Developing Country Studies
ISSN 2224-607X (Paper) ISSN 2225-0565 (Online)
Vol.4, No.8, 2014

Appreciating the Complexities in Accessing Health Care among Urban Poor: The Case of Street Children in Kumasi Metropolitan Area, Ghana

Joseph Edusei[1] and Padmore Adusei Amoah[2*]
1. M.Sc Rural and Urban Planning. B.Sc. Planning. Centre for Settlements Studies, Kwame Nkrumah University of Science and Technology, Ghana. Email: joeedus@yahoo.com

2. M.Phil. in Development Studies, B.Sc. Development Planning. Centre for Settlements Studies, Kwame Nkrumah University of Science and Technology, Ghana. *Email: padmoreamoah@yahoo.com

Abstract
For the first time in history, more than half the world's population live in cities. However, an estimated one third of all urban residents are poor. Almost half of the poor urban residents in developing countries are children and adolescents. These children are disproportionately affected by the many hazards and deprivations such as limited access to adequate health care. Their access to both preventive and curative health services is often entangled with numerous barriers. This paper uses five dimensions of access—availability, affordability, accommodation, accessibility and acceptability to qualitatively appreciate the access to health care among street children in Kumasi in Ghana. Issues relating to affordability and accommodation presented the most challenges to the children with regards to their access to health care. These dimensions also had greater influence on their choices and preferences with respect to factors relating to other dimensions of access. The paper posits that, urban poor consist of a heterogeneous group of people whose health needs; response to health problems and relationship with the different dimensions of access differ. Hence, attention should be given to the peculiar health needs of poor individuals and groups within urban settings through regular mapping and micro-planning schemes. Moreover, there is an urgent need to improve the health status of urban poor means by improving not only their singular access to health care but also their access to healthy life conditions.

Key Words and Phrases: Urban Poor, Access, Health care, Health services, Street Children, Kumasi

1.0 Introduction

For the first time in history, more than half the world's population live in cities. It is estimated that, over 90 percent of urban growth is occurring in the developing world. This represents an estimated 70 million new residents to urban areas each year in developing countries. Research concludes that, in the next two decades, the urban population of the world's two poorest regions—South Asia and Sub-Saharan Africa are likely to double (The World Bank, 2011). According to the United Nations (UN), the global urban population will grow from 3.3 billion people in 2008 to almost 5 billion by the year 2030 (Baker, 2008; UNFPA, 2007). Nevertheless, owing to inadequate and in some cases lack of some basic services and infrastructure, many households and individuals in many urban areas are being impoverished. In the words of Garland, Massoumi, and Ruble (2007, p. 1), *'the pace of urbanization far exceeds the rate at which basic infrastructure and services can be provided, and the consequences for the urban poor have been dire'.* Currently an estimated one third of all urban residents are poor, which represents one quarter of the world's total poor (Ravallion, Chen, & Sangraula, 2007). Thus, contrary to the assertion that urbanisation reduces deprivation; current conditions in some cities in many developing countries make the lives of inhabitants worse off. This situation constitutes the phenomenon of urban poverty which has recently attracted tremendous attention from researchers and policy makers (Garland et al., 2007). The world's urban poor live with several deprivations such as: limited access to employment opportunities and income; inadequate and insecure housing and services; violent and unhealthy environments; little or no social protection mechanisms and; limited access to adequate health and education opportunities (The World Bank, 2011). Some groups and individuals including homeless youth and adults, urban slum dwellers, street and working children and households living below poverty lines in many urban areas are thus bedevilled with all these development challenges which make their lives more difficult (Garland et al., 2007; WSP, 2009).

Moreover, the lives of urban poor are not just a collection of characteristics. Their lives entail a dynamic condition of vulnerability or susceptibility to various forms of risks including health risks. It is argued that, urban poverty is rooted in a complexity of resource and capacity constraints as well as inadequate policies both at central and local government levels (The World Bank, 2011).

Among their numerous everyday challenges, health remains an indispensible resource for the survival of urban poor. Health is thus "*a resource for everyday living that allows 'them' to cope with, manage, and even change our environments"* (Epp, 1986 cited in Gatrell & Elliott, 2009, p. 4). Without good health and even relevant health related knowledge and information, human survival, more especially among the poor will be impossible (Gatrell & Elliott, 2009; Grierson & Schnurr, 2003). Research among urban poor suggests that, addressing their health related issues is more often complex and requires systematic appreciation of individual and group conditions (Levesque, Harris, & Russell, 2013). Thus, health care—the act of taking preventative or necessary medical procedures to improve a person's well-being may sometimes lag behind among the urban poor. Moreover, the poor are often unaware of the relevant policies which may enhance their access to health services, and their attitudes and behaviour which may sabotage their health (WSP, 2009). This paper seeks to qualitatively appreciate access to health care and health services among urban poor. The paper focuses on the situation of street children. Access to health services among this group of urban poor is more often-overlooked. However, without practical measures, the opportunity and right for people (urban poor children in this regard) to identify healthcare needs, to seek health care, to reach, to obtain or use health services and to actually have the need for services fulfilled becomes an empty promise (Huls, 2005; Levesque et al., 2013).

Almost half of the poor urban residents in developing countries are children and adolescents who are disproportionately affected by the many hazards to which low-income groups are exposed. Children in general have particular requirements and vulnerabilities with regard to both their physical and social environments. Street children therefore require extra attention in terms of their access to health services (IIED, 2007; Peters et al., 2008). The situation and characteristics of street children represent a classical case of child poverty. Children living in poverty are often deprived of nutritious food, potable water and better sanitation facilities, access to basic health and education services, shelter and receive minimal participation and protection. Moreover, while a severe lack of goods and services hurts every human being, it is most threatening and harmful to children, leaving them unable to enjoy their rights, to reach their full potential and to participate as full members of society (Jones & Summer, 2011, p. 8). In many regions of the world, the phenomenon of street children is unabated, while it is emerging in others where it was unknown so far. While preventive interventions could remedy the situation, those children already facing the hardships of street life need immediate opportunities for human development through special protection programs (Thomas de Benitez, 2003; Volpi, 2002). Moreover, the health of these children to a greater extent is their most pertinent resource as their survival is dependent on their ability to work (Amoah, 2013). Owing to their living conditions including their sleeping places, their diet, type of jobs, constant exposure to bad weather and poor sanitary conditions of their immediate physical environment, street children are bedeviled with a broad range of health problems (Geber, 1997). They are often at high risk of contracting communicable diseases (such as malaria, fever, flu, cholera etc.) and non-communicable health problems (such as human immunodeficiency virus and drug addiction) as well as increased likelihood of getting injured or being maimed by others as compared to their domiciled counterparts (Amoah, 2013, 2014; Anarfi, 1997; Kwankye, Anarfi, Tagoe, & Castald, 2007; Thapa, Ghatane, & Rimal, 2009). However, their access to health care/services is often entangled with numerous barriers. The barriers to their receipt of health care are thought to include confidentiality issues, distrust of adults and professional agencies, their minor status, lack of familiarity with available services, need for parental permission to receive some services, denial of need for care, lack of coordinated services and outreach, and being uninsured (Geber, 1997). Moreover, it is forwarded that children and adolescents in general have unique barriers in accessing appropriate health care and exhibit poor patterns of preventive primary health care (Ensign, 2004).

It cannot be stressed enough that, given the high growth projections for most cities in developing countries, the challenges of urban poverty will only worsen in many places if not addressed more aggressively (The World Bank, 2011). This paper presents an empirical case on the state of access to health care/services among street

children in Kumasi—the second largest city in Ghana in terms of population (KMA, 2010). The paper uses the concept of access to appreciate street children's relationship with prevailing health services and interventions in the quest to address their health problems. The study will thus improve understanding on the subject matter and identify promising practices to reduce the health poverty of the children and other applicable urban poor. The paper is thus a call for adequate attention to be paid to the growing incidence of urban poverty especially those concerning children.

1.1 Street Children: The Concept

The United Nations defines a child as any person below the chronological age of 18 years (Ansell, 2005; Jones & Summer, 2011). It is estimated that children account for about 37% of the population in developing countries and as much as 49% in the least-developed nations (Jones & Summer, 2011). The term street children often refer to *children who live and/or work on the street* (James & James, 2012, p. 126). Schurink, (1993) gives a broader definition of the concept as *...any girl or boy who is under the age of eighteen and who has left his/her home environment part time or permanently (because of problems at home and/or in school, or try to alleviate those problems) and who spends most of his/her time unsupervised on the street as part of a subculture of children who live an unprotected communal life and who depend on themselves and each other, and/or not on an adult, for the provision of physical and emotional needs, such as food, clothing, nurturance, direction and socialization* (cited in Grundling & Grundling, 2005, p. 175). Street children may take to the streets not only because of poverty and the need to earn erratic incomes but also due to domestic violence and abuse which are often perpetrated by parents (James & James, 2012). In Ghana, family disintegration is the major cause of the street children phenomenon (Consortium for Street Children, 2003). The phenomenon of street children is a well-known reality in many countries. However, due to the obscured nature of especially their daily activities, it is difficult to paint a clear picture of them. This group of children spends intermittent periods with their families, or move from one city to another, depending on the time of year and their circumstances (Volpi, 2002).

Moreover, street children are a diversified group of people. They have different characteristics in terms of for instance their sex and ages (Amoah, 2014; Ansell, 2005). Three main categories of street children are identified in literature namely; *candidates for the street*—poor children who spend time hanging out or working on the street; *children on the street*—those who work on the street, but usually sleep at home. They therefore *"...drift between their family home and life on the street"* (James & James, 2012, p. 126) ; and *children of the street*—those who live on the street without family support and connection although they may have families accessible to them (Luiz de Moura, 2002). Street children are sometimes also referred to as *'runaway'* or *'homeless'* children (Flowers, 2010; James & James, 2012) and *'urban children at risk'*—children who are in (potential) danger, poor and requiring special programs to ensure their wellbeing (Boyden & Mann, 2005). The concept as well as its categorisations is sometimes deemed as misleading and practically inadequate since the children continue to defy the groupings by moving in and out of it on regular basis. It is also argued that, these conceptualisations may also be dependent on how the children are 'problematised'—as either a 'problem' to be addressed by the state or a 'cause' to be taken up by non-governmental organisations and other activists with interest in the street children phenomenon (James & James, 2012, p. 126). However, it is forwarded that, categorisation helps to contextualise and appreciate the conditions of the children and help to draw appropriate lines for analysis and interventions while not disregarding their heterogeneity and agency. Moreover, the labelling does not change the fact that there are children living their lives on the streets of major cities in the world (Kobayashi, 2004; Panter-Brick, 2002; Volpi, 2002). One could even extend that, the disagreement on a singular definition, the different categorisations and even different interests in the phenomenon by various governmental and non-governmental institutions are the reasons why figures on and attention given to street children in various places continue to oscillate. For instance, UNICEF estimates that, there are about 100 million street children worldwide. This figure is however contested by many institutions and individuals due to differences in their conceptualization of the concept. It is estimated that there are as much as 50,000 street children between the ages of 10 and 18 in Ghana (Street Kid News, 2007). Most of the street children in Ghana are estimated to be living in Ashanti Region and precisely Kumasi (CAS, 2003). There is also an estimated 23,000 porters in Kumasi with majority of them being children and living on the streets (Baah, 2007). (CSC, 2009; Volpi, 2002). Although there are no official statistics on the number of children in Kumasi and even Ghana, it is an undeniable fact that street children are

part of the urban scene of many cities in Ghana especially Kumasi and Accra just as the act of eking out a living on the streets of urban areas in Ghana (Adaawen & Jørgensen, 2012; Quarshie, 2011). Street children in Kumasi often lodge at Kejetia terminal—the biggest terminal for commercial vehicles intertwined with commercial activities in Kumasi; Adum—the main commercial centre for wholesale and retail of non-consumable goods with over 50,000 stores and stalls; Kumasi Central Market Area—the largest single open-air market in Ghana and West Africa; Asafo Market—the second largest market in Kumasi and Aboabo Station—a sub commercial terminal in Kumasi. These places represent the central business district of the city as shown in figure 1 (Amoah, 2013; Hashim, 2005; Kumasi Metropolitan Assembly, 2010; Kwankye et al., 2007). It is common to find children as young as nine years old at these places, fending for themselves on the street by engaging in odd jobs such as: helps in local restaurants, cleaners, bus conductors, errand boys to shop owners, truck pushers, hawking and head portering (often using pans) (Amoah, 2013, 2014; Boakye-Boaten, 2006)

1.2 Access to Health Care

One major objective in provision of social amenities and services is to improve accessibility. Notwithstanding the efforts of governments and non-governmental organisations, some groups and individuals within societies tend to have low access to some social infrastructure and services owing to diverse factors (Peters et al., 2008). For instance, people in poor countries tend to have less access to health services than those in better-off countries; and within countries, the poor have less access to health services (Peters et al., 2008). With respect to health care/services, access is central to their performance around the world. However, access to health care remains a complex notion as exemplified in the variety of interpretations of the concept across authors and researchers (Levesque et al., 2013, p. 1). The concept also remains ambiguous due to the different purposes for which it is used. For research purposes, access is defined as the degree of "fit" between clients and a particular system in question (Penchansky & Thomas, 1981). Others also define access as a way of approaching, reaching or entering a place, as the right or opportunity to reach, use or visit (Canadian Oxford Dictionary, 1998). Specifically, access to health care refers to "*… a broad or general concept that summarizes a set of specific dimensions or areas that influence the ability and desire of potential patients to use the healthcare system"* (Clark, 1983, p. 6). Access to health care therefore depends on two major conditions: *the compatibility between characteristics of providers and health services on the one hand and characteristics and expectations of patients on the other hand* (Clark, 1983, p. 6). Understanding access to health care therefore entails elucidating the factors which influence entry or use of a given health care system.

Access is sometimes deemed as being predominantly an attribute of every service. Factors such as availability, price and quality of resources, goods and services are said to determine the degree of accessibility of services. It is argued that, this perception could stem from the fact that, it is factors amenable to policies and organizational attention that should be targeted to improve people's access to various facilities and services. Levesque et al. (2013, p. 2) however posit that, in order for the concept to be more comprehensive, factors pertaining to the structural features (e.g. availability), features of individuals (consisting of predisposing and enabling factors) and process factors (which describe the ways in which access is realized) should be considered in its assessment. This broad dimension allows for more operational measures through the study of specific determinants of access to health care. However, measurement of access is a complex process (Penchansky & Thomas, 1981). The factors determining access to health care could be broadly grouped under *spatial* and *aspatial* factors. Spatial factors embody factors relating to geographical barriers such as time or distance between health service providers and consumers. *Aspatial* elements however entail non-geographic factors including social class, age, sex, health seeking behaviour, cultural traits, people's knowledge on health and health care as well as income levels as determinants of access to health care (Wang & Luo, 2005). The spatial and aspatial factors are deemed equally important in how they influence access to health care. The choices people make in addressing their health problems are influenced by one or a combination factors which may be related to *spatial* or *aspatial* elements (Wang & Luo, 2005). In line with the two broad factors, five dimensions have been identified in literature with regards to the factors which influence people's ability and willingness to enter or use a facility or service. These dimensions include: availability, accessibility (geographical access), accommodation, affordability and acceptability as discussed briefly below (Levesque et al., 2013; Penchansky & Thomas, 1981; Peters et al., 2008; Phillips, 1990).

Availability:
Availability connotes the opportunities and options people possess with regards to health care. Availability refers to the fact that, health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner (Levesque et al., 2013). It measures the relationship between the volume and the type of existing services and the needs of potential clients (Penchansky & Thomas, 1981). The availability of services is often measured using indicators such as the number of doctors or hospital beds per unit population. In most countries, there are wide geographical variations in the numbers of general practitioners per head of population, the proportion of the population registered with dentists, or the proportion accessing specialist surgical services (Gulliford & Morgan, 2003). Provision of health services are mostly undertaken by public and private sectors or both. Health services often take the form of both formal and informal services using western and/or traditional medicines/methods (Besio, 2003; Lewis, 2006). It is argued that issues relating to availability of health services are some of the reasons why the poor in societies tend to use services of informal health care providers (Peters et al., 2008). This situation goes for street children who are poor and may not be able to access formal healthcare services.

Accessibility:
Accessibility refers to the physical distance between the point of supply of a service and the location of users. Access is said to be restricted if available resources are unevenly distributed around a given geographical location and even across levels of health care (with specialty care developed at the expense of primary care) (Whitehead, 1992). Factors such as travel time, availability of adequate communication services, distance to facilities and quality of roads could determine when, where, and how people use particular health services (Peters et al., 2008; Phillips, 1990). Moreover, people's ability to reach available health care also relates to the notion of personal mobility, occupational flexibility, and knowledge about health services that would enable one person to physically reach service providers. For instance, restricted mobility of the aged and handicapped, or the inability of casual workers to be absent from work to consult medical providers would constrict people in accessing health services (Levesque et al., 2013). Some schools of thought argue that, there is an inverse relationship between distance to health facilities and the use of health facilities depending on type and severity of ailment. However, others posit that, people may be willing to defy long distances to access particular services based on their acceptance and comfort in using such services (Besio, 2003). Accessibility has a strong influence on the use of either formal or informal services. Informal services are often touted as more accessible as compared to formal services which are often outside the homes and even the vicinity of people (Phillips, 1990).

Affordability:
Affordability connotes the economic capacity to spend resources and time to use relevant health services (Levesque et al., 2013). The financial or economic component in accessing health care is one of the key factors that attract or deter potential patients from using health services of their choice (Besio, 2003). Economic costs in accessing health care include direct user charges and related costs such as transportation cost, cost of treatment drugs, lodging, and expenses on food and even the opportunity cost of travel and waiting times to the sick and their accompanying relatives/friends (Besio, 2003; Peters et al., 2008). These costs may vary by type and level of services, and depends on an individual's capacity to generate the needed resources to pay for the services (Levesque et al., 2013). Studies have shown that, the poor are often deterred by user fees (Peters et al., 2008). The impact of user charges and related costs on access mostly depend on the magnitude of the costs and on the user’s willingness and ability to pay (Gulliford & Morgan, 2003). Governments have therefore focused on reducing the direct and indirect economic costs in accessing health care through interventions such as credit facilities, scheduled payments, insurance systems, bill waivers and improvement of knowledge of users on these provisions and on health in general (Peters et al., 2008).

Accommodation:
Accommodation focuses on the *'....relationship between the manner in which the supply resources are organized to accept clients and the clients' ability to accommodate these factors and the clients' perception of their appropriateness'* (Penchansky & Thomas, 1981, p. 128). Factors such as appointment systems, hours of

operation, waiting times, the amount of time spent in assessing health problems and in determining the correct treatment; walk-in services, telephone services; and technical and interpersonal quality of the services provided may determine the accommodative nature of a given service. Accommodation thus entail factors such as adequacy of services—relating to the appropriateness of the services provided and quality—the way in which the services are provided and its integrated and continuous nature (Frenk, 1992; Krishnan, 2000). The status of one or more of these factors may either encourage or discourage some people from accessing particular health services (Penchansky & Thomas, 1981; Peters et al., 2008). Poor patients for instance may be faced with condescending attitude by health care personnel. This may deter them from accessing certain services (Phillips, 1990). People who lack knowledge and information on operations of health services are also likely to be excluded from accessing particular services. In a similar vein, Philips (1990) argues that, less educated members of societies suffer inaccessibility to some services due to illiteracy and ignorance. Thus, on the part of potential users of health services, accommodation is strongly related to their capacity to communicate as well as notions of health literacy, self-efficacy and self management in addition to the importance of receiving care that is actually appropriate for the person, given its resources and skills (Levesque et al., 2013, p. 6). The effect of these factors however depends on clients' ability and willingness to access a given service.

Acceptability:
Acceptability relates to cultural and social factors determining the possibility for people to accept or reject aspects of a given health service. For example, a society forbidding casual physical contact between unmarried men and women would reduce acceptability of care and acceptability to seek care for women if health service providers are mostly men (Levesque et al., 2013). Acceptability thus embodies the expectations and perception of people with regards to the services that are provided. This partly determines the type of services people may choose to access (Peters et al, 2008). People may have different attitudes about the characteristics of services provided. Attributes such as type of facility, neighbourhood of facility, religion and beliefs of clients, and providers’ relationship with clients; level of service and education or training of service providers may determine the type and the rate at which clients utilize some health facilities (Besio, 2003; Peters et al., 2008). For instance, studies in Burkina Faso and Bangladesh have revealed that, the perception of potential patients of health facilities affect utilization of services even than other factors such as prices (Peters et al., 2008).

Moreover, providers may also have the preferred characteristics of clients they wish to serve. Specialized services and gender biased services for instance will exclude people without requisite health conditions (Peters et al., 2008). Similarly, the choice between formal and informal health care are also connected to expectations which emanate from diverse reasons. It is contended that, informal health care providers such as itinerant vendors for instance have convenient hours and flexible locations of operations as well as lesser social barriers with their potential clients that encourages people to patronize their services. It is argued that, even with the presence of formal and orthodox health services, some people may choose to use informal services due to for instance culture and belief systems which give them positive expectations (Agostinho, 2011; Peters et al., 2008). The degree to which clients accept or are accepted by the available services and how they expect to be satisfied by these services may also influence people's access to health care. Poor and vulnerable children and adults in various urban areas are classified among people who have less access to health services (Panter-Brick, 2002) (Panter-Brick, 2002). They represent a distinct category of residents whose health care requirements should be appreciated in ways that will encourage their use of available health services.

1.3 Case Study: Access to Health Care among Urban Poor
Poor and vulnerable groups in many urban areas suffer from recurrent health problems including ones that could be prevented. Addressing these health problems are moreover affected by a number of broad factors including the availability of health services, accommodating nature of the available services, affordability of services, accessibility of the services, and how acceptable the available services and facilities are (Penchansky & Thomas, 1981; Peters et al., 2008). These dimensions and their respective factors which are context dependent may present numerous challenges as well as opportunities to urban poor in their quest to access health care/services. The opportunities and challenges may affect people's preferences and choices with regards to the type of health facilities/services they patronise. The dimensions and factors affecting access to health services/care are however

interrelated and intertwined in their manifestation. This section of the paper discusses the intricacies involved in accessing health services/care among street children—one of the groups classified as urban poor, in Kumasi Metropolitan Area and in Ghana (MESW & UNICEF, 2010).

1.3.1 Study Area and Research Methodology

This case study is taken from a broad study to investigate the health and health care related problems of street children in Ghana's second largest urban area; Kumasi and how the health problems are addressed (see Amoah, 2013; Amoah, 2014). However, the data for this paper was collected in two stages. The first stage took place from 15th June to 14th, August, 2012 as part of the main study while the second stage took place from 22nd to 27th February, 2014. Kumasi is centrally located at about 270km north of the national capital, Accra. Kumasi is the capital city of Ashanti Region. It covers a total land area of 254 square. It has about ninety suburbs and divided into ten sub-metropolitan areas (KMA, 2010). Kumasi's population as at 2010 stood at 2,035,064 with 972, 258 males and 1,062,806 females (GSS, 2012). The unique location of Kumasi coupled with its tertiary level infrastructure and services as well as its economy make it a viable place for a host of commuters (KMA, 2010). Indeed, over a third (34.3%) of Kumasi's population consists of both internal and international migrants including children (Baah, 2007; KMA, 2010; Kwankye et al., 2007). Majority (72%) of economically active people in Kumasi are employed in trade and commerce activities most of whom operate informally (KMA, 2010). The socio-economic characteristics of the city therefore create a hospitable environment for the street children phenomenon (see also Amoah, 2013; Amoah, 2014, p. 124).

The aim of this paper is to gain an in-depth understanding and knowledge on the state of access to health care/services among the poor and vulnerable children in Kumasi. Qualitative research method was therefore deemed more appropriate for the study as it helps to get the grip of people's health worries (Gatrell & Elliott, 2009). Using semi-structured interview guides, in-depth interviews and two focus group discussions (consisting of 6 members each of both sexes) and observation methods (using both participant and non-participant observations) were complementarily used to collect data from both primary and key informants (see Bryman, 2008; Crang & Cook, 2007; Gomez & Jones III, 2010; Kothari, 2004). A total of 34 informants consisting of 23 primary informants (*children of the street*, see Ansell, 2005) and 11 key informants who were selected from both governmental and non-governmental institutions participated in the study. The primary informants were selected based on their age (street children from the ages of 13 to 17 years), gender, and places of origin and length of stay on the streets (children who had stayed on the street for at least three months without any contact with their neither their family nor guardians were considered). The respondents came from 6 different regions out of the 10 regions in Ghana with majority of them migrating from the Northern and Ashanti regions as shown in table 1.

Table 1: Places of Origin of Primary participants

No.	Region	Number of Children
1	Northern Region	8
2	Ashanti Region	7
3	Brong Ahafo Region	4
4	Western Region	2
5	Greater Accra Region	1
6	Eastern Region	1
7	**Total**	**23**

Source: Fieldwork, July, 2012& February, 2014

Primary participants were selected from six neighbourhoods in the Kumasi Metropolis where street children are often found (Amoah, 2014; Kwankye et al., 2007). Five participants each were interviewed from Adum and Kejetia. Four children each were also selected from Aboabo Station and Central Market Area. Three children were also interviewed at Asafo Market area while 2 children were also interviewed at Pampaso area. These locations are shown in figure 1.

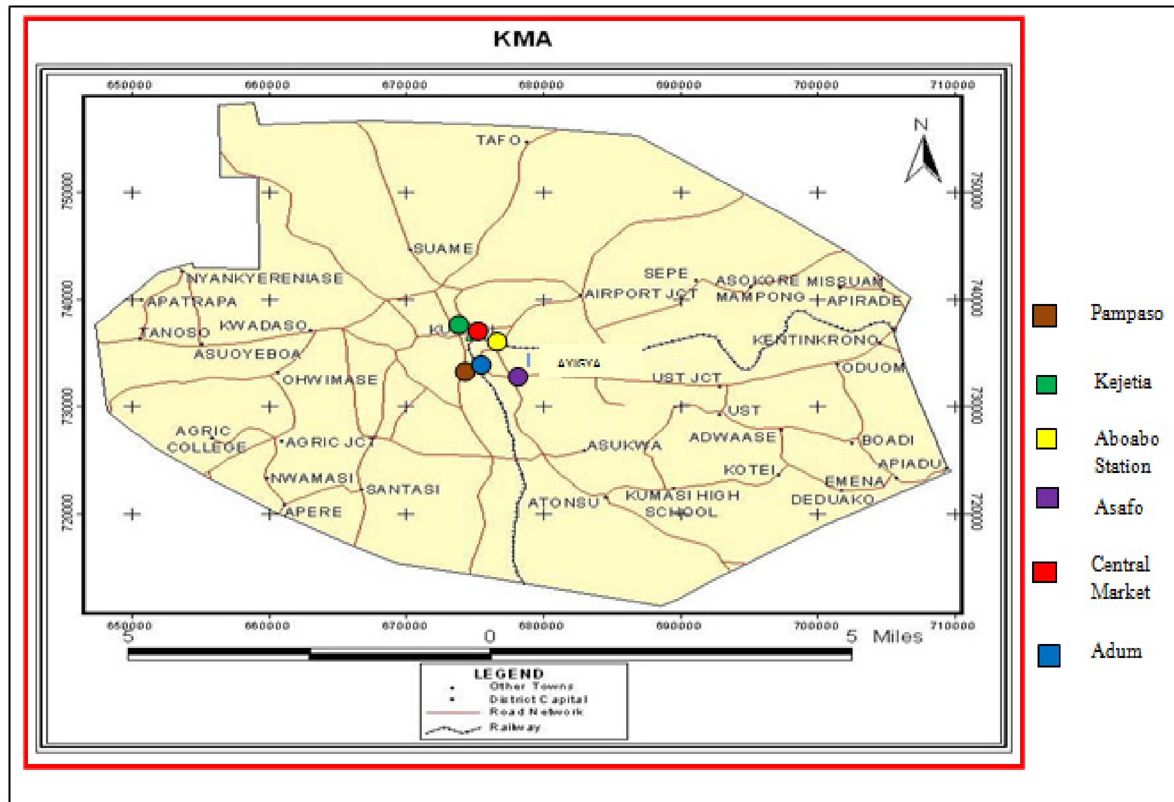

Figure 1: Data Collection Sites and Approximate Location of Street Children in Kumasi, Ghana (locations are not drawn to scale)

Source: *Source: Town and Country Planning Department, Kumasi and Authors' Construct, July, 2012.*

The primary data was buttressed with relevant literature and key informant interviews. Interviews were conducted with 1 physician and administrator from Kumasi Metropolitan Maternal and Child Health Hospital (MCHH, popularly known as Children's Hospital), 1 health assistant, and 2 licensed chemical sellers. Others were: 2 representatives from Kumasi Metropolitan Department of Social Welfare, 1 officer from Metropolitan Health Directorate, and a member each from Centre for Development of People (CEDEP) and Street Children Project (non-governmental organisations).

Selection of participants for the study was done using snowball and purposive sampling techniques (see Bryman, 2008; Gomez & Jones III, 2010; Kothari, 2004). Using snowball, street children who were initially identified aided in locating children in similar circumstances. Purposive sampling technique was used to intentionally select the children identified through the snowball technique by further inquiring about their backgrounds. This was done in order to reduce the propensity of informants to pass the researcher onto people whom they considered to be like-minded as them. The process also helped to select relevant participants for the study (see Kothari, 2004). It is important to note that, participant names used in this paper are pseudo names which were adopted together with the children during the fieldworks as part of measures to protect the participants.

1.3.1 Access to Health Services/Care among Street Children in Kumasi, Ghana

Availability of Health Facilities/Services in Kumasi

Health services in Kumasi just like other parts of Ghana are broadly grouped under formal and informal sectors (see Curtis & Taket, 1995; Smith & Hanson, 2012b). Moreover, the choice of service and type of medical practice rest on the consumers. Many public and private hospitals and clinics; pharmacies; itinerant drug vendors of both or either one of traditional and western drugs were also located at the centre of the city where the majority of street children in Kumasi live. On the one hand, the public health care facilities were formalised. On

the other hand, drug stores, methods and articles used for self treatment and services of itinerant drug vendors which were usually the children's first choice for addressing their health problems were mostly owned or managed by private men in both formal and informal forms (see Oppong, 2003). With regards to higher order health services, the majority of the children used public hospitals and clinics especially the Komfo Anokye Teaching Hospital (the only tertiary level hospital in the Ashanti Region) and Manhyia Polyclinic whenever the need arose instead of private practices (see KMA, 2008; KMA, 2010). This occurrence according to Phillips (1990) is common in many other developing countries. This is largely attributed to affordability of higher order public health services as compared to private ones. However, in general, owing to other relating factors including affordability, many of the children used lower order health services which were mostly privately owned as well as other informal health care services in their quest to address their health problems.

Utilisation of any given health service is partly determined by the type of services and the kind of medical practice (Phillips, 1990). While some of the children preferred orthodox medical practices, a few others preferred traditional medical practices. The majority of them however swung between the two practices depending on their ailment. Orthodox medicines just as many traditional medicines were administered both in formal institutions—hospitals or clinics or pharmacies and through informal practices—itinerant drug vending services and sellers of ingredients for traditional medicine. The central business district of Kumasi just as in many other cities in Ghana is flooded with many itinerant drug vendors (often carrying drugs in hand bags and on hand trucks) who sell both western and traditional medicines (see Oppong, 2003). Various forms of drugs could be obtained from itinerant sellers and pharmacies. In Kumasi, many of these traders were found in the central business district and within and around major transport stations in the Metropolis. One could acquire drugs from them even without medical prescription (see also Oppong, 2003; Salisu & Prinz, 2009). The majority of the children were able to mention the names and locations of at least two clinics and hospitals and locations of at least two pharmacies. Others were also able to give accurate directions to and description of some drug vending joints and itinerant vendors within their vicinity.

The use of available services however depended on the choices and preferences of the children. While some of the children preferred hospitals or clinics or polyclinics, many of them for various reasons preferred pharmacies and drug hawkers: *"...I always go to drug stores for treatment because the prices are cheaper and there is one close to Asafo Market where I sleep"* (Naomi, 13 year old girl). This finding is synonymous to that of a similar study in Dar es Salaam, where 46%, 28% and 26% of street children respectively used local pharmacies because it was a cheaper option; because the option saved time due ease of physical accessibility and also because it was effective (Amury & Komba, 2010, p. 19). However, for reasons such as *"...at the hospitals and clinics, there are equipments to conduct relevant medical tests to know the actual ailments so as to prescribe the right medicines*'' (Lamin, 17 year old boy), some of the children preferred hospitals. There were different kinds and forms of traditional medicines for almost all the common diseases that the children suffered, including drugs for malaria/fever, stomach ache, typhoid and cough on the market (see Oppong, 2003). However, the majority of the children used orthodox medicine as compared to traditional medicines. The major traditional drugs used by the children were *ointments* for body pains and creams for skin infections and rashes. When asked why they did not often use traditional medicines, the common responses were summed up in the words of two of the children as:

> *"...traditional medicines? Do you mean the likes of Yassin Mixture and Angel Herbal Mixture? (I responded yes to his questions). Those medicines are too expensive. They are common here but I can't afford them. Besides, some of them are in the form of syrup which makes it difficult to carry around. Sometimes they fall and pour off.....I don't like them" (Bright, 14 year old boy)*

> *"...Some of them are bomb (a term used among them to refer to fake or expired drugs). ....Some of them are made with fake and poor ingredients. ...They even sell them when they are expired because it is difficult to determine the expiry dates" (Kwaku, 16 year old boy)*

The above statements indicate that, although the children had fair knowledge on the availability of these kinds of medicines, their distrust of the quality as well as high cost of some of the traditional drugs excluded them from using such drugs. Besides, they had difficulty in keeping some herbal medicines especially those in syrup forms

due to their unstable and poor accommodation. Body pain ointments and medicated body creams were the most used traditional drugs amongst them. This is because, they were relatively cheaper (averaged about $ 0.5 for pain ointments and about $0.8 for body creams) than other forms of traditional medicines. However, even at these prices they were still comparatively expensive than single or double dose of western drugs for treatment of common cough, cold or even malaria/fever. This assertion is however contrary to the position of Sato (2012) who claims that traditional medicines are less costly. Nevertheless, the peculiarity of the situation of street children meant that, they could hardly prepare some of these medicines by themselves even when they could gain the ingredients for free. They therefore used already prepared ones which were sold at regular market prices. However, aside from the cost component, Phillips (1990) argues that (poor) adults in most developing countries are more likely to use traditional medicine than younger people as evidenced by studies in Nigeria and Namibia. This assertion may therefore partly explain the low patronage of traditional medicines among the street children.

Furthermore, some non-governmental organisations in the Metropolis including Street Children Project (SCP) also provided options for the children to address their health problems. The *available* medical services and the preferences of the children was summarised in the words of the Metropolitan Social Welfare Department Directress as:

> *"......some of the children usually go to public hospitals when they fall ill....Some carry out self medication. Some use traditional herbal medicines; some buy drugs from pharmacies and a few seek help from NGOs. Others....do nothing about their health problems"*

The children therefore lived in places where availability of health care facilities and services were at its peak and within walking distances both in quantity and quality. Their situation was therefore different from other urban poor groups and individuals who not only live in irregular settlements but also at places where they have no health clinics and other basic services and infrastructure including schools and transportation (Garland et al., 2007). However, accessing these available options was made difficult due to factors relating to dimensions of access as discussed below.

Affordability of Available Health Services

Financial accessibility represented one of the key challenges to accessing health care among the street children. The majority of them supported themselves with a number of menial jobs (Amoah, 2013). On the average, each child made about GH¢ 3.5 (about $1.4) per day; similar to what Kwankye et al. (2007) found in a similar study in Kumasi and Accra in Ghana. They spent about half of this amount solely on food. Some of them also spent part of their daily earnings on their sleeping places. The majority of them saved excess money with adult friends as well as with *'Susu'* operators—individual savings operators, for security reasons. Others also saved their excess money by themselves. However, the children were often hoaxed by their adult trustees leading to regular lose of money. Besides, the little that they managed to save by themselves was also sometimes lost to thieves. The majority of the children therefore lived on hand to mouth basis whereas others depended on their peers or even their adult friends for financial support. In the light of this, any 'need' with any form of financial strain was deemed as a 'want' amongst them. Accessing high order health services was therefore a challenge for many of them. They therefore substituted quality care for sub-standard care due to financial reasons. For instance, out of the 12 participants in the focus group discussions, 8 of them mentioned pharmacies (drug stores) as their first choice for treating their illness with financial constrains being a major reason behind their decision:

> *"...If the hospitals and clinics were free (financially) or cheaper than drug stores, ...I will always go there when I am sick...." (Raf, 14 year old girl).*

> *"When one visit the hospital, payment for registration alone may cost more than the price of drugs one could get from drug stores" (Lamin,17 year old boy).*

> *"....I do not want the clinics.... Why should I go there when they will charge me more for the same treatment as that of the drug store?...I am not stupid (laughs)...... It is too expensive for me. (S.O. 16 year old boy)*

Moreover, accessing even the cheapest forms of health care was difficult for some of the children due to financial constraints. Some of them depended on their friends for unused medicines since they could not afford one themselves. The priority they gave their health risks and problems as compared to other basic needs was therefore relatively lower owing to limited financial resources and also depending on the acuteness of their illness or injury. Besides, preventive measures such as use of mosquito repellents were overlooked by the children which they fictitiously attributed to unsuitability of their sleeping places. Some of them also chose to walk or in worse cases got carried on the backs of their friends to hospitals due to financial difficulties*: "I usually walk to the hospital because they are not far from me....Besides, I cannot afford to spend part of my money for treatment on transportation when I can walk there''* (Azara, 15 year old girl) (see Amoah, 2014). Therefore, in line with assertions of Smith and Hanson (2012a) and Phillips (1990), financial constrains did not only affect decisions relating to where and how the children addressed their health problems but also how they got to the chosen service centres/premises. Without financial obligations, some of the children claimed they would prefer to visit higher level facilities/services such as hospitals instead of pharmacies and drug hawkers and would be more cautious with preventive measures. Some of them however undermined their financial vulnerabilities in accessing higher levels of health care by attributing their inaccessibility to other factors especially those relating to availability and physical accessibility to their regular point of calls. In a similar study in Dar es Salaam, Amury and Komba (2010) found corresponding relationships, condition and choices among similar urban poor children in terms of their preferred health care facilities and financial accessibility to health services.

Moreover, the National Health Insurance Scheme (NHIS) introduced by the Government of Ghana and other initiatives such as health care fee waivers and free insurance for vulnerable and poor people which are administered by the Department of Social Welfare, had not had the needed impact on their situation (Blanchet, Fink, & Osei-Akoto, 2012; MESW & UNICEF, 2010). The street children could not even afford the preliminary registration and subscription premiums for the NHIS. Besides, the majority of them lacked knowledge and information on the functioning of prevailing social policies for health care such as the health care bill waiving system for poor and vulnerable. In confirming their financial difficulties in accessing health care, the administrator of Metropolitan Maternal and Child Health Hospital (MCHH) stated that: "...W*e have had to waive bills for some of them (referring to street children) after we established that they could not afford their bills"*. Financial difficulties therefore had greater impact on the choices the children made especially with regards to the type of healthcare services to address their health problems. This situation confirms the notion that, financial constraints represents a primary reason for poor access to health care among many urban poor groups especially those in developing countries.

Accessibility to Available Health Services

As established earlier, the children lived in high access zones with respect to availability of health services. Many of them lived within walking distance and within 10 to 20 minutes by car even at peak times from various kinds of health services and facilities. The Komfo Anokye Teaching Hospital for example is located within walking distance from Kejetia, Adum, Pampaso and even Aboabo Station where many of the children spent their day and night. For instance, when asked about the hospital or clinic she usually visited, Azara (15 year old girl) answered by pointing at the Children's Hospital which was located about 30 meters from where she and other children spent majority of their day and night. One of the children therefore stated:

> *"I don't have to take car to go the drug store....The one I usually visit is located not far from here (where the interview took place)...I can show you the place now if you want....It is even close to the place I work every day" (Sampson, 13 year old boy).*

This assertion was also confirmed by a key informant as: *"....many of them (referring to street children) make use of our service due to our strategic location..... Look (points to some street kids hanging around the shop's*

veranda), they are always around here. They have become our friends.." (Attendant, Kanbros Pharmacy, Adum). Physical accessibility to health care was therefore not a challenge for children but rather an opportunity for them owing to their places of abode. However, it is worth noting that many of the children were constrained in accessing the physically accessible services due to inadequate knowledge on the availability and what is more, the locations of some of the health facilities and the type of services they offered (see also Peters et al., 2008; Phillips, 1990). This also partly explains the deferring preferences and choices of the children with regards to health care/services.

Acceptability of Available Health Services

Aside from the issues discussed above, there are other factors which also affect and determine access to health care and the choices people make with regards to the type and kind of services they use. These include issues relating to attributes and expectations of both providers and customers. These factors determine how much clients feel accepted or rejected by particular services. Firstly, the set up and method of operation of most pharmacies made it more convenient and acceptable to many of the children especially the females to use their services because *".... at the drug store, I can choose the gender of the attendant who serves me. I prefer female attendants.... It is easy to talk to them than the males..... If I do not meet any female attendant, I wait till the next day"* (Julia, 16 year old girl). The set up of the pharmacies brought customers in direct contact with the health professionals and in a state where they could even choose who to serve them unlike the bureaucratic process in hospitals and clinics where they had limited choice. This was also confirmed by a female attendant at Kanbros Pharmacy when she revealed that some of the girls sometimes specifically asked for female attendants. This, she confirmed, was usually the case when their problem was related to their reproductive health especially menstrual problems. The children seemed more comfortable with attendants at drug stores and drug vendors. Some of them had developed an informal relationship with some of the attendants which made it easy for them to access the services they offered without any tension or shyness. This cordial relationship was partly why the majority of the children preferred drug stores and drug hawkers as compared to hospitals/clinics including herbal clinics especially in treatment of less serious illnesses and injuries. Thus, drug stores and drug vendors in the words of Phillips (1990, p. 210) provided a narrow *'social distance'* between the children and the sellers.

Acceptability to health services and their health related poverty was also affected and to some extent determined by language. The children came from different regions in Ghana (see table 1) with different ethnic backgrounds, culture and dialect. Owing to this and the fact that most of them were either school drop outs or had never been to school (Amoah, 2013; see also Hashim, 2005; Hashim, 2006; Kwankye et al., 2007), it was difficult for especially the children from northern Ghana to satisfactorily express themselves in '*Twi*' (local dialect in Kumasi) and even in English language which is the official language of the Ghana. Language was therefore a barrier for a number of the children in accessing health care. Some of the children admitted that they desisted from using services of hospitals and clinics because they could not adequately explain their health problems and symptoms to physicians. Some of them therefore preferred to go to specific pharmacies where there were attendants who understood or spoke their native language: "*I don't go to Komfo Anokye (Hospital),...I cannot explain my illness well to the doctors because I don't speak fluent 'Twi'* "(Azara, 15 year old girl). For this reason, some of them had enacted a coping strategy whereby those that spoke *Twi* fluently served as translators for their sick friends who could not express themselves in *Twi.* This was a common practice among the children as iterated by almost all the health professionals interviewed: *"...many of them cannot speak Twi nor English so it is difficult to deal with them....Sometimes they come with their friends who speak on their behalf......I have been here for long so I have picked up some of their words. I can also communicate with some of them using signs and actions so many of them come here"* (Attendant, Dominic Clement Chemical Store). The challenge was therefore being informally addressed as none of the institutions visited showed concrete strategies to address the problem except for the efforts made by the children themselves.

Preferences to some healthcare services were also based on their expectations and anticipated satisfaction from using specific services (Peters et al., 2008). Although pharmacies/drug stores are basic health services, many of the children preferred taking their health problems to pharmacies because they deemed treatment from pharmacies as more effective as compared to hospitals or clinics just as their counterparts in Dar es Salaam

(Amury & Komba, 2010). In fact, all the children *believed* their regular choice for health care to be the effective. However, to some extent, their confidence and trust in treatment offered by their usual services was influenced by other dimensions of access, especially affordability. They thus deemed their choices as adequate because that is what they could realistically afford or felt comfortable with. For instance, Azara (15 year old girl) consistently insisted that, pharmacies were better for her instead of clinics or hospitals although she was aware of locations of some hospitals and could afford to utilise the services. In-depth discussions with her withal revealed that, her ability to express herself fluently to the attendant of her preferred pharmacy who understood her native language was the key to her conviction in treatment from pharmacies. Their ability to express themselves, the cordial relationship with attendants and more especially their ability to afford the services of pharmacies gave the children more confidence in the services provided. One could also argue that, these factors reduced their expectations. Hence, any improvement in their condition after treatment was deemed as enough and successful. This situation may also apply to some other urban poor and vulnerable individuals and groups such as new migrants in a given location.

Access to Health Care: Accommodation

Accessing health care is also either constrained or encouraged by a number of factors which together determine how accommodating a given facility is. These factors include: hours of operation, walk-in facilities, telephone services, appointment systems, waiting times and credit or payment schedules (Penchansky & Thomas, 1981; Phillips, 1990). Conversations with the children and key informants revealed contrasting results with regards to how, where and when the children accessed health care due to one or more of these accommodation related factors. All the health facilities the children visited had walk-ins services—where one need not to book an appointment before visiting. This was also a common practice in most out-patient departments (OPDs) of clinics and hospitals in the Metropolis: *"...Anyone at all can come in for our service at anytime....However, everyone has to register as a new case or present evidence for us to retrieve previous records"* (Administrator, Metropolitan Children's Hospital*)*. Pharmacies and itinerary drug vendors operated just like any other shop where people could access the service at any time within their operational period even for window shopping. While hospitals and clinics often operated on 24-hour basis, the majority of the drug stores began operations at 8:30 am and often closed at 11pm. Most drug vendors roamed around with their items during the day. Others however set up tables at strategic locations at night where some of them operated till day break: *"....some of the drug sellers stay up with other vendors at Kejetia where I sleep throughout the night....I can buy medicines even at dawn.....Even when they sleep, they leave their items in the care of other vendors who wake them up at the call of customers''* (Kwame, 16 year old boy). Phillips (1990) assertion that, services of itinerant drug vendors are more convenient to users therefore partly explains why the children and other urban poor may prefer services of drug hawkers instead of pharmacies and hospitals.

Although hospitals and clinics are officially open for 24 hours, some of the children complained of inactivity at late evenings and nights: *"...I usually visit the Manhyia Polyclinic when I am sick..... When I go there in the evening, it always seems like the nurses are not ready for more patients....so I prefer to go there in morning or afternoon"* (Lamin, 17 year old boy). This is in line with findings from a similar study in Lusaka, Zambia (Mtonga, 2011) where some of the children revealed how inconvenient they felt at some health facilities especially hospitals. Some of the children felt shy to visit hospitals because of how they were received and 'looked' at by some staff and even fellow patients: "*...People at the hospital look at me differently....Sometimes I think it is because of my clothes.....At one time I went to the hospital and the nurses were not friendly. I did not like how they talked to me....I think they thought I could not pay for my treatment"* (Lamin, 17 year old boy). Another child added to this by stating: *".....At first I did not have good clothes so I could not go Komfo Anokye (Hospital) because.... I was shy..... Now, I have better clothes so I always make sure I look presentable before I go to there (hospital)...... When I look neat, people do not look at me as a street child"* (Rahi, 17 year old girl). Many of the children were therefore shied out from services of clinics and hospitals due to unaccommodating environment. However, key informants from the respective pharmacies and the Administrator as well as the physician from Metropolitan Children's Hospital were of contrary opinion as they saw their set up, atmosphere and environment as welcoming and convenient for everyone. Withal, the situation is further complicated with the opinion of the health professional at SCP who disagreed with the assertions of the other key informants by

stating that: *"...I used to be a nurse in a certain clinic (fails to mention the name). I can say that the way we dealt with street children was not the best especially when the pregnant ones amongst them came to deliver their babies..... We insulted some of them"*. She therefore admitted that, this behaviour of the some hospital staff members kept some of the children out of hospital and clinical services. Her assertion is moreover accorded by the Ghana Health Services who also recognise the poor attitude of some health care staff in Ghana. This explains why the institutions continually encourage health care workers to maintain respectable relationship with clients (GHS, 2007). The situation of the children remains peculiar. In the opinion of Jones and Summer (2011, p. 7) *"......[Street] children's needs and capabilities differ both from adults, and from those of other children depending on their life-stage, amongst other factors"*. Thus, unlike other urban poor groups and individuals, being children and even worse, being street children make the children's access to health care more complicated due to their differing needs and their very limited capabilities (De la Barra, 1998 in Panter-Brick, 2002).

Moreover, health care institutions in the Kumasi Metropolis were burdened with inadequate facilities, personnel and health logistics. This constrains their capacity to serve patients satisfactorily (KMA, 2010). This situation often resulted in long queues and long waiting times in various clinics and hospitals especially in public institutions (see GHS, 2007; Phillips, 1990). Almost all the children who had ever been to hospitals complained of this anomaly: "*... there are always many people at the hospitals....If you are not lucky, you might even spend the entire day there"* (Spendi, 17 year old girl). However, those that preferred and willing to use hospital services had enacted a solution to this problem: *"....I make sure I go to the hospital very early in the morning or in the evening when there are not many patients"* (Lina, 14 year old girl). In a similar study in Accra, Ghana, Anarfi (1997) found that, hospital and clinics were least patronised by street children because they could not afford to spend their working hours in long queues. Urban poor children in Tanzania have also demonstrated similar attitudes with regards to the long waiting times at health (Amury & Komba, 2010).

Furthermore, one major unaccommodating factor was the fact that, most health centres did not have facilities/arrangement for credit. Poorer people had no option but be able to afford the treatment before visiting various health centres. None of the children had ever purchased drugs or afforded treatment based on credit. However, this was due to the fact that none of them had attempted to access health services in times of financial difficulties and hence would not know if such services occurred or were possible. An attendant at Dominic Clement chemical store revealed that, they sometimes gave drugs on credit to some of the children who came to them without money. However, the service as deduced from the conversation depended largely on trust and familiarity between providers and clients—a bond which is usually formed as a result of long term relationship. Key factors relating to accommodation of health services therefore either encouraged or deterred these poor children in their bid to access health care.

1.4 Access to Preventive Health Services

Studies have revealed that ......*the urban poor are in many ways invisible to their governments* with regards to provision of basic services and infrastructure (Garland et al., 2007, p. 2). They tend to rely on private vendors for these services. The Government of Ghana through its decentralised institutions in the Kumasi metropolis including the Metropolitan Health Directorate, Department of Social Welfare and the Department of Children under the Ministry of Women and Children's Affairs have implemented a number of pro-poor health care/service interventions (including health insurance scheme; free subscription to the scheme for poor individuals and even health care bill waiver scheme for the poor and vulnerable) with the aim of increasing access to and utilisation of various forms of health services. Some non-governmental institutions (including CEDEP and SCP) were also actively involved in health related programmes and projects for poor and vulnerable in the city.

The Metropolitan Health Directorate and the Department focused on preventive health care. They offered educational programmes geared at preventing all forms of illnesses and injuries. However, as gathered from the key informants, these programmes were irregular; not well organised and; undertaken in ad hoc manner. Many of the children therefore had not experienced any of such educational programmes from these public institutions.

The same could be said about the Department of Social Welfare (DSW) whose 'regular' health education programmes had not as yet reached the street children. As a matter of fact, many children did not even know about the existence of the neither the institution nor location of the DSW and not to mention their primary objectives and activities. The ineffectiveness of some of these interventions culminated into the children's less knowledge on some common illnesses and their prevention. For instance when asked why he uses mosquito repellents, Joe (15 year old boy) responded *"...mosquitoes can cause diseases such as malaria and HIV/AIDS....They can transfer the blood of an infected person to an uninfected one''*. However, some of the children knew about some basic and even relatively advanced preventive health measures which they applied in their daily lives. For instance, when he was asked about why he was not at work, Musa (17 year old boy) responded as: *"...I have taken a break from work today....I feel tired so I want to rest....I want to regain my strength"*. In a similar vein, Sampson (13 year old boy) also recounted how he controlled what he ate: *"....I prefer to eat foods made with vegetables. Vegetables are good for health.....I also make sure the food is being sold in a hygienic surrounding otherwise I don't buy it''*. Thus, some of them showed appreciable awareness on some preventive health measures which also demonstrated their control over and concern toward their 'difficult' circumstances. However, their knowledge on these and other pro-health measures were often gained from their peers and adult friends who were no experts in human health. They were therefore always at risk of being misinformed and encouraged into some practices that were harmful to their health such as self medication (Amoah, 2014). It could thus be summed up that, many of these urban poor children, remained invisible to many of essential healthcare services and health promotion campaigns. The situation therefore requires urgent and efficient policies that will effectively include the health needs of the children into curative and preventive health activities.

1.5 Summary and Conclusion

Comparatively, the places the children found themselves put them at an advantage with regards to availability of various types of health services as well as physical accessibility to these facilities and services. They were presented with fewer opportunities with regards to acceptability of the available facilities and services. On the whole, issues relating to accommodation and affordability respectively presented the most challenges in their access to health services. The two dimensions constrained their ability to take advantage of the available but also accessible and relatively acceptable health facilities/services. Figure 1 diagrammatically depicts the hierarchy of access to health services amongst the street children with regards to the five dimensions to access based on the discussions above. In the diagram, the wider the circle, the greater the opportunities and fewer the challenges associated with the respective dimension. Thus, the smaller the circle, the more challenges and fewer opportunities the particular dimension presented to the children.

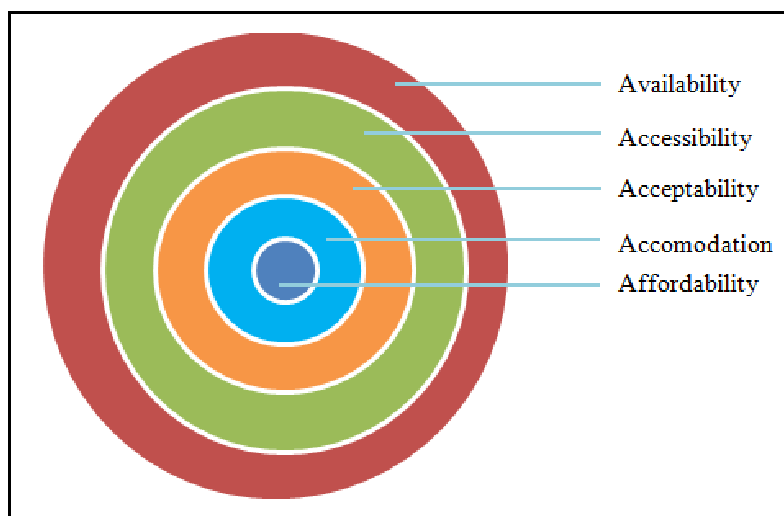

Figure 2: Hierarchy of Access to Health Facilities/Services

Source: Authors' Construct

Chronologically, the children therefore had less challenges with the factors relating to the dimensions of availability, accessibility, acceptability, accommodation and affordability respectively. Affordability and accommodation was therefore the most inaccessible dimension to health care which also influenced their choices and preferences with respect to considerations they gave to factors relating to the other dimensions of access. Moreover, financial constrains are not only a challenge for street children in accessing health care. It is also a major hindrance for other urban poor people including adults. Health care financing issues have therefore remained a priority for many governments and researchers over the years (Smith & Hanson, 2012a). The case study presented here however indicates that, access to health care is different for different groups of urban poor. Each group within societies may be bedevilled with peculiar constraints which have to be carefully studied, analysed and addressed in order to improve their access to health care. For instance, although factors relating to accommodation were a major challenge for street children in Kumasi, same cannot be said for poor adults on the streets of the Metropolis.

Moreover, access to preventive health interventions among the children was minimal. Owing to their peculiar situation of being urban poor and children, preventive health interventions should be a major priority for policy makers. Their current situation affirms the assertion of Adeyemi and Oluwaseun (2012, p. 88) that, street children constitute a marginalised group in most societies "*....who do not have what society considers appropriate relationships with major institutions of childhood such as....health*". This explains why the majority of the children and even many other urban poor remain invisible in the implementation of various health related initiatives.

In view of the above, poor populations should be empowered by divulging to them more information on disease prevention and treatment options. Health educational programmes should be a major priority and a frequent practice by relevant public and private institutions. These programmes should focus on the causes and prevention of health problems. The programmes should also entail education on appropriate places for them to acquire medical treatment and drugs. Moreover, key public and even private institutions should continually market their presence and functions as well as their relevant health interventions and programmes known to especially the poor in society who have less knowledge on their existence but need their assistance and services the most.

Furthermore, since some of them were already practising self treatment and medication (Amoah, 2014), it is suggested that some of the urban poor and vulnerable individuals be trained in basic first aid. The training regime could entail treatment of basic health problems such as mild sprains and wounds as well as education on appropriate handling and use of medicines. This training and education programmes could be incorporated into activities of the community nursing programs which are already running in many Ghanaian communities. Moreover, in the short term, in conjunction with other civil society partners such as the Department of Social Welfare and Department of Children, the Metropolitan Health Directorate should conduct regular mapping and micro-planning for the at-risk populations. Their locations and routines should thus be mapped and schemed in a way that would facilitate easy access to them in terms of physical access and meeting their peculiar health needs. Such mapping and micro-planning could be built into the routine health promotion activities. These activities will help focus on the health plights and in detecting health risks and inequities. Health related needs of urban poor such as health insurance subscription; child immunization and environmental health could be addressed easier through this systematic approach (Grundy, 2009).

Some individuals had made efforts at providing sleeping places for street children. In the long term, these efforts should be critically studied, improved upon and incorporated into both housing plans and policies. Studies have shown that, the condition of the physical environment and places of abode of urban poor affect their health more than any other factors. Moreover, since it is more prudent to prevent diseases than to cure them, this suggestion will help to reduce the rate at which poor groups such as street children fall ill. Such housing schemes could be in the form of moderate shelter provisions that could provide the children with decent places for good sleep and protection from physical assault by thieves and bad weather. New structural regulations such as the inclusion of basements could also provide accommodation for some of these groups of people could also be introduced into

the housing policies for buildings within and closer to the central business district (CBD) of the Metroplis. Moreover, any structure raised for the purposes of accommodating the homeless should be sited either within the central business district (CBD) of Kumasi or in areas not far from the CBD. Using the case of the street children above, any location far from the CBD will be least patronised as the children preferred to be closer to their sources of income and livelihoods. Moreover, since some of them were already paying to sleep at almost open places, these provisions could also be made available at reasonable prices which will not only discourage the street children phenomenon but also assist in the running of such facilities. Besides, this initiative will also make the children and other homeless adults more organised and easily accessible for inclusion in decision making process. Aside from this, reaching out to them with health related information and intervention will also be more effective and easier. Furthermore, those with complex and chronic health conditions such as mental illness and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDs) could be effectively monitored through community nursing programmes.

Adequate resourcing of the relevant institutions should also be a major priority in the fight against urban poverty. Many of the pro-poor institutions in the Kumasi Metropolis were woefully under resourced in terms of financial and human capital as well as logistics. The institutions were thus not vibrant enough to discharge their duties adequately. The office of the DSW for instance consisted of only the directress and one temporary assistant as at the year 2012. The gaps in human resources and logistics in public institutions should be addressed so as to enable them function satisfactorily. Non-governmental organisations could also be assisted with financial support, provision of needed logistics and technical assistance in dealing with the poor and vulnerable in general. The Kumasi Metropolitan Assembly should therefore work closely with these institutions to address their problems since their functions ultimately have greater impact on the living gained by the poor in the city.
Moreover, in view of the promotion of evidence based health promotion and practice in current public health practice (Green, 2010), it is suggested that, attention is paid to the petty hindrances in accessing health services among poor people such as street children. Factors especially those relating to accommodation of health services should be addressed. Health service professionals should be strongly encouraged to desist from discrimination and maltreatment of poor and vulnerable patients and other visitors. Culprits should be adequately sanctioned by the appropriate authorities. Aside from this, patients should be given the opportunity to participate in decisions concerning their health care. Patients should be as much as possible be involved in decisions such as who attend to them. Besides, there should be a diversification in the medium of expression especially at hospitals. As many health facilities as possible should be able to accommodate patients with different mother tongues as possible. Hospitals and clinics for instance could take conscious measures to assess its strength and weaknesses with regards to languages spoken by its staff. This process will help to find suitable persons to serve as translators for patients who may not be able to express themselves fluently in a particular language.

The general situation with regards to access to health care/services among urban poor in the Kumasi Metropolitan Area and in many cities in other developing countries is poor and need to be drastically ameliorated (Gatrell & Elliott, 2009; Smith & Hanson, 2012a). However, the paper concludes that, it is imperative to improve the health status of urban poor by improving their access to *healthy life conditions* and not simply removing the barriers to health care. Thus, common causes of ill health among urban poor groups such as poor access to sanitary facilities, poor accommodation conditions, and unhealthy social and environmental conditions in which people live and inadequate knowledge on especially disease prevention should be tackled alongside improving their access to health services. The concept of access should therefore be applied holistically to include people's access to both preventive and curative health services since the two go hand in hand.

Acknowledgement
The authors wish to express our profound gratitude to all individuals and groups who served as informants and field assistants in the study. Our sincere appreciation also goes to the Norwegian State Educational Loan Fund and the Nordic African Institute for funding the field work of earlier versions of this paper. We would in a special way also like to thank Associate Prof. Stig. Jørgensen (Department of Geography, Norwegian University of Science and Technology) for his immense contribution towards the production of earlier version of this paper

References

Adaawen, S. A., & Jørgensen, S. H. (2012). Eking out a living: The livelihood implications of urban space regulation on street hawking in Accra. *African Review of Economics and Finance, 3*, 49-95.

Adeyemi, O. S., & Oluwaseun, O. (2012). Economic Factors as Correlates of Streetism among Urban Children in Ibadan Metropolis, Nigeria. *Developing Country Studies, 2*(9).

Agostinho, A. B. (2011). Integration of traditional medicine in health systems in Africa. Retrieved 12th April, 2013, from http://www.universitasforum.org/index.php/ojs/article/view/68/257

Amoah, P. A. (2013). *Addressing the health problems of street children: The case of street children in Kumasi Metropolitan Area, Ghana.* (Master of Philisophy), Norwegian University of Science and Technology, Trondheim, Norway.

Amoah, P. A. (2014). Social Capital, Health and Health Care among Street Children: A Case Study of Street Children in Kumasi Metropolitan Area, Ghana. *Developing Country Studies, 4*(4), 119-132.

Amury, Z., & Komba, A. (2010). Coping Strategies Used by Street Children in the Event of Illness (Research Report 10/1 ed.). Dar es Salaam: Research on Poverty Alleviation.

Anarfi, K. J. (1997). Vulnerability to sexually transmitted disease: street children in Accra. *Health Transition Review,, Supplement to Volume 7,*, 281-306.

Ansell, N. (2005). *Children, Youth and Development*. London: Routledge.

Baker, J. L. (2008). Urban Poverty: A Global View *Urban Papers*. Washington: The International Bank for Reconstruction and Development/The World Bank.

Besio, K. (2003). Steppin' in it: postcoloniality in northern Pakistan. *Area, 35*(1), 24-33.

Blanchet, N. J., Fink, G., & Osei-Akoto, I. (2012). The effect of Ghana's National Health Insurance Scheme on Health Care Utilisation. *Ghana Medical Journal, 46*(2), 76-84.

Boakye-Boaten, A. (2006). *An Examination of the Phenomenon of Street Children in Selected Communities in Accra-Ghana.* (Doctoral), Ohio University, Ohio. Retrieved from http://etd.ohiolink.edu/send-pdf.cgi/BOAKYEBOATEN%20AGYA.pdf?ohiou1162599630&dl=y

Boyden, J., & Mann, G. (2005). Children's risk, resilience, and coping in extreme situations. In Ungar, M. (Ed.), *Handbook for Working with Children and Youth: Pathwas to resilience across Cultures and Contests*. London: Sage Publications.

Bryman, A. (2008). *Social Research Methods* (Third Edition ed.). New York: Oxford University Press.

Canadian Oxford Dictionary. (Ed.) (1998). Tronto: Oxford University Press.

Clark, D. W. (1983). Dimensions of the concept of access to health care. *Bulletin of the New York Academy of Medicine, 59*, 5-8.

Consortium for Street Children. (2003). A Civil Society Forum for Anglophone West Africa on Promoting and Protecting the Rights of Street Children. London: Consortium for Street Children.

Crang, M., & Cook, I. (2007). *Doing Ethnography*. London: Sage Publications.

CSC. (2009). Street Children Statistics. London: Consortium for Street Children.

Curtis, S., & Taket, A. R. (1995). *Health and Societies: Changes Perspectives*. London: Hodder Arnold.

Ensign, J. (2004). Quality of Health Care: The Views of Homeless Youth. *Health Services Research, 39*(4).

Flowers, R. B. (2010). *Street Kids: The lives of runaway and thrownaway Teens*. North Carolina, USA: McFarland & Company, Inc., Publishers.

Frenk, J. (1992). The concept and measurement of accessibility. In White, K. L., Frenk, J., Ordonez, C., Paganini, J. M. & Starfield, B. (Eds.), *Health Service Research* (pp. 858-864). Washington: Pan American Health Organization.

Garland, A. M., Massoumi, M., & Ruble, B. A. (2007). Gloal urban poverty: Setting the agenda. In Garland, A. M., Massoumi, M. & Ruble, B. A. (Eds.). Washington, D.C.: Woodrow Wilson International Center for Scholars.

Gatrell, C. A., & Elliott, J. S. (2009). *Geographies of health: An introduction* (Second ed.). West Sussex: Wiley-Blackwell.

Geber, G. (1997). Barriers to Health Care for Street Youth. *JOURNAL OF ADOLESCENT HEALTH 1997;21*, 287-290.

GHS. (2007). Quality Assurance Strategy Plan for Ghana Health Service 2007-2011. Accra: GHS.

Gomez, B., & Jones III, J. P. (2010). *Research Methods in Geography, Critical Introductions to Geography*. West Sussex: John Wiley & Sons, Ltd., Publication.

Green, J. (2010). *Health Promotion: Planning and Strategies*. London: SAGe Publications.

Grierson, J., & Schnurr, J. (2003). *Pathways to Livelihoods and Decent Work* (Vol. 2). Ottawa: The Canadian Youth Foundation.

Grundling, J., & Grundling, I. (2005). The concrete particulars of the realities of street children. *Human Relations, 58*(2), 173-190.

Grundy, J. (2009). Health Service Access Among Poor Communities in Phnom Penh Phnom Penh, Cambodia: Ministry of Health and UNICEF Cambodia.

GSS. (2012). 2010 Population and Housing Census (PHC): Final Results. Accra: Ghana Statistical Service.

Gulliford, M., & Morgan, M. (2003). *Access to Health Care*. London: Routledge.

Hashim, I. M. (2005). Research report on Children‘s Independence Migration from Northern to Central Ghana *Development Research Centre on Migration, Globalisation and Poverty*. Brighton, UK: University of Sussex.

Hashim, I. M. (2006). The Positives and Negatives of Children's Independent Migration: Assessing the Evidence and the Debates *Development Research Centre on Migration, Globalisation and Poverty*. Brighton: University of Sussex Centre for Migration Research.

Huls, N. (2005). Access to Health. *Review Digest: Human Rights & Health*, 20-46.

IIED. (2007). Addressing the needs of urban children and adolescents. *Urban Poverty.* Retrieved 11/03, 2014, from http://www.iied.org/urban-poverty

James, A., & James, A. (2012). *Key Concepts in Childhood Studies*. London: Sage Publications.

Jones, N., & Summer, A. (2011). *Child Poverty, Evidence and Policy: mainstreaming children in international development*. Bristol, UK: The Policy Press.

KMA. (2008). A brief profile of Kumasi: The Garden City of West Africa. Kumasi: Kumasi Metropolitan Assembly.

KMA. (2010). Development Plan for Kumasi Metropolitan Area 2010-2013. Kumasi: Kumasi Metropolitan Assembly,.

Kobayashi, Y. (2004). Economic Livelihoods for Street Children: A Review *HIV/AIDS Response Team*. Maryland, USA: Development Alternatives Inc.

Kothari, C. R. (2004). *Research Methodology methods and techniques*. New Delhi: New Age International Publications Limited.

Krishnan, T. N. (2000). Access to Health and the Burden of Treatment in India: An Inter-state Comparison. In Mohan, R. (Ed.), *Disinvesting in Health* (pp. 208-232). New Delhi: Sage.

Kumasi Metropolitan Assembly. (2010). Development Plan for Kumasi Metropolitan Area 2010-2013. Kumasi: KMA.

Kwankye, S. O., Anarfi, J., Tagoe, C. A., & Castald, A. (2007). Coping Strategies of Independent Child Migrants from Northern Ghana to Southern Cities (Working Paper T-23 ed.). Brighton, UK: University of Ghana and Development Research Centre on Migration, Globalisation and Poverty.

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health, 12*(18).

Lewis, M. (2006). Governance and Corruption in Public Health Care Systems *Working Paper*: Center for Global Development.

Luiz de Moura, S. (2002). The Social construction of street children: configuration and implications. *British Journal of Social Work 32*, 353-367.

MESW, & UNICEF. (2010). National Plan of Action for Orphans and Vulnerale Children 2010-2012. Accra: Ministry of Employment and Social Welfare, Ghana and UNICEF.

Mtonga, J. (2011). *On and off the streets: children moving between institutional care and survival on the streets. Jonnathan Mtonga.* (Master of Philosophy in Childhood Studies), Norwegian University of Science and Technology, Trondheim.

Oppong, J. (2003). Medical Geography of Sub-Saharan Africa. In Aryeetey-Attoh, S. (Ed.), *Geography of Sub-Saharan Africa*. London: Pearson Education Ltd.

Panter-Brick, C. (2002). Street children, human rights and public health: A Critique and Future Directions. *Annual Review Anthropology, 31*, 147–171.

Penchansky, R., & Thomas, W. J. (1981). The Concept of Access: Definition and Relationship to Consumer Satisfaction. *Medical Care, 19*, 127-140.

Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Rahman, H. M. (2008). Poverty and Access to Health Carein Developing Countries. *Ann. N.Y. Acad. Sci. , 1136:*, 161–171.

Phillips, D. R. (1990). *Health and Health Care in the third World*. London: Longman Group UK Limited.

Quarshie, E. N.-B. (2011). *Public's Perceptions of the Phenomenon of Street children: A Qualitative Study of Students and Shopkeepers in Accra, Ghana.* (Master of Philosophy), Norwegian University of Science and Technology, Trondheim, Norway.

Ravallion, M., Chen, S., & Sangraula, P. (2007). New Evidence on the Urbanization of Global Poverty *Policy Research Paper*. Washington: The World Bank

Salisu, A., & Prinz, V. (2009). Health Care in Ghana. In Yoshimura, D. (Ed.). Wien: Austrian Centre for Country of Origin & Asylum Research and Documentation.

Sato, A. (2012). Revealing the popularity of traditional medicine in light of multiple recourses and outcome measurements from a user's perspective in Ghana. *Health Policy and Planning*, 1-13.

Smith, R. D., & Hanson, K. (2012a). *Health Systems in Low-and Middle-Income Countries: An Economic and Policy Perspective*. New York: Oxford University Press.

Smith, R. D., & Hanson, K. (2012b). What is a 'health system'. In Smith, R. D. & Hanson, K. (Eds.), *Health Systems in Low-and Middle-Income Countries: An Economic and Policy Perspective*. New York: Oxford University Press.

Thapa, K., Ghatane, S., & Rimal, S. P. (2009). Health problems among the street children of Dharan municipality. *Kathmandu University Medical Journal, 7*(27), 272-279.

The World Bank. (2011). Urban Poverty: An Overview. Retrieved 12/03, 2014, from http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTURBANDEVELOPMENT/EXTURBANPOVERTY/0,,contentMDK:20227679~menuPK:473804~pagePK:148956~piPK:216618~theSitePK:341325,00.html

Thomas de Benitez, S. T. (2003). Working With Street Children, Exploring Ways for ADB Assistance. *Regional and Sustainable Development Department*. Manila: Asian Development Bank,.

UNFPA. (2007). State of World Population 2007: Unleashing the Potential of Urban Growth. New York: : United Nations Population Fund.

Volpi, E. (2002). Street Children: Promising Practices and Approaches. . In Institute, W. B. (Ed.). Washington, D.C. U.S.A.: The World Bank.

Wang, F., & Luo, W. (2005). Assessing spatial and nonspatial factors for healthcare access: towards an integrated approach to defining health professional shortage areas. *Health & Place 11*, 131–146.

Whitehead, M. (1992). The concepts and principles of equity and health. *Int. J. Health Services, 22*, 429-445.

WSP. (2009). Guidance Notes on Services for the Urban Poor: A Practical Guide for Improving Water Supply and Sanitation Services. In Sen, G. A. (Ed.). Washington: The Water and Sanitation Program.

The IISTE is a pioneer in the Open-Access hosting service and academic event management. The aim of the firm is Accelerating Global Knowledge Sharing.

More information about the firm can be found on the homepage:
http://www.iiste.org

CALL FOR JOURNAL PAPERS

There are more than 30 peer-reviewed academic journals hosted under the hosting platform.

Prospective authors of journals can find the submission instruction on the following page: http://www.iiste.org/journals/ All the journals articles are available online to the readers all over the world without financial, legal, or technical barriers other than those inseparable from gaining access to the internet itself. Paper version of the journals is also available upon request of readers and authors.

MORE RESOURCES

Book publication information: http://www.iiste.org/book/

Recent conferences: http://www.iiste.org/conference/

IISTE Knowledge Sharing Partners

EBSCO, Index Copernicus, Ulrich's Periodicals Directory, JournalTOCS, PKP Open Archives Harvester, Bielefeld Academic Search Engine, Elektronische Zeitschriftenbibliothek EZB, Open J-Gate, OCLC WorldCat, Universe Digtial Library , NewJour, Google Scholar