HEALTH AND ACCESS TO CARE: PERSPECTIVES OF HOMELESS YOUTH IN BALTIMORE CITY, U.S.A.

JO ENSIGN* and JOEL GITTELSON

1Department of Psychosocial and Community Health, University of Washington, Seattle, WA 98195, U.S.A. and 2Center and Division of Human Nutrition, Department of International Health, The Johns Hopkins School of Hygiene and Public Health, Baltimore, MD 21205, U.S.A.

Abstract—Homeless youth suffer from high rates of health problems, yet little is known about their perceptions of or context for their own health issues. In this study, a combination of qualitative techniques from participatory rural appraisal and rapid assessment procedures was used to investigate the perceptions of health needs of shelter-based youth in Baltimore, ML in the U.S.A. The most common youth-identified health problems included STDs, HIV/AIDS, pregnancy, depression, drug use and injuries. These correlate well with more objective health status data for the same youth. The youth spoke of environmental safety threats of violence and victimization by adults, as well as racism and sexism in their lives. Youth reported that trusted adult figures such as grandmothers are important sources of health advice. Many homeless youth from less than ideal family situations remain in contact with and continue to seek advice from parents and other family members. Health interventions with urban street youth need to acknowledge the primacy of the social context for these youth, as well as the reality of violence as a daily health threat.

INTRODUCTION AND BACKGROUND

Current UNICEF estimates of the numbers of homeless adolescents worldwide are 100 million: 40 million in Latin America, 30 million in Asia, 10 million in Africa and the remaining 20 million in Europe, the United States, Canada and Australia (Emblach, 1993). The majority of homeless adolescents worldwide are concentrated in large urban areas. In the United States, estimates of homeless youth range from 500,000 to 2 million (Finkelhor et al., 1990) and demographic characteristics of homeless youth reflect those of the local community (Kruks, 1991). In general, homeless people are difficult to study due to lack of address, mobility and mistrust of persons in authority and homeless youth are even more ‘hidden’ and difficult to access (Farrow et al., 1992).

Health status data on homeless adolescents is limited in both quantity and quality. Studies have found high rates of substance abuse, depression and suicide attempts (Sherman, 1992; Greenblatt and Robertson, 1993) as well as unintended pregnancy (Farrow, 1991). Injuries, dermatologic problems (including lice and scabies infestations) and malnutrition are also reported (Deisher and Rogers, 1991; Reuler, 1991; Farrow et al., 1992). Anecdotal evidence suggests that most homeless adolescents face multiple barriers to primary health care and tend to seek care at emergency rooms (ERs) (Deisher and Rogers, 1991). Differences in health status between subgroups of homeless adolescents have been noted in several studies, with street-based youth exhibiting more severe health problems than shelter-based youth (Ensign and Santelli, 1997) or than children ‘on’ the streets (a term for children in developing countries who work on the streets but who go home at night versus children who live and work on the streets-children ‘of’ the street) (Pinto et al., 1994).

None of the published reports of health problems of homeless youth reviewed, included qualitative information on the youths’ perceptions of their main health and access to care problems. Most reports are either clinic-based chart audit research (Farrow et al., 1992; Sherman, 1992) or quantitative surveys of shelter and street-based youth (Greenblatt and Robertson, 1993). Similar limitations exist in the research on the health of homeless adults. However, the volume of research available for homeless adults is much larger than that for homeless youth and there also exist ethnographies and case studies of homeless adults which help to contextualize the health research. For example, Snow and Anderson (1993) provide an in-depth case study of homeless adults in Austin, TX, from research they did over a 2-yr period in the mid-1980’s. They tracked the institutional contacts of 767 homeless adults (mostly male) and conducted field observations as well as lifehistories on 6 homeless key informants in order to document the subculture of street life. Such in-
depth qualitative research is not available for homeless youth.

Most of the literature pertaining to health education for homeless adolescents focuses on HIV/AIDS prevention. HIV education programs designed specifically for and used with homeless youth are found worldwide (Radford et al., 1989). A barrier to effective HIV education among street youth is the fact that the long-term threat of HIV infection is often seen as irrelevant by them in comparison to immediate survival needs (Center for Population Options, 1990; Brown, 1991; Lowry, 1991). International health groups working with such high-risk and difficult-to-reach populations as homeless youth are increasingly training youth to be health educators. No rigorous evaluation of these programs has occurred, but it has been pointed out that such efforts can successfully tap into the natural peer pressure influences of adolescents, as well as provide an opportunity for increased self-esteem of the youth educators (Dalglish, 1991). However, even the most innovative of these youth as educator programs relies on exclusive adult formulation of the educational agenda.

Traditional health needs assessments are characterized by reliance on readily available health data from large surveys, clinic-based reports and quick site visits by health experts (Chambers, 1992a). Large-scale health surveys are expensive, time-consuming and usually insensitive to inclusion of the social context and participation by persons targeted for interventions. Site visits are brief, superficial and usually largely biased by established community gatekeepers who control what the health experts are able to see (Varkevisser et al., 1993). Although not always well defined conceptually or operationally, community participation in health needs assessment and health interventions is now viewed as central to the success and sustainability of primary health efforts (Alihonou et al., 1993).

Newer and more comprehensive health needs assessment methodologies have been developed in the area of international health. The two main approaches to assessment that have been applied to international health are PRA (participatory rural appraisal) and RAP (rapid assessment procedures). PRA was developed in the mid-1980’s in Thailand from agroecosystem analysis (Chambers, 1992b). PRA researchers emphasize the process of empowering local people by assisting them in identifying their own problems and then in developing, implementing and evaluating their solutions. PRA relies on visual, flexible and creative data collection methods such as community mapping and Venn diagramming and has been adapted and used for planning a variety of health and nutrition programs in developing countries (Chambers, 1992b). The reliance on visual methods can be especially useful in working with less literate populations (Heaver, 1991).

RAP originated in the 1980’s in the field of applied anthropology and focused on health and nutrition issues related to child survival initiatives in developing countries (Scrimshaw and Hurtado, 1987; Manderson and Aaby, 1992; Ramos, 1992). RAP was developed as a way of more quickly and efficiently doing applied qualitative research than more traditional in-depth ethnographies. RAP techniques are similar to those for PRA, but with a greater emphasis on direct observation, in-depth interviewing and systematic interviewing techniques. RAP also has less inherent emphasis on client and community participation (Scrimshaw and Hurtado, 1987). In the past 5–10 yr, RAP has been used as a study technique in many settings worldwide, with the majority of applications being for diseasespecific health education efforts (Manderson and Aaby, 1992).

U.S. health initiatives using RAP and PRA are rare; however, U.S. applications of RAP in the planning and evaluation of AIDS education and outreach programs have been reported (O’Reilly and Higgen, 1991; Scrimshaw et al., 1991; Ramos, 1992). Questions of reliability and validity of data obtained through techniques included in RAP and PRA arise (Manderson and Aaby, 1992). Studies comparing the results from RAP and PRA to large questionnaire surveys have found that the RAP and PRA results are as accurate as those for the questionnaires and may provide the data more quickly and cost-effectively (Chambers, 1992b). Major strengths of the information resulting from RAP and PRA are in providing rich contextual data which provide people’s own points of view and priorities and assist in the interpretation of quantitative data (Chambers, 1992b; Kachondham, 1992; Scrimshaw, 1992).

In the present study, a combination of techniques drawn from both PRA and RAP was used to conduct a health needs assessment of homeless adolescents in Baltimore. This paper presents information about the health status and access to care issues of homeless youth from their own perspectives. The data presented here has been used to assist in the development and implementation of appropriate interventions with this particular population. We conclude with a critical reflection on how well this methodology worked with this population as well as implications for work with similar high-risk adolescent populations.

METHODS

Population and setting

This study was carried out in the two youth emergency shelters in Baltimore City, the only shelters in the city that are specifically designated for homeless youth. The shelters serve approximately 150 youth per year, ages 12–17 and 98% of the
youth are from Baltimore City. The shelters have a maximum length of stay of 30 d. Baltimore City has a racial/ethnic composition that is approximately 59% African-American, 39% White and less than 2% from other backgrounds (Baltimore City Department of Planning, 1991). Over half of all children and adolescents in Baltimore’s inner-city core live in poverty and almost half of Baltimore City public school students drop out by 16 yr of age (Baltimore City Department of Planning, 1992; Baltimore City Department of Planning, 1993). According to the most recently available mortality data (for 1990), the leading causes of mortality in Baltimore City among adolescents ages 15–24 included homicides, accidents, suicide and AIDS, with the highest mortality rates being for African-American youth (Beilenson, 1994). Homicides accounted for over half of all deaths for all races in this age group and were responsible for almost 70% of all deaths among African-American male youth. At the time of this study, there were no existing estimates of numbers of or health data on the homeless youth of Baltimore. As a result of parallel quantitative data collection, health data for these youth were documented (Ensign and Santelli, 1997, 1998).

The principal researcher for the study was a white female nurse practitioner who has worked with homeless populations for 10 yr. She had three male research assistants: a white/Latin American medical student, a Ghanaian physician and an African-American health educator. All three research assistants had experience working with urban high-risk adolescents in various international and domestic settings. In addition to conducting research, all researchers also provided health education for the shelter youth and the principal researcher provided on-site health care at the shelters over a 3-yr period.

Data collection and sampling

The study took place between December 1991 and October 1994 in Baltimore, ML. The sampling for the qualitative portion of the study was convenience, using the natural groups of youth residing in the shelters in Baltimore City at the time of data collection. The research was approved by the Committee for Human Research of the Internal Review Board of the Johns Hopkins University School of Hygiene and Public Health. Verbal consent was obtained from all participants.

A variety of methods was used, including the following:

- **Participant observations.** Participant observations involved time spent by the researchers hanging out at the shelters, as well as on streets and in parks where the youth were located. Hanging out sessions at the shelters continued at intervals throughout the research period. The researchers also participated in a variety of shelter activities, including dinner preparation, homework and recreation activities and an overnight camping trip.

- **Physical observations.** Two types of physical observations of the youth were included: (1) observation and recording of a sampling of graffiti messages written by the youth on their bunk beds at the shelters and (2) observations conducted during street outreach activities, noting police, drug and sex trade activities.*

- **Community mapping.** Twelve youth from each of the two shelters were asked to draw maps of downtown Baltimore focusing on the following items: (1) common youth hang outs in the city, both safe and unsafe and (2) health care locations where they would go in the area if they got sick or hurt. Five maps were generated by the youth using poster board, stickers and marking pens. They were asked to draw maps of the area of the city where they ‘had spent the most time in the past year; the area in Baltimore you consider “home turf” or where you ‘hang out’’. The five maps represented two main areas of Baltimore that the youth naturally divided themselves into. The ‘hang out’ portion of the community mapping was conducted in order to identify areas in Baltimore where high-risk youth are likely to congregate in order to plan targeted outreach activities, as well as to gather information on environmental safety issues from the youths’ perspective. The health care resource portion of the mapping was done to obtain further information on the youths’ knowledge of and perceptions of existing health care facilities. The youth divided themselves according to which areas they wanted to map, but there was considerable interchange of ideas as youth looked at other groups’ maps and added items. While the groups were mapping, the researchers were observing and interviewing the youth, asking for clarification of terminology and reasons behind items placed on the maps.

- **Key informant and in-depth interviews.** Three male (all African-American) and three female (one white, two African-American) shelter youth were identified and interviewed in-depth. The interviews covered issues of their daily lives, health problems and problems accessing health care. Due to relatively short stays at the shelters, no single youth was available for the entire study. Therefore, the researcher identified four additional young adult informants (two African-American males, two African-American females) from contacts in communities from which many shelter youth originated. These informants were interviewed at least once a month during the research. The most relied upon key informant

*Since this was done as part of outreach activities, only general observations were made (i.e. no specific names and illegal activities were recorded).
throughout the duration of the entire study process was a 20-yr old female who grew up and still resides in East Baltimore. She was working as a nursing assistant at the paediatric ER of The Johns Hopkins Hospital, was very knowledgeable of Baltimore youth, their health problems and their language, and patterns of interaction and had spent time on the streets as an adolescent.

Focus groups. Four focus group sessions were conducted with groups of 5–10 shelter youth. A total of 31 youth, 20 females (18 African-American, 2 white) and 11 males (all African-American) participated in the groups. The facilitators assisted two separate groups of youth (one all female; one with 4 males, 6 females) in a discussion of what they perceived to be the main health problems and the major barriers to health care of youth like themselves. This included an adaptation of the Nominal Group Technique for individual ‘brainstorming’ and group ranking of health problems of homeless youth (Delbecq and Van de Ven, 1971). The youth were asked why they ranked the health problems the way they did. Two additional focus groups of youth (one all female; one all male) covered the topics of health education needs and preferred education approaches.

Free listing. Free listing activities were conducted with 15 youth (10 females and 5 males). The researcher and research assistants gave each youth a pencil and paper and asked them to respond to the question ‘What are the different kinds of health problems that youth like you have?’. Then the following secondary question was asked: ‘Which of these health problems have you ever had?’ The most frequently mentioned health problems were written on cards and used in the pile sorting activity.

Pile sorting. The same 15 youth who participated in the free listing completed the pile sorting activity. The pile sorting items included the most frequently mentioned health terminology generated by the youth in the free listing exercise. Three separate pile sorting activities were completed including: (1) a free unstructured pile sort where youth were asked to sort the illnesses in any way that made sense to them, (2) a structured pile sort where youth were asked to sort the illnesses according to ones they had ever had and (3) a structured pile sort where youth sorted the illnesses by ones they were ‘afraid of, or worried about getting’. These activities provided an indigenous conceptual categorization of health problems.

Data management and analyses

Expanded notes of in-depth interviews and focus groups were entered into a microcomputer. Codes for identified domains were inserted into the text and then, using the computer package Gofer (Microlytics, 1989), relevant textual chunks were located and extracted for further analysis. These data were further analyzed using frequency tabulations and ethnographic modeling techniques (Gittelsohn, 1992). Individual life histories were combined with shelter chart data to produce case studies that were representative of the major patterns of health problems and homelessness noted among the youth. Findings from combinations of two or more of the techniques were triangulated to identify valid patterns and preliminary results of the group techniques were further validated by sharing them with the original respondents and refining the results based on their input.

Results from the free unstructured pile sort were analyzed using hierarchical cluster analysis using Anthropac (Borgatti, 1990) and the results were used to develop the taxonomy of health problems. Data collection from the different researchers using the same method were compared for verification of findings. This combination of analytical approaches (data type, data source, method and multiple researchers) is used to increase the validity and generalizability of qualitative research findings (Miles and Huberman, 1994).

RESULTS

The results are reported according to the following categories: (1) environment of homeless youth, (2) case studies of health problems and paths to homelessness of youth, (3) health problems perceived by youth, (4) sources of advice and health education, (5) health-seeking behaviors and access to health care, and (6) a summary ethnomedical model of homeless youth.

The environment of homeless youth

Shelters. The majority of youth view shelters as safe and adequate living situations, although they often complain about shelter rules. One male youth summarized these feelings: ‘they treat you like home a little here, but they do not let you go outside much — you start feeling cooped up and gotta let energy out — but it is better than being on the streets’. Towards the end of their shelter stay, many youth spoke of anxiety over leaving the shelter, moving to a new location where ‘you gotta meet new people and start in a new school’. One male youth summarized it by stating, ‘it will be too much’.

Streets

A composite of the results of the five community mappings is shown in Fig. 1. Boys were more likely to identify outdoor recreation sites such as parks and outdoor basketball courts as common hangouts. Girls were more likely to identify indoor locations such as stores, libraries and schools as hangouts. Older youth (ages 15–17) of both sexes frequently identified night-clubs as hangouts.
Perspectives of homeless youth in Baltimore City, U.S.A.
The description of street hangouts was expanded by asking the youth why certain areas were considered unsafe. The majority of responses reflected the fact that, ‘you can get shot there just standing around and minding your business’. African-American boys also responded that some areas were unsafe because they could be picked up by police, ‘just for being there’. Several girls identified unsafe areas as places where groups of men hang out and ‘pick on you and ask you for sex’. Both male and female youth identified abandoned buildings as unsafe because of drug-dealing and drug use that can occur in these settings.

Key informant interviews with the main informant illuminated the meaning of unfamiliar terminology and group behavior of the youth. She reported that she knew at least 6 homeless adolescents in a 6-block radius from the Johns Hopkins Hospital ER, 4 girls and 2 boys ages 13–16, who slept on porches in good weather and mostly in crack houses or abandoned houses the rest of the time. Most were from families whose parents were ‘strung out on drugs’ and that different neighborhood women would feed them. She reported that in her community, adults do not report these youth to authorities because ‘they will end up being taken out of the neighborhood and put in foster care; they are better off here around people they know’. She stated that the youth referred to themselves and that neighborhood people referred to them by the term ‘hangin’ (as opposed to ‘hanging out’) and not as ‘homeless’ which was only used to refer to ‘bums in the parks’ and people in shelters. In addition, several shelter youth reported that they do not consider themselves as ‘homeless’, but ‘just kids who do not have a place to go right now’.

Case studies

The following three case studies of youth are presented to illustrate different common scenarios of experience with homelessness and illness that were found among the homeless youth who come to the shelter.

Katy is a 15-yr old white female from South Baltimore, whose father left the family when she was 3 yr old. Her mother is an ‘off and on drinker’ who has 3 other children at home, all under 7 yr of age. Katy became pregnant at age 13 and her mother, ‘threw me out of the house when she found out’. She went to live with one of her mother’s female friends in the neighborhood for about 3 months, at which time Katy had a spontaneous abortion. She states that she self-induced this abortion with an overdose of laxatives. She was seen in the ‘University ER’ when the bleeding got heavy; she spent the night in the ER and was further scheduled for a follow-up visit. A few weeks later, she went to the adolescent clinic and they told her she had ‘an infection down there (pelvic)’. She did not go for any further scheduled visits, because she ‘felt better and I cannot stand those (pelvic) exams’. She has spent the past 2 yr living with her boyfriend, a 26-yr old drugs dealer. She left him a month ago because, ‘he beat me when he got drunk’ and she has been staying with different friends and on the streets since then. She states that when she had to stay on the streets and did not ‘have a guy around looking out for me’, she stayed on the roof of a house and with a knife to stay safe. Katy says that she phones her mother at least once a month and sees her in the neighborhood ‘once in awhile’. She called her mother when she was on the streets and asked if she could come home. Her mother’s live-in boyfriend refused, so Katy came to the shelter for assistance.

Tony is a 14-yr old African-American male from Central Baltimore with no siblings in his family. Both of his parents have a significant history of substance abuse (alcohol, heroin and cocaine). Tony has been in 5 foster homes since he was 2 yr of age because of parental substance abuse that ‘made them forget to feed me and stuff’. He has been living with his mother for the past 3 yr since she underwent substance abuse treatment and has been ‘clean’. His father has been in jail for the past 2 yr on a drug charge and he has not seen him during that time. Tony has a history of various injuries, including knife wounds to both hands a year ago requiring stitches. He says he got the cuts from ‘just playing around’ throwing his knife in his backyard and ‘it accidentally cut up my hands real bad’. His family has been receiving counseling and social support services from the Urban League for the past 6 months during which time Tony has repeatedly run away from home and stayed with friends on the streets. His mother suspects that he is dealing drugs and the Urban League has recommended a temporary shelter placement for Tony to give him a ‘time out’. In interviews, Tony reports that he has witnessed at least 3 fatal shootings of ‘guys I knew’ over the past 2 yr. He has been diagnosed with depression and when asked if he thinks he will live to be 18 yr old, he replies, ‘I will live to be 100, but I will always be sad’.

Sharon is a 16-yr old African-American female from East Baltimore who has been known to foster care since she was 5 when she was treated for chlamydia. After being sexually abused by her father, she was placed in temporary foster care for 3 months until her father left the house. Her mother was murdered when Sharon was 7 yr old and she has been living with her maternal grandmother ever since. Sharon has been treated for depression and a gastric ulcer for the past 3 yr at the near-by University-affiliated adolescent clinic. Sharon has been sexually active for the past year and was taking birth control pills. She states that she ‘ran out’ of the pills 3 months ago. She has been staying ‘out late’ with her boyfriend and her grandmother tells shelter staff ‘I cannot handle her anymore’. No other family members are willing to take her in, so Sharon came to the shelter. She calls her grandmother and her boyfriend every day and states that her boyfriend’s mother wants her to come live with them, but this has not been approved by her caseworker. On physical exam at the shelter, Sharon is approximately 1 month pregnant.

These case studies are representative of how youth become homeless in Baltimore City. The majority of shelter-based homeless youth in Baltimore City are from inner city areas close to the two shel-
The free-listing activity resulted in a total of 70 different health problems. Table 1 shows the 23 health problems that were listed by at least two youth. Most responses were for specific illnesses such as ‘AIDS, crabs, asthma’, but also included less specific conditions such as ‘skin problems’ and ‘trouble learning’. The frequency distribution for these health problems was examined and the 16 most culturally cognizant (listed by at least 25% of the respondents) were chosen for the pile sorting activities.

The results of the pile sorting activity are presented as a taxonomy (Fig. 2). The youth divided common health problems into ones that ‘deal with sex’ and ones that ‘happen to your body’. They further differentiated sex-related health problems into ones that youth ‘can catch from someone’ (i.e. STDs and HIV/AIDS) and ones that ‘just happen’ (teen pregnancy). They divided the health problems of ‘your body’ into ones that ‘can kill you’ (i.e. cancer), ones ‘not as serious’ (i.e. ‘bad colds’) and ones ‘in the mind’ (i.e. depression). According to the structured pile sorts, the diseases that youth were most afraid of getting were HIV/AIDS, followed by heart disease, pregnancy, STD’s and depression.

An all female focus group ranked the five most important health problems of teens as: (1) STDs, (2) teen pregnancy, (3) HIV/AIDS, (4) depression and (5) skin problems. A mixed-gender focus group ranked the five most important health problems as: (1) STDs, (2) AIDS, (3) cuts/injuries, (4) drugs and (5) pregnancy. When the groups were asked why they had ranked one item higher than another, several responses stood out as particularly important. The all-female group stated that they had listed teen pregnancy over HIV/AIDS because ‘more teens get pregnant than get AIDS, so even though AIDS can kill you, teen pregnancy messes up more kids’ lives’. The mixed-gender focus group stated that they ranked drugs over pregnancy ‘because drugs can just make you not care about anything including your health’.

In interviews, youth spoke of knowing at least one person who ‘has AIDS’. One youth stated ‘you see AIDS eating them up from inside — it is scary’. They reported having had health education in school focusing on HIV/AIDS and ‘how always to wear a condom — how easy it is to catch AIDS’. The youth also spoke freely of their knowledge of and exposure to street drugs, with many talking about parents or close relatives who ‘cannot shake it — once you get hooked on that stuff it is hard to get off’. Several youth reported that the main drugs of youth like them is alcohol and marijuana and that the main place to get these is at ‘parties’. One female reported that girls she knows go to parties, where they ‘meet guys, smoke reefer and do not go home — some of them will have AIDS soon’. A male youth who had spent considerable time on the streets spoke of the functional value of drug use, ‘sometimes it gets so bad out there, drugs get you through’.

One female youth who was interviewed talked about injuries as a health problem for both male and female youth. She stated that boys were ‘always getting into fights and getting cut up and bruised and stuff’ and that girls ‘fight too and they can fight dirty, like with razors. I know a girl who got banked (ambushed and beaten up) by two other girls and she got a hundred stitches in her’. A male youth who had spent several weeks on the streets during sub-freezing January weather, living in cars to stay warm, reported that injuries were his main health-related problem while on the streets. He stated that he broke a car window with his fist, ‘I covered it up with my T-shirt, but I still got all cut up’. He said that he tried to wash the cuts, but ‘they got dirt in them and got all infected’.

Youth stated that ‘depression’ was different from ‘mental problems’ in that ‘mental problems’ are ‘more serious — it is like being really messed-up in the head from being born that way’. A female youth reported that she had had depression and ‘got over it’. Many youth spoke of the anxiety and depression that comes from ‘not having a home — you know, a place you can count on’.

<table>
<thead>
<tr>
<th>Health problem</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>15</td>
</tr>
<tr>
<td>Bad colds</td>
<td>8</td>
</tr>
<tr>
<td>STDs</td>
<td>8</td>
</tr>
<tr>
<td>Asthma</td>
<td>7</td>
</tr>
<tr>
<td>Cancer</td>
<td>7</td>
</tr>
<tr>
<td>Syphilis</td>
<td>6</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>5</td>
</tr>
<tr>
<td>Flu</td>
<td>4</td>
</tr>
<tr>
<td>Crabs</td>
<td>4</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>4</td>
</tr>
<tr>
<td>Heart disease</td>
<td>4</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>3</td>
</tr>
<tr>
<td>Teen pregnancy</td>
<td>3</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>3</td>
</tr>
<tr>
<td>Herpes</td>
<td>2</td>
</tr>
<tr>
<td>Mental problems</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
</tr>
<tr>
<td>Trouble learning</td>
<td>2</td>
</tr>
<tr>
<td>Genital warts</td>
<td>2</td>
</tr>
<tr>
<td>Ear infections</td>
<td>2</td>
</tr>
<tr>
<td>Bad teeth</td>
<td>2</td>
</tr>
<tr>
<td>Skin problems</td>
<td>2</td>
</tr>
<tr>
<td>Menstrual problems</td>
<td>2</td>
</tr>
</tbody>
</table>
Fig. 2. Taxonomy of health problems of shelter-based homeless youth (n = 15).
Sources of advice and health education

Sources of advice. Youth stated in focus groups that they would first try to take care of a health problem themselves, then they would ask friends for advice or they would ask their mothers, grandmothers or other trusted adult figures. The female focus group reported that their friends might listen well, but ‘my girlfriend does not know much more than me, so I would want an adult with experience and who knows what they are talking about’. There was also a discussion of what types of adult behavior and attitudes on the part of adults that helped make it easier for youth to seek out advice. ‘I want to talk to someone not too old — it is not age — it is attitude, you know, ‘old’ is when they do not want to listen, they just want to preach at you’ and ‘adults need to listen to us and tell us what to do, not what not to do’.

In individual interviews with youth of both genders, it was commonly reported that youth were in regular contact with parents or other family members. This contact occurred by telephone and by visits in the community and was continued during times spent living on the streets. It was clear that these family members were important sources of support and advice about health issues for youth, even for youth who had experienced considerable neglect and abuse from these same families. One female youth summarized this sentiment by saying, ‘I cannot live with her, but she is still my mom’.

Health education. In focus groups, when the youth were asked to consider what was most helpful to them in health education, one youth stated, ‘Stuff that is not too boring or that only says what not to do — we have heard all that stuff — we need to hear what we can do, like what is real’. Several youth stated that personal testimonials is helpful, ‘You know, peoples’ real life stories about having been doing drugs and getting AIDS; it gets to you and makes you think’. Youth agreed that role-play in peer groups about common, difficult relationship issues, such as ‘talking to your boyfriend about condoms and stuff’, is useful and ‘real’. One youth commented that through this method, ‘you get to hear ideas about what you can say and maybe what you could do different next time’.

Health-seeking behaviors and access to care

Health-seeking behavior. The community mapping of health care resources was helpful in identifying youths’ health-seeking behaviors (Fig. 1). A focus group covering health access issues revealed specific sources of health care utilized by the youth that coincided with those included in the community mapping. The youth most often identified the ERs of the two major academic health centers located near the downtown area as places they would go if they got sick or hurt. Youth identified ERs as convenient, ‘they are always open — you may have to wait forever, but eventually you will get seen’. On further questioning, most of the youth (male and female) stated that they would go to the ER if they got hurt or ‘really sick, you know, something that cannot wait or if you do not have nowhere else to go’.

Many female youth identified the adolescent clinics at the two academic hospitals as places they would go for a ‘checkup or female stuff’. These university-based adolescent clinics, along with a mall-based teen clinic were well-liked by the youth. When asked why, the youth commented, ‘they are just for teenagers so everyone there is like us. They (staff) treat you with respect and give you test results without asking, ‘where is your mom?’’. The health department clinics were identified as places that they would go if they thought they had a STD (both male and female youth). Planned parenthood was identified by several female youth as a source of pregnancy testing and contraception. The researcher asked two groups, one composed of males and one of females, why they had not included the clinic for homeless people located downtown. Several responded that they did not consider themselves homeless, ‘at least not like them’. One youth responded that it was ‘just for adults and bums’.

Access to care. In interviews, several youth discussed problems with access to care, such as, ‘They hassle you about insurance and stuff’ and ‘They (kids) cannot make their own appointments; their parents have to go with them’. Confidentiality was cited as an issue: ‘They (youth) do not want their parents to know sometimes’. Specific comments of the youth reflected issues of access to care that also were pointed out in the in-depth interviews. These included health staff judgmentalism, ‘I hate it when they (doctor or nurse) says ‘you have what’ — you are too young to be doing that’. I hate being preached at and confidentiality, ‘I would go to the hospital or another clinic way out somewhere where they are not going to know me or have it get back to my mom’. Other frequently cited problems with getting health care were waiting times for both appointments and in clinics, lack of cleanliness in health facilities, lack of insurance/payment source and confusion over need for parental consent, ‘I never know when they are gonna make me bring my mom’.

Ethnomedical model of homeless youth

A summary ethnomedical model of the youths’ understanding of the relationships between components of their health needs was developed from the qualitative data (Fig. 3). Youth view health, health education and access to health care as part of a larger context that includes peers, friends and family. A variety of forms of violence is also a part of the social context for these youth. They see illnesses as being within the individual and caused
either by individual behaviors or by things ‘that happen to your body’ outside a person’s control. They speak of health as ‘being something you gotta take care of’, that comes mainly from individual self-care behaviors and from seeking medical care ‘when you need it’.

The youth place high value on peer interactions (shown within social context) as well as guidance from ‘adults with experience’. The youth seek advice from friends ‘cause they know what it is like’, but also seek advice from family. Many of the youth continue to have significant contact with parents, grandparents and other family members even during their experience with homelessness. The youth get angry at rules and boundaries set by adults, but they also seek out advice from adults who ‘do not preach’. They view doctors and the medical care system in a narrow biomedical context: ‘they give you medicine or they try to fix something’. Health education is outside the medical care system, being linked with various adult figures such as teachers, counselors or nurses with whom the youth interact on a daily basis.

**DISCUSSION AND RECOMMENDATIONS**

The data present the self-perceived health problems and access to care issues of the youth within socio-cultural context. The most common youth-identified health problems included STDs, HIV/AIDS, pregnancy, depression, drug use and injuries. These correlate well with findings from quantitative health assessments of homeless youth in Baltimore (Ensign and Santelli, 1997, 1998), as well as with information on homeless youth from other U.S. cities, including San Francisco (Sherman, 1992) and Seattle (Farrow et al., 1992). The youth acknowledge the role of individual risk-taking behaviors in the development of many of these common health problems.

Issues of confidentiality were important for youth, especially concerning sexually-related health problems. It appears that the youth avoid non-urgent ER visits and instead seek primary health care if it is available and ‘youth-friendly’. Access to community-based adolescent health clinics, such as school and mall-based teen clinics should be increased by local school and health department districts. It appears that health clinics for the homeless which mainly serve adults are not perceived as appropriate sources of health care by homeless youth. The general concern and confusion over need for parental consent for care indicates that health facilities should clarify their policies about the provision of health care to unaccompanied youth and should clearly post these policies in waiting rooms.

The youth spoke of environmental safety threats of violence and victimization by adults and other youth, as well as the reality of racism and sexism in their lives. The physical safety threats are supported by mortality data for Baltimore youth, as well as by
findings in the physical observation portion of the study. Any future health interventions with this population need to acknowledge the primacy of the social context for youth as well as the reality of violence as a daily health threat. For example, discussions with female youth about negotiating condom use need to address possible power inequities and overt violence within the relationship. In addition, immediate survival issues first need to be acknowledged and remedied before any health education efforts aimed at long-term health risks such as HIV/AIDS can be effective.

Interviews and discussions with shelter youth who had spent time on the streets as well as with adult key informants suggest that there are youth who are homeless, but who are not seeking assistance from shelters. It appears that these youth stay within the neighborhoods where they have been living and are often taken care of by a loose network of community residents. It also appears that neighborhood street youths’ health problems and access issues may be more severe than those of shelter-based youth who spend little time living on the streets. Follow-up research is needed on how best to identify these youth and assist them with appropriate access to health and social services. Such interventions should be done in conjunction with the existing community support networks for these youth. Efforts should be made to keep these youth in their own communities, perhaps through the addition of supervised group homes as an alternative to foster care.

The homeless youth see health education as being helpful if it provides examples of realistic peer interactions within the context of health behaviors and if it provides positive guidance instead of only negative, avoidance advice. The youth clearly want adult advice and guidance on health-related issues, as long as it is not judgmental or irrelevant to their current situation. The youth prefer the advice of trusted adults even over peers as sources of information on important topics. They frequently mentioned teachers, counselors and nurses, as well as mothers, grandmothers and aunts, as sources of support and advice. Community programs should be designed to assist these important support persons for youth by providing practical information on how to talk with youth about difficult subjects such as sex and drugs and by providing information on accessing local health and social services for youth in need. It is important to note that youth who are homeless and from less than ideal family situations remain in contact with and continue to seek advice from parents and other family members. These family connections should be recognized and supported whenever possible.

The youth showed considerable insight and creativity during discussions and activities about the identification of their health needs and were interested in being included in the planning and implementation of health education initiatives. The youth were generally energetic and talented in art, drama and music, and these media could be used for health education. There is the important issue of whether youth-identified health education needs and preferred health education approaches translate into effective health education interventions; however, it is doubtful whether any health education intervention ultimately can be effective without engaging youths’ interest and participation.

It is important to note that the youth included in this study were mostly African-American females. This reflects the overall demographics of the shelter and of Baltimore City and represents a subpopulation of homeless youth that is underrepresented in the literature. However, important gender and ethnic variations in responses may have been missed due to the convenience sampling. In addition, there are probable differences in responses between different age categories that were not captured in this research. The youth were all shelter-based and important differences may exist in the health perceptions of street-based homeless youth in Baltimore who were not assessed in this study.

Another potential limitation of the present study is that of bias in the youth’s responses to the researcher’s questions. It is possible that the youth either positively or negatively inflated their responses in order to elicit sympathy or shock in the researchers. However, our field experience indicated that this did not occur sufficiently to bias the results. The principal researcher also had the role of shelter nurse and health educator for the staff and youth during the entire 3 yr of the research and through this role developed rapport with the youth. While all of the youth participants were informed of the research, most seemed to view the research as part of the general provision of health care at the shelter. In addition, the research was triangulated by using multiple data-collection methods as well as multiple researchers and the findings were verified with the youth and key informants.

This research indicates that methods for conducting comprehensive health needs assessments for vulnerable populations in international settings are appropriate for use with similar U.S.-based populations and offer advantages in terms of creativity and enhanced participation by research subjects over traditional U.S. needs assessment methods. The two methods that appeared most effective in terms of yield of information relating to the research questions were focus groups and community mapping. These methods are interactive and empowering, attributes the youth identify as being important to them. The community mapping technique seemed to be the most enjoyable for the youth and similar visual techniques should be effective with this population. Although the entire time period for this study was almost 3 yr, the main qualitative data collection occurred over a ten
month period and could be replicated with other health needs assessments of similar youth populations.

While this study was not intended to be an in-depth ethnography of shelter-based homeless youth, capturing the entire socio-economic, political, psychological context for these youth, this study provided access to the social context of health for these youth, an area of intense importance for them. The RAP and PRA methods used in this study were useful in capturing this broader social context and permitting explanations of the youths’ health decisions and behaviors. In addition, the qualitative results served to compliment and assist in the interpretation of the quantitative health findings for these youth.

Many of the youth included in this study are surviving and even thriving despite significant negative socioeconomic pressures. Instead of focusing on the pathology of inner-city youth or street youth in particular, it would be beneficial for health researchers to begin examining the youths’ strengths and what is working with these populations. If the inherent energy, creativity and experience of such high-risk youth as these homeless youth could be encouraged and assisted, it would go a long way to improve their health and social outcomes.

Acknowledgements—This project was funded by the MCH Science Consortium, Baltimore, ML. Portions of this paper were presented in poster format at the APHA National Convention, San Diego, CA, 1995. The authors wish to thank Manami Jamal-Brown, Phyllis Thorne, William Adih, Arik Marcell and Patrick Corvinton for their invaluable advice and assistance in data collection and feedback throughout this project.

REFERENCES


Borgatti, S. (1990) ANTHROPAC 3.2. Columbia SC: Department of Sociology, University of South Carolina.


