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Access to health and rights of children in street situations and working children: a scoping review

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ABSTRACT

Background Street and working children (SWC) and young people (YP) are highly vulnerable to violence, exploitation, hazardous environments and human rights violations. While the UN Committee on the Rights of the Child and the International Labour Organisation provide some guidance, there is limited information on their right to healthcare. This study aims to identify enablers and barriers to healthcare access for SWC and document associated rights violations.

Methods From 2000 to the present, we conducted systematic searches for SWC (0–18 years) in databases including MEDLINE, PsycINFO, EBSCO, PUBMED and PROQUEST, using broad search terms related to street children, working children, healthcare access and rights. The searches were supplemented by grey literature and hand searches. Two independent reviewers finalised the included studies, and data were analysed using a rights-based framework with narrative analysis and thematisation.

Results The initial search yielded 7346 articles (5972 for street children and 1374 for working children), with 35 studies (18 for street children and 17 for working children) included in the review. Most studies on working children (13/17) focused on trafficking/commercial exploitation. Studies were predominantly from Africa, followed by the USA, Asia, the UK and Canada, with only two employing a rights framework. SWC face barriers such as cost, distance, visibility/accessibility of services, stigma, seclusion, threats of violence, lack of legal documents, crisis-oriented healthcare use and self-medication. Enablers included agency, self-efficacy, positive relationships with adults and proactive healthcare use when accessible. Emergency departments are frequently accessed by SWC, indicating a need for healthcare professionals to be trained and sensitised. Holistic and comprehensive healthcare is essential.

Conclusion Significant research gaps exist, with many SWC populations under-represented. SWC share healthcare access barriers with other marginalised groups. Healthcare for SWC must be tailored to their unique needs and strengths and be holistic and trauma-informed.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Street and working children are among the most vulnerable population groups the world over.
⇒ They experience rights violations, multiple adverse childhood experiences and harsh living and working conditions and thus bear the burden of a range of adverse health consequences.
⇒ Access to appropriate and quality healthcare is challenging for both groups of children, and young people.

WHAT THIS STUDY SHOWS

⇒ Street and working children share many barriers to appropriate healthcare access and rights violations.
⇒ There are significant gaps in the literature on healthcare access for this population, especially for working children.
⇒ Enablers were largely related to resilience and agency exhibited by these young people and the trusted relationships with significant adults who were responsive to their needs.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Given the scale of the problem, governments and relevant welfare agencies need to proactively establish health services that serve the special physical, mental and social health needs of street and working children and youth in a manner that consistently affirms their dignity and rights.
⇒ Child health professionals need to engage in research and innovation to address the rights of street and working children to optimal health and well-being; health professionals need training to enable responsive care and support attuned to the needs of street and working children.
⇒ There is an urgent need to better enumerate and make the significant challenges that street and working children face visible in accessing their right to optimum health and support services.

BACKGROUND

Despite their resilience and agency, street and working children (SWC) face precarious conditions, including violence, exploitation, hazardous and toxic environments, and profound human rights violations.[1] The United Nations Committee on the Rights of

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the Child, via General Comment–21, provides States with long-term national strategies for children in street situations.[2] The International Labour Organisation (ILO) provides frameworks for children's work via Conventions 138 (on minimum wage) and 182 (worst forms of child labour) and the Sustainable Development Goals' target 8.7, which aims to eradicate forced labour, modern slavery and human trafficking.[3] However, prioritising the rights, health, development and well-being of SWC and young people (YP), regionally and globally, remains a global challenge.

According to the Committee on the Rights of the Child, street children encompass two categories (1) children who depend on the streets to live and/or work, whether alone, with peers, or with family; and/or (2) a broader population of children who have formed strong connections with public spaces for whom the streets play a vital role in their everyday lives and identities.[2] Working children are typically considered renumerated, although much of their work, such as agriculture and participation in family businesses, is often unpaid. The ILO categorises working children as child labourers when their work is unsuitable for their age or harmful to their health, safety or morals.[4] The ILO's 'worst forms of child labour' are defined in Article 3 of ILO Convention No. 182, encompassing all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage, serfdom and forced labour, including forced or compulsory recruitment of children for use in armed conflict, child prostitution and child pornography.[4]

However, there are definitional issues with the groups of children and young people (CYP) presented above; for instance, the term 'streetism' describes children as 'living on the streets' or 'being of the streets'; furthermore, there is a significant pushback against stigmatising terms like 'child labour' in favour of 'child work' by organisation of YP and critical scholars who do research with SWC and YP.[5–7] All these CYP face common challenges, often working on the streets, experiencing marginalisation and encountering significant disruptions in their education and access to healthcare, particularly in low-resource settings. A systematic review of street CYP from low and middle-income countries by Woan *et al*, highlighted the disproportionate morbidity in the areas of infectious illness, psychiatric disease, reproductive health, but also exposure to violence, nutrition and growth problems, and substance use.[8] Access to healthcare was a significant concern and vast areas of health had not been investigated, including chronic diseases and cognitive deficits. Another systematic review by Batomen Kuimi *et al*, about the health status of working CYP identified nutritional concerns, injuries and harmful exposures as significant issues.[9] Similarly, Ibrahim *et al* cited poor growth, malnutrition, higher incidence of infectious and system-specific diseases, behavioural and emotional disorders and decreased coping efficacy in working CYP.[10] Several studies have pointed to the gaps in the literature and the significant access issues.

As members of the SWC Working Group, which is an active collaboration between the International Society of Social Pediatrics and Child Health (ISSOP), the International Society for Prevention of Child Abuse and Neglect and the Indian Child Abuse and Neglect and Child Labour Committee of the Indian Pediatric Association, we undertook to explore and map out the issues relating to healthcare access for SWC. Using a child rights lens, our scoping review aimed to identify the enablers and barriers relating to access to healthcare and associated supports for children and their families in street situations, and for working children, as well as to explore

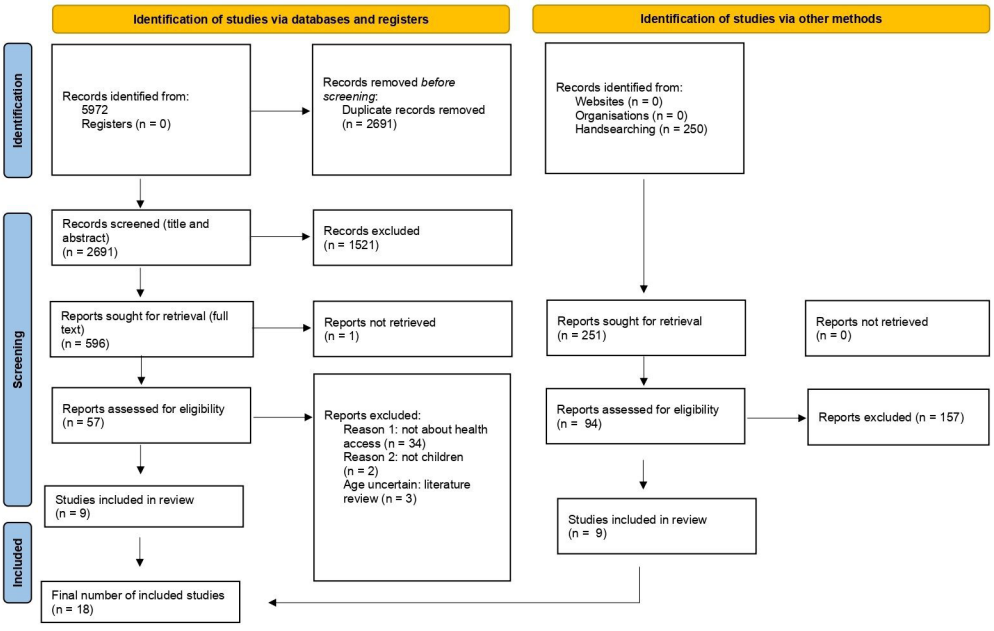

Figure 1 Flowchart of literature review (street children).

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the rights violations that occur in accessing optimum healthcare.

METHODS

The study design emerged via a collaboration between academics and professionals who work towards improved child rights and access to healthcare and are members of ISSOP's working group on SWC. Given the complex and multifaceted nature of healthcare access among SWC, we deemed a scoping review to be most appropriate for our study, as the approach allows for a broad examination of the literature while encompassing various study designs and methodologies and when the literature is yet to be comprehensively reviewed.[11 12]

Literature search

The literature search was conducted between August and October 2023. Two librarians played a crucial role in this process, assisting in developing search terms aligned with MeSH (Medical Subject Headings) terms and keywords from the databases EBSCOhost, MEDLINE, PROQUEST and PUBMED. We also considered articles from personal collections, as they were believed to enhance the indexed databases searched.

We acknowledged the complexities of the identities of SWC, where some aspects overlap, but others are exclusive. Therefore, we decided to split the search for the two groups and search for street children and working children separately to bring forward the specificities and commonalities between the two groups. EJ performed the search for street children, SN-R for working children and NH undertook the grey literature search. As recommended by our librarians, we kept the search parameters simple.

Inclusion and exclusion criteria

We included articles with the following parameters: (1) Original peer-reviewed research involving children under 18 years and (2) studies published from 2000 onwards. Abstracts, conference papers, books, reviews, commentaries and studies that did not include SWC/YP's access to and use of healthcare were excluded. We further included grey literature that featured keywords in the document title. Literature without data was excluded.

Search results for street children

For street children, we linked Boolean search terms such as 'street children', 'street involved children' and 'children in street situations' and to healthcare-focused terms such as 'healthcare', 'health care', 'health service' and 'health centre'. We refined results by applying filters such as 'children, youth, and paediatrics', which helped us focus on articles specifically addressing SWC as they related to healthcare.

The search yielded 5972 results for street children, from which 2691 were screened in title and abstract, and 596 records were screened further. Therefore, 57 were accessed for eligibility for the final screening stage, and 9 were included in the review. We located an additional 251

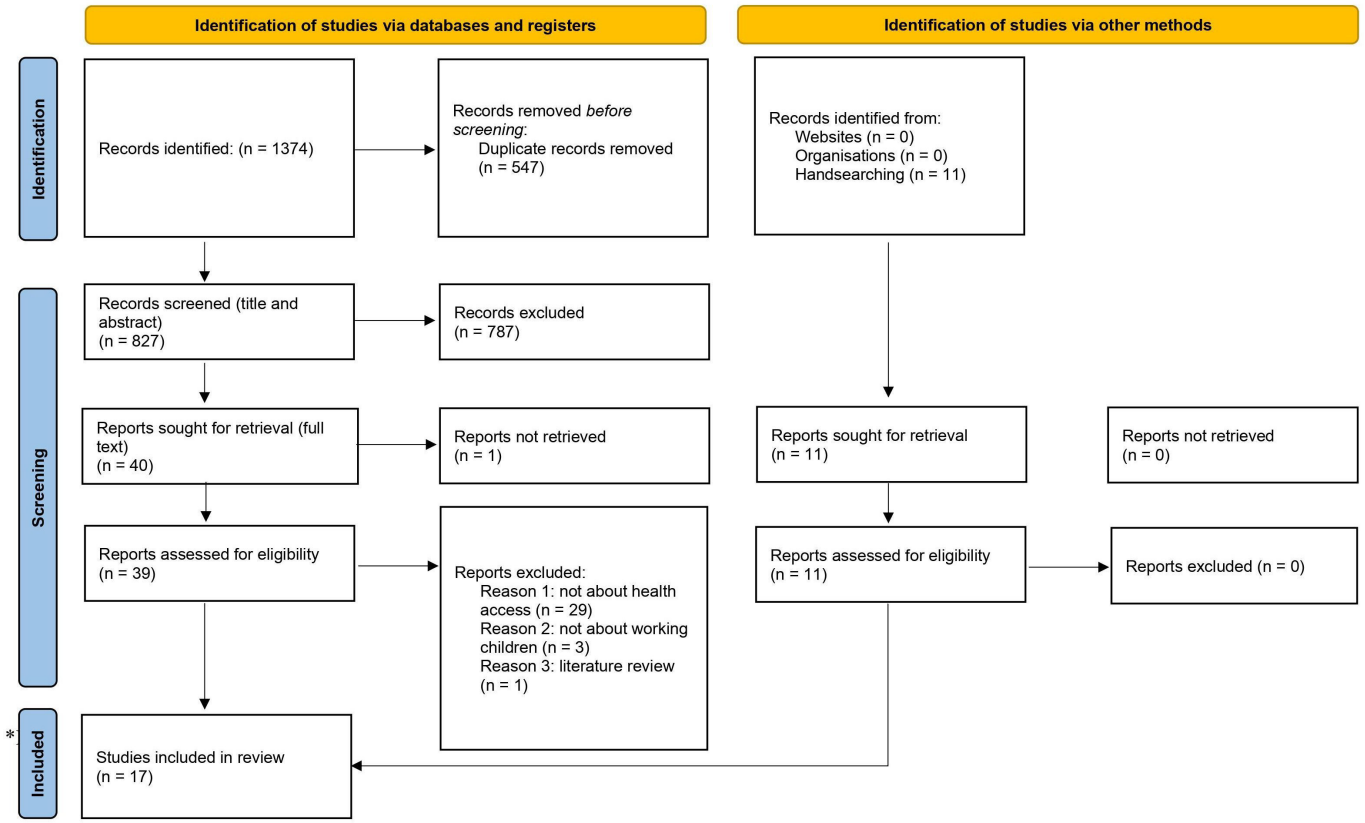

Figure 2 Flowchart of literature review (working children).

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records via hand searching, from which 94 were accessed for eligibility and screened, and 9 were included in the final review (figure 1).

Search results for working children

The search terms for working children included the same healthcare-focused terms as those used in street children's searches. These were combined with search terms focusing on working children, including 'child labo?r', 'working child*', 'child traffick*' and 'child beggar*'.

A total of 1374 records were identified from database searches, from which 827 were screened during title and abstract screening. The full texts of 39 records were assessed for eligibility, 33 of which were excluded (see figure 2 for exclusion reasons). In addition to the 6 studies included in the review from this final stage of screening, 11 studies were identified through hand searching, primarily using citation chaining, resulting in 17 total studies on working children being included.

Grey literature search

We searched grey literature on the websites of global agencies known for protecting street-connected and working children: UNICEF, ILO, Plan, Save The Children, Consortium for Street Children and Terre des Hommes. Search terms included 'working children' OR 'street children' AND 'healthcare' OR 'health services'. Although thousands of results were returned, most were news stories unrelated to our criteria. Further searches focused on narrowing results to specific publications, such as reports with relevant search terms in the title, yielding five publications. However, these did not meet our inclusion criteria.

Data extraction and analysis

SR, SM, SN-R and EJ led the data extraction. All authors participated in discussions regarding the results until they achieved a consensus. A spreadsheet was developed with specific questions to guide the data extraction, and each author was given three articles to analyse and input the relevant information regarding the study. EJ collected and synthesised the information in the spreadsheet and distributed it to the authors.

The analysis focused on access to healthcare and health interventions for SWC, underscored by a rights-based approach. SR, SM, SN-R and EJ performed a thematic analysis. As Saunders *et al*,[13] recommend, all authors met for practical thematic analysis, shared their perspectives and refined the themes until reaching a consensus.

Figure 1 (for street children) and figure 2 (for working children) present the review process results as a Preferred Reporting Items for Systematic review and Meta-Analysis flow diagram.

Patient and public involvement

No patients were involved in this study

RESULTS

The final included studies were 35 (18 for street children and 17 for working children); table 1 lists the characteristics of studies included for street-involved CYP, and table 2 for working children. The majority of included studies on street children were from Africa, whereas most of the studies on working children were from high-income countries. The studies appraised included CYP between the ages of 5 and 26 in street situations and who were workers, victims of trafficking or active users of healthcare services during the time of the studies. Some studies also involved adults, such as family members, health and care practitioners and officers, hospital personnel, non-governmental organisation (NGO) workers and other anti-trafficking stakeholders.

Barriers

The literature reviewed highlights several core barriers preventing SWC from accessing necessary healthcare and their entitled rights. These barriers relate primarily to poverty, social exclusion and the practicalities of service delivery.

Poverty

"There was absolute poverty at home… My parents got me married to a boy when I was 14 years old" (young woman exposed to trafficking).[14]

Poverty is the most apparent barrier, causing a higher likelihood of ill health as most medical care is rendered unaffordable.[15 16] Typically, private healthcare providers charge for the services they offer, and even state hospital treatment, supposedly free of charge, involves appointment fees and costly medication expenditures. For most SWC, these costs can be prohibitive. Embleton *et al*, for example, note that for street-connected boys in Nakuru, Kenya, 'the cost of medications is prohibitive when seeking care at public facilities'. At the same time, in other Kenyan cities, they report 'substantial difficulties accessing health care due to an inability to pay for services'.[16] Their findings have been corroborated by similar previous work in Ghana,[15] and Cambodia.[17] Evidence suggests that for many SWC the simple cost of transport to the doctor or hospital can be too high.[16 18]

Related to their poverty, many SWC are crisis-oriented in their use of healthcare and tend, where they take any action at all, to self-medicate. Obimakinde and Shabir, for example, triangulated interviews with 53 street children in Nigeria, and found lack of money to be essentially correlated with poor health-seeking behaviour, like self-medication or informal treatment, as demonstrated by the quote[19]: "When I have a headache, I pour cold water on my head, relax for 20–30 min it goes away and I stand up to continue my work" (17-year-old, female).

Finally, SWC, sometimes lack the legal or identity documents that enable access to free or reduced-cost healthcare[18] because these documents are too expensive for their families to obtain. Acquiring them later of their own accord may neither be practical nor affordable, particularly if access requires expensive bureaucratic procedures or bribes.

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Table 1 Description of included studies–street children

Author	Year	Setting	Participants	Methodology	Outcome/domain
Ali and de Muynck	2005	Rawalpindi and Islamabad in Pakistan	Street children aged 5–13 years	Qualitative: interviews	Perceptions of health and illness, and factors in health-related decision making
Ababor, Tesso and Cheme	2019	Nekemte, Ethiopia	219 street adolescents (140 girls, 79 boys)	Mixed methods	Health-related behaviour related to levels of access to family planning
Embleton *et al*	2013	Eldoret, Kenya	146 street children aged 10–19	Mixed methods: cross-sectional survey and group discussions	Barriers and facilitators in drug cessation for youth. Positive and negative elements identified.
Obimakinde and Shabir	2023	Ibadan Oyo state, Nigeria	11 children aged 13–17, 10 parents, 10 street shop owners, 12 welfare officers	Qualitative: interviews	Challenges identified regarding physical health, mental health and healthcare
Rivenbark	2018	Battambang, Cambodia	75 street and community-based children aged 10–17 (29 girls and 46 boys)	Quantitative: questionnaire	Healthcare seeking practices: difficulty seeking treatment, top choice for care-seeking, reason for choice and stigma
Rowan *et al*	2013	Canada	Homeless street youth aged 15–22 years	Mixed methods: EMR data analysis, document reviews and interviews	Evaluation of a dental programme along with its fidelity, dose, reach and satisfaction of users.
Edusei, Amoah and Rural	2014	Ghana	34 street children and practitioners	Qualitative: interviews	Access to healthcare and cost-related factors.
Embleton *et al*	2021	Kenya	100 street children	Qualitative: interviews and focus groups	Barriers and enablers in drug cessation. The role of the peer and social network in street children's substance use.
Fiasgabor and Fiasgabor	2015	Accra, Ghana	15 street children (6 girls, 9 boys) aged 7–12	Qualitative	Types of diseases experienced by street children and the actions taken to receive treatment.
Nicholas *et al*	2015	Canada	48 street youth aged 15–26	Qualitative: community-based participatory action research	Evaluation of the negative factors and gaps in the healthcare system experienced by street children and the subsequent impact on their health.
Nicholas *et al*	2016	Canada	41 service providers (20 community agency staff, 17 health service providers, 2 hospital administrators and 2 hospital security personnel)	Qualitative: focus group and interviews	Street youth access to healthcare from the perspective of the service providers.
Arabbadvi et al. 2023		Kerman, Iran	70 street children	Quantitative: survey and intervention	Knowledge, attitudes and behaviour mechanisms and how they contribute to nutritional improvement
Maclead, MacRae and Pimenta	2023	Qatar	30 street children aged 14–17 from 15 countries in Africa, Asia and South America, 4 adult young leaders and NGO staff	Mixed method: online survey and interviews	Barriers to accessing healthcare, including cost, discrimination, long waiting times and a distrust of care providers. Furthermore, supportive adults, such as NGO workers or family members in facilitating access to healthcare.
Cimdessa	2022	Addis Ababa, Ethiopia	103 street children (38 girls and 65 boys) aged 18non-governmental organisation18 years.	Qualitative: focus groups and individual interviews	Perceptions of health-related strategies and other intervention strategies

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Table 1 Continued

Author	Year	Setting	Participants	Methodology	Outcome/domain
Chairani *et al*	2019	Jakarta, Boor, Depok, Tangerang and Bekasi, Indonesia	115 street children and youth aged 12non-governmental organisation20	Quantitative: multivariate logistic regression analysis	Health literacy, knowledge and self-efficacy in access to healthcare
Embleton *et al*	2023	Kenya	100 participants, with 43 street youth	Qualitative: interviews and focus groups	SCY's strategies regarding patient-centred HIV services and how to address the heightened risk factors from issues such as food insecurity and homelessness.
Bwambale *et al*	2021	Kampala, Uganda	513 street children aged 12–24 years	Quantitative: multivariate logistic regression analysis	Patients' knowledge of their HIV status, use of contraception/family planning, use of SRH services

EMR, Electronic Medical Record; NGO, non-governmental organisation; SCY, Street-connected young people ; SRH, Sexual and reproductive health.

Social exclusion and its consequences

"I've tried to avoid them, my whole life. I just… I've heard too many bad stories" (street involved youth, Canada).[20]

The exclusion that derives from a lack of identity documents is mirrored in the social exclusion and marginalisation that characterises many SWC's hostile experiences of their daily lives. Necessarily, this translates into acts of direct exclusion, for example, where medical staff refuse to treat, or clerical staff refuse to admit, young people presenting as street-connected. It may further manifest indirectly, for example, where SWC's accounts of their experiences and medical needs are disregarded or considered a priori invalid.[20] Embleton *et al*, note in the case of Kenya that street-connected CYP 'face unique barriers to care that other low-income people of a similar age do not face…[including] considerable stigmatisation and discrimination, and their devalued status in society limits their ability to access services'.[16] Service provider respondents from multiple countries surveyed at the Street Children's World Cup in 2022 reported similar things.[18]

Stigmatisation and social exclusion also act recursively, as SWC self-exclude from healthcare as a strategy of self-protection. In their study with street-connected YCP in Canada, for instance, Nicholas *et al*[20] report that young respondents identified stigma and discrimination in statements such as, 'They [the hospital staff] treat us differently because we're on the street'. One participant described this negative experience as 'the attitude, the vibe, the snobbiness [sic]," and another stated that a healthcare provider 'treated me like nothing'.

Practical obstacles

"To access health services ID is being asked. For free medical insurance by government children need to have ID proof" (non-government organisation, India)[18]

Alongside structural, economic and social barriers, various basic, practical obstacles limit SWC's access to healthcare., For many, the distance between the individuals and the services they need can be too great to cover, with the additions of transport costs and foregone earnings marking a genuine limitation.[18 21] Furthermore, the visibility of programmes and services may not be adequate and, although free of charge, SWC may be unaware of them[15] or they have to rely on friends to act as interpreters due to language barriers.[15] Strained budgets for outreach can compound healthcare delivery[16] and an enduring problem for CYP living in street-based or informal settlements is the requirement to show identity documents.[18]

Gaps and rights violations

"The first time I saw a doctor was when I got pregnant" (young woman involved in sex work, Mumbai).[14]

The most blatant gap in the research is that most groups of CYP are not included. The gaps pronounced in the literature around working children are that the majority of studies were conducted in high-income countries and focused on trafficked CYP. A rights framework was rarely explicitly applied or alluded to, although Betancourt's study explored the risk and protective factors influencing the rights of children and families living in construction sites in India.[22] Additionally, Amoah and Edusei argue for participatory methods in implementing relevant policies for street children in Ghana, incorporating their agency and resilience.[23] Additionally, several studies explored barriers to CYP's access to healthcare and support services, venturing into the rights domain.

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Table 2 Description of included studies–working children

Author	Year	Setting	Participants	Methodology	Outcome/domain
Adhvaryu and Nyshadham	2012	Kagera region, Tanzania	1954 children, aged 7–19, sick with an acute illness	Quantitative: health and developmental survey	Sick children's healthcare access and schooling and labour decisions
Barnert *et al*	2019	Southwestern US	21 commercially sexually exploited young women aged 15–19	Mixed methods: surveys and in-depth interviews	Healthcare use of commercially sexually exploited young women
Betancourt *et al*	2013	Greater Delhi, India	Street children aged 5–13 years	Qualitative case study: interviews and focus groups	Child protection issues regarding children of migrant workers living on a construction site
Domoney *et al*	2015	Southeast London, UK	130 trafficked people: 95 adults, 35 children	Qualitative: analysis of electronic health records	Identification of trafficking victims by mental health services
Greenbaum *et al*	2018	Atlanta, USA	108 adolescents aged 12–18 years: 25 patients involved in commercial sexual exploitation, 83 patients experiencing alleged sexual assault	Quantitative: cross-sectional study	Development of a rapid screening tool to identify victims of child commercial sexual exploitation
Hornor and Sherfield	2018	Ohio, USA	63 commercially sexually exploited adolescents aged 13–19 years	Quantitative: retrospective chart review using descriptive statistics	Paediatric healthcare use by victims of child commercial sexual exploitation
Ijadi-Maghsoodi *et al*	2018	Southern California, USA	18 commercially sexually exploited youth aged 13–18 years	Qualitative: focus group discussions	Healthcare experiences of commercially sexually exploited youth
Kappel *et al*	2020	Washington DC, USA	78 youth victims of trafficking, aged 9–18 years	Description of healthcare programme	Assessment/ description of a programme using a medical home model of care to serve trafficked children
Karandikar *et al*	2016	Kamathipura, Mumbai, India	15 female sex workers trafficked as minors; age unspecified, average age at entry to prostitution=14 years	Qualitative: in-depth interviews	Experiences of trafficking, health problems and access barriers facing sex workers
Kearney *et al*	2020	Rural North Carolina, USA	140 Latinx child farm workers aged 11–19 years	Quantitative: respiratory assessment questionnaire and clinical assessment	Respiratory health problems and frequency of healthcare service use
Konstantopoulos *et al*	2013	International: London, Los Angeles, New York, Salvador, Rio de Janeiro, Mumbai, Kolkata, Manila	277 anti-trafficking stakeholders	Qualitative: interviews	Health system responses to sex trafficking among women and girls

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Table 2 Continued

Author	Year	Setting	Participants	Methodology	Outcome/domain
McClelland and Newell	2013	Northern England, UK	24 young people involved in or vulnerable to sexual exploitation, aged 13–18 years	Mixed methods: interviews (youth) and questionnaire (professionals)	Health needs, risk-taking and health-seeking of sexually exploited young people
Pocock *et al*	2018	Greater Mekong subregion, Thailand, Cambodia	275 men and boys trafficked for fishing, aged 12–55 years; 20 stakeholders/key informants	Mixed methods exploratory sequential: quantitative survey (fishermen), qualitative interviews (stakeholders)	Health burden and needs of trafficked fishermen
Posso *et al*	2021	Tigray, Amhara, Oromia and the SNNP, Ethiopia	2255 children, aged 5–15 years	Quantitative: analysis of child-focused panel survey data and regional data from the World Bank and Ethiopia's Federal Ministry of Health	Impacts of exposure to community-level health programme on child labour
Stanley *et al*	2016	UK	29 trafficked young people aged 16–21 years; 52 professionals	Mixed methods: health survey and qualitative interviews (young people); interviews (professionals)	Health and healthcare needs of trafficked young people
Wallace *et al*	2021	USA	17 homeless youth, aged 18–21 years, who were trafficked before age 18	Qualitative: semi-structured interviews	Healthcare use of sex trafficked youth experiencing homelessness
Westwood *et al*	2016	USA	160 trafficked people (43 aged 16–25 years)	Mixed methods: cross-sectional survey—structured interview and open-ended questions	Access and use of healthcare during and after trafficking

Enablers

Tailored programmes and interventions

"I would make clinics that are accessible, where you feel safe" (young woman, USA)[24]

The crisis-oriented behaviours around healthcare access are well documented,[20 24] and for commercially sexually exploited CYP, the crisis behaviour involves sexual and reproductive health services.[25] Exceptions include programmes and interventions tailored to SWC's needs. These services seek to facilitate access with various means, such as through 'community-partner health and rural outreach clinics' for children in agriculture labour,[26] in-home care,[24] mobile health vans,[25] walk-in services[15] or by conducting direct outreach among SWC to increase the approachability of health services.[16] In addition to being accessible, services also need to offer privacy and confidentiality.[21] An example of a solution to foster confidentiality is mental health services made available remotely via text messaging,[24] making it possible for SWC to see practitioners without having to sit in public waiting rooms.[27] Others call for SWC to be prioritised and to be able to skip queues.[16] Clinics having longer opening hours may allow SWC to fit healthcare around their daily activities aimed at survival.[28] Some clinics offer useful free items ('gum, vitamins, toothbrush and toothpaste, socks, Tylenol, birth control, and soap') to encourage attendance.[28]

Free or low-cost care can be more accessible where cost is a barrier,[24] such as targeted systems like the ID Poor Card used in Cambodia,[17] or the Community Health Card in Tanzania.[18] Providers offering services without requiring identity documents can make access easier for children and youth.[18 28 29] Where SWC have been trafficked across borders or have migrated to somewhere where they do not speak the local language, professional interpretation services may be required to give clear information about tests and treatment.[30]

When looking into evidence for peer-led mentorship, the results are mixed. While Ijadi-Maghsoodi *et al*[25] highlight how commercially sexually exploited youth in California valued mentorship from peers and adult survivors, some of the street-connected children and youth interviewed by Embleton *et al*[21] would prefer to get information about HIV from educated adults.

Trust

"It's very difficult to be treated without an adult. They must go with someone, if there is no someone, they are not being treated well" (team leader from programme, Burundi)[18]

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Trusting relationships are important for SWC's access to healthcare, both in terms of how they interact with health services and how other people, especially adults, can facilitate access.

Trust in health services may encourage SWC to use health services in the future and can be grown through experiencing satisfactory services for themselves or witnessing others' experiences.[20 24 31] Ideally, SWC would be able to see the same provider regularly, though this is not possible in practice, even in tailored interventions.[32] Street-connected children in Ghana offered cordial relationships with pharmacy attendants as one reason for seeking healthcare from pharmacies rather than clinics and hospitals.[15] Where ongoing relationships are not possible, personal rapport remains essential, with exploited young women recognising patience and humour as factors that made them comfortable with practitioners.[24] Research by Nicholas *et al*,[20] with street-involved CYP in Canada confirms that this group appreciates efforts made by health service personnel to be respectful and open in communication. It is crucial that they feel that they are being taken seriously and listened to, without being forced to recount traumatic experiences[27]; that their experiences are free of judgement from practitioners[28]; and they receive assurance that their interactions with healthcare providers are confidential.[24 27] Supporting children in understanding the benefits of specific procedures may encourage them to feel comfortable with consent.[32]

Several papers highlight how trusting relationships with known adults outside of the healthcare systems can support SWC in accessing healthcare. This could be family members,[24] NGO personnel,[18] friends, foster carers[27] or group home staff.[24] Support can come in the form of advocating for SWC or assisting them to access appropriate services, providing transport or supporting the scheduling of appointments, paying fees or accompanying them to appointments.[18 24 33] Youth workers or advocates attending health services with SWC can support the child by helping the child relax, asking the practitioner questions about ongoing care, or providing a history.[20] For those who have been trafficked or who are still in situations of exploitation, while adults may prevent young people from seeking appropriate healthcare,[29] support workers have also been shown to influence their use of appropriate sexual health clinics actively.[33]

Agency and self-efficacy

"It's good to listen to children…Check then what they say." (young woman trafficked for sex work, 18 years).[27]

Many SWC are or have been separated from their families and are thus accustomed to self-reliance. Those who have a relationship with their family may have decisions made for them by their parents but may also make their own independent decisions regarding healthcare.[34] Those who have been exploited may develop what Barnert *et al* term 'fierce autonomy', an amplified sense of self-determination that exhibits 'a firm commitment to ownership over decision making'.[24] Ijadi-Maghsoodi *et al*[25] report sexually exploited YP taking the initiative to seek sexual and reproductive healthcare, and to a lesser extent mental healthcare, to enable them to continue earning.

While self-reliance can discourage SWC from seeking medical care when they do not perceive a problem as an emergency,[25] taking responsibility for one's own health needs can give this group a feeling of pride.[24] They frequently self-diagnose, although not always correctly, and seek over-the-counter treatments as well as traditional remedies for minor ailments, expressing their agency and ability to make choices about their health.[23 35] Self-help strategies can replace or be used alongside other forms of healthcare.[33] Chairani *et al*,[31] found high self-efficacy, which they describe as 'a positive perception of oneself because of development of cognitive and moral functions' to be the strongest predictor of healthcare utilisation among street-connected children in Indonesia. Increased knowledge of services and of specific health conditions such as sexually transmitted infections can also motivate SWC to seek care themselves,[25] along with knowledge of where services can be accessed.[36]

Healthcare providers should recognise these children's agency and autonomy.[32] Through health promotion and education activities, they can be supported to make health-related decisions, including when to seek healthcare.[16] Girls appreciate the option to request to be seen by female practitioners.[27]

Pathways and potential solutions

A diversity of settings, pathways and solutions were explored in the studies. On-site healthcare for migrant or farm workers, where children were also involved, while they may be limited to workplace injuries or illnesses,[22] might nevertheless provide more comprehensive healthcare assessment and pathways to further services.[26] For example, Latinx farm working children in rural North Carolina had a thorough respiratory assessment as part of a community-based research project, which detected a high prevalence of breathing problems, including possible undiagnosed asthma among these children.[26] Posso *et al*, as part of the Young Lives study,[37] explored the role of health extension workers in Ethiopia in reducing child labour, finding that five additional health extension workers lowered the regional incidence of child labour by approximately 25%. The mechanisms postulated were eliciting behavioural change and showing households the value of educating children, especially girls.

Based on experiences of a medical home model in Washington DC, Kappel *et al*[32] suggest that services for commercially sexually exploited youth should be patient-centred (non-judgmental, avoiding re-traumatisation and giving the youth decision-making rights over their own care), continuous (allowing youth to establish relationships with providers and linking between services), comprehensive and coordinated (including a range of health and social services) and compassionate and

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culturally effective (trauma-informed and specific to the needs of the target population). Several studies call for holistically trauma-informed and multidisciplinary approaches that tackle several aspects of SWC's complex needs.[16 25 33] As emergency departments are disproportionately the first port of call for many SWCs, Greenbaum *et al* developed a simple six-item tool that can be used to effectively screen high-risk adolescents in the emergency setting to identify and respond to commercially exploited or trafficked youth.[38] Items included in this brief tool include: previous history of drug and/or alcohol use; ever run away from home; involvement with law enforcement; ever broken a bone, had a traumatic loss of consciousness or sustained a significant wound; history of sexually transmitted infections; and history of sexual activity with more than five partners. Extrapolating from this review, training for health professionals including paediatric medical and nursing staff, should therefore focus on sensitisation to the unique needs of this population of young people, enabling the use of validated screening tools in healthcare and high-risk settings, and promoting competencies in culturally-responsive, trauma-informed care

DISCUSSION

This scoping review aimed to identify the enablers and barriers to healthcare access for SWC using a rights-based approach, documenting the rights violations in accessing optimal healthcare. Our findings demonstrate that SWC face significant barriers when accessing healthcare, yet they possess agency and resilience that can be harnessed to improve their health outcomes. Key enablers for healthcare access included relationships with supportive adults, trained staff in front-line clinical settings and tailored healthcare programmes for SWC. Despite the enablers, the numerous and multifaceted barriers highlight the need for holistic, trauma-informed and targeted healthcare approaches. A major gap in the literature was the lack of primary studies from many regions, particularly for working children and youth.

SWC face interconnected barriers, primarily stemming from poverty,[39 40] social exclusion and practical challenges. Economic barriers, such as costs associated with transportation, medication and appointment fees, prevent many SWCs from accessing healthcare. Social barriers, such as stigma from service providers, can further compound these barriers as they can lead to self-exclusion and avoidance of medical services.[14 17] Additionally, the lack of legal or identity documents can prevent many SWCs from accessing free or reduced-cost healthcare.[18]

The social exclusion experienced by many SWCs also manifests in healthcare settings as discrimination and dehumanisation, often leading to direct exclusion, such as refusal of treatment, or indirect exclusion, where SWCs' specific experiences and medical needs are disregarded. The stigma and discrimination often faced by SWC can contribute to self-exclusion as a self-protective strategy, as healthcare settings can be perceived as hostile or judgemental. The compounded effect of these barriers can significantly limit SWCs' access to necessary healthcare services, exacerbating their vulnerability to health issues and rights violations. These access constraints and barriers are not limited to SWC and other vulnerable groups, which share many,[41] but the cumulative impact of the factors listed above makes the right to healthcare for this group of CYP particularly problematic.

The most striking enabler encountered in various studies was CYP agency and ability to relate to significant adults who advocated for them and eased their care pathways.[18] While several studies revealed how poorly services met SWC's needs, tailored services and emergency department care show that these young people *will* access care if enabled. In this review, there were examples of positive practice and engagement by healthcare providers as well as recommendations from SWC and YP.[16 25 38] Reviews on commercially exploited youth, who were the most frequently researched group, reveal abundant opportunities for healthcare professionals and planners to improve access to and quality of medical and mental healthcare for trafficked children—clearly with broader applications to SWC.[42] As a population with frequently deep traumatic experiences, SWC require trauma-informed care from health and social providers.[43] Elements of trauma-informed care include assurances and provisions of physical and emotional safety, trustworthiness and transparency to enable trust and autonomy, peer support and mutual self-help, shared decision-making that respects the unique voice and desires of each child or youth, and destigmatising support to learn positive self-definitions within the context of cultivating personal and collective agency.[43 44]

Healthcare providers should consider encouraging peer support while protecting personal health information and personal history disclosure. Partnering with SWC groups to co-design healthcare provision can support their sense of safety while delivering needed care. Strengthening the capacities and efficacy of SWC to improve their structural determinants of health, such as housing, food access, employability, job access and access to financial capital, and inclusion, may further and sustainably improve their health outcomes.[45 46]

Limitations and gaps

This review was limited by the paucity of data on SWC healthcare access. Given this was a scoping review, we did not exclude studies based on quality criteria; thus, the included data standard was variable. Despite performing a targeted grey literature search, we found significant gaps in the relevant literature. Studies involving working children were disproportionately from high-income countries, with vast swathes of the world unrepresented. We found no studies from Latin America or Africa examining healthcare access of working children despite significant populations of child workers in these regions.[47]

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Almost all included studies examining working children were concerned with trafficking and sexual exploitation, resulting in a narrow analysis of working children's attainment of healthcare rights far from providing an exhaustive account of these young people's experiences. While there was a slightly more representative spread of studies involving street children, data was still concentrated in specific geographical regions, with most studies coming out of Africa and, again, no studies from Latin America. Across included studies, we found little direct engagement with rights discourses. While reference to rights was implied in studies that examined SWC healthcare access, this exploration was not explicitly through a human rights framework. This points to a need for a more thorough engagement with the rights of SWC.

Conclusion

Barriers and rights violations are embedded in SWC's experiences. The CYP in the included studies faced violence, exploitation and hazardous environments, and medical settings often failed to account for their unique circumstances, hence failing to safeguard their right to health. SWC experience similar barriers such as many other marginalised groups and are often overlooked in targeted services. The significant literature gaps indicate that SWC's voices are not comprehensively represented. Therefore, the review underscores the critical need for healthcare systems and providers to be more responsive to SWC's unique needs, ensuring their right to health is upheld via inclusive, accessible and compassionate care. Training of healthcare professionals could be tailored for the competencies required to recognise and address the unique challenges SWC face. Such training should be incorporated into current educational and professional development frameworks. We also acknowledge the need to listen and respond to the voices of SWC/young people, including those still excluded from existing literature. Building the capacities of SWC may also include structuring relationships—mentoring, educational or professional—to support health literacy and the capacity to navigate life beyond the challenging contexts in which SWC may reside. This may include partnering with local NGOs, community leaders, school leaders and teachers, potentially families, and other stakeholders to provide a network of support for SWC—around the more acute healthcare delivery setting. At the centre of these relationships and alliances, as with healthcare delivery, should be the voice, needs, assets, and experiences of SWC.

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