Abstract

This study investigated the health-related concerns of adolescents living on streets as compared to poor and privileged adolescents living with their families in São Paulo, Brazil. The different groups of respondents were similar in terms of individuals’ fear of disease and lack of concern about health in old age. AIDS and cancer were feared by most of the respondents in the different groups, particularly because of their severity and people’s vulnerability to these conditions. Health in old age was not a major concern in any of the study groups. It is suggested that health educators take into account the wide range of concerns among adolescents on the streets in order to design interventions that cater for different levels of interest and motivation. It is also argued that there is a need for health education in order to clarify misperceptions about disease transmission, prevention and treatment among adolescents from different socioeconomic backgrounds.

Introduction

Adolescents’ health behaviour is a major area of concern among health professionals, policy makers and researchers worldwide (Valois et al., 1997; Brener and Collins, 1998; Carlini-Cotrim et al., 2000). While some behaviours acquired during adolescence might have a short-term harmful impact (e.g. use of drugs and unprotected sexual intercourse), others might persist throughout life and compromise individuals’ future health (e.g. smoking and use of alcohol). These are important aspects to be taken into account in the investigation and design of interventions aimed at promoting healthy behaviour in this age group. On the one hand, adolescence has been defined as a period characterized by a cluster of risky behaviour (Donovan and Jessor, 1985; Jessor, 1991). On the other hand, it has been argued that a stereotypical view of adolescence neglects variations between societies, within a particular society, and within and between communities (Aggleton, 1996). The relevance of the latter position is evident in the context of less-developed countries such as Brazil, where social inequalities are clearly demonstrated by the phenomenon of adolescents living on the streets of urban areas.

Risky behaviour among adolescents on the streets, usually called street children, is part of a myriad of health threats associated with their exposure to the street environment, and life apart from family and protection. The physical and psychosocial conditions of these individuals, as compared to housed adolescents, are linked to a range of health risks (WHO, 1993; Campos et al., 1994; la Barra, 1998). In terms of health-related behaviour, adolescents living on the streets in Brazil are reported to drink alcohol, use illegal substances and engage in unprotected sexual activities (Raffaelli et al., 1993; Campos et al.,...
1994; Forster et al., 1996; Inciardi and Surratt, 1998). These risky behaviours are clearly favoured by deprived life conditions and behavioural modification is most likely to be facilitated by programmes for improvement in adolescents’ socioeconomic conditions. An important element of these programmes is the implementation of health education initiatives to foster health-protective behaviour. However, adolescents with street-life experience might lack the motivation to respond to health messages and professional advice due to their lack of concern about health-related issues. It has been suggested that health-related issues are not a major concern for young people on the streets (WHO, 1993; Riihinen, 1993; Swart-Krueger and Richter, 1997). Street children are said mainly to be worried about their day-to-day survival, to disregard longer-term consequences of their behaviour and to consider themselves invulnerable. The importance of individuals’ health-related concerns is explicit in the Health Belief Model (Strecher and Rosenstock, 1997) and Protection Motivation Theory (Rogers and Mewborn, 1976; Rogers, 1983). According to these models, one of the factors that fosters the adoption of health-protective behaviour is the individuals’ perception of diseases as threatening conditions. Accordingly, disregard for health among adolescents on the streets has important implications for health education. Information and discussions concerning health conditions and health-protective behaviour might be meaningless for these individuals.

There has been a considerable amount of research regarding general health-related concerns (e.g. substance use, human sexuality and nutrition) among young people in developed countries (Sobal et al., 1988; Weiler, 1997; Reid and Hendry, 2001; Klein and Wilson, 2002). These studies do not provide information about the link between health-related concerns and socioeconomic conditions. The limited investigation into this association observed no correlation between worry about AIDS and socioeconomic variables (Carroll et al., 1999). Information about health-related concerns among adolescents on the streets in less-developed countries is lacking. The aim of this study is to address this gap in knowledge by investigating the association between street-life experience and health-related concerns among adolescents in São Paulo, Brazil. Specifically, the investigation is interested in how adolescents on the streets compare with permanently housed adolescents in terms of health-related concerns.

**Methods**

The study adopted a qualitative approach because of the lack of information about the health-related concerns of adolescents living on the streets. This approach was identified as the most suitable means to obtain this information because it provides in-depth descriptions of participants’ own point of view and experiences (Patton, 1990; Denzin and Lincoln, 1994). Moreover, qualitative methods offer the necessary flexibility and sensitivity to deal with particularities which individuals with experience of street life may present, such as illiteracy and short attention spans. The abuse of inhalants and marijuana among street children in Brazil has been fully reported (Carlini-Cotrim, 1995; Inciardi and Surratt, 1998), and inattentiveness is among the long-term and residual cognitive effects produced by these substances (Pope and Yurgelun-Todd, 1996; National Institute on Drug Abuse, 2000). In order to compare the health-related concerns of adolescents from different socioeconomic backgrounds, the study investigated three groups of respondents aged between 15 and 17 years.

The author carried out the interviews in the context of exploring adolescents’ views on different aspects of health and illness, including health-related concerns. The respondents were interviewed in the institutions where they regularly attended courses. The first group was made up of 31 deprived adolescents (21 males and 10 females) with recent experience of sleeping on the streets. The second group was composed of 20 permanently housed adolescents (11 males and nine females) from a state school in one of the poorest
regions. The last group comprised 20 permanently housed adolescents (seven males and 13 females) from a prestigious private school located in a privileged region. The interviews lasted approximately 30 min. Educational settings were selected because the findings of the study were thought to serve as background information for health education programmes. Respondents from the three socioeconomic groups were informed about the objectives and procedures of the study, and ensured of the confidentiality of their interviews. Adolescents were also informed that they had no obligation to take part in the study. The poor and privileged adolescents were reassured that their non-participation in the study would not affect their school performance. In the case of the schools, written agreement from parents or carers was obtained, following the schools’ regulations. Deprived adolescents provided only verbal consent since most of them were not in contact with parents or carers. Four of the adolescents approached at the child welfare centre either refused to be interviewed or avoided further contact with the researcher. A total of 30 adolescents at the state school and 24 at the private school were invited to take part in the research. Only one father at the state school opposed the participation of his daughter. The inclusion of respondents was determined by the identification of themes in the material from the interviews. The data analysis was simultaneous to the process of data collection. New respondents were included until no new theme or category was identified.

Information about adolescents’ health-related concerns was obtained through the following open-ended questions: ‘Are you afraid of any disease?’ and ‘Why?’, and ‘Do you think about your health when you get old?’ The responses were tape-recorded and transcribed. The data analysis comprised two phases involving inductive procedures (Patton, 1990). Logical categories in each of the topics under investigation were identified during the fieldwork. Subsequently, these categories were refined giving rise to subcategories and their frequency in each group was calculated.

In order to maximize the quality and credibility of the study, in line with the suggestions put forward by Patton (Patton, 1990) and Denzin (Denzin, 1989), the perceived effect of the researcher on the respondents was recorded through daily field notes. Reflexive considerations were also employed to assess the influence of the researcher’s own subjective field of experience on the research process and conclusions in accordance with the proposal put forward by Steier (Steier, 1991). Moreover, following LeCompte and Goetz (LeCompte and Goetz, 1982), low-inference descriptors—reports phrased very close to the participants’ accounts—are used in the manuscript in form of direct quotations.

Results

Lack of fear of disease

In response to the question on fear of disease, the different groups were divided between respondents who denied fearing disease and respondents who admitted to it. The minority of adolescents denied fearing any disease. These respondents were not asked to justify their responses because this procedure might be interpreted as a confrontation and would suggest that they were expected to report fear of disease. Table I presents the categories of reasons given by those youngsters who denied fearing disease and explained the reasons.

Although denial of fear of disease was detected in each of the different groups, the reasons for this lack of fear varied between the groups. There was a wider range of reasons among deprived adolescents than among the other groups, including responses that reflect the adverse life conditions on the streets. Among deprived and poor adolescents there were respondents whose explanations for not fearing disease implied that diseases are inevitable events. As the following examples show, diseases are presented in a fatalistic fashion, as events which cannot be predicted and prevented or which are determined by superior forces:
We don’t fear disease. It comes and catches us. We never know when it comes and when it doesn’t come. When we notice it we’ve caught it already. That’s why I ain’t afraid. [M7, poor]

I ain’t afraid of any disease, it comes from God. [M16, deprived]

The adversity of street life was suggested by a deprived respondent who reported to have experienced so many illnesses that he did not care about them any longer. This phenomenon was also suggested in the report given by another deprived adolescent whose account alludes to the irrelevance of health matters:

I live in a shelter which is rubbish, which I hate. A lot of guys who I hate and who keep on at me, do you get it? I don’t know, you don’t always get a plate of food, there’s a lot of bureaucracy. You have to sign 20 papers to have a plate of food. Sometimes I get fed up and tell them to bugger off with their food. You don’t have cause to think about disease. Life’s already so shitty that it doesn’t matter if you’re healthy or if you’re ill. [M26, deprived]

The last category of reasons for not fearing disease concerns lack of vulnerability to disease. Among the deprived and privileged respondents there were individuals who acknowledged AIDS as a dangerous condition. However, they claimed to be partially or totally protected against the transmission of the disease:

I ain’t afraid of AIDS because it’s a disease without a cure so far, but I’d only get AIDS from a blood transfusion or someone else’s mistake, because I have knowledge. Basically, it’d be difficult to get it. [M3, privileged]

I ain’t afraid of AIDS because I don’t go out with women. I keep quiet, thinking about life. [M18, deprived]

Fear of disease

In the case of those respondents who admitted to fearing diseases, AIDS and cancer were those most frequently mentioned. Other diseases and conditions that were also reported include leukaemia, paralysis, Ebola, tuberculosis, STDs, pneumonia, hepatitis, leptospirosis and leprosy. As Table II shows, three categories and 10 sub-categories of reasons for fearing diseases were identified.

The different study groups shared most of the reasons for fearing disease. Some of the adolescents from the three groups reported to be overwhelmed by fear of disease, in particular AIDS. As in the example below, in which the metaphor of a beast was used, diseases are portrayed as mysterious and dangerous:

I’m afraid of AIDS. I don’t know, everybody talks about AIDS and it gets into my mind. It’s an animal with seven heads and I get scared. Sometimes I think, imagine if I have AIDS. I’ll shoot my own head. [F11, deprived]

The majority of the reasons given for fearing disease in the different groups refer to features of the disease and illness process that characterize conditions as severe:
I’m only afraid of AIDS because there’s no cure. Nowadays it’s AIDS. A disease that I think should be curable. I don’t know, something very serious. Nothing to do with me, but I think about people suffering in the world… It’s a disease without a cure in Brazil and all over the world. Something that should be treated by some sort of medicine. [M20, poor]

According to the respondents in the different groups, AIDS was also to be feared because of its psychosocial impact. Respondents reported that people with AIDS suffer negative reactions such as rejection, prejudice and discrimination from other people:

[What do you mean by prejudice?] Prejudice…people know that you’ve got AIDS and discriminate. They don’t want to know how the other person is. After the person gets it: I don’t know you anymore. I don’t want to know you. You hear a lot of stories about it. I read in the paper that someone was sacked because he had the HIV virus. That’s the reason I’m afraid of AIDS. [M10, poor]

Another aspect raised by adolescents in the different groups, in particular that of deprived individuals, was the degenerative and destructive nature of AIDS and cancer:

[Why are you afraid of cancer?] I don’t know. I don’t like it very much, it’s dangerous. It’s a disease that eats you bit by bit until you’re damaged inside. It eats the person completely inside. [M2, poor]

Cancer, I’m afraid of cancer, like breast cancer which decays the person. Pieces from the person fall off. I wouldn’t want to look at myself and see my bits falling off. It’s decayed. [F4, deprived]

A feature of disease that caused fear among deprived and poor adolescents in particular was disfiguration. AIDS was said to cause an unbearable and hideous appearance:

I’m afraid of AIDS because I saw my friend suffer when he got it. I had frequent contact with him and I found everything very… For someone, of my age, to see something like that. I don’t know how to explain it. Very sad. Wounds in the leg. He couldn’t walk anymore. He became very skinny… It was very difficult for him and for me as well. AIDS is a horrible disease, very ugly. [F17, poor]

According to many deprived adolescents, the disfigured appearance of people with AIDS also has important psychosocial consequences.

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### Table II. Reasons for fearing disease by socioeconomic group

<table>
<thead>
<tr>
<th>Reason</th>
<th>Deprived ($N = 31$)</th>
<th>Poor ($N = 20$)</th>
<th>Privileged ($N = 20$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overwhelming threat</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Severity of disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lethal</td>
<td>7</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>suffering</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>psychosocial impact of AIDS</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>destruction of the body caused by AIDS</td>
<td>10</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>dependence</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>impairment</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Vulnerability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>limited control over transmission of AIDS</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>extreme contagion of AIDS</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>lack of control over cancer</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>family disease</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

*Respondents might have presented more than one reason.*
People’s features bring about recognition of the condition and thus stigmatization:

[Why are you afraid of AIDS?] I don’t know. It’s something like this, it shortens your life, then the person becomes a bit strange, gets thinner and thinner and other people notice. [F29, deprived]

Hah! can you imagine me with AIDS? I’m afraid of getting too thin, skinny, ridiculous. Everybody will be scared of me, people will run away. They shouldn’t do that, they [people with AIDS] get a bad reputation. [F15, deprived]

Among the privileged adolescents disease was also feared because of the dependence and physical impairment resulting from the healing processes:

I’m afraid of several diseases: leukaemia, AIDS and paralysis. I’m afraid of these diseases because they leave you completely dependent on other people. To live dependent on someone else because of the disease. Like when you have haemodialysis. [F13, privileged]

I’m most afraid of AIDS, meningitis…things which are serious. AIDS in particular because it doesn’t have a cure. I don’t know, I’m afraid of dying. Or sometimes a disease may even be curable but it has consequences that are restricting. [M10, privileged]

Although explanations of fear of disease linked to the perception of vulnerability were most common among privileged respondents, they were also detected in the other study groups. As observed in the following examples, respondents said they feared AIDS because people remain at risk of the disease despite awareness of it and preventive practices:

I’m afraid of AIDS. Although I protect myself, I don’t know if the other person has the virus. The condom might burst or something like that. [M8, poor]

I’ll be married in the future, and I don’t know if I’ll trust my husband. He may bring disease from outside the family. That’s what happened with many of my father’s friends. I don’t know. You may be at risk without knowing it. You’re always at risk. Like when you have a blood transfusion. [F13, privileged]

Concern about the transmission of HIV/AIDS was also voiced by a deprived respondent who perceived this condition as extremely contagious:

I can’t explain it. I’ve got a friend who has AIDS and when the person has AIDS other people can’t get close to them. Because when they’re eating we can’t eat from the same plate. It causes AIDS. My mother used to say that, but she died. She got it and I didn’t even get close to her. My grandmother used to tell me not to get close to her. She was scary. [M6, deprived]

Susceptibility to cancer was also mentioned by privileged adolescents as a source of fear. The condition was portrayed as unavoidable, uncontrollable and untreatable:

I’m afraid of cancer because I’ve had contact with a friend of mine who lost his father. Cancer is very frightening because you don’t get it from anybody, you don’t get it from the air, it’s just something that appears in your body. There’s no way to avoid it, there’s no cure. Cancer is something that I really fear. [M19, privileged]

The last category of reasons for fearing disease was observed only among poor adolescents. Two of the respondents explained that they feared leprosy and cancer, respectively, because their fathers had had these conditions in the past.

Health in old age

The analysis of the answers to the question concerning health in old age (Table III) revealed many similarities between the different groups of adolescents. Several respondents in each of the research groups, most notably among the deprived adolescents, declared that they had not thought about their health in old age. Even so, some of these respondents claimed to have positive expectations of being healthy.

Among those who acknowledged contemplating their health in old age were some who considered
possible health conditions in the future. Their accounts were based on considerations of the consequences of current unhealthy behaviours such as smoking, drinking, using drugs, the prognosis of current illnesses, and possible health conditions and illnesses which occurred among family members (physical restrictions of old age, nerves) which they might also present in the future. Some of these accounts went as follow:

I’m afraid, I don’t know. I’m afraid of becoming like my grandfather who doesn’t walk because it hurts. I don’t want to become stuck like that. Poor him, he suffers a lot... [M12, privileged]

I’ve already thought about it, many times. I don’t know, am I going to be ill? I think: am I going to get AIDS? The day I discover I have AIDS I will kill myself before I kill somebody else. [F20, deprived]

Adolescents from all the different groups talked about their investment for the future in terms of ‘current healthy practices’ including eating regularly, drinking water and milk, taking vitamins, and engaging in physical activities:

I do think about it. I exercise almost everyday, 3 or 4 days a week. I intend to do so when I’m old. I keep on doing it to avoid...to not be exposed to disease. [M7, privileged]

Among the privileged adolescents who claimed to have considered their health in old age, one also established a link between health and behaviour. However, he only planned to engage in healthy behaviour in the future:

I’ve already thought about it. That’s why I say I shouldn’t drink and smoke because when I get old I may have problems. I want to be healthy and everything else but I think I have to enjoy life now and when I get old I’ll try to keep it [health]. After this phase of going out, I’ll stop smoking, stop drinking, eat things that are good like vegetables, a lot of proteins, not eat the junk that we eat a lot of these days. I’ll try not to eat it when I get older, when I start university. [M17, privileged]

In contrast to these positive expectations of health in old age, several poor and deprived respondents had negative expectations of future health. These explanations were related to the physical deterioration of the body, and their habits of smoking cigarettes, using drugs and passive smoking:

No, but I think that I’m going to be like all old people. I don’t know, finished, unable to walk, staying in bed. We youngsters are healthy, we can do this and that. Then we get old and become soft. [F16, poor]

Negative expectations were also observed in the account of a deprived adolescent who expected a short life. As observed in the following example, this negative perspective was clearly linked to life experiences on the streets:

I thought about it once when somebody told me that I’m abusing the present, that I’d see later. Honestly, I believe that I won’t live long and get to be old. [What do you think is going to happen?] I don’t know, a lot of things in my head. I think I’ll die like a vagabond, something
like that. I’ve got too many problems here. The guys look at me and call me an idiot vagabond. These are the guys who want to kill me. [M22, deprived]

Discussion

The exposure of young people on the streets to a series of factors that might jeopardize their health has been well reported. It is suggested that one of these factors is individuals’ lack of concern about health-related issues and immediatism (WHO, 1993; Swart-Krueger and Richter, 1997). The findings of this study challenge these inferences. Although accounts of disregard for health and disease and fatalistic views were observed in the group of deprived adolescents, they were uncommon. The majority of the respondents in this group reported fear of disease for a variety of reasons, and most of their fears were also reported by permanently housed adolescents from poor and privileged backgrounds. Similarly, health in old age was not an important issue for several of the respondents in the different groups.

In support of the Health Belief Model (Strecher and Rosenstock, 1997) and Protection Motivation Theory (Rogers and Mewborn, 1976; Rogers, 1983), the study observed that adolescents from different socioenvironmental backgrounds perceived diseases to be threatening conditions, particularly in terms of severity, including medical, clinical and psychosocial consequences. In all groups, diseases such as HIV/AIDS and cancer were feared mostly because of their severity and peoples’ vulnerability to them. Feared diseases were represented as serious afflictions that are difficult or impossible to avoid, incurable, debilitating, destructive and lethal. HIV/AIDS were particularly threatening conditions for adolescents in the different groups. These conditions were reported to be highly destructive and lethal, and to have important psychosocial consequences in peoples’ lives. Health in old age was an issue considered by approximately a third of the deprived and poor respondents and half of the privileged adolescents. These individuals considered mainly the possibility of health conditions in the future and reported current healthy practices.

The findings of the study do not represent the perspectives of the population of adolescents on the streets in São Paulo, but are an illustration of a variety of perspectives within a group of individuals living in deprived socioeconomic conditions. There is a need for future research into adolescents’ concerns with other aspects of health—besides fear of disease and health in old age—such as well-being, mental health and violence. Research is also required to investigate the association between the health-related concerns identified in this study and adolescents’ health behaviour. Nevertheless, the current investigation provides useful information for health educators working with adolescents from different socioeconomic backgrounds.

In order to engage adolescents and foster health-protective behaviour, health education needs to be meaningful for individuals. In this context, adolescents’ health-related concerns should be addressed and their socioenvironmental conditions and life experiences taken into account. It is suggested that the concerns of adolescents from different socioenvironmental backgrounds should be addressed through a strategy informed by the self-empowerment model (Tones et al., 1990). Initially the role of health educators should be one of a facilitator in a process of discussion and exploration of adolescents’ concerns, feelings and experiences through group techniques. In a second stage, health educators should provide information about relevant aspects raised by the adolescents and clarify misconceptions. The findings of the study suggest that there is a need to dispel fatalistic views of disease in general, and elucidate causality, transmission, prevention and treatment related to HIV/AIDS and cancer among adolescents from different socioeconomic backgrounds. Subsequent to provision of information, individuals’ choices of action and social and environmental constraints should be explored and discussed. Finally, with the purpose of facilitating choice, health educators...
should employ strategies to foster self-esteem, self-efficacy beliefs and increase lifeskills.

Although there were many similarities between the groups, it was clear that street life was associated with distinct experiences and the prominence of specific fears. Health education aimed at deprived adolescents needs to take into consideration these issues. Evidently, life on the street hinders the personal development of adolescents and severely restricts their choices of action. Although accounts of disregard for health and disease, fatalist views, and negative expectations for the future were in the minority among deprived adolescents, these perspectives are relevant and indicative of adverse conditions. These individuals are in need of a fundamental improvement in their material and social living circumstances; conditions which are conducive to health and well-being, which encourage self-esteem, self-efficacy beliefs and lifeskills, and in which health-related behaviour is appreciated. Hence, health education initiatives for this group of adolescents are more likely to be meaningful and successful if they are part of a programme aimed at social reinsertion. This programme should focus on family reintegration, housing, school reintegration, job training and health support. Health educators should be part of a multidisciplinary expertise team, which also attend to adolescents’ physical and mental health needs. The wide range of health-related concerns observed in the group of deprived adolescents indicate the need for flexible health education strategies in order to meet the different levels of interest and motivation. Adolescents unconcerned with health matters and uninterested in taking part in health education initiatives should be initially encouraged to discuss and explore their life experiences, problems, feelings, values, perceived needs and expectations.

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