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Demonstrating Agency and Resilience amidst Recurrent Health Challenges: A Case of Street Children in Kumasi Metropolitan Area

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Abstract

A substantial number of people across the globe live in extreme poverty and deprivation. With regards to children, a significant number of them especially those in the developing countries are entrapped in a cycle of poverty which has extensively limited their development. One of such groups of children includes street children who often live on the margins of major cities. Their poor living conditions constantly expose them to diverse health related risks and problems. A number of these children have however thrived on streets amidst the prevailing health related challenges. According to research, this is attributed to skills and attitude which enables them to thrive adequately. These peculiar skills and attitudes are summed up in the concepts of agency and resilience. Emphasis has lately been placed on the ingenuity these group of children exhibit in dealing with their everyday challenges such as health problems. The paper finds that, despite their poverty levels and hardships, these children showed traits of self motivation, creativity, flexibility and adaptability which demonstrated their agency. Moreover, they were able take advantage of meagre opportunities such as their limited social capital, little erratic incomes and experience on the streets to address some of their health problems by themselves. The paper thus argues that, it is pertinent for these special skills and coping mechanisms to be critically incorporated into efforts geared at the health related wellbeing of poor and vulnerable groups. This could be done through the application of appropriate participatory methods in the initiation and implementation of relevant policies and strategies to give people the opportunity to demonstrate their inherent capabilities as human beings.

Key Words and Phrases: Agency, Resilience, Health, Street Children, poor and vulnerable, participation,

1.0 Background

A significant number of people across the globe live in extreme poverty and deprivation. Poverty is an issue that bears down across generations and affects the quality of life of young and old alike (James & James, 2012). With regards to children, a substantial number of them especially those in the developing countries are entrapped in a cycle of poverty which has extensively limited their development. An increasing number of children around the world find themselves with no choice but to make a living for their own survival and sometimes that of their families (Kobayashi, 2004). One of such groups of children includes street children. Although argumentative, these children constitute one of the groups of people who come from families that have only 60% of the median national income before housing costs are met (James & James, 2012, p. 93). The phenomenon of street children is thus basically propagated by poverty as well as factors such as family unrest and disintegration and natural disasters (Kwankye, Anarfi, Tagoe, & Castald, 2007; Thomas de Benitez, 2003, 2011). With regards to health, it is argued that every aspect of children's health are affected by poverty in terms of rates of sickness and mortality; incidence of mental health problems; quality of housing and education; involvement in crime and delinquency and employment prospects (James & James, 2012, p. 93). Inadequate access to basic needs such as health, education, potable water and adequate sanitation as well as financial constrains has led to a state of weakness at the wake of constant exposure to risk among some poor children.

Street children refer to *children who live and/or work on the street* (James & James, 2012, p. 126). Broadly, the term connotes "*....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*" (Schurink, 1993 cited in Grundling & Grundling, 2005, p. 175; see also Thomas de Benitez, 2011, p. 7). Street children often live in the margins of major cities. In most developing countries, these places include public areas

like avenues, mosques, market centres and churches. Moreover, these places may serve as risky grounds for some children in terms of their health related wellbeing. In public health, risk factors are variables that predispose an individual to ill health (Catherine Panter-Brick, 2002, p. 159). For street children, the decision to leave home either voluntary or involuntary to live on the streets is in itself a risk. Due to their living conditions and places of abode, street children are confronted with recurrent health risks and problems, illiteracy, and working instead of attending school at tender ages as proposed by the global models of childhood (see Ansell, 2005; Punch, 2003). Although some studies posit that less difference exist between the health risks and problems of street and other poor children and domiciled children (C Panter-Brick, 2001; Catherine Panter-Brick, 2004), the situation and condition within which some street children find themselves aside from being a threat to their health also inhibit their ability to access health care (Ansell, 2005; Macintyre, Ellaway, & Cummins, 2002). Moreover, in the view of Klein et al. (2000) street children are more likely than their domiciled counterparts to engage in risky sexual behaviours, drug and alcohol abuse, and increased exposure to physical and psychological threats. Besides, even in situations where fewer differences in health risks and health problems between street children and other groups of children have been established, street children have been found to have greater frequency of ill health. The streets and its accompanying threats have therefore left many street children vulnerable regarding their health related wellbeing. However, these places may offer some children the space and the opportunity to pull away from extreme childhood difficulties—including poverty stricken and abusive homes and hence the need to take such risks (Adeyemi & Oluwaseun, 2012; Mattews, 2003).

However, despite the inevitable health risks and their associated frequent health problems as well as other forms of hardships on the streets, the phenomenon of street children continue to grow. While those already on the streets are not decreasing in numbers, others continue to join them. Irrespective of the fact that the condition of these children is not ideal, their existence and related livelihood challenges are real and need to be addressed (Volpi, 2002). Their situation calls for special attention and understanding in order to ensure their singular wellbeing on the streets. A number of these children have however been able to withstand the prevailing hardships. According to research, this is attributed to a number of skills and attitude which enables them to thrive adequately. These peculiar skills and attitudes are summed up in the concepts of agency and resilience which are rapidly gaining grounds in development studies. Some of these children are able to act independently and have developed skills, mechanisms and attitudes towards overcoming the negative effects of the risks they are constantly exposed to as well as coping successfully with traumatic experiences (Fergus & Zimmerman, 2005; Zolkoski & Bullock, 2012). Emphasis has thus lately been placed on the ingenuity these group of children exhibit in addressing their health problems. This paper highlights the agency and resilience of people in development process and the need to put their peculiar strategies and practicalities into perspective in development initiatives and efforts geared at their health related wellbeing. The paper uses the case of street children in Kumasi Metropolitan Area in Ghana to demonstrate the agency and resilience of people with regards to health and health care.

1.1 Agency and Resilience

The constant call for recognising the uniqueness of individuals and groups has impacted positively on efforts geared at empowering people in development initiatives. This effort has not only affected adults but also children in various societies even in developing countries. In the view of Hardman, *'children should be seen as people to be studied in their own right and not just as receptacles of adult teaching'*. This approach is a more potent means to gaining rather different perspectives—child perspectives—on their social world (Hardman, 1973: 85 cited James & James, 2012, p. 114). The term agency refers to the ability of an individual to act independently and to make their own decisions and choices. Human beings are faced with diverse forms of adversity which are tied to the social, economic, environmental and political structures of their vicinity as well as their individual life trajectories (Dyer & McGuinness, 1996). Responses to these adversities are described in terms of 'risk'—"*variables that increase individuals' likelihood of psychopathology or their susceptibility to negative development outcomes* (Goyos, 1997 cited in Boyden & Mann, 2005, p. 6) and' resilience—"*the tendency to spring back, rebound, or recoil and involves the capacity to respond and endure, or develop and master in spite of life stressors or adversity*. *Resilient individuals successfully adapt and rapidly adjust to major life events or to chronic stressors*" (Garmezy, 1991; Werner, 1990 in Mandleco, 2000, p. 99). Thus, people only show resilience in the presence of risk factors. However, with the help of viable factors, they are able to produce positive outcomes and reduce or avoid negative outcomes. The concept therefore trades on strengths instead of negative outcomes (Fergus & Zimmerman, 2005). In the field of health, it means positive outcomes in spite of exposure to health risks. Resilience indicates the possession of several skills, in varying degrees, that help a person to cope with prevailing risks and challenges. Resilience communicates how individuals, families and communities cope, adapt and take advantage of their available resources when facing significant acute or chronic stress, or the

compounding effect of both together (Michael Ungar, 2012, p. 387; Zolkoski & Bullock, 2012). Resilience therefore explicitly expresses people's agency.

Resilience promoting factors are grouped into assets and resources (Beauvais & Oetting, 1999). Assets refer to the individual internal competencies, coping skills and self efficacy. Resources are however factors that are external to individuals including parental and family support and community organisations (Fergus & Zimmerman, 2005). In the case of street children, the presence of peers and other adults who they *bond*, *bridge or link* (see Amoah, 2014; Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006; Rigg, 2007) with on the streets with time generate the needed support for their resilience. For instance, a study in Addis Ababa indicated that, street children do show resilience in the face of diverse health problems through their social networks on the streets (Kassa, 2008). Moreover, cross-cultural research and international studies have revealed that, the meaning of risk and even adversity are culturally and contextually dependant. In this wise, understanding how people adjust and adapt to risk and adversity whether positively or mal-adaptation should be socially and culturally appreciated (Bottrell, 2009). For instance, in his work with 'troubled teens', M. Ungar (2004) asserted that, street children may see deviant lives as favourable factors that enable them to cope even under unhealthy circumstances. Thus, indulgence in 'disordered' or 'delinquent' activities, places and relationships including substance abuse, street culture, renouncing of families, and involvement with 'negative' peer groups are rather how some children find wellbeing, belonging, comfort and power (Adeyemi & Oluwaseun, 2012; Bottrell, 2009). Negative labelling rather motivates some children in difficult circumstances to forge resilient identities. Street children are commonly identified as children at 'risk'. However, it is understood that, in the face of adversity, many of these children have shown a great deal of resilience even than children that experience lesser risk by drawing on various conventional and unconventional methods and experiences to address their problems (Abebe & Bessell, 2011; McAdam-Crisp, Aptekar, & Kironyo, 2005).

Resilience thus comes with some critical attributes. Firstly, resilience entails re-bouncing and carrying on. Resilient people should and are able to get back to their lives or maintain high level of flexibility to take new paths in their lives in the face of adversity. The sense of self—a balanced perspective of one's life and experiences also accounts for how resilient people are. A hallmark of resilience therefore entails appreciation and acceptance of one's previous and current situation which serve as platforms to forge positive attitudes. Children that show resilience are therefore characterized by the traits of self motivation, creativity, flexibility and adaptability and are more proactive in solving their life problems (Mandleco, 2000). Resilience is also identified with the trait of determination. Resilient people irrespective of challenges persevere to achieve life goals. Obstacles should be viewed just as other life hurdles that have to be crossed. Resilient children for instance tend to be generally positive in their activities and put their abilities to good use whilst acknowledging their limitations. Owing to their personal attributes such as age, gender, and nature of physique, some children are able to endure painful and difficult situations constructively which give them experiences for survival (Mandleco, 2000). Aside from this, resilient children also show mental preparedness for adversity—a sense of having overcome one situation hence a possibility of mastering other situations and ultimately development of effective coping mechanisms (Dyer & McGuinness, 1996). Moreover, people's ability to overcome constraints by staying organised as well as their skills may not stem from only their capacity but also through collective self-help and even political action as well as prevailing structural and external conditions (see Giddens, 1984) that shape childhood and the way people do things. Individual agency is thus also a product of wider social forces. People's social ties and connection also play key roles in their resilience (Amoah, 2014; Jones & Summer, 2011; Perry, Williams, Wallerstein, & Waitzkin, 2008; Tusaie, 2004). Resilience is thus characterized by pro-social attitude. With regards to social capital, resilience requires an ability to deal with and tolerate other individuals and groups irrespective of their backgrounds. It is argued that, people who demonstrate resilience are socially skilled, socially responsive, demonstrate high level of tolerance and mix well with most people. In some contexts, these people based on religious beliefs and faith—a sense of coherence and rootedness and a conviction that things will turn up well in the end despite unfavourable odds, are able to withstand harsh circumstances (Dillen, 2012; Fergus & Zimmerman, 2005).

With regards to children, it is argued that their agency is generally exercised in the domains of the every day and personal situations. They are thus less likely to exert agency that is strategic and political, although they can do it with the support of adults through the supplements and extensions they may provide to the children's agency (Jones & Summer, 2011, pp. 19-20). Moreover, people's ability to remain resilient may also be as a result of over optimism against prevailing risks and problems (Sjöberg, 2000). It is therefore pertinent not to romanticize too much on the agency and abilities of street children while forgetting the fact that their existence is linked to prevailing social forces and perceptions which must be appreciated in order to understand how children survive even harsh conditions (Truong, 2010).

1.2 Agency and Resilience: A Health Care Perspective among Street Children

1.2.1 Methods

This paper is taken out of a broad study to explore the health related problems of street children. The study aimed at appreciating how the health related problems of street children are addressed through the efforts of the children themselves and the prevailing social structures. The data was gathered from Kumasi Metropolitan Area in Ghana. Kumasi is the second largest city in Ghana in terms of population with over 2 million people (GSS, 2012; KMA, 2010). In addition to its infrastructural base and its dominant informal commercial activities, Kumasi is strategically located at the central part of Ghana. Its location and economic activities make it more physically accessible and hence serves as a home for many commuters who seek greener pastures (Amoah, 2014; Edusei & Amoah, 2014; Kwankye et al., 2007).

Owing to the complexity and the descriptive nature of the information required for the study, the study used a number of qualitative data collection methods to gather data. The aim of this paper was not to measure people's (children) agency and resilience but to gain in-depth understanding of their unique personal and socio-economic characteristics/attitudes that enable them to withstand the harsh conditions (Bryman, 2008). The approach helps to get to the grips of people's health worries by engaging with them at length (Gatrell & Elliott, 2009). The study used mainly purposive and snowballing sampling techniques to select participants with direct reference to the research objectives/questions. Data were gathered from these people using in-depth interviews, two focus group discussions (consisting of 6 members balanced in terms of gender) and both participant and non-participant observation methods (see Bryman, 2008for details on these techniques). Using semi-structured interview guides, a total of 15 street children (consisting of children who had not had any contact with neither their family nor guardians for at least the 3 months prior to the interview. The children were aged from 13 to 17 years as these children were relatively more matured for the kind of data required for the study. None of the children had even completed basic education. Ten of them were primary school drop outs while 2 of them had never been to school. Contacts were made with street children from 6 neighbourhoods in the central business district of the Metropolis including: Pampaso area; Aboabo (station) and Asafo (market area), Central Market area, Kejetia and Adum. It is worth noting that participant names used in this paper are pseudo names which were adopted together with the children during the fieldwork as a way of protecting their identities. Eleven key informant interviews were conducted. The constituents of the key informant interviews are depicted in table 1.

Table 1: Participants of the Key Informant Interviews

Number	Key Informant	Number
1	Medical Officer (doctor)	1
2	administrator of Kumasi Metropolitan Maternal and Child Health Hospital (Children's Hospital)	1
3	Health assistant	1
4	Licensed chemical sellers	2
5	Representatives of Metropolitan Social Welfare Department	2
6	Metropolitan Health Directorate	1
7	Representative of Centre for Development of People (CEDEP) (NGO)	1
8	Representative of Street Children Project (NGO)	1
9	The Regional Director of Department of Children	1
	Total	**11**

Source: Field Work, July, 2012

These resource persons gave vital information to understanding the unique health related behaviour and choices of the children.

1.2.2 Resilience and Health Related Wellbeing on the Street

Many of the primary participants exhibited a great sense of awareness and knowledge about social and cultural practices which reflected their agency (see Giddens, 1984; Catherine Panter-Brick, 2002). The participants were faced with constant health risks and problems which they contended with, with each passing day (see also Catherine Panter-Brick, 2002). While some of the problems were taken to hospitals or clinics or pharmacies or self treated (see section 1.2.3), others were ignored and/or treated as not critical. Conversations with the participants revealed that, many of the children had developed a positive attitude towards their situation (see also Dyer & McGuinness, 1996). The majority of them therefore treated every livelihood problem and even physical health problems as normal challenges that every human being faces*: "They endure pain a lot! I mean...they*

overlook most of the diseases an ordinary person will take seriously" (Physician, Metropolitan Children Hospital). In fact this was the more reason why dangerous games and bad foods were often perceived as *'just'* games and food. Others ignored some health issues especially minor cuts and wounds: *"...I have a special body. Whenever I have a cut, it heals without treatment. Look at this one (indicates a healed cut on his scalp), it healed by itself. I did not have to do anything to it"* (Sampson, 13 year old boy). Similarly those that had contracted skin rashes, some of which they affirmed itched and made them uncomfortable were able to without treatment, live with the inconvenience and went about their normal duties as summarised in the words of Rahi (17 year old girl): *"I cannot afford to stay at home for every small illness.... I need money to buy food everyday and to pay for the place I sleep so I always strive to work....I only rest when I am severely sick"*. The children had therefore developed *a positive mental attitude* towards their conditions which partly explains their continual stay on the streets despite the inevitable health threats as established by Kwankye et al. (2007), Amury and Komba (2010), and Amoah (2013). To some extent, this was also an expression of their agency.

Their resilience moreover depended on their length of stay on the street. The long term exposure to the harshness had instigated some of the children to adopt special coping mechanisms. Those that had stayed longer on the streets were more adaptive to their conditions both mentality and especially physically. For instance, having lived on the streets for over two years, Kwaku (15 year old boy) stated: *"I have a good stomach. I don't get sick no matter the type of food I eat....I can eat everything. Some of my friends are very susceptible to things I can eat.....They easily fall sick when they eat some of the food I eat"*. However, when he was asked about his early days on the streets he conceded otherwise: *''...ok, when I arrived at first, I had stomach ache and sometimes I vomited whenever ate leftover foods"*. Many of the children also confirmed the fact that they were more vulnerable to many of the prevailing health risks in their early days on the street as compared to their present condition. In a related study in Addis Ababa by Kassa (2008), when participants were asked if leftover foods will not get them sick? One of children responded as: *"...how does food make you sick?"* (Kassa, 2008, p. 55). Indeed, the perception and attitude depicted by this statement is the more reason why many of the children undermined the negative effects of habits such as eating leftover foods and food scraps in market places. Many of the children had therefore developed immunity and robustness against many of their health risks and health problems especially illness such as malaria and its vector as a result of the long stay on the streets as confirmed by the participant physician (see also Cross, 2004). Many of the children especially the males often slept neither with blankets nor appropriate jackets without complain. For instance, when two boys who prepared to sleep were asked why they did not use any blanket or jackets, one of them responded as*: "...blankets? It is not necessary...Someone will even steal them in the course of the night.....my shirt is enough for me...I am not scared to feel cold (laughs)*" (Appiah, 14 year old boy). Although many of them admitted to have caught cold due to lack of proper sleeping arrangements, their attitude and response towards the situation however reflected a sense of flexibility and adaptability in view of their condition. Their quest to survive for their own wellbeing and sometimes that of their younger ones was paramount with respect to their health related risks and plights. The need to show maturity and dependability made their agency and resilience which might have been inhibited by domiciled lives blossom. They had learned to do without the little pleasures of childhood (see UNICEF, 2005) and even some necessary livelihood assets. Thus, the agency and resilience of the children were explicitly expressed by their experience on the streets and other livelihood challenges. Moreover, their ability and willingness to develop these coping attitudes overtime is a strong indication of their ability to act independently.

Their positive attitude towards their situation was also demonstrated by their view on health risks emanating from their physical environment as well as their religious orientation. For instance, despite the constant exposure to polluted air due to unkempt physical environment and fumes from numerous vehicles, many of them remained positive towards their condition as ensued in the conversation below:

> ***Question (Interviewer):*** *"....but don't you think the bad smell from the gutters and fumes from vehicles are harmful to your health"?*
> ***Response:*** *"...the smell is bad but everyone here breathes the same air.....it is not us alone....I know God protects us...."* (Appiah, 14 year old boy).

Appiah's account above represented the opinion of many of the children. They generally accepted the harmful nature of their places of abode. However, many of them after long stay and experience on the streets had developed a positive attitude towards their adversities. Moreover, religious affiliations and belief system is said to be one of the key factors which make people resilient (see Dillen, 2012; Fergus & Zimmerman, 2005). It has been evidenced that such belief systems aid in positive attitude even in difficult periods (see also Dillen, 2012; Gunnestad & Thwala, 2011). The last part of Appiah's response—*"...I know God protects us"*, supports this assertion. Based on personal and religious beliefs, some of the children remained hopeful, calm and realistic

about their situation assuming that all will be well with them irrespective of the adversities they faced. Such religious resilience is moreover common among many poor and vulnerable children in Sub-Saharan African as evidenced by the work of Gunnestad and Thwala (2011) in southern Africa. His entire response also shows that, the children's decision to live on the streets was critically analysed. They demonstrated a great sense of awareness of the socio-demographic and economic composition of their environment. They lived alongside the various socio-economic activities where they could constantly interact with other people who went about their everyday activities both as a form of protection and a means to earn a living.

Moreover, agency and resilience was also demonstrated by how they managed to survive the harshness of the streets given their very limited resources:

> *"...I used to eat fun yogurt (a type of ice cream) everyday but now I have stopped. I realised that it not good for my health and I spent too much money on it"* (Kwaku, 15 year old boy).
>
> *"I do not buy expensive clothes, my most expensive cloth cost GH¢ 1.00 (about $ 0.35). There are places, and times especially in the night when we can get second hand clothes at cheaper prices [Kwaku quickly jumps in: it is true, one time I bought two shirts for GHp20 (about $0.1)]* (Sampson, 13 year old boy).

The children therefore lived in a way that their meagre resources would suffice their basic and most pressing needs. They thus showed a sense of rationality with regards to their condition by prioritizing their needs with respect to their resources. However, some of their methods were too extreme and health deteriorating: *"....they hate to spend their money...If only they could survive without food, drinks and other basic needs,...I think they would never spend on food and not to even talk about health care"* (Health Officer, SCP). They were therefore adamant on earning erratic incomes irrespective of the health consequences of their decisions and methods (see Fergus & Zimmerman, 2005). To the children, these choices were however made as result of strategies to make their resources suffice and not to directly compromise their health care needs as a significant number of them protested. Moreover, this is not to say that they were self sufficient as many of them could hardly afford one square meal a day by themselves. Their ability to prioritize their resources however attests to their sense of adaptability, internal competencies and self efficacy towards their situation which needs to be considered in the planning and implementation of programs and projects which affect them. Thus, despite being young, they were able to embrace the realities of their lives including all the adversities they faced to enact strategies to survive the street (Boyden & Mann, 2005).

The children had therefore developed *street smartness*—skills and ideas that enabled them to cope with and consciously take charge of their lives despite the harsh conditions they faced (Boyden & Mann, 2005). However, to a larger extent, their resilience and 'smartness' could also be attributed to their *unrealistic optimism* towards their condition which should not be misconstrued as total control over their situation (Sjöberg, 2000). Hence, the opinion of Truong (2010), that the children's ability to withstand the harsh conditions should not be over-romanticised to the extent of ignoring their needs and potential interventions to aid their development.

1.2.3 Self Treatment of Health Problems: A Demonstration of the Children's Agency

The culture of self treatment of illnesses and injuries was a common practice among the children as they sought to address their health problems. Street children face numerous problems in accessing health services. Factors such as financial constraints and unaccommodating environment in some health related facilities inhibit the ability and viability of accessing health services among the less privileged especially those in developing economies (Edusei & Amoah, 2014). For this reason, many of these children often attempt to diagnose and treat their ailments themselves using either traditional or western medicines (see Abt Enterprises LLC, 2001; Kassa, 2008).

Based on their Knowledge and capability as social actors and independent people, the majority of the children knew of some basic treatment methods and medications methods of treating some common ailments. They often had their knowledge from their friends, their adult friends on streets, their guardians/parents when they were at home as well as through advertisement of some of these drugs and treatment routines on television and on radios. Acquisition of drugs unlike in many western countries is less restricted in Ghana. People can acquire all forms of drugs even those that require prescription from certified medical officers (Oppong, 2003; Salisu & Prinz, 2009). This situation therefore encourages the act of self treatment/medication which many ordinary citizens patronised. For instance, the commonality of self treatment in Ghana was confirmed through the interview with the physician at the Metropolitan Children's Hospital who iterated that *".....about 80% of Ghanaians can diagnose*

and treat malaria correctly". Moreover, their sources of knowledge for self treatment also reflect the fact that irrespective of their situation, street children still maintain a pro-social attitude and skills which also demonstrates their agency.

The majority of the children therefore treated less acute/critical illnesses and mild sprains and cuts by themselves. Orthodox drugs for illnesses such as malaria/fever, cold, headache, body pains and mild stomach aches such as paracetamol (for pains, headaches), Efpac (for pains, fever/malaria), Procold (for cold/flu drug), Magnesium Trisilicate tablet BP (for stomach upsets), were well known to many of the street children. Some of these children were therefore able to request for specific drugs over the counter after self diagnosis. Although they sometimes misdiagnosed and bought wrong drugs, their initiatives towards treating themselves attest to their agency and strive to remain resilient. Their eagerness to treat themselves is also demonstrated by the fact that, this group of people hardly access high order health services such as hospitals: *"....for this category of children, we hardly see them here. They come here usually because of severe injuries. For other diseases, they treat themselves. I have met only two of them here who came in with problems.... which were severe''*. (Medical officer, Children's Hospital).

Moreover, some of them used herbs and various kinds of spices to treat their illnesses. For instance, some of them chewed bark of mango trees for diarrhoea, fever and headache; lime juice was also used for stomach ache. Others also chewed *hwentia* (grains of selim seeds) for headache and cold/flu. The chewing of ginger in addition to sugar was moreover one of the most popular drugs for the treatment of cough. Others also drank *sobolo* (a drink made with hibiscus leaves) to prevent and treat fever/malaria. Charcoal was also used for stomach upsets such as nausea and pains. While some of them chewed pieces of charcoal, others grounded it and mixed in water.

> *"...Whenever I have headache or fever, I just find a small piece of the bark of mango tree to chew. It tastes sour but it is very effective.....whenever you (referring to the interviewer) have diarrhoea or headache give it a try" (Sampson, 13 year boy).*

The majority of these items owing to closeness of market centres were physically accessible and sometimes came at no cost as some of the species such as ginger and grains of selim seeds which are usually for sale were even obtained for free from market women and sometimes as leftovers at market centres. Furthermore, treatment of cuts and wounds were often done using common traditional methods and materials. All of them used one or more of bandages, methylated spirit, penicillin cream and pills and gentian violet. As part of common social practice, some of them randomly used warm water to clean their wounds before they applied any form of medicine. Upon recognising the children's need for warm water both for bathing and for treating their wounds which the children could not make by themselves, some adults (mainly women) had made a business out of it by making warm water for sale.

> *"I have spirit (methylated spirit) and gentian violet.... Whenever I get a cut, I rub it with spirit and then I apply some gentian violet and cover with bandage" (Musa, 17 year old boy)*

> *"When I get wounds, I usually clean it with warm water which I have to buy and then I apply 'shiikuro' (penicillin cream).....It always work for me (Julia, 16 year old girl)*

In a similar vein, mild sprains were also treated mostly by applying locally prepared/herbal ointments and then applying bandages to keep them in position. These findings are also confirmed by a similar study in Accra, Ghana. In his study, (Anarfi, 1997) found that about 80% of his participants treated themselves while only 6% and 4% did nothing or visited the hospitals respectively. Besides, similar occurrence has also been witnessed in a related study in Addis Ababa where the children used similar spices and methods to address their health problems (Kassa, 2008). The children's ability to treat themselves and their knowledge on these treatment and prevention methods which they gain through social interactions shows that they could be active participants in decisions. It is worth noting that almost all the children found their methods for addressing their injuries effective and most importantly cheaper for them.

Self treatment was therefore a common culture among street children and even other poor and vulnerable people. Their ability to live on the street was thus a manifestation of their toughness, flexibility and willingness to survive on their own. Many of them especially the males strived to stay strong even with inconvenient health problems as a way of expressing their resilience to their comrades. Self treatment instead of visiting clinics or hospitals was therefore a means of maintaining their dignity and avoiding a stigmatising label by their colleagues who might see them as weak.

1.3 Conclusion

A number of well documented cases demonstrate the willingness and ability of the poor to create and/or manage their own services (WSP, 2009, p. 5&19). Moreover, issues relating to health are more often very complex to comprehend and address. Factors considered in assessing and addressing health related issues tend to differ greatly between different socio-economic and cultural contexts. Moreover, assets and resources that assist people to overcome adverse effects of risks differ according to the population studied, context, and outcome (Fergus & Zimmerman, 2005; Zolkoski & Bullock, 2012). It is pertinent that all plausible avenues are explored in order to initiate adequate policies and strategies to improve the health related wellbeing of a given people within a given population. The concept of resilience presents "*an unevenly distributed variable of behavioural and emotional functioning that enables children and young people (and adults) differentially to cope with, and adapt positively to, adverse circumstances and experiences, thereby ameliorating of various degrees their negative effects and enabling positive adjustments to be made even in conditions of risk*"(James & James, 2012, p. 99). However, it has been argued that resilience may not necessarily always result in 'positive' outcomes as the definition of whether an outcome is negative/poor or positive is often subjective and context dependent (Wexler, DiFluvio, & Burke, 2009). This assertion is particularly proven in the case study above where some of the methods adopted by the children were [potentially] harmful to their health rather than making them healthier. However, regardless of the outcome, the willingness of these children to strive for the best amidst the numerous health related risks and problems indicates their agency—something that should not be ignored in efforts to improve the livelihood of not only street children but also all other people especially the poor and vulnerable in societies.

Poor health and safety outcomes, including chronic disease, traffic-related injuries, mental illness, substance abuse, teen pregnancy, and violence, are disproportionately high among low-income people around the globe especially those in developing countries (Prevention Institute 2003). Street children just like many other poor and vulnerable groups are in dire need of potent health related strategies backed by commitment to implement these strategies. Moreover, their willingness to survive on the streets despite the hardship as well as their strategies in dealing with these hardships should be considered in every effort for their wellbeing. Owing to their kind of life and the places they live, street children and other urban poor groups such as those living in slums and households living below the poverty lines should be encouraged to incorporate preventive health measures in their daily activities. Having to take charge of their own survival, and their need to remain resilient in order to last in the harsh conditions coupled with the need for them to stay healthy, poor groups such as street children will be more willing to adopt such health promoting ideas when they are effectively introduced to them. Studies show that resilient factors can counteract the negative impact of risk factors and that effective approaches need to include attention to both (Prevention Institute 2003). It is further contested that, research on resilience has the potential to guide the development of effective interventions for diverse at-risk populations. As seen in the case study, the concept of resilience offers researchers and practitioners a conceptual model to understanding how especially children and youth overcome adversity and how this knowledge can be used to strengthen and build positive characteristics of their lives (Zolkoski & Bullock, 2012, p. 2301). It is thus imperative that policies geared at addressing the health related problems of the poor and vulnerable such as street children include indications of their resilience which also express their agency. This may take the form of effective and applicable participatory methods [such as local initiatives and interactive and self-mobilization] (see Mikkelsen, 2005) in the initiation and implementation of such policies and strategies. These flexible platforms will give people the opportunity to express their views which also represent their resilience and ultimately, their agency as human beings and citizens of a given geographical context.

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