Recent statistics indicate limited condom use, high STI (sexually transmitted infection) rates, and a general lack of knowledge about reproductive and sexual health among homeless youth. This research focuses on the experiences of homeless female and transgendered youth, providing an insider's perspective on shaping sexual health interventions. This qualitative research is based on life history interviews and participant observation with eight homeless young women who reflect the diversity of the homeless population in Toronto, Ontario, Canada. Their particularized sexual experiences and health-seeking behaviors illustrate the range of issues faced by this community, speaking to the efficacy of current health promotion strategies. Too often faced with judgmental health and social service providers who they perceive to undermine their agency and empowerment, these women highlight the challenges they face when seeking sexual and reproductive health services and information. In addition to speaking to the struggles and frustrations they face in regard to their sexual health and the services with which they choose to interact, the women provide suggestions for improved care. From these, the authors include key recommendations for the provision of culturally competent, sex-positive, and nonjudgmental health services with the hope that health practitioners and promoters can learn from these experiences, both positive and negative, when caring for and supporting young women living in exceptional circumstances.

Keywords: child/adolescent health; cultural competence; health disparities; health promotion; qualitative research; sexual health; social determinants of health; women's health

INTRODUCTION

Each year in Canada, the Enhanced Surveillance of Canadian Street Youth surveys approximately 4,000 young homeless people, inquiring into their homelessness status and sexual health. Between 1999 and 2003, 95% of street youth surveyed indicated that they were sexually active. Among the mainstream population of the same age cohort (15-24 years old), only 46% answered the same question in the affirmative (Boyce et. al., 2003). Other statistics gathered by the Public Health Agency of Canada (PHAC) show that homeless youth are more likely to have sex for the first time at a younger age (14 years, as compared with 17 years); are more likely to have multiple sexual partners (22-23 partners, as compared with 1-4 partners), and a full 50% of homeless youth indicated that they did not use a condom in their last sexual encounter (PHAC, 2006; Council of Ministers of Education of Canada, 2002).

The stats above demonstrate a clear need for sexual health interventions with homeless youth, but they do not illustrate the particularized views of the young people who are often obscured by these numbers. This study focuses particularly on the self-described sexual health needs of homeless young women, taking the World Health Organization’s (WHO, 2004) definition of sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely...
the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (p. 3)

While their male counterparts are equally deserving of attention in this area, young women are treated separately here because of their specific sexual health concerns. This analysis of their sexual health and health service usage shows that homeless young women are in need of sexual education and sexual health services that are attuned to their particular life contexts—services that treat young women as agentic and capable, recognizing their self-efficacy and their status as independent young adults.

This article also takes into consideration the WHO Commission on Social Determinants of Health’s conceptual framework for action on health, which understands the ways in which socioeconomic and political factors create population stratification based on income, gender, sexuality, race, and other social positions (Solar & Irwin, 2010). Socioeconomic positioning and the related lack of social capital, then, affects living conditions, behaviors, and psychosocial factors, linking structural and social determinants of health. These social inequalities are then implicated in sexual health outcomes and in interactions with the health care system.

**BACKGROUND**

A study by Rew, Fouladi, and Yockey (2002) found that homeless youth possessed knowledge about the symptoms, transmission, and prevention of STIs (sexually transmitted infections), but they knew little about the longer term consequences of leaving such an infection untreated. On the other hand, Gelberg, Browner, Lejano, and Arangua (2004) found that homeless young women were ill informed about contraception and general issues concerning their reproductive health. The recent Toronto Teen Survey out of Planned Parenthood Toronto, which employed peer researchers to interview other youth about their sexual health, indicates that the general youth population lacks the knowledge necessary to make informed decisions about their sexual health (Flicker et al., 2009).

When asked about seeking sexual health care and sexual health information, young women in other studies have pointed to clinical characteristics that create barriers to care. Ensing (2001) asserts that one of the most significant issues with clinics designed for homeless youth is that they are designed by adults using an adult model of care, focusing mainly on reproductive health and paying little attention to the specific needs (e.g., sex-positive counseling or informal doctor–patient relationships) of out-of-the-mainstream youth. When young women feel that they have been treated poorly in a particular clinic or by a particular provider, they sometimes reject the system altogether assuming that all clinics and providers will make them feel the same way; thus remaining uninformed or untreated. In other studies, too, women have reported hostile behavior from practitioners that range from subtle innuendo to outright antagonism (Ensign & Panke, 2002). Hoffman and Coffey (2008) have labeled the two most common forms of treatment that homeless people face in their encounters with physicians: objectification and infantilization, whereby patients are treated either as numbers or as children.

Crucially, there are many barriers faced by homeless young women in accessing sexual health information and services, not least of which is the strong correlation that has been made between sexual abuse and homelessness among the female homeless population (Robinson, 2005; Tyler, Cauce, & Whitbeck, 2004). Many young women have histories of sexual abuse and trauma that begin at an early age and that continue to factor into their sexual practices and sexual and mental health throughout their lives. Fear of revictimization and further sexual trauma prevents engagement with service providers who women fear they cannot trust. The amalgamation of these factors signals a critical need to reconfigure sexual education and sexual health services in ways that are sensitive to the particular concerns and preferences of homeless young women.

Young women in this study were asked about their sexual experiences, the sexual health needs, and their encounters with health service providers to ascertain their views and opinions on the role of sexual health services in their lives. Although their sexual experiences cover a wide range of activity, each of the women interviewed in this work signaled the ways in which the providers of sexual health care could improve their sexual information–gathering practices and sexual health service experiences.

**METHOD**

This research uses a qualitative, multiple–case study approach to analyze the life history narratives of eight young women living in exceptional circumstances in order to investigate the factors that they perceive to have impeded or facilitated their ability to access health and social services, and how these factors have influenced their overall health and well-being. For the purposes of...
this research, health-seeking behavior is the search for, and access to, health services and healthy situations that enable young women to treat illness and preserve wellness. The life narratives of young women explain how they define their own health, what health issues they are experiencing, what services they use in seeking to care for themselves, and which factors they perceive as having influenced their access to health services. This research was conducted in Toronto, Ontario, Canada.

Life history interviews were completed with eight young women recruited from shelters and from street visits to those who were not sheltered. Given the time necessary to complete full life history interviews, the interviews generally took 4 to 6 hours, spread out over several sittings. An interview protocol outlined questions that traced the young women’s life histories in chronological order; however, participants often talked about their lives in nonsequential order as one experience triggered another that may have occurred earlier or later in the life course. This research also used participant observation when young women allowed me to shadow them through their days. These observations provided data that demonstrated the amount of work that the young women put into meeting their daily needs, as well as the daily realities of life in the shelter or on the street. Interviews were taped, transcribed, and coded. Participants volunteered to be interviewed, responding to visits to speak about the research at shelters and to the posters that were displayed in places where youth congregate in the city. Those young women interviewed here represent a range of races, sexualities, and ages to achieve variation among participants, allowing the heterogeneity of the population to be emphasized.

On completion of the interviews, all transcripts were inputted into qualitative data management software, NVIVO. Coding and analysis of data commenced using the constant comparative method outlined by Strauss and Corbin (1990). As codes were developed, they were applied and compared with newly collected data and modified as necessary. Descriptive codes were then combined to develop theoretical or analytical themes.

**DISCUSSION**

Sexual health, as it is understood here, is not just about STIs and pregnancy; it is also about pleasure, satisfaction, protection, and healthy relationships. Importantly, sexual health begins with ensuring that young women have positive self-conceptions and that they feel comfortable and confident in negotiating their sexual relationships (Jones-Johnson, Rew, & Weylin-Sternglanz, 2006). Positive sexual health outcomes among homeless youth are associated with sex education, an orientation toward the future rather than only the present, and the ability to assert one’s wishes to one’s partners (Rew et al., 2002). When participants were asked about their sexual health, they had a great deal to say; however, their comments can be thematized in the following way: sexual experience, engagement with sexual health services, and good sexual health service provision.

**Sexual Experience**

Sexual satisfaction is linked with positive self-concept and sexual motives such as caring and intimacy (Impett & Tolman, 2006). Research suggests that this trajectory begins in adolescence where sexuality is an integral part of girls’ lives, but where it is at best not often discussed and at worst labeled “slutty” or “promiscuous” (Impett & Tolman, 2006). Many of the young people involved in this research discussed their participation in a range of sexual activity, from virginity, to abstinence, to sexual monogamy, to sex with multiple partners concurrently, yet because of the fear of being labeled or judged, they were not asking the questions to which they needed answers (Table 1).

These feelings of shame and embarrassment were decisive factors in many young women’s decisions not to speak to adults about their sexual behaviors and curiosities. This barrier is especially significant in light of evidence that some young people lack information about safe conduct, especially in less traditional sexual situations: three of the young women had engaged in group sex; three had been involved in open relationships; two had engaged in anal intercourse; two had been involved in sex work or sexual bartering; and four had been identified as lesbian or bisexual. In each of these situations, the young women involved expressed that they were experimenting, and, although they were uncertain about particular aspects, they did not ask questions, but rather used a trial and error type of system, whereby they assumed that they had not contracted an STI or assumed that their partner was “clean” and were, therefore, safe to continue on in these sexual activities. The fact that some adults are uncomfortable discussing teenage sexuality does not prevent it from occurring; thus, young people need more information to make smart and informed decisions about sexual behaviors based on their own preferences and desires. Among the eight young women whose voices inform this research, top considerations on the subject of sexual health included sexual pleasure, negotiation of sexual control, and an outlet for their concerns about “normal” sexual functioning.
In Toronto, since 2001, rates of chlamydia, syphilis, and gonorrhea have increased among the general youth population, and the city also reports higher rates of STIs than anywhere else in Canada (Flicker et al., 2009). For young women who live on the street or in shelters, birth control and even condoms are difficult to hold on to because of theft by others or loss because of constant relocation. Echoing the findings of other research, in this case condom use, was limited and often misunderstood. Several of the young women said that they did not use condoms because they were unable to get pregnant or used birth control pills (Table 2). These findings are particularly stark in light of the fact that the prevalence of HIV among women is highest among teens and young adults (PHAC, 2006).

**Engagement With Sexual Health Services**

Data from this research suggest that feelings of embarrassment or shame, or the fear of being judged, prevent young women from talking to health care providers about their sexual health. Notably, in their research in the United States, Ensign and Panke (2002) found that one important undermining factor exists for homeless young women who are not currently, or who have never been, sexually active: Health care providers assume that they are sexually active and do not believe them when they insist that they are not. The non–sexually active women partaking in these interviews, too, raised this concern. One participant’s remarks reflected the opinions of a young woman who is not sexually active, yet she still feels hesitant and embarrassed at the thought of talking to a physician about sexual health–related matters. Conversely, the social stigmas attached to lesbianism, transsexuality, and sex work also create barriers for populations who are arguably most in need of sexual advice as they rarely see themselves reflected in any form of traditional sexual education. Moreover, the lesbian-identified participants spoke of the problems they faced with physicians who assume

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<th>TABLE 1</th>
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<td><strong>Sexual experience</strong></td>
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<td>“You’re scared and lonely or whatever so it’s easy to kind of find someone who you think you can be close to, but those relationships don’t last long sometimes only the night or the half an hour or whatever.” (Erin)</td>
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<td>“For me, I’m like, I don’t want to have sex. Ew. I don’t want to get pregnant, get pregnant and that would be horrible. Or I’ll get some disease, but I’m just so crazy. I’m so paranoid. I’m just nervous.” (Danika)</td>
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<td>“I gave in every once in a while because I couldn’t deal with his complaining and I wanted him to shut the hell up. But it was horrible. It was like . . . I can’t say it felt like being raped because I’ve never been raped, but I just it was just spectacularly painful. I had no desire to be there whatsoever.” (Radha)</td>
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<td>“So, we came to an understanding, ‘Okay, no sleeping with guys.’ But, at the same time, she still wanted to sleep with guys cause she was bi, and so my theory was, ‘Okay, well, we’ll start having threesomes and fix that problem.’ That way, you’re satisfied.” (Faith)</td>
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<th>TABLE 2</th>
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<td><strong>Condom use</strong></td>
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<tr>
<td>“Not really.” (Faith)</td>
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<tr>
<td>“Kind of sometimes, sometimes not.” (Raven)</td>
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<td>“I hate condoms, just personally. Not fun. They just don’t feel as good.” (Radha)</td>
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<td>“Sometimes I’ll do it without a hood.” (Erin)</td>
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<tr>
<td>“Sometimes I’ll use them. Usually.” (Savannah)</td>
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heteronormativity or who are themselves ill-informed about the sexual health needs of sexually diverse youth.

When they discussed their visits to clinics, hospitals, or community services, women also spoke about those issues that prevented them from returning or that confirmed their belief that providers were unable to understand and respect their particularized needs. Participants often discussed experiences with service providers who infantilized or marginalized them, making assumptions based on social stereotypes of homeless youth. Indeed, Rew, Rochlen, and Murphey (2008) work with sexual health service providers working with homeless youth demonstrates that young women’s perceptions are sometimes quite accurate. Providers in the study were surprised to find that young homeless people were quite sophisticated in their understandings of themselves and their needs. Moreover, on working with homeless youth, several of the providers admitted to having preconceived notions about homeless young people that led to false judgments about their potential clients (Rew et al., 2008).

Pelvic exams. Among the young women involved in this research, one of the most commonly cited reasons for not seeking sexual health care, and even health care more generally, is a fear of, or a negative experience with, pap smears and pelvic exams (Table 3). Gynecological exams are particularly dreaded, especially when taking past histories of sexual abuse into consideration. Other research with homeless women has found that survivors of sexual abuse often report trauma-like responses after undergoing vaginal examinations (Wezel, Anderson, Gifford, & Gelberg, 2001). Building trust between physicians and young women is critical if these women are expected to undergo screening for HPV (human papillomavirus) and STIs (Gelberg et al., 2004). Furthermore, women feel more comfortable receiving care from other women who they feel can relate to them and who they are more likely to trust not to exploit them. The young women also expressed concern with doctors’ approaches to pelvic exams, cringing at memories of the insensitivity demonstrated by the care providers who administered their first exams. Although no woman expects a pap smear or vaginal exam to be a pleasant experience, the degree of care exercised in the process clearly varies a great deal from provider to provider. If first experiences of pelvic exams are recalled as traumatic, painful, and humiliating, the chances that young women will continue with screening throughout their lives are slim. Particularly in light of some of these women’s sexual practices, the decision to discontinue vaginal examinations has serious implications for their health and well-being across the life course.

Good Health Service Provision

Although the young women shared their fears and frustrations in dealing with sexual health services and their providers, they also shared a number of insights into how the sexual health care system could better suit their needs, and what, in fact, those needs are. Service

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<th>TABLE 3</th>
<th>Pelvic Examination</th>
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Pelvic examinations

“I waited forever and it was my first pap smear. I was super, super nervous. She came in and did in 5 minutes and ran away. Then I said, you know, sex has been really painful for me for the past little while. And she said, use lube. And I said, no, I do. That’s not it. That’s not the problem, it’s like nerve painful. And she’s like, just use more. And I said that’s clearly not the problem, but she doesn’t even listen to me cuz if it’s not done in 5 minutes it’s not worth it. And so that was horrible. I cried a lot.” (Radha)

“I’ve had a pap smear because they didn’t believe that I wasn’t sexually active. They were doing a vaginal exam and they said something about my hymen being broken. So they did a pap smear anyway. They didn’t believe me. I don’t know. That was when I was about 17. I said I wasn’t sexually active, but they didn’t believe me so they went ahead and did it.” (Michelle)

“Seriously, I was like screaming, like ‘OW!’ and the lady told me that it couldn’t be that bad. She was so rude. And there were guys in the room too for some reason. Well, right outside the curtain anyway. They could hear me if I said where it hurts and why. I don’t know. The whole facility was just so ghetto. It was such a terrible experience.” (Danika)
providers can play a pivotal role in educating young people about all facets of their sexual lives: building trusting relationships, providing continuity of care, and teaching the skills necessary to negotiate sexual encounters safely and with agency (Harrison & Dempsey, 1998). As the young women maintained, providers of sexual health services can include physicians, nurses, educators, and online experts—all of whom they saw as potential allies, provided they were respectful and nonjudgmental. The young women suggested that environments that were sex positive rather than fearful would help ease their anxieties and create a more comfortable atmosphere for asking questions and seeking treatment.

The women who lend their voices to this work are often underestimated. They are capable, intelligent, and self-aware; however, they signal that they require more support from the community to acquire the education necessary to practice safe sex and form positive sexual identities. Homeless youth preferred self-care options to clinic options, which seems to signal that one possible intervention strategy might be to offer street and shelter-based self-care education seminars that would also teach young people about those aspects of their health with which they are unfamiliar and provide advice on how to protect themselves (Ensign & Bell, 2004; Lifson & Halcon, 2001). Rew and colleagues (2008) found that interventions with homeless youth aimed at increasing assertive communication skills paired with consistent social support creates increased self-efficacy, which includes behaviors such as proper condom use and increased aptitude in negotiating difficult sexual encounters.

The social capital acquired from building trusting relationships with trusted adults was often pointed to as a stepping-stone toward stability in their lives. Building trust with young people who face histories, and often recent or current episodes, of abuse is a critical factor in increasing service usage and in sexual health promotion within homeless communities. Participants point to collocation of health and social services as an incentive to enter a clinic, but they are quick to qualify those statements, asserting that no amount of programming or funding will serve their needs unless the service providers, from clinicians to receptionists, are respectful and treat them as self-sufficient adults (Table 4). Health care providers and educators alike need to adopt constructive, nonjudgmental attitudes when dealing with the sexual health of diverse groups of young women, recognizing that some young people are engaged in the same array of sexual behaviors experienced by adults, whereas others are not sexually active at all.

In addition, homeless youth often express profound alienation from mainstream society, but importantly for service delivery, they also feel alienated from the adult homeless population—believing for the most part that their circumstances are temporary and divergent from those of homeless adults (Miller, Donahue, Este, & Hoffer, 2004). This fact is important for delivery as innovative models of care that are youth focused are more likely to bring young people in contact with sexual health services. Youth in this study and others have said that the most useful and dignity-promoting health care services are those that account for the context of their lives (Ensign, 2004). In other words, cultural competency is a necessary component of accessing health care. Ensign and Panke (2002) define cultural competency as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals to enable them to work effectively in cross-cultural situations” (p. 167). Culturally competent care, then, occurs when providers see their relationships with clients as dynamic—as an exchange rather than a monologue, in which the life story and experiences of the patient are valued and relied on to make informed diagnoses and to provide appropriate treatment options. Importantly, culture does not solely refer to racial, linguistic, and cultural diversity but also to the unique culture of homeless young people who experience life differently than housed youth or adults in general.

Finally, the skills required by physicians and health promoters who work with vulnerable populations could also enhance their practice with mainstream patients as the number one request of young homeless women is that the physicians actually stop and listen to what they are saying rather than suffocating them with clinical expertise. Listening may allow the young person to explain their presenting issue as well as other issues that could be contributing or exacerbating that condition, whereas providing explanations that lack jargon allow young women to feel more in control of their bodies and their health (Ensign & Panke, 2002).

CONCLUSIONS

In the realm of sexual health, young women are seeking information that is relative to their everyday lives and that reflects their heterogeneity. Women who are not sexually active want to be believed and to be able to ask the questions they need to ask in order to create healthy sexual relationships when they do feel they are ready. Those who are sexually active want to feel safe to visit a provider who will not judge their behavior and who will provide advice not just on how to protect themselves from STIs and pregnancy but on

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how to negotiate sex in such a way that the experience is pleasurable and empowering.

Ammerman et al. (2004) note that there is often a mismatch between the biological age of homeless youth and their maturity levels. In this case, life course stage, again, becomes a more effective measure for how young homeless women should be treated. Young women know a great deal about how to treat themselves when they become ill with cold or flu symptoms or with minor cuts and burns—most of the young women in this research indicated that self-care was preferable to being seen by a physician in cases where they could be treated without antibiotics or clinical interventions. Physicians, then, must take this tacit knowledge into account when diagnosing and planning treatment for young people as paternalism only acts to further distance youth from the health care system. Facing the stereotypes of both homelessness and adolescence, young women are seeking providers who see them as more than just young and homeless.

Claiming to understand the situations that youth deal with on a day-to-day level does not amount to culturally competent care. Recognizing youths’ strengths and perseverance in the face of adversity highlights the positive attributes of youth, rather than just those that are more negative or risky. For health promoters and care providers, nurturing their relationships with their homeless clients is key to building the trust that will allow young women to feel safe in divulging information that they see as secret or shameful—the sort of information that can provide context for their overall health and well-being.

Although culturally competent care is one important strategy for working with and for homeless young people, the critical underlying issue remains: We must not only treat individuals but also transform the structures of constraint that maintain and perpetuate social and health inequity in the first place. Future research on homelessness should focus on these structural determinants of health, remaining critical of the systems and institutions that fail to provide adequate support for those most in need. The underlying causes of disadvantage must be addressed to create a health system, and, more important, a society that is responsive to eliminating structural barriers and to creating a more socially just future.

REFERENCES


