Illness incidence and health seeking behaviour among street children in Rawalpindi and Islamabad, Pakistan – a qualitative study

M. Ali* **and A. de Muynck†**

*Department of Health Policy and Planning, Institute of International Health, Graduate School of Medicine, The University of Tokyo, Japan, and
†Institute of Tropical Medicine, Antwerp, Belgium

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Abstract

Background This is the first study in Pakistan to elicit street children's perceptions of health and the barriers to service utilization.
Methods A descriptive, cross-sectional study was carried out during September and October 2000. The data were collected in twin-cities of Rawalpindi and Islamabad through individual, semi-structured street-based interviews; with 40 school age participants; in addition, three focus group discussions were also completed. The sampling was convenience based. This strategy was applied because of the non-existence of a sampling frame for the street-based children owing to the absence of any census or other reports, and also the difficulty of tracking very mobile street children.
Results Results indicate that these youth were highly susceptible to many adverse health outcomes. The common ailments were injuries, respiratory and skin infections. Along with low self-perceived severity of medical problems, self-medication was preferred and medical pluralism existed. Their perceived constraints to services included long waiting time, monetary, negative attitude of service providers and their inferior status.
Conclusions In developing user-friendly services, it is important to be sensitive to street children's needs and requirements. Eliminating these barriers and the integration of health services among public and private resources are imperative for the regular and sustainable provision of health care to this vulnerable, under-served group of children.

Keywords
health care seeking, health perceptions, Pakistan, street children

Correspondence:
Moazzam Ali, Department of Health Policy and Planning, Institute of International Health, Graduate School of Medicine, The University of Tokyo, 7-3-1 Hongo, Bunkyo-Ku, Tokyo 113-0033, Japan
E-mail: denube5@yahoo.com

Introduction

Homelessness affects more than 100 million people in the world (UNCHS 1996). It is projected that by the year 2015, 53% of the developing world population will live in cities (UNDP 2002). The rapidly escalating number of street children in cities of both developing and developed world is a matter of grave concern (Wright 1993; Ayaya & Esamai 2001). A classification scheme outlined by United Nations International Children's Emergency Fund (UNICEF) is commonly used in international literature to differentiate homeless youth: 'youth on the street' refers to youth who engage in street-based activities such as begging or peddling but have a home base to return to, while 'youth of the

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street' have weaker ties to their families, and 'abandoned youth' have no connection to family at all (Mufune 2000).

The reasons for being on the street vary but poverty is the root cause of this phenomenon (Aptekar 1988; Aneci *et al.* 1992; de La Barra 1998), they earn money either to take home to their families or to support themselves. Mostly, children survive by doing mobile street work such as washing and parking cars, begging, scavenging, hawking and so on (Swart-Kruger & Richter 1997).

Street children are highly susceptible to many adverse health outcomes related to their living style of extreme personal and high-risk behaviour (Ribeiro & Ciampone 2001). They are vulnerable because they move frequently and do not enjoy stable housing, formal education, or accessible health care services (Klein *et al.* 2000).

Street children have a broad range of health problems; (Sherman 1992) but generally, they do not consult for treatment (Pande 1993). The barriers to their receipt of health care are thought to include confidentiality issues, distrust of adults and professional agencies, minor status, need for parental permission to receive services and lack of co-ordinated services (Morey & Friedman 1993; Geber 1997; Christine *et al.* 1999).

Most street children do not suffer from chronic diseases (Pande 1993), but it is accepted that homeless children are much more likely to experience health problems than housed children (Berti *et al.* 2001). The common causes of morbidity in the street children are skin ailments (e.g. scabies), respiratory infections, vision, mental health, dysentery, injuries and dental problems (Wright *et al.* 1993; Nigam 1994; Nzimakwe & Brookes 1994; Senanayake *et al.* 1994; Ayaya & Esamai 2001; Berti *et al.* 2001). Slightly more street boys than girls are reported to suffer from all these health problems (Pande 1993).

Illnesses are generally classified as follows: (i) those that are curable with modern medicine; (ii) those that can be successfully treated only with folk curing methods (Young & Garro 1994); and (iii) those for which spiritual healers (Hunte & Sultana 1992) are preferred. Besides home/self-treatment, people tend to select treatment alternatives in accordance with one of two orderings, based on two key aspects of the available alternatives: (i) the likelihood that the use of the particular source of treatment would actually result in a cure; and (ii) the estimated cost associated with each alternative.

Studies highlight children's strong peer support system through which they care for and help each other financially, morally and emotionally. Many studies mention that street peers are considered 'dependable' in times of need (Gross *et al.* 1996; Baker *et al.* 1997; Rhode *et al.* 1998).

These young children do manage to survive quite successfully by their standards, the difficult circumstances in which they find themselves. Although they may be uncomfortable reminders of the malfunctioning of the society, they nonetheless bear witness to the endurance and potential of the human spirit (Chatterjee 1992).

The street children phenomenon is an increasing problem in most growing cities, such as Rawalpindi and Islamabad. Because of the dearth of literature on home desertion in Pakistan, various issues about the children involved are not known yet. It is therefore important to have baseline data on their health perspectives, in order to devise rational approaches for health care services delivery to them in future.

A descriptive study was conducted to enable an appreciation of some of the issues involved. The study reported here is the first attempt in Pakistan, aimed to ascertain the health-related concepts of street children in twin-cities of Rawalpindi and Islamabad. It attempts to understand their perceptions of health and illness, the process of their health care decision making and factors in their choice of health care provider. The study also investigated the perceived barriers to health care by street children.

Methods

A descriptive, cross-sectional study was carried out during September and October 2000. The data were collected in Rawalpindi and Islamabad through individual, semi-structured street-based interviews, with 40 school-age (8–14 years) participants, in addition to three focus group discussions. The sampling was convenience based. This strategy was applied because of the non-existence of a sampling frame for the street-based children owing to the

absence of any census or other reports, and also the difficulty of tracking the very mobile street children (Geber 1997; Dematteo *et al*. 1999; Adeyinka 2000; Ayuku *et al*. 2003). All respondents participated in a 1-hour semi-structured interview, guided by an outline which was developed to assess their demographic background, ethnic identity, concepts related to health, health care seeking behaviour and perceived barriers to service use. The in-depth interviews were analysed manually. They were coded, categorized, and domains were identified and later entered into software Statistical Package for Social Sciences (SPSS) version 8.0 for analysis. There are three focus groups with five or six participants, each conducting with 17 children selected through purposive sampling. Data from focus groups were analysed by focusing on meaning, context and internal consistency as well as frequency and intensity of comments. The responses were transcribed and deductions made, and thereafter included in the overall analyses.

Site description

Three focal areas in Rawalpindi and Islamabad twin-cities were chosen based on the recommendation of the agencies working with street children, systematic observation of the known areas where they congregate, and key informants in each city. In Rawalpindi, the main site selected was the bus station at committee chowk, which is a busy site. In Islamabad, Blue area, a main business centre, and Barri Imam, famous for the shrine, were chosen.

Results

Four main themes were identified from in-depth interviews and focus group data: (i) perceptions of health and illness; (ii) health care decision making; (iii) factors in choice of health care provider; and (iv) perceived barriers to health care.

Demographic characteristics

Respondents' background

There was a preponderance of male children (80%), with a mean age of 9 years (SD ± 2, Range: 9; 5–13 years). The ethnicities of the respondents were predominantly Pathan (82%) and Punjabi (18%). The majority declared poverty (75%) to be the main reason to be on the street. Even though 52% of the respondents went to school for some time, they left school and were unable to continue to the next level. The majority was living with parents (85%) or relatives (12.5%) and only 2.5% were living on streets. Most of them were flower vendors or car washers and were working between 8 and 12 h each day, earning approximately 60 rupees per day (1 US $ = 60 Rs.).

Respondents' parental background

The study also inquired about respondent's parental background. Most parents were alive (92%). Fifty-two per cent of fathers and 90% of mothers of street children were illiterate. A total of 58% of fathers and 97% of mothers were not engaged in any money earning activities. Those working were either in street trading or engaged in unskilled professions. Most of the families had six or more siblings.

Perceptions of health and illness

Their living circumstances shaped their concepts, as participants described illness as a condition which renders them unable to work. Health was defined as a state allowing them to work and earn income.

Participants categorized a minor illness as an infirmity which does not hinder their livelihood, including respiratory infections, minor cuts, burns, skin infections, cold, mild fever and diarrhoea. They identified a major illness as a condition necessitating them to stay away from work and demand some kind of medication.

The common major illnesses were persistent high-grade fever (39%), injury and severe diarrhoea and hepatitis, i.e. yellow skin, which restricted them from work.

The general physical examination of the respondents revealed that four had skin problems including scabies and dermatitis; one had chest infection and fever. Three other children were found to have minor cuts and bruises on their

hands, feet and faces, yet another was an established case of polio.

Health care decision making

Respondents pointed out that the decision to seek medical advice depends mainly on two factors: gravity of the illness and financial situation.

In all circumstances, the first and by far the most common initial response to an illness was an attempt at 'self-medication', using both home-made and commercially prepared remedies. In situations where ill health persists longer than a few days and immobilizes them, they seek health care.

As noted earlier, most of the children in the sample were residing with their parents; consequently family had a vital role in the process of decision making in seeking health care. The participants acknowledged that although their parents, especially mothers (47%) mainly took decision in seeking medical advice, they took independent decisions also, while few mentioned that their peers encouraged them to seek medical advice.

During visit to a health provider, they were mostly accompanied by parents (44%) or street friends (17%), but at times they went alone (39%).

They mentioned that economic circumstances play an important role in their decision making. When faced with economic crisis during illness, the majority would prefer going to a spiritual healer [Pir] (47%), as the latter do not charge or have only nominal charges. Seventeen per cent preferred self-medication. Eleven per cent would borrow money to go to a doctor, while 25% would only wait until the disease gets better by itself or someone sympathetically takes him to the doctor and bears the eventual expenses.

Participants acknowledged the important role the peers had in their lives. Although peers were considered reliable and from whom they would preferably borrow money (52%) in times of need, they were not always available, as they were also being busy in the survival struggle.

Factors in choice of health care provider

People everywhere must choose, from among the several possible courses of action available to them, in attempting to treat infirmity. The criteria for provider's choice were based on the perceived skills and existing financial possibilities.

In response to a question about their first choice, the majority opted for spiritual healer [Pir] (56%) for seeking medical advice during any illness, while 33% preferred medical doctors and few mentioned going to traditional healers [hakims] (11%).

Spiritual health care was central in all treatments. Participants generally believed that illness was mainly due to evil spirit and spiritual healers were thought to possess the right knowledge – their management focused on protection from evil and they accelerate the healing process. They stated that even if they consult a doctor, the treatment from a spiritual healer would continue alongside.

Those affirming allopathic doctors as their preferred choice mentioned that when it comes to acute problems such as injuries, and high-grade fever, doctors were preferred. They considered them expensive but believed that through their knowledge and effective medicine, they would swiftly restore health, thus reducing out-of-work days.

Traditional healers were considered economical, using safe herbal medicine. They carry the reputation of knowing secret cures for chronic and incurable diseases, so they are the preferred choice in situations where modern medicine fails or economic constraints become a key factor.

Perceived barriers to health care

A variety of barriers were identified that influence health care seeking behaviours. When youth described health problems, one-third often expressed concerns about not being able to bear the cost. In addition, as the children work daily for a living, long waiting time at the clinics was considered for some 25% to be an important restricting factor as they lose time during work hours.

Other factors include the fear that the health care providers would not take them seriously and would be disrespectful. Being a minority group, they distrusted the quality of care given to them.

Some mentioned being afraid that parents (7.5%) might dislike their independent decision in visiting a doctor, while a few mentioned that access

(5%) was one of the barriers to use of medical service. (See Fig. 1)

Discussion

To our knowledge, this is the first study in Pakistan that tries to explore the street children's perspectives on health and complexities involved in service utilization, an endeavour vital to address the needs of this group.

The day-to-day life of the street youth encountered in this study was characterized by a constant struggle to generate income and obtain sufficient food. This plight was frequently compounded by the health problems. They experienced a variety of health problems that appear related to the unhygienic, overcrowded surroundings, exposure to extreme weather and their 'hand-to-mouth' existence (Dachner & Tarasuk 2002).

The demographic characteristics and parental background are important antecedent variables, which could help in the understanding of pathways to home-desertion and forced-work among children. The picture depicts them to be predominantly boys, with an average age of 9 years, the majority residing with their parents. Few girls were interviewed. This may be due to two reasons: (i) they rarely stay away from home, or (ii) they hardly stay long enough on the streets to be noticed. Both situations could be due to alternative strategies open to them, such as mothering younger siblings and domestic employment.

Like reports from Brazil (Aneci *et al*. 1992), Columbia (de La Barra 1998), poverty was cited as the main reason for their being on the street; as they worked more than 8 hours everyday to earn approximately 1 US dollar. Our data point towards a typical family, where the majority of parents were illiterate, not engaged in any earning activity and had a family of six or more siblings, which is similar to findings in Nigeria (Adeyinka 2000). In studies done in Indonesia (Gross *et al*. 1996) and Nepal (Baker *et al*. 1997), the role of peer groups was highlighted and they were recognized as dependable friends. Our findings support these results. We observed that it is difficult for youth to rely on informal supportive networks during times of need as street friends are also preoccupied with survival issues. In brief, all have the common demands and constraints of living in the dangerous environments without conventional support from the adults.

Health is a prerequisite for work and is instrumental to survival, and their concepts about health are based on their everyday life experiences. For them, health is when they could work and vice versa. Like a study in USA (Christine *et al*. 1999), our study found self-perceived risk of diseases to be low, although many children reported that sometimes they had difficulties recovering from even minor colds or that these often developed into illnesses that are more serious. Furthermore, children with untreated infectious diseases constitute a pool from which other youth may also become infected. Our finding coincided with results from other studies (Wright *et al*. 1993; Nigam 1994; Senanayake 1994; Christine *et al*. 1999; Ayaya & Esamai 2001; Berti *et al*. 2001), which report a high prevalence of diseases such as respiratory infections, skin diseases, dysentery and injuries among street children. A few studies also highlight the incidence of sexual abuse and sexually transmitted

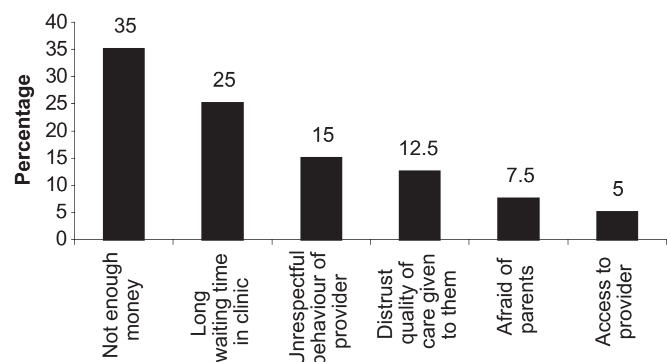

Figure 1. Perceived barriers to care.

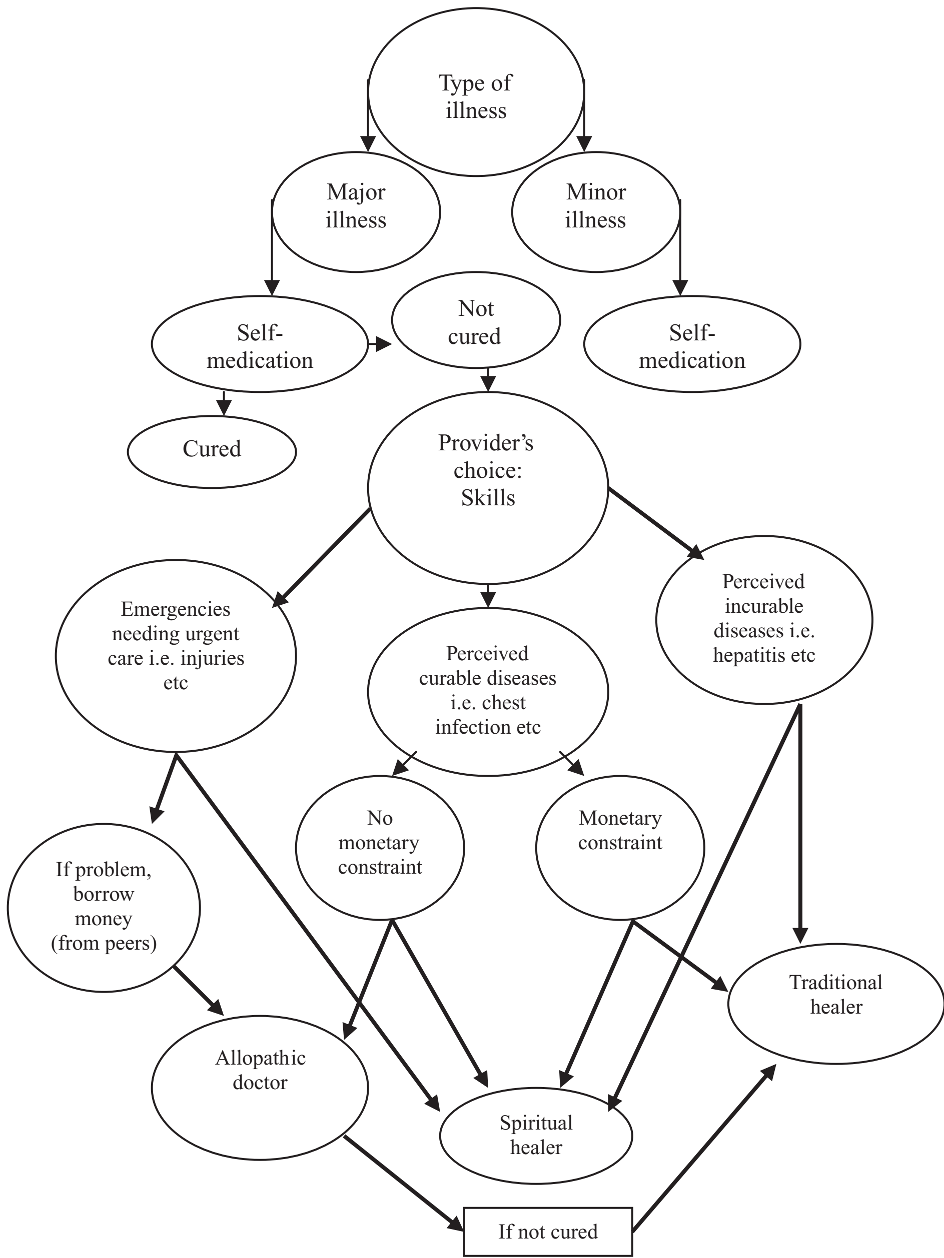

Figure 2. Street child: health care options and choices.

diseases (Christine *et al*. 1999; Rew 2002), but in our sample these were not reported.

Our findings suggest that although the majority of street children attempt self-medication, their decision to seek health advice is in accordance with one of two orderings: (i) the gravity of the particular illness; and (ii) the estimated cost associated with each alternative. Decisions are mainly made by the parents, but at times the individuals will also independently seek medical advice.

The result points out that choice depends on the perceived skills of the provider – the faith one has in the effectiveness of folk treatment, as opposed to medical treatment, in alleviating the illness, and the expenses associated with some alternatives and the availability of the resources to meet them. Faced with economic crises, most prefer spiritual healer charging nominal fees, or some would borrow money form peers, if their illness renders them out-of-work, to seek medical advice from an allopathic health care provider. (See Fig. 2)

In the past, many studies had acknowledged the fact that street children do not have access to regular health services (Morey & Friedman 1993; Geber 1997; Christine *et al*. 1999; Klein *et al*. 2000). It is distressing that children in need of medical care may not receive the attention they require. The low perceived severity of medical problems might also prevent street children from seeking needed medical care. Our study corroborates with that findings from other studies, which mentions monetary factor, attitudes and feelings of the health care providers towards the participants, as barriers to service use. Besides additional situational factors, such as long waiting time, lack of access to services, at the time when they are most needed. Some research reports highlight the problems such as health insurance, clinic timings (Geber 1997) and confidentiality issues (Christine *et al*. 1999), but these were not cited by the participants in our study.

Conclusions and recommendations

Further efforts are required to eliminate the barriers to use medical services if the health needs of these children are to be met. These findings point to the need in providing the necessary preventive and curative services by integrating services of both public and private sector in reaching the underserved segments of the population.

The qualitative data have helped to elucidate children's perceptions about health and the impediments in seeking health care advice. This study reinforces a number of themes from the literature, specifically including the low perceived risk among children, common medical ailments, and barriers to service use. It also highlights certain culture-specific health-seeking behaviour such as self-medication and preference for spiritual healers.

Future research must combine an assessment of children's need of services, with their service consumption relative to need. An in-depth analysis of barriers to service utilization among children needing treatment but not using any service must be identified. Such information will aid service providers in targeting children with unmet service needs and designing strategies for more effective intervention.

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