

Navigating Fragmentation: Community Health Interventions For Street-Connected Children Within Health Systems

Beranard Projest

Moshi co-operative University, Tanzania

Email: bwilliza@gmail.com

Abstract

Street-connected children live at the edges of urban health systems, where poverty, mobility, and stigma quietly shape who receives care and who is left behind. In Tanzania, community-based welfare interventions are often the first, and sometimes only, point of contact with health services for these children. However, how these interventions function in everyday practice remains underexplored. This study examined how community-based welfare initiatives support access to healthcare among street-connected children in Dodoma City, while also tracing the barriers that continue to limit service use. Using a qualitative case study design, in-depth interviews and focus group discussions were conducted with street-connected children and key stakeholders, including community health volunteers, NGO coordinators, and district health and social welfare officers. Thematic analysis revealed that outreach, referral support, case management, and accompaniment to health facilities play a critical bridging role between the street and formal care. Community actors frequently navigate health systems on behalf of children who lack identification, financial means, or adult advocates. Even so, access remains fragile. Direct and indirect costs, provider stigma, loss of insurance cards, and institutional practices that overlook street-connected children repeatedly interrupt care pathways. Many children depend on peer networks or NGO escorts to be acknowledged in clinical spaces. Community-based interventions ease immediate barriers but cannot compensate for fragmented health systems. Strengthening equitable access requires child-sensitive service pathways, reduced administrative obstacles, and integrated medical-social responses grounded in rights-based approaches. Without these shifts, street-connected children will continue to navigate care through improvisation rather than inclusion.

Keywords: Street-connected children, Community-based, Welfare interventions, Health services

Introduction

Children are the future of every nation. Ignoring the health needs of street-connected children increases structural inequalities, stigma, and marginalisation. Poor health among street-connected children leads to their low ability in education, growth, and rehabilitation programs, which in turn widens the poverty cycle. Globally, it is estimated that there are between 100 million and 150 million street-connected children, with numbers rising due to urbanisation and economic instability (UNICEF, 2023). According to Abate et al. (2022), UNICEF, and the Committee on the Rights of the Child, street-connected children are those for whom the street (including unoccupied dwellings, wasteland, etc.) has become their habitual abode and/or source of livelihood, and who are inadequately protected, supervised, or directed by responsible adults. They are classified as street-connected children on the street or working children, children of the street who have lost their family bonds, and children in street families.

Due to their risky living conditions, street-connected children are exposed to both communicable and non-communicable diseases, such as respiratory infection, sexually transmitted diseases, substance use, injuries, anxiety, depression, and behavioural disorders that hinder proper coping mechanisms and proper adjustment. Research indicates that the prevalence of mental health disorders among street-connected children can be as high as 80%, significantly exceeding that of their housed peers (Woan et al., 2023). Therefore, ignoring health accessibility prevents the treatment of preventable diseases, leading to chronic conditions that increase death and disability. In some regions, the mortality rate for children living on the streets is estimated to be 10 times higher than the general pediatric population (Mbae et al., 2020).

Community-based welfare intervention plays a critical role in complementing formal health systems by delivering both informal and formal services to hard-to-reach populations. These interventions are significant in contexts where health workforce capacity is insufficient to meet population needs. For instance, in Sub-Saharan Africa, where the health worker density is often less than 2.3 per 1,000 population, community actors are vital (WHO, 2022). In line with Kacheyo and Nyirenda (2024), community actors help bridge gaps between health systems and street-connected children, who lack health insurance and face critical discrimination in accessing care.

The World Health Organisation has renewed its calls to strengthen community-based interventions as a pathway to achieving universal health coverage, particularly for underserved populations, including street-connected children (Sacks, Schleiff, Were, Chowdhury, & Perry, 2020). However, all the commitments are going to waste, as there is low community involvement in planning for street-connected children's health interventions and equitable access to health care. Despite community-driven initiatives, studies show that up to 60% of street-connected children still report being turned away from formal health facilities due to a lack of identification or funds (Keith, 2021). Street-connected children have continued to carry a greater disease burden due to their exclusion from health systems, even if outreach programs are trusted and culturally sensitive.

As documented in previous studies (Embleton et al., 2020; Baggaley et al., 2022), community-based health interventions, such as community health workers (CHWs),

outreach services, mobile clinics, and shelters, are important for delivering health services to street-connected children. Evidence suggests that peer-led outreach can increase the uptake of HIV testing and basic first aid by over 40% among street-connected youth (Consortium for Street-connected children, 2022). Community-based interventions connecting street-connected children with health services include outreach, mobile clinics, peer-led programs, drop-in centres, NGO-coordinated referral systems, and integrated child protection initiatives, all of which improve continuity of care.

Mobile clinics and outreach programmes have overcome geographical, legal, financial, and cultural barriers that limit street-connected children's access to health services. Mobile clinics, often staffed by local community health workers, have shown positive outcomes in reaching mobile populations. In urban centres, mobile units have been found to reduce emergency room visits by 30% by providing early intervention for minor injuries and infections (O'Carroll et al., 2021). Community health workers link street-connected children with shelters, rehabilitation centres, and long-term care services, thereby facilitating access to health care through community- and government-financed interventions.

Although Tanzania introduced the Community Health Fund (CHF) in 2001 to improve access to health care for low-income populations, street-connected children remain excluded mainly due to the scheme's contributory nature and the absence of targeted community support mechanisms (Issel et al., 2021). Statistics from Tanzania suggest that while the CHF aimed for universal coverage, enrollment remains below 10% in many urban districts where street-connected children are most concentrated (USAID, 2022). As a result, significant gaps persist in linking street-connected children to essential health services due to the high cost of treatment.

Strengthening community-based health interventions for street-connected children supports global goals, including Universal Health Coverage (UHC) and Sustainable Development Goal 3 on Good Health and Well-being (Vandana et al., 2024). Despite efforts to improve street-connected children's health, little is known about how community health interventions connect them with health services, regardless of their extreme poverty, weak social networks, and the discriminatory attitudes of health workers. This necessitates community health interventions that deliver services in the streets and increase early identification and treatment. These interventions should address two main objectives: promoting health and preventing disease, and improving access to and utilisation of essential health services. This literature review examines studies on community-based approaches to delivering health services among street-connected children. examined the Community-level integration of health services and community health workers' agencies. The findings of Yarliani, Irayana, and Pratiwi (2023) indicated that involving community health workers in enhancing community engagement with health agencies promotes coping mechanisms, adherence, and referrals among street-connected children. Collaboration among stakeholders enhances health promotion among street-connected children and improves their health outcomes. Subhi, Cahyati, and Zainafree (2025) call for increased awareness and behavioural changes within the community regarding the health conditions of street-connected children, which will

contribute to improvements in public health. If street-connected children are not treated, they may spread infectious diseases to the broader population. However, community health workers (CHWs) need extensive health training, as they have limited information about the health programs they implement, low self-esteem regarding program ownership, and limited documentation.

In the same vein, Zulu and Perry (2021) conducted a study on community health workers at the dawn of a new era, highlighting the relationship between the health system and the community and underscoring their visibility as intermediaries between street-connected children and health facilities, facilitating access to essential health services. The community health workers' responsibilities include conducting outreach to identify and engage street-connected children, providing health education and information, assisting with referrals to appropriate healthcare providers, and advocating for the healthcare needs of street-connected children within the community and the healthcare system. To implement universal health coverage and eliminate the existing disparities in health provision that also discriminate against street-connected children (Kumar et al., 2021).

Community Health Workers face significant challenges, such as low payments and exclusion from formal health systems, which affect the quality and effectiveness of health delivery for street-connected children. Despite these challenges, community health workers remain valuable in countries with weak, fragmented health systems for delivering adequate health services to street-connected children by promoting access to care and advancing universal health coverage. (Mgawe & Maluka, 2021)

When healthcare systems are not inaccessible, outreach services through mobile clinics provide preventive care, treatment for common illnesses, health education, and referrals. According to Angela Coaston et al. (2022), Mobile clinics provide remedial treatment for chronic illness, make proper referrals, cover the costs of treatment, and thus address the health services gap for hard-to-reach populations. Outreach services also support the well-being of street-connected children through nutrition, psychological counselling, and protection. This finding aligns with prior research showing that street-connected children's experiences with community health interventions are highly context-dependent and lack comprehensive evidence to validate the economic impact of health systems (A Coaston et al., 2021).

An evaluation study by Embleton et al. (2020) found that 25,000 street-connected children with poor health conditions, high rates of HIV, STDs, respiratory diseases, skin conditions, diarrheal illnesses, malnutrition, mental health problems, and substance use are excluded from health services. However, drop-in centres connect them with health services through street-based outreach, health education, and rehabilitation programs.

The case management model is generated from the generalist model of welfare provision to a street-connected children-centred model of service delivery. It is multidimensional, with the case manager leading health interventions that determine the range of health services for street-connected children (Lukersmith et al., 2023). is used to coordinate and arrange medical services for street-connected children by advocating for

and linking them with health services available at health centres with which NGOs have established partnerships. As reported by Gursansky and Harvey (2020), case management involves multiple experts in assessing the health challenges faced by street-connected children. Every expert, under the leadership of a social worker, proposes a viable solution for how street-connected children can access health services.

Street-connected children's health-seeking behaviours are strongly influenced by their livelihood activities, which often dictate their mobility and availability (Tune et al., 2020). Barriers such as intimidation by healthcare staff, restricted facility hours, and long waiting lines further limit their access to appropriate health care. Shelter and drop-in centres are connected to health services, where they receive treatment for minor injuries and receive basic health education. Nevertheless, many shelters and drop-in centres face financial constraints and the fragmented nature of Tanzania's existing health systems. In Tanzania, mobile clinics have been introduced to serve the general population; however, few are specifically designed to address the unique health needs of street-connected children.

Literature Review

The integration of community-level health services is increasingly recognised as a cornerstone for achieving Universal Health Coverage (UHC), particularly for populations existing outside formal social safety nets. Ngwira, Mayhew, and Hutchinson (2021), in their study in Malawi, emphasise that Community Health Workers (CHWs) act as vital agents of "street-level bureaucracy." By employing qualitative methods such as participatory observation and in-depth interviews, they demonstrated that they are enhancing community engagement by promoting coping mechanisms, treatment adherence, and formal referrals for street-connected children. This role is theoretically grounded in structuration theory, which posits that health workers are not merely passive actors but individuals who both influence and are influenced by the social structures they navigate.

However, the efficacy of the community health workers model is not without contention. Zulu et al. (2015) present a divergent perspective, noting that many operate with limited information regarding the health programs they implement. Their research suggests that low program ownership, poor documentation, and low professional self-esteem can undermine the potential of community-led interventions. Despite these internal challenges, Zulu and Perry (2021) argue that in the "new era" of global health, CHWs remain the most visible intermediaries between marginalised youth and health facilities. Their responsibilities, ranging from street-based outreach and health education to aggressive advocacy, are essential for eliminating the systemic disparities that lead to the discrimination of street-connected children within formal clinical settings (Kumar et al., 2021).

In the Tanzanian context, the reliance on CHWs is often a response to the acute shortage of professional social workers. Mgawe and Maluka (2021) observe that while CHWs are indispensable in fragmented health systems, they frequently encounter barriers such as inadequate medical knowledge, gender-based biases, and low literacy levels.

These factors can limit the scope of care to basic first aid, leaving complex chronic or psychological conditions unaddressed.

Beyond individual volunteers, the institutional role of Non-Governmental Organisations (NGOs) and community-based groups is critical in bridging the "last mile" of healthcare delivery. Mulu et al. (2022) highlight that when formal healthcare systems remain inaccessible due to cost or distance, community groups provide a comprehensive suite of services, including preventive care, nutritional support, and psychological counselling. These organisations serve as a protective buffer, translating complex health protocols into culturally appropriate interventions.

The health profile of street-connected children necessitates such specialised approaches. An extensive evaluation by Embleton et al. (2020) identified that street-connected children face a disproportionately high burden of HIV, sexually transmitted infections (STIs), respiratory tract infections, and substance use disorders. Their findings suggest that drop-in centres are particularly effective because they utilise a "case management model." This model does not merely provide one-off treatments but coordinates continuous care by advocating for the child and linking them with established NGO-government partnerships. This structured coordination is essential for managing the long-term health needs of children who lack stable guardianship.

The physical and psychological distance between the street and the clinic remains a primary barrier to care. Malone et al. (2020) emphasise the transformative impact of mobile health clinics (MHCs) in the United States, noting that these units reduce healthcare costs by preventing the escalation of treatable conditions into emergency room crises. Mobile Health Clinics represent an "innovative intervention" that brings preventive strategies directly into the child's environment, thereby bypassing transportation and formal registration barriers.

The need for mobile services is further underlined by the livelihood-seeking behaviour of street-connected children. As Tune et al. (2020) argue, street-connected youth are often tied to their survival activities during the hours when clinics are open. Furthermore, experiences of intimidation by healthcare officials and the "stigma of the waiting room" deter them from seeking help. While MHCs address these issues by providing services in the communities where children live and work, they face significant sustainability challenges. In Tanzania, although mobile clinics serve the general population, there remains a conspicuous absence of MHCs specifically designed to address the unique medical and legal needs of street-connected children (Mgawe & Maluka, 2021). This gap in the current health infrastructure emphasises the need for targeted, community-financed interventions that integrate street-connected children into the broader national health framework.

Materials and Methods

Study Design

This study employed a qualitative, exploratory research design to gain an in-depth understanding of the role of community-based welfare interventions in facilitating access

to health services for street-connected children. This approach allowed for a nuanced exploration of outreach services, mobile clinics, shelters, drop-in centres, and the efficacy of the case management model in delivering healthcare within the specific socio-economic context of Dodoma City.

Study Setting

The study was conducted in Dodoma City, Tanzania's administrative capital. Dodoma is a rapidly growing urban centre characterised by significant migratory flows, which have resulted in an increasing population of street-connected children and marginalised groups. The research specifically targeted four wards with the highest documented prevalence of street-connected children: Majengo, Uhuru, Viwandani, and Makole. These areas serve as hubs for both public and private organisations providing social and health services to vulnerable youth.

Participants and Sampling Procedures

A multi-stage sampling strategy was utilised to recruit a diverse range of stakeholders. Street-Connected Children: 30 children (20 boys and 10 girls) were recruited across the four selected wards. To be eligible, participants were required to live permanently on the streets for at least 6 months. Participants were selected using purposive sampling to ensure a representative distribution of age and gender across the wards. The participants in the study were street-connected children aged 5 to 17 years, both boys and girls. It is worth noting that children could be subject to different experiences based on their developmental characteristics as they took to the street, making this age distribution important. Street-connected children (especially those < 10 years old) tend to be more reliant, either directly or indirectly, on peers or older street members for protection and survival, while street-connected children aged 15–17 years are likely to exert greater independence concerning their everyday activities and decision-making in the context of their homelessness. The recognition of these age differences facilitates an understanding of the diversity of experience between street-connected children, and allows the study to explore how age shapes exposure to risks, coping strategies, and access to welfare and health services.

Key Informants (KIs): Purposive sampling was used to recruit ten (10) key informants based on their expertise and decision-making roles. At the grassroots level, this included representatives from three supportive non-governmental organisations (NGOs) and the Chairman of the Social Protection Committee. At the district level, the study engaged the District Medical Officer (DMO) and the District Social Welfare Officer (DSWO), who oversee health policy and child protection coordination, respectively. Data collection continued until theoretical saturation was achieved, which occurred at a total sample size of 35 participants (30 children and 5 primary administrative KIs), as no new themes or significant information emerged in subsequent interactions.

Data Collection Tools and Procedures

Data collection took place between July 2025 and December 2025. The research utilised two primary methods: In-depth Interviews (IDIs). Semi-structured interviews were conducted with key informants to explore institutional frameworks and systemic barriers to healthcare. Focus Group Discussions (FGDs): Three FGDs were conducted with a group of street-connected children. To ensure a safe space for expression and to account for gender-specific vulnerabilities, groups were segregated by sex (two groups for boys and one for girls, the latter primarily from the Uhuru ward).

The interview and discussion guides were developed based on the UNICEF Street-connected children Protection Framework, also utilised by Save the Children and Plan International. To ensure linguistic and cultural competence, tools were translated into Swahili, Gogo, and local street lingo. All sessions were audio-recorded with consent, lasted 45-60 minutes, and were held in "safe-space" locations (e.g., drop-in centres) to ensure participant comfort.

Data Management and Analysis

Following the collection, audio recordings were transcribed and translated into English. To ensure accuracy, transcripts were cross-checked against the original recordings during segmentation. Data were analysed using Thematic Analysis as described by Braun and Clarke (2006), following six phases: data familiarisation, initial coding, theme identification, theme review, theme definition and naming, and final report production.

Coding was performed manually. To enhance the trustworthiness and inter-coder reliability of the findings, three independent researchers participated in the coding process. Discrepancies were resolved through peer debriefing until a consensus was reached. Finally, three themes were identified: modes of health delivery, community linkage, and barriers to access. The resulting thematic framework is presented in the coding tree (see Table).

Main Themes	Sub-themes	Initial Codes
1. Modes of Health Delivery	Outreach & Mobile Clinics	Street-based care, periodic visits, emergency first aid
	Shelter-based Services	Residential care, nutrition, hygiene support
2. Community Linkages	Case Management	Identification, referral tracking, follow-up care
	CHW Involvement	Peer education, bridge to formal systems, advocacy
3. Barriers to Access	Systemic Exclusion	Lack of ID, cost of CHF, healthcare worker stigma
	Socio-cultural Barriers	Language gaps, mistrust of authorities, "street lingo"

Source: Field data

Ethical Considerations

The researcher obtained permission from the University of Dodoma to conduct research in Dodoma City. The University issued a research clearance letter with Ref. No. MA.84/261/77/264 on 15 August 2025, on behalf of the Government and the Tanzania Commission for Science and Technology (COSTECH), which authorised the researcher to conduct the study. Written consent from the participants was obtained to serve as interviewees and to allow the interviews to be audio-recorded. Given the vulnerability of street-connected children, strict confidentiality was maintained, and all identifiers were removed during transcription. The study adhered to the ethical principles of the Declaration of Helsinki, safeguarding the rights and welfare of human participants.

Findings

Theme 1: Modes of Health Service Delivery for Street-Connected Children

The thematic analysis identified three primary models of health service delivery utilised to reach street-connected children in Dodoma City: outreach services, mobile clinics, and shelter-based services. Participants indicated that these models are strategically designed to mitigate systemic barriers, including social exclusion, high mobility, financial constraints, and the geographical distance between street environments and formal health facilities.

Sub-theme 1.1: Outreach Services and the Role of Volunteers

Outreach services emerged as a fundamental link between community initiatives and the health system. These services rely heavily on volunteer health workers who navigate street environments to provide immediate care. However, key informants highlighted significant challenges regarding the sustainability of this workforce. An outreach officer from a supportive organisation noted the difficulty in maintaining volunteer engagement:

“Yes, we have volunteers who are working with street-connected children in the city, but they are experiencing regular [attrition], and we are scarcely providing them with motivation or incentives. We provide them with training on how to identify newly arrived or sick street-connected children so they can facilitate their connection to formal health services.” (KII, Outreach Officer)

While outreach is effective for identification and initial contact, the findings suggest that the lack of a formal incentive structure for volunteers threatens the continuity of care.

Sub-theme 1.2: Perceived Limitations of Mobile Clinics

Although mobile clinics are intended to supplement outreach efforts, there was a notable discrepancy between the intended service and the children’s lived experience.

Focus group participants noted that existing mobile services are often generic and do not meet the specific health needs of street-connected populations. During a focus group discussion, one participant explained:

"Specifically, there are no special mobile clinics designed to provide health services to us; there are mobile clinics that deliver health services to the entire population for immunisation only. Outreach officers instead provide us with first aid services and recommend referrals to health facilities." (FGD, Male Street-Connected Child)

This suggests that while mobile clinics exist within the broader health system, they are not tailored to address the acute or chronic conditions prevalent among street-connected youth, leaving a gap that is only partially filled by basic first aid.

Sub-theme 1.3: Shelter-based and Drop-in Centre Services

Given the high mobility of street-connected children, which often impedes medication adherence and follow-up care, shelter-based services were identified as a more stable alternative. These facilities—often referred to as drop-in centres—provide a controlled environment for health interventions.

Key informants, including medical professionals and social welfare officers, emphasised the integrated nature of these centres. A medical doctor noted:

"There are drop-in centres where street-connected children receive treatment and basic health education. These shelters are connected with health services where trained nurses, employed by supportive organisations, provide basic health services such as treatment of minor injuries, counselling, and routine check-ups." (KII, Medical Doctor)

The findings indicate that shelter-based care provides a level of consistency that street-based outreach cannot, offering a hybrid model where NGOs employ professional staff to bridge the gap between the street and the formal hospital setting.

Theme 2: Community Linkage and Integrated Care Models

The study identified community linkage as a pivotal factor in bridging the gap between street-connected children and formal healthcare. This linkage is primarily operationalised through two mechanisms: the formal case management model and the informal networks facilitated by Community Health Workers (CHWs).

Sub-theme 2.1: The Case Management Model and Financial Protection

The case management model addresses the inherent disconnect between street-connected children and formal health systems by synchronising individualised interventions. By focusing on the role of a case manager who navigates the nexus of health and social services, the model provides a framework for continuity that generic outreach often lacks. This personalised support is essential for transforming sporadic health

encounters into a reliable pathway of care, shielding the child from the inefficiencies of a fragmented health infrastructure.

A significant finding within this model is the utilisation of the Community Health Fund (CHF). However, while the case management model facilitates financial access, the children's precarious living conditions pose a barrier to the security of their physical insurance assets. During a focus group discussion, one participant noted:

"Through case management, different stakeholders provide us with Community Health Fund (CHF) insurance cards. These help us reduce the treatment costs imposed by hospital staff. However, we are often unable to keep them because we have no permanent place to live, and sometimes the 'older brothers' [street leaders] take them away from us." (FGD, Male Street-Connected Child)

Consequently, the findings suggest that case managers must act as custodians of these legal documents. There is a documented need for CHWs to assist in tracing these children to ensure that the provision of insurance translates into actual healthcare utilisation when they fall ill.

Sub-theme 2.2: Community Health Workers and Informal Safety Nets

The involvement of CHWs extends beyond formal referrals to the cultivation of peer-led education and informal emergency response networks. The data suggest that under the guidance of CHWs, street-connected children have developed a degree of social capital that functions as a first-line response during medical emergencies.

One participant recounted a critical incident involving physical violence and the subsequent peer response:

"When the knife struck me in my stomach, my friend ran away, but other street-connected children helped me by contributing money for the transport that took me to the hospital, where I was admitted." (FGD, Male Street-Connected Child)

This narrative reinforces the existence of an informal safety net within street structures that, if properly supervised by CHWs, can be leveraged to improve emergency health outcomes.

Theme 3: Systemic and Interpersonal Barriers to Healthcare Access

Despite the implementation of Community Health Worker (CHW) programs and case management models, street-connected children continue to face multi-layered barriers to formal healthcare. These obstacles range from structural requirements, such as legal identification, to interpersonal challenges, including provider-based stigma and discrimination.

Sub-theme 3.1: Structural Barriers and the Paradox of Identification

A primary structural impediment to healthcare utilisation is the requirement for formal identification (ID) and a verifiable residential address for health insurance

enrollment. The high mobility of street-connected children, coupled with their severance from family units, renders them legally "invisible" within the administrative framework of the health system.

Focus group data highlighted the link between displacement and the inability to secure health documentation:

"I do not have identification documents to identify us since I escaped from home. I have never returned home, and my parents do not understand where I am currently living. I am always shifting from one city to another, depending on [economic] opportunities." (FGD, Male Street-Connected Child)

Outreach workers noted that this lack of a fixed base complicates not only the enrolment in insurance schemes but also the clinical follow-up and recovery management, as children may relocate before a treatment course is completed.

Sub-theme 3.2: Provider-Based Stigma and Discriminatory Practices

The findings suggest that the health-seeking behaviour of street-connected children is significantly suppressed by the perceived and enacted stigma from healthcare providers. Participants reported being marginalised based on their physical appearance and the absence of adult guardians, which often resulted in suboptimal care or clinical dismissal.

Gender-specific vulnerabilities were particularly evident regarding Sexual and Reproductive Health (SRH) services. Female participants reported a lack of clinical empathy and the denial of care:

"When we go to the hospital with concerns about sexual and reproductive health, we are not welcomed. Surgeons and doctors do not listen to us [attentively], and sometimes we are denied access to health services altogether." (FGD, Female Street-Connected Child)

The lack of adult supervision further exacerbates this discrimination. Without an adult advocate to navigate the hospital hierarchy, children are often bypassed or ignored in clinical settings.

Sub-theme 3.3: The Role of Institutional Advocacy and the Special Window

Key informants from supportive organisations emphasised that health facilities are not currently configured to accommodate the unique social profiles of street-connected youth. There is a notable absence of specialised windows or fast-track protocols for marginalised children, making them dependent on NGO intervention for basic recognition. A leader from a supportive organisation explained:

"Street-connected children are not treated in the standard line, and there is no special window specifically designed for them. Sometimes, it is only when we are accompanying them to the health centres that they are given attention." (KII, NGO Representative)

This reliance on third-party accompaniment suggests that the health system views street-connected children through a lens of criminality or deviance rather than as a vulnerable population with a right to care. As one participant noted, they are often treated as offenders, a perception that ignores the structural drivers of their homelessness and further entrenches their exclusion from the formal health sector.

Discussion

The present study explored the mechanisms through which community welfare interventions facilitate healthcare access for street-connected children. The findings reveal a complex ecosystem of support structures that emerge as a compensatory response to systemic dysfunction (Functionalism) while attempting to mitigate the multi-layered risks (Vulnerability Theory) faced by street-connected children. By analysing the roles of volunteers, peer networks, and NGOs, this discussion illustrates how community-led interventions strive to restore a sense of social equilibrium amid structural vulnerability.

A central finding is the indispensable role of community volunteers who act as a bridge between street-connected children and formal health services. This aligns with Skhosana (2020), who views community workers as essential conduits. However, the Vulnerability Theory lens reveals that while these volunteers provide linkage, the children remain acutely susceptible because they often lack the legal protocols or specialised training to address the complex psychological trauma of street life. As De Oliveira (2020) suggests, while organisations attempt to bypass systemic labelling by escorting children to hospitals, this remains a reactive measure that fails to address the underlying structural vulnerability that necessitates such an escort in the first place.

The findings highlight that healthcare exclusion is rooted in profound social biases where street-connected children are viewed through a lens of criminality rather than inherent vulnerability. This label represents a functional breakdown in the healthcare system's role as a universal provider of social protection. Solile et al. (2023) identified that social stigma and restrictive institutional hours disproportionately increase the disease burden among these populations. When the health system fails to fulfil its function of providing equitable care, it exacerbates the child's situational vulnerability. This systemic neglect of provider attitudes necessitates a theoretical shift from a model of social control to one of social protection, recognising that the "minority status" of these children is a product of social dysfunction rather than individual fault.

In the absence of formal state safety nets, street-connected children have developed sophisticated mutual-aid systems. Abekah-Carter (2024) and Yeboah (2023) documented how street-connected individuals utilise social capital to manage illness. However, Vulnerability Theory warns that these informal networks are often insufficient; reliance on peer-led self-medication underlines the compounded risks children face when formal care is unreachable. While NGOs in Tanzania focus on resource mobilisation and self-protection skills (Mwenda, 2022), from a Functionalist viewpoint, these informal networks are an organic response to the failure of family and state units; children create their own micro-social structures to maintain survival.

The case management and the composition of multidisciplinary teams comprising doctors, psychologists, and social workers reflect the need for a holistic social medicine approach. This is particularly urgent given the heightened vulnerability noted by Abdi et al. (2019), in which street-connected populations face increased risks of comorbidities and injuries. An integrated program ensures that the health system fulfils its societal function by treating the child not just as a clinical case, but as a vulnerable individual requiring comprehensive social reintegration.

Recomendation

The study proposes an integrated, client-centred intervention model that addresses both the structural dysfunction of the current system and the child's individual vulnerability. A medical-social hybrid model is required to repair the broken links between the street-connected children and the health systems. By integrating health education with job creation, the model acknowledges that a child's health is functionally dependent on their economic survival. Grounding this approach in the United Nations Convention on the Rights of the Child (1989) moves the discourse from charity to rights-based protection, aiming to eliminate the structural vulnerabilities of cost and lack of identification.

Conclusion

This study demonstrates that healthcare access for street-connected children in Dodoma is characterised by a precarious reliance on informal health ecologies and "fragmented improvisation." While Community Health Workers (CHWs), NGOs, and peer networks provide essential lifelines, these actors primarily function as compensatory mechanisms for a state health system that remains structurally exclusionary. The findings, viewed through the lens of vulnerability theory, reveal that the barriers to care extend beyond logistical hurdles to include deep-seated socio-emotional challenges, such as institutional stigma, legal invisibility, and the economic trade-offs of seeking treatment. These layered vulnerabilities ensure that care remains conditional and fragile, often dependent on third-party mediators rather than on institutionalised rights. Consequently, the current reliance on community-based interventions, while reflective of local resilience, underscores a systemic shift of responsibility away from the state, leaving children to navigate a landscape in which medical services are decoupled from the broader social protections necessary for their survival.

Moving forward, addressing the health disparities faced by street-connected youth requires a transition from a charity-based model of "temporary bridges" to a rights-based, integrated policy framework. This research argues for a hybrid delivery model that situates medical care within a broader multisectoral strategy encompassing drop-in centres, stability, legal documentation, and economic reintegration. By anchoring such interventions in the UN Convention on the Rights of the Child, healthcare can be reframed as a fundamental entitlement rather than a discretionary service. Such a shift demands not

only the formal integration of CHWs into decision-making structures but also a fundamental reform of hospital protocols to create child-sensitive, stigma-free pathways. Ultimately, achieving health equity for these street-connected children requires political accountability and sustained investment in formal systems that recognise the legal and social personhood of street-connected children, ensuring that their well-being is no longer a matter of chance encounter but a guaranteed institutional priority.***

Ethical considerations

The University of Dodoma issued a research clearance letter with Ref. No. MA.84/261/77/264 on 15 August 2025, on behalf of the Government and the Tanzania Commission for Science and Technology (COSTECH), which authorised the researcher to conduct the study.

Consent to participate

All participants voluntarily signed consent forms describing their participation, the data collected, how data are protected, and their rights as participants.

Consent for publication

All writing, graphs, and figures are the original work of the authors. No original quotes or identifying personal information are included in this manuscript.

Declaration of conflicting interests

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