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AIDS-risk Patterns and Knowledge of the Disease Among Street Children in Harare, Zimbabwe

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ABSTRACT

HIV/AIDS is perhaps the fastest growing worldwide health concern today. Universally, adolescents have been identified as a group at high risk of HIV infection (Richter & Swart-Kruger, 1995). Very little information is available on the lifestyles, health and rate of HIV infection among street children in Zimbabwe. Isolated studies focusing on street children have begun to emerge in some countries and show HIV infection as an issue of growing concern. Our knowledge on the subject is still very limited. This report outlines the patterns of risk to HIV by street children in Harare, especially street boys, as well as outlining an assessment of their knowledge of, and attitudes towards the disease.

Introduction

This report is not meant to over-emphasise the issue of street children as a very high risk group for HIV/AIDS infection. The danger is that this may cause discrimination against them as AIDS puts people into a condition of socially defined "impurity," if I may borrow the term from Mary Douglas (1966). One who suffers from the disease is socially defined as the "impure other." This is never more so, than when a disease is fatal and resonates with people's sexuality (Barnett & Blaikie, 1992:3-4), which above all is taken to coincide with morality. Unfortunately in the early stages in the quest for understanding the disease, AIDS has been seen as affecting some culturally defined groups of people like homosexuals, black people, foreigners, prostitutes, drug addicts, to name a few. For example early suggestions for a name indicate the prejudice so easily associated with the disease. It was referred to as GRIDS – for Gay Related Immune Deficiency Syndrome referring specifically to homosexual men (Barnett & Blaikie, 1992:1).

There are few countries in which cases of AIDS have not been reported. Thus the implications of the disease are international and transcultural. AIDS is not a

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disease of a particular people, gay, black, prostitutes and others. It is a disease of people. Many of the ways by which the disease is transmitted are transcultural and include many relations of intimacy (mutual sexual relations, pregnancy and birth) and relations of care (blood transfusion and medical treatment) as well as the darker sides of human experiences such as drug abuse, prostitution, and rape. In a nutshell, the disease is not exclusively sexually transmitted.

While many organisations and programs are making significant contributions to counter the spread of the disease, some marginalised groups like children in difficulty, still lack access to the education and resources available to the mainstream society. The purpose of this report is to share knowledge and to sensitise ourselves to include such children in our programmes as well.

This report is based on information that has been collected by the team of outreach workers of Streets Ahead, (a welfare organisation looking into the welfare of marginalised children in the city of Harare) within and outside the context of the AIDS education programme of the organisation; the clinic for street children that was eventually initiated by Streets Ahead as a result of the AIDS education programme as well as my own research for a doctoral thesis which is forthcoming (see, Dube, 1997 & forthcoming).

Within the AIDS awareness peer education programme, a number of settings and tools have been used to elicit useful information so as to design an information programme that is tailored to the specific needs of the children. Workshops have been another useful way of acquiring information as well as being useful in the learning process for the children. Within workshops and discussions, videos such as *Karate Kids* and problem-posing posters have been invaluable. In some instances, children have come up with their own drawings and comics to illustrate their feelings towards certain issues pertaining to HIV/AIDS. Such drawings have been invaluable in designing useful information for use by the children in peer education. This has been very important in that the peer education programme has been tailored to suit the realities of the children, not those of us as adults nor those of the institution we are working for. As in the words of Ennew (1996:203):

> *"Studies on children in general, and street children in particular, tend to rely on adults' assumptions about how the children think and what they must need. Children themselves are rarely asked about their lives. Instead researchers ask parents, teachers or staff of institutions. If they ask children directly they seldom pay much attention to making questionnaires and interview schedules relevant to children's experiences, interests or language. If they do try to approach children's worlds through non-verbal research methods such as collecting drawings, they frequently fail to ask children what the drawings are intended to represent, relying instead on adult interpretations, often using psychological concepts and research instruments derived from Northern contexts."*

The context

In Zimbabwe, persons aged 20 - 39 years of age account for a significant proportion of all known AIDS cases: see Table 1 below.

Table 1: Cumulative AIDS cases by Age Group: 1987 - March 1995

Age Group	Female	Male	Unspecified Sex	Total
0-4	2771	3177	39	5987
5-14	194	178	0	372
15-19	685	118	5	808
20-29	6371	5197	25	11593
30-39	4764	7493	35	12292
40-49	1607	3631	8	5246
50-59	504	1471	4	1979
60+	172	538	3	713
Unspecified Age	756	1092	460	2308
Total	**17824**	**22895**	**579**	**41298**

Source: AIDS Coordination Programme, Ministry of Health and Child Welfare

The above table shows that the 20-29 and the 30-39 age groups are the hardest hit by the AIDS pandemic. Within the two age groups, the worst hit are the males in the 30-39 age group and the females in the 20-29 age group. In third place are the males in the 20-29 age group, while in fourth place are the females in the 30-39 age group. Generally, the figures indicate that males tend to suffer more than their female counterparts, especially from the age group 30-39 and above.

Given the median latency period of 8-10 years between HIV infection and the development of AIDS (Sugerman, Hergenroeder, et al, 1991), it basically means that many of the young adults with AIDS, in the 20-29 year category, must have acquired the infection during their teenage years.

An explanation for the high incidence of AIDS cases amongst the females in the 20-29 age group is that older men (30s - 40s) are very often having sex with younger women or girls, contributing to what is generally known as "sugar daddies." The young girls usually have boyfriends of their ages and they invariably pass the infection to them, while the older men pass the infection on to their wives.

Women generally develop AIDS at a younger age than men on average because of the following:

- girls tend to be sexually active at a younger age than their male counterparts, and they tend to be involved with older men;
- girls may have riskier partners than boys of their own age. Girls are more likely to have an older partner for material benefits and status while at the same time have an affair with a boy of their age with whom they hope to settle down;
- men looking for a mistress specifically choose younger girls hoping they are free of HIV infection and for other reasons (such as "they are tender and fresh") and the men may therefore practise unsafe sex;
- young girls are more prone to sexual abuse, date rapes, incest and other forms of sexual abuse. While generally young women prefer an "experienced" man as a lover than younger man who prefer an inexperienced young woman.

The general pattern of sexual relationships is one in which large numbers of men, single or married, have sex frequently with relatively young women (as girl friends, sex workers and so on) who may have a number of male partners. The majority of married women do not have multiple partners, but are at risk because of their husband's extra-marital relationships (Jackson, 1992:61).

The statistical information that I rely on here on the situation of street children is based on data that came out of the clinic which was established as a direct outcome of the AIDS awareness and education programme. Unpublished institutional data from six clinic sessions in which 66 street children (all boys) attended as from March, 1996 to November of the same year, reveals that:

- 42,1% of the children suffered from infections such as chest and urinary tract, excluding sexually transmitted infections (STIs);
- 14,5% of the children suffered from sexually transmitted infections;
- 10,5% suffered from skin problems including scabies;
- an equal number of 9,2% of the children was split between ear, nose and throat problems (9,2%) and injuries due to violence (9,2%);
- a remainder of 14,5% represented children suffering from other unspecified ailments.

From the above information it is clear that sexually transmitted infections constitute a significant total of the health problems of street children in Harare.This is cause for concern because experts in this area are generally agreed that sexually transmitted diseases pose more chances for HIV infection.

General AIDS-risk Factors Amongst Street Children and Youth

Some children in difficulty are into commercial sex as part of their survival, while at the same time sex is also an avenue by which the children are exploited, especially by the powerful members of mainstream society. Despite that there is no systematic information available on HIV infection among street children, the fact that some children sell sexual favours to adults to survive poses a great danger for the future. The children are really at high risk of contracting HIV/AIDS.

Through experience in working with children in difficulty, it has become clear that existing programmes on STDs/HIV/AIDS for children and youth are carried out in schools and colleges and therefore are not accessible to children and youth who work and live on the streets. Even if this information were accessible, it does not address some of the specific circumstances in which these children find themselves.

Street children and street youth are regarded amongst adolescents generally, as being at increased risk for HIV/AIDS infection for the following reasons:

- they become sexually active at a younger age than adolescents generally (Rotheram-Borus, Becker, et al, 1991);
- they tend to have more sexual partners, because of the various forms of sexual relationships they engage in – for example rape, commercial sex, and survival sex (Athey, 1991);
- there is no useful information and services available to them to enable them to make informed choices in sexual matters. There is no system in place to make condoms available and accessible to the children on the streets who may require them for at least some protection when they are in difficult situations. They are cut off from the customary services of information such as the school and the family;
- they often use drugs, abuse substances such as glue and take alcohol which enhances sexual behaviour that in turn exacerbates risks of HIV/AIDS infection (Athey, 1991), as they engage in sex indiscriminately;
- survival on the streets entails giving higher priority to obtaining food, clothing and shelter than concerns with health or safe sexual practices (King, et al, 1989);
- the children tend to suffer from low-self esteem, indifference and fatalism;
- they have attitudes that are likely to mitigate against behaviours that could reduce the risk of HIV/AIDS infection (Richter & Swart-Kruger, 1995); and
- the children like other teenagers in general may perceive themselves to be both physically and psychologically invulnerable (Richter & Swart-Kruger, 1995:31; Swart-Kruger & Richter, 1996:237).

This report basically covers what we have found out with street boys. It is, however, important to spell out briefly what we know of street girls.

About street girls

In Harare, one sees very few girls on the streets. The girls that one sees on the streets usually accompany their blind parents who beg on the streets, while other girls work as vendors with their parents or groups of older women in the city centre. By nightfall, most girls working on the streets go home with the exception of some few groups. It is becoming clear that some of the girls who work as vendors are involved in prostitution especially girls that work as late as 10 pm and beyond. I have observed that girls and women who work until late usually operate close to a "night-spot." A woman or girl disappears for a while leaving her wares in the care of other girls and women. Some are picked up by cars to be dropped later, while others disappear into a close-by building or alley. This is common in the Kopje area.

Girls who are homeless are reportedly to be quickly taken by "aunties" and "uncles." Aunties are older women prostitutes whose attractiveness is on the wane. Such "aunties" or "madames" can continue to earn money by collecting under their charge young women with whom they can keep their clients content (see The Herald, 8 August 1990). The girls consequently have somewhere to stay and usually a relatively good income and smart clothes. Other homeless girls live on the streets with their homeless mothers or families. I have observed that some girls who live with their homeless mothers are encouraged into living with a man at an early age. The man is usually also homeless. The mother of the girl might be receiving assistance from her son-in-law, and in some cases both might be living together as one family. The "married" girl might be involved in prostitution as a way of earning an income, with her mother and "husband" aware.

A phenomenon that is on the increase in some streets of Harare is the "teenage girl street walker." This phenomenon seems to have developed from the Kopje area (west of city centre) into the Avenues (north of city) stretching into Greenwood Park (east of city centre). It is rife in the Avenues because the latter is partly a cosmopolitan suburb with lots of tourists and other people who are temporarily in the city. Furthermore, the Avenues predominantly houses bachelors, while some parts of the area that are used as offices by day, become very quiet and attractive to "street walkers." The Kopje and the Avenues are well known as very attractive places for casual sex.

A number of these child walkers are believed to come from high density suburbs, while some are thought to be in domestic employment within the Avenues and venture into prostitution at night to supplement meagre incomes. Being in

domestic employment by day might offer some girls slight "protection" and security.

It seems that the girl child is relatively "protected" when both working on the streets and while being a sex worker such that their visibility on the streets (especially by day) is minimal. The relative "protection" is basically that they appear as children accompanying their parents when in fact it may not be the case for every child.

Patterns of risk of street children (boys) in Harare

Circumstances of HIV/AIDS transmission to street children in Harare come in these various ways.

Firstly, transmission can take place through exchange of sex for money. Children are approached during the night (especially during week-ends) by adult males (who the children call *mangochani*) wishing, to engage them in sex in exchange for money. Sometimes they are offered a meal and gifts in exchange for sex. The children find it difficult to resist and many participate because of the pressure to earn money to survive. This is commercial sex or prostitution, which Bond, Mazin & Jiminez (1992:18) call "transactional" sex. It is also abuse and exploitation of the children by some unscrupulous adults. The act can be penetrative (penis in rectum) or "safe" sex (penis in thighs or mouth). Children who are often abused by the *mangochani* are referred to as *vakadzi* (Shona term for women) or *munha* by other street children. Love-making between a *munha* and *ngochani* is called *kukangana* (Shona term for roasting).

The second possible way of transmitting HIV/AIDS is through exchange of sex for security (survival sex). The street community has a well-established power balance and hierarchy. Many of the younger street children, especially when they initially enter street life, are required not only to pay in cash to older street people and to a *monya* (an older and stronger boy who controls the rest in a group) but are also required to submit themselves to sexual activities in exchange for protection, favours and other goods and services. The act is often penetrative rather than the "safe" sex variety mentioned above.

The third possible way of HIV/AIDS transmission is when children engage in sex as an exchange of experience. Some children who have been sexually abused by adults, or engaged in commercial and survival sex, cope with the sense of frustration and powerlessness by engaging other children in similar sexual activities. Other children, especially those that huddle together for warmth during winter nights, experiment sexually with one another as part of natural discovery. The children usually call this *kujumana* in their street argot. The act is often penetrative.

However, within the third type of sexual risk mentioned above, one cannot rule out what Bond, Mazin & Jiminez (1992) termed "comfort" sex. Unlike other sexual activities in which youth participate (for example, as a result of sexual abuse, as an economic transaction, or because of exploitation) "comfort" sex occurs as a result of mutual consent and is reported to be gratifying, or at least a pleasant experience by those who engage in it. The above authors (1992:18) elaborate by pointing out that:

> *"Comfort sex does not necessarily imply exclusiveness with a single companion or sexual partner; it is more a series of situational sexual encounters than a result of a permanent loving relationship. It is more a search for relief from the tensions caused by true transactional sex."*

The fourth way is when some older children pick up sex workers (prostitutes) during the night from night spots in and around the city. Some of the boys have developed a fairly stable relationship with some prostitutes who happen to be under the care of some older women. As has been noted above, these are women who are at an age when their attractiveness as prostitutes is on the wane and they collect some younger girls through whom they can continue to earn money. It is a brothel type of arrangement. With the HIV/AIDS epidemic, more men seem to prefer young girls to older prostitutes who they suspect to be HIV positive. "Aunties" cash in well on this. Furthermore, as a street boy grows older he may approach an "auntie" to find him a wife, in order to form a relatively stable relationship and have children (see also Bourdillon, 1994:519).

As has been hinted above, some girls are under the protection of males. This is true for homeless girls in and around the city centre who are vulnerable to men, and therefore need an influential man to protect them. Such men through the care of younger girls earn money as the girls pay for protection. The man who offers protection to the girls also charges other men and young boys who want to have sex with the girl. Some of the men who offer protection to girls are reported to sexually abuse the girls they are protecting as well as the young boys that come looking for girls for sex. It is reported that a boy can be forced by the "uncle" to submit himself for sex before he is given a girl.

In some cases older street boys live with street girls as husband and wives. This often happens in settlements of the homeless people in and around the city centre. The boys take responsibility for the security of the girls, ensuring that they have adequate food. In return, the boys are accorded all the treatment that befits a husband, including emotional and sexual favours. However, the fact that these girls and boys maintain "marital" relationships does not mean that they do not practice prostitution. On the contrary, the boys especially, seem to accept prostitution on the

part of girls as a normal income-generating activity for both of them. The money earned by the girl through prostitution is used by the "couple" to sustain themselves. While not being engaged in prostitution, the same girls ("wives" to some street boys) can be passed around among their male counterparts.

Each street boy is at risk through all of the above means thereby making the risk very significant indeed. According to Jackson (1992) anal sex is generally more riskier than vaginal penetration, while oral sex also carries a risk but is believed to be less risky than the penetration of the vagina and rectum. Any sexual act that tears the skin or mucosal membranes and thus draw blood and other body fluids is considered risky. It is thus termed unsafe sex. The full definition of unsafe sex as put forward by Jackson (1992:58) is, *"...penetrative sexual intercourse with no condom involving an exchange of body fluids through contact of the skins between penis and vagina, anus or mouth."*

Knowledge of HIV/AIDS by the children

The children seem reasonably informed about HIV/AIDS, which some of them refer to as "go-slow." This is a descriptive term of the slow and painful death which literally refers to the wasting away of the flesh and life. Other children euphemistically termed AIDS *"chirwere chemazuva ano"* (today's disease). The children know that AIDS is an incurable disease and are aware that it is predominantly transmitted sexually and through needles for intravenous drug injections as well as razor blades if used communally, and that condoms are good to use but have their own limitations. Despite this fairly good understanding of HIV/AIDS, some of the children's knowledge was problematic. The problematic facets of their knowledge concerns outright misconceptions as well as incorrect knowledge.

Misconceptions

Misconceptions covered the following issues below. Vulnerability to HIV/AIDS was attributed to the following characteristics:

- having casual sex with particular groups of people, like homosexuals *(mangochani)*, prostitutes and those with HIV/AIDS features, rather than a concern about the critical mechanisms of sexual transmission. Surprisingly the children did not include themselves within these groups of people, although they have many sexual partners. Related to the above was the misconception that someone weak, losing hair, with sores in the mouth, etc, is often an AIDS sufferer. Yet the person could be suffering from something else, or malnutrition. This meant that the children at times could identify

someone suffering from HIV/AIDS, but could also incorrectly diagnose the illness. HIV can also lie dormant for many years enabling infectious but asymptomatic people to appear healthy;

- the children expressed fear in touching someone with AIDS; the same applied to kissing, using the same utensils and sharing food.

However, in the final analysis the children's misconceptions are very much consistent with those of mainstream society in Zimbabwe. For example Moyo, et al, (1993) in a Knowledge, Attitudes and Practice (KAP) survey in the City of Harare amongst 2,109 adults noted the following:

> *"A quarter of all the respondents ....stated that they would evict lodgers with AIDS, would avoid either neighbour, co-worker or school mate with AIDS" (p 45).*

> *"The level of stigma against people with HIV/AIDS in the community is high. The groups which most people thought were at risk of being infected with HIV were prostitutes and promiscuous people. These responses which emphasise promiscuity stigmatise people with HIV/AIDS. More women (71%) than men (65%) stated that promiscuous people were at risk of catching AIDS and more women were also less supportive of people with AIDS" (p 48).*

Furthermore, Moyo, et al, refer to a study in Chilimanzi done by the Catholic Development Commission and note the following:

> *"The CADEC study in Chilimanzi found that 80% of the women interviewed stated that they would prefer AIDS patients to die in hospital" (p 46).*

In a way the children's misconceptions and those of the Zimbabwean society at large seem to be very much consistent with those of the global development of the understanding of the disease. In the early stages of the disease, it was common for it to be referred to as a disease of homosexual men and later on prostitutes were included – while of now it is very clear that it is a disease of people. In a way once more, this makes the children's knowledge fairly good, despite that they live on the fringes of society. As Barnett & Blaikie (1992:4) put it:

> *"While at first the epidemic may affect some population sub-groups more than others, the passing of time will ensure that its distribution within the population alters. Thus what was in North America and Europe, once seen*

as a disease of male homosexuals, haemophiliacs and intravenous drug users, is increasingly becoming a disease to which every sexually active person may be exposed, or which may affect those undergoing or practising surgery."

The fairly good but problematic knowledge of the children covered the following issues:

All children knew that AIDS exists and that there is no cure for it. But some felt that they will not die of it if they contract it, because they will use traditional medicines. Some boys said that there are older women who they sleep with after which they are given traditional medicine to cure STDs and they believe the same women can cure AIDS.

With particular reference to sex, the children were not clear that it is the sexual act which is important rather than who it is you are having sex with. They were not aware that it is impossible to tell who has AIDS or not and that the sexual act is important, especially penetrative sex as opposed to "safe" sex. Thus it has been important for the children to know that it is not just having sex but the nature of the sexual act.

With reference to the use of condoms, the children were aware that condoms have their own limitations. The children knew that effective use of condoms depends on how one uses or wears them, and how one stores them. Furthermore, condoms may not be readily available, and where available the children cannot access them due to social expectations that condoms should not be given to children, which can be an indicator of our society's sexual privacy and modesty, which unfortunately seems to carry with it moral overtones. The children were, however, not aware that condoms are first and foremost a birth control measure. Use of condoms in the prevention and control of STDs/HIV/AIDS is a secondary stop-gap measure to minimise risks but does not totally eliminate risk. Thus the children have a right to know that condoms are the only alternative that exists at the moment should one decide to get into a risky sexual act. The key factor is to minimise sexual partners by sticking to one lifelong faithful mutual relationship (but recognising that this may be difficult in their circumstances).

Conclusions

From a rational perspective, the most effective way of coping with the AIDS pandemic is to change sexual behaviour as well as avoiding possible infection from contaminated hypodermic syringes and other related gadgets. In order to achieve these, it is necessary to have an accurate explanation of how the disease is transmitted. Information has to be translated into knowledge and then into action,

which is principally behaviour change. However, this may not be an adequate account of how people actually deal with these risks. Here I do not mean refraining from sex and drugs, which might be unrealistic courses of action, but practising safer sex and drug-taking. In reality most of us cope with risks through a combination of rational and non-rational responses.

Education on the dangers of AIDS and seeking to minimise risks of HIV infection can only succeed in the context of overall personal development of the child. We cannot expect children to protect themselves if they have no sense of their own worth and self-esteem. Furthermore, we cannot expect the children to achieve this instantly. Any meaningful programme should go beyond meeting immediate health needs by also tackling the broader issues of why children are living on the streets. The threat of AIDS and other sexually transmitted diseases, increased drug addiction, etc, as have been spelt out in this document, cannot be separated from lack of choice and opportunity. Our work should in the long term be towards improving the general health and self-image of the children. Giving children the knowledge and the facilities to improve this, will increase their self-respect as well as reduce risks to HIV/AIDS infection. Thus, in order not to moralise and over-publicise the children as being at very high risk, we need to discuss safer sex in the context of the children's other concerns such as broader health issues apart from HIV/AIDS, personal safety, economic survival, housing, drug-taking, legal and other rights. If we encourage condom use by the children, we should emphasise that this applies to all sexual contacts with friends, adult clients and strangers.

Behavioural change on the part of the children can only come from promoting self-worth and creating an environment where children can make informed choices. This comes about when we also respect them as human beings, and treat them without any prejudices and moral judgements.

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