SEXUALITY EDUCATION NEEDS ASSESSMENT AND CURRICULUM FOR YOUTH LIVING IN OUT-OF-HOME PLACEMENTS

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PROJECT

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Division of Social Work
Abstract

of

SEXUALITY EDUCATION NEEDS ASSESSMENT AND CURRICULUM FOR YOUTH LIVING IN OUT-OF-HOME PLACEMENTS

by

Randilee Ann Groff

Every year in the United States, hundreds of thousands of adolescent females become pregnant. Teenage pregnancy is particularly detrimental for marginalized populations (Healthy Teen Network, 2008), such as youth living in out-of-home placements, including both formal and informal foster care. This population is at an elevated risk for pregnancy and for contracting sexually transmitted infections because of a variety of factors. For youth in out-of-home placements, multiple school and residential placement changes often contribute to a lack of access to accurate information and education which is detrimental to their current and future sexual health. This project consists of two parts which examine and address the specific needs of this population. The first part of the project includes a needs assessment based on secondary data collected by the Placer County Health and Human Services Department. The second part of the project is a curriculum entitled I Can..., which is based on the findings of the needs assessment. This project is particularly significant for professionals who work with youth in a variety of
contexts and has important implications for the provision of sexuality education to youth living out-of-home.

______________________________, Committee Chair
Joyce Burris, Ph.D.

______________________________
Date
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Chapter 1

THE PROBLEM

Introduction

Every year in the United States, hundreds of thousands of adolescent females become pregnant. In 2007, the most recent year for which statistics are available, approximately 445,000 young women, age 15-19, experienced pregnancy (United States Census Bureau, 2010). In contrast to past historical trends in which pregnancy and marriage were considered an acceptable rite of passage for young men and women pregnancy is often unintentional among young women in this age group (Lindenmeyer, 2002).

Teenage pregnancy is particularly salient for marginalized populations (Healthy Teen Network, 2008). Perhaps the most marginalized group of adolescents is those living in out-of-home placements, including formal foster care, residential care, kinship care, non-related legal guardian care, and informal foster care. This population is at an elevated risk for pregnancy and for contracting sexually transmitted infections because of a variety of factors, including disruption in family and peer lives, higher rates of physical and sexual abuse, and emotional and behavioral difficulties (Centers for Disease Control [CDC], 2009b). Although billions of federal dollars have been allocated to provide abstinence-based sexual education in public schools, no federal mandate exists which requires these schools to teach comprehensive sexual education, despite evidence that abstinence-only programs lack effectiveness (Advocates for Youth, 2008). On the
contrary, multiple studies have cited the effectiveness of comprehensive sexuality education in reducing teen pregnancy by as much as 50% when compared with abstinence-only sexual education (Kohler, Manhart, & Lafferty, 2008). One study cites more than one dozen comprehensive school and community-based programs and curricula which have been effective in delaying first sexual encounter, increasing condom use, and decreasing teen pregnancy rates (Inman, Van Bakergem, LaRosa, & Garr, 2011). For youth in out-of-home placements, multiple school and residential placement changes often contribute to a lack of access to accurate information and education, which is detrimental to their current and future sexual health.

**Background of the Problem**

Over the past 30 years, cultural perceptions about teen pregnancy in the United States have evolved dramatically. Teen pregnancy has not always been viewed as a catastrophic social problem. From a historical viewpoint, starting a family at a young age was a common theme among young men and women, as family production was important for the sustainability of the agricultural lifestyle (Teen Pregnancy, 2008). Prior to this time, the Comstock Act prohibited postal mail distribution of information about human sexuality and reproduction. The final remnants of this legislation were not repealed until around 1970 (J. Burris, personal communication, January 31, 2011). Many additional social, political, and economic shifts have occurred throughout the last two centuries which have resulted in many young men and women having the capacity and choosing to delay marriage and childbearing (Lindemeyer, 2002).
A societal point-of-view casting teen motherhood as immoral was a driving force in the welfare reform of 1996, and it continues to be a commonly held belief that teenage girls who have sex and become pregnant have loose morals. The classification of this issue as a significant social and moral problem initiated a series of efforts on a national level (Teen Pregnancy, 2008). The federal government began to allocate funds toward the creation and implementation of programs and curricula intended to address the “epidemic” of teen pregnancy in the late 1980s and early 1990s. These efforts were proven successful, as pregnancy rates among this population decreased dramatically between 1990 and 2005 (CDC, 2009a; Collins, Alagiri, & Summers, 2002; Child Welfare League of America [CWLA], 2008; Hamilton, Martin, & Ventura, 2007; Healthy Teen Network, 2008). However, hundreds of thousands of young women continue to experience unintended pregnancy in the United States each year, and this figure presents a cause for concern.

Research indicates that adolescents who become parents are at higher risk for a variety of social, educational, and economic problems, as are the children born to young moms (CDC, 2009a; CWLA, 2008; Constantine & Nevarez, 2003; Mendes, 2009). Young women who become mothers are less likely to graduate from high school and attend college than are adolescent females in general. Education levels impact the earning potential for young parents, and many are at a distinct disadvantage because of the disruption in education that often occurs at the onset of parenthood (Constantine & Nevarez, 2003). Young men who impregnate adolescent females have been shown to
achieve lower educational attainment and lower earning capacity throughout their lifespans, and this lower earning capacity contributes to higher poverty levels among this population (CDC, 2009a; Constantine & Nevarez, 2009).

The children of teen parents face multiple barriers that are less common among children born to women of older maternal age. Children of teen moms have higher pre-term birth and infant death rates, and are more likely to experience a variety of emotional and behavioral issues, including impulsivity, anxiety, low self-esteem, and cognitive delays (CDC, 2009a; Constantine & Nevarez, 2003; National Campaign to Prevent Teen and Unplanned Pregnancy [NCPTUP], 2008). Children born to teen moms are also more likely to become teen parents themselves, and the cycle of teen parenthood is often repeated throughout many generations (Meade, Ickovics, & Kershaw, 2008).

The social and financial costs of teen pregnancy are substantial. Financial costs to taxpayers are reflected in increasing budgets for child welfare, due to young women in foster care becoming pregnant, as well as the greater likelihood of children of teen parents entering foster care at some point in their lives. Hoffman (2008) estimated that taxpayers paid $2.3 billion in child welfare costs due to teen pregnancy in 2004 alone. The figures for 2008 show a decrease in the cost of teen pregnancy to taxpayers. Constantine, Jerman, and Nevarez (2010) estimated that adolescent parenting cost taxpayers $1.1 billion in 2008, which includes lost tax revenue of both teen parents and their children upon reaching adulthood as well as foster care and incarceration costs.

However, each of these studies utilize different parameters for measurement, making it
difficult to discern whether the societal cost of teen pregnancy have increased or decreased in recent years. Regardless of the fluctuation in societal expense, teen pregnancy continues to represent a significant financial burden on American taxpayers.

The number of children living in foster care in the United States has increased rapidly in recent years (American Academy of Pediatrics, 2002; National Kids Count Program, 2009). As of 2006, there were approximately 733,000 children in formal foster care in the United States (National Kids Count Program, 2009). It is estimated that this number would be much higher if youth living in informal foster care arrangements were included in this figure (Pecora et al., 2003).

A variety of factors are involved in determining why youth living out-of-home experience higher pregnancy rates, all of which are related to particular challenges that these youth face. Youth living in foster care arrangements are more likely to have been diagnosed with a psychological disorder (Courtney & Dworsky, 2005; Dworsky & Courtney, 2010; Pecora et al., 2003) and to experience alcohol and substance abuse (Courtney & Dworsky, 2010). These youth also lack long-term, stable, and trusting relationships with adults, which are said to greatly impact an adolescent’s risk for early pregnancy (Love, McIntosh, Rosst, & Tertzakian, 2005).

Although statistics for pregnancy rates among this population are lacking, multiple studies have confirmed that youth living in foster care are more than twice as likely to get pregnant by age 19 than same-age youth who are not in foster care (Becker & Barth, 2000; CWLA, 2008; Dworsky & Courtney, 2010; NCPTUP, 2006, 2009). The
many challenges faced by youth living in out-of-home placements are further compounded by unintended early pregnancy, and demonstrate a clear need for an effective method to address this issue. It stands to reason that population-specific sexual education curriculum which addresses the specific barriers and concerns of this population would meet the sexual health needs of youth living in out-of-home care.

**Statement of the Research Problem**

The lack of federal and state regulations that mandate sexual education in schools, coupled with the myriad of risk factors that youth in out-of-home placements face, put this population at particularly high risk for unintended early pregnancy.

**Purpose of the Study**

This researcher will utilize data gathered by Placer County Health and Human Services assessing the sexuality education needs of youth living out-of-home. The purpose of this study is to analyze secondary data and utilize these findings, derived from youth living in out-of-home placements in Placer County, integrated with research findings, to produce a sexual education curriculum that meets the needs of this population.

**Theoretical Frameworks**

Theoretical frameworks provide an important lens for understanding and addressing issues such as teen pregnancy. This study will take into account multiple theories for the analysis of teen pregnancy and the creation of a sexuality education curriculum. According to Social Learning Theory, behavior is learned through observing
models, particularly parents and other adult authority figures, who demonstrate what “good” and “bad” behavior looks like. Children gradually observe this behavior over time and eventually internalize expectations and standards of conduct based on their observations (Zastrow & Kirst-Ashman, 2010). Behavior is modeled and learned in educational and home settings, as well as within the context of close relationships with significant adults and peers. Because foster youth often lack consistent relationships with positive parental or adult figures, they may depend more heavily on schools or peers to fill in the gaps (Constantine, Jerman, & Constantine, 2009). For these reasons, it is useful to examine the issue of teen pregnancy through the Social Learning perspective in order to better understand what the sample population perceives as important in sexuality education.

Systems Theory and the Ecological Perspective provide further insight into understanding and effectively preventing adolescent pregnancy. According to Systems Theory, individuals function within multiple systems, and each of these systems should be taken into consideration when examining and addressing a specific problem (Greene, 2008). Theorists, using the Ecological Perspective, assert that there are three levels of systems that both influence the individual and are influenced by the individual. These include the microsystem, or all activities, roles, and relationships that exist at the interpersonal level; the exosystem, which encompasses smaller groups and communities with whom one interacts; and the macrosystem, which includes the larger-scale systems, such as culture, institutions, society, and policies that influence large organizational units.
in society (Greene, 2008). Together, Social Learning Theory and Systems Theory and the Ecological Perspective provide a comprehensive lens through which to view the problem of teen pregnancy among youth in out-of-home placements, and the researcher intends to integrate principles of these theories into the curriculum.

Assumptions

Multiple research studies have demonstrated a myriad of social, economic, and emotional problems that are often experienced by individuals who become pregnant as adolescents, as well as these children of teen parents. Due to the lack of familial support, many youth living out-of-home who become pregnant are more likely to end up relying on government assistance to meet their essential needs. As a result, teen pregnancy is viewed by this researcher as a significant social problem the profession of social work has an obligation to address. Prevention is a key component of addressing this problem, as providing education, information, and access is more cost effective and ethical than addressing this problem when the problem has further manifested in the form of an infant.

Justification

In alignment with the National Association of Social Workers (NASW) Code of Ethics (2008), one a core value of social work is service; social workers have an obligation to assist clients in addressing social problems. As mentioned above, teenage pregnancy has been labeled as a social problem in the United States, due largely to the negative impacts that young parenthood can have on both adolescent parents and their
children. Similar to the value of service is that of social justice. Social workers have the responsibility to challenge social injustices, by both working with vulnerable and oppressed groups, as well as by advocating for them (NASW, 2008). Teens who become pregnant and have little or no familial assistance are forced to rely on outside supports, often in the form of social workers, in meeting many of the physical and emotional needs of themselves and their children.

The NASW Code of Ethics (2008) also implores social workers to engage in evaluation and research, in order to both maintain the integrity of the profession as well as to increase the profession’s knowledge base. Conducting a needs assessment and creating a curriculum from the results of this need assessment serve the functions of both evaluation and research, as this information will further knowledge in the area of sexual education needs of youth living in out-of-home care. Many social workers are employed by child welfare or other related agencies who work closely with recipients and/or employees of child welfare, therefore having knowledge in this area could impact their practice significantly.

**Definition of Terms**

For the purpose of this study, the researcher wishes to examine the sexual education needs of youth in out-of-home placements, a term often interchangeably used with the term ‘foster youth.’ However, youth in out-of-home placements includes not only individuals who have spent time in foster care, but also youth who do not live with their biological parents for a variety of reasons, including homeless youth, displaced
youth, young men and women who are adjudicated and those living in informal care which may be provided by family and non-family members.

Limitations

The intended outcome of this study is the creation of a sexual education curriculum for a specific population: youth living in out-of-home placements. The curriculum will be geared toward all youth who are not living with biological parents, and therefore will not be specific to foster youth. While the curriculum may be helpful for educating adolescents in the general population, the goal of this study is to address the specific needs of youth living out-of-home. Another limitation of this study is the group small size of the geographic sample from which this data was derived. Placer County youth may not be representative of the nation’s population of youth living in placements that are out-of-home.

Summary

Due to a shift in cultural perceptions that cast teen pregnancy as a moral issue of epidemic proportions, teenage pregnancy has received an increasing amount of national attention in recent years. The prevalence of teen pregnancy in the United States, coupled with the negative outcomes for youth who experience early pregnancy, demonstrate a clear need for actions which address this issue. Although teen pregnancy rates have decreased in recent years, Americans cannot afford to become lax about this issue. Both adolescents who become parents and the children of these parents face a multitude of barriers to success and well-being. For youth living in out-of-home placements, many of
whom are already greatly impacted by the circumstances and experiences that led to placement, teen pregnancy can be devastating. The following study will serve as a means for addressing teen pregnancy among youth in out-of-home placements.
Chapter 2

LITERATURE REVIEW

Introduction

In this chapter, existing literature relevant to the topic of pregnancy among youth living out-of-home will be presented. First, adolescent pregnancy and foster care will be examined from a historical standpoint. Teen pregnancy among foster youth will be analyzed in depth, with an emphasis on factors that increase this particular population’s risk for high-risk sexual behavior. These characteristics unique to foster youth provide insight into the diverse sexual health needs of youth in out-of-home care.

A thorough analysis of research conducted on this topic would be incomplete without a discussion of the long-term consequences of adolescent pregnancy. Literature on the short-term and long-term implications of teenage pregnancy will assist in creating a better understanding of why this issue has been defined as a social problem. Research which illustrates both the positive and negative outcomes of pregnancy will be explored, as government officials and the media have historically cast pregnant and parenting teens in as immoral and irresponsible through focusing primarily on the negative outcomes of teen pregnancy.

The types of sexuality education and their levels of efficacy will be examined, as historical trends have demonstrated that adolescent pregnancy can be effectively prevented with proper education. Many programs and curricula exist throughout California which show promise for addressing teen pregnancy on a larger scale, not just
for youth in the general population but for unique groups as well, and these will be discussed in greater depth here. The final section touches on gaps in the literature in the areas of teen pregnancy and foster youth, as there are multiple facets of this topic lacking data or clarity.

**History of Teenage Pregnancy**

Teenage pregnancy in the United States is a topic that has been studied extensively in recent history. Although teenage pregnancy is not a new phenomenon in this country, it has only been framed as a major social problem in the United States over the last thirty years, beginning in the 1980s, when adolescent pregnancy and birth rates in the United States were at catastrophic levels (Collins et al., 2002). In the early history of the United States, beginning in the 1600s through the late 1800s, young men and women in America chose to have children and get married at a young age, as family production was a major component of familial self-sufficiency (Teen Pregnancy, 2008). The ability to bear children marked the beginning of adulthood for young women, just as the capacity to perform difficult manual labor marked the beginning of independence for young men. Beginning in the 1900s, a new ideology viewing adolescence as a distinct period of development emerged. Middle-class parents began sending their adolescents to school instead of allowing them to work or get married. Lawmakers followed suit with this paradigm shift, and child labor laws, compulsory education legislation, and the establishment of juvenile courts impacted society’s view of adolescence as a time of great turmoil and development, rather than the time in which young men and women should be
starting families (Teen Pregnancy, 2008). Although society’s view on teenage pregnancy shifted, many adolescents resisted these restrictions on their independence and autonomy, and this resistance was reflected in the record high birth rates and a dramatic rise in early marriage rates that persisted in the United States between the 1940s through the 1960s (Lindenmeyer, 2002; Teen Pregnancy, 2008).

Many societal, political, and economic shifts took place in the 1970s through the 1990s that influenced the reversal of these trends of early marriage and teen pregnancy. With the invention of reliable birth control, increasing divorce rates, higher rates of young adults choosing to attend college and many other factors, more young men and women chose to delay marriage and childbearing (Lindenmeyer, 2002). Additionally, the final remnants of the Comstock Act were repealed around 1970. This piece of legislation was passed in the early 1800s, and prohibited the sending of information about sexual health and reproduction via postal service (J. Burris, personal communication, January 31, 2011). The focus of many influential political figures in the country then shifted to addressing the issue of unwed motherhood. With the emergence of women’s rights, civil rights, the transition to a service-oriented economy, and the advent of Aid to Families with Dependent Children (AFDC), young unwed mothers were condemned as symbols of American immorality (Teen Pregnancy, 2008). In 1996, AFDC was discontinued, and the Personal Responsibility and Work Opportunity Reconciliation Act was passed, which offered incentives for the use of birth control and placed restrictions on federal assistance to unwed teen moms (Lindenmeyer, 2002; Teen Pregnancy, 2008).
In addition to welfare reform, which greatly impacted teen moms, the federal government also responded the perception of teen pregnancy as a social problem by creating and funding programs at the federal and state levels to prevent teen pregnancy (Boonstra, 2010). These efforts were proven effective in reducing sexual risk-taking behavior, and reducing the incidence of unplanned pregnancy (Healthy Teen Network, 2008). Evidence of this is seen in the nationwide steady, 15-year decline in pregnancy and birth rates, which occurred between 1990 and 2005 (CDC, 2009a; Collins et al., 2002; CWLA, 2008; Hamilton et al., 2007; Healthy Teen Network, 2008).

Despite these statistics, the United States continues to have the highest rates of adolescent pregnancy in the industrialized world (Constantine & Nevarez, 2003; CWLA, 2008). The teen birth rate per 1,000 young women between the ages of 15 and 19 increased slightly between 2005 and 2006, and then again between 2006 and 2007, following the dramatic drop in the pregnancy rate over the previous several years (Hamilton et al., 2007; United States Census Bureau, 2010). In 2007, more than 445,000 young women age 15-19 experienced a pregnancy resulting in a live birth (United States Census Bureau, 2010). Further, it is estimated that one in three girls in this country become pregnant by age 20, and most of these pregnancies are unplanned (CWLA, 2008).

California experienced a 50% decrease in the teen birth rate between 1991 and 2005, the largest statewide decline in the United States during this time (Constantine et al., 2010). While this is a vast improvement in comparison with other states, California
youth are still at risk for teen pregnancy for a variety of reasons. Research has shown pregnancy and birth rates to be the greatest among marginalized groups, including Latino and African American youth, children and teens living in foster care, lesbian, gay, bisexual, and transgender youth, immigrants, and young men and women who are adjudicated (CDC, 2009a; Healthy Teen Network, 2008; United States Census Bureau, 2010; Woronoff et al., 2006). The population of California consists of a proportionally large number of youth who fall into many of these marginalized groups and because of this status, are at inherently higher risk (Healthy Teen Network, 2008; United States Census Bureau, 2010).

The relationship between teenage pregnancy and poverty is another relevant issue in light of the recent economic downturn, both in California and nationally. Constantine and Nevarez (2003) describe poverty rates as the most accurate indicator of teen pregnancy rates. High poverty rates during a single year tend to predict drastically increased teen pregnancy rates the following year. To further exacerbate the issue, in California and nationwide, funding for teen pregnancy prevention programs has been scaled back, with further cuts pending, due to the current state of the economy and the political practices of legislators (Constantine et al., 2010).

Although great strides have been made in reducing the incidence of teen pregnancy, the United States continues to pay a high price for this social problem. Immediate and long-term social and economic costs of teen childbearing are high. In 2004 alone, financial costs of adolescent childbearing totaled over $9 billion, including
approximately $2.3 billion in child welfare costs due to children in foster care either having children themselves or having a child who enters the foster care system at some point in the child’s life (Hoffman, 2008). Constantine et al. (2010) estimate a decreased societal cost of $1.1 billion in 2008, which includes the lost tax revenue based on teen parents’ lower income and consumption, costs for increased foster care and incarceration rates of children, and tax revenue losses based on the lower income and consumption of children of teen moms when they reach adulthood. However, these two studies utilize different measures to determine overall cost to taxpayers, therefore making it difficult to determine whether societal cost of adolescent pregnancy has increased or decreased in recent years.

**History of Foster Care and Out-of-Home Placement**

The term foster care is often used to denote situations in which a youth is living in a setting other than in the home of his/her biological parents. Foster care exists in several forms, including formal, or traditional, foster care, and informal foster care. Traditional foster care involves the placement of youth in the child welfare system with an individual or family outside of their family-of-origin. Kinship care, on the other hand, occurs when children are placed by child welfare officials, with relative caregivers. Children in formal foster care can also be placed in such settings as group homes, juvenile detention facilities, and other institutions (Child Welfare Information Gateway [CWIG], n.d.). Informal care situations are not sanctioned or controlled by any child welfare agency, and may occur for reasons other than abuse and neglect. Examples of informal care situations
include youth who are “couch-surfing” and children or adolescents who live with relative or non-relative caregivers without the involvement of Child Protective Services (Carpenter, Clyman, Davidson, & Steiner, 2001).

Children enter into the foster care system for different reasons, including physical, sexual, and psychological/emotional abuse, neglect, or a combination of these factors. The most common form of abuse that research cites among youth in the foster care system is sexual abuse combined with another form of maltreatment, either physical abuse or neglect (Love et al., 2005; Pecora et al., 2003). The figures for the average amount of time in care varies considerably, depending on whether time in care is measured as continual time spent out-of-home or total amount of time living in foster care, adjusting for breaks when a child is reunified and then removed again at some point in the future. Therefore this figure varies between 3 and 7.2 years (Carpenter et al., 2001; Pecora et al., 2003).

Between 1992 and 2002, the number of children in formal foster care in the United States increased 65% (American Academy of Pediatrics [AAP], 2002). In 2002, there were approximately 542,000 children in formal foster care (Becker & Barth, 2000; Pecora et al., 2003). In the four years that followed, this figure increased to over 733,000, and 100,000 these children and teens reside in California (National Kids Count Program, 2009). Of the youth in foster care in California, approximately 13,000 are age 16-20, and are either transitioning out of foster care or preparing to do so (Constantine et al., 2009). These figures only represent those youth in formal foster care situations, and
would be much higher if informal foster care scenarios were taken into account (Pecora et al., 2003). Additionally, this number tends to fluctuate daily, as new children enter foster care and youth in the system are reunified, adopted, or turn eighteen, and are no longer under the care of the state. These statistics for youth in care represent an immediate concern as Dworsky (2009) reports that approximately 30% of those in foster care nationwide, or about 200,000 youth, are age 13 and older, and are at risk for pregnancy, because of their biological ability to reproduce.

**Risk Factors for Teenage Pregnancy Among Youth in Out-of-Home Placements**

Very little data has been made available in regards to pregnancy rates among youth in out-of-home placements, including both youth in formal foster care, as well as youth living in informal care (Child Welfare League of America [CWLA], 2008; Dworsky, 2009; Dworsky & Courtney, 2010; Healthy Teen Network, 2008; Love et al., 2005; NCPTUP, 2006; Planned Parenthood, 2009). The literature that does exist, however, focuses on adolescents who are currently in the child welfare system or have spent time in formal foster care at some point in their lives. The Midwest Study, a longitudinal study which tracked the outcomes of foster youth, reported that almost one-third of former foster youth polled at age 17 admitted to having been pregnant at least once, compared with 18% of peers not living in foster care (Courtney, Terao, & Bost, 2004). The National Campaign to Prevent Teen and Unplanned Pregnancy (2008) reports that 71% of young women who have spent time in foster care become pregnant at least once by age 21. Compared to teens in the general population, adolescent females in
out-of-home care are more than twice as likely to get pregnant and have a child either before age 18 or shortly after exiting the child welfare system (Becker & Barth, 2000; CWLA, 2008; Dworsky & Courtney, 2010; NCPTUP, 2006, 2009). This trend of higher pregnancy rates tends to continue into early adulthood. The Midwest Study reports that more than ¾ of former female foster youth study participants had become pregnant by the age of 24, compared with 40% of same-age females in the general population. Additionally, by the age of 24, 61% of young men who were former foster youth reported getting someone pregnant, versus 28% of their non-foster peers (Courtney, Dworsky, Lee, & Raap, 2010).

The unique challenges faced by foster youth are directly related to their higher risk for pregnancy. Youth in the foster care system tend to come from families-of-origin that are lacking in social and economic resources, located in large urban areas, and are of ethnic minority status (Courtney et al., 2004). The family problems experienced by youth who are placed in foster care, including neglect and maltreatment, often have major implications for the physical and emotional well-being of these youth (Dworsky & Courtney, 2010). According to Pecora et al. (2003), slightly more than half of youth living in foster care during one study had been diagnosed with a psychological disorder. Emotional disorders, as defined by the Diagnostic Statistical Manual, are the most prevalent, followed by learning disabilities, most commonly Attention Deficit Hyperactivity Disorder. The Midwest Study reported that at age 17, approximately one-third of all participants reporting a diagnosis of depression, dysthymia, post-traumatic
stress disorder (PTSD), social phobia, alcohol abuse, alcohol dependence, substance abuse, or substance dependence (Courtney & Dworsky, 2005).

Love et al. (2005) and Dworksy and Courtney (2010) assert that emotional, behavioral, and social difficulties put adolescents in foster care at elevated risk for pregnancy. Similarly, having a prior history of substance abuse and delinquency has also been shown to be a risk factor (Dworksy & Courtney, 2010). The relationship between mental illness, substance abuse, delinquency, and teen pregnancy are unclear, however the interplay between these factors seems to prove particularly detrimental for foster youth.

In addition to being at higher risk of pregnancy, foster youth are also more likely to engage in high-risk sexual behavior than their counterparts not living in out-of-home care (Guttmacher Institute, 2002; Healthy Teen Network, 2008; Love, et al., 2005; NCPTUP, 2006). High-risk sexual behavior includes non-use of contraceptives, having multiple sexual partners, and engaging in sexual activity with partners with known sexually transmitted infections (NCPTUP, 2006). One study found that non-use of contraceptives was particularly high among youth diagnosed with serious mental health problems, which puts many foster youth in an additional at-risk category, since they are more likely to have been diagnosed with a mental illness than their same-age counterparts (Courtney & Dworsky, 2005; Love et al., 2005).

Another common theme in the literature on foster youth is the lack of at least one stable, consistent relationship with an adult (Constantine et al., 2009; Dworsky &
Courtney, 2010; Love et al., 2005; Mendes, 2009). Love et al. discuss the importance of relationships between parents or other adults, and teens, in influencing whether teens become pregnant. Foster youth often lack these relationships due to frequent moves from foster home to another, educational changes, poor continuity of caseworkers, and less consistent adult support all-around (Mendes, 2009).

The incidence of young women who become pregnant on purpose is a facet of adolescent pregnancy that is often ignored but particularly salient among foster youth (Love et al., 2005). More than one-third of pregnant and/or parenting foster youth in a recent study indicated that they “definitely or probably” wanted to get pregnant (Dworsky & Courtney, 2010; Love et al., 2005). Evidence seems to suggest that at least some foster youth have the perception that the benefits of teenage pregnancy outweigh the costs. Constantine et al. (2009) suggest that foster youth who become pregnant on purpose do so because of an intense unmet need for unconditional love and belonging. These youth perceive that a baby will fill this void because babies are dependent on caregivers to meet their basic needs. In addition, many of these youth also reported that adolescent pregnancy tends to be largely accepted in these teens’ family-of-origin and among their peers. In addition, foster youth, and youth in the general population, may become pregnant purposely in an attempt to hold onto a partner (Dworsky & Courtney, 2010).

The reasons that youth report for desiring to become pregnant on purpose have important implications for the creation of appropriate sexual education curriculum, as providing this population with education and information about accessing birth control
may be insufficient in preventing pregnancy. Repeat pregnancies are of particular concern, as multiple pregnancies are more prevalent among foster youth than the general population (Courtney et al., 2010; Dworksy & DeCoursey, 2009; Dworsky & Courtney, 2010). Dworsky and DeCoursey (2009) estimate that at least 30% of foster youth who have been pregnant experience a second pregnancy shortly after their first pregnancy. Constantine et al. (2009), Dworksy and Courtney (2010), and Love et al. (2005) are careful to note that access to contraceptives does not guarantee that youth will actually use birth control. Therefore, appropriate sexual education programs that target foster youth should be designed to incorporate motivation for becoming pregnant into the development of prevention curricula.

Implications of Teenage Pregnancy for Adolescents

One common thread throughout much of the literature on teenage pregnancy rates in the United States is the increased risk for social, educational, and economic problems that teenage moms and their children often face. Constantine and Nevarez (2003) attribute poor outcomes for teen moms to interruptions in key social and emotional developmental processes. Educational attainment is often greatly affected by teen parenthood. Adolescents who become mothers are less likely to graduate from high school and much less likely to go attend college than young women who are not parents. Just over half of teens who become pregnant, graduate from high school, and only an estimated 1.5% of teenage mothers earn a college degree by the age of 30. The lower level of educational attainment and earning capacity result in higher poverty rates among
this population in comparison with adolescents who do not become teen parents (CDC, 2009a; CWLA, 2008). Adolescent mothers are also more likely experience single parenthood and instability in their employment, both of which also lead to a greater risk of living in poverty and depending on welfare assistance (CDC, 2009a; Constantine & Nevarez, 2003). The likelihood of teen moms living in poverty and depending on public aid is not specific to just the United States; the United Kingdom and Australia are seeing similar trends among adolescents who become mothers (Mendes, 2009).

Mental health is also affected by early pregnancy. Sexual behavior in teens tends to elicit more societal stigma for adolescent females compared with adolescent males, and as a result, teen girls tend to experience more negative personal and interpersonal consequences than do adolescent males (Hipwell, Loeber, Battista, & Keenan, 2010). Teen moms tend to experience a great amount of psychological distress and often exhibit depression and lower levels of psychological functioning than their same age counterparts who are not mothers (Constantine & Nevarez, 2003). One study indicated that teen moms report a lack of social and emotional support and feelings of loneliness, but whether this is an antecedent or consequence of teen pregnancy is unclear (Mendes, 2009).

Although not as much emphasis is placed on the roles, responsibilities, and consequences of teen pregnancy for adolescent males, becoming a teen father has important implications for young men. On average, young men who impregnate adolescent females tend to be three years older than their female partner and are often in
their early 20s (Dudley, 2007). They tend to be of low educational attainment and economic status, and although they are likely to work and earn more initially, their lifetime earning capacity and educational attainment are significantly lower than their non-parenting peers (Constantine & Nevarez, 2003; Dudley, 2007).

Since the majority of teen pregnancies are unplanned, and active fathering generally occurs more frequently when pregnancy is planned, teen fathers are less likely to play active roles in the lives of their children (Dudley, 2007). However, Dudley also suggests that the research literature and popular media both contribute to the creation and perpetuation of negative stereotypes about absent teen fathers that are not always accurate. Many teen fathers report that they wish to have a more active involvement with their child or children, and a large portion of teen fathers report attempting to increase the amount of quality interaction they have with their child or children (Dudley, 2007; Kalil, Ziol-Guest, & Coley, 2005). One study indicates that more than two-thirds of teen mom participants stated that their baby’s father played an active role in the child’s life, at least for the first two to three years (Kalil et al., 2005). Unfortunately, this involvement tended to wane over time, as this study and other studies demonstrate a decreased involvement in their children’s lives after the child turned three (Gee & Rhodes, 2003; Kalil et al., 2005). Subsequently, parental involvement as a father has the potential to either be a major support to teen mothers, or can be a source of conflict and strife (Lee, 2009).

Both conventional wisdom and professional literature tend to focus on the residual negative effects of teen pregnancy for both adolescent parents and their children.
Many of the research findings cast teenage pregnancy in the United States as a major social problem. This research has influenced the public to view teen pregnancy as the beginning of a downward spiral for adolescent parents and children alike, dooming them to lives of low-wage jobs, welfare dependence, and mental illness. However, many teens affected by teenage pregnancy view their experience as one that provides them with meaning and motivation to succeed, according to one study (SmithBattle, 2007b). The positive aspects of teen pregnancy are often ignored by researchers who study the topic (SmithBattle, 2007a). Although teen parents are more likely to experience social, emotional, financial, and educational hardships, many teen mothers perceive mothering as a journey to adulthood that, although taking less than an ideal path, provides them with meaning and purpose (SmithBattle, 2007a; 2007b). Long-term studies of children born to teen moms recognize the precedence of background factors, such as socioeconomic status, as more indicative of child success and well-being than maternal age (Turley, 2003). Courtney et al. (2004) mention the focus of prior research on populations of teens who are considered to be inherently “high-risk” for many behaviors because of their family-of-origin. More research is needed in this area, to examine the impact of teen pregnancy when background factors are controlled for, as most previous research samples consisted of young women who were already at a disadvantage before becoming pregnant (Constantine & Nevarez, 2003; SmithBattle, 2007a).
Implications of Teen Pregnancy for Children Born to Teen Parents

The long- and short-term outlook for children born to teen moms is bleak. Preterm birth, low birth weight, and infant death are just a few of the potential risks these infants may face at the start of life (CDC, 2009a; Meade, Ickovics, & Kershaw, 2008). Throughout the course of their childhood and adult lives, individuals born to teen moms are susceptible to a variety of concerns that are less common among children born to older mothers. Young males and females born to adolescent mothers are more likely to be impulsive or over-reactive, and to suffer from anxiety, loneliness, low self-esteem, and sadness (CDC, 2009a; NCPTUP, 2008). Cognitive problems are also common among children born to teen moms, including delays in overall cognitive and motor development, along with behavior problems such as aggression (Constantine & Nevarez, 2003; Luster, Bates, Fitzgerald, Vendenvelt, & Key, 2000). Long-term outcomes can include lower cognitive attainment in adulthood, chronic medical problems, and a higher chance of being incarcerated at some time before the age of 30. Similar to their mothers, children born to teen moms are also more likely to drop out of high school and become unemployed or underemployed, and to repeat the cycle of adolescent parenthood themselves (CDC, 2009a).

One study conducted by Constantine and Nevarez (2003) suggests that teen moms are often less verbal with their babies and provide them a less stimulating social environment than provided by older moms. Additionally, because of their own interruption in developmental processes, some teen moms participating in one study were
also shown to have unrealistic expectations about child development. However, Constantine and Nevarez (2003) also recognize that many of these problems faced by children of adolescent mothers may be due to socioeconomic conditions that exist regardless of their status as young moms.

The controversial issue of child abuse among children born to teen moms was inconclusive in the literature for a long period of time (Lee, 2009). The relationship between child abuse and teen parenting is complex, according to a recent study. However, the same study demonstrated higher likelihood of physical abuse and neglect among children born to teen moms, along with increased risk for child welfare involvement and foster care placement (Constantine et al., 2010). Research indicates that a variety of factors contribute to children of teen mom experiencing higher rates of physical abuse. The overall lower education levels attained by teen parents, often related to low-wage employment, have been shown to potentially increase the risk of child abuse (Afifi, 2007). Additionally, poverty has been substantiated in the literature as a major factor in physical abuse. Another factor that may put children of adolescent mothers at higher risk for physical abuse is mental health concerns, such as depression, psychological distress, and other situations in which mental health has been otherwise weakened (Lee, 2009). It is important to note, however, that the research does not imply a casual relationship between any of the above mentioned factors and likelihood for abuse among children of teen moms. Rather, these factors likely interact with one
another, and with environmental, social, and individual factors to create a heightened risk of child abuse for these children (Afifi, 2007; Lee, 2009).

As previously mentioned, the risk of repeating the cycle of teen parenthood is elevated for children who were born to teen moms themselves (CDC, 2009a). In fact, research has consistently shown that individuals born to teen moms are at significantly higher risk for becoming teen parents themselves than are their peers born to older moms (Meade et al., 2008). As with the case of child abuse, the likelihood of repeating the cycle of teen parenthood cannot be causally linked with specific factors. Meade et al. (2009) suggest that this intergenerational effect probably has more to do with individual, family, and environmental factors that are interrelated. The connectedness of these factors may lead daughters of teen mothers to internalize messages which place value on early childbearing and these young women thus develop a preference for having a child or children at a young age.

Provision of Sexual Education to Foster Youth: Who is Responsible?

School-sponsored sexual education is a controversial and complex topic, which is a source of much debate in the United States. Sexual behavior and the health implications that result from this behavior are a reality faced by American teenagers on a daily basis (Collins et al., 2002). Foster youth, as a group, present unique difficulties in the provision of sexual education for a variety of reasons. The Healthy Teen Network (2008) suggests that youth in foster care are unique in the way that they are less likely to engage in the usual sexual education delivery systems. The primary settings in which
teens are educated about sexuality are within the home via parents, or at school, where they participate in school-sponsored sex education classes. But many foster youth report that they do not receive information through either of these avenues. In one study, more than half of the former foster youth participants reported that they were neither offered nor did they use family planning services or contraceptives at any point while living in foster care (Becker & Barth, 2000).

According to a recent panel discussion hosted by the National Campaign to Prevent Teen and Unplanned Pregnancy (2009b), former foster youth report that foster parents and group home staff “should” be the ones to talk with youth about issues related to sex, however that often does not happen. A recent study of Child and Family Services caseworkers in three California counties indicates that only approximately one-quarter of social workers report discussing prevention of sexually transmitted infections and pregnancy with youth on their caseload. One factor that may contribute to the lack of communication between social workers and youth is the lack of clarity in policies, roles, liability, and youth confidentiality (Constantine et al., 2009). At the time of this publication, no other studies were available comparing and contrasting the mandates within and among states and counties regarding caseworkers’ responsibilities in this area.

The relationship that formal foster youth have with their caseworker may have the potential to influence their decisions regarding sex (Constantine et al., 2009). According to a study by Love et al. (2005), some foster youth report having solid, trusting relationships with their caseworkers, while others report that they are unable to talk with
them about important topics due to their caseworker’s inability to provide them with enough personal attention. Several researchers who have studied this topic proclaim a need for training and support for child welfare workers and foster parents, to better educate them on how to talk with youth about issues related to sexuality (Constantine et al., 2010; Dworsky & Courtney, 2010; Dworsky & DeCoursey, 2009; Love et al., 2005; NCTPUP, 2006; Pecora et al., 2003; Planned Parenthood, 2009).

**School-based Sexuality Education**

The only formal form of sex education available to foster youth when neither their caregivers nor their caseworkers talk with them about sexuality is through the public school system (Constantine et al., 2009). However, foster youth are less likely to be engaged in this delivery system because of school placement changes spurred by child welfare policies and/or decisions that result in frequent moves for the youth. Changes in school and foster placements can cause lapses in school attendance, causing youth to miss sexual education presentations (Becker & Barth, 2000; Healthy Teen Network, 2008).

According to Collins et al. (2002), sexuality education curriculum taught in public schools falls in one of two categories. Abstinence-only (or abstinence-based) sexual education teaches about the importance of abstaining from all forms of sexual activity outside of the marital relationship. Comprehensive (sometimes referred to as “abstinence-plus”) sexual education emphasizes the benefits of abstinence, while also providing information about contraception and prevention of sexually transmitted infections.
Federal law, however, does not require that sexual education be taught in all public schools. In California, the Comprehensive Sexual Health and HIV/AIDS Prevention Act dictates that all students should have “the knowledge and skills necessary to protect his or her sexual and reproductive health from unintended pregnancy and sexually transmitted disease” (California Education Code, §51930, p. 755). Under this act, the education provided within public schools must be comprehensive in nature, meaning that information must cover human development and sexuality, pregnancy, family planning, and sexually transmitted diseases (California Education Code). In addition, California Education Code §51933 explicitly states that school districts are not required to provide sexual health education, but should they choose to do so, they must comply with the above requirements.

Nationally, only about 60% of states required high schools to teach about pregnancy prevention in 2006, an increase from 45% in 2000 (CDC, 2006). At that time, 35 states had mandates in place regarding the provision of sexual education, and most of these mandates allowed for the specific content to be determined at the local level (Guttmacher Institute, 2006). Several sources have explored and substantiated the lack of evidence proving that abstinence-based sexual education is an effective means for preventing teen pregnancy (Advocates for Youth 2008; Collins et al., 2002; CWLA, 2008). Conversely, sex education curricula and programs which are comprehensive in nature have been shown to delay onset of sexual activity, increase rates of condom use, and decrease the incidence of unplanned pregnancy (Inman, Van Bakergem, LaRosa, &
Garr, 2011). However, a significant number of public schools continue to use curricula based the abstinence-only model, which is not only ineffective but also unrealistic (CDC, 2006; Guttmacher Institute, 2002).

The minority of foster youth who do report receiving sexual education in schools report that the information they receive is often too little, too late (Constantine et al., 2009; Love et al., 2005). In other words, by the time many foster youth are presented with information about protecting their sexual health, they are already engaging in sexual activity that puts them at risk for pregnancy and contracting sexually transmitted infections (Dworsky, 2009; Planned Parenthood, 2009). The literature points to a need for sexual education curriculum specific to the needs of high-risk, marginalized populations, which includes foster youth (Collins et al., 2002; CWLA, 2008; Healthy Teen Network, 2008; NCPTUP, 2006; Planned Parenthood, 2009).

**California’s Efforts to Prevent Teen Pregnancy among Foster Youth**

As previously mentioned, California made more progress than any other state in reducing the rate of teen pregnancy between 1991 and 2005 (Boonstra, 2010). Although there are currently no curricula being utilized statewide for special populations, including foster youth, California has made great strides in providing adolescent sexual health by increasing access to family planning services. The California Department of Education recognizes the importance of the sexual health of adolescents, and even though schools are not required to provide sexual education, HIV/AIDS prevention education is mandated by the state (California Education Code, §51930). California also runs the
Family Planning Access, Care, and Treatment program (Family PACT), the largest family planning program in the nation, which provides contraceptives and related reproductive health care services to adolescents and adults at no cost (Boonstra, 2010). Family PACT also guarantees that services are delivered confidentially, as the consent of a parent/guardian is not required to receive reproductive health care services in California (Boonstra, 2010).

To remedy the issue of a lack of sexual education information specific to foster youth, a curriculum entitled *Power Through Choices* was developed for use with teens living in out-of-home placements in California. *Power Through Choices* was created to meet the specific needs of foster youth, based on prior research recognizing the unique concerns faced by this population (Becker, Barth, Cagampang, & White, 2001). This curriculum was piloted and proven successful in multiple settings in several California cities, as well as in Alabama and Oklahoma (Becker & Barth, 2000; Becker et al., 2001; NCPTUP, n.d.). Presented in *Power Through Choices* are a variety of topics, including abstinence, proper use of contraceptives, talking with one’s partner about sex and birth control, how different types of sexual contact can lead to the transmission of STIs, real-life stories of teen pregnancy and parenting, and how to locate and access family planning services (Becker et al., 2001). The authors of *Power Through Choices* state that the main reason for the curriculum’s success is its incorporation of skill-building activities which empower youth to make healthier choices about their sexuality (Becker & Barth, 2000; Becker et al., 2001). This curriculum also emphasizes the importance of
communication, both among teens and between a youth and his/her caregiver. Opportunities for role-playing and communication to reinforce this skill are incorporated into the weekly sessions as well (Becker et al., 2001).

**Other States’ Efforts to Prevent Teen Pregnancy among Foster Youth**

Outside of California, other states are taking measures to meet the sexual education needs of foster youth in several different capacities. Examples include training for foster parents, group home staff, independent living instructors, and caseworkers, as well as curriculum development and implementation. These prevention and intervention methods disused below include those already proven successful as well as those that are still undergoing development, implementation, and evaluation.

There are multiple programs that are currently in the development stage. The state of Arizona is in the process of collaborating with probation offices to create and pilot pregnancy prevention programs for youth in foster care and within the juvenile justice system (NCPTUP, n.d.). In Virginia, the Family Planning Council is involved in an interagency collaboration to produce an effective model for reducing teen pregnancy among foster youth, age 16 and older (CDC, 2009b). A large social service organization in Chicago is in the process of training all of their staff in the *Power Through Choices* curriculum, in order to reach out to youth in residential and transitional teen living programs. New Futures for Youth in Arkansas is currently delivering a teen pregnancy program entitled “Be Proud! Be Responsible!” to foster youth within two independent living programs. This curriculum, although evidence-based, has only been proven
effective with youth in the general population. Whether or not this curriculum will be successful for youth living in foster care is not known at this point. Health Care Education and Training Incorporated is in the process of implementing a teen pregnancy prevention pilot program with foster youth in both Indiana and Wisconsin (NCPTUP, n.d.).

Many states have developed and are currently using various methods for supporting foster youth, foster parents, and child welfare providers in meeting the multiple independent living needs of these youth. Utah, for example, offers a life skills curriculum to foster youth, age 14 and older. The curriculum contains 13 modules, one of which covers information on preventing pregnancy and STIs, including HIV. The Utah Department of Education has approved the curriculum to count as high school elective credit for youth who participate. In Pueblo, Colorado, the City-County Health Department provides trainings to foster parents on preventing teen pregnancy. The Idaho Department of Health and Welfare also conducts trainings with foster parents intended to open the doors of communication between parents and youth on topics such as drug and alcohol use and sexual activity (NCPTUP, n.d.).

Perhaps the most comprehensive pregnancy prevention effort is the South Carolina Campaign to Prevent Teen Pregnancy. This agency works with child welfare agencies across the state to determine the needs of youth in foster care. They provide training to over 80 programs in the state utilizing evidence-based approaches to preventing teen pregnancy among both youth in foster care and in the general population.
Training is provided to educators, health care providers, community-based service providers, and individuals employed by faith-based social service institutions (NCPTUP, n.d.; South Carolina Campaign to Prevent Teen Pregnancy [SCCPTP], 2010). The SCCPTP also actively engages the community through focus groups conducted with foster youth, foster parents, and caseworkers, to gauge the needs and desires of these groups, as well as to disseminate information (NCPTUP).

**Gaps in the Literature**

As previously stated, one of the main gaps in the literature is the lack of data regarding the pregnancy rates of young women in out-of-home placements. Research has shown that this population is at higher risk for becoming pregnant, but the exact data on the number of foster youth who become pregnant, is lacking. The Midwest Study collected data on the number of current and former foster youth who had experienced pregnancy by the age of 17 (Courtney et al., 2004), as well as again at the ages of 19 and 23/24 (Courtney & Dworsky, 2005; Courtney et al., 2010). Socioeconomic factors are often excluded from studies on the risk factors and consequences of teen pregnancy (Constantine & Nevarez, 2003; Meade et al., 2009; SmithBattle, 2007a; Turley, 2003), and further research is needed to determine specific economic and social risk factors about foster youth who became pregnant. Existing research has repeatedly failed to control for socioeconomic factors which may put certain youth at higher risk for both pregnancy as well as social and emotional consequences often associated with pregnancy (Courtney et al., 2004).
Summary

Although teen pregnancy rates have leveled out in recent years, teen pregnancy is still a relevant concern in the United States because of the sometimes negative social, emotional, and economic outcomes that many adolescent parents and their children face. Teen pregnancy is particularly detrimental for foster youth, who often lack consistent and stable relationships with a trusted adult with whom to talk to about sexual issues. Particularly important to note about youth in out-of-home placements is their higher likelihood than the general population of getting pregnant on purpose, for a variety of reasons. Consequently, information about and access to birth control is not always sufficient for preventing pregnancy among this population.

The uncertainty about who is responsible for the provision of information to foster youth about sexuality issues can lead to foster youth slipping through the cracks. Youth in the child welfare system often miss sexual education provided at school due to lapses in school attendance which occurs because of changes in placement. When sexual education is offered within public schools, the consensus within the literature is that the curriculum does not address the specific needs of this population, and that the information comes too late, after many youth are already sexually active. A curriculum titled Power Through Choices was created to meet the various needs of foster youth, and the curriculum has been piloted in multiple settings in different states, including California.
Several states outside of California have established their own methods for addressing higher teen pregnancy rates among foster youth, including trainings and workshops for adults who work with foster youth, many of which have proven effective. Additionally, the literature demonstrates a need for training for child welfare workers, foster parents, group home staff, and other professionals who work with foster youth, as many of these individuals report that they are ill-prepared to address these issues with young men and women. The research relevant to this topic presents a myriad of options from which to choose in order to address teenage pregnancy among this population. Although action is needed on a larger level, the establishment of a curriculum which meets the sexual health needs of foster youth would provide an initial means for preventing pregnancy on an individual level.
Chapter 3

METHODS

Introduction

This research project, A Sexuality Education Needs Assessment, is a two-part study, including a needs assessment based on secondary data, followed by the creation of a sexuality education curriculum specific to youth living in out-of-home placements. The information below details the methods that will be utilized in the process of completing this research project. Topics detailing the methods include: the project’s study participants, the research design and instrumentation to be used to conduct the needs assessment, the research design which will guide the curriculum development, the strengths and limitations of these research designs, procedures to be utilized in the data analysis, as well as issues of reliability and validity. Finally, the steps taken to protect the safety and privacy of the participants will be discussed in depth.

Participants

There were no human subjects involved in this study, as the researcher will be using secondary data collected by Placer County Health and Human Services. The subjects of the original research were students, ages 12-24 who attended Chana High School, Alder Grove School, Sundown Youth Resource Center, or Honour Chaps School, at the time of the initial data collection. All of the above-mentioned are school sites located within Placer County. When the original research was conducted in early November of 2010, 156 subjects participated. For the purpose of this research project,
the data from surveys on 71 of the subjects was chosen for analysis. These 71 surveys were chosen because the focus of this research is to conduct a needs assessment on youth who are living out-of-home, and the remainder of the subjects disclosed that they were living with one or both biological parents.

**Design**

This project will have a dual purpose, requiring different designs for each purpose. These purposes include the analysis of secondary data in the form of a needs assessment, and the creation of a sexual education curriculum which incorporates information derived both from the needs assessment and existing literature on the topic. Both of these purposes will be discussed further below, as will the strengths and weaknesses of the research designs.

**Design of Needs Assessment**

The first purpose of this research study is to analyze the secondary data collected by Placer County Health and Human Services, November 1-19, 2010, and was an assessment pertaining to sexuality education of youth ages 12-24 residing in out-of-home placement in Placer County. “Out-of-home placement” includes youth who are both homeless and those who qualify as living in foster care. “Homeless” is defined by the McKinney-Vento Homeless Act as “individuals who lack a fixed, regular, and adequate nighttime residence” (Title VII-B, 42 U.S.Code §11431). “Foster care” is defined by the Child Welfare Information Gateway (n.d.) as youth living in situations other than with biological parents, and is inclusive of both formal arrangements in which
the child is considered a dependent of the state, as well as informal arrangements. This includes, but is not limited to, adjudicated youth, and youth who reside in group homes and other institutions. In the case of this survey instrument, the data which will be used by the researcher will be derived from youth who self-disclose, by checking a box that they are living with “other relatives”, living in “foster care” living with “friends” or in “I’m in juvenile hall” (see Appendix A, question 5).

The second part of the needs assessment will be based on the answer to a question on the survey about what participants feel would be most helpful in preventing teen pregnancy. Question 10 asked the participants to pick five items from a list that they feel are the most important for preventing teen pregnancy. The options include: after school programs, having someone to go to with questions, concerns, or help, access to clinic services, family/cultural values, family communication, life skills, sex education, programs specifically for males to learn about their own sexual health, planning for a positive future, having role models/mentors, healthy teen dating relationships, information from friends, and other. This question is the most important in generating descriptive data put to use in the next section of this project. Further information on the procedures for analyzing data is discussed in the Data Analysis section.

**Instrumentation of Needs Assessment**

As previously mentioned, this study will utilize secondary data collected by an outside agency, Placer County Health and Human Services. The agency has provided explicit written consent for the use of this data, and has expressed within this consent,
which demonstrates a thorough understanding of how the data will be used (see Appendix B). The instrument itself is an 11-question confidential survey, and asks participants to answer questions about demographics (age range, ethnicity, and gender), living situation, involvement with wider systems (including child welfare, counseling/mental health, and special education), risk of pregnancy, parenting status, and which components s/he feels to be most helpful in preventing pregnancy.

The researcher feels as if the wording of some of the questions lacks clarity. For example, Question 7 states, “Are you at risk of getting pregnant or getting someone pregnant?” This question is rather vague in nature, as ‘risk’ is a term that could be further operationalized. However, this question, while important in gaining an understanding of the topic, is of minimal importance to either of the purposes of this research project, so the vagueness in wording is of little concern to the researcher.

The research instrument does not contain questions which ask for personal identifying information, and as a result, the survey is kept confidential. The survey was created by Placer County Health and Human Services, for the purpose of obtaining federal money for the provision of sexual education to youth classified as “high-risk.” Please see Appendix B for a copy of the survey instrument.

**Design of Sexuality Education Curriculum**

Upon completion of the needs assessment, the researcher will utilize the descriptive data, integrated with research findings from existing studies and curricula to create a sexuality education curriculum to meet the specific needs of this population.
Fundamental to this curriculum will be its comprehensive focus, as research cites greater efficacy of comprehensive sexuality education as compared to abstinence-based sexual education (Inman et al., 2011; Kohler et al., 2008). Abstinence will be discussed as an alternative to engaging in sexual activity, and will be stressed as an option throughout the each session.

However, this researcher believes that a thorough sexuality education curriculum needs to include information regarding risk reduction as well, as the expectation that all youth remain abstinent is unrealistic (Collins et al., 2002).

Some of the activities and lessons included in the curriculum will be based on *Power Through Choices*, a sex education curriculum designed several years ago to be used with youth within the foster care system. *Power Through Choices* was piloted in several different settings in California and in a few other states, and has been proven effective in reducing the incidence of teen pregnancy among foster youth by addressing issues specific to this population that are often ignored in other sexuality education curricula (Becker & Barth, 2001). Throughout the development of the curriculum, the researcher will take into account risk factors faced by youth in out-of-home placements which put them in the high-risk category for teen pregnancy. One such example is the absence of relationships with reliable adults with whom to talk about sexuality-related issues (Constantine et al., 2009; Dworsky & Courtney, 2010; Love et al., 2005, Mendes, 2009).
**Strengths and Limitations of Research Design**

The overall research designs outlined above possess both strengths and limitations. The needs analysis portion of this project will have good face validity, as the survey instrument measures the factors that are appropriate and relevant to this project (Rubin & Babbie, 2008). The survey instrument contains questions similar to those that would be asked by the researcher if she were to design the survey herself, such as demographic information, whether the survey participant has been pregnant, impregnated someone else, or fathered a child, and most importantly, which items the participant deems most important in preventing teen pregnancy.

Perhaps the most significant limitation of this design, as is the case many research designs which analyze secondary data, is the uncertainty regarding the quality of procedures used (Rubin & Babbie, 2008). Because the researcher was not involved in the creation of the survey instrument or the data gathering process, the researcher is unsure of whether the data can be considered reliable, as data collected from a different sample of out-of-home youth may yield different results. Further considerations for limitations of this research design can be found in the Validity and Reliability Section of this chapter.

**Validity and Reliability**

Since the research instrument was created and implemented by an outside party, issues of validity and reliability present a relevant concern to the researcher. The researcher was not a part of the initial data collection, resulting in the potential for improper data collection methods, which can significantly affect both validity and
reliability. For example, a student may have been given the survey instrument in an open classroom setting, and did not answer the questions honestly because of lack of privacy. Internal validity could also be affected by selection bias, in which participants are selected because of the expectation that they will respond in a way which is favorable to the researcher (Rubin & Babbie, 2008). Since the agency responsible for collecting the data was doing so to obtain data with which to write a grant to obtain funding, the internal validity of this data set may be questionable.

The survey instrument itself may also pose validity and reliability concerns. The survey was created to ascertain much of the same information that this researcher is seeking, however the survey was implemented with a broader group of subjects than those than the participants who meet the specifications for this research; the survey was given to youth in the general population who attend the above-mentioned schools, including youth who live at home with biological parents, as well as youth living in out-of-home placements. If the method utilized was non-probability availability sampling, as is commonly used in social research, the sample may not be representative of the population, and generalizations about the population may be inaccurate (Rubin & Babbie, 2008). Whenever secondary data is utilized, problems of reliability and validity are common, as the researcher has no control over the creation of the research instrument, or the procedures used for data collection.
Data Analysis

Just as the study design section was broken down into two separate components based on the two purposes of this project, so too will the procedures for data analysis. First, the procedures for analyzing the secondary data to create a needs assessment will be discussed. Then, procedures for integrating this data into the sexuality curriculum will be explained.

Needs Assessment Data Analysis

The first step in data analysis for the needs assessment will involve sorting the surveys based on how the participants answer question 5, regarding living situation. The surveys which indicate that a subject lives with ‘one parent’ or ‘two parents’ will not be used for the purposes of this research study, as those subjects do not meet the requirements of living in out-of-home placements. The researcher will code each of the survey questions to create quantitative measures of study. The first data that will be examined for the needs assessment is demographic data, including age, ethnicity, and gender, questions 1, 2, and 3, respectively. Along with the data from a question which asks subjects to choose the top five methods, from a listing of several options, that they feel are the most important in preventing teen pregnancy. Bivariate analyses will be conducted based on the relationship between the above-mentioned demographic information and participants’ answer to the question about methods for preventing teen pregnancy.
Sexuality Education Curriculum Data Analysis

As previously mentioned, the researcher will be using the descriptive data derived from the needs assessment an important component in the development of the curriculum. The foundation for the curriculum will be the results of the question on the survey instrument asking about what the subjects view as the five most important items of those listed are most helpful in preventing pregnancy. The top five items will become major topics for each of the five sessions. Based on these main topic areas, the researcher will chose activities and lessons from *Power Through Choices*, as this curriculum has proven successful in preventing teen pregnancy among foster youth (Becker & Barth, 2001). The lessons, activities, and discussion topics will be created with particular risk factors for foster youth in mind, and will emphasize communication between youth and important adults in their lives. The final product will be a five-session curriculum, each session lasting 60 minutes, which the researcher hopes will effectively address the needs of youth who are living in home-of-home arrangements.

Protection of Human Subjects

The Protection of Human Subjects Application was approved by the Division of Social Work on January 7, 2011, with the classification of this research as exempt. The survey instrument itself contains no identifying personal information, which guarantees anonymity to the research subjects, and the last question of the survey asks the participant to add any information s/he feels is relevant and states, “Your information is important to us and will remain anonymous.” As an additional safeguard, the researcher will store the
surveys in a locked file cabinet in the researcher’s residence, and will return these surveys to Placer County Health and Human Services upon completion of the research project. The researcher’s personal notes for this project will be stored in a secure file cabinet inside of the researcher’s home.

Summary

The above topics outline the methods and procedures for the completion of this research project. The researcher will use the methods and procedures presented above in order to analyze the data to create a sexuality education needs assessment based on data derived from subjects who participated in the original research. The information that results from this needs assessment will be integrated into a sexuality education curriculum which the researcher hopes will successfully address the needs of this group. The researcher recognizes that problems of reliability and validity are inevitable in any research study, and similarly, that all research designs possess strengths and weaknesses. This is particularly true when the data was collected by an outside party. However, all possible efforts will be made to maintain the integrity of the data through closely following the methods discussed above.
Chapter 4
SEXUALITY EDUCATION NEEDS ASSESSMENT AND CURRICULUM

Introduction

This section includes a discussion on the findings of the needs assessment based on an analysis of the secondary data. Findings will be presented and compared with trends in the existing literature. Next, the I Can... curriculum will be introduced, including the development of the curriculum, and general overview of each of the sessions. Finally, the curriculum is presented in full, including goals of each session, activities and anticipated time for each activity within the session, and preparation considerations. An appendix at the end of the curriculum provides worksheets, visual aids, and additional resources.

Needs Assessment Findings

A data analysis of demographic information of this data set yielded a subject population of 69 study participants: 48 males and 21 females, ranging in age from 12 to 24. The ethnic makeup of the research participants was about half White (48%), approximately one-quarter Hispanic (23%), and 12% Multi-racial, with few other ethnicities represented (see Table 1).

The findings regarding age and ethnic makeup of the sample population are not consistent with recent findings on the population of this region. According to the United States Census Bureau (2009), approximately 77% of Placer County residents report being Non-Hispanic and White, with 12% reporting Hispanic as their ethnicity, and
approximately 3% consider themselves Multi-racial. Additionally, 50.5% of Placer County residents are female, while 49.5% are male (United State Census Bureau, 2009). While data is not yet available which breaks down Placer County’s population by both age and ethnicity, Hispanic individuals and males are overrepresented within this data set, and females and individuals of Caucasian, non-Hispanic ethnicity are underrepresented.

Table 1

<table>
<thead>
<tr>
<th>Ethnicity of Study Participants</th>
<th>Number of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>34</td>
<td>49%</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>16</td>
<td>23%</td>
</tr>
<tr>
<td>Multiracial/Multiethnic</td>
<td>8</td>
<td>12%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Filipino</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>100%</td>
</tr>
</tbody>
</table>
Along with demographic information, data regarding topics which participants considered most important to preventing teen pregnancy are of particular importance to the needs assessment. Participants were asked to pick five items which they felt were the most important in preventing teen pregnancy. Sexuality education received the most responses, with 84% of participants choosing sex education as an important component in preventing teen pregnancy. Access to clinic services was the second most prevalent item. Approximately half of the subjects believed it was important to have someone to go to with questions, concerns, or help. Having role models/mentors, and healthy teen relationships received an equal amount of responses (see Figure 1).

*Figure 1 Pregnancy Prevention Items*
Overall, these items were consistent with the existing literature on the adolescent pregnancy prevention. Over half of the participants valued having someone to go to with questions about sexuality. This is in alignment with the existing research, which shows that the lack of a stable relationship with at least one adult is a common theme among foster youth (Constantine et al., 2009; Dworsky & Courtney, 2010; Love et al., 2005; Mendes, 2009). Similarly, sexuality education was chosen by 84% of study participants as one of the top five items in preventing teen pregnancy, which is consistent with literature showing a need for sexuality education among foster youth and youth in out-of-home placements (Becker & Barth, 2000; Healthy Teen Network, 2008).

**Introduction to Curriculum and Curriculum Development**

Each of the five sessions which comprise the *I Can*... curriculum incorporate information from literature on the topic, as well as activities derived from existing curricula, specifically the *Power Through Choices* curriculum discussed in the literature review. The curriculum is also based largely on the results of the needs assessment discussed in the previous section. The development of the *I Can*... curriculum is presented in the proceeding sections.

*I Can*... is a population-specific sexuality education curriculum designed to address the unique needs of youth living in out-of-home placements. The curriculum consists of five, sixty-minute sessions, including activities and discussion topics based on topics, which youth stated are most important in preventing teen pregnancy. The curriculum was developed with flexibility in mind, as youth living in out-of-home
placements come from a variety of backgrounds and circumstances. *I Can...* contains activities and information which can be slightly modified for use in a variety of settings, including schools, group homes, juvenile detention facilities, and other agencies who serve this population.

The concept of “choice” is the overarching theme present in each of the five, sixty-minute sessions of the *I Can...* curriculum, as research has shown that many teens feel their lives lack freedom and power to make their own decisions. This is particularly true for teens in the formal foster care system, who are accustomed to others making life-changing decisions on their behalf (Becker & Barth, 2001). The curriculum was therefore titled *I Can...* to convey the sense of power and control that comes with making deliberate decisions regarding sexual activity. In addition to choice, communication is another theme woven into *I Can...*, as many curricula focus on communication as an important component in talking with teens about difficult issues (Becker & Barth, 2000; Becker, Barth, Cagampang, & White, 2001; NCPTUP, n.d.).

What follows is a general description of the *I Can...* curriculum. Below is a description of topics and activities of each session, as well as the resources utilized in developing the curriculum. The actual curriculum begins on page 58.

*Session #1* is devoted to familiarizing the group with the *I Can...* curriculum, setting ground rules, and becoming more comfortable with the subject matter and with fellow group members. Generally setting ground rules is a common component at the beginning of any group that involves members convening on a regular basis. Ground
rules are especially important in this curriculum, because of the sensitive subject matter. In addition, the Anonymous Question Box is included in several other sexuality education curricula, as it allows participants ask potentially embarrassing questions anonymously (Becker & Barth, 2000; Becker et al., 2001). The Anatomy Slang activity is one that the curriculum writer has observed throughout previous experience as a sexuality educator, and serves as an icebreaker and allows the participants to become more comfortable talking about sometimes uncomfortable issues.

Session #2 is divided into two activities: a discussion and small group activity exploring why people choose to have sex or to not have sex, and a second activity which allows participants to become familiar with the various contraceptive methods available. The “Why People Have Sex” activity was adapted from the Power Through Choices curriculum (Becker et al., 2001), with slight changes made to account for the shorter session time of the sessions in the I Can... curriculum. The “Listing Methods” activity was developed to incorporate the actual sexuality education that participants of the needs assessment felt was so important. This activity addresses the need for creating a positive future, through a brief discussion on behalf of the group leader at the beginning of the activity that emphasizes taking control of one’s body through making choices.

Session #3 is similar to Session #2, in that it focuses on another topic found in most other comprehensive sexuality education curricula: Sexually Transmitted Infections, or STIs. This activity ends with an oral quiz to check the knowledge of the group’s
participants, and allows for further clarification and discussion of the types of STIs and their symptoms.

Session #4 places an emphasis on communication. The “Communication Techniques” activity is borrowed from the *Power Through Choices* curriculum (Becker et al., 2001), but was adapted to include an activity that allows the participants to role play each type of communication, in order to give group members a chance to identify what each technique may look like in conversations with partners about sexuality-related issues. Role playing was incorporated into this activity to give participants an opportunity to practice communication skills, and helps to reinforce the learning process (Becker et al., 2001).

Session #5 begins with the discussion of the “Interviewing an Adult” activity, which requires each participant to have identified a trusting adult with whom to talk about sex. Once more, the idea for this activity was borrowed from the *Power Through Choices* curriculum (Becker et al., 2001), with slight adaptations made to accommodate the needs of all youth in out-of-home placements, and not just those in formal foster care. The results of the needs assessment also indicate a need for a role model or someone to go to with questions or concerns about sexuality; the purpose of this activity is to meet that need. Furthermore, participants of the original study upon which the needs assessment is based, also expressed an interest in increasing access to clinic services. It was difficult to incorporate resource identification into the *I Can...* curriculum, as the services available will depend on the location in which the curriculum is implemented.
Additionally, due to California’s current economic situation, the funding in place to serve the reproductive health care needs of adolescents is at risk of being cut. For that reason, the curriculum writer did not include that information in the curriculum, but rather has left that up to each group leader’s discretion, as the status of such funding is likely to change in the years following the publication of this curriculum. A curriculum evaluation is included at the end of the final session, so as to determine whether the curriculum adequately meets the needs of the group members.

Supplemental materials, including worksheets, the *I Can...* learning objectives poster, and the curriculum evaluation can be found in the appendix at the end of the curriculum. The appendix also lists websites for further information on several topics including contraceptives/birth control methods, STIs, and helpful websites with information relevant to adolescent reproductive health.
Curriculum Guide: I Can…

Several considerations should be taken into account before administering the I Can... curriculum. Prior to implementation of the curriculum, the presenter or presenters should be aware of their state’s sexuality education consent laws for minors, and should take the necessary steps to obtain parental consent, if necessary. This should be coordinated with the person who has authority at the site in which the curriculum will be implemented. Presenter(s) should also be conscious of the class size, as a smaller class size tends to facilitate greater trust among group members as well as increased participation. The recommended group size for this curriculum is 15-20. In addition, the goals listed at the beginning of each session provide the group leader with an idea of what students should know when that session is complete. It is up to the discretion of the group leader whether or not to share these stated goals with the participants.

Because of the sometimes sensitive nature of the subject matter, there is the possibility for problems to arise during the course of the program. One potential concern is that a student may disclose incidences of abuse, particularly sexual abuse. The group leader need not be well-versed in the counseling or therapeutic techniques in order to make the student feel safe throughout the duration of the curriculum. Students should be advised, however, that certain behaviors warrant a report to Child Protective Services (this is mentioned in the first session). Several actions can be taken to ensure that participants feel safe within the setting. Keeping the group size small will facilitate a more comfortable learning environment for many students, as will providing youth with
resources to address abuse. This may include a referral to professionals on-site (if applicable) who are trained to treat individuals who have been exposed to abuse, as well as information about resources within the community, and hotlines and websites (these can be found in the Curriculum Appendix).
Session #1: What is I Can…?

**Goals.**

By the end of this session:

- Participants will become familiar with the *I Can…* curriculum.
- Participants will understand the ground rules of the program.

**Activities.**

The first activity of this session will be an introduction to the *I Can…* curriculum. This will be followed by a group discussion on setting ground rules for the remainder of the sessions. Next, the group leader will present the anonymous question box and procedures for asking questions and having them answered. The final activity will allow group participants to become more comfortable with one another, as well as the subject matter.

**Introduction and overview of I Can… curriculum (5 minutes).**

Group leader will hang the *I Can…* Poster in the front of the room as a visual, and will explain to the group that the *I Can…* curriculum is based on three major concepts, all related to the power of choice:

1. I Can…make decisions that will have positive outcomes for me! (Group leader will explain the curriculum’s emphasis on developing and improving decision-making skills, with a specific focus on understanding that making choices give each person power over his/her own life).
2. I Can…make decisions based on accurate knowledge of how to prevent Sexually Transmitted Infections (STIs) and pregnancy. (Group leader will explain the goal of increasing knowledge of sexually-transmitted infections and pregnancy, including how each of these is prevented, as well as how STIs are transmitted.)

3. I Can…identify at least one trusting adult in my life to talk to when I have questions, need advice, or just need someone to talk to. (Group leader will explain that this value recognizes the importance of identifying and communicating with trusted adults. In this case, group leader should give some examples of trusted adults: aunts/uncles, foster parents, social workers, school counselors, etc).

**Establishing ground rules discussion (25 minutes).**

Group leader should discuss with class the importance of having a few ground rules for the remainder of the program. The following underlined rules will be written on a flip chart and presented to the group:

- **Respect:** no put-downs, no interrupting others while they are speaking, respecting others’ opinions, views, and choices

- **Confidentiality:** what is said in this room stays in this room.

- **Right to Pass:** understanding that some of the topics will be uncomfortable or very sensitive to some people, therefore they have the right to simply say “pass” if they are uncomfortable about participating in an activity, role play, or discussion.
After these are written on the flipchart, ask group members if they have other ideas in mind about what kind of rules may be helpful for this program. These might include guidelines that were used in previous sexual education classes or rules that have been established within their school or living situation. When a group member brings up a rule, allow the class to comment on it and voice their agreement or disagreement. Once the rules have been established, be sure to discuss child abuse reporting mandates before moving on.

**Anonymous question box discussion (5 minutes).**

Group leader will show the group what the anonymous question box looks like and will pass out about five index cards per student. Then, the group leader will explain that any time throughout the five sessions, participants can write a question on an index card and place it into the box (This box can also be left within the setting between sessions, if possible, to allow for group members to place questions in the boxes during the time between sessions). The group leader will answer questions at the beginning of each session. Participants will also be encouraged to speak with the group leader one-on-one before or after sessions to discuss issues further.

**Icebreaker: Anatomy slang group activity (25 minutes).**

Group leader will explain that the final activity of this session will serve as an icebreaker, to help each of the group members to become comfortable talking about sexual issues which can sometimes be awkward. On the board or flipchart, the group leader will create three columns with the following headings: “Penis”, “Vagina”, and
“Sexual Intercourse.” The group will be asked to shout out any slang words they’ve heard for each of these terms (if no group members volunteer initially, the group leader may have to begin with a few words, to facilitate this process, and to demonstrate that s/he is comfortable saying these words). In accordance with the rule regarding the right to pass, the group leader may call upon group members throughout this activity, but those group members have the right to say “pass” if they do not want to participate.

**Conclusion (a few minutes).**

Group leader should remind the group about the question box, and quickly review the procedures for asking an anonymous question.

**Preparation considerations.**

Prior to the first group session, the group leader should speak with leaders in charge of the setting in which the sessions will be held, to discuss the possibility of leaving the anonymous question box at the site during the time between sessions.

**Materials.**

- Notecards for anonymous question box
- Box with slit on top (can be decorated facial tissue box)
- Flipchart
- Markers for writing on flipchart
- *I Can*...Poster
Session #2: It’s not just birth control, it’s life control!

(*note: The rules from Session 1 and I Can...Poster should be hung at the front of the room at the beginning of each session)

Goals.

By the end of this session:

- Participants will have a general understanding of the reasons why people chose to have sex or to not have sex.
- Participants will be able to name several methods for preventing pregnancy and sexually-transmitted infections.
- Participants will be able to distinguish between contraceptives which prevent pregnancy only, and those which also prevent the spread of sexually-transmitted infections.

Activities.

Review of ground rules (5 minutes).

Group leader will remind group that the participants came together last session and agreed upon the ground rules. The ground rules will be discussed briefly, as will child abuse reporting rules prior to moving to the next activity.

Anonymous questions (5-10 minutes).

Group leader will take a few minutes to answer questions that were put into the question box. If the group leader is unsure of the answer to the question, the group will
be informed that the question will be discussed next session, so as to give the group leader time to do the research needed to find the answer.

Why do people have sex? (20 minutes).

This group leader should explain that this activity will explore the reasons why people choose to have sex or not have sex. The group leader will ask participants to form groups of 4, and will hand out 2 worksheets to each of the groups (Worksheet 2.1 and Worksheet 2.2). Groups will be asked to pair off, and each pair will be given Worksheets 2.1 and 2.2; one pair will take one worksheet, and one will take the other. These worksheets can be found in the Appendix at the end of the curriculum. The worksheets ask each pair to complete one of the two statements below:

Worksheet 2.1: People chose to have sex
because_______________________________________.

Worksheet 2.2 People chose not to have sex
because_______________________________________.

Groups will be given 5 minutes to complete the worksheet, and 5-10 minutes to take turns presenting their answers to the other group members. The small groups will then convene as a larger group, and the group leader will spend the remaining minutes discussing the importance of individual decision making, and that each individual has the power to decide to have sex or to not have sex.
Listing methods activity (30 minutes).

The group leader will explain to the group the purpose of today’s session: to take control of your life by taking control of your body. The group leader should explain to the group that birth control could also be called life control, because individual can exercise responsibility over their own life through the choices they make.

Group members will be instructed to get into groups of two or three, and will be given 1 minute to list as many contraception methods as possible, even if group members are unsure of what they are or how they work. At the end of the minute, the group leader will ask for volunteers in naming methods, which will be written on a flip chart. When all methods have been named, group leader will lead discussion on different types of methods: abstinence, withdrawl, hormonal methods and barrier methods, making sure to explain that hormonal methods are only intended to prevent pregnancy, and barrier methods are intended for pregnancy and STI prevention. The group leader should also discuss the diminished effectiveness of the withdrawl method in order to inform the group that the withdrawl method is very risky. If students ask questions about effectiveness rates, group leader should be sure to inform them that effectiveness rates listed on contraceptive packaging are often based on perfect use, and do not take into account user error.

(**Note: This activity assumes that the group leader is knowledgeable in the area of contraceptives. Please see the Curriculum Appendix for further information about birth control methods.)
**Preparation considerations.**

Prior to this session, the group leader may want to gather contraceptives to use as visual tools and to pass around. The Resources section at the end of the curriculum provides further information about where to purchase these kits.

**Materials.**

- Flipchart
- Markers for writing on flipchart
- Rules list from Session 1
- *I Can...*Poster
- Worksheet 2.1 & 2.2 (1 copy of each worksheet for each group of 4)
- Examples of contraceptives (optional)

**Session #3: The basics of STI’s.**

(*note: The rules from Session 1 and *I Can...*Poster should be hung at the front of the room at the beginning of each session)

**Goals.**

By the end of this session:

- Participants will be able to identify a few of the most common STIs.
- Participants will be able to differentiate between bacterial infections and viral infections.
- Participants will be able to name a few common symptoms of STIs in both males and females.
Activities.

Anonymous questions (5 minutes).

Group leader will take a few minutes to answer questions that were put into the question box. If the group leader is unsure of the answer to the question, the group will be informed that the question will be discussed next session, so as to give the group leader time to do the research needed to find the answer.

STI discussion and oral quiz (45 minutes).

Group leader will explain that today’s session will focus on Sexually Transmitted Infections (STIs), symptoms in males and females, and how to prevent them. The group leader will facilitate a group discussion about the different types of STIs, through first asking if group members are aware of the two different types of STIs—bacterial and viral. The flipchart will be used as a visual tool, drawing a line down the center of the paper to create two columns, labeled at the top with “Bacterial” and “Viral”. The group leader will explain that bacterial infections (Gonorrhea, Syphilis, Chlamydia, etc) can be treated and cured with medication, in most cases, and that viral infections can be treated, but not cured (Hepatitis B, HIV, Herpes, and Human Papilloma Virus). The group leader should also make mention of the long-term effects of untreated STIs, including cancer, pelvic inflammatory infection, infertility, and potentially death.

The group leader will then flip to the next page on the flipchart, drawing a Venn Diagram and writing “Female” in one circle, “Male” in the other circle, and “Both” in the overlapping section, asking group members about what kind of symptoms might indicate
that someone has an STI. It is important to point out to the group that many symptoms in females resemble symptoms of the flu (fever, stomach pain, vomiting, and diarrhea), and that most bacterial STIs don’t manifest in symptoms right away. The end of this discussion would be a great time for the group leader to remind the group of the importance of using barrier contraceptives (such as condoms), to protect themselves from both pregnancy and STIs.

Finally, the group leader will test the knowledge of the group by doing a quick oral true/false quiz using the questions below. It is recommended that the group leader give out candy or other incentives to the first person who answers the question right.

True or False: Viral STIs can be cured. (F)

True or False: Having a fever can be a symptom of an STI. (T)

True or False: Condoms can prevent the transmission of STIs. (T)

True or False: Some STIs can lead to death if left untreated. (T)

True or False: Most bacterial STIs have no symptoms. (T)

True or False: HPV (Genital Warts) and Herpes can be cured. (F)

True or False: Unusual discharge and sores are symptoms of STIs that only show up in men. (F)

(**Note: The activities included in this session are based on the assumption that the group leader is knowledgeable about STIs and their symptoms. Please see the Curriculum Appendix for further information about STIs.)
**Preparation considerations.**

The group leader should determine the best incentives for this group based on the setting in which the curriculum is implemented (for example, some schools don’t allow their students to eat candy in classrooms). This should be discussed with the person in charge of the setting prior to this session.

**Materials.**

- Flipchart
- Markers for writing on flipchart
- Rules List from Session 1
- *I Can...*Poster
- Candy or other incentives (optional)

**Session #4: Why communicate?**

(*note: The rules from Session 1 and *I Can...*Poster should be hung at the front of the room at the beginning of each session)

**Goals.**

By the end of this session:

- Participants will be able to distinguish between assertive, aggressive, and passive communication.
- Participants will have a general understanding of how to communicate with their partner about sex.
Activities.

Anonymous questions (5-10 minutes).

Group leader will take a few minutes to answer questions that were put into the question box. If the group leader is unsure of the answer to the question, the group will be informed that the question will be discussed next session, so as to give the group leader time to do the research needed to find the answer.

Communication techniques activity (20 minutes).

The group leader should explain that this activity will demonstrate three different styles of communication and will help group members become more effective communicators. The group leader should hang up the prepared visuals in the front of the room, and discuss each of the three communication techniques. The group leader should then give examples of each communication technique and ask the group to identify the technique. The examples below can be used, if needed:

- Passive: “I guess we can have sex if you want to, but I don’t really feel ready.” (body language: looking down at the ground, soft voice, fidgety)
- Aggressive: “You better use a condom or I’ll leave right now and never talk to you again!” (body language: posturing, loud voice, angry tone)
- Assertive: “I will not be willing to get more intimate with you until we both get tested. I care about you a lot, and I want to do be as safe as possible.” (body language: eye contact, firm but not angry tone of voice)
Communication role play activity (25 minutes).

The role play portion of this activity should take approximately 20 minutes, leaving 5 minutes at the end for a wrap-up discussion. For this activity, the participants will be instructed to get into pairs; one member will use Worksheet 4.1 and the other will use Worksheet 4.2 (see Curriculum Appendix). The worksheets have a list of different statements on them. The group members will be instructed to take turns reading the statements and using tone of voice and body language to convey the communication technique specified, and the other group member should then guess what technique the person is trying to convey. In the remaining five minutes, the group leader should bring the entire group back together to have a discussion about which communication technique is the most effective (the hope is that participants will recognize that the assertive technique is the best method for communicating effectively).

Introduction of next week’s interview activity (5 minutes).

The group leader should present next session’s activity, which will involve doing a little bit of homework involving finding an important adult in your life with whom to talk about sex, abstinence, birth control, and STIs. Explain that this could include parents, adult family members, social workers, counselors, etc. Worksheet 4.3 (found in the Curriculum Appendix) should be distributed, and participants should be reminded to bring the completed worksheet to the next session. If any participants express extreme discomfort either identifying an adult to talk to, or in actually asking the questions, ask them to talk with the group leader one-on-one after today’s session. The group leader
should help that participant brainstorm ideas for different ways to complete the interview (for example, the young man or woman could just give the interview questions to the adult to answer on paper). Please see preparation considerations section for suggestions on how to best facilitate this process.

**Preparation considerations.**

The group leader should prepare a visual ahead of time for the Communication techniques activity. The communication techniques are outlined below:

- **Passive**—non-direct or unclear message, no expression of feelings, easily persuaded, weak body language (no eye contact, fidgeting, soft tone of voice)
- **Aggressive**—forceful or hostile, expressing feelings in a disrespectful way, angry body language (glaring, posturing, yelling)
- **Assertive**—direct and clear message, honest expression of feelings, strong, non-threatening body language (direct eye contact, self-confidence, use of “I” statements)

The interview activity which will be discussed next session will vary largely depending on the setting in which this curriculum is presented. If the setting is a school, the group leader may want to speak with the school social worker or counselor about his/her willingness to talk with students who cannot identify another trusting adult in their life. If the setting is a group home or juvenile detention facility, the group leader should be sure to speak with the staff prior to this session about their willingness to talk with youth about sexuality-related issues. The purpose of this activity is to make sure
each participant can identify at least one trusting adult that they feel comfortable talking
to, so the group leader should be prepared to help participants accomplish this task by
whatever means necessary.

**Materials.**

- Flipchart
- Markers for writing on flipchart
- Rules list from Session 1
- *I Can...* Poster
- Posterboard/Flipchart page including each communication technique and
  the definition of that technique
- Worksheet 4.1 & 4.2 (1 copy of each worksheet for each group of 2)
- Worksheet 4.3 (one copy per person)

**Session #5: Putting it all together.**

(*note: The rules from Session 1 and *I Can...* Poster should be hung at the front of the
room at the beginning of each session)

**Goals.**

By the end of this session:

- Participants will be able to identify at least one adult with whom they
can talk about sexuality-related issues.
- Participants will be able to identify community resources to help meet
  their reproductive health needs.
Activities.

Anonymous questions (5-10 minutes).

Group leader will take a few minutes to answer questions that were put into the question box.

Interviewing an adult activity discussion (20 minutes).

The group leader should ask participants how many of them were able to complete the interview assignment, and how the assignment went. If most of the participants were able to find an adult to interview, go around the room and ask each participant to say one thing that s/he learned from this assignment. The group leader should be sure to ask if anyone had a bad experience with the interview, and explain that adults can be just as uncomfortable talking about sex as kids are, and that sometimes, it is just a matter of bringing the topic up, as some adults are relieved if you bring it up first. If any group members had a particularly negative experience, explain that it may be best to seek out another trusted adult to talk to. Depending on the setting and your professional role within that setting, inform the group that you are willing to talk with them privately after class, and distribute business cards to participants (see preparation considerations for more information).

Seeking out resources discussion (20 minutes).

(*note: This activity will be dependent the group leader’s familiarity with local resources, therefore the topics discussed will vary depending on available resources. Topics may include: local healthcare facilities which cater to adolescents, such as Planned
Parenthood, state adolescent health care laws and rights, pamphlets and flyers on STIs, teen pregnancy, healthy relationships, etc. This would be a good time to ask a representative from a local clinic to come and do a quick presentation about the services available to teens and how to go about obtaining and paying for those services).

**Curriculum evaluation (10 minutes).**

At this time, the group leader will thank the group members for their participation and willingness to talk about topics that are sometimes awkward and uncomfortable. The group leader will then ask if there are any final questions, and will distribute curriculum evaluations (see Curriculum Appendix) to be completed by the group.

**Preparation considerations.**

If the group member is not already familiar with reproductive health care resources available within the community, a good amount of time should be devoted to researching these resources and potentially arranging for a guest speaker to talk about community resources, prior to this final session.

Additionally, the group leader may want to arrange with the setting’s supervisor that the curriculum evaluations be picked up or mailed at a later date. Having the group leader absent during the evaluations may encourage group members to be more honest in their responses about ways to improve the curriculum.

**Materials.**

- Rules list from Session 1
- *I Can...*Poster
- Community resources materials such as pamphlets, business cards, etc (optional)
- Curriculum Evaluations (1 per participant)
Chapter 5

CONCLUSION AND IMPLICATIONS FOR SOCIAL WORK

Introduction

This final chapter begins with a review the findings discussed in the needs assessment, as well as a summary of the curriculum development and content. The project will then be discussed in terms of its implications to the field of social work. Suggestions will be made for improving both the needs assessment, and the content and structure of the I Can curriculum. Finally, the researcher will make recommendations for further research necessary to explore the various topics which impact the sexual behavior and decision-making capacities of youth living in out-of-home placements.

Review of Findings from Needs Assessment and Relevance

Most of the findings resulting from the needs assessment were consistent with the existing literature on sexuality education and pregnancy prevention. Sexuality education itself was chosen by over three-quarters of participants as an important component in preventing teen pregnancy. Although there is not enough information to infer that the youth polled did not receive any sexual education, the existing research suggests that foster youth are less likely to engage in sexuality education through the usual avenues (Becker & Barth, 2000; Healthy Teen Network, 2008).

Access to clinic services as a necessary resource, was chosen by 65% of study participants, which indicates a clear need for expanding sexual reproductive health care services, and making them more accessible to adolescents. The state of California has
recognized the need for increased accessibility of reproductive health care services for adolescents, which can be seen in the Family PACT program discussed in an earlier chapter. Family PACT is a family planning program, which delivers free and low-cost reproductive health care to adolescents and adults (Boonstra, 2010).

A consistent relationship with a trusted adult was another theme present in both the needs assessment and the existing literature (Constantine, Jerman, & Constantine, 2009; Dworsky & Courtney, 2010; Love et al., 2005; Mendes, 2009). More than half of the study subjects thought it was important to have an adult to go to with questions and concerns about sexuality, and 38% listed role models and mentors as one of the top five most important factors in preventing pregnancy.

**Summary of curriculum development efforts.**

The development of the curriculum was largely based on the needs assessment findings, and incorporates all of the above-mentioned themes, in combination with information from existing literature. Sexuality education, including factual information on contraceptive methods and the symptoms and transmission of viral and bacterial STIs, was interwoven into all of the five sessions. Two of the sessions have activities that emphasize relationships with trusted adults, seeking these relationships out, and initiating conversations with adults about sexuality-related issues. The final session of the curriculum allows for time to explore location-specific reproductive health care services available to adolescents, with the goal of meeting the need for increased access to clinic services.
Implications

This two-part project, including the needs assessment and curriculum developments, have important implications for agencies which serve young men and women living in out-of-home placements, including youth in both formal and informal foster care. The findings from the needs assessment provide much insight into the specific sexuality education and reproductive health care needs of this population. This data could be incorporated into various trainings for child welfare professionals, teachers, group home employees, therapists, and a variety of other professionals who serve this group. The needs assessment findings could also be used for the purposes of obtaining grant money to fund programs and curricula, which address the unique needs of these youth.

An important component of the I Can curriculum is its flexibility. The curriculum content was purposely kept broad, so as to increase adaptability for use by child welfare agencies, group homes, juvenile detention facilities, and educational institutions which serve this specific population. The short duration of the curriculum allows for practical, efficient delivery of pertinent information to help adolescents make deliberate decisions about their sexual health.

Although the needs assessment and curriculum guide could positively impact professionals working in the fields of social work and education, the researcher encountered various problems in the research design and overall framework of the curriculum materials. The central problematic issue surrounding this project is the
sample size, which was very small and only representative of youth in one location. Locating and identifying adolescents who qualify as informal foster youth poses a logistical issue, as there is no mechanism for tracking youth if they are not in formal foster care through child welfare services involvement. As a result, it is difficult to discern whether the participants of the original study were representative of all youth living in both formal and informal, out-of-home placements. The researcher is suggesting that future studies may be more representative of the population as a whole if they included a much larger sample size and include not only youth living in the suburban setting of Placer County, but also those who reside in intercity and rural locations.

Just as there were problems evident in the data used for the needs assessment, there were also a few problems within the curriculum guide itself. The contents of the curriculum materials were restricted by the short duration of *I Can...*, as well as the amount of time specified for each session and activity. Although the curriculum guide was developed to be time-efficient and practical for use in several settings, the short duration of the sessions could negatively affect the quality of the activities specified in the curriculum guide, and students may not learn the vital information intended for each session in only sixty minutes. Important topics were also excluded because of the time restrictions. Examples of such topics include healthy body image, relationship violence awareness and prevention, and sexual abuse. These problems could be addressed through
expanding session time to ninety minutes, and increasing the overall number of sessions so as to include other important topics.

**Recommendation for Further Research**

Overall, this data that was derived from the needs assessment represents only a very small window of insight into a complex and sparsely explored topic. More research is needed which is inclusive of all youth living in out-of-home placements, as the literature on pregnancy rates and sexual behavior of foster youth includes only those in the formal foster care system. This research could be more useful if it also includes information specific to why some youth living in various out-of-home arrangements purposely become pregnant. Furthermore, data on the specific pregnancy rates of this population could provide much-needed insight into information that could influence a much more comprehensive sexuality education curriculum than the one created for this project. As mentioned above, identifying youth who qualify as living out-of-home is perhaps the most challenging task in obtaining further information about this group. The researcher suggests that this may be best accomplished through extracting information from school and/or district databases. Schools may be the most reliable source of information regarding the living situations of young men and women, as youth are required by compulsory education laws to attend school. The likelihood that schools will cooperate with the release of such data is not known at this time; however one can predict that schools may not be willing to take the time necessary to query this information, as most schools are already stretched thin in terms of their staffing and financial resources.
Further exploration into each of these areas discussed above could have major implications in better understanding teen pregnancy among this population, and could lead to programs and curricula that better meet the needs of informal and formal foster youth.

**Summary**

This chapter included a summary of the two-part project in which the researcher analyzed the needs of youth in out-of-home placements and developed a curriculum to meet these needs. The needs assessment findings became the major themes of the *I Can* curriculum, along with information extracted from existing literature and sexuality education curricula. Through incorporating these findings, along with information derived from existing literature, the researcher was able to develop a sexuality education curriculum specific to the needs of youth living in out-of-home placements.

This project could potentially have significant implications for social workers and educators who practice in several capacities and settings. The sample size of the population from which the data was derived presented a significant concern. However, suggestions were made to create a sample size more representative of the population as a whole, including expanding the sample size to increase the number and diversity of participants.

Curriculum-wise, the structure of the *I Can* curriculum presented both strengths and challenges for implementation, due largely to time restrictions. Keeping the content concise and succinct led to an exclusion of topics relevant to sexuality and decision-
making. Perhaps the most important recommendation made by the researcher was to expand the curriculum to allow for more time for each session and to include a broader range of topics. Further research on the unique needs of youth living out-of-home is needed, as teen pregnancy is an issue that deserves the attention of social workers and educators alike. The *I Can* curriculum provides a foundation for expanding understanding of the topic, which could lead to better overall outcomes for this group.
APPENDICES
APPENDIX A

Survey

1. Age
   ☐ Under 11
   ☐ 12-14
   ☐ 15-18
   ☐ 19-24

2. Ethnicity
   ☐ American Indian/Alaska Native
   ☐ Asian
   ☐ Black/African American
   ☐ Filipino
   ☐ Latino/Hispanic
   ☐ Pacific Islander
   ☐ White/Caucasian
   ☐ Multi-racial/Multi-ethnic
   ☐ Other

3. Gender
   ☐ Male
   ☐ Female

4. Zip Code (fill in): __________

5. Do you live with (check all that apply):
   ☐ One parent
   ☐ Two parents
   ☐ Other relatives
   ☐ Foster care
   ☐ Friends
   ☐ I am in juvenile hall

6. Have you had experience with the following systems? (check all that apply):
   Counseling or mental health services
     ☐ Yes
     ☐ No
   Probation
     ☐ Yes
     ☐ No
   Child welfare/foster care
     ☐ Yes

7. Are you at risk of getting pregnant or getting someone pregnant?
   ☐ Yes
   ☐ No

8. If you are female, have you ever:
   ☐ Been pregnant?
   ☐ Given birth to a child?

9. If you are male, have you:
   ☐ Ever gotten a girl pregnant?
   ☐ Ever fathered a child?
   ☐ Are you involved in your child’s life now?

10. Please pick the five items below that you feel are most important in preventing teen pregnancy:
    ☐ After school programs
    ☐ Having someone you can go to with questions, concerns, or help (it can be a parent, teacher, a friend’s parents, relative, pastor, or ?)
    ☐ Access to Clinic Services (birth control, testing, etc)
    ☐ Family/Cultural Values
    ☐ Family Communication
    ☐ Life Skills
    ☐ Sex Education
APPENDIX A

Survey

- Programs specifically for guys to learn about their own sexual health, as well as the risks and responsibilities of becoming a teen dad
- Planning for a positive future
- Role Models/Mentors
- Healthy Teen Dating Relationships
- Information from friends
- Other (please specify): ___________________________

11. Thank you for your participation. Your information is very important to us and will remain anonymous. Do you have any further comments?

__________________________
__________________________
__________________________
APPENDIX B

Agency Permission Letter

November 29, 2010

Human Subjects Review Committee
California State University, Sacramento
Division of Social Work
6000 J Street
Sacramento, CA 95819-6090

To Whom It May Concern:

Randilee Groff, an MSW candidate at California State University, Sacramento, has requested to review data collected by Placer County Health and Human Services. I have been informed of the purpose, design, and procedures of the researcher’s thesis project. The purpose is to utilize the data to create a sexuality education curriculum for youth in out-of-home placements. This is a one-time needs assessment which will use secondary data previously collected from youth residing Placer County in the form of an anonymous survey. The data from the surveys will be transcribed into a database from analysis, and will be kept in a locked cabinet accessible only to the researcher. The analysis will contain only aggregate data.

Candy Jensen is the Health Educator for Placer County Health and Human Services who is responsible for creating and implementing this research instrument, as well as collecting and analyzing the data. As her supervisor, I hereby state that I fully understand how this data will be used and am authorized to grant the researcher permission to review and utilize the data as outlined above.

If you have any questions regarding this permission letter, please feel free to contact me (kklayman@placer.ca.gov, 530 889-7125) or Candy Jensen (cjensen@placer.ca.gov, 530 889-7147)

Sincerely,

Karen Klayman, RN, MPH
PHN Supervisor
Placer County Community Health
I Can!!!

- I Can…make decisions that will have positive outcomes for me!

- I Can…make decisions based on accurate knowledge of how to prevent Sexually Transmitted Infections (STIs) and pregnancy.

- I Can… identify at least one trusting adult in my life to talk to when I have questions, need advice, or just need someone to talk to.
Worksheets

Worksheet 2.1: What are some reasons why people choose to have sex?

Directions: Please use the space provided below to list reasons why people choose to have sex. They don’t have to be reasons you agree with, simply reasons why someone might choose to have sex.

People choose to have sex because:

• __________________________________________________________________________

• __________________________________________________________________________

• __________________________________________________________________________

• __________________________________________________________________________

• __________________________________________________________________________

• __________________________________________________________________________

• __________________________________________________________________________

• __________________________________________________________________________
Worksheet 2.2: What are some reasons why people choose not to have sex?

 Directions: Please use the space provided below to list reasons why people choose not to have sex. They don’t have to be reasons you agree with, simply reasons why someone might choose not to have sex.
 People choose not to have sex because:

 •  

 •  

 •  

 •  

 •  

 •  

 •  

 •  

 •  

 •  

 •  


**Worksheet 4.1**

*Directions: Read the following statements aloud to your partner, being mindful of your eye contact, body language, and tone. Then have your partner guess which type of communication technique you’re using: passive, aggressive, or assertive. Keep in mind that some of the statements may be classified as any one of the techniques, depending on how it’s presented.*

1. “I need you to get on the pill, right now!”

   Passive, Aggressive, or Assertive?______________________________

2. “I really care about you, and want to show you how much I love you. But I’m not ready to have sex yet. We could do other things though.”

   Passive, Aggressive, or Assertive?______________________________

3. “I don’t know where you’ve been, and I don’t want to get any STD’s!”

   Passive, Aggressive, or Assertive?______________________________

4. “I guess we could have sex without a condom this time, but I’m really worried about getting pregnant.”

   Passive, Aggressive, or Assertive?______________________________

5. “If you don’t have sex with me soon, I’m leaving you.”

   Passive, Aggressive, or Assertive?______________________________
Worksheet 4.2

Directions: Read the following statements aloud to your partner, being mindful of your eye contact, body language, and tone. Then have your partner guess which type of communication technique you’re using: passive, aggressive, or assertive. Keep in mind that some of the statements may be classified as any one of the techniques, depending on how it’s presented.

1. “We don’t have to use a condom, I guess. I mean, I’d like to, but I’ll do whatever you want to do.”

   Passive, Aggressive, or Assertive? ____________________________

2. “No sex without a condom, I do NOT want to be your baby daddy!”

   Passive, Aggressive, or Assertive? ____________________________

3. “I won’t have sex unless we use protection. Please don’t ask me again.”

   Passive, Aggressive, or Assertive? ____________________________

4. “I love you, but I love myself more. I really don’t want to get pregnant, so I don’t want to have sex until I get on birth control.”

   Passive, Aggressive, or Assertive? ____________________________

5. “I’ve been thinking we should both get tested, but only if you want to. We don’t have to.”

   Passive, Aggressive, or Assertive? ____________________________
Worksheet 4.3

Directions: Have an adult you trust and respect answer the following questions. This can be done in a conversation while making notes on this paper, or you can give this paper to an adult to fill out and give back to you.

1. Who was the first person you talked to about sex, either adult or peer? How old were you at the time?

2. How do you feel about teenagers having sex? Do you think they should be able to get birth control without parent/caregiver consent?

3. If I asked you to go with me or take me to a clinic to get birth control, get a pregnancy test, or get tested for Sexually Transmitted Infections, what would you say?

4. If you found out I was having sex, how would you feel?
**I Can Curriculum Evaluation**

1. Before the previous 5 week session, have you had sexuality education in the past?  
   Yes  No

2. Please rate your knowledge about sexuality, contraceptives, STIs, communication, and decision-making **before I Can**. Please circle your answer from the choices below:  
   0=No knowledge  4=Lots of knowledge  
   1=A little bit of knowledge  5=I’m an expert!  
   3=An average amount of knowledge

3. Please rate your knowledge about sexuality, contraceptives, STIs, communication, and decision-making **after I Can**. Please circle your answer from the choices below:  
   0=No knowledge  4=Lots of knowledge  
   1=A little bit of knowledge  5=I’m an expert!  
   3=An average amount of knowledge

4. What topic do you feel was the **most** helpful? Please circle your answer from the choices below.  
   Anonymous Question Box  Why do People have Sex Activity  
   Contraceptives Methods Activity  STI Discussion & Oral Quiz  
   Communication Techniques Activity  Interviewing an Adult Activity  
   Resources Presentation

5. Which activity/topic do you feel was the **least** helpful? Please circle your answer from the choices below.  
   Anonymous Question Box  Why do People have Sex Activity  
   Contraceptive Methods  STI Discussion & Oral Quiz  
   Communication Techniques Activity  Interviewing an Adult Activity  
   Resources Presentation

6. Please list at least one thing that you will remember from **I Can**:  
   ____________________________________________________________

7. Please provide any suggestions for improving **I Can**:  
   ____________________________________________________________

*Thank you ☺️*
Resources

This section contains further information about topics relevant to the I Can… curriculum, including resources for where professionals can purchase contraceptive kits, further information about STIs,

**Contraceptive kits.**

Kids Healthcare—A Guide to Contraceptives Kit:


Planned Parenthood—Contraceptive Teaching Kit:


Total Access Group—Contraceptive Educator Kit:


**Information about STIs.**

American Social Health Association:

http://www.ashastd.org/learn/learn_overview.cfm

Center for Disease Control (CDC):

http://www.cdc.gov/STD/

National Institute of Allergy and Infection Diseases:

http://www.niaid.nih.gov/topics/sti/Pages/default.aspx
Domestic Violence and Abuse.

Child Abuse Prevention Council

http://www.childabuseprevention.org/

Child Welfare Information Gateway—United States Department of Health and Human Services

http://www.childwelfare.gov/

HelpGuide.org: Recognizing and Preventing Child Abuse

http://helpguide.org/mental/child_abuse_physical_emotional_sexual_neglect.htm

National Center for Victims of Crime

http://www.ncvc.org

National Child Abuse Hotline (for individuals who have been abused as well as professionals who work with individuals they suspect are being abused)

1-800-4-A-CHILD (1-800-422-4453)

www.childhelpusa.org

National Domestic Violence Hotline

1-800-799-SAFE (1-800-799-7233)

http://www.thehotline.org/

National Sexual Assault Hotline

1-800-656-HOPE (1-800-656-4673)

http://www.rainn.org/

National Suicide Prevention Lifeline
1-800-273-TALK (1-800-273-8255)

http://www.suicidepreventionlifeline.org/

National Teen Dating Abuse Helpline

1-866-331-9474

http://www.loveisrespect.org/

Prevent Child Abuse America

www.preventchildabuse.org

Stop It Now: Together We Can Prevent the Sexual Abuse of Children

1-888-PREVENT (1-888-773-8368)

www.stopitnow.org

Victim’s Rights Law Center

http://www.victimrights.org/resources-victims

Other helpful websites.

The Annie E. Casey Foundation

http://www.aecf.org/KnowledgeCenter/Health/AdolescentReproductiveHealth.aspx

Centers for Disease Control and Prevention—Teen Pregnancy:

http://www.cdc.gov/teenpregnancy/

Child Welfare League of America:

http://www.cwla.org/

National Center for Youth Law:

http://www.youthlaw.org/
National Center for Youth Law: Teen Health Law

http://www.teenhealthlaw.org/reproductive_health/

The National Campaign to Prevent Teen and Unplanned Pregnancy

http://www.thenationalcampaign.org/

Sexuality Education and Information Council of the United States

http://www.siecus.org/
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