



While the exact rates of teen pregnancy and teen childbearing among foster care youth are not known, research indicates that youth in foster care have higher rates of early pregnancy and childbearing than youth more generally. Even less is known about those youth who exit the foster care system prior to their 19th birthday and how they compare to youth that stay in foster care longer.

This *Science Says* research brief presents data on pregnancy and birth rates, sexual behavior, and the use of reproductive health services among youth in foster care. In particular, two issues are addressed: (1) how foster care youth compare to youth more generally on these measures, and (2) how older adolescents who remain in foster care fare compared with those who “age out” of the foster care system. (State policies determine whether or not youth remain in foster care beyond age 18. Each year approximately 20,000 adolescents in the foster care system begin living independently.)

Two primary sources of information are used throughout this brief: 1) A survey of 732 youth in Illinois, Iowa and Wisconsin who were in foster care at the age of 17 and had entered the system prior to turning 16, which was conducted by the Chapin Hall Center for Children (CHCC) between 2002 and 2004 (see the methodology section for more details on this survey) and 2) The National Longitudinal Study of Adolescent Health (Add Health).¹ Readers should note that, whenever possible, data from the youth in the foster care survey are compared to their peers in the Add Health survey to highlight similarities and differences between foster care youth and adolescents generally. Overall, CHCC’s survey reveals disproportionately high rates of sexual activity, pregnancy, and parenthood among these youth when compared to all teens. It is important to note that of the three states included in the CHCC study, at the time of the study only one—Illinois—routinely allowed youth to remain in foster care beyond age 18. This variation is used to parse out some of the differences in the sexual behavior and pregnancy and birth rates among youth who remain in foster care at age 19 compared with those who have exited the system.

Highlights

- By age 19, nearly half of young women in foster care have been pregnant, compared to a fifth of their peers not in foster care. Said another way, those in foster care are 2.5 times more likely than those not in foster care to have been pregnant by age 19.
- By age 19, 46% of teen girls in foster care who have been pregnant have had a subsequent pregnancy, compared to 29% of their peers outside the system.
- By age 19, young women in foster care are more likely than those not in foster care to have had sexual intercourse (90% and 78% respectively).
- Rates of contraceptive use were equal (65%) among sexually experienced teen girls within and outside of the foster care system.
- By age 17, foster care youth are twice as likely to have received family planning services as other youth (15% and 7.5% respectively).
- Compared to 19 year olds still in foster care, foster youth who aged out of the system at age 19 are more likely to have become pregnant at least once and to have received prenatal care. Those who left foster care are less likely than those still in foster care to have received family planning services and to have used contraception at all during the past year.

These data indicate that foster youth are more likely to become pregnant and have a child compared to teens in general. Moreover, at age 19 foster youth who leave the system are at higher risk for teen pregnancy and birth than both their peers who remain in the system and youth who have never been in foster care.

Pregnancy and Parenthood

Pregnancy

Several studies have found that foster youth are a high-risk population with respect to teen pregnancy. In the CHCC survey, nearly one third of the girls reported that they had ever been pregnant by age 17 (32.9%), compared to 13.5% of their Add Health peers. By the time of their second interview (age 19), nearly half of the females reported that they had ever been pregnant (48.2%), a significantly higher proportion than the 20% of 19-year-old females in Add Health. Said another way, by the end of their teen years, girls in foster care are 2.5 times more likely to have been pregnant than their Add Health peers (Figure 1).

It should be noted that, although the foster care survey sample includes a higher proportion of African American youth than did Add Health (African American girls currently have the highest teen pregnancy rate among major racial/ethnic groups), this factor

does not explain the higher proportion of pregnant girls among foster youth. Even after controlling for race, female adolescents in foster care had significantly higher rates of teenage pregnancy than comparable youth in Add Health.²

FIGURE 1: Pregnancy and Childbearing Among All Teen Girls and Teen Girls in the Foster Care System

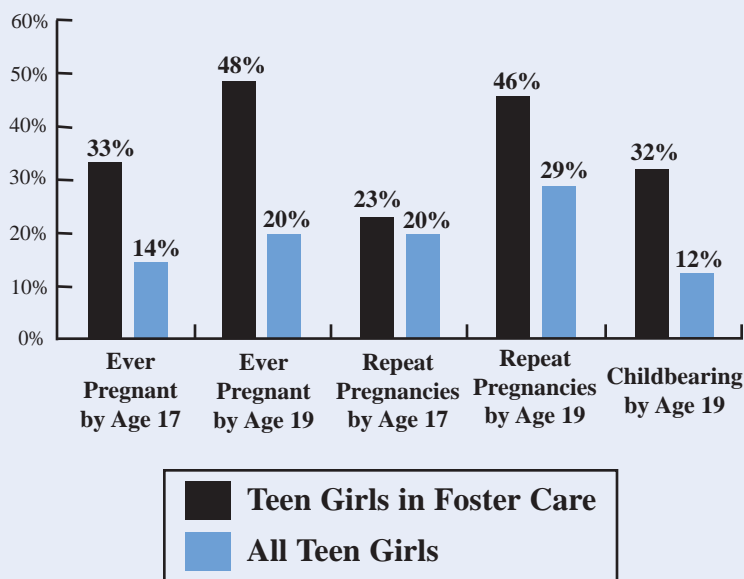
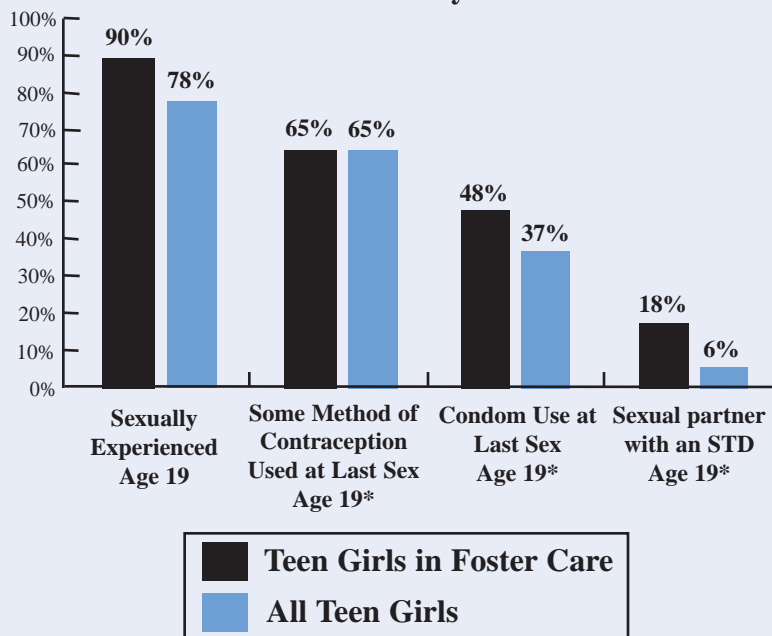


FIGURE 2: Sexual Behavior and Contraceptive Use Among All Teen Girls and Teen Girls in the Foster Care System



* Only Includes sexually experienced teens.

Repeat Pregnancies

The proportion of repeat pregnancies among young teen girls (those who reported a pregnancy by age 17) does not differ significantly between the foster care and Add Health groups. In both cases approximately one-fifth reported a repeat pregnancy (22.8% of those in foster care and 20.2% in Add Health). However, by age 19, girls in foster care were significantly more likely to report a second or higher order pregnancy (46%) than girls in the Add Health sample (29%, Figure 1).

Births

As noted earlier, youth in foster care have higher birth rates than other teens. The CHCC survey confirmed this - the 19-year-olds in the foster care sample were more than twice as likely as 19-year-olds in Add Health to have at least one child (31.6% compared with 12.2%). Older adolescent girls and boys in the CHCC and in Add Health surveys who did have a child were equally likely to be living with their child (Figure 1).

Sexual Behavior

- On measures of sex, contraceptive use, and sexually transmitted diseases, youth in foster care differ in some notable respects from their Add Health peers.

Compared with 19-year-olds in Add Health, girls in the foster care study were more likely to report having had sexual intercourse (89.8% compared with 77.9%). However, of those girls who reported having had sexual intercourse, rates of contraceptive use at last sexual intercourse were comparable in both studies (approximately 65%). When asked specifically about condom use, female youth (age 19) in foster care were more likely to report their partner used a condom the last time they had sexual intercourse than their Add Health counterparts (47.8% compared with 36.9% of Add Health teen girls). There was no statistically significant difference among the two groups in regards to consistent use of contraception during the past year. Young women (19 years old) in the foster care sample also were significantly more likely to report having had sexual partners with a sexually transmitted disease than those in Add Health. Fully 18% of foster care youth reported having had an infected partner during the past 12 months – over three times the percentage of Add Health’s young women (6%, Figure 2).

Reproductive Health Services

- The survey of foster care youth revealed that they were more likely to have received family planning services than teens generally. At age 17, approximately 15% of foster care youth reported having received family planning services, nearly twice as many as their Add Health counterparts (7.5%). Eleven percent of the foster care youth reported receiving family planning services between

ages 17 and 19. Young women in foster care who had been pregnant by age 19 were also more likely to have received prenatal care during their last pregnancy (70%) than Add Health respondents (62%).

Exiting Foster Care

- The CHCC survey allows not only for comparisons between youth in the foster care and those outside of that system, but also between foster youth and those who were previously in the system but exited foster care. At age 19, the time at which follow-up interviews were conducted, approximately 47% of the young adults in the CHCC study were still in care. In particular, interesting differences can be found in the use of health care services, as well as in the rates of parenthood and contraceptive use.

Health Care Services

- All individuals in the child welfare system receive Medicaid, and much attention has been directed at ensuring youth can access Medicaid-eligible services. Once youth exit the foster care system, however, securing health insurance and accessing health services becomes their responsibility. The CHCC survey found that, among foster youth who have exited the system by age 19, many have difficulty accessing care. Specifically, only 47% of those who exited foster care had health insurance at the time of the follow-up interview compared to 78% of 19-year-olds in Add Health. About one-fifth of foster youth who had exited care and Add Health youth reported that they failed to get needed medical care in the past year. This is considerably higher than the percentage of foster youth still in care who indicated that they did not get needed medical care in the past year (4.6%).

Reproductive Health Services

- Several indicators reveal that girls who have exited foster care have a greater need for reproductive health care than those still in the system. For instance, a higher percentage of girls who had left foster care reported getting pregnant (45% and 32% respectively) and having a repeat pregnancy (25% vs. 9% respectively) than their peers still in the foster care system. Interestingly, pregnant adolescents who had exited the system were more likely to have received prenatal or postpartum services than those still in foster care. The reasons for this discrepancy are unclear but suggest that some barriers to care exist in the foster care system for pregnant women. In contrast, 19-year-old males and females still in foster care were more likely to have gotten family planning services than their counterparts who had left the system (15.2% and 7.5% respectively). This difference persisted even when the analysis was limited to females.

Parenthood

- The proportion of teen parents among those still in foster care at age 19 (31%) and those who have left the system (32%) do not differ significantly. Only about half as many teen boys as teen girls reported having a child (15.1% of boys still in care and 12.7% of boys no longer in care). Of the boys who reported having a child, young men who left foster care (30%) were more likely than those still in care (5.6%) to be living with their child. Among females, 96% of those still in care reported living with their children compared with 90% of those females who had left care.

Contraceptive Use

- Among sexually experienced teens, patterns of contraceptive use between foster care youth and those who had exited the system vary. Those who had left the system were more likely to report not having used birth control at all during the past year (15%) than those still in the system (9%). Similarly, with respect to condom use, 20% of youth who had left care reported that they never used condoms compared with only 11% of those youth still in care (Figure 3). It is unclear the extent to which these disparities reflect risky sexual behavior as opposed to a deliberate attempt to have children. Data from the CHCC survey suggest that at age 19 over one-third of female foster youth who become pregnant wanted to become pregnant and more than one-half wanted to marry their partner. These indicators suggest that access to birth control alone may not be sufficient, in and of itself, to reduce teen pregnancy among this population.

Implications

The CHCC survey reveals disconcerting information about risky sexual behavior, teen pregnancy, and births among foster care youth that have implications for both those working directly with foster care youth and those focused primarily on preventing teen pregnancy.

Overall, foster youth have significantly higher rates of sexual activity and pregnancy than adolescents in the general population. Indeed, by age 19 nearly half of girls in foster care have been pregnant compared to about a fifth of their peers not in the foster care system. They are also more likely to have given birth and to have had subsequent pregnancies. This is explained in part by the fact that even though foster care youth are more likely to have received reproductive health and family planning services than other

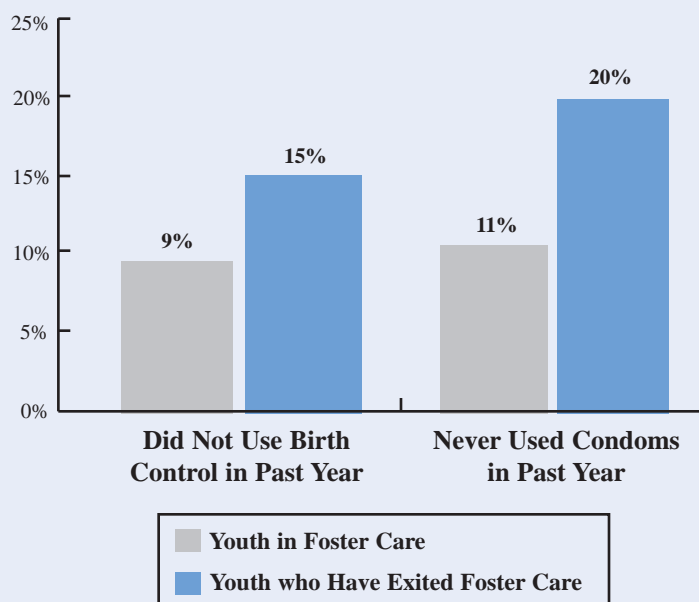
youth, they are no more likely to be using birth control than teens in the general population. Therefore, some type of barriers – logistical, attitudinal, or otherwise – are standing between these teens seeking services and taking steps to protect themselves from pregnancy. Because foster youth are more likely to have sexual intercourse than other teens, it seems particularly important to better understand and address these barriers in order to delay first sex and/or ensure sexually active teens use contraception consistently.

Ideas for addressing these barriers include the following:

1. More data are needed on teen pregnancy trends among foster care youth.

Although the data presented in this issue brief shed some light on the extent of teen pregnancy, parenting, and the sexual behavior of foster care youth, comprehensive and consistent data collection on these topics is lacking. Additional information would enhance understanding of the factors contributing to high rates of pregnancy and childbearing among

FIGURE 3: Contraceptive Non-Use Among Teen Boys and Girls (Age 19) Who Have Exited the Foster Care System and Those Still in Foster Care



foster care youth and those who have recently left the foster care system.

2. Pregnancy prevention programs for teens in foster care must start early and address both primary and secondary prevention.

By age 17, foster care youth already have higher rates of pregnancy than other teens, and this trend continues as they age. By age 19, women in foster care also are more likely to have had additional pregnancies than other teens. Clearly, efforts must begin early to help teens avoid becoming pregnant in the first place and to assist those who have already gotten pregnant to avoid subsequent pregnancies. (Given the prevalence of teen pregnancy and childbirth in this population, ensuring the use of prenatal care is an essential step in supporting good health for adolescents in foster care and their children.) The teen pregnancy prevention and child welfare fields should work together to help provide wide-ranging education about sex, love and respectful relationships.

3. Programs that focus on teen pregnancy should be evaluated specifically for their effectiveness with foster youth.

Although numerous programs have been shown to be effective in reducing teen pregnancy, improving contraceptive use and delaying sex, none have been evaluated specifically with foster youth. Testing their effectiveness with this population in particular would contribute to an understanding about what works and for whom.

4. More emphasis should be placed on motivations to avoid pregnancy.

Data indicate that even though foster care youth receive reproductive health services at higher rates than other teens, they are not more likely to use contraception and do not use it any more consistently. In fact, they are more likely to have sex, get pregnant and have a baby than the general adolescent population. One key piece that seems to be missing for these teens is the motivation to take steps to avoid pregnancy. Programs need to take this into account and address the complexities of what drives teens to

avoid becoming parents too soon. It is important to consider some of the unique issues facing many foster teens, including difficult or non-existent relationships with their parents, inconsistent relationships with other caregivers, and histories of sexual abuse. Programs also should consider the desire and motivation that many foster care youth have to become parents at an early age and encourage teens to delay sexual activity, pregnancy and childbearing until they are older.

5. Efforts need to address boys and young men as well as young women.

Although girls have traditionally been the major focus of efforts to prevent teen pregnancy, the importance of targeting teen boys and young men has been increasingly recognized by those who work with youth. One of the many reasons for this new focus is that the substantial reductions in teen pregnancy and birth rates in recent years can be attributed, in part, to dramatic shifts in the sexual behavior of boys. Those working with foster youth should make sure that programs, materials, services or messages about pregnancy prevention focus on boys and girls.

6. Service providers who work with foster parents and youth need support and training on addressing teen sexual behavior.

Even the best intentioned caseworkers and other child welfare providers will be reluctant to counsel youth on sexual health issues if they don't feel equipped to do so. Training these providers on topics such as adolescent development, and teen sexual behavior and attitudes will enable them to engage with teens around these issues more effectively and comfortably.

7. The fields of teen pregnancy prevention and foster care should seek opportunities for collaboration.

Most of the suggestions listed above can only be successful if practitioners and other leaders in child welfare and teen pregnancy prevention professionals collaborate. There are substantial overlaps in clientele and in goals for those clients, making partnerships beneficial not only for professionals working in those fields but also for the teens they serve.

Methodology, Background, and Limitations

CHCC Study

Researchers at the Chapin Hall Center for Children interviewed 732 youth between 2002 and 2004 in Illinois, Iowa and Wisconsin who were in foster care at the age of 17 and had entered the system prior to turning 16 years of age. Nearly two-thirds of them reported a history of neglect, and one-third reported physical or emotional abuse. About three-quarters of study participants came from single-parent homes, and over 70% reported that their primary caregiver suffered from one or more problems such as alcohol or other drug abuse, mental illness, domestic violence, or inadequate parenting skills.

When the state removes a child from a home due to abuse or neglect, he or she is placed in family-based or group out-of-home care settings. At the time they were first interviewed at age 17, two-thirds of study participants were living in a traditional foster home with non-relative foster parents or in a foster home with relatives. Another 18% were living in a group home or residential treatment facility. The goal of the foster care system is permanent placement for youth. Typically, this means returning children to their biological parent's home or allowing them to be adopted by relative or non-relative caretakers. In the case of older youth in foster care, these goals are much less likely to be achieved. Indeed, the youth in this study consisted of adolescents at risk of "aging out" of the foster care system - that is, hitting the age eligibility ceiling before ever receiving a permanent placement.

CHCC vs. ADD HEALTH

Comparisons are made between CHCC's sample of young adults and a nationally representative sample from the National Longitudinal Study of Adolescent Health ("Add

Health"). Add Health is a federally funded study that examines how social contexts (families, friends, peers, schools, neighborhoods, and communities) influence the health-related behaviors of adolescents. In-home interviews were completed with a nationally representative sample of students in grades 7 through 12 in 1994 and then again, with these same adolescents, in 1996. Study participants were interviewed a third time, when they were 18 to 26 years old in order to explore the relationship between adolescent health behaviors and young adult outcomes. In this issue brief, comparisons are made between the youth in the foster care sample and two waves of youth in the Add Health survey. When comparing statistics for 17 and 18 year olds, the first wave of Add Health data is used. For comparisons of 19 year olds, data from the third wave of data collection are used.

In terms of gender, the percentage of boys and girls in the foster care survey and Add Health survey were nearly the same (50.2% boys and 49.8% girls in Add Health, and 51.5% boys and 48.5% girls in the CHCC foster youth survey). However, the two surveyed groups differed demographically in several important respects. Over half of the youth in the CHCC study are African-American (57.3%) and mixed race youth (9.8%), compared with 18% African-American and 11% "other" or multiracial youth in Add Health. Moreover, less than 10% of the foster youth identified themselves as Hispanic (8.6%), compared with 11.7% of the Add Health sample. And, although 82.2% of the foster youth were enrolled in school at the time of the interview, several indicators suggest that many were struggling in school. For instance, nearly half had been placed in special education classes, and they were more likely to have repeated a grade, been suspended, and been expelled from school than their Add Health peers.

Comparison Limitations

While the CHCC study is the largest of its kind to date, its limitations should be considered when interpreting study findings. The population of older adolescents in states other than Illinois, Iowa and Wisconsin may differ in significant ways from those participating in the CHCC study. Although the study has a relatively large sample compared to other studies of foster youth, the sample is nevertheless not large enough to provide very precise estimates of very rare events, such as some sexual risk behaviors. Finally, while the CHCC study provides valuable information about the pregnancy and birth rates, sexual behavior, and the use of reproductive health services of the study participants, the study was not specifically designed to study these topics in detail. Finally, it is very important to consider that this analysis compares a large national sample to a smaller one limited to three Midwestern states. This limits the extent to which findings can be generalized and considered valid in a larger context.

Endnotes

- ¹ National Longitudinal Study of Adolescent Health, conducted by the Carolina Population Center at the University of North Carolina, Chapel Hill is a nationally representative study that explores the causes of health-related behaviors of adolescents in grades 7 through 12 and their outcomes in young adulthood. Add Health seeks to examine how social contexts (families, friends, peers, schools, neighborhoods, and communities) influence adolescents' health and risk behaviors.
- ² The Add Health figures were weighted to account for the fact that the racial and ethnic distributions in the two samples were different. The race weights were computed by dividing the percentage of the CHCC Survey youth who identified themselves as belonging to a particular race by the percentage of Add Health youth who identified themselves as belonging to that same race. For example, 57% of the CHCC Study youth were African American compared with 18% of Add Health youth. The weight assigned to each African American youth in the Add Health sample was $57/18=3.2$. A weight based on Hispanic ethnicity was similarly calculated. The adjustment by race was based on the race-ethnicity specific weight.

About Chapin Hall Center for Children

Chapin Hall Center for Children at the University of Chicago is a policy research center dedicated to bringing sound information, rigorous analysis, innovative ideas, and an independent multidisciplinary perspective to bear on policies and programs affecting children.

About the National Campaign to Prevent Teen Pregnancy

The National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan organization supported largely by private foundations and donations. The National Campaign's mission is to improve the well-being of children, youth, and families by reducing teen pregnancy. The National Campaign's goal is to reduce the teen pregnancy rate by one-third between 2006 and 2015.

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