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# Caregiver perceived barriers to preventing unintended pregnancies and sexually transmitted infections among youth in foster care

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ABSTRACT

Youth in foster care are at high risk of early, unintended pregnancies and sexually transmitted infections (STIs). Foster and kinship caregivers represent a potentially underutilized pregnancy and STI prevention resource. We explored foster and kinship caregivers' perspectives on barriers to communicating and monitoring foster youth around sexual health. We conducted 11 semi-structured focus groups with a diverse sample of 86 foster and kinship caregivers of adolescents in foster care. We analyzed data using Theoretical Thematic Analysis. Caregivers described institutional, relational, and individual barriers in three main thematic categories: 1) contributors to youth pregnancy and STI risk, including: pre-existing mental health and behavioral problems, pregnancy ambivalence, biological family and peer influences, and institutional barriers to reproductive healthcare access; 2) perceived barriers to communication about sex, including: discordance between caregiver and youth regarding generation, gender, or sexual orientation, youth developmental delays, caregiver lack of sexual health knowledge, and perceptions that talking about sex was against policy or put caregiver at risk of abuse allegations; and 3) perceived barriers to effective monitoring, including: lack of information about youth's prior risk behaviors or trauma, different or non-existent rules in past homes, difficulty matching strategies to the youth's developmental stage, and insufficient resources to appropriately supervise high needs youth. Foster and kinship caregivers encounter unique and complex challenges to promoting sexual health in youth in foster care. Training caregivers to tailor communication and monitoring strategies to a youth's developmental level and individual needs may be particularly helpful in helping caregivers reduce these barriers. Caregivers and youth would also likely benefit from clear messaging from child welfare agencies encouraging sexual health discussions and facilitation of access to reproductive healthcare.

## 1. Introduction

### 1.1. Youth in foster care and reproductive health risks

Although teen births are continuing to decrease in the United States (Martin, Hamilton, & Osterman, 2018), current and former youth in foster care remain at very high risk of early, unwanted pregnancies (Courtney et al., 2005; Courtney et al., 2016; Putnam-Hornstein & King, 2014). About 50% of young women in foster care report having had at least one pregnancy by age 19, and young men report higher rates of paternity as well (Courtney et al., 2005; Courtney et al., 2016). The majority of these pregnancies are unintended (Courtney et al., 2005; Courtney et al., 2016). Youth in foster care of any gender are also at 3–14 times increased risk of contracting several and sexually transmitted infections (STIs) when compared with non-foster youth peers (Ahrens et al., 2010; Shields et al., 2004; Surratt & Kurtz, 2012). Early pregnancies are associated with physical health, mental health, and economic costs across the lifespan including lower personal educational and economic attainment as well as poorer educational, behavioral, and health outcomes in offspring (Courtney et al., 2011; Department of Social and Human Services Office of Adolescent Health, 2016; Power to Decide, 2018). STIs have also been linked with significant economic costs and health risks including infertility, life-threatening infections, adverse birth outcomes, increased risk of certain types of cancers, and risk of acquiring other STIs (World Health Organization, 2016).

High rates of early, unintended pregnancies and STIs among youth in foster care are likely due to a complex interwoven set of pre-disposing factors including exposure to early adverse childhood experiences such as poverty, abuse, other forms of trauma, neglect, parental substance abuse, interpersonal violence, disrupted relationships with biological and other caregivers, and racial disparities in referral to and outcomes within the child welfare system (Courtney et al., 2005;

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Courtney et al., 2007; Courtney et al., 2016; Maloney, Jiang, Putnam-Hornstein, Dalton, & Vaithianathan, 2017; McGuinness, Mason, Tolbert, & DeFontaine, 2002; Shaw, Putnam-Hornstein, Magruder, & Needell, 2008). As a result of these factors, foster youth have higher rates of many sexual risk and related behaviors (e.g. substance use) that predispose them to early, unintended pregnancies and STIs such as earlier sexual debut, higher numbers of lifetime, recent, and infected partners, inconsistent condom and birth control use, and higher rates of engagement in sex for drugs or money compared with peers (Ahrens et al., 2010; Alexander, 1993; Carpenter, Clyman, Davidson, & Steiner, 2001; Courtney et al., 2005; Courtney et al., 2007; Courtney et al., 2016; Crocker & Carlin, 2002; Gauthier, Stollak, Messe, & Aronoff, 1996; Hacker, Belgrave, Grisham, Abrams, & Colson, 2013; Polit, Morton, & White, 1989).

Though effective youth-focused programs have been developed to reduce sexual risk behaviors in other groups, few have been evaluated specifically in youth in foster care (Becker & Barth, 2000; Boustani, Frazier, & Lesperance, 2017; DiClemente et al., 2008; McGuinness et al., 2002; Santelli, DiClemente, Miller, & Kirby, 1999; Slonim-Nevo & Auslander, 1996). Furthermore, among those that have been studied in this or other groups exposed to maltreatment and adversity, many have demonstrated incomplete or inconsistent long-term impacts across targeted risk behaviors (Oman, Vesely, Green, Fluhr, & Williams, 2016; Rotheram-Borus et al., 2003; Slesnick & Kang, 2008; St. Lawrence, Crosby, Belcher, Yazdani, & Brasfield, 1999). Experts have advocated for tailored approaches that integrate aspects of youths' larger support networks to improve outcomes for this and other groups at high risk of unintended pregnancies and STIs (Rotheram-Borus et al., 2009b; Rotheram-Borus, Ingram, Swendeman, & Flannery, 2009a).

### 1.2. Evidence on parent-oriented interventions to reduce reproductive health risks

Research conducted on non-foster youth strongly indicates that brief, parent-oriented interventions that emphasize communication and monitoring skills can significantly decrease sexual risk behaviors (DiClemente et al., 2008; Kirby & Laris, 2009; Milburn et al., 2012; Prado et al., 2012; Rotheram-Borus, Ingram, et al., 2009a; Rotheram-Borus, Swendeman, et al., 2009b; Santelli, Diclemente, Miller, & Kirby, 1999; Stanton et al., 2004; Yang et al., 2006).

The limited research on this topic conducted in foster care settings also suggests that caregivers may be a promising strategy for this group (Dworsky & Dasgupta, 2014; Kerr, Leve, & Chamberlain, 2009; Love, McIntosh, Rosst, & Tertzakian, 2005). Non-intervention research that has focused on understanding risk and protective factors for early pregnancies and STIs among youth in foster care similarly highlights the importance of caregivers. For example, in a longitudinal study evaluating youth in foster care as they aged out of care, having a close relationship with a foster or kinship caregiver and remaining in care longer were associated with significantly decreased sexual risk behaviors (Ahrens, McCarty, Simoni, Dworsky, & Courtney, 2013). Similarly, in a qualitative study youth participants described caregiver factors they felt were protective against unintended pregnancies and STIs, including frank discussions about condom/contraceptive use, enforcement of rules in a consistent yet respectful manner, and positive coaching regarding communication and other skills (Ahrens, Spencer, Bonnar, Coatney, & Hall, 2016).

Given that caregivers frequently care for multiple youth over time, well-trained caregivers have the potential to influence many youth over the course of their experiences as caregivers. However, foster and kinship caregivers are likely to face many barriers to preventing pregnancy and STI among the youth they serve. A lack of long-term experience with foster youth in their care, child welfare institutional factors, and pre-existing behavioral, mental health, and trauma-related issues among youth in foster care may interfere with caregivers' abilities to engage these youth in conversations around sex and effectively monitor and enforce rules (Anda et al., 2006). As of yet, no studies have specifically focused on understanding the needs of foster and kinship caregivers to help them more effectively communicate and monitor youth around sexual health (Love et al., 2005).

### 1.3. Study objectives

In this study, we sought to explore barriers to pregnancy and STI prevention in youth in foster care from the perspectives of foster and kinship caregivers. Our goal was to use data to inform the development of a tailored training for caregivers.

## 2. Methods

### 2.1. Recruitment

We partnered with the Washington State Department of Social and Health Services, the Los Angeles County Department of Children and Family Services, and two private foster care agencies in New York State to employ a maximum variation purposive sampling technique and recruit a diverse sample of 86 foster and kinship caregivers who had provided care to a foster youth aged 11–18 for at least 3 months in the past year. Participating agencies were given scripts to contact caregivers via email, letter, and/or telephone (based on agency preference regarding which would work best for their caregivers) to provide information on the study. We deliberately included participants from three different child welfare jurisdictions to get variation in terms of caregiver race/ethnicity, geographical location, and characteristics of the youth they serve. We also sought diversity in age and caregiving experience and asked agencies to recruit caregivers of various ages and levels of experience, but did not employ specific techniques to ensure variations on these characteristics.

### 2.2. Focus groups

Eleven focus groups were conducted by eight racially and ethnically diverse female leaders (2 African American women, 2 white women, and 3 Latina women), all but two of whom were highly experienced in conducting focus groups. Three of the leaders were members of the research team, the other five were part of a community-based child welfare agency in New York (2 leaders) or a non-profit with significant experience working with foster youth and caregivers in Los Angeles (3 leaders). Focus groups contained 5–10 participants and lasted approximately 1.5–2 h. Eight focus groups were conducted in English (4 in Los Angeles, 1 in Seattle, and 3 in New York) and 3 were conducted in Spanish (2 in Los Angeles and 1 in New York). Prior to each focus group, we obtained written consent and asked participants to complete a brief survey on demographics and caregiving experiences. Leaders used open-ended, semi-structured scripts focused on understanding barriers to communication and monitoring of foster youth related to sexual health (Table 1). Caregivers received $60 for participating, as well as reimbursement for childcare and transportation. Focus groups were audio recorded, transcribed, translated (if applicable), and reviewed for accuracy. The Washington State Institutional Review Board approved all materials and procedures.

### 2.3. Analysis

We used Theoretical Thematic Analysis (Braun & Clarke, 2006), a six phase coding process that includes: 1) familiarizing oneself with data, 2) generating initial codes, 3) searching for themes among codes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the final report. During Phase One, we conducted a close reading of transcripts to establish familiarity with the data and made note of emerging themes. During Phase Two, we generated a list of recurring themes or “codes.” In Phase Three, we employed an inductive approach

**Table 1**
Focus group questions regarding barriers to communication and monitoring.

| |
|---|
| I would like you to think generally about risky behaviors that teens engage in – drinking, drugs, driving unsafely, sexual activity, breaking the law, etc. From your personal perspective, what factors might make it difficult for a foster or kinship caregiver to talk to a teen in foster/kinship care in their home about risky behaviors? |
| We have heard from some caregivers that their own experiences/histories can change how they talk to the youth they care for. Does your own history influence how you communicate with your teen? If so, how? If not, why not? |
| What things might make it difficult to talk to YFC specifically about staying safe and protecting themselves from teen pregnancy and STDs? |
| Can anyone share a conversation about staying safe or protecting themselves from pregnancy that didn't go well with a teen in foster or kinship care in your home? Why did it not go well? What are some things that contributed to it not going well? |
| Can anyone share some of the ways that you have tried to supervise your YFC's behavior? What has worked or not worked? |
| Can anyone share an example of how you enforce rules, such as curfews, in their home with teens in your care? |
| How do you determine what a good amount of independence vs. supervision/monitoring, so that youth both remain safe AND learn to make healthy choices when they are on their own? |
| What type of guidance do FKC typically receive from social workers or other foster care professionals about talking to YFC about safe sex? |
| Has anyone given you information about reducing risks of teen pregnancies or STDs? If so, who? What was helpful or unhelpful about it? |
| Are there other factors, positive or negative, that might affect pregnancy and STD risks for youth in out of home placements? |

to develop a codebook of relevant themes. In Phase Four, we read all transcripts again to identify the presence of those themes; we also reviewed and revised codes to ensure they were accurate. In Phase Five, we used Atlas.ti software (version 6.1) to apply codes to all relevant quotes or sections from transcripts and ran queries of all quotes for each code and analyzed these for the significance of each theme. Preparation of this manuscript represents Phase Six.

## 3. Results

We initially describe caregiver participants' demographics, experience in foster caregiving, and beliefs about adolescent sexual activity to contextualize our data. We then describe what caregivers felt were the main barriers to communication about sex and monitoring of YFC.

### 3.1. Description of caregiver participants

Caregiver participants had an average age of 56 years, were predominantly female (79%), and identified as primarily African-American or Latinx/Hispanic (73% and 36%, respectively). Most caregivers had over four years of experience with children in foster care of all ages, as well specifically for teen and young adult youth, while some had only months of experience. Their caregiving experiences were varied: 71% had fostered non-relative youth, 36% had fostered relatives, 24% had adopted one or more youth, 5% had been group home caregivers, and 27% had multiple types of caregiving experiences (Table 2).

Caregivers had varied beliefs about which sexual behaviors are healthy or acceptable, but most caregivers expressed a belief that sex was often "inevitable" and part of the lives of many of the youth for whom they cared, even if it did not align with the caregiver's personal views about sex and relationships. Most caregivers endorsed that preventing unintended pregnancy and STIs was important.

### 3.2. Main themes

We explored barriers perceived by caregiver participants, which we ultimately organized into three overarching categories: 1) contributors to youth risk behaviors, 2) barriers to communication about sex with youth in foster care, and 3) barriers to effective monitoring of youth in foster care. The latter two categories (barriers to communication and effective monitoring) were expected a priori based on our script prompts; the first category (contributors to youth risk) was added during the analysis process. In each of these categories, participants identified three main types of themes: individual, relational, and institutional barriers perceived to impact teen pregnancy and STI prevention among youth in foster care. We define "individual" barriers as being intrinsic characteristics of a youth or caregiver, "relational" barriers as pertaining to any of the youth's relationships, such as with their caregiver, peers, or biological family members, and "institutional" barriers are those related to larger systems, including social services agencies, schools, or legislation. In the sections that follow, we present subthemes related to these types of barriers in each of our pre-defined categories.

**Table 2**
Demographic characteristics of Foster and Kinship caregiver participants ($n$ = 86).

| Characteristics | % or Mean (SD) |
|---|---|
| Gender | |
| Female | 79% |
| Male | 21% |
| Race[a] | |
| African-American | 57% |
| White | 27% |
| Other | 16% |
| More than one race | 4% |
| Ethnicity | |
| Latina/Latino/Hispanic | 36% |
| Age | 56 years (13.4) |
| Types of care currently providing | |
| Non-relative foster care | 63% |
| Kinship care | 35% |
| Group/residential | 0% |
| Adoptive | 20% |
| > 4 years of total caregiving experiences (%) | 81% |
| > 4 years of experience with youth ages 11–18 years | 70% |

[a] Race categories are not mutually exclusive.

#### 3.2.1. Contributors to pregnancy and STI risks

Caregivers described pre-existing youth characteristics they felt contributed to unintended pregnancy or STIs. Many participants had cared for youth who had been victims of neglect, physical abuse, or sexual abuse. Exposures to such trauma were perceived to increase the likelihood of youth perpetrating similar behaviors:

> "It may come out during counseling that this child was sexually molested for so long that, even at the age of 6 and 7, it becomes a way of life for them because that child was not taught you do not touch me here or there." – Foster Mother, LA County

Caregivers endorsed that youth in foster care, particularly young women, often expressed ambivalence towards even an overt desire for pregnancy, stating that youth believed that a baby would provide them with a relationship in which they would be able to give and/or receive the type of affection, love, and family connectedness they did not receive from their biological families:

> "[The youth] want someone to love, and treat better than the way they are treated . . . Mine told the psychiatrist when she was 13. 'I'm going to have a baby. And I'm going to raise mine better than the way my mom raised me.'…Because their mindset was, I want someone to love me unconditionally." – Foster Father, LA County

Caregivers also described relational factors that contributed to risk behaviors among youth in foster care. Unstable relationships between youth and biological family members were perceived to interfere with the ability to provide a stable, consistent substitute caregiving environment. Others described that their youth's unrealistic expectations

about reuniting with their biological family caused emotional distress, impeded positive connection with their caregiver, and increased the likelihood that they would engage in risk behaviors.

> "I got [my youth] back at the school, she was in therapy, stuff like that…At first her mom said she wanted her back. Then her mom didn't want her back…As soon as she told her that, it was a whole other story. Risky behaviors, it was just a lot of stuff that went on with her." – Foster Mother, New York

Caregivers described situations in which a youth's peer interactions, particularly with older youth, often negatively influenced their youth's attitudes or sexual behavior with pressure and false information. Several caregivers said that youth usually deemed sexual health information from peers as more valid than information provided by caregivers:

> "So the worst enemy you have is what someone else may say, because you offer 100% of the information you have, but [their] friend says: 'No, no, your dad told you to use protection? No, don't use that, you won't feel anything.' So they listen more to the friend and to their peers than to their parents in what they are going to do." – Foster Father, New York

Foster and kinship caregivers also described institution-level policies and barriers to preventing pregnancy and STIs in foster youth. Caregivers expressed that not being given legal responsibility for their youth's healthcare was a barrier to the youth accessing appropriate reproductive care, thus increasing the likelihood that a youth would not receive sexual health information and might engage in unprotected sex.

> "I talked to her about birth control…[The social worker] was telling me I cannot introduce her to or take her to the OB/GYN for birth control because I don't have legal rights to her health for her medical stuff…But if she gets pregnant then what do I do?" – Foster Mother, LA County

### 3.3. Barriers to effective communication

Caregivers identified several individual barriers to discussing sex with youth in foster care. Many caregivers cared for foster youth who had varying levels of developmental delays and expressed that it was challenging to effectively engage youth who lacked the ability to assess long-term consequences or comprehend and retain sexual health information:

> "Mine is 14, but he is about 6 or 7 mentally, so that's challenging…They don't compute…It's just pretty much wasting time talking to him about [sex]." – Foster Mother, LA County

Many caregivers found it difficult to communicate about sexual health when they lacked confidence in their own knowledge and education on the subject, particularly if they perceived the teen to have already engaged in sexual activity:

> "Some of [the youth] are much more knowledgeable—we had…a teen who was a prostitute. What am I going to teach her exactly about sex? I'm sure she had sex with a lot more partners than I ever had. So, is it really appropriate?" – Foster Mother, Washington

In terms of relational factors impeding communication about sexual health, the most common barrier identified by caregivers was perceived identity discordance from the youth in terms of age, sexual orientation, and/or gender. Caregivers consistently mentioned the challenge of coping with a substantial generation gap, which made them feel like youth in their care were being raised in cultural circumstances that were foreign to them:

> "We came from a generation where our parents were, 'You're not going to have sex, you're going to go to Sunday school, and you're going to be active in church. You're going to go home before the street lights [come on].'" – Foster Father, LA County

Some caregivers expressed that they did not feel comfortable or proficient at giving advice to or discussing sex with youth who had a different sexual orientation than them:

> "You find out that they like the same sex, it makes it extremely difficult. You have to find a really creative way to approach them when they have not confessed to being that…I got really embarrassed…You figure, 'If you're involved in sexual acts, it's very important that you understand the ramifications of what you're doing.'" – Foster Mother, LA County

Many caregivers also suggested that having a different gender than their youth made it more challenging or uncomfortable to approach sex topics:

> "If we're a male couple and we have a female in the home and we're trying to explain those things. It's like how do we have that conversation? Do we have the legitimacy in that child's mind to be able to have that conversation?" – Foster Father, Washington

With respect to institution-level barriers, many caregivers perceived that the messaging from their supervising child welfare agency was that discussing sex topics with youth in their care was discouraged or against policy. Some reported concerns that they would be placing themselves at risk of an abuse allegation or investigation if they approached the topic of sex with youth.

> "Some things you can say to the kids, and some things you can't…if the [case]workers get upset with you…they put you under allegations and want to take the kids out. Here you are, have spent ten years trying to get to point A, to get to B, helping this child. And then, they come and snatch the kid out. Then they go to 5 or 6 more homes." – Foster Mother, LA County

#### 3.3.1. Barriers to effective monitoring

Caregivers identified barriers they felt made it difficult to supervise youth effectively, thus making it harder to prevent them from surreptitiously engaging in risky sexual behavior. Many caregivers found it difficult if a youth had experienced vastly different rules and boundaries (or perhaps had no rules and boundaries) with their biological families or in past foster homes.

> "They come from other homes where they don't have the same rules…Then they don't like those houses where the rules are more strict, so you have to watch them closely constantly." – Foster Mother, LA County

On a relational level, some caregivers described it as challenging to balance between adequate monitoring and giving the youth an opportunity to earn trust and develop skills and independence in a manner appropriate for the youth's maturity level and developmental stage.

> "I cannot watch her everywhere…I'm supposed to have a little bit of freedom or leeway with a 15 year old. But if her mindset is, 'I'm going to get pregnant, I want to get pregnant, I want to have sex with everybody'…she's going to get pregnant." – Foster Mother, LA County

Caregivers also identified two institution-level barriers to effective monitoring. Some said that caseworkers and child welfare agencies did not provide them with sufficient information about the youth's history regarding behavioral issues, sexual abuse (as a victim or as a perpetrator), or physical abuse and neglect prior to placement, which impacted caregivers' abilities to implement effective and necessary monitoring strategies. In a few extreme cases, this produced dire consequences once the youth was placed in their home:

> "The boy that came into our home…he tried to molest my son…You

take these kids in, you don't know their experience that they have. These social workers are not honest." – Foster Mother, LA County

Caregivers also reported having insufficient support and resources from child welfare agencies to adequately supervise youth with high behavioral needs whom often required consistent one-on-one monitoring. Several caregivers also said that monitoring a youth's behavior became particularly difficult when the youth was in school, where caregivers felt a lack of control over how closely their youth were being monitored:

"I'm finding I have to talk to [my child] more about sexual things… I'm finding that some of these teachers and principals are…overwhelmed or just stupid…When you come to them and you bring [inappropriate youth activities] to their attention, they don't look into it." – Foster Mother, LA County

## 4. Discussion

Our findings contribute to and extend existing literature suggesting that brief caregiver-oriented interventions have the potential to reduce pregnancy and STI risks in youth in foster care (DiClemente et al., 2008; Dworsky & Dasgupta, 2014; Kerr et al., 2009; Kirby & Laris, 2009; Love et al., 2005; Milburn et al., 2012; Prado et al., 2012; Rotheram-Borus, Ingram, et al., 2009a; Rotheram-Borus, Swendeman, et al., 2009b; Santelli et al., 1999; Stanton et al., 2004; Yang et al., 2006). This study is the first study to specifically examine barriers to pregnancy and STI prevention in foster youth from the perspectives of foster and kinship caregivers (see Love et al., 2005 for a more general discussion on foster and kinship caregivers' perspectives on pregnancy prevention). As expected, foster and kinship caregivers on our study encountered unique and complex barriers to effectively communicate with and monitor youth in their care. There were four barriers that either cut across multiple categories or that were perceived to be critical by the majority of our focus group participants. First, caregivers perceived that individual youth characteristics including developmental delay, pre-existing mental health and behavioral problems, and maltreatment histories set the stage for sexual risk behaviors to occur, made it challenging to talk to youth about sex, and made it difficult to match monitoring strategies to the youth's developmental stage. Second, caregivers frequently felt unprepared to communicate with youth about sex due to differences in generation, gender, or sexual orientation and a lack of up to date sexual health knowledge. Third, caregivers perceived that biological caregivers and peers also contributed to risk and made effective communication around pregnancy and STI prevention difficult. Finally, caregivers perceived institution-level barriers to pregnancy and STI prevention: legal and policy limitations were perceived to reduce youth access to reproductive healthcare and made it difficult to communicate with youth about sex, and a lack of support from child welfare agencies and schools made it difficult to appropriately supervise high needs youth.

Based on our findings, we suggest several ways to improve caregiver communication and monitoring that could be explored in future research. Specifically, foster and kinship caregivers may benefit from developmentally-informed trainings in which caregivers are taught to tailor communication and monitoring strategies based on cognitive and social emotional development rather than age. Ways to non-judgmentally discuss youth's relationships with biological caregivers and peers should be included.

Caregivers would also likely benefit from training on how to approach communication about sexual health conversations with youth who have specific characteristics such as youth who have experienced sexual abuse or other trauma, youth who are different gender or sexual orientations than the caregiver, and/or when the caregiver perceives a large generation gap. Such trainings should normalize youth exploration of gender and sexual identities and that give them opportunities to practice having non-judgmental conversations in which youth are treated respectfully and in which sexual behaviors (or lack thereof) are not assumed based on gender identity, sexual orientation, or past experiences. Finally, caregivers would benefit from clear messages from public and private child welfare agencies and their designates (i.e. caseworkers) indicating that it is not only legal but promotes healthy behaviors when caregivers to talk to youth about sexual health.

There are several limitations to this study. First, due to the topic of our study, there was likely a selection bias towards caregivers who had a baseline comfort with discussing sex, therefore not capturing the perspective of those caregivers who are uncomfortable with or opposed to talking about sex. Second, while our sample included some caregivers with limited experience, more experienced caregivers are overrepresented in this study. Third, due to the qualitative nature of this study, data were collected from 86 caregivers from three exclusively urban settings. As a result, our findings may not be representative of foster and kinship caregivers in other geographical areas (e.g., smaller or more rural jurisdictions). However, it is important to note that our sample size was relatively large for a qualitative study, and our goal for this study was to gather in-depth data on the narratives of caregiver participants in order provide context for intervention development rather than aiming for generalizability. Finally, this study only explored the perspectives of caregivers; it is possible that other stakeholders such as youth in foster care or agency personnel may have different perspectives on the topics evaluated in this study and should be incorporated in future research to best inform policy and intervention development.

## 5. Conclusions

Foster and kinship caregivers encounter unique and complex challenges to communication and monitoring around sexual health. Effective trainings should to incorporate information on basic sexual health and adolescent development and explore the use of skills training on tailoring caregiving strategies to developmental level and needs of individual youth. Child welfare jurisdictions should also consider providing clear messaging to caregivers and agency personnel around discussing sexual health and helping youth access reproductive healthcare.

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