Children and youth in street situations in Nairobi. A study for a comprehensive model of care

Marzia Ravazzini°, Massimiliano Reggi°, Elena Magoni°, Paolo Inghilleri*

* Social Psychology Research Group,
Department of Cultural Heritage and Environment,
Università degli Studi di Milano,
Via Festa del Perdono 7, Milano, Italy,
e-mail: paolo.inghilleri@unimi.it.
GRT – Group for Transcultural Relations,
via Molino delle Armi 19, Milano, Italy.
e-mail: marziaravazzini@yahoo.it;
e-mail: m.reggi@grtitalia.org;
e-mail:kenya@grtitalia.org.

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Abstract

We investigated the profiles of children and youth in street situations in Mlango Kubwa slum in Nairobi. Through a quanti-qualitative questionnaire, we collected the responses of 300 children and youth, starting from the social determinants of health as indicators of vulnerability. The foremost objective is to understand their social and health conditions as vulnerable/at-risk street groups. The secondary goal is to identify the populations' strengths, inspecting protection mechanisms, survival strategies and dreams. The data show a complex situation: experiences of trauma, violence, conflict and abandonment; ambivalent family ties, school drop-out, lack of legal and physical protection, homelessness, living below the limit of extreme poverty. The street has activated survival strategies, mostly on an individual level, but functioning as a "base system" the street seems to act as a protective system and a possible scenario in which to create a different future together with youth workers: reconnecting with the family, liaising with expert figures in order to return to school or look for suitable training. Working with children and youth in street

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situations highlights the complexity of their vulnerability. This could be addressed through an integrated approach and a comprehensive primary health care model.

Keywords: children and youth in street situations, social determinants of health, primary health care, vulnerability

Background and rationale

About 4 Million people are currently living in the urban area of Nairobi (Indexmundi, 2019), among which 60,000 are street children living in a volatile and hostile socio-political context (Kisirkoi, Mse, 2016).

In spite of the launch of Kenya Vision 2030 (Kenia Vision, 2018) and the considerable Sustainable Development Goals SDGs (United Nations, 2020a) progress, education, HIV, socio-economic inequality, poverty and poor institutional capacity continue to undermine Kenya's potential. Approximately 60% of the population lives in neighborhoods characterized by high levels of social and health deterioration. Health, education, access to clean water and sanitation remain top priorities for the Kenyan Government, which aims to achieve social inclusion and the creation of job opportunities for the most marginalized (minors, people with disabilities, women and refugees), in order to create fair and sustainable development. A high level of socio-economic inequality, widespread poverty and weak governance continue to undermine Kenya's progress, highlighting the gap in income distribution with adverse effects on social welfare. Eastleigh is a large borough in Nairobi, predominantly populated by Somali refugees as well as Somali with Kenyan citizenship. MlangoKubwa, neighboring Eastleigh, is situated in the Starehe sub-county and merges with the large

Mathare slum, characterized by overpopulation, inexistent social services, crime, unemployment, unwanted early pregnancies, gender-based violence and substance abuse. Its population has been recorded to be 38,374 (of which 14% are under 14 years old), who live in destitution.

The present study, which investigates a particular population of these urban areas, is placed in the area of scientific literature that analyzes urban health and the health of slum dwellers (Ezeh, Oyebode, Satterthwaite, Chen, Ndugwa, Sartori, Mberu, Melendez-Torres, Haregu, Watson, Caiaffa, Capon, Lilford, 2017; Fayehun, Ajisola, Uthman,

Oyebode, Oladejo, Owoaje et al., 2022; Mberu, Haregu, Kyobutungi, Ezeh, 2016). The population being studied is particularly specific: they are not purely just "urban" because the characteristic of "being in transition" actually has to do with characteristics of chronicity; yet the population also does not correspond to the inhabitants of the slums, because they do not live in these places and were not even born there. In addition, they are children and young people, minors, whose characteristics are observed and described mainly by reports of appointed international agencies (CYC, 2004). Minors are particularly vulnerable: lacking significant family support they become exposed to the dangers of a life on the street (crime, drugs, and sexual transmitted diseases).

MlangoKubwa is the area where this study took place in 2017. The subject of this study are children and youth in street situations, according to the latest broad definition from UNICEF, Committee on the Rights of the Child, General comment No. 21 (2017) (UNICEF, 2017), where the term "children in street situations" is used to comprise: (a) children who depend on the streets to live and/or work, whether alone, with peers or with family; and (b) a wider population of children who have formed strong connections with public spaces and for whom the street plays a vital role in their everyday lives and identities. This wider population includes children who periodically, but not always, live and/or work on the streets and children who do not live or work on the streets but who regularly accompany their peers, siblings or family in the streets. The argument "to be on the street" is articulated. There are two categories of different street children populations. Children of the street are homeless children who live and sleep on the streets in urban areas. They are totally on their own, living with other street children or homeless adult street people. On the other hand, children on the street earn their living or beg for money on the street and return home at night. They maintain contact with their families (UNICEF, 2018a). More particularly children end up on the streets for one or more of the following reasons: low family income (many activities in the street contribute to family survival); homelessness (the lack of proper housing pushes entire families into the street;) neglect and abuse. This problem may be associated with parents' drug addiction and alcoholism, or the lack of time spent in significant interaction; school failure; loss of parents due to armed conflicts, natural disasters, HIV/AIDS and other epidemics, and refugee problems. Each street child's history is a unique blend of several of these elements (Volpi, 2002). Children and youth in street situations are a vulnerable group. The word *vulnerability* comes from the Latin

root *vulnus*, meaning wound. To be vulnerable means being capable of being wounded, both physically and emotionally, as Merriam Webster defined (2018). Besides physical and emotional vulnerability there is also a kind of vulnerability that refers to cognitive phenomena: "cognitive vulnerability" and in this study we intend to consider all the three realms, sympathetically (Boldt, 2019). Vulnerability is a basic assumption of this study; it is a starting point which highlights the need for a comprehensive approach that can focus both on reading the context and on addressing the problems to highlight and empower their own capability/health ability.

Following this logic, by collecting their voices, the study intends to deepen the understanding of the characteristics of this population and investigate possible strengths, pointing out the protection mechanisms that take place in the street and the survival strategies that are put in place, as well as illustrating possible improvements in terms of health and well-being. Therefore, the vulnerability experienced by the protagonists is analyzed starting from the intersection between the social determinants of health (SDH) (Marmot, 2008), through the formulation of the questionnaire, and the concept of health dynamics, in particular the Meikirch model, which explores the concept of "health – ability" (*Huber,* 2009), towards a new direction of primary healthcare interventions. The data collection is conducted referring to the above quoted theoretical frameworks:

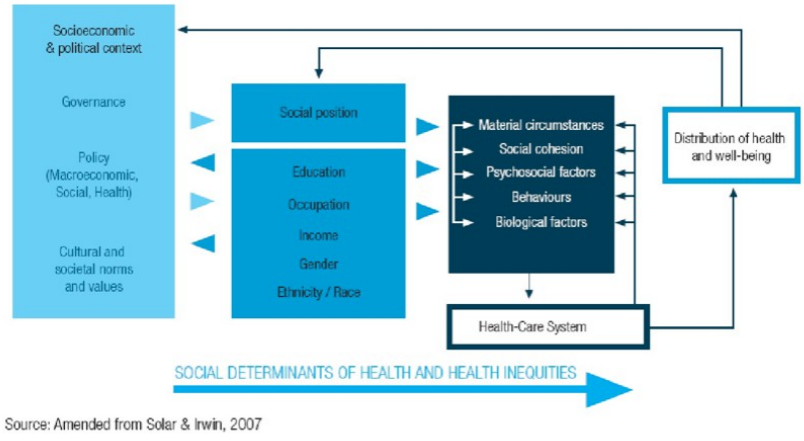

Fig.1 - *Social Determinants of Health (Solar, Irwin, 2010)*

1) social determinants of health – which brings our analysis to the awareness of children and youth in street situations in a very comprehensive way, with a wide horizon to be considered (see Fig. 1). Within that, we do call for the main determinants of health (see Fig.2).

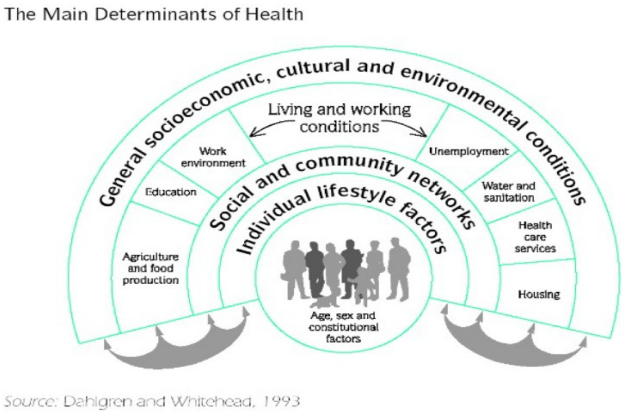

Fig.2 - *The Main Determinants of Health (Dahlgren, Whitehead, 2006)*

As illustrated, the health inequalities are affected by the high exposure to material, psycho-social and behavioral factors mainly in the most vulnerable groups with low income situations. The children and youth in street situations have no way out of this condition**.** In addition, chronic street and psycho-social factors such as anxiety, depression, low personal esteem and lack of safety, together with social exclusion and lack of any control on personal life and employment amplify the fragility of the situation (see Fig.3).

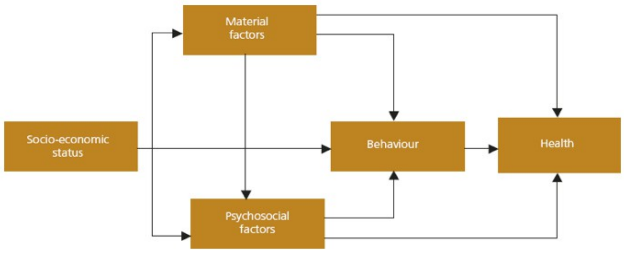

Fig.3 - *Social Determinants of health. The solid facts. (WHO Europe. RG Wilkinson, M Marmot, 2003)*

Clearly, the physical and mental well-being of children and youth in street situations are at risk. In this sense, the so-called Meikirch model of health can help understand the data, having in mind that "health is a state of wellbeing emergent from conducive interactions between individuals" potentials, life's demands, and social and environmental determinants" (Bircher, Kuruvilla, 2014). According to this Model, health occurs when individuals use their biologically given and personally acquired potentials to manage the demands of life in a way that promotes well-being. This process continues throughout life and is embedded within related social and environmental determinants of health. Health is constituted by all three dimensions – individual, social, and environmental determinants of health (see Fig. 4).

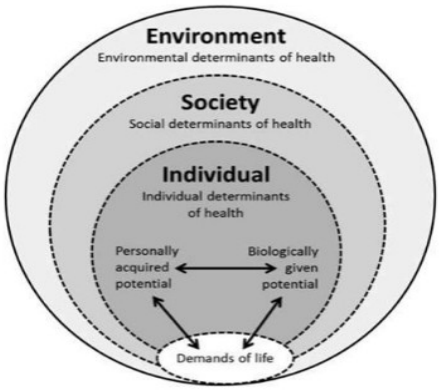

Fig.4 - *The Meikirch Model of Health (Bircher J., Kuruvilla 2014)*

In particular, starting from the concept of the environment and cascading through the concept of society and individuals, we analyze the demands of life that children and young people in street situations face every day.

From their voice, we collect the concept of health-ability, defined as the ability and the capacity to cope and self-manage, promoting the individual's functional capabilities (Huber, Knottnerus, Green, Horst, Jadad, Kromhout, 2011).

This concept highlights a new concept of health, which is no longer static, but more dynamic. It is also functional to plan health and care interventions for this population, in compliance with the comprehensive primary healthcare model.

The comprehensive primary health care is aligned with the Declaration of Alma Ata (UNICEF, 1978), recognising the expertise of the individual and the importance of community or individual empowerment. This model of care:

- takes into consideration a physical, mental and social well-being;
- addresses issues of equity and social justice,
- considers the impact of education, housing, food and income;
- acknowledges the value of community development;
- recognises the expertise of individuals regarding their own health;
- focuses on a comprehensive approach to chronic disease prevention, early intervention and management.

The WHO definition of comprehensive primary health care clearly identifies that social determinants of health have a relevant impact on physical health as well: primary health care has an all-inclusive approach to physical health and well-being centered on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing (United Nations, 2020b).

Goals, target population, materials and methods

The study aims to frame the situation of children and youth in street situations in order to understand their physical and mental well-being in Nairobi County. It targets 300 children and youth in street situations (8<24 years old), wandering around the Mlango Kubwa area as a vulnerable group. The data collection was carried out from May to November 2017, for a 7-month period of mapping activity within the project "Boresha Maisha".[1]

The basic tool to investigate was a structured and open-ended questionnaire, which was co-constructed by the project partners. In the process of co-constructing the questionnaire we started from the concept of *being on the street*. This implies the description of the physical, emotional and cognitive vulnerability to which children and young people are exposed in street situations every day. It also sheds light to the impact on the possible awareness that being on the street can

[1] The project "Boresha Maisha. Alternatives of life for street children and underage refuges in Nairobi" has been run for three years led by Group for Transcultural Relations (GRT) in partnership with Comitato Collaborazione Medica (CCM), RefuSHE, US ACLI, and together with local partners Starehe Sub County Children Office (SCO) and Starehe Sub County Health Office (SCHO) (www.grtitalia.org/en/project/childprotection/kenya/boreshamaisha).

activate, such as their own survival strategy, problems and people met and resources set in motion. The questionnaire is divided into 6 main sections, in order to collect: socio-demographic data; family information; education level; skills and training; social life aspects; and basic needs and medical focus on urgent care. The partners co-worked two months to draft the questionnaires, while the volunteers of the community were trained to conduct the interviews in Swahili. The questionnaire was tested prior to the actual implementation of the mapping on the field to ensure its easy comprehension by the target population. Special attention was given to approaching the respondents in the street and making them feel comfortable during the interview. The questionnaires were submitted orally one on one, and in the most comfortable language to the respondent (Swahili). The team agreed on the translation of the questions. The study itself presents a methodological anomaly that the working team, made up of international and national/local partnerships, considered enriching: the process was actually inverted as it has been part of a field cooperation project in which the recipients interviewed were already known by the team itself, and the bond of trust was active and attentive to ethical aspects. The questionnaire was also directed thanks to previous knowledge regarding data on the majority of street youth and children. The questionnaire could not be filled by the respondents directly because of their education level, living condition, and mental fragility, and each time, each respondent was informed prior about the anonymity of the case. Given the vulnerability and fragility of the interviewees, in particular with respect to situations of violence, high stress or substance mis-use, the team was prepared to face the possible situations of uncontrolled reactions or concentration difficulties; ethically speaking, the team was also prepared to report urgent cases in terms of both safety and health. The survey team is composed of 3 counselors/social workers of GRT Kenya, working on the field for more than five years together with 2 volunteer children officers of the Starehe Sub-County Office and 2 community health volunteers of the Starehe Sub-County Office (CHV), already experienced in the field.

Results

Indicators of vulnerability

The description of the population of this study, as expressed by the social-demographic data collected, follows these categories: numbers and gender, age, nationality, educational level gained and legal situation (birth certificates and ID), income, skills and talents, and family situation.

The population of children and youth in street situations is composed of 40 females and 260 males, totalling 300 people interviewed (87% of the sample were men). More than half of the population (52%) were under 18 years old: children made up 5% and teens made up 47% ("children" is defined as 0-11ys old and "teens" as 12-17yrs old). Young people (18-24 yrs old) were represented 41%; the remaining 6% were adults, defined as 25 years or older. The average age was 18 years old (range 5-40 years). 99% out of the 100% of the youth and children being surveyed declared to be Kenyan. Their level of education, income, and legal situation all contribute to defining the complexity of their vulnerability, as well as having an impact on their health and wellbeing, as the approach of the social determinants of health (SDH) have shown. 80% of the population had attended some grades of the primary school (30% between grades 1-5 and 41% between grades 6-8), while 6% completed at least 2 years of secondary school, and 5% had never gone to school (with a peak among females, of whom 13% never attended school).

In regard to the legal situation, 76% of children and youth in street situations were without birth certificate (227 said "not in possession"), only 14% owned one and 10% were not able either to respond or remember; for the ID document, more than half of population were not able to answer, while 36% declared "not in possession", while 10% replied yes. Even if our population is not a typical one with a regular job, the questionnaire aimed to explore the economic situation, asking for any sort of income children and youth in street situations were able to make in order to survive on the street. 78% claimed to have an income. We gathered four clusters as following: almost half of population earned less than 1.5 euro per day (the international extreme poverty line set in poor countries is at 1.9 dollar a day, World Bank, 2017), 22% between 1.6 and 2.5 euros, 7% up to 5 euros and 1% over 5 euro per day (based on the rate conversion as 1 KES = 0,0086 euro. Dec 2018).

The demands of life this population has to face are high. In order to analyze the way children and young people in street situations cope, we elaborated some questions about their own management. Skills and talents were investigated to understand their potentials. 86% of the population declared to have no skills. Among those who responded yes, 76% declared to have some talents which they detailed very precisely. The results were as follows:

- different artistic expressions: art, singing, acting, dancing, music (39%)
- job skills: mechanic, carpentry, hairdressing and barber, tailoring, wiring(5.5%)
- sport attitude: soccer and gymnastic (31.5%).

Family data is key to understanding each child's affective field, as they reinforce the status of health and well-being of every individual. The data collected focuses on three different aspects: parents' situation, siblings and family, and extended relatives. 69% of the children and youth in street situations had parents: both parents alive (46%) or at least mother alive (23%); 21% declared to have both parents deceased. 87% had siblings and 75% had someone from an extended family (detailed as: 9% aunt, 20% uncle, 21% one grandparent, 22% mixed).

Being in street situations

In this section we present some peculiarities collected around "being in street situations" concerning the sleeping "bases"[2] or locations, the working places our population attended, and the way they spent their time. Being on the street means literally living the street. The population investigated used to sleep in places on the streets, work or look for a job daily on the street, and spend all its time on the street.

To clarify the burden of the topic "being in street situations" we have gathered the topic "years on the street" in 6 periods, and the results are as follows: < 1ys 32%; 1-3ys 17%; 3-7ys 26% ;7-10ys 12%; b/w 10 and 20ys 12%; more than 20ys 1%. Almost half of the children and youth in street situations have been on the street for less than 3 years (49%), and half of them more than 3 years (51%) (Chart 1).

[2] As for "base" we mean "the location where a group of street children sleep and socialize each night, staying together for safety. Typically between five and ten individuals gather at a base, constituting what street children themselves term a 'street-family'", referring to Cottrell-Boyce, (2010)

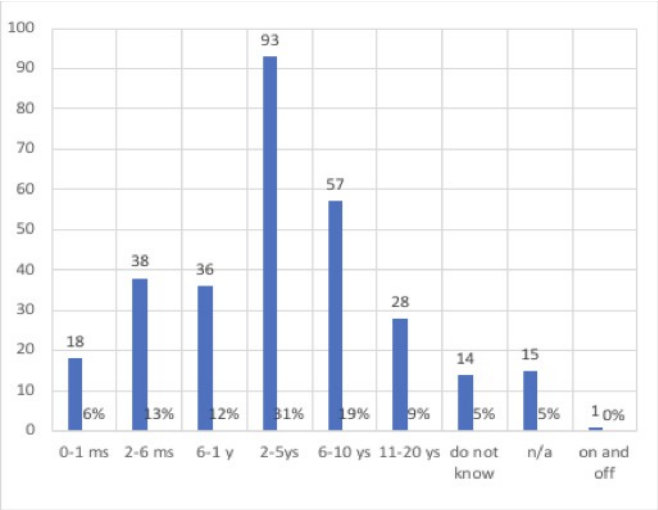

Chart 1 - *The children and youth in street situations, and period on the street (unit and percentage)*

Among the reasons cited for being on the street, 8 main reasons have been collected: peer (ingroup) pressure, lack of income, death or abandonment from family, physical abuse, family breakdown, conflict with the family, ill treatment by parents and/or extended family, and sexual abuse – shown as following (multiple-choice answers were registered for each person (see Tab.1).

Tab.1 - *Main reasons to be on the street (percentage, multiple choice answers). (data collected by questionnaires)*

Sexual abuse	Physical abuse	death/ abandonment	peer (in group) pressure	Ill treatment by parents	Conflict with the family	lack of income	family breakdown
3	5	10	11	1	7	10	3
5	39	55	85	22	30	64	33
8	44	65	96	23	37	74	36
3%	15%	22%	32%	8%	12%	25%	12%

Problems faced on the street

The children and youth in street situations faced many different problems. Among them 45% declared hunger, 43% harassment by police, 33% lack of shelter, 29% violence, 23% lack of blankets and/or

clothes, 22% discrimination, 16% bullying and unemployment, 15% illness, 12% theft, 11% sexual abuse and 1% hit by cars; only 8% replied to have no problems. It is important to consider these are multiple-choice answers, so often multiple problems were reported by the same person.

In particular, among the social and community networks illustrated by the SDH approach, we have taken into consideration the importance of social relationships and reference figures that can mean social ties and potential care for children and young people in street situations.

So, the questionnaire also examined the different figures to whom children and youth in street situations were used to talk to. Among the various profiles the most referred to were: 25% friend, 13% various figures, 7% teacher, 4% mother, less than 3% neighbor. About half of the population has no place to turn to:19% revealed to have no one to talk to and almost 30% were not able to answer.

Where and with whom children and youth in street situations stay

The children and youth in street situations sleep and work on the street. Knowing their habits and the chronicity of being on the street is a key to better understanding their environment and their behaviors.

Among the number of locations recalled by the children and youth in street situations within Nairobi, we assembled 9 main areas: 1 = Mathare; 2 = Starehe; 3 = Kamukunji; 4 = City Business Center; 5 = Kasari; 6 = Molologo; 7 = Westlands; 8 = Ruai (see Fig 5. e Tab 2.)

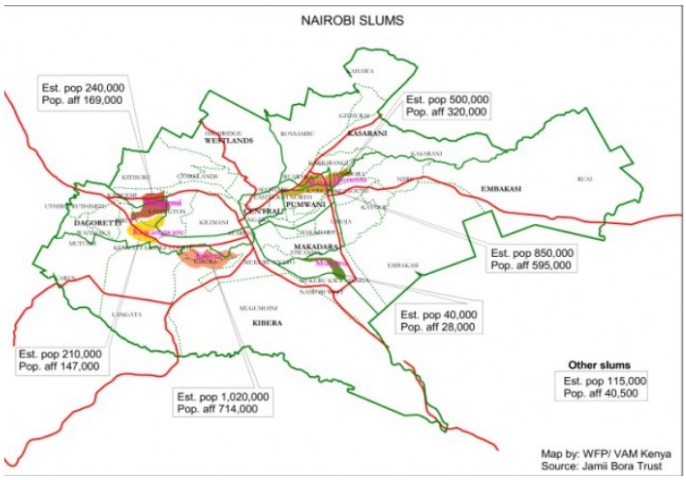

Fig. 5 - *Map of Nairobi*

Tab. 2 - *Locations/areas/ bases in Nairobi*

AREA	AREA	BASES
1	MATHARE	MLANGO KUBWA
		NIGERIA
		BONDENI
		NUMBER 10
		ESPANA
		KWA CHIEF
		MUTHAIGA STAGE
2	STAREHE (MATHARE IS PART OF STAREHE)	PARK ROAD
		PANGANI
		OTC-TUSKYS
		PUMWANI
		NGARA
		CHAI ROAD
		KIAMAIKO
		HURUMA
		MUKURU KWA REUBEN, KWA NJENGA
3	KAMUKUNJI	EASTLEIGH
		GIKOMBA
		MUTHURWA-FLYOVER
		COUNTRY BUS
		RIVERSIDE
		BLACK BASE
		KINYAGO
		MAJENGO
		DUMPSITE (DANDORA)
		JUA KALI
		ST.TERESA
4	CITY BUSINESS CENTRE	GLOBE ROUNDER ABOUT
		BOMBLAST
		RAILWAYS
		GEEVANJEE
		RIVER ROAD
		GROGAN (GARAGE)
		TOM MBOYA
		COMMUNITY
5	KASARANI	KOROKOCHO
		KARIOBANGI
		ROUNDER
		KOSOVO
		KAYOLE (EMBAKASI)
6	MOLOLONGO	
7	WESTLANDS	
8	RUAI	

63% of the population sleep in 2 bases (Mathare and Starehe), 28% in Kamukunji, and 6% in City Business Center, and about 2% among different areas such as Kasarani, Mololongo, Westlands and Ruai.

57% of children and youth in street situations worked in 2 locations (Mathare and Starehe), 25% in Kamukunji, 6% in City Business Center (CBD) and about 1% in Kasarani;.10% were not able to answer about the working location. A solid majority (74%) spent time in the base zones, looking around for some income mostly in Market and City Business areas.

74% of the population spent time with friends, 3% with siblings, 3% with mother and more than1% with relatives; 18% declared to be alone on the street.

Tightly linked to the family relationship, we observed the regularity with which the children and youth in street situations were able to see and spend time with their family, as well as the presence of their siblings on the street. 47% of this population were willing to go back to their extended family and live with them, while 26% preferred not to go back, 4% did not know where they live, and 23% were not able to answer. At the same time, 45% of the street children and youth thought that their extended family might be willing to take care of them, 20% affirmed that the family would not be willing to take care of them, and 35% were not able to answer this specific question. 87% declared to have siblings, among them 39% knew where they used to live and 10% did not know where they lived.

Economic aspect

Living on the street also means surviving. The crucial aspect is the working issue, in direct relation with the income and the expenses for living. The material circumstances along with social status strongly affect the psychosocial conditions and behaviors, having an impact on their health and well-being. Main provisional sources of income were detailed as follows: begging (46%), car washing and handcraft (2%), clothes washing (2%), selling bottles and juices (20%), and other different casual activities not defined as "other" (100%). To deeply analyze their strategy of survival, 38% of the children and youth in street situations spent money for their basic needs; 31% in food and drugs, 6% only in drugs**,** and 3% in helping others (usually relatives or parents away), while 22% of the population were not able to answer. About half of the population admitted they were not able to save any money (51%), 9% said they saved for future needs, 8% saved for basic needs, and 6% saved to help others in emergencies; 26% were not able to offer an answer.

The future imagined

In order to open up to new possibilities and improvements, the questionnaire conceptualized three questions to investigate the concept of health-ability (Huber et al. 2011). The goal is to investigate the individual's functional capacities and to link them to community and individual empowerment, as a basis of a comprehensive primary health care intervention (United Nations, 2020).

The children and youth in street situations were asked to imagine:

- the job/ activity they would like to do;
- the kind of assistance they would like to receive in the very near future;
- the way they think the healthcare services should be modified to improve their own usability.

The children and youth in street situations showed a wide range of desires. Among them: the wish to get a job (28%) is the most shared, followed by the wish to go back to school (20%), to get some training (5%), to become a musician/dancer (5%) or an artist (4%), to go back to family and to follow vocational paths (2%), to get out of the street, to follow a rehabilitation program and to receive some capital to start a business (1%); 1% of the population replied nothing and 1% did not know what their desires were (Chart 2).

The data showed a wide range of needs expressed simultaneously. The children and youth in street situations required different kinds of assistance, as follows: foster family; birth certificate; capital to start a business; employment; institutionalization; reconciliation with parents; healthcare; ID cards; food; relocation; schooling; clothes. To receive clothes and blankets (100%), schooling (34%) and relocation (25%), along with food (24%) have been the most requested needs; ID cards (16%), healthcare (15%) and reconciliation with parents (12%), together with institutionalization (11%) and a form of employment (10%) were the next requested percentages (Chart 3).

Furthermore, the children and youth in street situations had some ideas to get improved healthcare.

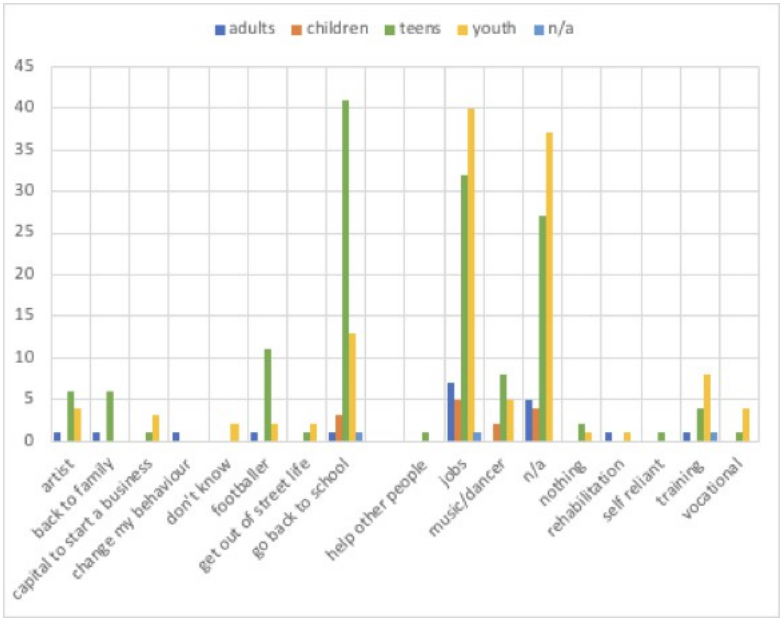

Chart 2 - *What the street children and youth would like to do, broken down by age group (unit)*

Notes: age groups are so defined: children as 0-11ys old; teens as 12-17ys old; youth as 18-24ys old and adults as 25ys old and more

That being said, the entire population suffers from drug addiction, and despite the 42% that were not able to answer, the rest of the available answers reflected suggestions as follows: 27% of our population would like to have a youth friendly clinic, with 24h available doctors and a help desk; 14% of them would like young counselors who can offer information; 9% would desire a dedicated health counseling corner and more educational material; and more than 7% wish for a 24h help desk.

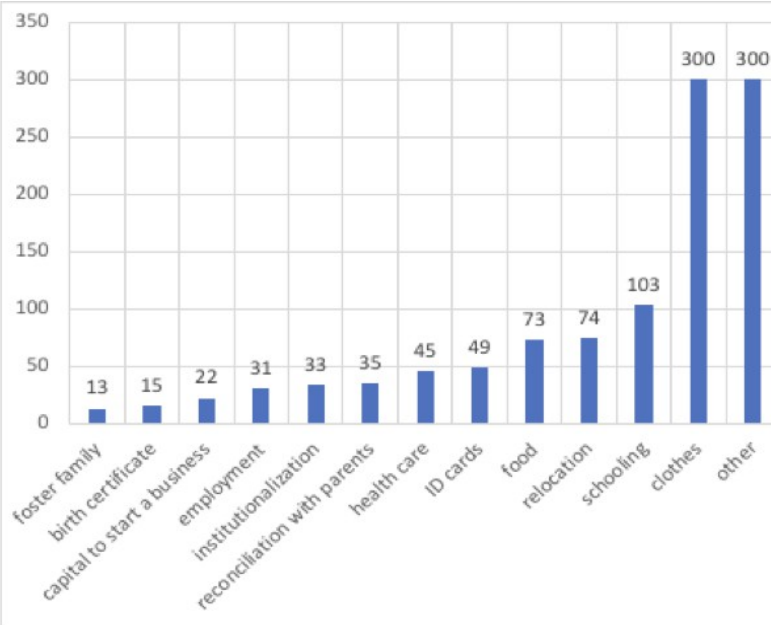

Chart 3 - *Assistance required for the future(unit)*

Discussion

The population of children and youth in street situations remains largely a problem to be addressed, both for the numerical relevance (an estimated 3,000 boys and girls spend their nights sleeping on the streets of Nairobi; nationwide, this figure is estimated to be anywhere between 250,000 and 300,000 children, (UNICEF, 2018b; The National Council for Children's services NCCS, 2015), and for the exposure to violence, exploitation and abuse (as many as 60,000 further children live and work on Nairobi's streets during the day (UN, Committee in the Rights of the Child, CRC, 2007).The data collection highlights the complexity of the phenomenon, which embraces several issues in terms of health. The possible areas of vulnerability are divided amongst the three levels mentioned above, in terms of physical, emotional and cognitive vulnerability, illustrating the areas/topics of discussion.

psycho-physical vulnerability. The indicators analyzed underline the role of the social determinants of health (SDH) (Marmot, 2008). The psycho-physical vulnerability and the substance abuse of a young population appear as a fact. This group is very exposed to many complex problems: absence of basic needs such as food (45%) and shelter (33%),

lack of any protection (100%), discriminations (22%), lack of documents (76%), dropping out of school (100%), substance abuse (100%), violence (sexual abuse 11%, bullying16%, harassment by police 43%, physical violence 29%), family abandonment (42%) or experienced trauma (physical abuse 15%, sexual abuse 3%, conflict 12%). All these elements are connected by strong dynamics, which are deeply social, political and based on power struggles. The social determinants of health theory can help to simplify the complexity the children and youth in street situations live in. Reading the health dynamics, indeed, can help identify the reality of inequities as well as social and cultural disparities in their lives. It also contributes to clarifying the importance of focusing on their dreams, potentials, and the linked interactions. Under this particular perspective, the data collection suggests two tracks to follow the comprehensive primary health care model.

1. *The street is not the point of arrival, but must be considered a starting point of a broad intervention of care with children and youth in street situations*. In the short term, being on the street is unchangeable. The way the children and young people recalled their own situation is not 100% negative. For them the street has been a way out from the hard situations in which they had lived, and therefore it is a possible place to start over. Being on the street reveals three main points: *a) the trauma experience,* from which they had run away. It reminds of the approach "forgive to survive" (Nugent, Sumner, Amstadter, 2014). Forgiveness is no longer an outcome, but it is a useful tool to indicate the kind of paths the children and youth in street situations would like to follow. The street has been chosen. In this sense, to be vulnerable becomes a creative moment. Children and young people claim to want a better life for themselves and are open to being healed. This way of forgiveness has shaped their responses. Children and young people want to move on and look ahead, trying to reconnect with family and with their future. Therefore, "it seems to consider a series of portraits of life where people come first" (Nugent, Sumner, Amstadter, 2014); *b) the value of parents and family situations.* This aspect appears both crucial and not urgent. The family is always mentioned, at different levels, as part of their personal narrative but at the same time it is mostly not present on the street (only 3% regularly meets with mothers and only 3% said to live on the street with siblings). The family itself has been a reason to escape (death/abandonment 22%, family breakdown 12%, ill treatments by parents 8%, physical abuses by extended family 15%) but parents are mainly alive (69% have both parents alive, or at

least 23% have one), 87% have siblings, and 75% have someone from the extended family. And yet, their attitude towards the family suggests that family could be a place to turn to: 47% are willing to go back, and 45% believed that the family could be willing to welcome them back; 12% declared their desire for a family reconciliation; *c) the lack of economic safety*: poverty and weakness are inserted in the wider system of social inequality and structured violence (Farmer, 2003); the population faced several hardships: 25% ran away for income reasons, and they simply tried to survive with any sources of income accepted (begging, car washings, selling bottles and casual illicit activities) to satisfy basic needs, to fight hunger and fear. In addition, the envisaged future is often shaped on a new job or learning, with the purpose of improving their economic status.

2. *Being on the street can be considered chronic, but not definitive. It is a "road to cross" together from the hardships and fears, towards social networks, community and future possibilities/opportunities.* The street is a place where children and youths live, sleep, and survive often for a long time. Their presence can be defined as chronic. The time spent on the street is quite long (51% more than 3 years) and it seems a hard situation to overcome; moreover, the time on the street is not invested on building upon their future but around surviving: with their low income (49% under 1.5 euro a day), 38% spent the money to cover basic needs, and 31% in food and drugs, 6% only in drugs.

This element guides us to better focus on the second level, the emotional vulnerability. The street is also a place where there are daily hardships and fears. They reported abuse, violence and harm (45% declared hunger, 43% harassment by police, 33% lack of any shelter, 29% violence, 23% no blankets and/or clothes, 22% discrimination, 16% bullying and unemployment, 16% illness, 12% theft, 11% sexual abuse and 1% hit by cars), with its own rules of coexistence together with the abuse of substances. In an attempt to avoid the constant feeling of unbearable fear, which is an enormous weight on children's minds (Cottrell-Boyce, 2010), they use glue and other substances to feel stronger, to overcome hunger, cold and fear. But, remarkably, it appears that the street is also a social place, where children and youth are not totally alone. Some of them look for friends (74% spend time with friends), family members and reference people to talk to (among all: friends 25%, teachers 7%, mothers 4%, neighbors 3%). These people also seem to act as reference points that the youth leans to for protection

and safeguarding. Child homelessness seems functional in providing a link to support the structure of the street family as a potential symbol of shared experience. The street, therefore, can act as an analogy that allows getting to know these children and youth in street situations better, and eventually to work with them to build possibilities.

The answers collected, considering the margin of inaccuracy, show a wide request for care, which starts from the basic needs, and which is then specified in the resolution of more complex problems, such as family relationships (47% reconciliation, 25% relocation, 11% institutionalization), education to be made more solid (34% schooling and 10% employment) towards a concrete future of subsistence and economic independence, and still a health care that is mainly specified in active listening and presence amongst patients(27% reports a youth friendly clinics open 24/7, 14% with peer counselors and educational materials, 7% peer listening).

The third level is cognitive vulnerability. Despite their difficulties and experiences with trauma, the children and young people in street situations in autonomy demonstrated that they have active resilience systems (Camfield, McGregor, 2005), through both a network of friends and with great awareness for their own individual situation.

Street survival also triggered a great sense of independence, forced or not. They all looked for some support, and they preferred to turn to educational figures instead of peers.

By demonstrating strong resistance, the children and young people in street situations also have shown hope in the future, to improve themselves in many ways. They dream about work, capital for a business to start, they want to reinforce skills and build a sort of professionalism (school and training), looking forward to getting off the street, as well as reconnecting with family or creating relationships of trust with key figures.

Their desire to advance their own situation highlighted the possibility of evolving differently. They want to express themselves, they try to justify their behavior, they try to refer to adults with competence and authority. This should be taken into consideration for future practical projects in the field, within a community approach.

Conclusions

The vulnerability of the children and youth in street situations is extreme and it calls for interventions that span multiple areas, challenging the comprehensive primary healthcare model.

At the same time, the attitude shown by the population of this study advances our analysis in a more comprehensive way. Focusing on health and well-being (Riva, Rainisio, Boffi, 2014), more elements should be included like food - nutrition, personal expectations, sanitary service, primary care assistance, which would allow people and patients to develop their own perception of well-being *(not a complete status)*. Concretely, it suggests to include three means: physical, mental, and relational/social, reflecting the three levels of vulnerability covered. Contrasting elements like population *components,* social environment, cultural and historical momentum should be taken into consideration, however what is important is that they are all necessary to give children and youth patients the ability to conduct a quality life, balancing constantly the demands of life.

If we are to respond to ill health, we need to respond to the social determinants as well as the presenting problem. Furthermore, the original ideal of primary health care has become known as comprehensive PHC, sharing in particular the focus upon equity, community participation, integration, intersectoral collaboration, multi-disciplinary teams and health promotion (Rogers, Veale, 2000) (Table 3).

Tab. 3 - *Comprehensive primary health model of care*
(Barr, Robinson, Marin-Link, Underhill, Dotts, Ravansdale, Salivaras, 2003)

	Comprehensive primary health model of care
view of health	positive wellbeing
locus of control over health	communities and individuals
Major focus	Health throughh equity and community development
Health care providers	Multidisciplinary teams
Strategies for health	Multi-sectoral collaboration

Therefore, taking care of children and youth in street situations challenges the comprehensive primary health care, as it is:

- an approach to health care that emphasizes social justice, equity, community control and social change;
- an emphasis on identifying, intervening or managing factors that generate ill health, not on intervention and treatment of health conditions;

- it includes but is not limited to health promotion, education, early detection and intervention, treatment of acute episodes and ongoing management of chronic conditions;
- Underpinning this is the acknowledgement and promotion of an individual's expertise and right to manage their own health (recalling the concept of health-ability itself (Huberet al., 2011).

In order to make this model of care more concrete, the so called "expanded chronic care model", an enlarged version - proposed by Canadian researchers (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravansdale, Salivaras, 2003) of the chronic care model, demonstrated that the clinical aspects are integrated with those of public health (see Fig.6).

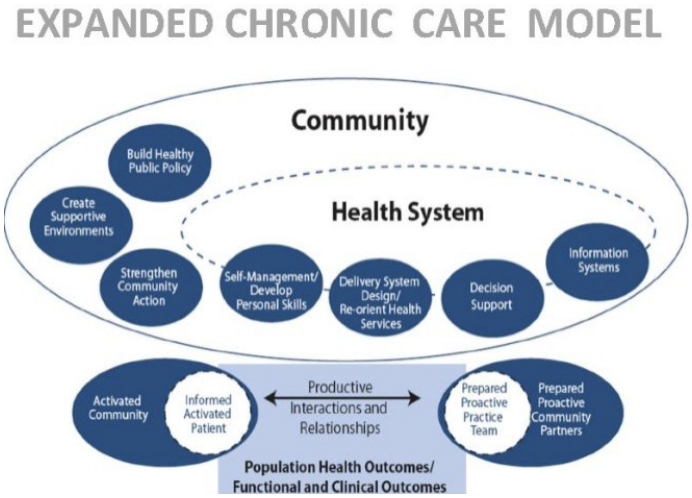

Fig. 6 - *The expanded Chronic Care Model*
(Barr, Robinson, Marin-Link, Underhill, Dotts, Ravansdale, Salivaras, 2003)

In particular, we would like to highlight key elements of the cure of chronicity (Maciocco, 2011), that seem suitable for the children and youth in street situations:

- primary collective prevention and attention to the determinants of health;
- outcomes that not only concern patients but also communities and the entire population;
- proactive assistance;
- primary care as the central point of the care model;

- assistance focused on the individual needs of the person in his/her specific social context;
- possibility to to leverage community participation;
- investment in the self-management of patients and caregivers;
- reliance on multi-professional teams that aim for continuous improvement.

The study identifies the need for healthcare in its fundamental aspects, which must consider vulnerability and the influence of socio-economic determinants as a key element of care. The suggestion that could be addressed to the institutions, associations, international and national non-governmental organizations is to develop good practices between public and private sectors, as a good model of healthcare initiative, specifically for the population of this study.

With the objective of understanding and addressing the conditions of street youth and children, a primary healthcare intervention can enhance the active participation of the children and youth in street situations as patients in two directions:

1. promoting the interests of the children and youth in street situations, in the field of welfare, equality and dignity, reinforcing the expression of protest and cultural participation against the tyranny of emergency (Bindè, 2000);
2. co-development, starting from constant active listening that prioritizes the local youth and children needs, some forms of support between health services within the communities, street children, youths, and local services, between the care seekers and the caregivers.

Dealing with this vulnerable group strengthens the comprehensive primary healthcare idea, characterized by the ability of experiencing challenges to manage and cope with one's lifestyle through time. Despite the age, culture, and history it is a challenge worth facing.

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