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HEALTH CARE SEEKING BEHAVIOR OF STREET CHILDREN IN RAWALPINDI

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Abstract

Background: *Street children experience substantial barriers to healthcare due to poverty, social exclusion, inadequate education, and unstable living conditions, making them highly vulnerable to poor health outcomes.*

Objective: *The objective of this research was to identify the health seeking behaviour of street children in Rawalpindi, focusing on the socio-economic challenges and informal healthcare practices that influence their access to medical care.*

Methodology: *This study used a phenomenological research design, in which qualitative methods (observations, recorded interviews) were used to examine the living and health conditions of 20 street children aged 10-19 and the data were analysed by means of Thematic Analysis.*

Results: *Findings revealed critical barriers to health care access, including low education levels, financial instability, and poor health care experiences. Additionally, nutritional deprivation and experiences of stigma within formal healthcare settings contribute to adverse health outcomes, with many children resorting to self-medication and informal healthcare Practices.*

Conclusion: *This study emphasizes the need for targeted interventions to include the quality of life of street children in Rawalpindi, addressing both their immediate health needs and broader economic factors that perpetuated their vulnerable status.*

Keywords: Care, Children, Experience, Health, Healthcare, Rawalpindi, Street

1. Introduction

The United Nations defines "street children" as any boy or girl for whom the street, in its broadest sense, has become their habitual residence and source of income, and who lacks adequate protection, supervision, or guidance from responsible adults (Ashraf et al., 2020). Street children phenomenon is a global issue; there are at least more than 150 million children all over the world who are living or working on the street (Sohel et al., 2024). The numbers of street children in Pakistan are estimated to be 1.5 million

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(Ashraf et al., 2020). An honest description of street children may be difficult to get because of the biased description given by the source(s). The media representation of street children for most of the times is done using emotional language and/or institutionalized press releases wherein the focus is not necessarily on method but mainly on fund-raising or publicity (Abdullah et al., 2014). Many child welfare and child protection organizations, including both government and non-governmental organizations, provide basic shelter, food and temporary rehabilitation for street children, but often without addressing the root cause of the problem, such as poverty, the disintegration of the family, limited access to education or health care services (Karanja, 2015).

Street children are a serious problem in big cities of Pakistan. National estimates suggest that there are about 1.5 to 2 million children living and/or labouring on the streets of Pakistan, a large proportion of whom are present in big cities, including Karachi, Lahore, Rawalpindi–Islamabad and Peshawar (Abdullah et al., 2014). Although they are numerous, these children appear to have been absorbed into a barely visible social group largely excluded from mainstream social services, political discourse and formal protective systems. This, in turn, makes it easier for policymakers and the public to view them as a marginal, or "inevitable," aspect of urban existence as opposed to a systemic failure (Vedadi et al., 2013).

There have been studies conducted on the health conditions of street children in Pakistan, including some in Lahore and Karachi as well, but existing research on street children of Rawalpindi often lacks depth and specificity regarding the unique challenges faced by his demographic (Abdullah et al., 2014). Moreover, there is a lack of recent research that provides a comprehensive view of the living conditions, socioeconomic background, educational status and access to social services among street children in Rawalpindi. This study on the living conditions and health seeking behaviour of the street children in Rawalpindi using qualitative approach, it fills a significant research gap by providing a comprehensive understanding of their circumstances and needs. By informing policy development and advocacy efforts, this research has the potential to contribute to meaningful improvements in the lives, living conditions and health related behaviour of street children in Rawalpindi, ultimately leading to a more inclusive and equitable society.

2. Methodology

The study was of qualitative approach using a phenomenological design was used to record the experiences of street children from the Rawalpindi community. This study was carried out in Rawalpindi, Punjab Pakistan between April 2024 and September 2024 for a period of six months. A phenomenological approach was used to gain insightful understanding of participants' in-depth lived experiences.

Study area and population

Two focal places in metropolitan Rawalpindi were chosen on my systematic observation of known areas where street children congregate. The bus terminal on sixth road had been chosen as the primary location. Another major hub was the commercial market. Inclusion criteria required all adolescents between the age of 10-19 in the designated areas. All of those street kids who worked for themselves on daily wages (in the informal sector), be it as a car wash, flower seller, peddler, newspaper vendor, shoe shiner, or doing any other job on the streets and are part time beggars. Exclusion criteria include all other children, on contract labour or working on monthly wages whether working in any industry, hotel or workshop other than being self-employed and included cognitive impairments or refusal to consent.

Sampling and recruitment

Participants were recruited using purposive sampling technique. This study used nonprobability method. Non-probabilistic methodology was employed in the investigation. The sample size of 20 participants was recruited.

Data Collection

Formal authorization was received from the ethics committee of the Health Services Academy, Islamabad. Permission was obtained from the guardians or family members of the street children; they were fully informed about the goal of the study. To facilitate the target group's comprehension, the semi structured questionnaires were translated into Urdu, the native language. Exact statements of the interviewees in Urdu were recorded through the phones and then later on they were translated in English and noted down the MS word for the analysis.

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Data analysis

The raw field notes from the depth interviews were expanded and input into the computer on the same day they are conducted. Every interview had its file created and were kept in an organized manner. Themes and codes were made to analyse the factors that compromise the health of the street children.

Ethical considerations

The study adhered to ethical principles outlined by the Internal Review Committee of Health Services Academy (IRCHSA). Informed consent was obtained, and confidentiality was maintained through anonymized data. The IRCHSA approved this research under notification F. No.000551/HAS/MSPH/2022 dated 28-08-2024.

3. Results

Total of 20 respondents were recruited out of which 70% were male and 30% were female. The demographic details of gender along ethnicity are shown in the Figure 1. Figure 2 shows the percentage of daily income. Rest of the details is shown in figures.

Figure 1

Demographic Details of Respondents

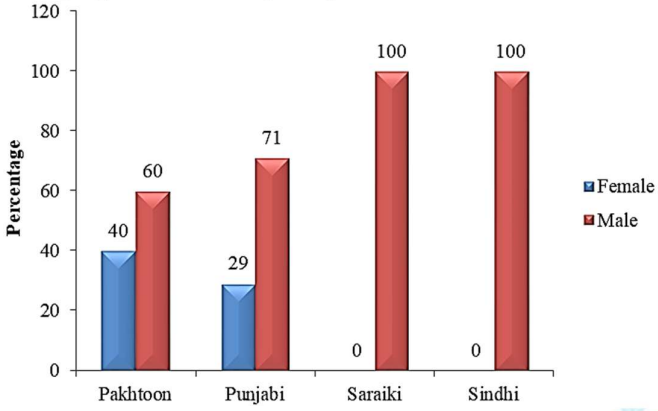
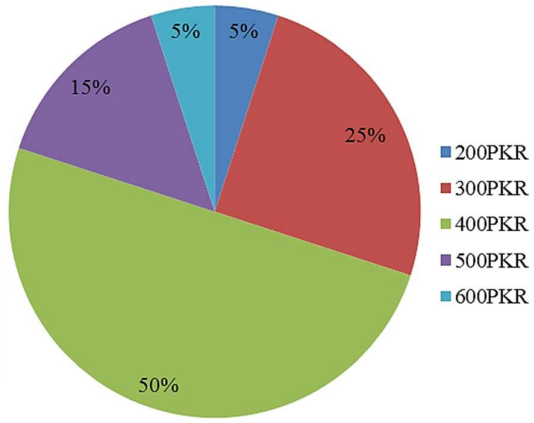


Figure 2

Daily Income Chart



The respondents were questioned regarding their personal history, relationship with family members, education, employment and health in order to investigate these antecedents. The factors influencing their health or creating a barrier to accessing basic to significant health resources were then connected to their answers to these questions. For this thematic analysis was done. Codes and themes were created by the transcribed version of the recorded data of the 20 participants. Targeted participants were aged between 10-19 years as shown in Table 1.

Table 1

Demographic Details of Participants

Sr. No.	Age (Years)	Gender	Ethnicity	Education	Time on Street	Daily Income (PKR)	Type of Work	Number of Siblings
1	14	Male	Punjabi	Nil	7 years	300	Flower selling, begging	7
2	11	Female	Punjabi	Nil	4 years	200	Hennah prints, begging	7
3	15	Male	Pakhtoon	2nd grade	9 years	400	Car washer, begging	7
4	13	Male	Punjabi	1st grade	5 years	300	Shoe polisher, begging	5
5	10	Male	Punjabi	Nil	4 years	500	Clay toys seller, begging	10
6	17	Male	Pakhtoon	Nil	7 years	400	Balloons seller, begging	6
7	12	Female	Pakhtoon	Nil	3 years	400	Drawing books	6

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Sr. No.	Age (Years)	Gender	Ethnicity	Education	Time on Street	Daily Income (PKR)	Type of Work	Number of Siblings
8	15	Male	Pakhtoon	Nil	10 years	300	seller, begging Shoe polisher, begging	7
9	14	Male	Sindhi	Nursery	9 years	300	Sell pens, begging	8
10	16	Male	Sindhi	Nil	11 years	400	Sell napkins, begging	8
11	18	Female	Pakhtoon	4th grade	13 years	400	Begging	5
12	17	Female	Pakhtoon	1st grade	12 years	400	Sell flowers, begging	4
13	14	Female	Punjabi	2nd grade	4 years	400	Begging	7
14	11	Male	Punjabi	1st grade	3 years	300	Begging	6
15	12	Male	Pakhtoon	4th grade	5 years	500	Begging	9
16	15	Male	Pakhtoon	1st grade	7 years	500	Begging	6
17	16	Male	Pakhtoon	2nd grade	9 years	400	Begging	8
18	17	Male	Saraiki	Nil	9 years	400	Begging	7
19	13	Male	Punjabi	Nil	5 years	400	Begging	7
20	15	Female	Pakhtoon	Nil	8 years	600	Sell drawing books, begging	7

Informal vs formal healthcare preference, economic barriers to accessing healthcare

Street children face immense barriers when it comes to accessing formal Healthcare. Most of these children prefer informal healthcare options such as clinics, pharmacies, or traditional healers because they are more accessible and less intimidating. One child explained, *"We don't go to hospitals because they ask for money we don't have. The medicine man on the street helps us for less."* These preferences not just about cost but also trust. Many street children were unwelcome and mistreated in formal healthcare institutions. They fear hospitals due to previous experiences of being judged or ignored by staff. As one child put it, *"Hospitals aren't for kids like us. They don' care if we're hurt; they just want us gone."*

Perceived health vs. actual health risks, role of peers and community in health knowledge and practices. Street children often have a distorted perception of their health, believing they are strong and healthy despite enduring frequent illness and poor living conditions. Many of them believe that being able to engage in their daily lives, including begging or working, is a sign of good health. One child said, "*I'm okay, I'm able to work every day even if I am coughing or feverish.*" Otherwise, self-medication is also common; children are often prescribing themselves to local pharmacies without the aid of a doctor or trusted adult and instead take to the establishment based on recommendations from others. One street child shared, if we don't feel good, we ask our friends what they do. Most of the time they simply say to go to the pharmacy and purchase medicines or smoke and feel better.

Food choices that are driven by income and availability, malnourishment and food insecurity. There are various problems that street children are getting when it comes to getting a nutritious food resulting in malnutrition and food insecurity. They usually have plentiful and consistent food sources, and many of them use food scraps from hotels, restaurants or street vendors. "*Most days we wait outside the hotels and hope that they will give us what is left over,*" said one child. "*Otherwise, we need to beg or get some food from the trash*." They readily admit that they were unaware of any balanced meals in their lives. With limited finances, children are forced to consume the very basic food available, which is frequently

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thick and processed, providing little nutritional value and resulting in poor nutrition and potential future health issues.

Economic survival affecting health seeking behaviour, financial instability as a constraint on the proper care received. Rawalpindi street children live in extreme financial insecurity, it directly affects their health-seeking behaviour as they don't have any regular source of income or support, a lot of children are getting occasional support from strangers or from hotel workers. "*Sometimes, when we feel hurt or sick, we reach out to the strangers to help us out, and if they feel sorry for us, they may give us little money, but not all the time we are on our own,*" one explained. The children always face the obstacle of financial instability when they want to get the right treatment. Although they know they need medical treatment, they may often be unable to afford it. One child said, "*I know that if I go to the hospital, I will get better but how will I pay for it? They ask for money, and I don't have any money, no one will help me*". This is also a feeling of helplessness which is an indication of how much influence economic survival has on their choices. They may need to forgo medical care or to access cheaper and less effective services, such as street clinics and traditional healers.

Child's labour's impact on physical and mental health, financial stress shaping health decisions. Street children working in a hazardous environment face long term health problems, ranging from respiratory issues caused by inhaling toxic substances to chronic musculoskeletal pain from heavy lifting and various skin related problems like rash, skin burns by direct exposure and constant exposure to sun rays and environmental pollutants. All of them combined pose significant risks to the physical and mental health of children. In addition to that, the mental toll of being exposed to dangerous condition also led to anxiety, depression and a sense of hopelessness. As one street children shared *"I know my back will hut forever but if I don't work, we won't have food"*. This highlights the heart wrenching dilemma these children face. Seeking medical attention becomes a secondary concern. Table 2 highlights the narratives of participants along with the themes.

Table 2

Participant Narratives and Themes

Theme	Example Narratives
Informal vs Formal Healthcare Preference	*"Hospitals aren't for kids like us. They don' care if we're hurt; they just want us gone.*"
Role of Peers in Health Practices	"*If we don't feel good, we ask our friends what they do. Most of the time, they just say to buy medicines from the pharmacy or smoke to feel better."*
Malnutrition and food insecurity	"*Most days, we wait outside the hotels and hope they'll give us whatever is left over. If not, we have to beg or find food in the trash*"
Economic survival shaping health seeking behaviour	"*I know going to a hospital could help me get better, but how can I afford it? They ask for money, and I don't have any, no one is going to help me with that*."
Child's labour's impact on physical and mental health	"*I know my back will hurt forever but if I don't work, we won't have food*."

4. Discussion

Street children in Rawalpindi exhibit health-seeking activities that indicate a complex interplay of social, cultural, and economic issues that profoundly affect their general well-being and access to healthcare. The study's findings highlight the significant obstacles these Kids must overcome and the ways in which their particular situation influences the health choices they make. In order to connect the primary findings to more extensive research and literature on street children and healthcare access, this discussion examines the important findings under a number of major themes. A mixed-methods study conducted in 2024, highlighted poverty, insufficient awareness, and family breakup as factors contributing to children taking to street-based

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earning, thereby pushing them away from the school and health care services in Rawalpindi and Islamabad, by adopting a mixed-methods approach. This implies that most of the street children out of school are involved in child labour, begging or cleaning up cars to survive and illustrates the impact of financial stressors, stigma and lack of access to formal institutions on decision making related to education and health-related support for street children (Fehmi et al., 2024).

Financial insecurity's effect on medical-seeking behaviour in these children is a key theme in the study. The mean of the participants' earnings was PKR 408.5 per day, which is below their basic needs. Their choices about their health are greatly influenced by their financial precarity. Some of the children, even when really ill, reported that they did not have sufficient resources to seek medical attention. The number of rural to urban migration of families seeking jobs is a major contributor to street children. The count of such informal settlements, with limited access to clean water, sanitation and health facilities is seen in Pakistan, which adversely affects children's health, pitting children against children in vulnerable homes. These families typically lack the means to access higher education or earn profits from skilled, high-paid endeavours, and are widely correlated with child health consequences, such as increased prevalence of infectious disease, malnutrition and delayed care-seeking (Mahmood et al., 2025).

Street children earn money at the cost of their health as a result of financial difficulties. Studies have found that begging and vending or informal employment is the only means of earning a wage for children and youth to be able to settle for their basic necessities; food and shelter. Some of the reasons why the children of the street are neglecting or delaying the care they need are because of the direct and indirect costs of treatment. In urban Pakistan, one in five children living in the street have highlighted the high cost of health care as a hurdle to accessing formal services (Ahsan et al., 2021). Low socioeconomic status is not an optimal environment to have access to professional treatment, and these kids are stuck in the weeds with little alternative but to be plagued by untreated illnesses and/or injuries. This is a common trend amongst street children around the globe (Jörgensen et al., 2024). Poor access to reliable adults or resources or legal documentation restrict street-living children's access to formal health services and consequently prevents the diagnosis or treatment of infections, wounds, respiratory illness or chronic pain. It is not only individual “non-compliance” with care, however, that leads to such exclusion, as the problems described in the systematics review and the qualitative studies are health problems that have also been experienced by treated and well treated health workers (TSs), and show that untreated or poorly treated health issues are a structural aspect of street-child life in low and middle-income countries (LMICs) (Cumber et al., 2015).

Street children in many improvised countries, including Rawalpindi, typically indicate high preference for informal healthcare options such as local pharmacies, traditional healers, or self-treatment. Their bad experiences with formal healthcare facilities, where they frequently run into prejudice, negligence, and a lack of empathy from medical staff made children neglect to seek formal healthcare facilities. Children reported feeling” unimportant and being mistreated during hospital visits made them feel discriminated. Street children are discouraged from obtaining medical attention, when necessary, because of the perceived stigma associated with formal health care system. When children choose to go to professional medical care in favor of efficient or even hazardous treatments, the ensuing reliance on I informal care can have terrible consequences (Macleod et al., 2023).

The reliance on friends for health advice can make worse unhealthy practices, such as self-medication or smoking as a copying strategy, ultimately leading to harmful health outcomes. These children may be reluctant to seek formal health services due to stigma, cause and reinforce their mental health problems and perpetuate their cycle and other health related problems (Ahsan et al., 2021).

The lack of food security and malnutrition were significant problems in this research. In almost all cases, the study participants reported that they primarily ate food left behind by groups that provide street food to children and young people, and that they have limited access to ‘balanced and nutritious' food, reflective of experiences of street-child across the world (Marasini et al., 2024). The absence of food signifies this not only to harm health in the immediate circumstances, but in the long-term it adversely affects physical growth, cognitive development and overall resilience (Gautama et al., 2026). Household food insecurity is a global issue and is recognized to be a risk for poor nutrition outcomes in children. Our

rural Pakistan results indicated that there was an inverse relationship between preschool children's weight-for-age and emergent literacy, independent of household food insecurity (Alsager et al., 2025). These findings highlight not only poor food security, but a significant public health concern that impacts children's nutritional status, physical development and cognitive outcomes in at-risk children, and indicate the need to implement more focused nutrition and social support interventions.

5. Conclusion

The health seeking behaviour of street children in Rawalpindi is influenced by socio-economic challenges, low education, and reliance on informal healthcare. Delayed medical care is linked to instability in finances and misconceptions about health care, until conditions aggravate. Stigma and discrimination in formal health facilities eliminate or discourage access to health services and poor nutrition coupled with bad habits like smoking increases risks to health. These factors, therefore, result in poor health outcomes and reliance on self-medication or informal practices. These are the reasons that need to be addressed in order to improve the health and wellbeing of this vulnerable population.

Limitations

First, the study was undertaken in two selected areas of metropolitan Rawalpindi so generalizing the findings may not necessarily reflect the varied experiences in other localities in other cities of Pakistan. Second, the number of respondents was also small sampling (20 respondents), thus the results of the research can only be applied in general population of street children limited. Third, the data were gathered was through self-reported interviews, which can be prone to recall for bias, social desirability bias and underreporting of sensitive experiences like substance use as well as exploitation or abuse. Fourth, due to careful transcription and translation, there could have been slight distortion or differences in meaning of nuanced expressions in the translation of all interviews from Urdu to English. Lastly, children's experiences in the cross sectional, phenomenological design occur at a particular time; thus, attention cannot be paid to changes in the children's health seeking behaviour or the family's living conditions as they increase in age, or transition from the street to the family, and vice versa.

Future Insights

Future studies could be expanded to involve larger and more diverse number of street children from various peri-urban and urban area of Pakistan to improve the generalizability of the results. Long-term qualitative or mixed methods studies could investigate shifts in health-seeking behaviours, mental health, and nutrition across time, including those associated with moves between street homes, family reunification, and institutionalization.

Ethics Approval

This study was approved by the Health Services Academy Institutional Review Board under order: F. No.000551/HAS/MSPH/2022 dated 28-08-2024.

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Conflict of Interests

The authors declare no conflict of interests.

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Data Availability

The datasets generated during and analysed during the current study are available from the corresponding author on reasonable request.

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