



The invisibility of adolescent sexual development in foster care: Seriously addressing sexually transmitted infections and access to services

Roni Diamant Robertson *

University of Illinois, Chicago, Jane Addams College of Social Work, United States

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ABSTRACT

Adolescents residing in foster care are at higher risk for acquiring sexually transmitted infections (STIs) and human immune deficiency virus (HIV) compared to their non-foster care peers. A literature review was conducted to determine whether youth residing in foster care face different barriers to sexual health care compared to their peers in the general population and, if so, what those barriers are. The review revealed barriers common to adolescents in general as well as additional barriers specific to the ecosystem of adolescents in foster care. Systemic issues that decreased access to sexual health services included child welfare policies that were either missing or implemented without fidelity; complicated financial factors; barriers to service utilization; lack of collaboration between child welfare and medical professionals; and limited information provided to foster youth on their sexual health and development. Consent and confidentiality issues that foster youth face in seeking sensitive health services also need to be resolved. More research is needed on how to facilitate development of coherent policies and effective practices that promote sexual health care access for adolescents in foster care.

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1. Introduction

The child welfare system in the United States has been slow in integrating well-being with permanency and safety goals for children in care, but change is in the wind. With the recent passage of the Child and Family Services Improvement and Innovation Act (P.L. 112–34) and, in 2008, the Fostering Connections to Success and Increasing Adoptions Act, the foster care system is undergoing dramatic reform (*Child Welfare League of America (CWLA), 2012*). Progressive legislation is addressing the health and safety of children in care by identifying their health care needs and mandating delivery, monitoring and documentation of appropriate health services (*GAO, 2009*). This is particularly important for the sexual health of adolescents in foster care since they are at much higher risk of exposure to sexual transmitted infections (STI), and may have even more barriers to access STI prevention, screening and treatment services than youth in the general population.

This article critically reviews the empirical literature to determine (1) the state of knowledge regarding access to sexual health services for prevention and treatment of STIs for adolescents in foster care; (2) whether these youth face different barriers to care compared to their peers in the general population; and, if so (3) what those barriers are. Understanding these issues can provide a clearer picture and inform improvements in policy and practice to better support the sexual health of adolescents in foster care.

2. Background

Nearly half of all STIs in the United States occur among adolescents and young adults (*Centers for Disease Control (CDC), 2009*). Adolescent females have the highest number of reported cases of chlamydia and gonorrhea of any age group, and adolescent males have the second highest rate of gonorrhea (*CDC, 2009*). The risk of human immunodeficiency virus (HIV) is especially concerning for youth of color. In 2009, of the adolescents and young adults diagnosed with HIV infection, 64% were African American (*CDC, 2010*).

Adolescents in foster care are a special subgroup of teens at risk for STIs and HIV. The exact prevalence of STIs and HIV among adolescents in care is difficult to determine; public health officials do not report rates for foster youth separately from rates in the general youth population. Nonetheless, multiple studies have found that youth living in foster care are at higher risk for acquiring STIs and HIV than are their peers who are not in foster care (*Ahrens, Richardson, & Courtney, 2010; Auslander et al., 2002; Polit, White, & Morton, 1987; Shields et al., 2004; Sullivan & van Zyl, 2008*). Data from the National Longitudinal Study of Adolescent Health found that, compared to their contemporaries in the general population, female adolescents who have been in foster care were three times more likely to have had Trichomonas (OR = 3.23; 95% CI = 1.45–7.23), and male adolescents who have been in foster care were more than three times more likely to have Chlamydia (OR = 3.07; 95% CI = 1.36–6.96) and 14 times more likely to have had gonorrhea (OR = 14.28; 95% CI = 2.07–98.28) (*Ahrens et al., 2010*). *Shields et al. (2004)* reported a 16.4% prevalence rate of chlamydia in female street youth who were formerly in foster

* University of Illinois, Chicago, Jane Addams College of Social Work, 1040 West Harrison Street, Chicago, IL 60607-7134, United States.

E-mail address: vrober4@uic.edu.

care compared to 6.8% of female street youth who had never been in care.

It is not surprising that teens in foster care experience STIs at higher rates than their non-foster care counterparts considering the prevalence of risk factors for STIs in the histories of foster adolescents. Risk factors include sexual abuse, exposure to violence and substance use, experiences that can contribute to youth having unprotected sex (Elze, Auslander, McMillen, Edmond, & Thompson, 2001; James, Montgomery, Leslie, & Zhang, 2009; Saewyc, Magee, & Pettingell, 2004; Thompson & Auslander, 2011; Trent, Clum, & Roche, 2007). Foster children and youth tend to initiate sexual activity earlier, have greater numbers of sexual partners, and engage in riskier sexual behaviors compared to youth who are not in care (Carpenter, Clyman, Davidson, & Steiner, 2001; Risley-Curtis, 1997). Data from the National Survey of Child and Adolescent Well-being (NSCAW), for example, found that more than one in four (28.5%) 12 to 14 year olds in foster care has already had intercourse (Leslie et al., 2010).

Much of the research and concern about sexual health of adolescents in foster care has focused on teen pregnancy. While this is a major concern, STI and HIV infections may be even more detrimental to foster teens than pregnancy. In a 30-year follow-up prospective cohort study, Wilson and Widom (2008) found that physically and sexually abused children were at greater risk for early sexual contact, prostitution and HIV infection in adulthood compared to nonmaltreated children. Other studies have documented an association between childhood sexual abuse and transactional sex or prostitution (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012; Windom & Kuhns, 1996). Surratt and Kurtz (in press) found that 17% of the African American female sex workers in their study had been in foster care with 62% active in the sex trade before 18. Also concerning was their finding that some study participants experienced sexual abuse after entering care.

Given the elevated risk, access to STI/HIV services for adolescents in general and foster youth in particular is of crucial importance. The World Health Organization (WHO) defines sexual health as “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity” (World Health Organization [WHO], in press). To reach and maintain this level of sexual health, adolescents in general and those living in foster care need accurate and timely information to help them make critical decisions affecting their health, and to access sexual health services to stay healthy and prevent STIs/HIV.

3. Theory and rationale

Obtaining STI/HIV care is inextricably tied to contextual factors in the environment (DiClemente, Salazar, Crosby, & Rosenthal, 2005; Kotchick, Shaffer, Forehand, & Miller, 2001). Bi-directional or transactional influences occur within and between systems that affect client conditions (Mattaini & Moore, 2004), including access to relevant information and effective services. Understanding the complex networks of transactions involved in adolescents' access to sexual health services is important in preventing and/or treating STIs/HIV. Conditions that facilitate or impede access to information and services may occur at all levels of the adolescent's ecosystem: *macro*-, *exo*-, *meso*-, and *micro*-system levels (Bronfenbrenner, 1979). For instance, a youth's decision to seek care could depend on cultural values and norms that adolescents should not be having sex (*macrosystem*); policies allowing youth to consent to STI testing and treatment (*exosystem*); community systems interacting with one another on behalf of the youth (*mesosystem*); and the youth's communication with a parent/guardian about sexual development (*microsystem*).

The ecosystem of adolescents in foster care is even more complex, with its own macrosystem values, exosystem policies and procedures, the additional microsystems of foster homes and foster families, case-workers, therapists and other helping professionals, and the interaction of these microsystems at the mesosystem level — all imbedded within

and transacting with the larger ecosystem experienced by adolescents in the general population. Transactions that involve “place” or where a person resides are important to consider, particularly when a person is “displaced” (Kemp, p. 120, 2010). Understanding the complex web of transactions that influence foster youth's access to sexual health services is important in identifying their health care needs and developing effective interventions.

4. Methods

A review of the empirical literature was conducted to determine what is known about barriers to adolescents in foster care face accessing STI/HIV prevention and treatment services and whether and how these differ compared to their peers in the general population. A search was conducted using social science, medical and public health research databases (e.g. Academic Search Premier, CINAHL, ERIC, Google Scholar, JSTOR, Medline, Science Direct, Social Work Abstracts PubMed PsychINFO). In addition, websites of organizations central to child protective services were searched including the Children's Bureau Information Gateway and the Child Welfare League of America, and those with a specific interest in disease including the Center for Disease Control (CDC) and the World Health Organization (WHO). Search terms related to study participants included foster care, child protective services, child abuse, child neglect, and adolescent; terms related to health included STDs, STIs, sexually transmitted diseases, sexually transmitted infections, human immunodeficiency virus, HIV, gonorrhea, chlamydia, sex, pregnancy, and contraception; and terms for services included reproductive health, sexual health, prevention, treat, access, health services, confidentiality, consent, notification, sex education, funding and testing. Terms were systematically varied to complete an exhaustive electronic literature search covering the period January 1980 to January 2012. Manual searches included following-up on references, footnotes and cross-references cited in relevant articles. Qualitative, mixed methods and quantitative journal articles were reviewed as long as empirical findings were reported. Non peer review articles most commonly cited in peer review journals were also included.

To be included in the review, empirical studies had to provide information on access to sexual health services for prevention and/or treatment of STIs/HIV for adolescents (12 to 21 years old) residing in foster care and be published in English. Samples could include other adolescents in the child welfare system, i.e., kinship care, guardianship, adoption, etc., for comparison as long as the review's focus was on adolescents placed in non-relative foster homes, group homes or residential facilities. Only three empirical studies were found that addressed how adolescents in foster care access STIs/HIV prevention and treatment and the barriers that exist. This necessitated expanding the search to broader sexual health services such as reproductive health, pregnancy testing and counseling, contraception, etc., and to include current and former children and adolescents in foster care (birth to 26 years old).

5. Results

Twenty studies met the expanded inclusion criteria. The empirical studies varied greatly in sample size, design, data analysis, measurement instruments, variables and demographic information describing the participants. Barriers impeding access to sexual health services for adolescents in foster care fell into five major categories: policy development, service delivery issues, financial barriers, lack of effective communication of sexual health information, and lack of privacy and confidentiality concerns. The table in Appendix A summarizes the 20 studies and classifies them according to one of four barriers: policy (4 studies); financial (2 studies); service delivery (4 studies); and communication/information (10 studies). No separate category was created for the lack of confidentiality/privacy because this barrier was identified in almost all of the studies. Studies that included multiple barriers were classified under the category most significantly related to their findings.

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