HIGH RISK SEXUAL BEHAVIOURS AMONG STREET ADOLESCENTS IN NDOLA, ZAMBIA

Ntinda Kayi and Kwaku Osei-Hwedie*

Abstract

The study investigated factors that precipitate high risk sexual behaviours among street adolescents in the context of the high HIV and AIDS incidence in Zambia. A descriptive, qualitative design was adopted. Face to face interviews and focus group discussions were used to collect data. The main findings are that street adolescents engaged in high risk sexual behaviours such as unprotected sex and commercial sex work as a means to earn a living. This is compounded by their low levels of knowledge and misconceptions about HIV and AIDS. The unsteady situation of street adolescents may not enable them to benefit from conventional HIV/AIDS prevention programs that stress non-risky sexual behaviours. It is necessary to reintegrate street adolescents into their society, create safety nets for them to meet basic needs, and make them receptive to health education programmes in order to reduce their vulnerability to risky sexual behaviours.

Introduction and Background to the Study

Several studies continue to indicate that young people, aged 15 to 24, have serious misconceptions about HIV/AIDS and its modes of transmission (see Cohall et al. 2001; Foster & Matenga 1993; Richter & Swart-Kruger 1993; Moore & Rosenthal 1991; Giles 1988). HIV/AIDS is not the only major concern among countries in Sub-Saharan Africa. Street children are yet another concern, with Lesotho, South Africa, Zimbabwe and Zambia experiencing high numbers. The General Board of Global Ministries (2005) indicates that there are about 10 million street children in Africa. Most of these are found in large, urban cities (Kopoka 2000; Massallay 1990; Obbo 1990; Taruvinga 1990). Advocates for Youth (2005) estimate that there are about 2 million street children in Zambia, whose ages range from 9

*Ntinda Kayi is a Demonstrator, Child and Human Development Studies, Department of Social Work, University of Botswana, Gaborone.
Dr Kwaku Osei-Hwedie is a Professor, Department of Social Work, University of Botswana, Gaborone.
to 19 years. Despite an increase in the number of street children in Zambia, little is known of their sexual behaviors, yet they are among the population most vulnerable to sexual abuse, prostitution, substance abuse, and HIV and AIDS infection.

Studies conducted by UNAIDS (2004) indicate that street children in Zambia are being driven into commercial sex work, exposing them to the risk of HIV/AIDS and sexually transmitted infections (STIs). Other studies that have addressed street adolescents' problems have found that most prefer the street life to being in school as they earn "easy income" from the different piece jobs they are involved in, like washing and guarding of cars on the streets (Bohmer & Kirumira 1999; UNICEF/USAID/WHO 1999; Banda et al. 1999; Hodne 1995; Foster & Matenga 1993; Richter & Swart-Kruger 1993).

This study, therefore, explores the high risk behaviours among street children in Ndola, Zambia, in the context of high HIV and AIDS infection rates. Ndola is the provincial headquarters of the Copperbelt Province with a population of approximately 1581,221 (City Population of Zambia 2004). Ndola was selected for the purpose of this study because it is a commercial, mining and a manufacturing centre.

Methodology and Conceptual Issues

The population for this study comprised of male and female street adolescents aged between 12 to 18 years. Purposive and snowball sampling methods were used to select the sample for this qualitative research. The 12 street adolescents who were in the case study were enough to provide the in-depth, rich data that was required in the study. It was necessary to hear the subjective experiences of the adolescents. This study, therefore, explores the high risk behaviours among street children in Ndola, Zambia, in the context of high HIV and AIDS infection rates. Ndola is the provincial headquarters of the Copperbelt Province with a population of approximately 1581,221 (City Population of Zambia 2004). Ndola was selected for the purpose of this study because it is a commercial, mining and a manufacturing centre.

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opinions and stories of those who have the direct experience of street life. This, therefore, necessitated the non-inclusion of elements of the population whose experience with street life is indirect. The main methods of data collection were in-depth interviews, focus group discussions and observations.

Of the twelve participants, six were between 12 and 15 years while the other six were 17 to 18 years old. However, this was as a result of the sampling procedure since participation was restricted to adolescents between the ages of 12 and 18. Eleven were Christians, four Catholics and 4 Methodists, and 3 with no specific faith. One followed African traditional beliefs. Seven had completed grade 7, but 2 dropped out of school in grades 5 and 6 respectively. Another 2 participants dropped out in grade 8 and 10, and one was still in school, and in grade 9. Only one participant had never been to school but could read and write.

Three of the six male participants had families headed by grandmothers, while the other 3 were headed by the mother, father and sibling respectively. Almost all participants had low socio-economic status; were poor; and had financial problems. The participants were involved in different kinds of piece jobs such as shining shoes, washing and guarding cars, lifting baggage, calling on passengers to board buses and begging for food and money. The support mostly needed by the majority was money as well as education. Three participants stayed and earned their living on the streets but returned to their respective homes at night. The other 3 lived on the streets permanently.

Of the six female participants, 3 had families headed by fathers, 2 by mothers and 1 by a husband. All families had financial problems, and all the respondents spent a lot of time on the streets selling products such as chips, cassava, mangoes, mushrooms, maize and second-hand shoes. However, though they spent time on the streets during the day and sometimes at night, they always returned home to sleep. It was evident that they needed money and education.

Street adolescents and street children are used interchangeably to refer to both males and females, aged 12 to 18, and include those who are 'on the street', and spend most of the days and some nights on the street because of socio-economic problems at home, including poverty and overcrowding; it also includes those who are 'part of the street family', and live on the sidewalks or city corridors.
with their families, and who are displaced due to poverty or disability such as blindness, and are now living on the street; and finally, persons who 'live on the street' and having no home but the streets (WHO 2000).

High risk sexual behaviours are activities that put adolescents at a greater chance of contracting sexually transmitted diseases including HIV/AIDS (Uwalalaka & Matsuo 2002). These are activities such as unprotected sex including non-use of condom, commercial sex work, and having multiple sexual partners.

**Urbanization in Zambia**

Zambia's growing numbers of street adolescents may be partly attributed to its fast rate of urbanization. Zambia is one of the most urbanized countries in Southern Africa (UN. Habitat 2006) and is considered to be the third amongst the most urbanized countries in Sub-Saharan Africa (World Bank 2002; Mutale 2004). Of Zambia's total population of about 10 million, 40% is estimated to live in urban areas (World Bank 2002). Habitat (2006) notes that Zambia's urbanization rate is second only to that of South Africa. Mutale (2004), similarly asserts that Zambia's urban population is higher than most of the countries in Africa. The Copperbelt Province of Zambia, which includes the two large towns of Kitwe and Ndola has been very central to the process of urbanization. According to the World Bank (2002), Zambia has eight major towns with population in excess of 150,000 of which most of these are in the Copperbelt Province. The Copperbelt Province ranks second to Lusaka Province as the main destination for rural migrants.

Zambia's large scale urbanization, especially on the Copperbelt, can be traced to the discovery of copper and the consequent boom that followed. This brought about the development of the Copperbelt towns. Mutale (2004:35) contends that “a deliberate imposition of hut tax and the attraction of exotic material possessions and lifestyle, forced men to migrate to the Copperbelt to sell their labour”. The discovery, production and export of copper brought about drastic changes to the economy and social lives of Zambians including rapid urbanization. The World Bank (2002) argues that as a result of copper production and export, Zambia experienced high levels of rural-urban migration as citizens sought to benefit from employment opportunities, subsidized food and infrastructure that became common.
features in the urban centres. Therefore, the copper boom precipitated the process of urbanization after Zambia's independence in 1964. Immediately after independence, as a result of the copper boom, the urban population growth rate increased tremendously. However, in the 1980s, the growth rate declined drastically. Nonetheless, the last decade (1990-2000) saw a slight increase in the urban growth rate. For example, Mutale (2004) indicates that from 1963 to 1969, the urban growth rate was 8.9 percent; between 1980 to 1990 it was 2.5 percent and from 1990 to 2000 it stood at 2.7 percent.

Besides Lusaka, the urban population in Zambia is concentrated mainly in the cities of Ndola and Kitwe on the Copperbelt. The process of rapid urbanization brings with it problems such as unplanned structures, slums, inadequate water and poor sanitation services and crime. The UN Habitat (2006), for instance, points out that in Ndola, Kitwe and Lusaka, over 40% of the population live in the squatter and unplanned settlements. Physical infrastructure and services in these settlements are either unavailable, very inadequate or in very poor conditions. Other common features in these settlements include overcrowding, inadequate water supply, and deteriorating environmental conditions characterized by poor sanitation, poor drainage, uncollected solid waste and insecure tenure for most of the population. Ndola is the second largest city in Zambia, and the hub of the Copperbelt due to its industrial base and as the centre of administrative activities (UN. Habitat 2006). The UN. Habitat (2006) reports that over 200,000 people in Ndola live in squatter settlements that are growing rapidly.

Street Adolescents in Zambia
A number of compelling factors have forced increasing numbers of children to live on the streets in Zambia. According to UNICEF (2006), about one and a half million children in Zambia live on the streets. However, the Family Care Foundation (2006) and Dachs (2006) report that an estimated 750,000 children are on the streets, and that seven percent have completely no home to return to. Therefore, a significant number of street children have homes where they can return to even though they still choose to stay on the streets. Among the street children in Zambia are some who just spend time on the streets and those who actually live on the streets.
In a rapid assessment of children spending time or living on the streets in Zambia conducted in 2001, Williamson (2005) found that 42 percent out of the 1,232 children surveyed had both parents living and another 36 percent had one parent living. Furthermore, 22 percent reported that they were double orphans whereas about two-thirds reported living with one or both parents or relatives. It can therefore be argued that a larger percentage of street children in Zambia have both parents living. In the rapid assessment conducted by Africa Kid Safe (AKS) Partners (Williamson 2005), it was found that some of the reasons that made children to spend time or live on the streets are poverty, pressure from friends, and family problems or child abuse.

Factors such as poverty, breakdown of the extended families, harsh economic conditions and HIV/AIDS have contributed to the increasing number of young destitute who ultimately end up on the streets to fend for themselves. Zambia is considered to be one of the world's poorest nations with majority of the people living on less than a dollar a day. Therefore, it has been argued that poverty is the main reason why children spend time on the streets (Dachs 2006). The poverty levels vary from rural to urban areas. The harsh socio-economic conditions in the rural areas have encouraged the rural-urban drift of the youth who end up on the streets. It has been reported that approximately 80 percent of the population in the rural areas live below the poverty line whereas in the cities, even very young children have no homes or families and are consequently forced to live on the streets (SOS Children's Villages 2006).

The poverty situation and the emergence of a large number of street children in Zambia can also be partly attributed to the government's privatization programme that occurred in the early 1990s. According to Dachs (2006), the privatization of national assets in Zambia brought about the collapse of social protection services and the emergence of an unprecedented number of street children. Privatization resulted in socio-economic hardships which put extreme pressure on the families that could not cope with the new trends. For instance, all social and economic indicators show that an increasing percentage of the Zambian population is becoming increasingly marginalized, with particular reference to women and children (Family Care Foundation 2006).
The economic challenges or difficulties have, to a certain extent, impacted on the livelihoods of the poor and forced some children to earn a living or to merely live on the streets. Poverty levels have in certain instances forced families to deliberately or unintentionally send their children on the streets. The Anglican Children's Project in Lusaka, for instance, has reported that the high school fees and having to live on less than a dollar a day (Family Care Foundation, 2006) make it literally impossible to send children to school as there are other priorities such as providing food for the family. In some instances, some parents end up putting their children on the streets to supplement family incomes (UNICEF 2006).

Family Care Foundation (2006) indicates that issues such as economic constraints and social services, income and inadequate nutrition have contributed to the disintegration of extended families. Tembo (2003) also asserts that the proliferation of orphanages and the unprecedented increase in the number of street children have so far demonstrated how the social fabric of Zambian society has collapsed due to the harsh economic climate and social changes which have, to a certain degree, eroded the ability of most citizens to meet their social responsibilities. Children who cannot be taken care of by the extended families opt to run away from hardships at home and end up on the streets instead. For instance, it is estimated that in Lusaka alone, 30,000 children live on the streets (UNICEF 2006; SOS Children's Villages 2006).

The HIV/AIDS epidemic has also contributed substantially to the number of street children, especially those who are orphaned and lack social support systems such as extended families. Some orphaned children end up on the streets because the extended families who are already over-stretched with their own large family needs fail to take care of them (Family Care Foundation 2006). The SOS Children's Villages (2006) points out that Zambia has the second highest number of orphans due to AIDS, and that an estimated 34 percent of all children under the age of 15 years are orphans. However, UNICEF (2006) reports that Zambia has the highest proportion of children who have been orphaned by AIDS in the world. The extended families have collapsed, older children have been left with the difficult challenge of taking care of their siblings. In

\footnote{An amount of US$50 is required every year to send a child to elementary school while $100 is needed to send a child to high school}
such situations, it becomes increasingly difficult to send the siblings to school and provide adequate food. As a result, many of the children leave home and end up on the streets (Family Care Foundation 2006).

Street children are exposed to dangerous situations on the streets that put their lives at great risk. A significant number of children living or spending time on the streets are sexually abused (SOS Children's Villages 2006). Sexual abuse puts the children at the danger of contracting HIV. UNICEF (2006) notes that street children are especially vulnerable to commercial sexual exploitation, and that the problem of child prostitution is widespread in Zambia. Children on the streets also put their lives at high risk of HIV/AIDS, drug abuse and other challenges due to their vulnerability (Family Care Foundation 2006), and the difficulties that they have to endure to get a meal or find a place to sleep.

Richter (1988) points out that many street adolescents have sexual intercourse with older rich men and women without using condoms. Generally, the use of condom among street adolescents is not common as clients pay more for unprotected sex as opposed to when condoms are used. In interviews with more than 500 African-American adolescent females, Crosby et al. (2002) found that more than 75 percent had sex with a steady partner without using a condom as this was seen as a sign of intimacy and trust. It is evident that street children engage in sex with many sexual partners. This is because sex plays a vital role in exchange for money, goods, services and sexual pleasure (Swart-Kruger & Richter 1997; Richens 1994).

Kirby (1992; 2002) on the other hand contends that adolescents, in general, find it difficult to perceive themselves to be at risk of HIV infection because they have limited personal knowledge of the disease as well as persons suffering from AIDS. A rapid assessment of 1,264 street children aged 12 to 18 years by Fountain of Hope et al. (2001) in Lusaka, Zambia indicates that knowledge of HIV/AIDS was relatively high among boys (over 80 percent) compared to girls who (65 percent) reported good knowledge of HIV/AIDS.

Furthermore, the Fountain of Hope et al. (2001) reports that drug use among street children is relatively high, with the majority of children in Zambia and South Africa using drugs and substances, especially marijuana, glue, uncured tobacco, cigarettes, petrol, beer and
cocaine. Mahoney et al. (1995) note that gender roles and issues of economic empowerment must be addressed if condom use or abstinence is to become widespread among adolescents. Furthermore, approaches must be developmentally, culturally and socially relevant. In addition, reproductive health education is vital in combating high risk sexual behaviours. Several NGOs and private organizations have joined forces to tackle the issue of street children in Zambia. For example, the Anglican Children's Project runs a home for street children and offers them help through psychosocial counselling, education sponsorship, and recreational activities (Family Care Foundation 2006).

**Findings from the Study**

**Characteristics of Respondents**

Both the male and female participants in the survey complained that they lacked employment to earn decent sums of money needed for their daily survival. As such, they were engaged in casual jobs to raise money for food and clothing for themselves as well as other family members. However, the incomes from selling these goods were usually inadequate for their general upkeep. Furthermore, although most participants had been to school, and a few were still struggling to stay in school, the poor socio-economic status of their families hampered the desire to stay in school. The few who were still attending school, rarely did so due to their inability to pay the school fees and the lack of school uniforms, among other needs. Instead, they spent time on the streets raising money through piece jobs, selling and begging.

All the female participants did not consider themselves at risk of contracting HIV/AIDS. They insisted that they were not sexually active and therefore it was impossible for them to contract the disease. Unlike the females, male participants saw themselves at risk of contracting HIV/AIDS. They conceded that they were sexually active and that neither they nor their partners were faithful. One said, "I sleep with people for money, both old and young, men and women. I do it because they pay well". Others reported that their street life left them with little choice but to share whatever they owned. "I share things like razors with my friends because I do not have money to buy my own," one respondent noted.

Another finding is that all the participants knew how to prevent themselves from contracting HIV/AIDS. Abstinence was
mentioned as the best preventive measure. Other measures include condom use, and not sharing sharp body piercing equipment such as needles and razor blades. However, a number of male participants explained that they shared items such as razors and pins because they could not afford their own. In addition, they could not buy condoms due to lack of funds. They also indicated that the condoms that were supposed to be distributed freely were never available in the clinics or the distribution points. With respect to HIV and AIDS, all the participants in the focus group discussion felt that almost everybody is at a risk of contracting the virus. Some male participants asserted that even if individuals were not sexually active, and therefore abstained, it is likely that they could get infected through non-sexual practices such as using and sharing equipment like needles and blades.

Nature of High Risk Sexual Behaviours among Street Adolescents

All the female participants reported that they had never used any alcohol, drugs or tranquillizers. They also indicated that they do not use condoms. The married respondents argued that married people do not use condoms. All female participants demonstrated the lack of knowledge concerning where condoms could be obtained for free or bought. Generally, they were somehow reluctant and apprehensive to talk about issues related to sexuality. This may be partly attributed to societal values and norms among women in Zambia which discourage an open discussion of matters related to sex.

Unlike their female counterparts, a number of male participants reported having used a condom at some point in their lives. They noted that sex with condoms was less enjoyable than without. One noted, “I use condoms because my clients insist on them and they also protect me from diseases such as HIV/AIDS. Left to me alone, I would not use condoms because I cannot afford them. To me, making money is more important than anything else”. They also knew of places where condoms could be obtained free of charge, such as the clinics. But they never bothered to collect them because they were difficult to get. In addition, they were of the view that they could not waste money buying condoms from shops while they did not have enough financial resources. During the focus group discussions, participants mentioned problems they encountered when using
condoms. They emphasized that condoms easily get torn during intercourse. Others stated the fact that condoms always had some lubricants which created friction during intercourse, and “made a lot of noise”.

Almost all male participants, with the exception of one, clearly admitted to using inhalants such as glue and petrol. One participant was even sniffing petrol during the interview. Another revealed that he used intravenous substances but had been clean for almost two years. Some participants reported that they use inhalants (glue and petrol) to relieve themselves of the loneliness and temporarily forget the harsh realities of street life. One respondent indicated, “I do not feel hungry when I sniff petrol. I can also sleep anywhere in the cold without blankets”. It seemed that the substances inhaled catered for the participants’ physical and material needs such as hunger, shelter, and clothing. Others expressed the fact that their street “life” was very stressful and humiliating. To escape the stress and humiliation, they usually sniff substances.

Strangely enough, all participants denied ever having consumed alcohol as they could not afford to buy it. However, they still felt that there is a strong link between alcohol and high risk sexual behaviours. They emphasized that when individuals get drunk, their thinking is affected and it becomes easy for them to have sex with someone, rape someone or even get raped by someone not using a condom. Most participants indicated that they were not at risk of engaging in any high risk sexual behaviour when intoxicated. They explained that when intoxicated by glue or petrol, they were left so powerless that they immediately felt asleep and hence had no chance of contracting STDs.

Generally, all the male participants perceived commercial sex work, vaginal sex and multiple sexual partners as high risk sexual behaviours. On the other hand, female participants perceived vaginal sex, commercial sex work, unprotected sex, multiple sexual partners, and sex before marriage as high risk behaviours. Anal sex was not very much considered as high risk behaviour by both male and female participants. Furthermore, both male and female participants did not perceive sex with relatives and friends as high risk sexual behaviour.
High Risk Sexual Behaviours and Knowledge of HIV and AIDS among Street Adolescents

The female focus group discussants noted that the major high risk sexual behaviour was having unprotected sex. The participants emphasized that adolescents were so careless with their lives that they “slept around” with individuals old enough to be their parents for money. All the female participants, however, agreed that poverty, which was considered as lack of money, food, school fees, shelter, and support from parents or relatives, usually drove most of the adolescents to practicing risky behaviours such as having multiple sexual partners. However, they did not condone the practice, saying adolescents could find other less risky means to meet their daily needs. Less risky means that were listed included selling products such as chips, groundnuts, mangoes and mushrooms. Other activities mentioned include cleaning homes and asking for help from kind people at the Catholic Dioceses. They would still consider “sleeping around” wrong if adolescents used condoms every time they did so.

Male participants in the focus group discussions, however, acknowledged that “sleeping around” was an easy and quicker means of earning money. Accordingly, they only did it to earn a living. Even though they agreed that it was a wrong behaviour to engage in, they admitted they had limited choices of earning money. This is due to the fact that almost everybody had some products or goods to sell although there were few buyers. Asked where they got their clients for sex, they laughed and said, “from around town”. One boasted, “I have rich clients who are old, both males and females. They pay me to have sexual intercourse with them and I always use condoms”. He added, “I sleep with them in expensive lodges in town and they pay me a lot”.

Measures to Combat High Risk Sexual Behaviours among Street Adolescents

Measures and ideas for combating high risk sexual behaviours from the participants included the following: divine intervention, helping those infected by providing love and material needs such as food and money for buying drugs and obtaining treatment. Government leaders and priests could encourage adolescents to follow Christian moral principles by practicing abstinence and encouraging the youth to disregard peer pressure which was seen as a major source of the
adolescents' wayward behaviour. Individuals who were infected could provide testimonies about HIV/AIDS for adolescents. In addition, the provision of sex education to adolescents by parents and concerned parties was seen as critical in reducing the spread of the disease.

Programmes to Combat HIV and AIDS in Zambia

Zambia has one of the worst HIV/AIDS epidemic in the world. Available data show that an estimated 16.5 percent of the adult population in Zambia is infected with HIV (Global Fund to Fight AIDS, Tuberculosis and Malaria 2006; U.S. President's Emergency Plan for AIDS Relief-Emergency Plan 2005). The HIV prevalence rate in Zambia is high among the age group 15 to 40 years old attending antenatal clinics in towns near the borders with neighbouring countries, and in commercial towns such as Kapiri Mposhi, Livingstone and Ndola, where 22 to 32 percent of pregnant women are HIV positive (National HIV/AIDS Council of Zambia, 2002). This situation has compelled the Government to formulate strategic policies and programmes to fight the epidemic. The government declared HIV/AIDS a national crisis, and between 2002 and 2005 a National HIV/AIDS/STI/TB Strategic Plan was implemented, and the National HIV/AIDS/STI/TB Council (NAC) established to spearhead the fight against the epidemic (U.S. President's Emergency Plan for AIDS Relief 2005). The programmes put in place are based on the government's policy to respond to the epidemic through prevention and control of its spread, to care for those who are infected and affected, and to reduce the personal, social and economic impact of the epidemic (Zambia Country Report 2005).

Declaring the HIV and AIDS crisis a national disaster has meant a number of stakeholders including international donors and other cooperating partners have to be involved in the process of formulating and implementing relevant programmes to combat the epidemic. Cooperating partners such as the U.S. President's Emergency Plan for AIDS Relief, The Red Cross, The Global Fund to Fight AIDS, TB and Malaria, NGOs, CBOs, Groups of PLWHA and private sector companies have been involved. The programmes on the ground include the administration of Antiretroviral treatment (ART), the provision of Mother-to-Child Transmission (PMTCT) services to pregnant
women, emphasising counselling and testing, advocacy for Abstinence, faithfulness and the use of condoms, dissemination of HIV and AIDS related information, and the promotion of safe sex practices, especially for the younger generation and for PLWHA.

The National HIV/AIDS/STI/TB Council (NAC)
The NAC has played a central and strategic role in establishing, coordinating and implementing programmes to combat HIV and AIDS. Through the NAC, it has been possible for the AIDS Task Forces to reach all the nine provinces of Zambia (U.S. President's Emergency Plan for AIDS Relief 2005). Since the vision of the government is primarily to prevent and control the spread of HIV/AIDS, critical policies and programmes have to be put in place. In this respect, it was decided that ART was to be provided free to all Zambians who were in need of treatment. In addition, the NAC formulated specific policies aimed at behaviour change. These include the promotion of information, education and communication (IEC) on HIV/AIDS, promotion of reproductive and sexual health education for young people, promotion of IEC and other health interventions for groups with high or increasing rates of HIV infection, promotion of IEC and other health interventions for cross-border migrants, expansion of access to essential commodities and the reduction of mother-to-child transmission rates (Zambia Country Report 2005). These policies are implemented by the government through different programmes and institutions such as schools, industrial establishments, NGOs, CBOs and private sector organizations.

Combating HIV and AIDS through Education
The dissemination of information is very critical in any programme as it gives all the concerned parties the opportunity to make informed decisions. Information also empowers people. Therefore, the Ministry of Education (MOE) has redefined the role that the education system can play in combating HIV/AIDS. For instance, teaching about HIV/AIDS has been integrated into the curricula at all educational levels (Zambia Country Report 2005). Another critical area where IEC has been used effectively is the workplace. In this area, the public sector, private sector and civil society has responded favourably by instituting programmes such as
workshops to help prevent HIV/AIDS among the workforce.

Civil Society Organizations (CSO) have also played a critical role in implementing the IEC policy on HIV/AIDS. The Zambia Country Report (2005), for instance, points out that the CSOs are central role-players in the development and implementation of innovative approaches that are culturally-sensitive and include issues of mainstreaming, decentralization, outreach and community participation. These approaches emphasize the importance of prevention, care and treatment. For example, the NAC through its cooperating partners such as CARE International, Kara Counselling and Training Trust (KCTT) and Copperbelt Health Education Project (CHEP) has undertaken national campaigns to encourage people to voluntarily go for counselling and testing (Zambia Country Report 2005).

President's Emergency Plan for AIDS Relief (PEPFAR): Zambia

Due to the high HIV infection rates in Zambia and the consequent adverse impact on the socio-economic fabric, Zambia is one of the countries included in President Bush's Emergency Plan for AIDS Relief. PEPFAR has played a very supportive financial role towards specific programmes that are established and implemented by NAC and other stakeholders. In contributing to the vision of combating HIV and AIDS in Zambia, the U.S. President's Emergency Plan for AIDS Relief: Zambia (2006), for instance, states that the U.S. Government directed up to US$71.5 million (through March 31, 2005) to create and intensify comprehensive programmes to combat the HIV and AIDS crisis. According to PEPFAR (2006), the U.S. Government will implement its Emergency Plan Activities through partnership with the public sector health system, NGOs, CBOs and the Zambian Defence Force's (ZDF) health system. The Emergency Plan puts emphasis on Abstinence and Faithfulness Programmes, Counselling and Testing (CT), HIV care/Palliative care, Anti-Retroviral Therapy (ART), PMTCT and other prevention initiatives such as Blood Safety. Similarly, PEPFAR, just like the NAC, focuses its efforts on providing integrated HIV/AIDS prevention, treatment and care services. As a matter of fact, in 2005, Zambia received nearly $130.1 million to support a comprehensive HIV/AIDS prevention, treatment,
and care programme, and in 2006, the U.S. government intends to provide approximately $149 million to support Zambia's fight against HIV/AIDS (U.S. President's Emergency Plan for AIDS Relief 2005).

The Global Fund to fight AIDS, Tuberculosis and Malaria (2006) has also outlined activities that are more or less in line with the policies and strategies of the NAC and PEPFAR for HIV/AIDS prevention. These include: intensifying and expansion of information, education, and communication and behaviour change communication, expansion of programmes and activities that promote VCT, strengthening home-based care programmes, improving access to treatment for PLWHA, supporting mitigation programmes for orphans and vulnerable children as well as developing a system to rapidly and efficiently disburse funds to NGOs, CBOs, Groups of PLWHA and private sector companies throughout Zambia.

**Emerging Issues**

Generally, the participants were of poor socio-economic status. Most male participants wore dirty clothes; their bodies emitted a pungent smell of sweat. Their hair was overgrown and dirty, and their feet, though not bare, were extremely filthy and cracked. The general appearance of the males was similar to that of most female participants. Even though the females had their hair plaited or trimmed, they still looked dirty and untidy. Their mouths were dry with cracked lips. They wore flip flops on their feet, which were cracked. Their clothing, whilst clean, was worn out, and their skins were dry due to lack of body lotion. All the participants were preoccupied with issues of earning money for day to day living. They worried about food, clothing, and shelter and other issues that affected their livelihood on the street. Therefore, for most of these adolescents the HIV/AIDS scourge was the least of their worries. However, the methods used in earning money differed between males and females. While the males were mainly engaged in piece jobs, begging and sex-for-money among others, the females were mostly hawkers.

Street adolescents of Ndola have low knowledge about HIV/AIDS including the mode of transmission and prevention. Even for the few who showed some understanding or knowledge of the ways in which one can reduce risks of infections, their comprehension was
limited and characterized by a lot of myths and misconceptions. When compared with street children elsewhere, they had low knowledge of HIV/AIDS. For example, street children in South Africa and Uganda were more informed about the disease (Swart-Kruger & Richter 1997; Nunn et al. 1996). On the other hand, the findings of the study are in line with findings from Ethiopia and other studies in Zambia. For example, street adolescents in Ethiopia are more concerned about problems of unemployment and poverty as opposed to the HIV/AIDS pandemic. Banda et al. (1999) and Taffa (1998) note that street adolescents in Zambia are also more worried about problems associated with their “street condition” such as unemployment, lack of shelter and food, but not about contracting communicable diseases such as HIV/AIDS.

Due to poverty, street adolescents resort to the use of practices for making easy and quick money for daily needs. These practices included having unprotected sex in exchange for money, having multiple sexual partners and engaging in commercial sex work among others. It is highly unlikely that these adolescents would abstain from sex, as it is a quicker way of earning money. The findings are the same as those with street adolescents in South Africa, who engaged in unprotected sex with old rich males and females merely for money (Swart-Kruger & Richter 1997). Kirby (1992) suggests that the reason why adolescents find it difficult to perceive themselves to be at risk of HIV/AIDS infection is that they have limited personal knowledge of the disease. However, this is not the case with the street adolescents in Ndola, most of whom had some knowledge about the disease. It is in view of this that Ruiz (1994) emphasizes that street life should be understood as a culture that promotes risk-taking such as having unprotected sex in exchange for money. This is because the main aim is to survive. Lack of discussion of sex and related issues between parents and adolescents is a problem that perpetuates lack of knowledge about sex-related diseases and risky behaviours. Both male and female participants reported that they were never taught anything in relation to sex by their parents. And as a result, what they knew about sex and related issues was obtained from friends and the radio.

Conclusions
The data presented suggest that most of the street adolescents, especially
males, were engaged in risky behaviours such as having unprotected sex, multiple sexual partners, and commercial sex work, among others, to earn income for survival. They also use intoxicating substances such as glue and petrol to help them forget the harsh realities of street life. These behaviours put them at risk of contracting STDs including HIV and AIDS. Furthermore, the participants displayed misconceptions and negative attitudes that may continue to expose them to HIV and AIDS infection. These attitudes include a reluctance to use condoms due to their scarcity and their inability to afford the cost of condoms.

It is necessary that the government of Zambia considers providing free primary and secondary education for street children who are vulnerable and disadvantaged. For those who are a bit well off, and may afford a number of basic needs, education could be subsidized for them. This should be part of the effort to reduce the numbers of street children. Besides, social workers should, through counselling, encourage street children to enrol in schools, perhaps for free education. The Zambian government, with the help of NGOs, international agencies and Christian missions, should put in place a mechanism to provide material needs such as food and clothing for street children to entice them to stay in school since most of them are on the street because they lack these basic needs. However, it must be noted that the solution to the problem of street adolescents may be found only in a comprehensive programme of poverty alleviation.

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