The Feasibility of a Clinic-Based Parent Intervention to Prevent HIV, Sexually Transmitted Infections, and Unintended Pregnancies Among Latino and African American Adolescents

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Abstract

The purpose of the present study was to examine the feasibility of conducting a parent-based intervention in a pediatric health clinic to prevent HIV, sexually transmitted infections (STIs), and unintended pregnancies among urban African American and Latino youth. Eight focus groups were conducted with health care providers, adolescent patients and the mothers of adolescent patients ($n = 41$) from December 2007 to February 2008. All participants were recruited from a community-based pediatric health clinic in the Bronx, New York. Content analysis of focus group transcripts identified results in three primary areas: (1) the role of parents and providers in preventing HIV, STDs and unintended pregnancies among adolescents, (2) feasibility of the intervention in the clinic setting; and (3) optimal recruitment, retention and intervention delivery strategies. Study results suggest that a parent-based intervention delivered in a community-based pediatric health clinic setting is feasible. Focused recommendations for intervention recruitment, delivery, and retention are provided.

Introduction

EPIDEMIOLOGIC SURVEILLANCE DATA show that Latino and African American adolescents bear a disproportionately high burden of HIV/AIDS relative to their white peers,¹ with heterosexual and same-sex sexual behavior accounting for the largest percentage of adolescent HIV infections each year.^{1,2} In addition, African American and Latino youth also are vulnerable to sexually transmitted infections (STIs)³ and unintended pregnancies⁴ during adolescence. A large body of research has examined potential mechanisms to prevent or reduce sexual risk behavior among adolescents.⁵ Within this literature, both parents and health care providers have been identified as influential sources of information, and clinic-based^{6–9} and parent-based^{10–15} interventions have demonstrated significant results toward reducing youth sexual risk behaviors.

Although these studies indicate that brief, theory-based interventions capitalizing on the expertise of either parents or health care providers may reduce the risk of HIV, STIs, and unintended pregnancies among African American and Latino youth, studies also indicate that both parents and health care providers struggle with effectively communicating with adolescents about sexuality and sexual behavior. Parents often feel embarrassed discussing issues related to adolescent sexual behavior and believe that they lack the time, knowledge, and skills to communicate successfully with their child about sex.^{16–18} Given these factors, it is not surprising that both parents and youth have expressed support for provider-initiated communication on topics such as sexual orientation, sexual behavior, condom use, and HIV/AIDS.^{19–21} However, provider-initiated discussions about adolescent sexual behavior are rare. A recent national survey found that while

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87% of pediatricians believed that discussing adolescent sexual risk reduction with parents was equal to or more important than discussing other health topics, only 25% had done so with 75% or more of their adolescent patients' parents.²² Similar results have been observed when asking adolescents to report on the frequency of provider-initiated discussions about topics such as sexual risk reduction, STIs and HIV/AIDS.²¹ Common barriers to provider-initiated communication include a lack of time, a lack of training, feeling awkward addressing sexual behavior with parents in front of adolescents, discomfort discussing sexuality issues, a lack of parental prompting, and concerns over adolescent and parent comfort.²²⁻²⁴

Taken together, the available literature suggests that additional research is needed to identify mechanisms to support the ability of health care providers and parents to communicate routinely and effectively with adolescents about sexual risk reduction. To date, we know of no clinic-based intervention that has targeted parents as the primary mechanism to prevent or reduce adolescent sexual risk taking. Most clinic-based interventions have focused solely on adolescents^{7,8} or have involved parents in a peripheral way.^{6,25} As a result, relatively little is known about the feasibility of conducting a parent-based sexual risk reduction intervention for adolescents in a clinic setting or about how best to maximize provider influence given existing time, practice, and resource constraints. The present study sought to address this gap by conducting focus groups with health care providers, parents, and adolescent patients on the feasibility of conducting a parent-based adolescent sexual risk reduction intervention in the clinic setting. It is distinct from previous research in that it focused explicitly on supporting the parent-adolescent relationship as a means of preventing adolescent sexual risk taking, and interviewed all three major stakeholders in order to obtain a comprehensive understanding of how best to design and deliver a parent-based intervention in the clinic setting.

Methods

Study population

From December 2007 to February 2008, a total of 8 focus groups were conducted with providers, adolescent patients, and mothers at a community-based pediatric clinic in the Bronx borough of New York. In addition to pediatric care, the clinic provides services in adult medicine, mental health, family planning, and HIV testing and care. The Bronx is New York City's poorest borough, with a median household income significantly below city and state averages.²⁶ New York City remains the epicenter of the nation's HIV/AIDS epidemic,²⁷ and Latino and African American youth in the Bronx are disproportionately affected by HIV, STIs, and unintended pregnancies relative to youth residing in other boroughs.²⁸⁻³⁰

Recruitment and data collection

Fourteen physicians and nurses, 14 mothers, and 13 male and female adolescents participated in the study. Two focus groups were conducted with providers, who were recruited directly from the pediatric clinic by project staff. Providers were eligible to participate if they were a physician or nurse

who provided services to Latino or African American youth. All providers completed consent forms. A trained facilitator used a semistructured interview guide to explore the following areas: (1) the feasibility of conducting a parent-based intervention in the clinic setting, (2) perspectives on clinic-based recruitment of adolescents and parents, (3) potential barriers to implementing a clinic-based intervention, and (4) perspectives on provider participation in the intervention. The focus groups were held during a regularly scheduled morning staff meeting and lasted for 90 min; breakfast was provided as an incentive.

Mothers and adolescents were recruited by a bilingual recruiter directly from the clinic waiting room. Adolescents and their parents were asked to participate in a focus group on how the clinic could provide additional programs to help keep adolescents healthy. Mother-adolescent dyads were eligible to participate if: (1) they were African American or Latino, (2) they received primary health care services at the pediatric clinic, and (3) the adolescent was enrolled in grade 6, 7, or 8. Grade was used instead of age as an inclusion criterion because the project was focused specifically on youth enrolled in middle school. Mothers completed consent forms for themselves and permission forms for their adolescent, and adolescents completed assent forms. Consent and assent forms were available in English and Spanish and were written at a fourth-grade reading level. Families received a research incentive of \$25, with \$15 for mothers and \$10 for adolescents.

Six focus groups with families were conducted with mothers and adolescents meeting in separate groups. Separate focus groups with African Americans and Latinos were held, as were separate English- and Spanish-speaking focus groups. On average, there were 5 participants in each group. Two trained facilitators led each group and followed a semistructured interview guide examining three topic areas: (1) the feasibility and acceptability of conducting a parent-based adolescent sexual risk reduction intervention in the clinic setting, (2) mother and adolescent perspectives on the role of health care providers in preventing HIV, STIs, and unintended pregnancies among adolescents, and (3) optimal intervention recruitment, delivery, and retention strategies.

Institutional Review Board approval for all focus groups was obtained from Columbia University and the University of California at San Francisco.

Data analysis

Focus groups were audiotape recorded and a written transcript was produced. The Spanish transcript was translated into English and checked for accuracy using the forward-backward method.³¹ Three independent coders conducted a computer-assisted content analysis³² of each written transcript to identify recurring thematic units in the data.³³ Each coder created a codebook using a "cut and paste" technique to organize themes into discrete categories and subcategories. Each coder separately counted the frequency that each category and subcategory was mentioned in the transcripts.³⁴ Upon completion of data analysis, the coders met to evaluate the level of correspondence in the coding. In cases where there was disagreement, this was formally noted and resolved via discussion between the three coders. Inter-rater reliability was 92% and was calculated by summarizing

the number of agreements and dividing this figure by the total number of agreements and disagreements.³⁴

Results

Table 1 provides demographic characteristics for the mother-adolescent dyads. Results were identified in three primary areas: (1) the role of health care providers and parents in preventing HIV, STIs and unintended pregnancies among adolescents; (2) the feasibility of conducting a parent-based sexual risk reduction intervention in the clinic; and (3) optimal intervention recruitment, retention and delivery strategies. Each theme was explored from the distinct perspective of providers, adolescents, and mothers.

The role of health care providers and parents in preventing HIV, STIs, and unintended pregnancies among adolescents

All three groups recognized the important role that parents and health care providers play in reducing adolescent sexual risk behavior and in preventing youth HIV, STIs, and unintended pregnancies. Providers believed that promoting parent-adolescent communication about sex was an important way to reduce the risks associated with youth sexual behavior, and stated that parents and adolescents often asked for assistance. One provider noted, "More and more parents are aware, but they don't know what to say to their adolescent." Another stated, "Sometimes the kids are coming in and saying 'I want to do this but I don't know how to interact with my parents.'"

For their part, adolescents viewed their provider as an important source of information on sexual behavior. Many stated that their doctor discussed issues about drugs, alcohol, and sex with them and appreciated their doctor's willingness to address these topics. Youth also said that while they wanted to talk with their parents about sex, their parents needed support to be better communicators. Adolescents felt that providers were in an ideal position to help because they were professional, influential, and had expertise on matters that were important to both adolescents and parents.

TABLE 1. DEMOGRAPHIC CHARACTERISTICS OF THE MOTHER-ADOLESCENT DYADS ($n = 27$)

	Mean or percent
Adolescents ($n = 13$)	
Percent female	83.3
Mean age	13.25 years
Percent Latino	41.7
Percent born in the U.S.	83.3
Percent speaks Spanish in the home	50.0
Percent indicating religion is very important	70.0
Mothers ($n = 14$)	
Mean age	41.08 years
Percent not living with a partner	53.8
Percent completed high school	77.0
Percent Latino	53.8
Percent born in the U.S.	53.8
Percent speaks Spanish in the home	53.8
Percent indicating religion is very important	66.7

Mothers also perceived their child's physician as a trustworthy source of information and support. All of the mothers were concerned about their child transitioning to early sexual activity, acquiring HIV, or becoming pregnant. Mothers said that one of the key persons they looked to for support was their child's health care provider and often directly asked their provider to help address issues related to adolescent sexual behavior and reproductive health.

Feasibility of the intervention

All stakeholders believed that a parent-based intervention in the clinic setting was feasible. Providers were open to the intervention but were clear that it could not interfere with the routine delivery of care. Providers faced multiple time constraints, such as numerous patients per clinic session, limited time per patient, caring for an underserved population, and adolescents' urgent care needs. As one provider stated, "Clearly, we are way too busy to stop what we're doing to model an intervention." Rather, providers felt that an intervention was feasible only if it could fit "into whatever we always do with families."

Like providers, adolescents and parents were interested in a program that addressed adolescent sexual behavior and the prevention of adolescent HIV infection. Adolescents liked the idea of an intervention that would promote parent-adolescent communication about sex and believed the clinic was an ideal setting to reach parents. In addition, adolescents endorsed a parent-based intervention because it would provide them with privacy to discuss sensitive topics with their parents. In turn, parents expressed a strong desire for clinic-based services that would support their ongoing efforts to keep their child healthy. Like providers, adolescents and parents felt it was important that the intervention not interrupt their receipt of care. An intervention was feasible provided that it did not "take away" from the care and advice normally provided by the pediatrician.

Delivery of the intervention in a clinic-based setting

The third theme addressed delivery mechanisms of the intervention, as well as recruitment and retention issues. Providers felt that the intervention should be packaged as an extension of clinic services, as this would capitalize on the existing community-clinic relationship. Providers suggested recruiting in the waiting room because this would not interrupt the delivery of care. Given the time constraints and demands inherent in their roles, providers made two specific recommendations for intervention delivery: (1) providers should endorse the intervention but a trained, allied health professional should deliver the intervention and (2) the intervention should be delivered to parents when providers examine adolescents.

Adolescent responses focused on recruitment and intervention delivery. Youth noted that adolescent health programs often targeted parents instead of them, a trend they found odd given the focus on adolescent health. Youth felt that the waiting room was the best place to recruit them and recommended the use of posters, pamphlets, videos, or brochures in the waiting room. Adolescents stressed the importance of respect; they did not want to be lectured, "talked down to," or to feel like they were being "accused of having a baby at an early age." At the same time, youth emphasized the

need for recruiters to clearly describe the health benefits of the intervention in ways that resonated with their lives.

Parents also wanted to be recruited in the waiting room, which they characterized as “lost time.” Like adolescents, parents emphasized the importance of respect and collaboration during recruitment. Many mothers feared being judged as “poor parents,” and did not want to be approached in a “judgmental” or “preachy” way. Building on this theme, parents felt that an intervention should be packaged as part of the clinic’s ongoing relationship with them, i.e., “Tell us, ‘We’re here to support you, to partner with you. We have a partnership.’” Parents also stated that clinic programs should emphasize both prevention and risk reduction. Parents feared that a sole emphasis on preventing sexual behavior would not attract parents with sexually active children. One mother stated, “You have it labeled as preventative. Those parents that have children that are already active—they can’t appreciate that—you have to advertise that it’s not only to prevent your child but to keep your child safe.” Another mother said that parents “should be told that it is not too late . . . people can change their behavior.”

Regarding intervention delivery, adolescents indicated that a physician recommendation would increase the likelihood of their being recruited and retained in to the intervention. Mothers also felt it was critical for the provider to endorse participating in the program to both them and their adolescent. Mothers were aware that physicians were busy but believed a brief recommendation would promote communication and encourage families to use intervention materials and activities at home. In addition, the majority of parents remained in the waiting room while their adolescent was examined and wanted to receive the intervention during this time. Mothers liked the idea of meeting with a trained professional who could provide them with information about preventing HIV, STIs, and teen pregnancy.

Mothers were more likely than providers and adolescents to address retention. Maternal responses focused on: (1) respectful recruitment efforts; (2) providing ongoing support after the intervention has concluded; and (3) emphasizing the partnership between families, providers, and the clinic. Mothers stated that support after the intervention would increase

the likelihood of them staying connected to a project. When asked how best to support them, mothers recommended mechanisms that would not overburden families, such as telephone calls, home visits or access to a program website. Finally, mothers indicated that they would be much more likely to stay involved if the program was a partnership focused on the long-term welfare of their children.

Discussion

Although a number of clinic-based interventions have been developed and evaluated, no studies have examined the feasibility of conducting a parent-based intervention to prevent or reduce adolescent sexual risk behavior in the clinic setting. Our study extends upon previous research by including the views of providers, adolescents and their mothers. Overall, our findings suggest that a parent-based intervention delivered in a clinic setting is feasible provided that it (1) maximizes the role of the health care provider, (2) is integrated into the routine delivery of care, and (3) is delivered through allied health professionals. Table 2 provides a focused set of recommendations for developing and delivering a parent-based intervention in an urban, pediatric health clinic.

Consistent with previous research,^{35,36} our findings suggest that providers can influence parent–adolescent communication about sex. Both parents and adolescents viewed their health care provider as an important source of support in this endeavor. This is good news for providers, as it suggests that their efforts in this area will be well received. At the same time, our results show that any intervention needs to be integrated into the routine delivery of care as providers are busy,^{37,38} and do not have time to participate in a lengthy intervention. Given that existing time constraints are unlikely to change, a critical question focuses on how best to maximize provider influence without interfering with patient care. Our results point to several alternatives. First, as suggested by providers and endorsed by parents and adolescents, the intervention should be delivered by a trained, allied health professional that is based in the clinic. Provider influence can be capitalized on with a brief endorsement to parents and adolescents, which can be easily integrated into standard

TABLE 2. RECOMMENDATIONS FOR DEVELOPING AND DELIVERING A CLINIC-BASED INTERVENTION FOR PARENTS AND ADOLESCENTS

Recommendations

Integrate the intervention into the routine delivery of patient care.
 Maximize the influence of the health care providers by having providers endorse the program to adolescents and parents.
 House the intervention with allied health care professionals
 Package the intervention as a special program that is being offered to families with adolescents as part of the clinic’s ongoing partnership with the community.
 Outreach to mothers and adolescents in the waiting room.
 Use developmentally and culturally appropriate language.
 State clear goals and objectives of the intervention to parents and adolescents.
 Focus on the common goal of helping adolescents to stay healthy.
 Use appropriate media, i.e., banners, posters, pamphlets and videos, in the waiting room.
 Meet with parents when adolescents see their healthcare provider.
 Intervene with adolescents and parents in a setting that affords privacy.
 Provide adolescents and parents with concrete information about pregnancy, STIs and HIV.
 Retain families by contacting them via telephone, home visits, and website technology.

STIs, sexually transmitted infections.

protocols of care. This finding is consistent with the use of coordinated service models between physicians and behavioral health professionals to improve patient care without overburdening primary care providers.^{39,40} Although colocation is most often used to address mental health issues,⁴¹ our results suggest that it may be a potential mechanism to reduce the risk of HIV, STDs, and unintended pregnancies during adolescence. Previous research with providers and adult HIV-positive patients also supports the use of allied health professionals as a practical way to support providers' prevention efforts.⁴² Future research involving allied health providers to deliver parent-based interventions in clinic settings also should examine the cost effectiveness of this approach, as this may present a potential resource constraint in some clinic settings.

Although waiting room times vary across clinics, it is estimated that family clinic patients spend approximately 20 minutes in the waiting room before seeing their provider.⁴³ All three groups identified time spent in the waiting room as an ideal recruitment opportunity. For providers, this approach was the least disruptive for patient care. For mothers, time in the waiting room was characterized as a "missed opportunity" to talk to families. In turn, adolescents believed that this time could be used to provide them with information on HIV/AIDS, STIs, and teen pregnancy. The results clearly suggest that the waiting room is an important time to engage and begin intervening with families without disrupting patient care.

Previous research on African American and Latino youths' involvement in clinic-based interventions suggests that involving mothers can assist with recruitment and retention efforts.⁴⁴ For families in our study, successful recruitment approaches also targeted both adolescents and parents. Both mothers and adolescents were concerned about being judged by program staff. While the reasons underlying these concerns are not known, they indicate that clinic-based programs need to carefully assess how families want to be approached and train recruiters to speak with families in a sensitive and nonjudgmental way.

With respect to intervention delivery, providers and parents identified the time when adolescents are examined as an optimal time to meet with an interventionist. This is a natural opportunity to engage parents and takes advantage of existing care protocols without overburdening clinic staff and resources. Indeed, other clinic-based STI and HIV risk-reduction interventions have stressed the importance of respecting existing time constraints in clinic settings.^{42,45} Our results also suggest that the intervention should be packaged as an existing service in the clinic that is being offered to families in a spirit of partnership, support, and collaboration. This approach has been used successfully in previous parent-based interventions with ethnic minority families.⁴⁶ All three groups felt this was important, with mothers voicing particularly strong support for this type of collaboration. Partnership, respect, and convenience also were listed as critical factors in retaining families. While most parents believed it was important to initiate recruitment in the clinic, they indicated that follow-up sessions could use other mechanisms such as telephone calls, home visits, and website technology. These findings are consistent with previous studies indicating that effective parent- and clinic-based interventions are flexible, convenient, and practical.^{42,45,46}

Conclusions

Community-based pediatric health clinics offer an ideal opportunity to implement adolescent sexual risk reduction interventions with large numbers of youth and their families. Our study suggests that a parent-based intervention delivered in a pediatric health clinic is feasible and provides important information on how researchers can design a parent-based intervention in the clinic setting to reduce the risk of HIV, STIs, and unintended pregnancies among urban Latino and African American adolescents. The findings should be interpreted in the context of study limitations. First, our research focused on health care providers and on African American and Latino youth and their mothers in a single pediatric clinic in a low-income, inner-city community that is disproportionately affected by high rates of HIV/AIDS, STIs, and teen pregnancy. Adolescents in other settings may see family practitioners who are confronted with different issues, resources, and constraints than the participants in this study. Second, the majority of adolescents in our study were female. As such, caution should be taken when applying these findings to other providers and families residing in diverse geographical contexts in the United States. Our study was qualitative in nature; as a result, no causal inferences can be made. Despite these limitations, a strength of the research was the integration of perspectives from three types of stakeholders: parents, adolescents and health care providers, and the identification of a needed and feasible intervention role for health care providers and allied health professionals practicing in health care settings.

Author Disclosure Statement

No competing financial interests exist.

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