

**SEXUAL AND REPRODUCTIVE HEALTH POLICIES
FOR ADOLESCENTS IN FOSTER CARE:
A LITERATURE REVIEW**

by

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ABSTRACT

Introduction: Adolescents are engaging in risky sexual behaviors, which result in high rates of STD infection and teenage pregnancy. These maternal and child health outcomes are indicative of the status of the sexual and reproductive health of adolescents and are of public health concern.

Background: Adolescents in foster care represent a sub-group of adolescents at high risk for teenage pregnancy and STD infection, due to the early onset of sexual activity, lower rates of condom usage, and intercourse with multiple sex partners. This population is medically underserved, although federal and state laws mandate Medicaid (health insurance) provision for children placed in foster care; however, policy plays a large role in how such laws are practiced.

Method: A literature review using seven databases and two search engines identified research/evaluation reports (with no time constraints) related to sexual and reproductive health policies for youth in foster care, utilizing 17 Boolean terms.

Results: Twelve relevant articles were identified. A 1987 article documented the existence of sexual and reproductive health policies for children in foster care in only nine states, and the other studies discussed practice and policy recommendations for improving the maternal and child health outcomes of adolescents in foster care.

Discussion: There is a lack of recent literature that documents the existence of sexual and reproductive health policies as they relate to youth in foster care, which suggests a gap of knowledge about the practice, research and policies governing sexual and reproductive health services. Furthermore, child welfare workers have expressed an increased need for explicit, written policies about their roles and responsibilities in the provision of sexual and reproductive health education and services.

Conclusion: There is a pressing need to dictate policies and appropriate funding, in support of explicitly meeting the sexual and reproductive health needs of adolescents in foster care. Multiple stakeholders need to foster communication and collaboration, in order to effectively research, develop and implement policies to better meet the sexual and reproductive health needs of adolescents in foster care. Further research on existing health policies, written guidance and additional training is necessary to enable practitioners to better address this public health need.

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PREFACE

This document is my thesis project for the conclusion of my joint Master of Public Health (MPH) and Master of Social Work (MSW) degrees at the University of Pittsburgh. Additionally, this report is an offshoot of my graduate internship at New York City's Administration for Children's Services- Office of Child & Family Health.

In completing this project, I am indebted to many people who helped me along the way, especially my entire Thesis Committee. Drs. Mark S. Friedman, Cynthia Bradley-King, Jeffrey Shook and Martha Ann Terry have been invaluable resources in guiding me throughout the thesis process. They have also been important sources of support for my academic and professional pursuits, and have kept my long-term career goals as the focal point of interest.

Most importantly, this thesis project would not have been conceptualized without the fortunate opportunity to intern with Director Beatrice Aladin of the Health Policy & Planning Unit at the NYC Administration for Children's Services. Under her direction, I contributed to the development of the agency's Sexual & Reproductive Health Policy for Adolescents in Foster Care. The project merged my interests in maternal and child health issues and child welfare populations.

1.0 INTRODUCTION

It is no secret that adolescents are engaging in sexual activity, often exhibiting risky behaviors, as evidenced with the 2007 ranking of the United States as having the highest teenage birth rate of any developed nation (Abma, Martinez, & Copen, 2010). These behaviors often impact rates of STD infection and teenage pregnancy, and ultimately affect maternal and child health which is an indicator of the health of a population; therefore, considering the high rates of sexual activity among adolescents in the United States, there is a need to address the sexual and reproductive health needs of all adolescents, including the provision of preventive services such as STD education, annual gynecological exams, and reversible contraceptive methods (Frost, 1998). Consistent with the sexual health challenges described above, the goals of Healthy People 2020 consider adolescent reproductive health to be a priority of high public health significance, noting the increased risks of pregnancy and STD infection in this population (Frerich et al., 2012).

Adolescents in foster care represent one particular sub-population that is at even higher risk of teenage pregnancy and STD infection. Research has demonstrated that youth in child welfare systems, and particularly those in foster care, generally experience worse physical, mental, social, and sexual and reproductive health (Hudson, 2012; Manlove, Welti, McCoy-Roth, Berger, & Malm, 2011; Risley-Curtiss, 1997). A 1990 study found that half of the surveyed youth who aged out of foster care indicated that they were not offered family planning services while in placement (Becker & Barth, 2000). Thus, the immediate goals of this thesis

project are to (a) describe the role of health policies in the sexual and reproductive health outcomes of youth in the child welfare system, highlighting gaps in knowledge, as priorities for future research; and (b) develop a survey tool for researchers, enabling them to support an informed decision-making process for policymakers, leadership, and practitioners.

1.1 HEALTH POLICY

Health policy is a subset of public policy. Although there is no absolute definition of public policy, a broad definition suggests that such policies are “authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others” (Longest, 2010), implying that health policies are public policies that pertain to health. The World Health Organization (WHO) expands upon this definition and states that:

Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people (WHO, 2013).

Therefore, this project will explore the role and need for an explicit health policy regarding sexual and reproductive health for adolescents in foster care.

1.2 SEXUAL AND REPRODUCTIVE HEALTH

In 1994, during the International Conference on Population and Development in Cairo, the following definition of reproductive health was adopted:

A state of complete physical, mental and social wellbeing and.... not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant ("Defining sexual health: report of a technical consultation on sexual health, 28- 31 January 2002, Geneva," 2006).

Further building upon this definition, and as a guide for the public health and public policy professions, a working definition of “reproductive health” was created during a 2002 Technical Consultation on Sexual Health. WHO reports that the Consultation expanded upon the definition by including,

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled ("Defining sexual health: report of a technical consultation on sexual health, 28- 31 January 2002, Geneva," 2006).

1.3 ADOLESCENTS AND SEX

According to the 2011 Youth Risk Behavior Surveillance System (YRBSS), almost half of all high school students indicated they had ever engaged in sexual intercourse, and about a third had sex during the previous three months leading up to the survey (CDC, 2012b). Of currently

sexually active respondents, more than one-eighth (12.9%) did not use any method of contraception to prevent pregnancy during their last sexual activity (CDC, 2012a). The 2011 YRBSS also reported that approximately 60% of currently sexually active high school respondents indicated they used condoms during their last sexual intercourse, with less than 10% condoms in combination with another method, such as birth control pills, Depo-Provera, Nuva ring, Implanon or any Intrauterine Device (IUD)(CDC, 2012b). Data from the 2006-2010 National Survey on Family Growth showed that among U.S. women, aged 15-19 years, nearly 70% were not using contraception, suggesting an increased probability of experiencing unintended pregnancies and STD infection (Jones, Mosher, & Daniels, 2012). Acknowledging that condom use is not perfect, the authors also suggested that there is a one in six chance that a woman will become pregnant within a year when relying only on the male condom as her sole form of contraception (Jones et al., 2012).

In addition to increased risks of unintended pregnancies, the inconsistent use of contraception and types of contraception used also impact the incidence rates of sexually transmitted diseases. The incidence rate of sexually transmitted diseases disproportionately affects this population, with young people (age 15-24 years) representing nearly half of the 19 million new STD diagnoses and about 8,300 young people (age 13-24 years) living with HIV (CDC, 2012a). In fact, about 25% of teenagers (ages 13-19 years) who are sexually active contract an STD (Risley-Curtiss, 1996).

In 2010, teenage women (ages 15- 19 years) delivered nearly 400,000 babies with a teenage birth rate of 34.2 live births per 1000 teenage women, accounting for approximately 10% of all births in the United States (Martin et al., 2012). Such high birth rates have a major impact on the maternal and child health status of the country. From 2000 to 2003, about 16.1% of

pregnant women under age 15 years and 7% of mothers aged 15-19 years did not receive prenatal care until their third trimester (if at all), thus increasing the chances of poor birth outcomes (Menacker, Martin, MacDorman, & Ventura, 2004). Amongst the various indicators of poor health outcomes, low birth weight predicts an increased risk of infection, illness, and infant and child mortality. Unfortunately, about 10% of adolescent mothers give birth to infants weighing less than 2500 grams (Crosson-Tower, 2013), compared to the average of 8% for all mothers (Martin et al., 2012). Yet, adolescent motherhood is not the only risk factor affecting the outcomes of these infants. Adolescent fatherhood also predicts a 13% increased likelihood of low birth weight, an 15% increased risk for premature birth, and a nearly a 25% increased risk of infant mortality (death within the first 28 days of life) (Reinberg, 2008).

In light of the prevalence of sexual activity among adolescents, their inconsistent use of effective contraceptive methods, and their high risk for STDs and pregnancy, it is necessary to educate adolescents about their sexual health and provide appropriate health care services that address the needs of this population. Written policy guides and ensures the provision of sexuality education and access to sexual and reproductive health services.

1.4 ADOLESCENT HEALTH POLICIES

On the basis of the right to health care, WHO has been supporting the promotion of policies that grant full and free access to sexual and reproductive health services, including sex education and contraception (Abbing, 1996). In the United States, a number of policies that affect the sexual and reproductive health of adolescents have been adopted in response to the high rates of teenage pregnancy (Crosson-Tower, 2013). These policies govern sex education and the right of minors

(under age 18 years) to give consent for certain health care services, without parental permission. However, individual states have the autonomy to make unique decisions with respect to the provision of sexual and reproductive health education for adolescents and medical consent laws for minors, unlike many developed nations in Europe (Roemer & Paxman, 1985). Through *parens patriae* (Latin for “parent of the nation”), states have the responsibility to protect the health and welfare of its citizens (Maradiegue, 2003). They have assumed the health policy role as educators, by governing and funding the schools where sex education is traditionally provided (Longest, 2010).

1.4.1 Sexuality Education

Many states adopted laws, regulations and other legally binding policies for the sexuality education of teenagers, after gaining public support due to public health concerns surrounding the high rates of teenage pregnancy and STD infection. Most often, sexuality education is found within the school setting, but the content of the curriculum varies by school districts (Besharov & Gardiner, 1997; Hudson, 2012). Currently, 20 states and the District of Columbia have policies that mandate both sexuality and HIV education in the public school curriculum (Guttmacher, 2012). Two other states mandate only sexuality education, while 13 others mandate only HIV education (Guttmacher, 2013c). However, the education provided may be inaccurate, with only 13 states requiring medically accurate and evidence-based information to be provided (Guttmacher, 2012). Information on condoms or contraception is required in 19 states, but more than twice as many states also require that abstinence be included when HIV education is taught, with over 70% of those states requiring that abstinence must be stressed (Guttmacher, 2013c).

Despite the increasing number of policies that regulate sexuality and HIV education in schools, many require some sort of parental involvement. In 35 states and the District of Columbia parents have the right to exempt their children from sex and/or HIV education (Guttmacher, 2013c), thus opening the opportunity for some adolescents to be misinformed or ignorant about the risks of unprotected sex. Some adults believe that children should not engage in sexual behavior, implying that there is no need to be exposed to any sexual and reproductive health education (Landry, Kaeser, & Richards, 1999; Roemer & Paxman, 1985). However, the absence of sex education does not mean that adolescents will abstain from sexual activity; instead, they will engage in riskier behaviors (Abbing, 1996; Lindberg & Maddow-Zimet, 2012; Mueller, Gavin, & Kulkarni, 2008) with unfortunate repercussions. Thus, in analyzing the existing sexual and reproductive health policies for adolescents in foster care, this thesis will also consider the role of sexuality education in meeting the needs of this population.

1.4.2 Medical Consent

The authority for minors to grant consent for health care has significantly expanded in the past 30 years, as public support spread for sexuality education in schools. In 1970, Title X of the Public Health Service Act established a national program of family planning clinics, and in 1978, it was amended to require that such clinics allow minors to assent to family planning services that included testing and treatment for sexually transmitted infections (Maradiegue, 2003), although the minimum age requirement varies by state. However, minors may refuse services since some states also grant physicians the right to inform parents that the child is seeking or receiving services (Guttmacher, 2013b). The District of Columbia and 21 states allow all minors to consent to such services, while the other states (except for North Dakota, Ohio, Rhode Island

and Wisconsin) have policies that grant the right to provide consent, to a select sub-group of minors (Guttmacher, 2013a). Those sub-groups are youth who are married, parents, pregnant or have ever been pregnant, and/or face a health hazard if she does not receive contraceptive services. For example, Florida, Illinois, and Maine do not explicitly allow minors to consent to services, but if the physician determines that it is medically necessary to receive contraceptive services, then the law allows them to assent (Guttmacher, 2013a). Similarly, eleven states (Alabama, Delaware, Hawaii, Illinois, Kansas, Mississippi, Nevada, New Hampshire, Pennsylvania, South Carolina, and West Virginia) have policies that provide eligibility requirements for minors to consent to contraceptive services. These requirements may include being a high school graduate reaching a certain age, receive a referral and/or reach a level of maturity (Guttmacher, 2013a). Therefore, there may be a large proportion of American adolescents who do not have access to sexual and reproductive health service; but an important component of addressing this barrier to health care includes enacting policies governing medical consent and confidentiality laws for the sexual and reproductive health of adolescents in foster care.

2.0 BACKGROUND

The Administration for Children & Families (ACF), under the Department of Health and Human Services (DHHS), has estimated that half a million children live in foster care and about half are adolescents (Gramkowski et al., 2009; Hudson, 2012; Kaplan, Skolnik, & Turnbull, 2009; Leslie, Kelleher, Burns, Landsverk, & Rolls, 2003; "Trends in Foster Care and Adoption- FY 2002- FY2011," 2012). Between 2002 and 2010, there was a 22% decrease with an estimated 415,000 children living in foster care on the last day of the federal fiscal year 2010 (which ended on 30 September 2010) and nearly two-fifths of these children are adolescents between the ages of 12 and 17 years ("Child Welfare Outcomes, 2007- 2010: Report to Congress," 2011). Child Protective Services determined whether to temporarily or permanently remove the child living in an abusive household (Hyde, 1997). Children in foster care have been removed from their parental home and legally placed in the custody of the state child welfare system for various reasons, including neglect, lack of adult supervision, abuse, abandonment or parent-child conflict (Benedict, White, Stallings, & Cornely, 1989; Manlove et al., 2011; Risley-Curtiss, 1997).

2.1 US CHILD WELFARE SYSTEM

Under the Social Security Act of the New Deal, federal funding for child welfare services began in 1935 (Boonstra, 2011), but the child welfare system has drastically changed over the course of

the last few decades. It is estimated that the federal government spends approximately \$23 billion per year to provide for children in foster care (Boonstra, 2011).

Initially addressed on a state level, the federal government became a key stakeholder in matters of child welfare when the Aid to Families with Dependent Children (AFDC) Foster Care Program was established in 1961 (Allen & Bissell, 2004). This program was established under Title IV-A of the Social Security Act and provided funding for states to provide care to the children living in AFDC-receiving households that had been deemed unsafe. Approximately 15 years later, the Child Abuse Prevention and Treatment Act of 1975 provided funding to prevent, identify, and treat child abuse and instituted mandated reporting of suspected acts.

Minor child welfare policy changes continued over time, with a focus on improving the quality of foster care, but major reform came in 1980 with the passage of the Adoption Assistance and Child Welfare Act (AACWA), which transferred the federal foster care program to the new Title IV-E of the Social Security Act. It continued to provide funding for abused and neglected children, but increased the emphasis on trying to keep children in the biological home through prevention and reunification efforts. In conjunction with Title XIX (which established the Medicaid program in 1965), this legislation significantly transformed the child welfare system by ensuring that children in foster care would be eligible to receive Medicaid- funded health care services (Allen & Bissell, 2004). Title XIX of the Social Security Act provides matching federal funds for programs that consider children in foster care, under Title IV-E of the Social Security Act, as an eligible group for medical assistance (Longest, 2010).

The Adoption and Safe Families Act of 1997 (ASFA) built upon the foundation of the AACWA and became the major governing legislation for the child welfare system, in response to the challenges faced by children in foster care. It reiterated that the foster care system was a

temporary resolution to the increased number of children affected by abuse and neglect, and these children needed a stable permanency plan (Allen & Bissell, 2004). Although 40% of adolescents are discharged from foster care with less than a year, approximately more than one-fifth have remained in foster care for more than three years ("Child Welfare Outcomes, 2007-2010: Report to Congress," 2011). Therefore, many children in foster care may enter adolescence while still living in foster care, with the average age of children in foster care at 9.4 years ("The AFCARS Report," 2012). Current legislation, Public Law 110-351: Fostering Connections to Success and Increasing Adoptions Act of 2008, calls for collaboration among child welfare systems, Medicaid, and the health care profession, but there continues to be a gap in service delivery (Leslie et al., 2010). It has been the most comprehensive legislation in more than a decade and provides funding for medical health coordination ("Opportunities to help Youth in Foster Care: Addressing Pregnancy Prevention in the Implementation of the Fostering Connections to Success and Increasing Adoptions Act of 2008," 2009).

2.2 DEFINITIONS

Two terms are essential to this thesis, in addition to the referenced definitions of 'health policy' and 'sexual and reproductive health.' Thus far, the terms "youth/adolescents" and "child welfare/foster care" have been used interchangeably, so for the purposes of this thesis, the definitions are provided.

2.2.1 Youth

The terms “youth” and “adolescents” refer to individuals in foster care, between the ages of 12 and 17 years, inclusively. The age of emancipation from foster care placement varies by state—this is when youth are no longer in the custody of the Commissioner [of the Administration for Children, Youth and Families under the U.S. Department of Health and Human Services] and have “aged- out,” but the age of majority/ recognized legal age of adulthood is 18 years, at which point the individual may choose whether to exit foster care. Some states emancipate all youth at the age of 18 years, while others may continue to offer services until age 21 (“Child Welfare Outcomes, 2007- 2010: Report to Congress,” 2011). As such, to enable appropriate comparisons across states, the recognized age of adulthood is 18 years. References to children also refer to this specific age group.

2.2.2 Foster Care

Youth in foster care placement represent a special population within the child welfare system.

According to the Federal Code 45 CFR 1355.20, the definition of Foster care is:

24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the State or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is Federal matching of any payments that are made (“Title IV-E of Social Security Act- Adoption Assistance and Foster Care Programs,” 2011).

Therefore, those who meet these criteria are considered to be in foster care and share a legal status, according to the government; yet they also share many other experiences that define them as a community. They are an explicit group of minors who may have been exposed to neglect, physical and/or sexual abuse, and maltreatment, thus sharing common characteristics, although not necessarily a geographical space (Manlove et al., 2011; McMurray, 2007). Furthermore, they may share a transitory lifestyle, due to prolonged stays in the system and multiple placements. These experiences have framed their common perspective and often link them together (MacQueen, McLellan, Metzger, Kegeles, & Trotter II, 2001).

As a group, their outcomes are also very similar and demonstrate disparities compared to their peers in the general population (Hudson, 2012; Jaudes, Bilaver, Goerge, Masterson, & Catania, 2004; Lewis, Beckwith, Fortin, & Goldberg, 2011; Risley-Curtiss, 1996; Schneiderman, Brooks, Facher, & Amis, 2007). Adolescents in foster care are more likely to drop out of high school, struggle with employment, suffer homelessness, enter the criminal justice system, and suffer mental and physical health problems (English, Morreale, & Larsen, 2003; Manlove et al., 2011; Schneiderman et al., 2007; "White Paper: Improving Outcomes for Older Youth in Foster Care," 2008). Most importantly, youth in foster care exhibit a greater prevalence of teenage parenting (Becker & Barth, 2000; Boonstra, 2011; Dworsky, Aherns, & Courtney, 2012). As such, although they may not share a geographical location, they are linked by the aforementioned federal code and its policies, and as a group, they have particular characteristics and needs that differentiate them from their counterparts outside the foster care system.

2.3 ADOLESCENT HEALTH POLICIES FOR FOSTER CARE

The child welfare system is entrusted with ensuring the safety of a child placed in the custody of the state and in foster care (Leslie et al., 2003; Schneiderman et al., 2007). However, at its minimum, this can mean treating and preventing child abuse and neglect (Schneiderman et al., 2007) and at its maximum, the child welfare system must also address the health needs of the child and pursue a permanency plan ((Leslie et al., 2003). Long before Title IV-E of the Social Security Act, some states adopted the latter definition of the role of child welfare and utilized Medicaid funding to pay for health care services for these children (Combs-Orme, Chernoff, & Kager, 1991; Jaudes et al., 2004; Leslie et al., 2003).

2.3.1 Health Insurance- Medicaid

Today, federal mandates under Titles VI-E and XIX of the Social Security Act and/or state regulations ensure that all children in foster care are Medicaid-eligible (Dworsky et al., 2012; English et al., 2003; Longest, 2010); however, some states do not enroll children who are in foster care for a short period of time, and they encourage kin foster parents to place children on private insurance policies (Geen, Sommers, & Cohen, 2005). Children in foster care represent less than 5% of all Medicaid- enrolled children (Rubin, Pati, Luan, & Alessandrini, 2005), but they account for 12.3% of Medicaid spending in that group (Geen et al., 2005), demonstrating their increased medical needs.

In an effort to reduce Medicaid costs, there has been an increasing trend of transitioning Medicaid programs to managed care (Leslie, Hurlburt, et al., 2003); however, there is a federal waiver that grants children in foster care an exemption from compulsory managed care

enrollment (Jaudes et al., 2004). Managed care plans dictate that enrolled members can see only specific providers; but youth are not aware that federal law allows them to seek sexual and reproductive health services from providers outside of their plan, who may be reimbursed by the state Medicaid program rather than the managed care program (Frost, 1998).

Youth have expressed a concern regarding confidentiality, because according to many of the plans, Medicaid reimbursement was available only upon reporting of clinical information. Therefore, the health status and medical diagnosis of adolescents in foster care must be disclosed to the insurance provider, before payment can be made (Frost, 1998). Oftentimes, the foster care agency also serves as the medical home, so access to this health information is technically available to those within the same entity.

In 2004, Jaudes et al. found that many children in foster care received a physical Medicaid card, which they could take to a provider of their choice. Yet it was noted that within a few years, it was possible that a separate Medicaid-funded, primary care-managed health care plan would be developed to explicitly serve this population (Jaudes et al., 2004). Some states like New York have already implemented such a system, wherein all services are provided within a network of providers enrolled in the managed care program, eliminating the need for a Medicaid card. This cost-cutting effort has, therefore, further limited access to outside sexual and reproductive health providers as youth in foster care also experience increasingly fragmented and inconsistent access to health care services (Gramkowski et al., 2009), often a result of the ever-changing rotation of their health care providers, due to changes in home placement (Leslie, Hurlburt et al., 2003).

2.3.2 Sexuality Education

The constant change in home placement not only causes changes in the health providers for these children, but it also affects other factors in their lives. Youth in foster care are subject to unstable housing, which impacts their school attendance. Therefore, they also end up missing classes, including the sexuality education that may be offered in that setting (Becker & Barth, 2000; (Young, 2010). As the major source of sexuality education in the United States, school curricula were often perceived as inapplicable to the home situations of youth in child welfare settings (Becker & Barth, 2000; (Hudson, 2012), so the youth chose not to retain the information. Youth in foster care indicated that the instruction assumed that the student had a parent with whom to further discuss matters of sexuality (Becker & Barth, 2000); however, many of them lack those connections. Children in foster care move around so much that it is difficult to develop and maintain relationships, so they do not have the privilege of sharing their concerns with a guardian and/or trusted adult.

Thus, some states have begun to develop other modes of educating youth in foster care about sexual and reproductive health. For example, California has a legislative mandate (AB 1127) that requires education on pregnancy prevention for youth in child welfare settings (Becker & Barth, 2000). This is in line with the Program Action developed at the 1994 United Nation's International Conference on Population and Development (ICPD), which calls for the "accurate, timely, and evidence-based" comprehensive sex education, both within the school setting and also outside of it (Boonstra, 2009).

2.3.3 Medical Consent

Children in foster care face a dilemma that affects their health. Parents still retain the right to make decisions about the medical health of their child, despite removal from the biological home and placement in the care of the state, unless the court has terminated parental rights. The ASFA introduced the possibility of terminating parental rights if the child had been in state custody for 15 of the past 22 months (Allen & Bissell, 2004), which affects approximately 15% of all children living in foster care ("Child Welfare Outcomes, 2007- 2010: Report to Congress," 2011). Regardless who has decision-making rights for children in foster care, the state is still responsible for the health of the child, whether parental consent is attained or not (Maradiegue, 2003). Thus, as in various social service delivery systems, the rights remain with the individual child, with the guidance of a court-appointed advocate. The source of medical consent for children in foster care varies, depending on the urgency of the medical care services; ultimately biological parents, foster care agency directors, and the courts may be involved in the decision-making process and give consent, based on the circumstances (Leslie, Hurlburt, et al., 2003).

Concurrently, adolescents in foster care are not excluded in the existing federal laws that allow minors to assent to STD testing and contraception. Therefore, those living in community foster homes have the right to seek and consent to sexual and reproductive health services, but those living within group homes and in treatment facilities may not be protected under the authority of those laws. Thus, there are a number of policies that may complement, supplement, or conflict with existing laws pertaining to the sexual and reproductive health care services of adolescents in foster care. Yet, for the purposes of this thesis, only policies that affect adolescents living in community foster homes and subject to the laws that entitle minors to the right to assent to sexual and reproductive health services will be considered.

3.0 METHODS

During the preparation of this thesis, numerous databases and search engines were searched for research/evaluation reports (with no year inclusion criteria) related to sexual and reproductive health policies for youth in foster care. To be included in this literature review, a study had to: (1) be published in English; (2) be an academic journal article, book, thesis, or published report by research institutes, advocacy groups, and professional organizations; and either (3) evaluate the existence or quality of policies governing sexual and reproductive health care needs of adolescents in child welfare systems; or (4) make recommendations regarding such policies.

3.1 SOURCES

Two search engines (Google Scholar and PittCat+) and seven academic databases were consulted. The databases were chosen based on their relevancy to the areas of public health and/or social work. Academic Search Premier and JSTOR contain multidisciplinary journals; Social Work Abstracts, SocINDEX with Full Text, and the Women's Studies International contain research in the social sciences (specifically social work and sociology). Most public health-related academic findings are listed in PubMed and in MEDLINE, which is a subset of PubMed. Multiple search engines and databases were utilized to search for literature on this topic, in order to ensure a comprehensive and systematic review of the existing literature.

3.2 SEARCH TERMS

An initial search was conducted in the PubMed database, which yielded results suggesting MESH Terms and Subject Terms of interest. Based on the results of each search, the terms were modified, until the search was exhausted and relevant articles were duplicated in the results. In total, 17 Boolean terms were utilized in all the search engines and databases. Listed in the order searched, Figure 1 (below) contains the list of search terms.

Boolean Search Terms	
1.	Foster care reproductive health
2.	(foster care) AND reproductive health
3.	((foster care) AND youth) AND (sexual and reproductive health)
4.	((foster care)AND youth) AND (sexual and reproductive health) AND (pregnancy)
5.	sex* AND (adolescents OR youth) AND (foster care OR child welfare)
6.	sex* AND (adolescents AND child welfare)
7.	sex* AND (adolescents AND foster care)
8.	(sexual and reproductive health) AND (adolescents OR youth) AND (foster care OR child welfare)
9.	(sexual and reproductive health policies) AND (adolescents OR youth) AND (foster care OR child welfare)
10.	(health policies) AND (adolescents OR youth) AND (foster care OR child welfare)
11.	(health policies) AND (adolescents OR youth OR children) AND (foster care OR child welfare)
12.	(health policies) AND (adolescents OR youth) AND (foster care OR child welfare) AND (sex*)
13.	(health policies) AND (adolescents OR youth) AND (foster care OR child welfare) AND (sexual)
14.	(family planning OR pregnancy OR sex education) AND (adolescents OR youth OR children) AND (foster care OR child welfare OR out-of-home care)
15.	(family planning OR sex education) AND (adolescents OR youth OR children) AND (foster care OR child welfare OR out-of-home care)
16.	(family planning OR sex education) AND (adolescents OR youth) AND (foster care OR child welfare OR out-of-home care)
17.	(contracep* services OR sex education) AND (adolescents OR youth) AND (foster care OR child welfare OR out-of-home care)

Figure 1. Boolean Search Terms (in order searched)

3.3 ACADEMIC DATABASES

Seven databases were also searched, using the Boolean Search Terms in Figure 1. Again, those searches yielded numerous results, covering a breadth of academic literature. The initial searched database was PubMed, and then the Boolean search terms were repeated throughout each database, yielding their own set of results (Table 1). Terms that yielded too many results were modified to narrow the search, but when too few results were found, the search was expanded. The more general the terms, the increased likelihood of returning thousands of results; as the search terms were narrowed, less articles were found. In the end, 12 of the 17 search terms yielded a manageable number of results across databases, and again were individually reviewed for relevance and duplicate citations.

Table 1. Database Search

<u>SEARCH TERMS</u>	Academic Search Premier	JSTOR	MEDLINE	PubMed	Social Work Abstracts	SocINDEX With Full Text	Women's Studies International
Foster care reproductive health	39985	1903	11558	67	119	4429	823
(foster care) AND reproductive health	8	1903	6	67	1	4	3
((foster care) AND youth) AND (sexual and reproductive health)	3	584	1	10	0	0	0
((foster care)AND youth) AND (sexual and reproductive health) AND (pregnancy)	1	445	1	9	0	0	0
sex* AND (adolescents OR youth) AND (foster care OR child welfare)	561	7333	271	2085	480	630	46
sex* AND (adolescents AND child welfare)	156	2926	127	1969	414	194	27
sex* AND (adolescents AND foster care)	72	1642	49	138	16	89	10
(sexual and reproductive health) AND (adolescents OR youth) AND (foster care OR child welfare)	8	1348	2	75	6	0	0
(sexual and reproductive health policies) AND (adolescents OR youth) AND (foster care OR child welfare)	58736	882	13148	16	154	5552	1192
(health policies) AND (adolescents OR youth) AND (foster care OR child welfare)	158	5345	10	1062	17	97	2
(health policies) AND (adolescents OR youth OR children) AND (foster care OR child welfare)	364	11218	72	3054	59	223	17
(health policies) AND (adolescents OR youth) AND (foster care OR child welfare) AND (sex*)	4	3024	1	80	3	5	1
(health policies) AND (adolescents OR youth) AND (foster care OR child welfare) AND (sexual)	3	2387	0	95	2	3	0
(family planning OR pregnancy OR sex education) AND (adolescents OR youth OR children) AND (foster care OR child welfare OR out-of-home care)	405	22069	754	3216	516	594	211
(family planning OR sex education) AND (adolescents OR youth OR children) AND (foster care OR child welfare OR out-of-home care)	134	19206	215	1167	179	248	118
(family planning OR sex education) AND (adolescents OR youth) AND (foster care OR child welfare OR out-of-home care)	34	9102	52	574	59	85	26
(contracep* services OR sex education) AND (adolescents OR youth) AND (foster care OR child welfare OR out-of-home care)	6	6832	15	374	36	20	13

3.4 SEARCH ENGINES

Although PubMed/MEDLINE were the first sources searched, two search engines were also consulted. Google Scholar allows one to conduct a multidisciplinary search through various scholarly works. These include journal articles, theses, books, abstracts and court opinions from academic publishers, professional societies, online repositories, universities and other web sites. The Google Scholar search results were filtered by date and limited to a 10-year time frame (1993 to 2013), due to the large number of results. Similar to Google Scholar, PittCat+ searches across the various resources available to the University of Pittsburgh but is limited to the University Library System’s digital catalog. Table 2 shows the results from both search engines.

Table 2. Search Engines

<u>SEARCH TERMS</u>	Google Scholar	PittCat+
Foster care reproductive health	50400	1353
(foster care) AND reproductive health	49800	3918
((foster care) AND youth) AND (sexual and reproductive health)	16700	580
((foster care)AND youth) AND (sexual and reproductive health) AND (pregnancy)	12800	428
sex* AND (adolescents OR youth) AND (foster care OR child welfare)	34600	55073
sex* AND (adolescents AND child welfare)	37100	22671
sex* AND (adolescents AND foster care)	39200	5619
(sexual and reproductive health) AND (adolescents OR youth) AND (foster care OR child welfare)	14100	2460
(sexual and reproductive health policies) AND (adolescents OR youth) AND (foster care OR child welfare)	13000	963
(health policies) AND (adolescents OR youth) AND (foster care OR child welfare)	34300	36013
(health policies) AND (adolescents OR youth OR children) AND (foster care OR child welfare)	30400	71231
(health policies) AND (adolescents OR youth) AND (foster care OR child welfare) AND (sex*)	19500	19337
(health policies) AND (adolescents OR youth) AND (foster care OR child welfare) AND (sexual)	19500	12444
(family planning OR pregnancy OR sex education) AND (adolescents OR youth OR children) AND (foster care OR child welfare OR out-of-home care)	104000	83323
(family planning OR sex education) AND (adolescents OR youth OR children) AND (foster care OR child welfare OR out-of-home care)	98400	60952
(family planning OR sex education) AND (adolescents OR youth) AND (foster care OR child welfare OR out-of-home care)	65400	34415
(contracep* services OR sex education) AND (adolescents OR youth) AND (foster care OR child welfare OR out-of-home care)	8710	18901

Organized by Boolean term searched, both Google Scholar and PittCat+ returned with thousands of findings that fit the search criteria. The titles of the results were skimmed to identify possible relevant sources, because there were too many articles. It was nearly impossible to read the abstract of each journal article, but once the title was determined to be a possible match, then the abstract was reviewed, to determine appropriateness for this thesis project further relevance. Additionally, these initial search engine results also helped identify some results that would later be redundant through the database searches and suggest a thorough search had been conducted.

4.0 RESULTS

The goals of this thesis were multi-fold, including (a) to identify available evidence of the existence and role of health policies in the sexual and reproductive health outcomes of youth in the child welfare system, highlighting gaps in knowledge, as priorities for future research; (b) to evaluate the role of sex education in meeting the needs of this population; and (c) to develop a survey tool for researchers, enabling them to support an informed decision-making process for policymakers, leadership, and practitioners. Therefore, considering the depth of the systematic review of literature surrounding the policies of interest, the search produced very few relevant findings. A total of 12 articles were identified that addressed the research questions posed by this thesis. An article was deemed relevant, if the title and/or abstract indicated that the literature evaluated the existence or quality of policies governing sexual and reproductive health care needs of adolescents in child welfare systems, or made recommendations regarding such policies. The articles were reviewed and revealed three main themes as strategies to address the sexual and reproductive health needs of adolescents in foster care: research, practice, and policy.

4.1 RESEARCH

All of the articles acknowledged the lack of research available on the topic of STD infection and teenage pregnancy amongst the foster care population (Boonstra, 2011; Hudson, 2012; James,

Montgomery, Leslie, & Zhang, 2009; Manlove et al., 2011; Risley-Curtiss, 1996, 1997; Young, 2010). Additionally, the sexual and reproductive health of adolescents in foster care was not noted as a research priority of published studies in social work/child welfare journals of the United States (Risley-Curtiss, 1996). More recently, interest has grown in the sexual and reproductive health status of adolescents in foster care, in order to inform the decision-making process and inform the strategies to reduce teenage pregnancy in this population (Manlove et al., 2011; Svoboda, Shaw, Barth, & Bright, 2012).

One study conducted telephone interviews that surveyed the child welfare agencies of 48 states, and inquired about the existence of sexual and reproductive health policies (Polit, White, & Morton, 1987b). Personal correspondence with the first author of this article did not reveal knowledge of other researchers with a focus on this topic area since that study. Another journal article stated that there was knowledge of only two previous studies that compared the risk of STI infection amongst youth in foster care to their peers (Ahrens et al., 2010). Even in 1996, a review of the literature found that only one article of seven studies specifically addressed the sexual and reproductive health of children in foster care (Risley-Curtiss, 1996). It was also noted that two studies in 1994 looked at the birth rates amongst young women who had aged out of foster care (Becker & Barth, 2000). Some studies explored the contributing factors to the high rates of adolescent pregnancy in this population (Boonstra, 2011; James et al., 2009). Those research studies validated the few existing studies and reiterated the demonstrated need for some sort of intervention in preventing adolescent pregnancy amongst adolescents in foster care.

4.2 PRACTICE

Existing reproductive and sexual health education curricula do not address the underlying factors that influence risk-taking behaviors of adolescents in foster care, including their desire for love and affection, the absence of a strong family support system, prior exposure to sexual violence and limited options for independence (Becker & Barth, 2000; Boonstra, 2011; James et al., 2009; Svoboda et al., 2012; Young, 2010). There is only one evidence-based sexual and reproductive health education program specifically for adolescents in foster care (Young, 2010).

Power through Choices was designed by the Family Welfare Research Group of the School of Social Welfare at the University of California at Berkeley, which received a three-year grant to develop an appropriate reproductive and sexual health curricula, targeting adolescents in foster care (Becker & Barth, 2000). They designed a 10-session prevention program focusing on the decision-making skills around sexual behavior, the identification of community resources, and the development of effective communication skills. Power Through Choices incorporated role-plays and interactive activities that revolved around a set of characters that intentionally reflected the diversity of adolescents in foster care. The educational curriculum's goal was to provide adolescents in foster care with a particular skillset that would decrease engagement in risky behaviors and the incidence of STD infection and teenage pregnancy.

Research also found that adolescents received limited health promotion and prevention services, with health providers talking only about barrier methods to contraception and excluding a discussion of HIV counseling and testing (Hudson, 2012). In 1996, despite the existence of legislation, only eight states provided contraceptive services to adolescents in foster care, and STD treatment was available in only five states (Risley-Curtiss, 1997). Since then, it has been

recommended that policy should enable health care providers to prioritize STD screenings for adolescents in foster care (Ahrens et al., 2010).

4.3 POLICY

A study of health policies of child welfare agencies in 48 states found that only nine states had formal written policies that attempted to meet the sexual and reproductive health needs of adolescents in foster care (Polit et al., 1987b; Risley-Curtiss, 1996). Many jurisdictions articulated a deliberate avoidance of the issue, because of its potential for controversy. Polit et al. (1987a) also found that only four of 19 states required caseworkers to attend trainings in adolescent sexuality. These trainings were also offered to foster parents in 29 states and attendance was mandated in five states. Approximately nine years after the 1987a study by Polit et al., Mayden (1996) reported a slight increase in the number of states reporting the existence of sexual and reproductive health policies for adolescents in foster care. Ten states had written policies (an increase of one state), about one-third of offered trainings for caseworkers, and 11 states had trainings for foster parents (Mayden, 1996; Risley-Curtiss, 1997).

The onus of providing additional supports and programming to existing community-wide services for adolescents in foster care lies on policymakers within the child welfare system, such as the Commissioners of the state foster care systems (Ahrens et al., 2010; Svoboda et al., 2012; Young, 2010). The Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) has caught the attention of various groups, including The National Campaign to Prevent Teen and Unplanned Pregnancy. It has made recommendations to incorporate sexual and reproductive health education and services as part of the implementation of the Act, on the

federal and state level ("Opportunities to help Youth in Foster Care: Addressing Pregnancy Prevention in the Implementation of the Fostering Connections to Success and Increasing Adoptions Act of 2008," 2009). In 2010, the DHHS allocated \$155 million for evidence-based teen pregnancy prevention programs. This funding encourages that the programs target 'hard-to-reach' populations, including homeless youth, those not in school, and adolescents in foster care (Boonstra, 2011).

5.0 DISCUSSION

The Child Welfare League of America (CWLA) has been at the forefront of addressing the sexual and reproductive health needs of adolescents in foster care. Since the early 1960s, it has made policy statements in support of sex education of or this population. In its 1964 CWLA Standards for Services of Child Welfare Institutions, it stated that “children (in foster care) should be given accurate and appropriate information about sex and should be helped to develop desirable attitudes and standards of sex behavior” (Sanctuary, 1971). This statement has been updated to reflect the need for collaboration by all parties, including biological parents, in meeting the sexual and reproductive health needs of these adolescents (CWLA, 1995). However, best practice in public health social work depends on research and evidence-based studies, which is lacking in this matter.

5.1 GAPS IN THE LITERATURE

The most obvious gap in research on sexual and reproductive health policies as it relates to youth in foster care is a lack of recent literature. Gaps in research also exist related to the few documented existing health policies, particularly regarding the effectiveness of the programs and interventions and their contributions to the health status of youth in and alumni of foster care. The Child Welfare League of America (2005) recommends that opportunities for leadership,

decision- making, and contributions to policy and program development be assured for youth in foster care (Kaplan et al., 2009); still, the existence of these documents should be explicitly recognized in state child welfare policy and related regulations. Additionally, gaps in service delivery also exist related to the lack of access to services and provisions currently offered under or mandated by federal and state law. Few states currently report details on their efforts to increase access and service delivery of sexual and reproductive health services for the youth placed in their care; therefore, there may be current efforts underway, but there is little literature to document them and effectively inform all stakeholders and policymakers about the current landscape of the sexual and reproductive health of adolescents in foster care. Several states have realized the need to address the health disparity among adolescents in foster care and are implementing various strategies, including research, program, and policy (Young, 2010). They have not been evaluated, but many of the interventions are in line with the recommendations of this thesis project in the conclusion.

5.2 IMPLICATIONS FOR RESEARCH

Thus far, the evidence supports the need for sexual and reproductive health services for adolescents in foster care. These services are technically available in many states, yet access to and knowledge of Medicaid coverage for these benefits is limited. Additionally, states may not be inclined to educate this population about the availability of these resources, because more adolescents may access them and increase the costs of the state's Medicaid spending. In light of the tight economic times, it may be a challenge to provide services (English et al., 2003) and evaluate the effectiveness of these policy implementations. As such, conducting further research

may reinforce the findings of this systematic literature analysis if policy changes are not effective immediately.

Increased accurate data collection and research should be conducted in this area, in order to gain a clearer picture of the scope of the problem. Of importance to note is that the YRBSS is conducted with high school students, which presents a limitation in its generalization to all adolescents in the United States (CDC, 2012b). The results of this survey exclude high-school aged teenagers who are not in school. Furthermore, the survey does not stratify the population by home placement status. As such, researchers have utilized multiple secondary sources to supplement their findings; yet, there is no one main source of data that provides a complete picture of the sexual and reproductive health status of youth in other settings and based on home status.

The methodological process for future research would include data collection from both primary and secondary sources. Primary data sources include surveys, questionnaires, focus groups and interviews. In utilizing these methods, the primary sources would provide both quantitative and qualitative data that address the research question of whether the youth have a knowledge base, access, and utilize the sexual and reproductive health services afforded to them, by virtue of the law and funding support through Medicaid.

5.3 IMPLICATIONS FOR PRACTICE

Despite funding access to health care services, the research has found that adolescents in foster care exhibit an increased likelihood of engaging in risky sexual behavior, which increases their risk for unplanned pregnancies and STD infections, including HIV/AIDS (Ahrens et al., 2010;

Hudson, 2012; Lewis et al., 2011). This may be due to high rates of sexual intercourse amongst this population and early onset of sexual activity, including consensual sex at age 13 or younger (Gramkowski et al., 2009; James et al., 2009; Risley-Curtiss, 1997). Adolescents with major family disruptions such as foster care placement are more likely to initiate sex before age 16, have lower rates of condom usage and increased teenage pregnancy rates (Perper & Manlove, 2009). Studies reported that more than half of teens in foster care were recently sexually active in their current home placement, and nearly two-fifths of the sexually active girls had experienced a pregnancy (Polit, White, & Morton, 1987a; Risley-Curtiss, 1997). Additionally, it is not surprising that teens with early sexual initiation tend to have multiple partners, which increases their chances of pregnancy (Abma et al., 2010; Ahrens et al., 2010).

Young women in the child welfare system have pregnancies at a younger age, compared to their peers not placed in the foster care system (Gramkowski et al., 2009); young women in foster are 2.5 times more likely than others to get pregnant by age 19 (Manlove et al., 2011; "Opportunities to help Youth in Foster Care: Addressing Pregnancy Prevention in the Implementation of the Fostering Connections to Success and Increasing Adoptions Act of 2008," 2009). Those in the child welfare system have high rates of running away, so for many of them trying to escape their housing situations, the idea of an older partner is very attractive. The latter usually represents independence, increased resources, and the potential for upward social mobility. In fact, amongst all teenagers, about 70% of pregnant women under age 18 were impregnated by men over age 20; and 25% of teenage fathers had older female partners (Males, 2010). The pregnancy outcomes of these adolescents are usually associated with poverty, low educational attainment status and poor health decisions (Svoboda et al., 2012), often times

because they have prematurely terminated their education, have limited employment skills, and lack the resources to access appropriate health care.

In addition to the aforementioned factors, teenage pregnancy amongst adolescents in foster care is also linked to family structure and previous history of sexual abuse; two studies found that about 60% of pregnant and parenting adolescents had been sexually assaulted (Males, 2010). A prior history of sexual assault and/or abuse was found to increase the likelihood that an adolescent would engage in drug and alcohol activity, thus increasing the likelihood of practicing risky sexual behaviors (Logan, Holcombe E., Ryan, Manlove, & Moore, 2007). Lastly, adolescent boys who have been sexually abused are usually at risk of also becoming perpetrators; in fact, it is believed that boys are the perpetrators of at least 50% of child sex abuse (Landry et al., 1999).

All those factors play a role in the way that child welfare workers conduct their practice, in light of these depressing outcomes. They are forced to accept the possibility that there is a high likelihood that the adolescents in their caseload may engage in these risky behaviors and experience pregnancy and/or infections, thus impacting their health status. Yet, youth in foster care may be unwilling to share information about their sexual health risk behaviors, for fear of the loss of privacy and having experienced the consequences of relaying personal events that resulted in removal from the home (Leslie et al., 2010). And as they transition out of care, they may also lose access to many of these services, thus preventing them from getting care, which was available while they were in foster care.

Similar to adolescent pregnancy, minorities are overrepresented in the foster care system (Svoboda et al., 2012); therefore, there is an increased need for culturally competent care in providing sexual and reproductive health services to those in foster care. Many social work

professionals have not been involved in the health care arena (Schneiderman et al., 2007), which provides an opportunity for lapses in communication and service provision. Child attorneys, Court Appointed Special Advocates (CASAs), youth advocates, and child welfare workers could play an integral role in advocating for increased access to the needed health care services. Multiple stakeholders need to increase communication and collaboration, in order to effectively serve the reproductive health needs of these adolescents (Schneiderman et al., 2007; Svoboda et al., 2012); these include, but are not limited to, the DHHS, the state child welfare agency, the state Medicaid system, the local/contracted child welfare providers, child welfare workers, individual health professionals, foster care parents, biological parents, and the youth in foster care.

5.4 IMPLICATIONS FOR POLICY

The responses of the youth are dependent upon the existing practices of the child welfare providers. There have been renewed calls to action, reports, lawsuits, data collection and commentaries, demonstrating the need for an honest conversation about this issue (English et al., 2003). Child welfare workers have expressed an increased need for explicit, written policies about their roles and responsibilities in the provision of sexual and reproductive health education and services (Svoboda et al., 2012). However, without such policies and appropriate training, many child welfare workers are unaware of and unable to inform the adolescents in foster care about their rights to certain health care services provided by Medicaid (English et al., 2003; Schneiderman et al., 2007). The lack of existing policy that regulates the data collection of the birth rate among adolescents in foster care (Svoboda et al., 2012) makes it difficult to measure

the extent of this problem. Thus, a change in policy would require that child welfare workers provide the necessary documentation, to inform further research and policy modifications (English et al., 2003).

6.0 CONCLUSION

Figure 2 shows the conceptual framework developed from the perspective of the public health social determinants of health, demonstrating the various factors that contribute to the pregnancy and STD infection rates of adolescents in foster care. The figure begins with the target population and provides a visual representation of the trajectory of outcomes when an explicit sexual and reproductive health policy is adopted. Based on the introductory and background research, a conceptual map was designed to show the associations between the various factors and their effects on the proposed outcomes of reducing unplanned teenage pregnancy and reducing STD infection rates. The intermediate outcomes, which would lead to these reductions in both incidence and prevalence rates, included the delivery of sexual and reproductive health education and receipt of timely and appropriate services. Therefore, the conceptual framework of the sexual and reproductive health status of youth in foster care served as a guide for this literature review.

(which includes focus groups and surveys) would also provide anecdotal evidence to substantiate the policy and practice recommendations.

The ability to support primary data with secondary sources strengthens the argument that the findings are valid. Some secondary sources include the Adoption and Foster Care Analysis and Reporting System (AFCARS), the National Child Abuse and Neglect Data System (NCANDS), Statewide Automated Child Welfare Information System (SACWIS), and the individual case files completed by the foster care agencies and the state agency. The AFCARS and NCANDS are two federally-sponsored, national welfare-related data systems that collect and analyze data on this particular population ("Child Welfare Outcomes, 2007- 2010: Report to Congress," 2011). Additionally, in order to compare the results of this study to adolescents who are not involved in the child welfare system, two potential secondary data sources are the National Longitudinal Study of Adolescent Health (Add Health) and the CDC's YRBSS. These sources would collectively provide data on the sexual and reproductive health needs of adolescents in foster care, and would supplement the initial research findings.

It is important to acknowledge that the recommended research study design may experience a number of limitations, because it proposes the discussion of a controversial topic - sexual and reproductive health for adolescents. Gaining consent from Institutional Review Boards and the governing child welfare agency would be significant barriers, because there may be concerns of confidentiality, especially when working with a special/ vulnerable population. However, an innovative approach to this assessment can be a major selling point—currently, there is a lack of knowledge surrounding this topic, so this would be a learning opportunity to determine whether the negative pregnancy and STD outcomes for youth in foster care can be addressed through the adoption of health policies.

Additionally, even if consent is given, maintaining confidentiality around sexual health and practices, along with individual responses would be another limitation—youth may not be willing to share information, unless a trustworthy relationship has been established. The expected low response and participation rate of the youth may be another limitation. Therefore, the researchers must be prepared to address those areas of limitations during the study design.

6.2 PRACTICE RECOMMENDATIONS

Youth in foster care need interventions that are specifically designed to address their particular needs, in light of their various disadvantages compared to their peers (Leslie et al., 2010; Perper & Manlove, 2009; Svoboda et al., 2012). The targeted policy and intervention should apply to all adolescents, including early and middle adolescents. Although the outcomes are not measured until late adolescence, it is suggested that research begin earlier, because the younger age group demonstrate lower risk-taking behaviors (Gramkowski et al., 2009) and may be more receptive to adopting healthy behaviors.

In some jurisdictions, youth are offered Independent Living skills training; the content of the workshops vary by locality and agency, covering such topics as job interviews, housing search, financial management and social skills (Becker & Barth, 2000). Sexual and reproductive health training may be offered in the Independent Living curriculum, depending on the facilitator. But the content varies, because there is no explicit existing policy dictating the provision of sexual and reproductive health education in the child welfare setting. As such, it is recommended that written policy require the inclusion of comprehensive sexual and reproductive health education in the life skills training curriculum for adolescents in foster care. Facilitators

should be comfortable in having conversations about sex with this population, in order to increase effectiveness of education (Becker & Barth, 2000). Therefore, it is of utmost importance that assets such as the Request for Proposal (RFP) made by The New York Community Trust, with the expressed goal to “Improve the Social Work Profession” are utilized, thus providing funding to train the child welfare workers about comprehensive sexual and reproductive health, so that they can effectively educate the target population.

6.3 POLICY RECOMMENDATIONS

Any attempt to address these issues and the sexual and reproductive health care needs of youth in foster care should involve a number of stakeholders. Clearly of utmost importance is the community itself: youth in foster care. Yet, as minors in the custody of the State, one of the most important stakeholders is the administration of the State child protective service agency, which must be included in the process, providing consent and ultimately adopting the policy recommendations for service provision. The list of stakeholders also includes medical health professionals who provide services to the youth, along with the local foster care agency staff (including case workers) who directly service the youth. The aforementioned parties all have a vested interest in this issue: the youth are directly impacted by the existence of the policy and access to service provision; the federal and state governments must develop, adopt, and implement the appropriate sexual and reproductive health policies; the practice of health care providers who interact with the youth will be affected by policy changes, and finally, the role of local foster care agency staff as the coordinators of care and advocates of the youth require knowledge and willingness to support the change.

Therefore, once the research results are determined and the findings are released, it is important to gain consensus about how to address the problem and what recommendations should be adopted. A sample group of adolescents in foster care should identify the pressing issues, with the most potential to impact their quality of sexual and reproductive health. A similar process should also be conducted with each individual group of stakeholders, so that they can also voice their opinions on the findings and make feasible recommendations. Once each group of stakeholders has reached a consensus about its priorities, then a community forum can be held, thus facilitating communication between all parties involved. This approach to consensus building helps each stakeholder know what is most important to the other stakeholders, and then they can begin the bargaining process to address the study findings and recommendations.

A potential concern of amending policy to increase knowledge and access to sexual and reproductive health services for adolescents in foster care is the expected increase in utilization rates of those particular services, thus increasing Medicaid expenditures. In many states, Medicaid budgets are facing fiscal challenges, so it is recommended that the policy should also incorporate funding available through the Maternal and Child Health Block Grant and the Title X Family Planning Services Program (English et al., 2003), thus alleviating the financial strain on Medicaid.

6.4 LIMITATIONS

There are several limitations to this study. The conclusion and recommendations of this thesis project are based upon the results of the literature review, which did not generate new findings

and ideas to the research topic of interest. Other limitations of this systematic literature review include the reliance on previously published research, the availability of the full-text of the findings, and the language exclusion criteria since the author was able to read only articles that were published in English.

Additionally, the cited research used to substantiate the need for sexual and reproductive health services, based on Medicaid utilization rates, may be inaccurate. The data may be overestimating the per-capita utilization rates, due to sampling bias that may misclassify and exclude children in foster care who don't use Medicaid as much (Rubin et al., 2005). Therefore, the statistics on which the argument for the existing need of this thesis project and its recommendations are based may be faulty and overestimate the health care needs of this population. On the other hand, this bias may also be underestimating the need, since it is unknown if the excluded children in foster care may actually express higher utilization rates, thus substantiating the need to address this issue (which is the more likely scenario).

6.5 SUMMARY

The federal government has been influencing “the placement, care and protection of children in foster care” (Allen & Bissell, 2004) through federal laws, regulations, administrative guidance and funding provision, for over 40 years (Allen & Bissell, 2004). Although teenage pregnancy is quite common amongst adolescents in foster care, little has been done to help prevent this outcome (Boonstra, 2011). Policy changes and reforms in the child welfare system are not common; however, systemic changes have been a result of advocacy, often in the form of class-action lawsuits and other litigation challenges (Allen & Bissell, 2004; Edwards, Bryant, & Bent-

Goodley, 2011). In the matter of sexual and reproductive health, policy changes would most likely occur when legal action is brought against the child welfare system; otherwise, public and political will to address the many needs of this vulnerable population is lacking (Edwards et al., 2011).

Without written government and agency policies, individual foster care providers decide how to enforce the federal and state laws concerning minors' consent to sexual and reproductive health education and services. There is the potential for individual providers to assert their own moral and religious beliefs regarding the matter, hindering appropriate education and undermining efforts to prevent teenage pregnancy and STD infections (Abbing, 1996). Therefore, there is a pressing need to dictate legislation, policies, and funding in support of explicitly meeting the sexual and reproductive health needs of adolescents in foster care.

APPENDIX

SAMPLE RESEARCH SURVEY QUESTIONS

- **Date:**
- **Contact Information**
 - Name
 - Title
 - Address:
 - Phone Number:
 - Email Address:
- **Jurisdiction**
 - State:
 - County:
 - City:
- **Foster Care Program Demographics**
 - Total Children Served:
 - Adolescents (ages 12-18 years):
 - Age of Maturation:
 - Placement Status:
 - Foster family homes:
 - Kinship Homes:
 - Group homes:
 - Emergency shelters:

- Residential facilities:
 - Childcare institutions:
 - Pre-adoptive homes:
- **Sexual & Reproductive Health (SRH) for adolescents, ages 12-18 years**
 - Average Total Pregnant Women:
 - Live Births:
 - Average number of children:
 - STD Infection Incidence (New cases):
 - Chlamydia:
 - Gonorrhea:
 - Syphilis:
 - HIV:
 - Herpes:
- **Health Laws, Regulations & Policies**
 - Age of medical consent for minors: _____
 - Existence of Written Health Policy: Y/N
 - Last Revision Date:
 - Existence of Written Policy governing sexual and reproductive health services for adolescents in foster care: Y/N
 - Last Revision Date:
 - Provision of Health Education (Check all topics covered):
 - Sexually Transmitted Diseases
 - Contraception
 - HIV Education
 - Abstinence
 - Family Planning
 - Rights to Medicaid-covered services
 - Medicaid- covered services (Check all that apply):

- Most FDA approved birth control methods, devices, and supplies (e.g., birth control pills, injectables, or patches, condoms, diaphragms, IUDs)
 - Emergency contraception services
 - Pregnancy testing and counseling
 - Screening and treatment for cervical cancer/ Pap Smear, urinary tract or female-related infections, and sexually transmitted diseases (STDs)
 - HIV counseling and testing
 - Counseling services related to preconception, family planning, pregnancy, informed consent, and STD/HIV risk
- **Medicaid Contact Information**
 - Name:
 - Title:
 - Address:
 - Phone Number:
 - Email Address:

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