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# Street children: our health and coping strategies when we are sick

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**Abstract**
Millions of street children in both developed and developing countries are left to survive on their own. They are ill-treated, half-starved, ruthlessly abused, exposed to the elements of nature, socially deprived and abandoned and denied affection, education and assistance. Street children often arrive in this dead end with poor health generally. This accrual, in combination with the inconsiderate circumstances of street life, soon contribute to the child's lowered immunity, morbidity, ill health and eventually, the child's exposure to health problems. Street children are one of the new categories of social actors resulting from the rapid urbanisation of cities of the South. Among the numerous problems they have to face daily, there are also obstacles related to disease and access to healthcare. This was a qualitative study conducted from late October to November 2014, on the streets and in market places of Accra. The sample size was fifteen (15) street children selected using a non-random snowball sampling technique. The findings on the diseases that the street children experience by living and working in the streets of Accra such as injuries and minor accidents could be due to the nature of their work and the environment (hawking goods on the busy streets of the city and carrying heavy loads. The findings of the study indicate that the health conditions of working street children are miserable and majority of the available health services are out of reach of street children and there are multiple obstacles faced by street children in accessing health care services. Various strategies should be applied in bringing about a social change, a major one being "Empowerment". This can be achieved through activities aimed at providing better economic opportunities through improved vocational and other skills leading to *'economic empowerment'* of the child and improved savings skills.
**Keywords:** street children, health, coping strategies, city, Accra

## 1. Introduction

Street children are one of the new categories of social actors resulting from the rapid urbanisation of cities in developing countries. Among the numerous troubles they have to face daily, there are also obstacles related to disease and access to healthcare (Pradhan, 2006).

The definition of street children adopted by this paper is that of children under the age of eighteen (18) who spend most of their life on the streets. There are those who live permanently on the streets "children of the street" (Rumbidzai and Bourdillon 2003). These live and earn their 'living' on the streets. There are also those who earn their living on the street but do not necessarily live on the streets. These spend most of their time on the street but usually return to some form of a 'family' unit where there is some kind of supervision or control. This group includes an increasing number of school children that spend most of the day on the streets. All these are considered as street children by this study.

Millions of street children in both developed and developing countries are left to survive on their own. They are ill-treated, half-starved, ruthlessly abused (Levenstein, 1996), exposed to the elements of nature, socially deprived and abandoned (Lugalla & Mbwambo, 1999) and denied affection (Foster, 2000), education and assistance (Boukhari, 1997). Street children often arrive in this cul de sac with poor health generally. This accumulation, in combination with the inconsiderate circumstances of street life, soon contribute to the child's lowered immunity, morbidity, ill health and eventually, the child's heightened vulnerability to health problems.

According to Lugalla and Kibassa (2003) the copious and frequent illness episodes street children are confronted with, are the result of their living conditions and of various behaviours adopted by them. Matters giving disease to street children include mosquitoes, food found in garbage places, meals poisoned or picked up in the streets. The children have to sleep on the street, in other words, the consumption of unsanitary water, unhygienic conditions, food, violence, alcohol and drugs have disastrous consequences on the health status of the children and result in various and frequent health related problems).

Health problems are major problems of street children in Ghana. Streetism exposes the children to a lot of health problems and other hazards. The children work in unhealthy environments and they are also vulnerable to defilement. Sexually transmitted diseases such as HIV/AIDS, Syphilis and gonorrhoea as sexual abuse becomes a reality. Aside these, those who sell on the streets stand the risk of being run over by moving vehicles. Moreover, teenage pregnancy is also a major problem of street children in Ghana. Teenage girls are often lured and raped by irresponsible men on the streets. Those who become pregnant in the process and are unable to cater for the needs of their children, end up offering sex for money (Anarfi, 1997).

In this paper, we discuss the issue of street children with reference to their health coping strategies. It is a known fact that disease and poverty together form the perfect mix of circumstances for physically, socially, and financially deprived living conditions. The constantly escalating numbers of children who are forced to work on the streets either to look after their households or simply to survive clearly demonstrate this. This study purports to look into the health coping strategies of street children, with a focus on where they go for health care in times of sickness. We discuss that, in the majority of the cases, there is evidence of the children in the streets of Accra indulged in self medication which they normally purchase from chemical hawkers in the markets and lorry stations.

## 2. Methods

This was a qualitative study conducted from late October to November 2014, on the streets and in the makola market of Accra. The sample size was fifteen (15) street children selected using a non-random snowball sampling technique. A total of twenty three (23) children were approached and the purpose of the study was explained to them in detail.

The sample size comprised the individual children who fully understood the purpose and gave verbal informed consent. Out of the fifteen (15) children selected for the study, nine (6) were working and living on the streets full time while the remaining six (9) belonged to the group of children of the streets, who have some kind of family units they return to at the close of day. When the interviews started with the participants we felt that, based on similar situations, the study achieved data saturation at fifteen (15) interviews. Other factors which also governed this number were the resources that were available to the researchers, as well as time constraints.

In addition, three (3) in-depth interviews were conducted with key informants, who were adult men and a woman who had spent their childhoods working on the streets. The purpose of these interviews was to discuss the sensitive issues of sexual abuse and substance abuse, which were deemed inappropriate to be discussed with the study participants

The data was collected by a team of interviewers; comprising of two research assistants. There was one supervisor who coordinated the activities of the team members. The team was provided with transport and communication facilities. The purpose of the study was very well explained to the participants and all their concerns and fears were addressed. They were assured of the confidentiality of all information that would be provided. Those who finally agreed to participate in the study were asked to give verbal informed consent; the low literacy level of the study participants was acknowledged. The data was collected using an unstructured interview guide.

Each interview took around 45minutes to 1hour. The interviews were audio taped wherever permission was granted. The audiotapes were transcribed within seven (7) days of the initial interview. The tapes were destroyed twenty (20) days after the interview. Key themes were identified and discussed after manual thematic content analysis was conducted.

### *2.1 Ethical considerations*

Informed consent was sought from the parents/guardians of eight (8) of the participants. The remaining seven (7) consented after extensive explanation of the research process.

For the children who had family contact, our first aim was to obtain verbal informed consent from a parent or care-giver. In cases where this was not possible, informed consent was sought from the participants themselves. Great care was taken to include only those children who consented and we took the information part of the informed consent very seriously. All the children were repeatedly told the purpose and methods of the study. Great care was taken to exclude those children who either failed to understand the purpose of the study or did not consent to the study.

The final result is a description of the phenomenon, as seen through the eyes of the people who have experienced it firsthand. To protect the identities of our children participants we did not use their real names.

## 3. Results

### *3.1 Demographic Characteristics*

Out of 15 participants, nine (9) were boys and six (6) were girls, representing 60% and 40%, respectively. The age composition show that 53% of the participants were between 7 to 12 years of age, 27%were also between 13 to 15 years old, while 20% were between 16 to 18 years.

Out of the fifteen (15) respondents, 67% had exposure to formal schooling at the very basic levels (primary and Junior High School), while thirty two (33%) had never attended school. Most of the study participants had Northern ethnic origins (53%), followed by children with backgrounds from neighbouring countries (27%), with the remaining children coming from other ethnic groups from the southern parts of Ghana (20%). Average time spent on the streets by these children was 7.5 years, and the average daily income was 2 USD/day. About 50% of the respondents had six (6) to 10 siblings.

*3.2 Initiation onto the streets*

Majority of the participants had been exposed to life on the streets in their early years. The average age of initiation of street life was 6years. Most respondents maintained some level of contact with their families and were forced onto the streets due to financial difficulties at home. One of the kids had to say:

> *'I have been selling and doing other things in the streets since I was five (5) years old; I am now fourteen (14) years old. My mother died when I was four (4) years old and my elder brother was twelve (12) years. My father brought another woman into our home, the woman was very wicked she refused to give us food; she beat us at the least provocation, we worked so much we were always late to school so one day my elder brother suggested that we run away from home to the city. He was sure that we would find jobs and would not have to go to bed on empty stomachs. I obliged and since then we have been in the streets doing whatever can give us money to buy food'.*

*3.3 Economic activities of street children that expose them to diseases/illness*

Table 1: Dangerous economic activities of street children

| **Activities** | **Absolute numbers** |
|---|---|
| Hawking | 8 |
| Begging | 5 |
| Carrying head luggage/load | 5 |
| Scavenging | 2 |

Children in the streets of Accra are found to be engaged in various economic activities. Table 1 presents data on some of the income earning activities of the participants that expose them to illness/diseases. Hawking in the busy streets of the city was the commonly cited economic activity by the street kids. More than half (8 out of 15) of the kids were involved in hawking. A significant number of the kids (5) were engaged in carrying loads (head porters; however, there were more girls involved in the head porter business) in the market places and lorry stations that were covered by the study. Begging was identified as one of the dangerous activities that the street kids were engaged in. The study found that some of the kids (2) were also engaged in scavenging.

*3.4 Common diseases of street children*

In order to assess the health practices and coping strategies of the street children, it was relevant to know the diseases and illnesses the street children suffer from. Thus the children were asked whether they had been sick during the past four (4) months and also to describe the disease they had suffered from. The findings are presented in Table 2 and 3 below;

Table 2: Children who took ill during the past four (4) months

| **Response** | **Absolute Numbers** | **Percentage (%)** |
|---|---|---|
| **Yes** | **14** | **93** |
| **No** | **1** | **7** |

The results in Table 1 indicates that almost all (93%) the street children that participated in this study suffered from diseases or illness during the past four (4) months. One of the street kids pointed out that;

> *Most of the children you see in the streets don't have homes that we go back to after working all day in the streets; we are exposed to mosquito bites and bad weather. Sometimes the bigger boys in the streets also beat us up badly to the point of even sustaining wounds on our bodies. We are always experiencing one medical problem or the other; anyway, they are not serious ones so we ignore them.*

Type Table 3: Types of disease experienced by street children

| **Disease type** | **Absolute Numbers** | **Percentages (%)** |
|---|---|---|
| Headache | 15 | 100 |
| Body ache | 15 | 100 |
| Minor accidents/injuries | 12 | 80 |
| Stomach ache | 10 | 67 |
| Malaria | 9 | 47 |
| Diarrhoea | 4 | 27 |
| Fever | 3 | 20 |
| Tooth ache | 2 | 13 |
| Cold | | |
| Boils | | |
| STDs (Gonorrhoea, HIV/AIDs etc) | 2 | 13 |

Results presented in Table 2 show that all the children who participants in this study suffered from headache (100%) and body ache (100%) during the past four (4) months. 80% and 67% of the children interviewed

 

suffered from minor accidents/injuries and stomach ache respectively. 47% also experienced malaria during the past month.

*It needs to be stated that the study did not do medical test to ascertain what diseases the street kids suffered from during the past four (4) months. These findings were only based on the oral post mortem approach.*

### *3.5 Health seeking behaviours/coping strategies*

In examining the health seeking practices and coping strategies of street children in Accra, the participants asserted that they employ various strategies to deal with diseases and illnesses they experience in the streets. The coping strategies/health seeking practices of the street children are presented in Table 4 below;

Table 4: Health practices/coping strategies of street children

| **Actions taken** | **Absolute Numbers** | **Percentage** |
|---|---|---|
| Hospital | 2 | 13 |
| Buying medicine/self medication | 13 | 87 |
| Herbalist | 12 | 80 |
| Treatment by friends | 5 | 33 |
| Sleeping off the sickness | 4 | 27 |

Buying medicine from the chemist and the medicine hawkers at the lorry stations is the most common means of seeking treatment when street children become sick. One of the children had this to say;

> *Whenever I feel sick/pains in any part of my body I buy medicine from the people who sell medicine to passengers/travelers here at the lorry park (she is a porter at the Tema station in Accra). I complain of my sickness to the medicine man then he gives me something to kill the pain.*

Also, sometimes other street kids offer their colleagues medicine they have from the last time they were sick. Another kid in the street pointed out that;

> *The last time I fell ill, Marcus gave me malafan and paracetamol he had from the last time he was sick; he did not use all the medicine he bought. Thus I did not buy medicine when I had malaria two (2) months ago.*

Data suggest that twelve (12) out of the fifteen (15) participants visited herbalists in and around the market place where the children work. One of the street kids interviewed pointed it out as follows;

> *Mostly, we prefer to use herbs when we are sick. There are people in the market who sell the herb to us. Once you tell them about your condition; they would give you some herbs to use. We like the herbs because they are cheaper and very effective. We sometimes take it even when we are not sick; we do this to prevent falling sick.*

Also, the study found that some of the street children (13%) went to the hospital when they took seriously ill and some further indicated that they sleep off their sicknesses due to weakness and inability to buy medicine or go to the hospital.

### *3.6 Challenges of accessing healthcare from health services*

The street kids face a lot of bottlenecks in accessing formal healthcare services like the hospitals. Below in Table 5 is presented the challenges street children face in accessing healthcare services.

Table 5: Why we take actions

| **Action** | **Reasons** | **Absolute Numbers** | **Percentage** |
|---|---|---|---|
| Hospital/clinic | Seriously sick, effective service | 2 | 13 |
| Purchasing medicine | Cheap, proximity, saves time, effective | 13 | 87 |
| Herbalist | Cheap, saves time, effective | 12 | 80 |
| Sleeping off the sickness | No option, no money | 4 | 27 |

The survey designates that the street children who go to the hospital resort to this action involuntarily in most cases; it is normally not the first option for them. They reported to the clinic when they were seriously sick. This was validated by one of the key informants from the in-depth interviews conducted.

> *Normally, we rush them to the clinic when they are seriously sick and we find them very weak. Some of them even collapse while working so we rush them to the clinic for treatment.*

Additionally, one of the street kids had this to say;

> *I prefer to buy medicine from the medicine seller at the station/market or some herbs from the herbalist in the corner there (he pointed to a place near where we were having the interview) when I am not seriously sick I don't like going to the clinic because it is expensive to access the clinics and it is also time consuming.*

Findings further reveal that most (87%) of the children bought medicine from the chemists or the medicine hawkers. It is a cheaper option as compared to going to the clinic. The study also found that street children prefer spending their time making money to feed to spending the time in the clinics where they meet very long queues.

For instance a twelve (12) year old girl had this to say;

> *I like buying drugs from the chemical shop so I can quickly go back to work to help my madam at the chop bar (local restaurant). You see if I don't wash the dishes and clean the place I would not get any food to eat. So I prefer going to the chemist to going to the clinic where I would spend the whole day to see a doctor and later sleep with an empty stomach when I am not lucky.*

## 4. Discussions

Initiation unto the streets and begging could expose the female street children to sexual exploitation; in this era of sodomy, the boys could also the vulnerable to sex exploitation thus increasing their exposure to HIV/AIDS. Scavenging is a very hazardous form of work that exposed the children to contagious diseases. The activity of carrying heavy loads by the street kids in the market places puts so much strain on the girls as they are found to carry very heavy loads that could cause aches all over the body and headache. They could also be pushed down by shoppers and other people in the market places. The findings of this study are consistent with Lucchini (2006) which found the street children were mostly engaged in economic activities such as begging, hawking, petty trading, scavenging etc.

The findings on the diseases that the street children experience by living and working in the streets of Accra such as injuries and minor accidents could be due to the nature of their work and the environment (hawking goods on the busy streets of the city and carrying heavy loads). This finding is consistent with the findings of Kadonya et. al. (2002) which found that street children who worked in the quarries, garages, and fishing and fish processes activities in Tanzania sustained various injuries. Also,

Buying medicine from the chemical shops/medicine hawkers from the lorry stations or sharing drugs with friends exposes the children to taking un-prescribed drugs and also taking of expired drugs especially those offered to them by their friends and those bought from the hawkers. It is likely that these children would not take the correct dosage or even complete the course of treatment to recover fully. This is also evident in the act of taking medicine from friends in the street. It is possible that these friends with left over medicine did not complete treatment of their ailments and also left over drugs given to sick friends may not be enough to fully treat the sick child. Incomplete treatments can further expose the children to more health problems in future. Whatever the circumstances, 'self- medication' was their first reaction or attempts to combat an illness. This was the foremost response to any illness and for this they would utilize remedies from home or the market (i.e. prepared at home or commercially). They only sought healthcare when they or their parents or relatives felt that the situations were worse and beyond their control. At the point that the circumstances immobilized them, especially when they are unable to work and their conditions persisted for many days, health care would be sought.

Furthermore, the act of sleeping off sicknesses can have serious implications for the health of the street children by delaying treatment. Delaying treatment and self medication are some of the coping strategies adopted by most of the street kids in Accra. This is consistent with two studies by Anarfi (1997) and (Thapa, Ghatane & Rimal, 2010) which found that a majority of street kids did not seek medical help for ailments, instead ignoring their symptoms or self-medicating when ill. Most importantly, the most crucial role for decision making was played by the economic circumstances of the participants.

Also, it is revealed in this study that street children are more concerned about food and this is consistent with the findings of UNICEF (2006) that most street kids were not bothered about their health because they have more pressing needs rather than treatment for their ailments.

It is deduced from the study that street kids do not have adequate resources to access healthcare even though the country operates a health insurance scheme which gives free healthcare to some extent once you are enrolled unto the scheme; therefore they resort to all manner of strategies to keep themselves healthy and strong for work. Poor financial conditions obviously did not allow street children to seek healthcare at the big hospitals or with health care providers who charged heavily. So, in times of dire need and during financial crisis, they preferred visiting an informal practitioner who would either charge a nominal fee or give credit (do not charge at that point) at the time of need.

## 5. Conclusion and policy recommendations

The findings indicate that the health conditions of street children are miserable and majority of the available health services are out of reach of street children; there are multiple obstacles faced by street children in accessing health care services. Findings of the present study not only corroborates with findings and themes from other studies and literature, but also does highlight more factors. In particular, the somewhat similar factors could include some common health (medical) problems and some other factors regarding barriers to health care service utilization. Also the street children were found to have preference for informal private providers in the market places when self medication failed.

It is recommended that considerable efforts should be made to find out about the extent of their

problems or diseases/illnesses they suffer from which could be helpful in planning and formulation of health programmes for these children.

Enrollment unto the NHIS and Medical treatment should be expanded to reach more and more children.

Health should be viewed as an important basic need of the street children, and should be advocated as an agenda for collaboration among public, private and government agencies. Sustained advocacy with policy makers by all concerned civil society groups regarding the health of street children should be pursued.

There can be other interventions such as use of 'street theatre' performed by street children and other general health awareness programs or campaigns targeting them. This could help increase awareness on human rights issues, general health, HIV/AIDS sexual exploitation etc.

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