

Health & Reproductive Rights

VISION STATEMENT:

At the Women’s Foundation of Minnesota, we envision a time when all women in Minnesota will have local, legal, affordable, and comprehensive health care.

OVERVIEW

Across many measures of wellness, Minnesota women are not faring as well as men and our women of color are disproportionately likely to suffer. Women and girls are more likely than the men to suffer from major depression and other negative mental health outcomes. This is due, in part, to the disproportionate burden poverty and violence places on the state’s women, and due, in part, to the unprecedented pressures of the triple bind that require our women and girls to be nurturing, economically successful and beautiful, all at the same time.

Decreases in physical activity and increases in weight interact with unrealistic, idealized body images to create a destructive physical and emotional environment for women and girls across the state.

While cancer and heart disease rates are generally down in the state, women of color are much more likely in most cases than white women to suffer and die from these leading causes of disability and death.

After more than a decade of decline, the teen birth rate in Minnesota is moving back up, particularly among girls of color. While comprehensive sex education

**WHAT YOU CAN DO in 30 minutes or less:
Improve the health & well-being of women and girls:**

- Bring healthy food to your next family, work or community gathering.
- Check-in with the women in your life to see if they are up to date on cancer screenings.
- Take the stairs, park the car at the far end of the lot, walk to the store, bike, do yoga -- whatever, just move your body! Encourage your kids, friends, family, colleagues to do the same.
- Mentor a girl or young woman in your life; caring relationships with adults help create resiliency.
- Send a healthy e-card to a friend: <http://bit.ly/9J2tr1> Add your ideas and check for others’ feedback on actions at www.wfmn.org.
- Invest in organizations that support or provide access to quality, affordable, comprehensive health and reproductive care for all women and girls.

remains unmandated across the state, the proportion of Minnesota's sexually active girls who use birth control or talk to their partner about preventing pregnancy or STDs is down since 1998.

ADD LGBTQ and IMMIGRANT REFUGEE paragraph

None of these trends is helped by the growing problem of a lack of healthcare access. Women of color are more likely to be uninsured than white women, with a quarter or more of Latino women falling into this category. Many more women than men are under-insured, unable to afford co-pays or private sector premiums that penalize women. Others are turned off or turned away by the lack of culturally competent care.

Women's Foundation of Minnesota grantees are tackling these difficult issues head-on and in an integrated way.

The Women's Environmental Institute at Amador Hill's (grantee) innovative Girl Farm is a summer farming program for low-income, at-risk Twin Cities' girls to learn sustainable farming and about healthy food choices and exercise for better health. The program's curriculum explores how sexism, racism and classism (corporate industrial farming) in rural areas affects food access and food justice in the urban areas for economically challenged communities.

CAPI (grantee) is leading the Refugee & Immigrant Women for Change, a collaborative of groups that serve Minnesota's refugee and immigrant communities, including the Liberian Women's Initiative of Minnesota, Centro Inc., Lao Assistance Center, SEWA-AIFW, and the African Health Action Corporation. The coalition will fight poverty and social inequalities through achievement of gender equality for refugee and immigrant women, including access to healthcare and healthcare needs unique to their immigrant communities.

Another health collaborative -- the Exploratory Research and Intervention Development to Reduce Unplanned Pregnancy in LBTQ (Lesbian, Bisexual, Transgender, Queer) Youth project -- is being lead by the Rainbow Health Initiative (grantee), which includes the Midwest Health Center for Women, Hennepin County Public Health Clinic, and the HOTDISH Militia. The coalition's research will help to determine the root causes of the significantly higher rate of pregnancy in LBTQ, female-born youth.

You can help, too. In less than 30 minutes, there are things you can do in your own community to help build a world that guarantees health and reproductive rights for all Minnesota women and girls (*see box, page 1*).

STORY:

A health crisis for Native American women and girls in Minnesota

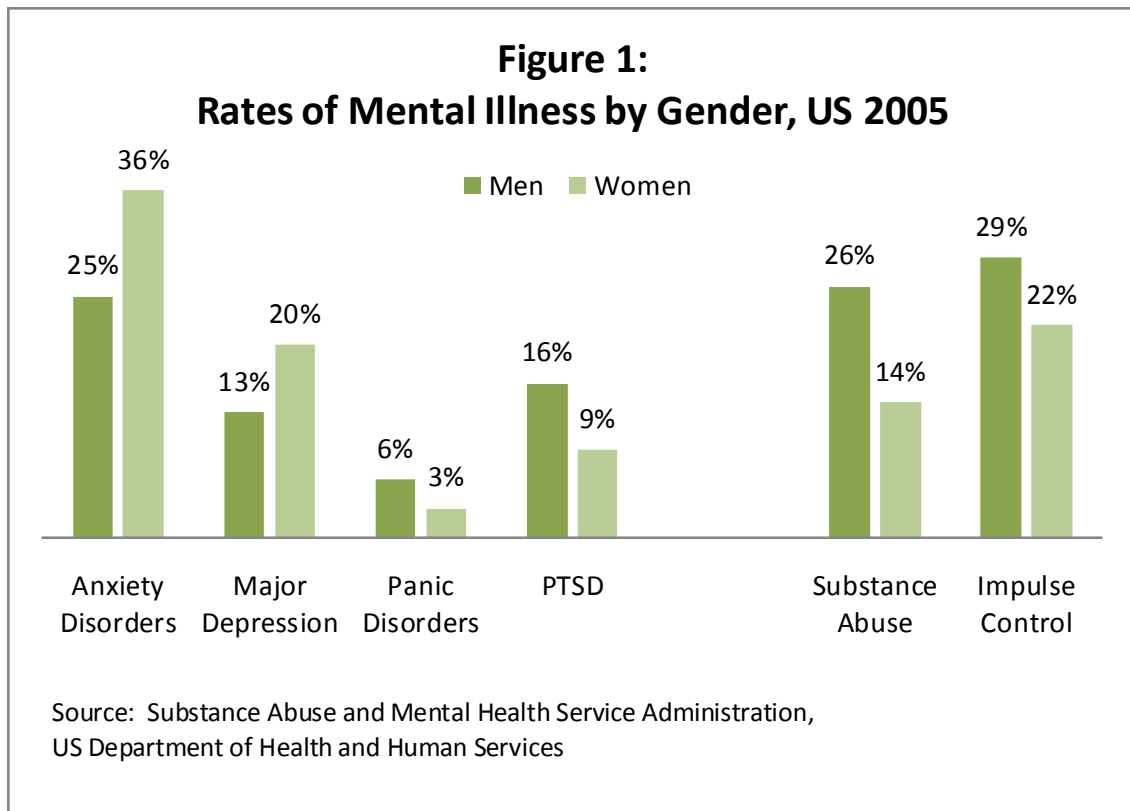
- **General Health.** Both Native American girls and women report worse than average general health. Women report bad health on a one third of the days in each month and a third of girls “get lots of headaches, stomachaches, or sickness.”
- **Obesity & Disease.** Native women are heavier, which leads to diabetes and death from heart disease. Fifty-five percent of Native American women are considered obese -- 20% higher than any other group -- and are twice as likely as other women to have diabetes. Native women have the highest heart disease mortality rates among all women.
- **Substance Abuse.** Native girls are more likely to drink, use marijuana, and smoke and at a younger age than other girls and they are two to three times more likely to have been treated for an alcohol or drug problem
- **Smoking & Lung Cancer.** As adult, American Indian women are also significantly more likely to smoke, leading to the highest incidence and mortality rates for lung cancer later in life
- **Reproductive Health.** Native girls have intercourse at the 9th grade levels at higher rates, have among the highest teen birth rates, especially in some rural areas, are the most likely to receive inadequate prenatal care, and have among the highest infant mortality rates in the state.
- **Mental Health.** Mental health measures for 9th grade Native girls are particularly devastating:
 - 46% have hurt themselves on purpose.
 - 40% are extremely or quite a bit hopeless.
 - 47% have suicidal thoughts.
 - 21% have attempted suicide.
 - 25% have been physically abused and 16% have been sexually abused.
 - Among those that have been sexually or physically abused, 34% have attempted suicide.

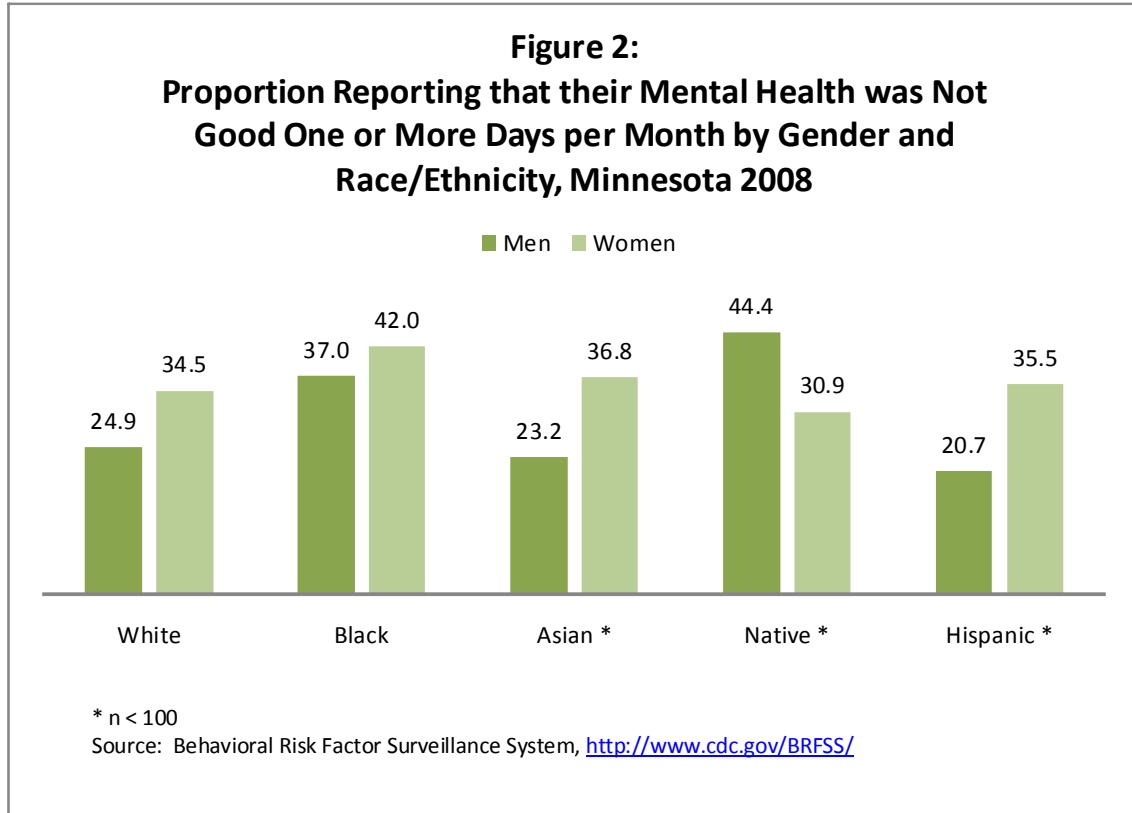
MENTAL HEALTH:

Contradictory and unreasonable expectations, violence and poverty take a toll on Minnesota women and girls' mental health

Research shows that there is a fundamental link between mental health, overall health and social well-being. Risk of cancer and cardiovascular disease, for example, increases for those who suffer from depression.

While men and women experience similar levels of mental illness overall, there are important gender based differences. According to the U.S. Department of Health & Human Services, “women are nearly twice as likely as men to suffer from major depression, which is associated with problems such as lost productivity, higher morbidity from medical illness ... and increased risk of suicide.”¹

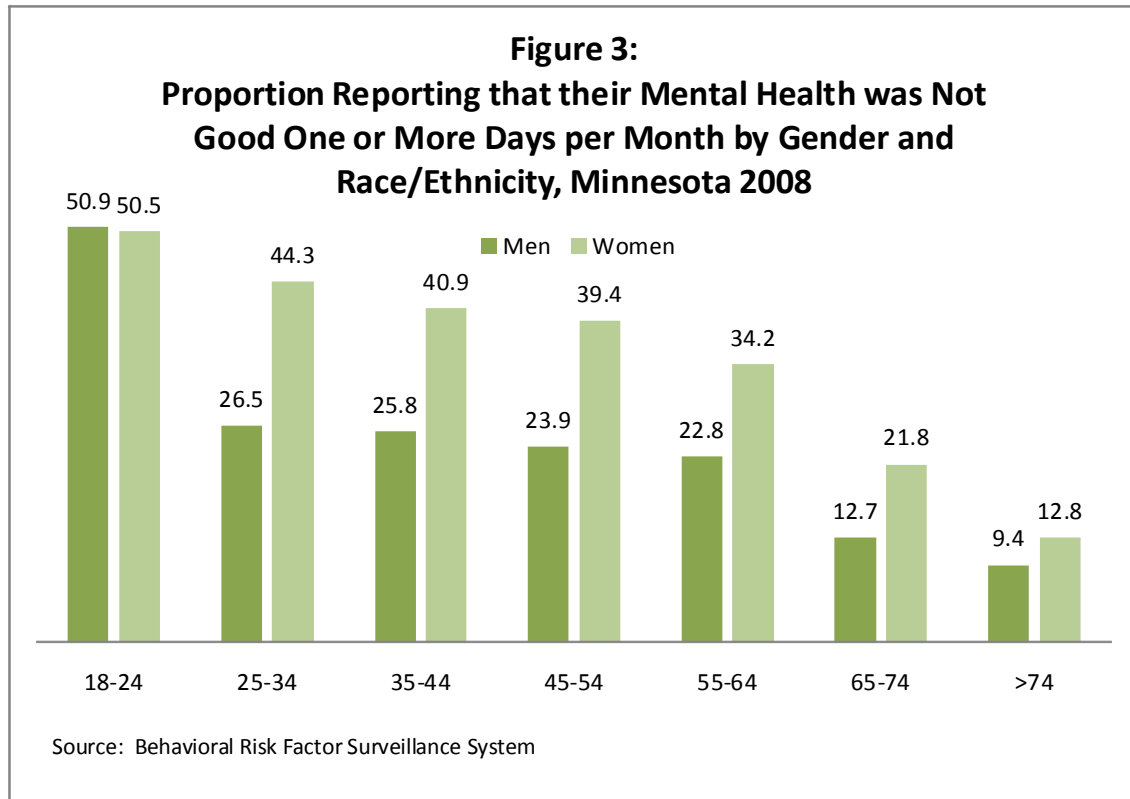




Women are three times more likely to attempt suicide (although men more often succeed) and two to three times more likely to have anxiety disorders, including post traumatic stress disorders. “Women represent 90% of all cases of eating disorders, which carry the highest mortality rate of all mental illnesses.”²

While research and debate continue, gender differences are thought to be related to a combination of heredity, biology -- changes in hormone levels, for example -- and environment.

Environmental factors include: “differences in the ways boys and girls are raised; **expectations about male and female roles in the family, workplace and larger society; and higher rates of abuse and poverty.**”³ Women of color who face environmental factors such as racism, discrimination, violence and poverty are at higher risk, as are the disproportionately female victims of “trauma, violence and abuse.”⁴



Indeed, Minnesota women report more bad mental health days than their male counterparts. **In a 2008 survey, a third or more (depending on race/ethnicity) of Minnesota women said that their “mental health was not good” one or more days per month, compared to a quarter of men in most racial/ethnic subgroups** (see Figure 2). Single women most frequently put themselves in this category and the proportion of women with at least one day of bad mental health per month declines as they age (Figure 3).⁵

Intersecting gender and racial disparities also show up across a wide variety of mental health indicators for Minnesota girls. Prominent Minnesota experts in adolescent health, such as Dr. Michael Resnick, have labeled the **state of Minnesota girls’ mental health a “crisis.”** Twelfth grade girls, for example, are almost twice as likely as their male counterparts to report a long-term mental or emotional health problem.

In his book, *The Triple Bind: Saving Our Teenage Girls from Today’s Pressures*, psychologist Stephen Hinshaw argues that “at the same time that opportunities abound for teenage girls to compete in both traditional male and female bastions, **conflicting messages to be ambitious, caring and effortlessly thin and glamorous have lead to a surge in adolescent depression, eating disorders, self-mutilation, suicide and aggression.**”⁶

Minnesota survey results do show that too many of our young women are experiencing these negative mental health outcomes. Based on the 2007 Minnesota Student Survey, 25% of the state’s 9th grade and 12th grade girls overall, and 46% of Native American girls, have hurt themselves on purpose, compared to 10% of boys. That translates into **12,000 6th, 9th and 12th grade girls who responded on the Minnesota Student Survey that they hurt themselves on purpose.**

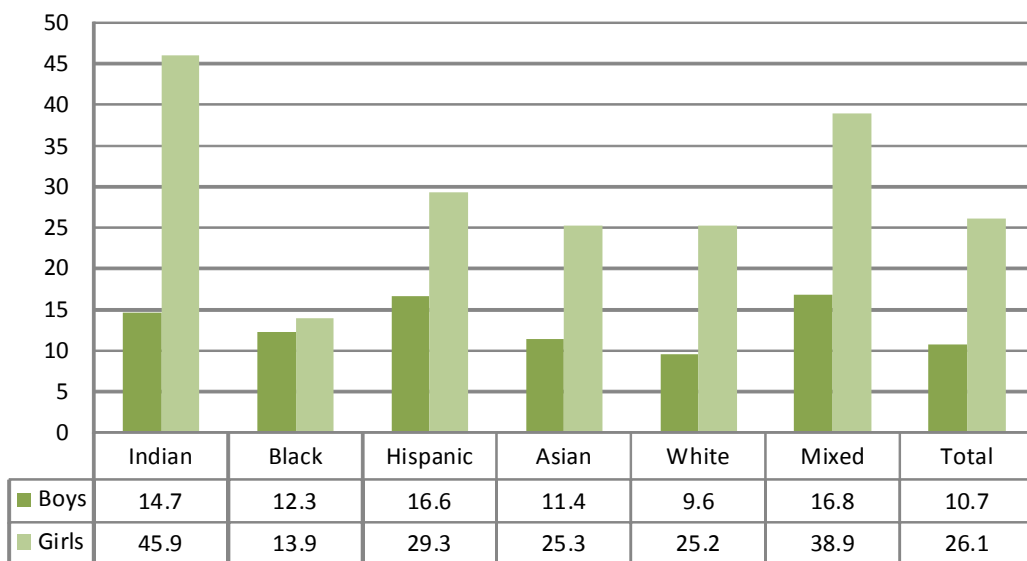
A teen health blog describes one form of self-mutilation, cutting, as “a way some people try to cope with strong emotions, intense pressure, or upsetting relationship problems. Some people cut to express feelings of rage, sorrow, rejection, desperation, longing or emptiness.”⁷

While Minnesota girls overall are two to three times more likely than boys to “hurt [them]selves on purpose,” girls who have been sexually or physically abused are two to three times more likely than their abuse-free female counterparts to engage in “self-mutilation.”

Sixty percent of Hispanic and white 9th grade girls who have been sexually abused have engaged in self-harm, compared to 27% and 23% of those that have not been abused.

Among Native American 9th grade girls, those without a history of sexual abuse have a relatively high-rate of self-mutilation (37%), but an even more alarming 65% of those sexually abused have hurt themselves. Rates are similar for girls who have been physically abused. For these girls, “self injury may feel like a way of ‘waking up’ from a

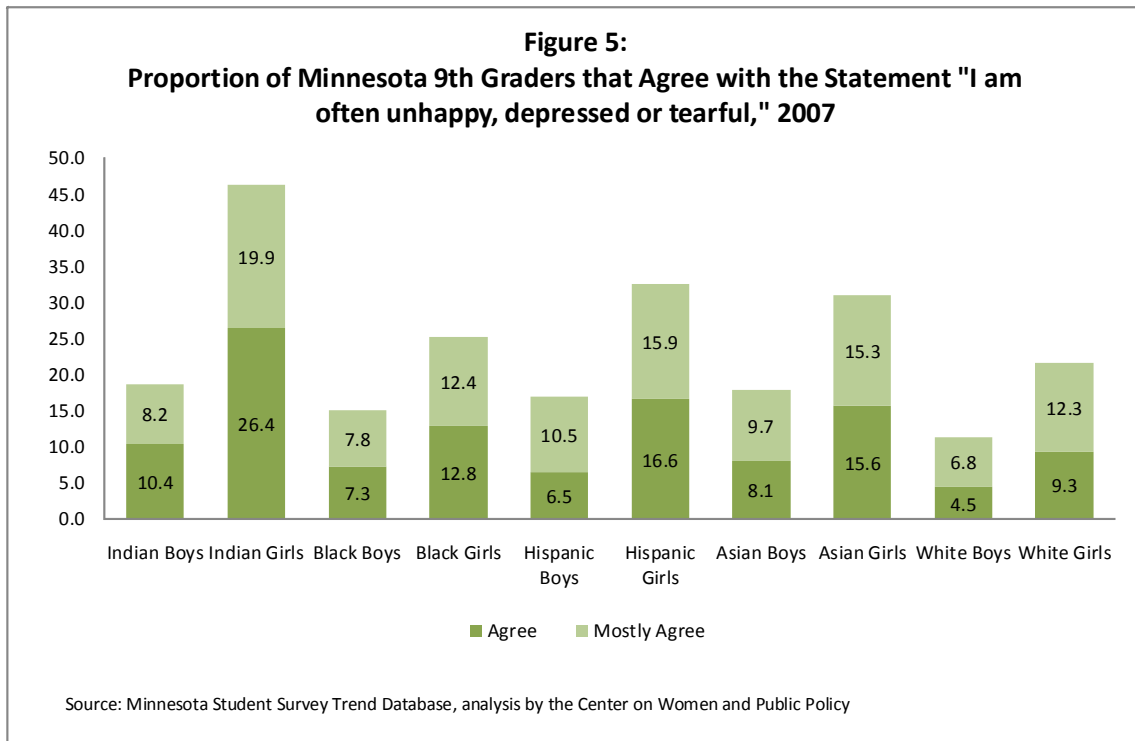
**Figure 4:
Proportion of Minnesota 9th Graders who Hurt Themselves
on Purpose, 2007**



Source: Minnesota Student Survey Trend Database

sense of numbness after a traumatic experience. Or it may be a way of re-inflicting the pain they went through, expressing anger over it, or trying to get control of it.”⁸

Forty percent of Native American, 28% of Hispanic, and 26% of Asian 9th grade girls are extremely or quite a bit hopeless, compared to 10% for boys, on average (Figure 5).
A third to almost a half of 9th grade girls are “often unhappy, depressed or tearful:”



46% of Native girls; 32% of Hispanic ones; and 31% of Asian 9th grade girls.

Depression and the Sexualization of Girls

A growing body of research links increases in depression among girls to the sexualization of women and girls that saturates in our society. According to the American Psychological Association Task Force, “sexualization” occurs when:

- A person’s value comes only from his or her sexual appeal or behavior, to the exclusion of other characteristics;
- A person is held to a standard that equates physical attractiveness (narrowly defined) with being sexy;
- A person is sexually objectified – that is, made in to a thing for others’ sexual use -- rather than seen as a person with the capacity for independent action of decision-making; and/or

- Sexuality is inappropriately imposed upon a person.⁹

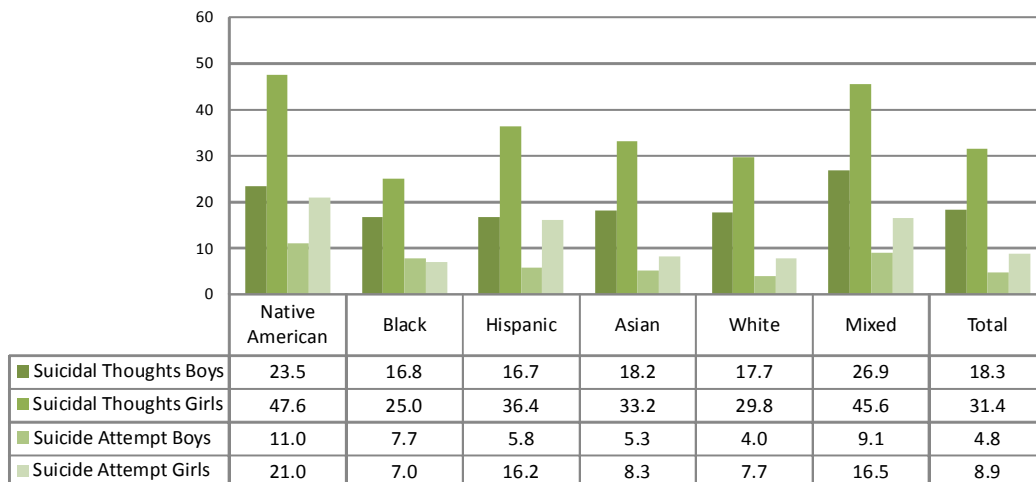
Several studies conclude that exposure to sexualized female ideals and self-objectification lowers self-esteem, increases negative moods, and results in “depressive symptoms” in girls.¹⁰

It is almost impossible for even young girls to avoid sexualized images. An analysis of children’s TV shows and G-rated movies from 2000-2006 revealed that a quarter to a third included female characters with unrealistically proportioned idealized bodies and sexually revealing outfits.¹¹

And it only gets worse as girls age in to the mainstream media where women’s bodies are used to sell everything from cars to beer and even sports heroines pose in men’s magazines in sexy outfits. In the words of one 16 year old girl: “Women that sell their sexuality on TV influences the way we want to be; for girls that already have low self-esteem it makes them feel even lower.”¹²

Hinshaw writes: **“Today’s teenage girls are literally collapsing under the weight of adult expectations, consumerism and a highly sexualized pop/cyber-culture that celebrates physical perfection and stratospheric success.”** The result, he says, of sexualization combined with expectations for girls to succeed, both in traditional female ways and in male ways, is onset of depression among girls at younger and younger ages, with onset falling from their 30’s in the 1970’s to their teens today.¹³

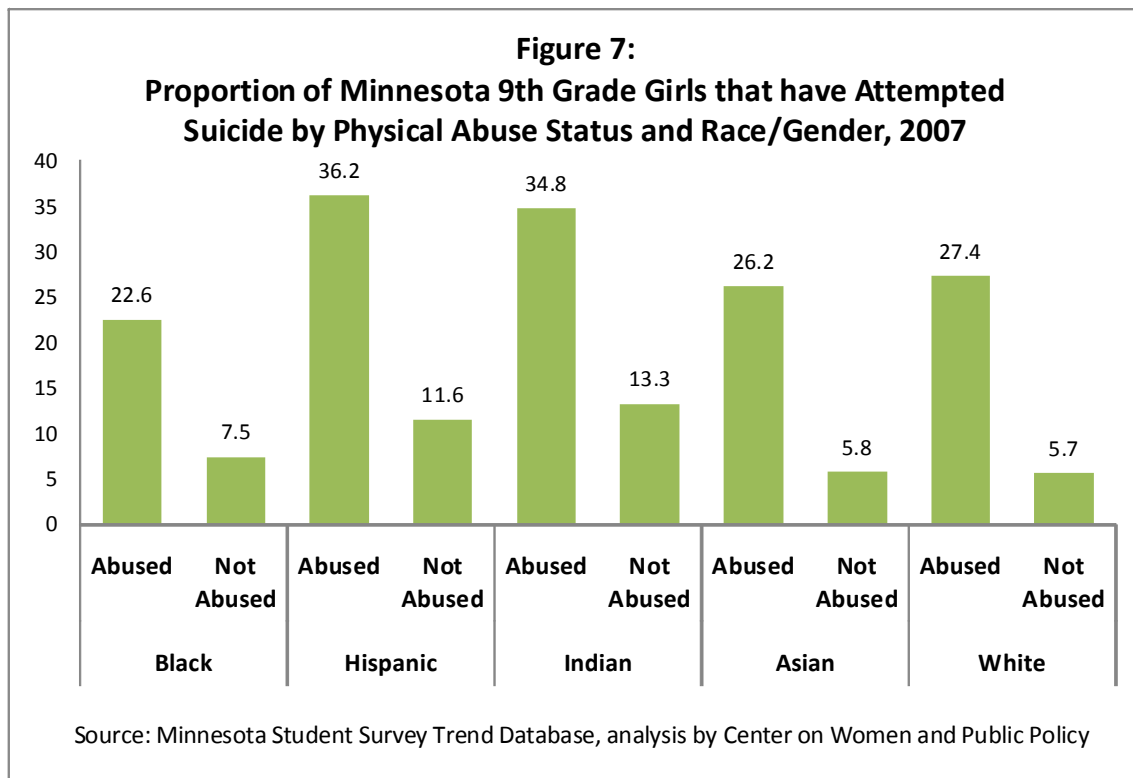
**Figure 6:
Proportion of Minnesota 9th Graders Thinking About or Attempting Suicide,
2007**



Source: Minnesota Student Survey Trend Database, analysis by the Center on Women and Public Policy

Depression puts girls and boys at risk for suicide. **Almost twice as many Minnesota girls had suicidal thoughts or attempted suicide as boys** (Figure 6). Girls of color are especially at risk: in 2007, 47% of Native American, 36% of Hispanic, and 33% of Asian 9th grade Minnesota girls had suicidal thoughts; and 21% of Native girls and 16% of Hispanic girls actually attempted it. Overall, **8.9% of girls compared to 4.8% of boys attempted suicide.**

These rates climb much higher for children who been either physically or sexually abused (as shown in Figure 7). Approximately 29% of sexually abused white 9th grade girls attempted suicide, with higher rates among some girls of color (40% of Hispanic, 34% Native American and 28% of Black counterparts).



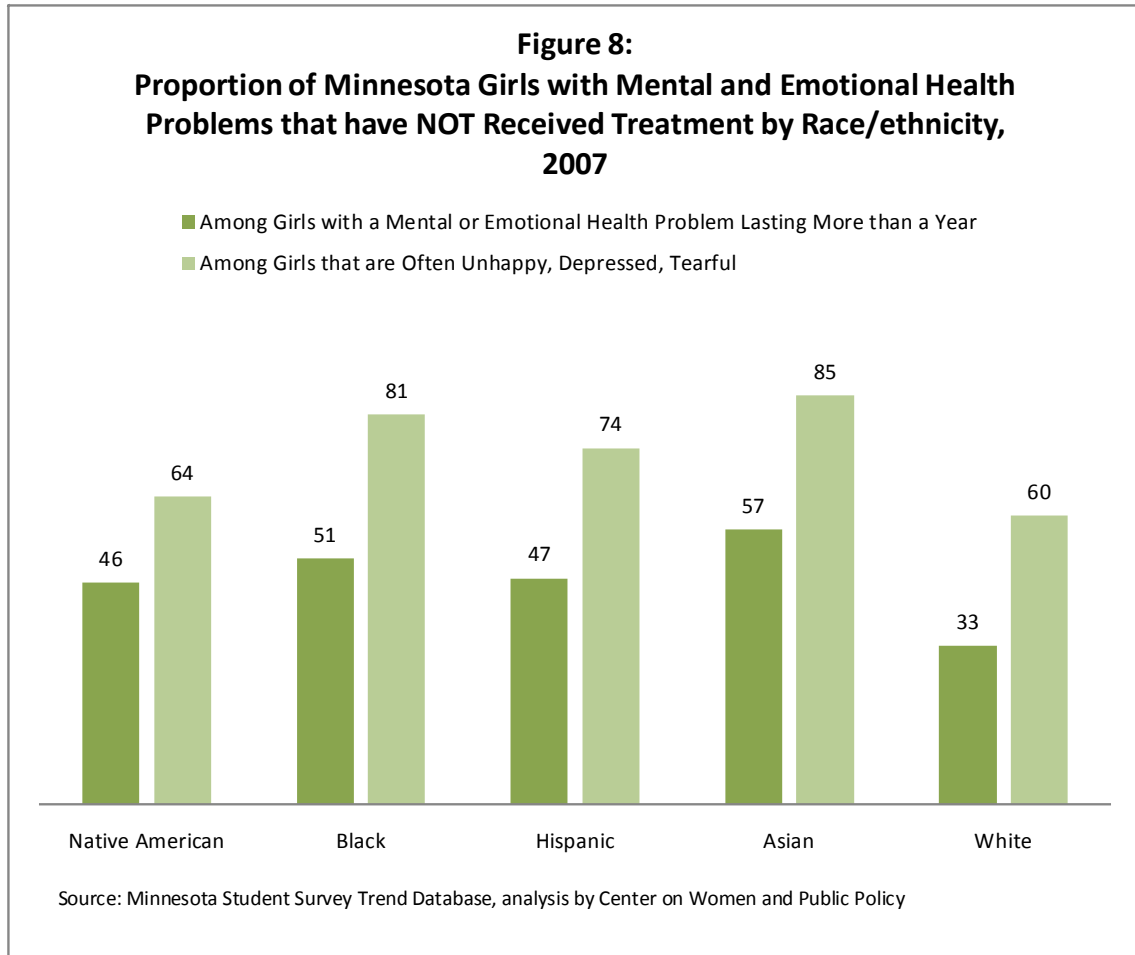
The 2007 Youth Risk Behavior Surveillance Survey of national trends places Minnesota 9th graders ahead of their national counterparts in the prevalence of suicide ideation (19% of 9th grade girls participating in the national survey seriously considered suicide and 13% made a plan compared 31% of Minnesota 9th grade girls who have thought about suicide) and slightly less likely to attempt suicide (8.9% of Minnesota 9th grade girls compared to 10.5% nationally).¹⁴ Nationally, the suicide rate for girls is

spiking after years of decline, increasing among 10 to 14 year olds by 76%, and among 15 to 19 year olds by 32%, between 2003 and 2004.¹⁵

In a recent report, the U.S. Dept. of Health and Human Services concluded: “Mental illnesses, including those that disproportionately affect women, such as depression and anxiety disorders, are often chronic and recurrent. If left unrecognized and untreated, mental illnesses that occur in childhood frequently persist into adulthood. Indeed, research on child and adolescent mental health indicates that no other illness has such damaging effects on children as does mental illness.” Researchers have found that episodes of major depression in teen years can alter brain chemistry, predisposing young women to recurrence throughout life.¹⁶

The U.S. Surgeon General’s report on mental health found that **there are a variety of effective treatments, but most individuals with mental illness do not get them.**¹⁷ The National Mental Health Information Center estimates that only about 20% of women who suffer from depression seek treatment.

In Minnesota, 37% of girls who said they had a mental or emotional health problem that lasted more than a year, and 60% to 85% of girls who were “often unhappy, depressed or tearful” said they had not had treatment.



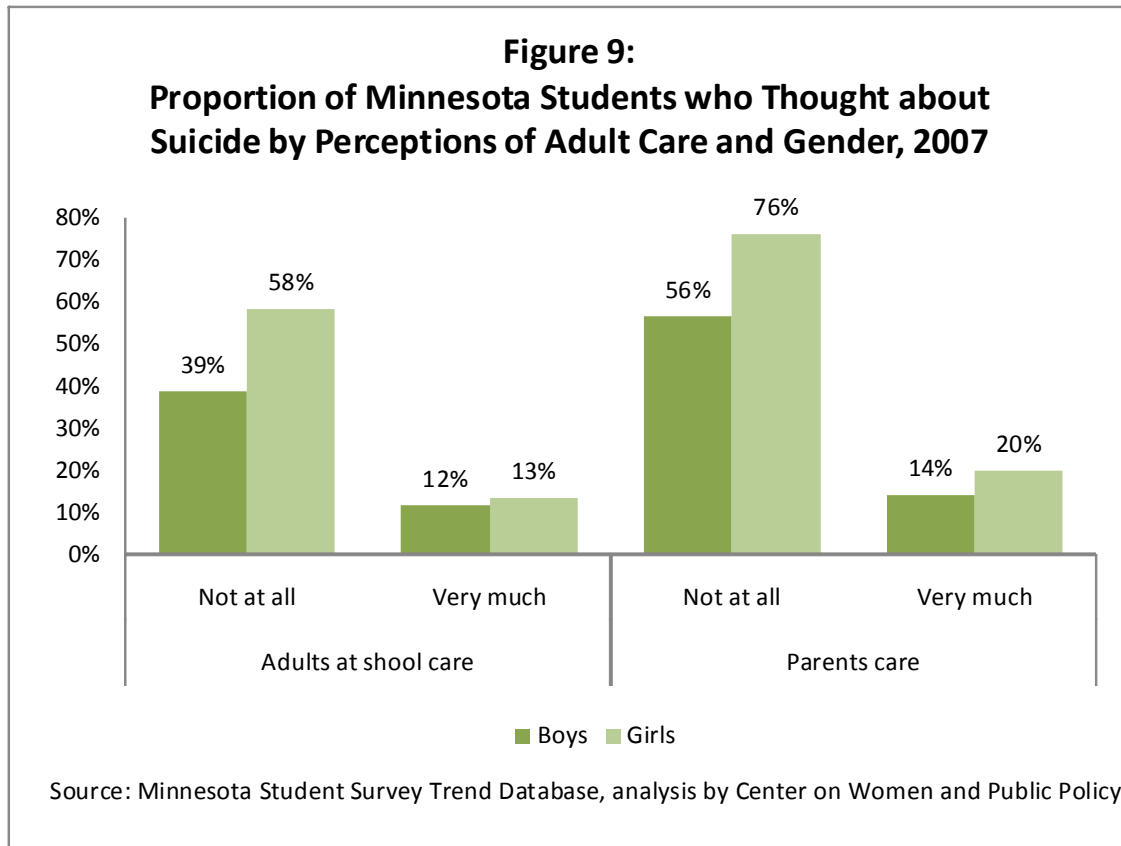
Women and girls of color are less likely than their white counterparts to receive treatment. For example, only 7% of black women nationally suffering from depression receive care.¹⁸ According to the MN Student Survey, more than half of Asian and African American girls (51 and 57% respectively) who reported a mental or emotional problem lasting a year or more indicated that they had not received treatment, compared to just 33% of white girls.

There are several reasons for generally low treatment rates, particularly in communities of color, including stigma, fear of discrimination, lack of access, cost, and a lack of treatment options that are culturally appropriate.

While getting treatment is important, those involved in adolescent mental health point to the power of various approaches to prevent negative mental health outcomes in the first place.

Various environmental factors have been shown to increase resiliency and a person's ability to handle difficulties and overcome genetic predispositions. Research

shows, for example, that connectedness to school and family can be “protective against emotional distress, suicidal thoughts and behaviors.”¹⁹



An analysis of MN Student Survey data shows that a higher proportion of students that feel school adults or parents do not care about them hurt themselves or think about suicide than the proportion of students who feel that these adults care a lot about them -- and the difference is more pronounced for girls than boys.

As Figure 9 shows, **58% of girls who think school adults don't care about them reported suicidal thoughts at some time in their life, compared to only 12% of the girls who thought school adults cared about them a lot.** There is only a minor difference between boys and girls who feel cared for by school adults, but a lower proportion (39%) of boys who didn't feel cared for by these adults reported suicidal thoughts compared to girls.

As Table 1, Figure 9 and many research studies show, connectedness can have an important protective effect for some girls and boys, but many young people who believe adults care about them do still hurt themselves on purpose and think about suicide, among other negative mental health outcomes.

Table 1: Proportion of Minnesota Students who Hurt Themselves on Purpose by Gender and Perceptions of Adult Care, 2007 (MN Student Survey)

Gender		Hurt Self on Purpose			
		Adults at school care		Parents care	
		Not at all	Very much	Not at all	Very much
Male	During past year	22.3%	6.8%	34.5%	6.7%
	More than a year ago	7.5%	3.7%	10.4%	3.6%
Female	During past year	35.7%	6.6%	52.3%	8.8%
	More than a year ago	14.5%	4.4%	13.1%	7.2%

OBESITY:

Obesity rates for Minnesota women climb steadily

While tyranny of the unachievable body image is wreaking havoc on the mental and physical health of Minnesota’s women and girls, obesity poses an equally real threat.

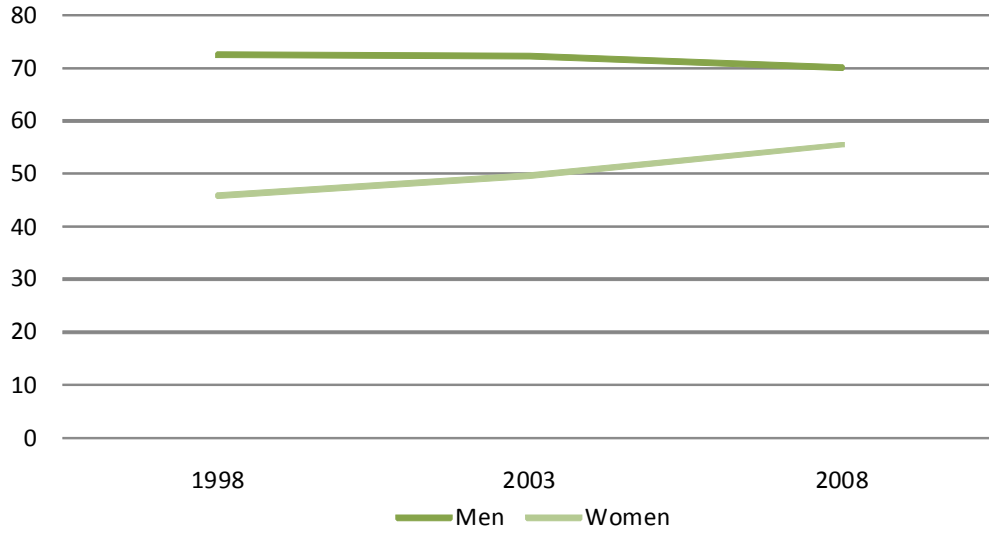
Approximately twenty percent of Minnesota girls (participating in the Minnesota Student Survey who provided weight and height information) whose BMI was normal or lower perceived themselves to be overweight. However, 31% thought their weight was just right when their BMI placed them in the overweight category. While BMI does not tell the whole story (girls with healthy lifestyles can have high BMIs and interpreting BMIs for children is complicated) and we need be cautious about setting up unrealistic standards, increasing obesity rates in Minnesota are taking a toll on the health of women and girls. Obesity increases the chances that women and girls will develop serious chronic health problems such as Type II diabetes, hypertension, heart disease and cancer.²⁰

Table 2: Proportion of Minnesota Adults that are Overweight or Obese by Gender and Year (BRFSS)

	Overweight Men		Overweight Women		Obese Men		Obese Women	
	MN	US	MN	US	MN	US	MN	US
1998	55.3	44.8	31.8	27.3	17.5	18.4	14.9	18.2
2003	47.1	44	28.9	29.1	25.2	23.2	20.8	21.9
2008	44	43.1	31.3	29.7	26.1	27.4	24.2	25.6

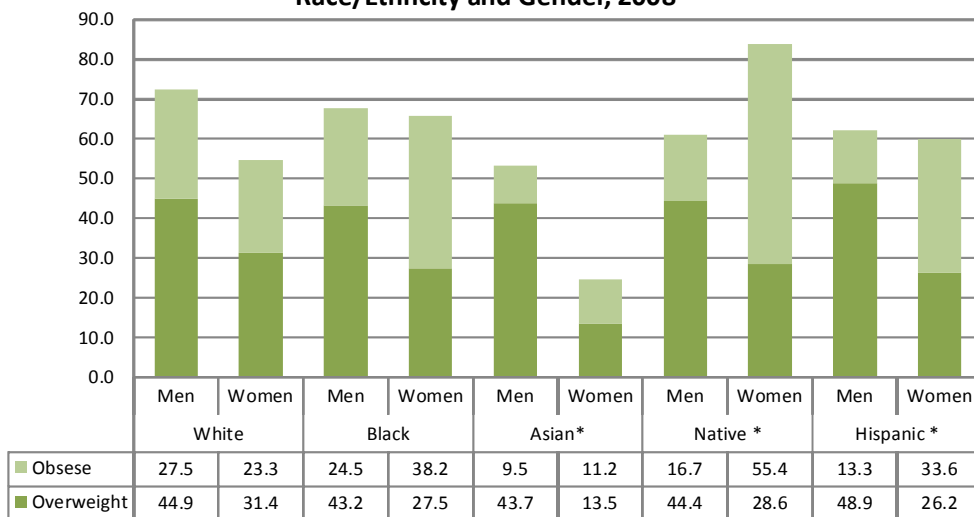
In general, men and boys in Minnesota and nationally are more likely to be overweight. However, the percentage of overweight Minnesota men has declined slightly since 1998, **while the rates for women have steadily climbed** (see Table 2 and Figure 10). In 2008, 25% of Minnesota women were classified as obese and another 31% were overweight. While the gap is closing, women’s rates remain lower than those of Minnesota men (who are 26% obese and 44% overweight).

Figure 10:
Proportion of Minnesota Adults that are Overweight or Obese by Gender and Year



Source: Behavioral Risk Factor Surveillance System

Figure 11:
Proportion of Minnesota Adults that are Overweight or Obese by Race/Ethnicity and Gender, 2008



* n < 100

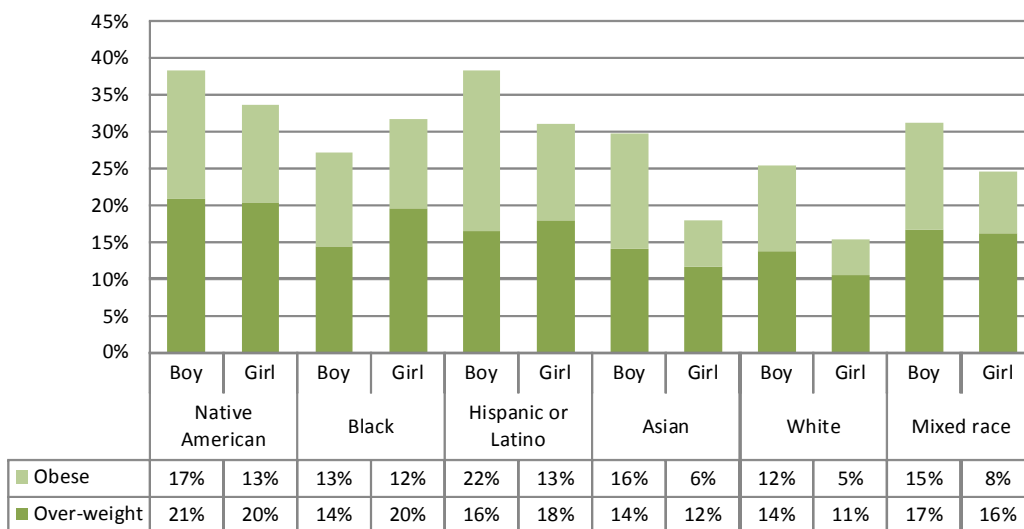
Source: Behavioral Risk Factor Surveillance System, <http://www.cdc.gov/BRFSS/>

In both Minnesota and the U.S. as a whole among women, Native American, African American and Hispanic women and girls have the highest rates of obesity, while Asian and white women and girls have the lowest rates. Sixty-five percent of Minnesota black women, 83% of Native American women and 60% of Hispanic women are overweight or obese (as shown in Figure 11).

Research shows some relationship between obesity rates and poverty. It also shows that women of color and their families are the most likely Minnesotans to be poor. “While individuals have choices about what they eat or how active they are, these decisions are affected by factors that are beyond individual control. For instance, in neighborhoods with limited grocery stores or unsafe parks, it is harder for people to eat healthy foods and be physically active.”²¹

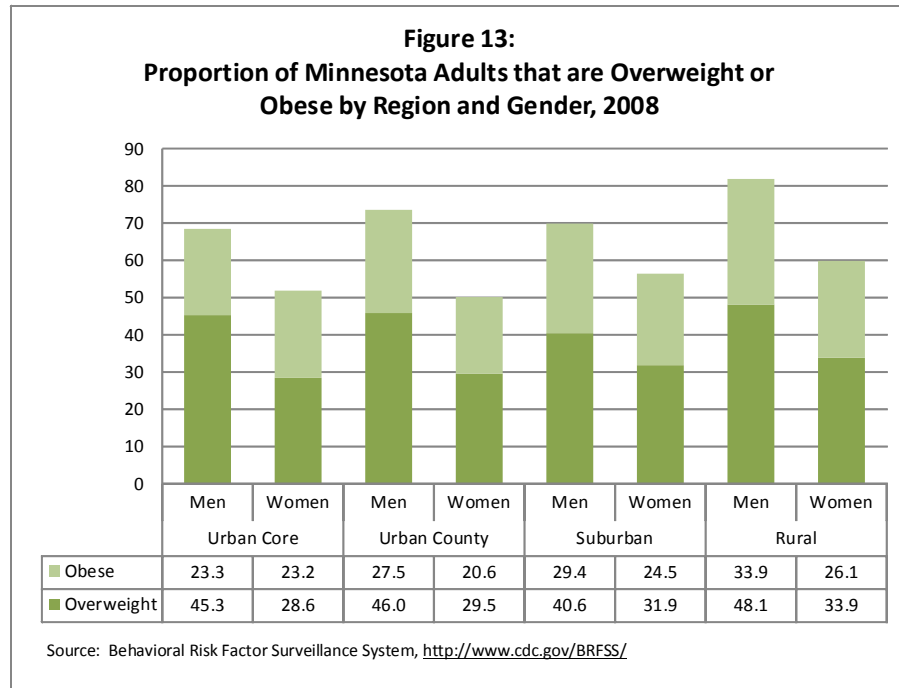
National studies place Minnesota as the state with the lowest levels of overweight or obese children (10 to 17 year olds), estimated at 23%.²² These percentages are consistent, although slightly higher than MN Student Survey (2007) results, which showed that 22% of 9th graders and 21% of 12th graders (listing weight and height in the survey) were classified as overweight or obese. Boys are more likely across most race and ethnicity categories (except black) to fall in these categories than girls (Figure 12).

**Figure 12:
Proportion of Minnesota Students (Grades 9 and 12) that are
Overweight or Obese, 2007**



Source: Minnesota Student Survey Trend Database, analysis by Center on Women and Public Policy)

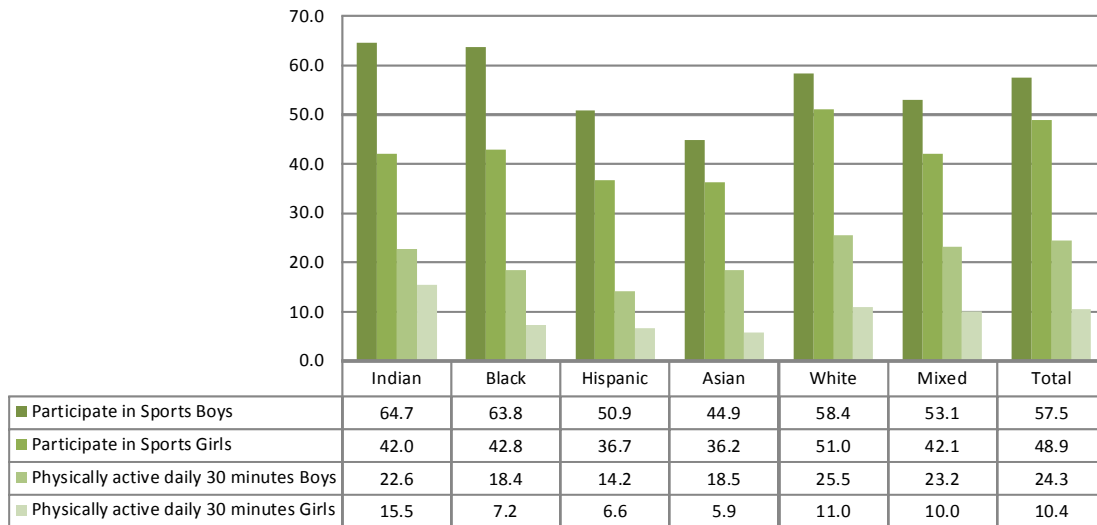
Minnesota women and men who live in rural areas of the state are more likely to be overweight or obese than suburban and urban men and women: 60% of rural women, compared to 56% of suburban, 49% of women who live in an urban county, or 51% that live in the urban core are classified as overweight or obese.



Decreases in physical activity nationwide contribute to the obesity epidemic. One important strategy for addressing obesity among women and girls without invoking the issues associated with “unrealistic body” image is advocating for healthy lifestyles that include eating well and exercising.

Unfortunately, according to research conducted by the Girl Scouts, “For most girls, being healthy has more to do with appearing ‘normal’ and feeling accepted than maintaining good diet and exercise habits.”²³

Figure 14:
Proportion of Minnesota 12th Graders Engaging in Physical Activities
by Gender and Race/Ethnicity, 2007



Source: Minnesota Student Survey Trend Database, analysis by Center on Women and Public Policy

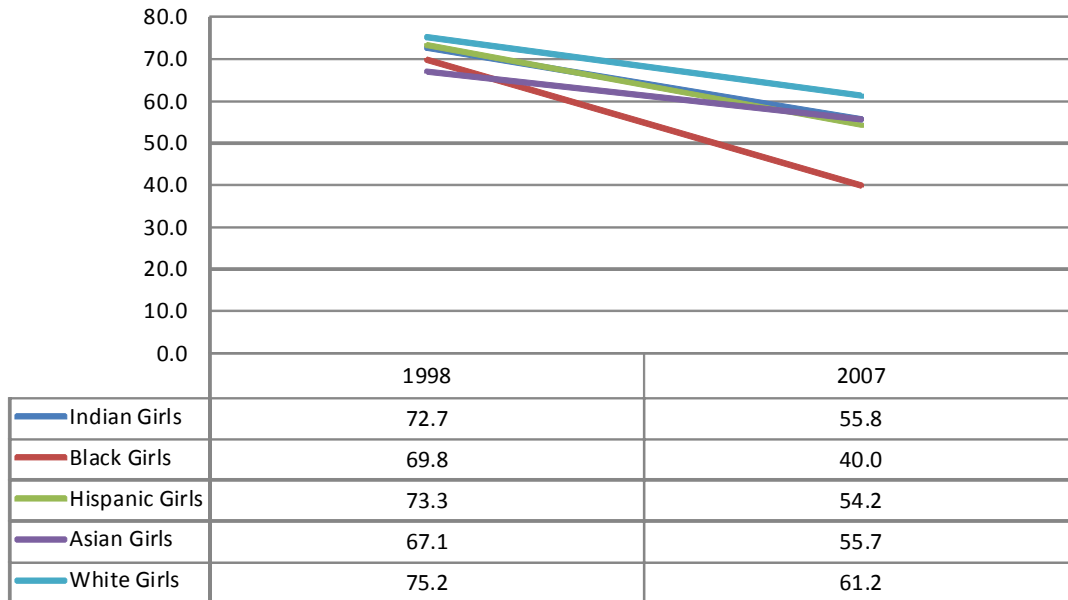
MN Student Survey (2007) results show that **Minnesota girls are less likely than boys to be physically active daily (10% of 12th grade girls compared to 24% of boys) or participate in sports (48% of 12th grade girls compared to 59% of boys)**. Most girls of color are less likely than white girls or boys to be physically active daily (11% white compared to 5.9 Asian, 6.6 Hispanic and 7.2 black) or participate in sports (see Figure 14).

Girl Scout researchers also found that “[t]he more physically active girls are, the greater their self-esteem and the more satisfied they are with their weight, regardless of how much they weigh.”

On the flip side, the Girl Scout researchers also found that inactive girls consider themselves overweight and are less satisfied with their appearance. “Many girls (ages 11-17) say they do not play sports because they do not feel skilled or competent (40%) or because they do not think their bodies look good (23%).”²⁴

MN Student Survey (2007) data show a **decline in exercise as a weight control mechanism**. Between 1998 and 2007, there was a drop of 29 percentage points among 12th grade black girls, a 19-point drop for Hispanic girls, a 17-point drop for Native American girls, and a 15-point drop, overall.

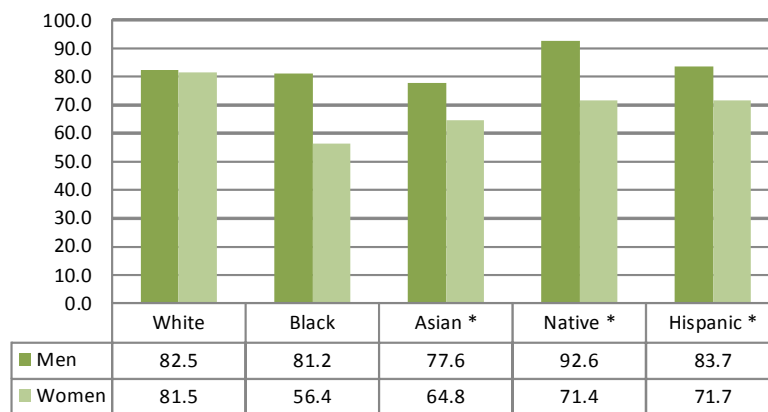
**Figure 15:
Proportion of Minnesota 12th Grade Girls that Exercise to Control Weight, 2007**



Source: Minnesota Student Survey Trend Database

The Girl Scout research points to the influential role mothers play in how girls define healthy lifestyles. Our research shows that many Minnesota women do not engage in any regular physical activity -- even though Minnesota ranks best in the nation for the low proportion of adults that are not

**Figure 16:
Proportion of Minnesota Adults that Participated in Physical Activities in the Past Month, 2008**



* n < 100

Source: Behavioral Risk Factor Surveillance System, <http://www.cdc.gov/BRFSS/>

physically active, 16.3%.

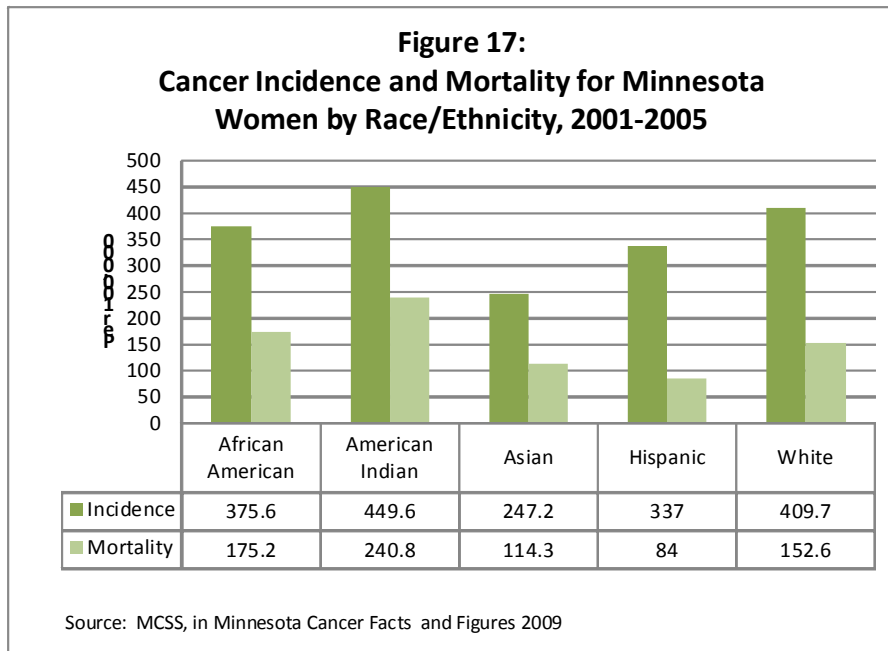
The averages, however, mask the differences among women. For example, 43% of African American women, 22% of rural Minnesota women, and 23% of 18-24 year old women report no physical activity in the past month. Overall, women are less likely than men to engage in physical activity in every race/ethnicity, although white men are only narrowly more active than white women. Eighty-one percent of black men participated in physical activities in the past month compared to just 56% of black women.

CANCER:

Almost half of Minnesota women will be diagnosed with a potentially fatal cancer during their lifetime and a quarter will die from some form

Overall cancer is declining both in Minnesota and nationally, but more rapidly for men than women. Based largely on a more rapid relative decline in heart disease, cancer became the number one cause of death in Minnesota around the year 2000. In 2006, 9,065 people in Minnesota died from cancer compared to 7,506 heart disease deaths.²⁵

With cancer and other diseases, significant racial/ethnic disparities exist in Minnesota. While cancer mortality in Minnesota is lower overall than the nation, Native American women in our state are two times more likely to die from cancer than Native American women nationally. **Native American women in Minnesota are 10% more**



likely to be diagnosed with cancer than white women, but 58% more likely to die from it.²⁶

Minnesota's African American women are 8% less likely than white women to get cancer, but 15% more likely overall to die from the

disease: 20% more likely to die from lung cancer, 40% more likely from colon and rectum cancer, and 21% for breast cancer.²⁷

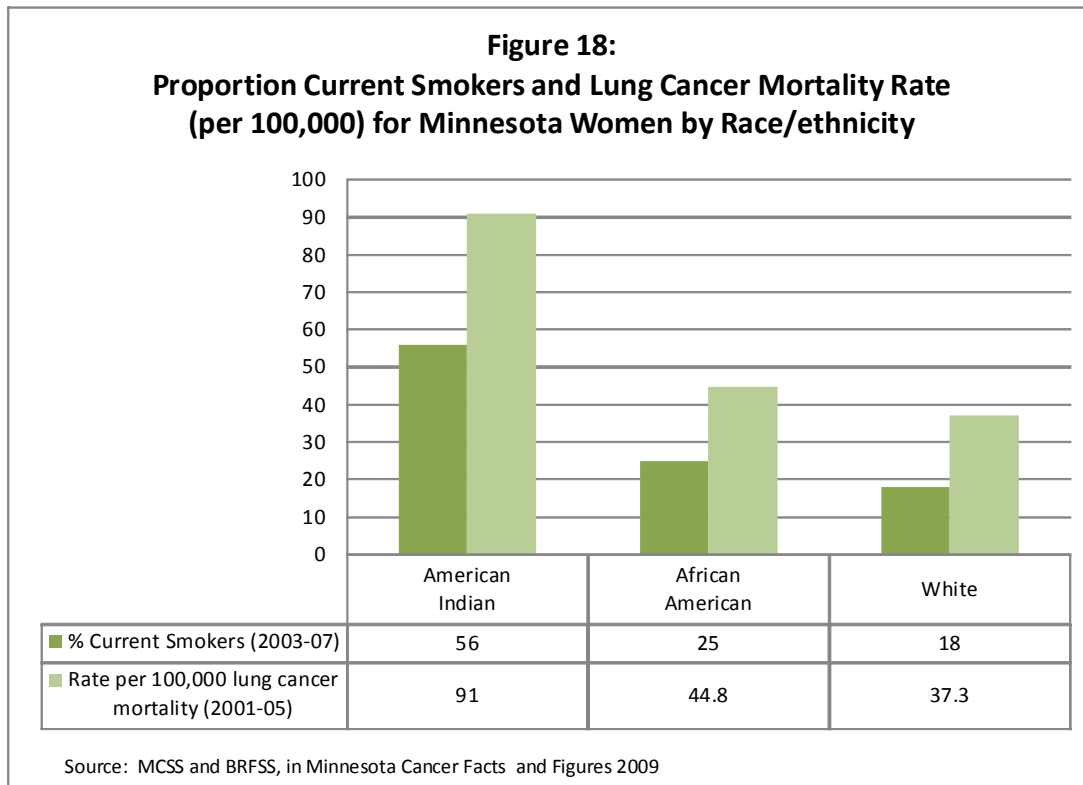
Cancer is **less prevalent** (18%) and **less deadly** (45%) for Minnesota’s Hispanic women compared to white women. According to the American Cancer Society, “Much remains to be learned about the causes of race/ethnic differences in cancer incidence and mortality, and the relative importance of cultural, social, economic, and genetic differences is controversial.”²⁸

Lung Cancer

Between the late 1980’s and 2005, the lung cancer mortality rate for Minnesota women climbed by 28%, while men’s rates declined 17%.²⁹

Even when diagnosed at the same stage, those with lung cancer are less likely to survive than those with other cancers. The American Cancer Society attributes 90% of lung cancer to cigarette smoking and disparities in lung cancer among Minnesota women track closely with smoking rates.

While smoking among adults and children in Minnesota has been on the decline overall, during 2003-2007 more than half of **Native American women** were current smokers, translating into the **highest lung cancer mortality rates among women** (91 deaths per 100,000 women). Lung cancer mortality rates for Native American women are **nearly three times** the rate of white women and **more than twice** the rate of African American women.³⁰

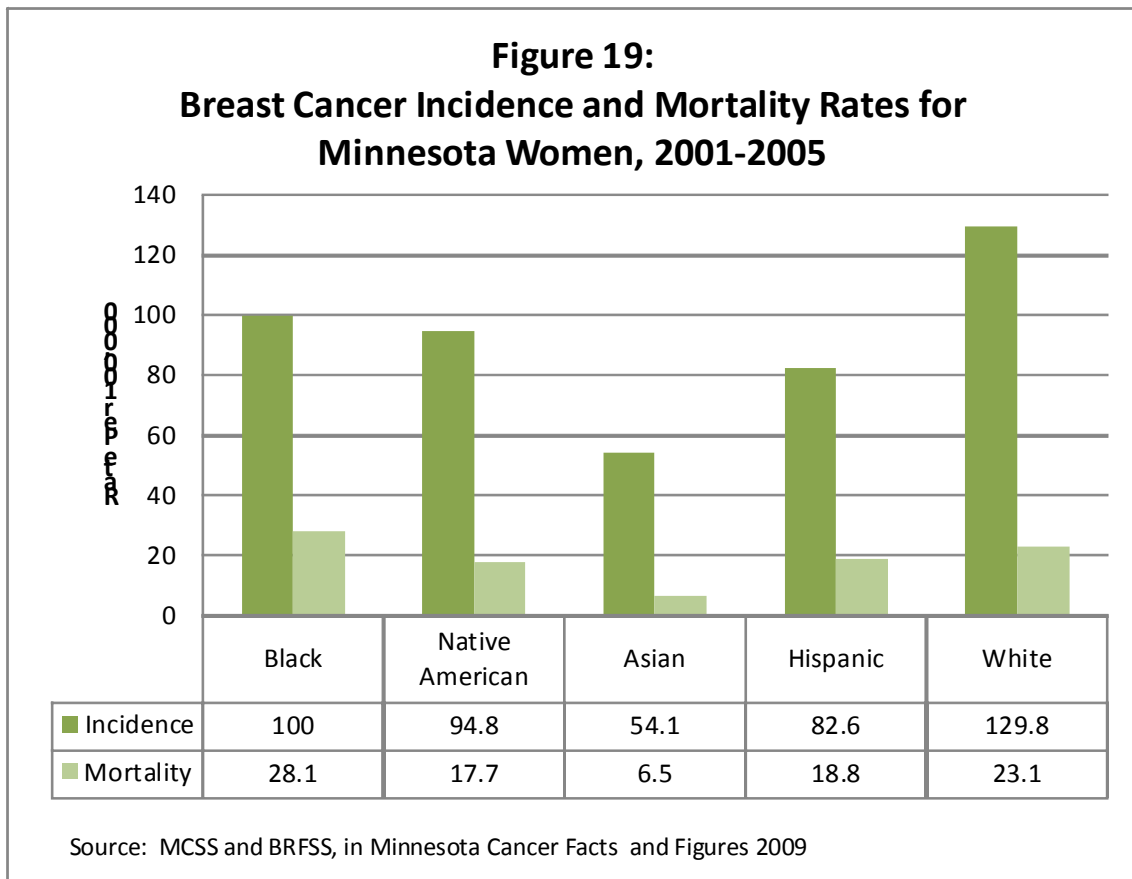


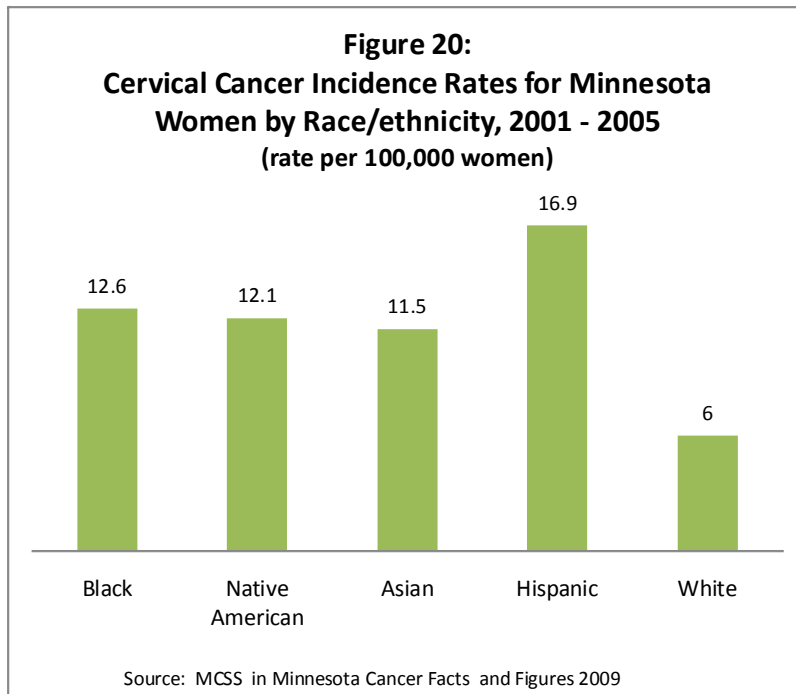
Breast Cancer

Despite dramatic increases in breast cancer research in recent years, known risk factors can only account for 30-50% of breast cancers. “The majority of women diagnosed with this disease do not have a known risk factor.”³¹

Experts suggest the best approach, given these unknowns, is identifying breast cancer early enough to successfully treat it. If detected early, breast cancer survival is relatively high at 98%.

Annually, approximately 3,500 Minnesota women are diagnosed with breast cancer and 650 die. White women are most likely to receive a breast cancer diagnosis, but African American and Native American women are less likely to survive the disease than their white counterparts.³²





Cervical Cancer

Cervical cancer and incidence are declining in Minnesota and nationally. However, cervical cancer strikes at an earlier age than other cancers. About 60% of the 170 women who get invasive cervical cancer annually in Minnesota are under 50 years old. An estimated 45 women die of cervical cancer each year here, and 30% of those deaths are among women

under 50.

Cervical cancer hits Hispanic women harder than other racial/ethnic groups, with a rate three times as high as white women. Other women of color in Minnesota have double the rates of white women. Evidence suggests that “less effective screening among women of color” is the primary reason for disparities.³³

INSERT MAP

Women in the northeast region of the state have higher than average rates for the most common cancers found in women, breast and lung. Women in northeastern Minnesota have lung cancer mortality rates of 43 per 100,000, compared to a statewide average of 37.3 per 100,000, and breast cancer incidence of 137.9 per 100,000 compared to a statewide average of 129.3. The region’s averages are driven up by its largest county, St. Louis with the state’s highest rate (146.3). Cervical cancer incidence is also higher in northeast Minnesota than the statewide average, 8.9 compared to 6.6 per 100,000.

STORY: Heart Disease & Strokes in Minnesota Women

While men have more heart attacks than women, and have them earlier in life, “Each year [nationally] about 55,000 more women than men have strokes, and about 60 percent of total stroke deaths occur in women.”³⁴

In Minnesota, equal numbers of men and women die from stroke each year (41 deaths per 100,000, 2005). Coronary heart disease, which causes heart attack, is the leading cause of death for American women, but 30% lower heart disease rates in Minnesota make it the second most common cause of death in the state.³⁵

The Mayo Clinic defines several ways in which risks vary for women. “Although the traditional risk factors for coronary artery disease — such as high cholesterol, high blood pressure and obesity — affect women and men, other factors may play a bigger role in the development of heart disease in women.” The list of factors includes:

- **Metabolic Syndrome.** This combination of fat around the abdomen, high blood pressure, high blood sugar and high triglycerides has a greater impact on women than on men.
- **Stress & Depression.** Mental stress and depression affect women's hearts more than men's. Depression is twice as common in women as in men, and it increases the risk of heart disease by two to three times compared with those who aren't depressed.
- **Tobacco Use.** Smoking is a greater risk factor for heart disease in women than in men.
- **Menopause.** Low levels of estrogen after menopause pose a significant risk factor for developing cardiovascular disease (small vessel heart disease) in the smaller blood vessels.³⁶

Ambiguous Warning Signs

The symptoms that women experience prior to a heart attack are not those typically experienced by men.

“The most frequently reported symptoms for women are unusual fatigue, sleep disturbances, shortness of breath, indigestion and anxiety. The majority of women (78 percent) reported at least one symptom for more than one month before their heart attack. Only 30 percent reported chest discomfort, which was described as an aching, tightness, pressure, sharpness, burning, fullness or tingling.”³⁷

“Many women tend to show up in emergency rooms after much heart damage has already occurred, because their symptoms are not those typically associated with a

heart attack.”³⁸ Since two-thirds of women who have a heart attack fail to make a full recovery, prevention is important.³⁹

Take Action to Prevent Heart Disease

- *Stop smoking.* Smoking is a greater risk factor for women than men.
- *Eat healthy.* Eating the right foods affects several risk factors: cholesterol, blood pressure, diabetes and overweight.
- *Be active.* Thirty minutes of physical activity daily can also help lower blood pressure, lower cholesterol and keep weight at a healthy level.
- *Reduce stress.* Stress can affect other risk factors and behaviors, including high blood pressure, smoking, physical inactivity and overeating.
- *Limit alcohol.* According to the American Heart Association, drinking too much alcohol can raise blood pressure, lead to heart failure or stroke and produce irregular heartbeats.⁴⁰

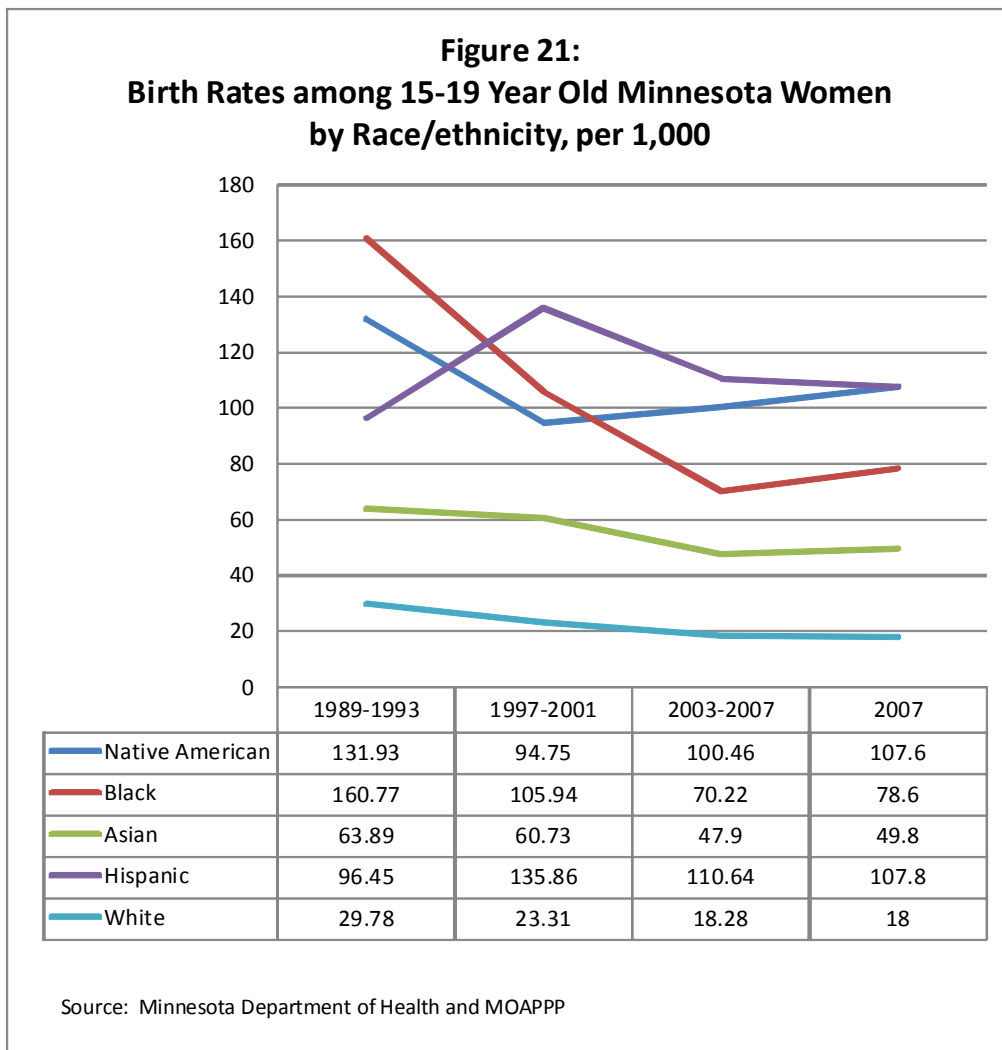
REPRODUCTIVE HEALTH

Teen birth rate rises as birth control use declines

After several years of decline, teen birth rates inched up, especially among girls of color both in Minnesota and nationally in 2006-07.^{41 42} It is unclear whether this is a one-time anomaly, or if rates will continue to climb.

While white teens in Minnesota have birth rates lower than the national average (18 per 1,000 compared to 27.2 per 1,000), **girls of color have higher rates.**

For example, the national birth rate for African American teen girls is 64.3 births (per 1,000 African American teen girls), compared to a Minnesota rate of 78.6.

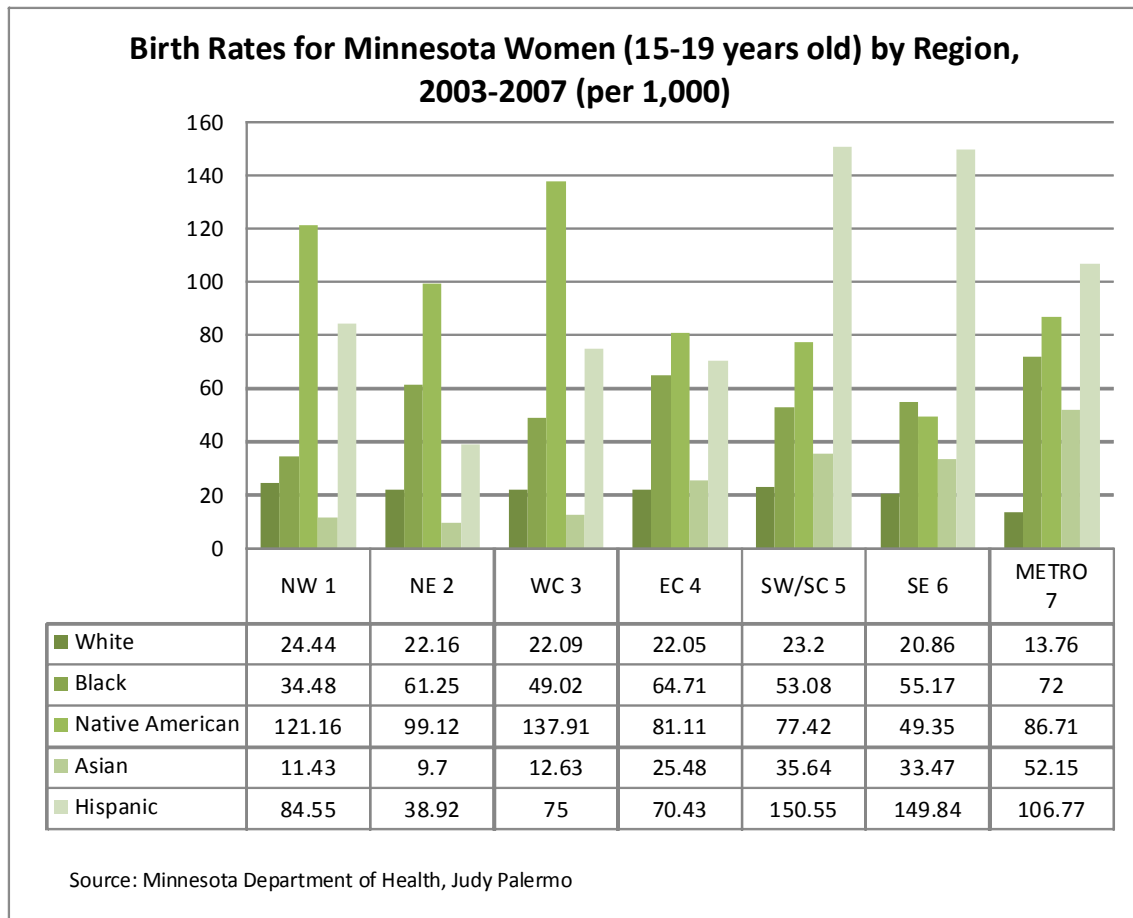


Among Native American girls, the Minnesota rate (107.9 births per 1,000) is almost double the national average (59 per 1,000). This holds true for Asian girls, as the state rate (49.8 per 1,000) is more than double the national one (17.3 per 1,000). Hispanic teens in Minnesota have a near-identical birth rate (107.8 in 1,000) to Native American teens -- the highest birth rates in the state -- compared to a national rate of 81.7⁴³, the highest birth rate nationally.

A significant portion of teen births are to girls who are already mothers. On average, **17.3% of Minnesota teen births are a subsequent birth**, compared to 19.6% nationally.

According to MOAPPP, around a quarter of births to black (22%), Native American (24%), Asian (29%), and Hispanic (21%) Minnesota adolescents are a “subsequent” or second (or more) birth.⁴⁴

Teen birth rates vary across the state. **Among white girls, rates in rural areas (2003-2007) are higher than in the metro area and higher than the statewide average.**



Among 18-19 year olds nationally, the decline in birth rates between 1995 and the early 2000's was primarily due to increased contraceptive use. For 15-17 year olds, on

the other hand, 75% was attributable to contraceptive use and 25% to reduced sexual activity.⁴⁵

These generally positive trends suggest the importance of sexual education for youth and access to contraceptives. Based on a review of hundreds of state and national studies, the National Campaign to Prevent Teen and Unplanned Pregnancy found that 75% of the 48 comprehensive sex education programs they reviewed that supported both contraceptives and abstinence had positive effects on sexual behaviors, including delayed initiation and frequency, reduced number of partners, and incidents of unprotected sex.

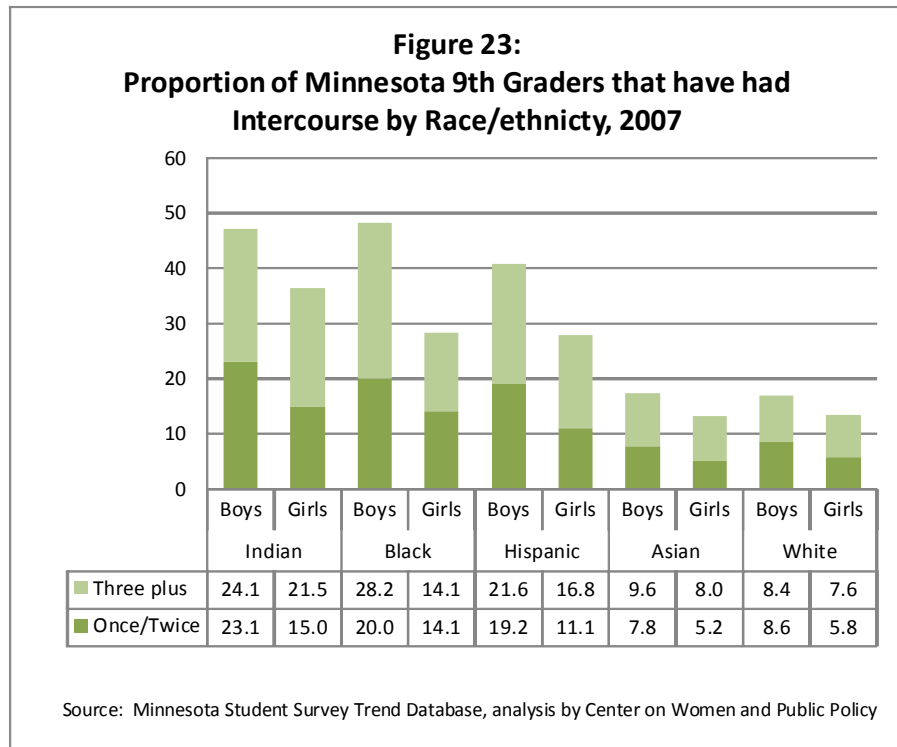
Similar evidence did not exist for **abstinence-only programs** reviewed by the National Campaign. In fact, strong evidence from multiple randomized studies showed **no impact, positive or negative.**⁴⁶

On a 2006 statewide survey, a majority of districts said that they teach both abstinence and contraceptive use. Since that survey, sex education experts in Minnesota contend that there has been a chilling effect resulting in teachers being less willing to talk about contentious subjects like how to use a condom.⁴⁷

Despite surveys that show widespread support across the state for sex education (91% support at the high school level and 84% at the junior high/middle school level or 89%), Minnesota does not require a standardized approach that includes both abstinence and contraceptives, or funding and training for teachers.⁴⁸

Teens, Sex & Risky Behaviors

The percentage of Minnesota students having sexual intercourse has generally gone down since 1998, but the rates of intercourse for 12th graders actually rose from around 46% in 2004 to

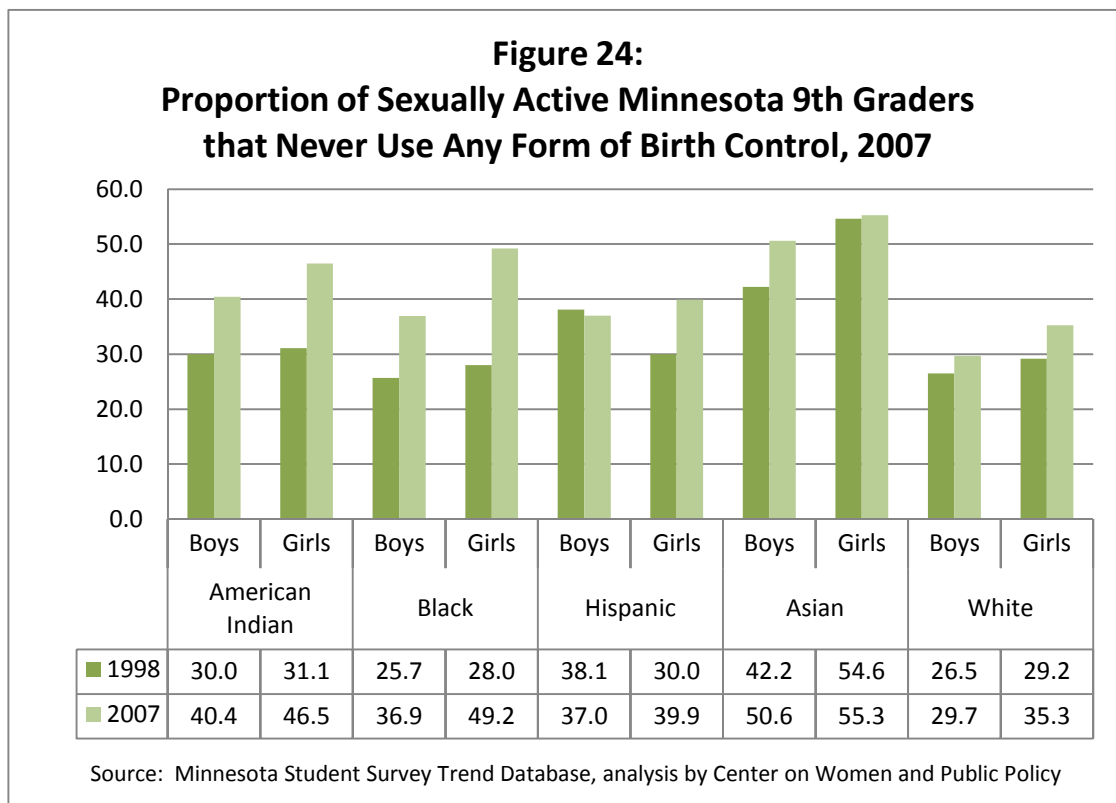


48.4% in 2007.

Among 9th graders, rates have continued to fall. For example, the MN Student Survey showed that in 1998, 35% of 9th grade Native American girls had intercourse three or more times; by 2007, the percentage had decreased to 22%. However, **a significant number of 9th graders remain sexually active.**

While sexual intercourse is down among 9th graders, for the teens that are sexually active, risky behaviors have been on the rise since 1998, especially among 9th graders.

An alarmingly high proportion of sexually active 9th graders neither talk about pregnancy prevention not use any form of birth control and these dangerous behaviors are on the rise across all racial/ethnic groups. Over half of sexually active 9th graders never talk to their partner about preventing pregnancy and 38% of sexually active 9th grade girls never use any form of birth control.

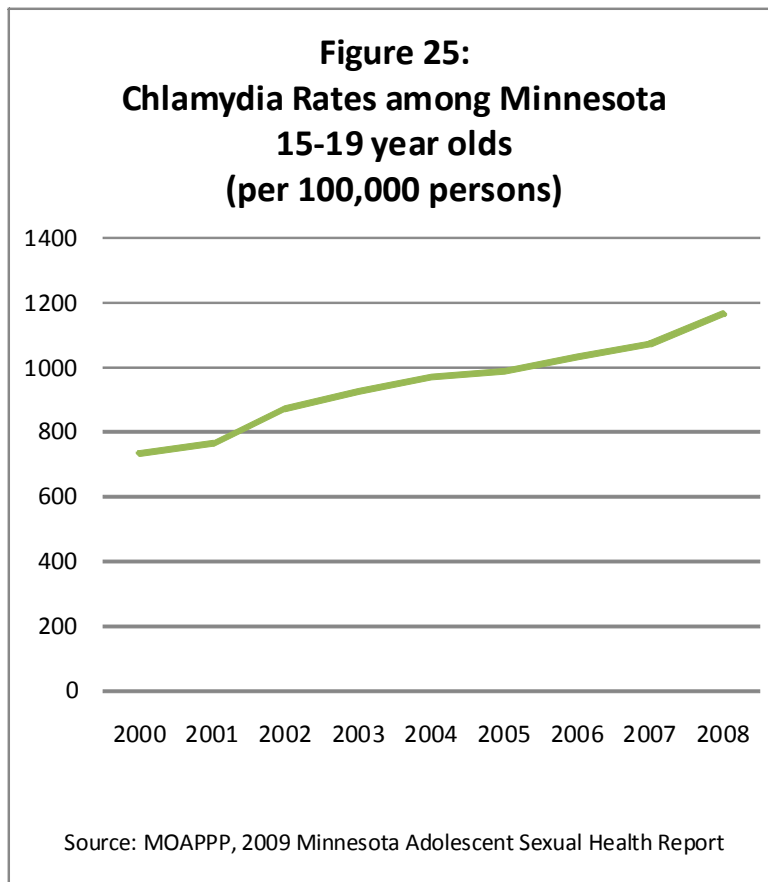


Fifty-three percent of sexually active 9th grade Hispanic girls never talk with their partner about STDs/HIV/AIDS, up from 40% in 1998; 49% of African American girls never use any form of birth control, up from 28% in 1998; 35% of white girls never talk with their partner about preventing pregnancy, up from 29% in 1998. Sexually active Asian girls and boys are less likely than other 9th and 12th graders to talk about or use birth control.

The 2006 survey found that at the middle-school level, schools are less likely than at the high school to provide information about contraceptives; only 35% of schools reported doing so.⁴⁹

Sexually Transmitted Diseases (STDs)

These behaviors also **contribute to high rates of STD infections among Minnesota’s adolescent girls.** According to MOAPPP’s *2009 Minnesota Adolescent Sexual Health Report*, the rate of increase in Chlamydia cases among the state’s 15-19 year olds doubled from 3% between 2005 and 2006 to 7.7% between 2006 and 2007.⁵⁰ “Even though they account for only 7% of the population in Minnesota adolescents aged 15-19 accounted for 30% of Chlamydia and 26% of gonorrhea cases in 2008.”⁵¹ In 2008, **girls account for 82% of the 2008 Chlamydia cases among 15-19 year olds.**



Minnesota’s girls of color experience much higher rates of Chlamydia than white girls. “Compared to white adolescents aged 15-19, the Chlamydia rate was 23 times higher for African Americans; six times higher for American Indians; four times higher for Hispanics; and twice as high for Asian/Pacific Islanders.”⁵²

Table 3:
Proportion of Sexually Active Minnesota 9th and 12th Graders
Engaging in Prevention, 1998-2007

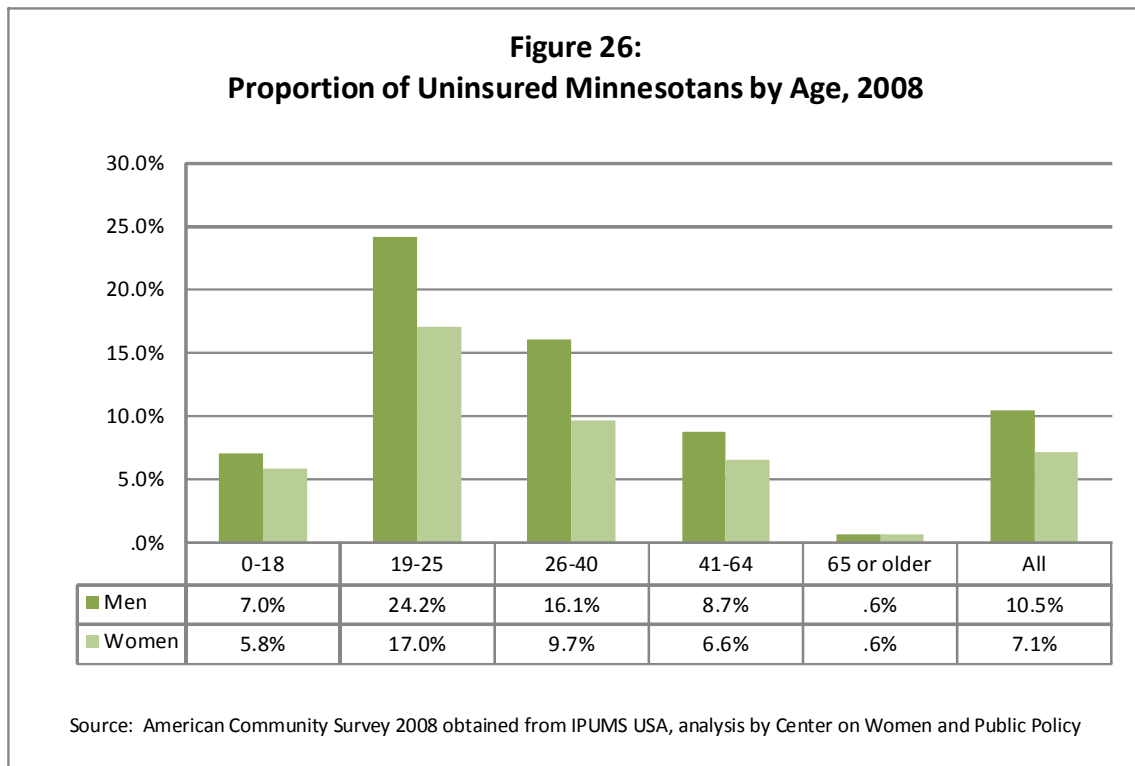
			Indian	Black	Hispanic	Asian	White	Total	
% Never talk with partner about STDs/HIV/AIDS	1998	Grade 9	Male	52.0	40.4	51.9	64.3	57.8	56.1
			Female	39.3	30.6	40.3	57.7	47.8	46.0
	Grade 12	Male	36.1	18.9	31.8	54.7	36.0	35.8	
		Female	29.4	32.3	41.9	63.8	27.3	28.4	
	2007	Grade 9	Male	54.1	48.3	48.7	72.7	62.4	59.6
			Female	48.3	56.5	53.1	59.3	59.6	57.3
		Grade 12	Male	44.9	41.9	40.1	56.6	44.9	44.9
			Female	41.8	41.6	37.8	50.3	33.5	34.6
% Never use any form of birth control	1998	Grade 9	Male	30.0	25.7	38.1	42.2	26.5	27.7
			Female	31.1	28.0	30.0	54.6	29.2	30.4
	Grade 12	Male	21.2	13.4	23.4	36.3	12.4	13.4	
		Female	8.1	20.6	15.7	36.2	8.9	10.1	
	2007	Grade 9	Male	40.4	36.9	37.0	50.6	29.7	33.1
			Female	46.5	49.2	39.9	55.3	35.3	37.9
		Grade 12	Male	29.6	23.2	20.9	40.3	14.1	16.4
			Female	18.8	22.5	19.8	39.8	11.1	13.2
% Never talk with partner about preventing pregnancy	1998	Grade 9	Male	57.7	40.6	54.1	69.0	57.2	56.3
			Female	45.6	29.3	37.7	57.0	45.9	44.5
	Grade 12	Male	26.1	21.4	35.9	55.2	28.8	29.6	
		Female	18.2	21.2	27.6	37.9	15.1	16.3	
	2007	Grade 9	Male	57.0	49.2	49.0	70.5	61.4	58.9
			Female	46.5	53.4	48.8	57.7	54.3	52.2
		Grade 12	Male	45.6	45.0	32.6	53.0	33.5	35.2
			Female	32.9	39.5	28.0	40.8	21.8	24.0

A majority of the state’s sexually active 9th graders are not communicating with their partner about STDs. Fifty-seven percent of Minnesota’s sexually active ninth grade girls and 59% of comparable boys never talk with their partner about sexually transmitted diseases. Among girls this rate is up from 46% in 1998.

ACCESS TO CARE

The number of uninsured Minnesotans climbed from an estimated 374,000 in 2007 to 480,000 in 2009

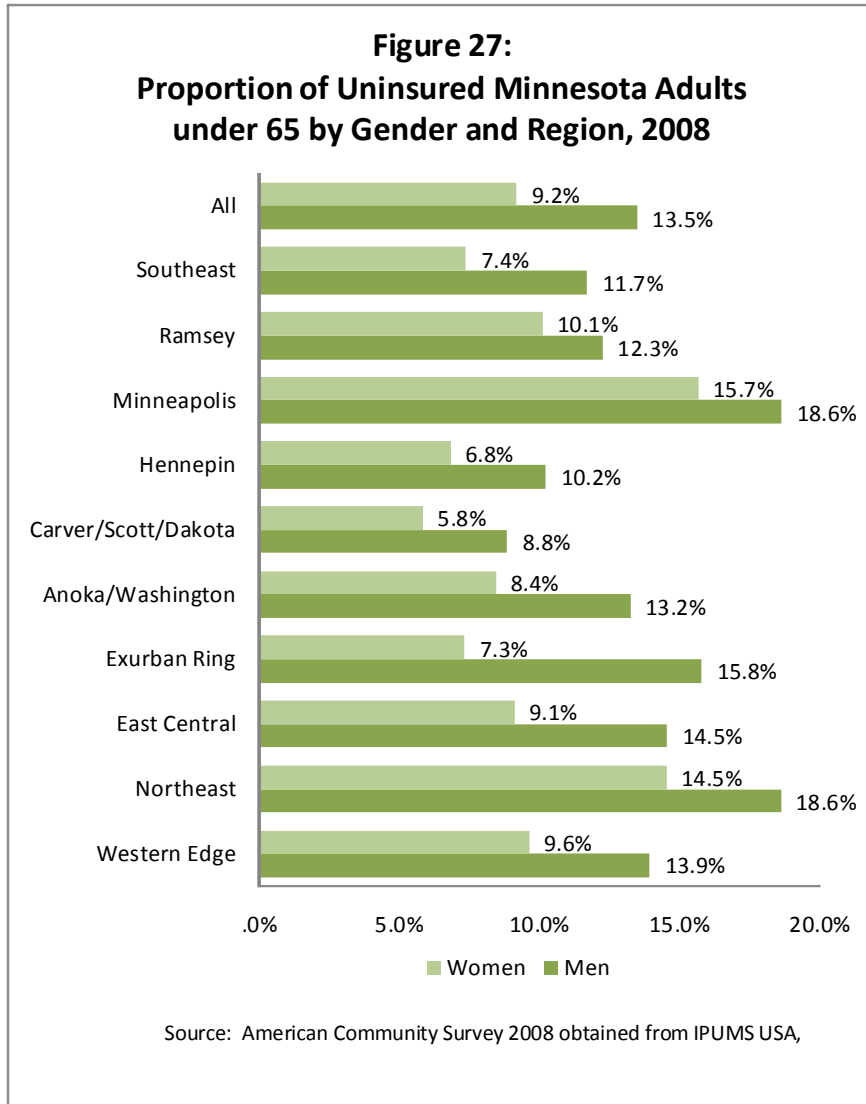
Even with recent increases in the number of people without health insurance, Minnesota continues to have one of the lowest uninsured rates in the nation.⁵³ The MN Department of Health (MDH) attributes the state’s unusually high rate of coverage to the number of individuals on employer provided care, although the proportion of Minnesotans with this form of insurance is declining, from 62.5% in 2007 to 57.2% in 2009.⁵⁴



Women in Minnesota are more likely to have coverage than men across all racial/ethnic groups. According to the latest MDH survey, 65% of those without insurance in Minnesota are men. Overall, 12% of Minnesota males were uninsured in 2009 compared to 6.3% of females.⁵⁵

American Community Survey (ACS) data from 2008 show slightly higher uninsured rates overall than MDH survey data. MDH attributes most of the recent increase in uninsured to recession-related job losses that have been disproportionately born by men. Based on both the MDH survey and ACS data, young adults (18-24) have the

highest uninsured rates in our state (as shown in Figure 26).



Insured rates vary across Minnesota for adults under 65. The highest uninsured rates, based on ACS data, are found in Minneapolis and rural regions, particularly northeast Minnesota which is at 18.6% for men and 14-15% for women (see Figure 27). The uninsured gap between men and women is smallest in the urban regions (Minneapolis and Ramsey County) and largest in the exurban ring,

where almost twice as many men as women are uninsured.

Uninsured rates also vary by race/ethnicity and gender.

According to the MDH 2009 survey, 16% of Minnesota’s African Americans were uninsured in 2009, 18.8% of American Indians, 9.1% of Asians, and 28.6% of Hispanics. Census data vary, particularly for Native American and Hispanic coverage, with somewhat higher rates in these subgroups (in Table 4). However, **both data sources indicate significant racial/ethnic disparities.**

Table 4:
Minnesota Uninsured by Age and Race/Ethnicity, 2008

(Source: American Community 2008)

		19-24	25-34	35-50	51-64	All 19-65
White	Men	45183 23.2%	54014 18.3%	53508 9.7%	25989 6.3%	178694 12.3%
	Women	29073 15.9%	29085 10.6%	36280 6.7%	21714 5.2%	116152 8.2%
Black	Men	3218 26.9%	8476 35.9%	4938 17.5%	776 7.1%	17408 23.3%
	Women	3242 24.6%	2696 12.3%	4344 16.5%	3268 25.8%	13550 18.3%
Am Indian	Men	2847 64.7%	1649 39.5%	2604 46.0%	440 17.8%	7540 45.2%
	Women	1386 37.6%	437 9.6%	1855 28.0%	896 19.5%	4574 23.5%
Asian	Men	1007 9.5%	903 6.0%	3163 12.6%	293 4.0%	5366 9.2%
	Women	1354 16.9%	1340 8.0%	1424 7.1%	1091 9.0%	5209 9.2%
Hispanic	Men	5930 52.0%	13176 52.8%	9516 39.1%	2449 28.9%	31071 44.9%
	Women	2532 24.8%	7748 47.9%	5380 26.7%	1487 19.5%	17147 31.6%

Looking just at Minnesota adults, (rates are generally lower for elders and children) using either ACS 2008 or MDH data, Hispanics and American Indians are much more likely to be uninsured.

Those in Minnesota without citizenship are also much more likely to be uninsured according to ACS data -- 35% of males (all ages) and 27% of females.

A study of Latino women with children in Minnesota found that the biggest barriers to insurance coverage were related to language (including an inability to understand and navigate the application processes for public insurance) and eligibility thresholds just below income levels.⁵⁶

The same study pointed to a **growing problem for uninsured and insured Minnesotans alike: the dramatic increases in co-pays, deductibles and premiums.**⁵⁷ The Kaiser Family Foundation found that premiums and deductibles have doubled since 1999 nationally, putting potentially available coverage out of financial reach for a growing number of Minnesotans.

The MDH survey shows that almost three-quarters of the uninsured have potential access to either employer (38%) or public insurance (61.1%). **A majority (61% overall) of those defined as uninsured in the ACS 2008 survey usually work full-time:** 61% of Hispanic women and 56% of Asian women who are uninsured work more than 35 hours per week. Most of these workers are in low-wage jobs, earning a median income in Minnesota of \$20,000 for women and \$22,000 men.

Minnesotans are not eligible for the state’s MinnesotaCare program if their employer provides coverage and pays at least half of the premium.⁵⁸ Unfortunately,

many low-wage workers can not afford even half of the premium charged by their employer, especially for family coverage.

For the 25% of Minnesotans who must seek insurance coverage in the private market, finding affordable care with adequate coverage can be difficult, especially for women. **“Gender rating” can make women’s policies, particularly those women under 35, 30-50% more expensive.**⁵⁹

Insurers argue that women use more health care, but the fact is that women pay more even if their policies exclude maternity care. Working-class women in this category must put off having children because they can not afford the “hefty” additional premiums charged for maternity coverage. While employers are prohibited by civil rights laws from charging women higher premiums, no such rule applies to those who offer policies in the private market.

Statistics that illuminate the magnitude of the “uninsured” population do not measure the growing concern of the “underinsured,” people with health insurance that does not cover healthcare costs adequately.

“Three-quarters of people driven into bankruptcy because of illness *did* have health insurance at the onset of their illness, but are among the growing number of ‘underinsured.’”⁶⁰ From 1981 to 2001, there was a 2,300% increase nationally in bankruptcy due to medical expenses.⁶¹

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