Exploring Sexual and Reproductive Health Needs and Associated Barriers of Homeless Young Adults in Urban Ghana: A Qualitative Study

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Abstract

Background  Homelessness has become a major global and public health challenge, especially in low- and middle-income countries. This phenomenon predisposes young adults to severe psychosocial and health challenges.

Aim  To explore the sexual and reproductive health needs and behaviours of homeless young adults and challenges in accessing these services.

Methods  A semi-structured interview guide was used for data collection from in-depth interviews, focus group discussions, and key informant interviews. Data were collected between 01 June and 31 July 2020 from 30 participants using in-depth interviews, two focus group discussions involving 12 participants, and one key informant interview. Thematic analysis was used to analyse transcripts from the interviews.

Results  The findings show that certain behavioural patterns associated with homelessness impact the lives of homeless young adults in their sexual and reproductive health (SRH) choices, beliefs, and perspectives. This group faces several challenges in accessing sexual and reproductive health services (SRHS) such as modern contraceptives and abortion care. The high cost, and undesirable and unfriendly attitude of service providers in health facilities pose as barriers to accessing SRHS by homeless young adults.

Conclusion  Sustainable and proactive measures must be put in place to address the identified barriers. Timely delivery of accurate information and educative materials, ensuring affordability, and setting up of accessible and friendly facilities could improve SRHS for this group.

Social and Public Policy Implications  This study may inform and support policy guideline development to address homelessness and SRH needs of young adults in urban Ghana.

Keywords  Homeless · Young adults · Sexual · Reproductive · Health

Abbreviations

FGD  Focus Group Discussion
HIV  Human Immunodeficiency Virus
KII  Key Informant Interview
LMICs  Low- and Middle-Income Countries
SRH  Sexual and Reproductive Health
SRHS  Sexual and Reproductive Health Services
STIs  Sexually Transmitted Infections
SSA  Sub-Saharan Africa
NGO  Non-Governmental Organisation

Background

In many low- and middle-income countries (LMICs), universal access to sexual and reproductive health services (SRHS) is yet to be attained. The use of modern contraception in sub-Saharan Africa (SSA) remains low due to health system...
barriers, religious and cultural restrictions, lack of partner consent and support, misconceptions, lack of education, etc. (Adedze & Osei-Yeboah, 2019). In the young adult population, contraception option, provider choices, and accessibility are key elements hampering SRHS provision (Radovich et al., 2018). Consequently, young adults experience higher unmet needs of SRHS and are faced with a higher burden of unplanned and unwanted pregnancies compared to other adults in the reproductive age bracket (Gottschalk & Ortayli, 2014).

Homelessness has recently become a worrying phenomenon in LMICs. This menace which mostly results from internal migrations in the quest of seeking a better living, intra-family conflicts, freedom from parental control, etc., is rapidly growing in Ghana. According to Amoah et al. (2014), domestic conflicts, disagreements with parents, violence on children, and family breakdown resulting in the abandonment of children contribute to the rising homelessness among young adults in Ghana.

Previous studies suggest that in as much as young adults may possess knowledge about the risky sexual behaviours and benefits of modern contraception such as condoms, oral pills, implants, etc. in preventing the transmission of infections and pregnancy, many remain reluctant to its use and still engage in risky and harmful sexual acts. The common reasons often cited for their disinterest in condom use are implied lack of trust, long-term relationships, the need to please the partner, and decreased pleasure from condom use. Other contributing factors are lack of knowledge of benefits, less fear of contracting human immunodeficiency virus (HIV) and other infections, influence of tradition, alcohol and drug abuse, peer pressure, lack of power to negotiate, gender issues, and the refusal of the partner (Asante, 2016; Kanda & Mash, 2018; Mulauzi & Jabuli, 2018; Nwozichi et al., 2016). This may be contributing to the high young adult pregnancies in SSA.

Homeless young adults are more likely to; initiate sex earlier (Ammerman, 2013; Maria et al., 2020; Misganaw & Worku, 2013), have multiple partners, use substances during sex, and are less likely to use a condom for varied reasons including desire for unprotected sex, inaccessibility, cost, and/or partner’s disapproval of condom use (Ammerman, 2013; Edidin et al., 2012; Hudson & Nandy, 2012; Tevendale et al., 2008; Thompson & Pollio, 2006).

Trading sex as a means of survival is not uncommon among homeless young adults, and this places them at high risk of sexually transmitted infections (STIs) including HIV (Rotheram-Borus et al., 2003; Walls & Bell, 2011). Studies suggest that about 10–27% of homeless young adults trade sex for survival though these rates could vary considerably (Gangamma et al., 2008; Whitbeck et al., 2004). Whitbeck et al. (2004) highlight that many homeless young adults who trade sex often do so most frequently for money (82%), a place to stay (48%), or substances (22%). Risky sexual behaviours are prevalent among homeless young adults in Ghana as they appear to have less knowledge about sexuality (Anarfi, 1997; Asante, 2016; Wutoh et al., 2006) and are more likely to survive through engaging in unprotected sex and high-risk sexual behaviours leading to unsafe abortions and maternal mortalities, which result from lack of safe abortion regulations due to legal restrictions in Ghana and most parts of SSA (Anarfi, 1997; Oduro, 2012).

Although both homeless young adult males and females have sexual and reproductive health challenges, the young adult females have additional gender- and age-specific burden (Atuyambe et al., 2015) and are far more at risk—two to four times likely—of sexual abuses than women in general (Misganaw & Worku, 2013). There exists a complex interplay of factors placing sexually active homeless young adult females at a higher risk of unplanned pregnancies. These factors include poor sexual health knowledge which diminishes their in-depth understanding of risky sexual behaviours and the associated dangers of STIs (Oduro, 2012), barriers to accessing services, provider biases, stigma, etc. (Gottschalk & Ortayli, 2014).

There are growing concerns about the public health implications of young adults’ homelessness as the phenomenon inherently precludes them from basic human needs such as decent housing, quality health care, education, etc. (Asante, 2016). Although global efforts to expand SRHS access for young people have been prioritised, only a few studies have focused on where young people obtain these services including contraceptives (Radovich et al., 2018); even with this, most of these studies on factors associated with SRHS patronage among young adults have been among predominantly literate populations either in schools or attending family planning clinics (Kareem & Samba, 2016).

The exigencies of homelessness among young adults almost diminish their social inclusion, protection of their fundamental rights to dignified healthcare, among others. In Ghana, where social and healthcare systems are still developing, the systemic challenges in accessing general healthcare and SRHS may be worse for homeless young adults. This study aimed to explore the sexual and reproductive health needs of homeless young adults in urban Ghana and the associated challenges in accessing these services.

Material and Methods

Design

This study utilised a qualitative study approach to delve into the perspectives and lived experiences of homeless young adults, to seek insights and tease out the relevant social structures and pathways that clearly explain people’s
behaviour in this population under certain circumstances (Tracy, 2013).

We conducted in-depth interviews, focused group discussions (FGDs), and a key informant interview (KII) during scheduled physical meetings at locations within the places of residence of the study participants. We integrated in-depth interviews and FGDs in this study to generate detailed individual data and explore additional insights and complementary data whilst focusing on group dynamics. This approach was intended to help the researchers assess the similarities and differences between the individual and group-generated data.

Though the situational challenges could not permit researchers to be completely embedded in the living spaces of the study participants, the conduct of the interviews at these places allowed keen observations of the living conditions of the participants which served as means to validate responses to key questions on practices and behaviours. At certain points, participants pointed to or made references to several circumstances and places around their habitats which could be verified by the researchers to emphasise a point or demonstrate a scenario.

The KII involved a key stakeholder from a non-governmental organisation based in Ghana that works with young adults. This interview was conducted via the web due to circumstances posed by the SARS-Cov-2 and COVID-19 global pandemic.

**Study Setting**

The study settings were identified locations in Kaneshie, Agbogbloshie, Tema station, Okaishie, and Kantamanto in Accra, Ghana, inhabited by homeless young adults such as the streets, lorry stations, slums, and informal settlements.

**Inclusion and Exclusion Criteria**

Homeless young adults who were between the ages of 10 and 24 could speak English, Ga, or Twi, living within the selected study sites, willing to participate voluntarily, or with parental or guardian consent were eligible to participate. The exclusion criteria were those who were below 18 years and could not get parental/guardian consent and young adults who were not residing in the selected study sites. Additionally, young adults who could not speak English, Ga, or Twi were ineligible.

**Data Collection**

**In-depth Interviews**

The study population recruited for data collection consisted of homeless young adults between the ages of 18 and 24 years. Data collection was done through in-depth interviews involving 30 homeless young adults. The 30 respondents comprised 15 males and 15 females. Data were collected using a semi-structured interview guide with open-ended questions. Eligible homeless young adults were briefed and understood the concept of the study before providing consent for the interviews.

**Sampling**

A purposive and convenience sampling approach was used in selecting participants for the interviews. A snowball approach was adopted within the course of the data collection to get more respondents. A community liaison who lived in the area was identified and served as a link between the researchers and the participants and helped in reaching out to eligible participants. The purposive approach was used to identify study sites where potential participants could be reached. The snowballing strategy helped us to identify about 65 potential participants, and applying inclusion and exclusion criteria, 40 participants agreed to participate, however, after conducting interviews from 30 participants, no new information was obtained, and saturation was considered to have been reached.

Semi-structured interview guides were used to explore their lived experiences and gain an in-depth understanding of the phenomenon of homelessness and SRHS during the period of the interviews between June and July 2020. The guides for the in-depth interviews and FGDs were structured into broad topics from which the relevant questions were generated. These broad topics were on socio-demographic characteristics of homeless young adults in urban Ghana, reproductive health behaviours and practices of homeless young adults in urban Ghana, and health services utilisation of homeless young adults in urban Ghana.

All interviews and discussions were audio-recorded with consent from participants. The researchers took field notes alongside observing facial expressions, body language, and tone of voice of participants.

**Focused Group Discussions (FGDs)**

Two FGDs were conducted with 6 participants in each group who were different from in-depth interview participants. The FGDs were done separately for males and females. The discussions took place at different times and places within the participants’ living spaces. The participants for the FGD were recruited with the assistance of the identified community liaison. The participants were briefed on the aims of the study and the concept of the FGD and gave consent to participate and be audio-recorded. They responded to questions they understood and could relate to in turns. Each participant was allowed to respond to the same questions, but
some participants made their contributions as build-up to the points raised by other respondents and others skipped some questions. The FGDs lasted approximately 30 min.

Key Informant Interview (KII)

As a supplementary approach, a KII was conducted as part of the data collection process for this study. The researchers arranged for an interview with a key player from a non-governmental organisation in Ghana that works closely with young adults. The interview was virtual but followed a semi-structured interview guideline. Due to the limitation of having the interview online, it was difficult to take note of some important elements like body language and facial expressions. The interview lasted 40 min including the time spent to explain the modalities of the interview and consent. Given the background of the key informant, the KII was relevant for probing the institutional, personal, and systemic challenges homeless young adults face in seeking sexual and reproductive health services in urban Ghana.

Data Analysis

Participants were assigned unique identification codes against their responses to conceal their actual identities during the interviews and these codes were used in the analysis. The interviews conducted in Ga and Twi were translated verbatim into English, transcribed into Microsoft Word, and coded and sorted into themes in Microsoft Excel as basic data. The themes were identified through an inductive process by following similar patterns among codes. We ensured these themes were accurate representation of the data as well as being useful. New sub-themes and patterns were added as they emerged. Thematic analysis was done, and the themes, sub-themes, and patterns were reported.

Ethical Considerations

Approvals were obtained from the Ethics Review Board of the University of Gothenburg and the Ethical Review Committee of Ghana Health Service (Ref.: GHS-ERC 029/12/21).

An information sheet providing an overview of the study including the aims, nature of research, study duration, relevance of the study, potential risks, benefits, cost, compensation, confidentiality, voluntary participation/withdrawal, outcome, and feedback to participants, funding information, sharing of participants information/data, provision of information and consent for participation, ethical approval, publication of findings, and contact persons was made available to the participants. This sheet was read and interpreted to the participants in the languages they understood and were allowed to ask questions or clarify any issues they had. All participants were then asked if they wanted to participate in the study, and those who wanted to participate were asked to provide an informed consent by filling a consent form. Unique identity numbers were used to conceal participants original identity during the study.

A community liaison who lived in the area was identified and served as a link between the researcher and the participants. Firstly, the community liaison was briefed on the concept of the study and engaged in a further discussion to understand the full scope of the study. In the next step, the liaison introduced the researchers to the homeless young adults at different locations. The involvement of the liaison enabled the researchers to freely communicate the details, the significance, and future implications of the study to the study participants. It also gave easy access to eligible participants who would otherwise be difficult to reach or may refuse to participate in studies of this nature.

To offset the possibilities of recruiting minors without parental/guardian consent, the liaison identified older homeless adults living at the study locations to whom the minors were attached and could play parental/guardian roles. These older adults were the targets for parental/guardian consent. These older adults should a minor be interested in the study; however, all participants recruited in this study were between 18 and 24 years.

Results

The study participants who were homeless young adults between 18 and 24 years shared their experiences on their sexual and reproductive health needs and services. The perspectives of the participants are grouped into four general themes (Fig. 1): Life, Practices and Behaviours, Service availability and utilisation, Barriers and Challenges, and Stakeholder perspective.

Life, Practices & Behaviours

This theme explored the participants’ practices, behaviours, and social background. Participants shared their knowledge on sexual and reproductive health (SRH) and delved into their sexual practices and behaviours whilst justifying these acts. Most participants (10 females and 12 males) in the in-depth interview had basic education (up to junior high school level). Four female participants and 6 male participants completed a second cycle institution (senior high school). The patterns which emerged under this theme include:

SRHS Knowledge and Sources of Information

Participants shared their knowledge about SRHS as well as the sources they obtain their knowledge and/or information. It is intriguing to note that most participants who had
fair idea of SRHS and rights were informed in schools, by peers, through the mass media, and through education at health facilities. Most of the female participants (12) and 7 male participants knew SRHS.

I gained some information about sexual reproductive health services and rights from school and in some hospitals, they give some education on it. Once, I visited the hospital and I heard about it (F09, 24-year female).

Some time ago they used to talk about this on the radio that was when I first got to know about it, but recently I do not get any information anymore (F11, 24-year female).

I was introduced to the subject of sexual and reproductive health services by my friends. They told me everything they knew and had also gathered from other friends. Since then, I endeavoured to get additional information by talking to those who had expertise like a community nurse I had as a friend (F15, 18-year female).

It emerged that 3 female and 8 male participants did not know about sexual and reproductive health services and/or rights. The excerpts below indicate that education and outreaches on SRH for young adults are primarily centred in schools and health facilities. The gaps in information dissemination are seen in the apparent neglect of those living on the streets. The role of peers in educating out of school homeless young adults on SRH could be harnessed.

I have never heard this from anywhere, today is the very first time I am hearing this. Is it related to people living out here? (F04, 18-year female)

I have not heard about this; I don’t know anything about this topic, and I don’t have kids, so it doesn’t concern me that much (M12, 24-year male).

Despite this gap in information and education dissemination, a key informant from a non-governmental organisation that is a major stakeholder in adolescent sexual and reproductive health rights and services advocacy explained the approach used to reach out to young adults in communities and schools:

We have grouped communities into zones and there are four zones in each community we operate and every month we meet the young adults and nursing mothers to educate them and empower them. In some areas, a zone may cover the young adults without a defined place of residence. We have senior high schools in the communities, and we collaborate with their teachers to organize seminars to give them information on sexual and reproductive health services. We organize these seminars because they don’t get details of SRH issues in the schools. We have two community radios what is usually referred to as information centres and we use these channels to relay information to everybody. This helps us to send information across which can be received by everyone. These are the two main approaches we use to send information at all levels and engage with young adults (KII).
Sexual Practices and Behaviours

Participants elaborated their sexual practices and behaviours and shared their lived experiences regarding sexual and reproductive health under this sub-theme. This sub-theme to a large extent exposes the precarious situations homeless young adults face including early and mid-teenage sexual debuts, multiple sexual partners, and risky sexual practices/sex trades.

Participants narrated the circumstances which led to their first sexual encounters as well as the ages these events occurred. The participants first sex experiences highlight the exploitative nature of these experiences and the problems related to consent such that participants were either manipulated or coerced in most instances.

There was a group of friends who told me they were moving to Accra to find jobs, they said all the money anyone ever wanted was in Accra, so I spoke to a man who worked as a mechanic where I lived in Kumasi to help me with some money so that I could move to Accra with my friends, he said he was going to help me but he would have sex with me. He told me it was not painful and that every girl does it. Time was running out since my friends were moving the next morning and I didn’t know the way to Accra by myself, so I agreed, and he had sex with me. I was 13 years (F03, 21-year female).

My first sex was at 15 years. I followed some friends to a party and after that, we shared ourselves into groups, I woke up naked and I realized I had had sex. I felt pain afterwards, but I felt fine later (F15, 18-year female).

I was 9 years. It was a girl who taught me this for the first time. It happened at a time I didn’t know so much about sexual issues especially with boys and girls. It was the girl who approached me and expressed interest in me. I agreed, and I had sex. We started having frequent meetings and I started sleeping over at her place at certain times (M01, 22-year male).

Participants disclosed the number of sexual partners they currently have. Most female participants cited financial circumstances as the reason for keeping multiple partners:

Currently, I have 4 lesbian partners, because when I go in for the men, they don’t give me much money and the coronavirus pandemic has worsened my situation with men. They give me a lot of money that I use to manage myself. If I visit my lesbian partner in Korle Gono and she does whatever she likes with me, she gives me money to at least feed myself. And now it has become part of me. It is the current global pandemic that has made some of us become lesbians although we were not lesbians initially (F03, 21-year female).

I have more than 8 sexual partners because I am not working, and I depend on them. I have both male and female partners (F04, 18-year female).

Currently, I have three partners, but I am more serious with one. I only rely on the other two for financial support (F06, 19-year female).

Conversely, most male participants gave financial reasons for not keeping multiple partners:

Currently, I am alone, I am single, and I don’t even feel the need to get a partner anytime soon. I don’t need anything from a woman anymore, whatever I wanted to explore I have already had it and I don’t have money to support a girl now (M03, 20-year male).

I don’t have any partner now, but before I had one, and because I don’t have a job and I cannot take a girlfriend. The money I make in a day, I can only eat from it and cannot share with anyone (M09, 21-year male).

Homeless young adults engage in several behaviours as means of survival. These behavioural responses expose them to severe risks and dangers. Participants in this study revealed deep-rooted risky practices and survival mechanisms among young adults. Some participants shared their experiences regarding exchanging sex for money, food and/or shelter. The responses indicate the extent of sex commercialisation among these young adults. Though the quotes from these participants show worrying practices among homeless young adults, several participants indicated they often have sex for fun, to celebrate, or to prove their love to their partners.

I do it mostly for food and shelter. Money is also very important for me. Some men promise money, but they finish [having sex] and they give excuses. Some promise GHS 10 ($1.60) but when we finish, they give only GHS 4 ($0.6). It is because of this attitude of men I like the lesbians because they are not stingy; they give so much money; I don’t know how come they have that much money, but we enjoy it (F03, 21-year female).

I give sex for money because I am not working. I get between GHS 50–150 ($8–24) and that is the money from which I will feed, buy clothes and sanitary items (F04, 18-year female).

I do it as means to survive, because after sex, whatever I get, I use it for food, pay for where I must sleep and eat as well. Even here on the street, if you want to be safe at night you have to pay to sleep at a decent place. So, it is for all (F07, 18-year female).
A girl has given me money for sex before. Sometimes it is food or when your sleeping place is flooded or destroyed, a girl who has a good place to sleep and likes you can take you to her place and you can’t refuse her if she asks for sex (M10, 19-year male).

Past Pregnancy and Prevention of STIs

This study explored past planned/unplanned pregnancy episodes among female participants and their attitudes and practices towards pregnancy and sexually transmitted infections (STIs) prevention. Past pregnancy strongly featured in the responses of the participants. Ten out of the 15 female participants in the in-depth interview had been pregnant recently or in the past year. Only one of these ten pregnancies was planned. Four male participants indicated their partners had been pregnant recently:

I got pregnant last year. This was not a planned pregnancy, and I didn’t have money at the time so I could not do anything to prevent it like taking pills before or after sex. These pills are expensive so I can’t afford them every day (F04, 18-year female).

I have been pregnant before and I have a child. The pregnancy was not planned but I had to give birth anyway. I decided to give birth and enjoy life later (F10, 24-year female).

I had an unplanned pregnancy last year. I was very worried because I least expected it and didn’t know what was going to happen (F14, 19-year female).

These quotes present a case of high risks of unplanned pregnancies and a potentially high prevalence of STIs among homeless young adults. This is confirmed by the accounts of participants on previous infections or treatment of venereal diseases. These accounts depict strong indications of low prioritisation of condom use among this population which could be as results of inadequate knowledge about condom use as expressed by some participants.

I experienced a severe burning sensation in my genitalia and some discharge last year some days after sex. I went to the clinic for treatment, and they advised me to protect myself. I usually take pills after sex and I prefer to have sex without condoms, but I know that is dangerous (FGDF1, 19-year female).

I had a bad infection; it was hard for me. It happened some weeks after sex with a guy. I don’t know what it was, but it was terrible, and my friends said I have been infected with an STI because I had sex without a condom (FGDF2, 22-year female).

It has happened a couple of times to me. You sleep with a guy with a disease, and he refuses to say it or use a condom and the next day you are infected. It is really painful dealing with it, and it is also expensive to get treatment (FGDF4, 19-year female).

I had gonorrhoea from a lady, I suffered. When I told my friends, they told me that the disease is from girls (FGDM1, 22-year male).

When asked about the use of condom for protection during sex participants shared varied opinions which mostly pointed to inadequate knowledge about condom use:

I don’t like condoms because I even heard on the radio that if you have sexual intercourse with a man using condoms you can contract certain diseases, so I think it is not good (FGDF3, 24-year female).

I think condoms are not good, I once used a condom with a man and I had a burning sensation in my vagina so, I now have sex without it. I only have to make sure I don’t get pregnant (FGDF5, 20-year female).

For me I don’t know much about condoms because I have never used them, I don’t know how to use them. I only know about family planning injections and pills (FGDF1, 19-year female).

Methods for Preventing Pregnancy

Female participants demonstrated concerns about preventing pregnancies rather than ensuring safe sex to prevent STIs. Female participants indicated the use of family planning methods such as pills and injections for pregnancy prevention. This implies that once pregnancy could be prevented using other means, the use of condoms which prevent STIs in addition to pregnancies may not be prioritised.

I use drugs to prevent pregnancies because if I don’t take the drug, it will be my burden. After all, the men always deny the pregnancy and they will say they are not the only ones having sex with you and they deny you. I just go to the drug store to buy drugs (F03, 21-year female).

I have been preventing pregnancy by using pills because I didn’t want to bring out all the children from my stomach so that when someone tries to marry me, I wouldn’t be able to have children for him (F15, 18-year female).

I know family planning and condoms help a lot, that’s all I know. Condoms can help prevent infections if they are good. I have used the 3 months method and it is not good for me, it makes me look awful, I don’t feel good about myself anymore. It makes me feel sick all the time and I want to take it off (FGDF1, 19-year female).

The responses of male participants indicate a delegation of pregnancy prevention responsibilities to their partners. It also shows low prioritisation of condom use for protection against STIs:
It is the lady who takes drugs to prevent pregnancy, but I don’t, I only give her money to buy it. She has the responsibility of ensuring she is not pregnant (M13, 24-year male).

The lady I had used to use drugs, I don’t remember the name of the drug, but she uses one often whenever we are about to have sex, because of the drug she doesn’t use any injections. Since she takes care of that I don’t pay attention (M10, 19-year male).

**Forced/Coerced Sex and Safety of Sexual Activities**

Under this sub-theme, participants shared their lived experiences on forced sexual encounters and described the safety of their sexual activities. Three male participants admitted to forcing their partners for sex:

*I used to force my partner with whom I had a child for sex. When I am in the mood, and she resists I try any means to overpower her to have my way (M03, 20-year male).*

*I have forced a lady for sex several times, because sometimes when I want to have sex and she is not getting in the mood like the way I want, and sometimes, she is resistant, so I get bad thoughts and I have to force her for sex (M04, 20-year male).*

Participants shared different views on what safety means to them and from the below quotes, it can be deduced that the safety of sexual activities of homeless young adults is highly endangered as safe sex is only understood as avoiding pregnancies. This could be due to the misconceptions about safe sex aimed at preventing pregnancy and ensuring reproductive wellbeing. Substituting the use of drugs, alcohol, drinking enough water after sex, or having sex only on safe days as safe sexual practices could rather exacerbate the dangers associated with unsafe sex. On the other hand, a score of the participants demonstrated knowledge of safe sexual practices and indicated how they prioritise these practices.

*For me there is no safety involved, I wouldn’t want to say we are prostituting but once we dress up and step out to be called by men, and they express interest in having sex with us, I think it is the same. And I have never used a condom and so I have little knowledge about it. I always do it ‘raw’, and sometimes I go in already drunk (F07, 18-year female).*

*I do not consider safety whenever I am having sex, and I don’t usually dictate whether the man should use a condom or not (FGDF1, 19-year female).*

*It feels safe for me because since I know the lady’s menstrual cycle and dates, I know when we will have sex and she wouldn’t get pregnant (M04, 20-year male).*

Sometimes, it all depends on the girl, some girls move from one man to the other and for those girls, before you do anything with them, you need to question yourself, and know this girl who doesn’t stay with one man, she is likely to get you infected with a disease, but if you are sure that the girl is committed to only you, nothing crosses your mind to use any form of protection but you only use your experience before you have sex with her. Apart from that, I am not scared of getting any infections, it all depends on your partner not being a promiscuous person (M06, 22-year male).

**Service Availability and Utilisation**

Due to the peculiar challenges of homeless young adults such as lack of jobs, poor educational background, low-income status, indecent accommodation, etc., they somewhat segregate from the larger population and accessing certain services become untenable. The study explored the availability of SRHS and sought to understand how these services are utilised. A key informant explained from a stakeholder perspective the role of NGOs and public facilities in providing SRHS to young adults:

*What we do for young adults when it comes to sex in reproductive health services is that we give them education concerning sexual and reproductive rights and services. Secondly, we provide them with all the family planning details they need especially the ones they decide to patronize, so we give them detailed education and information on where and how to access and utilize them. Additionally, reproductive health centres in most facilities provide this kind of education to young people (KII1).*

Quizzed further on the availability and accessibility of these services to young adults, especially the homeless, the key informant explained that the services provided are open and available to the public and reiterated the privacy of patrons of their facilities/centres is assured.

*It is open to everybody, so the homeless young adults can walk in and ask questions on anything bothering their mind and any service they want. Their privacy is assured, and the locations of the facilities are safe for them because mostly they come in and they are shy, so the name of the places is even friendly/motivating enough for them to go in and make enquiries. These are called youth-friendly centres. It’s convenient for them to go in (KII1).*

Three main sub-themes emerged under this theme and participants shared their experiences on accessing the available services and care.
Condom Access and Usage

Participants showed easiness in obtaining condoms from pharmacies or drug stores, though it sometimes becomes difficult to procure them due to age challenges. Though condoms are relatively easy to come by, some participants indicated previous use of condoms, and the decision to use or not was expressed variedly:

I buy condoms from the drug store, but it is not something I like, some of the girls like it when I use condoms, others will also tell me that I don’t love them that’s why I use a condom (FGDM1, 22-year male).

Getting a condom from a pharmacy is easy if you meet a younger person at the counter. The old men and women will always ask you questions before they give them to you. It is very bad (FGDM4, 20-year male).

It is the ladies who try to talk me into using it, a lady said I could find one from the drug store but over there they ask you too many questions before selling you the condom because they see you as a ‘teenager’ who shouldn’t be buying it (FGDM4, 20-year male).

It can be observed from the quotes below that there is inadequate education or information about condoms and contraceptives use among homeless young adults. The thoughts expressed in these quotes to a larger extent influence utilisation of condoms and other contraceptives.

Whenever I use condoms, the sex does not feel good and the man wouldn’t even give me a lot of money, the condom slows down the game so much! So, I have decided not to use them (F03, 21-year female).

I don’t like using condoms. I just don’t like it because now there are drugs to take so I prefer drugs to use a condom. If my partner wants to use a condom, I would not agree but if it’s a boyfriend I have found from the blues yes, I would agree to use a condom for protection (F09, 24-year female).

I have used a condom before but now I have stopped because it is not good. It causes a lot of effects, it makes the girl’s tummy swollen, if you use the condom for a long time, you will notice the girl’s stomach has become big as if she is pregnant, but she is not (M09, 21-year male).

Modern Contraception

It was observed from the responses provided by the participants that modern and quality contraceptive services including any use of oral contraceptive pills (daily/emergency), implants, injectables, contraceptive patch and vaginal ring, intrauterine device (IUD), female and male condoms, female and male sterilisation, and vaginal barrier methods (including the diaphragm, cervical cap and spermicidal agents) among homeless young adults are underserved although most participants, especially females, knew the sources where modern contraceptives could be obtained.

I get them from the pharmacy and from the hospitals too, but the ones sold at Korle-Bu (Teaching Hospital) are very expensive, they cost about GHS 300–400 ($48.5–64.7), and I can’t afford that, but the pharmacies sell more affordable ones (F04, 18-year female).

They sell these drugs along the street; you can just walk to them, and they know what to give you. We get some of these things too from drug stores or hospitals, it all depends on the amount of money you have at hand then you will decide where to get help (F07, 18-year female).

These products can be found in pharmacies and hospitals as well. The contraceptive service you get depends on how much you have or willing to pay. If you can pay for a quality one, you go to the hospital, otherwise, the pharmacy or those selling on the streets can help (F12, 19-year female).

The high cost of safe modern contraceptives can reduce uptake. In as much as this could play a role in low utilisation of contraceptives among homeless young adults, participants expressed several opinions on contraceptive use. The responses re-echo the need for prioritisation of sexual and reproductive health education and outreaches among homeless young adults as well as for fighting against misconceptions about contraceptives.

The 3-month method was not good for me so generally, I think it is not good… Some people do it and never menstruate, that is not a good thing (FGDF4, 19-year female).

I barely use any of these contraceptives, we rather take a lot of alcohol after sex, but my friends showed me some herbal preparations that I can take after sex and the semen will all come out. I am unable to afford contraceptives because the man gives me only GHS 20 ($3.2) after sex and if I use this money to purchase any of these things, I will not have anything left (F07, 18-year female).

I think it is not good. Someone told me some people go to the hospital and it gets expired in their body. And that comes with many side effects, so I think it is not good (FGDM1, 22-year male).

Abortion Care

From interviews and discussions with participants, it was noted that abortion is a major health challenge among homeless young adults. Participants responded
to undertaking abortion at least in the past year. Of the female participants, 12 responded to having had an abortion in the past year whilst 5 male participants indicated their partners have had an abortion.

I did an abortion the last time I got pregnant. How can I afford childcare with no work or money or support from anyone? My partner is not also working. We are all hanging out here, so it is difficult (F02, 20-year female).

Since we have no decent place to live nobody cares about us, so you must make your own decisions. I aborted my last pregnancy and plan to abort any pregnancy till I am ready because if I don’t, I will not be able to support myself and the child and there is no help anywhere (F03, 21-year female).

I aborted it myself, I went to buy drugs at the pharmacy, and it worked for me. The main reason was that I was not prepared for a child, even now. The burden will be too much if a child comes in (F04, 18-year female).

Sources of abortion care are crucial for safety reasons. Unsafe abortions contribute to post-abortion complications and mortalities and the practices shared by the participants in the above quotes present alarmingly dangerous situations. Self-medication with over-the-counter drugs or herbs is a major public health concern that could lead to several medical complications including death. Participants further revealed where they last got an abortion or would access abortion care if they or their partner(s) needed it and it was observed that most abortion services were obtained or would be undertaken by unqualified personnel, at unapproved facilities, and using potentially harmful medications.

When I go to the pharmacy and narrate the situation, they provide some help but if I have enough money I will go to the hospital where they will do it properly (F05, 21-year female).

I usually tell my friends about it, they call a certain man, and they show me which herbal preparations to use, they just take me to where they sell the drugs and we buy it, when I take it and start bleeding, they boil some extra herbs then I top it up with other drugs to get it completely done. I go often so they know which herbs are good for me and which ones are not (F07, 18-year female).

I got pregnant with one of my partners just last month and he suggested an abortion, he did not take me to the hospital, he took me somewhere and we bought a drug worth GHS 160 ($25.9), after taking the drug in the morning, by evening I started bleeding heavily with pains (FGDF5, 20-year female).

My first partner was pregnant, and we agreed to abort the first one and be careful subsequently, so we approached someone who knows how to do it and we paid him for it (FGDM4, 20-year male).

### Barriers and Challenges

This study explored the barriers and challenges homeless young adults face in accessing SRHS. The key informant identified what can be considered as complex and systemic barriers homeless young adults face whilst accessing sexual and reproductive health care. In addition to religious, financial, and healthcare providers’ attitude, homeless young adults also face peer influences and misconceptions which dissuade them from accessing these services.

Major barriers include religion, financial, and misconceptions and the others are peer influence and inadequate information about sexual and reproductive health services. Attitudes of healthcare workers towards these young adults are a key barrier to sexual and reproductive health services (KII1).

A major challenge the participants appear to face in accessing SRHS is the financial cost associated with these services and these young adults are mostly unemployed without regular income. The high costs of SRHS deter homeless young adults from patronising quality services provided by professionals at approved centres and facilities. The consequential effect of this is the use of self-medication and unprofessional services for SRHS, especially abortion.

I think it all depends on money because I think if you have money and you go to the hospital, you will not have any problems. For me, I do not even have the money, so I do not even think of going there. Sometimes we prepare our herbs, and we take them to make us feel better, so we do not go to the hospital. I have not been to the hospital to get these services, but I have heard about how those who go are treated. It is not the best (F07, 18-year female).

The prices of medication and treatments in the hospitals are too high but the ones on the streets are mostly substandard. It is very expensive to do an abortion in these public hospitals and my girlfriend said the family planning charges are also high there. Instead of spending huge monies at the hospital while we have nothing to eat, we would approach someone who can provide the services we are seeking. There are many places around here where give you a concoction for you to abort (M15, 18-year male).
Unfriendly Facilities & Provider Attitude

Participants shared healthcare provider attitudes towards homeless young adults seeking SRHS in health facilities. In most circumstances, the rights of these homeless young adults to healthcare are not respected. Participants recounted the unfriendly environment and circumstances which shows the extent of unprofessional attitudes or treatments from care providers they often received whilst seeking SRHS.

My experience with the staff of sexual and reproductive health services is that they do not give us so much attention and they treat us badly and for this reason, I would not want to go to the hospital for any service (F14, 19-year female).

Sometimes when we go to the hospital because we are young, they shout at us and waste our time, so this is one of the biggest problems I have been experiencing for which I am reluctant to seek any care there (F15, 18-year female).

It is difficult to go in and ask for an abortion especially if you are a young person. My friends and I always must look for an older person to act as an auntie or mother, so they don’t embarrass us (FGDF4, 19-year female).

Whilst participants who visited public hospitals had unfriendly reception, those who accessed SRHS from private clinics were generally satisfied with the services they received.

The last time I took a friend to a hospital for family planning and when we got there, one of the nurses said ‘young children like you, because of sex you are here’, I felt very ashamed and I didn’t want to stay, my friend was courageous to condone her attitude, but I couldn’t, so I left (F03, 21-year female).

My first experience there (at a hospital) was on account of pregnancy, and it was bad, and it doesn’t give me any joy or willingness to ever step there again, the scolding was too much…. The way the nurses shout at people is not good; because of these bad treatments I would rather go to the pharmacy and get treated (F04, 18-year female).

In the private hospital, they were good, the nurses spoke to me nicely and they were very nice to me so whatever was bothering me I told them about it because if the nurse is not cool with me, I wouldn’t tell him or her whatever problem I am having. Some of them can be very rude especially in the big public hospitals (F09, 24-year female).

Where I visited was a private clinic, the treatment was very good, and they treated me with respect I recommended it to my friends (F13, 19-year female).

In an overview of sexual and reproductive health care delivery, participants underscored the usefulness of these services and implored stakeholders and service providers to be proactive in addressing the systemic challenges they face.

I think the way they provide these services benefits us, as for me I feel they do not even care, they are just doing it for others. I believe the authorities can put the right structures in place to ensure those who need these services the most are not hindered from accessing them (M08, 18-year male).

These things are good for me personally, I wish I knew more to help myself and my partner, but we do not easily come by the services or information (M15, 18-year male).

It is a good thing, but we have to struggle before we get these services, and if you go too, they treat you badly (M09, 21-year male).

From a stakeholder perspective, sexual and reproductive health services for homeless young adults can be improved through health educations geared towards providing adequate information to deal with misconceptions.

Firstly, intensifying health education will help to clear doubts and misconceptions they have about sexual and reproductive health services. Secondly, by strategically setting up youth-friendly centres at well and convenient places where these homeless young adults can conveniently access these services without any hindrance. It would also be ideal to maximize these services for the homeless young adults who are not able to patronize them due to inadequate finances. (KII1).

Discussion

The findings from this study highlight arrays of practices and behaviours of homeless young adults in Ghana regarding sexual and reproductive health care. These findings shed light on the barriers homeless young adults face whilst accessing SRHS in the cosmopolitan city of Accra. The results present an overview of the SRH needs of homeless young adults and focus on exploring their practices and behaviours given the realism of their social status.

Studies suggest that homeless young adults in Ghana have less knowledge of sexuality (Anarfi, 1997; Asante, 2016; Wutoh et al., 2006) and have a high likelihood of engaging in unprotected sex for survival. In Ghana, education on sexuality and reproductive health is widely centred in school settings with often scrutinised content and a limited prioritisation of out of school homeless young adults (Amankwaa et al., 2018; Asante, 2016; Geugten et al., 2015). The gaps in outreach and information dissemination
to the homeless young adults on issues of SRH rights and services only increase the health inequities and deepen the systemic disregard of the SRH needs of these young adults.

Oduro (2012) describes in a prior study how young people employ their sexuality as a coping mechanism against poverty. This current study unveils such mechanisms as multiple sexual partners, illegal abortions, disregard for safe sexual practices, and trade of sex for financial and other personal gains. Previous studies suggest that having multiple sexual partners and unsafe sexual activities (inconsistent use of condoms) are closely related to the sex trade or transactional sex especially among female young adults (Asante et al., 2016; Valente & Auerswald, 2013; Wutoh et al., 2006). This practise is common among the homeless young adults in this study who consider it as a response to survival.

High rates of pregnancies, infections, and unsafe abortions among young adults have been blamed on the poor utilisation of SRHS (Ezenwaka et al., 2020), that notwithstanding, a cursory look at the availability of these services to vulnerable young adults brings to bear a twofold key contributory factor. Whereas young adults are reluctant to engage in safe sexual activities as a result of their exploitative nature, those who desire to use these services face numerous challenges (Ezenwaka et al., 2020; World Health Organization, 2018) and the status of homelessness adds further constraints. The results from this study highlight the knowledge of homeless young adults on the availability of SRHS at designated facilities and reveal their preferences for cheap and accessible alternative services regardless of the dangers involved especially with abortion care.

Misconceptions about reproductive health services greatly influence decision-making and choices and the homeless young adults encountered in this study who had taken stances on non-prioritisation or utilisation of SRHS appeared to have based their judgements on inaccurate information or uninformed conclusions. Perceived inefficiencies, inherent dangers associated with services, violation of rights by service providers/unfriendly providers, and religious beliefs contribute to the non-utilisation of services albeit possessing adequate knowledge (Adedze & Osei-Yeboah, 2019; Shabani & Tshitangano, 2019).

A prior study reports that young adults perceive four main barriers to access of SRHS which are identified as the facility level, provider level, community level, and personal level barriers (Abuosi & Anaba, 2019). It is apparent from the findings of the current study that facility and provider-level barriers are major challenges facing homeless young adults in accessing sexual and reproductive care. In as much as personal barriers including financial constraints play a major role, it is imperative to ensure that health facilities and professional service providers are welcoming and reassuring to create a friendly relationship.

It is evident from the gender variations in several responses to key questions on sexual practices and behaviours that the factors influencing practices and behaviours among homeless young adults are unparallel. From the experiences of female homeless young adults, major means of receiving financial support and other benefits is through keeping multiple sexual partners with the expectation that these partners would provide for their needs. This dependency on sexual partners may likely reduce their negotiation power for safe sex. In contrast, male homeless and often unemployed young adults tend to be guided by the financial implications of keeping multiple sexual partners and act otherwise.

The need to provide safe, accessible, and affordable SRHS to homeless young adults should be a shared responsibility to ensure comprehensive coverage and implementation of sustainable policies. Several actors including the government and state agencies such as the ministries of health, youth, gender and social protection, the social welfare department, and non-governmental organisations need to collaborate to tackle this menace. It is important that in planning interventions for the youth, stakeholders pay critical attention to the needs of homeless young adults as they fall in the ‘hard-to-reach’ bracket (Flanagan & Hancock, 2010).

Conclusion

This study has explored the lived experiences of homeless young adults and has provided significant knowledge on the numerous issues confronting them in terms of their SRH needs and services. In addition to living in harsh environmental conditions with multiple deprivations, SRHS remains a major challenge for homeless young adults in urban Ghana. A holistic view of this phenomenon needs to be undertaken to ensure that service delivery to this vulnerable group covers the basics of education and information delivery, setting up accessible and friendly facilities to provide these services at affordable costs. It would be an exercise in futility if factors influencing utilisation and the barriers hampering access are not adequately dealt with.

Social and Public Policy Implication

This study may support policy guideline development to address homelessness and SRH needs of young adults in urban Ghana. The study highlights the social and health aspects of the activities of homeless young adults. Advocacy for interventions from the state, stakeholders, and development organisations to re-think the growing health implications of the increasing homelessness among young adults could be staged on the account of the findings of this
study. This can lead to the development of skill acquisition and training strategies to empower these young adults and subsequently reintegrate them into society with the acquired skills.

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Data Availability All data obtained from the study are presented in the results.

Code Availability Not applicable.

Declarations

Conflict of Interest The authors have no conflicts of interest to declare that are relevant to the content of this article.

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