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RESEARCH POSTER SYMPOSIA I: QUALITATIVE RESEARCH

1.

"NO JUDGING EYES": YOUTH EXPERIENCES OF EFFECTIVE (AND INEFFECTIVE) PREGNANCY OPTIONS COUNSELING

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Purpose: Adolescents and young adults (AYA) aged 15-19 in the United States have the highest rates of unintended pregnancy compared to other ages, putting them in need of adequate pregnancy options counseling. Despite this need, available pregnancy options counseling training modalities have not been informed by AYA perspectives. This study explored AYA experiences and recommendations to facilitate the development of stakeholder-informed implementation of pregnancy options counseling for AYA.

Methods: We conducted semi-structured phone interviews with a purposive sample (including those who chose parenting, adoption, and abortion) of United States-based key informants aged 18-35 years who self-reported experiencing a pregnancy under 20 years old. We recruited participants through clinics, adoption-related organizations, Facebook, Craigslist, and a university-based research registry. We recorded and transcribed all interviews, then conducted content analysis informed by the Consolidated Framework for Implementation Research. After generating the initial codebook, we added and refined codes and identified key themes during coding meetings through an iterative process including coding reconciliation. Two independent coders identified facilitators and barriers to effective pregnancy options counseling through inductive and deductive analysis utilizing Dedoose (9.0.17).

Results: The sample included 52 participants, including 20 experiences of parenting, 18 of abortion, 17 of adoption, and 4 of miscarriage. Ages at time of adolescent pregnancy ranged from 13-19 years, with 8 pregnancies at age 15 and younger, 15 at ages 16-17, and 36 at ages 18-19. Fifty-one participants identified as female and 1 as non-binary. 14 identified as LGBTQ and the rest as heterosexual. 9 identified as African American or Black, 5 as biracial, 3 as Asian, 7 as Hispanic, 26 as Caucasian, and 2 as other. Participants named the following facilitators to effective options counseling for AYA: 1) positive provider communication skills (compassion/kindness, respect, attention to nonverbal cues, validation), 2) comprehensive content of provider discussion (discussing all options, asking the adolescent about feelings, choice, life plans, and available supports), 3) provision of materials (brochures, videos), and 4) intentional connection to resources/next steps (parenting class, support group, counselor/therapist, prenatal care, abortion provider, adoption agency). Barriers to effective options counseling included: 1) lack of counseling on all options and/or coercive/directive counseling, 2) poor communication skills (judgmental stance, too much/not enough information) 3) lack of available resources (such as provider time/knowledge and financial assistance), and 4) confidentiality concerns. We identified no differences in these perspectives across pregnancy outcomes. Participants who expressed having already decided on their desired pregnancy outcome prior to options counseling noted they still wanted unbiased counseling around all options.

Conclusions: Despite differences in timing, location, and other demographics, AYA who experienced a pregnancy in adolescence described suboptimal pregnancy options counseling when it was performed at all. Preserving confidentiality and ensuring developmentally-appropriate, respectful communication should be considered the basic minimum standards for pregnancy options counseling, but these are often not met. Understanding AYA perspectives on options counseling can inform the formulation of AYA-centered pregnancy options counseling training platforms for providers to effectively implement this essential practice.

Sources of Support: Society for Family Planning. NIH T32GM008425.

2.

AVAILABILITY OF YOUTH STI AND REPRODUCTIVE SERVICES IN URGENT CARE CENTERS

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Purpose: Youth bear a disproportionate burden of sexually transmitted infections (STI). Young people 15-24 years old only make up 27% of the sexually active population, but they account for about 50% of the 26 million new STIs in the United States. Evidence suggests Urgent Care Centers (UCC) are serving as a source of STI care. However, less is known about the availability of youth STI and reproductive services in UCC.

Methods: We conducted secondary data analysis of qualitative and checklist-based data collected from a 2017 rapid assessment of 19 UCC in the Atlanta metropolitan area . The data included an assessment of STI, and reproductive services offered at each UCC by population, including youth. We abstracted all data services UCC offered to youth, including qualitative data related to youth services, to contextualize quantitative data. Williams SP, Kinsey J, Carry MG, Terry L, Wells J, Kroeger K. Get In, Get Tested, Get Care: STD Services in Urban Urgent Care Centers. Sex Transm Dis. 2019;46(10):648-653. doi:10.1097/OLQ.0000000000001042

Results: All 19 UCC offered testing for gonorrhea, chlamydia, syphilis, and HIV, with varying protocols for onsite treatment and referrals for youth. Eleven UCC reported conducting sexual histories or risk assessments (SH/RA) with youth when patients had symptoms or diagnoses. An SH/RA was not a standard or typical procedure for any of the UCC. Most UCC did genital (n=15) and pelvic (n=13) exams for youth, with three requiring parental consent. Regarding reproductive services, all UCC offered pregnancy tests to youth. Two UCC indicated

testing youth only if accompanied by a parent or in the case of a sexual assault. Five UCC provided PAP/HPV tests to youth, and only two offered HPV vaccination. Four UCC offered emergency contraception to youth, 7 referred patients, and 7 did not offer them at all. Two UCC offered youth long-acting contraception for the 1st month only or a script, then referred youth to a primary health care provider (PHCP). Most UCC referred patients to health departments (HD) or a primary health care provider (PHCP) for services that may require repeat visits or follow-up. All UCC required some form of payment for services, with STI testing ranging between $100 and $500, not including visit fees. Several UCCs mentioned that youth were often reluctant to use insurance if they were on their parent's policy. Youth unable to pay cash or use insurance for services were referred to the HD.

Conclusions: Varying protocols around parental permission, treatment options (onsite testing, but referred treatment) and costs limits UCC accessibility and use for some youth, especially those with limited economic resources. UCC can serve as an option for STI and reproductive services for youth, offering the ability to access many services confidentially. Interventions to facilitate or deepen UCC partnerships and referrals to collaborating providers might help reduce patient point-of-care costs and link them to other care sources to expand the safety net of STI and reproductive health services for youth.

Sources of Support: Research conducted as part of work duties.

3.

IMPACT OF PARENT-ADOLESCENT RELATIONSHIP QUALITY AND SEXUAL HEALTH COMMUNICATION ON PARENTAL WILLINGNESS TO SUPPORT ADOLESCENT USE OF PRE-EXPOSURE PROPHYLAXIS FOR HIV: LESSONS FOR POST-PANDEMIC SEXUAL HEALTH INTERVENTIONS

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Purpose: Pre-exposure prophylaxis (PrEP) is a safe and highly effective method of HIV prevention, yet PrEP use among US adolescents at risk for HIV has been low. Sexual health communication between parents and adolescents has been shown to decrease teen pregnancy and increase condom use, but data are scarce on the impact of communication on PrEP use. We wanted to understand parents' perspectives on PrEP and the role of parent-adolescent relationship quality and sexual health communication on parents' willingness to support their adolescent using PrEP ("PrEP willingness"), to inform post-pandemic interventions to improve PrEP uptake among adolescents at risk for HIV.

Methods: We conducted N=34 in-depth interviews (IDIs) with parents of adolescents recruited from clinical sites in four US cities (Tampa, FL; Baltimore, MD; Chicago, IL; Denver, CO) as part of a larger, multi-center study on adolescents' and parents' involvement in HIV prevention research. IDIs were conducted by research staff using a semi-structured interview guide. IDIs were recorded, transcribed, and de-identified. A coding structure was developed using a stepwise iterative process as follows: 1) Initial codes were generated from interview guide topics; 2) literature review was used to provide theoretical foundations for codes on "relationship quality" and "sexual health communication"; 3) three authors (JR, RAS, AK) independently applied initial codes to two transcripts, iteratively discussing coding conceptualizations and discrepancies, and revised the coding structure accordingly; 4) the first author trained the fourth author using four transcripts, discussing coding discrepancies and revising coding structure. Preliminary themes were identified using applied thematic analysis, a rigorous and inductive process of identifying and examining themes from textual data.

Results: Parents were almost universally supportive of PrEP as a theoretical HIV prevention method for all populations. Two groups of parents emerged: "low" and "high" willingness to support their own adolescent using PrEP. Low willingness parents tended to either 1) not be aware of their child's sexual experiences, and/or 2) perceive their child as being at low risk for HIV transmission. High willingness parents expressed more open and specific sexual health communication with their child and used supportive and engaged language when describing their relationship with their child. Few parents in either the low or high willingness groups reported concerns about the efficacy or safety of PrEP, but those who did cited side effects more often than other concerns. Parents were supportive of clinic and school-based supports for parents and adolescents to improve sexual health communication and HIV prevention efforts.

Conclusions: Parents were largely supportive of PrEP as a general approach to HIV prevention, and largely willing to have their own adolescent use it. Parents with more engaged and supportive relationships, and those with more specific and open sexual health communication tended to express more PrEP willingness. Future work should focus on incorporating parents into PrEP uptake interventions given their key roles in adolescents' sexual health, while acknowledging pandemic-related changes to parents' and adolescents' relationships and contexts.

Sources of Support: National Institute of Mental Health (1K23MH123335-01, PI: Rusley) and the Adolescent Trials Network for HIV/AIDS Interventions (ATN, U01 HD040533 and U01 HD 040474).

4.

"WHO ELSE HAS THAT OPPORTUNITY BUT US?": ACUTE HOSPITALIZATION AS AN OPPORTUNITY TO ENGAGE YOUNG PEOPLE WHO INJECT DRUGS INTO TREATMENT

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Purpose: Hospitalized young people who inject drugs (YPWID) suffer from high hospital readmission rates, recurrent infections, and repeat surgical interventions, all of which contribute to high mortality and long-term disability. As hospitalization presents an opportunity to engage YPWID into treatment, there is an urgent need to identify strategies to engage and retain this vulnerable population into treatment. Our study examines barriers and facilitators to OUD treatment engagement among hospitalized YPWID.

Methods: We recruited 26 participants representing key stakeholder groups (hospitalized YPWID ages 18-30 years [n=6], hospital social workers [n=7], and nurses and other clinicians [n=13]). Participants were identified using purposive sampling. They completed 20-75 minute semi-structured interviews asking about barriers and facilitators for engaging YPWID into treatment. The interview guide was