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An Investigation into Sexual and Reproductive Health Needs among Street Children in Lusaka, Zambia

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Abstract— *As a consequence of poverty, large scale unemployment, and HIV/AIDS epidemic, the number of street children in Zambia has increased substantially. Street children face a myriad of health risks that must be identified and addressed adequately. The purpose of this study was to investigate the sexual and reproductive health needs among street children in Lusaka City. The study was a mixed methods study using key informant interviews with two organizations as well a structured questionnaires administered to 270 street children. The study had a total sample size 270 with a response rate of 100% as all the 270 participants and 2 key informants took part in the study. More than half (60%) of the participants were male. Most of the participants (55.6%) were between 11 and 14 years of age. Snowball and Purposive sampling criteria were used and the data were presented thematically and in frequency distribution tables, charts and figures. The major sexual and reproductive health needs of street children include access to accurate information, modern contraceptives and sanitary pads as well as child friendly and youth friendly services specifically for street children. Social needs included social support, empowerment and mentorship. Street children did not have a specific set of services dedicated to meet their needs but relied on already existing health services. Most of the street children did not have access to modern contraceptives such as condoms and could not even access most of the services available at the health facilities in Lusaka which provided most of the sexual and reproductive health services required by most of the street children. Many were not aware of sexual and reproductive health services and what role they played in their lives. The study also revealed that the major reasons why most of the children left their homes was because of poverty and parental abuse. Street children were more likely to live and work on the streets if they earned a measure of income and experienced fewer challenges. The study clearly demonstrated that street children continue to face significant health risks ranging from sexual to psychological with often poor access to tailor made health services. This calls for concerted efforts from the government, the community and ultimately all the relevant stakeholders involved in providing care for street children to galvanise an orchestrated and thematic socio-economic empowerment crusade among communities so as to curb streetism as a medium to long-term measure. However, as a short-term measure, there is need to provide tailor-made sexual reproductive health services by the Lusaka District Health Management structure.*

Keywords— *Investigation, Sexual Reproductive Health Needs, Street Children, Lusaka.*

I. INTRODUCTION

The United Nations estimates there are up to 150 million street children in the world. It is difficult to know the exact number because they are often unknown to social care and government organisations. However, what is certainly known is that their numbers are increasing for various reasons including the global population growth, poverty, rapid urbanization, and AIDS pandemic. The problem of street children is a global phenomenon with the challenge being even greater in urban settings of most developing countries (Ababor *et al.*, 2019; Habtamu and Adamu, 2013). There are up to 40 million street children in Latin America, and at least 18 million in India. The AIDS epidemic and civil wars in Africa have caused a surge in the number of street children as a result of the abandonment of AIDS orphans or fatalities due to armed conflict. Failing economies and falling currencies in Africahas worsened the situation. Street children have complex circumstances and are very vulnerable to victimization, exploitation and abuse of their civil and economic rights. In Ethiopia alone, over 4 million children are estimated to live under especially difficult circumstances. It is estimated that 600,000 children are taking part in street life and as many as 500,000 children find themselves at an extremely high risk of becoming involved in street life in Ethiopia (Habtamu and Adamu, 2013).

Article 27 of the Convention on the Rights of the Child (CRC) asserts that *"State Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development*." Homelessness denies each one of those rights.

More importantly, there are health issues for children who live and work on the streets. The lack of medical care and inadequate living conditions mean they are more susceptible to chronic illnesses. They may also be at greater risk of sexual and other violence, exploitation, drug use etc. This means they are more prone to ill Sexual and Reproductive Health (SRH). While it is estimated that there more boys (75%-90%) than girls on the streets, some places have equal number of boys and girls. The majority of street children in the world are aged 10 or older (Habtamu and Adamu, 2013).

Around 60% of the Zambian population lives in poverty. Over 40% are considered extremely poor in the sense that they cannot meet their daily basic subsistence needs. In absolute numbers, this corresponds to 7.9 million poor people, including 5.5 million who live in extreme poverty. Based on Human Development Index (HDI) standards, Zambia is still considered a low human development country. Poverty is spread out in terms of regions, districts and gender, but children are the most affected. Poor children are boys and girls

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who live in families whose income falls below the poverty line (UNICEF, 2014).

Poor children are more likely to enter school late, and, if they do, they are more likely to drop out before completing secondary education. If the child is a girl, there is a high chance she will have sexual intercourse with an older man when she reaches puberty. She might also get pregnant and drop out of school at around 14 or 15 years old. She may be given a chance to re-enter but the pressure to take care of her new-born is too high. As such, poverty in Zambia is transmitted from generation to generation (UNICEF,2014).

As a result of poverty (rural and urban), large scale unemployment and the HIV/AIDS epidemic, the number of street children in Zambia has increased substantially (Strobbe *et al*., 2011). Although the population of street children is said to be increasing in the country, the current population is unknown, even though, the 2015 National child policy quoted from a survey conducted in 2006 that there were about 13,500 street children in the country. A world bank document estimated the number of children to have doubled from 35,000 to 75,000 in the country (Strobbe *et al*., 2013). The effects of children living on the streets of Lusaka are numerous including, more substance abuse, 70% do not attend school, 67% cannot read a newspaper, 50% are uneducated, about 23% HIV/AIDS, and 38% do not know how to protect themselves from HIV/AIDS (Bruce, 2014).

A. *Problem Statement*

The number of children living on the streets of Zambia's cities are very high. It is estimated that one in five Zambian children do not live with their parents (Humanium, 2021). The life conditions of these children are desperate, exposing them to all the dangers of the streets which render them helpless victims of a host of abuses, including violence, drug / human trafficking, prostitution, alcoholism and drug addiction and exploitative labour (Humanium, 2021).

Despite global and local support and attention, there has been historical neglect of adolescent sexual and reproductive health which exposes the adolescents to risky sexual practices and early parenthood in developing countries (Morris and Rushwan, 2015; Salam et al., 2016; Warenius, 2008; Shaw, 2009; Woan et al., 2013). As evidence shows, poor adolescents, including street adolescents, are exposed to marginalization in social, political, and economic aspects and face discrimination, stigmatizations, isolations, and violations (PAHO, 2013; Chase and Aggleton, 2006).

Given this situation, street children continue to remain at risk of many health problems associated with poor access to sexual and reproductive health services such as unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs) and ultimately death associated with such health effects. Clearly, some of these issues can be addressed if the knowledge gap existing in addressing access to SRH services among street adolescents is bridged.

B. *Objectives*

- To explore the sexual and reproductive health and social needs of street children in Lusaka.
- To find out the nature and scope of sexual and reproductive health services for street children in Lusaka.
- To determine the proportion of street children who are aware and have used specific sexual and reproductive health services
- To establish the social factors that influence children to live on the streets

II. Theoretical Review of Literature

A. *General Introduction*

This section presents a review of the literature on the sexual and reproductive health and social needs of street children including risky sexual behaviour of adolescents and the consequences of the risky sexual behaviours; nature and scope of sexual and reproductive health services for street children; the utilisation of health facilities among adolescents predominantly in Africa; and the social factors that cause children to live and work on the streets. Utilisation of health facilities is one of the most important aspects because in Zambia most sexual and reproductive health services and SRH information is mainly provided by the Ministry of Health through its health centres. The review will also cover drivers of the mushrooming numbers of street children in most African countries.

B. *Sexual and Reproductive Health Needs of Street Children*

Substance use may cause sexual behaviour that expose the street children to STIs and AIDS. Alcohol and substance abuse is rampant among children in Zambia. Alcohol is the most commonly abused drug by children because it is readily available in liquor stores and it can easily be purchased across the counter. Furthermore, the use of volatile substances such as petrol, glue, aerosol, sprays and paint thinners as sources of intoxication is also common. These substances are not prohibited under Zambian laws. There are several causes of alcohol and substance abuse among children such as peer pressure, identity crisis, juvenile delinquency, ineffective parenting, family breakdown, availability and accessibility of alcohol and substances and inadequate recreation facilities in communities and inadequate enforcement of laws (national child policy, 2015).

Street adolescent girls involve themselves in sex work and prostitution in order to get money. In an Ethiopian study (40.6%) sexually active males reported having had sexual intercourse with sex workers in the past 12 months. A high level of sexual contact with commercial sex workers among street youth suggests these groups of the population are involved in high-risk sexual practices. In this study the prevalence of STI among street youth was 24.8% (Brhane, 2014). Unprotected sex is common among street children. This results in a variety of Sexual Reproductive Health problems. Their risk of acquiring STIs; such as syphilis, HIV and Hepatitis is increased (ibid).

On the other hand, non-use of contraception has resulted to unintended pregnancies. In Africa, a large proportion of teenagers and even young adolescents are having children.

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Among sexually active adolescents, there has been a very low level of contraceptive use despite widespread knowledge (Speizer et al., 2011). This, in part, may reflect both a lack of interest in the use of contraception among those who wish to bear children as well as socio-cultural barriers that attach a stigma to the use of contraception by young women, and thus prevent them from having access to contraceptive methods. Speizer *et al*. (2011), report that, only a small minority of adolescent women could identify their fertile period. The lack of understanding of the fertile period is a reflection of general deficit in basic knowledge about human reproduction. Such knowledge is particularly relevant to sexually active young people many of whom may have no access to contraceptives, and for whom the use of the rhythm method may be one of their alternatives.

A baseline survey in Southwest Nigeria on Factors associated with sexual and reproductive health behaviour of Street Involved Young People (SIYP) revealed that age and sex differences exist in the sexual risk behaviours of SIYP. Additionally, there is a high unmet need for contraception and inconsistent condom use among this population. SIYP need targeted interventions for age- and sex- stratified populations to implement programs that address their SRH needs (Olaleye et al., 2020).

Street children should be provided with information on growth and development, SRH, substance use, prevention of disease, promotion of good health and other issues such as rights and laws. Appropriate place to do this may be a challenge. A study was conducted to assess reproductive health behaviour and needs of street youth in Gondar city, North West Ethiopia. The study revealed that young people rely greatly upon interpersonal communication for sexual and reproductive health information as this survey complemented this idea. Thus, peer-based interventions should be initiated to ensure that street youth have access to accurate information by training them on sexual and reproductive health issues emphasizing that better understanding of factors that influence street youth sexual behaviours that result in risky sexual practices. A detailed study should be conducted to identify socio cultural factors affecting street youth reproductive health behaviour and sexual practices. Addressing the problem of street youth in a holistic manner requires involvement of policy makers to focus on preventive, corrective and rehabilitative measures to alleviate the problem of streetism (Brhane, 2014).

According to a qualitative study by Simabwachi (2017) on 'Life histories and health needs of street children in Lusaka city', the reproductive health challenges and needs for female street children were found to be rare contraceptive use and lack of basic knowledge on reproductive health; rare Maternal and Child Health (MCH) attendance; and Sexual assaults to street girls. The study showed that most female street children in Lusaka did not attend maternal health services, rarely practiced contraceptive use despite high sexual activity and rape cases among street girls as well as high numbers of teenage pregnancies. They lacked basic information on reproductive health. This reveals the needs of health information, maternal health services and protection from physical assaults.

C. Street Children's Social Needs

Life skills are positive behaviours that enable individuals to adapt to and deal effectively with demands and challenges of life. Helping street children think about strategies for getting off streets will need to include creative ways of getting them to think beyond their current situation.

A study in Tanzania on 'coping strategies used by street children in the event of illness, by Zena and Komba recommended that older street children (16-18yrs) 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 shops are two examples of business that require little capital to start and can be conducted in the streets where children are living. The businesses can be a source of income which the older children could use to meet their immediate social needs.

An ethnographic study by Nerg (2016) on children's perspectives and street children centres' strategies in Zambia, confirms that street children need education as well as learning the basic life skills that will enable them survive and earn money. The study does not specify the life skills required. It would be important to specify the specific life skills required so that appropriate support is rendered to the children to enable them survive out of the streets.

Safe and supportive environment is very crucial to the balanced growth of children. The term environment is used to refer to what a child encounters outside of himself or herself in daily life. It refers to the political, legislative, legal, economic, social and cultural context and gained livelihood skills. The aim is to create a positive behaviour.

The Growing up on the Streets network of young people living on the streets were involved in the development of a new legal framework for children in street situations, as part of global consultations initiated by the United Nations Committee on the Rights of the Child. The General Comment (UNGC) supplements and strengthens the UN Convention on the Rights of the Child (1989), addressing the rights of children growing up in street situations. Growing up on the Streets is a longitudinal and participatory research project with over 200 street children and youth in Accra (Ghana), Harare (Zimbabwe) and Bukavu (DRC) over three years, between 2012 and 2016 (Hunter *et al*., 2018).

The UNGC states that "Governments have responsibilities to children in street situations under 32 Articles across seven themes: a child rights approach; civil rights and freedoms; family environment and alternative care; adequate standard of living; disability and health; education, leisure and cultural activities; and violence against street children' (Hunter et al., 2018). The participants on this research project who were street understood their rights being right to be on the streets, to have their basic needs met, and to protection (Articles 15, 20, and 27 of the UNCRC) to have my freedom, which should not be stepped upon (ibid).

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D. Nature and Scope of Sexual Reproductive Health services

Research evidence clearly shows that adolescent women have a high level of unmet need for contraception. Overall, some 56,500 Zimbabwean adolescents do not want to become pregnant but are not acting on that desire by practicing contraception. Most of these women—62%, or some 35,000—are married and are thus unable to respond to government messages to abstain from sex (Remez *et al*., 2014).

Moreover, given a woman's heightened biological vulnerability to HIV infection and the minimal condom use within marriage, married adolescents' need for testing and counselling is especially high. That the rate of adolescent childbearing is increasing in rural areas is unexpected and cause for concern, even though the proportion of births reported as unplanned is declining in these areas. In Zimbabwe, higher educational attainment has been independently associated not only with delaying childbearing but also with staying HIV negative. Thus, it is essential that rural adolescent women remain in school as long as possible (Remez et al., 2014). This study does not differentiate the most vulnerable adolescents, for example those who live and work on the streets, or those with disabilities. It was vital to find out whether the already disadvantaged adolescents have access to contraception at any point.

A study on Young Males' Perceptions and Use of Reproductive Health Services in Lusaka, Zambia revealed that male adolescents did not access the needed services at a clinic due to negative perceptions of the health services and the health care workers in particular. Gender, cultural and social norms, lack of knowledge on available services, confidentiality and quality of care remained major barriers to accessing SRH services. The current public health service is not ―appropriate for meeting male adolescents' sexual and reproductive health needs. Major restructuring and reorientation are needed to ―win over male adolescents to the services (Kambikambi, 2014). A research gap exists on the voices on male adolescents on their thoughts of the most appropriate SRH services they require how the services should be administered.

E. Social Factors that Influence Children to Live and Work on the Streets

A study on Family structure and Street children in Zambia revealed that contrary to common belief, income is not a main determinant of the street children phenomenon as most families in this setting live below the poverty line. The health status of the male head of the household plays a fundamental role in determining the probability of the street outcome. Moreover, the extended family net matters as well. A higher number of husband's sisters and the presence of maternal grandparents reduce the probability of originating street children. Finally, a younger composition of children in the household, a lower presence of orphans as well as a higher share of girls in the household are all associated with a lower probability of the street children outcome. In addition, the role of the child within the family matters: nephews, stepchildren and household heads' siblings are less likely to end up on the street compared to natural son and daughters, thus indicating that when an extended family accepts nephews and stepchildren, it is because there is the intention to keep and protect them. Overall, these results seem to confirm the importance of the extended family safety net as well as the key role of the female presence in the household in reducing the likelihood that children end up on the street. They suggest that promoting the role of women in the household and supporting extended family links may represent an important avenue for policies aimed at reducing the risk of street life (Strobbe et al., 2011).

Manjengwa et al (2016) indicates that the five common reasons for children being on the streets were to earn income for self; Abused by parents or guardians; Earning income for family; Orphan hood and Dumped or chased away by relatives. The study further shows that these push factors can be addressed through providing more social protection, cash transfers to families, and education and health assistance. The study does not however tell us why the children still get back to the streets even when some development partners have offered to open up centres where the homeless children can be housed.

An ethnographic study on children's perspectives and street children centres' strategies in Zambia, found that children/youths had been staying in the streets from one day to years. The reasons for ending up in the street were multifaceted and included pull and push factors, being poverty; having nowhere to go and the need to survive due to death of parents; running away from physical abusive parents or caretakers; fear of mistreating or violent parent or step parent, peer pressure, to earn money etc. (Nerg, 2016). The study further revealed that street children run away from centres because they get used to the life on the street where they earn their own money and get addicted to glue and drugs. Children run away from centres because they are mistreated, they treated and talked to like animals, these centres are a source of income to the patrons, money is not spent on the children, they also run away due to violent care takers. The study further recommended that the children can be helped through counselling, those that go to the centres should be those that willing volunteer, children should also be taken to school.

F. Gaps in the Literature

A lot of gaps remain in literature regarding the sexual and reproductive health needs of street children in Lusaka. For instance, although literature explains the risky sexual behaviour the street adolescents get involved in, information on access to SRH services is limited. Besides, information on the awareness levels of street children of their SRH needs and services is limited. If the children are aware of their SRH needs and the services available to meet those needs, it is very likely that services will be sought. Statistics on unsafe abortions, teenage pregnancy among street children is important in order to fully understand the magnitude of the SRH issues. On the other hand, literature did bring out the push and pull factors that influence the children to be on the streets. What is missing is information that maps out the

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specific factors and the possible intervention to address the factors. This information would be important to significantly address the growing numbers of children on the streets.

G. Theoretical Framework

A number of theoretical frameworks as well as theories and models of behaviour relating to the utilisation of health services underpin this work. These theories mainly focus on different aspects of how an individual's attitudes, belief systems and social relationships impact on their engagement with available health services. In order to better understand adolescent access to SRH/HIV services, theories of health service seeking behaviour draw from social science disciplines such as social psychology, medical anthropology and sociology. In doing so, the most commonly applied behavioural models of health service utilisation include the 'Health Belief Model' (HBM), the 'Theory of Reasoned Action' (TRA) and the 'Theory of Planned Behaviour' (TPB). This study, however, is anchored on the the Theory of Reasoned Action.

The Theory of Reasoned Action (TRA) was developed by Martin Fishbein and Icek Ajzen (1986) in order to better understand relationships between individual's attitudes, intentions and behaviours (Montano and Kasprzyk, 2008). This model predicts both the intention to behave and actual behaviour and is useful for identifying where, and how to focus strategies for changing behaviour.

The TRA assumes that the behavior under investigations under voluntary control, that is that people believe that they can execute the behaviour whenever they are willing to do so. Gradually, the TRA was used more often for the study of behaviours for which control was a variable factor. For that purpose, the TRA was complemented by a component that was names perceived behavioural control. This concept represents the extent to which people believe they are able to perform the behaviour because they have adequate capabilities and/or opportunities or are lacking in these. It is very easy to see that this factor can substantially improve the generality of the application of the model because there are many behaviours that need specific skills or external facilities (Fishbein and Ajzen, 2017).

Three determinants of intention have been identified; firstly, attitude toward the specific behaviour, followed by subjective social norms such as normative beliefs and motivation to comply, and finally, perceived behavioural control. Generally, according to this model, the more positive the attitude and the subjective social norms are (towards for example, condom use) and the greater the perceived control is, the stronger will be an individual's intention (to use condoms) for safe sexual behaviour.

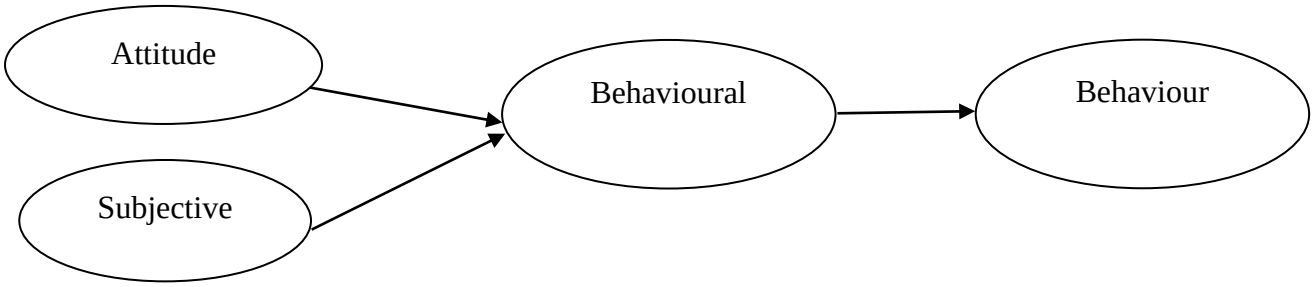

Fig. 1. Path model of the theory of reasoned action (Source: Ajzen & Madden, 1986)

III. Methodology

The study adopted both qualitative and quantitative approaches which were descriptive and analytical in nature. A descriptive research design attempts to identify and explain the variables that existed in a given situation and describe the relationship that exist between these variables in order to provide a picture of a particular phenomenon (Cooper & Schindler, 2008). Descriptive and analytical design was convenient for this study as it enabled the researcher make inferences on the effects of street adolescents. Since triangulation of research methods can overcome personal biases and limitations that stem from the use of a single method, cross-sectional quantitative and qualitative mixing methods were used (Habtamu and Adamu, 2013). Individual interviews using a structured questionnaire were used to gather relevant information from sampled children. Qualitative methods (key informant interviews) were conducted to verify data collected in quantitative method and to gain an in-depth understanding of the identified issues such as service provision, sexual behaviour etc. Cross-sectional quantitative and qualitative mixing methods were adopted through questionnaires with street children and interviews with key informants.

The current population of street children in Lusaka or even across the country is unknown. However, the population has been estimated to be 75,000 for the country (Strobbe et al., 2013). Street Adolescents (10 – 18 years) who live on the streets and come from their homes to the streets located specifically in Lusaka central business district, Soweto market, Kamwala, Main streets of Lusaka like Great East Road, Church Road, Independence Road, Kabulonga Road etc. formed the population sample for the study. Using Krejcie & Morgan's (1970) sampling formula ($n_1 = \frac{z^2 pq}{d^2}$,) the sample size of 270 street children was arrived at.

Using snowball and purposive sampling techniques, street children who were found in common areas like town centre, Soweto and Kamwala markets, Main streets of Lusaka like Great East Road, Church Road, Independence Avenue and

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Makeni Road were sampled depending on their availability and willingness. Key informants were sampled from local NGOs with street children programmes Fountain of Hope and Families are Nations.

Data analysis is the act of making sense out of the raw collected data from research, for purposes of resolving the research problem. Without data analysis, the data collected will remain data, and will not make sense and thus not provide answers to the research question (Mosweu and Mosweu, 2020). Data collected for this study was analyzed manually and through the use of the computer software statistical package for social sciences (SPSS) version 20, descriptive statistics were used to analyze data and presented using graphs, pie charts and tables. Bivariate and multivariate logistic regression analyses were used to assess associations. Data collected through in-depth interviews was analysed using thematic analysis.

In terms of ethical consideration, permission to carry out the study was requested from the respondents and an introductory letter from the university was solicited to make it easy to collect data and carry out the study. Participants were also informed of the right to withdraw from the study or decline to any questions. Confidentiality was also guaranteed to the respondents by making sure that none of their names are mentioned in this study. Guidance was also sought from the Ministry of Youth Sport and Child Development National Office Lusaka.

IV. Findings

A. Sexual and Reproductive Health Needs of Street Children in Lusaka District

Among the many needs that street children possess are the sexual and reproductive health needs. The study summarizes some of the implicit and explicit sexual and reproductive health needs of the street children. Most (68.5%) of the street children indicated that they had sexual intercourse mostly (63.5%) between 11 and 14 years particularly because of wanting to obtain satisfaction (65.2%). Less than half (48.3%) of those sexually active had at most 2 sexual partners with the rest having at least 3 sexual partners.

However, it is important to mention that most (86.7%) of the study participants did not use a condom during their sexual encounter indicating that they did not have access (60.4%), did not know about it (30.8%) or simply because they wanted to enjoy some form of pleasure (8.8%).

Besides the aforementioned, it was also observed that three quarters (75.4%) of the street children knew what HIV/AIDS was even though very few (11.2%) perceived themselves to be at risk of getting the infection. Additionally, the study revealed that most (82.6%) of the study participants did not see any pregnancy risk and yet close to 40% (37.4%) had a history of pregnancy.

With regards to preventing both pregnancy and HIV infection, the study revealed that in terms of preventing HIV infection, most (36.9%) of the study participants mentioned condom use while about 30% did not know how to prevent HIV infection. Furthermore, close to half (47.7%) of the participants mentioned street medicine as a way of preventing pregnancy.

Clearly, the study revealed a number of sexual risky behaviors among the study participants that define various sexual and reproductive health needs namely, access to contraceptives, knowledge on HIV/AIDS and pregnancy and their prevention.

The study also carried out interviews with Fountain of Hope concerning the needs of street children. They responded that most street children required access to modern contraceptives especially girls, access to accurate information and commodities such as hygiene sanitary materials. Some of the notable quotes by the key informants are indicated below:

> "*Sexual and reproductive health needs for these children include information on SRH; family planning services; contraceptives to prevent unwanted pregnancies especially girls*"

When asked the same question, a key informant from Families are Nations indicated that:

> "*First of all information, they do not know what sexual and reproductive health is all about, how it concerns them, they probably think it not for them. They also do not understand sexuality issues among themselves*."

"*They also do not have access to information and commodities when they do make up their mind. Commodities are especially difficult for girls. Stigmatization does not allow them as teenager/adolescents to go into a clinic and say I hear there is this and I would like to get it*".

Ladies face an additional need as indicated in the following quote "*Girls do not have sanitary commodities. They cannot plan, they do not know which [materials to use during menstruation] and when. They also do not have an understanding of why.*"

In another similar study about 72.5% of the respondents were sexually active during data collection and 84.3% of males and 85.7% of females tended to have multiple sexual partners (Habtamu and Adamu, 2014).

Most (86.7%) of the study participants did not use a condom during their sexual encounter indicating that they did not have access (60.4%), did not know about it (30.8%) or simply because they wanted to enjoy some form of pleasure (8.8%). Similarly, a study found that majority of the children had sex by the age of 10 – 15 years (41.9%) with older partners and did not use condoms (74.4%) (Kamanu *et al.*, 2010). Additionally, in another study it was found that about 93% of street adolescents reported difficulty in accessing contraceptives (Ababor et al., 2019).

B. Social Needs of Street Children in Lusaka District

When asked about the social needs of street children, Fountain of Hope revealed that "these children want security and protection, so they run to get married in order to get the security they lack at their homes" Fountain of Hope. This is also observed from the quantitative analysis. Figure 2 shows that earning money (104/270), prevailing poverty at home (75/270) and abuse at home (29/270) were the top three major reasons why most children left home for the streets.

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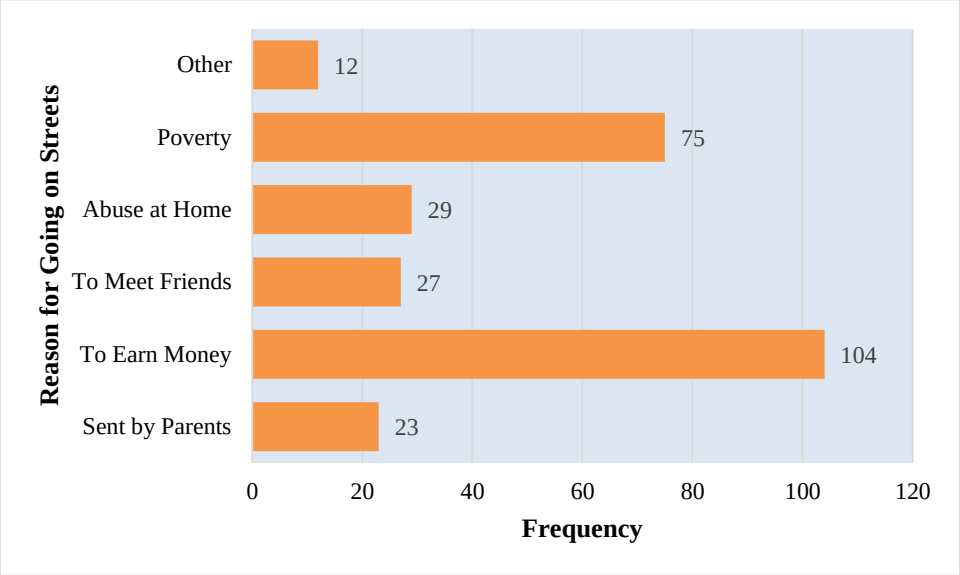

Fig. 2.

Source: Field Data (2021)

With regards to social needs a key informant from Families are Nations indicated that most children lacked social support. The key informant said "*they do not have any one much older and experienced to talk to and say whenever something has happened to them. They may be having health issues when they have sexually transmitted infections for example, but do not have anyone to talk to which affects them significantly.*"

According to the key informant "*mentorship is very important. While we are trying to empower them [children] we need to do first things first. We need to mentor them, make them understand why we are training them to get empowered and then give them the skills. The empowerment will not be effective, unless we understand why the children are on the streets in the first place. It is not always that a child is on the street because of poverty. At one time I met some teenage girls in Addis Ababa Drive and discovered that one of them was a child of a minister.*"

These findings tie well with findings from other studies which have cited abuse has been as being a contributing factor: in Brazil (Abdelgalil et al., 2004), in Egypt (Bibars, 1998) and in Turkey (Duyan, 2005); sexual abuse (Bibars, 1998), and verbal abuse (Duyan, 2005), were all cited as reasons which pushed children onto the street. When they experience, children run to the streets for security.

Poverty is another reason why children run to the street. UNICEF (2001) asserted that poverty was the major leading cause of children being on the street, and this was supported by WHO (2000). Several studies have also identified poverty as the main, or the only cause that pushed children onto the street. Research in Indonesia found that poverty was the dominant factor behind the emergence of children onto the street. Though the terms expressed by street children were found to be dissimilar, the importance of economic factors was supported by their economic motivation to earn money for a better chance of survival and self-reliance (Greska *et al.*, 2007).

To determine if the observations in **Figure 2** were significant, Pearson chi-square test statistic was performed using SPSS v.25. The results obtained indicated that condom use (p value = 0.001), number of sexual partners (p value = 0.007) and age group (p value = 0.053) were all significant predictors of HIV risk perception.

TABLE 1. Factors Associated with HIV Risk Perception among Street Children in Lusaka District

Variable	Categories	No	Yes	P value
Condom Use	No	133 (91.1%)	13 (8.9%)	0.001
	Yes	16 (66.7%)	8 (33.3%)	
Number of Sexual Partners	≤3 partners	109 (93.2%)	8 (6.8%)	0.007
	>3 partners	41 (78.9%)	11 (21.1%)	
Age group	≤14 years	151 (91.5%)	14 (8.5%)	0.053
	>14 years	64 (83.1%)	13 (16.9%)	

Source: Survey Data (2021)

C. Nature, Scope and Utilization of Sexual and Reproductive Health Services among Street Children in Lusaka District

In terms of healthcare seeking behaviour of street children, the study established that more than 3 quarters (87%) of the study participants did not visit a health facility to receive sexual and reproductive health services. This indicates a very poor health seeking behavior among the street children mostly owing to lack of awareness of available sexual and reproductive health services. Furthermore, it was revealed that the most utilized services by street children had nothing do with maternal and child health, pregnancy termination, sexually transmitted infections and contraception. Even though this was the case, it is noticed that some street children did use contraception, pregnancy, gynecological examinations, maternal and child health services and sexually transmitted infection services.

Available services also included sexual and reproductive health services provided by other organizations. Key

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Informant for Families are Nations said that "*I know of an organization that went on the street to help street kids with children already*". Additionally, the informant indicated that "*Families are Nations has a Memorandum of Understanding (MoU) with the Ministry of Health (MoH) on sexual and reproductive health services which offers Families are nations an opportunity to work with other organizations to provide these services*".

Besides these, it was mentioned that the Ministry of Health is involved in providing outreach services for all street kids. According to the Key Informant from Families are Nations "*they worked with Ministry of health which provided policy direction, technical support and needed information. Ministry of health was also involved in outreach services such as HIV testing to identify positive children that might need ARVs*".

Generally, it was found that there was no specific health facility dedicated towards providing health services for street children. "*There is no specific health facility for street kids instead they are mixed with other kids under youth friendly corners at most health facilities*".

Besides the aforementioned, the study revealed that even when these services were provided, there were a number of challenges and barriers to accessing these services. Some of these issues included stigma from the community and fear of embarrassment from the street children, inconsistent care grants from the government, poor monitoring of the care homes and their compliance towards established standards and lack of coordination and effective collaborations between the government of Zambia and other key stakeholders.

For instance, "*The Zambia National Service gathered all street kids and took them to camps. However, there was no communication on how the street kids could be helped given the changed circumstances by an organization that had shown interest in helping these children*" (Key Informant, Families are Nations**).**

Additionally, "*Fountain of Hope put in a place a clinic at one of the facilities so that they could make it possible for street children to have access to the services. But some of the girls would not like that because they would not want people who know them to see them going to the clinic and associate them with sexual activities*" (ibid).

Some of these services fail because "*key partners are often left out in the technical groups involved in addressing the issues that street children face making it difficult for these technical groups to take into account key implementation factors*" (Key Informant, Families are Nations).

In colloboration, another study in Ethiopia on the needs and access of sexual reproductive health services to street adolescents in Ethiopia revealed that the main barriers to access local SRH services among Nekemte town street adolescents are lack of information on available services for street adolescents, the behaviour of adolescents, inaccessibility adolescent-friendly service. The finding implies that street adolescents are highly deprived and need a particular focus on intervention. Accessing mobile peer-based and friendly services at facilities and in the community should be focused (Ababor et al., 2019).

D. Social Factors Influencing Children to Live and Work on the Streets in Lusaka District

TABLE 2. Social Factors Associated with Time Lived and Worked on the Streets

Variable	Categories	≤3 years	>3 years	P value
Last Grade Attended in School	≤Grade 3	120 (66.7%)	60 (33.3%)	0.013
	>Grade 3	46 (51.1%)	44 (48.9%)	
Length of Time in Town	≤13 years	131 (76.2%)	41 (23.8%)	<0.001
	>13 years	34 (35.1%)	63 (64.9%)	
Income	≤20 ZMK	119 (67.2%)	58 (32.8%)	0.007
	>20 ZMK	47 (50.5%)	46 (49.5%)	
Sex	Male	103 (63.2%)	60 (36.8%)	0.476
	Female	63 (58.9%)	44 (41.1%)	
Reasons for Going on Streets	Sent by parents	14 (60.9%)	9 (39.1%)	0.290
	To earn money	62 (59.6%)	42 (40.4%)	
	To meet friends	21 (77.8%)	6 (22.2%)	
	Abuse at home	21 (72.4%)	8 (27.6%)	
	Poverty	41 (54.7%)	34 (45.3%)	
	Other	7 (58.3%)	5 (41.7%)	
Engage in Begging on Streets	No	26 (78.8%)	7 (21.2%)	0.029
	Yes	140 (59.1%)	97 (40.9%)	
Engage in Sex on Streets	No	149 (63.7%)	85 (36.3%)	0.059
	Yes	17 (47.2%)	19 (52.8%)	
Challenges Experienced on the Street	No place to sleep	33 (58.9%)	23 (41.1%)	0.002
	No food	45 (66.2%)	23 (33.8%)	
	No money	9 (56.3%)	7 (43.8%)	
	Fighting	21 (77.8%)	6 (22.2%)	
	Chased from the streets	26 (83.9%)	5 (16.1%)	
	sickness	17 (45.9%)	20 (54.1%)	
	Other	8 (61.5%)	5 (38.5%)	
	No challenges	7 (31.8%)	15 (68.2%)	

Source: Survey Data (2021).

As depicted in Table 2, the researchers further took interest in determining social factors influencing time spent on living and working on the streets by the street children. The results obtained indicated that the last grade attended in school (p value = 0.013),

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length of time in town (p value < 0.001) income (p value = 0.007), engaging in begging on the streets (p value = 0.029 and challenges experienced on the streets (OR = 3.03; 95% CI: 1.70, 5.29) were significantly associated with the time spent living and working on the streets. Street children who attended a much higher grade, lived longer in Lusaka, obtained more income, engaged in begging and had little or no challenge on the streets were more likely to keep living and working on the streets. However, sex (p value = 0.476), engaging on sexual intercourse on the streets (p value = 0.059) and reasons for living home (p value = 0.290) had no significant association with time spent living and working on the streets.

To determine significant predictors taking into account the findings above and their interaction, logistic regression was performed and it indicated that only length of time lived in town, age group and engaging in begging were significant predictors the time a street child lived and worked on the street. Street children older than 14 years were 3.44 times more likely to continue living on the street compared to younger street children (OR = 3.44, 95% CI: 1.76 – 6.74) after adjusting for length of time lived in town and engaging in begging on the streets. Furthermore, street children who had lived in Lusaka for more than 13 years were 3.67 times more likely to live and work on the streets compared to those that lived for less than or equal to 13 years (OR = 3.67, 95% CI: 1.93 – 6.98). Additionally, street children who engaged in successful begging on the streets were 4.17 times more likely to stay on the streets compared to those that did not engage in begging on the street (OR = 4.17, 95% CI: 1.57 – 11.03).

TABLE 3. Multiple Logistic Regression for Predictors of Time Spent Living and Working on the Streets

Variable	Category	Adjusted OR	*p* value	95% CI
Length of Time Lived Town	≤13 years	1.00		
	>13 years	3.67	<0.001	1.93, 6.98
Age Group	≤14 years	1.00		
	>14 years	3.44	<0.001	1.76, 6.74
Engaged on Begging on the Streets	No	1.00		
	Yes	4.17	0.004	1.57, 11.03

Source: Survey Data (2021)

Similarly, a study conducted in Ndola found that older, male children and particularly orphaned children were more likely to wind up on the street (Strobe et al., 2010). Furthermore, street children who had lived in Lusaka for more than 13 years were more likely to live and work on the streets compared to those that lived in Lusaka for 13 years or less. This could be because they had gained more experience and had become very familiar with the town compared to those that had lived there for a short period of time.

V. Conclusion

The study clearly demonstrated that street children continue to face significant health risks ranging from sexual to psychological. While a number of services are available in our facilities, none of them gives due regard to the special needs of the street children. This is particularly due to low political will from the government to support both financially and technically, most of the care homes involved in providing alternative care for the street children. Additionally, most of the interventions pay so much focus on empowerment instead of providing mentorship to identify the major reasons why a child left home for the streets. This calls for concerted efforts from the government, the community and ultimately all the relevant stakeholders involved in providing care for street children.

VI. Recommendations

1. There is a need to address all sexual and reproductive health needs as well as social needs that street children continue to face. Interventions must be put in place to fill this need. Some of these interventions can include awareness and health education programs, provision of contraceptives and Hygiene sanitary pads as well as mentorship and child counseling.
2. Government must provide continued support to care homes financially, technically as well as at policy level. They must facilitate for effective inter-sectoral collaboration aimed at addressing the issues affecting street children. A few facilities must also be dedicated solely to providing tailor made services for all street children.
3. Street mobile SRH outreach service provision: Service providers should provide appropriate and more accessible services e.g., mobile services that are taken to the streets. The services should also include a wide range of services e.g. VCT, health education and promotion, pregnancy testing etc.
4. *Life skills Training*: Life skills training would provide an opportunity for street children to come up with innovative ways of getting off the street and protect from the many health risks that the street poses. *Create a Safe and Supportive Environment*. This includes creating opportunities for street children to get an education and gain livelihood skills as well as the opportunity to experience positive relationships with other people. *National policies:*
   (a) *Implementation of the National plan of action for the national child policy of 2015 should be enforced*: The Plan of action outlines strategies to end violence and abuse among children, as well as many other programmes for children living and working on the street such integration to families, empowerment etc. Strengthening monitoring and Evaluation of the National plan of action of the National child policy is key to have the appropriate strategies implemented and achieved
   (b) *National Health frameworks on Adolescents*: The government should prioritise health programmes for this special group – street adolescents - in terms of providing appropriate SRH service provision as well as allocation of budgets to such programmes.

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