MAKING HEALTH CARE ACCESSIBLE TO STREET CHILDREN

The 'Hospital on Wheels' Project
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To all the street children facing challenges, hoping and dreaming for a better life and to all the development workers who educated us and connected us to the vast possibilities.
Preface

Street children are increasingly seen as part of the urban landscape, the world over. India with its fast paced urbanization (29% in 2001) faces the challenge of increasing number of people living on the streets and children are part of this section. Street children are a result of a constellation of the 'drop outs' or 'push out' factors. The street child is the cumulative consequence of increasingly degraded rural environment, landlessness, migration, urban poverty, unemployment, inadequacy of infrastructure, development opportunities, domestic violence, abuse within and outside the home, and erosion of traditional social support systems. These young vulnerable people have to compete with adults for their share of basic services, development and income generating opportunities.

The Indian Constitution enjoins the state to provide facilities for healthy development of children [39(f)]. Our national policies have moved progressively in the direction of Child Rights Convention (CRC) ratified by India. The efforts have been to provide adequate appropriate services to children, to ensure their full physical, mental, social and emotional development and protecting them from harm. The government, civil and international bodies in India, has been striving to fulfill the obligations stated in our policies and ratification of the CRC. Health is recognized as one of the basic rights of every child, but all these agencies are generally overwhelmed with providing food, nutrition, clothing, shelter and education to the increasing number of vulnerable children. Macro level challenges continue to mar the attempts made to solve the multi-dimensional problems of street children. Studies reveal the inability of street children, to gain access to basic services in large cities. Health is one such issue.

The general health problems of street children and the need for providing health care services to street children have been stated in numerous documents prepared by NGOs and the government. As an organization aiming to improve the health of marginalized urban masses, it seemed inevitable that SNEHA ventured into and found an innovative way to understand and tackle the health problems of street children.

SNEHA’s mission to develop replicable models to health problems provided the rationale for developing the Hospital _ on _ Wheels project. It was undertaken as part of the “Centre for Vulnerable Women and Children” programme in SNEHA which reached out to vulnerable groups living in urban slums. SNEHA views ‘health’ not only as a much needed service but as a human right. Thus, a mobile, accessible and comprehensive health care approach was used for tackling the health problems of the street children during this project. The project team facilitated the partnership between MCGM, corporate sector and the NGOs for making this possible. The five year project provided innumerable learning experiences for the team, helped SNEHA to grow and add innumerable supporters to our list of people concerned with improving urban situation.
This report is aimed at sharing information about the project in the context of health problems of street children and to give credit to all who worked hand in hand in providing a comprehensive health care to street children. We also hope that this unique model of mobile comprehensive health care can be adapted, improvised, and utilized by many others who wish to make a difference to the lives of street children. The strategies used especially with building close networks and partnerships as well as finding new pathways for accessing the public health system are worth a trial in different urban settings and environments.

We are grateful to MCGM, Health Department, Lokmanya Tilak Municipal General Hospital and Medical College, Sion, Mumbai, the Department of Preventive and Social Medicine, Lokmanya Tilak Municipal General Hospital, and Urban Health Centre, Dharavi, for their support throughout this challenging project.

Without the generous support from the Academy for Mobilising Urban Rural Action through Education, (AAMRAE), SNEHA would have not been able to implement the H_O_W project smoothly. SHARE's support of a project staff member proved to be an extremely useful contribution. The networking with primary NGO staff went beyond the stipulated as they worked hand in hand with a single minded goal of reaching out to as many street children as possible. Deep gratitude goes to all the volunteers and donors who supported the project. Special thanks to Neena Shah More and Rebecca Sherman for reading through this document and providing useful comments.

Last but not the least we thank all the street children whom we met, interacted, helped and treated; who motivated us and will continue to do so in all our ventures for improving lives of the vulnerable women and children in Mumbai.

For SNEHA helping even a single child living, working or learning on the street had great value. SNEHA hopes this report gives an impetus to efforts for improving health status of this marginalized section of young people.

Dr. Armida Fernandez
Founder Trustee, SNEHA Mumbai
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Introduction

The term street children refer to children for whom the street more than their family has become their real home. It includes children who might not necessarily be homeless or without families, but who live in situations where there is no protection, supervision, or direction from responsible adults.

Human Rights Watch

Background
Street children are increasingly seen as part of the urban landscape, the world over. There are social and institutional factors that serve to sustain their presence. They are a result of increasing poverty and unemployment, increased migration of families, broken families, neglect, abuse, riots and violence, armed conflicts, natural and man-made disasters, decreasing resources in rural areas, and the attraction of cities.

Definition of Street Children
The term ‘Street Children’ denotes different categories of children who are living and/or working on the streets permanently or temporarily, with or without families. Universal categories of street children (developed by UNICEF and the World Health Organization) are:

a) Children on the Street: This category comprises children working on the street but maintaining more or less regular ties with their families and community.

b) Children of the Street: Children in this category maintain only tenuous relations with their families, visiting them only occasionally. They see the street as their home where they seek shelter, food and companionship.

c) Abandoned Children: Children in this category are also children of the street but are differentiated from category ‘b’, by the fact that they are cut off from their biological families and are completely on their own.

Street Children in India
Activists working with street children in India have generally adopted all the three categories for identifying this vulnerable group. The reasons for being a street child are varied and sometimes a mix of the ‘push and pull’ factors. Some of the prominent factors are:

• Physical, sexual or emotional abuse, caused by parents or guardians usually leads to the child running away from home and thereby being forced into child labour.

• The consequences of the actions of parents such as neglect, addictions, migration or directly sending their children out on the streets, forces them to fend for themselves.

• The feeling of inadequacy at school and discouragement from family adults and peers leaves the children isolated, angry and confused.

• The children are forced unto the streets to supplement the inadequate income of the household, often following the laying off from work of the primary bread
earner or due to family crisis like the illness or death of an earning member in the family. They work either of their own volition, or are prodded into it.

**Number of Street Children**
The complex situation of street children makes it difficult to get an accurate number of street child populations. In India, there have been various estimates of street children population. The 1991 Census recorded 18 million children. The United Nations High Commissioner for Human Rights (UNHCHR) in 1993, had reported that India had the largest population of street children in the world. In 1999, R. Agarwal estimated that India was home to about 20 million street children, i.e., approximately 7% of the total child population. Big cities draw in larger numbers of street children. The IPER study of 5 cities in India (Mumbai, Chennai, Kanpur, Bangalore and Hyderabad) recorded 314,000 street children. (IPER 1991); another study in 1997 estimated 500,000 street children living in seven large cities (CRIN).

A recent publication has reported 47 million homeless and runaway adolescents roaming on the streets of our country. The recent estimates of street children in metros shows a rise in numbers; in Delhi there are 100,000—500,000 street children, Calcutta has 200,000 and Mumbai has between 100,000 - 250,000, street children.

For most purposes for NGOs and activists in the field, however, figures are inconsequential because, “...even a single child living, working or learning about life alone on the street is one too many.”

**Living Conditions of Street Children**
Street children in India generally live in locations including streets, pavements, under and over the bridges, railway platforms, rooftops, sheds, booths, alcoves, beaches, markets, trains and places of worship. Street children live in physical surroundings that are unhygienic and dirty. Majority of them do not have access to bathing and toilet facilities. They are constantly exposed to sun, rain, cold, dirt, smoke, harmful waste and other environmental hazards. Though a section of street children live with their families, their essential needs are not met mainly due to extreme conditions of poverty and neglect. These family environments are functionally inadequate and therefore the children are functionally homeless. Some families are also found to be abusive. Most street children consume food found on the street, in garbage bins, and at cheap roadside stalls. Sometimes they eat vardi food (that is given away as charity in places of worship).

Street children are generally viewed as criminals, victims, or as fôde spirits. In truth, they struggle hard to survive. They are found in a variety of jobs, including rag picking, scavenging, begging, hawking, loading and unloading at railway stations, bus depots and market places, bootlegging, prostitution and theft. Some only work on the streets during particular periods of the year, and attend school or informal learning centres at other times.

Even those street children who connect with NGOs stay with the NGOs for short duration of time and sometimes shift from one NGO to another. The movement of

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1 A study done at a NGO run Child Observation Home (COH) for boys in Delhi showed physical abuse reporting by 38% children and sexual abuse by 14.6%. Most of the physically abused children gave history of physical abuse by family members. In an observation home at Bombay, 50% children reported physical abuse by parents or care givers.
Making Health Care Accessible to Street Children: The ‘Hospital on Wheels’ Project (2000-2006)

Street children and youth fluctuates between living at home, on the street or in NGOs centre due to various reasons like changes in weather, police or public focus, or changes in the family environment (social, economic change) or availability of resources with the family. The streets offer them a sense of freedom rarely experienced in the confines of a family. In a sense, street life grows on them and after a certain period of time, they find it very difficult to give it up. It becomes a ‘culture’, a ‘lifestyle’; one that defines them and becomes a part of their identity.\(^{19}\)

They spend most of their earnings on food and recreation. Their social environment has adult males involved in drinking and gambling and in other anti-social, unhealthy practices.\(^{20,21}\) Street children invariably become victims of abuse, violence, and exploitation by older children, adults, and police and other protection agencies.\(^{22,23,24,25}\) Moreover, they tend to be susceptible to addictions to substances like alcohol, drugs, thinners and whiteners\(^{26,27}\), etc. Street children receive very little family or other support and are deprived of basic amenities like food, shelter, education, health care, training and recreation. It is evident that Indian cities have large populations of street children who face multiple challenges in every day life.

**Governments’ Responsibility towards Street Children**

The Indian Constitution enjoins the state to provide facilities for healthy development of children \(^{39(f)}\); the National Policy for Children, 1974\(^{28}\) and the National Plan of Action for Children 2005\(^{29}\) promise provision of adequate services to all children. The Government of India having ratified the Convention on the Rights of the Child (1992) has been reviewing the national and state legislations in this light. Among the policy and law initiatives that were undertaken was the formulation of the National Charter for Children 2003, the National Plan of Action for Children 2005, and enforcement of the National Commissions for Protection of Child Rights Act 2006. The Juvenile Justice (Care and Protection) Act 2000 was amended in 2006 and the Central Model Rules in this regard are being formulated.\(^{29}\)

India is also a signatory to the World Declaration on the Survival, Protection and Development of Children. In pursuance of the commitment made at the World Summit, the Department of Women and Child Development under the Ministry of Human Resource Development has formulated a National Plan of Action for Children. Most of the recommendations of the World Summit Action Plan are reflected in India's National Plan of Action.\(^{30}\)

The Government of India has been running special programmes for the care and protection of children in crisis situations such as street children, working children, orphaned, children in conflict with law, children affected by conflict or disasters, etc. These programmes were mainly being implemented by the Ministry of Social Justice

\(^{a}\) According to a survey conducted by Bal Sahyog, YWCA and Indian Alliance of Child Rights, Delhi’s 5 million-odd street children are victims of rampant abuse and exploitation. The survey, also showed that these children are not even registered with the municipal authorities, which precludes them from being beneficiaries in state/NGO-funded welfare schemes.

\(^{ii}\) National Plan of Action for Children, 2005, promises total coverage and focus on the child in primary, secondary, and tertiary health and nutrition services. The comprehensive and holistic National Plan of Action for Children, 2005 sets time-bound targets for achievement in terms of reduction of infant and child mortality and HIV prevalence in infants, universal access to drinking water and basic sanitation, and the elimination of child marriages as well as the incidence of disabilities due to polio.
and Empowerment and have now been handed over to the Ministry for Women and Child Development. 31

Recognizing its basic responsibility towards street and vulnerable children the Government of India has been implementing an integrated Programme for Street Children\textsuperscript{iv} since 1993\textsuperscript{v}. Financial assistance is provided to the NGOs who are eligible and working for the welfare of the street children, for formal and non-formal education, shelter home, vocational training to children, nutrition, health care, sanitation and hygiene, safe drinking water, counselling, reintegration with their families, recreational facilities and protection against abuse and exploitation.

While this programme provides non-institutional services, the Ministry plans to simultaneously strengthen the institutional services for children. In particular an effort will be made to check deteriorating condition of children’s homes which have in the recent past been attracting adverse notice of the Parliament, the Courts, the National Human Rights Commission and the Media.\textsuperscript{32} The Ministry’s Annual Report (2006-07) states that since its inception, the programme has benefited 3,32,011 street children (out of 30 million children in the country who belong to families living below the poverty line and are out of school).

Other important recent developments that impact on the status of street children are (i) The amendment of Juvenile Justice (Care and Protection) Act 2000 in 2006 and the formulation of Central Model Rules in this regard (ii) Setting up a National Coordination Group on the Rights of the Child for implementation of child rights in the country, and instituting a Chair on the theme of Protection of Child Rights as part of the 10 Rajiv Gandhi Chairs in Contemporary Studies in central and state universities.\textsuperscript{33}

\textsuperscript{iv} The Scheme aims at providing full and wholesome development to children who are without homes and family ties, who are on streets and homeless and include the rag picking and vagabond children. The children without homes and family ties and children especially vulnerable to abuse and exploitation such as children of sex workers and children of pavement dwellers are the target group for this Programme.

\textsuperscript{v} In 1993, the Government introduced the Scheme for Assistance to Street Children which was renamed as Integrated Programme for Street Children in 1998. The programme was shifted to the Women and Child Development Ministry in 2006.
Health Status of Street Children

General Health Problems of Street Children
The UNICEF 2005 Report on India had pointed to the fact that about 63 per cent of Indian children go to bed hungry and 53 per cent suffer from chronic malnutrition, which reflects the poor status of children in general. The status of street children can only be assumed to be worse than the general category of children.

There have been few research studies on street children’s health problems in India, and these have been only in some cities. It is generally assumed that street children have more or less similar health problems throughout the country.

Street children experience high rates of physical, mental and emotional health problems. It is generally reported that street children are susceptible to cuts, injuries, dog and rat bites, skin infections, malnutrition, fevers, respiratory problems, and other infections. Studies show that most street children do not consume adequate food, and the quality of the food they eat is very poor. Majority of them suffer from protein deficiency and chronic diseases like asthma and dysentery.

A study conducted by Salam Balak Trust in New Delhi revealed that 20 percent of the street children at the railway stations were suffering from Tuberculosis. High prevalence of sexually transmitted diseases among street children makes them highly vulnerable to HIV. It is estimated that 60-90% of street children in Mumbai are sexually active. A study conducted in the slums in Chennai found that 80% of youth engaged in pre-marital sex; 85% of the same group reported never using condoms.

Mental Health Problems
Literature on mental health indicates that street children are generally found to be more vulnerable to impaired psychological health than any other group of youths. One of the study done in London on homeless children reported behavioral problems in 49% of these children. A study done in Johannesburg reported, “A higher rate of behavioural problems such as sleep problems, aggression, over-activity, shyness, withdrawal and emotional problems such as depression, anxiety, sadness, low self-esteem and self harm (scratching, head-banging, punching, etc.) was also common.”

In India there are very few research studies on the mental health status of street children. In a study done on street children in Delhi, high hopelessness was seen in 20.7%. Out of these, 12.9% gave history of suicidal thoughts, 12.9% reported planning suicide at any point of time and 3.2% of children gave history of attempting suicide. Depression (as observed by Beck Depression Inventory - BDI) was seen in 8% of children. Suicidal behaviors (thought, plan or attempt) were present in 8% of the children. More than 80% of children had antisocial behavior and 7.8% were neurotic. The author has concluded that the behavioral problems in the runaway or homeless children were significantly higher as compared to the housed school going children. Activists working with street children affirm the presence of these symptoms, although the extent is not known.
Self-management of health problems
Street children’s lives revolve around survival. They tackle health problems by finding their own strategies to overcome or cope with them. Often, street children neglect or treat illnesses on their own for as long as they can. This behavior often aggravates their health problems. Sometimes this neglect of health problems stretches on for so long that medical intervention cannot treat them effectively. Street children often attempt self-medication, such as applying ‘masala’ (spices) or ‘chuna’ (quicklime) to wounds, drinking ‘soda’ for gastro-intestinal problems, and taking over-the-counter drugs for all kinds of infections. In addition, recourse to addictive substances is seen as an alternative to dealing with all kinds of physical, mental and emotional health problems.

Access to Health Care Facilities
Health care seeking by street children is usually restricted by a number of factors, including the availability of resources, knowledge of health centres, time spent seeking care, travel distance, and faith in the health provider (clinics and doctors). A number of street children like other children, fear doctors and hospitals. Street children are especially wary of organ (especially kidney) or blood extraction without their consent. As they earn meager amounts or spend most of it on immediate needs and wants they are left with no or little resources for accessing medical care facilities in times of emergencies. Moreover, they cannot afford to pay high fees to private practitioners.

Though government and municipal hospitals are present in most cities in India and Health Posts and Dispensaries are set up to reach out primary health care to marginalized and vulnerable urban populations including street children, they have remained inaccessible due to various reasons. The situation of street children in terms of health issues is more or less similar to other cities.

New entrants in the city are generally unaware of the public health services available in different localities. Most street children are also unable to access public health services due to improper behavior of hospital staff. For example, street children are often shooed away from public health centres by ward boys and security guards. Street children and NGOs also report that doctors refuse to treat or operate needy street children because of their unclean appearance. Fear of rejection and past experiences of unapproachable and unresponsive health providers discourages street children from accessing public health services in times of need. Often public hospitals expect street children to pay user fees and purchase medicines from private medical shops. As a result many of them do not complete their treatment.

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vi It is not unusual to hear stories of exorbitant fees being paid to private doctors, during informal dialogues with street children and NGO staff.

vii The 3,600 odd cities and towns of India have about 3,000 urban local bodies. Out of these about 100 have some semblance to a health care service while the rest have only a sanitary inspector or even a lower functionary to look after the health care system. The few urban areas that have a health unit, provide health care services through the Urban Family Welfare Centres, Maternity Homes, Urban Health Posts and General Hospitals.

viii The health post and dispensaries are expected to reach out to the poor/ slum communities and provide primary health care programme. In Mumbai, there are 24 wards and these are served by 176 health posts and 168 dispensaries provided by Municipal Corporation of Greater Mumbai (MCGM).
Another obstacle in accessing public hospitals is that ill children requiring hospitalization are expected to have an attendant (24 hours). This rule is difficult to comply with since the street child is either living alone on the street or does not have adequate family or other support system. It is also difficult for NGOs serving street children to satisfy this condition. Dearth of medical and after-care facilities at public health centres for children with disabilities, child addicts and HIV positive street children is a gap that also needs attention. 49, 50 The problems faced by street children in accessing public health services in Mumbai are quite similar to those in other cities.

**NGOs Providing Health Care**

The gap in public health services for street children forces most NGOs to take on the responsibility of providing health services. Generally, NGOs working with street children in Mumbai39 take the ameliorative approach of providing access to basic needs such as food, shelter, protection, education, recreation, counseling and health services. NGOs encourage street children to have clean and healthy habits by providing them with water and soap for bathing, washing and toilet, hair and all cutting sessions, counseling, recreational activities, health education and awareness generation programmes.

NGOs also arrange for general health and dental check-ups and treatment. Some NGOs also carry out medical detoxification, and provide relevant information on issues surrounding sexual health and relationships. Majority of the organizations working with street children keep some over-the-counter drugs at their centres and approach the closest health centre during emergencies. Most NGOs do not have medical staff, and their paramedical staff is not trained in a consistent manner to manage health problems common to street children.51 High staff turnover also diminishes NGOs’ capacity to deal with health issues internally.

Thus, NGOs have to spend either substantial amount of time accessing public hospitals, or a significant amount of money on private health care facilities in the vicinity. There have been attempts made by some NGOs to run mobile health vans and paraprofessional and children’s health training programmes, which have proved to be useful and successful. 52, 53 However, such health programmes depend on the resources available to the NGOs and these vary from time to time.

On the whole, large numbers of street children in Mumbai have very little access to comprehensive health services in a sustained manner.

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39 The approximate number of NGOs working with vulnerable children in Mumbai as reported by CCVC (Coordination Committee for Vulnerable Children) is about 50. CCVC is a formal organization set up to coordinate work with street children in Mumbai.
The ‘Hospital on Wheels’ (H_O_W) Project

‘Accessible Health Care’: A Felt Need
The idea for a “Hospital on Wheels” transpired when Fr. Xavier of the NGO Shelter Don Bosco expressed this gnawing need\textsuperscript{xi} to Dr. Armida Fernandez, who was then the Dean of LTMG Hospital\textsuperscript{xii} (henceforth referred to as Sion Hospital) in 1999. He pointed out that it was very difficult for most NGOs to provide adequate health care to street children as one staffer (accompanying the child) would have to spend almost the entire day at the public health centre, as the waiting time and procedures for completing case papers, examination and treatment in general was long and arduous. He wondered if the health services could be brought closer to the NGOs, either to the shelter home or to the day shelter in a consistent manner. He imagined that this would not only save time and resources but would also make the public health services accessible to this needy section of society in an appropriate way. This view was reiterated by other NGOs working with street children in Mumbai at numerous meetings during that year (between 1999-2000).

SNEHA\textsuperscript{xiii} responded to these calls for change. It resolved to explore a model for making health care accessible to street children, as Dr. Fernandez firmly believed that “readiness to do something when we can or have the capacity to do so facilitates change in society.”\textsuperscript{54}

Since it was imperative that street children are provided health care on their own ‘turf’ and health status be understood from their point of view, a mobile health facility seemed inevitable. In keeping with its mission to develop replicable models to address health problems of the urban vulnerable populations SNEHA planned the ‘Hospital on Wheels’ project. The primary goal was of providing a comprehensive, mobile health care service that would be free, easy to reach, less time consuming, and have a sensitive and empathetic health care providers. Only this approach would make ‘access to health care’ for street children a reality.

Step-1- Planning

1. Putting together a Project Team
SNEHA, being based in an urban health centre and having health experts in its executive team, had the capacity to facilitate a comprehensive health care service programme for street children.

\textsuperscript{a} The term ‘accessibility’ here broadly refers to the ability of a person to avail health services. Accessibility is affected by factors such as prices, distance, the opportunity cost of obtaining treatment, etc.

\textsuperscript{xi} Shelter Don Bosco is a Non Governmental Organization working with the roofless and rootless street children of the city of Mumbai since 1987.

\textsuperscript{xii} Lokmanya Tilak Municipal General Hospital & Lokmanya Tilak Municipal Medical College, is located in central suburb, Sion, near Dharavi. It is the youngest of the three major metropolitan teaching hospitals of Greater Mumbai, and is a state of the art 1,416 bedded modern hospital. It is popularly known as Sion Hospital.

\textsuperscript{xiii} SNEHA was formed by a group of concerned doctors and social workers to address the special needs of women and children in urban slums. It was initiated by Dr. Fernandez in 1999 and was in its nascent stage when these discussions took place.
SNEHA approached UNICEF for resources for the H_O_W project and was directed to AAMRAE (Academy for Mobilizing Urban Rural Action through Education). This NGO responded generously by offering its van, driver, and fuel and vehicle maintenance.

The H_O_W project team including a Project Coordinator and two field workers from SNEHA was put in place and the office was located in Dharavi Urban Health Centre. The Project Coordinator planned, coordinated and implemented the work of project. She initiated networking with NGOs, corporate bodies and the Municipal Corporation of Greater Mumbai (MCGM), NGOs, donors and volunteers. The field staff in the team, volunteers, doctors and NGOs worked in close coordination with each other.

The first few months of the project were devoted to discussions with the interested ‘primary’ NGOs. This period was also utilized for working out the details of the project and garnering resources for its implementation. A thorough listing of primary NGOs, places frequented by street children, major health problems and emergencies, was prepared by SNEHA with support from different agencies.

The team took note of some of the past and ongoing projects like mobile health vans and ‘Bal Doctor’ (Child Doctor) initiated by NGOs and government bodies. These diverse health programmes had proved that the Government and NGOs could work together to bring health closer to this vulnerable section by strengthening some components of the existing health services and public-NGO networking. The need was to take the learning ahead in the new project.

2. Setting Objectives of the H_O_W project
The H_O_W project objectives reflected the aim of providing curative, preventive, promotive and rehabilitative health services to street children. The objectives were:

a. To establish a delivery system for curative health care needs of street children by providing a ‘Hospital on Wheels’.

b. To offer medical facilities for investigations, referral services, and institutionalization and care taker facility at the infirmary provided by SNEHA at the Urban Health Centre (UHC), Dharavi.

c. To focus on preventive and promotional aspects of health, like provision of health education and awareness generation.

d. To conduct training programmes and workshops for capacity building of NGOs working with street children.

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xv Dharavi is a large and one of the oldest slum settlements in the centre of Mumbai. It is sandwiched between Mahim in the west and Sion in the east. It is spread over an area of 175 hectares and has a population of more than 1 million people. It has a number of Health Posts, one of which called the Urban Health Center (UHC). SNEHA’s main office is located here and several of its projects were managed from this office.

xv Primary NGO is a term used in this report to indicate NGO that makes the first and consistent contact with the street children from different categories

xvi YUVA, BECC, Snehadan, and AAMRAE had tried out mobile health van and ChildLine had networked with Nair Hospital for emergency health care to vulnerable children.

xvii Preventive and Social Medicine (PSM) department of KEM Hospital, Mumbai had been providing health care facilities to slum communities and vulnerable children through the Child to Child Project, Malvani located in northwestern suburb of Mumbai.)
The Working Model
The H_O_W project team, the doctors from the PSM department and volunteers visited the primary NGO centres or any decided place on specific days and at appointed times. Here they would be examined by the doctors and given medicines or sent for referrals to a public institution. Prescriptions were given only in rare cases. The volunteers helped in organizing them for check ups, preparing their basic information forms (with name, age, sex) and also in explaining the dosage of medicines to be taken.

In case the child needed to be referred for further investigations, or advanced treatment, the H_O_W team helped the NGO to take the ill child to the appropriate referral units and in-patient care facilities. Whenever there was a call from ChildLineviii or any other NGO in an emergency, the team rushed to the spot for providing first contact aid to the ailing street child. The primary NGO staff would then take responsibility for continued medical treatment or follow-up of treatment for the needy child.

Diagram 2: H_O_W Project Partners and Their Contribution

viii In 1996, Mumbai launched CHILDLINE, the country’s first toll-free Tele-Helpline for street children in distress. It has responded to over 11 million calls from vulnerable children who live and work in Mumbai.
Step 2- Formulating Strategies for Implementation

Strategy 1: Building Civil society, Public, and Private Partnership

Although the Model was initiated by SNEHA, it needed close cooperation and coordination between other civil society agencies (SNEHA, primary NGOs and volunteers), the public (MCGM) and private agencies (donors, pharmaceutical companies). The H_O_W project had identified the roles of different partners (including its own) as per the strengths of each partner and it made efforts to involve all the interested partners from the beginning.

Civil Society

Networking with primary NGOs was essential for the implementation of the project as they had good rapport and contact with the street children. Thus primary NGOs became the first set of partners. The H_O_W Coordinator started networking with four NGOs - Anmol, Each One Teach One, Shraddha, and Shelter Don Bosco. With the help of some NGOs and CCVC (Coordination Committee for Vulnerable Children) the project could reach out to about 20 primary NGOs. This networking helped the H_O_W team to contact street children in many places; in the western suburbs (Mahim, Santa Cruz, Andheri, Vile Parle, Malad and Bandra); in central suburbs (from Dadar to Charni road); and in eastern suburbs (including Kurla, Dongri, Sion, Chembur, G.T.B. Nagar, Wadala, and Thane).

Public Partner

The MCGM with its health infrastructure could extend services through its medical facilities, referral, outpatient, and in-patient facilities to street children and was thus an essential partner in the model.

Doctors from the PSM Department of Sion Hospital were included in the project with the idea that they would benefit as much from this exposure as the street children would benefit from medical care.

The referral services for further investigations, hospitalization, and prolonged treatment, were provided mainly through Sion Hospital. The unique part of this referral service was the setting up of an ‘infirmary for children’ with the help of MCGM and an MOU formalised this introduction.

Partnership with Private partners

The private sector partners like private pharmaceutical companies, private practitioners and individual donors who agreed to the project’s goal became the third set of partners. Thus, the medicines and resources that were needed were acquired by way of donations from private pharmaceutical companies, private practitioners and individuals.

As networking spread and the volume of services expanded to reach out to more NGOs and street children, private health providers were requested to volunteer their

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xvi We networked with 20 NGOs but have listed only 18 NGOs who were working with street children in the table given in Annexure- 1. The other two NGOs were community based and are therefore mentioned separately below the table. See Annexure- 1 for list of primary NGOs working with H_O_W project.
time for curative services as well as for health education programmes. Some doctors had to be employed later on in the project.

**Strategy - 2: Reaching out to un-reached sections of street children**

A study of street children in Mumbai (2002) had pointed that 48% of the children were located in central Mumbai area (41% in the South Mumbai area, and 11% were in the north Mumbai area.\(^58\)) The south and central zones include major train terminuses that connect Mumbai to other parts of India, and have important market places, tourist spots, places of worship and industrial activity centres and are therefore areas most frequented by street children.

Since AAMRAE\(^59\) had been providing health services to street children from south Mumbai and referring them to Nair Hospital for investigations and hospitalization, it was planned that the H_O_W project would reach out to children in central Mumbai and some suburbs of northern Mumbai. Thus, the programme strategy (H_O_W) was to provide health care to those street children and primary NGOs who had no access to health services or were in untouched areas of Mumbai.

Initially the team found the street children rude, abrupt and skeptical and it soon realized the importance of improving rapport with them. One way of enhancing rapport was building a sensitive and communicative team of health providers. Another strategy was to organize recreational activities, like picnics and workshops occasionally. The third approach was networking with ChildLine and helping children in crisis.

At the end of the rapport-building phase, the H_O_W team found that there was a more open, friendly and trusting relationship between the team and the street children.

**Strategy 3: Involving Volunteers in a Sustained Manner**

The H_O_W project team was small, and their tasks required much time, energy and patience. Thus, there was always a need for more people to be involved in the programme delivery. Volunteers from varied socio-economic backgrounds (students, housewives, professionals, doctors, etc.) displayed the enthusiasm needed for making service provision an easy and enjoyable team activity.

Some volunteer doctors had the skill to deal with the children sensitively. As most street children enjoyed communicating with people who were empathetic, the non-medical volunteers would chat with them, listen to their stories and health problems, organize them for check ups, write down their profiles for records, and explain their treatments.

**Strategy 4: Annual Reviews for Improving Strategies**

The H_O_W team planned an annual review with all primary NGOs to discuss the implementation strategies, processes and problems encountered. This helped in reviewing activities implemented in the year and arriving at solutions through consensus. Regular reviewing helped the H_O_W team to work out practical solutions and fulfilling the planned objectives.
Step 3- Implementation of the H_O_W Project

The H_O_W project’s mandate was to provide comprehensive health services as planned (as per the objectives). However, it took on other responsibilities that seemed closely linked to their primary task.

I. Providing Comprehensive Health Services

In keeping with its plan for providing comprehensive health care services, the H_O_W team conducted curative, preventive and promotional health programmes with the children and the primary NGO staff.

Curative Services

Curative health services were provided in three ways:
(i) Regular Clinics
(ii) Special Health Camps
(iii) Special Children’s Events

(i) Regular Clinics:

Regular clinics were held at the primary NGO centers on specific days and at appointed times. The average number of visits made per NGO was one per month. The H_O_W team examined a total of 17,592 children$^{xx}$ over the project period, (2000- 2006) averaging 3,510 children per year. In the first year, H_O_W project provided health services to 1600 children, 76% were boys and 24% were girls. As more NGOs became partners, the number of children covered increased. Moreover, the profile of street children attending the regular H_O_W clinics changed. From the second year onwards the percentage of girls increased to 40% of the total children. About 15% of the street children attending the regular clinics were below 12 years but they reported about 80% of the illnesses. A large majority of children (85%) were in the 12-18 years age group and they reported 20% of the illnesses.

Table 1: Disease classification and percentages

<table>
<thead>
<tr>
<th>Disease classification</th>
<th>Percentage of (range) children (over five year period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory tract infections</td>
<td>28-35%</td>
</tr>
<tr>
<td>Fevers</td>
<td>10-13%</td>
</tr>
<tr>
<td>Skin ailments (scabies, pediculosis, pyoderma, boils, and others)</td>
<td>9-16%</td>
</tr>
<tr>
<td>Gastrointestinal infections</td>
<td>3-5%</td>
</tr>
<tr>
<td>Pain in abdomen</td>
<td>4-8%</td>
</tr>
<tr>
<td>Worm infestation</td>
<td>3-6%</td>
</tr>
<tr>
<td>Weakness, anemia and malnutrition</td>
<td>3-6%</td>
</tr>
<tr>
<td>Headaches</td>
<td>3-5%</td>
</tr>
</tbody>
</table>

$^{xx}$ This figure does not include children examined and treated in Special Health Camps and those attended to during Special Children’s Events, as the medical records of these children could not be maintained in the required format.
ENT problems | 3-4%
Injuries | 3-5%
Dental problems | 2-3%
Leprosy | Nil found
Vitamin deficiencies (A+B), Conjunctivitis, Stomatitis, Tuberculosis, Gynaecological disorders, Surgical cases, Joint pains, Burns, Lymphadenopathy, Drug Addiction \( ^{xxi, xxii} \), Others | Less than 2%

The ratio of child and illness reported was 1: 1.7. The most common illnesses among street children examined by H_O_W team were respiratory tract infections, fevers, skin ailments and digestive problems (gastrointestinal infections, worms and pain in abdomen).

It is important to note here that the street children population is a floating one, and they interact with NGOs in varied ways and at different times. \( ^{xxi} \) The children examined, treated or referred were those present or contacted at the NGO centre at a particular time period. Moreover, the primary NGOs provided first contact health care to these children. Therefore, this data may not reflect the complete picture of health problems of street children in Mumbai in general. Our analysis is based only on the children H_O_W examined over the five-year project period.

\( ^{ii} \) Special Health Camps
Apart from the regularly planned health services, the H_O_W project also provided Special Health Camps to children who were difficult to reach on a regular basis or who needed these health check-ups urgently. This included rescued child labourers from hazardous industries, newly contacted street children and slum children. In 2001, for example, 180 child labourers (from Pratham) and 160 street children (brought by BECC) were examined and treated. Similarly, in 2002 medical check-ups were done for 90 Balwadis \( ^{xxii} \) (run by Pratham in slum communities) and 800 slum children were examined and treated.

More than 1000 street children were provided health services during these Special Health Camps. A few other camps were conducted for migrant populations, women’s groups in a slum community and for rescued and vulnerable girls living in a Rehabilitation Home.

\( ^{iii} \) Representation at Melas (Fairs)
Having recognized the need for a health unit wherever there were children’s events, the H_O_W team participated in the Don Bosco Children’s Mela and other events organized by CCVC and ChildLine. During these events the children were free to enter the mobile clinics and take treatment. In this way, the H_O_W team provided health services to those who were unaware of its work and spread health messages to the untouched street children.

\( ^{xxi} \) The H_O_W team found negligible cases of addictions, as the primary NGOs managed them at their end.
\( ^{xxii} \) Street children and youth stay at the NGOs centre for short and long duration according to their whims and needs and depending on the programmes provided by NGOs.

\( ^{xxiii} \) Balwadi is a playgroup for children under six years.
Referral services:
Apart from curative services, children requiring further examination, treatment or hospitalization and emergency cases were referred to peripheral hospitals and followed up by H_O_W and NGOs jointly. Children who needed to be in hospice were admitted to the Infirmary at the Urban Health Centre (UHC), Dharavi. Both H_O_W team and the primary NGO shared the responsibility of care taking.

As per the records kept by the H_O_W project, referral cases to other public institutions were about three percent of the total children examined in the first year and eight percent in the last year. The percentage of referred cases for the other years was within this range. Cases referred to hospitals and specialist departments varied from year to year. But the pattern seen over the five-year period was as follows:

- Ophthalmology were 15-28% of the total referred cases;
- Dental were between 13 and 19%;
- Orthopaedic cases were between 6 to 15%;
- Surgical cases formed 6-10% and
- ENT cases were between 6 to 13%.

There were smaller percentages of referrals for Skin ailments, T.B., Paediatric, and Gynaecological health problems and for TT injections, X-rays, urine testing, etc.

Hospitalization & Infirmary
The MOU with MCGM had ensured that the Paediatric ward beds were made accessible to street children below 12 years. Arrangements were also made to admit older children in Sion Hospital. Doctors at the Hospital were informed that street children referred by the H_O_W project could be admitted through the Casualty. Hospitalization services for the H_O_W project were also utilized sometimes for detoxification of child addicts. This period generally varied from 4 days to 2 weeks. The major obstacle for hospitalizing street children in public hospitals was removed by appointing a caretaker/ attendant who would stay with the hospitalized child. Here the H_O_W team found a novel solution by employing the women coming to the Crisis Centre at SNEHA. While the woman received some remuneration, the child received the much-needed services of a caretaker.

The Infirmary initiated by the H_O_W project, which extended convalescent care to the sick and infirm children, also proved to be useful. There were generally about 6-12 children each year that had to be placed in the infirmary.

One of the cases brought to the infirmary was that of an 11-year-old girl:

Rani’s mother had sent her to work and live as a domestic servant with a family. She was then about 9 years old. When the family shifted to Punjab they took R along. For two years, Rani worked long hours and received insufficient food, and as a result she fell ill. The family brought her back to Mumbai and admitted her in a Municipal hospital, where they later abandoned her. As she was without a caretaker, Rani was discharged from the hospital but and had to stay on the roadside.
It was from here that ChildLine picked her up and referred her to H_O_W for medical treatment and rehabilitation. Rani was initially admitted to LTMG hospital and later on brought to the UHC at Dharavi for convalescence, where she stayed for sometime. Lack of timely treatment had taken its toll on Rani; she had lost 80% of her eyesight.

After completing her treatment, Rani refused to go back to her mother. So H_O_W team admitted her in Kamala Mehta Institution for the Blind located at Dadar. Here she received some vocational and survival skills. H_O_W’s last contact with her showed that she was happy.

Preventive health care services

a) Health Education for street children
The H_O_W team had planned for health education to form an important component of its health programme. One of the paraprofessionals had reiterated the need for health education to be conducted by the H_O_W team: “street children will listen to you (H_O_W team). If they find the doctor to be a sensitive person, they will respond immediately....will show respect and listen to their advice. So please advice our street children about health issues, about hygiene, about taking care etc. They take us for granted, they fool with us…but they will listen to you....”.

Thus the H_O_W team conducted more than 200 health awareness sessions on preventive health at NGO shelters, centres and homes. Doctors (volunteers and from PSM department) with the help of posters, cards, games, and audio-visual materials conducted these health education sessions. Sometimes a simple question and answer session worked well with children. They discussed several issues, like personal hygiene, nutrition, sexually transmitted diseases, drug addiction, tobacco and gutkha addiction\footnote{Guthka (also spelled gutka, guttkha, guthka) is a preparation of crushed betel nut, tobacco and sweet or savory flavorings. It is is a mild stimulant and is consumed like tobacco and is considered responsible for oral cancer and other severe negative health effects.}, T.B., malaria, scabies, worms, stomach infections, adolescent reproductive and sexual health and diseases including HIV/AIDS.

The health education sessions proved to be useful as the street children accepted the information, guidance and ‘dos and donts’ instructed by the doctors. The H_O_W team managed to involve doctors from other public and private hospitals for conducting health education sessions, thus enhancing the partnership model.

b) Capacity Building of NGO Staff
Since the H_O_W team could reach the NGOs only once a week, it was pertinent that the NGO paraprofessionals be trained on critical health issues to provide appropriate first aid in times of emergencies and manage common health problems with safe drugs at their facilities. The regular interactions with doctors helped the paraprofessionals to understand the concept of safe and rational treatment; especially caution needed while treating illnesses with antibiotics.
Apart from management of emergencies and general health problems, there were other issues that the NGO staff expressed as crucial to their functioning. Sexual and reproductive health and substance abuse (tobacco and gutkha) were mentioned as key health concerns. Since many of the paraprofessionals felt inhibited about these issues, SNEHA conducted workshops with the aim of providing them with knowledge and skills to deal with questions raised by children.

c) ‘Bal doctor’ Programme
The primary goals of the Bal Doctor were to build capacity of street children to manage some ailments; to promote healthier life for street children, and to demystify health concepts and the public health system.

At the request of YUVA, SNEHA facilitated the Bal Doctor Training Programme in collaboration with another NGO, Sneha Sagar and the PSM Dept of Sion Hospital, in which selected street childrenxxv were trained. This Training Programme provided information on health, first aid, common health problems and avenues for accessing public health services for the same. The trainees were also taken to public health institutions including dispensaries, health posts and peripheral hospitals to learn about the public health system.

The training equipped the Bal Doctors to understand health emergencies and to access the public health system in case of emergencies. Twelve street children completed the training and were given certificates at the end of the one – year programme.

Rehabilitative Services
An inherent part of street children’s health services is psychological assistance and counselling. Most children need someone to offer them emotional support for their personal struggles. Thus the H_O_W project team members counselled street children and sometimes ventured into counseling their friends and family members. The experience of H is and example of the benefits of this service.

A young boy Hari who was addicted to drugs and living in a shelter home was counselled by one of the H_O_W volunteer doctors regarding de-addiction. Through close interaction, this doctor persuaded the child and he went in for the detoxification programme organised by the primary NGO.

Hari came out clean and was on the rehabilitative programme of the NGO. He managed to stay away from drugs for two years. This child was so grateful to the H_O_W doctor that he would visit him often, bringing flowers, short poems and cards to say thank you.

Hari became a role model for many other street children who interacted with the H_O_W team.

xxv Children were selected by the primary NGO.
Il) Going beyond health

Going beyond health issues was a strategy adopted by H_O_W to fulfill its objectives. In the year 2002, SNEHA took on the responsibility of being a Support Organization for ChildLine and carried out outreach work between Sion and Mahim (including Dharavi). The H_O_W team carried out the following functions:

- Networked with the collaborative organization in the demarcated areas.
- Performed outreach work like sticking publicity posters of Childline in public places and checking PCOs for the connection of the Toll free Help Line- 1098.
- Contacted institutions and organizations like Police Stations, School, Colleges and other NGOs existing in the vicinity, to create awareness and sensitize them about street children.
- Reached out to street children in emergencies, to render medical treatment and to admit them to the infirmary or hospital, if necessary.

During the five years of the project the H_O_W team developed close relations with the street children and was invariably drawn in to deal with a few issues that went beyond its primary objectives. The H_O_W team responded to ‘calls for help’ in many cases like the one given below.

Case Study

**Mahesh** stayed in Dharavi with his parents and three younger sisters. Sadly, his father died in a railway accident, and a year later his mother died of AIDS. Before dying, Mahesh’s mother asked the SNEHA team to look after her children. The family had no relatives staying in Mumbai. When the H_O_W team visited the children, they found that the neighbours and others were trying to take over their house as the children were young, isolated and thus quite vulnerable.

The H_O_W team contacted Ms. Adenwalla, lawyer and child rights activist, who took up the case in the Mumbai High Court and the house was sealed after the court orders. The house is being kept under the caretaking of the government till **Mahesh** becomes an adult.

Until then, the four children are to stay in institutions: **Mahesh** was sent to one of Snehasadan’s Boys’ shelter homes and his sisters were put in CORP’s shelter home. Once in a few months, the H_O_W team arranged for all of the siblings to meet at SNEHA’s office. The team would also visit the children’s paternal home once in a while to ensure the lock was intact and there was no damage to it by miscreants.

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*ChildLine Support Organization receives calls from the collaborative organization and provides follow-up on a call, based on its area of operation.*

*Snehasadan is an NGO providing outreach, residential and family re-unification programmes for street children in Mumbai.*

*Community Outreach Programme (CORP) focuses on the slum dwellers of Mumbai. CORP also reaches out to street children and provides day care and shelter homes to them.*
Step 4: Review & Withdrawal of the H_O_W Project

While the annual review process had helped in sorting out several operational problems, the H_O_W project decided to have a more detailed review of the complete programme in late 2005.

Review done by NGOs

The H_O_W Project Coordinator and her field staff visited each of the partner NGOs to enlist their participation in the review process. An appraisal form was given to the NGO’s, so that they could respond freely and elaborately. The team reviewed formally the fulfillment of project objectives and the project’s continued relevance to the NGOs. The outcome of this initial meeting was unsatisfactory as attendance on the part of the NGOs was poor and the representation was that of paraprofessionals instead of senior functionaries of NGOs. However, the interview forms filled by about 50% of the NGOs showed that they were satisfied with the health care provided. They expressed the need for a regular training programme for the paraprofessional staff.

As most of the objectives of the H_O_W project were fulfilled and the model for delivery of comprehensive mobile health care services to street children had been evolved, SNEHA decided to end the project. The withdrawal phase of the project began in mid-2006 in and was conducted in a phased manner:

As SNEHA had set up a health center at Shastrinagar, Santacruz (Western Suburb), the H_O_W project was shifted to this centre. This shifting base from UHC, Dharavi to Shastri Nagar, made the H_O_W operations economically and physically difficult to continue. Unlike Dharavi UHC, this center was not centrally located. The established network of NGOs, volunteers and PSM doctors from Dharavi also became strained and needed fresh inputs for continuation. The impact was especially seen in the form of reduced referral and infirmary service utilization, and fewer volunteer doctors

With withdrawal on its anvil, SNEHA decided that it would provide health care to primary NGOs on an ‘as and when needed’ basis through its Shastri Nagar Health Centre. It also continued to support NGOs regarding referrals to appropriate MCGM health units. SNEHA resolved to focus its attention on training and capacity building of paraprofessionals working in primary NGOs in the last year of the project.
Achievements of the Project

1) Fulfillment of Objectives:
- The outreach of H_O_W project was quite widespread as the network of 18 primary NGOs were from the western and eastern suburbs. Considering that there were about 50 primary NGOs working with street children at that time in Mumbai, the H_O_W project worked closely with 36% of these organizations.
- Street children who had earlier refrained from attending the clinics or were unaware of its services started using the H_O_W facilities quite regularly as well as at special events.
- Curative health services were provided to 3510 street children per year. If this is calculated against an average of 200 working days annually, then the H_O_W team catered to 18 children per day for curative services. Apart from this the team provided health services to about 1000 street children at special camps and Melas. Moreover they conducted preventive, promotive and rehabilitative health programmes.
- Referral and infirmary services that were coordinated by SNEHA were very much appreciated by the primary NGOs and the street children as they had filled a yawning gap.
- The H_O_W team facilitated the contribution of partners in such a manner that each partner could extend its support as and when required.

2) Tackling Challenges
The H_O_W team tackled several challenges by identifying suitable strategies for dealing with them. The following table describes some of the challenges the H_O_W team faced and its strategies for overcoming these challenges.

<table>
<thead>
<tr>
<th>Challenges faced</th>
<th>Strategies used to tackle them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes PSM department doctors did not have time to join the mobile van, as they were busy with special lectures, exams, presentations, meetings etc.</td>
<td>Identified volunteer doctors to work with the H_O_W team.</td>
</tr>
<tr>
<td>Changes in school hours of children living in residential units required changes in timings of visiting doctors. This was not possible for the PSM department doctors.</td>
<td>Doctors from neighbouring areas were encouraged to volunteer and later on part-time paid doctors were employed by SNEHA</td>
</tr>
<tr>
<td>The mobile van, driver and fuel, which had been provided by AAMRAE, were withdrawn in the last two years.</td>
<td>The H_O_W project continued to conduct its routine activities by utilizing public vehicles like train, BEST Buses, auto-rickshaws and taxis.</td>
</tr>
<tr>
<td>Without the mobile van, it was difficult for the entire team of doctors, social workers, and volunteers to visit the NGO together.</td>
<td>The volunteers were free to join the team at the NGO center at the fixed hour thus minimizing the dependence on the van</td>
</tr>
<tr>
<td>NGOs sometimes made scheduling changes at the last minute, disrupting</td>
<td>The H_O_W team decided to call the host NGO on the day before</td>
</tr>
</tbody>
</table>
the plans of the H_O_W team. | each visit to confirm the schedule.  
---|---
Occasionally, when an NGO was conducting the programme in the slum or on the street, there was a demand for services from people other than street children. It was difficult to deny health services to these populations although they were outside the purview of the project. | H_O_W team reviewed its list of NGOs for networking and withdrew its services to NGOs who were not working with street children.

### 3) A Low Budget Project

The project was initiated with support from AAMRAE, which included the van, driver, fuel and maintenance cost. The H_O_W team worked on a shoestring budget and worked creatively to acquire free and subsidized resources while maintaining the quality of health services. The cost per child for the H_O_W project worked out to Rs. 12 per child per month.

This project cost was low as compared to YUVA’s experience of Rs. 40 per child per month, as the transportation cost was taken care of by AAMRAE. volunteers and private donors had contributed tremendously to the project. About 60% of the project funds were utilized for providing the comprehensive health service programme, salaries of staff (including part-time doctors) took 35%, and administration utilized only 5% of the total project fund.

### 4) Taking Lessons Learned Ahead

As a newly emerging NGO, SNEHA, learned a number of important lessons from this project, which have been crucial for its growth.

1. **Private, public and NGO partnership**

While SNEHA took the initiative to plan and facilitate the private, public and NGO partnership model, the public and private bodies extended adequate and timely support and resources like volunteer doctors, drugs and funds. This was possible because the common concern about street children was transformed into a common agenda. However, the partnership could have been formalized in the form of an MOU, as it has the potential of ensuring collective ownership of the project and encouraging each partner to take initiatives in the project.

2. **Involving volunteers**

The H_O_W project had enlisted the support of other NGOs as well as volunteers to help its small team. As the project team and volunteers shared a mutual respect for the common objective, they proved to be assets for the project. Involving volunteers also served the purpose of sensitizing common people to the lives of street children.

3. **Areas for improvement**

The five-year project had overcome several challenges but some had persisted. These were:

- Due to turnover of paraprofessional staff at primary NGOs, the tasks of treatment follow-up and case paper recording of were neglected. As a result, the H_O_W team had to continuously re-orient the new NGO staff with
key health messages and procedures to be followed. This problem could have been tackled with more discussions with primary NGOs.

- Due to a lack of resources, doctors working for the H_O_W project received low compensation. It was difficult to find doctors to work for this remuneration. This could have been budgeted in the project proposals in the following years.

- Capacity-building programmes and workshops for NGO staff did not yield expected results as the primary NGOs faced the problems of insufficient staff, turnover of staff, and lack of time for attending the H_O_W training programmes. This could have been developed in a more suitable way by seeking NGOs to give concrete and workable plans.

The experiences from this project provided SNEHA with insights for future development work. These insights were:

1. Preparing the ground for continuation, expansion and / or sustainability of the project keeping in mind the partners expectations and SNEHA’s capacity.

2. Securing adequate funds and resources for the project from time to time.

3. Regular critical reviewing and strengthening the operational programme

4. Ensuring all the partners have clarity on the outputs to be achieved at the end of the project

5. Role of each partner to be planned in the beginning and sustained throughout the project

6. Devising process documentation and record keeping formats from the beginning of the project that would help to assess the project more systematically

7. Keeping in mind the limitations of NGOs before planning networking with NGOs
Conclusions

As one of the most marginalized and victimized sections of society, street children should be provided with a comprehensive health services programme. While providing health care is the primary responsibility of the government, it is the obligation of everyone to contribute to the fulfillment of this responsibility.

A majority of street children, despite efforts made by government, NGOs, civil society and international agencies, remain marginalized and out of reach. Evidence shows that street children are unable to penetrate the barriers of access to health services. The model tried by SNEHA was both comprehensive as well as accessible to the street children under its purview.

Any programme aimed at improving the health status of street children will have to take into account street children’s strong sense of independence. If health care is to be accessible to street children, it must be free, easy to reach and access, less time consuming, sensitive and empathetic.

Apart from the valuable efforts already made by the Government of India in terms of policy and programmatic changes, there is a need for some additional changes at the state and MCGM level to make health care more accessible to street children. For example policies like no user fees, mobile services, reducing waiting time in outpatient departments, caretaking during admissions, provision of “after-care” facilities especially for children with disabilities, child addicts and HIV positive street children, and maintaining proper referral mechanisms for follow-up would go a long way in making health care accessible to street children. The lessons learned from the H_O_W project regarding developing systems for mobile services, referral, hospitalization and infirmary could be reviewed while formulating such policies.

There is much scope for sensitization of public health and private sector health providers regarding street children. This could ensure that all levels of public health care providers encourage street children to access public health services and improve their health status.

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 continued. Reiteration of the National Policy for Children, 1974 and the National Plan of Action for Children, 2005 at various forums would also be a step towards ensuring health and nutrition services to all vulnerable children, including street children.

As health and development are closely related, it is crucial that all concerned groups look beyond health programmes for street children.

Two vital points of concern for social activists in the field have been:
(1) The fact that the government has no database on street children. The parliamentary standing committee on human resource development panel in its report suggested that the ministry start preparing a data base detailing the number of children on the streets and those benefiting from this scheme.62 According to Baizerman (1988), “the politics of numbers can hide or distort the moral issue . . . and
street kids, both as people and as a symbol, may be used to mediate actual and symbolic relations between different social, ethnic, racial, and income groups”.

(ii) We need to take into account the ‘push and pull’ factors responsible for the increase in number of children on the streets. The government can expedite the process of formulating laws on Offences against Children, Prohibition of Child Marriage Bill 2006, and the Model Right to Education Bill as well as making amendments in the Criminal Procedure Code to make it child-friendly. Furthermore Identification and removal of gaps and anomalies regarding programmes and schemes that impact on children (food and nutrition, welfare programmes for eradicating poverty) will strengthen efforts made by the NGOs and other civil society partners. The merging of the current street child programmes with a broader Integrated Child Protection Scheme as suggested by National Institute of Public Cooperation and Child Development (NIPCCD) and which is on the anvil of the concerned Ministry will mean a concrete step taken in the right direction.

Finally, only a recognition of children as individuals with rights can pave the way for future action. In the absence of this, all efforts will be sporadic, addressing only some symptoms and not the root cause of the problems that affect the children of this country.
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Making Health Care Accessible to Street Children: The 'Hospital on Wheels' Project (2000-2006)


44 This has also been revealed by street children during informal discussions between the researcher, street children and NGO staff.


51 Informal discussions with NGOs in Mumbai


54 Dr. Fernandez during informal discussions regarding the project.


56 Manjiri Kalghatgi, A small toast to Mumbai's health -- Bal Doctors take to streets, The Indian Express, July 15, 1998

57 CCVC- is a network of NGOs working with vulnerable children in Mumbai

58 Barnabe D’Souza, Larissa Castelino, Dakshayani Madangopal, 2002, A Demographic Profile Of Street Children In Mumbai, Shelter Don Bosco Research And Documentation Center, Mumbai


60 The approximate number of NGOs working with vulnerable children in Mumbai as reported by CCVC (Coordination Committee for Vulnerable Children), is about 50.


63 Baizerman, M. (1990). If "out of sight, out of mind," then "in sight and in mind?" p. 14, as in The Child Care Worker, 8, 4-5 by Johann le Roux, Cheryl Sylvia Smith in “Public perceptions of, and reactions to, street children, Adolescence, Winter 1998