South African Street Children at Risk for AIDS?

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AIDS and the African Adolescent

When AIDS was first identified, it was believed to be a disease which was transmitted primarily through homosexual contact. Subsequently it has become clear that AIDS is an "equal opportunity disease" to which everyone is susceptible (DuPree 1993). In recent years there has been increasing concern about the susceptibility of adolescents to HIV infection and AIDS because of the prevalence of unprotected sexual intercourse and the extent of teenage drug use (Wendell et al. 1992). Adolescents also typically perceive themselves as physically and psychologically invulnerable (Moore and Rosenthal 1991), a perception which is believed to be at the root of much high-risk behavior and which could account for what has been found to be their generally casual attitude towards risk for HIV infection.

Although African students in South Africa (in both Johannesburg (Friedland et al. 1991) and Cape Town (Mathews et al. 1990)) have a good basic knowledge of AIDS (that it is incurable, and mainly a sexually transmitted disease), they have many misconceptions about transmission; this also appears to be the case abroad. The African youth in South Africa appear neither to perceive themselves at risk for infection nor to take precautions to prevent it (Friedland et al. 1991; Mathews et al. 1990). These findings are of great concern since in Africa and elsewhere, girls between the ages of 15 and 24 years now comprise half of the world's cases of HIV infection; infection in males tends to peak about ten years later (Foster and Matenga 1993). African adolescents in the South African township of Alexandra claim that they cannot get AIDS since it is a disease "of the older people." Girls who are sexually active hide this fact from their mothers and seem to believe that they will neither fall pregnant nor be infected with HIV. For teenagers in Alexandra, AIDS is unreal. When urged to stick to one sex partner they answer that this is exactly
what they do. However, closer questioning reveals that this fidelity usually lasts for periods of about three months only. It is clear, therefore, that they do not have a full understanding of the implications of their sexual activities nor do they accept that virus transmission routes have any relevance for them (Serote 1993).

Sleep
Photo: Terence O’Hara

Apart from seeing AIDS as a distant threat, adolescents have also been found to have an antipathy to the use condoms. There are two main drawbacks to their use: condoms are said to spoil sensation and condom use is thought to imply suspicion of either the sex partner’s fidelity and sexual health or one’s own. Two South African studies that examined African students' views on condom use found that students neither liked nor used condoms for the reasons given above. In addition they found community attitudes difficult to cope with (Abdool Karim et al. 1992; Frame et al. 1991); many students said that visiting family planning clinics is embarrassing and that they are treated with hostility by cashiers when they try to buy condoms (Abdool Karim et al. 1992). This is not uncommon elsewhere in the world; health and counseling services tend not only to be inappropriate, but also inconvenient and unattractive to adolescents.

This is the case despite the fact that there is extensive evidence that children become sexually active at an early age, that they will have had many sexual partners by adulthood and that they have high rates of Sills (sexually transmitted diseases) (Hein 1992).

In addition to these drawbacks, African students felt that condoms were incompatible with notions of manliness and said that they were not readily available when sexual opportunities arose. They added that condoms "waste sperm" and said that if a condom should slip off and be left in a woman’s vagina, this could lead to her death (Abdool Karim et al. 1992). Although it is known that these objections have also been voiced by adults in other parts of Africa, documented material is difficult to obtain. In a study for the WHO (World Health Organization) in Rwanda, more than half of the women who said that they disliked condoms gave as a reason that condoms could remain lodged in the vagina after intercourse (Carael et al. 1988). Sperm "wastage" may be associated with the belief that pregnancy should not be prevented during intercourse; in Africa female fertility still confers status and increases self-esteem (Brydon and Chance 1989; Preston-Whyte 1990). For instance, the African high school students in Natal viewed condoms with suspicion because of their contraceptive properties, believing that fertility should not be inhibited. In addition, they objected to the retention of sperm in condoms as they believed that this not only inhibited full sexual satisfaction but also prevented a woman from knowing that her male partner was fully satisfied (Abdool Karim et al. 1992). Condom retention and the notion of sperm wastage appear to be linked in
that both are related to a traditional belief that in sexual intercourse there must be an intermingling of bodily fluids (Carael et al. 1988).

**Street Children as a Group "at Risk" for Contracting AIDS**

As young people, street children have much in common with other adolescents, but some of their risk behaviors are more extreme. Not only do they have the adolescent's sense of personal invulnerability (Bond et al. 1992), but they tend to become sexually active sooner (on average at about 12.5 years of age), and to have more sexual partners than home-based adolescents. Many street children are raped; the sexual abuse of street girls abroad is 20 times higher than that of women in general (Sondheimer 1992). In America the likelihood that a child will be exposed to sexual abuse has been estimated to be about 30 percent when living at home, 85 percent when living on the streets, and up to 100 percent when in state detention (U.S. Senate Committee 1986). About 70 percent of street children in the United States who seek assistance at emergency shelters have suffered severe physical abuse or sexual molestation on the streets (Hersch 1988). Other articles in this volume [of Africa Insight] show that the sexual abuse of street children is widespread in Africa.

Street children are commonly forced to engage in survival sex and find that their clients often prefer, and pay more for, penetrative sex without condoms. A man who has been "hustling" on the streets of America since he was 14 years old explained that persons who bought sex wanted to buy fantasy, not reality; "They want fantasies. ...Condoms aren't part of fantasies. AIDS isn't part of fantasies, AIDS has no impact on what's going on in the streets" (Hersch 1988). Survival sex includes marketing sexual gratification on the streets in less direct ways; for instance, through the open sale of pornographic material where such material is not banned. Ten-year-old Sasha, an ulichnei deti (street child) from Moscow regularly makes more money in two days than his parents do in a month through his sale of pornographic magazines which exposes him daily to visual images of every conceivable form of sexual variety (Sarfati 1993). Apart from survival sex, street children also tend to have sexual partners of either or both sexes who may be engaged in survival sex and who do not use condoms. They distinguish clearly between the two forms of sex they have on the street; as one street youth in California explained, survival sex is "sex you gotta do," and sex with chosen partners is "sex you wanna do" (Pennbridge 1992). Because condoms are rarely used and sexual activity begins early, there is a high rate of pregnancy and STDs amongst street youth (Sondheimer 1992). It is well known that having an STD increases vulnerability to HIV infection (Department of National Health 1992).

The extent of hard drug use among street children in South Africa is unknown. There is a tendency to smoke dagga (marijuana) and to inhale the fumes of glue, petrol, benzine or thinners rather than to use hard drugs. In recent years there has been an increase in the smoking of "white pipes," a mixture of ground Mandrax and dagga. A situational analysis drug use amongst South African street children is urgently needed since it is common knowledge that drug racketeering is on the increase in South Africa. In parts of Latin America, street children are extensively involved in drug networks and there is an added danger of their becoming HIV
infected through the use of contaminated and shared injection needles (Goode 1987; Pollman 1986).

Because rigorous seroprevalence studies tend to be undertaken only if institutions, and street children lead, peripatetic lifestyle, the incidence of HIV infection amongst street youth it as yet unknown. However, some attempt has been made to test street children for HIV infection and the results indicate that seroprevalence rates tend to be higher than those for adolescents in general, ranging from 2 percent to 10 percent of street children in both industrialized and developing countries (Athey 1991; Childhope International 1989; Knaul and Barker 1990), while rates for other groups of adolescents are in the region of 0.2 percent to 0.4 percent (Sondheimer 1992).

**AIDS and African Street Children in South Africa**

**The Street Child Phenomenon**

The majority of street children in South Africa, of whom there are an estimated 15,000 (Swart-Kruger and Donald 1994), are African, although there are large numbers of so-called colored street children (i.e., children of mixed racial descent) in the Cape. This is partly due to the population distribution in South Africa, according to which proportionately fewer African people and more colored people live in the Cape. Street children also tend to come from the lower end of the socio-economic scale; in Cape Town, 83 percent of a sample of street children came from homes where household income fell into the lowest of three segments for the population as a whole (Giles 1988). Although the personal history of every street child is different, poverty, exacerbated by the apartheid system, appears to be the root cause of African and colored children ending up on the streets (Richter 1988; Swart-Kruger and Donald 1994).

As elsewhere in the world, South African street children are found in towns and cities but there have also been reports of children living alone or in groups in the veld and of children living on, in or near mine and rubbish dumps, mostly in close proximity to major cities. Children are generally about 10 to 12 years of age when they first take to living on the streets, but street children as young as four years of age have been found in Johannesburg and Pretoria.

**AIDS-Related Knowledge, Attitudes, Beliefs**

In 1992 the South African Department of National Health and Population Development commissioned the authors of this article to undertake a study on the AIDS-related knowledge, attitudes, beliefs and general sexual and behavioral patterns of street children in South Africa (Richter and Swart-Kruger 1993). Except where otherwise indicated, the information in the following sections is from this study, which is referred to briefly where necessary as "the South African study."
TABLE 1  Modes of AIDS transmission as perceived by South African and Australian street children and American school children.

<table>
<thead>
<tr>
<th>AIDS can be transmitted by:</th>
<th>SA shelter groups (percent) n=79</th>
<th>SA street groups (percent) n=62</th>
<th>Total: SA groups (percent) n=141</th>
<th>Brisbane street youth (percent) n=40</th>
<th>USA high school students (percent) n=8098</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing with or sharing injection needles</td>
<td>96</td>
<td>85</td>
<td>91</td>
<td>55</td>
<td>99</td>
</tr>
<tr>
<td>Anal sex</td>
<td>97</td>
<td>79</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral sex</td>
<td>68</td>
<td>100</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving blood</td>
<td>66</td>
<td>69</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donating blood</td>
<td>52</td>
<td>63</td>
<td>57</td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>Kissing</td>
<td>56</td>
<td>73</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking from the same glass</td>
<td>44</td>
<td>66</td>
<td>54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing a cigarette</td>
<td>47</td>
<td>56</td>
<td>51</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Breathing the same air</td>
<td>32</td>
<td>42</td>
<td>36</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Sitting on the same toilet seat</td>
<td>32</td>
<td>31</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touching someone who has AIDS</td>
<td>22</td>
<td>34</td>
<td>27</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The South African study was conducted in seven major South African cities and altogether 141 children between the ages of 11 and 18 years (mean age= 15 years) took part. Sixty-two of the children were living and working on the streets and 79 children who had been living on the street were housed currently in city shelters. Focus group discussions were arranged with groups of not more than eight to ten children at a time and were standardized by means of an interview schedule including a mix of open-ended and closed questions. Responses were recorded and content analysis used to assess the data.

**HIV- and AIDS-Related Knowledge**

None of the street children in the South African study knew what HIV meant, but all except five of them had heard of AIDS and most knew that AIDS is an incurable disease. Most of the street children knew that AIDS can be contracted sexually and they referred to casual sexual encounters and anal and homosexual sex especially as routes of transmissions. However, it became clear that they did not completely understand how AIDS was transmitted since they also indicated other (incorrect)
routes for transmission. Fairly mundane contact with infected persons, for example breathing the same air, was considered to put one at risk of getting AIDS. These findings are illustrated in Table 1, in which the main transmission routes given by the children are summarized.

Table 1 shows that there were differences in the perceptions of South African children still living on the streets and those who had left the streets to live in city shelters, but in addition, it shows that street youth in Brisbane, Australia (Matthews et al. 1990), had some of the same misconceptions regarding routes of transmission as the South African street children. American high school students (Kann 1991) whom one might expect to be more conversant with transmission routes, had certain misconceptions as well. Whereas the American youth identified the communal use of toilet seats as a probable source of HIV transmission, the street children, most of whom seldom use toilets, identified communal street activities such as sharing cigarettes. As noted earlier, African scholars and students in South Africa also have misconceptions about AIDS transmission.

The 141 children in the South African study had a limited and stereotyped notion of the people most likely to get AIDS. Gay men (moffies or bunnies) and female prostitutes were considered to be most at risk for infection, followed by persons who lead a promiscuous lifestyle. In addition the children mentioned people who exploited them sexually or in other ways as people likely to get AIDS. Only two groups said that street children were at risk of infection. While 5 percent of children said that only African people got AIDS, the groups from Natal were adamant that African people, and the Zulu people in particular, could not get AIDS. Most children (95 percent) agreed that men could get AIDS from women and from other men; 99 percent agreed that women could get AIDS from men and 85 percent agreed that children could get AIDS from adults. Only 66 percent agreed that children could get AIDS from other children and 15 percent were convinced that children could not get AIDS at all. The belief that children are invulnerable is, therefore, not as widely held among street youth as recorded earlier for the African home-based children in Alexandra.

In common with many adolescents, more than two-thirds of the street children in the South African study believed that people who look healthy could not have AIDS (Strunin and Hingson 1992), and that it was possible to identify persons with AIDS from their external appearance; on this basis one could associate or avoid associating with them. Some of the symptoms of AIDS that they identified were: looking "thin;" being weak; having sunken eyes; having pimples or sores and being constantly itchy; being unable to walk; and losing hair. Some of these symptoms have been evident in pictures in the news media of persons dying of AIDS and they are not, therefore, totally inaccurate. Nonetheless, they reflect the children's lack of knowledge about HIV infection and the latency period between HIV infection and AIDS; they seem to presume that full-blown AIDS develops virtually instantaneously, as do many other diseases.

Most of the children in the South African study knew that AIDS is incurable but some believed that it could be cured by sangomas (traditional healers), who have
extensive credibility in the African community in South Africa. In Alexandra township, for instance, 80 percent of the inhabitants seek treatment or advice from them regardless of whether they also approach western practitioners (Serote 1993). Recently it has been found that Tonga healers have doubled the white blood cell count of 26 HIV-positive patients whom they have been treating with herbal remedies (DuPree 1993), thus the faith of African street children in the powers of traditional healers to treat AIDS in the long term may not be so farfetched as it currently seems to the western mind.

In the South African study, 99 percent of the children said that they knew what a condom was and 85 percent said that they knew how to use one. The Xhosa children in East London called them isingxobosentonga or fakentongeni which, broadly interpreted, means "a sack for a stick." The Sotho children called them kgohalopa, a term derived from the phrase for "pull on boots." Terms derived from Afrikaans were balrekke (literally: ball elastic) and Pieprekkers (literally: penis elastics), and English terms included balloons, coats and bum suckers. Although some children said that they had raided the rubbish bins of doctors and, hair salons for rubber gloves from which they then cut the fingers for use condoms, without first washing the gloves, most admitted to not using condoms.

**HIV- and AIDS-Related Beliefs and Attitudes**

Homeless youth tend to be oriented to the present and this was also the case with the children in the South African study, whose priorities were found to lie in daily activities. The priorities for children in shelters were: cleanliness (100 percent), playing sport (90 percent), schooling (70 percent) and food (40 percent). For those still living on the streets, the highest priority was food (80 percent). Playing sport, schooling and clothing were less important (30 percent), and other priorities were money, sex, glue, avoiding the police, and cleanliness (10 percent). The children admitted that AIDS prevention played no part in their daily lives.

The feeling that AIDS is a distant threat is common among adolescents in general (Bond 1992) and was also found among African students in Cape Town (Mathews et al. 1990). Kirby (1992) and others have suggested that one of the reasons why adolescents find it difficult to see themselves to be at risk for HIV infection is because they have a limited personal knowledge of persons suffering from AIDS and seldom know anyone who has been diagnosed as HIV-positive. Only three of the street children in the South African study said that they knew, or knew of people with AIDS. No street children they knew had ever been found to be HIV infected, which probably made the disease more remote for them. In 1989, over 60 street children in a Johannesburg city shelter, who agreed to HIV testing, were found to be free of infection (Andrews, n.d.) and ten of the 141 street boys in the South African study had been tested for AIDS. Of these, three had been tested on their own initiative and seven at the insistence of various authorities (in some instances their parents). Five of the ten boys were told that the tests were negative; the other five were not told the outcome of the tests and presumed that they were negative.
The children's notions about the origin of AIDS were vague, but most believed that it is a foreign disease which probably came from America and from white people. Some believed that homosexuals and exiles, "the city," African countries (such as Zimbabwe, Ethiopia, Somalia and Tanzania), or inter-racial sex, were the source of AIDS. Some street children, especially those in Natal who said that Zulu people could not get AIDS, considered AIDS to be a scare tactic of the South African government to pressurize Africans into using contraceptives, while others believed that it was a germ introduced by the government to wipe out the African population.

Despite all the street children's statements concerning who was or was not likely to get AIDS, the most pervasive feeling among them was fear that they might get it. Pity was expressed for people who might have AIDS, and anger because of the danger it posed as well as their lack of information about its source. It is probable that their feelings are exacerbated by their general lack of knowledge of what AIDS really is and the mechanisms by which one may be affected. Other research has found that the less knowledge people possess about AIDS, the greater their fear of it (Petosa and Wessinger 1990).

Although the children expressed pity for those with AIDS, they also took a strongly punitive stance, saying that they would not associate with such people, and recommending that they be killed or isolated from society. This feeling concurs with that of home-based adolescents in other studies (Eiser et al. 1989; Kann et al. 1991). Some children in the South African study felt, nonetheless, that they would treat friends who contracted AIDS kindly, and that they would like to be treated normally by others if they were ever to get AIDS. They were sure that this would not happen, however. Some said that if they were infected, they would take revenge by going out and having unprotected sex with white people, and in ten of the groups children said that they would commit suicide if they got AIDS. These too, are not unusual responses; 21 percent of high school students in New York City said they would commit suicide (Goodman and Cohall 1989) and clinicians working with HIV-positive youth have reported that they go through a stage when they speak of actions to harm others (Rotheram-Borus 1992).

In the South African study, 75 percent of the street children said that they could prevent themselves from getting AIDS if they used condoms. However, they strongly disliked condoms, giving the same reasons which we have already noted for African adolescents- the belief that sperm is wasted, that they generate mistrust of partners and spoil sensation. Their incomplete knowledge of AIDS transmission led many children to the additional erroneous belief that prevention was possible by other means; some mentioned that proper eating habits, obedience to parents, home instead of street life, not sharing eating utensils with someone with AIDS, and visiting sangomas were ways in which one could protect oneself from getting AIDS.

**AIDS-Related Behaviors**
Throughout the world the sexual activity of homeless youth falls into three categories: rape, survival sex and love relationships, and includes anal, vaginal and
oral sex (Athey 1991; Ennew 1990). This was found to be true for the street children in the South African study as well. It is not perhaps sufficiently recognized that adolescent girls, including street girls (Ennew 1990) engage in anal sex, frequently as a contraceptive measure.

Street children in South Africa are widely exposed to sexual harassment and rape on the streets and in detention (Scharf 1986; Swart 1988; Swart 1990). Street girls in Cape Town have listed the fear of rape and sexual abuse as two of the main dangers of street life (Keen 1990). In the South African study one of the street children in a Cape Town group had been badly beaten up the night before the group discussion by a bunny (homosexual) and one of the Johannesburg groups told of a boy who had been forcibly sodomized two weeks previously and who had to be admitted to hospital for treatment.

The children in the South African study were hesitant to reveal their sexual activities. Nonetheless, 53 percent admitted to engaging in survival sex but many of them said they felt unhappy, angry and fearful about doing this. Assault (of boys especially, by homosexual men) appears to be not uncommon in these situations. Some of the children said that they felt good about "doing" survival sex because it meant that they had money. It was clear from the children's descriptions that they had multiple partners, often of both sexes, and that they did not use condoms. Women were said to pay the most for sex. The children, especially those from Pretoria and Johannesburg, said that survival sex was the best way to get money and that it generated a greater income than other street activities such as parking cars and begging.

The street boys were more open about their sexual behavior in love relationships than about survival sex; it was common practice to have more than one girlfriend at a time and not to use condoms in these relationships. Their girlfriends also practiced survival sex without the use of condoms.

In addition to the high-risk sexual behaviors of the children, substance abuse is common. About 60 percent of the children in the South African study admitted to having sex while under the influence of glue, dagga, or alcohol, and many said that they were more interested in sex and less likely to think of using condoms when "high." This ties up with other studies which have found that substance abuse leads to higher levels of high-risk sexual and other behaviors (Strunin and Hingson 1992).

Children living on the streets said they tended to avoid seeking medical help when they were ill and tried to sleep off their illnesses, whereas children in shelters went to doctors or to clinics. Children who receive medical attention are more likely to attract the attention of health personnel if they are HIV infected, and the self-selected recuperative behavior of children on the streets places them at higher risk of non-detection.
should they become HIV-positive. The average latency period for the HIV virus in healthy individuals is about eight to ten years but for street youth it is estimated to be about three to five years (Childhope 1989).

Although the street children in the South African study were fearful of getting AIDS and discussed various measures which they believed would prevent them from becoming infected, they did not put any of these into practice. It is not uncommon to find that behavior is unrelated to knowledge, beliefs and attitudes; in the United States there is widespread concern that increased awareness and knowledge of HIV and AIDS has not led to significant changes in risk behavior. Although, for example, intravenous drug use decreased slightly and condom use increased slightly between 1988 and 1990 (Strunin and Hingson 1992), there was an increase in the number of sexually active adolescents which statistically off-set any benefits associated with these changes (Sonenstein et al. 1989). The trends reported here for South African street children have been found to be similar for homeless youth in other countries (Sondheimer 1992).

**Conveying the Message about HIV and AIDS**

In the South African study, children still living on the streets said that they had obtained their information from radios, newspapers, magazines and "general talk on the streets." Since many street children are virtually illiterate it is unlikely that they would glean clear information from the written media. More of the children on the streets (56 percent) said that they discussed AIDS with their peers than did street children who had taken refuge in city shelters (40 percent). These percentages reflect less peer discussion than has been found in some other studies; 81 percent of runaway and homeless American youth interviewed (Sugerman 1991), for example, indicated that they had talked to a friend about AIDS.

Personal contact is a fundamental way of passing on information on the streets and Ennew (1990) has urged those involved in AIDS education to identify key personalities on the streets and use them as educators. She points out further that those people unaccustomed to learning through two-dimensional media (such as posters, books and videos), often have a different perception of such media and it is important, therefore, not to start AIDS education with videos and comics simply because it is known that children, in general, find these enjoyable. She recommends making communication props together with the children, rather than for them, if their use is felt to be imperative. Street children have demonstrated that they are able to identify their needs, to suggest solutions to their problems and to work closely with adults who seek to help them. They have proved to be effective as health promoters among their peers, especially with regard to drug and alcohol use and the prevention of sexually transmitted diseases (Towry and Connolly 1991).

The fact that peer group instruction can be effective is borne out from the findings of a number of studies which show that the adoption of safe sex practices is highly dependent on reference group support and endorsement (DiClemente 1992). Peer-assisted HIV education has thus been recommended as a preferred method to adult-led classroom education. Apart from the importance of peer group pressure


on sexual practice, the credibility of peer-source information has been recognized as important since "the more credible the source the more likely it is that attitude change will take place (Redman 1987)."

On the whole, the shelter children in the South African study demonstrated a better knowledge of AIDS than did the children still living on the street. Most of them had been exposed to AIDS education programs and videos, either in the shelters or in schools. However, the deficiencies in their knowledge seemed to indicate that a once-off program or talk is insufficient for entrenching knowledge. The children have other priorities, and any immediately irrelevant information is quickly forgotten or confused by additional input. One group which demonstrated fairly good knowledge about transmission routes lived in a shelter decorated with bright and simple pictures giving information about AIDS. It seems, therefore, that AIDS education should be an ongoing process, rather than a once-off intervention. In addition, routes of transmission highly salient to the children should be stressed relative to routes which have dramatic connotations, but are less salient to South African street children. For South African street youth, it is unprotected penetrative sexual activity rather than intravenous drug use which puts them at risk for AIDS. The irony is that the same behaviors that increase an adolescent's likelihood of survival on the streets, including prostitution, contribute to his or her increased risk of HIV infection.

AIDS education programs need to take specific socio-economic and ethnic differences in value orientation into consideration. The widespread view of African people and of street children in South Africa that the use of condoms "wastes sperm" is of relevance in this respect, as is the value placed on pregnancy and childbirth in African communities. Street children also commonly have a low degree of self-efficacy and self-respect. AIDS education can only succeed in the context of efforts to promote and assist their overall personal development.

**Conclusion**
Those children who have little sense of self-worth and a large degree of fatalism in their make-up can hardly be expected to protect themselves from contracting a virus of which they have heard but whose devastating effects they have not personally encountered. AIDS programs for street children need to be non-judgmental and need to encourage personal growth. Moreover, as one child in the South Africa study pointed out, it is only by addressing the issue of why street children are on the streets, combined with socio-political change, that the AIDS epidemic can be controlled at street level.

**Endnotes**
1. Reprinted with permission from *Africa Insight* vol. 26, no. 3, 1996.
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