Introduction

Adolescence is a critical period of physical and personal growth. As they transition to adulthood, youth experience the social, emotional and physical changes of sexual and reproductive development. Adolescents need support to feel comfortable with their sexuality, sexual orientation and sexual identity; develop positive sexual attitudes and healthy sexual relationships; have autonomy over sexual and reproductive health decisions; and have access to reproductive health care. For youth in foster care, the changes in adolescence occur in settings where they may lack the support of a trusted adult, autonomy to make decisions about their well-being, or awareness about health care resources. Understanding and supporting this group of adolescents through these changes can help ensure their healthy transition to adulthood.

Table 1. Rate of Minors in the Child Welfare System in California, July 1, 2009

Age Group	11-15 year olds		16-17 year olds		All minors 0-17 years old	
	# in care	Per 1,000	# in care	Per 1,000	# in care	Per 1,000
White	4,180	4.7	2,505	6.2	14,541	4.7
Black	5,079	29.1	3,006	37.0	15,305	26.6
Hispanic	7,221	5.3	3,680	6.4	27,316	5.5
Native American	227	12.9	107	13.7	759	16.3
Asian/Pacific Islander	464	1.7	254	2.1	1,572	1.5
All Adolescents	**17,176**	**6.1**	**9,553**	**7.9**	**59,509**	**6.0**

Source: Child Welfare Dynamic Report System, 2010

In April 2010, 47% of the 58,917 minors in California's child welfare system were adolescents ages 11-20.[i] Table 1 shows the most recent data on the number and rate of adolescents of different race/ethnicity, compared to the entire population of minors in the child welfare system. African Americans and Native Americans have the highest rates of adolescents in foster care.

Nationally, there is limited research on the sexual and reproductive health status and needs of adolescents in foster care. Furthermore, there are no evidence-based practices or policies to address those needs. The Power Through Choices curriculum is the only evidence-based sexuality education curriculum specifically developed for youth in foster care.[ii] In California, a recent study indicates that many local agencies and organizations do provide some youth with sexual health education, counseling or resources through case management or independent living programs. However, across both the state and county child welfare systems, there are no clear policies to ensure that all youth receive sexual health prevention education, or have access to reproductive health care resources.[iii] There is a need to both better understand the sexual and reproductive health, specifically, of California youth in foster care and develop programs and policies to ensure their well-being as they experience the social, emotional and physical changes of sexual and reproductive development.

Sexual and Reproductive Health Status of Adolescents in Foster Care

Outcomes such as child bearing and sexually transmitted infections (STIs) during adolescence receive a great deal of attention, primarily because of their social and economic impact. However, sexual behavior, psychological and social well-being, and access to health care are also key aspects of sexual and reproductive development. Gaining a greater understanding of the overall sexual and reproductive well-being of youth in foster care is critical to appropriately address their health needs and promote their healthy transition into adulthood.

Sexual and reproductive health outcomes among adolescents in foster care

The National Survey of Child and Adolescent Well-Being (NSCAW), an

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analysis of national data on 877 adolescents ages 14-18 in the child welfare system, found that 20% of women in foster care had experienced a pregnancy.[iv] Findings from the Midwest Evaluation of the Adult Functioning of Former Foster Youth (Mid-West Study), a longitudinal survey that followed 732 adolescents in Illinois, Iowa, and Wisconsin to age 19, indicate that higher percentages of adolescents in foster care experience pregnancy and child bearing and receive testing and treatment for STIs, as compared to a nationally-representative sample in the National Longitudinal Study of Adolescent Health, adjusted to account for socio-demographic differences (Table 2).[v,vi]

The NSCAW and the Midwest Study provide the only estimates of pregnancy, birth or STI rates. The studies are limited because they are based on youths' self-report, not medical records, neither reports actual STI rates and their samples do not reflect the socio-demographic diversity of California. While no pregnancy, birth or STI rate estimates for youth in foster care in California currently exist, a recent study suggests that pregnancy is common among youth in foster care in the state.[vii]

Table 2. Comparison of Sexual and Reproductive Health Outcome Among Youth in Foster Care and a Nationally-Representative Sample

	Mid-West Evaluation of Adult Functioning of Former Foster Youth	National Longitudinal Study of Adolescent Health
Pregnancy	50% of women had been pregnant by age 19 46% who had a first pregnancy had a subsequent pregnancy	20% of women have had a pregnancy by age 19 29% who had a first pregnancy had a subsequent pregnancy
Child bearing	32% of females & 14% of males had a child by age 19	12% of females had a child by age 19
STI testing and treatment	25% of 17 year olds reported having received STI testing or treatment	6% of 17 year olds reported receiving STI testing or treatment

Source: Courtney & Dorsky, 2006

Sexual risk behavior among adolescents in foster care

In the NSCAW study, 41% of youth in foster care reported having sex at 13 or younger and 68% reported using protection often or always. Similarly, comparison of the Midwest study with the National Longitudinal Study of Adolescent Health indicates that youth in foster care were more likely to engage in sexual intercourse at a younger age. However, other sexual behaviors, such as condom or birth control use or having multiple sex partners, did not differ greatly between the youth in foster care and other adolescents.[viii] For example, despite earlier engagement in sex, both male and female youth in foster care were less likely to have had sex recently, compared to the national sample. Males who had previously been in foster care demonstrated the same level of condom use and engagement in sex with a partner with an STI as the national sample. Females were more likely to report condom use at last sex and equally likely to have used birth control during last sexual intercourse, but were more likely to report having had a partner with an STI.

Access to reproductive health care and health education

Evidence suggests that, in general, children and adolescents in foster care are more likely to utilize emergency services for medical needs as compared to those who are not in the foster care system.[ix] Currently, no data exists regarding usage of or access to reproductive health services by California youth in foster care. Minors in California, including those in foster care, are eligible for confidential reproductive healthcare through Family Planning, Access, Care and Treatment (Family PACT). However, youth in foster care may not be aware of this resource or, due to frequent changes in placement, may lack knowledge of where to find a clinic or provider. Furthermore, youth, as well as caseworkers and foster parents, may not be aware of

adolescents' rights to consent to and receive confidential reproductive health care. As a result, youth may not feel comfortable accessing care or caseworkers or foster parents may provide inaccurate information about their rights.

California mandates that schools teach HIV/AIDS education and requires any sexuality education to be comprehensive, evidence-based and medically accurate.[x] However, due to frequent changes in schools, youth may miss sexuality or family life education courses. In addition, sexuality education curricula that emphasize abstinence or delay of sexual activity may not be appropriate for youth who are already sexually active.[xi] Curricula that do not acknowledge sexual orientation and the needs of lesbian, gay, bisexual or transgender (LGBT) youth may fail to provide effective information to a particularly vulnerable population of youth in foster care. While independent living programs may offer sexuality education, an assessment of such programs in three California counties found that participants were not required to attend and classes were not offered continuously throughout the year.[xii] Additionally, across these counties, there were no official policies to provide parenting youth with support or education to prevent a second pregnancy.[xiii]

Attitudes about sexual health risks and pregnancy

Youth in foster care report that they *are* aware of sexual health risks and the importance of prevention.[xiv,xv] However, they also report that youth experience peer pressure to have sex, commonly believe that a pregnancy or STI will not happen to them, or may be uncomfortable or frightened about discussing safer sex with a partner.[xvi,xvii] Within this context, foster youth and caseworkers in California also reported that early pregnancy is accepted among youth and their families.[xviii] Therefore, a pregnancy, while not necessarily desired, may not be perceived as a negative outcome.

Social support system

Youth, child welfare professionals, and foster parents report that youth in the foster system lack connections to and relationships with caring and trusted adults.[xix,xx] The study in California found a widely held perspective that youth in foster care may want a child to have a family to love or to create a family with a partner.[xxi] Participants of the NSCAW study who reported having peers that "get in trouble" were more likely to have had a pregnancy by age 19,[xxii] suggesting that not only the lack of social support, but the presence of negative influences, may be a risk factor for an early pregnancy.

Sexual and physical abuse and neglect

Youth in foster care are more likely to have experienced sexual and physical abuse and neglect, which may affect youths' sense of trust and safety around issues of sexuality.[xxiii] Survivors of sexual abuse are at increased risk of teen pregnancy and STIs, as well as related behavioral health outcomes, such as being younger age at first intercourse and engaging in risky sexual behaviors or substance use.[xxiv-xxv]

Mental health and substance use

Youth with a history of foster care placement are more likely to present with symptoms of anxiety and disruptive behavior and to have attempted suicide. They are also 50% more likely to have ever used alcohol and more than twice as likely to have ever used drugs.[xxvi] Mental health conditions and substance use may influence risk-taking behaviors and decision-making. In addition, because of mental health conditions or substance use, traditional approaches to sexuality education and reproductive health promotion may not be appropriate or sufficient to address behavioral or systemic challenges faced by youth in foster care.[xxvii]

Emerging Approaches in the Promotion of Sexual and Reproductive Health of Adolescents in Foster Care

Several states across the nation have begun to implement strategies to improve sexual and reproductive health outcomes among youth in foster care. The impact of these strategies has yet to be evaluated. However, the steps taken in these efforts provide ideas for strategies and lessons learned that could guide efforts in California at the state or local level.

Maryland: Using data to understand the sexual and reproductive health status of youth in foster care[xxviii]

Multi-level data collection and analysis is being conducted to produce a statewide profile of sexual and reproductive health of youth in foster care that will guide future policies and interventions.

- **Data analysis methodology to calculate birth rate –** Administrative and child welfare data was matched to calculate the statewide birth rate of adolescent women in foster care.
- **Focus groups with former male and female foster youth –** Participants were asked about the effectiveness of teen pregnancy prevention campaigns, attitudes towards sexual health and safer sex, and the resources needed to be healthy.
- **Survey of child welfare professionals –** Caseworkers were asked if they spoke with clients about sexual health issues, felt well-trained to engage in these conversations, and if their agency had a policy related to sexual and reproductive health.

Virginia: Using health education to inform youth and train caseworkers and foster parents[xxix]

A multi-level pregnancy prevention education program to work directly with youth in foster care and train adults who work with these youth was developed and implemented. To date, no evaluation has been conducted.

- **Evidence-based curriculum in foster group homes –** The 10-session Power Through Choices curriculum was co-facilitated by a child welfare worker and a public health professional to separate groups of males and females.
- **Workshops with foster parents –** Regularly scheduled training sessions were used to discuss topics such as how to speak with youth about sexuality.
- **Regional male health symposium –** Youth and male case-workers were invited to speak with child welfare professionals about effective approaches to engage male adolescents.
- **Statewide symposium for child welfare professionals –** Sessions were tailored for professionals and agencies prepared for different types of activities, such as policy planning for managers and the provision of individual counseling by caseworkers.

Massachusetts: Using legislation to mandate sexuality education for youth in foster care[xxx]

Health and child welfare agencies advocated for the state legislature to pass legislation in 2008 mandating that youth in foster care receive sexuality education and that the Public Health Department (DPH) and Department of Children and Families (DCF) work together to implement the law. Teen pregnancy prevention services include serving youth directly in foster care homes, educating foster parents, or integration of sexuality education into independent living programs.

- **Education and advocacy for state legislature –** Advocates created a brief to inform legislators about the sexual and reproductive health of youth in foster care, including national statistics and findings from key informant interviews with child welfare professionals and focus groups with youth.
- **DPH provided DCF with technical assistance –** Public health staff assisted with selection of appropriate curriculum, staff training and identifying relevant teen pregnancy prevention resources.
- **Implementation of evaluation data collection tool –** A question was added to the statewide sexuality education program evaluation survey that asks youth respondents if they are in foster care. Data will be collected on youth attitudes, knowledge, and behavior change.
- **Coordination at the community level –** A community liaison worked with community members and organizations to support local implementation of sexuality education strategies among youth in foster care.

Recommendations

Lessons learned from other states

Although the results of these efforts have not yet been determined, the strategies implemented in other states could be adapted and piloted in California. The lessons learned from the strategies in Maryland, Virginia and Massachusetts provide useful directions for individuals and organizations interested in working collaboratively to promote sexual and reproductive health of youth in foster care.

- **Create cross-sector partnerships.** The planning and implementation of each approach was led by partnerships of social services and public health agencies at the state and/or local level, group homes, foster youth-serving organizations, pregnancy prevention organizations, university researchers, and community representatives. Leaders from each agency or organization brought unique expertise and served as liaisons to their colleagues.
- **Take time to build understanding and trust between partners.** Working in partnership required being aware of differences in organizational goals and culture and taking the time to develop a common language, culture and trust among partners.
- **Provide appropriate training and technical assistance for partners.** Each state provided education to professionals, foster parents and policy makers so that they understood the importance of health promotion and how the foster care system functions. For example, public health professionals received training about the foster care system and child welfare professionals received training about sexual and reproductive health. Each group gained a better understanding of how to work with one another and the challenges of working within the foster care system and/or preventing pregnancy and STI's.
- **Reduce discomfort and stigma around adolescent sexuality and reproductive health by including discussion of individual's own beliefs and attitudes in all trainings.** Many child welfare professionals, foster parents, group home staff, and youth themselves were uncomfortable talking about sexual health issues. Acknowledging this discomfort and providing skills and information to overcome it was a critical aspect of program implementation.
- **Include youth perspectives.** Input from youth was essential to understand the needs of and issues that affect their sexual and reproductive health, as well as to guide the development of programs.

- **Use health education curricula or programs that are time limited.** Youth are frequently moved between placements. As a result, it can be difficult to conduct individual sessions with caseworkers or multi-session curriculums at group homes. Alternate venues for engaging youth, such as computerized training, should be explored.

Directions for California

Addressing the sexual and reproductive health of youth in foster care presents many challenges. Not only is there currently a lack of information to guide the development of new efforts, but the individuals and organization that work with youth in foster care and in health promotion already carry many responsibilities and often have limited resources. Similar to the strategies in other states, initial efforts in California to address sexual and reproductive health at the state or local level should include research and assessment, securing funding for planning and program development, and clarifying the roles and responsibilities of health providers, child welfare professionals, researchers, youth and their foster parents, and other service providers.

Research

- Collect and analyze data on youth in foster care. Specifically, conduct estimates of pregnancy, childbirth and STI rates among youth in foster care in California using representative samples from health and other administrative records.
- Examine other aspects of the sexuality of adolescents in foster care, including issues related to healthy relationships, sexual orientation, and gender expression.
- Examine how factors, such as mental health or substance use, influence sexual decisions and behavior and how to integrate information on these issues into sexual and reproductive health promotion.
- Provide assistance to organizations working with youth in foster care to evaluate programs and determine evidence-based or model practices.

Programs

- Health providers should conduct trainings for caseworkers and foster parents to be better equipped to promote sexual health and support youth to receive reproductive health care services.
- Make appropriate adaptations to sexuality education curriculum to ensure it meets the needs of different groups of youth, such as African Americans, Native Americans or LGBT youth. Reproductive health services and interventions must be responsive to their unique needs, cultural factors, and the effects of discrimination on their health.
- Child welfare professionals should increase the opportunities and support for youth to develop relationships with trusted adults with whom they can discuss romantic and sexual health issues.

Policies

- Clarify the consent and confidentiality rights of minors in foster care to seek reproductive health care.
- Create policies to affirm that all youth be informed of their right to express their gender identity and sexual orientation.
- Create and implement statewide data collection systems to document sexual and reproductive health outcomes among youth in foster care.
- Create local and state policies to ensure that youth in foster care receive sexuality education, such as requirements to integrate sexuality education into caseworker sessions, independent living programs, and/or other youth programs.

Who We Are

California Adolescent Health Collaborative (CAHC), a project of Public Health Institute (PHI), is a statewide public-private coalition of individuals and organizations that works to increase understanding and support of adolescent health and well-being in California.

CALIFORNIA ADOLESCENTHEALTH COLLABORATIVE
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Why We Are Here

The tremendous social, economic, and demographic changes that lie ahead place our state at an important crossroads. The challenge is to ensure that all of California's teens have the support they need for healthy development and a smooth transition to adulthood.

Resources

Fostering Connections: Improving Access to Sexual Health Education Policy. Recommendations to Enhance Success and Sustainability for Youth in Out-of-Home Care
The Virginia Roundtable on Teen Pregnancy Prevention for Youth in Foster Care: http://www.thenationalcampaign.org/fostercare/PDF/VA_FC_PolicyRecommendations.pdf

The National Campaign to Prevent Teen and Unplanned Pregnancy
http://www.thenationalcampaign.org/fostercare/

Midwest Evaluation of the Adult Functioning of Former Foster Youth
Chapin Hall, University of Chicago: http://www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth

Child Welfare Dynamic Report System
California Department of Social Services and University of California, Berkeley: http://cssr.berkeley.edu/ucb_childwelfare/

Center for Research on Adolescent Health and Development
http://crahd.phi.org/

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