Power through choices: The development of a sexuality education curriculum for youths in out-of-home care

Article *in* Child Welfare · May 2000

Source: PubMed

CITATIONS
51

READS
398

2 authors, including:

Richard P Barth
University of Maryland, Baltimore
377 PUBLICATIONS **17,122** CITATIONS

SEE PROFILE

Power Through Choices: The Development of a Sexuality Education Curriculum for Youths in Out-of-Home Care

Marla G. Becker and Richard P. Barth

Youths in out-of-home care demonstrate high rates of sexual risk-taking behavior and elevated rates of unintended pregnancy and sexually transmitted infections (STIs). This article profiles the development and characteristics of an innovative pregnancy/HIV/STI prevention curriculum tailored to the needs of youths in out-of-home care. Promising results from an implementation study suggest the need for further dissemination and rigorous testing.

Marla G. Becker, M.P.H., is Associate Director, Youth ALIVE!, Oakland, CA. Richard P. Barth, Ph.D., is Frank A. Daniels Professor, Jordan Institute for Families, University of North Carolina School of Social Work, Chapel Hill, NC. *This project was originated at the School of Social Welfare at the University of California at Berkeley and funded by the California Department of Health Services, Office of Family Planning. Opinions expressed and analyses are those of the authors and not the funder. The authors thank Helen Cagampang, Dana Harwood, Benita Korda, Selfa Saucedo, Rebeca Pastrana-Sheng, Carin VonLatta, and Ruth White.*

0009-4021/2000/030269-14 $3.00

More than 500,000 children reside in group homes, family foster homes, kinship foster care, or residential care in the United States [Maza 1996]. Due to the nature of out-of-home care and the events precipitating placement, youths in out-of-home care may change schools frequently and have substantial lapses in school attendance, thereby missing much of the sexuality education delivered in traditional schools. Youths in out-of-home care are, therefore, less likely to have had access to sex education and family planning classes, and often have less knowledge of the consequences of early pregnancy [Polit et al. 1989]. These youths are typically at elevated risk for teen pregnancy, HIV infection, and other STIs, often engaging in high-risk sexual activities, including unprotected sex with multiple partners. This is shown in high birthrates for females during and following out-of-home care. Cook [1994] found that 60% of the young women who had aged out of care had given birth to at least one child in the subsequent four years. This was far higher than the 24% rate for the general population. Needell, Armijo, and Barth [1996] matched foster care records and birth records and found that 5.2% of females in care in 1994 gave birth in care or within eight months after leaving care; among youths in the general population, the rate was 3.8%.

In a study of sexual activity and contraceptive use among children entering out-of-home care, youths as young as age 8 reported having engaged in sexual activity; 34% of youths age 8 to 18 reported being sexually active [Risley-Curtiss 1997]. Of those youths who self-reported sexual activity, more than one-third were not using contraceptives. Among youths age 13 to 18, more than 64% reported being sexually active. Of this subset, more than one-third of the sexually active youths were not using contraceptives and 15.2% reported a history of STIs. One crucial finding of the Risley-Curtiss study was the presence of serious mental health problems among those youths who reported sexual activity, particularly among those who were not using contraception. Over

70% of those youths who reported being sexually active demonstrated a history of behavior problems and current emotional or behavioral difficulties, including drug (14.9%) and alcohol (21.5%) use, and homicidal (15%) or suicidal (24.6%) ideation.

Adolescent females in out-of-home care are generally less knowledgeable about reproduction, contraception, and sexually transmitted infections than their peers not in care, and are twice as likely to get pregnant; the outcomes for them and their children are also usually worse [Allen et al. 1987]. The high teen pregnancy and STI rates among this population are associated with abuse, neglect, poverty, and other social factors that also tend to precipitate placement. Emotional problems, substandard education, and sexual abuse (conditions that generally foreshadow the possibility of teen pregnancy), are often exacerbated in out-of-home care situations or in the homes from which youths in out-of-home care have been removed [Brindis & Jeremy 1988].

An early examination of the relationship between out-of-home care and adolescent pregnancy involved 55 youths (mostly between the ages of 19 and 24) who had exited the child welfare system; the study sought to identify factors that influence outcomes for youths in out-of-home care [Barth 1990]. More than 40% of the respondents reported an unplanned pregnancy, impregnating a partner, contracting an STI, or being sexually active and never or rarely using protection. When the youths were asked if they were offered family planning services, more than half reported that they were neither offered nor did they use family planning services while in care. Nearly a decade later, there is little evidence that this has changed for the better.

A study of the consequences of pregnancy on teens who have been in out-of-home care, specifically as those consequences relate to the youth's successful transition out of the child welfare system, found that of the young women interviewed who had been out of care for two to four years, 60% were already parents [Cook 1994]. Cook found significant differences between the

young women who became parents and those who did not. The study concluded that the transition process for a youth leaving care is made dramatically more difficult if the youth is a teen mother, or becomes pregnant soon after leaving care.

A study by Roman and Wolfe [1997] underscores the seriousness of unintended pregnancies for youths in care. The authors interviewed homeless adults and found that those who had lived in out-of-home care and were parents were more than twice as likely to have their own children in placement as were homeless parents who had not been raised in out-of-home care. Helping youths in out-of-home care to develop the skills and commitment they need to prevent unintended pregnancies may offer a multigenerational benefit.

Curriculum Development Process

Existing pregnancy/HIV/STI prevention curricula rarely address the specific characteristics that may contribute to youths in placement becoming pregnant or engaging in sexual risk-taking behavior. The characteristics of these youths include, but are not limited to, an intense need for affection, the absence of a dependable family or social network, the desire to possess something of their own that they do not have to share, exposure to sexual abuse and violence, and limited skills in identifying and marshaling resources (other than sex) to support themselves now and in the future. These characteristics tend to be magnified among youths in out-of-home care because of prior deprivation and/or social isolation. During focus groups conducted by the authors with youths in out-of-home care throughout California, many of these individuals stated that even when they had received sexuality education and family planning education within the schools, it was marginally meaningful to them. They perceived many of the programs' themes and messages as irrelevant to their living and

social situations and more suited to youths who were residing in stable, single-family homes, with clearly identifiable and accessible parent figures with whom they could discuss the material.

The Family Welfare Research Group, a research division of the School of Social Welfare at the University of California at Berkeley, was awarded a three-year contract to develop an adolescent pregnancy prevention curriculum tailored to a specific population demonstrating high rates of sexual risk-taking behavior. Following the review of existing curricula and after investigating the need for a tailored curriculum among various populations, the authors identified youths in out-of-home care as the ideal population on which to focus their efforts, and developed the curriculum discussed below [Becker et al. 1997].

The curriculum, *Power Through Choices*, is a 10-session adolescent pregnancy/HIV/STI prevention program for youths in out-of-home care. The three-year development process included extensive focus groups with youths in out-of-home care throughout California, interviews with staff working with these youths, site visits, extensive pilot testing and revising of individual activities and sessions, full pilot testing and evaluation, and final revisions. The curriculum was revised six different times based on pilot testing results before being finalized.

Power Through Choices was developed in collaboration with a culturally diverse five-member team of skilled health educators from urban, suburban, and rural regions of California. They were involved in the selection of the target population and the conceptualization of the curriculum, conducted all pilot testing of activities and sessions, and provided feedback on curriculum activities and sessions during each stage of curriculum development. Participating individuals and agencies were currently implementing state-funded Information & Education (adolescent pregnancy prevention) programs.

The curriculum underwent extensive pilot testing with youths

in a variety of out-of-home care settings, including group homes, independent living skills programs*, court schools, and alternative schools. Youths in out-of-home care throughout the state provided important feedback throughout the development process. These youths were regarded as the "experts," and their suggestions resulted in direct changes to the curriculum.

Theoretical Framework

The curriculum is primarily based on four theories: the Health Belief Model, Self-Regulation Theory, Theory of Reasoned Action/Rational Model, and Social and Cognitive Learning Theory.

The *Health Belief Model* [Becker 1974; Mullen et al. 1987; Rosenstock et al. 1988] states that readiness for action stems from an individual's perception of the threat of an undesired outcome and the likelihood of being able, through personal action, to reduce that threat. In this case, the undesired outcome is an unintended pregnancy, or the contraction of HIV or another STI. The curriculum's skills-building approach and its focus on youth self-empowerment seek to increase participants' perceptions of their own abilities to reduce these threats.

The *Self-Regulation Theory* [Carver 1981; Mithaug 1993] views individuals as feedback systems attempting to bring their current states closer to their goal states. Consequently, the curriculum focuses on setting short and long-term goals, and on the importance of planning ahead for "safer sex."

The *Theory of Reasoned Action/Rational Model* [Mullen et al. 1987; Terry et al. 1993] states that behavioral intention is a strong predictor of behavior. This theory focuses on the individual evaluating the consequences of his/her behavior and his/her own attitudes as well as the attitudes of others. The curriculum's emphasis

* Youth in out-of-home care between the ages of 16 and 18 are generally eligible to attend a series of classes called an Independent Living Skills Program (ILSP) or Independent Living Program (ILP); the classes are primarily federally funded and designed to prepare youths in care to live independently once they exit out-of-home care. Courses vary by locale, but typically cover such topics as job interviewing, resume writing, finding an apartment, and budgeting. In California, youths typically receive a stipend to participate in the program.

on making choices and the impact of choices on an individual's future relates directly to this theory.

Finally, the *Social and Cognitive Learning Theory* [Bandura 1986; Rosenstock et al. 1988] states that actions are often learned by watching others model the action and then practicing the behavior. The curriculum provides multiple opportunities for observation and practice through role plays and other activities that engage the participation of the youths.

Curriculum Overview

The instructional approaches employed are based on research in behavior change and sex education and knowledge of the needs of youths in out-of-home care. The two major themes—self-improvement and the impact of choices on an individual's future—are reinforced through highly interactive, practical, and skills-building activities in each of the 10 90-minute sessions. An initial needs assessment in the first session of the curriculum facilitates curriculum adaptation so that the questions, concerns, and competencies of the youths in the program can be addressed. The curriculum focuses on recognizing and making choices related to sexual behavior, finding and using local resources, and developing effective communication skills. It emphasizes the importance of building skills related to effective contraceptive use and risk-reduction techniques and provides numerous, diverse opportunities for practicing these skills. Through role plays and other interactive activities, participants practice making reproductive health choices related to various lifestyles and adhering to those choices. They identify the series of choices in attaining short- and long-term goals, learn how to decide if and when they will choose to become a parent, and make a personal plan for avoiding an unintended pregnancy.

The curriculum's characters, whose experiences and relationships reappear throughout the sessions, help participants personalize the messages and themes. Photographs of "real" youths who depict each of these characters accompany the curriculum

and reinforce the relevance of the curriculum's scenarios. Extra photographs of youths from diverse backgrounds are provided so that health educators can tailor the characters' race, ethnicity and culture to each audience.

Participants are first introduced to some of the curriculum's characters in the second session of the curriculum, in an activity entitled, "Designing my Saturday Night." After viewing a photograph associated with the character of Frederic, participants learn that he is a 17-year-old who wants to be a teacher and is a junior in high school. Frederic has had sex with four different girls, has always used a condom, was sexually abused, and currently lives in a group home. Participants also learn that Frederic smokes marijuana and drinks sometimes, goes to the clinic for an HIV test every six months and has always tested negative, but has never been tested for other STIs. The facilitator then describes the nature of Frederic's current relationship with his girlfriend, Tanya, and asks the youths to act as the experts in helping Frederic and Tanya to "design a safer Saturday night." The facilitator asks the youths if they think Frederic and Tanya will and/or should have sex on this particular Saturday night, given the nature of their relationship and their character profiles. The facilitator then asks the youths to outline the steps that Frederic and Tanya need to take before Saturday night to ensure a "safer Saturday night," emphasizing the importance of planning for safer sex. Participants are reacquainted with Frederic and Tanya in a subsequent session, in an activity entitled, "You Decide." Youths once again listen to the descriptions of each character, including discussion of their sexual, drug, and alcohol history, and are asked to assist these characters in selecting the contraceptive methods that fit their particular lifestyles. This activity focuses on the advantages and disadvantages of various methods of contraception, as well as the importance of considering personal lifestyle habits when choosing a contraceptive method.

Youths in out-of-home care who participated in the pilot testing of this curriculum assisted in the development of these char-

acter profiles and relationships, maximizing the likelihood that youths receiving the curriculum would identify with its characters. Use of the curriculum's characters has proven to be a particularly engaging educational strategy and affords participants the opportunity to act as the experts in assisting the characters in the decisionmaking processes related to sexual activity and sexual relationships. As the curriculum evolves, characters start and stop relationships with other characters in a "soap opera" format that rings true for youths in out-of-home care. The curriculum's characters show increased levels of awareness, discretion, and skill as they re-emerge in new role plays and activities.

Goals and Objectives

The curriculum's goal is to provide youths in out-of-home care with specific skills and information to help them avoid high-risk sexual behavior and reduce the incidence of adolescent pregnancy, HIV, and other STIs. The curriculum's objectives are to enable participants to: (1) recognize and make choices related to sexual behavior; (2) build contraceptive knowledge and skills; (3) develop and practice effective communication skills; and (4) learn and practice locating and using local resources. The goals, objectives, materials needed, preparation required, and time estimates for each activity are listed at the beginning of each session.

The curriculum affords youths the opportunity to practice communicating about relationships, sex, and contraception with a partner, foster parent, group home counselor, or social worker, and to practice calling a local clinic to make an appointment to receive family planning services. The effects of past sexual abuse on an individual's sexuality are also addressed. The curriculum's activities constantly reinforce the theme of self-empowerment through skills-building activities, and the theme of making choices and evaluating their impact on an individual's future. This is achieved through activities that allow participants to personalize the lessons and identify the choices that they encounter in their own lives.

Delivering the Curriculum

Power Through Choices is designed to be delivered in a wide range of settings, yet there are a few constraints. Participants must be able to separate into small working groups, move around, participate in role plays, and use writing instruments. Some settings, (i.e., juvenile hall) restrict student movement and might, therefore, not be suitable for the implementation of this curriculum. Due to the interactive nature of this curriculum, it is best suited for small groups of eight to 20 youths.

The curriculum has been implemented in group homes, residential treatment facilities, and independent living skills programs (ILSP). During curriculum pilot testing, however, it was found that entry into each of these systems for the purpose of implementing the curriculum was often quite challenging. Strategies to overcome this obstacle included approaching administrators at networks of local group homes and requesting permission to implement the curriculum in multiple group homes within their network, sometimes combining group homes for the purpose of curriculum implementation; meeting with local ILSP coordinators to determine the most effective manner in which the material could be integrated into their existing curricula; and presenting the curriculum at local conferences to increase visibility and gain acceptance.

Whenever possible, the curriculum should be implemented within a time period of one month or less. During pilot testing, youths were found to retain and integrate the material more effectively, and were more open to building a positive relationship with the educator when at least two sessions were scheduled each week.

This curriculum is designed for female and male adolescents between the ages of 14 and 18. Some adolescents, however, are developmentally more advanced than others . This issue should be discussed with site staff prior to curriculum implementation to ensure that the curriculum is developmentally appropriate for each group.

Although the curriculum is tailored to meet the need of youths in out-of-home care, it can easily be adapted to work with other populations, and was successfully pilot tested in alternative schools and court schools.

Evaluation

A preliminary evaluation of the implementation of *Power Through Choices* was conducted in 1997 [Cagampang et al. 1997b]. During the final stages of pilot testing, 66 youths participated in the evaluation process. These youths completed pre- and posttests (42 matched pre- and posttests; decrease attributed to both attrition and late program entry) and satisfaction surveys, and participated in focus group discussions. In addition, classes were observed to learn about teaching styles and student participation.

The youths surveyed stated that what they learned in *Power Through Choices* will enhance their commitment and ability to practice safer sex. Posttest results demonstrated that the youths understood the curriculum's messages that abstinence is the only 100% safe method of protection from pregnancy, HIV, and other STIs, and that safer sex takes planning. The youths also responded that following completion of the program, they felt increased control over their lives and were significantly less likely to engage in unprotected sex than at pretest. Satisfaction survey results showed that 94% of the youths surveyed thought it would be easier to practice safer sex after participating in the curriculum, and 82% of the youths surveyed rated the overall program as being "very good" or "excellent."

Feedback from youths and observers clarified that the facilitator's teaching style greatly affected the manner in which the program was received by the youths. Evaluators observed that those facilitators who took the time and established rapport with the youths, demonstrated respect for them, and listened to their needs were most effective in conveying the curriculum's

messages. Evaluators also recognized the importance of providing sufficient training to facilitators in topic areas related to sexuality to adequately prepare them to answer the many questions raised by the youths. Additionally, observations during pilot testing revealed the need for facilitators to demonstrate a high level of comfort in dealing with issues related to adolescent sexuality for the youths to feel comfortable discussing such sensitive issues.

Because of the small sample size employed for the preliminary evaluation, a full-scale, longitudinal evaluation should be implemented with youths participating to better assess the efficacy of the curriculum. Given the need in the field, however, implementation should not wait until these extended trials have been completed, as the evaluation of a curriculum requires a long time and testing under a variety of conditions [Howard & McCabe 1990; Cagampang et al. 1997a].

In 1997, the California Department of Health Services, Office of Family Planning, awarded three-year contracts to select community-based organizations and county health departments in 12 counties in California to implement *Power Through Choices* as a demonstration project in their local communities. Representatives from participating agencies attended a four-day training and are currently implementing the curriculum in group homes, residential treatment facilities, and Independent Living Skills Programs throughout California.

Policy Issues and Implications

Given that youths in out-of-home care are at elevated risk for unintended pregnancy, HIV, and other STIs, and that the consequences are typically worse than for youth in general [Allen et al. 1987], the need to address the unique issues faced by youth in out-of-home care is apparent. Public policy is beginning to address this need. In California, a legislative mandate (AB 1127) exists that requires foster care providers of adolescents in long-

term out-of-home care to ensure that these youths receive age-appropriate pregnancy prevention information. This support for the delivery of pregnancy prevention information to youths in out-of-home care facilitates the implementation of a sexuality education program and provides an opportunity to make a difference in the lives of these youths.◆

References

Allen, M., Miller, S., & Abbey, J. (1987). *Teens in foster care: Preventing pregnancy and building self-sufficiency*. Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund.

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, NJ: Prentice-Hall.

Barth, R. P. (1990). On their own: The experiences of youth after foster care. *Child and Adolescent Social Work, 7*, 419–440.

Becker, M. G., Barth, R. P., Cagampang, H. H., & White, R. C. (in press). *Power through choices*. Tulsa, OK: University of Oklahoma National Resource Center for Youth Development.

Becker, M. H. (Ed.). (1974). *The health belief model and personal health behavior*. Thorofare, NJ: C. B. Slack.

Brindis, C. D., & Jeremy, R. J. (1988). *Adolescent pregnancy and parenting in California: A strategic plan for action*. San Francisco: Center for Population and Reproductive Health Policy, Institute for Health Policy Studies, University of California, San Francisco.

Cagampang, H., Barth, R. P., Kirby, D., & Korpi, M. (1997a). Education Now and Babies Later (ENABL): Life history of a campaign to postpone sexual involvement. *Family Planning Perspectives, 29*, 109–114.

Cagampang, H. H., Sather, S., White, R. C., & Barth, R. P. (1997b). *Preliminary evaluation of Power Through Choices*. Berkeley, CA: Family Welfare Research Group, University of California at Berkeley.

Carver, C. S. (1981). *Attention and self-regulation: A control-theory approach to human behavior*. New York: Springer-Verlag.

Cook, R. (1994). Are we helping foster care youth prepare for their future? *Children and Youth Services Review, 16,* 213–229.

Howard, M. & McCabe, J. B. (1990). Helping teenagers postpone sexual involvement. *Family Planning Perspectives, 22,* 22–26.

Maza, P. (1996). *Children and care: 1977 vs. 1994.* Washington, DC: U.S. Children's Bureau (unpublished report).

Mithaug, D. E. (1993). *Self-regulation theory: How optimal adjustment maximizes gain.* Westport, CT: Praeger.

Mullen, P., Hersey, J., & Iverson, D. (1987). Health behavior models compared. *Social Science Medicine, 24,* 973–981.

Needell, B., Barth, R. P., Armijo, M., & Bruce, E. (1996). Birthrates of foster youth and former foster youth. Berkeley, CA: School of Social Welfare, Child Welfare Research Center (unpublished paper available from the authors).

Polit, D. F., Morton, T. D., & White, C. M. (1989). Sex, contraception and pregnancy among adolescents in foster care. *Family Planning Perspectives, 19,* 18–23.

Risley-Curtiss, C. (1997). Sexual activity and contraceptive use among children entering out-of-home care. *Child Welfare, 76,* 475–496.

Roman, N. P., & Wolfe, P. B. (1997). The relationship between foster care and homelessness. *Public Welfare, 55,* 4–9.

Rosenstock, I., Strecher, V., & Becker, M. (1988). Social learning theory and the health belief model. *Health Education Quarterly, 15,* 175-183.

Terry, D. J., Gallois, C., & McCamish, M. (Eds). (1993). *The theory of reasoned action: Its application to AIDS-preventive behavior.* New York: Pergamon Press.

(Address requests for a reprint to Richard P. Barth, Jordan Institute for Families, University of North Carolina School of Social Work, 301 Pittsboro Street, Chapel Hill, NC 27599–3550.)