



## The impact of drop-in centres on the health of street boys in New Delhi: An interpretive descriptive study



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### ABSTRACT

Our objective was to understand how drop-in centres influence the physical health, substance use status, and mental health of street children in New Delhi, India using interpretive description methodology. We conducted face-to-face semi-structured interviews with 23 street children and two staff members from two drop-in centres in New Delhi. We asked participants to describe how they believed drop-in centres worked or did not work to influence street children's physical and mental health and substance use status. We analyzed the interviews using constant comparative method. Participants believed that because street children regularly visited drop-in centres, their health outcomes improved. Street children participated in drop-in services rather than services provided by other facilities because at the centres, the staff members were nonjudgmental, they were free to be a child, their daily struggles were lessened and they received protection. Staff at drop-in centres also provided children with moral direction and an opportunity for a better life. However, children continued to live on the streets despite what centres offered because street life had become normal to them. According to street children and staff members, drop-in centres positively influence the physical health, mental health and substance use status of street children by providing services in an environment tailored for street children.

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### 1. Introduction

It is estimated that globally there are up to 100 million street children, that is, children living or working on the streets (United Nations Children's Emergency Fund [UNICEF], 2003). Street children are divided into four classifications, according to UNICEF: *Children at risk*: those who live with their families but supplement their income by working on the streets; *children on the street*: those who spend a portion of their time on the streets but still have a place of residence with some family support; *children of the street*: those who maintain minimal relations with their families and spend the majority of their lives on the streets; and *abandoned children*: those who live completely on their own on the streets without any adult supervision (UN Dept. of International Economics and Social Affairs, 1986). With approximately 18 million street children, India has the largest population of street children in the world (Sen, 2009). Many street children experience ill health (Ali & De Muyenck, 2005; Ayaya & Esamai, 2001; Kudrati, Plummer, & Yousif, 2008), yet

there is little research on street child interventions that aim to improve their health outcomes.

Drop-in centres are one of most common programs for street children globally (Coren et al., 2013). They may provide street children with non-formal education, free lunches, recreational activities, preventative health services and basic medical care at strategic locations near railway stations and busy market areas for a few hours every day (Salaam Balaak Trust, 2015; War Child, 2014). They may also transition street children to shelter homes or restore them to their families. Staff members working at a drop-in centre in Brazil reported that these centres were necessary to the survival of street children because they ensured access to food, hygiene, health care and a space for the children to feel they belonged (Morais, Morais, Reis, & Koller, 2010).

Drop-in centre services including psychological care, case management and the provision of basic necessities have led to improvements in mental health, substance abuse and social stability among street youth in the United States (Slesnick, Kang, Bonomi, & Prestopnik, 2008). Unfortunately, few studies have described the outcomes of street children attending drop-in centres in low-income countries (Souza, Porten, Nicholas, & Graiss, 2011). In a Cochrane review that summarized the effectiveness of interventions for street children that promoted inclusion and reintegration and reduced harms, the authors remarked, "We did not find any sufficiently robust evaluations conducted in

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LMICs despite the existence of many relevant programmes” (Coren et al., 2013, p. 2).

## 2. Review of the literature

Street children commonly experience adverse physical health outcomes, substance abuse and poor mental health. We conducted a systematic literature search for peer-reviewed quantitative and qualitative publications up to July 2015 that looked at the physical health, mental health and substance use status of street children in low- and middle-income countries (LMICs) (Nath et al., submitted June 15, 2016 to *Children and Youth Services Review*). Studies that assessed the impact of street child interventions on health were also examined with respect to the intervention. Fifty-three publications met the eligibility criteria. Findings showed that street children commonly experience ill health and high rates of substance use.

With respect to physical health, publications in the review reported that skin infections, respiratory diseases, injuries, tuberculosis, and sexually transmitted infections were common physical health problems among street children (Ali & De Muynck, 2005; Kudrati, Plummer, & Yousif, 2008; Morais, Morais, Reis & Koller, 2010; Patel & Bansal, 2010). Street children experienced worse physical health than non-street children (Ayaya & Esamai, 2001; Huang, Barreda, Mendoza, Guzman, & Gilbert, 2004). The use of inhalants and alcohol were also common among street children, especially compared to non-street children (Ayaya & Esamai, 2001; Njord, Merrill, Njord, Lindsay, & Pachano, 2010; Pinto et al., 1994). Commonly used substances included alcohol, glue, tobacco and marijuana. Injection drug use varied among street children between the studies. Street children also experienced mental health issues, although the mental health results varied considerably among street children in the review, and none of the studies in this section used adequate comparison groups. More recent literature confirms the findings from our literature review (Hakim & Rahman, 2016; Mounir, Attia, & Tayel, 2016).

Overall, street children fared worse than non-street children on most of the assessed outcomes, except in cases of nutrition, where street children fared better than poor and rural non-street children. Despite the fact that street children in LMICs experience very poor health, there is little research on street child interventions in these countries that aim to improve health outcomes. Only four of the studies reviewed evaluated the impact of health-related interventions for street children, and none of these rigorously evaluated the impact of drop-in centres on street children's health.

We were interested in evaluating how drop-in centres impacted the health of street children. Specifically, our study aimed to understand how drop-in centres operated by non-governmental organizations (NGOs) influenced or did not influence the physical health, substance use status, and mental health of children accessing these services in New Delhi, India.

## 3. Methods

### 3.1. Study design

We used interpretive description methodology in this study. Interpretive description, developed by Thorne, Kirkham, and MacDonald-Emes (1997), is a qualitative methodology that goes further than simple description. The researcher is challenged to look beyond the obvious, and document patterns and themes among cases to understand the complex nature of a phenomenon (Thorne, 2008). One of the aims of interpretive description is to generate knowledge that is of clinical relevance (Thorne, 2008).

### 3.2. Sampling and recruitment

The overall sampling strategy was purposive, i.e., the sample selected consisted of data sources considered by the researchers most

appropriate for answering the research question (Sandelowski, 1995). Maximum variation sampling, a purposive sampling technique, was used to recruit a diverse range of street children to obtain a broad understanding of the issues. Maximum variation was sought in educational level, socio-economic background, age, and length of time at the drop-in centres. We also implemented criterion sampling to sample street children and staff members.

Eligibility criteria for the child participants were:

1. Between seven and 18 years of age when interviewed;
2. Visited the General Reserve Police (GRP) or Kishalaya drop-in centre regularly (defined by at least five visits of a minimum of an hour each in the prior month);
3. Met the United Nations definition of a street child, which is “any boy or girl...for whom the street in the widest sense of the word...has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults” (Panter-Brick, 2002, p. 149); and
4. Had lived or worked on the streets for at least one week.

Children were excluded if they had any serious mental health conditions, such as a severe anxiety disorder or intellectual disability, which prevented them from providing informed consent.

The eligibility criteria for staff participants were:

1. Is an employee at either the GRP or the Kishalaya drop-in centre; and
2. Is involved in the organization and implementation of day-to-day activities at the drop-in centre.

Thorne (2008) states that although the sample size could be any number for an interpretive description study, a sample size between five and 30 is common.

The study involved street children and staff members from two drop-in centres in New Delhi, which was operated by the same NGO. One centre, called the General Reserve Police or GRP Contact Point, was located at the New Delhi Railway Station. The other, known as the Kishalaya Contact Point, was located in Connaught Place, which is the city's centre or downtown. Both centres were open from 10:00 am to 1:00 pm, Monday through Saturday. Both centres provided free lunches, basic medical services, non-formal education, recreational activities, counseling, and referral to drug detoxification centres and shelter homes. The Kishalaya centre also provided a morning nutritional snack to the children. Typically, there were three to four staff members at each centre. One of the researchers (RN) had worked at the NGO prior to the study; therefore, community entry was not difficult. Both centres were sampled purposively to ensure we covered a diverse range of street children. Each of the two centres provided services to two types of street children, together covering three of the four types of street children, according to UNICEF's classification (UN Dept. of International Economics and Social Affairs, 1986): *children of the street*, *children on the street*, and *abandoned children*. The NGO's other 17 centres provided services only to *children on the street*.

### 3.3. Data collection procedures

Data were collected in one-on-one semi-structured interviews that lasted between 25 and 45 min. The three health indicators of interest – physical health, substance use status, and mental health – informed the development of the questions for the interview guides. We consulted the qualitative research literature on conducting interviews to develop the interview guides for the child and staff interviews (Bernard, 2005; Jacob & Paige Furgerson, 2012; Patton, 2002; Turner, 2010). Use of interview guides ensured the same general types of data were collected from each participant. Prompts were added to the open-ended questions and questions that participants may have felt more comfortable answering were presented in the beginning (Jacob & Paige Furgerson, 2012). The interview guides were pretested with a group of street children who shared similar characteristics to the target

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