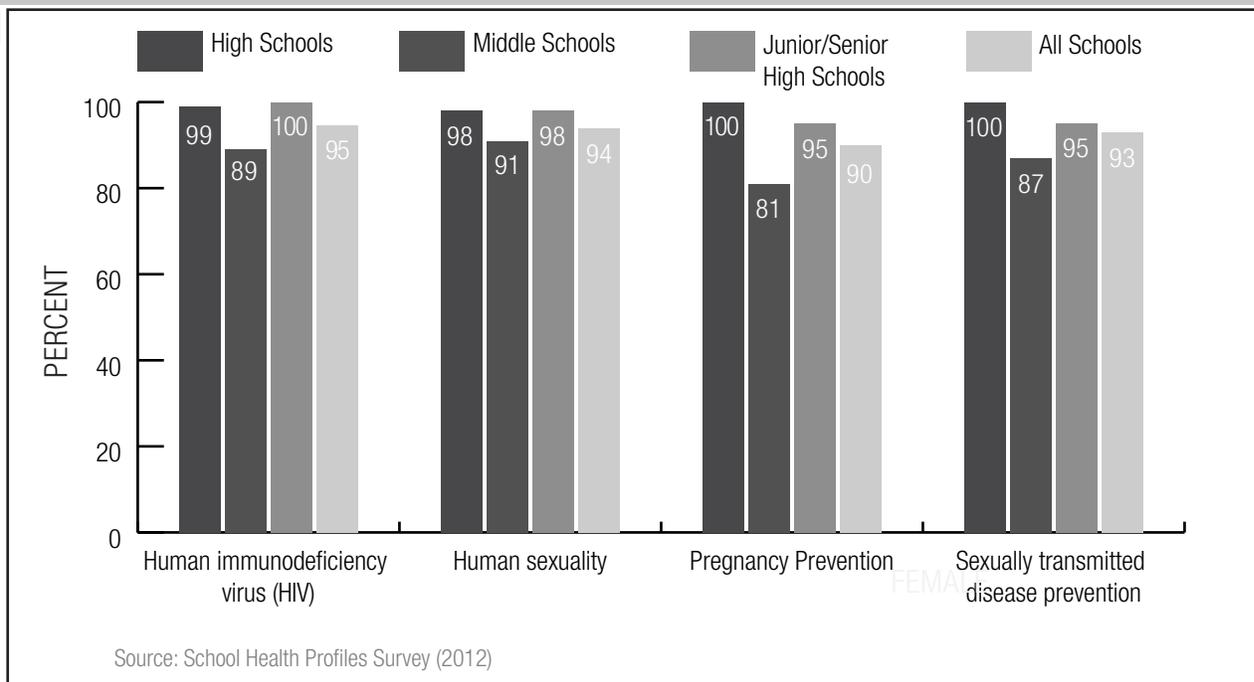


Figure 19 shows the percentage of health teachers who reported teaching their students with the intention of increasing knowledge by topical area in Oregon in 2012. Almost 100% of high school teachers reported they taught to increase knowledge about the “human immunodeficiency virus,” “human sexuality,” “pregnancy prevention” and “sexually-transmitted disease protection.” This also shows that fewer than 90% of middle school teachers reported teaching about “pregnancy prevention” and “sexually-transmitted disease prevention.”

Figure 19. Health teachers who taught to increase knowledge by topical area in Oregon, 2012

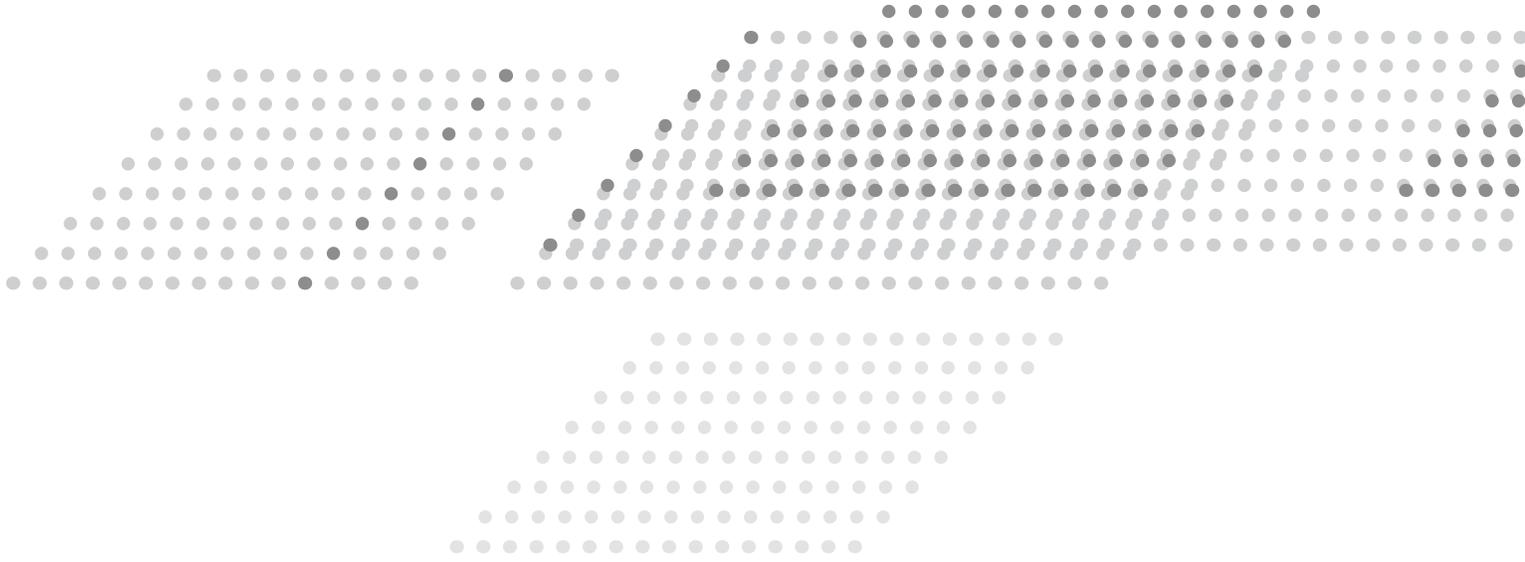


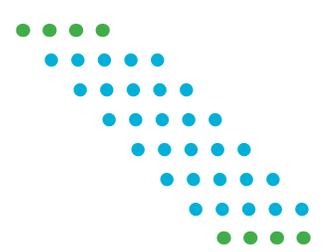
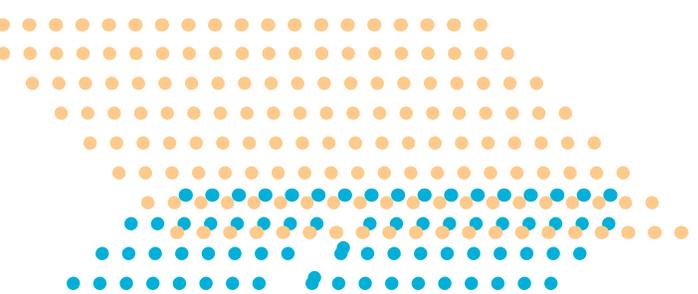
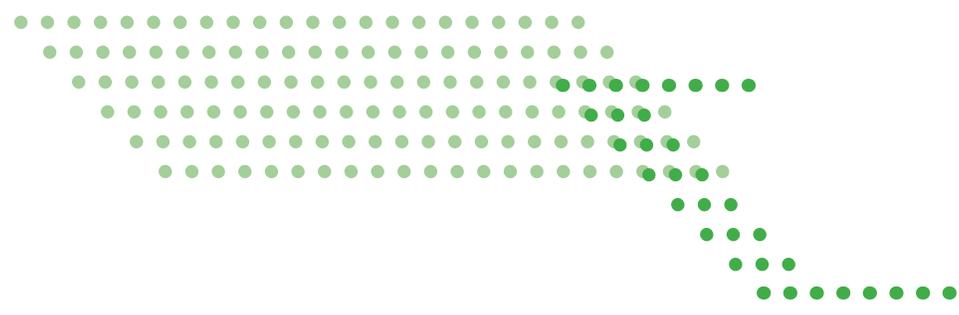
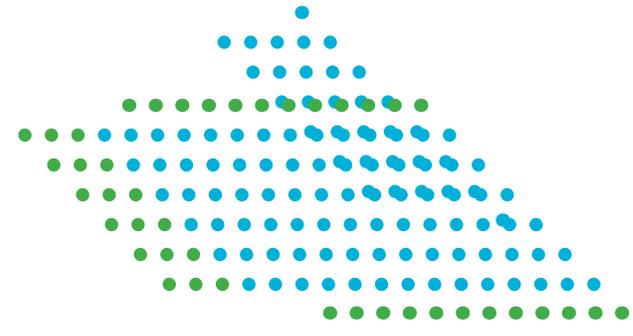
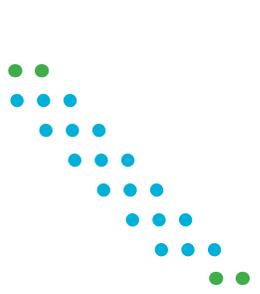
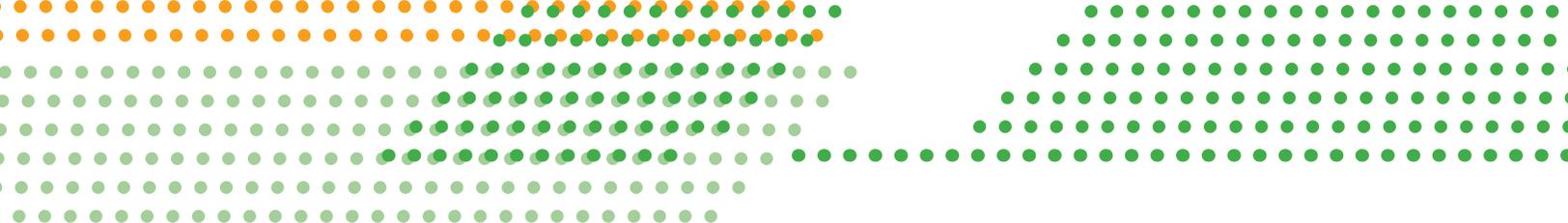


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