Children and Youth Services Review 101 (2019) 277–284

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

# "She was there through the whole process:" Exploring how homeless youth access and select birth control

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ARTICLE INFO

*Keywords:*
Homelessness
Adolescence
Birth control
Sexual health
Adolescent pregnancy
Interpretative phenomenological analysis

ABSTRACT

Homeless female adolescents in the United States have disproportionately high rates of pregnancy compared to general population youth. Little is known about how homeless youth decide whether to use birth control and which birth control method to select. The current study explores how homeless female youth participating in a holistic sexual health program called Wahine ("woman") Talk experience this process, using data from in-depth interviews ($N = 3$) with 11 homeless adolescent girls. Data were analyzed using Interpretative Phenomenological Analysis, proceeding through reading and re-reading, initial noting, forming emergent and super-ordinate themes, repeating steps for each interview, and developing final themes and subthemes. Four final themes emerged, which, for most participants, were experienced sequentially: Getting Acclimated, Becoming Close and Building Trust, Addressing Fear, and Making the Choice. Study findings suggest that for homeless female youth, basic needs and relationship building must be addressed prior to the delivery of trauma-informed birth control-related content and effective linkage to (sexual) healthcare. Implications for practice, policy, and future research are discussed.

## 1. Introduction and literature review

Understanding how homeless youth access and select birth control is critical in order to better address their sexual and reproductive health needs, reduce sexual health risks and unplanned pregnancy, and enhance individual and relational well-being. On any given day in 2018, there were approximately 36,361 unaccompanied homeless youth under the age of 25 in the U.S. (U.S. Department of Housing and Urban Development, 2018). The current study was conducted in Hawai'i, which has the second highest rate of homelessness per capita in the country (U.S. Department of Housing and Urban Development, 2018). Homeless youth, especially female youth, experience significant inequities in sexual and reproductive health, including high rates of sexually transmitted infections (STIs) and adolescent pregnancy (Greene & Ringwalt, 1998; Smid, Bourgois, & Auerswald, 2010). In Hawai'i, nearly half (44.6%) of homeless female youth have given birth to a child, the vast majority of whom (79.5%) are current caregivers to one or more of their children (Yuan, Stern, Gauci, & Liu, 2018). Helping youth prevent unplanned pregnancies is particularly important in order to support both the youth and, later, their children's health and well-being, yet little is known about homeless youths' experience of accessing and selecting birth control. The current study was designed to provide a rich, in-depth analysis and description of this phenomenon within the context of a holistic sexual health program, uplifting the voices and experiences of young women who are homeless. To frame the study and our findings, we first consider what is already known about how young adult and adult women access and select birth control, both in the general U.S. population and while homeless.

### 1.1. Access and selection of birth control among general population youth and women

Women in the general U.S. population contend with varied individual, interpersonal, and structural factors relevant to accessing and selecting birth control. Individual factors include reproductive history, relationship experience, and negative personal experiences with birth control. Half of young adult and adult women in the U.S. aged 15–44 years have discontinued contraceptive use due to dissatisfaction

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https://doi.org/10.1016/j.childyouth.2019.04.012
Received 11 December 2018; Received in revised form 10 April 2019; Accepted 10 April 2019
Available online 11 April 2019
0190-7409/ 

(Moreau, Cleland, & Trussell, 2007). Attitude also plays a large role in young adult and adult women's contraceptive choice and use, as ambivalence toward pregnancy often leads to nonuse of contraceptives and other risky sexual behaviors (Frost, Singh, & Finer, 2007). Interpersonal factors affecting access and selection of birth control among women aged 18–29 years include the information received from other people, frequency of sex, and whether or not women have a new sexual partner (Marshall, Kandahari, & Raine-Bennett, 2017). Whether a young woman or adult woman feels she trusts a healthcare provider and the method of birth control they provide has a large effect on her choice to use contraception (Frost et al., 2007). Frequency of sexual intercourse is another important contributing factor to women's selection of birth control (Frost et al., 2007). Young adult and adult women with one sexual partner in the past month are more likely to use oral contraceptives than condoms or no contraception in comparison to women who have two or more sexual partners (Krings, Matteson, Allsworth, Mathias, & Peipert, 2008). Structural factors are also relevant to women's access to and selection of birth control, including socioeconomic status, race, access to private health insurance, and social norms. Young adult and adult women who choose oral contraceptives over condoms are more likely to have had at least a high school education, be white rather than African American, and have private insurance (Krings et al., 2008). Social norms are another important factor in selection of contraception. Wright, Duffy, Kershner, Flynn, and Lamont (2015) found that peer norms among youth aged 15–21 years related to having sex, using contraception, and becoming teen parents directly influence adoption of contraception.

### 1.2. Access and selection of birth control among homeless youth

Compared to the general U.S. population, homeless youth aged 14 to 17 years are almost five times more likely to become pregnant (Greene & Ringwalt, 1998). Prevalence of pregnancy increases with age: a recent national study found 10% of 13–17 year old female youth and 44% of 18–25 year old female youth who are homeless are either pregnant or parenting (Dworsky, Morton, & Samuels, 2018). In Hawai'i, 44.6% of homeless female youth have given birth to a child, and the majority of these parenting youth are 18–24 years old (Yuan et al., 2018).

Myriad multi-level, interacting factors drive the disparity in pregnancy rates between general population and homeless youth. At the individual level, homeless youth engage in high risk sexual behaviors, including initiating sex at an early age, inconsistent use of condoms (Greene & Ringwalt, 1998), and a reliance on survival sex to meet their basic needs (Greene & Ringwalt, 1998; Winetrobe et al., 2014). Homeless youth describe birth control as “like another language,” report concerns about weight gain, and discuss condoms as being impractical to plan to use in part because they do not have consistent places to have sex (Begun, Massey Combs, Torrie, & Bender, 2019, p. 249). Homeless youth are less likely to adopt long acting reversible contraceptives (LARCs) than general population youth (Dasari et al., 2016), electing to use less effective methods such as withdrawal (Winetrobe et al., 2014). Pregnancy ambivalence poses another significant challenge to homeless youth using contraception (Dasari et al., 2016). Compared to non-ambivalent homeless youth, homeless youth who are ambivalent about pregnancy have lower rates of using contraceptives, and they may struggle to escape homelessness because of the additional stressor of caring for a child (Dasari et al., 2016). Homeless youth with pregnancy ambivalence describe that they might experience pregnancy as “a good shock” and report that a pregnancy would “help me in my focus” (Begun, Frey, Combs, & Torrie, 2019, p. 90–91).

Interpersonal relationships also affect homeless youths' decision to use contraceptives (Winetrobe et al., 2014). Homeless youth with one main partner are less likely to use condoms when compared to those who have casual partners (MacKellar, Valleroy, & Hoffmann, 2000). In addition, Smid et al. (2010) found that intimate partner violence affects contraceptive use and is often a cause of unintended or unplanned pregnancies as homeless youth in sexually exploitative relationships do not have the power to negotiate contraception or condom use to reduce unintended pregnancy. Such power issues are critical for all women experiencing violence and exploitation, and may be especially heightened among those who are also homeless. For example, Begun, Combs, Torrie, and Bender (2019) found that homeless youth's report of not using condoms results in a higher price during transactional sex.

A number of structural factors affect the process of accessing and selecting birth control among homeless youth, including cost, transportation, and stigma. Unintended pregnancy disproportionately affects poor, low-income women of color and contributes to difficulty escaping homelessness (Dasari et al., 2016). A study by Secura et al. (2014) found that removing financial and access barriers for LARCs reduces pregnancy, birth, and abortion rates among young and adult women aged 14–45 years; this may have particular implications for homeless youth with very limited financial resources. Drop-in centers, shelters, and other homeless services could help reduce barriers to accessing condoms and other contraceptives, increasing effective contraception use (MacKellar et al., 2000). Homeless youth report that inconsistent condom use and use of other contraceptives is due to multiple barriers, including cost and uncertainty about where and how to access them (Begun, Combs, et al., 2019), yet those who receive condoms from a shelter are four times more likely to report using them (Clements, Gleghorn, Garcia, Katz, & Marx, 1997). The availability of free condoms affords female homeless youth access to contraceptives without any barriers (Winetrobe et al., 2014). Additional structural access barriers to contraceptive use cited by youth who are homeless include transportation difficulties and concern about being stigmatized by healthcare providers (Begun, Frey, et al., 2019).

### 1.3. Current study

Given the extant literature on factors affecting selection and preferred types of birth control among general population and homeless youth, the current study extends the existing literature on understanding the lived experience of birth control access and selection among a key-affected group: homeless female youth. The current qualitative study thus allows homeless female youth to share in their own words how they experience the process of accessing and selecting birth control as participants of a holistic, community-based sexual health program. The current study is guided by the following research question: *How do female youth who are homeless experience the process of accessing and selecting birth control in the context of a holistic sexual health intervention?*

## 2. Method

The current study involved two in-depth focus group interviews ($N = 2$) with 10 homeless female youth, and one in-depth interview ($N = 1$) with one homeless female youth who was unable to attend the focus group interviews due to scheduling conflicts. Study participants completed a newly developed, holistic sexual health program for homeless youth and youth at-risk for homelessness (Aparicio, Phillips, Okimoto, Cabral, Houser, & Anderson, 2018) prior to data collection. The sexual health program, called Wahine (“woman”) Talk, was offered for 20 weeks at a youth drop-in center institutionally connected to a federally qualified health center located in Honolulu, Hawai‘i, in the United States. The main components of Wahine Talk include: 1. basic needs services; 2. peer mentoring; 3. weekly sexual health education groups; and 4. sexual healthcare. Wahine Talk is an incentivized healthcare program, wherein youth received a smartphone and data at program entry to facilitate connection to staff and to one another. They received data boosts as they attended weekly groups. Youth received a second, upgraded smartphone and data package if they elected to adopt

either Depo-Provera or a long acting reversible contraception (LARC). All study participants were self-identified girls and biologically female. Each focus group interview and in-depth interview used a semi-structured interview guide, were on average 37 min in length, and were facilitated by an external program evaluator. Participants were compensated with a $25 giftcard for the time they spent participating in the focus group or individual interview. Data were analyzed using Interpretative Phenomenology Analysis (IPA) (Smith, Flowers, & Larkin, 2009).

### 2.1. Research design, phenomenology, and hermeneutics

IPA is a qualitative research methodology grounded in phenomenological and hermeneutic traditions. IPA involves an in-depth exploration of the experience of and meaning assigned to a particular phenomenon (in this case, "accessing and selecting birth control") among a particular group of people (in this case, "female youth who are homeless"). IPA makes the role of the researcher and of interpretation explicit. IPA involves a "double hermeneutic," wherein the researcher is using his or her own interpretive lens when interpreting the participants' interpretations of their own experience. Thus, the researcher is a central part of the process as they systematically interpret the participants' experience through their own lens with great consciousness to their own potential biases. IPA recognizes the reader (e.g., the consumer of the research product) as a third interpreter; consequently, at the point of research dissemination, IPA involves a triple hermeneutic.

### 2.2. Sample

Participants were aged 14 to 18 years ($M$ = 15.6 years) and identified primarily as mixed race ($n$ = 7) or as Native Hawaiian and other Pacific Islander (Micronesian, Samoan, or Tongan) ($n$ = 4). Further race and ethnicity demographic details are provided in Table 1. The majority of participants were sexually active ($n$ = 9), among whom age at first sex ranged from 13 to 18 years ($M$ = 15.1 years). None of the participants were using birth control when coming into the sexual health program, and the majority ($n$ = 8) had adopted a birth control method within the last five months while part of the larger program. Of those eight using birth control, two participants had adopted a LARC method of either an IUD or hormonal implant (Nexplanon), five participants were using Depo-Provera, and one participant was using condoms.

### 2.3. Data collection

Two focus groups were conducted at a community-based youth drop-in center; one interview was held individually with a participant who was unable to attend the focus groups due to scheduling conflicts. The focus groups were audio-recorded and audio files were transcribed verbatim by the research team. All transcriptions were checked for accuracy against the audio recording by a second member of the team prior to beginning data analysis.

### 2.4. Ethical considerations

Prior to beginning data collection, all procedures were approved by the University of Hawai'i's and Texas A&M University's Institutional Review Boards. Each participant was assigned a participant identification (ID) number when enrolling in Wahine Talk. A document linking participants' ID numbers to their names was kept separately from any consent forms and collected data. All paper files were kept under double lock and all electronic files were kept in password protected team drives.

**Table 1**
Sample characteristics.

| Variable | *N* | % of sample | *M (SD)* | Range |
|---|---|---|---|---|
| Age | | | 15.64 (1.29) | 14–18 years |
| Race (categorical) | | | | |
| Native Hawaiian and Other Pacific Islander | 4 | 36.36% | | |
| Two or more races | 7 | 63.64% | | |
| Race and Ethnicity (all that apply) | | | | |
| Native Hawaiian | 5 | 45.45% | | |
| Filipino | 2 | 18.18% | | |
| Samoan | 2 | 18.18% | | |
| Tongan | 0 | – | | |
| Micronesian | 6 | 54.54% | | |
| Other pacific Islander | 0 | – | | |
| Chinese | 0 | – | | |
| Japanese | 2 | 18.18% | | |
| Korean | 0 | – | | |
| Other Asian | 0 | – | | |
| Caucasian | 1 | 9.10% | | |
| African American | 0 | – | | |
| Hispanic | 0 | – | | |
| Mixed Race/Ethnicity | 6 | 54.55% | | |
| Age at first sex | | | 15.11 (1.54) | 13–18 years |
| Number of pregnancies before Wahine Talk | | | 0.27 (0.91) | 0–3 pregnancies |
| Number of pregnancies since entering Wahine Talk | | | 0 | 0 pregnancies |
| Use of birth control before Wahine Talk | 0 | – | | |
| Use of birth control after Wahine Talk | 8 | 72.73% | | |
| Type of birth control used after Wahine Talk | | | | |
| LARC (injectable or IUD) | 2 | 18.18% | | |
| Depo-Provera | 5 | 55.56% | | |
| Pill | 0 | – | | |
| Condom | 1 | 11.11% | | |
| NuvaRing | 0 | – | | |
| Sponge | 0 | – | | |
| Other | 0 | – | | |

### 2.5. Data analysis

Data analysis followed the six-step IPA process outlined in Smith et al. (2009): (1) reading and re-reading; (2) initial noting; (3) developing emergent themes; (4) searching for connections across emergent themes (i.e., super-ordinate themes); (5) moving to the next case; and (6) looking for patterns across cases (i.e., final themes). Each step is detailed below. During step one, the first author immersed herself in the data in order to prepare to fully engage with participants' stories and experiences. She read the transcripts, one at a time, while listening to the corresponding audio-recording. After reading the transcripts, she acknowledged her biases and personal experiences as they related to the research question in a reflexive journal and engaged in peer debriefing with the rest of the research team. This was followed by a second read of all transcripts prior to any coding. During step two, initial noting, all statements pertaining to participants' experiences of or meaning ascribed to the phenomenon of interest (accessing and selecting birth control) were coded, using participants' own words whenever possible when creating the codes. Initial notes were categorized as descriptive, linguistic, or conceptual. *Descriptive* notes focused on the content of the participants' remarks, *linguistic* notes focused on language usage, and *conceptual* notes focused on questions that arose by the researcher pertaining to the participants' overarching understanding of the phenomenon at specific moments in the transcript (Smith et al., 2009). In step three, these initial notes were used to develop emergent themes. This step required grouping several related

notations with conceptual links into a single phrase that captured their essence. Emergent themes reflect both the participants' remarks and the researcher's interpretation of the remarks. In step four, these themes were then sorted into broader categories, called super-ordinate themes. Some emergent themes naturally became super-ordinate themes (a process called subsumption). Step five entailed repeating steps one through four with the second focus group transcript and interview transcript.

Finally, in step six, connections were made between the super-ordinate themes from all transcripts in order to create a final set of themes and subthemes (presented below). The first and last (senior) author did this collectively, looking for areas of convergence, divergence, and temporal meaning. Super-ordinate themes that were similar in description were merged. In some cases, super-ordinate themes were reworded in order to be more representative of convergent themes across transcripts.

## 3. Results

The meaning and experience of accessing and selecting birth control among homeless female youth who participated in a holistic sexual health intervention can be characterized by four main themes: Getting Acclimated, Becoming Close and Building Trust, Addressing Fear, and Making the Choice. For most youth, these themes were experienced sequentially. Each theme has several sub-themes, which are summarized in Table 2.

### 3.1. Theme one: getting acclimated

Participants' initial experience of the process of accessing and selecting birth control began with meeting youth drop-in center staff when they came to homeless encampments on outreach visits and through attending drop-in hours at the center. Youth indicated that this initial engagement period set the tone that one's autonomy, self-determination, and choices would be fully respected by program staff.

#### 3.1.1. Getting acclimated: phones as a youth-friendly introduction

For many participants, the expectation of receiving a cell phone as part of a sexual health program piqued their interest, leading them to want to learn more. Staff encouraged young women who were interested in the program to carefully consider if the program was right for them. Staff thoroughly explained the program and youth had an opportunity to ask any questions. This attention and care to the engagement process set the stage for an autonomous youth experience in accessing and selecting birth control. As one participant shared: *"I'm gonna admit, once I heard you could get a phone out of it, I was like [trying to] sign up [right then] but then I was like, I had to, like,... be patient and learn."* For some young women, having access to a phone and, later, data boosts, was a major incentive to remain engaged in the process of accessing and selecting birth control. Others, however, expressed disdain for young women in the program who, as one participant said, "*just came for the phone and left."* This caused some friction between the youth who rarely engaged with program staff and peers, and those who were beginning to build a relationship with one another: *"Sometimes they'll come back [and attend a group session just] for the data and then, like, when we say some of our experience, they look at us like [makes a confused face] -...And they, like, judge us. Like, [they just] look and judge. Not talking, but - And I swear that was, like, one of the rules we made up: no eye contact or no signals to show, ya know, disrespect."*

#### 3.1.2. Getting acclimated: Increased connectedness through phone usage

Having a phone enabled the young women to be socially engaged in expanded ways, even if they were not physically near their friends; as one participant explained: *"You don't need your friends [to be right there with you], you just got your phone."* Thus, the phones served as a connection to people outside of their immediate environment (typically, a homeless encampment). For some young women, phones allowed for increased mobility and were valued as a tangible resource. Young women used their cell phones to communicate with the sexual health program staff, particularly for transportation needs in order to attend sexual health education groups.

### 3.2. Theme two: becoming close and building trust

Feeling connected to the sexual health program staff and to one another were meaningful and important to participants, helping them to be more receptive to the process of accessing and selecting birth control.

#### 3.2.1. Becoming close and building trust: connecting with peers and staff

Participants derived great meaning from being close to their peers and to interdisciplinary staff as part of the process of accessing and selecting birth control. What entailed "being close" varied for participants. Some participants experienced their bond with staff as characteristic of a mother-daughter relationship. For instance, one participant stated that "*the people - I know I enjoy coming to see [them]*" and described two staff members as "*mom and mom*." Participants also expressed an ability to trust and rely on staff. One participant explained that "*like, if we need her, she'd be there.*" Another participant described a time when she was "*really, really, really sick*" and started vomiting all over the on-site clinic. She stated that the medical provider was "*babying*" her and "*really took care of [her].*" Youth also valued feeling welcomed. One participant reflected on how she loves coming to the drop-in center and "*like[s] how excited everybody gets to see [her]".* These experiences of being welcomed, being cared for, and belonging are especially meaningful in the context of homelessness.

Similarly, participants expressed generally experiencing positive interactions with other homeless female youth. As one participant stated, "*this group of kids, we all, we all practically live together. We get along like family."* Not all participants in the study were able to establish trusting relationships with one another; as one participant expressed: *"Um, I don't really connect with these people."* Nonetheless, these experiences were intensely meaningful for young women who were largely disconnected from their families of origin or, if living with their families in homeless encampments, frequently experienced major strain in their family relationships.

**Table 2**
Summary of themes and sub-themes.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Getting Acclimated | Becoming Close and Building Trust | Addressing Fear | Making the Choice |
| Phones as a youth-friendly introduction<br>Increased connectedness through phone usage | Connecting with peers and staff<br>Basic needs and services<br>Sense of autonomy<br>Being heard<br>Escape from reality | Fear of living on the street and being snatched<br>Pain from needles | Medical knowledge<br>Sex education from staff<br>Ease/burden of use<br>Support while getting on birth control |

*3.2.2. Becoming close and building trust: basic needs and social services*

Participants' access to basic needs and social services helped further the experience of becoming close and building trust during the process of accessing and selecting birth control. Some participants highlighted the free laundry and help with school, whereas others appreciated the free transportation, shower, food, composition books, shampoo and conditioner. Participants shared that the drop-in center "provide[s] a lot" and *"feels like home kinda, like yeah, there's…laundry…[staff are] there for you…you don't have to pay for nothing."*

*3.2.3. Becoming close and building trust: sense of autonomy*

For many participants, maintaining their autonomy throughout the process of accessing and selecting birth control was important. Participants appreciated that they were not questioned excessively at the drop-in center, or told what they could and could not do. As one participant explained, "*you don't have to worry if [staff are going to react] 'Oh - what - you're gonna do that?!' They totally understand. And they don't ask for more information - whatever you say is whatever you say.*" Being "free" was central to their experience and contributed to their desire to keep coming back.

*3.2.4. Becoming close and building trust: being heard*

Homeless youth felt listened to and heard, which further facilitated the process of accessing and selecting birth control. As one participant explained, "*having someone to talk to and feel comfortable with"* was a critical part of gaining closeness and building trust, facilitating conversations about birth control and about sexual health more broadly. Participants felt heard through multiple outlets, including in-person conversations, online/social media messaging, and text messaging. As one participant explained, texting provided an easy way to reach staff, who was "*somebody to give [me] advice."* This unwavering, ever-present support was meaningful; staff were demonstrably invested and available on the *youths'* time, and in a way that the youth felt comfortable communicating, to address their sexual health needs and general well-being.

*3.2.5. Becoming close and building trust: escape from reality*

Being homeless is in of itself a challenging experience for youth. Building close relationships with the staff and accessing resources proved to be a meaningful escape from this lived reality for many participants. As one youth mentioned, *"it's just fun that we actually had an activity to get us away from where we are."* Learning new sexual health concepts and interacting with different people was not only a welcomed experience, but, for some, was better than being at home. As one participant stated, "*we got all the time in the world [laughing], like, nothing exciting to go home to, well, nothing* that *exciting."* The experience of "getting away" from home provided a meaningful space to reflect upon how they might affect change in their current and future lives, including by accessing and selecting birth control, as most young women in the study were not planning on having children in the near future yet were rarely taking any steps to prevent pregnancy while sexually active.

### 3.3. Theme three: addressing fear

Getting acclimated, becoming close, and building trust served as an important grounding for unearthing and addressing fear about birth control, sexual safety, and well-being. Participants shared several deeply rooted fears, caused mostly by factors outside of their control, that played a role in their birth control decision-making process. The fear of living on the street and being "*snatched*" further motivated participants to select birth control.

*3.3.1. Addressing fear: fear of living on the street and being "snatched"*

Living on the street can subject youth to unwanted, often violent, sexual interactions. Our participants discussed their fear of men, particularly intoxicated men "*that could be just walkin' around in the streets just drunk and everything"*, and described the frequent occurrence of unsolicited sexual advances. For example, one participant highlighted having to be careful*"especially when we party. That's, like, another reason why we should get birth control, because shit happens."* Participants' everyday environment increased their risk of being sexually assaulted; thus, homeless youth experienced birth control as a protective factor against the seemingly unavoidable.

Participants further expressed a fear of *"being snatched"* and raped by multiple men and identified birth control as a form of protection, that they would at least be able to prevent unwanted pregnancy in the midst of these terrifying circumstances. As one participant stated, *"it's just for our safety."* Another acknowledged that she would consider getting on birth control so she would not get "*pregnant by accident…that's a monster's decision. It's not our decision to get raped.*" As one participant explained, *"one of [her] friends, she got 'Bang! Bang! Bang!' [raped repeatedly] by three other - three or more men. So good thing she got that [birth control]."* Homeless youth thus framed birth control as a protective factor against unwanted pregnancies resulting from rape, which made the selection of birth control seem that much more imperative to them.

*3.3.2. Addressing fear: pain from needles*

The process of accessing and selecting birth control prompted some participants to recognize and address their fear of needles. One participant explained that although she chose Depo-Provera (an injectable form of birth control), she did not realize that it was going to be delivered via injection. She had to give herself a "pep talk": "*ok, I'm gonna do this. I don't want anything going into my vagina, so I'm just gonna do this.*" More specifically, participants feared the size of needles and area of needle insertion. They compared the size of the needles used for Depo-Provera injection, vaginal numbing in preparation for IUD insertion (although, notably, this is not always medically needed), and skin numbing followed by Nexplanon insertion. Fear of needle size and needle placement was directly connected to the anticipated pain of the insertion and the embarrassment of exposing one's buttocks or vagina. One participant described learning she had a choice of Depo-Provera injection site: *"there's two spots that you can poke it in - the arm or your ass. And I'm over here like - [points to her arm] - and they're like… 'You sure you don't wanna get it in the ass? It's more meatier, you know, it's not gonna hurt you as much.' I was like, 'No, it's ok! I don't want you to see my ass.'"*

### 3.4. Theme four: making the choice

Despite their fear of needles, many participants selected Depo-Provera or a LARC method, including either Nexplanon or an IUD, which were the two methods of birth control being particularly encouraged during Wahine Talk due to lower maintenance requirements. Although these two methods were incentivized, participants described appreciating the upgraded smartphone and data package, but made it clear their decisions were based primarily on several other factors that facilitated birth control decision-making and follow-through.

*3.4.1. Making the choice: medical knowledge*

Once interested in exploring the possibility of acquiring birth control, participants' interaction with the medical provider played an integral role in their willingness to follow through. Participants described broadly fearing medical professionals and struggling to overcome their fear in order to receive sexual health services during adolescence. As one participant explained, *"kids [like me] would get scared to see their own doctors…[and the medical provider is] like those doctors that I'm kinda scared of - that I'm* really *scared of."* Such fear had previously caused this particular participant to avoid the medical provider all together, sharing that even when "*I had stitches on my lips and they were like, 'Oh, go check it out with [the medical provider],' I was like "Oh, that's ok.'"* Despite fearing the on-site medical provider (a physician's assistant), participants expected that she share a high level of medical knowledge

when they did meet. Participants experienced the same medical provider, who provided similar sexual health-related counseling to each young woman, somewhat differently, with some wanting more information about birth control and some feeling as though they received more information than they needed. As one participant explained, *"because she's a [medical provider], I kinda, like, expected a little bit more -....Yeah. I wanted her answers to be at least calming, and at least a little bit more different than everybody else [on staff]."*

#### 3.4.2. Making the choice: sex education from staff

Participants' process of selecting birth control was further facilitated by knowledge gained from other drop-in center staff members. When asked if there was anything with which the staff was able to help, one participant immediately responded with *"safe sex,"* more specifically, *"what's good and bad about sex."* Another responded with *"protection."* In contrast to the medical provider, youth interacted with the peer mentor and health educator more frequently, both in person and through text messaging and social media, and were thus able to establish a friendly rapport.

#### 3.4.3. Making the choice: ease/burden of use

When selecting a particular type of birth control, participants compared the relative pros and cons of each option. One participant explained that she chose LARC because *"I've been on the birth control, the pills part, but it didn't really help as much...'cause I wasn't reliable [in terms of] taking [the pill] every single day."* Selecting a relatively low-maintenance birth control option was particularly meaningful given the often-chaotic and insecure context of homelessness.

#### 3.4.4. Making the choice: support while adopting birth control

For those who followed through with adopting a method of birth control, having staff support them through the process was a crucial part of the experience. Staff provided frequent verbal affirmation while participants adopted various birth control methods, which brought them even closer to staff and was truly meaningful to these young women. One participant explained that while getting an IUD, *"she [the health educator] was right there in the room with everything, [with] the covers and everything, and she was like, 'You got it, boo.'"* Another participant shared how the on-site medical provider comforted her when "*my stomach felt, like, too much butterflies to do that [start the Nexplanon insertion process], [the medical provider] was like, 'It's ok, it's ok,'"* providing care, building trust, and taking the process at a pace comfortable to the participant. Support in the form of physical touch and demonstrated acts of concern also added meaning to the overall experience of adopting birth control. One participant noted that the health educator *"was there through the whole process, squeezing our hand,"* making it easier to complete the process of accessing and selecting birth control.

## 4. Discussion

The current study illuminates the meaning and experience of how homeless youth participating in a holistic sexual health program called Wahine Talk access and select birth control. This process is characterized by four main themes: Getting Acclimated, Becoming Close and Building Trust, Addressing Fear, and Making the Choice. In addition to significantly adding to the literature on sexual health among homeless youth, these findings have particular implications for interdisciplinary social service and community health and well-being practice within and beyond the Wahine Talk intervention as well as implications for policy and future research.

### 4.1. Meeting their needs: being heard

The current study found that an integral part of accessing and selecting birth control for homeless youth is connecting with staff and feeling heard. Having someone to *"actually talk to and feel comfortable with,"* as one study participant shared, is something that the youth appeared to lack outside of the sexual health program (Wahine Talk) and thus found unique to their experience in the program. Although this study examined birth control access and selection in the context of a larger sexual health program, feeling heard by community health, social service, and medical providers is an integral first step in accessing many types of birth control and receiving ongoing sexual health services. Thus, building these relationships should be prioritized when working to address sexual health among homeless youth, irrespective of their involvement in a sexual health program. Without this foundation, all other services may not be received as intended. As noted by youth in this study, such communication can be facilitated in multiple ways, including by use of cell phones. Tyler and Schmitz (2017) similarly found cell phones to have excellent potential for reaching and maintaining connection to homeless youth, both for intervention and data collection purposes. Homeless youth reported receiving daily text message prompts helped them to feel cared for and heard (Tyler & Schmitz, 2017). The importance of adult-adolescent sexual health communication, more generally, has been well-supported by earlier findings. Greater levels of adult-child communication is associated with reduced cases of sexual intercourse and unprotected intercourse (Hutchinson, Jemmott III, Jemmott, Braverman, & Fong, 2003) and the use of birth control (Aspy et al., 2007). In addition, youth who discuss one or more sensitive health topics with their physician have an increased odds of reporting that their doctor understood their problems, eased their worries, and allowed them to make decisions about treatment (Brown & Wissow, 2009). Homeless youth, however, have reported challenges with trusting their provider enough to discuss survival sex due to anticipated stigma, and report choosing self-induced abortion as opposed to medically-induced abortions due to the embarrassment of going to a clinic (Ensign, 2001) or not knowing where to access abortion services (Begun, Massey Combs, Schwan, Torrie, & Bender, 2018). Connecting with medical staff and building positive relationships can help to mitigate homeless youth's avoidance of medical care.

### 4.2. Meeting their needs: linkage to care

Current study findings indicate that the experience of accessing and selecting birth control among homeless youth may be largely impacted by the felt presence of medical staff. Having youth-friendly, trauma-informed providers who are experienced as kind and accessible may be especially important for homeless youth given their frequent disconnection from regular medical care. An intentional linkage to care approach, such as what is used in Wahine Talk, can help reduce homeless youths' experience of being uncertain of where to access birth control and address feelings of birth control being "like a different language," as homeless youth in Begun, Combs, et al. (2019) study shared (p. 249). Prior studies among the general population have found that both trust with a healthcare provider (Frost et al., 2007) and trust with a non-medical provider versed in contraceptive options (Madden, Mullersman, Omvig, Secura, & Peipert, 2013) impacts young women and women's choice of contraception. Trust in a medical provider has particular implications related to LARC as a lack of knowledge of LARCs, misconceptions about LARCs, and limited access to LARCs has been associated with reduced contraceptive use (Dasari et al., 2016). As the homeless youth in the current study experienced, interacting with medical staff became routine during the process of accessing and selecting birth control, and thus became normalized. Linking homeless youth to medical professionals has considerable implications for their overall well-being extending beyond the decision to access and/or select birth control.

### 4.3. Meeting their needs: establishing a practical birth control routine

Accessing birth control and utilizing it as intended requires some

degree of maintenance irrespective of the method selected. For example, Depo-Provera requires an injection administered every three months, whereas an IUD must be replaced every three to twelve years depending on the brand selected. For homeless youth, even with the added support of Wahine Talk, keeping up with these birth control maintenance requirements while dealing with any side effects and navigating interpersonal sexual relationships can be quite challenging and may result in youth using birth control ineffectively, or not at all. These findings are in line with that of Moreau et al. (2007), who found that 42% of women aged 15–44 years have discontinued use of at least one contraceptive method because they were dissatisfied with it. In Begun, Frey, et al. (2019) study on attitudes towards contraception among homeless youth, youth shared that use of condoms and other contraceptives is inconsistent for many reasons related to practicality (e.g., cost, not thinking of using condoms in the moment, concern about gaining weight). In the current study, attending the holistic sexual health program provided a space for the participants to not only access and select birth control, but also escape from their daily challenges. They were afforded a supportive environment to focus on their needs and hopes for the future, including how use of birth control could facilitate these needs and hopes.

Thus, as findings of the current study indicate, homeless youth carefully consider what is required in order to use different forms of birth control effectively. Allowing adolescents the space away from their routine environment in order to consider and discuss their needs with a trusted adult is important. These discussions should be carefully guided by trauma-informed service providers aware of the particular considerations elucidated by this study relevant to how and why homeless youth may select birth control, such as fear of needles and sexual assault. Further, it is imperative that those working with homeless youth consider the environment in which youth are making these decisions and encourage choices that are most likely to result in the effective use of birth control.

### 4.4. Limitations

The current study findings are based on a sample of 11 homeless female youth who reside in Hawai'i. Cultural beliefs and practices regarding birth control, along with one's experiences as a homeless youth, may differ in Hawai'i when compared to homeless youth in other geographic locations. In addition, data were collected primarily through semi-structured focus groups. Discussing birth control, intimate partner relationships, and sexual health behaviors in a group setting can be challenging, particularly for adolescents, which may have affected how much some youth were willing to share. Lastly, not all adolescents who participated in the holistic sexual health program participated in this study because many youth were no longer coming to the drop-in center. It is possible that those no longer coming to the drop-in center would have had other perspectives to offer.

### 4.5. Implications for practice, policy, and future research

The current study has several implications. Social service and community health practitioners should work to foster trust, ensure youth feel heard, establish a strong linkage to medical care through a warm hand-off and youth-friendly trauma-informed provider follow-up, and help youth establish a practical birth control routine. Providing homeless youth with smartphones as part of a larger intervention effort may help facilitate communication in multiple ways. Further, enabling youth to escape their daily challenges when participating in the sexual health program, build positive relationships with program staff, and both strengthen and broaden their peer network has implications for youths' mental health and well-being and social capital. As such, future research that aims to develop and test programs designed to enhance homeless youths' access and selection of birth control should account for these indicators as possible intervention mechanisms or outcomes. Future research is also indicated to explore the process of accessing and selecting birth control among homeless youth outside of an organized sexual health program as well as among homeless youth in other settings (e.g., those in shelters or not accessing drop-in program or shelter services at all). Future studies could also more explicitly explore cultural factors relevant to the process of accessing and selecting birth control.

### 4.6. Conclusion

Our findings suggest that the process of assessing and selecting birth control for many female homeless youth engaged in a holistic sexual health program (Wahine Talk) follows a sequential process that fosters youths' autonomy, trusting and non-judgmental interpersonal relationships with peers and staff, a welcoming environment with basic needs and services, the ability to address one's fears regarding birth control and sexual safety, adequate medical knowledge, and unwavering staff support. In order to reduce the rate of unintended pregnancies among homeless youth, social service and healthcare providers must strive to create environments that facilitate each step in this process while utilizing youth-friendly, trauma-informed best practices.

## Acknowledgements

The authors gratefully acknowledge the youth who participated in this study, sharing their experiences so that other homeless youth may be better served by our social service and healthcare systems. We also extend our deep gratitude to Whitney Garney, Jordan Nelon, Kelly Wilson, and the whole iTP3 team for their guidance and support during our studies with homeless youth.

## Funding

This opportunity is made possible by Grant Number TP2AH000046 from the HHS Office of Adolescent Health as part of the Innovative Teen Pregnancy Prevention Programs ($iTP_3$) project. Contents are solely the responsibility of Waikiki Health and do not necessarily represent the official views of the Department of Health and Human Services, the Office of Adolescent Health, or Texas A&M University.

## Conflicts of interest

The authors declare that they have no conflicts of interest.

## References

Aspy, C. B., Vesely, S. K., Oman, R. F., Rodine, S., Marshall, L., & McLeroy, K. (2007). Parental communication and youth sexual behaviour. *Journal of Adolescence, 30*(3), 449–466.

Aparicio, E. M., Phillips, D. R., Okimoto, T., Cabral, M. K., Houser, C., & Anderson, K. (2018). Youth and provider perspectives of Wahine Talk; A holistic teen pregnancy prevention program developed with and for homeless youth. *Children and Youth Services Review, 93*, 467–473.

Begun, S., Frey, C., Combs, K. M., & Torrie, M. (2019). "I guess it would be a good shock": A qualitative examination of homeless youths' diverse pregnancy attitudes. *Children and Youth Services Review, 99*, 87–96.

Begun, S., Massey Combs, K., Schwan, K., Torrie, M., & Bender, K. (2018). "I know they would kill me": Abortion attitudes and experiences among youth experiencing homelessness. *Youth & Society,* 1–22 (0044118X18820661).

Begun, S., Massey Combs, K., Torrie, M., & Bender, K. (2019). "It seems kinda like a different language to us": Homeless youths' attitudes and experiences pertaining to condoms and contraceptives. *Social Work in Health Care, 58*(3), 237–257.

Brown, J. D., & Wissow, L. S. (2009). Discussion of sensitive health topics with youth during primary care visits: Relationship to youth perceptions of care. *Journal of Adolescent Health, 44*(1), 48–54.

Clements, K., Gleghorn, A., Garcia, D., Katz, M., & Marx, R. (1997). A risk profile of street youth in northern California: Implications for gender-specific human immunodeficiency virus prevention. *Journal of Adolescent Health, 20*(5), 343–353.

Dasari, M., Borrero, S., Akers, A. Y., Sucato, G. S., Dick, R., Hicks, A., & Miller, E. (2016). Barriers to long-acting reversible contraceptive uptake among homeless young women. *Journal of Pediatric and Adolescent Gynecology, 29*(2), 104–110.

Dworsky, A., Morton, M. H., & Samuels, G. M. (2018). *Missed opportunities: Pregnant and parenting youth experiencing homelessness in America.* Chicago, IL: Chapin Hall at the University of Chicago.

Ensign, J. (2001). Reproductive health of homeless adolescent women in Seattle, Washington, USA. *Women & Health, 31*(2–3), 133–151.

Frost, J., Singh, S., & Finer, L. (2007). Factors associated with contraceptive use and nonuse, United States. *Perspectives on Sexual and Reproductive Health, 39*(2), 90–99.

Greene, J. M., & Ringwalt, C. L. (1998). Pregnancy among three national samples of runaway and homeless youth. *Journal of Adolescent Health, 23*(6), 370–377.

Hutchinson, M. K., Jemmott, J. B., III, Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother–daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health, 33*(2), 98–107.

Krings, K., Matteson, K., Allsworth, J., Mathias, E., & Peipert, J. (2008). Contraceptive choice: How do oral contraceptive users differ from condom users and women who use no contraception? *American Journal of Obstetrics & Gynecology, 198*(5).

MacKellar, D. A., Valleroy, L. A., & Hoffmann, J. P. (2000). Gender differences in sexual behaviors and factors associated with nonuse of condoms among homeless and runaway youths. *AIDS Education & Prevention, 12*(6), 477–491.

Madden, T., Mullersman, J., Omvig, K., Secura, G., & Peipert, J. (2013). Structured contraceptive counseling provided by the contraceptive CHOICE project. *Contraception, 88*(2).

Marshall, C., Kandahari, N., & Raine-Bennett, T. (2017). Exploring young women's decisional needs for contraceptive method choice: A qualitative study. *Contraception, 97*(3), 243–248.

Moreau, C., Cleland, K., & Trussell, J. (2007). Contraceptive discontinuation attributed to method dissatisfaction in the United States. *Contraception, 76*(4), 267–272.

Secura, G., Madden, T., McNicholas, M., Mullersman, J., Buckel, C., Zhao, Q., & Peipert, J. (2014). Provision of no-cost, long-acting contraception and teenage pregnancy. *New England Journal of Medicine, 371*(14), 1316–1323.

Smid, M., Bourgois, P., & Auerswald, C. L. (2010). The challenge of pregnancy among homeless youth: Reclaiming a lost opportunity. *Journal of Health Care for the Poor and Underserved; Baltimore, 21*(2), 140–156.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* London, United Kingdom: SAGE.

Tyler, K. A., & Schmitz, R. M. (2017). Using cell phones for data collection: Benefits, outcomes, and intervention possibilities with homeless youth. *Children and Youth Services Review, 76*, 59–64.

U.S. Department of Housing and Urban Development (2018). The 2018 annual homeless assessment report (AHAR) to congress. Retrieved from https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf.

Winetrobe, H., Rhoades, H., Barman-Adhikari, A., Cederbaum, J., Rice, E., & Milburn, N. (2014). Pregnancy attitudes, contraceptive service utilization, and other factors associated with Los Angeles homeless youths' use of effective contraception and withdrawal. *Journal of Pediatric & Adolescent Gynecology, 26*(6), 314–322.

Wright, A., Duffy, J., Kershner, S., Flynn, S., & Lamont, A. (2015). New opportunities in teen pregnancy prevention: Identifying individual and environmental differences between youth who abstain, use contraception, and use no contraception. *Journal of Community Psychology, 43*(8).

Yuan, S., Stern, I. R., Gauci, K. T., & Liu, L. (2018). *Street youth study.* Honolulu, HI: University of Hawai'i, Center on the Family.