Risk discourse and sexual stigma: Barriers to STI testing, treatment and care among young heterosexual women in disadvantaged neighbourhoods in Toronto

Josephine Pui-Hing Wong¹, Karen B. K. Chan², Renee Boi-Doku², and Simone McWatt²

¹ Daphne Cockwell School of Nursing, Ryerson University, Toronto, ON
² Toronto Public Health, Toronto, ON

Abstract: Available data on indicators of sexual health among Canadian youth indicate that many Canadian young people are experiencing better sexual health outcomes (e.g., lower rates of teen pregnancy) than youth in the past and more of them are engaging in safer sex practices. However, young people who experience social and economic marginalization tend to have poorer sexual health outcomes including higher rates of sexually transmitted infections (STIs). The present focus group study of 49 young women aged 16 to 24 from two underserviced and disadvantaged neighbourhood clusters in Toronto yielded insights into their perspectives about STIs and their strategies for dealing with sexual stigma associated with STIs. Our findings indicated that fear-based messages and sexual stigma discouraged these young women from accessing sexual health care. According to the respondents the school-based sexual health messages they received privileged a biomedical approach, emphasizing individual responsibilities. These messages may have inadvertently reinforced stigmatization of STIs in a way that discouraged these young women from engaging in STI prevention education or seeking early testing and treatment. Some young women felt disempowerment and limits on their potential to fully embrace their sexualities. The implications of our findings for effective sexual health promotion include the adoption of socio-environmental approaches that address social and economic marginalization and youth-driven strategies that challenge moralistic discourses and sexual stigma.

Acknowledgements: This project was funded by Toronto Public Health. The authors would like to thank Deborah Waddington, Coordinator of the Taking Action on Chlamydia Campaign at Toronto Public Health for her support during data collection for this study, and Peggy McDonough and Maurice Poon for their valuable feedback on an earlier draft of this article.

Introduction

From a review of the sexual health of Canadian youth over the last several decades, Maticka-Tyndale (2008) concluded that there have been few changes in the patterns of sexual behaviours among the general population of Canadian youth. For example, indicators such as the age of first sexual intercourse and the number of lifetime sexual partners have remained stable. Overall, more Canadian young people are experiencing better sexual health outcomes such as lower rates of teen pregnancy and rates of condom use have increased (SIECCAN, 2010). However, many Canadian youth are at risk for negative sexual health outcomes. Young people who experience social and economic marginalization (e.g., youth from low-income neighbourhoods; sexual minority youth; racialized newcomer youth; and street-involved youth) tend to have poorer sexual health outcomes such as sexually transmitted infections (STIs) or unplanned pregnancy (Hefferman, 2002; Miller, McDermott, McCulloch, Fairley, & Muller, 2003; Smith-Fawzi et al., 2003). Other studies suggest that the collective historical and persisting experience of racism and forced assimilation contribute to problems such as STI and HIV infections, addiction, and violence among racialized minority youth.
subpopulations (Singera et al., 2006; Steenbeek, Tyndall, Rothenberg, & Sheps, 2006).

Similarly, geographic mapping of chlamydia distribution in Toronto has shown a pattern of higher reported rates of chlamydia in neighbourhoods that are disadvantaged in terms of income, education, community resources, and racialized minority status (Gournis & Achonu, 2005; Hardwick & Patychuk, 1999). The unequal distribution of reported chlamydia rates raises questions not only about the impact of poverty and inequality on sexual and reproductive health but also about levels of access to effective sexual health promotion education and services for young people in disadvantaged social and economic environments. Evaluation studies of pregnancy and STI/HIV prevention programs based on behavioural change theories have demonstrated that such programs can be effective in promoting safer sex and contraceptive practices among young people (Albarracín et al., 2005; Johnston, Fernando, & MacBride-Stewart, 2005; SIECCAN, 2010). However, other studies point to a disjuncture between some sexual health education programs and the sexual realities of young people; these programs have been criticized for their narrow focus on knowledge, attitude and behavioural risks while ignoring the meanings of sexual encounters in young people’s lives (Ashcraft, 2006; Hirst, 2004; Rogow & Haberland, 2005). Furthermore, it has been argued that many interventions are primarily female targeted and white middle class biased, that they perpetuate myths of male sexual prowess and females’ responsibility for safer sex practices (Allen, 2005b, 2007; Larkin, Andrews, & Mitchell, 2006), and fail to reach young people of diverse and marginalized backgrounds (Noguchi, Albarracin, Durantini, & Glasman, 2007; Taylor, 2007).

**Dominant discourses about youth sexuality**

The perspective underlying this study is that ideas about young people’s sexuality are constructed through discursive practices in social spaces such as media, law, school, family, and so on. Discourses are not merely language or representations of social life; they are a system of institutionalized practices and authorized knowledge that structure the way we perceive our everyday reality (Foucault, 1972). Discourses are produced through rules of exclusion, prohibition, division and rejection to create a common sense of what is considered true/false, normal/abnormal, good/bad, and who is authorized to say what counts as truth (Foucault, 1984). These “common sense” notions and “expert opinions” become internalized and unquestioned.

The promotion of young people’s sexual health is often addressed in a predominately biomedical context and research focuses on the knowledge, attitudes and sexual behaviours of young people (Chan & Reidpath, 2003). Results of behaviourally focused studies can be sanctioned as “expert” knowledge that defines the norms of “healthy” sexual behaviours, against which individuals and groups are constituted as “risk-makers” or “at-risk subjects” (Tulloch & Lupton, 2003). Furthermore, it has been argued that these risk discourses intersect with other moralistic discourses to perpetuate adult anxiety towards young people’s sexuality (Hughes, Morrison, & Asada, 2005).

One powerful disciplinary regime used by adults and internalized by young people is labelling (Goffman, 1963). When young women are perceived to be or are identified as deviating from the expected norms (e.g., disinterest in sex, playing the role of sexual gate-keeper, or sexual monogamy), they are labelled as at-risk and/or promiscuous. These labels reinforce biased stereotypes of youth subpopulations that do not fit into narrowly perceived normative standards (Andres & Adamuti-Trache, 2008; Hamilton & Armstrong, 2009). The labelling of youth subpopulations as at-risk and problematic draws attention away from the structural influences of racism, classism, sexism, homophobia, and poverty that mediate young people’s sexual health (Mill, Edwards, Jackson, MacLean, & Chaw-Kant, 2010; Omorodion, Gbadebo, & Ishak, 2007).

**The present study**

The present study was part of a Toronto Public Health campaign to address high chlamydia rates among young women aged 16 to 24 living in disadvantaged neighbourhoods characterized by economic marginalization, limited access to health and social resources, and lower education attainment (Gournis & Achonu, 2005). Initially, Toronto Public
Health planned to develop a social marketing campaign to promote chlamydia testing and safer sex practices among young women from disadvantaged neighbourhoods. In the planning process, it was recognized that there was a scarcity of relevant knowledge and local evidence to guide the development of an effective and inclusive campaign. As a result, we undertook a qualitative study to explore the young women’s experience in accessing sexual health care.

The research questions included: (a) When and where do sexually active young women in these neighbourhoods access sexual health care?; (b) What are the barriers to and facilitators of proactive STI testing among these young women and their peers?; and (c) What would young women consider to be the key elements of an effective social marketing campaign to promote chlamydia testing among young women in their local communities.

This article reports on the young women’s experiences in accessing sexual health information and care, and the individual and structural factors that influenced their STI testing behaviours. Specifically, we focused on the themes of moralistic discourses, sexual stigma, social regulation of young women’s sexuality, and related issues identified from the focus group discussions.

Methods

Theoretical approach
This study was informed by a critical social science paradigm, which proposes that people’s everyday experiences are shaped by historical, social, economic, and political forces (Eakin et al., 1996). This perspective recognizes that power is implicated in knowledge production and exercised through discourses (Foucault, 1978, 1984). It also assumes that the social world is an open system in which outcomes of social interactions are determined by contexts and spatio-temporal relations, and that individuals have the free will to act but within the structural constraints of their society (Porter, 2002).

Sampling sites
This study used purposive sampling specific to the research goals stated above. We used the geographic mapping of epidemiological data to identify priority sampling sites, that is, neighbourhoods that had the highest rates of chlamydia among young women aged 15 to 24. Twenty out of 140 neighbourhoods in Toronto were selected and these neighbourhoods constituted two general clusters in two geographic regions of Toronto. To ensure that we were reaching the intended participants, the first three digits of potential participants’ postal codes were used as a sampling criterion in the participant screening process.

Participation criteria
Criteria for participation in this study were determined based on the purposes of the research and included: self-identification as a woman; age 16 to 24 years; living in a priority sampling site as determined by postal code; having had sexual intercourse within a period of 12 months prior to the study; and being available to attend a 2.5-hour focus group. The age criterion was based on epidemiological evidence that women aged 15 to 24 had the highest rates of chlamydia. Fifteen-year old women were not included in this study due to the legal requirement of parental consent to participate in research. Given the sensitive nature of the study and the barriers and safety issues many 15-year-old women might encounter in obtaining parental consent, we excluded women under the age of 16.

Recruitment strategies
Strategies for recruiting study participants included: flyers posted in youth-friendly and youth-focused community agencies; e-distribution of flyers to youth service organizations; word-of-mouth among young women; and promotion by Toronto Public Health staff and community colleagues at programs and events for young women in the priority sampling neighbourhoods.

Data collection
This study used focus groups to explore the participants’ experiences in accessing sexual health information and care, their knowledge and perspectives about chlamydia, and their ideas for an effective social marketing campaign to promote chlamydia testing. Before each focus group interview, participants were invited to complete a short survey. The purposes of the survey were to collect demographic and contextual information about the participants and to provide an opportunity
for participants to answer personal and sensitive questions in privacy. Unlike conventional surveys, participants were not given specific categories of ethnicity to choose from; instead, they were asked to fill in a blank space to freely express their self-defined ethnic identities. The framing of this question was chosen to align the survey with the purpose for this study, that is, to explore how the young women made sense of their ethnic and cultural identities in order to reach them in an effective social marketing campaign.

Other questions in the survey included: age; languages spoken at home; languages spoken with friends; work/school status; parenthood status; number of visits to a doctor in local neighbourhood and outside neighbourhood within the last 12 months; number of visits to a walk-in clinic in local neighbourhood and outside neighbourhood within the last 12 months; status of having a family doctor; three key factors that affected where participant went for sexual health care; and the three most important sources of sexual health information that they had accessed.

Focus group interview guide

We developed an interview guide with four key focus areas. First, we asked the young women about their experiences in using sexual health services: “Where do you go for general health care?,” “Where do you go for sexual health care?,” “Describe one of your best experiences in getting sexual health care,” and “Describe one of your worst experiences in getting sexual health care.”

Second, we asked about the young women’s knowledge and perception about chlamydia. Probing questions included: “Where did you hear about chlamydia?,” “Who gets chlamydia?,” “How does a person get it?,” and “How does it affect someone who is infected?”

We also used the following case scenario to encourage discussion about chlamydia testing.

Stephanie is 19; she has been dating her boyfriend for 6 months. She is on birth control pills; she and her boyfriend had decided to stop using condoms during sexual intercourse 3 months ago. Last week, Stephanie heard rumours that her boyfriend’s ex-partner had tested positive for chlamydia. Stephanie wanted her boyfriend to go for testing, but he refused. Now, she doesn’t know what to do about testing.

We invited participant responses to this scenario by asking them probing questions such as: “What advice would you give Stephanie?,” “Should Stephanie be tested?,” “Who in general should be tested for chlamydia?,” “Where?,” “What is involved in testing?,” and “Why might young people be hesitant about being tested?”

Third, we explored participants’ perspectives on factors that promote chlamydia testing among young women by posing a follow-up scenario.

Stephanie is going to see Dr. Myers in her neighbourhood for her asthma management and birth control prescriptions. She has booked an appointment with Dr. Myers for tomorrow to discuss her new asthma medication. Stephanie feels too embarrassed to ask Dr. Myers for a chlamydia test.

In this case, our probing questions focused on reticence about suggesting or asking for chlamydia testing. The questions were: “What needs to happen if Stephanie were to have a chlamydia test tomorrow during her visit with Dr. Myers?,” “What kinds of tips do you have for Stephanie to bring up the topic and to ask for a chlamydia test?,” “If you were Dr. Myers, how would you help patients like Stephanie to bring up the topic of STIs or ask for STI testing?,” and “If neither Stephanie nor Dr. Myers brought up the topic of chlamydia testing, who else could play a role in this, and how?”

Lastly, we explored the participants’ ideas about social marketing campaigns and effective messaging for young women about proactive chlamydia testing. Our questions included: “Where do young women like you get information about sex and sexual health?,” “Describe an advertising campaign that you remember the most. What made it memorable?,” and “How were you persuaded by it?” To gain further insights, we divided the participants into two groups and asked one group to design a social marketing campaign to promote chlamydia testing among
sexually active young women and the other group to design a campaign to promote proactive chlamydia testing among doctors who work with sexually active young women.

**Data analysis**

Our thematic analysis consisted of two complimentary components: technical data management using the N-VIVO computer software, and cognitive analysis and interpretation. All focus group interviews were audio-recorded with permission from participants. The interviews were transcribed verbatim. The N-VIVO program was used to organize the data and assist with the thematic coding. To derive thematic categories, we reviewed the transcripts and field notes to develop a broad understanding of the data. Then we re-read the transcripts and data using both inductive and deductive reasoning to identify categories that were articulated by the participants and that were theory-based; this indigenous and sensitizing process was guided by the research questions and the theoretical framework of the study (Merriam, 2009).

**Ethical considerations**

This study received formal ethics approval from Toronto Public Health’s Ethics Review Board. We obtained written informed consent from all participants; we also emphasized that participation was totally voluntary and participants could withdraw at any time in the study. The focus groups were organized based on participants’ proximity in age to minimize potential barriers in communication associated with age-related power, lived experience, and cultural differences. The focus groups were held in three local agencies serving youth to facilitate a sense of comfort and safety. Each participant received three tokens of appreciation and recognition for helping to generate local knowledge to guide public health programming: specifically an honorarium of $50, two-way public transportation fare, and a light pizza meal. We also provided participants with a list of community health and sexual health resources for young women.

**Results**

**Participant characteristics**

A total of 49 young women participated in the study: 45% of them were aged 16-19 (n=22) and 55% were aged 20-24 (n=27). All of the participants came from the sample priority neighbourhoods characterized by low income, low education attainment, and inadequate access to health and social services. All participants reported sexual activities with male partners. Within the age 16-19 focus groups, 23% (n=5) were mothers as were 67% (n=18) of participants in the age 20-24 groups.

In the age 16-19 groups, 77% (n=17) were attending high school or college; the remaining participants were either working part-time or unemployed. In the aged 20-24 groups, 30% (n=8) were attending high school/college; 26% (n=7) were unemployed, and 22% (n=6) were working part-time (see Table 1).

The survey results also showed that a majority (66%) of the participants were from ethno-racial minority backgrounds. Since we asked the participants to freely define their ethnic backgrounds, the results did not fit neatly into a list of conventional ethnic categories. The participants defined their ethnic backgrounds in numerous ways: by skin colour (e.g.

<table>
<thead>
<tr>
<th>Work/employment/ school attending status</th>
<th>Age 16-19 (N=22)</th>
<th>Age 20-24 (N=27)</th>
<th>Total (N=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending high school</td>
<td>68%</td>
<td>7%</td>
<td>35%</td>
</tr>
<tr>
<td>Attending college/university</td>
<td>5%</td>
<td>22%</td>
<td>14%</td>
</tr>
<tr>
<td>Working part-time</td>
<td>27%</td>
<td>9%</td>
<td>24%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>18%</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>Working full-time</td>
<td>9%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>“Stay-at-home mother”</td>
<td>--</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Ontario Disability Support (ODSP)</td>
<td>--</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Youth employment training</td>
<td>--</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Did not complete</td>
<td>5%</td>
<td>7%</td>
<td>4%</td>
</tr>
</tbody>
</table>
“White”, “Black”), by region (e.g. “Newfoundland”), by cultural heritage (e.g., Jewish), or by country of origin (see Table 2). Many of them also reported multi-ethnic or multi-racial identities.

**Thematic categories**

Our analysis resulted in five thematic categories that are listed here and then documented below: (1) Risk and moralistic discourses in everyday life; (2) Safer sex is understood but fear impedes STI testing; (3) Sexual stigma and young women’s self-concept; (4) STI-related stigma and relationship conflicts; and (5) Resistance: creating new rules.

**Theme 1: Risk and moralistic discourses in everyday life**

Most of the young women in this study indicated that sex education at school neither addressed their needs nor reflected their realities. Over 70% of the total sample cited friends as their key sources of sexual health information; less than 50% sought information from doctors, nurses, or counsellors. Among the young women aged 16 to 19, only 32% identified school as their main source of sexual health information. Many indicated that their expression of sexual interest was denied or frowned upon by their teachers and other adults at school. Some of the young women resented the dominant messages of abstinence and sexual risks that were imposed on them.

We didn’t even care about what we were hearing [in sex education classes]; it was like, “Oh wait till I turn twenty-four,” you know. In grade nine they emphasized abstinence a lot. It’s almost like, they tried to scare you with all these STDs. (FG#1: aged 16-19, Participant #5)

Many participants perceived the risk discourse as a way that adults tried to scare them into compliance. One young woman lamented that condom advertisers understood young people’s sexual desires more than their teachers.

They [teachers] try to take us away from it [having sex]. They tell us, “Be informed and wait until you mature in the next five years,” whereas [name of a condom ad] know that we are having sex. They know. They don’t have to question that we are, they speak to the fact that we are having it and that we also want pleasures. (FG#1: aged 16-19, Participant #7)

The narratives of the participants reflected their desire for adults to acknowledge that young women are active sexual agents who not only want but also have a right to sexual pleasure.

For many participants, denial of young people’s sexualities was not only common at school, but also at home and in the community. Initially, most of the participants reported that sexuality was a tabooed topic at home or something that was never talked about, but as they engaged in the discussions,

<table>
<thead>
<tr>
<th>Table 2 Self-identified ethnic backgrounds of participants*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-identified ethnic background(s)</td>
</tr>
<tr>
<td>African Canadian</td>
</tr>
<tr>
<td>Austrian-Hungarian</td>
</tr>
<tr>
<td>Barbados</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Canadian</td>
</tr>
<tr>
<td>Maltese Canadian</td>
</tr>
<tr>
<td>Chinese</td>
</tr>
<tr>
<td>French</td>
</tr>
<tr>
<td>Guyana</td>
</tr>
<tr>
<td>Haitian</td>
</tr>
<tr>
<td>Italian</td>
</tr>
<tr>
<td>Jamaican</td>
</tr>
<tr>
<td>Jamaican Canadian</td>
</tr>
<tr>
<td>Jamaican, Irish, Native</td>
</tr>
<tr>
<td>Jamaican, Scottish</td>
</tr>
<tr>
<td>Jamaican, White Canadian, Native Indian</td>
</tr>
<tr>
<td>Jewish</td>
</tr>
<tr>
<td>Latino</td>
</tr>
<tr>
<td>Native</td>
</tr>
<tr>
<td>Native Canadian, Jamaican, German</td>
</tr>
<tr>
<td>Native Indian</td>
</tr>
<tr>
<td>Native Indian, Irish, Newfoundland</td>
</tr>
<tr>
<td>Scottish Jamaican</td>
</tr>
<tr>
<td>South African</td>
</tr>
<tr>
<td>Spanish</td>
</tr>
<tr>
<td>Spanish, Italian, Newfoundland</td>
</tr>
<tr>
<td>Tamil</td>
</tr>
<tr>
<td>Tanzanian/Trinidadian</td>
</tr>
<tr>
<td>West Indian</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Did not complete</td>
</tr>
</tbody>
</table>

*Participant’s personal designations.

---

The Canadian Journal of Human Sexuality, Vol. 21 (2) 2012
many recalled getting sexuality messages from their parents or caregivers. However, only two out of the 49 participants reported that they were able to talk openly with their parents/caregivers about their sexual decisions and received respect and positive support. Others recalled negative and punitive messages when their parents/caregivers discovered they were sexually active.

I don’t deal with my dad at all. My mom, she just gets mad at me and calls me a slut or something. (FG#1: aged 16-19, Participant #6)

Your parents may turn around and start saying, “You’re a slut, you’re a whore. [Others agreed.] You shouldn’t be living here under my roof”. Like, a friend of mine went through something, not chlamydia, but something else and her parents completely just turned the other way and said, “Get out of here.” (FG#5: aged 20-24, Participant #7)

Some participants experienced stigmatizing attitude from health care providers.

You go in the room [at the doctor’s office] and you automatically get this putdown, “You’ve been having sex since you were twelve? You’re going to get pregnant.” And you automatically just get the [judgment of] “there’s no father around.” (FG#4: aged 20-24, Participant #2)

I don’t really go to any other doctors, you know. I just go to my family doctor and he’s not terribly nice. He’s been my family doctor since I was young and he’s always had something bad to say about what I’m doing. When I got pregnant, he was acting more like a parent than a doctor; he was telling me to have an abortion. (FG#1: aged 16-19, Participant #8)

Other participants who were young mothers reported experiences of disrespect and distrust from other health service providers.

When I had my son I was nineteen years old. They did not see me as a mother; they only saw my age at the hospital. I was under the impression that I could leave the hospital once I had given birth as long as my baby had a clean bill of health and he did. So, I wanted to leave. I wanted to go home to my own bed and lie down and they called Children’s Aid on me. So, Children’s Aid showed up to my home. Little did they know I had been married since I was seventeen years old. I had a home for myself. I found it really appalling that just because I was nineteen years old, they thought I was incapable of taking care of my baby and they had to call Children’s Aid without having any reason to. (FG#3: aged 20-24, participant #5)

These young women’s narratives show that these moralistic discourses are not individual actions but collective practices that are supported by social institutions of family, education and health care to create a culture of surveillance and regulation to institutionalize individual responsibility and compliance to dominant norms.

Theme 2: Safer sex is understood but fear impedes STI testing

The focus group findings showed that safer sex messages indeed reached these young women. All of the 49 participants were able to articulate that unprotected sex would put them at risk of getting HIV and STIs. However, their narratives also suggested that safer sex messages were compromised by misconceptions that generated fear towards STIs.

I think a lot of people, when they think of STDs or something they think it’s incurable. They’re like, “Oh my God, if I ever catch an STD, I know I’m going to die.” But clearly they need to know you can actually treat them. (FG#1: aged 16-19, Participant #4)

Some participants shared that they only learned about HIV/AIDS at school and nothing about other STIs. The fear message discouraged them from seeking sexual health care.

All you hear is AIDS, no cure, but you don’t hear that there are a lot of common STDs that
have a cure. Like, I did not know. I know that my friends don’t know. At the beginning of this conversation about chlamydia, I was kind of scared of it, but right when she said there are antibiotics, it made me want to be tested much faster. (FG#2: aged 16-19, Participant #3)

The powerful message of ‘no cure for AIDS’ which had dominated early HIV prevention education in the 1990s seemed to impose an ongoing fear among some of these young people. Furthermore, this fear was experienced not only at the individual level but also collectively in the community.

P1: My guy friends, they’re scared nowadays, they are using condoms like crazy. They’ll ask me if I can go get them some condoms from the centre because, like, there is hearsays that [x neighbourhood] has AIDS and it’s going around like crazy. Like, a lot of people know that [x neighbourhood] has AIDS. (Cross-talking.)
P2: Really? I just moved out of there, like three years ago.
P1: That was, like, (cross-talking) in the middle row [of the housing project].
P3: That’s so scary. They said fifty-two per cent of the population at [x neighbourhood] have HIV. This guy, he infected like thirty or thirty-five people, the same guy tried to court my cousin; thank God she never fucked him. (FG#5: aged 20-24)

The young women’s discussion reflected the heightened fear and a strong sense of sexual danger among their peers in a local neighbourhood. Their perception of being at high risk influenced some of them to take up condom use. At the same time, their narratives also highlighted the paralyzing effect of fear-based sexual health promotion messages, as well as the power embedded in sexual rumours within their social networks. Paradoxically, their fear of a potential STI or HIV diagnosis became a barrier for them to seek timely STI testing, treatment, and care.

Theme 3: Sexual stigma and young women’s self-concept

Most of the young women reported that STIs were seldom talked about openly among their peers; they indicated reluctance to access STI testing or treatment because of STI related stigma and the fear of being ostracized within their own social networks.

STDs are usually given such a bad rap of being, like, dirty, filthy. The fact that you have an STD implies that you have been sleeping with men who aren’t clean and by association you sort of brand yourself into the category that you might be a slut. You might be a whore and it’s not cool. (FG#1: aged 16-19, Participant #4)

Some participants suggested that there was a general belief among their peers that only people with multiple sexual partners would get STIs.

The only time you actually hear about STDs is when someone is like, “That girl has herpes.” [Cross-talking.] You make fun of people who have it. It is a bad thing to have a STD. It’s dirty. Umm, there’s a whole lot of judgment that only people who are openly sexually active have the chance of getting a disease rather than anybody else. [Others agreed.] Like, those having multiple partners. (FG#2: aged 16-19, Participant #3)

The young women’s narratives also showed that sexual stigma and discrimination affected their subjectivity. When they embodied these discourses, they often experienced guilt, fear, shame and anger, as expressed by one of the participants.

It’s gross. It’s scornful. Once you’re in that room and the doctor says, “You have chlamydia,” you’re not going to sit there, you’re going to want to go home and bathe your skin and sit in a pot of hot boiling water. You’re going to think about it. It’s always there. You don’t talk about it but you’ll always remember it. (FG#5: aged 20-24, Participant #6)

Another participant highlighted the negative social consequences of living with an STI like herpes beyond the psychological stress of guilt and shame.
A friend of mine, she got herpes from her boyfriend and she doesn’t want to leave him because she feels that no one else would want to be with her. Basically, I think that it would be really hard for her to meet someone new and say, “You know what, I have herpes.” Do you think they are going to stick around? They are going to say, “Oh, get away from me.” [Others agreed.] So, she’s with him and she is not going to leave him on the count of her feeling insecure about being with anybody else. (FG#5: aged 20-24, Participant #7)

The narratives of these young women implied that STIs could bring on a sense of powerlessness and diminished self-worth.

**Theme 4: STI-related stigma and relationship conflicts**

During our discussion of the chlamydia scenario, many of the young women spoke about the challenges of talking to their partners about STIs.

Girls will also lie about [having STIs] because with guys a lot of words get around. If I had some sort of STD and I broke up with my boyfriend, he could tell his friends and the whole neighbourhood would get to hear about that, and it’ll be like, walking around with people looking at you or, you know, you become paranoid. I know people that have felt like that before, and they thought about committing suicide because it got to that point when they felt so shameful that they didn’t want to be around. (FG#1: aged 16-19, Participant #9)

The young women also talked about the culture of “assumed monogamy”. One participant reported that despite a collective awareness and implicit understanding that concurrent sexual relationships were common practices, many of her peers continued to promote monogamy as the ideal relationship and pretended that monogamy was their sexual reality, making it difficult for everyone within their social networks to be honest about their sexual practices.

Oh, well, females cheat. [Laughter] And when they’ve caught something from the person they cheated with, they’re not going to want to say, “I cheated on you.” They are going to say, “You cheated on me.” Like, because I know I would say that so I look innocent. (FG#5: aged 20-24, Participant #5)

For many young people, the need to safeguard their sexual reputations and to avoid being stigmatized often lead to relationship conflicts, as one young woman explained:

I was with this guy for a while and he told me, “I think you gave me something.” But before I was with him I got tested and everything was fine with me. I think he gave it to me and he didn’t know how to say it. Later on, I broke up with him. (FG#4: aged 20-24, Participant #7)

The young women suggested that open discussion about STIs seemed to be impossible because of the common culture of blame around STIs.

**Theme 5: Resistance: creating new rules**

Although the young women in this study were faced with gendered normative rules such as abstinence and monogamy, some of them refused to follow these rules and created their own space for alternative sexual practices.

Nowadays it’s okay to cheat, for guys to cheat on their girls and for girls to cheat. It’s like that with the girls I know, I’m like that too. As long as I know that he’s going to cheat or he’s sleeping with somebody else, I am okay with it. (FG#5: aged 20-24, Participant #1)

Another participant shared that concurrent sexual relationships were part of her social reality and openness within these relationships was critical because it enabled her to practice safer sex with her partners.

It comes down to just saying, “Okay, you know that we are not together but we are sleeping together, and if you are going to
sleep with somebody else, let me know. And if you haven’t used precautions, let me know.” Everyone can be open and honest and just say, “Okay, you are not the only one, but I’d still like to sleep with you.” That gives you the power to decide whether you want to sleep with him. (FG#5: aged 20-24, Participant #2)

However, this young woman also acknowledged that honest communication about her concurrent relationships was not always easy because some of her partners preferred to maintain the idea that she was in a monogamous relationship with them, and she did not want to hurt their feelings.

**Discussion**

The present study focused on facilitators and barriers to sexual health care and STI prevention and testing among young women aged 16 to 24 living in two disadvantaged urban neighbourhood clusters characterized by socio-economic marginalization, racialization, lower educational attainment, and higher rates of chlamydia. The demographic characteristics of our participants reflected the profiles of young people living in these areas. The unemployment rate was 18% for the younger women aged 16-19 and 26% for those aged 20-24. Two thirds of the sample cited ethno-racial minority backgrounds. The high proportion of racialized participants illustrates the phenomenon of “racialization of poverty” whereby racial minority groups such as Aboriginal peoples, Africans and Blacks, Latinos, Jamaicans, West Indians, and Asians experience disproportionate social and economic marginalization (Galabuzi, 2006; Ornstein, 2006). Disadvantaged neighbourhoods have a large proportion of such racial minority groups because the cost of housing is within their financial means.

**Parenthood**

Other demographic characteristics of our participants are also of interest. One-quarter of the women in the aged 16-19 groups (n=5), and two-thirds of the women in the aged 20-24 groups were mothers (n=18). In terms of ethno-racial diversity, half of the young mothers were White and half of them were of racial minority backgrounds. The narratives and interactions of participants in the age 20-24 focus groups suggested that motherhood was an accepted norm among their peers. Studies show that young people’s decisions to become parents or to avoid parenthood are influenced by many individual and structural factors, including the desire for love, the perception that co-parenting strengthens intimate relationships (Kegler, Bird, Kyle-Moon, & Rodine, 2001), and the presence (or absence) of permissive norms of early parenting (Mollborn, 2010). Other research shows that young people who experience social and economic marginalization are often disposed to consider marriage and starting a family as the only available route to achieve adulthood (Andres & Adamuti-Trache, 2008). Thus, it is critical to recognize that current norms about the “appropriate” age for parenthood in Canadian society reflect the dominance of middle-class values and subordinate working class culture and values.

**Discourses about sexuality and STIs**

This study identified multiple factors that discourage young women of disadvantaged neighbourhoods from engaging in open dialogue about their sexualities among their peers or with the adults in their lives or from seeking STI testing and sexual health care. Similar to the results of other studies (Ingham, 2005; Langille, MacKinnon, Marshall, & Graham, 2001; Svidal, 2007), most of the young women in this study reported that sex education at school and at home neither met their learning needs nor reflected their sexual realities. Many of them rejected the messages of abstinence and sexual risks. Since they perceived the adults in their lives as being judgemental or unsupportive, they sought sexual health information and support from their peers. The young women’s lack of trust towards adults suggests that messages of abstinence and sexual risks are ineffective; they also deter young women from seeking sexual health information or services from adults, putting young women further at risk for negative sexual health outcomes.

The young women’s narratives suggested that discourses of sexual morality permeated their everyday social space. Many of them reported experiences of stigmatization and marginalization manifested as name-calling and being kicked out...
of the home, from their parents, teachers, health providers, and sometimes their peers. We argue that these discourses, expressed in stigmatizing labels such as “slut” and “whore”, function as a disciplinary regime (Foucault, 1978) to regulate young women’s sexuality. In constructing and reinforcing the division of young people into categories of good vs. bad, moral vs. immoral, self-respecting vs. self-disrespecting, those in dominant positions are able to justify the infliction of guilt, shame or abuse on young women whose sexualities do not fit with the dominant sexual norms. The fear of being ostracized often drives non-normative sexual practices underground and their invisibility in turn reinforces normative sexual values and practices.

All of the young women in this study were aware that condom use is critical to STI and HIV prevention. However, they also expressed some misconceptions about STIs and HIV, namely that all STIs are incurable. The fear of being diagnosed with an incurable disease discouraged these young women from seeking early STI testing and treatment. In addition, they also expressed their fear of being stigmatized. Like other social discrimination, STI-related stigmas are underpinned by moralistic, racist, sexist and classist discourses (Cahill, 2010; Dua, 2004; Giroux, 2000; Shimizu, 2007) that reinforce dominant sexual ideologies. These discourses structure the way young people perceive themselves and their evaluation of others (Cahill, 2010; Dua, 2004). Young women who have been diagnosed with STIs often view their bodies as markers of unworthiness. Some of them may perceive themselves to be inferior or undesirable, making it difficult for them to negotiate satisfying and equitable sexual relationships, and putting them at increased risk of staying in relationships that are exploitative or abusive (Vézina & Hébert, 2007).

Our study found that many of the young women and their peers had internalized the dominant risk discourses, resulting in a collective fear that motivated them to engage in “reflexivity”, an ongoing process in which they looked to local and expert knowledge to assess their sexual risks (Lupton, 1999). It is important to recognize that a population is constructed as “risky” and “at-risk” based on “risk profiles” that are constructed through what Foucault (1978) calls the technology of power and knowledge production. The knowledge of risk is produced through techniques of surveillance and statistical calculations; it is legitimated through power relations to produce the discourses of lifestyle and individual responsibilities. When marginalized individuals are designated as members of a risk group, they are exhort to “engage in self-regulation” based on the expert knowledge (Lupton, 1999, p. 97). These young women also tried to make sense of their sexual practices through a specific cultural frame that was constructed through the moralistic discourses specific to their local neighbourhoods. Consequently, condom-use becomes a “technology” used by the young women and their peers to govern themselves as at-risk subjects. They also become active participants in the surveillance and disciplining of the risk-makers in their neighbourhood.

The collective fear of being stigmatized and ostracized was a significant barrier for young people to engage in open dialogue about their sexualities or sexual histories with their sexual partners. Stigmatized individuals and groups that experience fear, guilt and shame often engage in stigma-management strategies including “passing” as normal; “covering up” through nondisclosure; “deception” through lying; and “deflection” by assigning blame (Nack, 2000; Victor, 2004). Participants in this study reported that these stigma-management strategies about STIs were common practices among their peers. They also explained the contextual logic behind these strategies, that is, the presence of an STI symbolizes a “broken trust” and challenges the “assumed” monogamy in a relationship. Taboos around having “concurrent” sexual partners or being in “friends-with-benefits” relationships, for example, make it almost impossible for young people to be frank with their sexual partners about
their sexual practices or sexual health histories. When young people are diagnosed with STIs, many are pushed into the position of engaging in stigma management such as deception, blame, denial and argument. Their unresolved conflicts lead to relationship break-ups, which constitute one of the pivotal events that are associated with significant emotional and mental distress among young people (Bourke, 2003; Sankey & Lawrence, 2005). However, the issues of stigma management and related emotional stress are seldom addressed in the field of young people’s mental health.

As Foucault (1978) suggested, “...where there is power, there is resistance” (p. 95). Some of the young women resisted the double-standard gendered expectation of monogamous practice among women. They reported that having concurrent sexual partners was their social reality despite the common denial among their peers. They also redefined trust—not as fidelity—but as openness about their sexual practices and STI statuses. They desired sexual pleasure and valued satisfying sexual relationships that were underpinned by mutual dialogue and honesty, and not necessarily compulsory love. However, we caution against a naïve conceptualization of resistance simply as an opposing force to domination. The sexual agency of these young women reflected what McNay (2008) refers to as “freedom in constraints” (p. 193). Although some of them appeared to view concurrent relationships as acceptable or positive, they continued to use language reflective of the dominant discourse (e.g., “cheating”).

**Study limitations**

The recruitment of participants was guided by the purpose of the study, which was to generate local knowledge to inform a sexual health promotion campaign to reduce chlamydia rates among young women in disadvantaged neighbourhoods in Toronto. Since purposive sampling was used, the study results cannot be generalized to wider populations of young women, for example, young women in middle-class and/or affluent neighbourhoods.

**Concluding observations**

Effective sexual health promotion and STI prevention for young women, particularly for those living in socio-economically disadvantaged and racialized circumstances, requires the use of a socio-environmental approach that addresses social and economic marginalization. It must also include youth-driven strategies that address moralistic discourses and sexual stigma to facilitate open dialogue about diverse sexual practices and collective empowerment.

**References**


