Through the Cracks and Between the Lines: 

A Personal Response to Conducting a Sexual Health Resource Evaluation 

with Street-Involved Youth 

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Introduction 

Human behaviour can be a challenging thing. It is challenging to predict; challenging to understand; and especially challenging to change. Within the field of prevention, and particularly within the realm of preventative health education, this complexity plays an integral role in the planning, evaluation, and potential success of prevention initiatives. 

HIV/AIDS is one topic in which behavioural change can play a pivotal role in the development of the epidemic. Since red AIDS awareness ribbons created by Visual AIDS Artist Caucus burst into mainstream celebrity fashion in the early 90’s, the issue of HIV/AIDS has emerged as a mainstay in popular dialogues about sexual health. This emergence into mainstream consciousness occurred almost ten years after the first case of AIDS was reported on June 5th, 1981 by the Centre for Disease Control in Atlanta, Georgia (Whiteside, 2008, p.1). In the three decades since that first case was reported, concerning rates of new HIV infections and AIDS related deaths have continued to garner international attention. The United Nations Acquired Immune Deficiency Syndrome Report (UNAIDS, 2008), a widespread synopsis of the 164 commonwealth countries which make up the United Nations, estimates that in 2007 alone, 370,000 children under the age of 15 became newly infected with HIV – the virus that causes AIDS (UNAIDS Report, 2008, p.8). Furthermore, in a figure even more staggering than the annual number of new infections, UNAIDS estimates that, worldwide, there are between 30 and 36 million people living with HIV (UNAIDS Report, 2008, p.5). To put the statistic in perspective, globally, there are more people living with AIDS than the entire population of Canada.
Through the Cracks and Between the Lines

Canada is fortunate to be in the company of other countries such as Australia, Mexico, Spain and Greenland, with some of the lowest reported prevalence of national HIV rates – estimated between 0.1% and < 0.5% (UNAIDS Report, 2008, p.5). Moreover, the annual number of HIV cases in Canada has remained relatively stable over the past decade (Public Health Agency of Canada, 2010, p.15). While this prevalence seems encouragingly low, it is not without its casualties. Since the Public Health Agency of Canada first began recording AIDS cases in 1979, up until December 31st, 2009 there has been a cumulative total of 21,681 AIDS cases reported to Public Health Agency of Canada (PHAC) (Public Health Agency of Canada, 2010, p.8). This number of cases must be interpreted with the consideration that this statistic reflects only the number of individuals who have been identified as having HIV, and does not speak to the persons who may be infected but not seeking, or unable to access, HIV testing.

HIV does not present with a uniform prevalence throughout all subgroups of Canada’s population. In fact, throughout the world, with the exception of sub-Saharan Africa, “HIV disproportionately affects injecting drug users, men who have sex with men, and sex workers” (UNAIDS Report, 2008, p.9). Canadian statistics show that individuals who engage in these high-risk behaviours are indeed at higher risk of contracting HIV. In Canada, though HIV infection attributed to men having sex with men (MSM) has decreased from 80% in 1985 to 41.8% in 2009, MSM is still the predominant exposure behaviour for new cases of HIV (Public Health Agency of Canada, 2010, p.3). In addition to men having sex with men, heterosexual contact, followed by injection drug use, are the top three methods of transmission in new HIV cases (Public Health Agency of Canada, 2010, p.3).

I recently overheard a man expressing that he did not understand why new cases of HIV were still occurring. According to his logic, we already know the methods of transmission: contact with HIV positive blood or bodily fluids such as semen and vaginal fluids. Therefore, he wondered, why don’t people just stop doing the things that put them at risk for infection, such as having unprotected sex or sharing injection needles? Consider all of the health challenges that could be avoided if people changed their behaviour based on knowing what was “good” for them. No one would smoke
cigarettes. No one would eat fast food. Everyone would exercise regularly. The science of prevention is far more complicated than dispensing information and expecting people to adapt their behaviour accordingly. There are contexts to consider; an individual’s environment, culture, social norms, gender, sexuality, ethnicity, prior knowledge of the issue, education level, socioeconomic status, and the list goes on. All of these factors might influence the type of preventive measures best suited to that individual.

In his book, *HIV/AIDS*, Alan Whiteside boldly states that “a person who is HIV positive has almost certainly had sex with someone who is infected” (Whiteside, 2008, p.121). While this statement does not ring true for cases of mother to child transmission, reflected in both global trends and trends within Canada, sex with an infected person is the primary method of new infection with HIV (Public Health Agency of Canada, 2010). Therefore, an integral step in developing effective AIDS education programming is determining which populations are frequently engaging in unprotected sex, then assessing what those individuals already know, what they want to know, and how the appropriate information can be presented in a way that is relevant, accurate, retainable and, ideally, able to affect positive behavioural change.

The Rise of the Harm Reduction Approach

Harm reduction is a prevention approach that began to gain momentum in the United States in the late 70’s and early 80’s within the community of mental health disorder prevention. However, at the time harm reduction was beginning to take root in North America, several other countries had already adopted this theory and put the theory into action. Parts of England, Italy and the Netherlands were implementing harm reduction programs regarding drug use, such as needle exchange programs, as early as the 1960’s and 70’s (Tsui, 2000, p.243).

In the article “Deviance and deviants: Why adolescent substance use prevention programs do not work” (1993), Joel Brown, senior evaluation scientist at Pacific Institute for Research and Evaluation, and Jordan Horowitz, project director at Southwest Regional Laboratory, describe that it used to be common practice for pre-harm reduction prevention programs to equate any participation in
a behaviour as excessive. This was, and continues to be, particularly apparent within the field of substance use in which “there exists the constant assumption that those who use any alcohol or drugs constitute the moral equivalent of those who abuse alcohol or drugs” (Brown & Horowitz, 1993, p.541). Early prevention initiatives could compartmentalize behaviour on a checklist, and on that checklist “there are only two choices: abstention or abuse” (Brown & Horowitz, 1993, p.542).

Take, for example, the behaviour of injecting heroin. The behavioural checklist might look like this:

☐ Abstain from injecting heroin  ☐ Abuse injecting heroin

This example could be construed as a “black and white issue” because most people would argue that any instance of injecting heroin would constitute abuse of the substance. However, it becomes more difficult to use a checklist approach when the behaviour being categorized is less extreme; for example, the behaviour of consuming alcohol. The behavioural checklist might look like this:

☐ Abstain from consuming alcohol  ☐ Abuse consuming alcohol

How might this checklist accommodate people who regularly have a glass of wine with dinner? Does someone who consumes alcohol once a week require the same type of prevention education or intervention as someone who consumes a litre of alcohol per day? In pre-harm reduction prevention initiatives, there was no way to account for individuals who casually, or inconsistently, participate in a behaviour. These varying degrees of participation must be taken into consideration when developing and implementing effective prevention initiatives.

Harm reduction accounts for these “grey areas” of behaviour between abstinence and excess by measuring behaviour on a continuum, not as a checklist. As Ming-sum Tsui, senior lecturer at Hong Kong Polytechnic University, describes: one end of the behavioural continuum represents excessive use, the opposite end represents abstinence, and the majority of the continuum is degrees of behaviour between the two extremes (Tsui, 2000, p.244).

An example of a continuum of behaviour representing injection drug use might look like this:
The language used in a harm reduction approach echoes this shift in assessing behaviour. Instead of classifying any type of behaviour that is not absolutely abstained from as “excessive”, harm reduction approach acknowledges that an individual can participate in a behaviour without that behaviour being abusive (such as occasional alcohol consumption).

In addition to not judging any use or participation in a behaviour as excessive, the harm reduction approach goes so far as to acknowledge that experimentation is a normative component of the adolescent experience. Brown and Horowitz argue that adolescent “problem behaviours” such as experimenting with drugs, alcohol and sexual behaviour, are actually a “developmentally appropriate form of limit testing and not indicative of an implacably deviant population” (Brown & Horowitz, 1993, p.548). This perspective has implications for prevention initiative development because “instead of maintaining the assumption that adolescent behaviour is maladaptive, researchers and programmers can now realistically examine an alternative prevention strategy: adolescent alcohol and drug experimentation and harm minimization” (Brown & Horowitz, 1993, p.548).

Whereas earlier prevention efforts were successful only if the individual abstained completely from the behaviour, the harm reduction approach celebrates any progress in moving toward the left side of the continuum. Continuing with the example of an individual using drugs, “the harm reduction approach aims to change the drug taker from excessive to moderate use and then to total abstinence as an ultimate goal” (Tsui, 2000, p.244).
Applying the Harm Reduction Approach to Sexual Health Education

Most literature regarding harm reduction is in regards to substance and/or alcohol use. In addition to drug and alcohol use, Tsui argues that “the harm reduction approach can be used for all kinds of addictive behaviour” including gambling and pornography addiction (Tsui, 2000, p.244). However, I would argue that harm reduction is not only useful with behaviour that is “addictive”, and therefore can also play a key role in programs which aim to prevent the spread of sexually transmitted infections (STI). For example, if someone regularly has unprotected sex with multiple concurrent partners, that person is not necessarily “addicted” to engaging in unprotected sex, but rather participating in a non-addictive high risk behaviour. Harm reduction would encourage that individual not necessarily to abstain from having sex with multiple partners, but to use protection more frequently. A harm reduction continuum for this example might look like this:

Figure 2 Harm reduction continuum of unprotected sex.

Again, the goal of the harm reduction approach is to have the individual’s behaviour continue to move towards the left-side of the continuum.

However, despite its wide acceptance, the harm reduction approach remains a controversial and contentious issue. Within the field of substance and drug use, Brown and Horowitz highlight that the harm reduction approach creates the challenge of “how to refocus the field toward minimizing the consequences of alcohol and drug use without condoning use” (Brown & Horowitz, 1993, p.549). The fear that teaching people how to reduce the risk of a behaviour somehow equates to endorsing that behaviour is not limited to substance and alcohol prevention alone. This is also a common objection to sharing information about sexual health, particularly with adolescents.
Lisa Marr, author of *Sexually transmitted diseases: A physician tells you what you need to know*, points out, “some people have claimed that if we teach people, especially young people, about sex and how to prevent STDs, then they will become more sexually active” (Marr, 2007, p.90). However, Marr refutes that “nothing is further from the truth” and describes that “studies have shown that the level of sexual activity among young people who are provided with sexual education either stays the same or decreases” while “the degree of condom use and reliance on other safer sex practices increases among young people who are already sexually active” (Marr, 2007, p.90). Marr’s sentiments are echoed in *The purity myth* which incorporates a poignant quote from Bill Maher, comedian and social commentator, to summarize the misinformation that access to sexual education is equivalent to endorsing sexual behaviour. Valenti writes “I rarely quote Bill Maher, but he was right on when he noted” that equating sexual education with promoting promiscuity “‘is like saying if you give a kid a tetanus shot, she’ll want to jab rusty nails in her feet’” (Valenti, 2008, p. 71).

Tsui describes that one of the benefits of the harm reduction approach is that it can help to facilitate evaluation because there is a scale of measurable short-term operational goals, and therefore, it is easier for the researchers to evaluate its effectiveness (Tsui, 2000, p.245). However, the ease of measuring these short-term goals may be more feasible with a drug or alcohol prevention program. Blood and urine tests can objectively identify the amount of a substance an individual has been using (or abstaining from using). This amount can be compared to tests of previous drug and alcohol amounts to evaluate the effectiveness of the intervention. One of the significant challenges in evaluating the effect of STI prevention programs is that data collection relies largely on self-disclosure of participants. While there are different types of tests that can identify if an individual already has an STI, there are no tests to determine if an individual is using a condom, or tests to identify in which types of behaviours an individual is engaging. In certain communities, individuals may be unwilling to share their behaviour candidly with a researcher – particularly if they know what the desired responses should be and fear negative judgment.

*Harsh Reality: A different kind of sexual health resource*
After months of preparation, the fourth edition of *Harsh Reality* was printed and ready to hit the streets of Winnipeg in spring of 2008. Originally created in 2001 with the support of Kali Shiva AIDS Services, AIDS Community Action Program, and the Public Health Agency of Canada, *Harsh Reality* is a print resource (240 pages in length) aimed specifically towards the population of street-involved youth in Winnipeg. *Harsh Reality* contains topics relevant to street-involved youth, such as: health and nutrition, drugs and alcohol, mental health, gangs, and a primary focus on sexual health issues such as STI and blood borne pathogens. *Harsh Reality* is a unique hybrid of factual information, and art and written experiences submitted by local street-involved youth themselves. *Harsh Reality* is grounded in a harm-reduction approach, and offers youth information about how to reduce the risk of participating in behaviours (such as safer sites on the body to inject drugs, and safer methods of engaging in safer sex). A youth working group, comprised of local street-involved youth, collaborated with Margaret Ormond, a research nurse with extensive experience working with street-involved populations in Winnipeg, to oversee the topics and information included in *Harsh Reality* and the physical lay-out of the resource. *Harsh Reality* was designed with the intention of being a stand-alone instructional resource with copies of the book freely circulating amongst youth.

The appearance and content of *Harsh Reality* are markedly different than other print resources directed toward youth. It is a mix of many different fonts and graphics, including graffiti from local artists. The text incorporates a substantial amount of profanity and slang. It was not put together by a slick professional graphic designer. It does not shy away from potentially uncomfortable topics such as anal sex, self harm, or mental illness. It is unlikely that *Harsh Reality* would be eagerly snapped up for distribution by school divisions for fear that conservative community parents might incite a riot. In short, the reasons why it would not be a suitable resource for the general population are the same reasons that make *Harsh Reality* an appealing and well-suited resource for street-involved youth.

Who are “Street-Involved” Youth?
They are the young people squeegeying windshields at the corner of Broadway and Colony Street. They are the people busking in Osborne Village. They are the people with the big backpacks and a few dogs in tow trying to find warmth in bus shelters during winter. They are the street-involved kids, the homeless kids, and they exist in every country in the world.

However, while key characteristics of street-involved youth can often be found throughout existing literature, it is rare to find two identical definitions. In many cases, the terms “street-involved youth” and “homeless youth” are used interchangeably. This paper will largely employ the term “street-involved” due to the misconception that the term “homeless” applies only to those who live and sleep outside “in the street”.

In fact, the terms “street-involved” and “homeless” encompass more than individuals who sleep outside on the street. Individuals who access the services of shelters, including spending the night at shelters, are also included in the “homeless” category (Zerger, Strehlow, & Gundlapalli, 2008; Haldenby, Berman & Forchuk, 2007; Taylor-Seehafer, Johnson, Rew, Fouladi, Land & Abel, 2007). In addition, the term “homeless” includes youth who are “doubling up” such as staying with friends (Zerger et al., 2008, p.825), or staying with lovers (Ensign & Santelli, 1997, p.817). It is common for youth who are categorized as “homeless” to be “continuously moving between temporary housing arrangements” (Haldenby et al., 2007, p.1232) and to “lack a fixed, regular and adequate nighttime residence” (Taylor-Seehafer et al., 2007, p.38). This chronic transience is often referred to as “couch surfing” (Haldenby et al., 2007) because youth are rotating, or “surfing”, from couch to couch in different locations.

Individuals who are “homeless” in the traditional sense of the word face the challenge of having to find creative locations where they might spend the night. This may include “sleeping in parks, stairwells, or abandoned cars” (Haldenby et al., 2007, p.1237) or “camping out on the street and in public places” (Zerger et al., 2008, p.835) such as bus shelters and parkades. Some researchers have also included youth who live in “substandard housing” (Zerger et al., 2008, p.826) and “unstable residences” (Taylor-Seehafer et al., 2007, p.38) as part of their definition of homelessness.
Researchers have different ideas regarding to what extent the term “homeless” includes systems-based youth, such as youth in the foster care system or in correctional facilities. Zerger et al. caution that youth being released “from the foster care or corrections system after aging out at 18” are two of the most common means by which youth become homeless (2008, p.835), but stipulate that the term “homelessness typically encompasses only those actively using services such as shelters and health clinics” (Zerger et al., 2008, p.826). Haldenby et al. also do not include systems-based youth under the umbrella of homelessness (2007).

Conversely, Taylor-Seehafer and colleagues include youth within “system-based institutions” as part of their definition of homeless youth (2007, p.38). Ensign and Santelli (1997) developed four widely-referenced categories for classifying homeless or street-involved youth, one of which pertains exclusively to systems-based youth. The following table summarizes their classifications:

<table>
<thead>
<tr>
<th>Runaways</th>
<th>Throwaways</th>
<th>Street Youth</th>
<th>Systems Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth who left home voluntarily</td>
<td>Youth who left home involuntarily</td>
<td>Youth doubling-up with friends or lovers</td>
<td>Youth involved in institutional or foster care system</td>
</tr>
</tbody>
</table>

(Based on Ensign & Santelli, 1997, p.817).

While this system of classification is helpful, it is not without its shortcomings. For example, how would an individual who ran away from home and is now living in a shelter be categorized: as a “runaway” or “systems youth”? Despite potential limitations, Ensign and Santelli’s classifications begin to address the often complex and compelling reasons that drive youth to become street-involved.

There are a variety of factors which may precipitate or increase one’s risk for becoming homeless. For instance, young people are significantly more susceptible to becoming homeless than adults. Zerger et al. attribute this to youth being

Less likely than older adults to have resources in place to prevent homelessness or to cope should it occur…They are more likely to have low-paying jobs with few benefits and are less likely to have health insurance, substantial savings, or experience with housing matters, legal rights, or community resources. (2008, pg 825)
In addition to lack of life experience compared to adults in similar situations, one of the most cited factors that precedes youth becoming street-involved is their family context. This might include “a family without the means or desire to support them” (Zerger et al., 2008, p.825), “being kicked out of home by disapproving parents” or “escaping an abusive parent” (Zerger et al., 2008, p.835). The avoidance of abuse is a recurring theme in existing literature; Haldenby and colleagues describe “various forms of abuse, including physical, sexual or emotional, as main factors that can cause young people to flee their homes” (Haldenby et al., 2007, p.1233). Despite the hardship of life on the streets, for youth experiencing familial abuse, these hardships may be preferable to the environment they endure at home.

The examples of the differing reasons why youth may become homeless serve to illustrate that there is not just “one type of person” who becomes street-involved. Haldenby et al. point out that, in the past, “many researchers have tended to characterize this population as a homogenous group. In effect, this depiction negates the importance of gender, race, ability, or other social locations and identities” (2007, p. 1234). Zerger and colleagues echo this sentiment, and describe that currently “researchers are beginning to develop a more sophisticated understanding of issues facing this non-homogenous group” (2008, p.827).

However, when examining the characteristics of individuals who are street-involved, there can often be subgroups within subgroups. One of the subgroups gaining increased attention for their heightened vulnerability are street-involved youth who are gay, lesbian, bi-sexual, transgender or questioning (GLBTQ. In some literature this acronym includes an additional “T” to represent individuals who are two-spirited: GLBTTQ). This subgroup is “overrepresented among homeless youth; precisely to what extent we do not know” (Zerger et al., 2008, p. 832). Further, “homeless youth who self-identify as GLBTQ exhibit greater risk and negative outcomes than those who are heterosexual” (Zerger et al., 2008, p.832). To these points, I would add that youth who do not self-identify as GLBTQ but are perceived to be GLBTQ are also at heightened vulnerability. For example, many males who work in the sex trade and engage in sexual acts with men are actually heterosexual, but “work as a gay young person to earn money” (McIntyre, 2007, p.58). These males, referred to as
“gay for pay”, are just as vulnerable to gay bashing and harassment as their fellow sex-trade workers who may be homosexual.

There is evidence that suicidal ideation is prevalent among street-involved youth as a whole, but “this risk is amplified among gay, lesbian, bisexual, and transgender youth” (Haldenby et al., 2007, p.1233). In addition, “this subgroup is more likely to have early onset of sexual experience, involvement in prostitution or survival sex, multiple sex partners, and other sexually risky behaviours” (Zerger et al., 2008, p.832).

Whereas one’s sexuality may not be overtly observable, one attribute which is often visibly identifiable is an individual’s gender. Gender is also a key characteristic which may greatly influence a street-involved youth’s experience. To this end, the subgroup of street-involved women and girls is particularly vulnerable. Haldenby et al. go so far as to state that “the unique challenges faced by homeless female adolescents” render them “the most vulnerable subculture within the homeless population” (2007, p.1234). Female street-involved youth and women have expressed that they are more susceptible to violence and exploitation on the street, including being “significantly more likely to be sexually assaulted than men and boys” (Haldenby et al., 2007, p. 1234).

On top of fundamental considerations such as food and shelter, there are additional financial considerations which are necessary for females; such as funds “needed for feminine hygiene products and birth control” (Haldenby et al., 2007, p.1239). Zerger et al. point out that many “homeless young adults are also raising children of their own” (2008, p.825) and, in many cases, this parenting responsibility lies primarily with the mother.

The acknowledgement of different subgroups under the umbrella of street-involved youth is an important step in developing an understanding of their daily context. Just as there is not one type of individual who becomes street-involved, the resources and supports required to survive on the street may be markedly different for individuals with differing characteristics. These differences can impact a youth’s safety, vulnerability, and personal experience. More importantly, these differences can impact the ability of a street-involved youth to continue to exist in an often unpredictable and unsafe environment.
Getting By: Survival on the Street

Although Canada is, by world standards, an affluent and developed country, it is not uncommon to hear the word “survival”. University students might refer to “surviving first year Medicine”; colleagues might breathe a sigh of relief after “surviving fiscal year end at work”. But, when street-involved youth talk about survival, it is not a hyperbole or a euphemism for “busy period”. Survival is just that: not dying; scraping your way through another day, another week, maybe another hour. Survival on the street is not limited only to finding a place to spend the night. Fundamental considerations such as food, bathrooms and hygiene, and basic personal safety must be addressed on an ongoing basis. Haldenby and colleagues describe that “living on the streets often forces adolescents to focus on daily survival” (2007, p.1241). They continue to describe that for the street-involved youth who participated in their study,

Being exposed to constant threats of violence with no safe place to go, the youth’s daily focus was on meeting their urgent safety and physical needs…The fact that they were living on the streets and still alive was something they were proud of. (Haldenby et al., 2007, pg. 1238)

For these youth, survival itself is the most important accomplishment.

A welcome distraction from the ongoing struggle of survival on the street often can be found in the escape of drugs, alcohol, or other substances. There is a strong connection between street-involvement and substance use. “Several small and large scale studies have found 70% to 97% of homeless youth abuse alcohol, illicit drugs, or both and noted that risk increases with age and duration of homelessness” (Zerger et al., 2008, p. 833). Funds are required for individuals to purchase substances they use and, in some cases, are addicted to. For some street-involved youth, the desire to procure these substances may supercede other basic necessities for survival.

Just as there are multiple reasons why youth may become street-involved, there are multiple reasons why individuals may begin to use substances. One of the primary driving forces is mental health problems, which “are not uncommon among homeless youth and frequently occur in combination with one or more substance use disorders” (Zerger et al., 2008, p. 833). While some
mental health disorders may have been pre-existing (such as depression), some mental health disorders, such as post-traumatic stress disorder (PTSD), may have been incurred as a result of abuse incurred before the youth became street-involved. In particular, “a history of childhood sexual abuse increases the risk of substance abuse among homeless youth” (Haldenby et al., 2007, p. 1234). In addition to substance use, self-harm practices such as cutting and burning, may also be employed to deal with mental health disorders.

While in some cases substance use may be to deal with the mental and psychological aspects of life, substance use can also mitigate physical effects of life on the street. Sacol, a glue commonly used to repair shoes in Colombia, is frequently used as an inhalant by street-involved youth in the city of Medellin. Sacol’s popularity is based largely on its affordability and its ability to diminish feelings of cold and hunger for the user. In Winnipeg, solvent users may switch from their usual solvent of choice (such as glue) to inhaling wood lacquer in the winter months. Similar to Sacol, inhaling wood lacquer, more so than other solvents, diminishes feelings of cold in the user.

However, although the use of substances may help to deal with the adverse environment of the street, use of substances also impedes youth’s ability to access services; access to shelters in Winnipeg provide one such example. While there are multiple shelters for the street-involved population in Winnipeg, only one, Main Street Project, allows patrons to access services while under the influence of drugs, alcohol or other substances. Therefore, in winter months, an individual inhaling wood lacquer to diminish feelings of cold would be ineligible to stay in the majority of Winnipeg shelters. This could result in the individual having to spend more time outside in the cold, which would require finding a strategy to stave off the cold, such as inhaling more wood lacquer. For individuals who use substances in order to deal with the elements, this becomes a difficult cycle to break.

In addition to mitigating physical challenges such as hunger and cold, substance use can also serve to numb the mind or body to activities that are harmful or painful. Haldenby et al. describe that “there are reports that a relationship between substance abuse and prostitution among homeless female adolescents exists, which is thought to have adverse consequences for the women’s physical and
emotional health” (2007, p.1234). This relationship between substance use and the sex trade is not limited to females alone. Between 2005 and 2008, Dr. Sue McIntyre conducted a study, Under the radar, throughout Western Canada in order to gain a better understanding of males involved in the sex trade. In the Manitoba phase of the study, the majority of the 40 participants expressed negative feelings towards working in the sex trade; 20% reported “hating” how they felt, 13% felt “nervous”, and 34% felt “dirty” (McIntyre, 2007, p.43).

McIntyre describes that these males involved in the sex trade feel exposed to the public and also, in many cases, must grapple with unpleasant feelings and inner turmoil about the work they are involved in. Therefore, these males numb themselves, psychologically and physically, “to deal with the shame they feel. Substances such as alcohol and drugs help them achieve this sensation of numbness” (McIntyre, 2007, p.43). Substance use is prevalent among street-involved youth in general, but this prevalence is even more elevated among those involved in the sex trade.

Survival sex, the exchange of sex acts for money or in order to meet needs, is a reality for many street-involved youth. In Under the radar, McIntyre describes that none of the 40 participants had the goal of entering the sex trade. Instead, “over 75% saw this activity as a short-term method to make money so they could survive” (McIntyre, 2007, p.36). However, once one becomes involved in the exchange of sex acts for money or basic needs, it can become very difficult to extricate oneself from that lifestyle.

Often, individuals initially become involved in the sex-trade because they are new to life on the street and are attempting to meet their urgent needs, such as food and shelter. In Haldenby and colleagues’ study, the adolescent participants “shared that women are more likely to sell their bodies as a means to meet their various needs, one of which was a place to sleep” (Haldenby et al., 2007, p.1239). Under the radar highlights that this phenomena also occurs with street-involved males, particularly when the males are new to the street or have recently run away. Of the 40 participants, “eighty-one percent of those who had run away were offered food and/or shelter: however, for 73% there were conditions attached to this offer. Most of these conditions were sexual in nature, representing an introduction and entrance into the sexual exploitation trade” (McIntyre, 2007, p.37).
It should come as no surprise that the ongoing struggle to meet basic needs and the resulting inconsistent access to shelter, food, sleep, and safety have an adverse effect on street-involved youth’s health and well-being. Life on the street has many implications for the overall mental and physical health of street-involved youth; from the physical effects of compromised nutrition and substance use, to mental challenges such as high rates of self-injurious behaviours and suicidal ideation (Zerger et al., 2008, p.834). Research has also shown that “poor health outcomes in homeless youth…multiply in number as the duration of homelessness lengthens” (Rew et al., 2005, p.11). While describing all of the potential health risks associated with life on the street is beyond the scope of this paper, a topic of particular significance is the relationship between street-involvement and the prevalence of sexually transmitted infections, and specifically the prevalence of HIV.

Sexually Transmitted Infections and Street-Involved Youth

Physician Lisa Marr posits that, in general, adolescents are more susceptible to the transmission of STI than adults. This is consistent with cases of chlamydia and gonorrhea in Manitoba; the majority of cases occurring among 15–24 year olds (Manitoba Health, 2010, p.5). Marr acknowledges that “although anyone, of any age, can become infected with an STI, teenagers are particularly vulnerable because of lack of information” (Marr, 2007, p.82).

In addition to adolescents’ heightened vulnerability due to lack of information, Rotheram-Borus and colleagues draw from various studies to assert that a number of physical characteristics present in adolescent females further increase this subgroup’s vulnerability. In particular, Rotheram-Borus et al. note that “the columnar epithelium of the cervix is more exposed during adolescence than adulthood and is a primary site for chlamydia and gonococcal infection” (Rotheram-Borus, O’Keefe, Kracker & Foo, 2000, p.18). Furthermore, “the immune-protective factors of the cervical mucus do not fully develop until 2 to 3 years after menarche” (the first menstrual cycle) (Rotheram-Borus et al., 2000, p.18). This means that sexually active adolescent females who have not yet menstruated, or are within a few years of their first menstruation, are one of the groups most vulnerable to contracting an STI.
In the general population of Canada, “by age 14 or 15, about 13% of Canadian adolescents have had sexual intercourse” (Statistics Canada, 2005, p.11). However, “homeless youth are more apt than their housed peers to be sexually active and to have started having sexual intercourse 2 to 3 years earlier than other adolescents” (Zerger et al., 2008, p.830). The age of sexual debut is of importance because “the sooner that young people start having sex, the longer they are exposed to the risk of…contracting a sexually transmitted infection” (Statistics Canada, 2005, p.9). Furthermore, “the younger a woman begins penetrative sex, the greater her risk of infection due to the danger of tearing of the vagina” (Whiteside, 2008, p.45). This logic may also be applied to males; the earlier a male engages in penetrative sex, the more likely tearing may take place that could facilitate exchange of bodily fluids.

One of the most effective methods to prevent transmission of STI during sex is through the use of condoms. However, multiple studies have documented that condom use is not normative amongst street-involved youth (Zerger et al., 2009; Rotheram-Borus et al., 2000; Ensign & Santelli, 1997; Rew et al., 2002). This no doubt has contributed to the rates of STI infection among homeless youth being “3 to 10 times higher than rates among their housed counterparts” (Zerger et al., 2008, p.830).

The incidence of survival sex among the street-involved population also plays a role in the elevated rates of STI. Haldenby et al. describe that because “homeless adolescents are often forced to engage in ‘survival sex’…as a result, these adolescents might have more sexual partners than the adolescent population in general” (2007, p.1233). Additional studies also discuss that street-involved youth’s engagement in both the sex trade and unprotected sex are consistently associated with HIV (Zerger et al., 2008; Rew et al., 2002). Compounding the risk of individuals involved in the sex-trade becoming infected with an STI through unprotected sex, these individuals are also at heightened risk for sexual violence, such as rape (Haldenby et al., 2007; Zerger et al., 2008). Any time there is sexual violence, there is an increased chance of ripping or tearing in the victim being assaulted. This, in turn, facilitates a higher risk for transmission of infected body fluids.
Existing rates of STI, such as chlamydia, gonorrhea, and herpes, can also play a significant role in terms of HIV infection and prevention. Even outside of the street-involved population, STI are becoming increasingly prevalent. For example, in the United States, “by the age of twenty-four, one of every three sexually active people will have a sexually transmitted disease” (Hyde & Forsyth, 2007, p.81). As Whiteside explains, STI which cause genital ulcers and sores “create a portal for the virus to enter the body, and at the same time the presence of the cells HIV seeks to infect, CD4 cells and macrophages, is increased” (Whiteside, 2008, p.42). Therefore, the ability to recognize the potential symptoms of an STI, and ability to access testing and treatment are valuable assets to prevent the transmission of STI, particularly HIV. In fact, Rotheram-Borus et al. go as far as to declare that prevention, detection, and treatment of adolescent STIs is not only valuable, but essential to HIV prevention in adolescents (2000, p.18)

Evaluation of Harsh Reality: A Personal Response

As evidenced in the existing literature about rates of sexually transmitted infection amongst street-involved youth, a preventive intervention to share information about how this population might reduce the risk of STI transmission is of great value. To this end, Harsh Reality provided one such intervention. Conducting an evaluation of Harsh Reality provided the basis for my Master of Education thesis (available on DSpace, reference information included). While discussing the specific research questions, methodology, data and analysis is outside the scope of this paper, I would like to share what has become, to me, the most valuable component of the evaluation.

To begin to sort through the data from the 100 individual interviews and 3 focus groups, I created Excel spreadsheets to organize the responses. Each evaluation question had a separate sheet in the Excel workbook, each row and column neatly labeled. It was, I think, a tidy and organized strategy for organizing the data. But as I looked over my pages of spreadsheets to do the analysis, I couldn’t help but feel like they were…flat. I could just tell there was something missing. Of course, the squares were neatly filled up with data; but I felt as if the data was talking around the subject of STI prevention for street-involved youth instead of engaging in it. In looking at the spreadsheets, I did not
feel like the consecutive tidy rows of cells and compartmentalized topics reflected the kids I had talked to. Their lives weren’t neat or orderly. Their lives were messy and chaotic and no one variable could be isolated from anything else. Odd as it may sound, I felt like the data had no spark; it had no heart.

I began to think about how I could make the data capture the vibrancy of the street-involved youth who had participated in the evaluation, and how I had been changed by the experience of spending time with them. I did not feel moved by looking at the spreadsheet. I did, however, feel moved by listening to the youth’s stories during the interviews and focus groups. As a result, I returned to the focus group transcripts and created a Word document summarizing all of the “filler” comments; comments that were not specifically answering an evaluation question, but that provided valuable contextual information about the lives of these youth.

To me, this document has become the heart of this evaluation. In preparing my presentation for the Graduate Student Symposium in March, 2011, I wanted to incorporate my discovery of this crucial element of the Harsh Reality evaluation. I contacted an artist I met in Medellín, Sir Oliver Zamora Suaza, and asked if he might be able to create a piece of art that embodied these contextual “filler” comments. The following are the images Oliver created based on the participants’ words: *Figure 3* Image to represent street-involved participants’ context and experiences.
(Used with permission, Zamora Suaza, 2011)

Figure 4 Image to represent street-involved participants' context and experiences.
In order to help the audience at the Graduate Student Symposium understand the words that the images were representing, I chose some of the comments I thought were most powerful to display surrounding one of the images.

*Figure 5* PowerPoint slide from Graduate Student Symposium presentation 2011

(Used with permission, Zamora Suaza, 2011)

To me, the document summarizing the participants’ experiences is the most valuable thing I have learned from participating in this evaluation. While, of course, I have learned tremendous amounts about program evaluation, and data collection and analysis – learning more about the population of street-involved youth in Winnipeg has been the experience that has changed me. If data analysis had consisted of spreadsheets and Word documents alone, I think I would have missed the most important component of the evaluation. I can recite statistics and facts about rates of sexually transmitted infections and list challenges and benefits of a harm reduction approach, but I will never be able to design a resource for street-involved youth if I don’t engage meaningfully with street-involved youth. A wise friend of mine once told me that she thought it was unethical for researchers to work with vulnerable populations and not be, at least somewhat, emotionally invested in them. I would have to agree, but I can also see how it happens. That is not to imply that all data “has no
heart”. But data divorced from the context of the participants can limit one’s ability to connect, on more than a purely cerebral level, with one’s research topic.

This idea of interconnectivity is central to HIV/AIDS education. We can’t go and teach kids AIDS related facts without considering the context of the learners. We can’t slap a “wear a condom” message on a billboard and expect transformative behavioural change without talking to people to understand why they aren’t using condoms. Life is messy. Nothing is neat and linear, and rarely does one aspect of life exist in isolation. Clearly, it is not pragmatic to suggest that an HIV/AIDS education program could aspire to address all aspects in the context of its target audience. But certainly, designing programs and interventions blind to the context and influences and interconnectivity of people’s situations will only achieve fractions of the success possible if these factors were acknowledged.

In my very first class of the graduate program, I was assigned to read Pedagogy of the oppressed by Paolo Freire (2007). I found the book transformational, and have quoted it in almost every paper I’ve written during my time in the program. Freire does not gently encourage, but rather implores educators to engage in partnership with oppressed populations in order to facilitate their education, and through education, their liberation. Winnipeg’s street-involved youth are the type of oppressed population that Freire is referring to. Marginalized and vulnerable, they are at heightened risk for violence, exploitation, mental health disorders, health concerns such as sexually transmitted infections, and even death. Educational initiatives such as Harsh Reality offer an opportunity to partner with this population, to create meaningful opportunities for education, and an opportunity to create space for this population’s unique voice. Freire describes that “no pedagogy which is truly liberating can remain distant from the oppressed by treating them as unfortunates” (Freire, 2007, p.54). Rather, it is only by learning about a population’s lives and experiences, and through the sharing of ideas and dialogue to see what the population knows and wants to know that truly effective and liberating education can take place.
References


