Stakeholder perceptions of barriers and facilitators to sexual health discussions between foster and kinship caregivers and youth in foster care: A qualitative study

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ABSTRACT

Purpose: Youth in foster care are more likely to contract a sexually transmitted infection (STI) and become pregnant than other youth, who have not been in foster care. This study explored stakeholder perceptions of barriers and facilitators to conversations about sexual health between foster/kinship caregivers and youth in foster care, with the goal of developing a brief, scalable sexual health training for caregivers.

Methods: We conducted individual phone interviews with twenty stakeholders from a variety of occupations that work closely with foster and kinship caregivers in New York, NY, Seattle, WA and Los Angeles, CA. Stakeholders were asked semi-structured open-ended questions regarding their thoughts on a caregiver's role in discussing sexual health, barriers and facilitators in having these conversations, and staff members' comfort level in having these discussions with youth in foster care. We coded and analyzed transcripts using Thematic Analysis technique.

Results: Themes emerged around three main categories: 1) barriers to sexual health conversations with youth in their care, including caregivers' religious and personal beliefs impeding youth access to accurate sexual health information and crucial medical services, staff and caregiver lack of sexual heath knowledge, caregiver and/or youth discomfort in engaging in sexual health conversations, and a lack of mandatory training for caregivers and staff on sexual health; 2) facilitators to sexual health conversations with youth, including open and nonjudgmental communication between youth in foster care and caregivers, and engagement in deliberate relationship-building activities with the youth; and 3) recommendations for content and format of a training for caregivers and agency staff to address barriers to conversations, such as making trainings mandatory and in-person.

Conclusions: Stakeholders identified several barriers and facilitators to sexual health conversations and viewed conversations between caregiver and the youth in foster care as essential to the youth's wellbeing. Clear guidance from child welfare agencies and caregiver-oriented trainings that include straightforward information and skill-building strategies could help to mitigate these barriers and related health disparities.

1. Introduction

1.1. Sexual health among adolescents and young adults

Sexually transmitted infections (STIs) are a critical public health concern for adolescents. Youth and young adults aged 15–24 have the highest risk of contracting STIs and account for almost half of all new reported cases of STIs (Satterwhite et al., 2013). In 2016, approximately one million adolescents and young adults reported having a chlamydia infection and there were 460,000 new cases of gonorrhea (Centers for Disease Control and Prevention, 2017). Medical care costs associated with STIs were roughly $16 billion (Owusu-Edusei et al., 2013).

Similarly, teen pregnancy is an impactful outcome associated with significant economic and educational costs. Although rates are declining, in 2015 almost 230,000 births were from women aged 15–19, with one in five being a repeat birth (Martin, Hamilton, & Osterman, 2017; Schelar, Franzetta, & Manlove, 2007). Teen births have several effects on educational attainment, financial costs and perinatal outcomes. Data indicates that only one third of teen moms who give birth before age 18 will obtain their high school diploma before age 19 (Perper, Peterson, & Manlove, 2010). Data from 2010 and 14 years prior indicated that taxpayers spent $9.4 billion in services associated...
with teen childbearing (Power to Decide, 2013). Additionally, new-
borns born to teen mothers are more likely to be born preterm, to be
low birth weight, and to be born stillbirth (G. C. Smith & Pell, 2001;
Torvie, Callegari, Schiff, & Debiec, 2015; Wilson, Alio, Kirby, & Salihu,
2008).

1.2. Parental role in adolescent sexual behavior

In a survey of 1000 adolescent females, almost 90% felt that open
and honest conversations with a parent would facilitate the delay of
sexual debut and preventing pregnancy (Power to Decide, 2015). Ob-
servational studies with parents have confirmed these findings: for
example, in a study conducted by DiClemente et al. (2001), less com-
unication between parent and adolescent was associated with de-
creased use of contraceptives and condom use (Aspy et al., 2006;
Dilorio, Kelley, & Hockenberry-Eaton, 1999; Whitaker, Miller, May, & Levin, 1999). Similarly, several interventions tailored to improve
parent-child communication have shown an increase in condom use,
self-efficacy to refuse pressure to have sex, and knowledge of STIs
(Dancy, Crittenden, & Talashek, 2006; Dilorio et al., 2006; Dilorio,
McCarty, Reznicow, Lehr, & Denzmore, 2007; Lederman, Chan, & Roberts-Gray, 2008; Prado et al., 2007; Stanton et al., 2004).

1.3. Sexual health among adolescents and young adults in foster care

There are approximately 437,000 children in the foster care system
in the U.S., and roughly 35% of those youth are adolescents aged 11–18
(U.S. Department of Health and Human Services et al., 2017). Com-
pared to youth in the general population, youth in foster care have
higher rates of both STIs and early pregnancies, likely due to the effects
of trauma or a lack of guidance or modeling around healthy behaviors.
Specifically, they are 3 to 14 times likelier to acquire STIs (Ahrens et al.,
2010). Two longitudinal studies of youth from four different states who
were transitioning out of foster care suggest that youth in foster care are
also two to four times likelier than their peers to have an unintended
pregnancy: almost half of young women in foster care become pregnant
before they turn 19 as opposed to 20% of young women in the general
population; male youth in foster care were also more likely to im-
pregnate a partner (Courtney et al., 2005; Courtney et al., 2016). Youth
in foster care have higher rates of engagement in high risk behaviors,
including an earlier age at sexual debut and a higher number of total
and casual partners (Ahrens et al., 2010; Ahrens, Spencer, Bonnar,
Coatney, & Hall, 2016; Carpenter, Clyman, Davidson, & Steiner, 2001;
Courtney et al., 2005; Courtney, Terao, & Bost, 2004). These outcomes
and related behaviors have significant costs and implications both for
the wellbeing of youth in foster care and for public health (Ahrens,
Garrison, & Courtney, 2014; Cates, Herndon, Schulz, & Darroch, 2004;
Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Tyler & Melander,
2010).

1.4. Foster care-specific programs

The disparity in risks of engaging in sexual behavior, pregnancies,
and STIs among youth in foster care compared with other youth has
prompted the creation and adaptation of programs designed to address
unsafe sex practices and teenage pregnancy in this population (Becker
& Barth, 2000; Boustani, Frazier, & Lesperance, 2017; Dworsky
& Dasgupta, 2014; Slonim-Nevo, Auslander, Ozawa, & Jung, 1996; T.
Smith, Clark, & Nigg, 2015). These interventions have typically focused
solely on youth and consisted of sessions that address knowledge and
understanding of STIs and HIV transmission, condom use, contraceptive
methods, and communication skills. However, it is important to note
that findings have been inconclusive as to whether this approach is
feasible and effective in this population for several reasons, including
placement instability and competing demands on youths’ time to ad-
dress educational, housing, mental health, and other needs.

Furthermore, for agencies serving primarily youth placed in single fa-
mily kinship or foster homes, a lack of geographic co-location is likely
to compound challenges to a weekly in-person group format. Overall,
only two youth-focused interventions have been rigorously evaluated in
a randomized controlled trial among child welfare-involved youth—
one did not demonstrate long-term effects (Slonim-Nevo et al.,
1996), and one demonstrated reduced self-reported pregnancy risk, but
no significant changes in STI risk or other risk behaviors (Covington
et al., 2016). Additionally, both of these interventions were delivered in
group living rather than kinship or family home contexts. The former
suffered from significant retention issues with only 61% completing the
entire training and even fewer completing the long-term follow up as-
sessments.

Training of foster and kinship caregivers, rather than just youth,
may be a promising approach, either as a supplement to youth-focused
intervention work, or as a more achievable standalone intervention to
reduce unintended pregnancy and STIs in youth in foster care. Research
in other populations supports this assertion; even brief, single-session,
caregiver-oriented interventions emphasizing communication and
monitoring of youth have been shown to reduce sexual risk behaviors in
other high-risk adolescent populations (Stanton et al., 2004).

To the authors’ knowledge, only one evidence-based training has
been developed for foster/kinship caregivers and caseworkers. Results
from a short-term pre-posttest evaluation suggested that participants
had modest short-term improvements in sexual health knowledge and
attitudes around talking to youth about sex (Dworsky & Dasgupta,
2014). In prior work done in a qualitative study with foster and kinship
caregivers, caregiver participants described several barriers to com-
munication, including personal discomfort with having conversations
about sex, lack of sexual health knowledge, generational, gender, and
sexual orientation differences, and youth and biological family char-
acteristics which may limit their ability to communicate effectively
(Albertson et al., 2017).

1.5. Current study

Studies described in the previous sections suggest the importance
and potential impact that foster and kinship caregivers can have in
helping youth to make healthy choices and thus reduce unintended
pregnancies and STIs; and provide information regarding the barriers
that foster and kinships caregivers face, from the perspectives of the
caregivers themselves (Aspy et al., 2006; Dilorio et al., 1999; Dworsky
& Dasgupta, 2014; Whitaker et al., 1999). However, it is also critical to
understand the perspectives of stakeholders, such as social workers and
administrators, to maximize effectiveness and feasibility of caregiver-
oriented interventions. Understanding the unique barriers and facil-
 iterators to communication around sexual health may help social services
agencies to develop trainings and other resources to more effectively
support caregivers. Thus, our main objective in conducting this quali-
tative study was to explore stakeholder perceptions of barriers and fa-
cilitators to conversations around sexual health between caregivers and
youth in foster care, and to identify key elements of an effective training
agencies would be able to implement in a variety of child welfare set-
tings.

2. Methods

2.1. Sampling and recruitment procedures

We recruited stakeholders involved in child welfare systems in the
following jurisdictions: King County in Washington, Los Angeles County
in California, and New York City in New York. We recruited using
purposeful sampling methods, also called purposive sampling, a
strategy used in qualitative research to identify participants based on
specific criteria (Miles & Huberman, 1994). In each jurisdiction, we
recruited at least one stakeholder with an administrative role and one

435
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