Direction de santé publique
Agence de la santé et des services sociaux de Montréal

Pregnancy and contraception among Montreal street-involved girls

Focus Groups

GARDER notre monde ENSANTÉ

Québec

Direction de santé publique
Agence de la santé et des services sociaux de Montréal

Pregnancy and contraception among Montreal street-involved girls

Focus Groups

Nancy Haley
Véronique Denis
Élise Roy
Gabriel Gervais

2009

GARDER notre monde ENSANTÉ

Agence de la santé et des services sociaux de Montréal
Québec

Produced by the Healthy Schools and Communities sector
Direction de santé publique
Agence de la santé et des services sociaux de Montréal
1301, rue Sherbrooke Est
Montréal (Québec) H2L 1M3
Telephone: 514 528-2400
www.santepub-mtl.qc.ca

Collaboration
The authors acknowledge with appreciation the contribution of many individuals and organizations who helped us realize this research project: our collaborators Louise Charbonneau, Guylaine Cyr, Mireille Lajoie and Edith Guilbert; all partner organizations that welcomed and helped us recruit young girls; Natalie Kishchuk, who facilitated the focus groups and contributed to the data analysis; Sylvie Gauthier for her translation skills; and Christine Guigue for her precious secretarial work. Finally, we wish to thank all the street-involved girls who generously accepted to participate in the study and share their experiences with us. We are very honoured and extremely grateful to have learnt so much from them.

*The present study was funded by Human Resources and Skills Development Canada (*Supporting Communities Partnership Initiative – SCPI*) and Health and Social Services Quebec (Direction générale de la planification stratégique et de l'évaluation et de la gestion de l'information – DGPSEGI).*

ORIGINAL TITLE
Étude sur la grossesse et la contraception chez les jeunes filles de la rue.
Rapport sur les groupes de discussion (2005)

ISBN 978-2-89494-855-2 (print version)
(Original version: ISBN 2-89494-470-5)
ISBN 978-2-89494-856-9 (PDF version)
Legal deposit – Bibliothèque et Archives nationales du Québec, 2009
Legal deposit – Library and Archives Canada, 2009

Price: $10.00

Table of contents

TABLES

Summary

Although the rate of unplanned pregnancies is very high among young women living on the streets, very few studies have examined this issue. The goal of this study was to explore the significance of pregnancy among female street youth and to understand their experiences with contraception in the specific context of street life. We also wanted to learn more about their use of sexual health services, with the ultimate goal of improving sexual health education and prevention activities among this clientele.

To attain our research objectives, we chose a qualitative methodology, using focus groups to gain insight about the experiences and perceptions of the participants. Seven focus groups were held and 34 street-involved young women, aged 14 to 21 years old, participated. Groups were divided according to whether they had experienced pregnancy or not.

Among these street-involved girls, the importance that pregnancy holds in their lives varied considerably. While a minority of these adolescents never thought about the possibility of pregnancy, another minority wanted to become pregnant and perceived it as a life project. However, the great majority of the young women interviewed wanted to avoid pregnancy until a much later stage in their lives. Most agreed that their current living environment and lifestyle were incompatible with a healthy pregnancy and that several conditions must be met before considering it.

Despite young street women's determination to avoid pregnancy there was a great incoherence between their attitudes and their actions. Many contextual barriers impacted their ability to use contraception effectively. As well, some beliefs and misconceptions about fertility limited their use of effective contraception.

Results concerning sexual health services demonstrate that young street women are very satisfied with the sexual health services specifically designed for them. However, adolescents who had a history of pregnancy identified several negative points regarding sexual health services. Young women felt that clinic staff pressured them to have an abortion, as if this option was the only one available to them. As well, the adolescents felt they were judged negatively if they had repeat abortions. Few youth felt that clinic staff

allotted enough time to exploring the difficulties they had finding a contraceptive method that was compatible with their lifestyle and beliefs.

Participants offered several practical solutions for health staff to enhance ways to improve sexual health promotion and services for street-involved girls:

1. Provide individual counselling to explore the reasons for discordance between attitudes and actions concerning pregnancy prevention.

2. Verify attitudes, knowledge and beliefs of youth and the youth counsellors working with them related to different types of contraception .

3. Increase access to information on new types of contraceptives.

4. Increase availability of preventive materials such as lubricants and condom holders.

Their suggestions will serve as a basis to develop interventions in youth clinics and youth community organisations to improve sexual health among vulnerable young women more effectively.

Chapter 1
Research question

1.1 Introduction

During the last decade, the number of youth living and working in the streets of large North American cities has been increasing. In Montréal, an estimated three to four thousand young people live on the streets, (Fournier and Chevalier, 1998), and about a third of them are girls (Roy, Haley, Leclerc, Lemire, Boivin, Frappier and Claessens, 2000). These young people end up on the streets for many different reasons and their precarious lifestyle often includes risky behaviours such as polydrug consumption and unsafe sexual practices (DeMatteo, Major, Block, Coates, Fearon and Goldberg, 1999; Roy, Haley, Lemire, Boivin, Leclerc and Vincelette, 1999; Roy et al., 2000; Noell, Rohde, Ochs, Yovanoff, Alter, Schmid et al., 2001; Roy, Haley, Leclerc, Boivin, Cedras and Vincelette. 2001; Haley, Roy, Leclerc, Lambert, Boivin, Cedras and Vincelette, 2002). For young female adolescents, living on the streets can have serious consequences on their health. Sexually transmitted infections, unplanned pregnancies and exposure to abuse and violence (Roy, Haley, Lemire, Boivin, Leclerc and Vincelette, 1999; Roy et al., 2000; Haley, Roy, Leclerc, Lambert, Boivin, Cedras and Vincelette, 2002) are very common among these young girls. (Haley et al., 2002; Haley, Roy, Leclerc, Boudreau and Boivin, 2004). Pregnancy rates are higher among young women living on the streets than among any other group of adolescents (Greene and Ringwalt, 1998).

In the United States, it is estimated that about 10% of adolescents in the general population have unplanned pregnancies (Kaiser Family Foundation, Hoff, Greene and Davis, 2003). In Canada, the annual rate among young girls under 20 years of age was almost 4% in 2001 (Statistics Canada, 2005). Among homeless female adolescents in the United States, about 50% of girls aged 14 to 17 reported having been pregnant (Greene and Ringwalt, 1998). In Vancouver, Canada, 55% of homeless female adolescents aged 12 to 18 reported having been pregnant (Tonkin, Peters and Murphy, 1994), while in Montréal, the figure is 42% among girls aged 14 to 19 (Haley et al., 2004). It is not uncommon for female

street youth to have had more than one pregnancy (Haley, Roy, Leclerc, Lambert, Boivin, Cedras et al., 2002; Halcon and Lifson, 2004).

How do we explain these high pregnancy rates among young women living on the streets? Studies draw attention to the high frequency of risky behaviours associated with unplanned pregnancies in this population (Kral, Molnar, Booth and Watters, 1997; Ensign and Santelli, 1998; Roy, Haley, Leclerc, Lemire, Boivin, Frappier et al., 2000; Haley, Roy, Leclerc, Lambert, Boivin, Cedras et al., 2002; Rew, Chambers and Kulkarni, 2002; Halcon and Lifson, 2004). Being sexually active at a young age, having numerous sex partners, irregular or improper use of condoms or other contraceptives, as well as problematic alcohol or drug consumption associated with sexual activities are often documented in this vulnerable population (see Appendix 1 — Literature Review).

To come to a better understanding of why pregnancy rates are so high among street adolescents, it is important to examine the contexts in which these risky behaviours occur. It is essential to understand the attitudes of homeless young girls towards pregnancy and contraception and the barriers they face living in such precarious living conditions. This information will enable us to be more aware of the context and explore with them practical solutions to improve their sexual health and well-being.

1.2 Study objectives

The objectives of this qualitative study were to

1) Explore the meaning of pregnancy for adolescent street-involved girls in Montréal;

2) Examine the difficulties with contraceptive use in the context of street life;

3) Describe the particular strategies street-involved girls use to avoid getting pregnant as well as their knowledge of and attitudes towards different types of contraception;

4) Document their utilization of sexual health services for contraception and pregnancy, as well as their opinions about how to improve sexual health education and care.

Chapter 2
Methodology

The focus group research method was chosen to encourage participants to talk among themselves, to ask themselves questions, and to comment on their peers' statements (Kitzinger and Barbour, 1999; Rice and Ezzy, 1999; Robinson, 1999). In this manner, each participant can compare and contrast his or her point of view with those of others, which provides the advantage of generating an abundance of data.

The research protocol was approved by the Institutional Review Board at McGill University's Faculty of Medicine.

2.1 Selection criteria

The population of interest in this study was young women living on the streets of Montréal. To be eligible, participants had to 1) have looked for a place to sleep more than once in their lifetime (separate episodes) or have visited community groups helping street youth regularly (more than three times); 2) be between 14 and 22 years of age inclusively; and 3) have been sexually active.

To foster a better understanding of pregnancy and contraception among homeless young women, focus groups were organised around a strategic variable: history of pregnancy. We conducted focus groups with adolescent girls living on the streets who had never been pregnant (NP: never pregnant), that is, who had never had miscarriages or abortions, or who had never given birth, and other groups with young women who had had at least one pregnancy (EP: ever pregnant), regardless of the outcome. This approach guaranteed a certain homogeneity within each group. Findings are discussed globally unless significant differences were expressed by those with a history of pregnancy (EP) and those who had never been pregnant (NP).

2.2 Recruitment strategy

The recruitment period extended from February to April 2005. We used three strategies to recruit homeless young women into focus groups. Firstly, we sought the cooperation of a research group that had been working with street youth for several years (the Montréal Street Youth Cohort led by Roy et al.) and of various downtown Montréal community groups targeting street youth: Le Bon Dieu dans la rue, En-Marge 12-17, Regroupement des infirmières de proximité, CLSC des Faubourgs youth clinic, les Pairs Aidants and Passage (see Appendix 1 for the list of partners). Staff from the groups were asked to talk to the young women they met. A poster advertising focus groups on the issues of pregnancy and contraception was put up on the premises of each of these organisations (Appendix 2). Young women who were interested in participating were then asked to call the research agent. The cooperation of these various groups was extremely valuable to our study.

The research agent also recruited participants in the field. A week before the focus groups were held, she went to two Dans la rue sites — the Bunker (Dans la rue's shelter) in the morning, and the Chez Pops day centre in the afternoon — to talk to adolescent girls about the study and ask for their participation. It is important to note that a lot of youth go to the day centre.

Finally, we also used the "snowball" strategy, which consisted in asking young women encountered in the field or who participated in a focus group to refer other adolescents who may be interested in participating.

When the research agent came into contact with a young girl, most of the time in person but also sometimes over the telephone, she would explain the study objectives and what happens during a focus group, as well as the fact that the groups are anonymous and confidential in nature. She also told them they would be given $25 in compensation and to thank them for participating in the study. If a young woman indicated she was interested in participating, a recruitment form (Appendix 3) was completed to ensure that she was eligible and to assign her to the appropriate focus group (has or has never been pregnant). The research agent then gave her a small card on which was written the date and time of the focus group. The day before each focus group, the research agent telephoned the young women to remind them of the appointment or left them a message in a place where they were likely to get it.

Seven focus groups were held: four with homeless young women who had never been pregnant, and three with adolescents who had. In all, 34 young girls participated.

2.3 Facilitator and discussion guide

A key element for the success of the focus groups was how it was led. A facilitator who leads a group has a great deal of influence on the quality and validity of data that stem from these exchanges (Rice and Ezzy, 1999). For this reason, we entrusted the focus groups

to Ms. Natalie Kishchuk, who has much experience in this area. We met with her a few times beforehand to discuss the best way to organise the groups and to develop a discussion guide.

The discussion guide was elaborated in advance, based on the research question and objectives. It was then submitted to our partners for validation (Appendix 4), which enabled us to improve it. The second version of the guide was validated with two young peer helpers from Pairs Aidants who are themselves ex-street youth. Again, this consultation enabled us to make changes. We should mention that following the first two focus groups, we needed to revise the guide and reformulate certain questions since we had observed that some of the questions led to confusion while others did not help us meet our research objectives. Therefore, the final version of the guide (Appendix 5) was used for the five subsequent groups. The guide was divided into three parts. The first was on pregnancy in general and in the context of the streets. The second dealt with contraception in the context of the streets, and the third raised the issue of services linked to pregnancy and contraception.

2.4 Focus groups procedure

The focus groups were held at the Chez Pops day centre (six groups) and at the Bunker (one group). These sites were chosen because they are well known to street youth and the youth feel comfortable there. Moreover, both sites allow young people to bring their dogs, which is a considerable advantage given that many of them have dogs.

The seven focus groups were arranged into four sessions. The four groups for homeless girls who had never been pregnant all took place mid-morning. Although, at first glance it could seem difficult to hold focus groups with street youth in the morning, this constraint did not appear to bother the participants, either at time of recruitment or on the day of the meeting itself. The three groups for street-involved girls who had been pregnant before were conducted in the early afternoon.

The focus groups lasted between an hour and a half and two hours. When they first arrived, participants were asked if they wanted a snack (juice, muffins, granola bars), and to read and sign the consent form (Appendix 6). After the facilitator went over the study objectives and how the meeting would proceed, the discussion began. Sessions were tape recorded, with the agreement of the participants. During each session, the principal researcher and the research agent were there to observe the group and take notes. At the end of the discussion, participants completed the "Participant profile" questionnaire (Appendix 7) with the help of the research agent or principal researcher, and signed a form certifying their presence (Appendix 8), after which we gave them $25 in compensation and to thank them for their participation.

After each group met, the facilitator, researcher and research agent got together to go over important points in the discussion and to suggest changes, if required, to improve the process or productivity for the groups that followed.

2.5 Data analysis

To begin with, the focus group cassette tapes were transcribed in full by a professional transcriber. The research agent then revised and corrected the transcriptions to ensure their accuracy, especially in relation to the expressions and vocabulary particular to street youth.

Next, since qualitative data from the focus groups were analysed using NVivo, data were imported into the software and encoded to correspond to the structure of the interview schedule. The research team reviewed the initial coding and then, using NVivo, focus group transcriptions were encoded using the revised coding structure. In the course of the coding process, categories and links among categories were added and refined based on analysis results. In other words, the qualitative data analysis was both deductive and inductive.

Quantitative data derived from the "Participant profile" questionnaire were compiled and analysed with SPSS.

Chapter 3
Results

3.1 Participation

Study participation rate was high. A total of 42 young women were recruited, 34 of whom participated in focus groups. In general, only one or two of the participants who were scheduled to attend each focus group failed to show up. On more than one occasion, all the adolescents recruited to a group were present.

The focus groups proceeded very well. Overall, the dynamics among participants were very good and participants were mostly open and respectful, and paid attention to whoever was speaking. They were very comfortable sharing their points of view and experiences, and listening intently to the others. Most participants took an active part in the discussion. Some girls were less talkative and more reserved and, consequently, the facilitator tried to help them engage in the discussion. The discussion turned to sexual aggression more than once, a subject that was too sensitive and emotional for some participants and which required the facilitator to step in. In addition, two participants had obviously consumed some type of substance before coming to the session; however, this did not seem to have had a negative effect on the other participants or on the discussions.

3.2 Profile of participants

As can be seen in Table 1, the 34 focus group participants were between 16 and 22 years old. Adolescents who had never been pregnant (average age: 18.6 years) were slightly younger than girls who had been pregnant before (average age: 19.6 years).

Table 1 — Age of participants

Age	Has never been pregnant	Has been pregnant	Total
16 years	1	0	1
17 years	3	2	5
18 years	6	2	8
19 years	4	3	7
20 years	1	3	4
21 years	2	6	8
22 years	1	0	1
Total	18	16	34
Average age	18,6	19.6	19.1

The sociodemographic characteristics in Table 2 show that about 40% of participants were born in Montréal or its suburbs, and that almost half were from other cities in Quebec. Most participants reported they were from an "average" socioeconomic background.

Table 2 — Sociodemographic characteristics of participants

Characteristic	n (%)
Place of birth	
Montréal	10 (29.4)
Suburb of Montréal	4 (11.8)
Elsewhere in Quebec	16 (47.1)
Elsewhere in Canada	3 (8.8)
Outside Canada	1 (2.9)
Socioeconomic background, as perceived by the participants	
Well off	8 (23.5)
Average	15 (44.1)
Poor	11 (32.4)

Close to half of participants were between 13 and 15 years old the first time they had to look for a place to sleep (Table 3). Half of the girls were between 16 and 18 years of age when they first came into contact with services for street youth.

Table 3 — Age of participants the first time they were on the streets

Caracteristic	n (%)
Age the first time they had to look for somewhere to sleep	
12 years old and under	3 (8.8)
13 to 15 years old	16 (47.1)
Between 16 and 18 years old	14 (41.2)
19 years old and over	1 (2.9)
Age the first time they used services for street youth	
12 years old or under	3 (8.8)
13 to 15 years old	10 (29.4)
Between 16 and 18 years old	17 (50.0)
19 years old or over	4 (11.8)

Table 4 presents the participants' sexual history. It shows that almost half started being sexually active between the ages of 14 and 16 (47%). It should be noted that the proportion of girls who were 13 years old or younger the first time they had sexual relations is also very high (44%). In this table we can also see that 44% of participants determined they had had 11 to 50 male sexual partners in their lifetime, and that 24% estimated they had had over 50.

Table 4 — Sexual history of participants

Characteristic	n (%)
Age at first sexual relation	
13 years old or under	15 (44.1)
14 to 16 years old	16 (47.1)
17 years old or over	3 (8.8)
Number of male partners (lifetime)	
< 11	11 (32.3)
11 to 50	15 (44.2)
> 50	8 (23.5)

Table 5 — Outcome of participants' pregnancies

Outcome of pregnancy	Total
Medical abortion	9
Self-induced abortion[1]	6
Miscarriage	9
Live birth[2]	3

1 By over consumption of alcohol or drugs.

2 One participant was pregnant during the study and is not counted in the table.

The next three chapters present the focus group analysis. Chapter 4 looks at pregnancy from the perspective of homeless young female adolescents; contraception and contraceptive use are the subjects of Chapter 5; and Chapter 6 examines young street-involved girls' experiences with sexual health services. A discussion of the study results then follows.

It is important to note that there were few major differences between the attitudes of young girls who had never been pregnant and those who had. For this reason, the results group together both types of experiences [never been pregnant (NP), ever been pregnant (EP)]. Distinctions that needed to be made based on history of pregnancy are clearly indicated in the text.

Chapter 4
Pregnancy experiences of street-involved girls

4.1 A situation to avoid

For the most part, pregnancy was an important concern for most participants in the study. Both groups — those who had been pregnant in the past (EP) and those who had not (NP) — considered it as something to avoid. Pregnancy was perceived as something that would hinder their present lives. It is interesting to note, however, that such concern for pregnancy did not always translate into disciplined use of contraceptive methods. Only a minority of participants (all of whom had never been pregnant) were not concerned with pregnancy. A very small minority stated that pregnancy was a project for them in the near future.

The participants were unanimous when speaking of the incompatibility of raising a child while living on the streets. According to them, stopping alcohol and drug use, becoming responsible towards oneself and others as well as maintaining stability in finances, housing and with their partner were all conditions that were required before considering having a child.

4.2 Why do certain street-involved girls become pregnant?

Many reasons were given by the participants to explain the high rates of unplanned pregnancy in the street youth population.

Accidents

"*Accidents*" were an often-cited reason. According to the participants, this would explain most pregnancies. First, they spoke of "accidents" due to the failure of their contraceptive method. This situation is exemplified by the following accounts:

> "*The first time I became pregnant, it's because the pill didn't work for me. […] And my boyfriend said "we're gonna use a condom", the condom broke, I'm pregnant! […] People'll say that it's cause you're not responsible, you know, and you didn't watch out. No! Look, accidents happen.*" (Group 2: EP*)

> "*Well [contraception] it's not a 100%. It's not fail-safe, that's what we're saying, it's not fail-safe. Look at those girls, the morning after pill didn't work.*" (Group 2: EP)

> "*Yeah, the condom didn't work, the morning after pill didn't work, two big number ones that didn't work!*" (Group 2: EP)

Secondly, there are "*accidents*" due to the improper use of contraceptive methods or forgetting to use them:

> *"You know, like me, it was accidents. I forgot to take the pill for two, three days, I don't remember, bang! I'm pregnant. The condom broke, bang! I'm pregnant. The damn withdrawal method that doesn't work, bang! I'm pregnant."* (Group 2: EP)

Lack of responsibility

According to many participants, in particular those having never been pregnant, street-involved girls lack responsibility vis-à-vis pregnancy and contraception:

> "*That, I think, is being irresponsible. Street kids, it's not everyone who's gonna think of it. I didn't give a shit for a long time. I don't even know how I woke up. You know, one day I went "Ah!" by myself, you know. It's really a personal thing.*" (Group 4: NP*)

As related by some participants who had been pregnant, it is sometimes difficult, in the heat of the moment, to think of contraception and to put a stop to intercourse if no condom is used.

No future

During a group discussion, participants spoke of the "no future" movement, a movement in the street youth community according to which the youths live a day at a time, disregarding the future and the short or long-term consequences of their actions. As demonstrated by the following quote, the "no future" movement is directly linked to a certain carelessness pertaining to the risks of pregnancy:

* EP: Ever pregnant; NP : Never pregnant

> "*It's like just the "no future" type, I don't give a fuck 'bout anything! and, like, we'll see tomorrow morning like, you live one second at a time and it's like not really important. Same thing with drugs and everything, even if you have hepatitis C and you're all messed up, who cares, there's always tomorrow!*" (Group 3: NP)

Drug use

Drug consumption also seems to contribute to this "day-to-day" mentality, making contraception and pregnancy of minor importance.

Catalyst for change

Although pregnancy is widely considered a hindrance, some street-involved girls see it as a catalyst for change; this was, however, the subject of much debate amongst the participants. Some believed, based on an acquaintance's or a friend's experience, that pregnancy could have a positive effect:

> "*It can change someone's life cause… I knew a girl who was taking lots of drugs and then, well, she got pregnant and then she stopped taking drugs and she realized that there were other things in life. Now, well, she spends her life giving to someone.*" (Group 4: NP)

Meanwhile, others think it is very unlikely that pregnancy can have a positive effect. In fact, the participants who had brought their pregnancy to term were the most sceptical:

> "*Like me, that's what I was thinking, like "Ah, as soon as give birth, I'm gonna have a job, and I won't have to go to shelters", but it didn't work the way I wanted it. You know, I thought that even pregnant, I'd be able to find a job and that I'd have lots of cash and…No, it doesn't work that way.*" (Group 2: EP).

Fills an emotional void

Pregnancy was also seen among the participants as a means to fill an emotional void. This became an important subject of discussion in many of the meetings:

> "*So, you know, I think, the kids who're in the streets, it's cause they're lacking affection, they're lacking attention, they weren't educated, all those problems of the past. In a way, having a baby for half those people is a solution. You solve everything, you'll have attention, you'll be loved unconditionally, you'll have everything you've never had before in your life.*" (Group 7: EP)

One participant expressed the profound desire to become pregnant and have a child in the near future. This would allow her to receive and give unconditional love:

> "[…] *It's what I want most in the whole world, it's to have a child. You know, it's a little selfish cause a baby'll love you unconditionally right. It's like "this is my mother" you know. It's just having someone who'll love me for real, you know, he won't say "I love you" because he wants something, but because it's really what he thinks. […] Cause I have love to give, and I need love, and, the love a guy can give, it's nothing in comparison.*" (Group 7: EP)

One participant also pointed out that not only adolescent street-involved girls but adolescent girls in general often have a child in order to have a loving relationship:

> "*Not only in the street, it's the main reason of the young women, the mothers who have children too young. It's the main reason. They need someone to love and who'll love them back. Usually, when you're pregnant and you decide to keep it, it's the main reason.*" (Group 5: P)

Sexual abuse

Pregnancy can also result from sexual abuse. At the specific request of one participant, the animator changed the topic of discussion. Clearly, the subject of sexual abuse is a delicate one amongst street-involved girls. The group discussion format did not offer a propitious context to explore the issue further. Considering that many adolescent street-involved girls are victims of sexual abuse, it is certainly an issue that requires more study to better understand unplanned pregnancy in this population.

4.3 Support for pregnant street-involved girls

The participants also discussed support for pregnant street-involved girls; although material support was often cited, moral support seemed to be of most concern:

> *"Well, it's someone who won't start by telling you, you know like, "do this or do that", someone who'll encourage you in what you really want. […] Well, you know, someone positive who'll encourage you in your decisions. He'll support you and encourage you. He'll support you and he'll always give you his time and help. He'll always be there to listen.*"
>
> "*It's moral support, really.*" (Group 4: EP)

Friends

According to the study participants, there are many means of moral support. Friends are at the core of the moral support system of many participants:

> "*I have a very good group of friends. They give me moral support. Like, when I was pregnant, they were always there for me and when I needed something, I don't know, anything, they'd help me get it. All sorts of things like that.*" (Group 2: EP)

Youth workers

Street youth clinic and community youth resources provided considerable moral support for girls in Montréal.

> *"I'd go to the Bunker. Since I was 11 or 10, I go there. They've always been there for me and, like, I think of them more as my parents than my own parents. […] At the Bunker, the staff, they're like my moms and dads. It's funny to say, but they've always been there for me and they're the ones who showed me how to do my laundry, etc. I'd go see them."* (Group 3: NP)

These same resources are said to be of great help in the decision-making process related to pregnancy.

> *"There are always places, like the Bunker, Chez Pops. There are places everywhere and these people can guide you and help you make good decisions to know what to do. They can help all through your pregnancy and give you places to go."* (Group 4: NP)

However, some participants who had experienced multiple unplanned pregnancies cited shame and a feeling reticence to speak of their situation:

> — *Well, I talked about it once when I got pregnant and after I felt it wasn't worth it.*
>
> — And whom did you speak to?
>
> — *Well, with a caregiver I was working on a project with last summer, but the rest of the time, I found it wasn't worth it. You know, when it's been three times that you tell someone that you're pregnant, at one point you get sick of it. Look, you just don't feel like saying it, you figure it out yourself. Anyway, I'm like that.*
>
> — Why didn't you feel like talking about it?
> — *Cause I think it's stupid after let's say three times. […] Well, I found I was a little irresponsible and that it wasn't worth it talking about it. You know, I talked to my boyfriend*

about it, but other people don't have to know. It's my business. (Group 2: EP)

In addition, some participants said they were reticent to speak about their pregnancy to caregivers such as social workers in the formal health care system:

— The first time, I talked about it. So, obviously my mother supported me. After that, well I was fourteen, I went to [Hospital X]. Well, there I met a social worker, I talked about it a little but then I couldn't say everything to the social worker…

— You don't trust them.
— No, you don't trust them, it's not someone you know. (Group 5: EP)

Partners

According to certain participants, partners are not always reliable sources of support for young women who become pregnant. According to them, adolescent boys confronted with pregnancy tend to be irresponsible and are more likely to flee the situation:

"It's a shame, cause I see it happen all the time. I know a bunch of girls who got dumped by their boyfriends: 'Ah, you're pregnant? Bye!' It's a shame, real shame." (Group 2: EP)

Other participants spoke of responsible fathers who had fully assumed their responsibilities towards their child:

"*At our age, I'd say that at last three quarters of the time, the girl ends up alone with the child cause the dad wants to go have fun or something like that. But I know some couples who have had kids, who are 21 and who are responsible. They live together, they work and everything. It depends on the guy too.*" (Group 2: EP)

The role of the partner in the decision-making process surrounding pregnancy and abortion was a subject of debate. Some participants believed the couple should decide, whereas others thought the girl alone had this right:

"*It's done as a couple, that's it. I think those are really couple decisions so, like it or not, maybe the guy thinks about it less often or he's less preoccupied by it cause he's not the one who's pregnant but still he's there, you know.*"

> *"Well, it's my decision too. Let's say I don't want the kid, but he does, well, it's not his choice, it's mine. He can get pissed if he likes, or whatever, I don't care, it's my decision."* (Group 2: EP)

4.4 Choices when faced with an unplanned pregnancy

The context of living on the streets and becoming pregnant puts adolescent girls in a difficult position, as they must make a decision in regards to their pregnancy. The participants spoke eloquently of the importance of acting responsibly:

> "*But then, it's your responsibility to think 'Do I have money?' It's tough but it's like that. 'Do I have money to bring up a child, do I have the time?'"*
>
> "'*Do I have the strength?*""
>
> "*Yeah, that's it, 'Am I responsible enough to look after a kid?' 'Do I have a place to bring up a kid?' You have to be responsible, you know. In both cases—you keep it, you don't keep it—you have to be responsible.*" (Group 2: EP)

Once confronted with unplanned pregnancy, adolescent street-involved girls acting responsibly do not have a multitude of possibilities. In fact, as suggested by this quote, there remains only two possibilities, they can "change their behaviours and pursue the pregnancy" or seek abortion:

> "*[If I'm pregnant in the street] there's no one else but me at that point. There's another one. I better change or I stay as is and then get an abortion. It's one or the other.*" (Group 4: NP)

Among the young street-involved girls we met who had already been pregnant, medical abortions represented the most frequently utilized means of interrupting pregnancy.

For some participants, the choice of abortion was clear. For others, the decision was more difficult and disheartening but they ended up choosing abortion for the sake of the child:

> "*Like it or not, you decided to do it [get an abortion] and you know it's better, and you know that it's the right decision. Anyway, I almost went crazy looking at my baby disappear. It's like…the maternal instinct is still there. It's that, it's not because you got an abortion that you don't like children. Actually, I think it's the opposite. You love them enough to know that you won't put them in shit.*" (Group 2: NP)

As we will see in the following section, some participants confronted with unplanned pregnancy decide to terminate the pregnancy on their own, without the help of medical services. This practice is termed "self-induced abortion".

Abortion by over consumption of illicit drugs

It is apparent that many adolescent street-involved girls put an end to their pregnancy by themselves. Although there was little talk of this in the group discussions, the "profile of the participant" questionnaire revealed it to be a much more common practice. We can appreciate the difficulty for participants to talk about this issue in front of a group. According to the participants, it is not uncommon for street-involved girls who are pregnant, or believe they are, to consume large quantities of drugs or alcohol in order to cause a miscarriage:

> — *Me [when I got pregnant] I was at my mother's. And it happened like that, with one of my boyfriends. I told myself "well, let's go, I'm dating him, it's not that bad" and then I went to tell him. I told him and he laughed at me. I didn't find it funny. So I wanted to get rid of it. I did what I had to. The good old way!*
>
> […]
>
> — What's the good old way?
>
> — *Couple rounds of PCP, lots of alcohol and it causes, in certain people it causes them to have a miscarriage.* (Group 5: EP)

The majority of participants knew about this type of "self-induced-abortion" by using illicit drugs. However, it was considered not only dangerous both for the young girl and for the foetus but also irrational, considering the accessibility of medical abortions:

> "*Sometimes, there are junkies or crackheads who realize that they're pregnant and then they just do more. That, that works, it's crazy, but you destroy yourself at the same time.*"
>
> "*Yeah, there's that. There's that and there's also the fact that the baby can be really, really tough. Then you're gonna mess up your pregnancy, you won't have lost your baby. Then it's gonna be born with all these handicaps, all these things. You know, in the end, you should have gotten an abortion, girl. You can't take care of a child. Can you imagine a mentally retarded one? […]* " (Group 2: EP)

The participants mentioned other forms of "self- induced abortion", such as self-inflicted wounds to the abdomen, inserting objects into the vagina and illegal abortions.

In summary, most girls in the streets are very concerned about avoiding pregnancy. A minority of adolescents simply did not think about the possibility of pregnancy. Conversely, for another small minority, pregnancy occupied a preponderant place and was a life project for the near future. Most young women however perceived pregnancy as something to be avoided, especially in the context of street life. They agreed that their current environment and lifestyle are not compatible with pregnancy, and that if they wish to proceed with a pregnancy, they will need to change their environment and lifestyle, as well as acquire a sense of responsibility, be in a stable relationship and have residential and financial stability.

However, despite their responsible approach to pregnancy in the context of life on the streets, many young women nonetheless become pregnant while living on the streets. Participants mentioned two factors to explain unplanned pregnancies among street adolescents. Some girls become pregnant "accidentally", which is due, in their minds, to the fallibility of contraceptives, their improper utilization and the difficult context of street life. On the other hand, others do not take responsibility for pregnancy prevention and this is often linked to a "no future" attitude. Although the participants did not explicitly mention alcohol and drug consumption, substance use was often linked to "accidents" and failing to act responsibly.

When they got pregnant, most young women we met chose abortion. Only a few participants carried their pregnancies to term, and they did not have legal custody of their children. The focus groups also enabled us to learn about a practice which young street women turn to when they think they are pregnant, that is, self-induced abortion through over consumption of alcohol and drugs. The frequency of this act was unexpected and merits further investigation.

Chapter 5
Use of contraception

Although most adolescents stated that pregnancy is to be avoided while living on the streets, their contraception practices do not reflect their will to postpone pregnancy. The focus groups helped us understand this incoherence by exploring the young women's knowledge, attitudes and lifestyle context.

5.1 Knowledge about fertility

The subject of fertility emerged from qualitative studies and is important to street-involved girls' comprehension of pregnancy and contraception. Most participants were confused as to when during a woman's menstrual cycle she is most fertile. This is exemplified by the following quote:

> "*It's 13, 14 days before the egg forms. So before that, in the end, you're safe, you know. When you've had your period, like to be sure 12 days after you've had your period, you're safe. After, obviously it's more risky cause your egg is already formed."*
>
> *"[…] You know, in the end it's like 11 days before being in your week, you're more at risk of getting pregnant.*"
>
> *"No, I think it's after."*
>
> *"After or before? I thought it was before.*"
>
> *"Before you have, like, less risk. I don't know. I think it's that. Is it?"*
>
> *"Cause, like, I think that when you're in your week, it's the non-fertilized eggs that fall."* (Group 4: NP)

As noted in the "Participant profile" questionnaire, participants where asked a specific question regarding the period of fertility in a woman's menstrual cycle. Less than half the participants answered the question correctly and this in both groups—those who had been pregnant before and those who had not. Therefore, most participants did not know when she is most likely to conceive during the menstrual cycle .

Table 6 — Awareness of peak fertility period

At what moment in a woman's cycle does she stand the greatest chance of getting pregnant?	Has never been pregnant	Has been pregnant	Total
Just before her period	6	3	9
Just after her period	2	2	4
In the middle of her cycle	7	7	14
I don't know	3	4	7
Total	18	16	34

Furthermore, there were mixed opinions concerning the link between fertility during menstruation. According to many of the girls, amenorrhea, i.e. lack of menstruation for a certain number of cycles, indicated an absence of fertility:

> *"Like me, I was always told that if you don't have your period, you can't get pregnant."*
>
> *"But even before you have period, you know, when we were young and we didn't have menstruations, I was told that…"*
>
> *"You can't get pregnant if you haven't had your period like."*

Others mentioned that, contrary to what had been stated, the absence of periods was not a sign of infertility:

> *"It's not because you're not menstruating that you can't get pregnant."*
>
> *"No, that's it, cause you never know when you're gonna be."* (Group 3: NP)

It is important to note that many participants who had never been pregnant in the past questioned their ability to conceive. Some, due to their at-risk sexual activity and absence of pregnancy in the past, wondered about their own fertility:

> *"I don't even know if I'm fertile. Cause if I was fertile, well, I think I would've gotten pregnant pretty often already."* (Group 1: NP)

Others felt confronted with infertility, be it theirs or their partner's:

> *"I think that it'll never come back. Fertility for me, I think it's finished."* (Group 1: NP)

> *"I don't use condoms or anything and I've been with the same guy for two years and I've never gotten pregnant. I never took the pill. My boyfriend, he thinks he's sterile. He thinks that his sperm, that they're aren't enough or…He thinks that he can't reproduce. […] Cause he always stayed a long time with girls and they never got pregnant and he was having sex without condoms."* (Group 6: NP)

5.2 Drug consumption as a disruptor of fertility

The great majority of participants, regardless of whether or not they had ever been pregnant, established a direct link between their lifestyles (especially their drug consumption) and their fertility. According to many participants, drug consumption has disrupted their menstrual cycle and brought on amenorrhea:

> *"[…] When you do a lot of dope, your cycle is fucked up. You don't have your period of a couple months. […] I didn't know that, it had been about four months that I hadn't had my period and I didn't know that happened when you did too much dope. So I was going crazy."*

> *"- Yeah, I went a year and a half without having my period."*

> *"- I was six months without my period."* (Group 1: NP)

> *"[…] But I think that I need some [contraception]. I'm like not having my period. […] I'm not healthy you know. Like I use too much drugs or something."* (Group 3: NP)

Participants made a direct association between drug consumption and reduced fertility, even infertility:

> *"But I think that there are maybe some who, at the same time, if you started young…When it's been a long time you've been taking drugs, you know, I wasn't even regular yet in my cycle and I think my body like grew with the drugs and it like whipped my ovaries."* (Group 3: NP)

This infertility however is reversible, according to the women interviewed. Reducing drug use would render them fertile once more. The presumption that they or their partner

was infertile brought certain young women to neglect contraception, which led, in a few cases, to unplanned pregnancies.

As we can see, the homeless girls' perception of fertility in general, and of their own fertility in particular, modulates their contraceptive practices.

5.3 Use of contraception among street-involved girls

Condoms, the pill and hormone injections were the most frequently used contraceptive methods among the participants. Hormone injection was more common among participants with a history of pregnancy, whereas the contraceptive pill was more popular among participants who had never been pregnant. The majority of participants had used emergency contraception in the past.

Table 7 — Participants' contraceptive practices

	Has never been pregnant n = 18	Has been pregnant before n = 16
Condom use during sexual relations		
1- Always	2 (11%)	4 (25%)
2- Most of the time	6 (33%)	2 (13%)
3- Half the time	0 (0%)	3 (19%)
4- Rarely	2 (11%)	2 (13%)
5- Never	8 (44%)	5 (31%)
Currently using a contraceptive method other than condoms		
1- Contraceptive pill	5 (28%)	1 (6%)
2- Hormone injection	3 (17%)	7 (44%)
3- Contraceptive sponge	0 (0%)	1 (6%)
4- No other method than the condom	10 (55%)	7 (44%)
Not using any contraceptive method, neither condoms nor any other type	5 (28%)	0 (0%)
Have you ever used emergency oral contraceptive (EOC)?		
Yes	10 (55%)	10 (62%)

The importance of contraception in their present lives

The importance given to contraception varied among the participants. For certain participants, contraception was considered very important whilst others were not at all

concerned by it. Contraception use often depends on the context of the sexual partner, as is demonstrated in the following quote:

> *"It's always been important [contraception] in my work with clients. I have had clients, since I was eleven that I have clients, but I always used a condom with clients. Stoned or not, I could be fuckin' stoned, I didn't even know my name like, I knew I needed to use a condom. But with my boyfriends for example, as soon, I was too vulnerable, as soon as I fell in love with him…then I would stop [using the condom]."* (Group 7: EP)

Contraception is seemingly important in the case of casual sexual relations but less so when it comes to more stable loving relationships. Two hypotheses could explain this occurrence: the fact of being in a stable relationship makes the women more comfortable with the idea of assuming a pregnancy if it were to happen; or certain street-involved girls are emotionally vulnerable and discussing the use of condoms with stable partners appears more difficult for them.

Some young women used condoms to prevent pregnancy while others, and especially those with multiple partners, used them mainly to prevent sexually transmitted infections (STI). One of the participants deemed oral contraception useless, especially in a context of heavy drug use.

The following sections examine the most prevalent contraceptive methods used by street-involved girls: condoms, the pill, hormone injections, and emergency contraception. Participants discussed their use (or non-use) of these methods as well as the difficulties encountered with each method.

Views on condoms

Condom use was much discussed in the groups, either as a means of contraception or,as protection against STIs.

Many participants did not use condoms regularly, usually for the following reasons:

Being in a stable relationship led to participants stopping to use condoms for a certain time since they thought the risk of STI transmission was diminished:

> *"Well, cause when you have a stable partner, you know that he's not cheating and you neither. You both know that you don't have STIs and that you're taking the pill let's say, well there isn't much risk, you know. I don't see the need anyway to use a condom when you have a stable partner and that you know that both of you…you don't have the risk of getting a disease."* (Group 4, NP)

Converserly, having short-term relationships implied using condoms essentially to prevent STI transmission.

A lack of trust in the condom's effectiveness often led many young street women to neglect its usage. Certain adolescent street-involved girls preferred not to use any means of protection during intercourse rather than using a condom, which they did not trust.

> *"The second time I got pregnant, I hadn't used anything cause I told myself that it was useless. […] I told myself it was useless since [the first] time, it didn't protect me so…It happens that the condom breaks, it happens regularly that it breaks. So, in a way, what's the use… Most of the time, I don't use a condom and I don't hide it. I'm like that. What happens, happens. In the end, I don't care."* (Group 5: EP)

Lastly, a few participants mentioned they could not use condoms because of a sensitivity or allergy to latex.

> *"I can't use the condom cause I'm allergic to latex and I don't have the money to buy a $5 or $10 condom, you know."* (Group 5: EP)

Problems linked to condom use

Although participants were unanimous when discussing the efficacy of condoms in preventing STIs, they were unsure as to whether or not condoms could effectively prevent pregnancy. They identified many difficulties linked to the use of condoms that could place them at greater risk of becoming pregnant. One such difficulty is improper use by men:

> *"Often, guys don't put them on right."*
>
> *— […]*
>
> *"That's it, usually it's a stupid thing like the guy doesn't pinch the end of the condom and then the pressure builds and it breaks. Sometimes, it's a stupid thing like that, pinching the end of the condom so it doesn't break."*

Another issue is negotiating condom use with men:

> *"I have difficulty asserting myself with guys. I like have a hard time knowing what to say to guys. I'm shy. […] I don't know what I am scared of […] So I don't say anything and I put up."* (Group 4: NP)
>
> *"(…) My boyfriend doesn't feel like it [using a condom]."*

"Yeah, but what about you? You should talk about it first." (Group 5: NP)

Some participants were comfortable negotiating condom use, since they were very concerned about STI transmission:

"Before, he didn't want to wear any. He was like, 'Well, you're taking Depo Provera, you won't get pregnant.' I was like, 'Well look, it's cause I'm not the only girl you've slept with and certainly not the only one you're sleeping with right now. So, I don't feel like catching the shit of Miss So and So, it's like No.'" (Group 2: EP)

The biggest difficulty concerning the use of condoms, however, was breakage. According to the girls interviewed, this happens frequently. We sought to understand the reasons behind this problem. According to many participants, their lifestyle causes decreased vaginal lubrication, which they felt was often responsible for condom breakage:

"You know, it's like, we sometimes use condoms, but we don't always have lube and you know, it's like, the condom, it breaks easier. Anyway, it depends on the girl, but the condoms break easier…" (Group 5: EP)

As well, use of certain drugs causes dehydration and reduces vaginal lubrication:

"Cause, often, it's like, let's say you take pills or whatever, you know you're dehydrated. Your mouth is all dry. If your mouth is all dry maybe it's not only those lips that are dry…"

"Yeah, I know. I've already done the test, I made love on ecstasy, ok. Forget it, it's not just the mouth that's dry." (Group 5: NP)

On the other hand, frequent intercourse, particularly relating to sex work, can have a negative effect on a woman's ability to lubricate:

"I thought maybe too, since I, you know, since I meet a lot of clients. I couldn't lubricate anymore. Inside of me, it was dry, dry, dry. I like the guy, I wanted pleasure and all, but I couldn't come cause I was doing that fifteen, twenty times a day…" (Groupe 7: EP)

Other than lack of vaginal lubrication, the participants talked about frequent breakage of condoms resulting from improper storage due to their street lifestyle.

> *"An old condom that you keep let's say in a bag. And at the bottom of your bag you have two, three needles, you have keys, you have…you know…they're not well stored and then oops! A needle goes through it, you don't see it, you use the condom and, yeah, you're screwed."* (Group 3: NP)

> *"Well, I know that during the winter, when we had our condoms, they would break all the time, since they would freeze. (…)"* (Group 6: NP)

Because of this concern, participants described a trick that they used to verify the quality of their condoms:

> *"In winter, we would go get them [the condoms] when we needed some. We would keep them in a good pocket that was real close, that would keep them warm. And we would check: if there's still air, it's still good. You just have to remember to check them. […] Well when it's in the packet, there's air inside, when there isn't air left, if you can like touch both sides of the packet, it's no good. There has to be air for the sides not to touch."* (Group 6: NP)

Finally, some participants felt that the condoms provided by resource centres were not always of good quality, which participants thought could explain their frequent breakage:

> *— There are some coloured ones. One time, I don't know, do you remember, in the resource centres, it was all coloured condoms.*
>
> *— Yeah… there were fancy condoms.*
>
> *— […] the Latex, you know the Latex brand, but I know they were colour condoms and they were everywhere. […] Yeah, they were condoms but it was cause of the colouring they put in it. It would make them less resistant. So during that time, a lot of people would come and say, 'My condom broke, don't take the coloured ones!'"* (Group 3: NP)

Hormone injection (Depo Provera)

Hormone injection was a subject of much debate among participants. Opinions of this contraceptive varied considerably. However, participants who were using hormone injections at the time considered it a satisfactory:

> *"And hooray for Depo Provera!"*

"It's the only thing that works in my case, you know." (Group 2: EP)

"I told myself I was gonna get the Depo. You know, at that time it was like, I was really happy cause I didn't need to think of it. Then I would go to the CLSC every three months and it was like perfect for me cause I didn't need to think of it. I had, like, the rest of my mind at peace." (Group 3: NP)

Some participants said they were unable to live with the side effects of this method:

"I never had any problems. I was told that people who took it would gain weight, I didn't gain any…I didn't lose any, I didn't gain any." (Groupe 5: EP)

Others said they had had problems with hormone injection that caused them to abandon the method:

"I tried Depo Provera and it was a lot, a lot of problems so I happily, with a smile, asked not to use it."

"Me too." (Groupe 5: EP)

Whether or not they had used hormone injections, many participants expressed reticence towards this method. The young women criticized the imbalance it caused in their menstrual cycle. In their opinion, not menstruating, as is generally the case when using hormone injections, is far from natural for women. Furthermore, many participants worried that use of hormone injections could render a woman sterile:

"Does Depo Provera make you infertile?"

"I don't know. What do you think?"

"Well, I don't know. I read a thing and it said that it made you infertile after a while." (Group 3: NP)

Finally, some participants did not like the idea of the injection associated with this method. They did not know what was going into their bodies and compared it to getting vaccinated. One participant felt it was easier to trust your pusher than the medical profession.

"Yeah, when you buy from a pusher, you don't always know what you're getting but you're at least a bit aware."

Oral contraception

As was the case for hormone injections, experiences linked to the use of oral contraceptives were mixed. Some participants only use this method:

> *"I find that for women who don't have any problems getting sick with the pill, I think that it's the best method of contraception."* (Group 1: NP)

Others have stopped using oral contraceptives because of the multiple side effects:

> *"I stopped using it cause it gave me stomach aches and nausea, and I felt dizzy. […] So I stopped for health reasons, cause I wasn't well…"* (Group 4: NP)

Problems linked to oral contraception use

The participants reported a number of difficulties linked to the use of oral contraception. Based on their friends' experiences, some participants have come to question the efficacy of oral contraception in preventing pregnancy.

> *"Well, like, there are a lot of girls who have taken the pill and have still gotten pregnant."* (Group 1: NP)

During the discussion, the difficulty of using oral contraceptives while living on the streets was very apparent. For many young women, the regularity this method requires was incompatible with street life and forgetting to take the pill is common. Many girls in the NP group expressed concern about the level of hormones contained in oral contraceptives, especially when a forgotten dose had to be taken with the next one. One participant said she had developed a trick to remember to take the pill: a friend reminds her and she does likewise.

Many youth believed that drug consumption makes oral contraceptive use impractical as well as less effective. According to several participants, drug use cancels the effects of oral contraceptives and renders them useless. It is therefore apparent that the irregularity of life in the streets and the drug use often associated with it compromise the proper use of oral contraceptives considerably.

Emergency contraception

Most participants had used emergency contraception. Although a few of them mentioned not having had any side effects, most found the experience difficult:

> *"I was sick. I was dizzy, I didn't understand anything anymore, I was really emotional, I was crying for nothing, I was laughing for nothing, I got in a fight with my boyfriend cause, you know,*

it's a hormone boost so, like it or not, it makes you unstable."
(Group 2: EP)

Problems linked to the emergency contraception use

Most participants were familiar with emergency contraception. However, when they were in situations where they risked getting pregnant, they did not always think of it.

For other participants, knowing about emergency contraception did not necessarily lead them to use it since they believed pregnancy "wouldn't happen to them".

"I often thought of going and getting it and I never did. I think, 'Ah, maybe I should go,' and then I never do. You know, it's like, when you're young, you're less conscious of that…"
(Group 4: NP)

Although many participants were not completely against the use of emergency contraception, they feared its side effects. According to some of the young women, the danger linked to using this method lies in it becoming a habit, thus decreasing the use of regular contraception:

"Apparently, you can become addicted to it (laughs). I don't know. That's what my doctor told me!"

"Create a addiction?"

"I think you can use it, I don't know…I don't think it's an addiction. I would be more psychological, like saying, 'I won't use condoms, anyway I have the morning after pill you know. It's a bad habit you can get into to think to just use the morning after pill or get an abortion to get out of it.'"
(Group 5: EP)

Other methods of contraception used by participants

The condom, the contraceptive pill, hormone injections and emergency contraception were the four methods of contraception most frequently used by participants. However, the young women were also familiar with many other contraceptive methods, such as the contraceptive sponge, cervical cap and diaphragm The participants' level of knowledge relative to these methods of contraception varied widely. Less conventional means of contraception such as the female condom and the contraceptive patch were mentioned but it was obvious during discussions that the participants were reticent to use them:

"And yeah…other than that, the female condom…"

"Euhh! That damn thing is hard to use! And it's this big…

Forget it! A damn thing." (Group 1: NP)

Lastly, so-called "natural" contraceptive methods such as *coitus interruptus* and the calendar method were discussed. Although some participants had used these methods in the past, they all agreed that these were not reliable for preventing pregnancy.

5.4 Views on contraception and access

According to the participants, partners do not always assume their share of the responsibility regarding contraception:

> *"I think he [my boyfriend] doesn't even know what it is."* (Group 1: NP)

Often, the partner's attitude signifies the woman must take full responsibility for contraception. In other words, it is her responsibility to ask, or even demand, that a condom be used:

> *"If you make a decision and you say, 'We're gonna use a condom,' the guy is gonna be like, 'If I wanna do it, I have to put one on, it's fine.' If not, they don't give a shit and they won't use one. I think that's how it works."* (Group 3: NP)

However, other participants were more nuanced, explaining that a certain number of partners were concerned by contraception:

> *"There are lots guys who think of it, and there are lots who don't. It all depends."* (Group 2: EP)

According to the participants, older male partners were more active in decisions related to contraception. According to one participant's experience, the partner can become responsible "by force", that is, when he is confronted with his partner's pregnancy.

There was a high degree of regarding the ease of access to contraceptives for the street youth population in Montréal due to the availability of health services and especially of free condoms. Most stated it was easy for them to get free condoms:

> *"But you know the rubbers, they bring them to us in the squats. The street workers, they pass with their boxes and they say, 'Who wants condoms, I have grey ones, white ones and red ones!'"* (Group 3: NP)

Participants in one group even severely criticized the fact that young women had unplanned pregnancies when contraception is so easily available. In their opinion, this was nonsensical:

> *"I always said, 'If you're ready to play grown-up games, be ready to accept the consequences,' If I was pregnant, if I had been pregnant, I would have kept it. It's my responsibility. With all the contraceptive methods out there, I don't see how you can get pregnant without wanting it." (*Group 3: NP)

5.5 Conclusion

Young women living on the streets in Montréal attach variable degrees of importance to the use of contraception. We observed that the relational context in which sexual relations take place seems, at least in part, to determine importance. When engaging in casual sexual relations, contraception becomes essential, especially the use of condoms to protect against STI rather than to prevent pregnancy. Few participants mentioned the fact that condoms, while good for STI protection, are not as effective for pregnancy prevention. A number of participants stated that when they are in stable relationships, they do not worry about contraception; however, they protect themselves more in casual and work situations.

Furthermore, although a few participants said they always used contraceptives, it was not clear that most adolescents we met used contraception to prevent unplanned pregnancies, despite its widespread availability. Several factors seem to be involved. First, there is a certain amount of confusion concerning the issue of fertility. On the one hand, most participants do not know at what time a woman is most fertile during her menstrual cycle. On the other, some street-involved girls think, rightly or wrongly, that they or their partners are sterile. Significant drug consumption was deemed the main element that temporarily or permanently disrupts fertility. This belief influences negatively their use of contraceptives.

Participants also identified numerous difficulties relating to contraceptive use that merit particular attention. Some homeless young women do not trust condoms as a method of contraception; without question, the major problem they associate with condoms is frequent breakage. According to the participants, their lifestyle (drug consumption, involvement in prostitution) is likely to cause vaginal lubrication problems, which increase the chances of a condom breaking. In addition, hormonal contraception does not generate unanimous approval among participants; many of them expressed a certain reluctance to use this type of contraception due to its possible adverse effects. Participants felt that hormone injection unbalances a woman's cycle. However, participants who had been pregnant expressed a preference for this method. The contraceptive pill seems especially difficult to manage in the context of life on the streets and significant drug consumption, but few participants were aware of alternative methods such as patches and intravaginal devices.

Chapter 6
Experiences with health services

All participants knew of at least one place they could go to have access to services for pregnancy and contraception. Not one adolescent said she did not know where to get contraceptives or abortion services in Montréal.

What emerges from the focus groups is that when they have a choice, homeless young women living on the streets are more likely to go to health services specifically designed for street youth. In this regard, one medical clinic meets this criteria: the Clinique des jeunes de la rue, CLSC des Faubourgs. This is without question the medical care service that participants are most familiar with and use most often. To quote one of the girls:

> *"Everyone living on the streets goes there. It's THE clinic, y'know?"* (Group 2: EP)

This clinic offers street youth a panoply of general and sexual health services free of charge. Young people can also take showers there, access social services and get psychological help. The participants were much more reluctant to use sexual health services available in other clinics, CLSCs or hospitals. The young women talked about their previous experiences with sexual health services in other centres.

6.1 Positive experiences

When the participants were asked about their positive experiences with sexual health services, they almost all automatically talked about the street youth clinic. (Clinique des jeunes de la rue). A large majority of them had benefited from the services, as well as free contraceptives such as birth control pills or hormone injections. The young women held this clinic in high regard:

> *"Thank God they're there."*
>
> *"Yeah, they're really great."* (Group 1: NP)

If the participants appreciate the street youth clinic to that extent, it is mainly due to the competence and the professionalism of the medical personnel who work there, as well as the staff's ability to develop personalized relationships with the patients. Participants who had undergone an abortion at this CLSC clinic appreciated the kindness and competence of the personnel even though the experience had been difficult.

It was also noted that clinic staff transmitted information clearly and that access to health care was granted without requiring a health insurance card. The quality and access of the services intended for street youth, whether regarding sexual health or other issues, were better than a number of participants expected. Some of them even went as far as deploring the fact these services were not available for all young women, not only those living on the streets.

6.2 Negative experiences

The participants were asked about negative experiences they might have had with health care services. The experiences mentioned were mostly those of traditional services. One participant described her disastrous abortion experience in a clinic in a suburb of Montréal.

> *"And the place I woudn't want anyone to go to, never go there, it's [Clinic Y][2]. I once had to go to the ER after I had an abortion there. I never saw such incompetent people in my life. It's ridiculous! The nurse never did an ultrasound. She said, 'Yeah, you're probably at about one month.' When I got on the table, I was at three months. It's not the same size tube. They had to reopen my cervix, it really hurt, I was losing a lot of blood. I had to return to the hospital cause it was so serious. […] Really, I got so scared and I'm never getting an abortion there again. I'm too scared."* (Group 2: EP)

Access to emergency oral contraception without a health insurance card is difficult, even impossible, in traditional health services. Many participants had to deal with this situation. Street youth often do not have identity cards, much less health insurance cards. Some participants believe that lacking this card is perceived, in public health services, as a sign of marginality and as a result, causes them to receive inferior health care services compared to the rest of the population. The participants expressed concern not only for sexual health services but also for traditional health services in general. They did not feel very welcome, and went as far as saying they experienced discrimination because of their appearance.

[2] For confidentiality purposes, we will not name the traditional services about which participants reported having negative experiences.

In regard to sexual health, whether in traditional health services or those specially designed for street youth, participants described a number of negative elements that deserve particular attention.

Pressure to get an abortion

Young female street youth who had been pregnant expressed having felt pressured by doctors, nurses, social workers and community workers to opt for abortion as the only conceivable outcome for their unintended pregnancy. In their opinion, this pressure reduced the possibility to make a choice.

The participants believed this pressure reflects the community's and medical and social workers' disapproval of street youth pursuing a pregnancy. The youth felt that this explained the lack of resources available for pregnant street-involved girls:

> *"There aren't that many resources for that. Anyway, I haven't heard of them. I haven't heard that a girl can show up somewhere, say, 'I'm pregnant, I want to keep my kid, I'm in the street, I have a drug problem, help me!' Most of the time they're gonna say, 'Well…'."*
>
> *"Can't do anything!"*
>
> *"'Go into detox, go to a shelter', but you know often, it's limited periods of time and there's no follow-up and if the girl has a problem…"* (Group 5: EP)

It is important to note however that the participant who was pregnant at the time of the discussions mentioned the helpful attitude of the personnel at the Street youth clinic:

> *"I had support at the street youth clinic. […] At the beginning, I didn't want an abortion. Because like I said before, I didn't want to bring a kid into a disgusting world like this. And then I went to a social worker and she helped me make a decision cause I really didn't know if I was going to keep it or not. I wanted to get an abortion, but at the same time I wanted to keep it and in my head, it would have been too much to get an abortion, because I wanted it. I was at four months. I could feel it inside me. You know, it was like hard to think of that. So it was her who helped me decide. […] That's what saved my life."* (Group 7: EP)

Feeling judged

Some participants who had had more than one abortion said they had been negatively judged by medical personnel:

> *"I don't feel like showing up in a clinic and say, 'Yeah, hi, I'm pregnant, it's the fifth time,' and the nurse goes (sigh!). It's like, 'Look, calm down, you work here, you're not supposed to judge me for this stuff. You know, it's totally an accident'."* (Group 7: EP)
>
> *"And they all do that."*
>
> *"And, like, they always make you feel bad."*
>
> *"'Abortion is not a means of contraception.' Well yeah, I know. 'Look, you think I'm happy to be here, cause, like, it hurts, I don't know if you know this but it's not fun.'"*
>
> *"You know, there was even this woman once, she asked me if I was a prostitute. I was like, "look, no, I'm really not"."* (Group 2: EP)

Participants who have had such an experience think that the personnel should not judge them because of they are in need of an "nth" abortion. Their feelings of guilt and even irresponsibility are so profound they need empathy, not judgement.

Discomfort with male physicians

A few participants mentioned having felt uncomfortable with male physicians:

> *"Well me, the only time I felt uncomfortable with health care services, it's when I got a test—a Pap test—done by a guy. Just the fact it was a guy, I felt like he was abusing me. It's dumb to say, cause I knew he wasn't, but I had such an impression that I was being raped."* (Group 1: NP)
>
> *"What I didn't like was when it was a man who was doing it. I didn't like it. When they would tell me that it was a man, sometimes I would skip my appointment."* (laughs) (Group 4: NP)

Thus, some young women would prefer not having a gynaecological exam rather than having it done by a man.

6.3 Ways to improve sexual health care services

We asked participants to identify possible ways to improve sexual health care services and to prevent unplanned pregnancy in street youth. Most youth, especially those who had never been pregnant, thought that prevention of unplanned pregnancy was an individual responsibility: it was up to young women to learn about it and use contraception responsibly.

> *— I think it's really a personal thing. You can't force someone else to wake up. And I think you could use all the ads in the world, if the person doesn't want to, it's useless.*
>
> — And when will this happen?
>
> *— Well that depends on the person. It depends on how that person evolves. You know, I really can't say. Some, the first time they'll use [contraception], others'll never use it, they won't give a shit. It really depends on every person. (Group 4: NP)*

Nevertheless, many participants mentioned that being aware of the importance of contraception did not necessarily translate into concrete action:

> *"You know it, but, like, it doesn't really change the fact that…"*
>
> *"Well, you know it or you don't…"*
>
> *"We know it, that's for sure, but it doesn't mean that…"*
>
> *"That you're gonna do it." (Group 3: NP).*

The participants viewed prevention of unplanned pregnancy in street youth as a considerable challenge. Despite their often pessimistic views on this issue, they were able to formulate some concrete ways of improving the situation.

Almost all youth in the discussion groups agreed that the sexual health services and resources available to them were clearly identified and that all the resources collaborated in dissminating the information.

One suggestion was to improve the attitudes of medical personnel. Some participants mentioned that it would be easier for youth to consult if they were greeted respectfully without being judged for who they are or the state they are in.

> *"That you won't be judged. You'll get there, you know, all fucked up and scrapped, you were stoned all night and you got your bags down to here and then never mind. You get there and*

they'll just greet you like you are. […]" (Group 3: NP)

Also, it appears to be easier to discuss questions of pregnancy, contraception and sexual health with a female physician. They suggested that a choice be given as to the sex of the treating physician.

> *"You know, they should tell us, 'Do you feel more comfortable with a guy or a girl?' They should ask you, instead of throwing any doctor at you."* (Group 1: NP)

In addition, the participants discussed the opening hours of the street youth clinic. Although many participants were satisfied, others suggested that the clinic be opened in the morning sometimes rather than only in the afternoon. To justify this need, participants raised the fact they generally have nothing to do in the morning since most other services are not open. In addition, it would be easier for them to get to the clinic in the morning before their social activities begin (pan handling, drinking, etc.), which were likely to reduce their chances of going to the clinic.

Furthermore, it was recommended that the personnel of sexual health services adopt a more proactive attitude. The youth would appreciate if the nurses could anticipate their eventual needs and difficulties and explain what to do if they have a "problem" (fori instance, skipped pills, unprotected sex, or slipped/broken condom), especially during consults pertaining to contraception.

Two suggestions were given to help reduce the risk of condom breakage. The first was to have health care workers offer lubricants in addition to condoms. The second was to provide condom containers to keep condoms from being damaged.

Every participant was aware of available written materials on contraception and other questions pertaining to sexual health, which are available in many health centres. They admitted rarely reading them since the materials were often too complex (vocabulary) or too lengthy. One group offered an alternative to fliers: put up, in strategic areas, more posters with new information (e.g. vaginal ring, Plan B, or others).

As well, a number of participants expressed an interest in spreading information on this subject to other street youth. They felt that street-involved girls would relate to them as peer educators.

Many participants considered pregnancy prevention among young women street youth as more than just transmitting knowledge on contraception. To really prevent unplanned pregnancies, a global approach is needed to help street youth have a long-term view about their health.

> *"It's more than that, I think it goes further than a little intervention that we could do like that, like hand out fliers. It's really inside people. People who don't give a shit, it would be to*

help them be more aware of what's going on, to be able to figure out what's gonna happen tomorrow." (Group 3: NP)

6.4 Conclusion

The homeless female youth with whom we met were very satisfied with the sexual health services especially designed for them. Their experiences with these services were mostly positive, although a few participants stated they felt a bit uncomfortable with the idea of receiving sexual health services from a male physician. Participants who had been pregnant identified two negative points regarding sexual health services, whether from traditional sources or from the street youth clinic. On the one hand, they felt the staff pressured them to choose abortion, as if it were the only option open to them. On the other, they felt they were judged negatively if they had repeat abortions.

Despite their satisfaction with services developed for them, participants had a few suggestions for improvements, including longer opening hours for the street youth medical clinic and the adoption of proactive interventions by staff regarding contraception. Another suggestion was to hand out lubricant and condom containers to reduce the risk of condom breakage.

Most participants perceived prevention of unplanned pregnancies to be a major challenge. Although they felt they were pretty well informed about services, they nonetheless admitted that information on new methods could be improved. They suggested that educational information posters be put up in strategic places to raise awareness of new types of contraception and what to do in case of unprotected sex.

As well, they emphasized the importance of helping street-involved girls care enough about themselves to protect their sexual health.

Chapter 7
Discussion and conclusion

The goal of this study was to explore the meaning that pregnancy has for street-involved girls, the importance of contraception in their lives, and their use of contraceptives and sexual health services.

The young women we met during this study had extremely varied attitudes towards pregnancy. A minority of them felt "indifferent", that is, they simply did not think about pregnancy and did not use any form of contraception. Another small minority of participants said they truly wanted children and for them, maternity was presently a short-term goal.

However, for the great majority of participants, pregnancy was to be avoided in their current lives since, in their eyes, they did not have a lifestyle or the skills required to go through pregnancy and have a child. Participants spoke very responsibly about pregnancy in the context of living on the streets. For these adolescents, pregnancy is an event to consider in the future, once their lives meet certain conditions they deem necessary, such as living in a better environment, acquiring a sense of responsibility towards themselves and the potential child, and having a certain social stability. Their discourse is very similar to that of more socially advantaged young women reported in some studies (Jewell et al., 2000; Free et al., 2002; Dufort et al., 2000). Motherhood is a long-term objective for most street youth. However, unlike adolescents in these other studies, young women living on the streets did not perceive pregnancy as an impediment to their future aspirations. Rather they perceived it as hindering their youth and current lifestyle, that is, living in the here-and-now, partying and consuming alcohol and drugs.

Among young women who said they wanted to avoid pregnancy while street-involved, only a small number had behaviours coherent with their attitudes. Although the majority of participants stated they wanted to avoid getting pregnant at this time, few used contraceptives consistently. While they thought it important to live their lives on the streets and to "grow up" before getting pregnant, they took few measures to really avoid unplanned pregnancy.

Although the responsible attitude on pregnancy articulated by participants may be attributed to a social desirability effect, we believe that they truly want to postpone pregnancy as much as possible. Numerous barriers among homeless young women impeded their determination to avoid pregnancy while living on the streets.

Street-involved young women have individual barriers which hamper their use of contraception. Their *knowledge* level was variable. Many girls were confused about the menstrual cycle and fertility. Most participants, including those who had already been pregnant at least once, did not know when women were most fertile during the cycle. , their knowledge about contraceptive methods also varied. Several participants told us they thought, or were even convinced, that they (or their partners) were sterile and therefore did not need to use any contraception. They came to this conclusion based generally on two elements: drug consumption disrupts fertility, and they have never gotten pregnant despite the high number of unprotected sexual relations they have had. In such contexts, using contraception is absolutely unnecessary, in their eyes.

Another individual barrier we observed among these young women was their negative *attitudes* toward certain contraceptive methods, especially hormonal methods (Ensign, 2000; Kendall et al., 2005). Some adolescents were more hesitant to use them because of the numerous adverse effects—real or perceived—of these contraceptives. Young women living on the streets feel much more positive about condoms and use them willingly, especially to protect themselves against STI. They perceive condoms as being more natural than hormonal methods.

Homeless adolescent women are also confronted with *contextual* barriers to contraception, that is, barriers linked to their lifestyle, which have also been discussed by other researchers (Ensign, 2000; Gelberg et al., 2002). With a lifestyle of partying, consumption of psychoactive substances, and irregular schedules, it goes without saying that proper utilization of oral contraception is not evident for this population. Moreover, according to participants, they mentioned having significant problems with condom breakage. Several factors associated with living on the streets contribute to this problem: insufficient vaginal lubrication due to drug consumption, difficulties related to condom storage, and young street men's improper condom use.

In terms of sexual health services, young girls living on the streets know where to go to obtain contraceptives. Our study indicates that, unlike in the United States (Ensign and Panke, 2004), homeless young girls in Montréal have very good access to both sexual health services and contraceptives through a medical clinic specifically intended for Montréal street youth. This clinic appears to be well adapted for this clientele, and participants in our study were very satisfied, and reported fewer negative experiences with this service than with traditional clinics. Contraceptives, including condoms, are also very accessible from community groups serving street-involved youth, either on site or through outreach workers. This service is greatly appreciated by the young women, and helps increase accessibility of contraceptives among this population.

Despite the high level of satisfaction expressed by participants regarding sexual health services especially designed for them, the young women still offered a few suggestions to improve services: extended opening hours in the morning (not just afternoon hours), and more proactive teaching about contraception by the staff. Another suggestion that could help improve prevention of unplanned pregnancy among young street-involved girls was to distribute condom holders and lubricant to overcome the problem of frequent condom breakage. Participants considered that putting up posters with information and prevention messages in strategic places (e.g. clinic waiting room and public toilets) would be more effective in raising awareness about the importance of using contraceptives than the many pamphlets available.

Although the study helped identify several elements that are factors in unplanned pregnancies among young street-involved women, more research is needed to further explore this issue. The discrepancy between the girls' attitudes and behaviours to pregnancy prevention should be explored more closely. While our study can partly explain this attitude by some girls' lack of knowledge or specific beliefs, there may also be other explanations. Does their inconsistency point to ambivalence about pregnancy, as suggested by Spear (2004) and Kendall et al. (2005)? Does it reflect a carelessness peculiar to homeless young women because they do not think about the future, an attitude that is, according to some of the participants, characteristic of street youth, who live day to day without regard for the consequences of their actions or for their future? Can it be explained by drug consumption, which reduces the importance of contraception in the young girls' lives, as suggested by Gelberg et al. (2002)? In our study many of these reasons could explain the inconsistencies found among our participants.

Another element that emerged from the study was the varying degree of importance accorded to contraception based on the type of partner relationship. Contraception was very important for occasional sexual relations and less so in more stable relationships. We have put forward two hypotheses: either that when they are in a couple, young women feel they are in a better position to deal with a pregnancy, should the situation arise, or that some young women living on the streets are so emotionally vulnerable that it becomes difficult for them to raise the issue of contraception with their partners or even to think about it.

Moreover, sexual abuse unquestionably provides a possible explanation for unplanned pregnancies among homeless adolescent girls. In Montréal, 65% of young street-involved girls report having been sexually abused, either by a family member or by someone else (Roy, Haley, Godin, Boivin, Claessens, Vincelette, Leclerc and Boudreau, 2005). Therefore, the possible link between sexual abuse and unplanned pregnancy among young women living on the streets should be investigated further, particularly through individual in-depth interviews, which facilitate the study of more intimate and sensitive issues.

Finally, homeless young women sometimes choose self-induced abortion through over consumption of alcohol and drugs, as revealed in the study conducted by Ensign (2000) in the United States. However, unlike American sexual health services that are less accessible

to homeless young women, abortion services are very accessible to adolescent girls living on the streets in Montréal. The practice of self-induced abortion among street-involved girls was an unexpected and worrisome finding. It is important to explore further why these young women would choose to end their pregnancies themselves rather than turning to a health professional to do so.

7.1 Study strengths and limitations

This study enabled us to explore, using the focus group method, issues linked to pregnancy and contraception use among young women living on the streets, from their perspective. It provides valuable data on their attitudes towards contraception, as well as possible explanations for the high rate of unplanned pregnancy among this population. Our study underlines the numerous difficulties young street women face in relation to adequate contraception use, despite good access to care.

The study has certain limitations. Focus groups do not enable us to investigate in detail issues that are rather sensitive. Such is the case for the question of sexual abuse, for example, which could not be explored more thoroughly. Individual interviews could allows us to delve deeper into this issue because of the intimacy that can develop between the interviewer and interviewee. Furthermore, a focus group situation can prompt participants to provide socially acceptable answers because they are afraid of being judged by others. The moderator's respectful attitude may have limited the "social desirability" effect. In addition, the sample included very few homeless young women who continued the pregnancy and gave birth, which could restrict generalisability of results to all young women living on the streets. Finally, although participants were only recruited from a few sites, which also limited the findings, we took care to recruit them based on certain parameters, such as age, time spent on the streets and number of pregnancies, to ensure that the broadest diversity of experiences were represented.

7.2 Conclusion

With this study, we gained valuable knowledge for interventions that could help prevent unplanned pregnancies among homeless young women.

1. Lubricant and condom holders should be made available to help decrease condom breakage.

2. Given the inconsistencies shown by many homeless young women regarding pregnancy prevention, health care personnel should be clear about the barriers to pregnancy prevention during consultations for contraception. Professionals should also explore homeless young women's desire to avoid pregnancy or, in the words of Stevens-Simon, Beach and Klerman (2001), their "intent to remain non-pregnant". In the case where there is inconsistency between adolescents' wish to avoid getting

pregnant in the short term and their behaviours regarding contraception, professionals can explore the individual factors that result in ineffective utilization of a contraceptive method.

3. Increase young women's knowledge about new contraceptive methods. The effectiveness of the various contraceptive methods, including condoms, needs to be clarified during consultations. Health care professionals should also discuss and plan with the young women the steps to take should they "hit a snag" with the chosen contraceptive (e.g. forgetting one or several pills, missing an appointment for a second hormone injection, dealing with condom breakage), and remind them about the existence of emergency oral contraception.

4. Explore the resistance that street-involved girls may have regarding certain contraceptive methods, especially hormonal contraceptives. It seems essential to address their beliefs and attitudes since there are currently two very effective hormonal contraceptives that could be extremely useful to homeless young women: hormonal injection and the contraceptive patch.

5. Promote the design and distribution of educational posters about innovations in contraception (for example, the contraceptive patch and contraceptive ring) in places that street youth frequent.

6. Encourage community workers and health professionals to adopt a proactive approach regarding contraception when homeless young women consult them, and to discuss fertility, contraception and street life.

7. Encourage community workers and health professionals to be open and respectful with young street-involved girls who are pregnant, and work to develop a climate of trust so as to discuss all possible avenues with them.

BIBLIOGRAPHY

Adler EM, Zdanowicz Y, Smart RG. Alcohol and other drug use among street-involved youth in Toronto. *Addiction Research* 1996*;4:*11-24.

Beal AC, Redlener I. Enhancing perinatal outcome in homeless women: The challenge of providing comprehensive health care. *Seminars in Perinatalogy* 1995*;19*(4):307-13.

Breheny M, Stephens C. Barriers to effective contraception and strategies for overcoming them among adolescent mothers. *Public Health Nursing* 2004*;21*(3):220-7.

Canadian Paediatric Society. Bringing street youth out of the shadows. *CPS News* 1996*:*5-6.

Cochran BN, Stewart AJ, Ginzler JA, Cauce AM. Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health* 2002*;92*(5):773-7

Coley RL, Chase-Lansdale PL. Adolescent pregnancy and parenthood. Recent evidence and future directions. *American Psychologist* 1998*;53:*152-66.

Corcoran J. Consequences of adolescent pregnancy/parenting: a review of the literature. *Social Work Health Care* 1998*;27:*49-67.

Covington DL, Justason BJ, Wright LN. Severity, manifestations and consequences of violence among pregnant adolescents. *Journal of Adolescent Health* 2001*;28:*55-61.

DeMatteo D, Major C, Block B, Coates R, Fearon M, Goldberg E et al. Toronto street youth and HIV/AIDS: prevalence, demographics and risks. *Journal of Adolescent Health* 1999*;25:*358-66.

Direction de santé publique. Prévenir la grossesse à l'adolescence : Défi ou illusion ? *Prévention en pratique médicale* Sep. 2003.

Dufort F, Guilbert É, Saint-Laurent L. *La grossesse à l'adolescence et sa prévention : au-delà de la pensée magique* [Report]. Québec: Conseil québécois de la recherche sociale; 2000.

Ensign J. Reproductive health of homeless adolescent women in Seattle, Washington, USA. *Women and Health* 2000*;31*(2-3):133-51.

Ensign J. Quality of health care: the views of homeless youth. *Health Services Research* 2004*;39*(4):695-707.

Ensign J, Panke A. Barriers and bridges to care: voices of homeless female adolescent youth in Seattle, Washington, USA. *Journal of Advanced Nursing* 2002*;37*(2):166-72.

Ensign J, Santelli J. Health status and service use. *Archives of Pediatrics and Adolescent Medicine* 1998*;152:*20-24.

Foster HW, Bond T, Ivery D, Treasure OA, Smith D, Sarma RP et al. Threatened pregnancy: environment and reproduction at risk. Teen pregnancy-problems and approaches: panel presentations. *American Journal of Obstetrics and Gynecology* 1999*;181*:S32-S36.

Fournier L, Chevalier S. Dénombrement de la clientèle itinérante dans les centres d'hébergement, les soupes populaires et les centres de jour des villes de Montréal et de Québec 1996-97: 2. Montréal : premiers résultats. Québec, Santé Québec; 1998.

Free C, Lee R, Ogden J. Young women's accounts of factors influencing their use and non-use of emergency contraception: in-depth interview study. *British Medical Journal* 2002*;325:*1-5.

Gelberg L, Leake BD, Lu MC, Andersen RM, Wenzel SL, Morgenstern H et al. Use of contraceptive methods among homeless women for protection against unwanted pregnancies and sexually transmitted diseases: prior use and willingness to use in the future. *Contraception* 2001*;63:*277-81.

Gelberg L, Leake B, Lu MC, Andersen R, Nyamathi AM, Morgenstern H, Browner CH. Chronically homeless women's perceived deterrents to contraception. *Perspectives on Sexual and Reproductive Health* 2002*;34*(6):278-85.

Gilliam ML, Knight S, McCarthy M. Importance and knowledge of oral contraceptives in antepartum, low-income, African American adolescents. *Journal of Pediatric and Adolescent Gynecology* 2003*;16:*355-60.

Greene JM, Ennett ST, Ringwalt CL. Substance use among runaway and homeless youth in three national samples. *American Journal of Public Health* 1997*;87*(2):229-35.

Greene JM, Ringwalt CL. Pregnancy among three national samples of runaway and homeless youth**.** *Journal of Adolescent Health* 1998*;23*(6):370-77.

Halcon LL, Lifson AR. Prevalence and predictors of sexual risks among homeless youth. *Journal of Youth and Adolescence* 2004*;33*(1):71-80.

Haley N, Bélanger L, Roy É, Morissette C, Poirier L-R, Crago A-L et al. Rapport sur les groupes de discussion chez les jeunes de la rue : accessibilité aux services de santé. Montréal: Direction de la santé publique, Régie régionale de la santé et des services sociaux de Montréal-Centre; 1999.

Haley N, Roy É, Bélanger L, Morissette C, Poirier L-R, Crago A-L et al. Health care needs and access: listening to street youths. *Journal of Urban Health* 2002*;79*(4):5139.

Haley N, Roy É, Leclerc P, Lambert G, Boivin JF, Cedras L et al. Risk behaviours and prevalence of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* genital infections among Montreal street youth. *International Journal of STD and AIDS* 2002*;13:*238-45.

Haley N, Roy É, Leclerc P, Boudreau J-F, Boivin J-F. Characteristics of adolescent street youth with a history of pregnancy. *Journal of Pediatric and Adolescent Gynecology* 2004*;17:*313-20.

Hanna B. Negotiating motherhood: the struggles of teenage mothers. *Journal of Advanced Nursing* 2001a*;34*(4):456-64.

Hanna B. Adolescent parenthood: a costly mistake or a search for love? *Reproductive Health Matters* 2001b*;9*(17):101-107.

Jewell D, Tacchi J, Donovan J. Teenage pregnancy : whose problem is it? *Family Practice* 2000*;17*(6):522-28.

Kaiser Family Foundation, Hoff T, Greene L, Davis J. National survey of adolescents and young adults: Sexual health knowledge, attitudes and experiences. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2003.

Kendall C, Afable-Munsuz A, Speizer I, Avery A, Schmidt N et al. Understanding pregnancy in a population of inner-city women in New Orleans: results of qualitative research. *Social Science and Medecine* 2005*;60:*297-311.

Kipke MD, Montgomery SB, Simon TR, Iverson EF. Substance abuse disorders among runaway and homeless youth. *Substance Use and Misuse* 1997*;32:*969-86.

Kitzinger J, Barbour RS. Introduction: The challenge and promise of focus groups. In: Rosaline S. Barbour and Jenny Kitzinger, editors. Developing focus group research. Politics, theory and practice. London (u.k.): Sage; 1999. p. 1-20

Kral AH, Molnar BE, Booth RE, Watters JK. Prevalence of sexual risk behaviour and substance use among runaway and homeless adolescents in San Francisco, Denver and New York City. *International Journal of STD and AIDS* 1997;*8:*109-17.

Molnar BE, Shade SB, Kral AH, Booth RE, Watters JK. Suicidal behaviour and sexual/physical abuse among street youth. *Child Abuse and Neglect* 1998;*22:*213-22.

Montgomery KS. Planned adolescent pregnancy: What they wanted**.** *Journal of Pediatric Health Care* 2002;*16*(6):282-9.

Moore KA, Myers DE, Morrison DR, Nord CW, Brown B, Edmonston B. Age at first childbirth and later poverty. *Journal of Research on Adolescence* 1993;*3:*393-422.

Morantz-Ornstein G, Haley N, Roy É. Improving the sexual health of street youth: what do outreach workers suggest? *Journal of Urban Health* 2003;*80*(2):ii73.

Morgan DL. The focus group guidebook. Thousand Oaks: Sage Publications; 1998. (Focus Group Kit, vol 1).

Noell J, Rohde P, Ochs L, Yovanoff P, Alter MJ, Schmid S et al. Incidence and prevalence of chlamydia, herpes, and viral hepatitis in a homeless adolescent population. *Sexually Transmitted Disease* 2001;*28:*4-10.

Noell J, Rohde P, Seeley J, Ochs L. Childhood sexual abuse, adolescent sexual coercion and sexually transmitted infection acquisition among homeless female adolescents. *Child Abuse and Neglect* 2001;*25:*137-48.

Pires A. De quelques enjeux épistémologiques d'une méthodologie générale pour les sciences sociales. In JP Deslauriers, L Grouxl, A Laperrière, R Mayer and J Poupart, editors. La recherche qualitative : enjeux épistémologiques et méthodologiques. Boucherville: Gaëtan Morin; 1997. p. 3-54.

Quinlivan, JA, Petersen RW, Gurrin LC. Adolescent pregnancy: psychopathology missed. *Australian and New Zealand Journal of Psychiatry* 1999;*33:*864-8.

Rew L, Taylor-Seehafer M, Fitzgerald ML. Sexual abuse, alcohol and other drug use and suicidal behaviours in homeless adolescents. *Issues in comprehensive pediatric nursing* 2001;*24*(4):225-40.

Rew L, Chambers KB, Kulkarni S. Planning a sexual health promotion intervention with homeless adolescents. *Nursing Research* 2002;*51:*168-74.

Rice PL, Ezzy D. Qualitative research methods: A health focus. Melbourne: Oxford University Press; 1999.

Ringdahl EN. The role of the family physician in preventing teenage pregnancy. *American Family Physician* 1992;45:2215-20.

Ringwalt CL, Greene JM, Robertson M, McPheeters M. The prevalence of homelessness among adolescents in the United States. *American Journal of Public Health* 1998;*88:*1325-9.

Robinson N. The use of focus group methodology with selected examples from sexual health research. *Journal of Advanced Nursing* 1999;*29*(4):905-13.

Rohde P, Noell J, Ochs L, Seeley JR. Depression, suicidal ideation and STD-related risk in homeless older adolescents. *Journal of Adolescence* 2001;*24:*447-60.

Roy É, Haley N, Leclerc P, Boivin JF, Cedras L, Vincelette J. Risk factors for hepatitis C virus infection among street youths. *Canadian Medical Association Journal* 2001;*165:*557-60.

Roy É, Haley N, Lemire N, Boivin JF, Leclerc P, Vincelette J. Hepatitis B virus infection among street youths in Montreal. *Canadian Medical Association Journal* 1999;*161*(6):689-93.

Roy É, Haley N, Leclerc P, Lemire N, Boivin JF, Frappier JY et al. Prevalence of HIV infection and risk behaviours among Montreal street youth. *International Journal of STD and AIDS* 2000;*11:*241-7.

Roy É, Haley N, Godin G, Boivin JF, Claessens C, Vincelette J et al. L'hépatite C et les facteurs psychosociaux associés au passage à l'injection chez les jeunes de la rue. Rapport d'étape numéro 3. Montréal: Direction de la santé publique, Régie régionale de la santé et des services sociaux de Montréal-Centre; 2004.

Roy É, Haley N, Godin G, Boivin JF, Claessens C, Vincelette J et al. L'hépatite C et les facteurs psychosociaux associés au passage à l'injection chez les jeunes de la rue. Rapport d'étape numéro 4. Montréal: Direction de la santé publique, Régie régionale de la santé et des services sociaux de Montréal-Centre; 2005.

Smart RG, Adlaf EM. Substance use and problems among Toronto street youth. *British Journal of Addiction* 1991;*86:*999-1010.

Smart RG, Walsh GW. Predictors of depression in street youth. *Adolescence* 1993;*28:*41-53.

Spear HJ. Personal Narratives of Adolescent Mothers-To-Be: Contraception, Decision Making and Future Expectations. *Public Health Nursing* 2004;*21*(4) :338-46.

Statistiques Canada : Grossesse chez l'adolescente, selon l'issue des grossesses et le groupe d'âge, nombre et taux pour 1000 femmes, Canada, provinces et territoires, 1997-2001. http://www.statcan.ca/francais/freepub/82-221-XIF/2004002/tables/html/411_01_eng.htm (site consulted in May 2005)

Stevens-Simon C, Beach RK, Klerman LV. To be rather than not to be: That is the problem with the questions we ask adolescents about their childbearing intentions. *Archives of Pediatrics and Adolescent Medicine* 2001;*155:*1298-1300.

McCreary Centre Society. Adolescent Health Survey: Street Youth in Vancouver. Prepared by Larry Peters and Aileen Murphy. Principal investigator: Roger Tonkin. Burnaby (BC): The McCreary Centre Society; 1994. 1-85.

Unger JB, Kipke MD, Simon TR, Montgomery SB, Johnson CJ. Homeless youths and young adults in Los Angeles: prevalence of mental health problems and the relationship between mental health and substance abuse disorders. *American Journal of Community Psychology* 1997*;25:*371-94.

Whitbeck LB, Hoyt DR, Bao WN. Depressive symptoms and co-occurring depressive symptoms, substance abuse and conduct problems among runaway and homeless adolescents. *Child Development* 2000*;71:*721-732.

Appendix 1

Literature Review

Attitudes and perceptions of young street-involved girls regarding pregnancy

In her 2000 study on the sexual health of homeless adolescent women in Seattle, Ensign argues that pregnancy is one of their main health concerns. However, she remains silent on the way young homeless girls express this concern. To our knowledge, no study has attempted to understand specifically the attitudes and perceptions of young street-involved girls concerning pregnancy. We have, however, compiled a few studies on this topic that have been conducted with adolescent girls in the general population or from disadvantaged neighbourhoods.

First, a feeling of indifference towards pregnancy is characteristic of some adolescents from disadvantaged neighbourhoods (Breheny and Stephens, 2004; Spear, 2004). This feeling is expressed in the fact that they do not feel concerned with the possibility of getting pregnant.

Moreover, it appears that some young girls might feel they are not vulnerable to pregnancy (Free, Lee and Ogden, 2002; Breheny and Stephens, 2004). Adolescent girls in whom such feelings were observed believe they cannot get pregnant, even though they do not use contraception. This feeling of invulnerability is often linked to the belief that either she or her partner is sterile (Breheny and Stephens, 2004). According to a study by Free et al. (2002) that included young homeless women, it is mostly young women or girls from disadvantaged neighbourhoods who present such an attitude. Similar to Jewell, Tacchi and Donovan (2000), Free et al. noted that young girls who are more socially advantaged — and also have great social (studies, career, etc.) and personal (desire to travel, etc.) ambitions — feel much more vulnerable with regard to getting pregnant[3].

[3] This is not to say, however, that young girls from more affluent backgrounds adopt safer sexual behaviours more readily. On the contrary, the study by Jewell et al. (2000) highlights the fact that they had as many unprotected sexual relations as socially disadvantaged girls. The difference arises mostly in the way they react

Furthermore, some studies reveal ambivalent attitudes towards pregnancy (Spear, 2004; Kendall, Afable-Munsuz, Speizer, Avery, Schmidt and Santelli, 2005): young girls say they do not want to get pregnant but, conversely, they do not take concrete action to prevent it, that is, they do not use contraceptives at all or do not use them regularly. In this regard, Free et al. (2002) found that when they experience a great deal of anxiety regarding the risks of pregnancy, some adolescents totally avoid thinking about it and, consequently, adopt riskier behaviours (for instance, not using contraceptives or not procuring emergency oral contraceptives).

Finally, some adolescents, especially girls with little education or who are socially disadvantaged, might want to get pregnant and pregnancy may be a short-term goal. From the point of view of these young women, and as suggested in the literature, pregnancy seems to bring them benefits and opportunities they would not have otherwise (Ringdahl, 1992; Coley and Chase-Lansdale, 1998; Hanna, 2001a; Hanna, 2001b; Montgomery, 2002; Kendall et al., 2005). According to Montgomery (2002), adolescents can have several reasons for planning a pregnancy. Their motivations include the desire to become and be perceived as being more mature and responsible, longing to have someone to love and care for and wanting a better life, free of drugs and criminality, for example. If such an attitude is less common among young girls from more affluent backgrounds, it is because, as we saw earlier, they are more focused on personal development or career. For them, pregnancy is a long-term goal (Jewell et al., 2000; Free et al., 2002)

In the light of the studies we have just considered, we believe that it is important to be aware of young street-involved girls' perspectives regarding pregnancy. Their viewpoints need to be taken into account before implementing educational programs and services. Adolescent girls can have a variety of attitudes toward pregnancy, whether it is feeling vulnerable, ambivalent or invulnerable, or even desiring to have a child. They might perceive pregnancy during adolescence as unacceptable or, on the contrary, as something to consider or that is even desirable. Finally, pregnancy can be a reality that simply does not exist in the minds of some adolescents. It goes without saying that such attitudes and perceptions regarding pregnancy influence contraceptive use as well as the steps to take in case of unplanned pregnancy.

Barriers to effective contraception use among young women living on the streets

The rate of contraception utilisation among young women living on the streets is quite low. A study of Montreal street youth showed that only 25.4% of them always use condoms, 17.3% always use birth control pills, and fewer than 3% hormone injection (Haley

afterwards: the former tend to use emergency oral contractives, while the latter are nore likely to wait and see whether or not they are pregnant.

et al., 2002). These results signify that a large number of young women use contraceptives irregularly or not at all. They seem to be confronted with a certain number of barriers that make it difficult for them to use contraception regularly and properly.

Barriers to contraception among young female street adolescents can be grouped into five categories. The first, as we saw previously, relates to their attitudes and perceptions with regard to pregnancy. Thus, the fact of feeling indifferent, invulnerable or ambivalent concerning pregnancy contributes greatly to hampering regular contraceptive use.

The second category is linked to knowledge about contraception. Several authors have explained that young women who live on the streets seldom use contraceptives or use them incorrectly because they lack the required knowledge (Gelberg, Leake, Lu, Andersen, Nyamathi, Morgenstern and Browner, 2002; Gilliam, Knight and McCarthy, 2003) or the information they have is incorrect (Kendall et al., 2005). Thus, there would be a particularly high number of young women living on the streets who do not know how to use contraception, which contraceptive method to choose (Gelberg et al., 2002), or what to do in case they forget to take one or several birth control pills (Ensign, 2000; Gilliam et al., 2003; Kendall et al., 2005). However, it is important to note that this argument—that young street-involved girls lack knowledge about contraception—is not unanimously accepted by researchers as an explanation for the low rates of contraceptive use. Some researchers who have studied adolescent mothers or future adolescent mothers have observed that these young women are, in general, quite knowledgeable about contraception (Breheny and Stephens, 2004; Spear, 2004). The problem, according to these authors, is that good knowledge is not enough to ensure that contraceptives are used effectively.

A third category of barriers concerns young street women's perceptions of and attitudes towards contraception. It is clear that adolescent street-involved girls do not trust hormonal contraception (the pill and injections) because it is a chemical contraceptive and is not natural (Ensign, 2000). According to these young women, this type of contraceptive causes a number of deplorable adverse effects (Ensign, 2000; Kendall et al., 2005). Several elements also dissuade young women from using condoms: lack of trust in this contraceptive method, risks of breakage and the need to always have some on hand (Kendall et al., 2005). It can also be particularly difficult for a young girl to ask a boy to wear a condom and then to confront him should he refuse. Factors that contribute to non-utilisation of emergency oral contraception include the side effects it provokes, the perception that using it is shameful, and not knowing how to get hold of it or feeling uncomfortable about using it, especially if it is not the first time (Free et al., 2002).

A fourth category of barriers involves the context in which young homeless women live and their lifestyles. As Ensign notes (2000), the pill requires a certain discipline, that is, it must be taken regularly every day around the same time, which is extremely difficult to sustain in a context of life on the streets. Consequently, these young women often forget to take it. Although forgetting one or several pills is not unique to adolescents living on the streets and any adolescent can fail to remember regardless of her socioeconomic background

(Dufort, Guilbert and Saint-Laurent, 2000), living on the streets certainly constitutes an additional obstacle to proper use of this contraceptive method. Moreover, a high level of drug consumption, often associated with street life, can mean that contraception is far from being a priority. Gelberg et al. (2002) came to this conclusion when they noted that itinerants who had experienced episodes of drug abuse were those who detected the greatest number of deterrents to contraception. Finally, again in Gelberg et al.'s study (2002), being homeless makes it very difficult to use contraceptives, especially the pill, particularly due to storage issues.

In short, a certain number of factors can have a negative influence on street-involved young women's contraceptive use, whether because of the girls' attitudes towards pregnancy and their knowledge and perceptions of contraception methods, or the context of living on the streets. However, it is important to emphasize other factors that could facilitate use of contraceptives in this same context. For example, very easy access to condoms and the protection they provide against sexually transmitted infections make them very appealing to homeless adolescent women who use them (Ensign, 2000). Hormone injection provides the advantage of not having to think about taking a pill every day. Furthermore, this contraceptive could be a method of choice for young women who are unable to use other contraceptive methods properly (Jewell et al., 2000).

Finally, we should note a fifth category of barriers that can limit homeless young women's appropriate contraception use, the problem of access to sexual health services. But inasmuch as it falls within the broader context of problems of access to health services in general, we will deal with this issue in a separate section to provide a better account of this problem.

Barriers to access to health services faced by young women living on the streets

Street youth's access to health services is very limited in spite of the fact that they have more health problems than do adolescents in general (Ensign and Santelli, 1998). They are confronted with a number of barriers related to various aspects of health services. According to several studies (Ensign and Panke, 2002; Haley, Roy, Bélanger, Morissette, Poirier, Crago and Plante, 2002; Ensign, 2004), obstacles can be grouped into two categories: on the one hand, organizational barriers (having to provide an address and ID card, having to pay for services received or medications, age limit, settings that do not respect confidentiality, opening hours) and, on the other, individual barriers (lack of money, lack of trust in traditional medicine, fear of being judged, difficulty communicating with health professionals, lack of self-esteem, mental health problems, perception of medical staff's negative and disrespectful attitudes towards them). Indeed, traditional health services do not seem to suit street youth for a number of reasons. Studies show that consequently, street youth use these services very little. They prefer to try to cure themselves or go to health

services that are specifically for them (Ensign and Panke, 2002). They use traditional health services only as a last resort, and often only when they are very sick.

Very little is known about the use of sexual health services by street youth. However, it is possible that street youth face the same obstacles to these services as they do to health services in general (Morentz-Ornstein, Haley and Roy, 2003). Indeed, a study by Ensign (2000) revealed that pregnant young girls living on the streets may try to end their pregnancies themselves (by hitting themselves or getting someone else to hit them, by over consumption of alcohol or drugs, or by using coat hangers or plants that induce abortion) rather than going to abortion clinics. We must also put into perspective the reluctance or mistrust street youth may feel towards traditional health services.

In short, street youth are little inclined to use traditional health services for general health or sexual health matters. They face several barriers to services, which can turn into barriers to contraception. In this regard, a study by Free et al. (2002) on the use of emergency oral contraceptives shows that medical consultations during which young girls are blamed for risks taken when having sexual relations considerably reduce the chances that these adolescents consult again to obtain this type of contraceptive. Conversely, positive, friendly interactions with health professionals who are understanding encourage young women in difficulty to pursue such an approach. What street youth are seeking, first and foremost, from health services and the medical staff are respect, acceptance of their lifestyle, and a relationship based on trust and confidentiality (Ensign, 2004).

However, it should be noted that most studies on obstacles to health services originate from the United States or Europe and that, consequently, the social and political contexts differ greatly from those in Canada or Quebec. We may think that because health services, medications and contraceptives are free for this clientele, Montréal street youth have much easier access to health services. Indeed, as a result of a study conducted by the Montréal Public Health Department on the obstacles street youth encounter when accessing health services (Haley, Bélanger, Roy, Morissette, Tremblay, Poirier, Crago and Plante, 1999), a medical clinic specifically designed for street youth—the CLSC des Faubourgs street youth clinic—was opened to improve their access to health services. However, to date and despite increased access to health services, irregular use or non-utilisation of contraception remains high (Roy, Haley, Godin, Boivin, Claessens, Vincelette, Leclerc and Boudreau, 2004).

Conclusion

Despite the high rate of pregnancy among young women living on the streets, very little is known on this subject. We do not know if these pregnancies reflect inadequate contraceptive use linked to a number of barriers, or if the pregnancies are planned and desired. But living on the streets and being socially vulnerable are certainly major obstacles to effective contraceptive use and have a negative impact on full-term pregnancies. In addition, there are no data on the fate of homeless adolescents who continue their

pregnancies. Yet, continuing a pregnancy while living on the streets is not without problems for both the young woman and the foetus, even if only to receive prenatal care in a timely fashion (Beal and Redlener, 1995). The future of these adolescents and their children can be severely compromised (Coley and Chase-Lansdale, 1998; Corcoran, 1998; Quinlivan, Petersen and Gurrin, 1999). Studies of adolescent mothers in the general population reveal that many of these young women do not finish school, raise their children alone, live below the poverty level (Moore, Myers, Morrison, Nord, Brown and Edmonston, 1993; Foster, Bond, Ivery, Treasure, Smith, Sarma et al., 1999; Hanna, 2001), and are victims of domestic violence (Covington, Justason and Wright; 2001). It is likely that the situation is worse for homeless girls.

It is in this context that we conducted a study on pregnancy and contraception among young female street youth. We sought to better understand their points of view on pregnancy and contraception, with the ultimate goal of improving educational and prevention activities designed for this clientele.

Appendix 2
Lists of partner organizations

Le Bon Dieu dans la rue/Le Bunker (shelter)
1664, rue Ontario Est
Montréal (Québec) H2L 1S7

Le Bon Dieu dans la rue/ Chez Pops (Day centre)
1662, rue Ontario Est
Montréal (Québec) H2L 4G7

Les Pairs Aidants (Peer intervention project)
1058, rue Saint-Denis
Pavillon Rolland-Bock bureau 2509
Montréal (Québec) H2X 3J4

La Clinique des jeunes de la rue du CLSC des Faubourgs
1250, rue Sanguinet
Montréal (Québec) H2X 3E7

Le regroupement des infirmières de proximité
Médecins du monde Canada
338, rue Sherbrooke Est
Montréal (Québec)
H2X 1E6

Passage (shelter for young girls)
C.P. 1414, Succ. Desjardins
Montréal (Québec) H5B 1H3

En-Marge (shelter for minors)
1278, rue St-Christophe
Montréal (Québec) H2L 3W6

La Cohorte des jeunes de la rue (research group on street youth)
Programme de toxicomanie, Secteur recherche
Université de Sherbrooke
1111, rue Saint-Charles ouest
Tour ouest, Bureau 500
Longueuil (Québec) J44 5G4

Appendix 3
Poster

La CONTRACEPTION et la GROSSESSE te concernent ?

Tu as envie d'en discuter ?

Nous aimerions connaître ton opinion lors d'une rencontre-collation qui aura lieu en mars ou en avril prochain.

Appelle Véronique au : 528-2400 poste 3019.

Appendix 4
Recruitment — Questionnaire

Focus-groupe « Étude sur la grossesse et la contraception chez les jeunes filles de la rue »

Salut! Nous aimerions organiser des groupes de discussion avec des jeunes filles pour parler de sujets touchant la contraception et la grossesse chez les jeunes. Est-ce que ça t'intéresserait de participer à un de ces groupes? Si ça ne te dérange pas, je vais te poser quelques questions pour vérifier si tu es éligible à l'étude.

RENSEIGNEMENTS GÉNÉRAUX

1. a) Quel âge as-tu?_____

b) Quelle est ta date de naissance?_____/____/19_____
jour/mois/année

2. Es-tu originaire de Montréal?

☐ Non➔ Tu es originaire de?_____

➔ Depuis quand es-tu à Montréal?_____

☐ Oui

3. As-tu déjà eu besoin de te chercher un endroit pour dormir comme un refuge ou un centre d'hébergement pour jeunes?

☐ Non
☐ Oui➔ Passer à la question 6

4. As-tu déjà eu besoin de dormir dans un parc, un squat ou un terminus parce que tu n'avais pas d'endroit où dormir?

☐ Non
☐ Oui

5. As-tu déjà eu à être hébergée chez des amis ou de la parenté parce que tu n'avais pas d'endroit où dormir?

☐ Non
☐ Oui

6. Quel âge avais-tu la première fois que tu t'es retrouvée dans une de ces situations?_____

7. Dans la dernière année, as-tu fréquenté un ou plusieurs centres qui offrent des services aux jeunes (hébergement, roulotte, soupes populaires, échange de seringues, etc.)?

☐ Non
☐ Oui➔ Peux-tu me les nommer?

Accueil Bonneau	____
Cactus	____
Chez Doris	____
Chez Pop's (Centre de Jour)	____
Dîners rencontre St-Louis de Gonzague	____
En Marge	____
Ketch Café	____
L'Anonyme	____
Le Bon Dieu dans la rue (Roulotte)	____
Le Bunker	____
Le TRAC	____
Passage	____
PACT de rue	____
L'X	____
Le Roc	____
Spectre de Rue	____

8. Quel âge avais-tu la première fois que tu as fréquenté un de ces centres qui offrent des services aux jeunes?_____

JE VAIS MAINTENANT TE POSER UNE QUESTION CONCERNANT LA SEXUALITÉ.

9. Dans ta vie, as-tu déjà eu une relation sexuelle avec pénétration?

☐ Non ➔ Jeune fille non éligible
☐ Oui

10. Pour parler de contraception et de grossesse, nous allons former deux groupes de discussion. L'un d'eux regroupera des jeunes filles qui n'ont jamais été enceintes de leur vie et l'autre, des jeunes filles qui ont déjà été enceintes. Dans quel groupe dois-je te placer?

☐ Jamais enceinte

10.1 Cela veut dire que tu n'as jamais vécu de grossesse, est-ce exact?
☐ Non
☐ Oui

10.2 Cela veut dire que tu ne t'es jamais faite avorter, est-ce exact?
☐ Non
☐ Oui

10.3 Cela veut dire que tu n'as jamais vécu de fausse couche, est-ce exact?

☐ Non
☐ Oui

☐ Déjà enceinte

10.4 Dans ta vie, combien de fois as-tu été enceinte?_____

11. Éligibilité

☐ La jeune n'est pas éligible
☐ La jeune est éligible

☐ Et elle refuse de participer

☐ Et elle accepte de participer

➔ Je te remercie d'accepter de participer à notre étude. Je veux juste te mentionner que ta participation sera tout à fait confidentielle. Aussi, pour te remercier d'avoir participé au groupe de discussion, nous te remettrons 25$ à la fin de la discussion.

12. Groupe de discussion

La jeune est invitée à participer au groupe de discussion qui se tiendra :

Date :_____
Heure :_____
Lieu :_____
Recruteur :_____
Date : _____/_____/2005
jour *mois* *an*

Lieu du recrutement :_____
Heure du recrutement :_____
Nom de la jeune :_____
Numéro ou endroit où la rejoindre :_____
Ami(e) par qui la rejoindre :_____

Appendix 5
Collaborators

Ms. Mireille Lajoie
Direction de la santé publique de Montréal
1301, rue Sherbrooke Est
Montréal (Québec) H2L 1M3

Ms. Guylaine Cyr
CLSC des Faubourgs
Clinique des jeunes de la rue
1250, rue Sanguinet
Montréal (Québec) H2X 3E7

Dr. Louise Charbonneau
CLSC des Faubourg
Clinique des jeunes de la rue
1250, rue Sanguinet
Montréal (Québec) H2X 3E7

Dr. Édith Guilbert
DSP de Québec/INSPQ
2400, rue D'Estimauville
Beauport (Québec) G1E 7G9

Appendix 6
Discussion guide

Étude sur la grossesse et contraception chez les jeunes filles de la rue

Introduction (15 minutes)

En arrivant, les participantes sont invitées à écrire leur nom sur un carton et à prendre une collation.

Présentation de l'animateur et des observateurs

- Étude menée par la Direction de la santé publique

Objectifs et procédures

- On va parler de la grossesse et de la contraception chez les jeunes filles de la rue.
- Notre objectif est de vous écouter pour connaître ce que vous pensez de la grossesse et de la contraception. Il n'y a pas de bonnes ou de mauvaises réponses, nous cherchons à connaître vos opinions.
- Ce que vous avez à dire nous permettra de mieux comprendre les besoins des jeunes filles de la rue en matière de grossesse et de contraception.
- Lors des discussions, c'est important de se respecter et de ne pas s'interrompre.

La discussion est tout à fait confidentielle

- Enregistrement audio pour analyse subséquente, cassettes détruites après, pas de noms ou informations permettant d'identifier des individus dans les écrits.
- Il est aussi très important que chacune respecte la confidentialité de ce qui sera dit ici.

Rôle de l'animateur

- Rôle de l'animateur est de s'assurer que tout le monde a sa chance de parler, que tout le monde ne parle pas en même temps, et aussi d'encourager la discussion entre vous. Il ne s'agit pas d'une entrevue, ni d'un questionnaire, mais bien d'une discussion en groupe.

Avant de commencer la discussion, demander à chaque participante de se présenter brièvement aux autres.

1. Grossesse (*30* minutes)

On va débuter la discussion en parlant de la grossesse

Brise glace

- On va d'abord procéder à une petite activité histoire de briser la glace un peu.
- La grossesse peut vouloir dire différentes choses dans la vie d'une femme.

Prenez un crayon et un papier : Pour vous, là maintenant dans votre vie, la grossesse vous fait penser à quoi? Écrivez le premier mot qui vous vient en tête sur la feuille, et on va les coller sur le mur.

Grossesse Signification/Place dans la vie

1.1 La grossesse, est-ce quelque chose d'important dans votre vie actuelle ?

Oui…..pourquoi ?
Non…pourquoi ? pour quand ? Quelles conditions sont nécessaires pour poursuivre une grossesse ?

1.2 La possibilité de devenir enceinte, y pensez-vous dans votre vie de tous les jours ?

Qu'est-ce qui vous amène à penser à ça ?

OU (Si non)

Qu'est-ce qui fait que vous n'y pensez pas

1.3 Être enceinte quand on est dans la rue, comment voyez-vous ça ? (ou qu'est-ce que ça veut dire pour vous ?)

Quels sont les côtés négatifs dans le fait d'être enceinte dans la rue ?

Y a-t-il des raisons pour une fille dans la rue de vouloir une grossesse ?

Quels sont les côtés positifs dans le fait de devenir enceinte dans la rue ?

1.4a **(pour les filles jamais enceintes)**

Lorsqu'une fille de la rue tombe enceinte, pensez-vous que c'est possible pour elle d'avoir du support ?

Explorer les types de support possibles : Psychologique/moral, physique
De qui ? (organismes communautaires et intervenants, amis, entourage, famille, milieu médical, etc.)

1.4b **(pour les filles déjà enceintes)**

Dans quel contexte viviez-vous quand vous êtes tombées enceintes?

Quand vous êtes tombées enceintes, avez-vous eu du support?

Explorer les types de support possibles : Psychologique/moral, physique
De qui ? (organismes communautaires et intervenants, amis, entourage, famille, milieu médical, etc.)

2. Contraception (60 minutes)

On va maintenant parler de la contraception

- La contraception peut vouloir dire différentes choses dans la vie d'une femme.

  Prenez un crayon et un papier : Pour vous, là maintenant dans votre vie, la contraception vous fait penser à quoi? Écrivez le premier mot qui vous vient en tête sur la feuille, et on va les coller sur le mur.

2.1 La contraception, est-ce quelque chose d'important dans votre vie actuelle?

Si oui…. Pourquoi?
Si non….pourquoi?

2.2 Est-ce que ça vous arrive des fois de parler de contraception avec quelqu'un?

Avec qui? (partenaires, amis, intervenants, autres)

Si non, qu'est-ce qui fait que vous n'en parlez pas?

On va maintenant parler de la contraception dans le contexte de la rue.

2.3 Comment voyez-vous l'utilisation de la contraception quand on est dans la rue?
- *Avantages/désavantages*
- *Difficultés/facilités*
- *Mythes*
- *Gestion*
- *Disponibilité/Obtention, etc.*

2.3.1 Trouvez-vous que vos partenaires se sentent concernés par la contraception?

2.4 Connaissez-vous la contraception orale d'urgence?

Si elles ne connaissent pas ça, mentionner que c'est la « pilule du lendemain »?

Que savez-vous à son sujet?
Qu'en pensez-vous?

Pause 15 mins

2.5 Autres que la contraception conventionnelle (condom, pilule, stérilet diaphragme, etc.), utilisez-vous des trucs ou des stratégies particulières pour éviter une grossesse non-desirée?

2.6a **(pour les filles jamais enceintes)**

D'après les études, environ 50% des jeunes filles de la rue à Montréal ont déjà vécu au moins une grossesse dans leur vie. Comment expliquez-vous le fait que vous n'ayez jamais été enceintes?

2.6b **(pour les filles déjà enceintes)**

D'après les études, environ 50% des jeunes filles de la rue à Montréal ont déjà vécu au moins une grossesse dans leur vie. Comment expliquez-vous ça?

Les « accidents » : comment les expliquez-vous?

3. Services en santé sexuelle

On va maintenant terminer notre discussion en parlant des services que vous avez utilisés en lien avec la grossesse et à la contraception

3.1 Pouvez-vous nous parler de votre expérience, que ce soit la vôtre ou celle d'une amie, par rapport aux services liés à la grossesse ou à la contraception

- Accessibilité
- Satisfaction
- Amélioration/si non autre suggestions pour aider les filles qui arrive sur la rue i.e.

3.2 Selon vous, de quoi les filles de la rue ont besoin pour prévenir les grossesses non-désirées?

De l'info? Par qui?, etc.

4. Question de clôture

Comment avez-vous trouvé cette rencontre??

Merci beaucoup! Cette discussion va nous aider à mieux comprendre vos besoins en matière de grossesse et de contraception!

Appendix 7
Consent – forum

ÉTUDE SUR LA GROSSESSE ET LA CONTRACEPTION CHEZ LES JEUNES FILLES DE LA RUE

Titre de l'étude

ÉTUDE SUR LA GROSSESSE ET LA CONTRACEPTION CHEZ LES JEUNES FILLES DE LA RUE

Ce projet est mené par le Dr Nancy Haley à la Direction de santé publique de Montréal.

Introduction

Nous conduisons présentement une étude visant à mieux connaître les circonstances entourant la grossesse chez les jeunes filles de la rue, et leur utilisation de la contraception. En participant aux groupes de discussion, tu pourras nous aider à améliorer les services de santé sexuelle pour les jeunes filles de la rue.

Déroulement du projet

Nous recrutons des jeunes filles pour participer à des groupes de discussion. Elles sont recrutées sur une base volontaire dans les organismes qui desservent les jeunes de la rue. Nous voulons organiser six groupes de discussion avec 6-8 participantes par groupe.

Ta participation à cette consultation consistera à prendre part à un groupe de discussion qui durera environ deux heures et qui sera enregistré puis retranscrit. Durant la discussion, nous allons aborder les thèmes principaux suivants :

1) la grossesse dans le contexte de la rue;
2) la contraception dans le contexte de la rue;
3) les stratégies particulières utilisées par les jeunes pour éviter la grossesse, leurs connaissances et attitudes en regard de la contraception;
4) les facteurs aidant ou contraignant la contraception dans le contexte de la rue;
5) l'utilisation des services reliés à la contraception et à la grossesse.

Bénéfices et risques possibles

Il n'y a pas de risque associé à ta participation à cette consultation, mais le fait de répondre aux questions pourrait t'amener à poser un regard différent sur ta situation.

Il n'y a pas de bénéfice personnel, si ce n'est d'avoir contribué à l'avancement des connaissances qui pourront servir à l'élaboration de matériel éducatif et l'amélioration des services. Nous prévoyons qu'à la fin de cette recherche, les filles pourront recevoir de l'information sur la contraception et de meilleurs services pour la santé sexuelle.

Compensation

Nous t'offrirons une somme forfaitaire de 25,00 $ à la fin de la rencontre pour te dédommager de ta participation.

Confidentialité

Les informations te concernant demeureront strictement anonymes. Tout ce qui pourrait t'identifier sera modifié lors de la transcription et il ne sera pas possible de lier ton nom au contenu des discussions. De plus, si tu nommes le nom d'un ami lors de la transcription, son nom sera changé par un mot clé qui n'est pas un prénom. Cette procédure permettra de protéger l'anonymat de ces personnes. Toutes les transcriptions seront conservées dans un fichier informatique protégé par un code d'accès connu seulement de l'équipe de recherche. De plus, un système permettant de cacher le fichier dans l'ordinateur sera utilisé. Toutes les cassettes enregistrées seront détruites à la fin de la recherche.

La liberté de participation

Ta participation à cette consultation est tout à fait libre et volontaire et ta décision n'influencera en rien les services auxquels tu as droit. De plus, tu peux cesser ta participation en tout temps sans aucun préjudice et sans explication de ta part.

Personnes à contacter pour mes questions

Pour plus d'informations concernant le projet, tu peux contacter la chercheure principale, docteur Nancy Haley, au (514) 528-2440 poste 3893.

Formulaire de consentement

La nature et le déroulement du projet m'ont été expliqués et les réponses à mes questions sont à ma satisfaction. J'ai pris connaissance du formulaire de consentement et on m'en a remis un exemplaire. Si je veux de plus amples renseignements, je peux contacter la chercheure principale de ce projet, Docteur Nancy Haley, au (514) 528-2400 poste 3893.

Je consens à participer à ce projet.

SIGNÉ À _____ LE _____ 20_____

SIGNATURE DU PARTICIPANT _____

NOM EN LETTRES MOULÉES _____

SIGNÉ À _____ LE _____ 20_____

SIGNATURE DU MODÉRATEUR_____

NOM EN LETTRES MOULÉES _____

SIGNÉ À _____ LE _____ 20_____

SIGNATURE DU CHERCHEUR PRINCIPAL_____

NOM EN LETTRES MOULÉES _____

Appendix 8
Participant profile

Focus-groupe « Étude sur la grossesse et la contraception chez les jeunes filles de la rue »

Groupe des jeunes filles ayant DÉJÀ été enceintes[4]

Date : _____/_____/2005
jour mois an

Renseignements généraux

1. a) Âge : _____

b) Date de naissance : _____/_____/19____
jour mois an

2. a) Où es-tu née?

☐ Au Québec ➔ Dans quelle ville? _____
☐ Ailleurs au Canada ➔ Dans quelle province?_____

☐ À l'étranger ➔ Dans quel pays? _____

➔ Tu es au Canada depuis quand?_____

3. Selon toi, tu proviens d'un milieu :

☐ Très aisé
☐ Aisé
☐ Moyen
☐ Pauvre
☐ Très pauvre
☐ Autre (précisez) _____

4. Quelle langue utilises-tu dans la vie de tous les jours?

☐ Français
☐ Anglais
☐ Autre (précisez) _____

[4] Le questionnaire « Profil des participantes » était le même pour les jeunes filles n'ayant jamais vécu de grossesses hormis la section « Renseignements sur la grossesse ».

5. a) Dans ta vie, as-tu déjà eu besoin de te chercher un endroit pour dormir pour au moins une nuit?

☐ Non
☐ Oui ➔ Quel âge avais-tu la première fois que tu t'es retrouvée dans cette situation?_____ ans

➔ Est-ce arrivé dans les six (6) derniers mois? ☐ Non ☐ Oui

b) Dans ta vie, as-tu déjà fréquenté les organismes communautaires pour les jeunes?

☐ Non
☐ Oui ➔ Quel âge avais-tu la première fois que tu t'es retrouvée dans cette situation?_____ ans

➔ Est-ce arrivé dans les six (6) derniers mois? ☐ Non ☐ Oui

Renseignements sur la vie sexuelle

6. Dans ta vie, avec combien de partenaires différents as-tu eu des relations sexuelles incluant des partenaires réguliers, occasionnels, clients ou personnes à qui tu donnais quelque chose en échange d'activités sexuelles?

Partenaires masculins

☐ Aucun
☐ 1
☐ 2
☐ 3 à 5
☐ 6 à 10
☐ 11 à 25
☐ 26 à 50
☐ Plus de 50
☐ Je ne sais pas

Partenaires féminins

☐ Aucun
☐ 1
☐ 2
☐ 3 à 5
☐ 6 à 10
☐ 11 à 25
☐ 26 à 50
☐ Plus de 50
☐ Je ne sais pas

7. Quel âge avais-tu au moment de ta première relation sexuelle avec pénétration?

_____ans

Renseignements sur la contraception

8. Selon toi, à quel moment de son cycle menstruel une femme a LE PLUS de chances de devenir enceinte?

☐ Juste avant ses règles
☐ Pendant ses règles
☐ Juste après ses règles
☐ Au milieu de son cycle
☐ Je ne sais pas

9. Comment considères-tu tes chances de devenir enceinte durant la prochaine année?

- ☐ Aucune chance
- ☐ Faibles chances
- ☐ Pas mal de chances
- ☐ Beaucoup de chances

10. Pour toi, la contraception est :

- ☐ Pas importante du tout
- ☐ Un peu importante
- ☐ Pas mal importante
- ☐ Très importante

11. Utilises-tu le condom lors de tes relations sexuelles avec pénétration?

- ☐ Non
- ☐ Rarement
- ☐ La moitié du temps
- ☐ La plupart du temps
- ☐ Toujours

12. Utilises-tu actuellement un moyen de contraception (autre que le condom)?

- ☐ Non
- ☐ Oui➔ Lequel? (coche tous les choix qui s'appliquent) :

  - ☐ Pilule contraceptive
  - ☐ Injection d'hormones (Dépo Provera)
  - ☐ Gelée, crème ou mousse contraceptive
  - ☐ Éponge contraceptive
  - ☐ Diaphragme/cape cervicale
  - ☐ Stérilet
  - ☐ Méthode du thermomètre/rythme
  - ☐ Retrait (coït interrompu)
  - ☐ Autre moyen (à l'exception du condom)

    Lequel :_____

13. As-tu l'intention d'utiliser un moyen de contraception durant la prochaine année?

- ☐ Non
- ☐ Oui➔ Lequel?_____

14. As-tu déjà utilisé un contraceptif oral d'urgence (« pilule du lendemain »)?

☐ Non➔ Pourquoi?
- ☐ Je n'en ai pas eu besoin
- ☐ Je ne savais pas où aller le chercher
- ☐ Je ne savais pas que ça existait
- ☐ Je ne veux pas en utiliser
- ☐ Autre : Précise : _____

☐ Oui ➔ Si oui, combien de fois?_____

➔ Où as-tu obtenu un contraceptif oral d'urgence (« pilule du lendemain »)? (coche tous les choix qui s'appliquent)

- ☐ À la clinique des jeunes de la rue du CLSC des Faubourgs
- ☐ Dans un autre CLSC
- ☐ Dans une pharmacie
- ☐ Dans une clinique privée
- ☐ Autre :précise :_____

Renseignements sur la grossesse

15. Présentement, es-tu enceinte?

☐ Je ne sais pas
☐ Non
☐ Oui➔ Cette grossesse était-elle?

- ☐ Désirée et planifiée
- ☐ Désirée, mais non-planifiée (pas le bon moment par exemple)
- ☐ Non-désirée

16. As-tu déjà passé un test de grossesse dans ta vie?

☐ Non
☐ Oui ➔ Si oui, combien de fois?_____

➔ Où as-tu passé ton (tes) test(s) de grossesse? (Coche tous les choix qui s'appliquent)

- ☐ Test urinaire passé à la pharmacie
- ☐ Test « maison » acheté en pharmacie et fait à la maison
- ☐ Test urinaire passé dans un organisme communautaire
- ☐ Consultation dans un CLSC ou une clinique médicale
- ☐ Consultation à l'hôpital
- ☐ Autre : précise : _____

➔ À quand remonte ton dernier test de grossesse?_____

17. Combien de grossesse as-tu déjà eues?_____

18. Cette (ces) grossesse(s) était(ent)-elle(s) planifiée(s)?

☐ Non
☐ Oui
☐ Certaines oui, d'autres non ➔Combien étaient planifiées?_____

➔Combien étaient non-planifiées?_____

19. T'es-tu déjà faite avorter dans une clinique :

☐ Non
☐ Oui➔ Combien de fois?_____

20. As-tu déjà tenté de t'avorter toi-même?

☐ Non
☐ Oui ➔ Combien de fois?_____

➔ De quelle(s) façon(s)?_____
_____

21. As-tu déjà perdu un bébé au cours d'une grossesse (fausse couche)?

☐ Non
☐ Oui➔ Combien de fois?_____

22. As-tu déjà accouché d'un enfant?

☐ Non
☐ Oui➔ Combien de fois?_____

➔ Qu'est-il arrivé avec ce (ces) bébé(s)? (coche tous les choix qui s'appliquent)

☐ Enfant mort à la naissance
☐ J'en ai la garde
☐ Il est gardé par un membre de ma famille
☐ Il a été mis en adoption
☐ Il a été placé en famille/centre d'accueil

Renseignements sur la santé sexuelle

23. Quand as-tu eu ta dernière visite médicale en lien avec la sexualité?_____

24. As-tu déjà passé un test PAP (frottis du col) dans ta vie?

☐ Je ne sais pas c'est quoi
☐ Non
☐ Oui ➔ Combien de fois?_____

➔ À quand remonte ton dernier test PAP?_____

25. As-tu déjà eu une infection transmissible sexuellement (une MTS) dans ta vie?

☐ Je ne sais pas
☐ Non
☐ Oui ➔ Combien de fois?_____

➔ Laquelle (lesquelles)? (coche tous les choix qui s'appliquent)

☐ Chlamydia
☐ Gonorrhée
☐ Condylomes (verrues génitales)
☐ Herpès (ulcère ou feu sauvage génital)
☐ Syphilis
☐ VIH/SIDA
☐ Hépatite B
☐ Autre(s) : _____

26. Es-tu vaccinée contre l'hépatite B?

☐ Je ne sais pas
☐ Non
☐ Oui➔ Combien de doses as-tu reçues?_____

Commentaires :_____
_____
_____
_____
_____

Merci de ta collaboration

Agence de la santé et des services sociaux de Montréal
Québec

ORDER FORM

QUANTITY	TITLE OF PUBLICATION (printed version)	UNIT PRICE (included all charges)	TOTAL
	Pregnancy and contraception among Montreal street-involved girls. Focus groups	**$10.00**	

ISBN NUMBER (printed version)
ISBN number 978-2-89494-855-2

Name _____

_____

Adress _____
No Street Apt.

_____
City Postal Code

Telephone _____ Fax _____

Orders are payable in advance by cheque or money order made out to the **Direction de santé publique de Montréal**

Please mail your order to :
Centre de documentation
Direction de santé publique
Agence de la santé et des services sociaux de Montréal
1301, rue Sherbrooke Est
Montréal (Québec) H2L 1M3

Information : 514 528-2400 poste 3646

Agence de la santé
et des services sociaux
de Montréal
Québec