Social Capital, Health and Health Care among Street Children: A Case Study of Street Children in Kumasi Metropolitan Area, Ghana

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Abstract
The interest in the relationship between social connections and health related wellbeing of a given population has received a major boost in public health recently. This relationship either produces or prevents health risks and health problems. This paper qualitatively explores this relationship using the case of a unique group (street children) in Kumasi Metropolitan Area in Ghana. Contrary to the notion that street children are incapable of making social connections, the children demonstrated a high sense of pro-social attitude by building and maintaining social relationships which proved beneficial to their health related wellbeing. It is therefore proposed that, reaching out to the children and other vulnerable groups should strongly involve their social networks as such networks have greater influence on their health related choices and decisions. Moreover, it is suggested that, a social marketing approach should be adopted in the design and implementation of relevant policies in order to systematically and successfully influence the health related behaviour and choices of people. The paper however concludes that, social capital is a contextual concept and should be assessed and applied as such so as reduce its potential adverse effects on health related wellbeing of people.
Key words: Social capital, Street children, Health care, health related wellbeing, social marketing

1.0 Background

Development initiatives, especially in the past two decades have focused on people centred approach to development. An approach which prioritizes the flourishing of humankind in development processes (Friedman, 1992; Pieterse, 2010). Development work moreover is about change. Change in a direction which creates enabling environment for human development. These changes may not be in the form of only physical infrastructure but also in the ways people do things, their attitudes, norms and practices. These practices and behavioural norms emanate from how people organise themselves. Such organisations may either be built through formal and/or informal relations and may have differing impact on the lives of people and their respective communities. These social organisations and practices may also be stimulated by prevailing development interventions and policies. Immense interest have therefore recently been shown in the role of families, schools, social organisations and communities in current development practice as part of initiatives to put people at the centre of development projects (Mikkelsen, 2005). It is particularly forwarded that, the culture, socio-economic context and environmental condition of a given geographical area may shape the health status of the people therein by either producing or preventing diseases (McMichael, 2002). Factors such as accommodation characteristics, educational facilities, types of jobs, and health services, population characteristics such as ages, gender and cultural traits including social norms and practices could influence the health related wellbeing of inhabitants by either reducing harmful health related exposures or increasing their propensity of any health maladjustment. In view of these, health is sometimes defined ...*in terms of adaptability and is related to complex systems of interaction among habitat (environment,) population and cultural behaviour* (Meade & Emch, 2010, p. 27). Despite its recognition, less attention has been given to the intangible aspect of societies in relation to their health related wellbeing in both research and practice. A number of recent studies have thus argued for a strong linkage between the strength of people's social assets and access to basic services including education, sanitation and especially health care/services (Poortinga, 2006b). This paper focuses on the connection between the social capital—*the social 'glue' or 'fabric' that holds or knits people (street children) together and, in so doing, creates societies* (Rigg, 2007, p. 51), and the health related wellbeing people. The paper uses the case of a unique group of people; street children—a group of people who are sometimes touted as socially discounted individuals, to demonstrate the social capital and health nexus.

The environments within which this category of children finds themselves more often than not expose them to diverse health risks and problems. The majority of them suffer recurrent health problems. Aside from being a threat to their health, their situation also do inhibit their ability to access health care (Ansell, 2005; Panter-Brick, 2002). However, owing to the nature of their living conditions, their health is arguably the most important

resource for their survival on the streets. The living gained by street children is thus inseparable from their health status (Grierson & Schnurr, 2003). It is argued that, especially for poor and vulnerable groups including street children, *".... health is...a crucially important economic asset.....Their livelihoods depend on it"* (OECD, 2003, p. 1). Addressing these health risks and problems among such a group however entails a complex process. They often have to make tough choices regarding where, when, how and which health services and methods to use in addressing their health problems (Panter-Brick, 2002). Like many other poor and vulnerable groups in societies, street children are often under resourced in many facets of their lives. Many of them therefore tend to depend on the social connections they establish on the streets to access the needed livelihood resources (Boyden & Mann, 2005). Street children have been described by many as psychologically and irretrievably vulnerable group who cannot form appropriate social relationships. These assertions have however been proven otherwise in some situations as many of these children have showcased an ability to form and maintain groups which sometimes tend to replace their families (Amoah, 2013; Ennew, 1994). Such groups have been found to be beneficial to members especially in times of ill health (Kassa, 2008; Stephenson, 2001).

This paper discusses the relationship between social capital as concept and health and health care in current development literature with focus on children and more especially street children. The discussions are buttressed by a case study taken from Kumasi Metropolitan Area in Ghana. The case study borders on how the social connections of the street children influence their health status and related choices in terms of their attitudes towards potential health risks and problems as well as how these health risks and problems are addressed. The paper puts forth arguments and evidence to suggest that social capital have a strong relationship with health even for people with fewer opportunities to forge strong social ties. Based on the empirical case, the paper makes arguments and propositions on the need to effectively incorporate the social assets of ordinary citizens into relevant health policies and strategies. The paper is thus an attempt to broaden the elements in public health policy making process especially those concerning poor and vulnerable groups in societies.

1.1 Street Children: The Use of the Term

"A child is a human being in the early stages of its life-course, biologically, psychologically and socially; it is a member of a generation referred to collectively as 'children' who together temporarily occupy the social space that is created for them by adults and referred to as childhood" (James, 2012, p. 8). Moreover, age has been the main factor in determining who a child is. The United Nations (UN), just as by law in Ghana defines a child as any person below the age of 18 years (Government of Ghana, 1998; Jones & Summer, 2011). In this paper, age refers to the chronological age of people (Ansell, 2005). It is estimated that people below the age of 18 years account for about 37% of the population in developing countries and as much as 49% in the least-developed nations (Jones & Summer, 2011). Children represent the future of every nation and culture. Moreover, their roles, conception and characteristics differ in different parts of the world. Children in the developing world are often entangled in a number socio-cultural and economic conditions and changes which make their conception and roles within their respective societies different from that of children in developed economies (Abebe, 2010; Bourdillon, 2006; Punch, 2003). For instance, many children in Africa including Ghana have had to work or leave home to fend for themselves due to diverse socio-economic strains on their families. Such strains often put additional responsibilities on children (Abebe, 2008, 2010; Hashim, 2006). Some children therefore learn to earn erratic income at tender ages. There is therefore an existence of diversity of childhood across the globe based on prevailing social, cultural and economic conditions (James, 2012; Punch, 2003). Attention is thus currently given to the diversity of childhood especially on issues including children poverty and wellbeing in development research (Jones & Summer, 2011). The United Nations Children's Fund (UNICEF) labels the conditions in which some children find themselves as 'difficult' and 'abnormal' (Ansell, 2005; Punch, 2003). These categories of children among others include children without primary caregivers (including street children) (Ansell, 2005).

Definition of the term street children as well as acknowledgement of the term has been at the centre of contestation among academic researchers, practitioners and policy makers. However, one of the most cited definitions is that of United Nations which defines street children as….*any girl or boy... for whom the street (in the widest sense of the word, including unoccupied dwellings, waste lands etc) has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults (cited in Thomas de Benitez, 2011, p. 7).* Other definitions however give much attention to the experiences of the children and hence are more appropriate for this paper. One of such definitions is that of Schurink, (1993) who defines street child 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 are therefore peculiar based on the time they spend on the street, the street as a source of livelihood, the lack of protection and care from adults and the state of their social relations while on the streets.

Street children consist of a heterogeneous group of people. They are differentiated by ages, sex, places of origin and even reasons for leaving homes. These reasons also determine the kind of relationship they have with the streets (Ansell, 2005). UNICEF differentiates between three main categories of street children: *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, 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). These categorisations and labelling have however been found practically inadequate as children continually defy the generalisations by drifting in and out of the categories (Panter-Brick, 2002). However, it is argued that categorisation helps to contextualise and appreciate the conditions of the children and help to draw appropriate lines for analysis and interventions but not disregarding their heterogeneity and agency. Moreover, the difference in labelling does not change the fact that there are tens of thousands of children living on the streets of major cities in the world (Kobayashi, 2004; Panter-Brick, 2002). However, the differences in definitions and conceptions have made it difficult to accurately estimate the number of street children around the globe or even within countries (Ennew, 2003). For instance, UNICEF estimated about 100 million street children around the globe in 1989. However, the same figure was quoted by the organization even in 2009. The basis for this estimation is not factually established. Nonetheless, it is believed that there are tens of millions of children living on streets worldwide as evidenced by the astonishing situation in many African countries (CSC, 2009; Ennew, 2003).

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 an estimated 23,000 porters in Kumasi with majority of them being children and living on the streets (Baah, 2007). Accra, the capital city of Ghana harbours about 21,140 street children with as many as 6000 street babies. About 14,050 children in Accra could also be classified as urban poor children—who are at risk of taking to the streets (CSC, 2009). All these are however estimations and not absolute head count. It is therefore uncertain as to the actual number of street children in Kumasi and even in Ghana as a whole (Consortium for Street Children, 2003). Street children in Kumasi are often located in 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 (KMA, 2010; Kwankye, Anarfi, Tagoe, & Castald, 2007). Thus, street children live and spend their time in and around the central business district and the major market centres in Kumasi.

Street children in Ghana just like those in Kumasi take to the streets for diverse reasons. However, poverty seem to be the underlying cause for most of these factors (Anarfi, 1997; MESW & UNICEF, 2010, p. 8). Other factors include rural–urban migration coupled with rapid urbanisation in Ghana—especially population movement from northern Ghana to Southern and Central parts of the country for greener pastures (Hashim, 2005; Kwankye et al., 2007); dysfunctional families (About 86% of streetism in Ghana are caused by family disintegration), increased divorce rates, peer influence, and child abuse are some of the major factors that contribute to the increasing number of street children in Ghana (Consortium for Street Children, 2003). In their bid to survive, street children in Kumasi engage in menial forms of jobs including aiding disabled people, serving as helps in local restaurants, cleaners, bus conductors, errand boys to shop owners, hawking, head portering (often using pans), selling of sweets such as chewing gums and candies, polythene bags and articles including pens, razor blades and toilet rolls. Others are also truck pushers, cobblers, and even religious preachers. Their livelihoods therefore entail extreme energy sapping activities (CAS, 2003; Hashim, 2006; Kwankye et al., 2007).

1.2 Social Capital and Health
Social capital is said to have been used first by Jacobs in the 1960s when she established a relationship between social relations and socio-economic change and urban redevelopment (Parker & Doak, 2012). However, the concept of social capital was explicitly introduced in its current state by the works of Bourdieu (1980) and Glen Loury (1977) while the works of Coleman (1990), Putnam et al. (1993) and Portes (1998) ensured the modification, dissemination and appropriateness of the concept into diverse fields of study (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006). Social capital entails "...*the social relationships and patterns of*

reciprocal, enforceable trust that enable people and institutions to gain access to resources like social services, jobs, or government contracts....it is also a structural aspect of communities, embodying the context-specific networks that people and institutions use to achieve their goals" Schneider (2004, pp. 7-8)*.* Putnam et al. (1993) define social capital "*....as the features of social organisation, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions"* (cited in Islam et al., 2006, pp. 4-5). Indeed, Pretty and Ward (2001, p. 211) identify four dimensions of social capital namely:

Trust relations: This is deemed as a lubricant of human relations and cooperation. Trust cuts down on transaction cost among people and thereby liberates resources for the wellbeing of people.

Presence of exchange and reciprocity, or 'gift' relations: This entails both simultaneous exchanges of items and unrequited exchange of items at any given time. The lending and obligatory favours encourage many people to join in such social networks.

Presence of rules, norms and sanctions: This entails informal collective rules and regulations that are kept by members of a given society. These rules may be either for the benefit of such groups or the individuals therein.

Connectedness or group or network membership: This consists of continual social gatherings and meetings either formal or informal which tend to bring people closer. This may be through sporting activities, work related groups and even connections with other social groups.

In their words, Parker and Doak (2012, p. 190) state that, the four dimensions above *"...centre around knowing, trusting and becoming enmeshed in moral obligations to a group of people as part of a network of mutual interest".* The concept thus encompasses all forms of conscious and unconscious individual and group relationships. These relationships are in many situations a result of individual investment strategies as well as a cultural behaviour. The investments may thus present both short and long term useable and beneficial relations (Parker & Doak, 2012). Moreover, social capital is recognised as a 'good thing' in promoting individual and group cohesion for successful operation (Rigg, 2007). Edwards (2000) thus sometimes refer to the concept as the *'missing ingredients'* or *'elixir'* in development practice (cited in Rigg, 2007, p. 52).

Social capital consist of two major components namely cognitive and structural aspects. The cognitive component of social capital entails norms, values, attitudes and beliefs. The cognitive aspect help to understand people's perceptions of prevailing interpersonal trust, sharing, and reciprocity (Islam et al., 2006). It thus refers to how people *feel* which makes it subjective (Ichiro Kawachi, Subramanian, & Kim, 2008). In relation to public health, cognitive social capital is often associated with good mental health. Structural component of social capital however refers to what people *do* with respect to their associational links or networks. It thus entails externally observable aspects of social organization, such as the density of social networks and patterns of civic engagement (Ichiro Kawachi et al., 2008). These two components are therefore complementary in their nature (Cullen & Whiteford, 2001; Islam et al., 2006; Krishna & Uphoff, 1999; McKenzie, Whitley, & Weich, 2002). Structural social capital could be verified through observation or people's personal records. It could moreover be in the form of formal networks (recognized social groups related to school, sports, religion, politics or hobbies) and informal networks (friends, family, neighbours, work partners) (Ichiro Kawachi et al., 2008). Social capital is also further grouped broadly under *horizontal* and *vertica/linking* ties. Horizontal ties entail the connections which exist among individuals or groups of equals or near-equals with respect to for instance their ages, power and resources. Vertical or linking ties refers to hierarchical or unequal relations among individuals and groups due to differences in power, resource base and status in society (Islam et al., 2006). Horizontal ties further consist of *'bonding'* and *'bridging'* aspects. Bonding social capital is based on closed networks and usually holds family, kins and ethnic groups together. It is therefore inward looking and exclusive. Bridging social capital however makes bridges between different groups or heterogeneous groups including friends, neighbours and work partners (Rigg, 2007). Moreover, it is contested that, the interest in the social capital paradigm should not concentrate only on people's social connection but delve deeper into the *quality* of such relations and how they are maintained or encouraged. This will create a better platform in the design and implementation of relevant policies (Parker & Doak, 2012).

The impact of such social relationships on the lives of people has been evidenced through numerous studies in different places. Social capital was initially thought to have less influence on the health related wellbeing of people (Putnam, Leonardi, & Nanetti, 1993). However, a number recent studies have empirically demonstrated that there is a strong connection between social capital and health outcomes such as self-rated health, morbidity and mortality rates. In the field of public health, the social capital is now one of the most popular concepts in

understanding health related wellbeing of individuals and groups (Poortinga, 2006a). Wilkinson (1996) asserts that, social capital provide a buffer against livelihood challenges. It is also a conduit for disseminating pertinent health related information and knowledge quickly especially within communities and groups. For instance, Durkheim's work on social capital and suicide in 1951 showcased the pertinence of social relations in public health. It has been established that bonding social capital helps in ensuring healthy norms and in curbing unhealthy social behaviour. Bridging social capital also disadvantaged give poor and vulnerable groups (such as street children) access to key material resources through their connections with socially advantaged groups (Islam et al., 2006). There has been evidence of strong association between high level of social capital and reduced all-cause mortality rate and better self-rated health. Social capital is also deemed to play a role in the relationship between income inequality and access to health care. Thus, poor people with strong social ties could rely on their well to do friends and relatives for financial support in accessing health care (Ichiro Kawachi, Kennedy, & Glass, 1999). It is also forwarded that, people in well-connected neighbourhoods receive better psychosocial support in accessing health services as compared to those with poor social connections (Gatrell & Elliott, 2009; Perry, Williams, Wallerstein, & Waitzkin, 2008). However, the measurement of how social capital influence access to, use of, and satisfaction with health services is difficult to entirely appreciate and understood and should therefore be contextually appreciated (Perry et al., 2008).

Social capital is thus criticised in terms its real quality and abilities as it may mean different things to different people. Factors such as cultural and even economic differences may influence the meaning and attributes of the concept in different contexts. Besides, the notion that the concept is the missing link in development initiatives as well as an all encompassing term to capture gaps in knowledge is also criticised in the sense that, it makes the concept more of a panacea for gaps in development practice which does not represent reality. The concept is also seen as capable of exploiting, destructing and being harmful to interest of individuals due to prioritization of group interests. It has the capacity to limit individual initiatives and capabilities. The concept may thus be a source of social strain emanating from actions of the social networks of individuals. These strains may include excessive demands, criticisms, constant invasion of privacy and meddling which may in extreme situations cause a person to experience adverse psychological stress (Green, 2010). Forms of social capital such as bonding social may also exclude people in need from experiencing the advantages accruing from such relationships. For instance membership of family groups tend to exclude non-members and in many situations entering into such groups may be complicated and may not even be possible sometimes (Islam et al., 2006; Rigg, 2007). Others have also argued that, the push for the concept to be integrated into mainstream development policies have ended up in 'victim blaming'—a situation where the ordinary persons are blamed for being poor. For instance, people within deprived socio-economic conditions may be blamed for their lack of initiatives in mobilising themselves for improved livelihoods (Ichiro Kawachi et al., 2008). Notwithstanding the concerns raised, the benefits accruing from the bonds, bridges and links people and groups make and maintain are in many circumstances indisputable (Ottebjer, 2005)

Moreover, the majority of the works on social capital have concentrated on adults with less emphasis on children and adolescents. Concerns have therefore been raised as to how the concept can be applied to the lives of young people (Schaefer-McDaniel, 2004). For instance, the assertion that social capital dwells in civic engagement and concentration on community and institutional level participation practically make children invisible in the creation and use of social capital (Goodwin & Armstrong-Esther, 2004). However, the work of Bourdieu (1986) which emphasizes on individuals as key agents in the process of socialisation gives grounds to children especially those in difficult situations in the use of social capital (Morrow, 2001; Stephenson, 2001). Besides, gaining social competencies is also embedded in everyday activities and practices which everyone including children gain with time (Stephenson, 2001). For instance, research among homeless individuals reveal a strong association between social capital and access to basic services including health and housing (Rosenheck, Morrissey, Lam, & al., 2001). These children have been identified to have a sub-culture or a distinct social world on the streets which tend to shape many of the livelihood decisions and choices they make (Ennew, 1994; James, 2012). Moreover, for the purposes of this paper, social capital is conceptualised as the attachment of any kind to other individuals (both young and adults) on the streets which may have either positive or negative influence on the health related decisions and choices of the children (see Ichiro Kawachi et al., 2008).

1.3 Social Capital and Health: Case Study

1.3.1 Study Area and Research Methodology

Data for this paper was gathered as part of a study to explore the health related problems of street children in Kumasi Metropolitan Area in Ghana and how the health problems are addressed through the efforts of the children and prevailing social structures. Kumasi is the second largest city in Ghana in terms of population. The

city is centrally located about 270km north of the national capital, Accra. It covers a total land area of 254 square. Kumasi is the capital city of Ashanti Region. It has about ninety suburbs and divided into ten sub-metropolitan areas (KMA, 2010). According to the Ghana Statistical Service, 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 coupled with the tertiary level infrastructure and services as well as its economy make Kumasi a viable place for a host of commuters (KMA, 2010). About a third (34.3%) of Kumasi's population therefore 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 the trade and commerce activities most of whom operate informally (KMA, 2010). The socio-economic characteristics of the city therefore create a hospitable environment for children who for various reasons find their home environment no longer hospitable.

The type of information sought for and the complexity of their living conditions made qualitative method more appealing for this study. Moreover, with respect to health related research, it is argued that, by engaging with people at length, qualitative approaches help to get the grip of people's health worries (Gatrell & Elliott, 2009). Some schools of thought believe that, the small samples which are often used in qualitative researches makes the results less representative and biased to some extent and hence results cannot be generalised. However, the aim of this paper and qualitative approaches in general are not to generalize but rather to give a deeper and authentic understanding to a research problem through lengthy engagement with the target group (Gatrell & Elliott, 2009).

Information and data for this paper consisted of both primary and secondary sources (Crang & Cook, 2007). The study used in-depth interviews, two focus group discussions (consisting of 6 members each of both sexes) and observation methods (using both participant and non-participant observations). Semi-structured interview guides were used for almost all the interviews and discussions (see Bryman, 2008; Crang & Cook, 2007; Gomez & Jones III, 2010; Kothari, 2004). A total of 26 informants participated in the study. Fifteen of whom were primary informants. The rest were key informants from both public and private institutions. Primary data was gathered from *children of the street* (see Ansell, 2005)—consisting of children who had stayed on the street for at least three months without any contact with neither their family nor guardians. 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. The respondents came from five different regions out of the ten regions in Ghana with majority of them migrating from the Northern region as shown in table 1.

Table 1: Places of Origin of Primary participants

No.	Region	Number of Children
1	Northern Region	5
2	Ashanti Region	4
3	Western Region	2
4	Brong Ahafo Region	3
5	Greater Accra Region	1
6	**Total**	**15**

Source: Fieldwork, July, 2012

The highest educational level experienced by any of the children was Junior High School of which three of the children had attended but could not complete. Two of the participants had never been to school while ten of them had primary school education. The entire fieldwork took place from 15th June to 14th, August, 2012. Street children were selected from six neighbourhoods in the Kumasi Metropolis. Two participants each were interviewed from Pampaso area; Aboabo (station) and Asafo (market area). Central Market area, Kejetia and Adum areas also contributed three participants each. The primary interviews were conducted during weekdays and also weekends when the children were less busy with work in the morning and late evenings. 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. The primary data were buttressed with relevant literature and key informant interviews with health professionals including 1 medical doctor 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 of 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). Secondary data (see Bryman, 2008; Kothari, 2004) were sourced from books, articles, the internet, related thesis, and relevant grey literature from relevant national and non-state institutions including Metropolitan Health Directorate, Metropolitan Department of Social Welfare, and Centre for Development of People.

Two sampling techniques; snowball sampling and purposive sampling (Bryman, 2008; Gomez & Jones III, 2010; Kothari, 2004) were complementarily used in gathering data for the study. Using snowball, initially identified street children were asked to assist in locating children with similar characteristics (children *of* the street) as themselves. Although many children roam on the streets in the central business district (CBD) of Kumasi, it was difficult to identify those that met the criteria for the research. Using snowball technique therefore helped to easily identify relevant participants. 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 (see Kothari, 2004). Children identified earlier on were therefore asked for others in the same situations as them but were not their immediate friends. Besides, attention was paid to as many potential participants as possible for inclusion in the study due to the heterogeneity of the primary informants (see Kothari, 2004; Panter-Brick, 2002). Purposive sampling was also used in the selection of institutions and their respective informants, gatekeepers and field assistants.

1.3.2 Social Capital and Health and Health Care among Street Children in Kumasi
The living conditions of street children make them more susceptible to health related risks/problems. 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. In places such as Kumasi and other Sub-Saharan African countries, the majority of them are forced to engage in all kinds of risky activities and choices including life threatening jobs; sleeping in the open and insanitary places; feeding on contaminated foods and scraps; immoral behaviours such as stealing; confrontations with abusive adults on the streets; and living with/or in extremely poor hygienic conditions in order to make a living (Adeyemi, 2012; Kassa, 2008; Kwankye et al., 2007). Thus, communicable illnesses such as malaria/fever, cold, headache, cough, cholera, skin rashes, catarrh, stomach-ache as well as other physical health problems such as injuries and body pains tend to be common among these children (Amoah, 2013; Anarfi, 1997; Ayaya & Esamai, 2001; Panter-Brick, 2002).

Aside from the opportunities offered by prevailing governmental and non-governmental institutions and their respective policy initiatives in addressing their health problems, the absence of family and parents/guardians nonetheless creates a gap in their quest to seek solutions to their health related plights. However, contrary to the opinion that street children are socially disconnected group of people, many of them demonstrate mainstream moral and social attitudes. Thus, life on the streets does not entirely damage the cognitive functioning of street children as many of them function well emotionally and socially (Ansell, 2005; Ennew, 1994). Ennew (1994) cited in Ansell, 2005 p.204) posits that *"street children's network are often well developed and friendships are a very important source of emotional support"*. Fergus and Zimmerman (2005) further argue that, street children are often characterised by a pro-social attitude as well as skills and tolerance for other people. To a greater extent, these assertions were confirmed among the children who participated of this study with respect to how they addressed their health related problems.

The three forms of social capital: *bonding, bridging and linking* (Islam et al., 2006; Rigg, 2007) were demonstrated in the kind of associations the children kept. They often lived in groups which were often unconsciously formed based on a number of factors including gender, ethnicity, jobs and sometimes based on age. The males often spent their days with fellow males while the females often spent their times together. This was also evident in how they slept in groups and where they even slept. Those that spoke the same language and shared similar ethnic backgrounds often spent time together. This was very common among children from the three northern regions of Ghana: *"...yes they (referring to street children from northern Ghana) live in groups..... for example, those from town 'A' stay together and those from town 'B' stay together....so they live according to their places of origin...just like that"* (Health Personnel, Street Children Project). In this respect, those who did the same/similar jobs also spent more time together. The children thus unconsciously created a series of *bridging* and a kind of *bonding* social capital on the streets with their peers and fellow street dwellers. Moreover, they also maintained an association with several adults on the streets—a demonstration of *linking* social capital. While some of them had formal relationships with these adults, others had informal relationships with them due to long term working relationships. These adults were usually traders consisting of mostly market women, food vendors and shop owners. Their struggle for a living and survival on the street therefore created avenues that brought the children together with other people who helped in addressing their livelihood problems including their health problems.

Accessing health services: contribution of the children's vertical/linking social capital
Some adults on the streets served as resource persons for the children in addressing their health problems and risks. They assisted the children both in material and immaterial terms. Many of them encouraged the children to lead healthy lifestyles. One of the boys elaborated his encounter with a food vendor whom he assisted as follows:

"....the brother I work with inspects me any time I go to work with him,....he makes sure I have taken my bath and my clothes are clean....Sometimes when my friends come to the place we sell the food, he drives them away unless they are clean...My friends have to clean themselves before they could have part of the leftovers.... He always advises me not to fight and not to take alcohol nor steal" (Sampson, 13 years).

Moreover, while some children were given money for drugs and health care, others were taken to hospitals by some of these adults themselves who took care of their medical bills: *"...sometimes when I feel sick and I don't have enough money for treatment, I go to the brothers (adult friends) to tell them my problem....They always give me money for drugs"* (Appiah, 14 year old boy). These assistance or favours were mainly because of the services the children rendered to these adults by cleaning their shops' surroundings and sometimes helping them to pack and unpack their goods before and after each day's activities.

Owing to the complexity of their living conditions, the culture of self treatment of illnesses and injuries was a common practice among the children as they sought to address their health problems (see also Anarfi, 1997; Kassa, 2008). Some of the children revealed that, their knowledge on drugs and methods for self treatment were gained from some of these adults who thought them how to deal with common illnesses such as cold, fever and headaches. Some of them chewed 'hwentia' (grains of selim seeds) to heal their headaches and cold/flu while others used ginger and sugar to treat cough. These spices were sometimes gotten for free from some of the women who traded on the streets at night. Their social connection with these adults therefore granted them free access to several medicinal spices and herbs which they would otherwise have paid for.

Some of the females also learnt vital puberty lessons from women they worked for. One of the girls told her story as:

"The woman I work with provide me with clothes and sometimes help me to get treatment when I am sick.....When I had my first period (menstruation),....I did not understand what was happening to me.....but she explained it to me and thought me how to handle it....She gave me money to buy tampon and showed me how to use it" (Gloria, 15 year old girl).

Some of these adults therefore played the roles of the parents or guardians of the children would ideally play. The cases of Appiah, Sampson and Gloria, depicts a *linking* social capital which some of the children had with some adults on the street. To some extent, it also demonstrated a form of *bridging* social capital which allowed some of the children to freely request assistance in dealing with their health problems from their adult friends. Moreover, some adults also voluntarily helped the children in addressing their health problems especially those who were found in critical conditions. The need to assist these children however depended largely on how some of these adults perceived the children. Those that saw the children as vulnerable people (see also Panter-Brick, 2002) lent support to those who found themselves in critical health conditions as one of the girls revealed:
"One time I got knocked down by a vehicle..... I broke my arm and had a lot of cuts....I could not move well....then a lot of people came around to help me....They insisted for the driver to take me to the hospital for treatment. He took me to Komfo Anokye and took care of all my bills....One of the women traders who I often carried goods for even visited me at Komfo Anokye" (Rahi, 17 years).

Thus, even adults on the streets who may not have any association with the children sometimes offered helping hands to them in times of acute health conditions. This exhibits a *linking* form of social capital (see Rigg, 2007). Adult traders and hawkers on the streets of the Metropolis therefore served as a safety net for many of the children in addressing their health problems and even health risks. In tougher situations, some of the children resorted to begging from the adults in order to raise money to access health services. Assistance from adults in times of ill health moreover is not only common among street children in Kumasi. In a related study in Dar es Salaam, Amury and Komba (2010) found numerous instances where adults were of immense assistance to street children in addressing their health problems. However, it is also worth noting that some adults saw these children as nuisance and even criminals and hence failed to assist them but instead harmed them as revealed by some of the children and as collaborated by Quarshie (2011) in his study of the public perception of street children in Accra, Ghana.
Accessing Health Services: Contribution of the children's horizontal social capital

The act of living in groups and making friends also provided an alternative for addressing the children's health problems. Assistance from their peers in times of ill health often took the form of financial aid, caring for the sick ones, physically aiding others to access health care and assisting each other in treating their health problems. As Perry et al. (2008) assert, low-income individuals do sometimes rely on their social networks for financial support in health care. Many of the children were excluded from some health services due to financial constraints as well as their ignorance on interventions geared at their health related wellbeing. In the light of this, many of the children relied on their *bridging* social capital often entailing their friends for financial support during times of ill health. Many of the participants had either borrowed money from or to others for the purposes of health care: *"I have borrowed money several times to my friends to buy drugs....., Yes, I have also borrowed money from my friends to buy drugs..."* (Musa, 17 year old boy). The financial assistance was also initiated on group basis. Whenever someone among a group of friends got ill and could not take care of his/her medical expenses, the healthy ones contributed small amounts to cater for the health needs of the sick:

"....they help each other a lot.....One time a group of the children (street children) brought one of their friends for treatment....and then after consultation they insisted on taking their prescription home when we have asked them to get their drugs from the hospital's dispensary....Later they returned with the money for their drugs and treatment......We then discovered that they did that because they could not afford their drugs instantly and had to go for money from their other friends" (Physician, Metropolitan Children's hospital).

Their bridging social groups therefore offered them the needed support in accessing health care. However, the closeness and exclusiveness of some of their friendship groups to some extent depicted more of *bonding* social capital than bridging social capital. They saw some of their friendships as more of a family than casual allies. Moreover, as emphasised by Phillips (1990), the cost of accessing health care also include the cost of transportation aside from the cost of consultation and related bills. Among the children, financial assistance was not only given for direct medical treatment but also for transportation to health centres especially in critical situations. Besides, in situations where access to commercial transport was scarce or when the health facilities were closer to them, the healthy ones carried their sick friends on their backs to access health care.

The children also demonstrated a sense of care for the sick and convalescents amongst. Since many of them lived on hand to mouth basis, being sick meant that one could not afford to go about his/her normal duties and hence could not take care of their daily needs. Some of them therefore relied on their friends for food and drinks, finding appropriate places to rest during the day and even paying for the places they spent the night when necessary. Others also borrowed their jackets to sick friends that felt cold and shivered. It was observed that, males often took care of their male friends while the females also did same for themselves. This further confirms the composition of their associations and friendships.

Furthermore, their friends and peers were often the first group of persons they discussed their health problems with before any adult or even health professionals. This was largely due to their curiosity to acquire knowledge to treat themselves when ill (see also CAS, 2003). They therefore primarily consulted their friends in assessing their options for health care with regards to how, where and even when they needed to see a professional with their problems.
"....the decision to go to hospital is always ignored by them because they do not want to spend their money on their health even in critical situations....if their friends do not coerce them to address their illness,... they might even ignore it until it kills them" (Health officer, SCP)

Their friends therefore provided them with the support and necessary push and information with respect to appropriate places to access health care and methods for addressing their health problems. Their friends therefore served as their immediate family and confidants with regards to their health related choices.

The support and care by their peers in times of ill health also extended to the culture of self treatment. Due to the physical and exhaustive nature of their jobs and livelihoods (Amury & Komba, 2010), many of them ended their days with body pains, aches, cuts and even sprains. They therefore helped each other to regain their strengths by massaging each other. Those with cuts were also helped by their friends to clean and dress them. Moreover, a major self treatment practice was in the form of sharing of drugs: *"......when someone has the same illness I used to have, I pass my leftover medicines to him......For example, if the person has headache and I have Paracetamol,.....I give it to him...Some of my friends also do same for me"* (Bright, 14 year old boy). This behaviour was also confirmed by the physician from the Children's Hospital who echoed that, the children usually fail to take the full course of the drugs prescribed for them both at the hospitals and pharmacies. Hence, many of them kept leftover drugs which they could pass on to their friends. These favours to their peers however came at an indirect cost. The act was largely in anticipation of receiving similar favours from others in the future.

Moreover, these kind of assistance to fellow friends on the streets is not only common among street children in Kumasi as related studies in Accra, Dar es Salaam and Addis Ababa revealed similar findings among street children (Amury & Komba, 2010; Anarfi, 1997; Kassa, 2008). The bridges, bonds and links the children formed on the street therefore sometimes provided opportunities for addressing their health problems.

However, in line with the assertion of Ali and De Muynck (2005), the attention the children and people in general pay to their health problems often depend on the acuteness of the illness, injury or sprain and also the potential cost in treating them. Since their peers and adults who were not experts in health care had immense influence on the children's health related decisions and choices, many of the children either ignored less acute health problems or treated them by themselves. Moreover, due to inadequate knowledge on the symptoms and evolution of some of their health problems, the sick, their peers, and adult friends sometimes misdiagnosed and hence wrongly treated their ailments. Thus, illnesses and health problems whose symptoms were uncommon or unknown to the children and their peers were therefore either ignored or misdiagnosed and mistreated amongst them. This situation meant that, the children put themselves at a very high risk by relying on their social connections for health related information and decision making. The participating health professionals therefore agreed that, this attitude sometimes rather worsened their conditions: "*Sometimes they misdiagnose and mistreat their illness by themselves.....Their cases therefore sometimes get more severe and difficult and expensive to treat.....They assume that every illness is malaria and hence treat them accordingly.......but in some cases they get it wrong* (Physician, Metropolitan Children's Hospital). For instance, in the view of the physician, the children and even pharmacy attendants often misdiagnosed typhoid fever as common cough and malaria. The benignity of their comrades therefore sometimes ended in misfortune for the children.

1.4 Discussion and Conclusion

This paper has shed more light on the concept of social capital and its importance in health related wellbeing of people. Arguments have been presented in support of both major discussions regarding social capital and health care using the case of a unique group of people—street children in Kumasi Metropolitan Area, Ghana. Thus, although social relations could serve as a buffer for health related needs and plights, it may also encourage habits which may be detrimental to people's health (Poortinga, 2006a). The paper have more importantly put forth a strong argument in support of the argument that irrespective of the fact that street children live without their primary care givers, they are not socially broken as have been forwarded elsewhere. The participants in this study have demonstrated that, street children are able to develop their own subcultures that are characterised by unique forms of values, beliefs, practices and even language (James, 2012, p. 126). In the words of Beazley (2000, p. 208) such subcultures provide the children with 'a positive self-identity and sense of belonging'. Street children therefore have the potential of forging and maintaining social relationships contrary to the position of other schools of thought. Owing to the case presented above, one could confidently state that, the social assets of the children have aided in maintaining their functioning as human beings as well as improved their mental and physical health to cope with the unhealthy environment. (Green, 2010).

The children demonstrated Mittelmark (1999) and Berkman et al.'s (2000, cited in Green, 2010) proposed pathways on how social ties affect people's health. Firstly, the connections the children made on the streets served in many instances as *a source of vital health related information* which helped them to avoid the inevitable constant high health risks or stressful situations. Some of the adults also served as *positive role models* for the children by introducing them to acceptable norms, practices and behaviour. Their social capital also offered them the needed basic *tangible support* in the form of access to resources and material goods including financial support, food, clothing and shelter. Moreover, despite the absence of their families and guardians, their pro-social attitudes also offered them the needed *emotional support* during difficult moments such as acute ill health. The diverse forms of support they received on daily basis also gave them the *psychological boost* that support was always available. This enabled them to forge ahead by even taking obvious health risks to make ends meet. Their ability to make social connections, seek and offer help therefore partly explains their resilience amidst the health threatening environment as explained by the likes of Fergus and Zimmerman (2005), Gunnestad and Thwala (2011) and Boyden and Mann (2005).

Owing to the above discussions, it is imperative that much more attention is given to the social connections of the children and people in general in the planning and implementation of health care and health promotion policies and strategies. New strategies which reflect the current and future dimensions of health needs of distinct groups and individuals should be encouraged in policy making (Green, 2010). It is recommended that, the rapidly growing telecommunication /mass media industry should be used in persuading street children as well as other poor and vulnerable individuals and groups to adopt healthy behaviours. Ghana's telecommunications industry is one of the fastest growing industries in the country with regards to its revenue generation. It is

estimated that the industry accounted for a third of Gross Domestic Product (GDP) growth in Ghana in 2010 (Koi-Akrofi). Health promotion messages through televisions, radios, mobile phone networks, the internet and the print media should not only encourage people to live and make healthy decisions but also entreat them to carry the message to their neighbours, friends and families. Fortunately, the use of friends, neighbours, family members, and the communities within which people find themselves as a resource or means of accessing resources is a common practice among Ghanaians and many other African societies (Caria, Teal, & Zeitlin, 2009). Through various shop and transport operators in their vicinity, many of the street children have access to both print and electronic media on the streets. Regular and effective messages across these media could therefore make an impact in not only the health related wellbeing of the children but also the poor and vulnerable adults who live and/or make ends meet on the streets. Moreover, in order to make the use of the media in health promotion and behavioural change efforts more effective, it is suggested that a *social marketing approach* (see Cheng, Kotler, & Lee, 2011; Green, 2010; Kotler, Roberto, & Lee, 2002) should be incorporated into the relevant policy making process. Social marketing entails the *'.....use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify or abandon a behaviour for the benefit of individuals, groups, or society as a whole'* (Kotler et al., 2002). Its strategies entail a mix of economic, communication and educational schemes. In extreme situations, social marketers may use the law or courts to push forth required behaviours. Unlike ordinary mass media approach, the economic, education and legal components make social marketing approach more effective especially in an attempt to change health behaviour among people in unusual situations such as street children (Green, 2010).

Street children should be empowered by divulging to them more information on disease prevention and treatment options. The process could be undertaken either directly and/or indirectly. Thus, the process of disseminating health related information among the street children could be undertaken either through personal interactions with individuals and groups or through their identified social connections. Interactive health educational programmes should be a major priority and a frequent practice by relevant public and concerned private institutions such as the Kumasi Metropolitan Directorate of Health in conjunction with Department of Social Welfare in Ghana. These programmes should focus on the causes and prevention of their health problems especially those relating to infectious diseases. The programmes should also entail education on proper places for them to acquire medical treatment and drugs. This programme should be specifically designed to the health needs of the children. This could complement the general information through the mass media. What is more, few of adults on the streets who have direct contacts with the children could also be strategically selected (for instance based on their location and gender) and trained in basic first aid. Focus could be given to appropriate methods of treating basic and common health problems among the street children such as mild sprains and wounds as well as lessons on safe and appropriate use of pharmaceuticals.

Moreover, it is suggested that health related programmes, policies and strategies for poor and vulnerable groups such as the street children should include group dynamics in their design and implementation process. Children with different background profiles could be brought together during process. Such inclusive programs would help to build wider and stronger social networks for the children alongside the health promotion activities. Such social ties will also serve their health needs in the long run as more of the children will be open to the idea of helping each other on regular basis (Schneider, 2004). Due to the immense influence they have on their comrades, reaching out to the children in groups would make set targets more achievable.

It is however worth nothing that, social capital is a contextual concept and should be assessed and applied as such. The nature and characteristics of social capital could be determined by the specific prevailing norms, values and social practices. For instance, street children in Kumasi as has been presented consist of children from different ethnic backgrounds. In the light of this, health related policies and strategies which seek to incorporate the concept of social capital should also take into consideration the social, cultural and historical settings of the individuals and groups concerned (Ichiro Kawachi et al., 2008). Finally, this paper acknowledges that social capital is not a panacea to all health related problems of groups and individuals. However, as Hawe and Shiell (2000) posit, solutions to health problems lie in many places. The usefulness of the concept among poor and vulnerable groups such as street children should therefore not be entirely disregarded but critically embraced. Thus, since reliance on their social connections in addressing their health problems and risks is inevitable, it is imperative that much consideration is given to social assets of street children and other poor and vulnerable groups in relevant policy design. In the long run, such systematic incorporation of social capital into policy making will help to curb its adverse effects of on people's health related wellbeing.

Acknowledgement

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