UNLV Center for Democratic Culture
Edited by Dmitri N. Shalin

The Social Health of Nevada

Leading Indicators and Quality of Life in the Silver State

Teen Sexuality and Pregnancy in Nevada

Dr. Sandra Owens, *School of Social Work, University of Nevada*
Dr. Marya Shegog, *The Lincy Institute and School of Community Health Sciences, University of Nevada*

Introduction

We begin this report by examining recent data regarding the national and Nevada specific trends in teen sexuality and pregnancy and discuss the socioeconomic determinants and disparities in teen pregnancy. Next, we focus on the national and local policies and programs designed to reduce teen pregnancy and to promote health equity among teenage youth. We conclude with a survey of programs that provide housing, case management, mental health services, life skills, career counseling and teen parenting education in Las Vegas and in Henderson, NV.

Highlights

- In 2015, the teen birthrate declined in the U.S. to a historic low of 22.3 births per 1000 females aged 15-19 – down 8% compared to previous year.
- In the same year, birthrates declined to 6.9 for Asian or Pacific Islander, 16.0 for non-Hispanic White, 25.7 for American Indian or Alaska Native, 31.8 for non-Hispanic Black, and 34.9 for Hispanic female teenagers aged 15 - 19.
- Sustained progress in teen pregnancy prevention requires multi-pronged, targeted community level efforts to address and decrease the racial/ethnic, geographic and other factors impacting the teen pregnancy rates.

Appendix provides information about local and national community resources that readers can use to further their understanding of the issues raised in this chapter and learn more about the best practices designed to prevent teen pregnancies.

How to Cite this Report

Owens, Sandra and Marya Shegog. 2017. "Teen Sexuality and Pregnancy in Nevada." In *The Social Health of Nevada: Leading Indicators and Quality of Life in the Silver State*, edited by Dmitri N. Shalin. Las Vegas, NV: UNLV Center for Democratic Culture, http://cdclv.unlv.edu

Teen Sexuality and Pregnancy Patterns

Census data for 2015 indicate that the birth rate for adolescents ages 15-19 dropped eight percent between 2014 and 2015, reaching a historic low of 22.3 births per 1,000 females (Martin, Hamilton, Osterman, Driscoll and Mathews, 2017). The birth rates for teenagers aged 15-17 and 18-19 declined in 2015 to 9.9 and 40.7 (per 1,000) respectively – record lows for both age groups. Still, racial/ethnic and geographic disparities in teen birth rates persist. For example, in 2015, the birth rate of Hispanic teens (34.9 per 1,000 females) was two times higher than the rate for non-Hispanic white teens (16/1,000). And the birth rate of non-Hispanic Black teens (31.8/1,000) was almost twice as high as the rate among non-Hispanic White teens, while American Indian/Alaska Native teen birth rates (25.7/1,000) remained more than one and a half times higher than the non-Hispanic white teen birth rate (16/1,000 females aged 15-19). Geographic differences in teen birth rates persist, both within and across states. Even though teen birth rates (births per 1,000 females aged 15-19 years) declined in 37 states between 2014 and 2015, geographic disparities are tangible, with state-specific 2015 teen birth rates ranging from 9.4 in Massachusetts to 38.0 in Arkansas (Martin, Hamilton, Osterman, Driscoll and Mathews, 2017).

In Nevada, the 2015 birth rates for adolescents aged 15-19 was 27.5 births per 1,000 females, which is a little higher than the national rate of 22.3 (Martin, Hamilton, Osterman, Driscoll and Mathews, 2017). In 2015, non-Hispanic White females in the U.S. gave birth to 39% of babies born to mothers under age 20, and non-Hispanic Black females gave birth to 22% of all babies born to women under age 20. In Nevada in 2015, non-Hispanic White females under the age of 20 gave birth to only 27% of the babies, and non-Hispanic Black females gave birth to 17% of the babies born to young mothers. The Nevada and national percentages of births to females of Asian or Pacific Islander, and of American Indian or Alaska Native were all at 2% in 2015. However, 52% of Nevadan adolescent females under 20 who gave birth in 2015 were Hispanic. This is substantially higher than the 35% of Hispanics under age 20 who gave birth nationally in 2015. This distinction is important because of the current population statistics regarding the numbers of Hispanics living in Nevada as compared to national statistics. For example, the 2016 population estimate for the state of Nevada was 2,998,039 and the percentage of Hispanic residents was 28.5% for a total of 854,441 residents (U.S. Census Bureau, 2018). In Nevada, approximately one half of the population or 427,220 residents are female. And since 23% of Nevadans is under 18 years of age, we can estimate that a total of 98,260 Hispanic youth living in Nevada in 2016 were under the age of 18. If the current adolescent birthrate of 52% for Hispanic females under age 20 continues, a high

percentage of Hispanic adolescents will become mothers in their teens, and they will face the educational, financial and career disruptions characteristic of teen moms in America.

According to the Center for Disease Control (CDC, 2017), only about half of teen mothers earn a high school diploma by age 22, compared to 90 percent of women not affected by teen birth. Teenage mothers are more likely to live in poverty and depend on public assistance. Compared to older parents, children born to teen parents are also more likely to settle for lower school achievement, enter the child welfare and correctional systems, drop out of high school, and become teen parents themselves (CDC, 2017). Teen births are known to result in significant costs to extended family members, taxpayers and states – the groups and agencies that provide medical, economic and social support to teens during pregnancy and their children thereafter. Thus, Nevada practitioners and policy makers should pay close attention to best practices that help decrease the rate of adolescent birth – particularly in the Hispanic population.

Socioeconomic Disparities in Teen Birth Rates

According to the CDC (2017), socioeconomic conditions in communities and families may contribute to high teen birth rates. Among these factors are low education attainment and low-income levels of a teen's family; limited opportunities in a teen's community for positive youth involvement; neighborhood racial segregation; physical degradation (e.g., graffiti, abandoned vehicles, litter, alcohol containers, cigarette butts, glass on the ground); and neighborhood-level income inequality. Additionally, teens who are involved in the child welfare and juvenile justice systems are at increased risk of teen pregnancy. For example, young women living in foster care are more than twice as likely to become pregnant than those not in foster care (CDC, 2017). Nevada is currently ranked 47th in the nation for having the worst levels of socioeconomic wellbeing, health, education, and family and community support for youth (Casey Foundation, 2017).

Eliminating Disparities and Addressing Social Determinants of Teen Pregnancy

Addressing teen pregnancy will require multi-pronged community-level efforts to decrease the racial/ethnic, geographic and other social factors impacting the teen pregnancy rates. To implement individual and community-based programs combating disparities in teen pregnancy and birth rates, one should take the following steps: (1) Help achieve health equity; (2) improve the life opportunities and health outcomes of young people; and (3) reduce the economic costs of teen childbearing (CDC, 2017). With this goal in mind, the CDC is supporting three organizations from 2015 to 2020 to enhance youth-friendly sexual and reproductive health services in publicly funded health centers and increase the number of young people accessing sexual and reproductive health services. These programs focus on linking vulnerable young people to these services, including individuals in foster care, juvenile justice and probation, and housing developments. Three organizations funded at over $650,000 each were designated to carry out this work: Sexual Health Initiative for Teens North Carolina (Durham, North Carolina), Mississippi First, Inc. (Coahoma, Quitman, and Tunica counties, Mississippi), and the Georgia Association for Primary Health Care, Inc. (Chatham County, Georgia). Additionally, the US Department of Health and Human Services' Office of Adolescent

Health and the CDC are pulling together resources to fund the evaluation of innovative interventions targeting young men aged 15-24. The goal of such programs is to reduce the risk of fathering a teen pregnancy. Interventions will focus on young men at high risk of causing a teen pregnancy – those exposed to health disparities due to low socioeconomic status, race/ethnicity, or exposure to other social determinants negatively affecting health. The organizations funded to conduct this work are Columbia University, New York University, and Promundo – an advocacy program that works to promote healthy masculinity and prevent violence.

Reducing Teen Pregnancy and Promoting Health Equity Among Youth

Teen pregnancy prevention is one of Center for Disease Control's top seven priorities in in public health. Such preventive measures directly impact the health and quality of life for American youth (Division of Reproductive Health, 2017). CDC supports the implementation of evidence-based teen pregnancy prevention programs that have shown their effectiveness in preventing teen pregnancies, sexually transmitted infections, or sexual risk behaviors. Almost 50 evidence-based teen pregnancy prevention programs have been identified by the US Department of Health and Human Services TPP Evidence Review, which used a systematic process to assess evaluation studies against a rigorous standard. Currently, the Evidence Review covers a variety of diverse programs, including sexuality education programs, youth development programs, abstinence education programs, clinic-based programs, and programs specifically designed for diverse populations and settings (Office of Adolescent Health, 2017). In addition to evidence-based pregnancy prevention programs, teens need access to youth-friendly contraceptive and reproductive health services, and support from caregivers and other trusted adults – those who help teens make good choices about sex and birth control (Division of Reproductive Health, 2017).

Teen Sex Education in Nevada

The Las Vegas Review Journal (June 6, 2018) reported that the issue of sex education came up during a recent board of trustees meeting of the Clark County School District – the largest school district in Nevada and the fifth largest school district in the nation. Right now, students in Nevada receive sex education only if their parents "opt in." Board of Trustee Carolyn Edwards would like trustees to support the opposite approach, with every student receiving sex education except those who "opt out." However, no consensus was reached so far, and trustees are expected to revisit the topic in July 2018 after newly appointed Superintendent Jesus Jara starts his tenure at CCSD.

In Nevada, Alabama and Utah, minors must have written parental consent to receive sex education. However, these minors, just as minors across the country, can consent to be tested and obtain treatment for sexually transmitted infections (STIs) without parental permission (Guttmacher Institute, 2018). Eleven states (excluding Nevada) require that a minor be of a certain age (generally 12 or 14) before being allowed to consent. And 18 states (excluding Nevada) allow physicians to inform a minor's parents that he or she is seeking or receiving STI services. With the exception of one state that calls for parental notification in the case of a positive HIV test, no state currently requires that physicians notify parents about services (Guttmacher Institute, 2018). Thus, Nevada youth need

parental consent to receive sex education, but they don't require parental consent to get treatment for STIs that may result from unprotected sexual activities.

Teen Sexual Activity and Reproductive Health Care

Risk behaviors and prevalence in teen sex

Between 1991 and 2015, the Centers for Disease Control and Prevention (CDC) has conducted a randomized national survey of youth risk behaviors and prevalence, known as the Youth Risk Behavior Surveillance System (YRBSS) (Lensch et al., 2015). Sexual behaviors and risk related to pregnancy, STI and HIV, were among the key areas explored in this survey. Although data collection in Clark County was not as comprehensive as initially planned, it did show 38.5% of high school students identified as sexually active, with 27.1% reporting having had sex within the three months prior to the survey (Lensch et al., 2015). Over half (56.9%) reported using a condom during their last sexual experience. Over 20% reported that alcohol or drugs were used before their last sexual encounter, with only 10% reporting that they had ever had an HIV test. Ten percent of Southern Nevada high school students reported having an intimate partner and experiencing sexual violence within their relationships – about the same as the national average reported by the YRBSS (Lensch et al., 2015).

Reproductive rights have been legislated for and about women since the dawn of modern politics. The challenge grows even more complicated when it comes to youth and young adults. Other than a few barrier methods of contraception such as condoms, most birth control remains under the control of licensed healthcare practitioners. What this means is that youth and young adults are likely to stay on their parents' insurance and face hurdles in accessing effective birth control. The morning after pill was first introduced in the U.S. in 1999, and then only as prescription. For the next dozen years, there were multiple petitions and court cases seeking to remove the restriction on the morning after pill (Heavey, 2009). It was not until 2011 that the morning after pill became available in this country without age restrictions. As an over the counter drug, teens and young adults now can secure this form of birth control without physicians, pharmacist or parents' permission (Reuters Staff, 2013)

Abortion

Legislation focused on abortion has remained a constant in American politics. Since the 1973 landmark decision Roe v. Wade that made abortion legal, heated debates swirled around the questions of who can obtain abortion, who is going to pay for it, and whether federal funds can be used to perform the procedure. Currently, there are no federal funds allocated to support abortion, and only limited funds are available (through Medicaid) to organizations providing abortion, sexual health education and clinical services. A 1990 Nevada Referendum on abortion established a policy that spelled out the requirements for (a) informed consent, (b) decision to provide notice to custodial parents, and (c) the nature of information required for an abortion to be performed within the state of Nevada. Although a minor can seek an abortion, it is up to the physician to determine if and when custodial guardians are to be notified (Nevada Revised Statute, 1990). With the integration of technology into clinical health care settings, abortions have become available via tele medicine known as Medically Assisted Abortions (MAB). MAB has significantly improved access to abortion. In fact, a physician in another state now can

facilitate an abortion in Nevada through close circuit video conferencing in a medical clinic in the valley.

Thirty-seven states require parental consent or parental notification of a minor's decision to have an abortion, usually 24 or 48 hours before the procedure; a handful of states require the involvement of both parents (Guttmacher, 2018). The U.S. Supreme Court has ruled that states may not give parents an absolute veto over their daughter's decision to have an abortion. Thus, most state parental involvement requirements include a judicial bypass procedure that allows a minor to receive court approval for an abortion without her parents' knowledge or consent (Guttmacher Institute, 2018). Nevada, Alaska and New Jersey provide the most open access to teen abortion in that they only require parental notification rather than parental consent for the decision to have an abortion.

The increased availability of emergency contraception, telemedicine, abortion and barrier methods has offered teens an increased opportunity to make decisions concerning their sexual health and birth outcomes. However, the remaining obstacles limit access, increase the costs, and complicate the decision-making process with the requirement of parental consent of one or both parents.

Teen Sex Education and Treatment Initiatives

Nationally Funded Programs

The Division of Adolescent and School Health (DASH), within the CDC, provides funding to state and local education agencies through several funding streams to better student health, implement HIV/STD prevention programs, collect and report data on young people's risk behaviors, and expand capacity-building partnerships (Division of Reproductive Health, 2017). In FY 2016, DASH provided funding to 18 state and 17 local education agencies to help districts and schools strengthen student health through exemplary sexual health education (ESHE) that emphasizes HIV and other STD prevention, increases access to key sexual health services (SHS), and establishes safe and supportive environments (SSE) for students and staff. DASH also provides funding for state, territorial, and local education agencies and state health agencies to establish and strengthen systematic procedures to collect and report Youth Risk Behavior Surveillance (YRBS) and School Health Profiles data for policy and program improvements. In FY 2016, there was one DASH grantee in Nevada funded to collect and report YRBS and School Health Profiles data (1308 Strategy 1): The Nevada Department of Health and Human Services ($65,000) (Division of Reproductive Health, 2017).

The Office of Adolescent Health (OAH), within the U.S. Department of Health and Human Services (HHS), administers the Teen Pregnancy Prevention Program (TPPP), which funds evidence-based (or innovative evidence-informed), medically accurate, and age-appropriate programs to reduce teen pregnancy (Division of Reproductive Health, 2017). OAH will provide program support, implementation evaluation, and technical assistance to The Nevada Primary Care Association (NVPCA). NVPCA is a non-profit organization that aims to aid health centers and other community health care providers in improving service effectiveness and efficiency (Lensch et al., 2015).

NVPCA will partner with Federally Qualified Community Health Centers (FQHC) in Nevada and the Nevada Division of Public and Behavioral Health to administer the TPPP Tier 1A funds. NVPCA will implement Blueliner, a program intended to build the capacity of community health centers and provide evidence-based programs to teens in clinic and community-based settings. Programming will be available to Latino and African American youth in two urban counties and five rural counties with some of the highest teen birth rates in Nevada. NVPCA aims to serve 500 young people ages 15-19 per year over the five-year grant program (Lensch et al., 2015).

Nevada Funded Programs

The Southern Nevada Health District (SNHD) is located in Las Vegas, and it is one of the largest local public health centers in the United States, serving more than 1.7 million residents that make up 70% of Nevada's total population. With a budget of $749,999, the district provides administrative, clinical, community, and environmental health services to residents and visitors of Clark County (Southern Nevada Health District, 2016). With its TPPP funding, SNHD will offer programming to young people in two Clark County communities within the Cities of Las Vegas and North Las Vegas. SNHD plans to carry the Southern Nevada Teen Pregnancy Prevention Replication Project designed to implement the following curricula in juvenile detention, community-based programs, and out-of-home placement for young people in foster care: (a) Families Talking Together, (b) Be Proud! Be Responsible!, and (c) Sexual Health and Adolescent Risk Prevention (SHARP). SNHD aims to reach at least 800 young people per year and 3,200 young people total over the grant period.

Income-based Medicaid expansions have been shown to be effective in reducing births among teens aged 15–19 years (CDC, 2016). States can expand access to their Medicaid family planning program and reduce teen births by extending coverage to teens under age 18 years and setting the income eligibility level for family planning coverage to at least the same income level required for pregnancy care coverage (this level varies by state). Expanding Medicaid coverage for family planning services is consistent with US Department of Health and Human Services recommendations to support reproductive and sexual health services and with Healthy People 2020 family planning objectives (CDC, 2016). Other strategies for reducing teen pregnancy that are supported by scientific evidence include providing sexual health education for adolescents, using positive youth development approaches, and improving parent-child communication and parental monitoring of youth behavior (CDC, 2016).

Title X is the only federal program dedicated solely to the provision of family planning and related preventive services. The Office of Population Affairs (OPA) administers the Title X program and serves as the focal point of advice to the Secretary and the Assistant Secretary for Health on a wide range of reproductive health topics, including family planning, adolescent pregnancy, sterilization and other population issues (U.S. Department of Health and Human Services, 2018). You can locate a family planning clinic by entering an address or a city and state on the portal of their website https://www.hhs.gov/opa/. Additionally, on their website you can locate information about topics such as performance measures of contraceptives, and information about a variety of other suggested reproductive health practices and programs.

Conclusion

In the past decade, the rates of teenage pregnancy nationally and in Nevada have continued to decline. However, Nevada still faces the challenge of providing wide-spread, culturally appropriate and effective school-based education to its' youth population. Sex education policy has remained a burning issue for the Nevada school boards, Nevada legislators and Nevada parents insofar as there has been a great many discussions of policy change but no substantive changes in recent years. If no changes to policy and practices are made in Nevada, our teens will continue to face high risks of unplanned pregnancy, STIs and HIV contraction.

Some national and state-based clinical and community-based programs have received funding to support sexual health education and teen pregnancy prevention however, much more funding is needed – especially funds targeted for our large Latino youth population. Currently in Southern Nevada there are only two operational programs, Living Grace and Southern Nevada Children First, that provide comprehensive housing and reproductive health services to pregnant and parenting teen mothers. Both programs include such services as housing, case management, mental health services, life skills training, career counseling and parenting education. You can contact Living Grace at 702-212-6472 and at their website https://livinggracehome.com/. You can contact Southern Nevada Children First at 702-487-5665 and at their website http://www.childrenfirst-nv.org/leadership/. Please help support these programs and the pregnant and parenting teens in Nevada.

References

Annie E. Casey Foundation (2017). Nevada and the annie e. casey foundation 2016 kids count data book. Retrieved from http://www.aecf.org/where-we-work/location/nv/.

Center for Disease Control and Prevention (2017). About teen pregnancy. Retrieved from https://www.cdc.gov/teenpregnancy/about/index.htm.

Division of Reproductive Health. (2017). Teen Pregnancy in the United States Atlanta. Retrieved from https://www.cdc.gov/teenpregnancy/about/index.htm.

Guttmacher Institute (2018). Minors access to sti services. Retrieved from https://www.guttmacher.org/state-policy/explore/minors-access-sti-services.

Guttmacher Institute. (2018). Sex and HIV Education Public Policy Office. Retrieved from https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education.

Heavey, S. (2009, April 29, 2009). Timeline: Key Dates in Morning -After Pill Controversy. Reuters.

Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., & Yang, W. (2015). 2015 Nevada High School Youth Risk Behavior Survey (YRBS). Retrieved from Reno, NV: https://www.unr.edu/Documents/public-health/2015-Nevada-HS-YRBS-Final.pdf

Martin, J. A., Hamilton, B.E., Osterman, M. J. K., Driscoll A. K., and Mathews, T. J. (2017). Births: Final data for 2015. National Vital Statistics Reports, 66(1). Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf - PDF.

Nevada Revised Statute. (1990) Abortion § 442.240 - 422.270. Retrieved from Nevada Revised Statute. (1990) Abortion § 442.240 - 422.270.

Office of Adolescent Health. (2017). Office of Adolescent Health Retrieved from https://www.hhs.gov/ash/oah/facts-and-stats/index.html.

Center for Disease Control and Prevention. (2016). Prevention Status Reports: Teen pregnancy. The Center for Disease Control and Prevention. Retrieved from https://wwwn.cdc.gov/psr/NationalSummary/NSTP.aspx.

Review Journal. (June 6, 2018). Clark county schools begin drawing up legislative priorities. Retrieved from /https://www.reviewjournal.com/news/education/clark-county-schools-begin-drawing-up-legislative-priorities/.

Reuters Staff. (2013). Timeline: Key dates in legal battle over "morning after" pill. Politics. Retrieved from https://www.reuters.com/article/us-usa-contraception-ruling-timeline/timeline-key-dates-in-legal-battle-over-morning-after-pill-idUSBRE9340NH20130405.

Southern Nevada Health District. (2016). Teen pregnancy prevention program. Retrieved from http://www.southernnevadahealthdistrict.org/stats-reports/tppp-reports.php.

United States Census Bureau (2018). Quickfacts: Nevada. Retrieved from https://www.census.gov/quickfacts/NV.

U.S. Department of Health and Human Services. (2018). Office of population Affairs. Retrieved from https://www.hhs.gov/opa/.

Appendix

Community Resources

A-Z Women's Center

A-Z Women's Center is a private medical office that offers the Abortion Pill (RU-486) and specializes in first trimester abortion and second trimester abortion care. At A-Z Women's Center we recognize and believe that all women who come to us for abortion services have individual needs and circumstances. Because of this, we always provide individual one-on-one discussions in complete privacy. We never use "group" counseling. Our motto is that we try to be "the nicest place that you never want to come back to," https://www.drramoslasvegas.com/.

Birth Control Care Center

Birth Control Care Center is the oldest and most trusted abortion clinic in Las Vegas, Nevada providing abortion services for residents in Nevada, Southern Arizona and Utah since January 1973. We provide: medical abortion by pill/RU486 up to 10 weeks, surgical abortions up to 24 weeks, local or intravenous sedation, personal care by supportive staff, strictly confidential, finest modern facility and equipment, immediate appointments, and Saturday appointments available.
https://www.birthcontrolcarecenter.com/

Centers for Disease Control and Prevention

The CDC has a locator service that helps visitors search for testing centers where they can receive STD and HIV testing services, as well as vaccines for Hepatitis B and HPV, https://gettested.cdc.gov/.

Clark County, Nevada Guide to Community Resources

https://www.snvrha.org/pdf/Forms/Guide%20to%20Local%20Resources_English.pdf.

Clark County, NV Resource Guide for Homeless Services

http://www.clarkcountynv.gov/social-service/Documents/Resource%20Guide%201%20pager%20032016.pdf.

Embrace Grace

Having an unplanned pregnancy or being a young, single mom can be a time of mixed and bittersweet emotions but the one thing you need to know is that you are not alone. We offer two types of support groups created just for you! Embrace Grace was designed to help and encourage young single women that are experiencing an unintended pregnancy and Embrace Life is a support group for young single moms after giving birth. Both groups provide spiritual and emotional support through the local church. Often part of the struggle is trying to find people that can relate to your situation and understand all of the highs and lows of emotions that you are experiencing. By joining a local Embrace Grace or Embrace Life group, you will have

the opportunity to meet other moms who may be in a similar life season. https://embracegrace.com/find-a-group/.

Guttmacher Institute
Although teen pregnancy rates have declined in recent decades, the U.S. rate is still one of the highest in the developed world. By tracking the changing health care landscape and providing quality data and policy analysis, the Guttmacher Institute strives to shed light on U.S. teen pregnancy and on the social and economic factors that contribute to it. Guttmacher promotes policies and programs to enable teens to avoid unintended pregnancy, https://www.guttmacher.org/united-states/teens/teen-pregnancy.

Health and Human Services Healthy Dating Relationships in Adolescence
Healthy relationships in adolescence can help shape a young person's identity and prepare teens for more positive relationships during adulthood. Providing adolescents with tools to start and maintain healthy relationships (with romantic partners as well as peers, employers, teachers, and parents) may have a positive influence on young people's overall development, https://www.hhs.gov/ash/oah/adolescent-development/healthy-relationships/dating/index.html.

Living Grace Home
Recognizing that teen mothers who remain single and choose to parent their child are less likely to finish high school, and more likely to spend an extended period of time in poverty than those who marry, or those who place their child for adoption. We work closely with local and national programs to encourage marriage, paternal involvement, or adoption as preferable to single parenting. However, if a mom does make the choice to parent, our goal is to make sure she has the best possible outcome for both her and her child; including support, father and/or family support, as well as the best parenting skills, http://helphopehome.org/wp-content/uploads/2016/02/9-Living-Grace-Homes.pdf.

National Provider Identifier Database
With the implementation of the Affordable Care Act, the need to find healthcare providers by consumers as well as medical billers and coders has dramatically increased. One of the provisions of the Affordable Care Act requires all providers of medical or other items or services & suppliers that qualify for a National Provider Identifier (NPI) to include their NPI number on all applications to enroll in the Medicare and Medicaid programs and on all claims for payment submitted under the Medicare and Medicaid programs. NPIdb allows you to perform NPI Lookups of doctors & various medical entities for their unique NPI number. There are 61 federally qualified health centers in Nevada, https://npidb.org/organizations/ambulatory_health_care/federally-qualified-health-center-fqhc_261qf0400x/nv/.

Office of Adolescent Health
Leading the nation to ensure that America's adolescents thrive and become healthy, productive adults. The Office of Adolescent Health (OAH) is dedicated to improving the health and well-being of adolescents. OAH leads through promoting strength-based approaches, bolstering multi-sector engagement, and bringing in youth voices to support healthy development and transitions to productive adulthood. Authorized by the Public Health Service Act, OAH supports research, services, prevention and health promotion activities, training, education, partnership engagement, national planning, and information dissemination activities, https://www.hhs.gov/ash/oah/

Office of Population Affairs
Federally funded Title X family planning clinics offer low-cost STD testing and contraceptive services for all who want and need them. By law, priority is given to persons from low-income families. Adolescents and others can find a Title X funded clinic by zip code, https://opa-fpclinicdb.hhs.gov/

Office of Women's Health
30 Achievements in Women's Health in 30 Years (1984 – 2014)
Since the establishment of the HHS Coordinating Committee on Women's Health (CCWH) in 1984, we have made significant strides in improving the physical and mental health of women in the United States. Along with the U.S. Congress, the White House, and millions of women, health care providers, and researchers, the agencies and offices represented on the Committee played a key role in these achievements. Together we have improved access to health care, implemented new programs, developed or funded new treatments and screening techniques, executed key policy changes, approved lifesaving vaccines, issued landmark reports, and much more, https://www.womenshealth.gov/30-achievements/nancy-lee.

Planned Parenthood
Planned Parenthood is one of the nation's leading providers of high-quality, affordable health care, and the nation's largest provider of sex education. They offer compassionate care, backed by medical experts and more than 100 years of research in reproductive health. Their services include: Abortion Services; Abortion Referral; Birth Control; Emergency Contraception (Morning-After Pill); General Health Care; HIV Services; LGBT Services; Men's Health Services; Patient Education; Pregnancy Testing & Services; STD Testing, Treatment & Vaccines; and Women's Services. https://www.plannedparenthood.org/

There are two Planned Parenthood offices in Southern Nevada, https://www.plannedparenthood.org/planned-parenthood-rocky-mountains/who-we-are/las-vegas-health-centers, 35 offices in Northern Nevada and Central California, https://www.plannedparenthood.org/planned-parenthood-mar-monte.

Power To Decide
Power to Decide, the campaign to prevent unplanned pregnancy, works to ensure that all young people—no matter who they are, where they live, or what their economic status might be—have the power to decide if, when, and under what circumstances to get pregnant. We do this by increasing information, access, and opportunity. Power to Decide works toward three goals: (1) reduce teen pregnancy rates by 50 percent by 2026; (2) reduce unplanned pregnancy rates among women age 18–29 by 25 percent by 2026, and (3) reduce racial/ethnic and socioeconomic disparities in teen and unplanned pregnancy rates by 50 percent by 2026.

Our approach focuses on five key strategies we believe are critical in reducing unplanned pregnancy among teens and young women: (1) making it the norm among young people to act consistently with their decisions about if and when to get pregnant; (2) ensuring that all young people have a champion, mentor, or social network with which they can discuss sex, relationships, and their futures; (3) ensuring that everybody has reliable, resonant, and accurate information about sexual health, including all contraceptive methods, (4) ensuring that everybody has access to the full range of contraceptive methods within 60 minutes of where they live; and (5) making pregnancy planning standard practice in settings influential in the lives of young people, https://powertodecide.org/about-us.

Reno, Sparks and Washoe County Community Resource List
https://www.washoecounty.us/health/files/cchs/sexual_health/2015-community-health-resource-list-english.

Southern Nevada Children First
Southern Nevada Children First (SNCF) is a non-profit organization created to mentor, educate and support homeless, pregnant and parenting youth and young adults while providing support services to their children. Without someone to guide them, care for them or provide for them, they become extremely vulnerable to drugs and alcohol to numb the pain, they are forced to participate in survival sex and prostitution for shelter, food and protection; or they hide their situation hoping it will go away. Pregnant and parenting youth not only need basic necessities like food and shelter, they must also learn to be effective parents and independent adults committed to self-sufficiency. SNCF is committed to partnering with government agencies, the education community, early childhood educators and other local and national non-profits; however, SNCF fills a gap to serve those that many others do not. http://www.childrenfirst-nv.org/.

Southern Nevada Health District
The Family Planning Clinic is a low-cost clinic for Clark County residents who need birth control or who want to plan and space their pregnancies. Confidential services are offered and parental permission is not required. A full list of services and types of birth control we offer is available on the services webpage. Services are available to clients who want to plan and space their pregnancies and are uninsured or have

Nevada Medicaid, HPN Medicaid, Amerigroup Medicaid or Nevada Check up. The cost of all services is calculated on a sliding scale based on your income and the number of people in your household. Please bring proof of income and photo identification to your visit so we can calculate your fee based on the sliding scale. We accept any photo identification that includes a photo of you. You will not be turned away due to inability to pay on the day of your visit, http://www.southernnevadahealthdistrict.org/family-planning/index.php.

Southern Nevada Parent Resource Guide
http://caanv.org/wp-content/uploads/2015/12/Parent-Resources-Southern-Nevada.pdf.

Sunrise Hospital Sunny Babies
Early and continuous prenatal care is important to the future health of both you and your baby. Studies show that women who utilize early and continuous prenatal care tend to have fewer problems during pregnancy and may significantly lower their risks of a problem pregnancy. Sunrise Children's Hospital offers the Sunny Babies program, a program that encourages pregnant women to seek early and continuous prenatal care, beginning in the first trimester of their pregnancy. Sunny Babies can help: Find a physician so you can get early and continuous prenatal care; Apply for Medicaid to insure both you and your baby; Register for free childbirth classes at any Sunrise Health facility (Sunrise Children's Hospital, MountainView Hospital or Southern Hills Hospital); and Pre-register your delivery at the Sunrise Health Hospital (Sunrise Children's Hospital, MountainView Hospital or Southern Hills Hospital) of your choice. For your convenience please call (702) 961-9140 to make an appointment at a location nearest you, https://sunrisechildrenshospital.com/service/sunny-babies.

Washoe County Health District
The Family Planning Clinic provides: birth control counseling with most kinds of birth control available; pregnancy testing and counseling; sexually transmitted disease testing and counseling (with treatment as needed); HIV testing and counseling; testing and treatment of vaginal and bladder infections; counseling regarding women's health (referrals as needed); and vasectomy services. Your health care at the Washoe County Health District's Family Planning program is voluntary and confidential. This means that you are here because you have chosen to come here. It also means that no information will be given out about you without your written permission except as required by law or to provide services to you in compliance with Federal Privacy and Security Standards. https://www.washoecounty.us/health/programs-and-services/cchs/sexual_health_program/family-planning-clinic.php#wwd.

Women's Health Associates of Southern Nevada
We are a leading group of board-certified and board-eligible obstetricians and gynecologists who specialize in providing high quality healthcare for women. We offer a full range of innovative techniques and technologies to promote and maintain good health practices through all phases of a woman's life. We are proud to offer 19 convenient locations spanning southern Nevada, each providing patients with the highest level of personalized service at the care center level. WHASN was created in

2009 with two purposes in mind. The first was to adapt to the changing healthcare industry. The second was the idea that by combining the knowledge and expertise of many, we would be able to improve the healthcare of women throughout southern Nevada, http://whasn.com/resources/

Nevada Adolescent Reproductive Health Facts

Nevada was ranked 13 out of 51 (50 states + the District of Columbia)[1] on final 2015 teen births rates among females aged 15-19 (with 1 representing the highest rate and 51 representing the lowest rate).[RH1]

[1]Rank calculated from birth rates for this publication.

https://www.hhs.gov/ash/oah/facts-and-stats/national-and-state-data-sheets/adolescent-reproductive-health/nevada/index.html

Number of births to females under 20 years of age, 2015 [RH3]

Total[1]	**Nevada**	**United States**
Females under 20 years of age	2,385	232,215
Females aged	**Nevada**	**United States**
Under 15	16	2,500
15-17	637	61,184
18-19	1,732	168,531
15-19	2,369	229,715
Mother's race/ethnicity	**Nevada**	**United States**
Non-Hispanic white	646	91,415
Non-Hispanic black[2]	403	50,884

Mother's race/ethnicity	Nevada	United States
American Indian or Alaska Native[2,3]	54	4,791
Asian or Pacific Islander[3]	71	4,334
Hispanic[4]	1,237	81,350

1. Includes all births, including those with Hispanic origin not stated and not shown separately.

2. Race and Hispanic origin are reported separately on birth certificates. Persons of Hispanic origin may be of any race. Race categories are consistent with the 1977 Office of Management and Budget (OMB) standards.

3. Includes persons of Hispanic, non-Hispanic and origin not stated according to mother's reported race.

4. Includes all persons of Hispanic origin of any race.

Teen birth rate (births per 1,000 females aged 15–19), 2015 RH1

Total[1]	**Nevada**	**United States**
Females aged 15-19	27.6	22.3
Females aged	**Nevada**	**United States**
15-17	11.6	9.9
18-19	56.0	40.7

Percent change[a] in the teen birth rate, 1991-2015 and 2014-2015 RH1, RH3

Total	**Nevada**	**United States**
Change in rate to females aged 15-19 (1991 to 2015)	-63%	-64%
Change in rate to females aged 15-19 (2014 to 2015)	-4%	-8%

a State-level change calculated for this webpage.

The U.S. teen birth rate peaked in 1991 at 61.8 births per 1,000 teen females aged 15-19.

Of all births to females under 20 years of age, percent[a] by race/ethnicity, 2015 RH1, RH3

Mother's race/ethnicity[1]	Nevada	United States
Non-Hispanic white[2]	27%	39%
Non-Hispanic black[2]	17%	22%
American Indian or Alaska Native[2,3]	2%	2%
Asian or Pacific Islander[2,3]	3%	2%
Hispanic[4]	52%	35%

a. Percentage calculated for this webpage.

1. Includes all births, including those with Hispanic origin not stated and not shown separately.

2. Race and Hispanic origin are reported separately on birth certificates. Persons of Hispanic origin may be of any race. Race categories are consistent with the 1977 Office of Management and Budget (OMB) standards.

3. Includes persons of Hispanic, non-Hispanic and origin not stated according to mother's reported race.

4. Includes all persons of Hispanic origin of any race.

Of all births to females under 20 years of age, percent repeat births, 2015 RH1, RH3

Total[1]	**Nevada**	**United States**
Females under 20 years of age	18%	17%
Mother's race/ethnicity	**Nevada**	**United States**
Non-Hispanic white[2]	17%	14%
Non-Hispanic black[2]	20%	17%
American Indian or Alaska Native[2,3]	*	18%
Asian or Pacific Islander[2,3]	15%	16%
Hispanic[4]	18%	18%

a. Percentage calculated for this webpage.

1. Includes all births, including those with Hispanic origin not stated and not shown separately.

2. Race and Hispanic origin are reported separately on birth certificates. Persons of Hispanic origin may be of any race. Race categories are consistent with the 1977 Office of Management and Budget (OMB) standards.

3. Includes persons of Hispanic, non-Hispanic and origin not stated according to mother's reported race.

4. Includes all persons of Hispanic origin of any race.

Percent[a] low birthweight births, among females under 20 years of age, 2015 RH1, RH3

Total	Nevada	United States
Females under 20 years of age	9.7%	9.5%

a. Percentage calculated for this webpage.

Low birth weight is defined as less than 2,500 grams (about 5.5 pounds or 5 pounds and 8 ounces).

Teen pregnancy rate (pregnancies per 1,000 females aged 15-19), 2011 RH2

Total	Nevada	United States
Females aged 15-19	62%	52
Females aged	**Nevada**	**United States**
15-17	32%	27
18-19	112	89

Percent change[a] in the teen pregnancy rate, 1988-2011 RH2

Total	Nevada	United States
Change in rate to females aged 15-19 (1988 to 2011)	-57%	-53%

a. Percent change calculated for this webpage.

In 1998, the teen pregnancy rate was 143 pregnancies per 1,000 females aged 15-19 in Nevada, and 111 in the U.S. The U.S. teen pregnancy rate peaked in 1990 at 117.6 pregnancies per 1,000 females aged 15-19, but state data are not available for that year.

Teen abortion rate (abortions per 1,000 females aged 15-19), 2011 RH2

Total	Nevada	United States
Female aged 15-19	17%	14
Females aged	**Nevada**	**United States**
15-17	9%	8
18-19	30%	22

Percent change[a] in the teen abortion rate, 1988-2011 RH2

Total	Nevada	United States
Change in rate to females aged 15-19 (1988 to 2011)	-71%	-68%

a. Percent change calculated for this webpage.

The U.S. teen abortion rate peaked in 1988 at 44.0 abortions per 1,000 females aged 15-19. The teen abortion rate for Nevada was 59 abortions per 1,000 females aged 15-19 in 1988.

Sexual behaviors among high school students (grades 9-12), 2015 RH4

Percent of high school students who report they have ever had sexual intercourse	Nevada	United States
Total	40%	41%
Male	41%	43%
Female	40%	39%
Percent of high school students who report they had sexual intercourse for the first time before 13 years of age	**Nevada**	**United States**
Total	3%	4%
Male	4%	6%
Female	2%	2%

Percent of high school students who report they have had sexual intercourse with 4 or more persons	Nevada	United States
Total	11%	11%
Male	13%	14%
Female	9%	9%
Percent of high school students who report they drank alcohol or used drugs before last sexual intercourse	**Nevada**	**United States**
Total	19%	21%
Male	21%	25%
Female	18%	16%

Birth control use among sexually active high school students (grades 9-12), 2015 [RH4]

Percent of high school students who report they or their partner used a condom during last sexual intercourse	**Nevada**	**United States**
Total	54%	57%
Male	58%	62%
Female	49%	52%
Percent of high school students who report they or their partner used birth control pills before last sexual intercourse	**Nevada**	**United States**
Total	20%	18%
Male	17%	15%
Female	24%	21%
Percent of high school students who report they or their partner used an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon) before last sexual intercourse	**Nevada**	**United States**
Total	2%	3%
Male	1%	2%

Percent of high school students who report they or their partner used an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon) before last sexual intercourse	Nevada	United States
Female	3%	5%
Percent of high school students who report they or their partner used a shot (e.g., Depo-Provera), patch (e.g., OrthoEvra), or birth control ring (e.g., NuvaRing) before last sexual intercourse	**Nevada**	**United States**
Total	3%	5%
Male	1%	3%
Female	5%	8%
Percent of high school students who report they or their partner used birth control pills; an IUD or implant; or a shot, patch, or birth control ring before last sexual intercourse	**Nevada**	**United States**
Total	25%	27%
Male	19%	20%
Female	31%	34%

Percent of high school students who report they or their partner used birth control pills; an IUD or implant; or a shot, patch, or birth control ring before last sexual intercourse	Nevada	United States
Total	6%	9%
Male	5%	6%
Female	7%	12%
Percent of high school students who report they or their partner did not use any method to prevent pregnancy during last sexual intercourse	**Nevada**	**United States**
Total	12%	14%
Male	11%	12%
Female	14%	15%

Relationship violence among high school students who report dating in the past 12 months (grades 9-12), 2015 [RH4]

Percent of high school students who report they experienced physical dating violence, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with (during the 12 months before the survey)	**Nevada**	**United States**
Total	10%	10%
Male	9%	7%
Female	11%	12%
Percent of high school students who report they experienced sexual dating violence, including kissing, touching, or being physically forced to have sexual intercourse (when they did not want to) by someone they were dating or going out with (during the 12 months before the survey)	**Nevada**	**United States**
Total	12%	11%
Male	8%	5%
Female	14%	16%

Forced sex among high school students (grades 9-12), 2015 [RH4]

Percent of high school students who report they were ever physically forced to have sexual intercourse (when they did not want to)	Nevada	United States
Total	8%	7%
Male	6%	3%
Female	11%	10%

DATA NOTES

All percentages (other than percent low birthweight births), have been rounded to the nearest whole number.

* Figure does not meet standards of reliability or precision; based on fewer than 20 births in the numerator.

N/A: data do not exist on this measure for this state.

1. Includes all births, including those with Hispanic origin not stated and not shown separately.

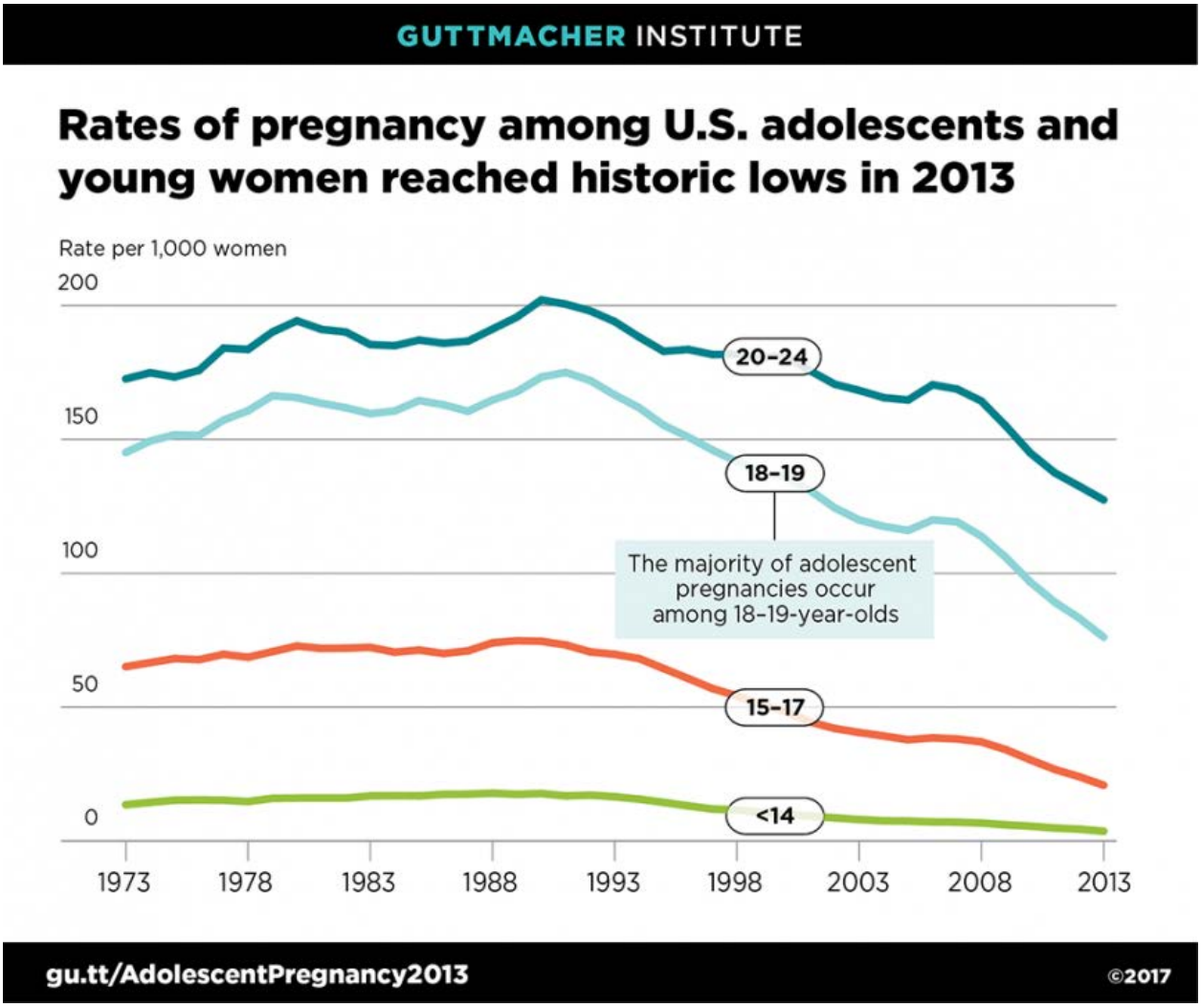
2. Race and Hispanic origin are reported separately on birth certificates. Persons of Hispanic origin may be of any race. Race categories are consistent with the 1977 Office of Management and Budget (OMB) standards.

3. Includes persons of Hispanic, non-Hispanic and origin not stated according to mother's reported race.

4. Includes all persons of Hispanic origin of any race.

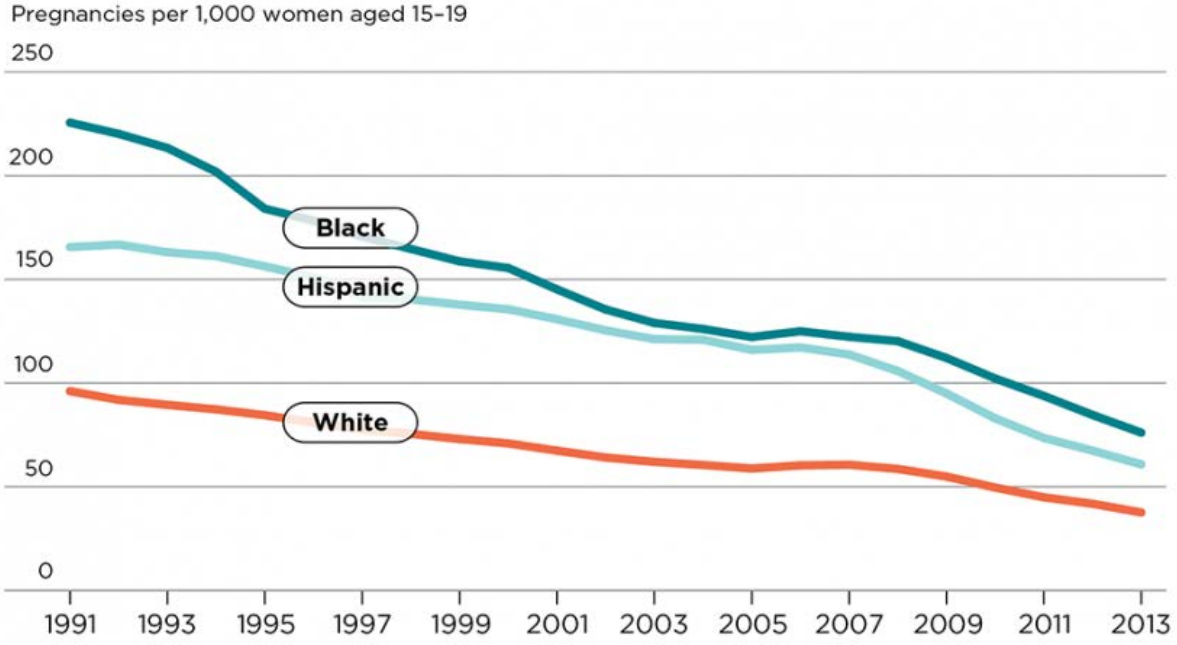
Guttmacher Institute Data

https://www.guttmacher.org/news-release/2017/us-rates-pregnancy-birth-and-abortion-among-adolescents-and-young-adults-continue



GUTTMACHER INSTITUTE

Pregnancy rates have declined among black, Hispanic and white adolescents, but differences persist

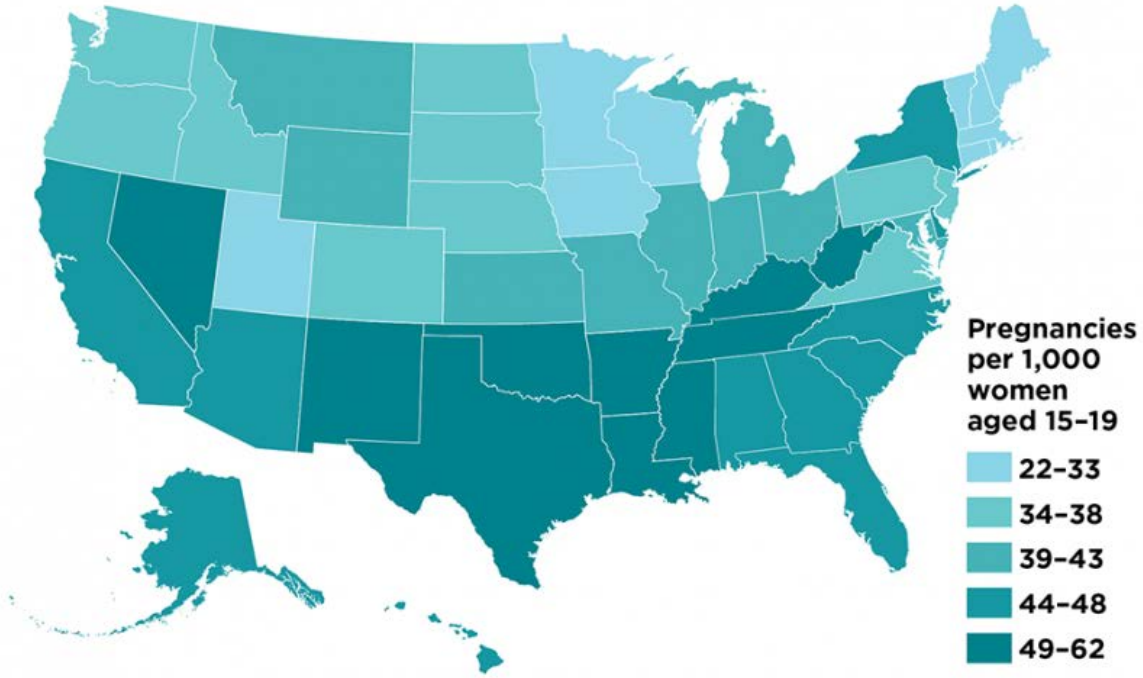


gu.tt/AdolescentPregnancy2013

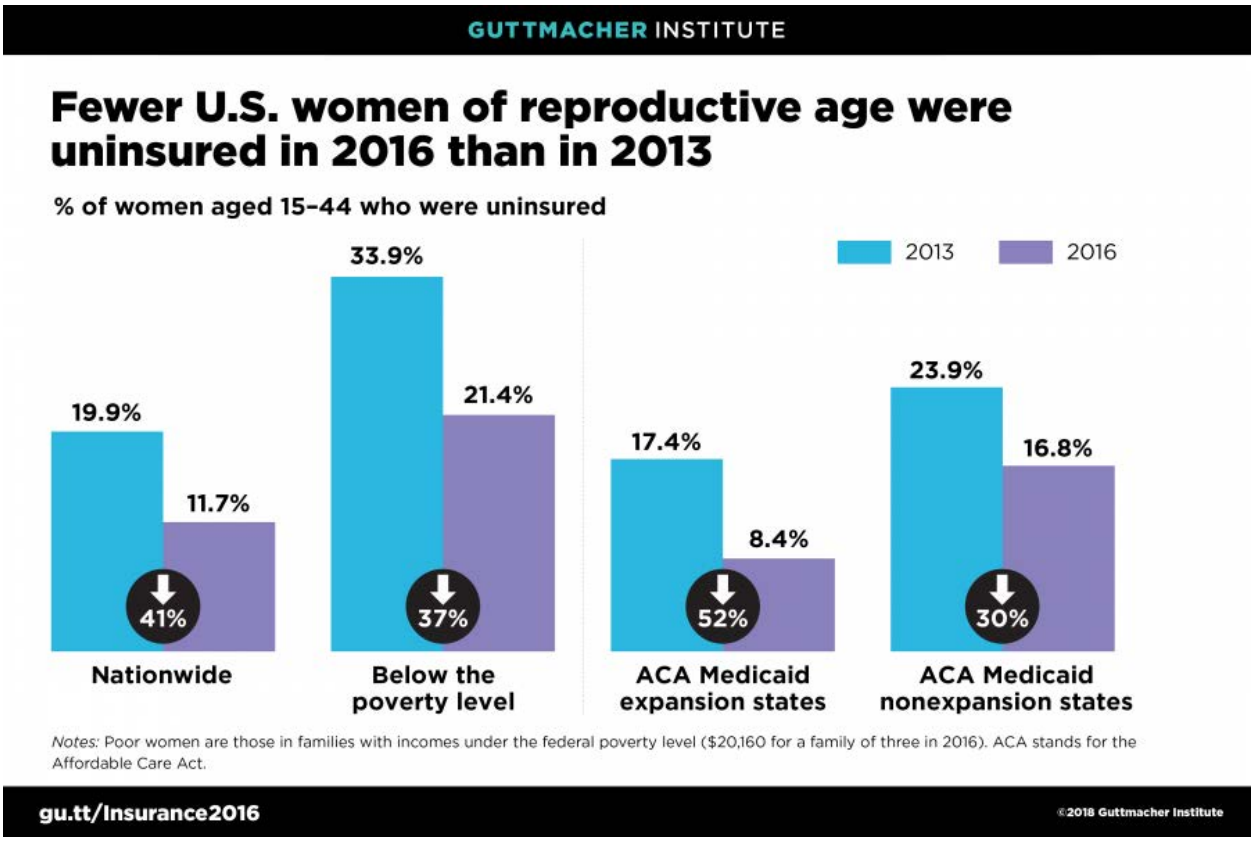
GUTTMACHER INSTITUTE

U.S. adolescent pregnancy rates in 2013

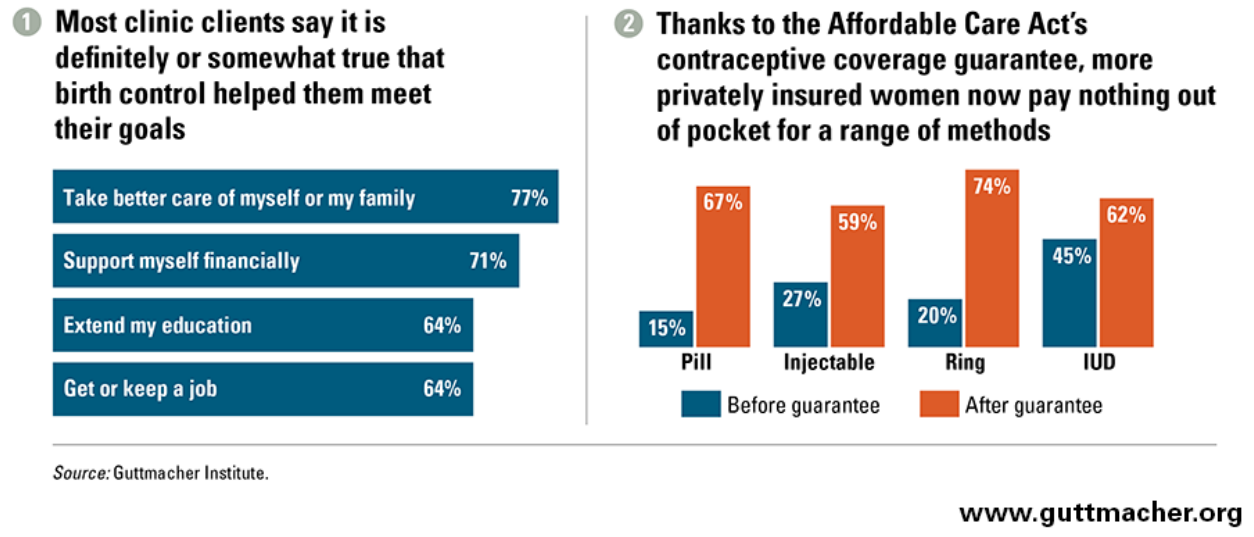
Pregnancy rates among U.S. adolescents vary widely by state



gu.tt/AdolescentPregnancy2013



https://www.guttmacher.org/infographic/2018/fewer-us-women-reproductive-age-were-uninsured-2016-2013



https://www.guttmacher.org/gpr/2017/01/what-stake-federal-contraceptive-coverage-guarantee

STATE	MUST BE PERFORMED BY A LICENSED PHYSICIAN	MUST BE PERFORMED IN A HOSPITAL IF AT:	SECOND PHYSICIAN MUST PARTICIPATE IF AT:	PROHIBITED EXCEPT IN CASES OF LIFE OR HEALTH ENDANGERMENT IF AT:	"PARTIAL-BIRTH" ABORTION BANNED	PUBLIC FUNDING OF ABORTION		PRIVATE INSURANCE COVERAGE LIMITED
						Funds All or Most Medically Necessary Abortions	Funds Limited to Life Endangerment, Rape and Incest	
AZ	X	Viability	Viability	Viability	X	X		X
CA				Viability		X		
CO							X	
FL	X	Viability	24 weeks	24 weeks	▼		X	
NM	Xξ				Positive Viability			
NV	X	24 weeks		24 weeks			X	

▼ Permanently enjoined; law not in effect.
*** Exception in case of threat to the woman's physical health.**
† Exception in case of rape or incest.
‡ Exception in case of life endangerment only. A 2016 New York Attorney General opinion determined that the state's law conflicts with U.S. Supreme Court rulings on abortion, and that abortion care is permissible under the U.S. Constitution to protect a woman's health, or when the fetus is not viable.
Ω Exception in case of fetal abnormality.
ξ Only applies to surgical abortion. In New Mexico, some but not all advanced practice clinicians may provide medication abortion.
Φ Law limits abortion provision to OB/GYNs.

€ A court has temporarily blocked enforcement of a Mississippi law that would have banned abortion at 15 weeks after the patient's last menstrual period.

Overview of State Abortion Law (1 of 2)

OVERVIEW OF STATE ABORTION LAW (PAGE 2 OF 2)

STATE	PROVIDERS MAY REFUSE TO PARTICIPATE		MANDATED COUNSELING INCLUDES INFORMATION ON:			WAITING PERIOD (in Hours) AFTER COUNSELING	PARENTAL INVOLVEMENT REQUIRED FOR MINORS
	Individual	Institution	Breast Cancer Link	Fetal Pain	Negative Psychological Effects		
AZ	X	X				24	Consent
CA	X	Religious					▼
CO							Notice
FL	X	X				▼	Notice
NV	X	Private					▼
NM	X	X					▼

▼ Permanently enjoined; law not in effect.
§ Enforcement temporarily enjoined by court order; policy not in effect.
Φ Fetal pain information is given only to women who are at least 20 weeks gestation; in Missouri at 22 weeks gestation.
þ Both parents must consent to the abortion.
ξ Specified health professionals may waive parental involvement in certain circumstances.

◊ In South Dakota, the waiting period excludes weekends or annual holidays and in Utah the waiting period is waived in cases of rape, incest, fetal defect or if the patient is younger than 15.

https://www.guttmacher.org/state-policy/explore/overview-abortion-l

GENERAL REQUIREMENTS: SEX AND HIV EDUCATION

STATE	SEX EDUCATION *MANDATED	HIV EDUCATION MANDATED	WHEN PROVIDED, SEX OR HIV EDUCATION MUST				PARENTAL ROLE		
			Be Medically Accurate	Be Age Appropriate	Be Culturally Appropriate and Unbiased	Cannot Promote Religion	Notice	Consent	Opt-Out
Arizona				X			HIV	Sex	HIV
California	X	X	X	X	X	X	X		X
Colorado			X	X	X		X		X
Florida				X					X
Nevada	X	X		X			X	X	
New Mexico	X	X							X

* Sex education typically includes discussion of STIs.
† Sex education is not mandatory, but health education is required and it includes medically accurate information on abstinence.
‡ Sex education "shall not be medically inaccurate."
Ω Localities may include topics such as contraception or STIs only with permission from the State Department of Education.
Ψ Sex education is required if the pregnancy rate for 15-17 teen women is at least 19.5 or higher.
ξ State also prohibits teachers from responding to students' spontaneous questions in ways that conflict with the law's requirements.
https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education

CONTENT REQUIREMENTS FOR SEX* AND HIV EDUCATION

STATE	WHEN PROVIDED, SEX EDUCATION MUST								WHEN PROVIDED, HIV EDUCATION MUST	
	Include Information on					Include Life Skills for			Include Information on	
	Contra-ception	Abstinence	Importance of Sex Only Within Marriage	Sexual Orientation	Negative Outcomes of Teen Sex	Avoiding Coercion	Healthy Decision-making	Family Communication	Condoms	Abstinence
Arizona		Stress		ϕ	X	X				Stress
California	X	Cover		Inclusive		X	X	X	X	Cover
Colorado	X	Cover		Inclusive		X	X	X	X	Cover
Florida		Stress	X		X					Stress
New Mexico	X	Cover		Inclusive		X	X	X	X	Stress

* Sex education typically includes discussion of STIs.

ϕ If HIV education is taught in Arizona it cannot "promote" a "homosexual lifestyle" or portray homosexuality in a positive manner. Mandated HIV education in Oklahoma teaches that among other behaviors that "homosexual activity" is considered to be "responsible for contact with the AIDS virus."

Ω Localities may include topics such as contraception or STIs only with permission from the State Department of Education.

ξ State also prohibits teachers from responding to students' spontaneous questions in ways that conflict with the law's requirements

Nevada has not set content requirements yet.

https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education