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Research Report 10/1

Coping Strategies Used by Street Children in the Event of Illness

By Zena Amury
and Aneth Komba

RESEARCH ON POVERTY ALLEVIATION

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Abbreviations

CBO	Community-Based Organisation
ILO	International Labour Organisation
MCDGC	Ministry of Community Development, Gender and Children
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PA	Participatory Approach
SAP	Structural Adjustment Policies
SP	Sulfadoxine-Pyrimethamine
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections

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'To the children living on the streets…who are struggling to become what they should have been'

Zena Amury and Aneth Komba

Abstract

Worldwide, street children are highly vulnerable to illness, disease and injury but tend to under-utilise health services. It is therefore critical to understand the coping strategies street children use when ill and the barriers they face in accessing health services.

This study examined the health-seeking behaviours of street children in three municipal districts of Dar es Salaam, Tanzania. The research was carried out in October 2005 and involved 272 street children (163 boys and 109 girls) aged 10 to 18 years. Both quantitative and qualitative methodologies were used for data collection.

Findings reveal that street children frequently experience illnesses and injuries, including fever, skin diseases, headaches, respiratory infections, diarrhoea and stomach upsets. However, the majority of children did not use health services. The cost of services and unfriendly attitudes of health workers were the barriers to access most often cited by participants. The children preferred to buy medicine from local shops and pharmacies because it is cheap and saves time, thereby allowing them to focus on income-earning activities. Participants were also found to engage in high-risk behaviours, including unsafe sex, which increased their risk of contracting HIV/AIDS and other sexually transmitted infections.

1 Introduction

1.1 Background: The Phenomenon of Street Children

Millions of children and adolescents live and/or work on the streets of large cities worldwide[1]. Many of these children are denied access to their basic rights, including education, healthcare, and protection from abuse and exploitation. On the streets, they frequently survive by scavenging, begging, stealing or working in informal sectors in low-paying jobs. Some exchange sex for money, thus increasing their risk of contracting HIV and other sexually transmitted infections.[2]

In sub-Saharan Africa, the number of street children has been increasing due to the growing number of AIDS orphans. UNICEF (2003) estimated that eight out of every ten children who have lost parents to HIV/AIDS live in sub-Saharan Africa, and between 1990 and 2001 the proportion of orphans whose parents died from HIV/AIDS rose from 3.5% to 32%. UNAIDS (2006) estimated that there are more than 34 million orphans in the region, 11 million of them orphaned by HIV/AIDS. In the past, most orphaned children were cared for within the extended family.[3] However, due to the high death rate associated with AIDS and increasing poverty in sub-Saharan Africa, many orphans live in elderly- or child-headed households that are unable to meet the children's basic needs of food, clothing and shelter.[4] As a result, many orphans have no option but to live and work on the streets.

In the Tanzanian context, visible numbers of street children have been apparent since the 1990s.[5] Various factors have led to this increase. As in other parts of sub-Saharan Africa, the AIDS epidemic is one of the major factors. According to UNAIDS, about 1.1 million Tanzanian children under 17 years of age have lost one or both parents to AIDS.[6] As parents fall sick and die of AIDS, many families fail to take care of the orphans. As a result, many children must take on the responsibilities of parents and/or guardians, including income generation to support their households.

The impact of AIDS has been compounded by high poverty levels. As a result of growing economic disparities between urban and rural areas in Tanzania,[7] many people from rural areas migrate to urban areas in search of economic opportunities. Due to economic hardship, many parents/guardians in urban areas also send their children to the streets to engage in income-generating activities, and eventually these youth start living on the streets. A number of studies have found that extreme poverty in many families lay at the centre of the increasing number of street children in Tanzania.[8] For instance, Evans (2002) found that the inability of parents and guardians to pay school expenses resulted in high drop-outs rates which, in turn, led to children having to earn a livelihood on the street.

Non-income factors such as marriage breakdown and divorce, young parenting and domestic violence are also contributors to the increase in the number of street children in Tanzania. Research by the Mkombozi Centre found that family breakdowns and the inability

1 UNICEF 1989, Raffael et al. 1993, Scanlon et al. 1998
2 Raffael et al. 1993, Evans 2002, Anarfi 1997, Kamala et al. 2001
3 Ntozi 1997, Barnett & Whiteside 2002
4 UNICEF 2003, Loewenson & Whiteside 2001
5 Kopoka 2000, UNICEF 1990
6 UNAIDS 2006
7 Messkoub 1996, Cornia et al. 1987, Global Exchange 2001
8 Lugalla & Mbwambo 1999, Evans 2002, Community Development Department 2002, Yamamoto 1996

of extended families to take care of the children are major factors in the increase in children living on the streets in Kilimanjaro.[9] Moreover, ILO/IPEC (2001) found that many children migrate to the streets in search of employment because of physical abuse and domestic violence, including sexual abuse and exploitation by relatives, parents and/or guardians.

In addition, secondary schools and vocational training centres in Tanzania do not have sufficient places for all children who complete primary education. For a large proportion of Tanzanian children, their formal education finishes at the end of primary school. As a result, many of these children end up on the streets. A review by the Social Action Trust Fund (SATF), a non-government organisation supporting orphans and vulnerable children (OVC) in Tanzania, shows that out of the 1,447 OVC surveyed who completed Standard VII in 2004-2005, only 311 children (21% of the total) were selected to join government secondary schools. Left without support, many of these children have no alternative but to earn a livelihood on the street.

The Ministry of Community Development, Gender and Children (MCDGC) has put in place a child development policy, which aims to educate the public about the rights of children, and to provide guidance on caring, supporting and protecting children in Tanzania.[10] The policy, however, does not provide specific guidance on supporting vulnerable groups of children, such as children living on the streets, which necessarily impacts how interventions are designed for these groups.

Of the many vulnerable members of Tanzanian society, children living on the streets are among the most at risk.[11] Street life exposes children to a variety of socio-economic problems, including ill health and injury.[12] Health policies, programmes and services are therefore required to meet the needs of street children. To improve the design and implementation of these interventions, it is important to understand the current circumstances of street children in Tanzania, their vulnerability to poor health outcomes, and the strategies they use to cope with illness.

1.2 Research Problem and Significance of the Study

Children who are living on the streets are vulnerable to social and economic problems which may not be experienced by other young people. In particular, life on the street exposes children to illness and disease.[13] Ensuring street children's access to health services is crucial to improve their health and well-being. For this aim to be realised it is important to investigate the coping strategies used by street children when they get sick. This will help to design healthcare interventions and service delivery for this population.

In Tanzania, studies have investigated the vulnerability of street children to HIV,[14] and a situation analysis of street girls has been conducted.[15] The extent of child labour in Tanzania

9 Mkombozi Centre 2005
10 MCDGC 1996
11 UNICEF 1989
12 Raffael et al. 1993, Population Reports 2001, Swart-Kruger & Richter 1997, Anarfi 1997, Kabondo et al. 2004, Kamala et al 2001, Kadonya et al. 2002
13 WHO 1993
14 Evans 2002, Amury 2004, Rajani & Kundrati 1994
15 Yamamoto 1996

has also been examined.[16] In addition, a number of studies have investigated the nature and causes of street children and the problems they face on the streets.[17] No studies, however, have been conducted to assess coping strategies used by street children when they get sick. This has hindered the design of relevant health services and health programmes for street children in Tanzania, particularly in Dar es Salaam, which has a large population of children living and working on the streets.

This study seeks to provide information for the proper planning of health services and programmes to meet the special needs of street children. In particular, it aims to understand gender differences in health-seeking behaviours, so as to inform the design of gender-specific health interventions for both street boys and girls. The circumstances of street children must be well understood to improve their access to health services which, in turn, will contribute to improved health outcomes for this vulnerable population.

1.3 Research Objectives

The broad objective of this study is to understand the coping strategies used by street children when they get sick. More specifically, the study aims to:

- Identify the diseases or infections that children living on the streets frequently succumb to
- Determine the health-seeking behaviours of street children
- Identify the barriers to accessing health services faced by children living on the streets
- Provide recommendations on health services and programmes to meet the health needs of this population.

1.4 Research Questions

Information and data collection was guided by the following main research questions:

1. What diseases or infections are common to street children?
2. What behaviours put street children at risk of contracting infections and diseases?
3. How do street children seek treatment when they are sick?
4. Is there any significant difference in health-seeking behaviours between girls and boys?
5. Do street children use available health services? If so, why?

16 ILO/IPEC 2001
17 Lugalla et al. 1999, Mvungi 2002, Lugalla & Kibassa 2003

2 Literature Review

This chapter analyses literature relevant to street children and their vulnerability to disease. To begin, Section 2.1 provides the definition of children living on the streets adopted by the current study. Section 2.2 discusses Tanzania's national health policy with a focus on access to healthcare. Section 2.3 then discusses recent research on health-seeking behaviours of street children and their access to health services. The final two sections of the chapter examine evidence on the vulnerability of children living on the streets to disease (Section 2.4) and the gender dimension of street children's vulnerability (Section 2.5)

2.1 Definition of Children Living on the Streets

This study defines 'children living on the streets' as children 18 years or younger who live independently on the streets in urban areas, largely supporting themselves by begging and scavenging on the streets or working in the informal sector, without adult supervision and with little or no family contact. Street children may also be breadwinners for poor households or children from street families, i.e. those who were born on the streets.

2.2 Tanzania's National Health Policy and its Implications for Access to Healthcare

The overall objective of Tanzania's National Health Policy is to improve the health and well-being of all Tanzanians, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people.[18] The policy's specific objectives include ensuring the availability and accessibility of health services to all people in urban and rural areas, and to sensitise the community to common, preventable health problems. It also seeks to improve the capability – at all levels of society – to assess and analyse problems and to design appropriate actions through genuine community involvement.

To better respond to the health needs of Tanzanians, the Health Sector Reform Programme was commenced in 1994. The major aim of the reforms was to develop a health service system that would be equitable, sustainable, and involve both public and private modalities of healthcare delivery. Under the reforms, the Government is committed to provide essential health service functions commensurate with its budgetary capacity, and to facilitate the development of quality services in both public and private sectors.

Significant progress in the health sector was achieved through the reforms. Health infrastructure has been expanded such that 93% of the population lives within 10 km of a health facility and 72% within 5 km.[19] However, national averages do not take into accoun geographical and other local variations, quality of services, and direct and indirect costs which determine accessibility to services.

This is particularly important in the case of street children, as the majority of them have limited access to mainstream social services. Rajani et al. (2001) found that, despite the fact that public health facilities were very widely distributed and geographically accessible, cultural barriers and inattentiveness to adolescents' needs rendered health services inaccessible to the adolescent population, including street children.

18 MOH 1990
19 MOH 1996

Indeed, none of the objectives in the National Health Policy address adolescent health generally or street children specifically. Moreover, the policy recognises the need to improve and develop urban health services, but specific provisions are not included to meet the challenge of the large influx of street children into urban centres. There is little evidence of any awareness of street children as a population group with special needs. Of serious concern, the Government's guidelines regarding user charges for health services do not identify street children as a vulnerable group.[20] According to the guidelines, only children under five years of age are exempt from payment of fees. Street children are not identified as a special group to be exempt.

2.3 Accessibility of Healthcare and Health-seeking Behaviour of Children Living on the Streets

Evidence indicates that children who are living on the streets tend to under-utilise the existing health services.[21] A number of factors contribute to this problem. Of importance is that the majority of health services and programmes have been developed by adults for adults.[22] They often fail recognize the unique issues of adolescents in general, and children living on the streets in particular, and rarely accommodate their behaviours.

For example, Tanzania's main health programmes – such as maternal and child health, family planning and AIDS control – do not have a component for street children. The principal focus of these programmes is the reproductive role of women.[23] The programmes also target children in school but commonly exclude youth who have dropped out and street children. Yet children living on the streets are amongst the poorest and most vulnerable adolescents.

It is also important to note that for children living on the streets the struggle to get daily food and shelter overrides concerns about their health. Kruger and Ritcher (2003) found that street children are more oriented to the present and not concerned with their future health. Other studies have found that even if these children appreciate the risk of getting infected with diseases, many believe that they are personally invulnerable.[24] This perception may result in children not using health services.

Even if street children want to use the health services, many are below the age of consent but neither have a parent/guardian to accompany them for treatment nor the necessary documentation.[25]

The inaccessibility of healthcare to street children in sub-Saharan Africa has been exacerbated by the introduction of user fees for health services since the mid-1980s.[26]

20 MOH 1997a
21 Kabondo et al 2004, Anarfi 1997, Kruger & Ritcher 2003, Dilip 2004
22 WHO 1993, Rajani et al. 2001
23 MOH 1997b, MOH 1994, TACAIDS 2003
24 Anarfi & Antwi 1995, Amury 2004
25 WHO 1993
26 Mujinja 2000

In South Africa, children living on the streets said that they did not seek treatment when they were ill because they did not have money and instead tried to sleep off their illnesses.[27] In Tanzania, an unpublished study showed that when street children fall ill they have to look after themselves, prescribe their own medications, and buy drugs from local pharmacies.[28] Research in Tanzania and Ghana also found evidence of repeated illness and sexually transmitted infections (STIs) among street children that were inadequately treated.[29] Left untreated, STIs can increase susceptibility to further infections, including HIV/AIDS.

2.4 Vulnerability of Street Children to Diseases and Illnesses

Children living on the streets worldwide are vulnerable to a range of health and other problems, including HIV/AIDS, which may not be experienced by other young people.[30] A number of behavioural and social characteristics of street children substantially increase their risk of contracting HIV. Studies have found that this population becomes sexually active earlier than most other groups of children, and they are known to engage in sexual activity with peers and adults from within and outside their social circle.[31]

Research has also shown that children living on the streets are likely to be raped or forced into sexual relationships on the streets, and that they use condoms infrequently and inconsistently.[32] In addition, children living on the streets are more likely to exchange sex for money.

Furthermore, children living on the streets often receive limited information about reproductive health and HIV/AIDS due to illiteracy and non-attendance at school.[33] They also know very little about other STIs.[34] Akwara et al. (2003) argue that exposure to AIDS information tends to lead to higher awareness of the disease which, in turn, influences self-assessment of risk and a decrease in high-risk sexual behaviour, thereby reducing vulnerability to HIV.

In many societies, children living on the streets are also perceived as a threat. They are often vulnerable to discrimination and can be a very difficult population to reach and work with.[35] As a means of coping, many children living on the streets are involved in substance abuse. A study in Dar es Salaam found that street children were involved in marijuana smoking and substance abuse to endure tough jobs, discrimination and long days without food.[36] Drug use may further lead to a high risk of psychiatric disorders, such as mood disorders, depression, suicide, anxiety and phobias, sleep disorders and eating disorders.[37]

The environments in which street children live can make them emotionally and physically vulnerable. In Tanzania, these children commonly sleep in hazardous environments such as in abandoned, broken-down vehicles, at bus stops and in bars.[38]

27 Kruger et al. 2003
28 Amury 2004, Kamala et al. 2001
29 Kamala et al. 2001, Anarfi et al. 1995
30 Situmorang 2005, Kamala et al. 2001, Rajani et al. 2001
31 Raffael et al. 1993, Swart-Kruger et al. 1997, Rotheram-Borus et al. 1991, Anarfi 1999, Rajani and Kundrati 1994, Rau 2002
32 Kruger et al. 2003, Anarfi 1997, Anarfi 1999, Kamala et al. 2001, Rajani et al. 1994
33 Filgueiras 1993, Swart-Kruger et al. 1997, Campbell & Ntsabane 1995
34 Anarfi 1997
35 Csete & Whitman 2001, Ntarangwi 2003
36 Kamala et al. 2001
37 Friedman 1989, WHO 1993
38 Lugalla & Kibassa 2002, Mvungi 2002, Kopoka 2000

In addition, many children on the streets live, work and scavenge in dangerous and/or unhygienic conditions, exposed to discarded hospital needles and syringes, broken bottles and dangerous chemicals. They typically wear no protective gear such as gloves, helmets, gum boots, masks and glasses.[39] Living in such conditions at a young age subjects children to considerable stress and emotional turmoil, and many of the strategies they use to cope with their problems are harmful to their health and increase their vulnerability to diseases. A World Health Organisation (WHO) study found that street children suffered health problems including injuries from accidents and violence as well as industrial and environmental poisoning.[40] In Mwanza, Tanzania, many working children and children living on the streets were engaged in quarrying, garage work, fishing and fish processing, and complained of body pains, injuries and abuse, as well as frequent respiratory illnesses, and water-borne and other water-related diseases.[41]

In addition, the unhygienic conditions on the streets expose children to infectious diseases such as diarrhoea, typhoid, cholera, tuberculosis, skin diseases, respiratory tract infections and parasitic infestations.

2.5 The Gender Dimension of Vulnerability

Girls who are living on the streets are even more vulnerable than boys. In addition to the health risks experienced by street boys, adolescent girls are at risk of early, unplanned pregnancies with minimal, if any, antenatal care. Severe health risks, including maternal mortality, are associated with practices for terminating pregnancies.[42]

Furthermore, more girls than boys experience sexual abuse and exploitation in the streets. In Zimbabwe, a study of sexually active street girls found that the majority had been forced into sex[43] and, in Ethiopia, a study involving 32 girls living on the streets reported that 21 of the participants had been raped.[44] A Tanzanian study by ILO/IPEC showed that most girls working on the streets had experienced sexual abuse.[45] Similarly, Evans (2002: 59) found that:

> *A street girl is in a lot more danger than a boy. Many, many women at the bus stand are raped. You hear the older boys saying,'There are girls sleeping in a certain place, let's go and find them'. But a boy can sleep anywhere; he does not have any problem because he is a boy.*

However, younger boys living on the streets are also particularly vulnerable to sexual exploitation. A focus group discussion with street children in Mbeya Municipality elicited that younger boys were engaged in sex for protection while others were raped by older men or older boys in the streets.[46] In South Africa, younger boys living on the streets claimed to have been often raped by older boys.[47] These factors significantly increase the risk of contracting HIV/AIDS and other STDs.

39 Kadonya et al. 2002, Lugalla et al. 2002, Mvungi 2002, Kopoka 2000
40 WHO 1993
41 Kadonya et al. 2002
42 WHO 1993, Kabondo et al. 2004, Kamala et al. 2001
43 UNICEF 2001
44 Lalor et al. 1992
45 ILO/IPEC 2001
46 Amury 2004
47 Kruger et al. 2003

3 Methodology

This chapter describes the methodology used for this study. Section 3.1 outlines the research approach, and Section 3.2 identifies the study locations. The sampling procedure is then discussed in Section 3.3 followed by description of data collection procedures and instruments in Section 3.4 and data analysis in Section 3.5. The final two sections of the chapter discuss the ethical considerations involved in conducting the research with children (Section 3.6) and the limitations of the study (Section 3.7).

3.1 Research Approach

Denzin (1989) argues that triangulation of research methods can overcome personal biases and limitations that stem from the use of a single research method. Therefore, both quantitative and qualitative data collection instruments were used in the current study. To begin, individual interviews using a structured questionnaire were conducted to gather quantitative data on the coping strategies used by children living on the streets in case of illness, as well as demographic data of participants. Qualitative methods were then conducted to verify the data collected and to gain an in-depth understanding of the children's coping strategies. The qualitative methods employed were semi-structured interviews, and participatory mapping and drawing exercises. To facilitate comprehensive responses to questions related to diseases or infections experienced by participants, a list of diseases common to street children was employed. However, no medical tests were conducted to diagnose the diseases identified by participants.

3.2 Study Locations

The study was conducted in the three municipal districts of Dar es Salaam: Ilala, Kinondoni and Temeke. The city was selected for the research because it is the largest urban area in Tanzania, and attracts many children and youth who are searching for employment.[48] In the most recent national census, Dar es Salaam's population was estimated to be 2,497,940 people.[49] The city has a high population of street children who are engaged in the informal sector.

Data was collected from the following sites:

- Ilala District – sites included Kariakoo market area, Mnazi Mmoja, Kidongo Chekundu, Buguruni, Feri, Fire and Jangwani;
- Kinondoni District – sites included Ubungo terminal bus stand, Mwenge, Magomeni and Manzese (Uwanja wa Fisi);
- Temeke District – sites included Chang'ombe, Tandika Sokoni, Kurasini (dampo area) and Mbagala.

The research took place in areas where street children typically congregate, such as bars, bus stands, local brew shops, shopping centres, market areas and on the streets.

48 UNICEF 1990
49 United Republic of Tanzania (URT) 2002

3.3 Study Participants and Sampling Procedure

As defined in Section 2.1, the study's target population was children who were living or working independently on the street. Owing to the lack of census data on children living on the streets in Dar es Salaam and the difficulty in tracking this highly mobile population, the study established the following criteria for selecting respondents:

i) children had to be between 10 and 18 years of age; and
ii) had to have lived/worked on the street for more than three months.

In total, 272 children participated. Survey interviews were conducted with 234 participants, participatory exercises engaged 30 participants (six groups of five children), and semi-structured interviews involved 8 participants (see Table 1).

Table 1: Number of Participants

Methods	Number of Participants
Survey interviews	234
Participatory exercise	30
Semi-structured interviews	8
Total	**272**

Control Sample

To ensure that study findings were reliable, additional interviews were conducted with a control sample of 40 boys who had previously worked or lived on the streets. The interviews involved 20 children from Dogodogo Children Centre in Kigogo (Ilala District) and Children in the Sun Centre in Mbezi (Kinondoni District). The children interviewed had been staying in the centres for more than one year. Participants were asked to describe their experiences while they were on the street. The same questionnaire used in the field was administered to the control sample. Findings from the control sample were compared to data collected in field interviews to assess any bias in the responses of children currently living and working on the streets (see Appendix 1).

3.4 Survey Instruments and Data Collection

Structured interview questionnaire

The structured interview questionnaire was developed in English and translated into Swahili. (see Appendix 2 for the questionnaire in Swahili and Appendix 3 for the English version). Principal topics covered by the questionnaire included:

- Social and demographic characteristics of participants, including age, gender, place of residence and level of education
- Diseases experienced by participants
- Coping strategies used by street children in case of illness
- Health-seeking attitudes and behaviour, including those related to HIV/AIDS.

It has been argued that information obtained using structured questionnaires is limited by the categories imposed by the researcher, and interesting replies by participants may be lost.[50] To minimise this problem, an 'other' category was provided for every question to ensure that all responses from the children were able to be recorded.

The questionnaire was piloted with 25 street children (who were not included in the main sample of 234 children interviewed). Based on pilot findings, revisions were made to the questionnaire. For example, it was found that children had difficulty recalling illnesses they had suffered over the past six months and, hence, this period of time was reduced to three months in the final questionnaire.

Data collection was face-to-face. Interviews were conducted in Swahili on the streets at research sites after respondents had been given information about the research and had provided their oral consent.

Semi-structured interviews

Semi-structured interviews were conducted to further investigate the coping strategies and health-seeking behaviour of street children. The researchers followed an interview guide (see Appendix 4), but also probed for more information based on participants' responses. The interviewer also had a chance to clarify responses from the interviewee. Moreover, the semi-structured interviews provided greater insight into the social factors underlying street children's coping strategies and health-seeking behaviour. The researchers piloted the interview guide with two children prior to field interviews, but no changes were needed to the guide.

Field interviews were conducted on the streets at research sites. Each interview lasted for about 30-40 minutes, and was tape-recorded with the permission of participants.

Participatory exercises: Mapping and drawing

Johnson and Nurrick (2000) note that:

> *Participatory visual methods can play an important role in helping children to present and analyse their own perspectives on issues that directly affect their lives. Such an approach is shown to promote learning and education (particularly in the non-formal sector) and also to provide the means by which children can inform decision-makers of their priorities and concerns, and provide solutions to problems that face them.*

In the current study, mapping and drawing exercises were used to allow more active participation of children in sharing information about their coping strategies. The exercises did not require reading or too much writing but rather involved drawing, mapping and discussions. Large quantities of information were produced as discussions during the exercises were tape-recorded.

Participatory exercises were conducted in Swahili, on the pavements, and involved six groups of five street children each (see Appendix 5).

50 Bryman 2001, Memon 1990, Denscombe 2003, Franfort-Nachmians and Nachmians 1996

3.5 Data Analysis

After data collection, open-ended questions were pre-coded. Preliminary analysis was also completed on the demographic characteristics of participants. A second stage of analysis was then completed using the *Statistical Package for Social Science* (SPSS) and chi-square tests were performed to determine any significant differences between genders in relation to children's coping strategies and health-seeking behaviours.

Qualitative data was analysed in accordance with analytical procedures suggested by Marshall and Rossman (1999). Recordings from the semi-structured interviews were transcribed by listening to the tapes in conjunction with reading fieldwork notes. This exercise was done separately by two people (the researcher and a research assistant) and transcriptions were compared to ensure reliability of the findings. Transcriptions were then translated from Swahili to English, after which the common themes and patterns were identified.

3.6 Ethical Considerations

The ethical principle governing research is that participants should not be harmed as result of the research, and should give their informed consent.[51] In particular, Allmark (2002) notes that research with children must be ethically sound, and undertaken with proper respect for the children's safety, integrity and privacy. It is also argued that consent to participate in the research should be given by someone competent to do so.[52]

However, in the current study, parents/guardians were not available, so children were asked personally for their consent to participate in the research. All participants were given full information regarding the purpose of the research, what was expected from them, how long the interviews or exercises were expected to last, and that participation was voluntary. In addition, the research did not expose the children to any physical or emotional stress.

3.7 Limitations of the Study

There is potential for interviewer bias during face-to-face interviews. However, the use of a standardised questionnaire as well as piloting of the questionnaire, and training of interviewers on interview skills helped minimise this effect.

Some children were also scared to be interviewed by strangers (researchers) and at times were reticent to discuss their experiences, especially personal behaviours. Sound interviewing skills, such as establishing rapport, putting children at ease and remaining non-judgemental[53] were used to help children overcome their shyness. In addition, children were involved as facilitators in the mapping and drawing exercises, which encouraged their active participation.

51 Bowling 2002
52 Beuchamp and Childress 2001
53 Bowling 2002

Privacy was another problem as the study was conducted on the streets at research sites. There were some distractions from other street children and onlookers during interviews. Therefore, where possible, depending on the flexibility of individual respondents, interviews were conducted in relatively quiet places, away from the busy streets where most street children were found. Of note, girls were invisible during daytime and many refused to be interviewed in areas where there was no privacy. However, conducting interviews early in the morning and late in the evening in the places where they sleep (street pavements) helped to increase the sample size of street girls who participated.

Six participatory exercises were conducted instead of the planned eight. Participants for the exercises in Temeke District did not turn up and, due to the time limitation in the research clearance letter for that district, it was not possible to re-schedule this fieldwork.

In addition, some street children were unable to be interviewed as they were drunk at the time of interview. This was a frequent problem in Manzese (*Uwanja wa Fisi*), where most children in the area were drunk. Nevertheless, researchers persevered and interviewed those respondents who were ready and available.

4 Findings and Discussion

This chapter presents and discusses the findings of the study. Section 4.1 provides the general characteristics of respondents. Data on diseases and illnesses that street children frequently suffer, and their health-seeking behaviours are then presented in Sections 4.2 and 4.3 with a focus on gender differences in coping strategies. Section 4.4 details children's reasons for not using health services, and Section 4.5 presents children's suggestions to improve their access to healthcare. Finally, Sections 4.6 and 4.7 outline and discuss findings on behaviours and activities that put street children at risk of contracting diseases and illnesses, including HIV/AIDS.

4.1 General Characteristics of Respondents

Structured interviews were conducted with 234 street children, of whom 140 (59.8%) were boys and 94 (40.2%) were girls. Semi-structured interviews and participatory exercises involved 38 respondents (23 boys and 15 girls). Table 2 summarises data on the characteristics of respondent involved in structured interviews including age, length of time on the street, level of education attained and usual sleeping place.

Almost two-thirds of the street boys (63%) were aged between 11 and 15 years, and approximately one-quarter (24%) were aged between 16 and 18 years. Only 13% of respondents were aged 10 years. Among the street girls interviewed, 33% respondents were aged between 11 and 15 years, while 61% were aged between 16 and 18 years.

These findings indicate that boys leave home earlier than girls, which may be attributed to prevailing gender roles in many ethnic groups in Tanzania. Whilst girls are commonly socialised for reproductive roles[54] and obliged to engage in household chores, their male counterparts are frequently socialised to engage in remunerative productive roles, thus allowed to go on the streets to look for money earlier than girls.[55,56] These findings are consistent with a study in Mbeya Municipality which found that boys are likely to start living on the streets at a younger age than girls.[57]

Table 2: General Characteristics of Respondents

Variable	Male (N=140)		Female (N=94)	
Age	**Frequency**	**Percentage**	**Frequency**	**Percentage**
10 years	18	12.9	6	6.4
11-15 years	88	62.9	31	33.0
16-18 years	34	24.2	57	60.6
How long living / working in the street (years)				
Under one year	28	20.0	28	29.8
One year	26	18.6	15	16.0
More than one year	86	61.4	51	54.2

54 Reproductive roles involve the care and maintenance of the household and its members, including bearing and caring for children, preparing food, collecting water and fuel, housekeeping and family health care. It is almost always the responsibility of women and girls (Moser 1993).
55 Productive roles involve production of goods and services usually paid or income generating (Moser 1993).
56 Mwageni et al. 2001
57 Amury, 2004

Table 2 (continued): General Characteristics of Respondents

Variable	Male (N=140)		Female (N=94)	
Age	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Education Level				
No education	26	18.6	15	16.0
Drop-outs	70	50.0	30	31.9
In school	4	2.8	6	6.3
Completed primary education	40	28.6	43	45.7
Place to Sleep				
On the street	48	34.3	18	19.1
At home	41	29.3	51	54.3
Ghetto	51	36.4	25	26.6

The findings further show that over half of street boys and girls (61% and 54% respectively) had lived and/or worked on the streets for more than one year. This suggests that many of these children started living on the streets at very young ages. The children who were working were commonly engaged in activities such as selling foods, fruit or sweets, washing cars, or involved in illicit activities, such as drug dealing and commercial sex work.

With respect to educational attainment, half of the street boys (50%) and almost one-third (32%) of girls had dropped out of school. This is consistent with a study done by Mkombozi Centre (2005) in Kilimanjaro, which found that many children living on the streets were school drop-outs. Many parents or guardians are too poor to provide school requirements for their children, such as uniforms and books. As a result, many children drop out of schools and find their way to the streets.

In addition, more street girls (46%) than street boys (29%) had completed primary school. In this respect, the findings do not match those of Anarfi and Antwi (1995) whose study in Ghana found that street boys were more likely to have basic primary education than street girls. On other hand, 18% of street boys and 16% of street girls have never attended school. It may be argued that because street boys in the current study were living on the streets earlier than street girls, that they were less likely to finish or to attend primary school.

Furthermore, more street boys (34%) than street girls (19%) are sleeping on the streets while 36% of street boys and 27% of street girls are sleeping in a 'ghetto'. According to them, a ghetto is a cheaply rented room which accommodates between 10-20 children and is mainly rented for sleeping at night. This type of sleeping accommodation arrangement may expose children to the danger of getting air borne diseases.

4.2 Common Diseases and Illnesses of Street Children

In order to assess the health-seeking behaviour and coping strategies used when street children fall ill, it was important to know if respondents had ever been sick. Therefore, participants were asked whether they had been sick during the past three months and to describe the diseases they had suffered. The findings are summarised in Tables 3 and 4.

Table 3: Children Who Experienced Sickness During the Last Three Months

Response	Male (N=140)		Female (N=94)	
	Frequency	Percentage	Frequency	Percentage
Yes	132	94.3	84	89.4
No	8	5.7	10	10.6

Results in Table 3 show no significant difference ($p>0.05$) by gender in relation to whether or not children had been sick during the past three months. Almost all children had suffered from diseases or illnesses during the past three months (94% of street boys and 89% of street girls).

Table 4: Diseases/Illnesses Frequently Experienced by Street Children*

Type of Disease/Illness	Male (n=132)		Female (n=84)	
	Frequency	Percentage	Frequency	Percentage
Diarrhoea	33	25	24	28.6
Skin diseases[58]	53	40.2	26	30.9
Chest diseases[59]	33	25	14	16.7
Fever	87	65.9	58	69
Headache	39	29.5	36	42.9
Stomach ache	41	31.1	29	34.5
Accidents/Injury**	50	37.9	13	15.5

Notes: * This was a multiple response question, therefore, total frequencies and percentages exceed the total sample size (N=234) and 100% respectively, as some children suffered more than one disease during the last three months;

** $x^2 = 13.055$= significant difference ($p<0.01$) between genders

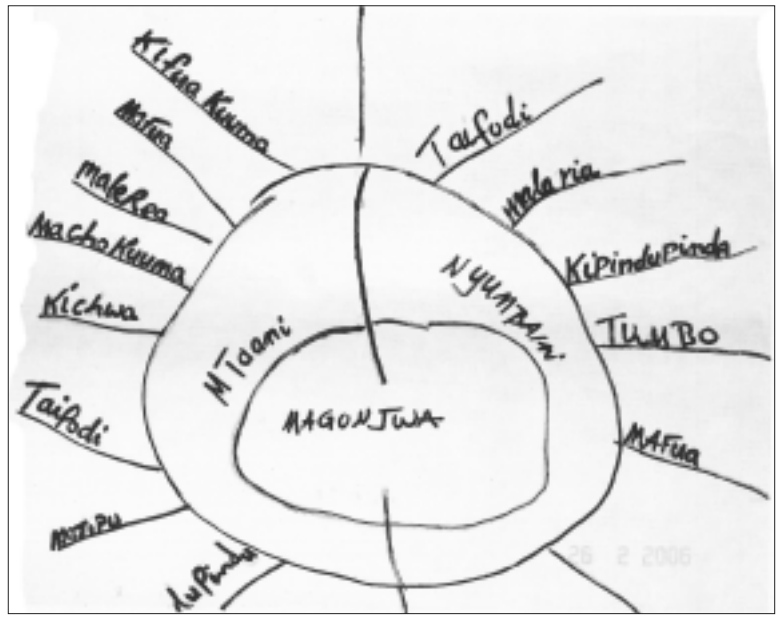
Data in Table 4 show that around two-thirds of street boys (66%) and street girls (69%) had suffered from fever. In addition, 40% of street boys and 31% of street girls had suffered from a skin disease during the past three months.

Results also show a significant difference ($p<0.01$) by gender in relation to experiencing accidents and injuries in the streets. Overall, 38% of boys had experienced injuries and accidents during the past three months, as compared to 16% of girls. This may be related to the nature of the work that boys are engaged in when on the streets. Kadonya et al. (2002) found that many street boys in Mwanza, Tanzania – who were involved in quarrying, garage work, fishing and fish-processing activities – complained of sustaining injuries.

Consistent with interview data, findings from the participatory group exercises revealed that street children are at risk of suffering diseases and illnesses. Figure 1 below illustrates the illnesses (*magonjwa*) suffered by participants when they were still living at home (*nyumbani*), and when they were living on the streets (*mtaani*).

58 Skin diseases referred to any type of skin rash
59 Chest diseases referred to pain in chest

Figure 1:
Spider diagram showing the types of diseases / illnesses suffered by participants when living at home, and during the past three months on the streets.



Responses indicate that street children suffered from a wide range of illnesses, including malaria, typhoid (*taifodi*), flu *(mafua)* coughs *(kifua)*, stomach aches (*tumbo*), and headaches *(maumivu ya kichwa)*. These findings are further corroborated by qualitative data from the semi-structured interviews. As one participant related:

> *'I have been suffering from malaria many times, and also chest pains, cough and flu.'* (Boy, 16 years)

However, it needs to be noted that the current study used an oral post-mortem approach, and no medical tests were done to confirm if the children had ever suffered from illnesses such as malaria and typhoid. The children, therefore, may have experienced other conditions with similar symptoms to malaria and typhoid.

4.3 Health-seeking / Coping Strategies Used by Street Children

To examine children's health-seeking behaviour and coping strategies, participants were asked what they usually do when they get sick. Findings are summarised in Table 5.

Table 5: Health-seeking Behaviour/Coping Strategies Used by Street Children When They Get Sick

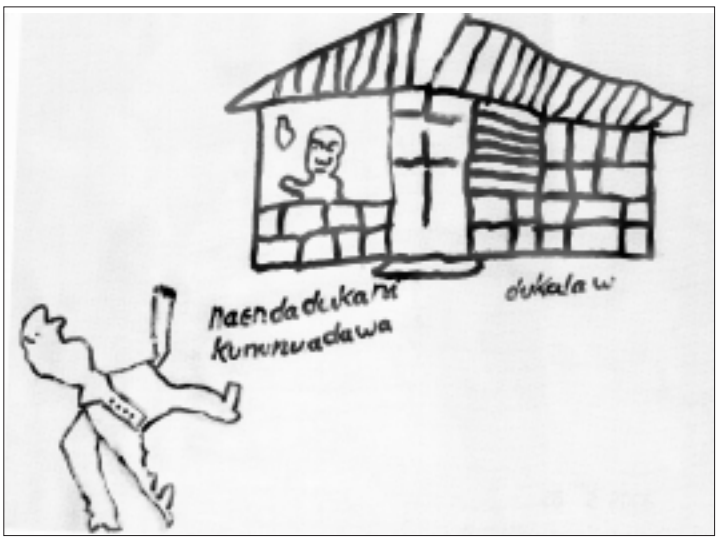
Action	Male (n=132)		Female (n=84)	
	Frequency	Percentage	Frequency	Percentage
Go to hospital	30	22.7	23	27.4
Go to traditional healers	12	9.1	7	8.3
Sleep off the illness	31	23.5	15	17.9
Buy medicine	59	44.7	39	46.4

No significant differences (p>0.05) by gender were found in relation to their health-seeking behaviour. Buying medicine at the local shop or pharmacy was the most common means of seeking treatment when they get sick (45% of boys and 46% of girls). This type of behaviour was also revealed in responses during the semi-structured interviews, as shown by the following excerpt:

> *'I don't usually go to the hospital when I am sick. Many times I bought drugs from pharmacies.'* (Girl, 13 years)

Results were further confirmed by participants' input during the drawing exercises. Figure 2 illustrates a respondent going to the local pharmacy to buy medicine.

Figure 2:
A 14-year-old boy's drawing of himself (left) going to the pharmacy (right) to buy medicine



Sharing medication was another means of coping with illnesses, as evidenced by one child:

> *'When I was suffering from malaria…I did not buy medicine. My friend gave me SP tablets [60] which were left over from when he was sick…After taking those tablets I got cured.'* (Boy, 16 years)

By buying medicine direct from pharmacies or sharing with friends, street children are exposed to the danger of taking drugs without a proper diagnosis or prescription from a health practitioner. They may not receive the correct medication and recommended dosage, or complete the required course of treatment to fully recover. Inappropriate and/or incomplete treatment, may also contribute to the further development of drug resistance.

Data in Table 5 further reveal that 23% of boys and 27% of girls went to hospital when they were sick. However, almost one-quarter (24%) of boys and 18% of girls said that they sleep off their illnesses, which may seriously impact the children's health through delays in getting proper treatment. This behaviour is further evidenced by Figure 3, a drawing done by a 12-year-old boy, which shows him lying down when he was sick.

[60] Sulphadoxine-Pyrimethamine



Figure 3:
A street boy's drawing (12 years old) of himself when he was sick –
'I was suffering from headache and slept without medicine.'

Delay in seeking treatment and self-treatment has also been identified as a coping strategy used by the majority of poor people in Tanzania. Many tend to mobilise resources for seeking treatment only when they are seriously sick.[61] This generalised behaviour may influence the coping strategies during illness used by children living on the streets.

It should also be noted that families with low incomes also tend to under-utilise available health services. Poor households are frequently forced to resort to self-treatment or ineffective alternatives, and may access facilities too late for care, often with fatal consequences. Many of these households resort to traditional healers and/or buying medicine from local shops or pharmacies.[62] Children from low-income families may, therefore, be using the same health-seeking behaviours and coping strategies as children who are living on the street.

To better understand street children's behaviour, respondents were also asked to give their reasons for choosing the three coping strategies most commonly cited: 'going to a hospital', 'buying medicine' and 'sleeping off the illness'. The results are summarised in Tables 6 through 8.

Table 6 shows that out of the 50 respondents who chose to go to a hospital, 38% of children went because they were very sick, 30% because they trusted that the hospital services were effective, and 32% because they were advised to do so by their friends or relatives.

61 Save the Children 2003
62 Women's Dignity Project 2004, Guy 2003, Save the Children 2003

Table 6: Children's Reasons for Going to the Hospital When Sick

Reason	Respondents (n=50)	
	Frequency	Percentage
Very sick	19	38
Hospital services are effective	15	30
Advised by a friend/relative	16	32

From these results, it may be argued that 'going to hospital' is actually not the first alternative for the 38% of children who reported going to hospital only when they became seriously ill. This is also supported by the following quote from a semi-structured interview:

'If am not serious sick, I just sleep off my illness or I buy drugs from pharmacies. I go to the hospital when I am seriously sick.' (Boy, 14 years)

Table 7: Children's Reasons for Buying Medicine When Sick

Reason	Respondents (n=92)	
	Frequency	Percentage
Cheap	42	45.6
Saves time and nearby	26	28.3
Effective	24	26.1

The results in Table 7 show that 46% of children opted to buy medicine when they were sick because it was the cheap alternative, while 28% of respondents chose to buy medicine because this saved time and it was available nearby. In addition, findings from the semi-structured interviews revealed that street children spent most of their time looking for money to buy food, and hence they are not likely to spend much time seeking treatment. As one boy pointed out:

'When I get sick I buy drugs from local pharmacies and I go to the war (begging)…You know, brother, if you don't go vitani (in the war)…there is no food…That's why I like going to the pharmacy because it saves my time.' (Boy, 13 years)

Street children's struggle to get food each day can, therefore, override any concern for their health. Amury (2004) also found that many street children were not concerned about their health because they had more pressing needs than seeking treatment.

Table 8: Children's Reasons for Sleeping Off Their Illnesses

Reason	Respondents (n=46)	
	Frequency	Percentage
No alternative	27	58.7
Effective	7	15.2
Very sick	12	26.1

Data in Table 8 show that more than half of the respondents (59%) who chose to sleep off their illnesses said that they had no other alternatives, and 26% of respondents revealed that they sleep off their illnesses because they were so sick that they could not go to hospital and they did not have anyone to help them to the hospital.

To further assess their coping strategies, participants in the semi-structured interviews were asked about sources of cash for treatment. Several responses are presented below:

> *'When I suffered from gonorrhea, I first used traditional medicine from Masai…but I did not get well…I [then] decided to buy medicine from pharmacy…My condition became worse…Then my friends contributed money and took me to the hospital.'* (Boy, 17 years)

> *'When I get sick…I tell my friends…If they have money they buy drugs for me…If we don't have money …I just sleep…You know we are very poor…and our life here in the streets is very hard.'* (Boy, 16 years)

> *'One day my friend was very sick…He was unconscious…We contributed some money and took him to the hospital. Therefore, if we don't have money we don't go to the hospital…until we contribute or borrow money from each other.'* (Boy, 18 years)

> *'In the past two months I got problem in throat…It was so big that I failed to eat…I was coughing a lot and I became very thin…My friends told me to go to Mdoe Street…There is a traditional practitioner who treat me for 3000/-. My friends contributed money for me.'* (Boy, 18 years)

These excerpts reveal that street children have very limited individual resources to access health services, and rely on their friends to contribute money for drugs or treatment and to assist in getting to a hospital if they suffer a serious medical problem.

4.4 Children's Reasons for Not Using Health Services

In order to gain more insight on how to improve access and provision of healthcare services for street children, the respondents who did not go to a hospital were asked to give their reasons for not doing so. The data in Table 9 show that more than half of the street boys (60%) and street girls (53%) did not go to hospitals because it was expensive. These findings indicate that user fees for hospital services – that were introduced during the 1980s in Tanzania – are a frequent barrier to street children accessing health services. As one boy described:

> *'The main problem of getting treatment is money…Money to pay for medicine and money to pay to doctors…Money is the issue here.'* (Boy, 15 years)

Table 9: Children's Reasons for Not Going to the Hospital

Reason	Male (n=78)		Female (n=38)	
	Frequency	Percentage	Frequency	Percentage
Expensive	47	60.3	20	52.6
Hospital staff are unfriendly	10	12.8	11	28.9
To save time	11	14.1	2	5.3
Illness not serious	10	12.8	5	13.2

In addition, 13% of boys and 29% of girls did not go to hospital because they considered that hospital staff are unfriendly. As one child related:

> *'Other watchmen in the hospital prevent us from entering the hospital gates. They say we are going to beg in the hospital.'* (Girl, 13 years)

Likewise, children's illustrations from the group drawing exercises show that children living on the streets do not like to go to hospital because they are chased away by the hospital staff. Figure 4 shows a street girl being chased away by the guard, before she enters the hospital gate. The words – *'You won't get medicine here unless you have money'* – are written between her and the hospital.

Figure 4:
A drawing by a 15-year-old street girl (left) being chased away from the hospital by a watchman (right).



WHO (1993) also argued that street children are not likely to go to hospital because hospital staff treat them very badly.

4.5 Children's Suggestions to Improve Healthcare Access

A principal aim of the research is to identify strategies to improve health outcomes for street children. Therefore, respondents were asked for their recommendations that would improve their access to health services. Findings are summarised in Table 10.

Table 10: Children's Suggestions to Improve Healthcare Access

Suggestion	Respondents (n=188)	
	Frequency	Percentage
Free services	92	48.9
Cost should be reduced	24	12.7
There should not be a long queue (i.e. reduce waiting time at the hospital)	30	15.9
Staff should be friendly	20	10.5
Don't know	32	17

Consistent with survey findings that the cost of treatment represented a significant barrier to participants in accessing care, almost half of the children (49%) suggested that health services should be free, and a further 13% felt that the cost should be reduced. In addition, 16% of respondents cited the need to reduce waiting time at the hospital. These recommendations again highlight children's requirements to save time and money so as to attend to their other immediate needs, such as food and shelter. The following quotes from the semi-structured interviews reinforce the importance of these issues:

'I would like the health services to be free of charge because even if you have 500/- it is not enough to get treatment…You need to buy a registration card [and] drugs…You need to pay 100/- for an injection…At the same time you don't have money to even buy food.' (Girl, 18 years)

'Health services should be offered free of charge to street children…Nurses and doctors should be compassionate to street children…When we go to the hospital …they shouldn't be asking us too many questions…Even the police should give us a report that allows us to get treatment for free.' (Boy, 17 years)

4.6 Sexual Behaviours that Put Street Children at Risk of Contracting HIV/AIDS and other Sexually Transmitted Diseases (STDs)

To assess street children's risk of contracting HIV/AIDS and STDs, respondents were asked if they had ever had sex and, if so, whether they had ever used condoms. Findings are presented in Table 11.

Table 11: Children's Sexual Behaviour

Behaviour	Boys (n=139)		Girls (n=92)	
	Frequency	Percentage	Frequency	Percentage
Ever had sex				
Yes*	68	48.9	67	72.8
No	71	51.1	25	27.2
Ever used condom				
Yes	18/68	26.5	26/67	38.8
No	50/68	73.5	41/67	61.2

*x^2 = 13.026= significant difference ($p<0.01$) between genders

Note: only 40 participants responded to sexual behaviour questions i.e. 24 boys and 16 girls.

A significant difference ($p<0.01$) in sexual activity was found between boys and girls. Approximately three-quarters of the female respondents (73%) had ever had sex compared with about half of the male respondents (49%). However, it must be noted that the age of the girls surveyed was higher than the age of the boys. Overall, 61% of girls surveyed were aged 16 to 18 years compared with 24% of boys in this age bracket.

Among respondents who had ever had sex, 74% of boys and 61% of girls had never used a condom. Other studies have also found low levels of condom use among of street children.[63] Evidence from the semi-structured also indicated that sexually active respondents used condoms infrequently or inconsistently, or were unable to negotiate safe sex. As one boy described:

> *'I prevent myself from getting HIV/AIDS by using condoms but I was infected with gonorrhea by my lover because I got drunk and I didn't use condoms…But I usually use a condom.'* (Boys, 17 years)

One girl related feeling powerless to demand that her partners use condoms because they gave her money for living expenses:

> *'I would really like to protect myself against AIDS by using condoms…but when I tell my sexual partners to use condom they refuse…and I can't stop having sex with them because they give me money to buy food and clothes.'* (Girl, 18 years)

This inability to negotiate safe sex among girls living on the streets significantly increases their risk of contracting HIV and other STIs.

Other research studies have found that women in general, not only street girls, lack confidence and communication skills in issues related to sexuality.[64;65] Freudenthal (2001) also argued that young girls and women in many African countries not only lack the skills but also the resources and power to negotiate safer sex with men. This is particularly true for street girls who engage in sexual relations with older men or fellow street boys to get money to survive. Anarfi and Antwi (1995) found that girls on the street are more likely to be sexually exploited, but do not have the qualifications to secure an alternative livelihood.

4.7 Activities that Put Street Children at Risk of Contracting Diseases and Illnesses

Table 12 presents data on income-earning activities of respondents. Petty trade was the most frequently cited income-earning activity by both genders. About half of the boys (52%) and girls (48%) were engaged in petty trade. A significant difference by gender was found in the incidence of begging among street children. More girls (34%) were engaged in begging to earn income than boys (6%). Begging may expose street girls to sexual exploitation, hence increasing their risk of contracting HIV/AIDS. In contrast, a higher

[63] Campbell Ntsabane 1995, Anarfi and Antwi 1995
[64] Philemon & Kessy 2008
[65] Mwageni et al. 1998

proportion of boys (24%) than girls (18%) were engaged in scavenging. Scavenging is an extremely hazardous form of work, exposing children to infectious diseases, particularly hepatitis and tetanus. Small percentages of boys were also engaged in car washing and carrying luggage – 6% and 13% respectively – but no girls were involved in these two activities.

Survey findings are consistent with Kadonya et al. (2002) which found that street children were more likely to engage in petty trade, scavenging and begging.

Table 12: Income-earning Activities of Street Children

Activity	Male (n=140)		Female (n=94)	
	Frequency	Percentage	Frequency	Percentage
Petty trade	73	52.1	45	47.9
Scavenging	33	23.6	17	18.1
Begging*	8	5.7	32	34.0
Car washing	8	5.7	0	0
Carrying luggage	18	12.9	0	0

*x^2 = 25.81 = significant difference ($p<0.05$) between genders

With respect to income, street children revealed that they usually earn an average of Tshs 200/- to 1,000/- shillings per day, but money earned can fluctuate widely. As two children related:

> *'My life depends on begging…I usually get an average of 400/- a day. If it is a lucky day…I can even get 800/-.'* (Boy, 14 years)

> *'Sometimes I get Tshs 1,000/- after scavenging…They usually buy used plastic bottles for Tshs 400/- per kilogram…so if I manage to get two kilograms I can get 1,000/- per day.'* (Boy, 15 years).

As one girl pointed out children's income was not guaranteed especially if sick; sometimes they do not get any money at all.

> *'Sometimes it is very difficult to get even 100/-…especially when you are sick…You cannot work and hence you won't have money for food…We have a very difficult life.'* (Girl, 16 years)

It is important to note that the minimum cost for an outpatient in government hospitals and dispensaries in Tanzania is Tshs 1,000.[66] If the study data reflect the level of income earned by street children – i.e., between Tshs 200-1,000 – then this clearly indicates that the cost of health service is unaffordable to children who are living on the streets.

The next chapter summarises the major findings and conclusions from the study, and provides recommendations on policies and interventions to reduce their risk of contracting diseases and to increase access to health services for children living on the streets.

[66] MOH 1997a

5 Summary of Key Findings, Conclusions and Recommendations

5.1 Summary of Key Findings

The major findings from this study are:

- Street children frequently experience illnesses, particularly fever, skin diseases, injuries, headaches, diarrhoea and stomach upsets.
- Children who are living on the streets under-utilise available health services.
- Buying medicine from local pharmacies and sleeping off illnesses are the major coping strategies used by street children when they are sick.
- No significant differences in health-seeking behaviour were found between boys and girls living on the streets.
- The cost of healthcare services, including user fees at health facilities, is the principal barrier deterring street children from accessing appropriate healthcare.
- Street children engage in high-risk behaviours, including unsafe sex, which increases their risk of contracting HIV/AIDS and STDs.
- The income-earning activities frequently cited by participants, especially scavenging and begging, exposed them to serious health and safety risks.

5.2 Conclusions

In light of study findings, a number of conclusions can be drawn. Firstly, the cost of health services for street children will need to be reduced if their access to healthcare is to be improved. The study showed that participants typically did not have the individual resources to pay the user fees and charges at health facilities, and so were unable to promptly access care when sick. However, providing free or reduced cost services *per se* may not be sufficient to achieve effective access. Healthcare staff must also be given training to better understand the special needs of street children and to provide youth-friendly services. In addition, the study revealed that under-utilisation of health services for street children is related to other factors such as time saving, so that they can attend to other immediate needs, such as food and shelter. Reducing waiting times at facilities will be needed to decrease the opportunity costs incurred by all patients, including street children. Achieving this outcome will require much greater investment in healthcare personnel.

Secondly, if street youth continue to engage in unsafe sex, they are at high risk of contracting HIV/AIDS. It is therefore critically important to provide children with information about prevention of HIV/AIDS. However, increasing their HIV knowledge and prevention skills per se may not mitigate their vulnerability to poor reproductive health outcomes. As the study revealed, their risk of becoming infected with HIV is closely related to the economic and social conditions which drive them to live and work on the streets. Therefore, efforts must be also made to improve their socio-economic opportunities and life skills – for example, through enrolment in school, vocational or entrepreneurial training, and support for livelihoods – if there is to be a significant and sustained impact on their vulnerability to HIV/AIDS. Organisations working with street children must also recognise and develop gender-sensitive interventions which address the multi-faceted social, economic and cultural factors affecting the vulnerability of street girls and street boys to HIV.

Lastly, a close relationship exists between abject poverty and street children. Improving the socio-economic status of poor households with children will be critical in reducing the numbers of children who have no alternative but to live and work on the streets as a means of survival.

5.3 Policy Recommendations

Tanzania's National Health Policy

The Tanzania National Health Policy should recognise the need to improve and develop urban health services to meet the challenge of the large influx of street children into urban centres and cities. Furthermore, the policy should recognise that street children are a population group with special needs. In addition, government guidelines regarding user charges for health services should take into account that street children are a vulnerable group that needs to be exempt from user fees. This is because the study reveals that children living on the streets are vulnerable to a range of diseases and other health problems, but under-utilise health services largely because the direct and opportunity costs of accessing health facilities are too high.

Tanzania's Child Development Policy

The Child Development Policy should identify street children as a special target group, and participatory strategies should be devised to reduce their vulnerability to diseases. Currently, the policy does not recognise street children as a target populations requiring special attention.

Tanzania's National AIDS Policy

The Tanzania Health Policy, the Tanzania National AIDS Policy, and the National Multi-Sectoral Strategic Framework on HIV/AIDS should take into consideration the involvement of street girls in commercial sex work and develop age-appropriate interventions. This study revealed that girls under 18 years of age are frequently involved in commercial sex work to make sufficient income to survive.

5.4 Recommendations for Practical Action to Support Street Children

Interventions to improve street children's access to healthcare should not only provide free health services to these children, but also address the social, cultural and environmental factors that restrict access. In this regard, the following interventions are recommended to Government, NGOs, and community- and faith-based organisations and individuals who are working with street children.

Basic Education and Vocational Training for Street Children

Efforts should be made to ensure that children who drop out of school and other street children are provided with basic primary education. Complementary Basic Education in Tanzania (COBET) may represent a key programme for this population.[67] COBET aims to increase access to education to out-of-school children, youth and illiterate adults, and ensure they have access to high quality learning opportunities. Special or non-formal primary education programmes will be critical in reaching children living on the streets.

[67] Ministry of Education and Culture (MOEC) 2002

It is acknowledged that the provision of street-side schools does not guarantee that street children will attend, as they may have more immediate needs such as securing food and shelter. In addition, street children may have developed health, psychosocial and behavioural problems in the streets that may affect their concentration and social relations at school.[68] Encouragingly, an intervention run by the the Faraja Trust Fund in Morogoro, Tanzania helped street children with their day-to-day survival concerns and, as a result, more children attended school consistently.[69] In addition, the Mkombozi Centre adopted the COBET programme in providing basic education to street children in Kilimanjaro region.[70] Using this approach, the Undugu Society of Kenya trained 2,000 street children between 1990 and 1995 who later joined ordinary primary and vocational schools.[71] Based on this evidence, such a programme should be adopted and expanded to other regions and districts in Tanzania.

Ideally, children who have completed primary school should be offered tailor-made vocational training such as carpentry, masonry, cooking and tailoring as a foundation for income-generating activities. If possible, government and NGOs should also provide start-up tools to enable youth to establish small businesses. However, for street children to participate, vocational training will need to be cheap or free, conveniently located, and focused on practical skill[72]; and should incorporate play, social or leisure activities and adopt a flexible schedule so as to motivate children.[73] With such training and support, street children will have much greater capacity to meet their basic needs.

Residential Homes and Drop-in Centres for Street Children

Residential homes and drop in-centres are also required to provide shelter, food and health services to street children, as well as counselling. Services should be available to re-unite children with their families and communities where possible. However, children living on the streets cannot be forced to leave the streets. In order for the programme to be successful, this socialisation will likely take place in the streets, and the process of leaving the streets should be voluntary. The Faraja Trust Fund has been successful in re-uniting street children with their families using this approach.[74] But some children have completely lost contact with their families while others tend to return to the streets due to the hardship of life at home. In these cases, residential homes will be needed to provide long-term accommodation, care and vocational training until children reach adulthood. In addition, homes and drop-in centres should work in partnership with the families and communities from which the street children came. In Kenya, Kwetu Training Centre observed that the rate of street children who were returning to the streets after being re-united with their families fell by 50% after the programme started to involve parents and communities. These are important groups that need to be prepared for the integration of children returning to their homes.[75]

Income-generating Projects for Children Living on the Streets

Older street children (16-18 years) should be helped to secure premises and facilitated to acquire start-up tools and capital to undertake income-generating activities. Training programmes in entrepreneurial skills would also be valuable. Car washing or shoe shine

[68] Volpi 2003
[69] Faraja Trust Fund 2000
[70] Mkombozi Centre 2005
[71] Volpi 2003, Muli 2000
[72] Frew 2003
[73] WHO 2000
[74] Faraja Trust Fund 2000
[75] Ruto 1999

shops are two examples of businesses that require little capital to start and can be conducted in the streets where children are living.

Partnerships Between Government, Health Facilities, Civil Society Organisations and Communities Involved in Programmes for Street Children

Increased collaboration between all stakeholders will help to maximise the benefits of interventions, minimise duplication of efforts, and utilise scarce resources more effectively.

5.5 Recommendations for Future Research

Greater knowledge and understanding of the circumstances of children living on the streets is necessary to inform appropriate policies, programmes and health services for this highly vulnerable population. The current study covered only one city, Dar es Salaam. A larger study encompassing different urban areas in Tanzania needs to be carried out. Such research would provide a more comprehensive understanding of the health-seeking behaviour and coping strategies used by street children in diverse urban contexts in Tanzania. A complementary assessment of existing policies and interventions to support street children will further facilitate the development of appropriate local and national strategies to meet the needs of all street children.

The study findings also indicate an urgent need to investigate street children's attitudes towards condom use and their ability to access them. Further research is also needed to examine the attitudes and practices of health personnel towards children living on the street. This will inform the development of a sensitisation and training programme for health workers to better understand the needs, behaviour and norms of this population, so that they are able to deliver appropriate youth-friendly services.

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Appendices

Appendix 1: Findings from the Control Sample

To ensure the reliability of survey results, data were collected from a control sample of 40 boys who had previously worked and/or lived on the streets. Tables A1 and A2 present findings from the control sample, and the results are compared with survey data below.

Table A1: General Characteristics of the Control Sample

Variable	Respondents (N=40)	
Age	**Frequency**	**Percentage**
6-10	13	33
11-15	19	48
16-18	8	20
How long living / working in the street (years)		
Under 1 year	12	30.0
Over 1 year	28	70.0

Table A2: Key Findings from the Control Sample

Variable	Frequency	Percentage
Diseases that street children frequently suffer (N=40)		
Diarrhoea	14	35
Skin diseases	25	63
Chest diseases	13	33
Fever	22	55
Headache	17	43
Stomach ache	14	35
Accidents/Injury	21	53
Health-seeking behaviours / coping strategies (N=40)		
Going to hospital	11	28
Going to traditional healers	0	0
Sleep off the illness	8	20
Buying medicine	21	53
Reasons for buying medicine (n=21)		
Cheap	9	43
Saves time and nearby	7	33
Effective	5	24

Results from the control sample correspond to major findings among the survey population. Consistent with the survey population, the majority of respondents in the control sample had lived/worked on the streets for more than one year (control sample 70%; main survey, boys 61% and girls 54%).

Respondents in the control sample also frequently cited suffering various diseases/illnesses while on the streets including skin diseases, headaches, fever, accidents and injury, and diarrhoea. As found in the main survey, buying medicines from local pharmacies was the most common coping strategy for illness cited by the control respondents. Moreover, the reasons provided by respondents for this behaviour corresponded closely to the testimony provided by survey participants. In both control sample and survey, the two reasons most commonly cited for buying medicine were it was cheap and it saved time. By adopting this strategy, children could attend to their other immediate needs, such as looking for food and a place to sleep.

Appendix 2: Swahili Questionnaire

MBINU WANAZOTUMIA WATOTO WANAOISHII MITAANI KUJITIBU WANAPOKUA WAGONJWA

A. Habari za Msingi

Kata ... ... Mtaa ... ... ……..

Jinsia ... ... Tarehe ... ... ……..

1. Umri
    a. Miaka 6-10
    b. Miaka 11-15
    c. Miaka 16-18
2. Kwa kawaida huwa unalala wapi?
    a Mtaani
    b. Nyumbani
    c. Mtaani na nyumbani
    d. Geto
    e. Sehemu nyingine (elezea)
3. Kama huwa unalala nyumbani, ni nani unayeishi naye?
    a. Wazazi wote wawili (baba na mama)
    b. Mama
    c. Baba
    d. Bibi
    e. Babu
    f. Wengine (elezea)
4. Je mama yako yuko hai?
    a. Ndio
    b. Hapana
5. Je baba yako yuko hai?
    a. Ndio
    b. Hapana
6. Kwa muda gain sasa umekua ukiishi/kufanya kazi mitaani?
    a. Kwa muda usiozidi mwaka mmoja
    b. Mwaka mmoja
    c. Zaidi ya mwaka mmoja
7. Ni kazi/ shughuli gain unayofanya mtaani?
    a. Kuuza chakula
    b. Kuuza magazeti
    c. Kuokota majalalani
    d. Kuomba omba
    e. Nyingine (elezea)_____
8. Kiwango cha elimu
    a. Hajasoma
    b. Hajamaliza elimu ya msingi
    c. Bado anasoma
    d. Amemaliza elimu ya msingi
    e. Elimu ya Sekondari

B. Magonjwa yanayowashambulia watoto waishio mitaani

9. Je umeshawahi kuumwa kwa kipindi cha miezi mitatu iliyopita?
   a. Ndio
   b. Hapana

Nimagonjwa gain uliyoumwa? (Usisome majibu)

Ugonjwa	Ndio	Hapana	Idadi ya siku
Kuharisha			
Magonjwa ya ngozi			
Kifua/kukohoa			
Malaria			
Homa			
Tumbo			
Kichwa			
Ajali/ vidonda			
Kuumwa na nyoka			
Mwingine (elezea)			

C. Mbinu za kujitibu

10. Kama ulishawahi kuumwa magonjwa yeyote kati ya hayo uliyotaja kwenye swali la 9, ulifanya nini? (Usisome majibu)
    a. Nilienda hospitali
    b. Nililala
    c. Nilienda kwa waganga wa kienyeji
    d. Nilinunua dawa
    e. Mbinu nyingine (elezea)_____

11. (Kulingana na jibu la swali la 10) Kwa nini ulichagua mbinu hiyo?
    a…….
    b. ……..
    c……..
    d…….

12. (Kulingana na majibu ya swali la 10) kwa nini haukuchagua kwenda hospitali? hospital?
    a. …….
    b……
    c……
    d…….

13. (Kulingana na majibu ya swali la 10) nani aliyekushauri kuchagua mbinu hiyo?
    a. Mimi mwenyewe
    b. Rafiki yangu
    c. Ndugu yangu
    e. Mwingine (mtaje)_____

14. Kama ulienda hospitali, ni nani alikupeleka??
    a. Mimi mwenyewe
    b. Rafiki yangu
    c. Mama
    d. baba
    e. Mwingine (mtaje)_____
    d. Others (specify)

15. Kama ulikwenda hospitali, ulipata matatizo yeyote katika kupata matibabu?
    a. Ndio
    b. Hapana

16. Kama ndiyo (kulingana na swali la 15) ni matatizo gain uliyokutana nayo? (Usisome majibu)
    a. Sikuwa na pesa za kutosha kununua dawa
    b. Nilifukuzwa nisiingie hospitali
    c. Watumishi wa hospitali walikua wakatili kwangu
    d. Tatizo lingine (elezea)_____

17. Ili uweze kwenda hospitali na kupata matibabu, ungependa huduma za afya zeweje?
    a. ……
    b. ……
    c. ……
    d. ……

D. Maswali kuhusu Tabia zinazoweza kufanya kuambukizwa UKIMWI

18. Je unajua kondomu ni nini?
    a. Ndio
    b. Hapana
19. Umeshawahi kusikia kuhusu kondomu?
    a. Ndio
    b. Hapana
20. Umeshawahi kutumia kondomu?
    a. Ndio
    b. Hapana
21. Ni sababu gain zilizokufanya utumie kondomu?
    a. Kuzuia mimba
    b. Kuzuia kumpa mamba mpenzi wangu
    c. Kuzuia kuambukiza magonjwa
    d. Kuzuia kuambukizwa magonjwa
    e. Sababu nyingine(elezea)_____
22. Umeshawahi kufanya ngono?
    a. Ndio
    b. Hapana
23. Je, ulitumia kondomu mara ya mwisho ulipofanya ngono?
    a. Ndio
    b. Hapana (Nenda swali namba 24)

24. Kwa nini hukutumia kondomu?
    a. Mpenzi wangu alikataa
    b. Sikujua kuhusu kondomu
    c. Kondomu inazuia kufurahia ngono
    d. Niliona aibu kumwambia mpenzi wangu
    e. Sababu nyingine (elezea)
25. Je unafanya kitu chochote kujikinga na UKIMWI?
    a) Ndio
    b) Hapana
26. Kama ndio, unafanaya nini kujikinga na ugonjwa wa UKIMWI? (Usisome majibu)
    a) Kutumia kondomu
    b) Kuepuka ngono
    c) Kujitibu mapema magonjwa ya ngono
    d) Sijui
    e) Njia nyingine(elezea)_____

Appendix 3: English Questionnaire

Name of Research Assistant_____ **Date**_____
District _____ **Place**_____

COPING STRATEGIES USED BY STREET CHILDREN INCASE OF ILLNESS

Questionnaire

B. Social Demographic data

Ward …… Street …….
Sex……...Date……..

1. Age
    d. 6-10 years
    e. 11-15 years
    f. 16-18 years
2. Where do you usually sleep (Probe but do not read out list)
    a. In the street
    b. At home
    c. In the street and home
    d. Ghetto (not at home not in the street)
    e. Others (specify)_____
3. If you sleep at home, with whom do you live with whom do you live with?
    a. Both parents (mother and father)
    b. Mother
    c. Father
    d. Grandmother/
    e. Grandfather
    f. Others (specify)_____
4. Is your mother alive?
    a. Yes
    b. No
5. Is your father alive?
    a. Yes
    b. No

6. For how long have you lived/worked in the street
    a. Less than one year
    b. One year
    c. More than one year
    d. Others (specify)_____
7. What type of work are you doing in the street?
    a. Food vending
    b. Selling magazine
    c. Scavenging
    d. Others (specify)_____
8. Level of education
    a. No education
    b. Have not completed primary school
    c. Still in school
    d. Completed primary education
    e. Secondary education

B. Different Diseases experienced by street children

9. Have you ever been sick for the past six months?
    a. Yes
    b. No

What did you suffer from and for how long? (Probe but do not read out list)

Diseases	YES	NO	Number of Days
Diarrhoea			
Skin diseases			
Chest diseases			
Malaria			
Fever			
Stomach ache			
Head ache			
Accidents/injury			
Snake bite			
Others (specify)			

C. Coping strategies used and Health seeking behaviour

10. If you have ever suffered from any of the diseases in question 9, what did you do? (Probe but do not read the list)
    a. Go to the hospital
    b. Sleep
    c. Go to the traditional healers
    d. Buy medicine
    e. (specify)

11. (According to the answer in question 10) why did you choose the mentioned alternative?
    a. ……
    b. ……..
    c. ……..
    d. ……

12. (According to the answer in question 10) why didn't you go to the hospital?
    a. ……
    b ……
    c ……
    d ……

13. According to the answer in question 10) who advice you to choose the mentioned alternative?
    a. Myself
    b. A friend
    c. A relative
    e. Others (specify)

14. If you went to the hospital, who took you to the hospital?
    a. Myself
    b. My friend
    c. My mother
    d. My father
    e. My relative (mention)_____
    d. Others (specify)

15. If you went to the hospital, did you face any problems in getting treatment?
    a. Yes
    b. No

16. If yes, (according to question 15) what problems did you face in getting treatment? (Probe but do not read the list)
    a. I didn't have enough money to buy medicine
    b. I was chased out of the hospital
    c. hospital staffs were unfriendly
    d . Other (specify)_____

17. In order for you to go to the hospital and access the treatment, how would like the health services to be?
    a ……
    b ……
    c ……
    d ……

D. Behavioral questions

18. Have you ever heard about AIDS?
    e. Yes
    f. No
19. Have you ever heard about condom?
    g. Yes
    h. No
20 Have you ever used condom?
    i. Yes
    j. No
21 What was the main reason why you used condom? (unprompted)
    k. To avoid pregnancy
    l. To prevent making partner pregnant
    m. To avoid giving diseases
    n. To avoid getting diseases
    o. Others (specify)_____
22. Have you ever had sex?
    c. Yes
    d. No
23 Did you use condom last time you had sex?
    i. Yes
    ii. No (Go to question 24)
24 Why didn't you use condom? (Unprompted)
    iii Partner refusal
    iv. I didn't know about condom
    v. Condom limits feeling
    vi. Too embarrassed to talk to the partner about condom
    vii. Other reason (mention)
25. Are you doing anything to protect yourself from AIDS?
    a) Yes
    b) No
26. If yes, what are you doing to protect yourself against AIDS?
    if (Probe but do not read out list)
    a) Use condoms
    b) Avoid sex
    c) Early treatment of STDs
    d) Don't know
    e) Other (mention)_____

Appendix 4: Semi Structured Interview Guide

Topic: Coping strategies used by street children incase of illness

Good morning/afternoon / evening. Thank you so much for accepting to participate in this discussion. I would like to ask you some questions regarding issues of accessibility to health care, treatment and experiences in ill-health

I will appreciate if you could provide me with honest information and feel free to discuss your opinions. There is no right and wrong answer or opinion so be free to bring forward your thoughts, experiences and explanations in relation to this subject and I assure you that the information you give will remain confidential.

General Information:

1. What is your name? (Not necessary)
2. How old are you?
3. Sex_____
4. Are your parents alive?

Questions

A. Health seeking behavior/ Coping strategies

1. Where do you normally go to the hospital when you are sick?
Probe questions

- Why do you go to that place (according to response)
- Why don't you go to the hospital (if he/she go to the hospital)
- Who take you to the hospital/ other place where he/she seek treatment
- Who do you tell when you feel you are sick?
- Where do you get money for treatment?

B. Kind of diseases that affect street children most

2. What type of diseases or health problems you have experienced in the last two months?

Probe questions

- How many days didn't you work or play in the street as the result of that disease?
- What did you do?
- How did you know that you were sick?

3. For you to go to the hospital when you are sick, what would you like the health services to be?

C. Behavioral questions

4. What do you do to protect yourself from diseases?

Probe questions

- Have you ever heard about AIDS?
- Have you ever heard about condom?
- Have you ever used condom?
- How do you protect yourself from AIDS, STDs, Malaria, skin infections etc.
- Have you ever sex?

D. Sources of cash?

- What kind of work are you involving in the street?
- How much do you earn per day?

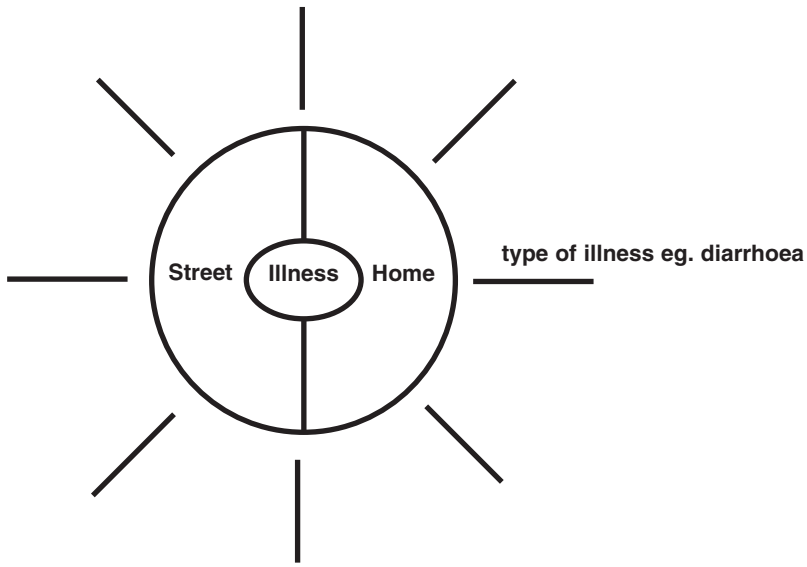
Thank you very much for your time. This is the end of the discussion.

Appendix 5: Participatory exercises guideline

Exercise 1: The spider diagram of street children experiences of health/diseases in their homes and while on the streets

- This exercise will involve two groups (one of street girls and the other of street boys)
- The street children will be given flip charts and marker pens and we will be told to draw a diagram of spider.
- The researcher will explain to street children that inside the body of the spider is the illness (the child will be told to write) and the outer circle is divided into two parts (home and streets). Each participant will write the diseases they have experienced in the past two months in the spider legs (see figure 1. below).

Figure 1: Spider diagram



- Using the health complaints mentioned, a table will be made and, by group consensus, they will rank the most frequent diseases attacking them and the places where they go for treatment or the coping mechanism they used during their sickness (see the table below). One child who knows how to write will be chosen to write down the scores agreed by the group.

Illness →								
Frequency								
Treatment sought/coping strategies								

Table to be completed by street children to show their illness and the action taken

- The discussions emerging from these exercises will be tape-recorded and the field notes will be taken.
- To researchers will be guiding the participants in this exercises.
- Each exercise is expected to take about 40 minutes.

Exercise 2: Mapping exercise to identify the places where street children go to seek treatment incase they are ill.

- This exercise will involve two groups (one boys and the other girls); each group will be consisted of 5 street children
- Street children will be given flip charts and maker pens and will be told to map the areas/places they go for treatment when they get sick
- The children will be told to explain what the map/drawing represents and the discussions that will emerge during the exercise will be tape-recorded and the field notes will be taken
- The exercise is expected to take about 30 minutes

Exercise 3: Mapping/drawing exercises to show the barriers the children are facing in accessing health services

- This exercise will involve two groups (one boys and the other girls); each group will be consisted of 5 street children
- Street children will be given flip charts and maker pens and will be told to map/draw the barriers they face in accessing the health services.
- The children will be told to explain what the map/drawing represents and the discussions that will emerge during the exercise will be tape-recorded and the field notes will be taken
- The exercise is expected to take about 30 minutes

Exercise 4: Mapping/Drawing exercise to show what the children do when they get Sick

- This exercise will involve two groups (one boys and the other girls); each group will be consisted of 5 street children
- Street children will be given flip charts and maker pens and will be told to map/draw the barriers they face in accessing the health services.
- The children will be told to explain what the map/drawing represents and the discussions that will emerge during the exercise will be tape-recorded and the field notes will be taken
- The exercise is expected to take about 30 minutes

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