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Vulnerability to sexually transmitted disease: street children in Accra

John K. Anarfi

Institute of Statistical, Social and Economic Research, University of Ghana, Legon

Nearly twenty years since its discovery, AIDS still remains a 'planetary emergency', in the words of the UN Secretary General. AIDS is a threat to humanity which affects all societies and hinders social and economic development. It causes physical and emotional suffering, and is often used to justify grave violations of human rights. Although we have learnt much about how the disease is transmitted and the groups that are at higher risk, we still do not know how to protect the rights of people with HIV/AIDS, and of people who are particularly vulnerable to infection.

People react to issues according to the way they perceive them. AIDS seems to have thrived on controversy; at first over the origin of the virus which causes it. Blaming certain groups as the source of the disease has now stopped, perhaps because of theories which implicate the people who began the blaming. Many people do not seem to know the other controversy over the HIV theory of AIDS: that HIV is the sole cause of AIDS in human beings. For almost as long as AIDS has been with us, a small group of scientists has been trying to draw attention to inadequacies in the theory that AIDS was caused by a deadly new virus, HIV. This group claims that the disease is not behaving as would be expected if the cause really was a new virus; that the way the syndrome develops within individuals, and the pattern of spread within society, suggest its origins may be better explained by a variety of exceptionally risky circumstances in the lives of those affected (Hodgkinson 1996).

This theory is supported by the fact that after ten years of work the AIDS vaccine program has raised more questions than it has answered and is considered by many to be heading nowhere. Despite several highly speculative theories, there is still no firm evidence on how HIV could be doing the damage attributed to it, and efforts to defeat it with antiviral drugs have often done more harm than good. The epidemiology of AIDS — in particular, the statistical evidence linking HIV-positivity with disease — is also not nearly as clear as it once seemed.

Furthermore, findings from experiments with animals call into question the reliability of the HIV test, and challenge the conventional meaning of a positive HIV test. One possibility is that HIV-positivity signifies that a person's immune system has been challenged by exposure to foreign cells. Another possibility is that the challenge sometimes comes through an auto-immune process, in which cells within one's own system have become confused and can no longer discriminate between friend and foe, 'self' and 'non-self'. Either way, the mechanism could still be harmful, perhaps life-threatening, but the implications for prevention and treatment, and for public health, are very different from those that have accompanied the 'deadly new virus' idea. The scientific community should consider all options at this stage of our search for a way out of the AIDS impasse.

However, these different viewpoints have much to offer in hope for more successful approaches to HIV infection among vulnerable groups. The 'non-HIV' school of thought is

suggesting that the acquired immune deficiency syndrome which afflicts certain people could be the result of their way of life. Baumgartner, who acknowledged his homosexuality nearly ten years ago and has served as an AIDS chaplain at San Francisco General Hospital, says:

> The fact of the matter is, a lot of gay men are ruining their lives… Being in the closet is the first major health risk — constantly hiding. But then, maybe as a reaction, there is the fast life, partying every night, having very little rest, not eating properly, working to be better than other people, using recreational drugs, sexual stimulants (Hodgkinson 1996:12).

In Africa, the condition may be the result of multiple infections under conditions of poor nutrition due to poverty. It may not be a mere coincidence that AIDS is exacting its toll in the era of structural adjustments in Africa. It is notable that more serious strains of diseases thought to have been eradicated decades ago are now appearing — buruli ulcer in place of yaws for example — as are fatal diseases hitherto unknown and apparently incurable: ebola fever is the leading example.

On the other hand, Sabatier (1987) has explained that when the AIDS virus is introduced into a society it follows the path of least resistance, among people who are the poorest, most disadvantaged, least powerful, or most stigmatized. It appears that the controversy lies only in the realm of science. For social scientists and policy makers, it is clear who the target groups are: the vulnerable.

One group vulnerable to STD/HIV infection consists of young people. The issue of the reproductive health of young people, particularly those out in the street, has become so topical that a UNICEF-sponsored International Workshop on 'Africa's Urban Poor Child: towards African Child-Friendly Cities' was held in Accra, Ghana, from 11 to 13 March 1997. Sexually transmitted diseases, including infection with HIV, are some of the reproductive health risks to young people. Millions of them around the world become infected with STDs every year. Among all age groups in the US for example, girls aged 15 to 19 have the highest incidence of gonorrhoea among females, and boys in the same age group have the second highest incidence among males (US 1995). Furthermore, at least half of the people infected with HIV are younger than age 25 (Population Reference Bureau 1994). Of the over one million cases of AIDS throughout the world, the high incidence among people now in their twenties indicates that many contracted HIV infection before reaching age 20. Transmission patterns in both developing and developed countries indicate that young women are the group running the highest risk of HIV infection through heterosexual contact (CDCP 1993). In a recent study in Zimbabwe, for example, 30 per cent of pregnant girls aged 15 to 19 were HIV-positive (Verkuyl 1995).

Young people are particularly vulnerable to STDs because most know little about STDs, even if they are sexually active (Abdool Karim et al. 1992); even when they know about STDs, young adults use condoms inconsistently (Goicochea 1990; Egger et al. 1993); the earlier people become sexually active, the more likely they are to change sexual partners and thus face a greater risk of exposure to STDs (*Population Reports* 1995). STD pathogens can more easily penetrate the cervical mucus of young women than of older women. The cervix of a young woman is more susceptible to gonorrhoeal and chlamydial infection as well as to the sexually transmitted human papilloma virus, which causes cervical cancer (Moscicki et al. 1989; Mati 1989; Moscicki et al. 1990; Bradin 1993).

Young adults may be even more reluctant than older ones to seek treatment for STDs because their sexual activity is frowned upon. Also, young people may not know they have a disease. They may be too embarrassed to go to a clinic or be unable to afford services. Many go instead to unqualified traditional healers, or obtain antibiotics from pharmacies or drug hawkers without proper diagnosis. The result is untreated STDs which make them susceptible to further infections including HIV (Gyepi-Garbrah et al. 1985). Throughout the developing

world millions of adolescents live or work on the street, and many sell sex to make a living, increasing their exposure to STDs. The tendency of street youth to drug abuse increases their susceptibility to sexually transmitted infection as they lose the power to take rational decisions (Barker 1993; Raffaelli et al. 1993; Fieldman 1994; Ruiz 1994; Raffaelli et al. 1995). Young people may be forced into sex or otherwise have little power in sexual relationships to negotiate condom use, particularly if their sexual partner is older, which is often the case (Meursing and Sibindi 1995).

Children and AIDS in Ghana

The number of people with AIDS in any age group is not an indicator of the number of people infected with HIV in that age group, because HIV has a long asymptomatic period, now reported to be five to ten years. In Ghana, AIDS cases have been identified in all age groups,but the age groups most affected are between 20 and 49 years: about 86 per cent of all AIDS cases officially reported. Within these age groups the most affected groups are the 20-39 year-olds who alone constitute over 72 per cent of the cumulative figures reported since 1986. Most of these individuals had the sexual contact that infected them while they were teenagers.

HIV transmission in Ghana follows a similar pattern to that in other African countries. Heterosexual contact accounts for 70 to 80 per cent of infections; infection from mother to child and contact with contaminated blood and blood products accounts for the remaining 20 to 30 per cent (NACP 1996).

Studies have observed that Ghanaians behave in some ways that put them at risk of getting HIV. An AIDS knowledge, attitude and practice study of young people in Ghana in 1991 showed that 72 per cent were sexually active (McCombie and Anarfi 1991). Most of those who were sexually active were under 18 years when they first had sexual intercourse. The same study revealed a mean number of sexual partners of five (7 for males and 3 for females) among those who had ever had sex.

Background

Since independence Ghana's population has been growing steadily at a rate between 2.5 and 3.5 per cent per annum. This has not been matched by an equally vibrant economy which rather stagnated from the mid-1960s to the mid-1970s and experienced a negative growth thereafter. Many Ghanaians became destabilized resulting in the movement of many people, mainly the young, to other countries (Anarfi 1982; Gould 1985). Although the economy seems to have stabilized lately, its casualties have yet to find their feet. There is now a large influx of people from the rural to urban areas for jobs which are non-existent. Among the rural-urban drifters are young people including many teenagers; these are very visible in the streets of the cities and big towns where they sell petty items to earn a living.

As a nation, Ghana has done much to demonstrate its realization of the need for special attention for children. Ghana was the first signatory to the United Nations Declaration of the Rights of the Child of 20 November 1959. This was followed by the establishment of the Ghana National Commission on Children in 1979 which coincided with the United Nations declaration of that year as the International Year of the Child. The concern for children was taken further by ensuring that the rights of Ghanaian children are enshrined in the 1992 constitution. Despite these shows of concern, the plight of more and more children is becoming worse every year as their numbers on the street grow. Nobody knows exactly how many street children there are in Ghana; in Accra where the problem of street children is most acute a recent newspaper publication put the number at 17,000. Catholic Action for Street Children estimated the number as 10,000. Both figures are, at best, mere guesses. Last Easter,

JOY FM Radio station organized a soup kitchen for street children and issued 5,000 invitation cards. However, on the actual day of the exercise the organizers were overwhelmed by the extra young claimants who had not been issued with cards. This only confirms the fact that street children are quite numerous in Accra and are very visible.

Definition of street children

In the Ministry of Employment and Social Welfare Street Children in Ghana Policy Framework (1995), a street child is a person under the age of 18 years who spends a significant amount of time living or working on the street. The framework recognizes that one precise definition is inadequate to describe all children on the street. As in other developing countries, two categories of street children have been identified in Ghana as children *of* the street and children *on* the street (Apt et al. 1991). According to Kaime-Atterhog (1996:28)

> Children of the street consists of boys and girls who see the street as their home. They may still have some family ties but seek shelter, food and a sense of family among their companions on the streets or they may have completely broken ties with their families and literally live on the streets.

The second group, children on the street,

> includes those who still have family connections. They live at home, often in no more than shacks, sometimes even attend school, but are sent to the streets by parents or go of their own accord to supplement the family income (Kaime-Atterhog 1996).

Street children are often referred to in the literature as 'runaways' or 'throwaways', reinforcing the notion that many are escaping domestic crises (Young et al. 1983; Kufeldt and Nimmo 1987; Janus et al. 1987). In the case of the runaways the child gets to the street without a parent's permission, while the 'throwaways' are overtly rejected by their parents. Street children, therefore, could have been abandoned by their parents, could be orphans, or runaways from neglectful or abusive families. Street children are, however, not a homogeneous group, but are members of smaller subgroups or subcultures. On the basis of choices made while on the street, children can be placed into broad categories for purposes of analysis. This study identifies the various categories of street children in Accra, and examines some of their activities that may predispose them to contracting HIV infection. This is done against the background of their awareness and knowledge of HIV/AIDS and other STDs and what they do to protect themselves from contracting the disease.

Conceptual framework

Kaime-Atterhog's (1996) conceptual framework for understanding the street children phenomenon is adopted for this study (Figure 1). The framework presents the phenomenon as a kind of continuum. At one end are causal factors, that is, complex and interlinked factors that push children to the street. At the other extreme are aggravating factors which are the high-risk behaviour of children who remain on the street and the resulting problems. Linking the two are intervening factors which influence the children to either stay or leave the streets.

Among the causal factors the child's own personality plays a major role in whether or not he will run away to the street. But children belong to families and live in societies. Throughout the world there is a gradual transformation of the family from the extended to the nuclear. Where the nuclear family predominates, there are apparently fewer relatives to provide support in times of crisis (Kalu 1986). The nuclear family itself appears to be in

danger of collapsing with rising divorce rates and increasing numbers of one-parent families. Before 1950 in Accra divorce was relatively uncommon in families with children. By 1982 one out of every two marriages ended in divorce (Winn 1984:124). There is now a change in the family structure in the city and with it men are seen as shadowy figures, drifting in and out of the family and avoiding responsibility (Liebow 1967; Burman 1984).

Mistreatment of children by adults and institutions charged with their protection is increasing. According to Korbin (1983), these children are victims of idiosyncratic behaviour that departs from what is normal or acceptable within their community. Children thus become most vulnerable when the people responsible for their care and safety betray that function, becoming instead direct threats to their health development or even their life (UNICEF 1986).

The view has been expressed that the incidence of child maltreatment is higher in urban than rural communities and is particularly widespread in societies undergoing rapid social and economic change (Korbin 1983). The consequences of such change include increased stress on adults and the isolation of nuclear families. Where extended families or other support networks are strong, abuse is far rarer (UNICEF 1986:13).

Strict adherence to a culture in the face of strong and increasing influences from other cultures could result in social vulnerability. For example, many African parents still want their children to conform to cultural norms. Children are still taken through sexual and other initiations in many African societies and those who do not comply become social outcasts. The tendency for parents to see children as a kind of property and the assumption that children do not have rights can have serious implications. For example some African parents give their children tribal marks at an age when they cannot resist and which they are to carry forever.

In many African families the child is seen not just as a mouth to be fed but also as another pair of hands to help with production. In such circumstances one cannot tell the difference between what constitutes child work that is acceptable and child labour which is harmful and, therefore, threatens the physical, emotional and social development of the child.

Intense economic and social stress in times of economic crisis has combined with the foregoing tendencies to bring about child abuse and neglect in many Ghanaian societies. The driving force behind this relatively new development is poverty. In such circumstances neglect occurs through no fault of adult caregivers (Boyden 1991). Some observers see it more as a problem of political economy (Scheper-Hughes 1989). It could thus be concluded that the street child phenomenon is a product of both individual and collective vulnerability.

The study

Data for the study came from three main sources: a questionnaire survey, focus-group discussions and in-depth interviews. The survey which ran from 13 May to 9 June was conducted in four clusters, Kokomba Market, Agbobloshie Market, Kantamanto Market and Tudu-Makola Market area including the transport stations adjoining them. To ensure an adequate representation of all categories of street children the study targeted a sample of 1,500 children aged 7 to 18 years. In the end 1,247 people were interviewed but only 1,147 aged 8 to 19 years were included in the analysis as 100 were found to be above the age limit.

Three interviewers were assigned to each cluster. In addition, three adults who work closely with the children, two females and one male, were used as contact persons. They helped to locate the street children and one of them served as an interpreter in interviews involving children from the northern part of the country. Sampling was basically purposive and the snowball technique was used to move from one respondent to another.

Four focus-group discussion sessions were conducted for the general street child population on the basis of age and sex. There were two age groupings: 7 to 12 years and 13 to 18 years. In addition, there were two other sessions, one for girl mothers and another for

prostitutes. Information was supplemented with that from in-depth interviews with about 30 children.

A few problems were encountered. The street children were generally apprehensive and they were not very co-operative in the absence of the contact persons. This situation affected the pace of the interviewing, necessitating the extension of the period of interview for one more week. Interviewers expressed misgivings about the interpreter's competence, particularly in extracting information about sensitive issues. In addition, the wide age difference between the interpreter and the children had a negative influence on the interviews. In most societies in Ghana there is very little or no intergenerational discussion about sexual matters for example.

Characteristics of sample

Personal characteristics

The sample of 1,147 children consisted of 60 per cent males and 40 per cent females. Three-quarters of them were concentrated in the 15-19 years age group. Only about two per cent were aged below ten years. The mean age of the sample was 16.1 years with males being slightly older than females (16.3 years and 15.9 years respectively). The children came from all the ten regions in Ghana. The highest proportion came from the Ashanti Region with 22.1 per cent, followed closely by the Northern Region (20.1%) and the Eastern Region (14.6%) (see Table 1).

The children from the Northern Region are more likely to be females than males (35% and 10.2%). More than half of the sample were Akan and 23 per cent were Mole-Dagbani from the northern regions of the country. Ewe constituted about 11 per cent of the sample and Ga-Adangbe made up 9.3 per cent.

It was observed that most of the sampled street children migrated from other regions of the country. They were largely primary migrants and their movement to Accra followed some of the patterns observed with adult migrants (see Nabila 1974). The children from the northern parts of the country in particular were more likely to adopt stepwise migration to Accra. This is illustrated by the following account from a 16-year-old boy:

> I boarded a truck that carries cattle to Kumasi. I worked as a porter for one year at Kajetia in Kumasi. One day I ran away with somebody's load containing sixty thousand cedis and I used the money to transport myself to Accra.

The educational standard of the children was very low (Table 2).

Table 1
Basic characteristics of sample

	Males	Females	Both sexes
Age (%)			
Below 10 years	1.6	2.4	1.9
10-14	20.9	27.2	23.5
15-19	77.5	70.4	74.6
Total	100.0	100.0	100.0
Mean age (years)	16.3	15.9	16.1
Region of origin (%)			
Western	6.0	0.9	3.9
Central	10.5	7.0	9.1

Greater Accra	7.3	8.7	7.8
Volta	10.6	12.2	11.2
Eastern	15.5	13.1	14.6
Ashanti	28.3	12.6	22.1
Brong-Ahafo	3.6	3.1	3.4
Northern	10.2	35.0	20.1
Upper West	2.2	2.2	2.2
Upper East	2.9	2.6	2.8
Outside Ghana	2.9	2.6	2.8
Ethnicity (%)			
Akan	63.2	34.4	51.7
Ga-Adangbe	8.1	11.1	9.3
Ewe	10.0	11.3	10.6
Northern	14.1	36.2	22.9
Hausa	1.3	2.8	1.9
Non-Ghanaian	3.2	4.1	3.6

Table 2
Level of education by sex (%)

	Males	Females	Both sexes
No education	27.5	51.9	37.2
Primary incomplete	25.0	23.3	24.3
Primary complete	11.5	5.0	8.9
Middle/JSS incomplete	16.4	14.0	15.4
Middle/JSS complete	18.4	5.4	13.3
Sec./SSS incomplete	0.6	0.4	0.5
Sec./SSS complete	0.3	0	0.2
Post-secondary	0.3	0	0.2
Total	100.0	100.0	100.0

About 62 per cent could not complete even primary school education. The females were more likely than males to be without primary education (75.2% and 52.5%). At every stage of the educational ladder those who dropped out far exceed those who finished; again this phenomenon is more pronounced among females than males.

A majority of the children (59%) professed to be Christians and a fifth said they were Muslims; nearly 78 per cent of the Muslims were from the northern regions of the country. About 18 per cent had no religion. The children appear to take their religious activities seriously. About 21 per cent said they pray daily or attend daily religious services. About a quarter say they attend weekly religious services and nearly one-third either pray or attend religious services occasionally.

Background of parents

The characteristics reported by the children about their parents present them as people of very low socio-economic status (see Table 3). Nearly two-thirds at best had basic education up to the middle school level. Over 95 per cent of the children reported that their parents were working, but a majority of them are in low-status jobs such as fishing or farming (34%), artisan-mechanic (19.3%), manual labour (4%) and clerical work (3%). It follows from the

parents' background that most of the children in the streets are part of a cycle of poverty and gross disadvantage.

Table 3
Parents' highest educational level (%)

	Males	Females	Both sexes
No education	25.2	41.2	33.3
Primary incomplete	3.3	4.2	3.7
Primary complete	1.1	3.2	2.1
Middle/JSS incomplete	4.9	7.4	6.1
Middle/JSS complete	18.9	11.7	15.3
Sec./SSS incomplete	3.0	1.6	2.3
Sec./SSS complete	4.1	2.0	3.0
Post secondary	4.6	0.9	2.7
Total	34.9	27.8	31.3
	100.0	100.0	100.0

About 42 per cent of the children came from broken homes. Only 19 per cent have their parents in Accra. The rest are either outside Accra (66%) or deceased (12%). There appear to be very few ties between the children and their parents. Asked about how often they see their mothers, only 11 per cent said daily, four per cent said weekly and eight per cent, monthly. The ties with fathers were even weaker with three per cent, two per cent and five per cent seeing them daily, weekly and monthly, respectively. Another aspect of the loose ties between the children and their parents is that they would rather discuss their problems with friends (47%) or siblings (14%) than with mothers (7%) or fathers (0.9%).

Street experience

For purposes of health promotion and the development of education strategies for street children, it is necessary to understand the circumstances that motivate children to run away to city streets and know as much as possible how they live. If change must occur, it should be within the context of their street experience. This section, therefore, examines why children leave home, how they survive on the street and the importance of other elements within their environment.

Why they left home

About three-quarters of the children interviewed gave as their reason for leaving home to 'work and get money' (see Table 4). In addition, about six per cent said they want 'money to learn trade' and another four per cent said specifically that they left home because of poverty. These responses of the children were reinforced in the focus-group discussions.

Table 4
Reasons why children left home (%)

	Males	Females	Both sexes
To work and get money	75.1	69.9	73.1
Brought by relative	8.0	10.5	9.0
Money to learn trade	5.5	5.4	5.5
Ran away from parents	1.7	1.5	1.6
Maltreatment	2.5	4.4	3.2

Poverty	4.2	3.5	3.9
Parent related	2.8	4.4	3.4
Refugee problem	0.2	0.4	0.3
Total	100.0	100.0	100.0

Poverty turned out to be the main factor pushing Ghanaian children into city streets. According to the children in the focus groups, the main problem for Ghanaian children now is how to cater for themselves since their parents cannot shoulder all their responsibilities towards them. One outcome is for the children to go to the street to look for their daily bread as parents are unable to put them, or retain them, in school. Said one participant:

> We are looking for nothing more than what to feed ourselves with; that is why we left our homes and came here. Our fathers could not put us in school so we came here to fend for ourselves.....The feeling for our mothers in particular makes us want to travel down south to look for money to go back and help them (boy, 16 from the Northern Region).

Behind the destabilized situation of some of the children were parent-related factors. About five per cent of the children mentioned that they 'ran away from parents' and another three per cent referred to maltreatment at home. It emerged from the focus-group discussions that most of the parent-related factors involved broken homes and dysfunctional families. A 16-year-old girl summed it up:

> The truth is that I was going to school. My parents got divorced and I was left in the care of a stepmother. My father was not taking good care of me. Quite often I was sent out of school to go for my fees. But always the way my father treated me made me feel too bad so I ran away from home.

Some of the children were on the streets because their parents had died and there was nobody to take care of them. Such cases reflect a breakdown of the traditional extended family system and of community values; this is a major factor in the increase of children in the streets. Whereas extended families could be depended upon to help families who could not adequately care for their children in the past, now this is not so because of the general economic hardship. The communal spirit of neighbourhood groups has also suffered for similar reasons.

The idea that children run into the street to escape domestic crisis is further reinforced by their decision making process. Only 11 per cent said they discussed their decision to leave home with their parents and another four per cent said their departure was instigated by their parents (see Table 5). Nearly half (48%) said they planned the movement alone or that it was spontaneous. Boys appear more adventurous in this respect than girls (54% and 39%). About a quarter informed relatives in Accra before they left home.

Table 5
How children reached decision to leave home (%)

	Males	Females	Both sexes
Spontaneous action	25.0	13.9	20.6
Planned alone	28.6	25.5	27.4
Informed relative in Accra	24.8	28.8	26.4
Informed relative at home	7.6	8.3	7.9
Influenced by advertisement	0.4	0.2	0.3
Instigated by parents	3.1	4.1	3.5

Discussed with parents	7.6	15.3	10.6
Others	2.9	3.9	3.3
Total	100.0	100.0	100.0

That suggests a chain migration process which is characteristic of migratory movements in Ghana (Caldwell 1969). Some of the children went straight into the street on arrival in Accra.

This is illustrated by the case of an 18-year-old girl:

> I was going to school but I could not cope because I was not clever. So I stopped going to school and asked my mother to help me learn dressmaking. She in turn asked me to help with the sale of her plantains to enable her to accumulate enough money. When after a long time she was not doing my wish I came to Accra, heard of a place called Kantamanto and made it my home.

Others first went to live with relatives or surrogate mothers and later moved into the streets. A 16-year-old girl tells her experience:

> My sister brought me from Cape Coast to help sell her meat pies. Every day we carried the meat pies to sell at Tema barrier. We were two girls. She gave us two hundred cedis each day (about US10c). This was all we had to live on the whole day as she often left home and did not come back till next morning. When I could no more live on the 200 cedis I ran away to another sister at railway quarters. Later she told me that she was being ejected so I should find my own way. That was how I came here.

There appeared to be no serious conflict between most of the children and their parents at the time they left home. Their problem, therefore, may relate to ambitions they thought could only be fulfilled after leaving home and coming to Accra. Such perceived ambitions or expectations may have been built upon what they heard about Accra, from friends or relatives or other means. Certainly the children did not calculate the dangers of leaving home and coming into the unknown. They did not consider the kind of influence the environment into which they were coming could have on them. Some came with genuine intentions but they were soon overwhelmed by the powerful influence of street life in Accra.

Meeting basic needs

While the streets present opportunities for work and freedom, they also violate children's dignity and adversely affect their physical, emotional, and overall well-being. The effect may differ between children **on** the street and children **of** the street.

Accommodation

There are no agencies which provide full accommodation to street children in Accra. Catholic Action for Street Children (CAS) provides a place of refuge for street children only during the day. On average they receive about 80 children a day. Response, another organization, runs a refuge for girls who are pregnant and about to deliver. That means street children in Accra have to find their own accommodation in the night. Only 12 per cent sleep at home, 1.2 per cent sleep in 'kiosks' (wooden structures), and 1.8 per cent at police stations. The remaining majority sleep outside, in places like the market (48%), transport stations (22.3%) and the front of shops (14.4%).

It follows that most of the children are exposed to the vagaries of the weather and other elements that may be harmful to their health and their life in general. Significantly, females appear more vulnerable in this respect than males and the situation has serious implications for the sexual behaviour of the girls.

Food

Eating is one area in which the children's independence clearly shows. Only eight per cent reported that parents provided them with meals: 86 per cent said they provided their own meals. As with accommodation, not many agencies physically provide meals for street children; only 1.3 per cent said that non-governmental agencies give them meals.

From the number of times the children say they eat in a day, it appears they have no food problem. Over 80 per cent said they eat three or more times a day. Only 0.5 per cent said they eat once a day. Where the children take their meals, however, is a different story. Taking meals at home or in an established restaurant denotes relaxed, proper eating conditions. Only five per cent ate at home and one per cent in restaurants. About 52 per cent ate casually on the street and 42 per cent at wayside eating places. It follows that not only have the children developed casual eating habits, they are also exposed to health hazards associated with food sold under unhygienic conditions.

Finances

The children have translated their motive for moving on to the street into action and almost all of them (94%) said they work for income. The main economic activities of the children include selling on the street (reported by 36%), porterage (24%), shoe shining (12%) and cleaning (8%) (see Table 6).

The females are more likely to be porters first (43%) or street vendors (38%). The males, on the other hand, are likely to be street vendors first (34%) or shoeshine boys (20%). In addition, about a tenth are porters and cleaners.

A few of the females (0.5%) mentioned prostitution as their main source of income and fewer still of the males (0.2%) sell hard drugs to earn a living. The importance of these activities is not so much the proportion of people involved in them but the fact that such unlawful ventures are operated in the environment of the children. The health implications of the activities have been the subject of study by many researchers (see Boyden 1991; Kaime-Atterhog 1996).

Table 6
Main economic activities by sex (%)

	Males	Females	Both sexes
Nothing/relax	8.1	8.7	8.4
Porter	11.0	43.1	23.9
Cleaning	10.9	4.8	8.4
Selling on the street	34.3	38.3	35.9
Loading trucks	4.6	1.1	3.2
Shoe shining	19.8	0.9	12.2
Truck pushing	5.1	0.2	3.1
Prostitution	-	0.5	0.2
An aid	3.1	0.2	2.0
Barber/hairdresser	0.7	1.1	0.9
Chop bar attendant	-	0.5	0.2

Begging	0.7	0.6	0.7
Fishing	0.4	-	0.3
Packaging foodstuffs	0.3	-	0.2
Selling hard drugs	0.2	-	0.1
Driver's mate	0.6	-	0.3
Total	100.0	100.0	100.0

Commentaries by some of the children in the focus-group discussions reveal other sources of income not covered by the questionnaire. In one session, all but one of the six participants confessed that they live by picking pockets. A participant said:

> Every day when we wake up we go to town. If we are able to steal somebody's money, that is what we live on.

In addition to pickpocketing, all of them do other petty jobs either as a cover or as a genuine supplementary source of income. For example, one boy carried foodstuffs for money; in addition to the monetary payment, he also got some of the foodstuffs which he sold. They can sometimes steal some of the items they carry. One boy helps pack oranges and other foodstuffs in bags and sew them up. In the process he steals from the women when they are not watching. In the words of the boy, 'I steal their money when they lose guard'.

There was one focus-group session with six current prostitutes, and another one with girl mothers and pregnant girls (8 in all) all of whom were either past or current prostitutes. When they were asked about their sources of income they endeavoured to justify 'survival sex'. Said an 18-year-old girl:

> At one stage my boy friend refused to look after me so I decided to go to Kwame Nkrumah Circle area to solicit for clients. On one of such rounds I was arrested and fined ¢200,000.00 (about US$110). As I could not pay it I was jailed for three months. After the prison term I stopped going to the Circle and stayed with my old boy friend until the pregnancy came. Since he refused to accept the pregnancy I have been forced to go back to the Circle. That is where I get money to feed myself.

Health and hygiene

About 92 per cent reported that there are toilets in the areas where they operate: these include pit latrines, pan latrines, and water closets, but the owners of these toilets charge fees for their use. Those who do not want to pay defecate in the open.

The situation is similar with bathrooms. There are various types of bath-houses in the areas, some public and others privately owned; almost all operate on a commercial basis. In some of the bath-houses the cost covers water, soap and sponge. There are no towels and children either use their shirts or allow the water to dry on their skins after the bath. Because of the cost, bathing is not regular and most of them wash only once a day. When there is a windfall and enough money to pass around, they can shower about three times a day: the quality of the children's personal hygiene is determined by the availability of money.

Two related diseases were mentioned as the ones the children suffer most often in a year: headache and malaria (see Table 7).

Table 7
Diseases suffered most by the children (%)

	Males	Females	Both sexes

No disease	26.7	28.6	27.5
Headache	24.7	24.4	24.6
Malaria	23.2	23.5	23.4
Bodily pains	8.5	6.5	7.7
Stomach problems	7.7	9.8	8.5
Eye troubles	1.2	-	0.7
Skin troubles	6.0	4.8	5.5
Diarrhoea	1.9	2.2	2.0
Toothache	0.1	0.2	0.2
Total	100.0	100.0	100.0

Stomach troubles, bodily pains and skin troubles follow; a few specifically mentioned diarrhoea. The pattern of diseases reported by the children indicates their exposure to the vagaries of the weather and the effects of their way of life.

In the last three months of the survey the range of diseases reported by the children increased with the inclusion of menstrual problems (2), common cold (7), gonorrhoea (1), measles (2), and boils (1). Gonorrhoea was mentioned by all the groups, both male and female, in the focus-group discussions. One boy said that his brother, also on the street, has had gonorrhoea: pus from the penis and a burning sensation when urinating. Two other boys complained of blood in their urine for which they were not receiving any treatment. Most of the girls in the focus groups complained of menstrual and lower abdominal pains. In addition, one girl mentioned a painful lump in her cervix.

The children resort to self-medication when they are sick. About 80 per cent said so and six per cent said they do nothing when they are sick. Only four per cent said they go to the hospital and another one per cent report to CAS. The children either have no time to go to the hospital or they feel cut off from the mainstream health services.

Knowledge of AIDS and STDs

AIDS education has been carried out in Ghana for about a decade now. However, it cannot be said with certainty that all societies have had equal access to the education, given the unequal access to sources of information in a developing country. It is, therefore, appropriate to assume that some people may not have heard of AIDS. Also, it is important to ascertain the quality of information the people have about the disease. These considerations are even more necessary in the case of street children as they are out of the school system and are often removed from the mainstream educational campaigns. This section thus outlines what street youth know about AIDS and other sexually transmitted diseases, and includes information about where they obtain facts about AIDS and other STDs.

Being aware of AIDS and other STDs and having accurate information about the modes of transmission do not guarantee that a person will take precautions against contracting them. Constant education is necessary to sustain the awareness and to propel the individual to a threshold where informed decision is made about socially acceptable behavioural change.

Attitudes towards AIDS information

The street children were asked their views about AIDS educational campaigns and the kind of information that is given. Their response is generally positive. Many have realized that AIDS is dangerous and has no cure (41%) and that it is real (23%).

Only three per cent felt the information given is inadequate and another two per cent said the disease is not real. The proportion of children who showed indifference by either not

responding or replying 'nothing' however, was a little disturbing: 23 per cent and four per cent respectively.

Knowledge about AIDS

The level of awareness of the disease among the street children is very high. About 93 per cent of both sexes said they had heard of AIDS. The level was significantly much higher among males (96.7%) than females (87.8%). Similarly, the children were aware that AIDS cannot be cured, with males showing a slightly higher level of awareness (96.4%) than females (93.9%).

Mode of transmission

During the interview, the street children were asked to mention three modes of transmission of the AIDS virus. Their responses are presented in Table 8.

The table shows that a quarter could not name any mode of transmission of the virus, less than half could name two and less than a fifth could name three. Sexual transmission appeared as the commonest mode of transmission mentioned as a first response, followed by the use of contaminated razor blade and blood transfusion. Mother-to-child transmission was mentioned as a very weak third response. Apart from these, the children's responses reveal grave misconceptions about AIDS. These include transmission through 'eating bad food', 'use of toilet', 'touching someone with AIDS', 'flies or dirt', 'sharing plates, clothes, room with someone with AIDS', 'witchcraft' and 'talking with someone with AIDS'.

As a further test of their knowledge about AIDS, children were asked to respond to eight items of the possible modes of transmission of the virus. They were asked to say 'yes' or 'no' to such questions as 'can you get AIDS if you talk to someone with AIDS?'. Between 74 and 82 per cent agreed correctly to statements related to contaminated razor blades and needles, and sexual intercourse. Again there were misconceptions such as getting AIDS from non-sexual contact with someone with AIDS (see Table 9).

Table 8
Children's responses about mode of transmission (%)

	Males	Females	Both sexes
Eating bad food	0.2	0.2	0.1
Through sex	55.6	10.4	2.0
Blood transfusion	0.9	2.7	2.2
Use of used blade	8.5	21.0	3.9
Use of toilet	0.3	0.8	0.8
Women travellers	0.3	0.2	-
Sex with dogs	0.2	-	-
Eating with someone with AIDS	0.3	0.2	0.3
Touching someone with AIDS	0.1	2.0	3.3
Kissing	0.3	1.1	0.1
Talking with someone with AIDS	0.1	0.2	0.1
Sharing plates	1.4	1.9	1.6
Prostitution	6.4	2.3	0.2
Flies, dirt	0.3	0.4	0.1
Sharing clothing	-	0.3	0.9
Sharing one room	-	0.2	0.3
Witchcraft	-	0.1	-

Mother to child	-	-	0.3
Not stated	25.1	56.1	83.9
Total	100.0	100.0	100.0

Table 9
Can you get AIDS if you do the following? (percentage who said 'yes')

	Males	Females	Both sexes
If you talk to someone with AIDS	10.9	8.7	10.0
If you touch someone with AIDS	11.8	12.4	12.0
If you eat from same plate with SWA	28.9	30.3	29.5
If you use clothing of SWA	31.3	35.3	32.9
If you use razor with SWA	80.7	68.0	75.6
If you use same needle with SWA	78.6	57.3	74.1
If you use same toilet with SWA	32.1	31.2	31.7
If you have sex with SWA	85.9	74.7	81.4

There is a close relationship between what the young people know about AIDS and what they think they can do to protect themselves from getting the disease. The largest proportion correctly responded 'avoid casual sex' (see Table 10).

Differences between boys' and girls' responses were not significant, which may indicate that they get information about AIDS from similar sources.

Sources of information about AIDS

Street children's sources of information on AIDS are presented in Table 11.

Table 10
What can you do to protect yourself from getting AIDS? (%)

	Males	Females	Both sexes
Nothing	3.4	2.8	3.1
Keep one sexual partner	10.8	12.4	11.4
Use condom	15.1	8.9	12.6
Avoid casual sex	30.0	28.8	29.5
Use own blades	10.3	85.0	8.2
Avoid blood transfusion	0.1	0.4	0.3
Prayers	1.7	1.1	1.5
Take care of oneself	5.7	4.4	5.1
Eat good food	10.3	17.0	13.0
Avoid kissing	3.8	6.3	4.8
Avoid sharing plates	0.7	0.2	0.5
Avoid sex with prostitute	1.6	-	1.0
Go to hospital when sick	0.1	0.4	0.3
Keep self clean	0.3	-	0.2
Take pills	0.1	-	0.1
Don't know	6.0	12.2	8.4

Total	100.0	100.0	100.0

Table 11
Sources of information on AIDS

	Males	Females	Both sexes
N.A.	3.3	12.2	6.9
Friends	31.0	35.7	32.9
Parents	4.5	2.4	3.7
Relatives	9.4	10.9	10.0
Other people	4.2	5.0	4.5
Forum/Durbar	1.6	3.5	2.4
Health worker	4.1	5.9	4.8
News media	28.5	17.4	24.0
School	11.9	6.5	9.8
Church	1.5	0.5	1.0
Total	100.0	100.0	100.0

Friends appear as the main source of information, mentioned by nearly a third of the children. If we add relatives, other people and parents, it is clear that informal, person-to-person contacts are the major source of information on AIDS for street children.

Nearly a quarter mentioned the news media as the source of information: the television was the most popular source followed by the radio and then newspapers. Given the children's level of education, the print media will continue to be an unimportant source of information. The television is indeed very popular and children hang around shops, windows and the front of houses to watch popular programs. It has also been observed that watching videos is an important pastime of the street children. The television can, therefore, be used more intensively to reinforce or supplement interpersonal sources.

Knowledge of other STDs

When children were asked to mention other sexually transmitted diseases 59 per cent could not mention any. Females were more ignorant about other STDs than males (68.4% and 52%). Gonorrhoea was the most frequently mentioned venereal disease (39%), which is not unexpected because terminologically there is virtually no other known STD locally. The local names *babaso* and *kikae* are often used interchangeably. The latter, however, means 'burning sensation' which is a symptom of the former. Similarly, terms like *babaso nini* and *babaso kraman* (male *babaso* and dog *babaso*) only describe the acute stage of progression of gonorrhoea. Other STDs mentioned included syphilis (1.3%), leucorrhoea (0.6%) and herpes (0.2%). As with AIDS, interpersonal sources accounted for about 68 per cent of all the sources of information on other STDs. Health workers are more important sources than the news media (16% and 9%). This may relate to the fact that there has not been consistent formal public education on other STDs as with AIDS. In the opinion of the young people who know of other STDs, anyone who is sexually active is at risk of getting an STD (44.2%). They also mentioned prostitutes and those who sleep with them (34%).

Risk behaviour

The environment in which street children operate makes them emotionally and physically vulnerable. By leaving home at a young age they subject themselves to considerable stress and emotional turmoil. They lack protection and are exposed to older people who may take

advantage of their vulnerability. Many of the strategies they use to cope with their problems are harmful to their health. In this section attention is directed to young people's activities which may predispose them to contracting HIV and other STDs, specifically, their sexual activities and high-risk behaviour related to AIDS.

Sexual activity

The majority of the street children (64%) said they had friends who were sexually active. Significantly, more males (68%) than females (58%) said this about their friends. When the question was directed to themselves, a reduced percentage but still a majority affirmed that they were sexually active; about 53 per cent had experienced sexual intercourse. Females were a little more likely than males to be sexually active (54% and 52%). Currently, none of the children aged below ten years is sexually active (see Table 12).

Table 12
Distribution of children who have ever had sexual intercourse by age and sex

	Males		Females		Both sexes	
	N	%	N	%	N	%
Below 10 years	0	0	0	0	0	0
10-14	25	17.4	17	14.0	42	15.8
15-19	333	62.3	231	71.0	564	66.1
Total	358	52.0	248	54.0	606	52.8

However, between four and five per cent of the children had actually experienced sexual intercourse for the first time below age ten and another 39 per cent by age 14. The mean age at first sexual intercourse is 14.5 years for both sexes.

Attitudes can predispose people to behave in certain ways. An attempt was, therefore, made to find children's attitude towards sex. First they were asked if it was possible for a normal person to go for a long time without having sex. The majority said they did not know. There was a negative relationship between age and knowledge about the issue at stake. About 23 per cent of both sexes said it was not possible for a person to go without sex; boys were more likely than girls to hold that attitude (26% and 20%). Their reasons were that sex was natural, a biological necessity (53%), that one falls sick or becomes stupid without sex (15%), and the desire for a child (13.3%). With these attitudes, it follows that for the children who are sexually active, sex is driven by such views.

The street children were also asked how often a person must have sex. About 42 per cent did not answer this question. Of the rest about 35 per cent reported from once a day to once a week and another 12 per cent said fortnightly to once a month.

To provide an idea of the children's sexual orientation they were asked to mention what they consider to be abnormal sexual practice. Their responses are presented in Table 13.

Table 13
What children consider to be abnormal sex (%)

	Males	Females	Both sexes
Sex between man and animal	0.2	0.2	0.2
Oral sex	5.5	5.4	5.5
Anal sex	2.3	2.2	2.3
Lesbianism	2.3	2.4	2.3
Homosexuality	12.5	5.7	9.8
Standing	0.4	-	0.3

Rape	1.2	0.7	1.0
'Open sex'	0.3	0.2	0.3
No response	75.3	83.2	78.4
Total	100.0	100.0	100.0

Although only about 22 per cent responded to the question, their answers are quite insightful. The largest proportion of 12 per cent mentioned same-sex practices: homosexuality and lesbianism. Also mentioned were oral sex and anal sex. Almost all the remaining responses reveal some of the reckless sexual practices in the environment of the street children. They include rape, sex outdoors and sex while standing. What is more important is that the practices mentioned by the children are not just ideas they have learnt but rather 29 per cent said they know of people who have experienced them. In fact some of the children claimed to have experienced one or another of these practices: 18 mentioned homosexuality, seven oral sex, six lesbianism, five anal sex and one sex standing up. The revelation dispels the notion held by African researchers that homosexual practices are not usual in Africa. It could also be said that the street children have developed their own sexual subculture alien to the norms of the general society.

Risk-related sexual behaviour

Those who have sexual relations with multiple partners place themselves at high risk to contract and transmit HIV, more so when sexual activity is pursued without protection. It is during unprotected sexual relations that other sexually transmitted diseases are contracted and spread.

Table 14
Number of people children have ever had sex with over certain periods (%)

	No. of people	Males	Females	Both sexes
In the last two weeks	0	74.6	73.0	73.9
	1	15.1	13.9	14.6
	2-3	4.8	3.9	4.5
	4+	2.5	5.5	3.7
	Too many to count	3.0	3.7	3.3
In the last three weeks	0	66.9	64.5	65.9
	1	19.0	19.2	19.1
	2-3	7.7	3.9	6.2
	4+	3.1	7.8	5.0
	Too many to count	3.3	4.6	3.8
In the last year	0	58.1	56.2	57.4
	1	15.0	19.8	16.9
	2-3	14.4	9.4	12.4
	4+	7.6	8.9	8.1
	Too many to count	4.9	5.7	5.2
In life time	0	48.0	46.0	47.2
	1	9.2	11.1	9.9
	2-3	19.0	16.1	17.9
	4+	17.1	19.8	18.2
	Too many to count	6.7	7.0	6.8

Multiple sexual partners

Table 14 shows street children's sexual partners over certain periods. It reveals that in their lifetime, most of the children who are sexually active have had two or more sexual partners. A small but significant proportion reported too many sexual partners to count. Even over the two weeks before the interviews some children reported too many sexual partners to count. Such children could possibly be in commercial sex. There is no significant difference between males and females in their number of sexual partners.

The general consensus in the focus-group discussions was that the rate of sexual activity among the street children is very high and has risen in recent times. The young people have sex mainly for pleasure.

> When I feel like having sex, I go to a house close by operated by an old woman. There are always girls around and with 1,500 cedis (almost US$1) you can have sex with anyone of your choice. As you approach, each of them will call out 'customer, customer'. Out of the 1,500 cedis, 500 cedis goes to the old woman and the prostitute takes 1,000 cedis (16-year-old boy).

Most of the male participants in the focus-group discussions were regular visitors to the old woman's place. A few were not.

> I do not go to the old woman's place. The prostitutes stay at the timber market. Around 4.30 to 5.00 PM you can have sex with as many of them as you can just for 500 cedis (14-year-old boy).

It appears some of the boys have sex not just for pleasure but because it is easy to get. Said a 15-year-old boy:

> In the night the older girls go to the Circle leaving the younger ones behind and we practise with them.

The young people could be reckless with their sexual behaviour, especially if under the influence of drugs. Sexual intercourse can take place at any time and around the corners if both partners are under the influence of drugs. These are what the children refer to as 'standing' and 'open sex' in Table 13.

There is not much regular sexual relationship among the street children at any point in time. Only 28.5 per cent of the sexually active young people said they have regular sexual partners. Girls were more likely than boys to enter into regular sexual partnership (34% and 27%). The boys feel that most of the girls are prostitutes and those who are not are not faithful. They would rather find money to visit a prostitute than to maintain a regular partner. It appears that sexual activity among the street children is very high because there are many girls around who are ready to sell sex for money, sometimes a mere pittance. One of the boys said 'Even while you are asleep they come to call you to come and have sex'.

Another reason why the boys do not like regular partnership is that it involves regular payment of money to the girl. As regular partners the girls will not take less than 2,000 cedis, whereas 400 cedis can be enough to buy sex from another girl. How much they pay depends upon the type of girl: if she is neat or sophisticated, the minimum fee is 1,500 cedis, if she is shabby, it is 500 cedis or less.

As already mentioned, most of the street girls have sex for survival. An 18-year-old girl explains:

> There are no jobs so if any man proposes love we are forced to agree hoping that through that we will get some money to cater for ourselves.

Concerning commercial sex, there is a kind of vicious circle caused by inflation. As one girl puts it,

> If you go out with a man and you get 10,000 cedis it cannot buy you a piece of cloth. So we must kill ourselves to make as much money as possible. Yet we can hardly save anything and we are forced to remain in commercial sex.

For those who thought they could make a windfall and branch out into a more respectable job, the idea has become an illusion. The participants in the focus-group discussions observed that the number of prostitutes in Accra has increased in recent times. The disturbing aspect is that more and more teenagers are getting involved. Males of all ages and status use the prostitutes including the small girls, some of them as young as ten years; they are mainly found at the railway station.

Unprotected sexual activity

Although 83 per cent of the young people knew about condoms, only 28 per cent had ever used them. Fewer still used them in the last three months to the interview (21%) indicating inconsistent use of condoms among the street children. This is not surprising because only half of them said condoms could protect them from getting AIDS. The rest either did not believe in the protective qualities of condoms or did not know. Most of those who are not using condoms (80%) just do not like them and a few said they do not make sex enjoyable or that they can burst. Some do not use condoms for religious reasons (2%); eight per cent do not use condoms because they think their partners are faithful. A negligible proportion of those not using condoms are too shy to buy them (0.7%).

Other STDs

The main mode of transmission of HIV in Ghana, as in the rest of sub-Saharan Africa, is through heterosexual activity. If someone gets any sexually transmitted disease, therefore, that person has a very high probability of contracting HIV, since the disease is now firmly established in the Ghanaian society and more and more people are getting infected every year. The link between STDs and HIV transmission is a further cause for concern. It is believed that the open sores associated with certain STDs, such as genital herpes and chlamydia, result in a greater likelihood of HIV infection.

A little over seven per cent of the young people reported that they had ever contracted any kind of an STD (see Table 15).

Table 15
Distribution of children who have ever had an STD by age and sex

	Males		Females		Both sexes	
Age	No.	%	No.	%	No.	%
Below 10 years	0	0	0	0	0	0
10-14	2	1.4	2	1.6	4	1.5
15-19	56	10.5	25	7.7	81	9.5
Total	58	8.4	27	5.9	85	7.4

Boys are more likely than girls to contract an STD (8.4% and 5.9%). The probability of contracting an STD increases considerably with age; this implies that the longer the young people remain on the street, the greater the chance of contracting an STD. Almost all those who had ever had an STD contracted the disease while on the street.

Those who had ever contracted an STD were asked where they received treatment. Only 18 per cent mentioned hospital. Females (30%) were more likely than males (12%) to go to the hospital for the treatment of their STDs. The infected persons either directly self-medicated (34%) or went to the dispensary (31%). In both instances, males are more likely than females to resort to these modes of treatment (43% and 35% against 15% and 22% respectively). Females are more than five times as likely as males to consult herbalists for the treatment of their STDs. The commonest self-medication was penicillin taken in palm wine or *akpeteshie*, a local gin. Many uninformed Ghanaians assume any capsule to be an antibiotic. Those who self-medicate, therefore, may take anything for the treatment of their STDs, so most STDs remain uncured.

Opinions about Ghanaian children and AIDS

The future of AIDS in Ghana and how it spreads among young people, particularly those in the street, will to a large extent depend on the way they perceive the disease. Any education aimed at street children must take into consideration their perception of their chances of contracting the disease. The young people were, therefore, asked whether or not they thought Ghanaian children were at risk of getting AIDS: 65 per cent answered yes, only three per cent said no and the remaining 32 per cent were not certain. Those who thought Ghanaian children were at risk of getting AIDS were asked their reasons.

Of the concerns expressed 47.1 per cent related to the sexual restlessness of children in Ghana, especially those on the street. Reasons given include what the children term sex abuse, the fact that most are prostitutes, and early sex. Added to these is that they have unprotected sex and that they lack proper education. Other predisposing factors mentioned include loneliness and what they termed money consciousness.

Summary

The study confirmed the findings in earlier studies in Ghana and elsewhere that street children are a vulnerable group of young people whose life styles place them at high risk for the contraction and transmission of HIV and other STDs. They are exposed to elements of the physical and social environment which may adversely affect their health. They are among the known high-risk groups for the spread of HIV/AIDS. Most eat irregularly and under unhygienic conditions. There is evidence of repeated illness and infections which receive inadequate treatment and, therefore, may facilitate HIV infection. There is further evidence of drug use which may also increase their vulnerability to HIV infection by weakening them physically and reducing their capacity to make rational decisions. Under the influence of drugs they tend to be reckless in their sexual practices.

Most of the street children are sexually active and most had their first experience on the street and with prostitutes. Some of the girls engage in sexual activity for money in order to survive. Most of them have multiple sexual partners and there is evidence that some experiment with unconventional sexual practices including homosexual acts. Some of them think sex is pleasurable and is a biological necessity which must be engaged in as often as possible.

Street children are aware of AIDS and regard themselves as in danger of contracting it. Nevertheless, the level of their condom use is very low and the use patterns are inconsistent. Generally, they are not doing much to protect themselves from contracting HIV, which is also

influenced by the kind of misconceptions they have about the disease. The children appear a little more ignorant of other STDs than AIDS. A few of them had been infected by some kind of STD. Self medication is the general practice for the treatment of STDs and there is evidence of inadequate treatment. Such a situation increases their chances of contracting HIV.

Recommendations

It is agreed that the phenomenon of street children is part of the process of rapid urbanization and general economic hardships. Nevertheless, efforts must be made to provide specialist services for children, such as education and vocational training and, in cases of family breakdown, substitute care.

The life of the children in the streets is hazardous, but government's response to their plight so far is poor. There is need for more co-ordination between the various agencies of government responsible for children. Government needs to evaluate the efficiency of public sector spending as it affects children.

The growing number of groups and individuals interested in the welfare of street children in Ghana is reassuring, but it is questionable how successful these groups are in meeting the needs of the children. More attention must be paid to the views and feelings of the children involved. We must see them as the subjects not objects of our interventions and policies.

The participation of children in decisions which affect their lives must be given priority in accordance with the UN convention on the Rights of the Child. They also require a voice in the political forums which crucially affect their lives.

The problem of child prostitution is an integral part of the phenomenon. The UN convention on the Rights of the Child specifically emphasizes the need to protect the child from all forms of sexual exploitation and sexual abuse such as inducement and coercion of a child into unlawful sexual activity, prostitution and pornography. Attempts must be made to break the 'system' behind street child prostitution and other sexual exploitation of children. Existing laws on such abuse of children must be enforced. Both those who organize child prostitution and the clients must be held criminally responsible. The link between prostitution and drug abuse observed by the study may require efforts for rehabilitation of liberated children.

The street children's level of awareness of HIV/AIDS is quite high but there is still room for improvement. The knowledge they have must be reinforced. In particular, their misconceptions about the disease must be corrected through intensive education. AIDS educational messages must be tailored to suit the needs of street children. Peer educators should be trained and made active partners in the whole intervention program.

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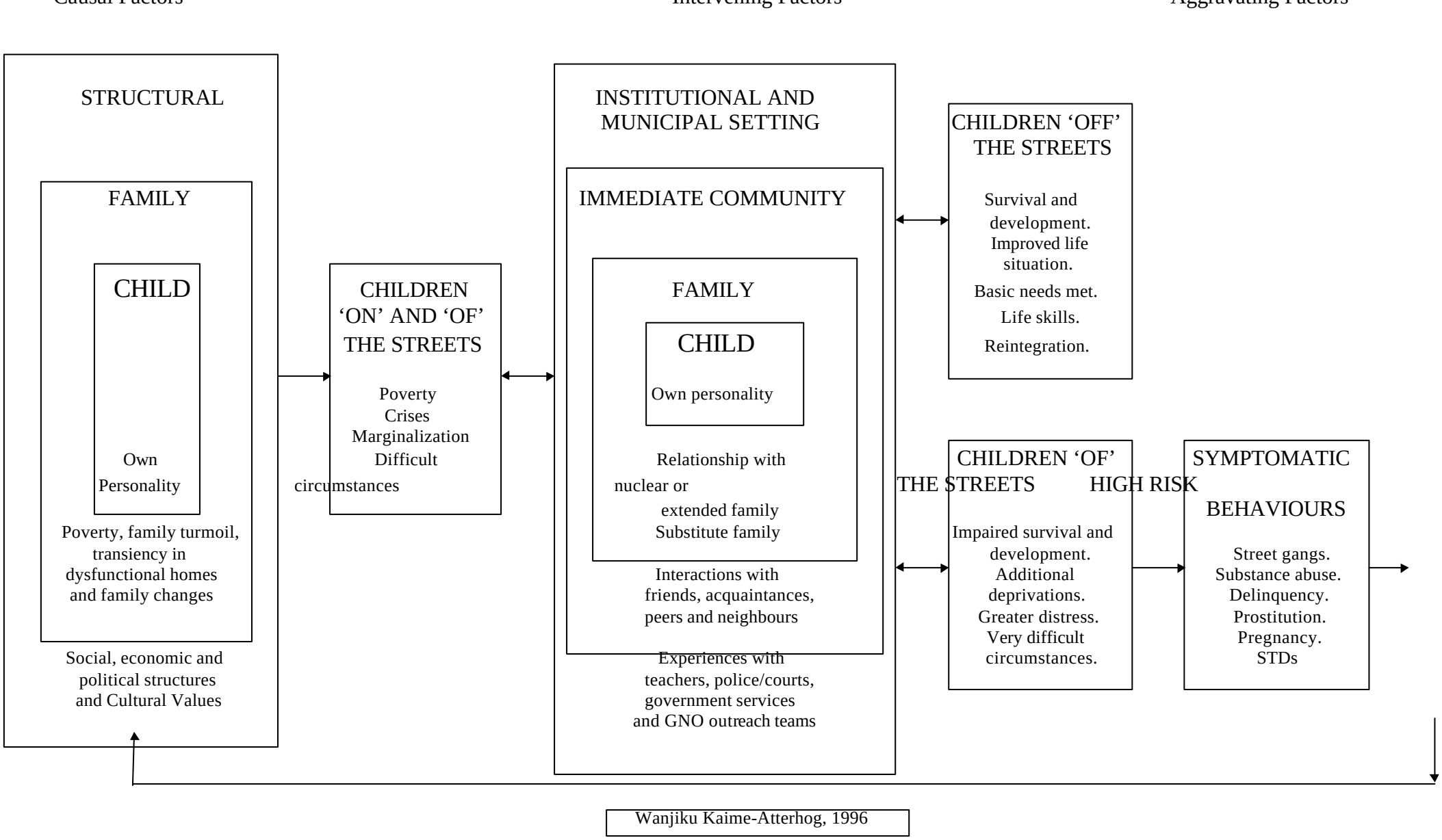
Figure 1
A framework for understanding the street children phenomenon


Causal Factors
Intervening Factors
Aggravating Factors
STRUCTURAL
FAMILY
CHILD
Own Personality
Poverty, family turmoil, transiency in dysfunctional homes and family changes
Social, economic and political structures and Cultural Values
CHILDREN 'ON' AND 'OF' THE STREETS
Poverty
Crises
Marginalization
Difficult circumstances
INSTITUTIONAL AND MUNICIPAL SETTING
IMMEDIATE COMMUNITY
FAMILY
CHILD
Own personality
Relationship with nuclear or extended family
Substitute family
Interactions with friends, acquaintances, peers and neighbours
Experiences with teachers, police/courts, government services and GNO outreach teams
CHILDREN 'OFF' THE STREETS
Survival and development.
Improved life situation.
Basic needs met.
Life skills.
Reintegration.
CHILDREN 'OF' THE STREETS
Impaired survival and development.
Additional deprivations.
Greater distress.
Very difficult circumstances.
HIGH RISK
SYMPTOMATIC BEHAVIOURS
Street gangs.
Substance abuse.
Delinquency.
Prostitution.
Pregnancy.
STDs
Wanjiku Kaime-Atterhog, 1996