

**The knowledge of street children in Pretoria, South Africa, of sexuality and of HIV and AIDS**

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*MSW (Health Care)*

by

**Nicole Andree Montanez**

in the

*Department of Social Work and Criminology*

*Faculty of Humanities*

*University of Pretoria*

*Supervisor Dr. C.L. Carbonatto*

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**RESEARCH PROPOSAL & ETHICS COMMITTEE**

## DECLARATION

Full name : Nicole Andree Montanez

Student Number : 28536747

Degree/Qualification: MSW (Health Care)

Title of thesis/dissertation: The knowledge of street children in Pretoria, South  
Africa, of sexuality and of HIV and AIDS

I declare that this thesis / dissertation is my own original work. Where secondary material is used, this has been carefully acknowledged and referenced in accordance with university requirements.

I understand what plagiarism is and am aware of university policy in this regard.



SIGNATURE

November 2011

DATE

## **OWN WORK DECLARATION**

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## **ABSTRACT**

**Title: The knowledge of street children in Pretoria, South Africa, of sexuality and of HIV and AIDS**

**Candidate name: Nicole Andree Montanez**

**Department: Social Work and Criminology**

**Degree: MSW (Health Care)**

**Supervisor: Dr. C. L. Carbonatto**

This study unleashes the harsh realities of living and working on the street in Pretoria, South Africa. The study focuses on connections between street children, sexuality and HIV and AIDS. Understanding how street children live and how they obtain their information are major contributors in trying to help solve this global crisis.

Therefore, the goal of the study is to explore street children's knowledge of sexuality, HIV, and AIDS in Pretoria, South Africa through using a qualitative research approach. The researcher's choice of using a qualitative research approach results in an in-depth personal investigation of a sample of Pretoria's street children's. The researcher used snowball sampling and by asking other street children where to find the participants. Through this sampling method, credibility of the researcher and confidence by the participants grew and allowed for the researcher to obtain the necessary information needed through a semi-structured one-to-one interview as the method data collection.

As defined in the text by the researcher street children are individuals under the age of 18 who primarily cohabit on the street, survive on their surroundings, and may have no parents or guardians. There are millions of street children globally who flee to the streets for a variety of reasons. These motivations can include the need to raise money for themselves or family members. The children could possibly encounter physical or emotional familial abuse or have no family or support system to help them grow as individuals. There are many more concerns that the children have which create the feel or 'need' for them to flee towards street life.

The findings derived from the interviews have been analyzed and categorized into themes and sub themes, in association with questions asked in the semi-structured one-on-one interviews using an interview schedule.

There were two themes identified through this study, theme 1 is sexuality followed by the 5 sub themes in this category being: intimate and/or sexual relationships, support base, body image, understanding key concepts and sexual behaviour. Theme 2 is HIV and AIDS and the sub themes that correlate with this theme are general knowledge of HIV and AIDS, information distribution, transmission, prevention, the effect of HIV on street children and treatment.

Through interviewing fifteen street children these individuals opened up by talking about their lives on the street, their sexuality, including sexual and non-sexual relationships, how they feel about themselves as sexual beings and as children living on the street. In addition, what they know about HIV and AIDS, their relationships with those who are infected, how it has influenced their lives and what they know about this global epidemic. Knowing where these 12 to 17 year old participants receive their information can help for future programme development and distribution of information on sexuality and HIV and AIDS, to keep the streets safer from such unfortunate circumstances.

Some key findings in this study address the lack of knowledge street children have about themselves as sexual beings and their lack of knowledge regarding HIV and AIDS. The children hustle for money in many different manors including selling their bodies for money and standing on street corners begging. Although some of the participants are educated, their lack of support systems and scrutiny for the community they live in and possibly family members leaves little room for growth and development in society.

The recommendations are arranged to target the themes and sub themes. Some of the recommendations include governmental and nongovernmental help with increased volunteerism, information distribution, job creation, housing, shelters, education and support.

Many of the children have lost someone due to HIV or AIDS. Children living on the streets are surrounded by AIDS daily and the matter of fact is, that if one talks about HIV they have to talk about sex. This leads individuals to questions surrounding sexuality and their bodies. This study helps to understand children's views of these topics.

**LIST OF KEY TERMS:**

*KNOWLEDGE*

*SEXUALITY*

*HIV*

*AIDS*

*STREET CHILDREN*

*SOCIAL WORK*

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## CHAPTER 1

### GENERAL INTRODUCTION AND RESEARCH METHODOLOGY

#### 1.1 INTRODUCTION

This chapter introduces and clarifies various aspects of the global calamity of street children. The chapter contains a concise explanation of the connection between street children, sexuality and HIV and AIDS. The purpose of the chapter is to describe how the research will be carried out, and to explain the problem formulation, the goal and the objectives. Additionally, this chapter considers ethical issues and sets out the limitations to the study.

##### 1.1.1 RATIONALE

“Millions of street children in the developed and developing world are left to survive by their own wits” (Van Rooyen & Hartell, 2002:188). “The phenomenon of street children is global, alarming and escalating” (*Exploitation of street children*, 2000). No country in the world is without children on the streets, which is indicated above as a crisis in both developed and developing countries. It is almost impossible to know the number of street children worldwide, yet the social phenomenon of street children is increasing as the world’s population grows (*Exploitation of street children*, 2000).

Approximately 15% of children in the world live in hardship; 100 million children have laboring jobs, more than 50 million are street children, and over 100 million are refugees or displaced children (Velis in Brink, 2001:79). Furthermore, up to 100 million children have been recorded as living or working on the street, where they struggle to survive with no adult support or protection, and little or no education (United Nations Development Programme, 2000:41). The estimates and statistics indicate the scope of the various tragedies that children face today.

The term ‘street children’ is much debated but is “often used to describe *market children* who work on the streets or on city markets selling or begging, and living with their families. The term also describes *homeless street children* who work, live and sleep on the streets, often lacking any contact with their families” (*Exploitation of street children*, 2000). For this study, the term street children will mean children who primarily live and work on the streets and must survive off their surroundings. The term ‘street children’ in this study is not intended to be used as ‘labeling’ but merely to identify children who live and work on the street.

Some maintain that a child is a person who has not reached an age of discretion (*The Concise Oxford Dictionary*, 1984:160). The researcher believes that the worldview of children, as well as the relationships they have with other people and with themselves, are important. The researcher maintains that children are already at an age of discretion, but their emotions, values and attitudes towards certain aspects of life may change, as they get older. However, that does not mean it is correct to discount their thoughts and feelings. Therefore, in

this study, a child is simply every human being below the age of 18 years (Convention on the Rights of the Child, 2002; Republic of South Africa, Children's Act, 2006).

As indicated in the United Nations Convention on the Rights of the Child, (2002) childhood lasts from 0-17 years. This suggests that once children turn 18 years of age they are legally obliged to take care of themselves and reap the consequences of their actions. However, from a developmental standpoint, adolescence is recognized by the stages of development linking childhood to adulthood (Louw, Van Ede & Louw, 1999:384). Although there are many different developmental paradigms that try to describe the developmental process, Berk (in Louw *et al.*, 1999:384) outlines adolescence in three main stages:

- Early adolescence, which is ages 11 - 14 years;
- Middle adolescence, covering the ages 14 - 18 years;
- Late adolescence, from 18 - 21 years of age.

Because of the many levels of adolescence and the different terminologies, the researcher will define adolescence as lasting from 12 - 17 years of age. Although children have been defined as anyone under the age of 18 years, for the purpose of the study, the participants will be within the 12 - 17 year age range. This will allow the researcher to gain an in-depth view of a smaller target group. Further, in the study, the terms 'child' and 'adolescent' will be used interchangeably.

Street children are often more vulnerable to psychological and physical disturbance owing to their circumstances. They tend to resort to petty theft and prostitution for survival. Also, according to *Exploitation of street children* (2000), these children, "are extremely vulnerable to sexually transmitted diseases, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)." Additionally, approximately 90% of street children are addicted to inhalants like shoe glue or paint thinners, which may cause kidney failure, "irreversible brain damage and, in some cases, death" (*Exploitation of street children*, 2000). Sadly, many street children may not have official papers documenting their birth, so they do not 'officially' exist. It is estimated that one third of children born worldwide each year, which is approximately 40 million newborns, are not lawfully registered (*Exploitation of street children*, 2000). This leads to a number of problems, such as school registration, access to health care and vaccinations (*Exploitation of street children*, 2000).

Although circumstances are difficult on the street, children go there for many complex reasons. The majority are voluntary runaways escaping from troubles in the family, as "problems at the family level can, in many cases, be attributed to more complex and fundamental problems at community and even social levels" (Brink, 2001:81). The table below presents possible reasons why children turn to the street:

**Table 1: Reasons why children turn to the streets:**

Root Causes SOCIETY	Underlying Causes COMMUNITY	Immediate Causes FAMILY
<ul style="list-style-type: none"> <li>• Economic problems (most common)</li> <li>• Social changes i.e. rapid urbanization, high population, growth, unemployment</li> <li>• Cultural changes as a result of social changes i.e. material goods key to recognition of social acceptance</li> <li>• Political unrest</li> <li>• Natural disasters, i.e. drought, floods, earth quakes</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate employment opportunities</li> <li>• Uneven distribution of resources, services and opportunities i.e. land ownership</li> <li>• Poor working conditions</li> <li>• No access to basic services i.e. housing, transportation, water, electricity</li> </ul>	<ul style="list-style-type: none"> <li>• High unemployment levels</li> <li>• Large and poor families</li> <li>• High divorce/separation rate, i.e. single-headed household</li> <li>• Educational achievement (parents and children)</li> <li>• Alcoholism</li> <li>• Abuse in the home: physical, mental and sexual</li> <li>• Lack of care, affection and emotional support</li> </ul>

Derived from: (Barrette in Brink, 2001:80)

The table shows that children turn to the streets for various reasons. They start with immediate familial causes, ranging from unemployment and alcoholism to underlying problems like the lack of basic sanitary needs. More enduring societal root causes include political unrest and natural disasters, which can also cause children to turn to the street.

Life on the street has many varied facets. For instance, most street children are boys. Fewer girls turn to the street, which is perhaps a cultural matter. For example, many cultures believe that both the family and the reputation of the girl are at risk if the girl roams freely without adult supervision, and girls who do leave their families are commonly driven to prostitution (Brink 2001:81).

Consequently, according to Van Rooyen and Hartell (2002:191), street children have lost their responsibility for their bodies and their right of ownership over them. These children desperately need both money and needs fulfillment. Although everyone has the right to say no when approached, street children tend to engage in sex for money, goods and protection. Street children are highly visible on the streets, making local communities and tourists alike aware of their presence. They are photographed in powerful images evoking pity (Ennew, 2000:1). Street cases are complex. The real needs of street children can be challenging to understand, but one definite fact is that street children must fend for themselves (Brink 2001:81). This statement helps validate the

importance of understanding the problem at hand, which is a lack of information on street children's knowledge of sexuality, HIV and AIDS.

The extent of this problem is vast, incorporating many concerns, one of which is the HIV and AIDS epidemic in South Africa. For instance, it is estimated that 5.7 million people are living with HIV in South Africa. About 3.2 million are women and 280 000 are children between the ages of 0-14 years (United Nations AIDS South Africa Country Situation, 2008). "South Africa, with less than 1 percent of the world's population, now bears 17 percent of the world's burden of HIV infection. It has more HIV infected people than any other nation" (Dugger, 2009). The high infection rate could be attributable to poverty and/or lack of education. Globally, half of all new infections occur in people between the ages of 15 and 24 years (UNAIDS, 2008b). In 2007, it was estimated that, worldwide, 1.8 million orphans aged 0 through 17 years had lost their mother, father or both parents as a result of AIDS (UNAIDS, 2008a:6). Owing to the number of deaths from HIV and AIDS in South Africa, many children are homeless. This adds to tribulations such as poverty, malnutrition and essential needs, forcing young people to face problems of gargantuan proportion on their own.

Other factors also lead to problems for street children. Lawrence (in Van Der Merwe, 2001:8) concurs with Van Rooyen and Hartell (2002:188) that contracting HIV depends largely on the strength of the immune system. Street children's resistance is low, due to their excessive contact with bacteria and disease, creating a heightened susceptibility to the HIV infection. Unprotected sexual intercourse puts everyone, especially those with compromised immune systems, such as street people, at high risk. It is therefore necessary to determine why health care does not appear to be a priority. It is actually a challenge to find care after falling sick (Van Rooyen & Hartell, 2002:190, 191). Mathiti (2000:iii) states that street children showed a constricted social network limited primarily to peers. The study also illustrated street children's awareness of the dangers of drugs, yet it was difficult to identify their understanding of health awareness, sexual abuse and HIV and AIDS. Their knowledge-level was therefore labeled as low.

HIV and sexuality go hand in hand. After all, talking about HIV also means talking about sex and sexuality. Pattman and Chege (in Bhana, 2007:311) point out that the identities, concerns and pleasures of young people and the meaning they attach to sexuality is rarely taken into account. Understanding sexual identities is a significant component in development. Children are active agents, and, when properly educated and recognized as individuals with the ability to understand their bodies and take their needs and/or wants into account, encompassed with the correct knowledge base, they can protect themselves from harm and risky behaviour (Pattman & Chege in Bhana, 2007:311). Similarly, when caregivers dismiss or ignore children's questions pertaining to sex and sexuality, they perpetuate childhood innocence and parental dependency, which sequentially silences the voices of children and unconsciously leads to the perception of children as desexualized beings (Robinson, 2005:74; Bhana, 2007:309). Yet if children have inadequate or no adult figures educating them about sexuality, how are they to learn to express themselves? Furthermore, it is necessary to address how and where children receive information about sexuality and HIV and AIDS.

In conjunction with the notion that some street children may not have parents or parental figures to whom they can address their sexual and health-related needs, the researcher believes that the world's view of children as innocent beings applies to all children, no matter their status. Therefore, if the world sees children as innocent beings, some of whom choose or are forced to live their lives on the street, we as people need to view and treat children differently according to their context. For example, if a 13-year-old child is living on the street and is continually asked to prostitute for money, but does not understand the concept of prostitution, the child may agree, being unaware of the possible dangers. In this scenario, the idea of prostitution should be taught in order to prevent a child from complying with an unknown concept. On the other hand, a 13-year-old living in a secure home would probably not be in such a situation, so a conversation clarifying prostitution could be held later in life. Children should be addressed according to their life status and surroundings.

The researcher wishes to gather information about children's knowledge of sexuality and HIV and AIDS to gain a more thorough understanding of these two factors as they relate to children on the streets. The acquisition of information on street children's knowledge of sexuality and HIV and AIDS may contribute to and provide more understanding of street children. This will be done by addressing the various phenomena on the street, such as: unsafe sexual practices, incorrect information on HIV and AIDS and sexuality, and the children's feelings about themselves and their partners. This will directly address the understanding of street children's knowledge of sexuality and HIV and AIDS.

## **1.2 PROBLEM FORMULATION**

Trockim (2006) describes how problem formulations are developed; researchers develop research topics through experiencing practical problems in the field. Direct engagement in the social, health or human service fields assists researchers in constructing their ideas according to what is happening around them in the hopes of reducing the scope of the problem. The problem the researcher has noticed in the health care field is the lack of information on street children in relation to sexuality and HIV and AIDS.

Tragically, a large number of street children globally are reduced to living in poverty, along with situations of extreme sexual, physical and emotional abuse. Due to their vulnerability, these children may be coerced or choose to become involved in criminal activities, including drugs, sexual exploitation and trafficking (*Protecting street children*, 2005:1; *Exploitation of street children*, 2000). It was estimated that between the years 2005-2010, the number of street children increased by 20 million in sub-Saharan Africa alone (*Protecting street children*, 2005:54). This increase can be attributed to family conflicts, conflicts with the law, unmanageable urbanization linked to poverty and children being orphaned due to deaths linked to HIV and AIDS (*Protecting street children*, 2005:78; Brink 2001:80). While it is impossible to say exactly how many street children there are currently, the estimates cited below provide a terrifying approximation of the numbers of street children in the following countries: 11 million in India, 445 226 in Bangladesh, 250 000 in Kenya, 39 000 in South Africa and 630 000 in the United States (*Protecting street children*, 2005:78; Mickelson, 2000:27).

Literature confirms the need for this study. For example, “the contradictions that children face around sex and sexuality need to be given greater focus in future research to understand children’s experiences and concerns around these issues” (Robinson, 2005:75). In addition, Michael Lawrence (in Van Der Merwe, 2001:8), the chief executive officer of the Haven, a drop-in center for street people in Cape Town, South Africa, says that there is an enormous amount of sexual activity on the streets and most intercourse is unprotected. Furthermore, street children are less likely to get support both emotionally and medically because of community reaction, which is based on ignorance. Lawrence (in Van Der Merwe, 2001:8) also indicates that it is critical to approach the issue. UNICEF inquires about the percentage of young people who have a comprehensive knowledge of prevention methods relating to HIV and AIDS, but no numbers are indicated (UNICEF, 2010b:4). It is hoped that, with the realizations to be gained from this study, the body of knowledge about sexuality and HIV and AIDS among street children will be expanded.

Because of child numbers on the streets and the lack of information on these children, the researcher is hoping to gain an understanding of their plight by directly addressing their knowledge of sexuality and HIV and AIDS. The researcher will gain information on what street children know and/or do not know, focusing on the understanding of street children’s knowledge of sexuality and HIV and AIDS. If social workers, practitioners, scholars and other helpers and healers are unaware of what children on the street perceive to be the truth about sexuality and HIV and AIDS (encompassing life on the street, and excluding affection from family, safekeeping, proper education, health care services and resources), the problem cannot be addressed. The researcher’s recommendations for intervention with street children are set out in Chapter 4. It is hopeful that these will link children with resources and information, positively empowering them to make safe decisions about sexuality and HIV and AIDS.

In essence, the focus of the study is to gain an understanding of street children’s knowledge of sexuality and HIV and AIDS. Through this, an understanding of the attitudes to the sex practices of children living on the streets, how they feel about their bodies and what they know about HIV and AIDS may arise. As indicated above, information on sexuality, HIV and AIDS among street children is lacking. It is thus essential to explore these matters. In order to do so, the researcher will investigate street children’s knowledge of sexuality and HIV and AIDS, their insight into sexuality and their awareness of the implications of sexual behaviours and HIV and AIDS.

### **1.3 GOAL**

The term goal can also be used interchangeably with the words purpose and aim, this broad concept implies the end towards which effort or ambition is directed (De Vos, 2005:104). Therefore the goal of this study is:

- To explore street children’s knowledge of sexuality and HIV and AIDS in Pretoria, South Africa.

## 1.4 OBJECTIVES

The term objective is more concrete, and deals with the means in which, or steps taken to reach the end goal (De Vos, 2005:104). Therefore, the objectives of this study are:

- To conceptualize the phenomenon of street children and their knowledge of sexuality and HIV and AIDS;
- To explore street children's knowledge of sexuality and HIV and AIDS.
- To make recommendations for intervention with street children regarding sexuality and HIV and AIDS.

## 1.5 RESEARCH QUESTION

This research question has allowed the researcher to explore street children's knowledge of sexuality and HIV and AIDS, and to consider the role they play in the children's sexual behaviour and everyday lives.

Fouché and Delport (2005:80) maintain that if a researcher decides to conduct a qualitative study, a research question must be formulated and used as the guideline for the study. According to Clough and Nutbrown (2002:36), the research question entails the three following points:

- Identify the limits of the study;
- Clarify the research study;
- Identify empirical issues.

The researcher has formulated the following research question according to these guidelines:

What is street children's knowledge of sexuality and of HIV and AIDS in Pretoria, South Africa?

## 1.6 RESEARCH APPROACH

The researcher followed a qualitative research approach. The definition of a qualitative research approach is ambiguous (Fouché, 2005:267). According to Fouché (2005:262), a unique step is linked to the qualitative process, which is to select a paradigm integrating the following steps:

- Nature's reality;
- Relationships between the researcher and the topic of research;
- The function of values within the study;
- The research process.

Fouché (2005:272) maintains that, even though a paradigm may not answer critical questions, it may go towards directing one in the search for answers. The researcher's choice of a qualitative research approach will result in an in-depth, personal investigation of Pretoria street children's knowledge of sexuality and HIV and AIDS.

## **1.7 TYPE OF RESEARCH**

Research is identified as either basic or applied. Applied research is the scientific planning of stimulating change in the context of a troublesome situation (Fouché & De Vos, 2005:105). The researcher used applied research to gain information on the knowledge of sexuality and HIV and AIDS among street children in Pretoria, South Africa.

## **1.8 RESEARCH DESIGN**

The researcher used a qualitative research design that explores or deeply analyses a single case or multiple cases (Creswell in Fouché, 2005:272). The research design chosen is the collective case study, identified by Mark (in Fouché, 2005:272) as valuable in furthering the understanding by the researcher in a social issue or population. Furthermore, specific cases are selected to make comparisons between cases and concepts in order to expand ideas (Fouché, 2005:272). Therefore, the researcher used in-depth analysis in multiple cases to explore street children's knowledge about sexuality and HIV and AIDS.

## **1.9 DATA-COLLECTION METHODS**

There are two types of one-to-one interviews, which are the unstructured and semi-structured interviews (Greeff, 2005:292). Greeff (2005:292) names semi-structured one-to-one interviews as a method of information collection. The semi-structured interview is used to “gain a detailed picture of a participant's beliefs about or perceptions or accounts of, a particular topic” (Greeff, 2005:296). This data-collection method is therefore ideal for discovering the knowledge of sexuality and HIV and AIDS among street children.

After an in-depth study of literature and speaking with experts in the field (Strydom, 2005b:206), the researcher developed a semi-structured interview and conducted two pilot studies with street children, who were not used in the main study. The participants in the pilot study concurred that the questions were understandable and the researcher believed they could therefore produce the necessary data.

Moreover, a semi-structured interview was ideal for the researcher to use based on the population at hand. For example, some participants might be illiterate, and would therefore be unable to complete a questionnaire on their own. A semi-structured one-to-one interview allowed the researcher to assist in the documentation of responses, which meant reading the questions aloud and writing down their responses, as well as tape recording what they said. Furthermore, the children used in the study had to understand English, and to have communication skills for fully understanding and answering the questions posed. If, in the introduction, the children showed that they did not possess the English skills the researcher required, they were not be used in the study. It was kept in mind, however, that English was not their first language and that a translator would be available if necessary. In addition, the researcher was solely responsible for conducting the interviews, so the data gathered was more likely to be valid and reliable.

A number of tools can be used for data collection. The researcher used an interview schedule for the semi-structured interview. An interview schedule is a “questionnaire written to guide interviews” (Greeff, 2005:296). The interview schedule contains a list of themes and questions including information to be elicited from the participants. Furthermore, the interview schedule was helpful in providing a more in-depth view of the street children’s knowledge of sexuality and HIV and AIDS indicated in the participants’ answers (Greeff, 2005:296). It is important for these questions to be asked delicately. Greeff (2005:296) addresses the importance of question arrangement in relation to sensitive topics. The interview schedule is arranged beginning with less intrusive questions and building up to more personal or in-depth questions (Greeff, 2005:296). These points led to appropriate methods for interacting in an interview, and helped the researcher in preparing for the interview process.

In addition, Brink (2001:80) indicates that some street children offer misleading answers to please the interviewer. However, individual discussions are usually an accurate display of their true feelings (Brink, 2001:80). Because the children may be dishonest in the interview, the researcher believes that, practically speaking, it is necessary to ask various open-ended questions in order to build a congenial environment, allowing the children an opportunity to discuss their feelings freely.

The questions for the interview schedule are open-ended, so the researcher can ask the participants probing questions and gain an in-depth understanding of their knowledge of sexuality and HIV and AIDS when necessary. The interviews were tape-recorded after permission had been granted. The interviews took place during the day from 8:00 - 18:00. They were held on the University of Pretoria campus to secure a safe environment, where both the researcher and the children’s safety were taken into account. The researcher strove to make the atmosphere quiet and secluded by using a private room. First, the letter of informed consent was discussed with the children and once they had agreed to participate voluntarily and the document had been signed, the researcher was able to commence. The interviews lasted for approximately thirty minutes to one hour, depending on the response rate and amount of information the participants provided. The researcher gathered information from the street children until saturation was reached, to make sure that a full knowledge base for the research was met, which equaled 15 participants.

## **1.10 DATA-ANALYSIS**

“Data analysis is the process of systematically applying statistical and/or logical techniques to describe and illustrate, condense and recap, and evaluate data” (*Responsible conduct in data management*, 2005). In dealing with questions of a qualitative nature, such as open-ended questions regarding feelings, the researcher uses quotations from participants about their experiences and develops themes based on their responses (Fouché & De Vos, 2005:134).

When using qualitative data analysis there is a process to be followed, although it does not have to be done in a specific order. Creswell (in De Vos, 2005:334) derived the following points from literature, which are touched upon in the qualitative data analysis process:

- Planning for recording data

The researcher planned the data recording systematically, taking the setting, the participants and awareness of proper interviewing techniques into account (De Vos, 2005:334). The researcher planned the pilot test, the recording of information, the interview schedule and possible venue options.

- Data collection and preliminary analysis

In qualitative research data collection and analysis go hand in hand to strengthen coherent interpretations of the data (De Vos, 2005:335). The researcher attempted to provide a quiet, private, safe location for the interview process, which was a practical lecture room at the University of Pretoria in the Humanities Building.

- Managing or organising the data

Most data analysis is gathered at the site, yet managing or organising of data is the first step that takes place away from the site (De Vos, 2005:336). This step deals with the important task of organisation, such as making sure all notes and data are complete, properly labeled and copied for safekeeping (De Vos, 2005:33). Steps have been taken to make sure that these participants remain anonymous, by giving them pseudonyms. In addition, copies have been made and stored at the University of Pretoria for 15 years to ensure safekeeping. The notes are labeled with colours depending on the responses and related themes.

- Reading and writing memos

Following organisation and conversion of data, researchers continue the analysis through acquiring a “feeling for the whole data base” (De Vos, 2005:337). Reading intensely, familiarizing one’s self with the information and organising has helped the research process.

- Generating categories, themes and patterns

This complex, creative and congenial phase requires focus to the data; this process involves “winnowing of data, reducing it to a small manageable set of themes to write into the final narrative” (De Vos, 2005:338). As stated above, the researcher used the qualitative process to develop themes based on the participants’ responses. Themes and sub themes that have been identified are marked with coloured highlighters in the notes.

- Coding the data

When the analyzing categories and themes were complete, the researcher applied a coding scheme to these categories and themes, which take many forms, such as abbreviations, coloured dots, or numbers to uncover new understandings (De Vos, 2005:338).

- Testing the emergent understandings

This step incorporates searching through challenging data and evaluating data for its usefulness (De Vos, 2005:339).

- Searching for alternative explanations

“As the researcher discovers categories and patterns in the data, [s/he] should engage in critically challenging the very patterns that seem so apparent. The researcher should search for other, plausible explanations for these data and the linkages among them” (De Vos, 2005:339).

- Representing and visualizing

Last is the presentation of data in a table or other form (De Vos, 2005:334). The researcher has developed a clear representation for the data collected.

The process above guided the researcher to stay focused, on track and organised in the data collection process. It also facilitated the researcher’s in-depth look at the research after collection. In addition, scenarios and themes were created to better understand and explain the responses. This was carried out by taking a broad view of the situation and narrowing it down into specific themes to understand the reasoning behind certain behaviour.

### **1.11 PILOT TEST**

Pilot Study ([sa]:1) defines a pilot study as a small-scale practice study that the researcher conducts before the main study. A pilot study is essentially a run-through of the study involving a selected group of people. The researcher conducted interviews with two participants who were not used again in the main study but specifically selected for the pilot test. This test helps to identify flaws, such as a question that is difficult to understand, whereupon the researcher can solve the problems before commencing the main study.

### **1.12 FEASIBILITY OF THE STUDY**

The feasibility of the study addresses the practical situation and the nature of the problem, the researcher’s awareness of the topic, and the relevance and amount of information on the subject matter. This allows the researcher to prepare him/herself for all potential circumstances and know how to cope with them (Strydom, 2005b:208,209). In addition, the costs of the study has been covered by the researcher. This included transport to and from sites and the cost of paper for printing the letters of informed consent and the schedule for the interviews as well as costs of printing the mini-dissertation.

## **1.13 DESCRIPTION OF THE POPULATION, SAMPLE AND SAMPLING METHOD**

### **1.13.1 RESEARCH POPULATION**

The population, according to Strydom (2005b:194), “is the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned.” The population in this case is street children in the city of Pretoria, province of Gauteng, South Africa.

### **1.13.2 SAMPLING METHOD AND SAMPLE**

Arkava and Lane (in Strydom, 2005b:194) identify a sample as a subset of measurements drawn from the population in which the researcher is interested. This sample is studied in order to understand the population at hand (Strydom, 2005b:194). Finally, the sample was drawn from street children in Hatfield, Brooklyn, Colbyn and Sunnyside in Pretoria, South Africa. This was convenient for both the researcher and the participants as these areas are close in proximity to the university. The reason for questioning participants off the streets rather than taking the sample from shelters is that, fortunately, most of the shelters in Pretoria place the children directly into schools and programs when they have taken them off the street. The researcher wanted participants who do not have the luxury of schooling and who primarily cohabitate or work on the streets.

Strydom (2005b:203) identifies the sampling method, being non-probability sampling, and the method used was snowball sampling as, the researcher approaches one individual within the confined context of the sample and asks this street child to refer the researcher to other street children and provide information, such as the location of other individuals in the same context. This is what the researcher did.

## **1.14 ETHICAL ISSUES**

Kumar (2005:303) maintains that ethics is a core requirement in a research study. If one cannot be ethical then it would be inadvisable to undertake the evaluation because people would be at risk of harm. In this case, the researcher evaluated the different interests of each stakeholder. Furthermore, according to Kumar (2005:212), there are many ethical issues relating to participants in research. Given this, the researcher followed the ethical issues derived from Strydom (2005a:58-66) concerning research participants.

### **1.14.1 AVOIDANCE OF HARM**

It is possible for participants to be harmed physically and/or emotionally (Strydom, 2005a:58). Before the study commences, it is therefore necessary to inform the participants about “the potential impact of the investigation” (Strydom, 2005a:58). Enabling the participants to be aware of harm decreases the chances of possible offences, harm or crossing ethical boundaries. To prevent potential harm, the exact purpose of the research was explained to the participants. Once this information was available to the participants, they had the right to withdraw from the study before it began, thus completely avoiding any potential harm. This also allowed the researcher to see whether the participants showed any signs of being upset. In this particular case, the researcher had the opportunity to discontinue the individuals’ participation in the research and thereby avoid harm. On the other

hand, if the individuals chose to participate, the information given in the letter of consent allowed them to understand the true purpose of the study and they were then required to give their consent. It was important to investigate whether the study would harm participants in any way and review how to minimize potential risk (Kumar, 2005:303).

Another possible topic of difficulty is HIV and AIDS. Some children on the streets have lost their parents or loved ones as a direct result of AIDS, so there was no parent or guardian to give permission and only the street child could give consent. The researcher is also aware that, although the children may hear the words 'HIV and AIDS' often, there may be no real comprehension of what the virus is. This could be a possible embarrassment to certain children. Being supportive and caring through the interview was of extreme importance to avoid harm.

### **1.14.2 INFORMED CONSENT**

As indicated in Strydom (2005a:59), participation in a study can be done for numerous reasons. For example, individuals, such as children, who feel they have less power, may feel obliged to participate, or see participation as a cure for boredom. To avoid this, the researcher must remain aware of hidden intentions (Strydom, 2005a:60).

Because the participants are dependent on themselves, the researcher obtained consent from them in person. They were given information on the goal of the study and on topics to be discussed in the study. They were also given a letter of consent, as they are below the age of 18 years, so that the researcher could receive informed permission to conduct the study in an ethically sound manner. In cases of illiteracy, the researcher read the letter of consent to the children, who were able to make an informed decision about participating. In order to keep the study equivalent the researcher read the letter to each participant. Furthermore, the researcher was prepared to remove individuals from the study if there was an indication of extreme vulnerability, such as obvious physical or emotional abuse (Kumar 2005:303; Strydom, 2005a:58,59).

### **1.14.3 DECEPTION OF SUBJECTS AND/OR PARTICIPANT**

Deception of subjects means intentionally providing false information to participants. "No form of deception should ever be inflicted on participants. If it happens inadvertently, it must be rectified immediately after or during the debriefing interview" (Strydom, 2005a:61). It was therefore necessary for the researcher to make the participants aware of the actual information required.

### **1.14.4 VIOLATION OF PRIVACY/ANONYMITY/CONFIDENTIALITY**

Privacy, anonymity and confidentiality in this respect are indistinguishable. Strydom states (2005a:61) that there are numerous ways in which a researcher can violate privacy by means of hidden devices such as tape recorders, cameras or one-way mirrors. This can be avoided by clearly stating privacy either verbally or in a covering letter, or by marking the questionnaires (Strydom, 2005a:61). In order to avoid these possible

violations of privacy, the researcher requested the participants' permission prior to the interview to use a tape recorder during the explanation of the 'letter of consent'. In addition, the researcher has protected the anonymity of the subjects, and has thoroughly explained the importance of the research (Strydom, 2005a:62).

#### **1.14.5 ACTIONS AND COMPETENCE OF RESEARCHERS**

"Researchers are ethically obligated to ensure that they are competent and adequately skilled to undertake the proposed investigation" (Strydom, 2005a:63). The researcher is confident that eleven years of experience in working with children through counseling and teaching, along with a six-year passion for working with individuals infected and affected by HIV and AIDS as well as passing a module in research methodology is an adequate background to conduct the study professionally, competently and ethically. Furthermore, the researcher has made no value judgments, and is sensitive to all cultures (Strydom, 2005a:63). The researcher is under the supervision of a member of the Department of Social Work and Criminology at the University of Pretoria.

#### **1.14.6 RELEASE OR PUBLICATION OF THE FINDINGS**

It is important for researchers to observe the following (Strydom, 2005a:66):

- An accurate, objective, clear unambiguous report;
- Changing or altering information to bias results is unethical and must be avoided;
- No plagiarism;
- Errors and omissions have to be declared;
- The researcher will debrief to make sure that no harm has occurred.

The findings will be released in the form of a mini-dissertation, an article to be published in a scientific journal with the supervisor as co-author, and an international conference presentation. It is crucial that confidentiality regarding participants must be kept at all times. The researcher guaranteed this by giving each participant a pseudonym before transcribing the interviews.

#### **1.14.7 DEBRIEFING OF PARTICIPANTS**

Debriefing participants is an important part of the process and allowing the participants to acknowledge their experiences during the study. On completion of the project, the researcher had to identify any possible misrepresentation of the participants (Strydom, 2005a:66). Finalizing the project was possibly difficult for participants due to the experience and content of the study. Concluding the debriefing sessions was dealt with in a sensitive manner (Strydom, 2005a:66).

There were a number of areas of ethical concern in this study, such as asking children about sexuality. The street children were asked to explain how they felt about themselves and their bodies. The children may have a history of sexual abuse and would therefore have difficulty discussing this topic. It was essential to ascertain

whether the participants were aware of the purpose and depth of the study, as is explained in the letter of assent. Some of the children may have had difficulty coping with their immediate situation. Following the interviews, the researcher therefore debriefed the participants and assessed whether they needed further counseling. If a child was emotional, the researcher planned to refer the participant to a social worker and/or counselor in the designated Pretoria district where the participant most commonly resided.

### 1.15 LIMITATIONS TO STUDY

According to the researcher, the following components could have affected the research process:

- **Access to information:** There is a lack of information on the field of study and the limitation to relevant and time-appropriate (post 2000) data from the library.
- **Being foreign to South Africa:** This includes both ethical and social differences when it comes to staff and participants in relation to communication and time.
- **Communication tools:** There were several electronic challenges, such as emails not going through because of problematic servers, which in turn delayed the writing process. There were also times in the interview process when the researcher had to repeat the same question a number of times in order for the participant to fully understand the question, and vice versa.
- **Findings:** These cannot be generalized to the whole population because of the ages of the participants, the fact that they were all male and the sample size was small.
- **Logistical problems:** Time was a problem for the participants. This was exacerbated by problems with the venue, including finding, keeping and traveling to a venue on the campus. For example, while the street children were cooperative, the researcher had difficulty in retaining the venue. Some interviews were interrupted by phone calls from departmental staff saying that they would need the key, as no other venue was available. The researcher consequently had to hurry to complete the interviews.
- **Interpreters:** The interpreters caused difficulties with conducting the session and time. In the few instances when the researcher used an interpreter, there were challenges in getting hold of one. Further, interpreters created unnecessary distractions during interviews, for example, talking to the participant when they had not been asked to do so, or having to be somewhere after the interview and trying to speed up the process.
- **Misinterpretation:** Certain interviews might have been misinterpreted because English was not the participants' first language. The researcher might have thought they were saying one thing, when in fact they were saying something else. For example, many of the participants use "he" and "she" interchangeably. For example, if the participant was talking about a girl and used the pronoun "he", the data reported may be incorrect. However, the interviewer did try to be specific when situations such as this arose.
- **External support and liaison:** Individuals and organisations were occasionally problematic. At certain stages, people were uncooperative for various reasons, which included failure to return phone calls or give

information needed for completing specific processes. At other times, individuals were unable to assist owing to workload and other priorities.

- **Participants' age:** Due to the children's interest in participating, a potential problem arose. It is possible that individuals were not being truthful about their ages. The researcher was very clear that they could only answer the questions if they were between the ages of 12 and 17 years. Most of them had no birth certificate, or any other identification, so it can only be hoped that they were being truthful. The researcher tried to avoid this by asking other individuals how old the next participants were, and they were not used in the research if they were over 17 and under 12 years of age.
- **Finding participants:** In the search for participants, the researcher spoke to a number of people on the street who were between their 20s to mid-50s. One street person in his 20s took the researcher into an alley where some street people reside. The researcher was introduced to the "head" man of this alley and was given rules to be kept if the researcher was to talk to the street people, such as personal anonymity and keeping the places where they were staying furtive.
- **No incentives:** The children were all very open and happy to share their experiences with someone who seemed to care, and were very open about asking for help. The researcher refused to give the individuals any incentives such as money, food, water and clothing, and explained instead that this was a project. The researcher added that they would be helping each other if they answered the questions, because people would have an in-depth look at and understanding of street children in Pretoria, South Africa.

## 1.16 RESEARCH REPORT

The research report will incorporate the following chapters as follows:

### Chapter 2 STREET CHILDREN, SEXUALITY AND HIV AND AIDS

The literature review targets significant issues in the field of study and is connected closely with the relevant objectives of the report. The literature review addresses only the necessary details (Chinneck, 1999:13; Strydom, 2005b: 252). This section will therefore focus on street children, sexuality and HIV and AIDS as well as how they relate. There is limited information on the knowledge of sexuality and HIV and AIDS among street children, so the section is a brief exploration of these components and how they relate to one another.

### Chapter 3 RESEARCH FINDINGS

This section comprises the findings of the empirical study (Strydom, 2005b:253). It is a complete analysis of the findings on street children's knowledge of HIV and AIDS and sexuality in Pretoria, South Africa. The researcher presents this chapter according to themes and sub themes. The researcher will use quotes from the participants and will relate the answers to literature.

## Chapter 4 **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

This section “presents a summary of the investigation and further interpretation, as well as the conclusions and recommendations” (Strydom, 2005b:253) provided by the researcher. The researcher provides a summary of the study, which incorporates how the goal and objectives were met, the research question answered and making conclusions and recommendations.

The following chapter will focus on the phenomenon of street children and HIV and AIDS.

## CHAPTER 2

### STREET CHILDREN, SEXUALITY, AND HIV AND AIDS

#### 2.1 INTRODUCTION

This chapter identifies what the study is about and explains each of the three primary aspects of the study. There will be a brief description of the extent of street children's knowledge of sexuality and HIV and AIDS, showing how they are connected. This is one of the primary objectives of the study. It will include their knowledge of how HIV and AIDS are transmitted, and whether or not the children use protection if they are sexually active. A further component is to acknowledge their reasons for being sexually active, which may be for money, sexual satisfaction or wanting to feel needed in a relationship. The researcher will explore all these potential components in the literature. The two focal points of the research are sexuality, HIV and AIDS, which can be viewed in broad terms. The researcher will identify specific aspects of the children's knowledge of sexuality, HIV and AIDS along with secondary components of interest in relation to the topic.

To recapitulate, these components relate to the children's understanding of sexual identity, self-image, health, HIV and AIDS and feelings associated with sexual activity and peer relations. Unless the academic community is aware of the children's knowledge of sexuality and HIV and AIDS, they cannot address them.

#### 2.2 DEFINITIONS OF KEY CONCEPTS

##### 2.2.1 KNOWLEDGE

"Knowledge is information and skills gained through experience or education" (*The Compact Oxford English Dictionary for Students*, 2006:562). Likewise, knowledge is also referred to as knowing, familiarity gained from experience (*The Concise Oxford Dictionary*, 1982:556). Understanding this word in the context of the study is vital to its relevance. The researcher defines knowledge in the context of this study as basic understanding of the subjects of sexuality and HIV and AIDS.

##### 2.2.2 SEXUALITY

"Sexuality incorporates physical, social and psychological characteristics including temperaments, feelings, values and norms regarding one's actions" (Chilman, 1990:123; Delamater & Hasday, 2007:254). Bhana (2007:309) views children "not simply in terms of their need for sexual rights but as potentially active participants in the negotiation of their rights." Sexuality is also defined as "a person's capacity for sexual feelings" (*The Compact Oxford English Dictionary for Students*, 2006:946). Sexuality will be defined in the context of sexual awareness among children. The researcher defines it as being aware of one's body and responses as well as the ability to control, or be aware of feelings associated with sex and sexuality.

### **2.2.3 HIV**

Although the origin of HIV is still the subject of debate, it stands for, “human immunodeficiency virus, the virus which causes AIDS” (*The Compact Oxford English Dictionary for Students*, 2006:480). HIV is a virus, the type called retrovirus, which infects cells of the human immune system. It attacks CD4+ T cells and macrophage—key components of the cellular immune system, and destroys or impairs their function. Infection with this virus results in the progressive deterioration of the immune system, leading to immune deficiency. The immune system is deficient when it can no longer fulfill its role of fighting off infections and diseases. Immunodeficient people are more susceptible to a wide range of infections, most of which are rare among those without immune deficiency. Infections associated with severe immunodeficiency are known as opportunistic infections because they take advantage of a weakened immune system (UNAIDS, 2008b). The researcher defines HIV, for the purpose of this study, as a virus transmitted through blood, semen, vaginal secretion and breast milk. The virus attacks the body by affecting the CD4 cell count, which is lowered to +/- 200, thereby changing the dynamics of the body and rendering it unable to fight common diseases.

### **2.2.4 AIDS**

Aids is “a disease caused by the HIV virus and transmitted in body fluids, in which the sufferer’s natural defenses against infection are destroyed” (*The Compact Oxford English Dictionary for Students*, 2006:18). “AIDS stands for acquired immunodeficiency syndrome and is a surveillance definition based on signs, symptoms, infections, and cancers associated with the deficiency of the immune system that stems from infection with HIV” (UNAIDSb, 2008). For the purpose of this study, the researcher defines AIDS as a ‘syndrome’ caused by HIV, whereby the body’s CD4 cells continue to plummet and the immune system worsens.

### **2.2.5 STREET CHILDREN**

Street children are “urban children in distress” (Brink, 2001:80). Barrette (in Brink, 2001:80) believes this includes “completely abandoned children who live and work on the street and have no contact with their family, or children that live on the streets but maintain regular or irregular contact with their family, or finally children that live together with their family on the street and work to contribute to the family income.” Ennew (2000:42) maintains that street children live and work on the streets and experience similar environmental hazards, including traffic, police, lack of shelter, privacy and sanitation. The researcher defines a street child as an individual under the age of 18 who primarily cohabits on the street and survives on his/her surroundings and may have no parents or guardians.

## **2.3 CHILDREN LIVING ON THE STREETS**

Street children, meaning people under the age of 18 who spend most of their time either living or working on the street, have more than likely experienced family trauma, hunger, neglect, and domestic violence (*Protecting street children*, 2005). In comparison, a child who is raised in the highest income bracket in South Africa and a

child in the lowest bracket is reduced by two times in relation to receiving sufficient sanitation and water, two times less probable to receive early childhood development programmes as well as, “ three times less likely to complete secondary education; seven times more likely to experience hunger; and [25] times less likely to be covered by a medical scheme” (South African Human Rights Commission & UNICEF, 2011:3). Therefore, the monetary gap that children are born into sets the possible foundation for their future.

“With the advent of democracy in 1994, the post-apartheid government set out to develop a unified health system capable of delivering quality health care to all the citizens efficiently and in a caring environment” (Human Sciences Research Council, 2010:xvii). Yet racial disproportion in South Africa remains deep-rooted. For instance, a black African child, in comparison with a white child, has a greater risk of being raised in poverty almost 18 times over (SAHRC & UNICEFF, 2011:3). For instance, nearly 4.5 million working-aged South African citizens are unemployed, which statistically speaking is one in every four people of this group (SAHRC & UNICEF, 2011:2). Apart from this, practically two out of five South Africans are under 18 years of age; 7 million of these children reside in the poorest 20% of homes, if any (SAHRC & UNICEF, 2011:3). Therefore, although people are supposed to be equal and have health care, the government is unable to cope with the level of poverty in the country and the health crisis therefore, remains largely unchanged, from access to medicine to clinics, including transportation to and from these places if individuals live in rural communities with limited resources.

In an effort to escape the life they have been dealt many children live partly or fulltime on the streets (*Protecting street children*, 2005). Parents sometimes send their children to beg or prostitute themselves in order to bring money or goods back to the family (*Protecting street children*, 2005). If children sell themselves as sex objects and are able to supply bread and milk for the family with the money they earn, they are made much of when they come home. How the food was provided is not discussed and the parents praise the child for good behaviour.

Globally, governments began to take notice of and show concern for children living and working on the streets in 1979, also known as the International Year of the Child. In 1986, UNICEF’s Executive Board approved the suggestion that children in difficult circumstances be a priority (Department of Social Development, 2010.:vi). In South Africa, the predicament of children living on the street became a main concern. With this came the Children’s Act (No. 38 of 2005). Now these children can be protected by both governmental and non-governmental organisations, in the form of social assistance, child protection and child-care services strategy guidelines for children working and living on the streets. Since the law protects the children, they should feel safer and have access to information about where to go if they need help, but they are often left in the dark about such things and feel alone. What is said on paper is compelling, yet the assessment and actualization of testimonies are lacking.

Such laws have been made “to give effect to certain rights of children as contained in the Constitution” as cited in the Children’s Act, Act No. 38 of 2005. According to the Constitution of the Republic of South Africa, Act No. 108 of 2006 in section 28, all children have the right to the following:

- A name and nationality from birth;
- Family care, parental care, or alternative care when detached from the family;
- Basic nutrition, shelter, health care services and social services;
- Protection from maltreatment, neglect, abuse or degradation;
- Protection from exploitative labour practices;
- Not to work or provide services unsuitable for the child’s age;
- Well-being, education, physical or mental health, spiritual, moral or social development must not be placed at risk;
- Not to be jailed unless as a last resort, then to be detained only for the shortest appropriate period of time;
- The right to be kept separate from detained persons over the age of 18years;
- To be treated in a manner, and kept in conditions that take account of the child’s age;
- To have an attorney;
- Not to be used in armed conflict, and to be protected in times of armed conflict;
- A child’s best interests are of paramount importance.

A further point derived from the Children’s Act 38 of 2005 (2006:38) is:

- Responsibilities of children:

“Every child has responsibilities appropriate to the child’s age and ability towards his or her family, community and the state.” The researcher believes that although this is a good law, in that it protects the child from having to do more than is appropriate for the child’s age, children in the street do not have anyone to look after them and their surviving and/or functioning family. These children bear daily concerns quite unlike those of a ‘normal’ human being. Street children do not have the luxury of behaving like ordinary children; instead, they have responsibilities. Sadly, this forces them to behave in a manner beyond their years as children. Although obeying, being grateful, and abiding by rules set by the family within reason and the law are worthy responsibilities, it is more important for a child to have a childhood. Being able to act as a child in youth should be a given, but these children have limited opportunity for this and there are few people who can give them their youth.

Although it seems that thorough and adequate laws have been made, according to the Department of Social Development (DOSD) (2010:2), services are frequently disjointed and inadequately monitored. This is regardless of the fact that the children are unaware of the services available to them. Ignorant of services and care, the majority of street children are also illiterate (*Protecting street children*, 2005). They have little or no support if they want to study, so dropping out of school, turning to the street, and sometimes joining street

gangs for protection seem to be ‘the best’ options (*Protecting street children*, 2005). These gangs of street children tend to prey on younger children, sometimes making them sex slaves by using drugs, food and fear to control them (*Protecting street children*, 2005). Furthermore, “[s]treet children are the poorest of the poor; they are vulnerable and weak and unless they are helped they will be the HIV and AIDS victims of the future. They are forced to be child prostitutes and attract foreign sex tourists. They are susceptible to becoming criminals or even terrorists” (*Protecting street children*, 2005). While this may seem drastic, it is the reality of the situation in every country in the world.

“Countries should include anti-stigma strategies as integral components of their national plans, investing in a broad range of activities, including public awareness and know your rights campaigns, legal services for people living with HIV, expansion of access to antiretroviral drugs, and expressions of national solidarity in the HIV response” (UNAIDS, 2010a:64). Empowering individuals with support and knowledge of their rights is important and helps individuals take advantage of possibilities, particularly when it comes to children living on the street. If they knew their rights and abilities, it would give them the support base that they so desperately need. In fact, there are numerous amendments for protecting children living on the street, although the children are usually unaware of these helpful laws, also assessment of the laws that are in place is inadequate.

### **2.3.1 CAUSES OF CHILDREN LIVING ON THE STREET**

“Street children in Africa are a recent development according to frequently-reflected patterns of exploitation emanating from colonialism in the early 20<sup>th</sup> century” (Kilbride, Suda, & Njeru, 2000:4). Le Roux (in Kilbride *et al.*, 2000:4) suggests that street children in South Africa are of African origin owing to the racial segregation of apartheid. One can then gather that throughout the world one reason for the existence of street children is the social and political upheaval created by one society dominating or taking over another and claiming a higher status than the other. In addition, “children living and working on the streets are a manifestation of the problems which children and families experience in communities as a result of health, social and economic factors which render homes less effective in providing for the children’s well-being, thus leading to their marginalization” (DOSD, 2010:vi). There are thus many reasons for the phenomenon of street children in all cultures and countries. The reasons may seem numerous, but two reasons identified here are segregation due to political unrest and familial struggle.

Other causes identified by Kilbride *et al.* (2000:4, 5, 25, 30) are:

- Poverty due to unemployment or personal interest;
- Structural adjustment of their lives if there is someone new in the house, i.e. a stepfather;
- Famine from lack of clean water, good soil or money;
- Child soldiers as a result of kidnap and brainwashing;
- AIDS due to unprotected heterosexual intercourse (greatest reason for infection in SA);
- Family tragedy, such as a death;

- Absence of a father if he is not there to support morally or economically;
- Decline of indigenous family values;
- [Polygamy], sleeping with multiple partners, with its effect on the spouse and/or children;
- Adolescent pregnancy - not being taught proper protection techniques or abstinence;
- Ethnic/Refugee difficulties, not feeling welcome or comfortable at home;
- Lack of government programs owing to lack of funding, implementation, or corruption;
- Recruitment by street children to possibly feel a sense of community;
- Increase in cost of living owing to economic decline.

Similarly, adapted from *Protecting street children* (2005), macro- and micro-level causes that could result in children living on the street are:

- Social devastation, including, but not limited to the HIV and AIDS pandemic, ethnic conflict, trafficking;
- Political unrest, including, but not limited to war, corruption, wastage or lack of resources;
- Natural disasters, including, but not limited to famine, tsunamis, earthquakes;
- Poverty due to unemployment or personal interest;
- Rural-urban migration, moving the family and being unable to acclimatize;
- Economic collapse due to government spending;
- Family breakdown, such as one parent leaving, separation or tragedy;
- Alcohol or drug abuse in the family;
- Child abuse in the family, including violence, neglect, sexual or emotional abuse;
- Sexual exploitation, including child labour.

The government and the community are two recurrent themes in discussions on the reasons for the existence of street children. Two references, Kilbride *et al.* and *Protecting street children*, deal with the two primary aspects of money and family. Either the parents/guardians have no money for their children or the family is no longer alive. There are some 3 million orphaned children in South Africa, counting those whose parents have died of AIDS, and over 60% of children exist in impoverished circumstances (HSRC, 2010:xix). The factors listed above suggest that street children are without money for themselves, their siblings or other family members. This, being the case, the lack of food and other primary necessities forces children onto the streets to look for work.

### **2.3.2 WORK AND LIFE ON THE STREETS**

“All countries should ensure rigorous enforcement of antidiscrimination measures to protect people living with HIV” (UNAIDS, 2010a:64). The researcher believes this should include both the individual and the treatment options. Many individuals on the streets steal one another’s ARV’s to mix with other drugs to roll and smoke with the intention of getting high on the concoction. Street children’s medication is often stolen and they should have the option of taking their medication regimen in a safe place, such as at a local clinic.

Kilbride *et al.* (2000:700) have recognised different begging styles, including verbal requests, holding out the hands, pouting, exaggerated smiling, threatening gestures, kneeling on the ground and limping.

The researcher has observed that street children in Pretoria, South Africa, have a number of ways of initiating their routine. For example, street people often stand at busy intersections waiting for the cars to stop and then proceed to kneel on the street, painting their faces as the mimes do, dancing and holding clever cardboard displays saying 'YouTube', acting as if they were disabled or maybe approaching each car while the light is red. Many of the street children seem to work in the same location, apparently territorial about their space. It is also common for street children to stand outside fast-food restaurants, pointing at the sign, their mouths or stomachs simultaneously as a non-verbal request for food. Other than begging, some street children also prostitute themselves for food, goods or money, which Kilbride *et al.* (2000:123) identify as survival sex. Selling oneself on the street poses a multitude of risks, including rape, physical abuse, and exposure to sexually-transmitted infections and HIV and AIDS.

According to the World Health Organization (2000:17), other factors that influence street children's daily activities and lives are:

- **Chance:** On arriving on the street after leaving home, whomever the child meets is key. It could be a group of car-washers or drug traffickers, but whatever their influence on the child is and what group the child chooses as well as who takes him/her under their wing is very important.
- **Exploitation:** This means taking part in unhealthy or dangerous activities to survive. Others, such as those who run the sex and drug trades, could effortlessly make victims of them.
- **Additional support techniques:** There is often a leader, and the different roles in the group may depend on personal strengths and weaknesses. Street children tend to protect one another from other groups and authorities or in unsafe situations.
- **Peers:** They can be close in age or likes and dislikes. Peer groups are important to street children because they fulfill the child's need for acceptance, belonging and protection.
- **Personal strengths:** These are qualities like individual resourcefulness, resilience and determination.

When it comes to the hardships on the street, many of the children use drugs, such as sniffing glue, which many of them abuse. This is because it is so easily obtained at a low price. In addition, it suppresses depression, builds the confidence to beg, and fights hunger and cold (Kilbride *et al.*, 2000:70,122). Survival for street children depends on obtaining food, clothing and shelter, as well as protecting themselves against violence and other forms of abuse. It all depends on how well street children cope with the points mentioned above.

Children who work on the streets have to be aware and concerned about the different things that could possibly influence their workday. Arrest or bad weather disallows a day's earnings. If the weather is cold or rainy, they have to move location. If the authorities are aware of where they are staying that night, their routine may have

to change. Being concerned with survival, weather, authority and health, the daily life of a street child is by no means easy.

### **2.3.4 PREVENTION OF CHILDREN LIVING ON THE STREET**

While reading about and observing street children, the researcher has identified prevention strategies in the literature listed below that may be useful. First, in order to design appropriate prevention techniques for children living on the street or wanting to live on the street, we must go back to section 2.1.1 and review the reasons why children choose to do this. Understanding the causes could help create solutions. For example, creating a community ‘big brother’ type of project for children who have no father could create a feeling of connectedness to a positive male figure.

In addition, when considering hunger, for example, it would be advantageous to teach communities to farm and live in a sustainable manner; food would be readily available, which would allow for proper nutrition. These solutions would not be difficult, but they would require planning and execution. Communities could solve existing issues like unemployment and poverty. Various types of education, such as farming, would be the primary factor in prevention when it comes to street children.

Understanding and reducing the root causes for children going onto the streets would mean educating them on how to take care of themselves, or their families. There could also be therapy and counseling for families who have children with disabilities or for families who do not get along. So many different things lead children onto the streets, and there could be numerous ways of preventing them from going there.

## **2.4 SEXUALITY AND YOUTH**

Sexuality is part of every human being’s makeup, and questions associated with sexuality begin early in childhood. The sections below discuss sexuality in childhood and youth.

### **2.4.1 A BRIEF HISTORY OF SEXUALITY**

A brief history is necessary if we are to understand the importance of sexuality throughout the ages and for all people. Garton (2004) maintains that, “sexual practices may persist through time, but history also illuminates how sex and sexuality are surprisingly mutable.” This means that sexuality changeable, whether from person to person, culture to culture or throughout time. For example, while many countries tried to understand the manifestation of sexuality and sexual labour, in South Africa the Apartheid rule seemed to suppress discussion by means of “repressive state laws and censorship; specifically, the unyielding avowal of the apartheid regime to prohibit sex across racial boundaries” (Steyn & van Zyl, 2009:120). Different circumstances can therefore inhibit sexual expression.

South African sexuality was influenced by culture. Other factors that have influenced sexuality throughout history, according to Garton (2004:32,49,76,89,125), are:

- Dominance of male or female;
- Submission of male or female;
- Religion and belief systems;
- Tradition of the partners or family;
- Culture based on norms of the country;
- Class based on money or status.

The above influences affect sexuality and whether it can be openly discussed and expressed throughout the world. Using South Africa as an example, although the government has changed, there are statistics indicating that women are murdered daily during physical and sexual assault within their communities. Steyn and van Zyl (2009:130) maintain that political structures and countries like South Africa overtly “support gender inequality.” One is left thinking that repression and the inability to speak openly about sex and sexuality may lead to further repression and unwanted acts. Talking about sexuality with one’s partner and, more importantly, understanding what an individual wants, is essential for a healthy sexual experience, which relates to how street children feel and act in relation to their own sexuality.

Weeks, Holland and Waites (2003:86) say:

A skilful representation of self as sexually knowing might be produced by a young woman, who is in fact unknowing. This disjunction between knowledge and self image can lead young women into sexually unsafe situations. Young women can spend a good deal of time on their outward appearances in order to construct a female body which will act as a magnet to attract men, but they may have little control over whom they attract, and the sexual expectations that they are then supposed to meet.

The researcher concurs that knowledge is power and young men and women alike should be well informed about their bodies and sexual experiences, as well as the implications of sexual activities. Often, however, when a young woman does spend time on her outward appearance and dresses carefully, it is not for the sake of attracting men, but possibly to feel good about herself or to fit in. If a child’s garments are inappropriate and attract someone of the same or the opposite sex, and sexually assaults the child, it is not her fault. It is, of course, the fault of whoever commits the assault, as they are unable to control their sexual desires. It is equally important that young girls realize the possible dangers inherent in their actions.

From the early 1960s, clinicians have propounded a great many theories and ideas on sexual response and stimulation. This knowledge allows people to better understand the stages of sexual response (Rice & Dolgin, 2005:15). As well as what happens to the body, the feelings associated with bodily changes and dysfunctional sexual activities.

Society seems convinced that children, meaning those under the age of 18, are still pre-sexual or desexualized beings. However, statistics tell us that this is not the case (Waites, 2005:14). For instance, it has been shown

that most young people have sexual intercourse by their mid to late teens. Developmentally or physically, their bodies may be ready, but emotionally this has the potential to scar or hinder sexual experiences in the future (Rice & Dolgin, 2005:16).

The researcher maintains that not talking about sexual expression, understanding one's body or the physical and emotional changes one goes through in puberty, only prohibits the child's understanding and can cause them to prematurely engage in sexual acts. An understanding of physical and emotional changes can enhance sexual knowledge, allowing that individual to make informed and conscious decisions. Acknowledging children as sexual beings and deeming their changes as normal may, in fact, help their decision-making powers and potentially prolong their so-called virtue, whereas not addressing the changes and feelings may create a longing to explore and find answers. If children are given the tools, that is, knowledge, less damage and confusion may arise.

Puberty means an increased interest in sex (Rice & Dolgin, 2005:193), but children who talk about sex or make jokes to normalize the situation are often thought of as crude. In South Africa, childhood sexuality is fraught with such taboos (Steyn & van Zyl, 2009:323). With the child's increased interest comes an interest in experimentation, which can be motivated by curiosity, desire, release, and the need for love, affection, intimacy and acceptance (Rice & Dolgin, 2005:193). Children and teens have a great desire to be needed and to experience emotional fulfillment. Gaining reassurance from others is a strong motivator for participation in sexual activity (Rice & Dolgin, 2005:193). Consequently, once children begin to talk or joke about sex, it is necessary to discuss the topic to prepare the child fully for the physical and emotional feelings associated with sex and desire.

Furthermore, certain biological changes during adolescence influence children's development sexually, physically and physiologically (Rice & Dolgin, 2005:23), with numerous studies seeking to understand their sexual and physical behaviours (Rice & Dolgin, 2005:26). Adolescents decide to experience intercourse at an early age for a number of reasons. One of the best-known theorists in this field is Sigmund Freud, whose theory included the stage known as the genital stage, which relates to urges and desires (Rice & Dolgin, 2005:26). This stage is accompanied by the maturation of external and internal sexual organisms, which creates the need to release sexual build-up, and results in children looking for others to release their sexual tension (Rice & Dolgin, 2005:26).

Although children look for release in physical activities, the physical changes in the brain precipitate the transformation (Rice & Dolgin, 2005:77). These changes in the brain begin by channeling a variety of endocrine glands, increasing the production of hormones that act as chemical messengers flowing through the bloodstream and affecting other cells. The part of the brain connected with puberty and sexuality is the hypothalamus (Rice & Dolgin, 2005:77). Sex relates to pleasure, desire and power, while sexuality alludes to the way sexual practices generate a type of social and sexual identity (Garton, 2004:x; Weeks *et al.*, 2003:119; Stern & van Zyl, 2009:22).

Sexual and social identities are very important to teenagers, as is body image. Many adolescents have the physical body of an adult, with concomitant needs and desires (Hatchell, 2003:1; Weeks, *et al.*, 2003:85). One factor that affects adolescents' self-esteem is sexual polarization as opposed to bisexual confusion. Defining what it means to be a male or female by social standards and developing or adapting to a sexual identity can be challenging (Rice & Dolgin 2005:175). Although these teenagers may look and sometimes act like adults, their life experience is limited, and making decisions that affect the rest of their life can be burdensome.

According to Strasburger (in Strasburger, Wilson & Jordan, 2009:212), owing to the failure of effective sex education at home or school, the media, including television, has become a leading source of sex education. In addition, a primary method of selling products is using sex and sexually explicit tactics. Thus, if children view this as an effective avenue of gaining knowledge, they may also think that by acting in a sexually explicit manner they will get what they want (Strasburger *et al.*, 2009:212).

When the two concepts conjoin, meaning that the media is a primary source of sexual education and 'sex sells', street children may indeed use media tactics as a way of fulfilling their needs. On the other hand, this may not be the number one source of education to street children. It is an unknown area that will be explored in this study. If the source of street children's information on sexuality and HIV and AIDS could be ascertained, it would be possible to address the general ignorance about street children and possibly to enhance the avenue of education they use.

Increasing understanding of sexuality will help researchers determine problematic aspects of adolescence (Schmitt, 2006:45). Street children have many daily concerns, as previously discussed, which affect their lives and development. The researcher maintains that during development it is important to be aware of one's sexuality and how it influences in both the decision-making process and daily experiences. When street children sell themselves in order to survive on the street, it raises the question of what they feel about their self-image and self-worth. This is an obvious link between street children and sexuality.

Romantic relations are an important aspect of adolescent social life (Giordano, Manning & Longmore, 2006:127). Although these relationships are a key factor in sexual development, they also cause high levels of social awkwardness, including that of communication (Giordano *et al.*, 2006:132). Understanding romantic relationship experiences can be challenging for any adolescent.

Values may be an important aspect of sexual development and understanding one's sexuality, but if a child is in the situation of sexual exploitation, the formation of a personal belief system may change course. This means that children who never have to compromise themselves by selling their body for survival may have a different outlook on sexuality. Such children would view their bodies differently and would maintain an attitude towards sexual experiences quite unlike that of a child who does not have the chance and the time to explore personal ideals and who uses sex as a tool. In trying to understand values and sexual changes, children may engage in risky behaviour to establish their boundaries and views of sexuality and recognize how they react in certain

situations. Sexual experiences pose risks such as unwanted pregnancy, sexually transmitted infections, a lost reputation and HIV and AIDS (Shucksmith, 2004:5).

“They are developing breasts, growing body hair, having wet dreams, experiencing mood changes, and starting their menstrual cycles. Their bodies are changing so quickly and unpredictably that teens are astonished” (Bradley, Jarchow & Robinson, 1999:10). While all adolescents experience this process, most of them have a support system at home and at school. Street children begin to have questions about their sexuality, and possibly journey to unfamiliar places and people to find answers; they are unaware of potential harm, such as incorrect information or abuse, which could result in emotional and physical anguish. Each relationship can be interpreted differently according to how the individual views a relationship and what they want out of it.

The researcher believes a support system is essential early in life. If the family system is disturbed in any way, it may bring developmental problems and a sense of emptiness. Because street children are without social support other than peer associations, their desperation and forlornness could lead them to confide in anyone who enters their world to fulfill basic needs. These are things like food, shelter, love, and acceptance, the need for which could result in their becoming sex objects or prostitutes (Van Rooyen & Hartell, 2002:190).

After reviewing the hardships that children face when trying to understand their sexual identity and all of the other aspects that go along with understanding one’s sexuality, HIV and AIDS must be considered. “The HIV/AIDS pandemic has proven to be a major catalyst for sexuality research” (Peltzer, Pengpid & Mashego 2006:3). Linking the two concepts will allow for a better understanding of both sexuality and HIV and AIDS, talking about HIV means talking about sex.

## **2.5 HIV AND AIDS**

The estimated number of children in sub-Saharan Africa living with HIV in 2009 is 2.3 million (UNAIDS, 2010a:27). Specifically, “South Africa has the highest number of children living with HIV in the world with an estimated 280 000 children below the age of 15 years living with the infection. The risk of HIV infection among children 15 - 18 years of age is predominantly through unprotected heterosexual intercourse” (HSRC, 2010: xix).

HIV stands for the human immunodeficiency virus. This virus can develop into acquired immune deficiency syndrome, also known as AIDS (Center for Disease Control and Prevention, 2010). Over 25 million people infected with HIV have died since the 1980s or the start of the epidemic (UNAIDS, 2010a:32). Over 1,000 babies are born daily with HIV, many of whom will die before they reach the age of two years if they do not immediately receive anti-retroviral medication (ARV). Children who are infected at birth may have difficulty entering adulthood as a HIV-positive person. Those who receive ARV medication in due time could decrease the chances of the child becoming infected and moving forward towards a HIV negative life.

There are two types of HIV. Both HIV-1 and HIV-2 destroy CD4+ T cells. These cells fight disease in the body and, with the HIV infection destroying the cells, the immune system weakens and there is a greater possibility

of other sicknesses. The majority of people in Africa are infected with HIV-2. Globally, some people are infected with both HIV-1 and HIV-2. If someone is infected with only HIV-2 they can live longer than those infected with HIV-1; furthermore, transmission of HIV-2 from mother to child is uncommon (CDC, 2010).

When HIV was discovered, there were many non-progressive policy decisions. By denying that transmission of HIV was linked to sex and drug-related conduct, many governments denied that a problem existed and that it was likely to become the worst epidemic of all time (Bowtell, 2007). During the 1980s and 1990s, not many countries dealt with the consequences of HIV and AIDS, so the infection spread and is now known as the biggest pandemic to have ever hit the world. The amount of people receiving antiretroviral drugs in low- and middle-income countries has increased 10-fold since the 1990s, exceeding 3 million people (UNAIDS 2010a:130). After realizing this, some countries formed a set of prevention strategies, which include the distribution of condoms, information, testing and clean needles (UNAIDS, 2010a:12). “Long-term success in responding to the HIV epidemic will require sustained progress in addressing human rights violations, gender inequality, stigma, and discrimination” (UNAIDS, 2010a:64). As mentioned above, many hate crimes take place in South Africa, resulting in deadly attacks caused by stigmatization and other violations.

“Young people aged 15–24 account for 45% of all new HIV infections, and many young people still lack accurate, complete information on how to avoid exposure to the virus” (UNAIDS, 2010a:96). Educational investment, backed up by policy support mandating primary and secondary education globally, would considerably decrease the risk of HIV and vulnerability for the population at hand (UNAIDS, 2010a:64). This implementation has to be properly assessed for the children in schools in South Africa. Although there are laws that attempt to keep children at school until matriculation or 18 years of age, the rate at which children stay in school, particularly after their parents have died of AIDS, is low.

The HIV and AIDS pandemic has changed since the 1980s. There is an increased understanding of how it is transmitted and of the fact that no one is secure against contracting HIV unless they take proper precautions, although no one is ever 100% protected. Eliminating the virus through education and acceptance is our greatest challenge and necessity.

### **2.5.1 HIV PREVALENCE**

There are roughly 49.9 million people in South Africa, 18.6 million of them below the age of 18 years (SAHRC & UNICEF, 2011:2). These children are defined as follows: 85% are Black African; 8% are Coloured; 5% are White; and 2% are Indian/Asian (SAHRC & UNICEF, 2011:2).

Africa is young, urban and poor. Approximately half of the population is under 15 years of age, and 34 of the world’s highly indebted countries are in Africa (*Protecting street children*, 2005). For every two people who begin taking antiretroviral drug treatment, a further five are newly infected. “The natural age distribution in many national populations in sub-Saharan Africa has been dramatically skewed by HIV, with potentially perilous consequences for the transfer of knowledge and values from one generation to the next” (UNAIDS,

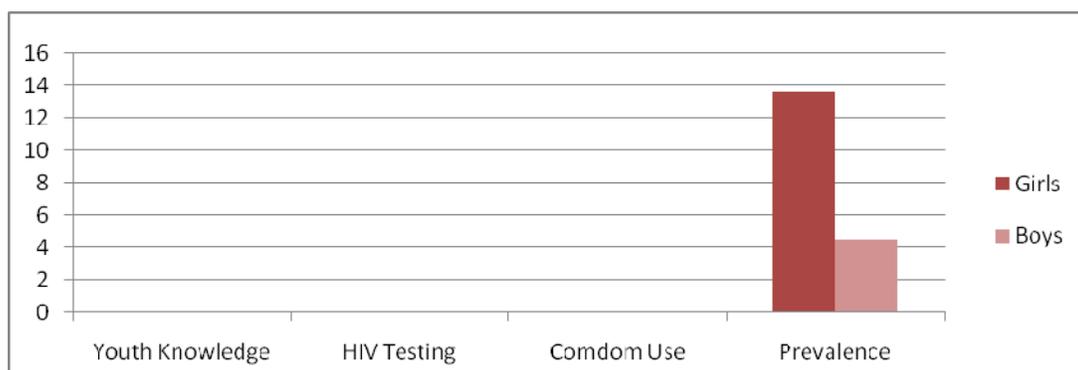
2010a:13). “Child poverty was reduced by 13 percent between 2004 and 2008” (SAHRC & UNICEF, 2011:4). Almost 11.9 million individuals under 18 years of age (64 % of all children) exist in poverty. Two provinces in South Africa, Gauteng and the Western Cape, include child poverty rates below the national average (SAHRC, 2011:4).

Since 2000, it seems that the number of adults worldwide who are infected with HIV has leveled out (UNAIDS, 2010a:30). On the other hand, infant mortality rates in South Africa for children under the age of 5 years have risen from 44 to 48 and 56 to 67 fatalities for every 1 000 births from 1990 to 2008 (HSRC, 2010:xvii). Sadly, these cases are mostly preventable and are caused by “AIDS (35%), neonatal causes (30%) and pneumonia and diarrhea (17%)” (HSRC, 2010:xvii). Owing to the lack of accessible healthcare as discussed above, these preventable deaths are common.

Although the percentage of infected people has stabilized over the past eleven years, the number of people with HIV has gradually increased and new infections continue to outnumber AIDS-related deaths (UNAIDS, 2010a:30). Interestingly, very limited HIV data is obtainable from children. Generally, data is captured from antenatal clinics, including from pregnant females approximately 15 years of age and above; the majority of ‘national population based surveys’ counting HIV examinations consist of adults only. Children’s HIV status is therefore commonly modeled on HIV predominance in females (UNAIDS, 2010a:37). This deficiency in information means that we are unable to address all the concerns related to HIV-positive youth, such as how to prevent further spread, because the avenues of transmission are unknown.

The frequency of HIV decreased in 33 countries by approximately 25% from 2001 to 2009. Although young people’s knowledge about HIV is increasing, this must improve (UNAIDS, 2010a:9). The knowledgebase has to increase in countries with the highest infection rates, such as in sub-Saharan Africa. These countries include Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe (UNAIDS, 2010a:8). These countries have stabilized or shown signs of decline, which is an extremely positive development, but the knowledgebase in some places is unknown or very low, which should be verified and addressed.

**Chart 1: Young People on knowledge, testing, behaviour and prevalence:**



Derived from: (UNAIDS, 2010b) Key: White columns means there is no data on this subject.

The chart above shows four major factors that contribute to the transmission of HIV. These four topics are youth knowledge, HIV testing, condom use, and prevalence. The white space in this chart represents unknown data.

In sub-Saharan Africa, more women than men are living with HIV; females 15–24 years of age are up to eight times more likely than men to be HIV-positive (UNAIDS, 2010a:10). This may be because, in many countries, nations and territories in Africa, monogamy is not practiced, so if one man is infected and sleeps with six different women on a regular basis, the women may be unable to ask the man to use protection because of their inequality. This sets up a platform for HIV infections and dehumanization. About 40% of all adult women with HIV live in southern Africa (UNAIDS, 2010a:28). Protecting females from HIV includes defensive actions against gender violence, encouraging economic independence and education on protection in sexual practices and knowing women’s rights (UNAIDS, 2010a:10). It is thus necessary to see what needs to be done in order to protect women from becoming infected, as stated above by UNAIDS. Education and independence from sexual exploitation and understanding women’s rights to their own bodies is necessary for the women of Africa if they are to protect themselves from HIV infection. This knowledge and power may also help women in their everyday experiences through enjoying their femininity and right of ownership of their body and life choices.

**Table 2: HIV prevalence (%) by province 2002-2008:**

Province	2002	2005	2008
KwaZulu-Natal	11.7	16.5	15.8
Mpumalanga	14.1	15.2	15.4
Free State	14.9	12.6	12.6
North West	10.3	10.9	11.3
Gauteng	14.7	10.8	10.3
Eastern Cape	6.6	8.9	9.0
Limpopo	9.8	8.0	8.8
Northern Cape	8.4	5.4	5.9
Western Cape	10.7	1.9	3.8
National	11.4	10.8	10.9

Derived from: (Averting HIV and AIDS, 2010)

The chart above shows the prevalence percentage by province in South Africa. The prevalence has decreased noticeably in most of the provinces listed above. Furthermore, one can infer from the chart that the lowest known prevalence rates over the years have been in the coastal regions like the Western Cape, the Northern Cape and the Eastern Cape. The chart below states the estimated prevalence of HIV among young South Africans.

**Table 3: Estimated HIV prevalence (%) among South Africans aged 2 years and older, by age, 2002-2008:**

Age	2002	2005	2008
Children (2-14 years)	5.6	3.3	2.5
Youth (15-24 years)	9.3	10.3	8.7
Adults (25 and older)	15.5	15.6	16.8
15-49 year old	15.6	16.9	16.9
Total (2 and older)	11.4	10.8	10.9

Derived from: (Averting HIV and AIDS, 2010)

The tables above indicate the prevalence of South African youth and young adults. The two tables have been separated into province and age. In the table reflecting age, the prevalence is changeable throughout 2002 and 2008. Nevertheless, the estimated HIV prevalence among South Africans seems to be the highest between the ages of 15-49 years of age.

Although knowledge campaigns are becoming more numerous, correct knowledge on HIV and AIDS is still low (Avert, 2010). Another reason that knowledge of and education on HIV and AIDS are not known or advertised is that, worldwide, over 80 countries have laws against same-sex behaviour. Such laws are prejudiced and unjust, even though this is discriminatory. HIV positive individuals feel the need to hide their condition, so the virus is not spoken about. This is dangerous because it inhibits proactive attempts at encouraging prevention, testing, treatment and support (UNAIDS, 2010a:10). The researcher believes that stereotyping and rejecting one's health and personal preference in any respect is unreasonable. Individuals have the right to express themselves until there is a possibility of direct harm to another individual. Being open and helpful to others' needs and feelings would help open up communication and extend education, and would in turn create greater knowledge and answer questions for those in need.

In 2009, between 5.4 and 5.8 million people were living with HIV in South Africa, so that this country's epidemic remained the largest worldwide (UNAIDS, 2010a:28). South Africa, in addition, is one of a few countries where both child and maternal deaths have increased since the 1990s (UNAIDS, 2010a:8). "The high dropout rate in South African schools could also compromise effective HIV and sex education" (Avert, 2010). This dropout rate could be contributing to the fact that AIDS is the main source of maternal fatality in South Africa and moreover is the cause of approximately 35% of children's deaths among children below five years of age (UNAIDS, 2010a:29). South Africa, as the largest infected nation worldwide, is a cause for concern for program implementation both inside and outside schools. Due to the large number of AIDS-related deaths in South Africa and the high transmission rate from mother to child, there are many children without parents. These HIV positive children have resorted to living on the street with limited medical coverage, if any.

It is necessary to address sexual behaviour in order to prevent HIV through sexual transmission. Multitudes of new infections in sub-Saharan Africa occur through unprotected heterosexual intercourse and can be transmitted to newborns during pregnancy or through breastfeeding (UNAIDS, 2010a:30). Across all age

groups and sexes, few people understand that condoms and fewer sexual partners lower the risk of infection (Avert, 2010). In 2010, the World Health Organization revised the treatment guidelines, which recommended that individuals with a CD4 count of below 350 cells should receive antiretroviral therapy. As a result, the number of people living with HIV increased and those who qualified for treatment increased in number by approximately 50% (UNAIDS, 2010a:96). The understanding of prevention is limited, so the cell number was lowered in order to try to lengthen the lifespan for individuals infected with HIV. Hence, it is necessary for children living on the streets to be aware of these possible transmissions, such as sleeping with street workers without protection or having multiple partners. These children also need to be aware that their status matters, and to know whether they are positive or negative and to take the necessary precautions so as not to spread or contract HIV.

## **2.5.2 MEANS OF TRANSMISSION**

HIV exists in the bodily fluids of an individual who is infected with HIV. These bodily fluids include “blood, semen, vaginal fluids and breast milk” (UNAIDS, 2011a:1). For the transpiring of HIV two things need to take place, the virus has to find a way into the blood stream and the virus must take hold (Van Dyk, 2008:34). The transmission of this virus, as indicated by UNAIDS (2011a:1), is by the following means:

### **2.5.2.1 SEXUAL TRANSMISSION**

Sex without protection, including vaginal, anal and oral sex with an individual who is infected with HIV also those individuals who have other STI’s are more prone to being infected with HIV (Van Dyk, 2008:34, 35). Women have a greater possibility of becoming infected than men for numerous factors including socio economic status, although during unprotected vaginal intercourse during menstruation woman are highly infectious due to the high presence of HIV infected blood (Van Dyk, 2008:35). Mathews (in Karim & Karim, 2010:157) estimates that South African youth usually become sexually active between 12 and 14 years of age. Therefore, there are many opportunities to become infected, those who live on the street regularly do not use protection and engage in sex for money, other goods or to feel accepted and will abide by the paying individuals request to use protection or not.

### **2.5.2.2 EXPOSURE TO BLOOD**

This section includes any exposure to blood or blood products, including blood transfusions, occupational exposure, contact sport, needle stick injuries, fights, sharing of needles or any other exposure to the blood of an infected individual. Individuals who share syringes and needles for drug use have a high risk of being infected with HIV because the needles are usually injected directly into the bloodstream (Van Dyk, 2008:39 & Leggett, 2010:240). Van Dyk (2008:41, 41) admits that South Africa is gradually developing into a common point of destination for drug trafficking and this method of infection can therefore become an increasing problem.

Moreover, heroin use in South Africa has been on the rise since 2000 and continues to increase (Leggett, 2010:242).

### **2.5.2.3 BLOOD TRANSFUSION**

Concerning blood transfusions, South Africa is one of the African countries with a safe, reliable blood transfusion service. There is a 90 to 95 percent chance that if someone receives blood from an HIV positive person that they themselves will become infected (Van Dyk, 2008: 38). Blood is now also more closely monitored when used for donation purposes, yet the six-month window period still makes it challenging for such services (Van Dyk, 2008:39). The following is a list of possible ways of being exposed to blood products of an infected person. A person who has in the past six months: had multiple sexual partners, had sex with someone who's sexual activities are unknown, men who have sex with men (MSM), homosexual intercourse, had sex for money, or other material goods, has STI's, had accidental exposure to blood or bodily fluids, has been raped, has injected drugs, or has had previous blood transfusions (Heyns & Swanevelder, 2010: 229). Therefore, knowing the status of an individual who you are receiving blood from or sharing needles with is of crucial importance.

### **2.5.2.4 MOTHER-TO-CHILD TRANSMISSION**

Mother-to-child transmission can occur during pregnancy, in childbirth or through breastfeeding when the mother is infected. This is one of the foremost causes of HIV infection in children (Van Dyk, 2008:41). If preventative measures are not taken, approximately 20 to 40 percent of babies born from HIV positive women are infected (Van Dyk, 2008:41). The risk factors of the child becoming infected include the severity of HIV, the delivery process and breastfeeding including the breast milk viral load, duration of breastfeeding and breast abscesses (Coovadia, 2010:205).

Although South African mortality rates among mothers and children have increased, the elimination of mother-to-child transmission is achievable. In 2009, some 370 000 children became infected with HIV within the prenatal to breastfeeding period. This number decreased from 2001 when the number was 500 000 (UNAIDS, 2010b:9). All these ways of transmitting HIV are preventable. If street children were to be aware of this information, they would be aware of the protocol necessary to keep their baby healthy in the event of pregnancy. There has been a lot of back and forth banter in South Africa about breastfeeding. On one hand, there are many benefits for the child, yet, if the mother is not receiving ARV medication and counseling when breastfeeding the child may become infected (WHO, 2011b). This is a dilemma, especially in a country with many health care obstacles, including the lack of access to safe drinking water and electricity for many South Africans. In other words, the argument is that bottle-feeding could be more detrimental to the health of the baby than breastfeeding, due to use of unsterilised bottles and water, making the baby more susceptible to diarrhea.

The means of transmission of HIV in South Africa, which is the highest, is heterosexual intercourse. There are many other ways HIV can be transmitted but they are less common, such as cases where professionals suffer a needle-stick injury. The important message that should be propagated is that each individual should take responsibility for their actions, for instance having unprotected sex with an individual whose sexual history is unknown to you, is risky. In addition, as discussed previously, if individuals are in a motor vehicle accident or a fight, blood may be mingled and if one person is HIV positive, the others could be at risk and should be tested. If street children are aware of these possible dangers and risks associated with HIV, they could protect themselves by protecting themselves. Therefore, being educated and aware of the means of transmission could help to protect street children from becoming infected and knowing the risks of infecting others.

### **2.5.3 PREVENTION OF HIV**

Transmitting HIV is preventable. The effectiveness of some of the techniques for preventing HIV follows. According to the UNICEF (2010a), prevention methods can be followed in these ways:

- Know your HIV and AIDS status; get tested at least every six months if you are at risk.
- If you have HIV or AIDS, get treatment and support; go to a clinic or hospital and receive counseling.
- If you are pregnant and HIV positive, get treatment to reduce the possibility that your baby will contract HIV and in this way continue the fight against mother-to-child transmission. Approximately 370 000 children were infected with HIV in 2009 (WHO, 2011a:1). Risk of mother-to-child transmission could be reduced if the mothers took ARV medication before giving birth. A caesarian birth is also advised, as is direction on breastfeeding (UNAIDS, 2011a:1).
- Use latex condoms or abstain. Lambskin condoms are porous and give less protection. Condoms are highly effective and should be used whenever engaging in intercourse. Correct use is of the utmost importance (UNAIDS, 2011a:1).
- Male circumcision reduces the risk of HIV transmission; the easiest time for this to be done is at birth (UNAIDS, 2011a:1).
- Do not inject drugs, or, if you do, use clean needles. Stop taking drugs, but if this is no possible never re-use the equipment and clean it properly before use. Cleanse the skin with alcohol and make sure the needles come from a dependable source (UNAIDS, 2011a:1).
- A lubrication gel, microbicide, is in the process of development for women to use during intercourse. Some say it will help if it is used properly, while skeptics say that increasing the amount of lubrication in the vagina may not have the desired result and will create a chapped wall lining, leading to the increased possibility of infection.
- If you are exposed to HIV, obtain treatment immediately, as ARV medication can prevent infection if taken at once.

HIV and AIDS continues to be the cause of immense suffering in South Africa, although there have been significant strides in the fight against it, particularly when it comes to the prevention of mother-to-child transmission and the importance of condom use (HSRC, 2010:ix). It is important for people to know their health status at any given point to protect themselves and others. Taking the initiative to know and take care of one's body is crucial in the prevention of HIV. Limitations in the health-care systems are slowing the progress of HIV treatment programs, emphasizing the need for action in strengthening the health systems (UNAIDS, 2010a:130). Consequently, if the health care systems are not appropriately educating even people who have money and status, how will it be possible to educate the street community on prevention methods? Education for the street community is the only way of reducing HIV transmission.

#### **2.5.4 SYMPTOMS ASSOCIATED WITH THE STAGES OF HIV AND AIDS**

When infected with HIV, the immune system weakens and further complications can occur. The first signs of the HIV infection are often enlarged lymph nodes. Below are further symptoms (University of California San Francisco, 2011a:1).

Symptoms of HIV and AIDS according to CDC (2010) linked to the stages of HIV in UNAIDS (2011b:2):

- Stage 1: Window period and seroconversion. The lymph nodes swell;
- Stage 2: Asymptomatic. Can include loss of weight and a cough;
- Stage 3: Symptomatic. Including diarrhea, fever, white blotches on the tongue, bacterial infections, tuberculosis. (If someone is in this stage, they may have AIDS);
- Stage 4: Advanced symptomatic. Includes 22 opportunistic infections or cancers related to HIV. (If someone is in the clinical stage 4, they have AIDS).

An individual can be infected with HIV and not experience symptoms for months or even for over 10 years; this is called the asymptomatic period (UCSF, 2011:1). Symptoms tend to disappear within a week or a month and can be incorrectly diagnosed as a different viral infection, yet children who are born with HIV tend to have symptoms two years from birth (UCSF, 2011:1). Having these symptoms does not always mean that an individual is infected, but if the symptoms persist it is essential to be tested. This is especially important if the person believes they could have been infected or been in a situation where transmission was possible, it is then important to get tested. People who are HIV positive and have these symptoms can often be helped with treatment and a healthy lifestyle.

The symptoms of these stages are not the only ones associated with HIV and AIDS. Below follows (Pinsky & Douglas, 2009:80,81) a list of symptoms as shown in *The Columbia University Handbook on HIV and AIDS*. These symptoms are often similar to those of a common illness, but if they are severe enough, it is necessary to see a practitioner:

- Fever: Temperature is above 100.4°F (38°C) for 48 hours or longer. Fever indicates underlying illness and is not dangerous in itself unless it is very high. Fever can be lowered with medication.
- Weight loss: Unexplained loss of more than 10% of your body weight. “Unexplained” means that there is no change of behaviour that would logically have caused the weight loss (such as dieting, exercising a lot, or not eating because you are depressed, anxious or in love).
- Headache : Headache is unusually severe (“worst headache ever”). The headache lasts much longer than previous headaches.
- Diarrhea: Three or four liquid bowel movements per day. Diarrhea is combined with increased frequency of defecation, stomach cramping, or loss of control of your bowels. Symptoms persist for more than a few days. There is a change in stools, and there is blood or mucus in the stool.
- Vaginal bleeding outside the menstruation period:
- Nausea, vomiting, marked loss of appetite: nausea or vomiting lasts for more than 1 day;
- Noticeable but inexplicable loss of appetite;
- Pain when swallowing: Pain lasts more than a few days, and may appear in the middle of the chest under the breastbone,
- Breathing (respiratory) symptoms: Shortness of breath goes on for more than a few days. Look out for unusual shortness of breath on exertion. If you can normally climb flights of stairs and you now notice that you must rest between flights, call your doctor;
- Coughing dry, nonproductive (no mucus) cough that goes on for more than a few days;
- Severe abdominal pain: Abdominal pain is accompanied by fever, particularly if you have a history of pelvic infection.
- Persistent colds or sore throats: Cold or sore throat goes on for three weeks or more:
- Night sweats: More than one episode of night sweats (pajamas and/or sheets drenched). A sweaty neck or scalp is not a night sweat;
- Mental changes: Recent onset of confusion or memory loss;
- Rashes over entire body: Localized rash lasts more than two days;
- Muscle weakness: Muscle weakness or loss of functioning on one side of your body;
- Change in vision: Blurred vision, blind spots, or increased floaters;
- Fatigue: Unusual and unexplained fatigue for more than three weeks;
- Vaginal itching or discharge: Symptoms are persistent or unresponsive to self-treatment;
- White patches or sores in your mouth: These symptoms can often be treated easily, but may be a sign of decrease in the immune function;
- Swollen lymph nodes: Nodes swell very rapidly, particularly if swelling occurs on only one side of the body;
- Purplish or discoloured area on the skin: Skin discolourations get darker rather than fading, get hard, or do not blanch when pressed.

Clearly, many of the symptoms are similar to those of a common cold, as indicated earlier, but the more you know about your body and the differences it is going through, the faster one would get to the doctor and start medication if necessary.

Understanding the CD4 count and the viral load if you are HIV positive or have AIDS is important in assessing how your body is coping with the disease or the medication. A T-cell count, which is also referred to as a T4 count, or in this study as a CD4 count, measures the presence of a certain kind of white blood cell (Pinsky & Douglas, 2009:52). When HIV-infected people are successfully treated with antiretroviral medication, CD4 cells gradually increase. AIDS CD4 cells drop below 200 (Pinsky & Douglas, 2009:56). When the viral load increases, the CD4 cell count decreases.

Understanding the symptoms associated with HIV is therefore crucial, especially if you are at risk. Knowing one's body and how it operates is essential to the fight for remaining healthy. If your body is behaving differently from the way it normally does, you should see a doctor. An infected person should stay abreast of the symptoms associated with the stages and the viral load count. Being aware of one's body and health equate with a stronger, healthier and longer life.

### **2.5.5 TESTING FOR HIV AND AIDS**

As discussed above, knowing one's status is crucial for living a healthy life, receiving medication, and, if positive, being careful. Unfortunately, in South Africa, when individuals undergo a test, it is often during a later stage of infection (Avert, 2010). "South Africa has the largest antiretroviral therapy [program] in the world, but given it also has the world's largest epidemic, access to treatment is low" (Avert, 2010). The stage at which someone begins antiretroviral therapy greatly affects his or her chances of responding well to treatment (Avert, 2010). It is important to understand one's body if one is to help it; there are many different tests available for HIV and AIDS. There are tests for individuals who want to know their status and there are tests for individuals who are organ donors and have passed away. The reason it is important to screen donors is that the virus must not be transmitted.

One should be tested for HIV if there is any risk of infection. Medicine can now delay AIDS more effectively and prolong healthy living (Pinsky & Douglas, 2009:43). There are numerous tests for HIV and AIDS detection, which will be clarified below. More often than not, the antibodies are tested rather than testing for the virus itself. Antibody tests are typically used for the following reasons: the test is less expensive, simpler to perform and interpret, standardized, and widely available (Pinsky & Douglas, 2009:43). Pinsky and Douglas (2009:43) also maintain that additional testing to detect the virus itself can be useful in specific cases.

Pinsky and Douglas (2009:44) describe antibodies as proteins manufactured by the immune system to indicate the presence of unwanted foreign material like bacteria or viruses. An HIV antibody tests blood and can determine if someone is infected with HIV by indicating the presence of antibodies to HIV. This type of test has an almost perfect rate of accuracy (Pinsky & Douglas, 2009:44).

Other HIV tests described by Pinsky and Douglas (2009: 46) are below:

- The rapid test: Many rapid HIV antibody tests produce results in less than one hour by testing blood or buccal tissue.
- Viral testing: These determine whether the virus is in the blood, and are referred to as polymerase chain reaction tests or nucleic acid amplification tests detecting RNA and DNA.
- Antigen Testing (p24): This determines the protein that is part of HIV and can be abundant early in the infection period.

Rules for HIV testing on children:

The Constitution of the Republic of South Africa No. 108 of 1996 (130) states that children may not be tested for HIV unless the following criteria are met:

- If it is in the best interest of the child;
- If consent is given by a caregiver, or test ordered by a child protection organisation, or head of a hospital;
- If a health care worker contracts HIV due to contact with the child;
- If any person contracted HIV due to contact with the child;
- If it has been authorized by a court;
- If the child is at least 12 years of age.

Understanding all the rules that go along with child protection is difficult, but they are there for an important reason. Although the child's needs, as indicated above, should always be paramount, some of the rules may seem to inhibit them. For example, many of these rules consider the health of others rather than the child.

It is necessary to be tested at least once a year or once every six months for individuals who are at risk of HIV, including those who have multiple partners or are shared-needle users. Being aware of the tests available is important and people can select the most effective method for themselves. The researcher maintains that being prepared and having a social worker or therapist who is trained in acclimatizing individuals to their potential new status is helpful. For this reason the researcher does not advise home testing kits unless someone is undetected and would like to stay informed on their status, although this is not relevant in most parts of Africa. Advancement is uneven and the future of the epidemic is not known, so there is a need to increase action to improve universal access to prevention, treatment, care, and support in relation to HIV and AIDS (UNAIDS, 2010a:12). When there is more emphasis on the necessary areas of HIV, as discussed above, the changes may become more stable and effective. For children living on the streets to be educated and aware of the different types of testing and their rights according to the Constitution would be helpful in decreasing the transmission rate among their community or those who carry out sexual acts with them. One can thus conclude that, in the HIV and AIDS section, education for street children is necessary and not as widely available as is indicated in the laws of the country.

## 2.6 SUMMARY

The aim of this chapter is to understand the primary aspects of this study, street children, sexuality and HIV and AIDS, as well as how they interconnect. Street children and how they cope with their realities, sexuality and how it relates to life and culture, as well as HIV and AIDS and how it is transferred, detected and prevented are all discussed. Clearly, there have been studies focusing on these topics, but the street children's knowledge of these and where they obtain their information is lacking or unknown.

The following chapter will focus on a profile of the participants as well as the research findings.

## CHAPTER 3

### RESEARCH FINDINGS

#### 3.1 INTRODUCTION

This chapter explores three aspects of the study: the methodology followed, a biographical description of the street children who participated in the study, and the research findings emerging from interviews investigating the knowledge of sexuality and HIV and AIDS among street children in Pretoria, South Africa.

#### 3.2 RESEARCH METHODOLOGY

The research study followed applied research approach and qualitative approach. The researcher used interviews and an interview schedule to gather data from street children on their knowledge of sexuality and HIV and AIDS. This study allowed the researcher to enter into the lives of these children living and/or working on the street, and to gain an insight into the children's knowledge base.

The researcher used a case study research design. Specifically, collective case studies were used and 15 separate interviews were conducted with street children in Pretoria, South Africa. Each case gave their own insight into sexuality and HIV and AIDS, making it possible to compare each individual case and correlate the findings. This in-depth analysis allowed the researcher to explore each of the street children's thoughts and views.

##### 3.2.1 SAMPLING PROCEDURE

Initially it was rather difficult to secure participants. However, the researcher lives in the Hatfield area close to where one young man in particular guards cars and is highly respected by his peers, the street children. This individual accompanied the researcher for the first two days to find the first participant and then to have others suggested, using probability snowball sampling. This allowed the street children to understand that it was safe to go with the researcher to the venue. Initially, many of them were hesitant, and did not want to talk or answer questions because they were afraid of getting into trouble for providing information. After being assured that it was confidential, they opened up. As the researcher walked around and conducted more interviews, the children began to notice her in the area, and felt more comfortable in her presence. The researcher's increasing 'street credit' made it acceptable to be part of the study. The researcher would hear earlier participants say, "Did you talk to her yet?" "Oh, I did yesterday." If the other street children asked what it was about, they would reply with, "I'm not going to tell you, you have to talk to her yourself." By the third day of the interviews, the children were full of enthusiasm, running up to the interviewer to ask whether they could be part of the study.

Many of the participants knew or recognized each other. The street community, although large, seems to be aware of others in the same predicament. This helped the sampling process, because by word of mouth and asking other participants where the researcher could find others, the snowball effect sampling procedure worked perfectly.

### **3.2.2 DATA-COLLECTION METHODS**

The researcher obtained an appropriate venue to use for the interviews from the Department of Social Work and Criminology at the University of Pretoria in order to have a quiet, safe facility for her and the participants. Next, the researcher went to the security personnel at one of the main entrances to the University and explained the project to the security guards employed by the university. These guards check individuals and cars as they enter and leave the campus, and they allowed the researcher access with the participants.

The researcher then walked around the Hatfield, Brooklyn, Colbyn and Sunnyside areas looking for participants who met the sampling criteria. The previous participants pointed out likely candidates. Once a potential participant was found, the researcher would explain the research and, if they were interested in voluntarily participating, the researcher would walk the individual back to the university or set a time to meet in front of the university at the previously chosen gate. Once the researcher and the participant were at the university, the security guard would monitor what the participant looked like, noting the time to ensure that both individuals were accounted for. The researcher then went to the venue and read the contents of the letter of assent to the participant. If the participant agreed to take part in the study voluntarily, the participant and the researcher both signed the letter. The participant received a copy of the signed letter with the researcher's contact details in case any further inquiries were necessary. The researcher then turned on the tape recorder with the permission of the participant and began the interview. The research was conducted by means of a semi-structured interview, which allowed the researcher to probe and ask additional questions, with reference to the interview schedule if necessary. After each interview, the researcher debriefed the participants. The researcher would then walk the participant back to the university exit with the knowledge of the security guard, and the process would continue until all the participants had been interviewed.

The street children were unexpectedly willing to answer questions and were profusely grateful to have someone talk to them as if they were a human being and not 'a rat'. As a result of this, there was a steady daily flow of children who were willing to participate.

### **3.2.3 DATA-ANALYSIS**

The researcher transcribed the tape-recorded interviews, and after, the comments were analyzed. The data showed participants' experiences and the researcher has placed their responses within quotation marks in order to present a verbatim account of what the children said. Themes and sub themes were identified from the children's responses.

As stated in Chapter 1, there is a process to be followed in qualitative data analysis. Although it does not have to evolve in a specific order, Creswell (in De Vos, 2005:334) listed the points that should be touched on. These are:

- Planning for recording data

The researcher planned the data recording by using a tape recorder and by writing down field notes on interesting points after the interview. The researcher's interview techniques seemed to work without difficulty. This was clear in the pilot study, when two participants chosen with the same sampling criteria were interviewed in the same venue, using the proposed interview schedule. They did not partake in the main study.

- Data collection and preliminary analysis

The researcher provided a quiet, private and safe location for the interviews, which was a venue attached to the Department of Social Work and Criminology at the University of Pretoria. The interviews were conducted according to the interview schedule and a tape recorder.

- Managing or organising the data

Organisation is an important aspect of notes and data. The researcher's field notes were complete, properly labeled and copied onto an additional USB. The participants remained anonymous, and were referred to by pseudonyms. A number was allocated in the order in which they were interviewed. In some cases, the location they named, such as where they slept, has also been changed for safety's sake. The researcher also prepared copies to be stored in the Department of Social Work and Criminology, University of Pretoria, for 15 years, as required. The notes were labeled by colour to refer to the themes and sub themes according to the responses. Each participant was represented by an individual colour in order to connect them as individuals and make the reading more appealing to the eye.

- Reading and writing memos

The researcher became familiar with the analyzed data by reading and listening to the responses a number of times. This familiarisation with the information was very helpful in the organisational process.

- Generating categories, themes and patterns

The researcher has categorized the findings and created themes that emerged from the responses. The themes and sub themes identified were marked with coloured highlighters in the notes.

- Coding the data

The researcher incorporated a number of coding schemes into the note-taking process, such as abbreviations and numbers, in order to create an integration of information and understanding.

- Testing the emergent understandings

The researcher went through all the data and evaluated its usefulness for incorporation into the study.

- Searching for alternative explanations

Although some patterns may seem obvious, the researcher searched the layers of information provided and identified patterns in order to group data by other linkages and gain a better insight into the responses.

- Representing and visualizing

The researcher developed clear representation for the data collected.

The above process led the researcher to organise the data and to remain focused. It allowed the researcher to look in-depth at the research after collection. Scenarios and themes were created to better understand and explain the responses. Whilst writing the report it is important to remain aware of trustworthiness and avoiding researcher bias. Strydom (In De Vos, 2009:63) says this can be done through not concealing media and making the participants aware of tape recorders and so on, protecting their privacy is crucial and has been done in this study by using numbers, also, the research must be carefully explained and the respondents' rights adhered and listened to, which was strived towards in the study, using the letter of assent.

### **3.2.4 PILOT STUDY**

The researcher conducted two pilot tests. The participants met the same sampling criteria as those used in the study. The pilot interviews did not feature in the research findings, but were conducted to ensure that the participants would understand the questions and make any necessary adjustments to the interview schedule if needed. The two pilot interviews allowed the researcher to discover appropriate points at which to probe the participants and be aware of possible highly emotional junctures in the interview schedule where the researcher should be more sympathetic. This also allowed the researcher the opportunity of realizing when to explain a question and when to listen only to what their personal thoughts and beliefs and definitions were. At the end of the interview schedule, under a section on 'questions or comments', the researcher asked the participants their reasons for wanting to come and answer the questions. These minor adjustments to the interview schedule allowed the researcher to obtain better information with interesting results.

### **3.2.5 ETHICAL ISSUES**

According to Kumar (2005:212), there are many ethical issues concerning participants in research, and the researcher followed the ethical issues derived from Strydom (2005a:58-66):

#### **3.2.5.1 AVOIDANCE OF HARM**

Strydom (2005a:58) states that participants can be harmed in a physical or emotional manner, particularly emotional in regards to social sciences. In order to avoid this, the participants were told about the exact purpose of the study before their interview. The researcher told them that some of the participants could possibly find certain topics emotionally difficult to discuss. Being honest with them made the participants aware of any possible harm, so they could decide for themselves whether they wanted to continue with the interview process. As pointed out above, the participants were required to give voluntary assent, and they were debriefed after the interview.

### **3.2.5.2 INFORMED CONSENT**

The researcher remained ‘aware of hidden intentions’ (Strydom, 2005a:60) and told the potential participants that they would not be receiving any compensation for taking part in the study. It was challenging for some of the participants to accept this, because the researcher was, after all, taking them off the street where they had the opportunity to make money. The researcher did lose potential participants when they understood that they would not be receiving money or goods.

The researcher read the letter of assent aloud to each participant and then discussed any queries. Each participant voluntarily signed a letter of assent and received a copy of the signed document.

### **3.2.5.3 DECEPTION OF SUBJECTS AND/OR PARTICIPANT**

Strydom (2005a:61) believes that a line can be drawn between deliberate deception and deception the researcher is unaware of. In order to evade both deliberate and unknown deception, the researcher did not find participants by giving out false information about the study, but made each participant aware of the true nature of the study and the information required.

### **3.2.5.4 VIOLATION OF PRIVACY/ANONYMITY/CONFIDENTIALITY**

This study treats privacy, anonymity and confidentiality very seriously. All individuals have the right to their personal information remaining private and providing anonymous data ensures the participants privacy (Strydom, 2005a:61). The participants were aware of the tape recorder, as it had been discussed in the letter of assent and was placed directly in the middle of the table to be visible all the time. The participants were therefore aware of all the devices being used. As stated above, the researcher did not use the names of the children during the interview. They are referred to as participants and some of the locations indicated by the participants were then changed in the research report, but the originals remain in the field notes and ‘tape’ recordings.

### **3.2.5.5 ACTIONS AND COMPETENCE OF RESEARCHER**

The researcher is adequately skilled, and believes that the interview process was a success. The researcher is confident that more than eleven years’ experience in working with children in counseling and teaching, accompanied by a six-year passion for working with individuals infected and affected by HIV and AIDS, as well as passing a postgraduate module in research methodology, is an adequate background for conducting the study professionally, competently and ethically. The researcher also received guidance from her supervisor at the university. The researcher passed no value judgments and was sensitive to all cultures and individuals in the interview process (Strydom, 2005a:63).

### 3.2.5.6 RELEASE OR PUBLICATION OF THE FINDINGS

The researcher has produced an accurate report without altering the information to create a biased result; some words may have been changed to ensure that the reader understands the response. Sources are referenced and the researcher debriefed each participant to make sure that the participants came to no harm (Strydom 2005a:66). The findings are presented in this mini-dissertation.

### 3.2.5.7 DEBRIEFING OF PARTICIPANTS

Debriefing sessions allow the participants an opportunity to work through their experiences in the study, the researcher rectifies any misperceptions and then the researcher sensitively brings the session to a close after all possible harms are dealt with (Strydom, 2005a:67). On completion of the interview schedule, each participant was taken back through the questions. Any information they did not understand or fully answer in the interview process was explained. Any personal traumas that arose in the interview were discussed and the children were given directions on how to contact social workers or therapists in their area. The researcher gave them her contact details for any further help that they might need.

## 3.3 PROFILE OF STREET CHILDREN IN PRETORIA, SOUTH AFRICA

A biographical background of the participants is provided below. The participants gave the researcher details about their lives on the street prior to the findings on the knowledge of sexuality and HIV and AIDS. The researcher is sharing some of this information to familiarize the reader with the profile of the 15 street children that were used for this study in Pretoria, South Africa. Therefore, supportive literature will be intertwined in the themes and sub themes section after the discussion of the profile of these participants. The interviews were open to street children between the ages of 12 and 17 years. Below is a chart displaying the sex of the children interviewed by the researcher and the number of participants who were found and interviewed within each age category.

(Please note that parentheses used in the participant's explanations below are to help clarify situations with greater ease. Meanwhile, brackets are used to change a word for better understanding or for confidentiality. For example, in reference to never meeting one's father a child may say "never" yet to understand the situation the researcher will add (I have never met my father). Then, if brackets are used, the researcher has changed a name of a person or place for anonymity purposes or the child said "with" and meant in, the researcher will produce the following sequence: [in].)

**Table 4: Participants age and sex:**

Age	Number of participants	Sex
14	1	Male
15	3	Male
16	3	Male

17	8	Male
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Of the 15 participants interviewed, 10 live permanently on the street. Either they have nowhere else to go or they do not want to go anywhere else. The other five have a house, a shelter, a shack or a squatter camp to go to when they have enough money for transport to go home. It can sometimes take days, weeks or even months to collect this amount of money, and they live on the streets while collecting it. The following sections reveal information provided by the children interviewed about their lives on the streets. This includes factors of street life, personal reasons for going to the street, feelings associated with living on the street, working on the street, detainment, support, cleanliness, sleeping habits, drugs, alcohol, family, friends and returning home. These sections give an in-depth view of these 15 children's lives.

### 3.3.1 WHY CHILDREN GO TO THE STREETS

Children have numerous motives for fleeing to the streets. The quotations below give various reasons for children being on the streets in South Africa:

#### Participant 1

"There are many consequences about life. I can see someone in the street I don't know what have done in the home there are family matters, others are crisis family matters, someone parents they left them and they go, they don't know where their parent are, they don't know other relative of them or other families you see. There are many South African children in the street, others it's the child abuse in fact children to run away at home they go all of this place, others they steal at home, they get shy to beg at home they say I must leave here ... If you make wrong it is a wrong you must correct to be right to be a correct child in life, you see the life of now is too hard you must learn and go to school it's the key of success you can live nicely in the life, your life would be easy."

#### Participant 2

"We stay in the street because we don't have parents and we don't have a family, that's why we don't have someone that can help us stay in the houses we don't know where we must go that's why we stay in the street."

#### Participant 3

"Because some other people don't have parents, other they are suffering at home other they use it for drugs, other just for their needs actually to have their own money to buy what he or she wants, because I not ask my mum for money."

#### Participant 5

"Eish, because many fathers and mothers abandon their children."

#### Participant 6

"To buy clothing for their children, to get something to buy the food and the clothing's and the clothes of the school you see."

#### Participant 7

“Because maybe a lot them their parents passed away and they are orphans some they fight with their parents. And drugs.”

Participant 10

“Because I can say in South Africa there is a lot of poverty, people don’t like each other they don’t take care of each other. In our colour, black people don’t really help each other, mostly black people they don’t like to help each other, because white people are the people who help us mostly that is the truth.”

Participant 11

“Because others they suffer, like me for instance, I was living with my parents, and then they divorced and then they died were living in a shack at a squatter camp.”

Participant 12

“Because their parents some of them dies, some of them just left them and threw them out. The parents are dead maybe accidents or diseases you don’t know sometimes, others maybe there are problems at home.”

Participant 13

“They are not the same, others they don’t have parents others came to the street because of drugs other then come to make crime at the street others they don’t have food, they don’t have parents.”

Participant 15

“It is because of lack of financial work and more poverty than some other countries you see.”

These are not all of the reasons why there are street children in South Africa, and the participants have repeated ideas. The participants suggest that the primary reasons for the existence of street children are:

- Parents abandoning their children;
- Parents dying;
- The need for money;
- Suffering at home;
- Child abuse;
- Drugs;
- Poverty.

These factors explain why street children think there are street children in South Africa. They have most likely spoken to other individuals on the streets and heard stories about why others have come to the streets. They have also provided some of their own reasons, possibly derived from personal experiences.

Next, the participants explain factors of street life.

### 3.3.2 FACTORS OF STREET LIFE

Considering how street children view themselves and other individuals on the streets may allow the reader to become aware of their situation and better understand them as individuals. The participants define street children according to the following characteristics and circumstances:

### Participant 1

- No home;
- Lives on the street;
- Eats food out of the waste refuse;
- Helps other street people;

### Participant 3

- Looks for money;
- Helps family buy food;
- Fulfills own needs;
- Too young to work anywhere else;
- Failed school;
- Guard cars.

### Participant 4

- Guard cars;
- On drugs;
- Do not work;
- Do not wash body or clothing.

### Participant 7

- No home;
- No parents;
- No support;
- Not well groomed;
- Someone who is in a lost state of mind and does not know what he/she is doing with his or her life.

### Participant 8

- No food;
- No money;
- Guard cars;
- Support younger siblings;
- Abandoned.

### Participant 10

- No support or care from others;
- Treated like criminals;
- Difficult to live in the street.

### Participant 11

- Someone who suffers in the home he comes from;
- Run away from home;

- Some like to stay on the street for freedom;
- No food;
- No money;
- Ask for food and money from others.

#### Participant 13

- Family members passed away;
- No food at home;
- Other family on the streets;
- Beg for money.

#### Participant 14

- Does everything for themselves;
- Not taken care of by parents;
- Experiences life alone.

#### Participant 15

- Lives on the streets;
- Begg people for food;
- Looks for shelter;
- Smoke drugs;
- Looks for money.

When reviewing these points, one may be able to distinguish how street children feel about themselves or others who also live on the street. These observations could have been derived from what they have seen or experienced on the streets. There are recurring factors, which are cleanliness, food, money, work, family, lack of support, helping others on the street and drugs. Because these points recur, it probably shows the prominence of these aspects of their lives.

### 3.3.3 PERSONAL REASONS FOR GOING TO THE STREET

#### Participant 1

“Me I come to street to get something to eat at home I made plan to get place where I can stay, I have a step father I am not his child, my mother, my parent is my parent. It’s his home, he buy it, when I want to go I can go.”

#### Participant 2

“Because I don’t have a house where I can go that’s why I must live in the street because no one can help me.”

#### Participant 3

“That’s guys that I work with told me come maybe we can make something to satisfy our needs, but you see there is no job here.”

#### Participant 4

“I (lost my job) so I came here to see if I can make some money.”

Participant 5

“Cause (after my mother died) I had no where to stay no accommodation.”

Participant 6

“I am suffering my mother and father cannot afford to buy the clothing for my sisters I am not going to the school you see. I am the only one (that works) I buy the clothes for them. My mother is not working my father is not working. I try to give them all R10 or R7 or R5 I must try to keep money to give them every day.” (R1 is approximately 0,15 USD).

Participant 7

“After my parents died I came.”

Participant 8

“Eish long time, because I must live there in the street because I didn’t get the food you see and I didn’t get the job that’s why I come in the street. I work for my small brothers, because you see my parents she leave us.”

Participant 9

“At the school I didn’t have pocket money it was a problem. [I] matriculated.”

Participant 10

“Inside the house, as I said my mother passed away and my granny and I lived with my aunt and even the husband of my aunt said we can’t eat saying we should work because I am the oldest, I have to be like a slave in the house so I think about my younger brother and I take him from there that’s why I take him to the street.”

Participant 11

“After my family no longer wants me I have to go and stay somewhere alone.”

Participant 12

“Since my brother came with his wife there but eish I think maybe she don’t like me I don’t know she is always telling him I saw stealing and she is lying I never did that she doesn’t want my brother and I to be happy, my life is my brother.”

Participant 13

“Because I didn’t have a family anymore, my brother is 13 years (I have for him he does not go to school).”

Participant 14

“I didn’t get along with my step father.”

Participant 15

“It is because when I don’t have money to return back home its expensive to go home R46.”

Above are the personal reasons why these particular street children have decided to live and/or work on the street. Each child’s reasons are different, yet there are underlying recurrent matters that lead to the children’s need or desire to come to the street. These underlying matters are family, death and money.

### 3.3.4 FEELINGS ASSOCIATED WITH LIVING ON THE STREET

Children go to the streets for a variety of reasons, as shown in the section above, and they harbor different feelings about this. Some feel that it is a better environment than their homes; others feel that they have nowhere else to go. Below are some of the mind-sets derived from street children in Pretoria, South Africa based on how they feel about living in the street.

#### Participant 1

“It’s not right to live in the street, how can the human being can live the street, people are living in the house look their plasmas making the play station. Something you want to do you do if you want to bath you bath if you want to do a cappuccino you make. It’s a nice life. When I live in the street there is nothing you can say in life that’s going on, you life just a small, what must I say like a cockroach it’s not nice.”

#### Participant 2

“Since now at least maybe I try but myself they chased us out of the house when my mom died.”

#### Participant 3

“It’s enjoyable for me because I am helping other people for their cars to be safe you see.”

#### Participant 6

“I don’t like that job the problem is when I am staying just there at home I can check the cars I am suffering my shoes is finished not enough money I try to do other things you see it’s not enough for all my problems.”

#### Participant 7

“I feel sad, worried, angry. Because that’s the life somebody has to live I think I deserve better a home like everybody else a home, parents.”

#### Participant 8

“It’s not good.” (This participant was extremely emotional, he wept, we took an intermission in the interview process, he then decided to continue on).

#### Participant 9

“I don’t like that job because I am suffering, I don’t even have a Mielie Meel at my place. Even now I was taking money from other people saying I could give them when I come back you see.”

#### Participant 10

“Very bad, we wish to be nice and get work and be nice, enjoy ourselves even us, even us we are human beings and people take us.”

#### Participant 11

“Now, it’s been a long time I don’t even feel it, it’s like its home for me I have lived here for a long time.”

#### Participant 12

“Eish very bad, ‘not nice. Because people sometime they tell me to go and wash, to look for a job to go to school others they just look at me like I am maybe paper or something (referring to trash) very sad, it’s not nice.”

#### Participant 13

“It’s bad, it’s not okay we don’t have something to sleep just sleep over the box and plastics we don’t have blankets it’s okay okay to stay in the street.”

Participant 14

“Living on the street is very challenging but in the same time it is a life that everyone that is living on the street likes because there is no one telling you what to do, that is the thing that got us out in the streets because we didn’t want to listen to our parents.”

Participant 15

“I feel bad but there is nothing I can do because I need to survive like anyone else.”

These children have lived on the street for between one and 13 years. Some of them were dropped off on the street as infants and were expected to survive on their own; others feel they could have a better life on the street and some simply have no one else to turn to, or at least this is how they feel. These children experience a range of feelings about living on the street, many of which correlate with how long they have spent there.

### 3.3.5 WORK ON THE STREETS

Each of the street children interviewed has some way of making money. Most of them stand on the street waiting for cars to park in their area and watch that they are not stolen or damaged. When the owner of the car comes back, he/she usually gives the child between R2 and R20 if they are satisfied. These individuals call themselves car guards. They also sometimes wash the cars for a fee. Other street children interviewed do ‘piece’ jobs, going around to different stores in the area and asking if they need anything washed or cleaned that day. The business remunerates them for their help. Other street children make goods such as brooms and sell them on the street. Sex trade is also common, which will be further discussed in the section on sexuality. The income bracket per day for these jobs can range from R10 to R180 depending on the job and how busy the day is.

The most common things the children buy with their money are food, cosmetics such as soap, as well as clothing, blankets, materials to make a shelter, schooling supplies for younger siblings or children, cigarettes and alcohol.

### 3.3.6 DETAINMENT

Of the 15 participants, eight admitted to being arrested at least once. The reasons for their arrests vary. Below are personal encounters that were shared with the researcher when asked whether they had been arrested.

Participant 2

“Yeah one time, suspect. Another guy they were taking his cell phone and after he saw me he said it was me but they had to leave me because they didn’t [prove] that I did anything so I could go, they were nice to me.”

Participant 4

“Yeah here in the streets, for the car guards. Just tell me when I check the car I am not allowed to wash the car when I wash the car he come and arrest me. Or if I jump the street if the robot is [red]. I don’t know what [I can’t wash the car] maybe is someone acts like that want the wash the car maybe I want to steal something, just look it don’t wash it. Yeah he just arrest me. Not the police the security from the street. And take me to the jail for 2 days don’t tell me why just write something down don’t even charge me with the finger prints or what or what.”

Participant 8

“For in the street, arrested me for pedestrian for standing in the street. Not nice, why she arrest us in the street because we don’t stay there. It wasn’t nice.”

Participant 9

“For the check the cars. The police will come there and arrest you because they say that job is not a job, they don’t have permission to check the car. They took me to the police station and gave me a warning because there was no case.”

Participant 10

“Yeah for being in the street sleeping under the bridge you know. They treat us badly like we are criminals you know the South African police, they hush and bully us they talk to us so badly you see. When they are together they show off and act like one.”

Participant 11

“Once, for trying to steal from the Pick n Pay they found me with a small polony and a loaf of bread, I didn’t have any money and I was stealing it, [I was in jail] for 7 days, they are always mean. That I mustn’t stay and I have to ask for money but I said I didn’t get any money, he started to hit me, he hit me with a torch on the head, he said I mustn’t steal.”

Participant 12

“Yes, for smoking marijuana. They just wanted me to show them where I buy it, I sleep in jail for two days and then they let me go. Before I tell them where I buy it they were beating me, but after that they just locked me up. After two days they open and say I can go. It’s not nice in jail.”

Participant 15

“Yes I have been arrested for pedestrian I was sleeping close here and they took us to the police station and they searched our fingers and they saw we were innocent but we sat there from Thursday until Friday morning. They were harsh they searched us I tried to explain that I was selling brooms and, they were rough with us and shouting at us maybe as if we are criminals and we did something wrong.”

There is no proper police force in South Africa, locals told news reporters when asked what they would change about their country (BBC News, 2004). Not only is safety an issue, but in many cases so is brutality, as demonstrated in recent police attacks and killings, because the firearms laws have changed for the special force.

Two tourists visiting South Africa were furious when they saw police harassing street children (Antwood, 2008:3). When the tourists approached the newspaper about the story, human rights groups were outraged. When asked why they had attacked the children, the police said they committed crime all the time, yet these same children were known in the community for keeping themselves out of trouble (Antwood, 2008:3).

Each of these eight participants had a different experience, ranging from the reasons for being arrested to their treatment by the officers. Some of the interactions were just, while others were violent and frightening experiences for the children.

### 3.3.7 SUPPORT

The researcher asked the children if they had anyone to talk to when they were in trouble:

Participant 1

“Sister.”

Participant 2

“No. no one to talk to.”

Participant 3

“Yeah my uncles but they are living at Limpopo Province I can see them after two months.”

Participant 4

“Yeah one of my families just because I don’t have parents I am staying with my family. Cousin.”

Participant 5

“If I am in trouble there is no one.”

Participant 7

“Yeah the security guys. Most of the time they help us of the bigger guys are harassing us they call him to order, they tell them they will take them to the police station if they don’t leave me.”

Participant 8

“No one.”

Participant 9

“It’s my mother. Maybe if I am in the jail, call me come there to bail me and go out of the jail.”

Participant 10

“I can say at the moment no, there is no one I have to do it on my own. It’s either maybe if I go to the police station I can’t just say they will help they won’t but sometimes they can help.”

Participant 12

“Yeah someone, my brother, he is older. (he helps me) sometimes, but not all of the time.”

Participant 13

“No there is no one.”

Participant 15

“Around Schosogoove there is no one. Here (in Pretoria) I could go to the social workers or maybe the police when I need help sometimes. I have seen the social worker here she once helped me with some food and stuff.”

The majority of these children do not feel that they have anyone to talk to when they are in a problem situation; some of them talk about family members or security that could help them when they are in trouble.

### 3.3.8 CLEANLINESS AND SLEEP

Hygiene is a major concern for these street children, as indicated in previous sections. Here the children shared personal details about where they washed and slept. The participants first revealed their access to water, where they washed and used the bathroom. The second point refers to where they were sleeping.

#### Participant 1

Washing: “There is a tap in the street you just open water you get water with your scooper or your bucket I buy a [solution] to mix some boiled water together to wash myself.”

Sleep: “I buy a sponge (egg crate) and make beds for me and my children.”

#### Participant 2

Washing: “I wash ... at the river. I just wash myself; I don’t know where I must go to wash myself that’s why I go to the river.”

Sleep: “I sleep there under the bridge. Sometimes police come and say we take things from people.”

#### Participant 3

Washing: “At home I live in Mamelodi with my mom and two younger brothers my old brother he is at jail. And my sister she passed away last year so it is only me my little brother and my mother at home now. My daughter lives at home but goes to preschool.”

Sleep: “At my mother’s home. One bed at home for me my girlfriend and child we are the one with the bed and use the same bathroom.”

#### Participant 5

Washing: “Where I stay, like at some place, it’s just an empty building. It was a company where they worked with [bricks] and the company closed down, it’s just an empty building.

Sleep: “[I stay and sleep there] alone.”

#### Participant 7

Washing: There in [Brighton] under the bridge, I use the water, me I don’t feel anything because I am use to it. There is no other way.

Sleep: “I sleep under the bridges. A blanket is R10. Somethings is differs because sometime if you have money you come there is you don’t have money you go stay anywhere in the street it’s people who live in the street but they are there for a long time they have everything. [I do not feel safe] because you don’t know those people they don’t think anything they can get you injured that they can do anything to you some are influenced by drugs.”

#### Participant 8

Washing: “Maybe sometimes when I sleep here at town I like to wash there in [Brighton], when I don’t sleep here in town I wash at home at Mamelodi, I sleep 3 or 4 days in town.”

Sleep: “There in the [Brighton] street next door to Engine Garage in the Super Quick, between Engine and Super Quick when we close the garage us we come in later and sleep in there. In Mamelodi I sleep at home my small brother my sister and another one. We do not have a bed my sister she got a bed my small brother is sleeping on the floor. That house eish I don’t know my mother is paying from where it is a long time she doesn’t show. We buy lonely electric on a card R10, R20 you see.”

#### Participant 10

Washing: “Sometimes there by the soup kitchen the granny helps me, or go under the bridge so I can hide myself and wash you see. Maybe inside McDonalds, it depends on who the security guard is if I know him he will let me if not I have to make a plan and go to the parks where I can hide.”

Sleep: “Near the train station bridge. It’s a little bit of comfort but it is worrying to be there under the bridge you think of being scared of something, there are bushes there is scary stuff snakes many things there that are dangerous spiders, mosquitoes. It’s not comfortable.”

#### Participant 11

Washing: “At the bridge there is a water going through there and we use soap to wash there and wash clothing. I’ll ask maybe at the shops sometimes.”

Sleep: “Under the bridges, when there is rain the rain doesn’t come here and I sleep under there at the shop doors because its much safer than sleeping in the bushes there are snakes and dangerous things. There is nothing I can do it’s ordinary for me sleeping there you see, I feel safer than sleeping in the bushes. About 7 people sleep under the bridge.”

#### Participant 13

Washing: “At the streets, near to Brooklyn mall, there is a river. We wash at the river, we get in. [Same for bathroom].”

Sleep: “Sleep there at the river, we just plastics as shelter in the bushes. I stay with my brother and my friend we are three.”

#### Participant 15

Washing: “When I am at home, I only go to the toilets and wash my face because here (in town) I don’t have cosmetics, I only wash my face when I stay here at the garage or at the mall.”

Sleep: “I am around town I sleep under the shelters where there is no one or at the garages you see. When I have money I go home when I don’t have I sleep here. My gran has passed away now it’s my aunt and my niece and me. My aunt is nice but she drinks sometimes she is rude you see that’s why sometimes I sleep in town. We don’t pay rent because it’s a squatter camp. She helps us, I don’t give her money because she drinks it’s better to buy food than money.”

Most of the children wash in the river and either sleep under a bridge or build some kind of shelter or protection from animals and the elements.

### 3.3.9 DRUGS AND ALCOHOL

Drugs and alcohol are cheap and easily available on the street. Many of these children do not use these substances, but others are dependent on them. Drugs are common and are used on almost every street where the researcher spoke to a child. They may not take drugs themselves, but the people they work or sleep with do. It comes down to personal choice and their state of mind, shown below are answers to questions about their friends' addictions to cigarettes, alcohol, and other drugs, as well as their own and the reason behind the need, the yearning or desire for the substances.

**Table: 5 Participants and peers that smoke cigarettes:**

Participants that smoke cigarettes		Friends of participants that smoke cigarettes	
Yes	No	Yes	No
12	3	13	2

Smoking is very common in South Africa. There could be a number of reasons for the majority of these participants choosing to smoke cigarettes. Sometimes it induces relaxation, or it could be for enjoyment. Another reason the child may smoke is to pass time or to feel as if they 'fit in' while standing on the street, most South Africa's smoke in early adulthood.

Below are points that examine the drug and alcohol intake of both the participants and their friends. The first point deals with the participants' friends, who drink alcohol, sniff glue or take any other drugs. This is followed by whether the participants themselves have drunk alcohol, sniffed glue or taken any other drugs. Finally is the reason for the drug use.

#### Participant 1

Friends: "I never say it's my friend, you know I mean to talk general."

Participant: "I drink on special occasions when I am happy I like to say I can drink, to relax my mind."

Reasons: "Yeah because there are many things in the brain of people they don't know what they are things trouble, stress, made amazing thing, or a violent thing, wants to forget."

#### Participant 2

Friends: "No, no no."

Participant: "No alcohol or drugs."

Reasons: "They are arrested now. They sell drugs. Just sell it."

#### Participant 3

Friends: "Yeah I am also drinking sometimes like everyone else I want to be happy."

Participant: "I have never been into that (drugs)."

Reasons: "Yeah that friend that I am talking about. I don't know because he has problems I don't know what. He doesn't tell me, he maybe things he is clever when he is smoking drugs. It is too dangerous many people that have died from smoking drugs."

#### Participant 4

Friends: “Yes to alcohol no drugs.”

Participant: “Alcohol”

Reasons: “Alcohol don’t talk to much when they don’t drink but when they drink they talk wawawawawawa it makes them free. When they don’t drink it doesn’t make it nice. I drink because I am worried sister, my mom my dad is dead one of my family was always drunk and beat me and that why I stay with my cousin.”

#### Participant 5

Participant: “No I don’t I did drink alcohol when I moved into the town because of street at night because of stress and when I drink at night I could sleep.”

\*This participant claims not to interact with others therefore he does not consider anyone as a friend.

#### Participant 6

Friends: “Yeah my friend is drinking the alcohol, the other one is smoking the drugs.”

Participant: “No I am not drinking I am not smoking, I was smoking last year but I am finished I say on the packet of the cigarette that smoking can kill you, you see. Smoking is too dangerous you see it’s not alright.”

Reasons: “When I am asking they don’t want to talk about it they stay stop talking about that they don’t like it.”

#### Participant 7

Friends: “No alcohol.”

Participant: “Smoke, nyoupe, it’s what do you call it, heroine, I do it to forget sometimes I do it to forget about my problems it becomes easy for me. It’s R30 per pack. Maybe one a day and maybe I’ll do it after 3 days I usually skip two days there days because the money is hard to get. It’s bad but it makes us feel you can’t see anything because you are drunk at that time, I know it’s bad but I don’t know why I can’t stop.”

Reasons: “I think the same as me because we are usually together we do things together.”

#### Participant 9

Friends: “Yes, to alcohol and cigarettes.”

Participant: “I am not drinking I am not smoking.”

Reasons: “They say they drink if they have a lot of stress and drink alcohol. I don’t do that because that stuff can kill me it’s not alright you see.”

#### Participant 10

Friends: “They don’t drink alcohol. There are some they are addicted in glue but we are not staying with them because they are not working they can’t do anything, because they are always drunk even then they are a problem because we take care of them too you see.”

Participant: “No no no. I was addicted to weed and then I left weed because my younger brother was crying and said I was always hushing on him when I was smoking.”

Reasons: “Maybe sometimes they give up on themselves in the moment no better way they can be nice or having a nice time because we are in different problems at the moment. I see that drugs take people, it makes you dumb doing drugs, you don’t see. Some others it makes them flex others is makes them sleep you see.”

#### Participant 11

Friends: “There is this other one that sniffs glue he is mentally ill. Those who smoke they are not my friends but we live together you see.”

Participant: “No, maybe sometimes but not know, at that time my parents died I wanted to take out stress and maybe alcohol would help me but it didn’t. I saw that there is nothing I can do even if I take those things they can bring back my family I gave to carry on.”

Reasons: “Stress, other just enjoy taking them.”

#### Participant 12

Friends: “I never see them. Only sometimes I see them smoke marijuana, when he sleeps, before he sleeps he is smoking.”

Participant: “When I can sleep maybe just marijuana.”

Reasons: “To forget, to forget. And sleep.”

#### Participant 13

Friends: “Yes he is drinking; it’s my brother who takes those things. Nyoupe is heroine smokes it.”

Participant: “I don’t drink anymore.”

Reasons: “Because he doesn’t have parents anymore he just thinks it’s the end of his life, that’s why he is taking drugs I think so. Drugs is not good I want to be okay and working, if I take the drugs I will not get a job anymore that’s why I don’t smoke the drugs because I like myself, I want to have a job. “

#### Participant 15

Friends: “He drinks alcohol sometimes; I drink sometimes when I am angry we don’t do such things as drugs.”

Participant: “I want to conform myself, I don’t think of anything else when I drink just sleeping and relaxing I don’t like it, I only do it sometimes.”

Reasons: “We don’t commit ourselves in such things I see many people who are smoking drugs and they end up in jail and steal, I am afraid of police I don’t want a criminal record.”

These participants explain if and why they and their peers use substances. There are many reasons, which include stress and the ability to sleep. Some of these individuals try to lose themselves in the substance in order to cope with the reality of their situation, to forget that they no longer have a family or to endure the weather conditions at night.

### 3.3.10 FAMILY

The children say whether they have a family and discuss their relations with them:

#### Participant 1

“Yeah my family eh, are far away. I must make it I must end up with myself to focus in life I need nice things in my life, I pray I tell god what I need in life be with me God please God help me, I must pray.”

#### Participant 2

“Since I was born I didn’t see my family, my mother died in 1999 and I don’t have a father since I was born I didn’t see my father. I lived with her when I would young, I was angry when my mother died I didn’t have [anyone] to take care of me.”

#### Participant 4

“My family is good they just take care for me they don’t even give me trouble. I live with my kids. My cousin [Dineo]. I don’t have a father or a mother. It’s not a permanent house we just stay there, we are waiting for the permanent. Lived there for 8 years. No longer stay with the child’s mother.”

#### Participant 5

“Uh, a uncle and grandmother only. [I do not see them often] ‘cause they are there by the rural areas, here I came when my mother was alive. We were tenants she dies in 2008. I was unable to pay the rent so the landlord kicked me out. [I’m] sad that’s all.”

#### Participant 7

No, I’m an orphan. They died, I was maybe around 12, 11 so 5 years back. They were sick.

#### Participant 8

“My family don’t check us. (Begins crying) my family didn’t come to us to visit didn’t check us didn’t buy for us any food and they just stay there far away. My family she don’t want to hear us she don’t want to see us because why my mother leave us. Last year she just leave because she like another guy you see she don’t stay with my father. My father when I go to see him my stepmother chases us away she don’t let us see my father. She we wanted money she don’t want my father to give us money she just says go go. My grandmother she don’t stay here anymore she is at old age. Sometimes [I visit], it’s nice to see her because sometimes she buys us a ‘Mielie Meel’ and some sugar.”

#### Participant 9

“I’m suffering in my family. I have a mother, father, and two young sisters. Yes sisters go to school, I pay for their school and their clothes. My father was working but now he is old and my mother is no longer working this year.”

#### Participant 10

“My mother died 3 years back. Our father left us when we were young, then we stayed with our granny and she passed and then my aunt didn’t treat us well so we decided to go to the street. His children [are] the favorite he buys things from them, we don’t have the right clothing to stay with him. It’s not better (to stay on the street) but nicer than having the stress inside the house, it’s more stress but I can cope because now I am telling myself life will go on, I do try and find a job.”

#### Participant 11

“Yes but they stay far and since my parents died they no longer see me as family. I had a brother but he died in a car accident. Once I went there but they didn’t treat me like before I didn’t get food.”

#### Participant 12

“Yes, my brother, it’s only him I have my mother is dead and my father he left I don’t know him. I can’t remember (when my mother died) I was still young. My grandmother lives far away. My brother stays in

Mamelodi, his wife is not nice she makes him to fight with me. After time (I go see him) he will come get me here, but afterwards he changes.”

Participant 13

“My father and mother passed away, my father passed away 2004 and mother 2003. They’ve got the sick. HIV.”

Participant 14

“No. None. Nothing.”

Participant 15

My mother passed away when I was 2 years 95 or 96 I think, I never seen (my father) in my life. They never told me exactly what she passed of. I never knew what the problem was. I use to have a sister she has gone to Joburg I have not seen her and she left the child at home and my aunt and I look after the child when I am at home. I buy the child clothing when I have money and buy her food most of the time when I go home.”

Family seems to be a difficult subject for these participants. The reasons may be that they either do not have family, have the means to see their family or have been out casted by their remaining family for a number of reasons, one being that their parents have passed from AIDS. While in the community with the participants or other street children when they saw a family walk by one could see the devastation in their hearts that they do not too have that love and support.

### 3.3.11 FRIENDS

The participants say whether they have friends and talk about the roles they play in their lives:

Participant 1

“Yeah that one, he advise me when I do wrong things he says do right things when I need something he will buy me you know we live together we must share.”

Participant 3

“Only my girlfriend. I have had friends but they are not a good friend that I can make my friends because he is smoking drugs I was always telling him to stop smoking but he didn’t so that’s means everything I am telling him is bullshit which means he is not my friend. My girlfriend is only my friend.”

Participant 4

“When I stay with them and go relax somewhere else. It’s not good because he is drinking too much and he fights with me but I must remember that I don’t have a family anymore and I like my friends.”

Participant 7

“My friends are those one who are in the streets. They are my family. We share everything we sleep together everything we do together in the morning we are together in the evening we are together we share a lot of things sometimes we make each other laugh to forget about the problems he is a good friend, sometimes we comfort each other, don’t worry it will pass.”

Participant 8

“I have friends, my friends and just here in the street. We are just working in the street together to get the food, we just sleeping together.”

Participant 9

“Yes I have friends, drinking the beer, smoking the cigarettes maybe he will buy me a cool drink, because me I am not smoking or drinking, me might buy me fruits an apple, banana, orange, pineapple, something like that pears, you see.”

Participant 10

“Yes I do have friends, the friends are the ones I live with here in town. We help each other if we don’t have food we share together, most of the things we do together you see.”

Participant 11

“Those ones who I stay with. People who park cars together, we sleep together even ask advice together, because they are family for now you see they are like a family to me.”

Participant 12

“They are good friends, we share many things. My friend is the one who showed me where to sleep; I didn’t know where to go when I first came he said you can go work and guard cars there. Told me where I can sleep.”

Participant 13

“Yes only one friend. My friend is good people I live with him. He is my friend because he likes me and he doesn’t want to see my suffering.”

Participant 14

“Yes, my friends are people I do things with everyday to survive, I sleep with, I learn things from.”

Participant 15

“Yes I do have one friend, he is a nice guy I sell brooms with him and I spend most of my time with him. We work maybe someone calls us to say clean and when we get something we share because he is a real friend to me.”

Many of the participants seem to see their friends as a vital part of their lives and a large support system for having fun, forgetting about their problems, loaning each other money or buying one another food. It seems that they share almost everything, including where they sleep. They seem to view their friends as family and treat them with respect and appreciation.

### 3.3.12 RETURNING HOME

Although many participants do not have the luxury of going home due to their parents’ death, some of the street children do have extended family or siblings that they go visit or try to live with. Below are some reasons why street children have gone home and then returned to the street.

Participant 1

“I go home and I come back to the street again. I was in the moment I want to go home today, if I get 30 bucks I can go home and relax.”

Participant 5

“Yeah, last year. Cause there my uncle is the kind of guy that is violent he doesn’t even take care of my grandmother he doesn’t even get along with me he says it’s him house. Even when my mother was alive they always fight you see.”

Participant 7

“I can’t go back home, because there is no home.”

Participant 8

“Maybe sometimes when I buy for my brothers something to eat I go to give them some food and come back tomorrow. It’s my small brothers they stay at home always.”

Participant 10

“Yes like last year was the last time I went to my aunt because where my aunt stays is the family stays where my mom stayed it was my granny’s house and you think that when you come back your family would be happy to see you but I feel like I make more stress even thought they wanted to keep my younger brother but I didn’t allow that.”

Participant 11

“They changed they don’t like me the way that they did I would rather leave them and stay in the streets.”

Participant 12

“Yeah sometimes my brother he come to get me, people where he is living are asking where I am, he comes to get me. But after 3 or 4 days he starts shouting at me I don’t know maybe, me I think it’s his wife, because when we are two he thinks nice and can see I am his brother but after he is with his wife, eish, he changes. That I when I come back here.”

Participant 13

“Yes to my grandmother. She doesn’t have the money to look after me. That is why I am coming back to the streets (she is nice) Soshongoove even 4 months just for one day. My uncle doesn’t like me. When I go there he is just talking about food there is no people who can buy you food you must go to work and get some food to eat, your mother is not here my father is not here you need to go get a job.”

Participant 14

“Yes, they came to fetch me here, because my mother was concerned where I was but that didn’t work out because the very same thing that got me out of my parent’s house continues, fighting with that step father of mine. He was beating my mother in front of me and telling me bad words that I am not his son.”

The participants say whether they sometimes feel sad or angry and some of them go on to talk about who they speak to if they feel this way.

Many of the children have nowhere to go and if they do, it is far away or they do not feel welcome by their family.

Below, the children discuss how they feel about living and/or working on the street:

Participant 1

“I feel sad about my life, why I live this life, my mind is broke. There is a psychologist I go to and I talk to him when I need things in life. He was a psychiatrist he sleeps there outside now.”

Participant 2

“Sometimes I just feel angry, I stay with my younger brother and my grandmother, I think that I am just going to stay with them all my life, my grandmother is blind, and my brother is still a young child that’s why I must try and go make some money.”

Participant 4

“No I feel angry. Just people I have a really small mind and I have two child’s. Boys and girl. My first born is a girl she is 8 years old and my boy is 5 years. I talking to one of my family.”

Participant 6

“Eish, when I’m hungry. Yeah, just the caretaker of that place he will help me work there sometimes.”

Participant 7

“Most of the time, because this life we are living is not the life it’s sad when you pass other students and some people are eating and you, you are starving and you see someone he is walking with their parents and then your heart becomes sad.”

Participant 8

“Yes, because my mother the way she leave us, eish I don’t like. When I think about my mother eish I feel angry because why she leave us like this she don’t come to check up she don’t buy for us the food why did she do like that? I don’t tell anyone because in my heart I feel angry sometimes.”

Participant 9

“Yes I feel sad, because I don’t maybe, I’m not alright or okay you see. If I’m sick I feel sad. Or maybe I want for other things, my girlfriend tell me problems, I need to make money or something like that.”

Participant 10

“Yes mostly, maybe if I don’t get something if I am hungry, if my younger brother is not near me, I get stressed what is he eating where is he? He does not work, I help him too.”

Participant 11

“Yes, because sometimes seeing people with their families it makes you sad that you can’t stay with your family it makes you feel bad.”

Participant 12

“Eish, always, because sometimes I don’t think it’s nice to live people don’t like us they always tell us to go and wash, to go back home to find a job but there is no job or school. People they fight.”

Participant 13

“Yes because people they are calling us ugly names, they call us dogs we don’t even like ourselves why are we staying in the street and after we get angry.”

Participant 14

“Always sad. Because I am not having a good life, not having the life that I want. No, because there is no one to talk to.”

## Participant 15

“Most of the time, sometimes its hunger when I haven’t sold, I wish my parents could be here and see what is happening maybe they could help.”

Above, the participants expressed their feelings about living on the streets and in some cases how they feel about themselves and the way others speak to them, which influences their self-esteem. The participants expressed a range of feelings based on different things like hunger and family.

The above sections provide a view of the 15 participants interviewed and how they feel about certain situations they come across on a daily bases. Next, the researcher will discuss the different themes and sub themes generated from the data collected in the interview process.

### **3.4 THEMES AND SUB THEMES**

The research findings are presented below in the form of themes and sub themes generated from the data, supported by the direct quotations from participant interviews and substantiated by literature. The following sections provide the participants responses to inquiries associated with sexuality and HIV and AIDS. These sections are set out according to themes and sub themes for better understanding and viewing the data.

#### **3.4.1 THEME 1: SEXUALITY**

Sexuality as defined in this study “incorporates physical, social and psychological characteristics including temperaments, feelings, values and norms regarding ones actions” (Chilman, 1990:123; Delamater & Hasday, 2007:254). Sexuality is also regarded as sexual awareness among children. The researcher maintains that this is awareness of one’s body and responses as well as being able to control, or be aware of feelings associated with sex and sexuality. This theme will show how the participants’ view sexuality, along with the discussions in the sub themes, expands on this through personal experiences and thoughts.

##### **3.4.1.1 SUB THEME 1.1: INTIMATE AND/OR SEXUAL RELATIONSHIPS**

Understanding what a boyfriend or girlfriend means to the participants is important, as it allows us an insight into how the children interact socially with the opposite sex or the same sex. It also shows the meaning and emphasis they put on intimate or sexual relationships. There are so many interpretations for words such as lover, partner and boyfriend. Below, the participants explain what they think the meaning of a boyfriend or girlfriend is.

#### Participant 1

“They mean they must wake up and make nice life and progress if I like you I like you to make marriage and children.”

#### Participant 2

“Uh, there is no meaning there to me because I see most of the time; I stay with another friend there. Maybe we want to make a family with my girlfriend. I don’t have.”

Participant 3

“We can share a lot of ideas and help me with somethings maybe I don’t know and build a good family for our future to have a home and everything good for my children you see.”

Participant 4

“That means that I have a child with them that’s why I call them girlfriends.”

Participant 5

“A boyfriend or girlfriend is the kind of person you can talk to when you have problems share ideas you see.”

Participant 6

“Helping working wash your clothes you when you care coming from the job you can’t do anything.”

Participant 7

“A boyfriend or girlfriend means someone who is maybe not your friend but is the other sex and you feel like when you are with that person you feel like everything is changing, because when you have a girlfriend most of the time they will help you to spend your money wisely and you don’t have to buy drugs.”

Participant 8

“I don’t have. I don’t like it. The girls are sick. Since HIV is coming, I’m scared.”

Participant 9

“You can’t stay alone you must get a girlfriend you see. It’s nature for any person when you are a girl you must get a boyfriend, it depends on the age if you are 16 or 17 you must get a girlfriend, there are not things I can share with my mother I cannot sleep with my younger sisters or my mother.”

Participant 10

“I can say uhhhh ... knowing how to help each other in life being good, help each other in life. Share some good advices together. Building the nice future together.”

Participant 11

“A person who maybe you have a relationship with you see. A person who you love and going to spend your time with.”

Participant 12

“When I have a girlfriend it means she loves me and I love her.”

Participant 13

“Nothing. We were talking about sex and life.”

Participant 14

“It means someone who I can start a life with, who I can build a future with.”

Participant 15

“She is an important person because sometimes I need a family and I need to know how to live and communicate with her and I must not live how my parents lived [she] help me sometimes and give me some ideas and advice and how to do this and how not to do this you see.”

According to Schwartz (2006:57), “attachment, intimacy and sexual competence in youth is important for the mature ego and adult capacity for commitment and happiness.” If children have a partner or companion, it is a positive thing for their development. There are many ideas about what a boyfriend or girlfriend is. The majority of participants talked about the future with their partner and having children with them. Others thought it meant nothing or it meant that if you had a child with a girl that meant she was your girlfriend. This is a prime example of how different people understand the same word in different ways, although most of these participants had one cohesive view of what a partner means, yet this meaning may differ cross culturally.

Of the 15 participants, seven of them said they had a girlfriend. Examples of this follow:

Participant 3

“Yeah I do have a girl friend 3 years.”

Participant 4

“It’s a girlfriend’s, yes because I am not married. Two of them, only two.”

Participant 6

“Yeah I have, only 1.”

Participant 15

“I have a girlfriend and a boyfriend because that guy is a boy and he is my friend.”

The remaining 8 participants indicated that they did not have a partner 3 of which said they have recently broken up with their girlfriend as one may see below:

Participant 7

“Use to in town a girlfriend. They took him I don’t know where they went maybe it’s their family I don’t know because she was like my soul mate me were sharing everything.”

Participant 10

“Yeah I did have a girlfriend but we are not longer together because she is smoking and selling herself, her body. She’s drinking a lot now.”

(Certain discrepancies in the use of the gender pronoun are obvious. For example, participant 7 uses both he and she. In most instances, the researcher makes sure to specify which gender the participant is referring to. This continues throughout the data analysis. Please note that some of the children are illiterate and this is not the first language for any of the participants.)

Romantic relationships are a significant part of the adolescent’s social world. In other studies, the definition of a relationship is one in which you like someone and they like you back (Giordano, Manning & Longmore, 2006:136). Here the participants talk about whether they have a girlfriend or a boyfriend and what it means to them. They discuss feelings associated with the relationship. A recurring association was that of support and encouragement. Some of the participants brought up the topic of the future, wondering whether there was any possibility of a future or a family. Participants also discussed children, asking, if they were the father of a child,

whether the mother of the child was their girlfriend. It is then discussed that if they have a relationship, sexual or otherwise, it is not recognized as a girlfriend unless she is the mother of his child.

Once the participants had identified the concept of a boyfriend or a girlfriend, the researcher investigated whether the participants had 'sex' with their boyfriends, girlfriends, or others; in most cases, the number of times they are sexually active per week is indicated in their responses. The parameters for the word sex were not discussed.

Participant 2

"With one time. There at capital, they sell it there. 40 bucks."

Participant 4

"Yes, Everyday."

Participant 7

"Those who are selling in the streets sometimes you go to them."

Participant 8

"No, [because of HIV] yes."

Participant 9

"Yes 3 times sometimes 5 times you see a week."

Participant 10

"Yes but before [she] was selling because her mother lived here too under the bridge but they moved and she influenced her daughter to do those things."

Participant 11

"Yes but not always. Maybe 3 times a month because she stays with her parents."

Two of the 15 participants said they had never had sex. Most of the participants have sex with their current girlfriends or go to the streets to buy sex from a female prostitute for R40 (approximately \$6 USD). Some of the participants therefore displayed risky sexual behaviour, defined by Snyder (2006:163) as "sexual activity that places youth at heightened risk of pregnancy or contracting a sexually transmitted infection." Snyder (2006:163) continues: "Three measures of risky sexual behavior are examined: having multiple lifetime partners, combining sex with alcohol or drug use, and not using condoms." This defines the behaviour of some of the street children in this community. Some of them have specific reasons for not having sex, such as being afraid of contracting HIV. Many of the participants numbly prostitute themselves on the streets; they do not think about the act and sometimes do not use protection. This means that the participant's risk of HIV infection from multiple partners or prostitutes increases if condoms are not used. This shows that the participants do not know about this risk factor of unprotected sex, or they do not care.

### 3.4.1.2 SUB THEME 1.2: SUPPORT BASE

As indicated above, many of the participants no longer have family or anyone they feel they can talk to when they are in trouble. The next section provides an insight into which the participants are comfortable with when talking to about sex and sexuality.

#### Participant 1

“With my girlfriend.”

#### Participant 2

“Uhhh, they didn’t talk to me about the sex. I just know about it but I don’t talk to anyone about it.”

#### Participant 5

“No one. I don’t talk about those things.”

#### Participant 6

“My girlfriend.”

#### Participant 7

“My friend is the person I talk to.”

#### Participant 9

“My girlfriend.”

#### Participant 10

“No one because maybe I can stay people the sisters in the soup kitchen they do tell us things like we must take care of ourselves don’t go to ladies who sell, use condoms. In to soup kitchen they do tell us.”

#### Participant 11

“Maybe my friends, the people I sleep with.”

#### Participant 12

“Sometimes me and my friend, only my friend.”

#### Participant 14

“No one.”

#### Participant 15

“Only my friend and my girlfriend sometimes when I am with her.”

Children need tenderness, love and positive emotion, as well as available parental figures and rules; there is a possible connection between relationships and behaviour between the love for oneself and the love others give (Wight & Henderson, 2004:24). As can be inferred from the participant’s responses, they do not have a large support system. Research carried out by Evans (2002:51) and Dowsett (2003:25) shows that street children who have been orphaned by AIDS can be subjected to “rejection and exploitation by extended family after the death of their parent(s).” Most of these participants talk to their girlfriends about sex and sexuality or possibly to their friends, but many of them do not talk to anyone at all. This means that, if the participants are not talking to their peer groups, they are not talking to adults or extended family.

### 3.4.1.3 SUB THEME 1.3: BODY IMAGE

The participant's self-esteem is low, which can be seen when they are talking about their feelings associated with street life. In the next section, we are going to explore how the participants feel about their bodies.

Participant 1

"I like my body, all of it"

Participant 2

"Yes I like my body."

Participant 3

"Yeah 100%."

Participant 4

"Yeah, everything."

Participant 11

"No, because when you stay here in the street you fight, you see get into the street you are not a person who is ordinary you don't wash for a long time your skin to too dry."

Besides participant 11, the remaining participants praised their bodies and had no complaints about how they looked or felt about their external appearance. However, Cohane and Pope (2001:373) maintain, "body image dissatisfaction in boys is common and often associated with distress." Furthermore, adolescents' self-evaluation and self-representation forms a large part of their own body image (Jones, 2002:645). As the researcher pointed out at the beginning of the section, many of the participants have low self-esteem and a poor view of themselves as positive individuals in society, yet almost 100% of the participants are perfectly comfortable with their body.

### 3.4.1.4 SUB THEME 1.4: UNDERSTANDING KEY CONCEPTS

Understanding terms is an essential component of this study. Although some of these sections may not seem to fit into this sub theme, the researcher has looked 'outside of the box' when categorizing in order to create a sub theme that will hopefully allow individuals to distinguish some of the understanding and misunderstanding that arise from words. First, the participants define what the word sexuality means to them:

Participant 1

"Sexuality? Eish I don't understand. Me when I can take with my brain thinking, it's something that we have made sex with someone, or it's like sexual abuse or what?"

Participant 2

"Eh, sexuality? I don't know the meaning of sexuality."

Participant 3

"I'm a male."

Participant 4

“Sexuality? What you mean? That mean I’m not gunna become anymore is South Africa, when you give maybe the guy some job or some food or some clothes.”

Participant 5

“Um, I don’t know.”

Participant 6

“Eish I don’t know.”

Participant 7

“Is like maybe sex, I don’t know sleeping together.”

Participant 8

“Is a what? I don’t understand.”

Participant 9

“I don’t know.”

Participant 10

“Eish what can I say? Can you give me a clue? It’s like maybe an abuse or something. I don’t know.”

Participant 11

“Like? What like having sex things like that?”

Participant 12

“Sexuality? Hum, I don’t know.”

Participant 13

“What? I don’t understand sexuality.”

Participant 14

“Is when two people meet.”

Participant 15

“It is between two people having sex or maybe making a baby I don’t know how to finish it.”

The term sexuality, as discussed above, has some of the implications expressed by Bhana (2007:309), when he says that we see “children not simply in terms of their need for sexual rights but as potentially active participants in the negotiation of their rights.” Sexuality is also defined as “a person’s capacity for sexual feelings” (*The Compact Oxford English Dictionary for Students*, 2006:946). Once more, the researcher defines sexuality in this study as being aware of one’s body and responses as well as the ability to control, or be aware of feelings associated with sex and sexuality. None of the participants understood what the word sexuality meant. Some of them cleverly heard the word sex and tried to extract a meaning from that. One example was, “I’m a male.” This participant clearly thought that sexuality was solely gender-related. Others thought it was associated with meeting someone or reproducing. Although some of these concepts may fit into the idea of sexuality, this word is not in the participant’s vocabulary, so they cannot talk accurately about the concept.

Being aware of specific words when you are sexually active is essential for safe sex practices. The next word the participants identified was contraceptive:

Participant 2

“I don’t understand the meaning of contraceptives.”

Participant 3

“Pardon? Contra what is that? Ahhhhhh, I can’t understand what you mean actually.”

Participant 5

“Things use to protect you from getting infected with AIDS.”

Participant 7

“I don’t know what is contraceptives.”

Participant 9

“The place where I have sex with my girlfriend.”

Participant 10

“Like, you can give me just a clue? Uhhh .. let me see. I don’t know, eish.”

The participants’ responses show that they do not know what the word contraceptive means. There were only a few attempts at explaining it. Participant 9 believed it was a place, and another said it was something that protects you from AIDS. Children who are having sexual intercourse ought to know about contraceptive methods. In South Africa, the most accessible contraceptives are condoms, the injection Depo-Provera and the birth control pill, which are free at any public health clinic.

Other forms of contraceptives include other estrogen/progestin hormonal injections, hormonal implants, the hormone patch and the vaginal hormonal ring. Female barrier contraceptives are the cervical cap, contraceptive sponges, diaphragms, female condoms, spermicides. Other contraceptives are emergency contraception, also known as the morning-after pill, female sterilization, the lactation amenorrhea method, and natural family planning (Children’s Hospital Boston, 2008:1). Everyone who is intending to have sexual intercourse should review the advantages and disadvantages of each of these contraceptives. Some of them are not age-appropriate for children, but being aware of one’s choices is best. The most reliable contraceptive method is abstinence.

Third, within this sub theme of understanding terms the participants talk about whether they are sexually active or not:

Participant 1

“I’m flex or what? (after explaining the meaning) Oh yeah I’m sexually active. They are things of life.”

Participant 2

“One time.”

Participant 4

“Yes.”

Participant 8

“No.”

Participant 11

“Yeah.”

Participant 12

“I don’t understand that (after explaining the meaning) no”

Participant 13

“Yes with my girlfriend”

Participant 15

“No.”

This may not seem to fit into the topic of understanding the terms, but the above discussion has established that only two of the 15 participants said they had not previously had sex. Yet four of these individuals stated that they were not sexually active, while only one indicated the length of time he had been sexually active once. Further, two of the participants did not understand the meaning at all, until the researcher explained the concept to them. Understanding the relationship basis for these participants helps us to see whether a participant is having casual sex, sex with a partner on a consistent basis, or both. With this information, we can distinguish whether the participant is indeed sexually active, although he may not have understood the phrase (Snyder, 2006:167). Hence, deciphering the relationship status can help us learn about the sexual and other relationships that are happening on the streets. This will allow us to understand what children of this age and status are comfortable with and how they define their relationships.

The last term relating to this sub theme is sexual behaviour. The participants discuss below whether they have ever been exposed to sexual behaviour:

Participant 1

“I don’t make strangely I make gently and cool and nicely.”

Participant 3

“Nah, ever.”

Participant 4

“Yes, ssssssseish. I don’t understand that sexual.”

Participant 5

“Eish, explain it.”

Participant 7

“Yes. Maybe somebody wearing a short skirt and taking something and she is doing it purposely.”

Participant 8

“Yes (The participant seemed confused).”

Participant 11

“No.”

Participant 12

“I don’t understand that one.”

Participant 14

“No.”

The participants do not understand this term, and, once again, the numbers of partners or other parts of their answers are inconsistent with their previous responses. There are numerous forms of sexual behaviour. Some definitions are broad, dealing with everything one can relate to sexually, including how you behave around someone you are interested in, body language and what you do alone when you are sexually aroused. Silverberg (2009:1) characterizes sexual behaviour as sexual activities people do with others, such as kissing, touching, and intercourse, or it can be solo masturbation. Other activities associated with sexual behaviour are abstinence, coitus, prostitution, sexualism, including trans-sexualism (Health SA, 2010:2). The researcher defines sexual behaviour as how one views sexual interactions and how the individual reacts in specific situations. This could include any of the acts listed above, and possibly more. The sexual behaviour of the participants is discussed in the next sub theme.

### 3.4.1.5 SUB THEME 1.5: SEXUAL BEHAVIOUR

This sub theme focuses more on the specific aspects of the street children’s sexual activities. This section begins with a consideration of whether the participants had ever been approached for sex or sexual favors, and how they reacted to the situation:

Participant 2

“Yes, that one he paid me, she asked me to have sex and gave me 40 bucks.”

Participant 3

“Yeah a lot of people. They love me they want to have sex with me. And me I just look at them like bitches.”

Participant 4

“Yeah it’s one of my girlfriends, not for money just to have sex.”

Participant 7

“Many times. For money they pay. Many there are many big people rich people they go with cars. Women and men. Men for masturbating and then gays and then women straight. We have sex. R150 but they will come after a long time. We are many in the streets sometimes maybe they take that one. If you get them you are lucky you see. I don’t feel anything because I just have an erection and then do something. Because of money.”

Participant 8

“Maybe white person. She say I must come in the car she go with me she say I must suck him. I get in the car but when she drive she start to tell me like this. Got out of car. Give me 40 bucks I said no I don’t do that thing.”

Participant 10

“Yes old old old madams you know old madams they come here and ask us to go with them, there are too many, even like gays they come you see they ask us to go with them and sleep with them those madams, they

gays come to go and have sex with them you know, for money. Because they talk about money so you can go with them maybe they give you R150. Mostly it's white people. (Do they ask to use condoms?) Some they do some they don't some don't like condoms because they don't like they can feel it. I like to use the condoms I go with them when I am stranded and I don't have anything to eat. They treat me nice. But you know you get scared going with a person you don't know or taking you to his house or something on the bridge, I do it just to help myself to help to eat something, if my brother is looking for something to wear. (How do you feel when you go with them?) scared but I don't have I want to be with something even me.”

Participant 11

“Yeah, it was this woman who always came here he wanted to take people to come and sleep with them, it was a white woman, she promised people money about R100 she takes you and you go sleep with her, I refused that time she asked me but this other friend of mine went with her, I don't like doing things like that you can get sick doing things that that, he wanted money.”

Participant 15

“Yes, I refused. She was another white lady here around town when I was selling I told her I was too young for her and she told me she would offer me a place to stay and give me money, I was afraid, I was scared. She was very nice she approached me very nicely like she wanted to buy brooms.”

Participants 1, 5, 12, and 14 said they had never been approached by anyone for sex or sexual favors and participant 13 said he had been asked by his girlfriend and his friend, who is a girl, while 9 and 6 said they had only been asked by girlfriends, but not for money.

Orphaned children are vulnerable emotionally and financially, as discussed above. Some children sleep with these men and women for security, payment, companionship, intimacy or goods. Sometimes this makes them even more susceptible to “sexual exploitation, abuse and survival sex” (Evans, 2002:56,58). Interestingly enough, most literature avoids discussing street boys having sexual relations with adults for money or any of the other above reasons. However, certain research writings discuss girls prostituting themselves, maintaining that “street boys, for their part, do not generally hold street girls in high regard, friendships notwithstanding.” This research found, however, that 7 out of the 15 participants said they had at least been approached, and most of them had agreed to engage in oral, anal, or vaginal sex with their ‘client’.

In the next section, the participants talk about how often they have sex with their partners, or someone they had previously regarded as their girlfriend, or any other person, and how many times this occurred within a weekly time frame:

Participant 1

“Girlfriend 5 times.”

Participant 3

“With my girlfriend and I am jolling (partying or having fun) with other girls you know I am a man, but I am condomizing don't forget for the sake of a healthy life style.”

Participant 4

“Every day, 2 of them.”

Participant 6

“3 times 4 times you see. Only my girlfriend.”

Participant 7

“Maybe like after 2 months with the prostitutes and maybe after those rich people come and they take me and I do sexual favors for them. If [someone] pays I sleep with them.”

Participant 9

“3 to 5 times a week and only with girlfriend.”

Participant 10

“Mostly they are old people, womans big womans, once or two times a month.”

Participant 11

“Girlfriend 3 times a month only her.”

Participant 13

“Twice a week when I had a girlfriend, I don’t have sex now.”

Participant 14

“Only girlfriend, twice a week.”

Participant 15

“Most of the time on the weekends when I am at home, when I am not at home I don’t, only my girlfriend.”

Participant 5 again said that he had had only one sexual experience. Participants 8 and 12 said they had never slept with anyone. All of the other participants said they only slept with their girlfriends and 4 of the participants, as seen above, have multiple sexual partners, including their girlfriends, or prostitutes of both sexes. Not much is known about individuals under the age of 18 and their sexual experiences. This might be because it is taboo to talk about children and sexual intercourse. Although it does take place, most information is directed at parents about sexually educating their children. Unfortunately, most of these participants no longer have that option.

Next, the participants discuss whether they have the right to say no if they do not want to have sex:

Participant 1

“Yeah I can say no, you never say no if I am your boyfriend, if you are tired they are tired what can I do.”

Participant 2

“Yeah I have to do it if someone wants to.”

Participant 4

“Yes.”

Participant 5

“Yeah if I don’t want to I can.”

Participant 7

“If you don’t want to have sex you say no.”

Participant 12

“Yes you can say no.”

Participant 13

“If I don’t want to do it I’m telling I don’t want to do it, if I like it I’ll do it.”

“Teens need to know that they are in charge of their own bodies and they have a right to say “no” at any time they don’t feel comfortable (Bradley *et al.*,1999:31).” Children should be empowered and aware of their sexual urges and personal boundaries (Bradley *et al.*,1999:31). With the exception of participant 2, all of the other participants were aware of their rights over their bodies and knew that they had the right to choose. This is interesting, because rape in South Africa is very common. However, these participants have a firm understanding of women’s rights of ownership over their own bodies. Although, if the participants were in a situation where they could force sex on someone, we do not know what they would do. We can only trust in their answers and that they respect others’ choices and bodies, which is heartening.

The participants now discuss whether it is acceptable for someone else to say ‘no’ to them if they want to have sex:

Participant 1

“Yeah I must listen to you.”

Participant 2

“If you don’t want to that’s okay I can’t force them.”

Participant 3

“Yeah they can.”

Participant 4

“Yes.”

Participant 5

“Yes they can, because if I force it’s against the law you see?”

Participant 6

“She can say no yeah, today I don’t want it I can’t make it a problem sometimes you say you don’t want it.”

Participant 7

“Yes they can. Because it is his body or her body I can’t for someone to have sex with me if they don’t want to.”

Participant 9

“Yes, I get on my girlfriends a lot of times and she tells me I don’t want to do that today.”

Participant 10

“Uhhhhh, yeah they can say no. because if they don’t want they don’t want there is no force.”

Participant 11

“Yes they can because you cant force them to do sex if they don’t want”

Participant 12

“Yes, because it’s not nice to force someone to do something.”

Participant 13

“No, yes they can say no, because they don’t want to have sex I can force them.”

Participant 14

“Yes.”

Participant 15

“Yes that’s what I think because I cannot force her, that would make her angry and I don’t want to make her angry. They don’t have to have sex with me.”

All the participants agreed that an individual has the right to choose whether they want to have sex or not. The participants continually used the word force, and explained that it is not acceptable to make someone have sex if they do not want to. This section establishes whether these participants believe it is ‘wrong’ to rape someone. This is interesting, considering that a woman born in South Africa has a greater chance of being raped than of learning how to read (Rape Statistics, 2010:1). Furthermore, approximately 500 000 rapes are reported in South Africa each year, and we do not know how many go unreported (Rape Statistics, 2010:1). This is a surprising opinion from the participants, because, in South Africa, there are still many individuals who believe the myth that having sex with virgins, most commonly infants and children, is a cure for AIDS.

Now the participants discuss whether they have ever been forced to have sex or have been raped:

Participant 3

“Yes, never been raped, but forced me, [coercion].”

Participant 6

“I just say I don’t want to have sex, no.”

Participant 10

“Yeah before because the first time when I met the other person, they never told me what we were going to there in the first place so I just see him coming to me telling me I want this and this and he just forced and told me I would not get out of the house and he forced me I ended up doing it with him. (In reference to prostitution).”

Participant 13

“Yes (forced) my sister, not my blood sister she took my clothes off then I was sleeping and took me by force, I woke up and she was on top of me, I feel angry, I didn’t do nothing, I didn’t push her off. [I later] asked what are you doing, told me liked me loved me, I did not want to do that.”

The remaining participants said they had never been forced to have sex or had not been raped. In other studies, boys have reported harassment from older males and females, as well as friends in the same age group, as has

been identified here also (Peltzer, Pengpid & Mashego, 2006:67). Some of the street boys said they had been raped by older white men and by females in their own age group.

The reasons why the participants have sex are significant if we are to understand their sexual behaviour. This is discussed next:

Participant 1

“Sex eish, it’s like romantic, when you make love with someone our love must be glad and nice.”

Participant 2

“Sex was just did it for maybe want to make a child and make sex. Maybe I wanted to make some children.”

Participant 3

“Feeling to have sex. Male feelings, somethings maybe I want a child, and sometimes enjoyable for me.”

Participant 4

“Because someone must use sex. Maybe to get a child, to make a child and to marry. To make big family. Just because if someone does not want to have sex they are angry they just yell what what.”

Participant 5

“Because I felt like doing it. Cause the person I did it with he wanted to have and he also you see (did you like the person) yeah we did.”

Participant 6

“It’s a nature.”

Participant 7

“Sometimes to relieve the stress sometimes to have fun. And sometimes it for money, most of the time it’s for money.”

Participant 8

“[I] don’t have sex because scared of the HIV.”

Participant 9

“It’s a nature.”

Participant 10

“I take it as part of making love, not all the time. Mostly when I do it it’s because I want money, I’m bored, I don’t know what to do.”

Participant 11

“When you have a girlfriend you can’t always stay with her without having sex.”

Participant 13

“Because I want to make sex because I want a family. I want a child like other people.”

Participant 14

“Eish, for pleasure.”

Participant 15

“It is because, it’s fun and sometimes its peer from friends maybe if we are dinking we entertain ourselves, its an entertainment.”

Young people seek a variety of things from sex and sexual relationships, including “intimacy, excitement, higher social status, sexual pleasure, economic security, and so on” (Wight & Henderson, 2004:20). The reasons why these participants have sex are many, and include the following: enjoyment, pleasure, entertainment, reproduction, nature, money and boredom. It is also regarded as a requirement in a relationship.

#### **3.4.1.6 SUMMARY OF THEME 1**

The themes were derived from the participants’ responses. Below is a synopsis of theme 1 and the consequent sub themes associated with the discussion of sexuality and premises alike. The questions posed to the participants and data collected emerged with these themes, which may allow us to understand their understanding of sexuality better, as well as how it is expressed and viewed on the street. Theme 1 explored sexuality under five sub themes, which help explain how these children feel about intimate sexual relationships, a support base, body image, understanding key concepts and sexual behaviour. The people living on the street do not understand words and key concepts easily, but they do seem to have a good grasp of how they feel about themselves, their relationships and what they are comfortable with in relating to sexuality.

**Theme 1:** Sexuality - Relates to the participants understanding of their bodies, as well as their thoughts and desires associated with sex, sexual acts and the meaning of sexuality.

**Sub theme 1:** Intimate and/or sexual relationships - Defining what a partner is and what relationships mean to them in a sexual or intimate way. The participant’s concepts of relationships differed greatly, as most people do. Defining a relationship can help people understand what they want out of the relationship and what it means to them.

**Sub theme 2:** Support base - Here the participants discussed anyone they can talk to about sex and sexuality. Their support base is limited primarily to peers and their intimate partners. They therefore have nobody with the knowledge that would help them through difficult situations dealing with relationships and sexuality, so the participants have to get through these challenging developmental times on their own.

**Sub theme 3:** Body image - Here the participants talk about how they perceive their body image and how they feel about the way they look, and present themselves to others. All but one participant enthused about how they loved their body and felt comfortable ‘in their own skin’, with no desire to change anything about their bodies.

**Sub theme 4:** Understanding key concepts - Sexuality, contraceptives and sexual activity fell into this category, but the participants did not seem to have a firm grasp of these concepts.

**Sub theme 5:** Sexual behaviour - This focused on the participants’ sexual behaviours, and their reactions in sexual interaction, including how they felt about their sexual activities and what they would do for money and affection.

In the next section, theme 2 and the corresponding sub themes, which were drawn from the study, are discussed.

### 3.4.2 THEME 2: HIV AND AIDS

This theme will help us to understand what children living on the streets know about HIV and AIDS. The sub themes answer many questions, including where the participants obtain their information, what they know about transmission and how HIV and AIDS affect them.

#### 3.4.2.1 SUB THEME 2.1: GENERAL KNOWLEDGE OF HIV AND AIDS

The participants speak broadly and discuss what they know about HIV and AIDS:

##### Participant 1

“I know many things, when you do sex you must make a condom make safety. I know about HIV you much get nice food fresh food you must always take exercise.”

##### Participant 2

“I know when you want to have sex you must wear some condom. If you have sex with a woman who you HIV you are going to get it because you didn’t wear a condom. Even HIV when someone his blood is here and you can touch him.”

##### Participant 3

“It’s too dangerous, my sister is dead because of that thing. If you are positive they don’t eat, always feel pain. Even the mind somethings, like crazy people. Loosing weight.”

##### Participant 4

“If you don’t want HIV you must use a condom always. I was seen my friend at the hospital and eish she was not good. And she was HIV+ just because I don’t use a condom. She was my first friend.”

##### Participant 5

“What I know is that it kills and it gets infected by blood to blood and stuff, having sex.”

##### Participant 6

“I don’t know nothing about that.”

##### Participant 7

“That it’s killing our country. It’s a disease it gets to you by blood exchange and by having sex injections using the same blades.”

##### Participant 8

“I know about that in the school. Was another program for HIV in the school there. Where did you get the information from? The school said don’t sleep without condom if you sleep with people who got the HIV you don’t make sexual without condom. Just tell us we must check the blood.”

##### Participant 9

“About that I don’t know nothing.”

##### Participant 10

“That thing kills you have to be protected you have to scrutinize it’s a bad disease you have to take care of yourself.”

Participant 11

“I know that it’s a virus that kills people a lot.”

Participant 12

“Eish I know nothing, but it’s killing people I just know that.”

Participant 13

“I don’t know nothing.”

Participant 14

“HIV and AIDS is a disease which kills, it is caused by sexual intercourse and it’s protected sexual intercourse.”

Participant 15

“What I know is that HIV it kills and that AIDS it affects you during unprotected sex you see.”

The primary association these participants make with HIV and AIDS is death, which is understandable in view of their experiences.

Normal individuals and health care providers alike fear HIV. In one study relating to the stigma and fear associated with HIV, health care professionals express a certain level of negative attitudes and beliefs about HIV positive patients. They also express fear of being infected (USAID, 2008:iii).

For others, the anxiety runs so deep that they fear even going for a test. On the other hand, some people are so fearful after having a potentially risky experience that they are tested all the time. For example, one male has been struggling with the fear of being infected with HIV for months. He was possibly exposed to it when sleeping with a prostitute without protection, and now fear has engulfed his life. Every time he has a headache, sneezes, has swollen glands or feels pain, he is afraid that he is infected (UCSF, 2011b:1).

The number of HIV and AIDS-infected individuals in South Africa is astonishing, and most of the participants have had family members or friends who have died from the virus. This explains why they may feel that HIV and AIDS are a ‘death sentence’.

#### **3.4.2.2 SUB THEME 2.2: INFORMATION DISTRIBUTION**

This section explains where the participants obtain their information about HIV and AIDS. This could potentially lead to the further distribution of condoms:

Participant 1

“Yeah they give me many information at the school many places they talk about HIV at the church they tell us about AIDS.”

Participant 2

“Yeah, a teacher in primary school, they teach me about the AIDS. I stopped school in 2003. Since my mother died no one cared about me.”

Participant 3

“Yeah, they do give me information maybe a clinic, hospitals, commercials. HIV is dangerous and how you can prevent it.”

Participant 5

“Yeah, at school, when I was at school. (stopped in 2008 grade 7 when I had nowhere to stay and started living by the streets, mom died from illness).”

Participant 7

“A bit most of them I get from the hospitals because I like to read. I did grade one grade two until grade six. They were not telling us anything in school that time I was young.”

Participant 8

“Yes in the school. I stopped going to school last year in grade 7.”

Participant 10

“Yeah in the soup kitchen there only that’s where they help us there.”

Participant 11

“Yeah by the nurses and the doctors and maybe you go to a clinic for a check up they give you advice and things like that.”

Participant 12

“Yes at school. I left in standard seven because I didn’t have money to go to buy lunch, a lunch box I see other children eat at school and I failed. I failed a lot. Maybe I’m not clever.”

Participant 14

“Yes. A social worker in the clinic at Mamelodi.”

Participant 15

“Yeah by a social worker I must be far from girls and that I must be far from silly things that I must be safe and when I am with my girlfriend I must use protection because I don’t know who she is with when I am not at home.”

The remainder of the participants, even those who had been to school, said they had never received any information about HIV and AIDS. South African schools have curriculum guidelines that are supposed to be followed, but certain aspects of education are bypassed in many schools, which discourage children from making “meaning of HIV, AIDS and sexuality” (Bhana, 2007:311). This is distressing, because many street children do attend school when they are younger, as shown above. If schools dispensed the obligatory information, the children would have more access to facts and may be able to make decisions that are more informed. Furthermore, if the participants had not attended school at all, they would have had very little exposure to HIV and AIDS information.

### 3.4.2.3 SUB THEME 2.3: MEANS OF TRANSMISSION

Here, the participants talk about how they think someone becomes infected with HIV:

#### Participant 1

“You get HIV when you sleep again, when someone pierces you with injection if you have a lot of infection, when you kiss a girlfriend if your lips are broken.”

#### Participant 2

“Like if you want to have sex you must wear some protection.”

#### Participant 3

“Maybe to sleep with, maybe I am positive and she is not and we did not condomize she will get it because I am positive and she is negative. Maybe with injections.”

#### Participant 4

“With your blood.”

#### Participant 5

“If you have sex with someone who is infected without using a condom, or maybe someone is injured and you touch his blood without using gloves and stuff.”

#### Participant 6

“A lot of persons that bring HIV they are foreigners you see that person will come from other countries like Nigerians, Zimbabweans you see, I think so.”

#### Participant 7

“Having sex without a condom. Touching someone’s blood who is infected with AIDS not wearing gloves.”

#### Participant 8

“You get it maybe sleep with like a woman changes two men and she don’t use a condom.”

#### Participant 9

“I don’t know.”

#### Participant 10

“Like uh, having sex without condom when you are touching something with HIV connecting the blood you know.”

#### Participant 11

“Having sex without using a condom. Touching other person’s blood and eating without washing your hand or using the same needle.”

#### Participant 12

“When you sleep with a person who has HIV or if your blood mix. Maybe you cut your hand and your blood comes to mine.”

#### Participant 13

“By blood I know that only.”

#### Participant 14

“By having unprotected sex with somebody who’s affected.”

Participant 15

“When she or he has sex with someone who has HIV and they have sex unprotected. It’s the easiest way. When you have been raped with someone who had that disease.”

Many of the participants know about the transmission of HIV by means of blood, needles, and not using condoms, although none of them talk about mother-to-child transmission. In fact, they know very little.

### 3.4.2.4 SUB THEME 2.4: PREVENTION OF HIV

The participants describe what they think a condom is:

Participant 1

(What is a condom?) “Is a protector when you making some sex protect many diseases to come in you in the body.” (Who told you about them and how to use it?) “My mother when I grew up.” (Do you use condoms?) “Yeah I use it when I make sex.” (Who do you use condoms with?) “With my girlfriend, when I cheated on my girlfriend you know us guys we like the girls.”

Participant 2

“Is a protection.” “(My old teacher told me about condoms).” “Yes (I use them).” “(I used it) that time I was having sex with that person.”

Participant 3

“It’s a protecting for maybe sickness you see. I do use condoms but not all the time, with my girlfriend we don’t use condoms because of status.”

Participant 4

“Is a something like a plastic? My friend in the hospital told to use a condom all the time because AIDS is to dangerous. Always all the time.”

Participant 5

“Just a plastic thing used when having sex. I learned at school, my teachers and stuff.”

Participant 6

“Safe things like for HIV or other sex you see.”

Participant 7

“Something to protect you when you have sex. Most of the time I hear people talk. People in the streets friends, that we bigger than us older than me to they pass it to us. If I have somebody to have sex we use condoms [with everyone].”

Participant 8

“A choice. For if you want to take the condom or if you don’t want to take it. To use it.”

Participant 9

“It something that will protect from HIV. Make the sex use that thing to protect from HIV. If I want to make a child you see I am not wearing it you see. I don’t want a child I am not working you see.”

Participant 10

“It’s something that protects where you cannot be infected with AIDS.”

Participant 11

“It’s a plastic that protects you from having that virus called HIV. The doctors. Yeah all the time. They are for free in the shops or I buy them if I have money.”

Participant 12

“It’s to protect from AIDS.”

Participant 13

“Is something to protect you from AIDS. Yes all the time. My parents [told me about condoms].”

Participant 14

“Yes, all the time. (I use them with my girlfriend).”

Participant 15

“A protection that you wear during sexual intercourse I hear it from the TV, social workers and those student advisors that give condoms and tell you how to live life and also at school I use condoms most of the time when I am with my girlfriend.”

The basic definition, according to the participants, is that a condom is: a plastic protection against HIV and AIDS, but you do not use it if you want to have a child. Individuals’ motivation for using a condom or not coincided with “the development of the emotional content of their relationship” (Cusick & Rhodes, 2000:480). Similarly, not all the participants use condoms with every sexual experience. It seems more common to use condoms with people who are not your partner because of the uncertainty of their status, which makes them less reliable.

### 3.4.2.5 SUB THEME 2.5: THE EFFECT OF HIV ON STREET CHILDREN

This section deals with the participants relationships with individuals who are infected with HIV or AIDS. It also deals with whether they know someone who is infected and how they feel about that individual:

Participant 1

“Yeah he’s dead. Eh I was feel ashamed and shy to go to him I was giving him things to buy food when he was a life.”

Participant 2

“Yeah I know. I feel angry about it because when I saw him he is so small and he can’t most himself he don’t have the powers.”

Participant 3

“My sister, the one that died because of that thing. It was very painful I miss her. She suffered before she dies.”

Participant 4

“It was just my friend. She died. Eish, I was feel bad just because my friend the first time she was big but then when I go to the hospital then she was thin thin thin thin, I was asking what about my friend and she said you must you a condom because you don’t want to die young.”

Participant 6

“Yes I know. Eish I am feeling ashamed you see bad you see that person was so big you are losing weight.”

Participant 7

“I knew my parents and then they died. They both died of AIDS. When I was a kid I didn’t know that they had AIDS it’s just something I knew when I got older that my parents died of AIDS it was a big secret.”

Participant 8

“Yes. I don’t feel good. Because he is weak and changing, the face. Even the hair is changing, its fluffy it’s coming out. (do they take medication? yeah) Eish I don’t feel good because it’s not good HIV. Makes me scared, I’m scared that I get sick.”

Participant 10

“We even stay with a person, I feel very bad. In the situation they are stressed thinking about killing themselves we make food for them and take care of them they are more stressed than us you see.”

Participant 11

“Yes I always treat them night I get the fruit and stuff many of my friends have that you see, they are sick.”

Participant 12

“Yes eish it’s sad because I know that after some time they are going to die because of AIDS.”

Participant 13

“No not now, (parents died of it) my grandmother told me. I feel bad because they didn’t tell me first that they’ve got the sick, of HIV.”

Participant 14

“I feel very bad I feel ashamed for you. Because I know one day his life or her life is in danger they can die.”

Participant 15

“Yes I know, I feel bad but there Is nothing I can do because it has affected them and they also know there is this virus and they didn’t take it serious that is why I feel ashamed for them.”

Participants 5 and 9 said they had never known anyone with HIV or AIDS. Stereotypes of HIV and AIDS do not seem to apply as far as these street children are concerned. They talk about how they feel ashamed and sad for those who are sick or have passed away because of AIDS, but they do not talk negatively about the people who are infected with HIV, or of those who once were. However, they seem to have a somewhat apathetic view towards their illness. Most of the participants knew someone who had HIV or AIDS. These people were subjected to harassment, especially if it was a family member, which may explain why the children seemed to be caring or affectionate towards individuals who are infected (Evans, 2002:60).

Now the participants express how they would feel if they were HIV positive:

Participant 1

“I would feel ashamed but I would push for life.”

Participant 2

“Eish, I would feel angry [madam]. Because it’s heavy that thing.”

Participant 3

“If I can realize that I am positive I am going to use the ARV’s to give me a boost.”

Participant 4

“I would feel worried not feel happy. I would feel bad bad bad like I’m dead.”

Participant 5

“I would just take it the way it is, take medicine and stuff so I can live long you see.”

Participant 6

“Eish I would feel like maybe it’s better if I die.”

Participant 7

“I would feel angry sad not want it like maybe my life is over I don’t want AIDS. Because I see it’s killing people.”

Participant 8

“Make I will feel weak and I will feel my body is changing. I can go to see the doctor.”

Participant 9

“Eish, I can go stay at the hospital and someone can help me. Eish I don’t like that. Feel sad because maybe I am going to die.”

Participant 10

“I don’t think I would be here I think I would kill myself, living on the street we get sick more there are no clinics here where you can go and get pills for free we have to make money for then to get ARV’s when there is no money they get more sick.”

Participant 11

“I would want to live with that thing, you can’t get stressed thinking you are going to die you have to live with it like it’s a normal thing. “

Participant 12

“I would kill myself.”

Participant 13

“Feel terrible, because it’s not good to be to have AIDS. (is HIV and AIDS the same thing?) I don’t know.”

Participant 14

“Sad and feel like my life is doomed.”

Participant 15

“I would feel more aggressive because I know that my days are numbered. I could feel pain when it’s time to, if I have friend that are negative and they tell me about the disease it hurts you see.”

Some of the participants said that they would go into a deep depression and even contemplate suicide, while others said they would try to remain positive, live life to the full and get medication. They thus experienced a mixture of negative, neutral and positive reactions.

Next, the participants explain if they believe HIV could affect them or if they were susceptible to the virus:

Participant 1

“Yeah I know.”

Participant 2

“No.”

Participant 3

“I make sure I never get that’s thing.”

Participant 4

“No.”

Participant 5

“Uh, no”

Participant 6

“No no.”

Participant 7

“Yes if I don’t play safe.”

Participant 8

“I don’t think I can affect me [because I don’t have sex].”

Participant 9

“No.”

Participant 10

“No. because using a condom. If you use a condom and you take care of yourself. I didn’t use a condom once where I remember I didn’t use it.”

Participant 11

“Yes I can. Maybe my having sex getting a cut and blood.”

Participant 12

“No because I never sleep with someone or play with blood.”

Participant 13

“No because I like myself. I use condoms.”

Participant 14

“Yes.”

Participant 15

“No because I am protective.”

Most of the participants do not believe that HIV could affect them. In this context, the participants saw HIV as an infection rather than as something that would affect them emotionally as an individual. Some of the participants acknowledged that they could contract HIV, and others said they could not, for a number of reasons. Some reasons were, they use condoms, they are abstinent, they do not play with blood, or they feel invincible. These answers seem realistic, although no one knows how they would react in a certain situation. Many individuals who are diagnosed as HIV positive suffer from an adjustment disorder, including anxiety, depression, and a combination of both behavioural and emotional disturbances (Van Dyk, 2008:272).

#### 3.4.2.6 SUB THEME 2.6: HIV TESTING AND TREATMENT

The participants tell the researcher the appropriate avenues for being tested for HIV and say whether they have been tested:

Participant 1

“Hospitals. Yes, 4 times 6 times, I’m alright I’m negative, since last year I didn’t test this year.”

Participant 2

“Yeah at Mamelodi Day Hospital. Tested last year, tested 2 times.”

Participant 3

“Yeah at hospitals, any hospitals. Last year December, after one year.”

Participant 4

“Go to hospital. Yes, I think maybe it was last year February I only went one time.”

Participant 5

“At the clinics, hospitals. No never been tested.”

Participant 6

“To the doctor or the clinic or hospital you see. Yeah, to Mamelodi last year November.”

Participant 7

“At a clinic. No. I never thought of it.”

Participant 8

“Yes, in Mamelodi hospital. Yes, 2009 one time.”

Participant 9

“At the clinic. Yes, last year I have been tested two times.”

Participant 10

“Where there is surgery there are some people in the mall there South African Blood Service comes in there to test the blood.”

Participant 11

“The clinics and hospitals. No (never been tested)”

Participant 12

“At the hospital never been tested.”

Participant 13

“The clinic, yes last year twice.”

Participant 14

“Yes, clinics, hospitals, doctors surgeries. Yes, October. Once a month.”

Participant 15

“ICT or the clinics, yes on the street, the people that sit there on the street and they test you for free ... they take my blood with the injection and they just check it and after 30 minutes then tell me the results only once it was 2007.”

Lastly, the participants say whether they believe that AIDS is curable and suggest where people could go for treatment if they had HIV or AIDS:

Participant 1

“A cure is a disease. Medicine of AIDS I don’t know.”

Participant 3

“Yeah, ARV’s they are a good medicine for HIV.”

Participant 4

“Yes, when you get AIDS you must go to check up always at the hospital. Hospital and to the clinic. Just give you some tablets. (does it take it away?) Yes.”

Participant 8

“Yeah, you got AIDS you must go to check up you see it’s like make when you get TB (tuberculosis) you see. It cools off if you go on the treatment.”

Participant 10

“No I don’t think there is a cause, in the mall here there are the people who test for blood and others they ask for blood for people when they are there you can go and ask there.”

Participant 11

“No, in the clinics or hospitals ARV’s.”

Participant 13

“Yes because AIDS is killing (is that a cure?) Yes it’s killing, AIDS is not good.”

Participant 15

“No there is not cure there is only treatment, the treatment is anti retroviral drug it means its ARV.”

The remaining participants said there was no cure for AIDS. They did not know what the treatment was called and said that someone who was infected could go to the hospital or clinic for treatment.

### 3.4.2.7 SUMMARY OF THEME 2

**Theme 2:** HIV and AIDS - This included understanding the key concepts associated with HIV and AIDS, what it is, how it is transmitted, what the prevention methods are, where their information is obtained, how it affects them on an everyday basis and what the treatment options are.

**Sub theme 1:** General knowledge of HIV and AIDS - The participants spoke about what they knew about HIV and AIDS. The consensus was that it kills. Some mentioned the importance of wearing a condom, but the main theme was that it kills and you must be careful, because if you were to get it you would die. There was no reassurance or hope in their voices, no talk of medication; they went directly to the bottom line.

**Sub theme 2:** Information distribution - The purpose of this was to understand and identify what information the participants had been given about HIV and AIDS and who was dispensing it. This could hopefully extend the distribution basis. Although not many places appeared to be distributing information, the participants did talk about the mamas at the soup kitchen telling them to be careful and about the traveling HIV testing centers that go into areas to test.

**Sub theme 3:** Transmission - When it came to transmission, the primary ways were kissing with broken lips, touching blood, using needles, and having sex without a condom. They therefore had a grasp of both blood-to-blood contact and semen to vaginal fluid contact, yet they did not know about mother-to-child transmission.

**Sub theme 4:** Prevention - This sub theme entailed getting to know what the participants knew about prevention methods such as condoms. The participant's answers were similar, in that a condom is a plastic protection against HIV.

**Sub theme 5:** The effect of HIV on street children - Almost all the participants had lost their parents to the disease or had seen someone die from it before their eyes. Here the children were graphic about their stories of friends and family dying of AIDS and the physical changes their bodies went through when they were near death. Weight loss seemed to be a dominant feature that stood out in the participants minds.

**Sub theme 6:** Treatment - The participants knew that they could go to a hospital or clinic to be tested for HIV, although not many of them went regularly to be tested, and some had never been at all.

### 3.5 SUMMARY

This chapter focuses on the methodology used in the study, a description of the profile of the participants and research findings of these street children's thoughts, ideas, views and the understanding of sexuality and HIV and AIDS. Many opposing viewpoints are presented in this chapter as generated into the themes and sub from the data as discussed above.

Theme 1 and its sub themes derived from the interview schedule related to sexuality help correlate the participants' attitudes and beliefs about sexuality, including their belief systems as individuals with the bodies,

other's bodies and the mindset related to sexual activities. The sub themes included the following: intimate and/or sexual relationships, support base, body image, understanding key concepts and sexual behaviour.

Theme 2 and sub themes allow us to understand how children living on the streets feel, think and comprehend HIV and AIDS and how it infiltrates their everyday lives. The sub themes included general knowledge of HIV and AIDS, information distribution, transmission, prevention, the effect of HIV on street children and treatment.

The subsequent chapter deals with the conclusions and recommendations.

## CHAPTER 4

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 4.1 INTRODUCTION

This chapter presents a summary of meeting the goal and objectives of the study and the research question. Conclusions are drawn and recommendations for practice and research are set out.

#### 4.2 SUMMARY

##### 4.2.1 GOAL OF STUDY

The goal of the study was: “To explore street children’s knowledge of sexuality and HIV and AIDS in Pretoria, South Africa.” The goal was met as follows:

Chapter 2 was a literature review, which explored the primary concepts dealt with in this study. These are sexuality, HIV and AIDS. The following areas associated with street children were discussed: the causes of children living on the street, life on the streets, working with street children, and preventing children from going onto the streets. With reference to sexuality, this chapter discussed sexuality and youth. With reference to HIV and AIDS, the chapter explored the morbidity rates of HIV, primarily in South Africa, as well as the means of transmission, prevention, symptoms, stages and testing.

This empirical study focused on what the street children knew about sexuality and HIV and AIDS, as well as where they obtained their information. Presentation adhered to the following themes and sub themes. The first theme was sexuality and the sub themes were intimate and/or sexual relationships, support base, body image, understanding key concepts and sexual behaviour. The second theme was HIV and AIDS, and the sub themes were general knowledge about HIV and AIDS, information distribution, transmission, prevention, the effect of HIV on street children and treatment. Each of these aspects refers back to what street children know, understand, believe, feel or have experienced in relation to sexuality, HIV and AIDS, which was limited.

##### 4.2.2 OBJECTIVES OF THE STUDY

The objectives of the study were as follows:

- To conceptualize the phenomenon of street children and their knowledge of sexuality and HIV and AIDS;
- To explore street children’s knowledge of sexuality and of HIV and AIDS;
- To make recommendations for intervention with street children in relation to sexuality and HIV and AIDS.

The research study met the objectives in the following ways, which are discussed below:

- **Objective 1:** To conceptualize the phenomenon of street children and their knowledge of sexuality and HIV and AIDS.

This objective was met in a literature study. Chapter 2 drew upon available literature to provide a basis for the study and an understanding of sexuality and HIV and AIDS in relation to street children.

- **Objective 2:** To explore street children’s knowledge of sexuality and of HIV and AIDS.

This objective was met through this qualitative research study by conducting interviews, using an interview schedule and asking participants questions relating to their knowledge of sexuality and HIV and AIDS, which were transcribed and interpreted into different themes and sub themes. These are discussed in Chapter 3.

- **Objective 3:** To make recommendations for intervention with street children relating to sexuality and HIV and AIDS.

This objective is discussed in Chapter 4. Later in this chapter, recommendations are made, which are derived from the research findings. Conclusions are drawn later in the chapter to enhance the knowledge regarding what the participants know about sexuality and HIV and AIDS. This will hopefully help towards future research, as well as provide information to fill the gap in literature.

#### 4.2.3 RESEARCH QUESTION

This research question has allowed the researcher to explore the knowledge of street children’s sexuality, as well as their knowledge of HIV and AIDS and the role it plays in their sexual behaviour and everyday lives. The research question is:

What is street children’s knowledge of sexuality and of HIV and AIDS in Pretoria, South Africa?

The data collected during the interviews with the street children revealed various themes and sub themes relating to sexuality and HIV and AIDS, which is discussed in depth in Chapter 3.

#### 4.3 CONCLUSIONS

Themes and sub themes deduced during the qualitative interviews with the street children in Pretoria, South Africa, are set out below:

**Table 6: Themes and Sub themes:**

<b>Theme 1: Sexuality</b>	<b>Theme 2: HIV and AIDS</b>
<b>Sub theme 1.1:</b> Intimate and/or sexual relationships	<b>Sub theme 2.1:</b> General knowledge of HIV and AIDS
<b>Sub theme 1.2:</b> Support base	<b>Sub theme 2.2:</b> Information distribution
<b>Sub theme 1.3:</b> Body image	<b>Sub theme 2.3:</b> Transmission
<b>Sub theme 1.4:</b> Understanding key concepts	<b>Sub theme 2.4:</b> Prevention
<b>Sub theme 1.5:</b> Sexual behaviour	<b>Sub theme 2.5:</b> The effect of HIV on street children

The conclusions are structured according to the themes and sub themes.

#### **4.3.1 Theme 1: Sexuality**

The participants were largely unaware of what the word sexuality meant and did not understand how it related to them. They were not aware that sexuality could both relate to them through their sexual acts with themselves, others, boundaries, and gender preference. Thus, their knowledge of the term sexuality was limited.

- **Sub theme 1.1: Intimate and/or sexual relationships**

Many of the participants were or had previously been in a relationship, and all but two had been sexually active in this relationship. Their definitions of a relationship differed. Some preferred the idea of multiple partners, while others wanted monogamy. They believed that a partner is someone who bears your child, or someone whom you want to be the mother of your children. In some cases, they are also someone with whom you spend time and with whom you have intimate relations. However, they did not think of this person as a girlfriend, but as someone with whom you spend time. They are not 'attached' to this person in the way you are to the woman who is the mother of your child. The participants discussed feelings, and put forward the notion that this other person could help you through emotional and difficult times by making you want to be a better person or help with things around the house. The wish for a sexually intimate relationship seems strong, as is the wish for acceptance and appreciation. Experiencing this need so young could lead to infection with HIV, because of risky sexual activities with multiple partners, some of whom sell themselves for companionship or money.

- **Sub theme 1.2: Support base**

Many of the participants had no support base or anyone with whom they could discuss such topics as sexuality and HIV and AIDS, other than their peers, with whom they seemed to spend most of their waking and sleeping hours. These individuals assume the role of family, so whomever the children spend time with defines much of whom they are and what they know. Thus, if they spend most of their time with people on the street who are crime-oriented, then they could be exposed to negative actions and possibly get involved. Because there is no family or anyone else to warn them about crime, the children could end up dead or in jail. The different groups on the street behave in different ways and get their money through piece jobs and guarding cars. Children therefore have to be strong enough to find their own group. Usually the first group they meet and 'fall into' becomes their support.

- **Sub theme 1.3: Body image**

The way in which the children viewed their body image was overwhelmingly positive. This is interesting, because when they feel negatively about themselves emotionally, as most of these participants do, then the physical aspect of their bodies might also feel damaged, although this does not seem to be the case. All except

one participant said that they were confident and happy with their bodies and would not change anything about their external appearance. They were generally very pleased with the way they looked. These participants therefore appreciated their bodies and were comfortable in their own skin. This could be because they have more important things to think about on an everyday basis, such as how to find food.

- **Sub theme 1.4: Understanding key concepts**

There were a number of words or concepts that could have fit easily into another theme or sub theme, yet once the participants had answered the questions it became apparent that they did not understand certain concepts. When asked about the different terms, the participants gave somewhat outlandish answers. The researcher believes this was because they did not understand the vocabulary. The participants' ideas seemed ill formed, as they did not think about the word or try to expand on it, but stated the first thing that came to mind. In most cases, unless the participant really had no idea of the answer and possibly felt embarrassed, they always tried to answer the question fully and to the best of their ability, which was admirable. Children on the streets are in great need of information on sexuality and HIV and AIDS. The children struggled to understand key concepts and the meanings of certain words. This lack of knowledge could be changed only by educating the children on relevant topics to do with HIV and AIDS.

- **Sub theme 1.5: Sexual behaviour**

This sub theme discussed how the participants felt about their worth as sexual beings and what sexual activities they were comfortable taking part in. It also defined certain relationships, what the participants were willing to do for money and their feeling of being accepted. Primarily older men and women approach the children for sexual favors in exchange for money. Some of the children, when approached, perform sexual favors ranging from oral sex and anal sex to vaginal penetration, sometimes with and sometimes without condoms, usually depending on the buyer's preference. Many of the participants do not understand how they feel about selling their bodies to get through the next day. Some of them do not think about it and do whatever they can for money, some do not enjoy the experience, while others long for sexual and emotional contact. One participant said he wanted to be with [someone], even him. He therefore felt the need for companionship and felt this was a good way of finding it. These acts put the client and the child at risk of sexually transmitted infections (STI) and HIV, not to mention the possible physical and emotional abuse that could occur with either heterosexual or homosexual clients.

Children on the streets are sexually active, as emerged from the study. Children should learn to appreciate their own worth as individuals and know who they are. It is saddening that most of the children presume they will be paid if they are sexually active with certain people. This destroys the developmental process and understanding of sexuality, which could severely disturb the individual's idea of relationships and sexuality later in life. Sex is regarded as a service, something one does for money, not for love in a relationship, or for procreation. If later the individual finds a woman who wants a healthy sexual relationship, the man may expect something in return,

or be unable to give himself emotionally to the woman in the way she wants, because this is not what sex means to him.

#### **4.3.2 Theme 2: HIV and AIDS**

Here the participants talked about what they think HIV and AIDS is. They define these topics from what they make up, what they think they have heard or what they were told when they were at school or in clinics and soup kitchens.

- **Sub theme 2.1: General knowledge of HIV and AIDS**

This theme goes towards showing what the participants know about HIV and AIDS in a broad sense. Whatever they thought of when asked about HIV and AIDS was included in this sub theme. The two main points raised were that HIV and AIDS kill and you could become infected if you do not use protection during sexual intercourse. Their general knowledge base is therefore very limited. The idea that AIDS kills was very common in this study. The participants did not understand this is a disease that someone could live with and remain healthy by taking medication. Instead, it is a death sentence. As far as they were concerned, the only avenue for transmission was sexual intercourse, meaning vaginal intercourse. Their general knowledge was low and they misconstrued the idea of HIV because of what they had witnessed on the streets, and their friends and family dying of AIDS with no support and no medication.

- **Sub theme 2.2: Information distribution**

The participants talked about where, if ever, they had received information about HIV and AIDS. Some of them had previously been at school, although they had not all received information on HIV and AIDS. Very little information on HIV and AIDS is distributed to children on the streets. Nevertheless, the participants seem to appreciate the limited information they can gather. They seem to acquire most of their information in clinics, soup kitchens, schools and from activists passing by.

- **Sub theme 2.3: Transmission**

The participants understood that blood and sex were avenues for HIV transmission, but most of them did not know the extent of these, and none of them mentioned mother-to-child transmission. Thus, their level of knowledge was very basic and lacking. The participants understood that contact with blood and having sex without a condom might give them HIV, but that was the extent of their knowledge. Many of them did not know how these methods of transmission work.

- **Sub theme 2.4: Prevention**

The participants were well aware of condoms, but were not familiar with any other contraceptives or means of prevention. Although in some cases it was challenging for the participants to define what a condom was, almost all of them said it was “a protector.” It was not identified that the condom protected against anything else other

than HIV and there were other family planning regiments. Billboards, commercials and the free distribution of condoms in South Africa have had some success. When asked what a condom was, some were not even able to describe what it looked like, and merely said it was a protector. Given that, condoms have proven to be the most well known preventative measure considered in this study.

- **Sub theme 2.5: The effect of HIV on street children**

Many of the children have lost someone due to AIDS, and are surrounded by people on the streets who have AIDS but are not accessing treatment and are dying. They feel the need to help these ailing individuals but it should not be their responsibility to take care of them.

It was challenging for some of the participants to talk about this, because almost every one of them had a friend or family member who was dying or had died of AIDS. Most of the participants lived in the same surroundings as those who were dying, without access to medication. They were therefore watching these people perish. The support from the children and others within the street community for individuals infected with HIV or AIDS was strong. They were helpful, and they mentioned assisting people with food and other necessities. Stigmatization associated with the actual disease seems to be reasonably rare, although getting the disease, as discussed before, is viewed as a death sentence. The participants were very deeply affected by HIV and AIDS, and it is a part of their everyday lives. They do not take care of only themselves but also of the others in their families and communities who are close to death.

- **Sub theme 2.6: Treatment**

Most of the participants thought it was possible to get medicine at the clinic or hospital if you were sick. Some thought AIDS was curable and referred to it as being the same as tuberculosis.

This was not discussed in the interviews, but the researcher heard this on the street and saw it for herself. The children understand the concept of going to the hospital to receive treatment, but some of them think AIDS is curable, while others say they would not even consider treatment. Some of them said that if they became HIV positive while still living on the street, they would end their lives to avoid suffering.

HIV and AIDS are thus familiar to these participants. They see it every day, or have lost someone from the disease, which they carry with them emotionally. However, their knowledge of HIV and AIDS is limited. They are rarely given information about the disease and, when they are, they are usually just told to wear a condom. Although this is a very good message, they are not given more information than that. The use of condoms is not restricted to male to female penetration, but they can also be used during most forms of sexual action. The participants did not know this. However, if they do know, but still do not use the condoms knowing that the risk of becoming infected is so high, we must ask where health care is placed on the participant's priority scale, especially if they know it will be challenging to obtain medication.

These participants had very little understanding of the remaining sub themes discussed, that is, general knowledge of transmission, prevention and treatment. These problems are deep-seated and will never be resolved without education and information distribution. There is no access point for the children to learn this information on the streets. The shelters are to maximum capacity and there are few volunteers who dedicate their time in teaching HIV and AIDS education. The participants do not know where to find the information on their own, therefore this is a vicious cycle that has to be broken through the intervention of knowledge, which will lead to safety and power over one's body and mind.

### **4.3 RECOMMENDATIONS**

The recommendations below relate directly to this study:

- Education distribution should take place within the communities regarding stigma and neglect, through social workers going into communities and relaying information about HIV in every community and how street children are living. Children should be regarded as individuals rather than being judged by their family's reputation or banished from the extended families home if their parents have died of AIDS. This is understandably a cultural dilemma, but helping the families realize the full extent of the disease may alter their mindset of how the children should be treated. Rather than extended family taking no responsibility for the child, and sending them to the street, the child should be seen as an individual with their own decision-making skills not to be aligned with their parents.
- Government services should enhance the support base for children living on the streets. It is important to make contact with their families, who should be aware of their conditions. Therefore, the families need to be found or spoken to about family responsibility and neglect, meaning improving legislation in this regard.
- Services should be rendered by both the state and NGOs to those children living on the streets who are not in shelters.
- NGOs and the state should create more shelters and greater access to shelters, where street children could have a place of their own. This would help the children build a wider and more productive support base. Seeing others who have surmounted the street, and are now enrolled in school with a place to call home may help the children plan for the future.
- Social workers, psychologists and lay counselors should be available through NGOs or as volunteers to street children if they need to talk about the emotional experiences of living on the streets or the effects of HIV and AIDS in their lives.
- Students at higher education institutions, as part of their community engagement responsibilities, should be encouraged to get involved with street children i.e.:
  - Education students can offer lessons for schooling.
  - Medical students can offer medical checkups and can spread general knowledge about HIV and AIDS.
  - Social work students can render much needed intervention and spread general knowledge about HIV and AIDS.

- Students in the Arts, such as drama and music, can educate through street theater and involve these children in these activities, thus developing new skills, build confidence and hopefully get them off the street. They can also hold road shows or “street theater’s” teaching others about HIV, prostitution, violence, drugs and other dangers of living on the streets through acting and song.
- Sport science students should be encouraged to become involved in working with street children and using sport as an incentive and learning tool. Using this could be a positive force in developing programs, such as physical exercise for example could help them release energy, reduce stress levels and in doing so, lead to a more balanced and healthy life.
- Volunteers from the community, churches, schools, hospitals, clinics and other established organisations should place information in soup kitchens or have mobile medical services (i.e. vans that travel to different locations checking individuals’ status). These services will facilitate advocacy to the youth on the street, provide information and answer questions for the children to stay HIV negative or educate them on how to live a healthy life as a HIV positive individual. For example, venues such as soup kitchens and schools have been avenues that proved workable and should therefore be encouraged in communities. NGOs and community leaders ought to be available and visible, giving information on a regular basis, focusing on sexuality and HIV and AIDS, to keep the children aware of their health, HIV status, emotions and their bodies. This would allow the perfect opportunity for children to ask questions in a supportive environment. This will also help them take responsibility for their actions.
- Program development through as many avenues as possible i.e. tertiary institutions, schools, NGOs and government is essential, along with the assessment of already-existing programs. Monitoring the effectiveness of school curriculums, which deals with HIV and AIDS in Life Orientation is important. A number of the child participants who had been enrolled at school earlier in their lives and had received information in class on HIV and AIDS no longer remember what was discussed, or else they said it had not been discussed thoroughly. As a preventative measure, schools should integrate courses into their curriculum about the possibilities and dangers of becoming a street children and explaining the harsh realities of life on the street and emphasise the importance of education.
- ARV medication should also be easily accessible for those who need to receive them. Allowing HIV positive street children to take their medication at the clinic and monitoring them there, rather than keeping it with them on the street is advised, to help eliminate the theft of ARV’s for others’ personal use, i.e. to mix with other drugs to get high. It is crucially important to educate the children on ARV treatment, adherence and where it can be accessed. They should also learn how they could live a long healthy life as an HIV positive individual with a lifelong commitment to ARV’s.
- Research should be conducted on a larger scale nationally to determine the actual extent of street children as phenomenon in South Africa.
- Research similar to this study should be conducted on a national scale, to be able to generalize these findings and make appropriate recommendations that can be launched on a national level.

The recommendations below are broader recommendations, which apply to street children:

- All children have the right to education, treatment, family life and more in accordance with the Constitution of the Republic of South Africa, Act 108 of 1996. Thus, street children should be receiving more direct services from the state in order to help them receive the proper and promised services to help get them off the streets. For example, policies focusing on the needs of current street children as well as the prevention of future street children should be implemented, planned and evaluated regularly.
- More shelters should be made available nationally by the state to address the increasing problem of street children being left with nowhere to go.
- Tertiary institutions, specifically schools of social work, should incorporate some content of street children into a module in the existing curriculum, in order to train future social workers on this phenomenon and educate them on how to intervene appropriately.
- Training and service delivery for auxiliary social workers to work with street children should receive attention.

The crucial recommendations below include possible long-term actions that could be taken to help these children find a more normal and possibly successful life:

- Housing and shelters could be made available by turning certain churches buildings or business premises into shelters at night. Rather than charging a fee for the shelter, the children could clean or do other work for the establishment, creating a positive alternative for both parties.
- Education should be encouraged and made possible to these children. This can be done by using volunteers such as retired teachers or students training to become teachers. There could be available, free transport to and from the school. Currently, the children are unable to pay for transport, or it is simply not available so they cannot go to school. Alternatively, classes could be available three times a week or for half days, allowing the children to work and earn money during the week for survival.
- Jobs should be created for the children to boost their confidence, help them with skills development and allow them to make enough money to have somewhere to grow or buy food. Jobs could be created in the form of piece jobs, cleaning and cooking. Finer tradesmen skills such as electrical work, welding, painting or repairing cars should be developed. Creating skills classes for the children to learn a trade and use it would help reduce the number of children on the street.
- Support should be enhanced by providing individuals who are readily available in the community with whom the children discuss their concerns, possibly at a shelter. Having support and someone to listen is necessary for any developing adolescent. Informing the children about what is already available in the area is also necessary.
- Drug and alcohol counseling and education on the causes and effects of drug use should be available in the hope that the children would desist from further use.

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## **APPENDICES**

**APPENDIX 1:**  
**ETHICAL APPROVAL LETTER**



7 December 2010

Dear Prof Lombard

**Project:** The knowledge of street children in Pretoria, South Africa, of sexuality and of HIV and AIDS  
**Researcher:** NS Montañez  
**Supervisor:** Dr CL Carbonatto  
**Department:** Social Work and Criminology  
**Reference number:** 28536747

Thank you for your response to the Committee's correspondence of 29 November 2010.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 6 December 2010. Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

**Prof. John Sharp**  
**Chair: Research Ethics Committee**  
**Faculty of Humanities**  
**UNIVERSITY OF PRETORIA**  
**e-mail: john.sharp@up.ac.za**

**APPENDIX 2:**  
**CHILD ASSENT LETTER**

## Child Assent Letter

### Research Information for Participants under 18 years of age

Researcher: Nicole Andree Montanez

**Title of the Study:**

Street Children's knowledge of sexuality and HIV and AIDS in Pretoria, South Africa

**Information:**

Thank you for considering being a part of this study. This letter of informed assent will provide information about the research, what it is about, why it is being done, and what it means for you to participant. If you have questions please ask.

**Purpose of the study:**

This study is about understanding what street children know about sexuality and HIV and AIDS. There is little information on what street children know and how they gain their information. This study is being done to become aware of what street children know and to gain an in-depth understanding of how they feel about their bodies, sexuality, and what is known about HIV and AIDS and if it has affected your life. If you explain what you know about these subjects then it will be easier for people and organizations to better implement programs, so that you can make safe and conscious decisions about your body and HIV and AIDS.

**Procedures:**

The researcher will meet with you the first time to discuss this letter of assent and if you agree voluntarily to participate, you will be given a copy of this letter you have signed. Then an appointment will be made with for an interview at a time that is convenient for you. The interview will be conducted with you, so you can answer questions that will tell the researcher what you know about sexuality and HIV and AIDS. This interview will be tape recorded, so that researcher can use this information for her research. the University of Pretoria or a shelter in your area, where it is safe. Some of the questions may be personal for you and therefore difficult to talk about. You may ask the researcher to stop the interview at anytime. You are also allowed to ask questions at any time.

**Potential benefits:**

Your participation in this study will help future researchers understand what street children know about sexuality and HIV/AIDS, through this more services may be provided to street children and a better understand of street children will be achieved.

**Your rights:**

The researcher will do their best to ensure that your rights are upheld. The study is completely voluntary and you have the right to withdraw at anytime without negative consequences. You also have the right to ask questions or voice any concerns in the interview.

**Confidentiality:**

All of the information you provide in the study will be confidential. Your name will not used in the research report and your identity will be kept anonymous. All records from the study will only be handled by the main researcher and after that will be safely and securely stored at the University of Pretoria for 15 years. If you withdrawal from the study at anytime the information that you provided will be destroyed.

**Access to the researcher:**

If you have any questions you can contact the researcher. It is your right to have access to the researcher and you have control over your participation.

Researcher: Nicole Montanez

E-mail: [montaneznicole@yahoo.com](mailto:montaneznicole@yahoo.com)

Sincerely,



Nicole Montanez

Researcher

Dr. C. L. Carbonatto

Supervisor

## Consent Form for under 18 year old Participants

Please sign the below consent form

I understand what has been explained to me, and I understand what it means to take part in this study. This hereby shows that I agree to give informed assent to take part in this study.

I, \_\_\_\_\_ hereby freely give permission to take part in this study as explained above.

### **Participant:**

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Name in Print: \_\_\_\_\_

### **Researcher:**

I have explained the study to the participant, and provided him/her with a copy of the participation information sheet.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Name in Print: \_\_\_\_\_

**APPENDIX 3:**  
**INTERVIEW SCHEDULE**

## Interview schedule:

# The knowledge of street children in Pretoria, South Africa, of sexuality and of HIV and AIDS

### Part One: STREET CHILDREN

- How old are you?
- How would you define a street child?
- Why do you think there are street children in South Africa?
- What do you do to get money? How much money do you get?
- What do you use your money for?
- Tell me where you get food, water and clothing?
- Tell me where do you wash and use the bathroom?
- Tell me where do you sleep?
- Is there anyone you can go to for help when you are in trouble?.
- Do you sometimes feel sad or angry?
- Do you have any family? Tell me about them.
- Do you have any friends? Tell me about them.
- Do you have friends that smoke cigarettes? Do you smoke cigarettes?
- Do you have friends that drink alcohol, sniff glue or take any drugs?
- Have you ever drank alcohol, sniffed glue or take any drugs?
- Tell me why do you think your friends take drugs?
- How did you come to live on the street?
- How long have you lived/worked on the street? Maybe about 5 years
- How do you feel about living /working on the street?
- Have you ever gone back home and then ended up back on the streets again?
- Have you ever been arrested?

- If street children no longer want to live on the street what can people do to help street children get off the street?

## **Part Two: SEXUALITY**

- What is sexuality?
- Who do you talk to about sex and sexuality?
- What does a boyfriend or girlfriend mean to you?
- Do you have a boyfriend or girlfriend?
- Do you have sex with your boyfriend/girlfriend/others?
- Do you like everything about your body?
- Have you ever been exposed to sexual behavior?
- Have you ever been approached by someone for sex or sexual favors?
- Are you sexually active?
- What are contraceptives? Do you use them?
- If you have sex, how often do you have sex and with who?
- If you do not want to have sex are you able to say “no”?
- If the other person does not want to have sex but you do, do you think they have the right to say “no”?
- Have you ever been forced to have sex or raped?
- Tell me the reasons why you have sex?

## **Part Three: HIV and AIDS**

- What do you know about HIV and AIDS?
- Have you ever been given information about HIV and AIDS? Where did you get the information from?
- Can you tell me how someone becomes infected with HIV?
- Do you think HIV can affect you?
- What is a condom? Who told you about them and how to use it? Do you use condoms? Who do you use condoms with?

- Do you know someone who is HIV positive or has AIDS? If yes, how do you feel about them?
- How would you feel if you were HIV positive?
- Do you know where to go to get tested for HIV? Have you ever been tested for HIV?
- Do you think there is a cure for AIDS? Where do you go for treatment of AIDS?
- Any questions or comments?