LIFE HISTORIES AND HEALTH NEEDS OF STREET CHILDREN IN LUSAKA CITY, ZAMBIA

BY

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DECLARATION

I, Joel Zama Simabwachi declare that this dissertation submitted to the University of Zambia as partial fulfillment for the award of the degree of Master of Public Health (Health Promotion and Education) is my own work and has not been submitted either wholly or in part for another degree to this University or any other or Institute of higher Learning.

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ABSTRACT

Street children are among the helpless, marginalized and most at risk populations in society. They are exposed to increased social, physical and psychological sufferings which affect their health and the health of others. There are a number of government and stakeholder's programs that target to help vulnerable children including street children. Despite these programs, street children keep getting back to the streets and suffer negative health effects. Even though many studies have been done concerning street children, not much has been inquired regarding life histories and health needs of street children in Zambia with regards to exploration of compatibility of interventions provided, and the actual needs of street children. A qualitative narrative approach of a life history design was used. Data was collected using four Focus Group Discussions with street children aged 12-18 years of age, five key informant interviews, ten (10) life history timeline interviews and observations. Participants were purposively selected. Thematic and narrative analysis were used.

Histories and backgrounds of street children revealed that most children were compelled into street living due to hardships such as coming from broken homes, loss of parents, irresponsible parents, and poverty. Others were attracted to streets by peer pressure and money seeking habits. Study also revealed that street living exposed children to negative physical, social and psychological health effects arising from hardships such as lack of safe water and food, road accidents, missing vaccination schedules, sexual harassments, rape and illegal drug use. The study also observed a possible gap in conducting removal programs for street children from the streets without working against factors that caused street children's strong attachments to street living. This was identified as a potential cause for street children's reverting to street living after removal despite reintegration to families or adoption by institutions of care. Children are probably attracted and forced to street life by several factors which may need to be considered during planning processes aimed at removing street children from the streets. When designing programs that are intended to meet the needs of street children, it could be helpful to carefully consider factors that cause street children to have strong attachments with street living.

Key words: Street children, life-histories, experiences, health needs.

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DEFINITION OF KEY TERMS

Children at Risk: These are children who are at risk of poor outcomes in such areas as school performance, health and mental health due to family or life circumstances known as risk factors.

Children of the Street/ Street Based Children: Homeless street children who are totally dependent on the streets for their home and source of livelihood. They spend their nights in temporal shelters, abandoned buildings etc.

Children on the Street: Street children who spend majority of their day time on the street before returning to the homes and families.

Health Needs: Requirements and necessities for health but lacking. Those needs felt and expressed by the individuals as well as those defined by professionals.

Health Needs Assessment: A systematic method of identifying the unmet health and health care needs of a population, and making changes to meet those unmet needs.

Life History: The sequence of events related to survival of an individual in a society or group from inception.

Life History Timeline: A way of displaying a list of key events in an individual's history in a chronological order.

Marginalized Population/ Group: A group of people that is socially excluded from full participation in society.

Most at Risk Population: a population most marginalized and more vulnerable to HIV infection due to a variety of factors such as; frequent exposures to the virus, risky behaviors, lack of resources and limited access to health-care services.

Pull Factor: Something that attracts people to a place or an activity.

Push Factor: a factor that leaves one with no choice but to leave his or her current home or environment.

ABBREVIATIONS

AIDS……………………………………….Acquired Immune deficiency Syndrome

CBO……………………………………..Community Based Organization

CCWWR……………………......................Community Children World Wide Resource Library.

CPU……………………….....................Child Protection Unit

FGD ………………………………………Focus Group Discussions

HIV……………………………………...Human Immune-deficiency Virus

MCD………………………………………Ministry of Community Development

MCH………………………………………Maternal and Child Health.

MG….…………………….....................Ministry of Gender

NGO……………………………………..Non-Governmental Organization

OVC……………………………………..Orphans and Vulnerable Children

STD……………………….....................Sexually Transmitted Diseases

STI………………………………………Sexually Transmitted Infections

UNESCO……………………...United Nations Educational Scientific and Cultural Organization

UNICEF……………………………………Unite Nations Children's Educational Fund

UNZA……………………………………...University Of Zambia

UNZABREC…………………University of Zamia Biomedical Research Committee.

WHO……………………………………....World Health Organization.

CHAPTER 1

INTRODUCTION

1.1 Background Information

Street children are among the most vulnerable and marginalized members of society, who regularly lack access to basic needs such as shelter, food, health care, safety and education (Shrestha, 2009). World-wide, these street children experience countless problems (UNICEF, 2007). They are exposed to inhumane conditions; suffering hunger, persecution, physical abuse and, are disadvantaged due to lack of basic services like education and health (Vanessa, 2007 cited in Kebende, 2015). In order to survive, most of them resort to begging, stealing and scavenging (Menon, 2015). Adolescent street children are unguarded with regards to contracting HIV/ADS and sexually transmitted diseases because of early exposure to sexual activity, poor use of contraceptives and high chances of partner change while lacking adequate information on sexual activity (Menon, 2015). Sexual abuse is one of the main problems faced by street children and the youth (Menon, 2015). Street children are usually regarded as a major obstacle to social-economic progress and a substantial threat to national security. These apparent and real threats triggered the current flow of global interest in street children (Basu and Tzannontos, 2003).

According to the United Nations Educational Scientific and Cultural Organization (UNESCO) street children are described as "boys and girls for whom the street has become their home and or source of livelihood and are inadequately protected or supervised by responsible adults. They are temporarily, partially or totally estranged from their families and society" (UNESCO, 2006). Street children are generally classified in three main categories. The first category being; "Street" children who are totally estranged from their families. The second category consists of children "on the street" who spend the majority of their day on the street before returning to their homes at night. The last category include children living on the street with their families (UNESCO, 2006). Street children in some countries are also commonly known as homeless adolescents or homeless youth (Mufune, 2000).

1.1.1 Statistics on Street Children.

It is estimated that there are over one hundred and fifty million street children world-wide and 30% are in sub-Saharan Africa (CCWWR Library, 2010). In the year 2010 the number of street children in Zambia was estimated to be at 13,000 (UNICEF, 2008) and was later

reported to be over 13,500 by the year 2012 according to the Zambian Ministry of Gender and Child Development (2012) of which 11475 were male and 2026 were female.

Though the estimations of the number of street children are provided by some organizations such as UNICEF, there is still a strong conviction that the actual number of street children in Zambia is unknown. This is because street children are a mixed group of those who live at home and spend much of their time on the streets and those that do not have specific places to live but spend most of their time on the street and spend their nights in places such as in abandoned buildings and underground parking lots (Lemba, 2002). According to Turgut (2015), a number of organizations employ different methodologies of counting street children causing exaggeration or under estimations of the actual numbers. This means that the number of street children could be far much more or extremely less than what is generally reported.

1.1.2 Programs for Street Children in Zambia

The Zambian government through the Ministry of Community Development (MCD) and Social Welfare has been having programs for orphans and vulnerable children including linking street children to NGO's, foster families and rehabilitation centers such as street kids International (Blackman, 2001). Programs designed for street children in Zambia are reported to be shunned by most street children who go back to the streets (Mufune, 2000). The Ministry of Youth, Sports, and Child Development is responsible for street children's affairs in Zambia.

Table 1. Summary of some Programs for Street Children in Lusaka/ Zambia.

ORGANIZATION	PROGRAMS FOR STREET CHILDREN
MINISTRY OF YOUTH SPORT & CHILD DEVELOPMENT	Linking Orphans and Vulnerable Children (OVCs) to Supporting Organizations. Rehabilitation programs through Zambia National Service (ZNS)
UNICEF	Capacity building to Government, NGOs and CBOs on child protection programs targeting; OVCs, Child sensitive justice and Birth registration. Risk reduction on exploitation and abuse of children.
PROJECT CONCERN INTERNATIONAL	Principal Recipient for funding of Other NGOs working towards the welfare of OVCs Monitoring
USAID	Funding and Monitoring Of Programs to Reduce the Impact Of HIV which includes

	funding programs for Street / at risk children.

Street children have their own life histories that can be explored to understand their lived experiences and pathways into homelessness and street life. According to the Merriam – Webster Dictionary, a life history is defined as “a story of an individual’s development in his or her social environment.” Dhumpath and Samuel (2009), explain that life histories of individuals can be systematically gathered, analyzed and used to present views of individuals involved in a way that challenges the traditional and modernist understanding of truth, reality, awareness and personhood. Etherington (2010), reasons that life history research can be used to explain cause and effect to predict and control reality, and to create clear objective truth that can be proven or disapproved.

Street children are among the highly marginalized populations (KidsRight, 2012). The life history approach provides a basis for research methods that explore into complex research questions with marginalized populations (Buchanan et al, 2010). Through exploring the life histories of street children, their health needs and pathways into street life can be learnt.

1.1.3 Health Needs of Street Children.

A need is generally understood as anything that is necessary but lacking, it may also refer to a condition that requires relief. Abraham Maslow (1970) reasons that every human being has needs and these can be in a hierarchy. He describes physiological, safety, love and esteem needs as ‘deficiency needs’ that a human being is driven to satisfy and he describes a need for self- actualization as a ‘need of being’ where individuals are not really driven to, but are drawn to the need. Maslow hypothesized that psychological health was only possible when the four basic needs were satisfied (David et al, 1983).

Health needs are among the basic needs of life and street children have a very wide range of health needs (Sherman, 1992). Nanda (2008) reports that despite having many health needs, most street children do not consult for treatment because they feel a barrier to accessing health care services as some of the issues including confidentiality, lack of trust, lack of respect of providers due to low status and also due to inadequacy of services in a coordinated way.

The World Health Organization (WHO, 2001) describe health as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.” Health and wellbeing are the consequences of a wide range of factors, summarized in a rainbow model from Dahlgren and Whitehead (1991) as shown in figure 1 below.

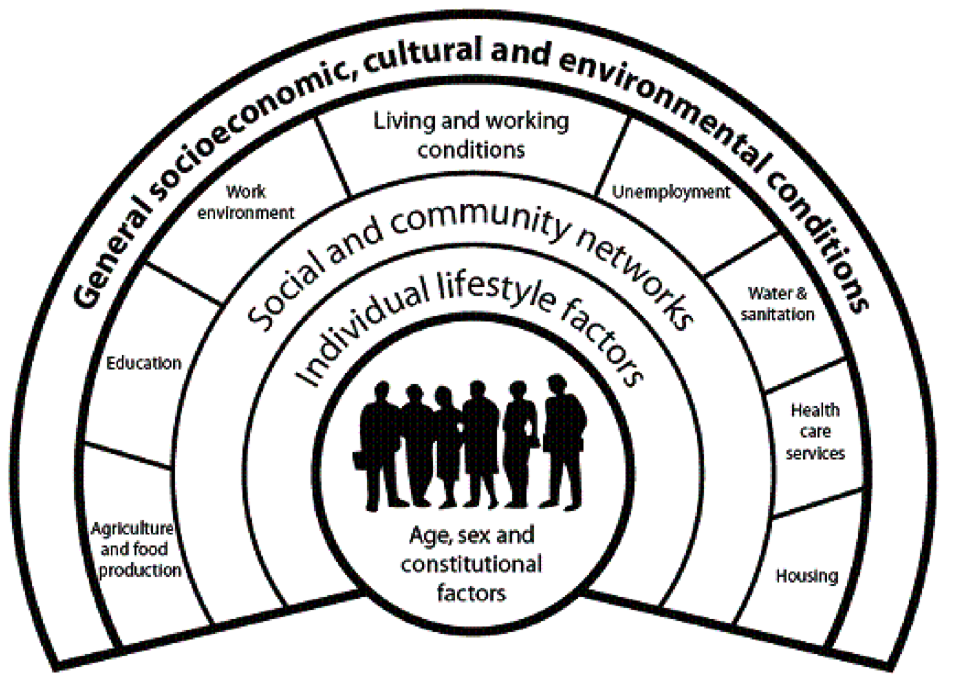

Figure 1. The Dahlgren and Whitehead Model. Source: Dahlgren and Whitehead (1991)

The rainbow by Dahlgren and Whitehead above and the definition of health by WHO demonstrate that the determinants of health are not only biomedical in nature but diverse. According to the People’s Charter for Health, “health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are the roots of ill health and the deaths of the poor and marginalized people.”

According to the Dahlgren and whitehead rainbow model in figure 1 above, the first layer shows how personal behavior and ways of living can promote or damage health. Norms of the community, choices to smoke or not to smoke can be influenced or affected by friendship patterns. The second layer is about social and community influence and the third has to do with structural factors such as housing, working conditions and access to services.

The three layers of the model explained above can apply to street children's situation in understanding what socially determines their health. Their working and housing conditions, the influence among them and common behaviors, norms and friendship patterns among them. Exploring their social backgrounds, their physical, social and psychological environments can give a clue on their health needs.
The concept of health needs in health needs assessment refers to those needs felt and expressed by the individuals as well as those defined by professionals (Rowe et al' 2001). To understand health needs of individuals therefore requires the taking into consideration of the social and psychological wellbeing. Thus, this study seeks to understand the health needs of street children and the origins and experiences of their situations through exploration of their life histories.

According to Thomas de Benitez (2007) many studies across a number of countries have been done with regards to the plight of street children. Most studies on street children in Zambia have focused on plight of street children, mental health problems of street children and care of residential based street children in rehabilitation centers (Mumbi 2006. Imasiku and Banda 2012, Lemba 2002). Even though studies have been done in this field, not much has been done in looking at life histories in relation to health needs of street children. It was therefore the aim of this study to seek understanding of the life histories and health needs of street children in Lusaka city.

1.2 Statement of the Problem

Street children have human rights, but are highly marginalized and vulnerable (UNICEF, 2007).They lack access to basic needs which include quality health care services, they are exposed to early sexual activity without contraception, high partner change and highly exposed to HIV and STIs (Menon, 2015). Designed programs assumed to represent needs of street children are shunned by end users as of marginal relevance (Mufune, 2000). Many preventive and curative health programs are designed and implemented in Zambia, but it is not clear if they are compatible or relate to the needs of street based children and how compatibility or lack of compatibility affects access to the services. There is a perceived difference between what is assumed to be the needs for street children and their actual needs.

There is therefore need to learn street children's life histories to explore their health needs through narrative enquiry.

1.3 Research Questions

1. What are the experience, health needs and trajectories of street children based in Lusaka Zambia?
2. Based on street children's perceptions and key informant interviews, how responsive are government programs to street children and their needs?

1.4 Objectives of the Study

1.4.1 Main Objective.
To explore the life histories and health needs of street children in Lusaka city.

1.4.2 Specific Objectives.

1) To explore the social backgrounds and histories of the street children.
2) To explore the physical, psychological and social health needs of the street children.
3) To understand sexual and reproductive health challenges and needs of female street children.
4) To explore the compatibility of government programs in meeting the health needs of street based children.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of literature related to life histories and health needs of street children. Most articles for the literature review were obtained by use of structured and non-structured search from the following data Bases; Google Scholar, Pro-Quest, CINAHL, The oxford journal Data Base, UNICEF data base and the Consortium for street Children Data Base. The search process involved the use of key words and related terms from the focused question which were combined using Boolean operators “AND” and “OR” for structured searches and using the focused question and related key terms directly for non-structured searches. Articles from peer reviewed journals that met the inclusion criteria were selected for use in the literature review.

Existing knowledge from studies on the subject of street children and health needs included some of the findings described below in different studies conducted in Ethiopia, Malawi, Indonesia, South Africa, Uganda, USA and Zambia.

2.2 Health Needs of Street Children.

2.2.1 Physical health needs;

Study carried out in Bandung, Indonesia by Patriasih and others (2010) aimed at analyzing food habits, nutrients intake and health, and nutritional status of street children. The study findings showed that most street children did not meet the recommended required daily allowances of nutrients in their diets. 41% were underweight while 80% of the street children had stunted growth. The study further indicated that common illnesses among street children included diarrhea, skin infections and Acute Respiratory Infections (ARI) among others and noted exposure to poor hygiene and daily exposure to heavy metal polluted air from vehicle

fumes on the streets. Similarly, a study done in Malawi by Kalimbira and Chipwatali (2007) also indicated that most street children where undernourished and some of them presented with severe wasting and stunting. Other physical health challenges reported in a study done by Kebende (2015) included physical injuries commonly sustained from fighting among street children. 5.9% of participants reported sexual abuse on the streets in the same study. The studies revealed only few physical challenges and lacked detail.

2.2.2 Psychological and Social Health Challenges:

Mental and social health challenges are among problems faced by street children. A Study on mental health problems of street children in residential care in Zambia conducted by Imasiku and Banda (2012) revealed that behavioral and emotional disorders were common among street children in Lusaka. The study findings also indicated a strong correlation between co-morbidity (a presence of two or more disorders or diseases in an individual) and overall stress levels. 15% of street children in residential care had high stress levels and 74% had a mental health problem. Street children were also exposed to a number of physical diseases more than mental disorders. However, the findings in the study above does not clearly show if street children that are not in residential care are equally exposed to the same mental health challenges and risks as those that are in residential care. A study done in Hawassa Ethiopia (Kebende, 2015) revealed that street children suffered a lot of psychosocial problems as they reported being threatened and beaten for no reason by older street children and by police and sometimes older street children taking away their money and clothes which they worked for, leaving the younger street children depressed due to lack of protection from such abusers.

Very few non-ethnographic studies have addressed mental health issues of street children in Africa in spite of the fact that they are considered as a vulnerable population that suffers from adult mistreatment in all forms, poor quality of life and stress, often leading to mental health problems.(Aptekar and Ciano 1999; Duyan, 2005). Their behaviors were frequently reported in the literature, and diagnostic criteria were not described and tools for used for testing were not validated. (Aptekar and Ciano 1999; Ayaya and Esamai 2001; Seager and Tamasane, 2010). Mental health conducted in West and East Africa reported traumatic experiences among street children, but different methodologies were used, making it difficult to compare the results. The findings of these studies reported that some street children were more likely to report feelings of hopelessness and the general suicide rate among street children was

reported to be fairly low at around 2% among the street children population; female street children in particular were more susceptible. (Aptekar and Ciano 1999; Ayaya and Esamai 2001; Seager and Tamasane, 2010)

2.2.3 Social Health Challenges

Barry and others (2002) highlight social health challenges faced by street children, explaining that these children are medically underserved, have poor access to primary healthcare, engage in substance abuse, survival sex, and that studies indicate high rates of HIV infections, STDs, depression, suicide attempts and unwanted pregnancies. According to Shrestha (2009) street children lack shelter and education which is essential for good health. 80% of street children use drugs regularly especially glue which is easily accessible to many and is used as a way of coping with fear, hunger, loneliness, unhappiness, and as a way of uniting the street children together (Mumbi, 2006). The study done in Hawassa Ethiopia also revealed that homosexual activities are common among street children and sometimes younger male street children are abused by older street children sexually (Kebende, 2015).

2.2.4 Health seeking behavior

A study on street children done in Malawi by Kalimbira and Chipwatali (2007), revealed that very few street children and only in very rare occasions visited hospitals when sick, but majority bought medications over the counter or depended on herbal medicine. Poor health seeking behavior may suggest poor health among street children and self-medication has potential risks to health. According to WHO (2000) self-medication has potential health risks which may result from incorrect self-diagnosis, incorrect choice of therapy, failure to recognize special pharmaceutical risks as well as failure to understand warnings, contra-indications and precautions of drugs.

2.2.5 Reproductive health needs of Female street teens:

According to Mumbi (2006) teenage pregnancy is almost universal among street girls and over 25% report one or more abortions. Despite such a statistic the study does not detail the source of the information to verify the claim. According to Cumber and Tsoka-Gwegweni (2015), statistics on unwanted pregnancies including morbidity and mortality among street children are usually unknown.

Sexual abuse is also reported to be common among street girls. Cumber and Tsoka-Gwegweni (2015) report that sexual abuse to date has the lowest reporting rates compared to that of other crimes. They report that some authors believe that this might be due to the stigma attached to sexual abuse. However, the study does not show any statistics supporting the same and it is silent on weather this is a world-wide claim or if there are specific parts of the world most affected.

Most literature reviewed provided less information and details on maternal and child health services access to female street teens who get pregnant.

2.2.6 Pathways to street life

There are multiple causes of homelessness for street children and no single cause can be identified as the cause. Most of the reasons however, can be classified in three generally related factors; Push factors, Pull factors and seeking freedom from parental control (Asante, 2015; CAS 2010; Oduro 2012). Push factors refer to factors or conditions that compel children to make the streets their home while pull factors refer to factors that attract children to street living.

Though most studies indicate that street children leave their homes due to poverty and HIV/AIDS (Mumbi, 2006), the study by Kebende (2015) in Ethiopia indicated that only 30% were on the streets due to poverty. 18% were on the streets due to peer pressure and about 14% due to family break down, and 18% due to death of parents. On the other hand, studies conducted on homeless children in South Africa and Uganda showed that death of a single parent or both parents were evident in 79 and 75% of the explanation given by participants interviewed about why they left home respectively. (Seager 2010; Swahn et al, 2012) cited in (Asante, 2015).

Summary

In a nutshell the literature revealed that street children are on the streets due to various reasons and they undergo a number of physical challenges, social and psychological health challenges which include poor diets, physical and mental stress and abuse but also have coping strategies which are sometimes against their health. However the literature shows general information which may not be the Zambian situation with regards to the health needs

of the local street children. The literature clearly shows that street children from different places have health challenges and have different social backgrounds. Literature does not show how much understanding street children have on health information such as to protect themselves from infectious diseases like cholera, Malaria, STIs and HIV/AIDS. The health seeking behaviors are poor according to the studies but reasons are not clearly captured thus it is important to explore the compatibility of programs targeting street children in meeting the health needs of street based children in the Zambian setting and the their actual health needs.

CHAPTER THREE

METHODOLOGY

The study was a qualitative research based on a narrative approach and life history design. It included qualitative methods of field work and analysis. A purposive sample of street based children of Lusaka city aged from 12 to 18 years of age was selected using quota and snowball sampling. Focus group discussions and Timeline interviews were used to gather data on the life histories and experiences of street children in relation to their health needs. Key informant interviews were also conducted with five relevant organizations. A narrative design was preferred as it is an interpretive approach that involves storytelling and has capacity to convey tacit knowledge and sense making from told stories (Mitchell and Egudo, 2003). Life History types are most suitable for studies with marginalized populations as they provide a platform to explore complex issues that reveal the inner feelings as expressed by participants (Etherington, 2010). Therefore, a life history type of narrative was used in this study with the marginalized population (street children) to identify their health needs.

3.1 Study Setting

The study was conducted in Lusaka city. Discussions with street children were done at Lusaka's Soweto City Market, Lusaka town center and Kamwala where street children are usually found. The interviews were done during daytime in working hours when street children are known to be friendly, in a begging mood and less violent. Observations were done at the same time of interviews and also at separate time covering even the places where street children spend their nights, pick foods and where they bath and wash from.

Lusaka city was selected as it is the biggest city in Zambia and is thought to be among the cities with more street children according to literature and has a total general population that is over 2, 669, 249 (Central Statistics Office, 2014).

3.1.1 Study Population and Target group

The study population was composed of street based children aged from 12 to 18 years old. The target group was male and female street children who lived on the streets and did come from their homes to the streets.

Primary population included street children who were fully based on the street and **secondary population** included key informants that gave information concerning street children and available programs and services for street children.

3.1.2 Inclusion Criteria

The study included respondents from Governmental or Non-Governmental Organizations that conduct or support or have information concerning programs for street children in Lusaka.

3.1.3 Exclusion Criteria

Study excluded children on the street that come from their homes to the streets and were under care of responsible adults as well as respondents from Organizations that had no information or linked to street children programs in Lusaka.

3.1.4 Sample Size and Sampling Procedure.

Non probability purposive sampling was used to sample participants. Quota sampling was used to enroll participants according to age and sex categories. Participants were selected based on being street children who were fully based on the streets and spent the nights on the streets. Quota sampling was used to categorize participants according to sex and age and this was followed by snowball sampling to identify and enroll participants of similar characteristics for each category. One focus group discussion was selected from Lusaka's Soweto city market and two focus group discussions from Lusaka town center and one from Kamwala township. Ten participants for timeline interviews were sampled from the three places mentioned above. Key informants were purposively selected based on the inclusion criteria detailed in chapter 3.1.2 above. A total of 46 participants were enrolled as shown in the table below.

Table 2. Indicating Data Collection Methods used and Participants.

Data collection method	Participants	No. of Participants In Each FGD
2 focus group discussion	Female street children aged from 12-18 years	Female FGD=8 Female FGD=7
2 focus group discussion	Male street children aged from 12–18 years	Male FGD =8 Male FGD =8
1 key informant interview 1 key informant interview 1 key informant interview 1 key informant interview I key informant interview	Ministry of Youth Sport and Child Development (MoYSCD) National office. MoYSCD provincial office. Child Protection Unit (CPU). Fountain of Hope (NGO, OVC). Lusaka Urban Railway Clinic.	
Life history timeline interviews Lite history timeline interviews	5 male street children aged from 15-18 years 5 female street children aged from 15-18 years	
Total number of participants	**46 in 19 Discussions**	

Data collection was done by the principal investigator. Interview guides were used for key informant interviews as well as life history timeline interviews and Focus group discussions. Interviews with street children were done in Chi Nyanja and written verbatim then translated into the English language. Life history timeline interviews were done to one participant at a time to ensure confidentiality and each interview took enough time to allow each interviewee to fully express oneself during narration of the life stories. Member checking was done with each participant and group discussion at the end of each interview to ensure validity of information collected.

3.1.5 Focus group discussions

A total of four FGDs were conducted as indicated in table 1 above. The focus group discussions targeted 12 to 18 years of age but the majority of participants were aged from 14 to 18 years of age. Female participants were separated from boys to allow freedom of expression on issues that pertain to females only.

3.1.6 Timeline Interviews

This method of life history research was used because it allows the interviewee to participate in the reporting of the interview which gives rise to the ownership and sharing of analytical power in the interview situation. It provides an opportunity for linking the story with the wider social, political and environmental context during the interview (Adrianse, 2012).

A total of 10 participants aged from 15 to 18 years were interviewed using the life history timeline interviews 5 participants were female and five male. This allowed views of both gender regarding their life histories and specific health and social needs.

Life history timeline interview tool used for this study was adopted from Adrianse, 2012 but was translated into local language.

3.1.7 Key Informant Interviews.

Five key informant interviews were conducted to get secondary information concerning street children. Organizations that participated included; Ministry of Youth Sport and Child Development both national and provincial offices, Child Protection Unit (CPU) which was operating under the supervision of ministry of community development and social welfare at time of interview, Fountain of Hope (FoH) an NGO that deals with orphans and vulnerable children's affairs and Lusaka Railway Urban Health Center located nearest to Lusaka central business and was more accessible by street children.

Table 3. Characteristics of Life history timeline interviews participants.

Age commenced. Street living	No.	Place of origin.	No.	Once housed in Institution but Reverted to streets.	Engage in drugs use No.
6 -8	4	Misisi	5	6	10
9-10	2	Kanyama	1		
11-12	2	Chibolya	2		
13-14	3	Matero	1		
15-16	1	outside Lusaka	1		

3.1.8 Data analysis

A digital audio recorder was used to record the interviews and FGDs and information was later transcribed into verbatim and was reviewed. Data was analyzed using Thematic Analysis.

Thematic Analysis was performed through the process of coding in six phases in order to create established, meaningful patterns. These phases were familiarization with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and finally producing the final report.

3.1.9 Validity and reliability of the study

Both the use of note taking and voice recording was used to ensure accuracy of information provided by participants. During and after each interview member checking was conducted with participants to ensure that what was noted down represented the confirmed, participants' real views and words. With regards to reliability, the researcher compared the findings of this study with those of other researchers on similar studies (Kebende, 2015; Kalimbila and Chipwatali, 2007; Patriasih et al, 2010; Mumbi, 2006) and others.

3.2.0 Ethical Considerations

The majority of the participants in this study were children below the age of 18 years who under normal circumstances cannot sign consents and at the same time did not live with responsible parents or guardians to consent on their behalf. Moreover street children belong to a marginalized and most at risk population that is usually taken advantage of. However consent from street children themselves was the only way of conducting the study despite the majority being below the age of 18 years. This was done with guidance from research ethics committee and written permission from Ministry of Youth Sport and Child Development national office Lusaka.

3.2.1 Approval and Permissions

Approval of research proposal was granted by University of Zambia Biomedical Research Ethics Committee (UNZABREC). Overall permission to carry out study with street children was granted by the Ministry of Youth Sport and Child Development to carry out the research. Permission was also sought from individual sectors and Organizations that provided key information such as; Fountain of Hope, Child Protection Unit and Ministry of Community Development and Social Welfare.

3.2.2 Confidentiality and Respect for Participants

Anonymity of participants was assured by not writing participants actual names and by not mentioning them in the study article. Participants' privacy during the interviews was also observed and data was not availed to any an authorized persons. All documents containing response information from participants will be destroyed after publication of results within time frame recommended by ethics committee. The benefits and risks of the study were

communicated to participants. Street children were granted little refreshments after taking part in the study to compensate for their lost economic time during participation.

3.2.3 Autonomy

Freedom for any participant to withdraw participation at any time of the study without consequences was communicated and assured. Participants who did not want their voices to be recorded had their choices respected and voice recording was only done with permission from participants.

CHAPTER FOUR
FINDINGS

This chapter presents the findings of the study concerning the life histories and health needs of street children. The chapter begins with a display of a table showing demographic data and social backgrounds of street children. Then presentation of major themes, categories and explanations of each sub-theme with verbatim quotes used to illustrate the findings in a clear manner. Thematic analysis led to identification of nine major themes and thirty five categories as shown table 4 below.

Table 4. Demographic characteristics of street children.

Age of street child	No. per age .Females	No. per age. Males
12	00	01
13	02	00
14	04	02
15	05	06
16	03	07
17	02	03
18	03	03
Total	19	22

Table 5. Showing Themes and sub themes for social backgrounds and histories of street children.

<table>
<tr><th>OBJECTIVE</th><th>MAJOR THEMES</th><th>SUB THEMES</th></tr>
<tr><td rowspan="2">To explore the social backgrounds and histories of street children</td><td>Social backgrounds of street children</td><td>➢ Street life at preadolescence age
➢ Most children from poor sections of town.</td></tr>
<tr><td>Histories of street children</td><td>PULL FACTORS
➢ Influence from friends/siblings
➢ Seeking money
PUSH FACTORS
➢ Loss or imprisonment of parent/ guardian
➢ Problems with step parents
➢ Extreme poverty
Irresponsible parents</td></tr>
</table>

4.1 Social Backgrounds and Pathways to Homelessness (histories)

Generally the study indicated that there are a number of reasons expressed in the histories of street children that indicate their pathways into homelessness. Some children leave their stable homes and families and begin street living due to some attractions in the initial stages, while others are just forced due to circumstances beyond their control. The details are explained under the sub themes below. Short histories of a few selected participants are included within specific themes. The names indicated are not the real names of the participants.

4.1.1 Social backgrounds of street children.

Apart from one whose town of origin was Livingstone, the rest of the street children that participated in the study came from Misisi compound, Chibolya, Kanyama, Lilanda and Mandevu and these are primarily among the poor sections of Lusaka.

4.1.2 Age of commencing street life

Most street children interviewed indicated that they first began street living or visiting the streets in their pre-adolescent ages. Out of the ten (10) participants that took part in life history timeline interviews eight (08) began street life before the age of 12 years as shown in table 3.

4.1.3 Histories of street children.

Trajectories of street children begin from how they first began street life. Semi histories on what attracted or compelled street children into street living is presented below in form of life stories but on specific themes.

4.1.4 Pull factors

The term ‘Pull factors’ as used in this study refers to factors that attract or draw children to the streets.

Influence from friends and siblings and desire for money at early ages are some of the reasons that attract street children to begin frequenting the streets and later end up leaving their homes to live fully on the streets.

4.1.5 Influence from friends/siblings

Out of 10 life history interview participants, 3 mentioned influence from friends or relatives as the reason for beginning street living. One key informant out of five said the same and 2 participants in a FGD of 8 boys and 1 participant in a FGD of 7 girls said was attracted to street living due to friend's influence.

A Case of John (Not a real name) a boy aged 16.

John was born from a stable family and was going to school under the sponsorship of parents. In the ninth grade John started going to the streets with the influence of friends that went there for fun. Later, John developed some strong attachments with street life that kept him away from school and he started avoiding home. He would play cards with friends and got involved in use of illegal drugs till he started living on the streets and only went home when ever sick or if he felt so.

> My parents live in Kanyama and there is really no problem at home at all. I would say it's just strong influence from friends that got me living here instead of home. My parents still tell me to go home but I don't feel like going back there.

4.1.6 Seeking money

Out of 10 Life history timeline interview participants, 3 mentioned attraction to money begging and doing little business in town at tender age as reasons why they first began street life. 4 in an FGD of 7 girls mentioned the same and 3 from an FGD of 8 boys reported the same. Two key informants equally mentioned money seeking as one of the reasons they know regarding what pulls children to the streets.

Case of Nandipa (Not a real name) girl aged 18 years old

Nandipa grew up with both parents until at age of six when her father was arrested and imprisoned at Kamwala prison for eight years. Life was a bit hard such that her mother would spend much time away from home trying to raise money for the family. As early as the age of six Nandipa was influenced by friends to be going to town to sell empty bottles with older children. They enjoyed making little money for themselves to buy anything they wanted as children. Then they noticed other children begging for money from passersby in town and decided to try the same. They got excited with receiving free money and got into the habit of

begging money like other street children. Soon she learnt many street habits and one evening became her first night to spend with friends on the streets.

> We continued going to the streets until we began spending nights at the railway station. My parents came

Nandipa openly said she became a full time street child after beginning the money begging habit but was later withdrawn from the streets by her mother and only returned to the streets years later as a teenager after her parents died. At the age of 18 she was still on the streets but selling her own bananas to help her baby.

4.1.7 Push Factors

The term ‘push factors” as used in this study generally refer to factors that compel children to begin street living.

Most Street children point their pathways into homelessness to conditions that push them to the streets against their ordinary will. They state push factors which include loss of parents or guardians, problems with step parents, extreme poverty, and fear of punishment as well as irresponsibility of parents.

4.1.8 Loss or imprisonment of parent/ guardian:

Case of Shadrach a boy aged 17.

Shadrach was born in a stable home. With both parents alive he lived normally and progressed well in school and got good marks after grade nine exams. After death of his father all property was grabbed by relatives and he was taken to live with the new family administrator, his aunt whom he described as very mean and mistreating. She later chased him to go and live with his mother who at this stage was married to another man. Shadrach moved to his mother’s new home but his step father demanded that he leaves since he (step father) had no child of his own in the new marriage and was not ready for extra responsibility. An arrangement made by Shadrach’s mother for him to live with another relative was not welcome to Shadrach due to experience of mistreatments with previous relatives. Shadrach decided to find his own way and ended up joining some gangs on the streets with other street boys.

> I just said I will find somewhere to go on my own but I could not find a place or job so I started stealing anything I found easy to steal for survival and living on the streets and sleeping in market places. It's so painful that my dad left a house yet am still suffering on the streets to this day.

4.1.9 Problems with step parents:

Out of 10 life history timeline interview participants, 3 stated that they were compelled to begin street living due to problems with step parents. 1 participant mentioned the same in a FGD of 8 boys and 2 girls stated the same reasons in a FGD of 8 girls. 3 key informants mentioned the same reason as one of the common complaints they find in their programs with street children.

Case of Miriam girl aged 18

Miriam grew up with her step mother and never had a chance to see her own mother.

> I have never seen my own mother and my step mother always chassed me from home telling me to go and find my biological mother. Dad never did anything about it as he was away most of the time.

With the continued persecutions from step mother, one day at a tender age Miriam joined friends that were walking around asking for help from people in town and Miriam failed to get back home to the cruel mother and found some comfort in friends that slept on the streets. She had been on the streets without her parents coming to get her back home. Miriam at age of 18 was still living on the streets and grew up without continued guidance from responsible adults.

About half the number in all the 4 FGDs mentioned poverty and lack of food at home as reasons for resorting to street living. 4 of the 5 Key Informants and 5 of the 10 life history interview participants mentioned poverty as main reasons for being on the streets though most of them mentioned multiple reasons and a state of poverty being the first reason for being on the streets.

4.1.10 Extreme poverty

Case of Mable 18 years of age.

Mable was only 8 years old when her father passed away. There was less food at home and the mother could not provide enough. At the age of 10 years, Mable was influenced by her cousin's daughter to be going to the streets with her and getting back home in the evening. Her mother got married to a man who did not want to keep a step daughter. Mable was then taken to an orphanage and lived there. She found rules to be too strict and ran away from the orphanage to join friends on the streets and spent some nights at Lusaka city market. She decided to go to her mother where it was safe but the step father would always chase her from home and she would only go back to the streets.

> I don't like being on the streets. We get raped here and some police officers used to come and beat us in the night at city market. But now when I go home, my step father keeps chasing me. I once got pregnant from someone that I don't know and my brother withdrew me from here to be with him at his home. Soon after I delivered his wife influenced him to chase me and they did, and she got the clothes that my brother had bought for me. My baby was taken by my sister who said she could only manage to keep the baby and not me. If only I can find money for business so that I start selling eggs I can leave this place.

4.1.11 Irresponsible parents:

Case of Jelita (not a real name) a street girl aged 17 years old

Jelita was born from a stable family until at the age of nine when her father began the habit of drinking excessively and left his own wife and family for another woman. Life became hard and children were most of the time kept without food. They started looking for survival alternatives at young age and found themselves on the streets.

> Ba dady banabwela bapondoka bakwatila na kwinagu. (Our dad just turned against us and even married another woman) and life became hard for us and mum, that's why we started coming to the streets for survival, for me that was the beginning of street life.

Jelita would be left with siblings at home and she would go with them to the streets while her mother was out for work. She later got addicted to drugs and started living on the streets.

> I would still go to school but after classes I would carry my young siblings with me to town to pick bottles for sell for and begging money from people till I got into the habit of sniffing 'sticker' (the drug). 'Pa last ninabwela napondoka che elo nayamba kunkala mu town naine' (I ended up changing and started living in town like my friends).

Table 6. Showing Themes and Sub-themes on challenges and needs of street children.

To explore the physical, psychological and social health needs of the street children.	Physical / Physiological health Challenges & Needs	➢ Lack of Shelter and sanitary accommodation. ➢ Sexual assaults to young boys. ➢ Use of drugs as coping mechanism to harsh conditions. ➢ Survival sex. ➢ STIs/TB most common. ➢ Road traffic accidents ➢ Poor access to quality food and water.
	Social Health Challenges and Needs	➢ Non-coverage of street children in vaccination/preventive programs ➢ Poor access to health information. ➢ Social Stigma
	Psychological Health Challenges and Needs	➢ Poor adherence to treatment ➢ Unsafe misconceptions on diseases ➢ Mental Health Problems.

		➢ Poor health seeking behavior
To understand sexual and reproductive health challenges and needs of female street children.	Reproductive Health Challenges & Needs	➢ Rare contraceptive use and lack of basic knowledge on reproductive health. ➢ Rare MCH attendance ➢ Sexual assaults to street girls
To explore the compatibility of government programs in meeting the health needs of street based children.	Government Programs In Relation To Actual Needs Of Street Children.	➢ Re-integration to families ➢ Street children removal from the streets to Institutions.
	Common Street Children's Reaction To Government's Programs	➢ Refractoriness to rehabilitation. ➢ Escape from Institutions and places of safety. ➢ Re-escape from homes to street life. ➢ Refusal to comply due to Force.
	Hindrances to giving up attachments With Street Life.	➢ Addiction to drugs (Solvents). ➢ Sexual Relationships. ➢ Habituation to Money Handling. ➢ Refractory juvenile's influence on street children. ➢ Freedom
	Challenges On Consistence with Street Children's Programs	➢ Inadequate resources for programs ➢ Conflicting Priorities.

4.2 Physical, Social and Psychological Health Needs

Living on the streets expose children to physical, social and psychological health challenges that lead to negative health effects and clearly points out some of the serious health needs that emerge from that. Street children expressed the following; sexual harassments, use of illegal drugs or unhealthful drugs, engaging in sexual activity as means for earning a living. Living without proper shelter, sanitary accommodation, adequate clean and safe food as well as safe water for drinking. Road traffic accidents also affect street children quite frequently.

4.4 Physical/ Physiological Health Needs

4.4.1 Sexual assaults to young boys

Most street children reported sexual harassments and assaults on the streets. Young boys were reported of being sodomized by older street children against their will and forced to smoke dagga and other drugs. Information from child protection unit (a police department that takes a social approach in helping the vulnerable children) stated that such was very common on the street with street children and is handled differently from ordinary cases.

> I can tell you what goes on here on the streets, young boys are sodomized by bigger boys and forced to smoke dagga. (17 years old street boy)

4.4.2 Use of drugs as coping mechanism to harsh conditions

During observations most street children were seen inhaling some solvents. Apart from three participants of all that were interviewed during focus group discussions and life history interviews, all the other street children openly accepted being involved in the use of drugs especially a solvent they called sticker or glue which was commonly sold among them. In all the four different places of Lusaka the street children commonly said that use of the drugs helped them to cope with harsh conditions on the streets. They also openly stated that the negative effects of drug use caused weaknesses and confusion which led to many being bashed by cars in town. One boy during a focus group discussion had this to say;-

> When I sniff sticker (the drug) I can sleep peacefully, even if a mosquito bites me, I don't feel it. It is amazing because even when it is cold or am getting soaked in the rains I just sniff enough sticker and before I know it, am dry and not feeling much cold. (15 years street boy).

4.4.3 Survival sex

Prostitution is one of the things that street children admitted that they engage in. Some boys reported that it is easier for boys to raise money on the street as they easily engaged in little economic activities like washing cars, drawing water, cleaning tables and carrying luggage apart from begging. On the other hand street girls do not easily raise money as much as boys do and were said to be the ones that offer sex to street boys in exchange for money or engage

in prostitution with other men. Regarding sex as means for survival one girl had this to say during a focus group discussion with girls;-

> On the streets here life is so hard. There are only two ways to survive here. It's either you beg for money or food or you sleep with someone for money that's all. (18 years old street girl).

4.4.4 Sexually Transmitted Infections (STIs) and Tuberculosis (TB).

Among the diseases mostly mentioned as commonly suffered by street children included sexually transmitted diseases and tuberculosis. In all the focus group discussions and life history interviews street children seemed to be quick on mentioning STIs and TB as the commonest illnesses among them and they described STIs very well. The information was matching with that of key informants who equally mentioned STIs, TB and even added HIV as high among street children. One key informant had this to comment;-

> Street children usually come here and sometimes they do the money begging from places near this clinic. Sometimes they come for help when they are in pain due to STIs. STIs are very high among street kids. (Key informant health facility)

4.4.5 Lack of shelter and sanitary accommodation

Though street children have specific locations where they stay or are found doing their economic activities, they generally reported that they have no proper shelter for habitation. To spend a night and protect themselves from extremes of weather they depend on abandoned building structures, public places like the intercity bus terminus or the market places. Some reported that during the dry season they sleep under bridges and in trenches and dry drainage spaces. They can keep a few belongings such as clothes in such places. However for sanitary accommodation, the street children reported that they just use any hidden place since they have to pay if they used public toilets. For bathing most street children bath in waste water in the stream which collects the water drained from the city drainage systems. During a physical observation street children were observed sleeping near wall fences and bathing in waste water drained from factories and industrial places. During focus group discussion the following is what some participants had to say:-

> For sleeping we just change places depending on the season. Sometimes we spend our nights under bridges or in trenches and sometimes we make a big fire near the

market place and sleep but trouble comes during the rainy season. We are found around corridors and unfinished buildings and when the rains are so heavy it is common to get soaked even in the corridors. (15 years old street boy)

When we want to bath we go to the stream that flows from ZESCO, we call it 'big bafa' (the big bathroom) we wash clothes and bath there but for younger ones to bath you really have to endure beatings and bullying from bigger youths, there is real slapping that goes on. For that reason, I take weeks without taking a bath to be honest." (17 years old street boy)

4.4.6 Poor access to quality food and water

Street children reported that they do not have permanent places for food preparation and even water for drinking but depended on begging and buying from cheaper restaurants. Some mentioned that they picked foods from the bins or eat left over foods in the restaurants or left over foods given to them by motorists. During field observations many were observed at Soweto market picking and spoiled fruits that were disposed by traders in the refuse storage bins. Sometimes they really found it hard to find food. They took any water from nearby non restricted taps even from the taps in the public toilets.

Water is not a problem we just drink from any tap around even in the public toilets there are taps for washing hands, we drink from those taps. For food I usually stick around restaurants and I pick some good left overs and when I beg or work for money I buy some food (15 years old male street child).

4.4.7 Road traffic accidents

Road traffic accident were reported to be commonly affecting street children. They reported that the Lumumba road was the one that most street children got bashed by cars especially at night when vehicles moved faster. Some participants cited use of sticker/Jenkem to be part of the reason why most street children got hit by moving cars as the drug caused them to feel weak and dizzy and reduced day time alertness.

When you are under the influence of sticker (the drug), it distracts from paying attention to moving cars when crossing roads, you may not even hear the horn of a car. From the time I came to the streets I have seen over 20 street children bashed

> by cars but not all have died from that, some just sustain injuries. (17 years old street boy)

4.5 Social Health Challenges

4.5.1 Social Stigma

Street children also complained of how they get socially stigmatized by some members of the general public and key informant mentioned the same also adding that this also causes some street children to be violent sometimes.

> One of the things that really hurt me on the street is on how some people regard us. Some treat us as if we are not human beings. If you pass near a restaurant they chase you and pour water on you, some people don't want us near them.

4.5.2 Misconceptions and health Information need

Health information is one of the needs for street children. Most of them were unable to read and write and had less access to media and proper health education. During a focus group discussion most street children showed misconceptions and lack of updates and knowledge on basic health issues. When asked about cholera and possible knowledge of any street child that ever suffered or died of cholera, they all laughed and had this to say;-

> Street kid sadwala cholera, elo sitinanvelepo (a street child can never suffer from cholera and we have never heard of any). We pick foods even from the bins and we eat and we have never seen any suffer from cholera, cholera only attacks those that are too clean, not a street child, never! If any one ever said a street child had cholera I can't agree. (15 years old street boy)

4.5.3 Non coverage of street children in vaccination programs

No routine health services are carried to street children except in rare cases, HIV/AIDs counselling and testing activities by some NGOs. Outreach vaccination or information regarding the same is never targeted to street children. Most street children as well as key informants reported that street children were not considered even in mass vaccinations such as cholera vaccination that was in Lusaka in year 2016 (a year before this study was conducted) and Supplemental measles vaccinations that targeted children up to the age of 15

years did not cover the children living on the street. All activities or services intended for street children are regulated by the ministry in charge and all partners operate within available policy.

> Generally government does not encourage taking any services to street children while they are on the street because in doing so we might be encouraging the street living habit. We would rather remove them from the streets first and help them from homes or institutions where facilities for such are available. However, a few NGOs sometimes still carry some programs like HIV/AIDs testing to the streets but as government we don't. (Key informant Government department)

4.6 Psychological Health Challenges/ Needs

4.6.1 Poor adherence to treatment and poor health seeking behavior.

Most street children have poor health seeking behavior. It was commonly reported by key informants from the institutions of care and the street children themselves as well as key informant at Lusaka railway clinic that most street children only seek medical help when they are extremely sick and very weak. Many times they have to be carried by other people to the health facility. Key informant from the health facility had this to say;-

> I would say that street children have very poor health seeking behavior because they come when conditions are really bad and sometimes they are brought in semi-conscious conditions. The other problem is that even when we give medication to them, they rarely finish the course. Even those on anti-retroviral treatment (ART) have very bad adherence to medication. (Key informant at health facility).

4.6.2 Mental health problems

Many street children generally appear and present with a common sign of mental health challenges detected from speech, dressing and behavior a clue of what may be originating from the social and physical environments. Reports from the Railway clinic which was nearest to city central business confirmed the observation. One key informant from a health facility had this to say over their observation;

> Yes we have also observed that a number of street children that come here present with some kind of mental disorders and partly it could be related to substance

> abuse especially the drugs they sniff. Some cases received are purely due to substance abuse. (Key informant Lusaka Railway Clinic)

4.7 Reproductive Health Needs

All the five girls that participated in the timeline interviews reported to have had an STI before, and all had been pregnant at least once and one was pregnant during the interview. In the 2 FGDs for girls all of them testified that they had been raped at least once while living on the streets.

Some adolescent girls living on the streets were observed to be pregnant and some with children. Most teenagers interviewed acknowledged that they either had a child or had been pregnant before and all that were interviewed admitted being sexually active and having boy friends among their fellow street residents. However, reproductive health services provided in the health facilities are not highly utilized by street girls despite being free and accessible.

4.7.1 Maternal and Child Health (MCH) Attendance

Some of the street teen girls who got pregnant sought medical attention and antenatal services though the habit was not reported common among them. NGOs like Fountain of hope located near town had support programs for pregnant street teens who were noted. However, despite free services from government health facilities and hospices, most street teens did not seem to appreciate the importance of such services.

> Street teens do not really care so much about their health. We do find the pregnant street girls during our field work and we met one of them even yesterday who expressed no interest in going for antenatal services. On their own they care less about health. (Key respondent Ministry of youth Lusaka)

4.8.2 Low contraceptive use and Lack of basic Knowledge on Reproductive health.

Though unwanted pregnancies are generally high among street teens, use of contraceptives is extremely low. Most street girls did not show understanding of the importance of contraceptive use and reproductive health in general when interviewed. Railway clinic indicated that only very few street girls sought family planning services.

> Family planning services are available that street children can benefit from but only very few come for family planning services. (Key informant Railway clinic)

4.8.3 Sexual Harassments and sexual Assaults to street girls

Most street girls listed sexual assaults such as rape as the greatest concern they had on the streets. All the street girls that participated in the study reported that each one of them had been raped at least once from street boys, older street youths or other men who took advantage of them. The girls narrated that the drugs they sniff made them to too weak to defend themselves from sexual assaults most of the time. Some of the girls had pregnancies and children without knowing the responsible person due to being raped by men. During a life history interview one girl narrated her experience as quoted below;

> To tell you the truth uncle, most of these men you see around are not good people at all. They like beating us for no reason and raping us. Almost every night we have to look for proper hiding places to sleep if we have to be safe from being raped. Believe me even tonight we are in trouble. I have been raped several times before and I had been pregnant more than twice without knowing who was responsible. I lost all the babies that I have had. A night that I will never forget is when I was gang raped by four men who just left me alone after doing what they wanted. In such situations you just know that one of those may leave you pregnant and others may give you diseases. (18 years old street girl at Lusaka town center)

4.9 Common Street Children's Response to Government's Programs

Government of Zambia through the responsible sectors working hand in hand with private partners have programs aimed at improving the lives of the marginalized, and has specific programs for street children. The major programs in place aims at removal of street children from the streets and re-integrate them with their own families directly or after some rehabilitation program. Children whose families cannot be traced are taken to institutions of care until they mature enough to take care of themselves. However, an exploration of the situation on the ground indicated some evidence of little success and a number of challenges in the success of the activities. Some challenges noted are detailed below.

4.9.1 Refractoriness to rehabilitation.

Most street children taken to institutions for rehabilitation were reported to have gone back to the street as refractory Juveniles who have failed to change. These are juveniles who were once housed and taken for rehabilitation but went back to streets and some ended up having children right on the streets increasing the number of vulnerable children and were reported to be among those mostly involved in criminal activities. One key informant had this to say;-

> Though we have had success in rehabilitating some street children, we still have many who have been escaping from institutions or fully trained in skills but still did not change and went back to live on the streets. We call them refractory juveniles. These have bad influence on street children and many of them engage in criminal activities. (Key informant CPU)

4.9.2 Escape from Institutions and places of safety.

Removal of street children from the streets has been going on by government and many partners. The majority of street children narrated that they had opportunities of being to institutions of care but chose to leave and opted to get back to street living. During a focus group discussion one had this to say.

> There are only few people here who have never been to orphanages and centers, it is just hard to live in those places. They have too many rules and being on the streets is much better. Regarding going to the centers no one here can be interested, unless if some people gave us some money to do business and rent a house for us we can be happier. (16 years old street girl)

4.9.3 Re-escape from homes to street life.

During re-integrated process of street children with their families. Professional counselling, and material or financial empowerment are provided to the families to ensure safety. However, the findings indicated that a number of street children still left their homes and got back to the streets.

> The social welfare people usually come with a truck, they catch us and go with us to see where we come from, they just look at your home, if they find that you are poor, they take you to the centers but if your parents are there and not poor, they

> beat them up for letting you live on the streets. But even when they take us there we have still come back here. (Street girl 15 years old)

4.9.4 Refusal to comply due to Force.

According to key informants, procedures of street children's removal by the ministry concerned, does not include the use of force. However, the street children relate to moments when force was used on them and they tend to develop a negative attitude towards complying with the idea of street removal and moving to institutions whenever force is used. One street adolescent had this to say during the focus group discussion;-

> Tell them to be coming in a friendly way if they want to take us anywhere, not in the way they usually come, handling us like thieves in a brutal way and carrying us by force to the centers, one day we will riot am telling you… (18 years old street boy)

4.10 Hindering Factors to Giving Up Attachments with Street Living.

Despite hard living conditions on the street, most street children developed strong attachments that caused them to not easily give up street living. Most street children confessed that it is not easy to leave street life due to some habits that they indulge in. The most common things listed were free use of drugs, relationships, habituation to money handling, sex and freedom. The majority reported that they had opportunities of being taken to institutions of care but escaped due to the habits and factors listed above.

4.10.1 Drug addiction

Drug addiction has a big impact on street children's attachment to the streets. Key informants from Fountain of Hope, an OVC care center and from government narrated that most street children who are taken to institutions of care like Fountain of Hope and others, usually escaped because they could not follow the rules that restrict drug sniffing. Some street children failed to be re-integrated with their families due to drug addiction. Street children

also confessed that automatic withdrawal from the drugs was not easy on their part. One 12 years old boy who left a safe home from parents had this to say;-

> I have both parents alive and well in Matero and I used to go to school until my brother influenced me to come to the streets. When life gets hard here I try to get back home, but each time I go home I miss ‘sticker’ (the drug commonly sniffed by street children) so I keep escaping back here where it is readily available and I beg for money to buy it.”

One 15 years old boy had this to say regarding casual sex and drugs

> These girls really trouble us. They are unable to work as much as boys do to make money, so they offer us sex so that we buy them sticker for K2 only and when you buy for her just know that in the night it will happen.

4.10.2 Sexual Relationships.

Sexual relationships are common on the streets. Most girls reported that they had boy friends among street children. Older youths and some below 18 years have children together and still lived on the streets. Key informants from institutions reported that a number of street children cited missing of their boyfriends or girlfriends as reasons for escaping from the institutions of care and went back to the streets.

> We develop good rapport with street children and we make follow up if they go back to the streets and among the reason they cite for reverting to street life includes missing of ‘sticker’ and some say they missed their boyfriends or girlfriends and they fail to comply with rules here that inhibit such behaviors. (Key Informant 1).

4.10.3 Habituation to Money Handling.

The habits of begging for free money and generally handling money is equally strong in the lives of street children. Key informants and street children themselves all talked about failing to be in places where they are restricted from raising money for themselves and break away

from the daily habit of begging so they prefer being in the streets where they practice such activities. One FGD participant narrated the following;-

> At the centers they have problems, you can't have all you need. They take long to give you new clothes and you can't find money. You have to be broke all the time. I prefer being on the streets, here you raise some money and get some of the things you want. (15 years old street boy).

4.10.4 Freedom

Freedom from restrictions and rules is one of the things that kept most street children on the streets than in institutions or homes. The most common response from street children on reasons for avoiding institutions of care was issues of difficulties in complying with rules. Some Street children's reason for leaving their own homes to the streets included search for freedom from school rules or work responsibilities in their homes.

> I was at an orphanage from the age of six and had been to different orphanages and centers but I failed to stay there after growing up a little bit. They have a lot of restrictions. They punish even for little mistakes like plucking a mango from the tree to eat without permission. I could not feel at home so left at an early age and came to the streets. (16 years old street girl)

4.11 Major Challenges on Consistence with Street Children's Programs

A number of successes in street children's programs were on record and plans for continuation were all in place. Despite the well written down programs and step by step procedures for helping street children, the activities had not always been carried out in the desired manner due to limiting factors. Major limitations mentioned were inadequate resources and having limited spaces in institutions of care for vulnerable children.

4.11.1 Inadequate resources for programs

The findings indicated that most programs were not always carried out due to limitations in resources since carrying out removal requires a lot of steps and adequate resources to implement and make follow ups. Limitations of funding in this matter affected both government and partners.

> It's a long time since we ever carried out removal of street children from the streets due to limited resources and competing priorities. We also have challenges with limited spaces in institutions and we have less man power in our system for this program. (Key informant 3)

4.11.2 Limited spaces in institutions.

Despite programs of taking street children to institutions of care, the activities depend on availability of space in the institutions. The reports from key informant indicated that it was not an automatic procedure to house street children but needed to accommodate them when space was available for them and other vulnerable children.

> In this place we only have capacity for 60 vulnerable children, if we want to keep street children, how many can we keep? We can only take a few and keep offloading some to take in some more. It is an on-going process and when they come here we prepare them to re-integrate with their own families because we believe that family is very important. (Key informant Fountain of Hope)

Summary of results

In summary, the results present the common histories of street children regarding their causes for choosing to live on the streets. The study also explored the experiences of children living on the streets and the negative health effects that arises from street living and the situation of female street children. The findings also cover an exploration of existing programs aimed at helping street children and the factors that work against the success of the programs in place, exposing the gap between what is expected and what is observed.

CHAPTER FIVE

DISCUSSION

This chapter discusses the findings of the study in answering the question on what the trajectories, experiences and health needs of street children are, and the question on how responsive government programs are to the actual needs of street children in terms of health needs. The objective of this research was to explore the life histories and health needs of street children in Lusaka city by specifically exploring the social backgrounds and histories of the street children. Exploring the physical, psychological and social health needs of the street children including sexual and reproductive health challenges and other needs of female street children. And also exploring the compatibility of government programs in meeting the health needs of street based children.

A narrative approach is predominantly valuable in addressing such a study and questions because it provides an analytic space in which the voice of the marginalized finds protection and representation.

5.1 Major Findings

The analysis of this study revealed social backgrounds and common children's pathways into homelessness explaining reasons for children's choices of beginning street living. It also looked at street living experiences that negatively affect health, reproductive health needs of female street adolescents, existing programs for street children in Zambia, hindrances to giving up attachments with street living and challenges on consistence with street children's programs in Zambia.

5.2 Social backgrounds and histories.

The study findings in chapter 4.0 indicated that street children were either attracted to streets life, or due to unavoidable circumstances, compelled into street living. The pull factors detailed included; influences from friends or relatives and early development of money seeking behavior. The push factors however were; extreme poverty and hardships arising from losing a parent or guardian, bad relations with step parents and having irresponsible parents. The social background information indicated that most street children trace their origins from poor sections of Lusaka city such as Misis, Chibolya and Kanyama compounds and majority were introduced to street living as early as in their preadolescent ages.

The stated findings above are similar with the findings of studies on common pathways into homelessness for street children in other countries. The studies reviewed in the literature (Nanda, 2008; Imasiku and Banda, 2012; Asante, 2016), reveal similar findings they are with regards to main reasons why street children become what they are. Generally all reveal that there is a variety of reasons why children make streets their home and no single specific reason but all border on being forced or attracted to street activities.

Using the life histories approach this study was able to dig deeper on the trajectories of street children, identifying the stages that children pass through before fully being on the streets. This study demonstrates that most street children do not begin with intentions to shift to the streets. They get attracted or compelled to get to the streets for money and food begging. Then by indulging in common addictive activities such as drug use, sex, and card playing

children develop strong attachments with street life and enjoy freedom of such indulgences away from restrictions found in homes, school environments and with adherence to such routines live fully on the streets.

The common age that street children begin street living may indicate inadequate or lack of parental guidance as a result of disorganized homes. While alms giving to street beggars may be viewed as good acts of charity, this study reveals that some street children from stable homes are attracted to the streets by money begging before they learn habits which enslave them into full time street living.

5.3 Physical, psychological and social health needs of the street children.

An exploration of physical, social and psychological health challenges to identify the health needs revealed that street children are exposed to harsh physical, social and psychological conditions which include lack of shelter, injuries, inadequate and lack of safe food, sexual harassments, rape, and non-coverage in vaccination, stigma and mental health problems. Leaving them in need of shelter, safe food and water, protection, street children friendly health services and health care services as well as a sense of belonging.

Studies conducted by Asante (2015), Shrestha (2009), Imasiku and Banda (2012) Kebende (2015), had similar findings regarding physical, psychological and social challenges and needs of street children, listing survival sex, STIs, lack of shelter, rape, inadequate food among others. However, in this study the findings go a little further listing health needs such as vaccinations which are not provided to target the street children population.

Generally the exposure to such challenges are a result of living on the streets indicating that removal of street children from the streets to healthier environments is the best action for improvement of the health of these homeless children. However, since removal of street children requires a process, it may be very necessary to provide health services to street based children while living on the streets to reduce their health problems and minimize the negative health impact that may affect the health of other populations.

Vaccinations not covering street children may impact negatively on public health at large. According to UNICEF (2016), Vaccinations against cholera were conducted in Lusaka city during a cholera outbreak. Supplemental Immunization activities against measles are also carried out for children up to the age of 15 years in specific set dates to ensure herd immunity in order to prevent virus circulation. Leaving out such services from street children who are in fact more vulnerable to cholera and other vaccine preventable diseases due to their lifestyle may impact negatively on their individual health and the health of the community at large.

According to Carl Rogers (1995), childhood experiences affect the personality development of children and family plays an important role in personality development of an individual at different developmental levels. In the situation of the street children in Lusaka, this may mean that the personalities developed in the street life environment may cause permanent negative developments in street children due to harsh condition exposures. Therefore provision of an environment where children will have a sense of belonging may provide for the psychological need.

The other importance of the findings on physical needs is on communicable diseases. Street children's lack of shelter exposes them to mosquito bites and poor sanitation, making them possible hosts of malaria, cholera and other infections which have a negative impact on the community at large apart from their individual health therefore, provision of health services along with systematic removal programs may lead to better public health outcomes.

5.4 Sexual and reproductive health challenges and needs of female street children.

On reproductive health needs the analysis of the study showed that most female street children in Lusaka did not attend maternal health services, rarely practiced contraceptive use despite high sexual activity and rape cases among street girls as well as high numbers of teenage pregnancies. They lacked basic information on reproductive health. This uncovers the needs of health information, maternal health services and protection from physical assaults.

The outcomes in this study agree with findings of Mumbi (2006) over teenage pregnancies being almost universal among street teens. And the study by Menon (2015) over rare

contraceptive use. However this study indicates the need of health information sensitization among female street children as they indicated ignorance on basic information on importance of Maternal and Child Health service (MCH) attendances even though they knew where to access free services of this nature. The study also revealed poor health seeking behavior among street children and these are important findings as they give light on necessary interventions to consider in planning programs for such populations.

5.5 Compatibility of government programs in meeting the health needs of street based children.

An exploration of how responsive government programs are to the needs of street children showed that re-integration of street children to families and movement of street children from streets to institutions did not meet much success. Most street children responded by reverting to street life after removal from street. The study also explored factors that hinder street children from giving up attachments with street life and challenges of government in carrying out effective programs for street children. These factors include; drug addictions, sexual relationships, habituation to money handling and seeking freedom from rules and restrictions. Government's common challenges were inconsistence on planned programs due to insufficient resources and limitations on space in institutions.

A study by Crombach et al (2014) similarly mentions integration of street children to institutions as one of the common programs targeting street children in Burundi though the study's aim is on mental health impairment levels of re-integrated children.

However, the findings in this study on this subject indicate that despite activities of street children removal from the streets to integration with institutions or re-integration with families. Most street children revert to street life. This could be because street children have strong attachments with street life which is not taken into consideration when carrying out removal. Drug addiction is one of the main reasons street children report to be reason for going back to the streets, therefore without in cooperating drug withdrawal programs to street children most street children would not easily cope with institutional life where drug use is prohibited. Sex among children is equally prohibited in institutions and most street teens in search of such freedom say they would rather have their freedom than be in an institution. It is

Government according to chapter 4 does not encourage offering of services to street children while on the street but puts emphasis on removal and re-integration. However the gap caused by limitation of space in institutions and inadequate funding for consistent removal activities of street children, leaves street children exposed to street harsh conditions, worsening the communicable disease circulation within and without the street children's community. This makes it important to consider provisional of special health services suiting the needs of the street children.

5.6 Limitations of the study.

The study was conducted in one specific area and on a small population and can therefore not be generalized though transferability to similar settings is possible.

Street children are highly mobile and have a very short attention span therefore getting very detailed information that needed much time and follow up was not possible.

Participants aged from 12-14 were very few at time of data collection and could not easily be traced and information gathered might not be from well-balanced views.

Some street children showed some expectations of help during and after the interviews despite repeatedly making clarity that information that was being collected was purely for research. This might have given room to some bias in information provided. However, to minimize the bias, information was not only collected from one particular group and place but was collected from three different places of Lusaka with different focus group discussions and data triangulation was also in place for cross verification from three different sources mentioned in the methods section.

5.7 Suggestions for further research

It would be important for future research to target the younger participants on the streets as well as street youth older than 18 to have a wide range of information in this area of study.

It would also be helpful to carry out implementation research on provision of health services to street children.

Conduct a specific study with refractory juveniles or street children that revert to street living despite having passed through rehabilitation or re-integration program.

5.8 Summary of discussion

This chapter presented a discussion on the life histories and health needs of street children in Lusaka city. The study established that street children's pathways into homelessness are diverse yet border on attractions and compelling factors. Street children pass through stages of habits that enslave them into street living. Street living exposes children to harsh conditions that negatively affect their safety and health and places them in need of shelter, protection, addiction withdrawal services and other general health and health care services. The discussion also looked at importance of government to consider programs that work against factors that cause street children to have strong attachments with street living than conducting only removal from the streets. Non provision of special health services to street children with view of discouraging street living may have a negative effect on public health in general since removal is a process.

CHAPTER SIX

CONCLUSION

An exploration of the life histories and health needs of street children shows that hardships in homes and attractions to the streets lead children to adopt street living habits which exposes them to many negative health effects. This study showed that this process includes stages of habit forming before children become fully street based. And these stages are important to consider in planning interventions against street living behavior. In short this study suggests that efforts to remove street children from the streets without attending to root causes of their problem and their addiction habits provides less success. Street children develop strong attachments with the street living environment which cause them to revert to streets after efforts of removal from the streets. Such attachment habits include drug addictions, sexual relations and money handling among others. This suggests that moving them to institutions

that has rules against such indulgences, without provision of habit withdrawal programs may yield poor results

In the fear of encouraging street living behavior, most services are not provided to street children while they are based on the streets but efforts to remove them is considered the best approach. On the other hand, this study suggests that provision of special health services to street children while they are still based on the streets is necessary since removal programs take long processes and are frustrated by many limiting factors and some failures. This leaves street children exposed to non-limited unhealthful conditions that compromises their health and the health of the general population. Provision of health services will minimize their poor health and limit spread of communicable diseases.

The study has showed that there is less compatibility of existing programs and the actual needs of street children. This is because the needs of street children begin with root causes of street life and become complicated by formed habits during street living, and these make up the actual needs of street children. These need to be considered in the programs for street children in addition to basic removal and reintegration activities.

6.1 Implication of the study

The implications of the findings of this study will be considered in terms of two sets of issues; the implication for public health and health promotion, and the implication for policy and practice.

6.1.1 Implication for public health and health promotion.

The findings in the study demonstrate that social circumstances on street children may have direct and indirect health consequences and also impacts on behavior. Issues such as unhealthy diets, illegal drug use, unprotected sex and notable material constraints which limit street children's opportunity to make healthy lifestyles all call for emphasis on issues of health in all policies program. This therefore calls for health promotional efforts to consider planning and programing against health effects that are socially determined, so as to prevent

and manage and minimize the health problems of street children through a multi-sectoral approach.

The findings of the study also imply that it is necessary to provide special health care services to street children while they are based on the streets for their own health and prevention of communicable disease spread to other populations.

These study's findings also form a good basis for future research and adds to the body of knowledge required regarding the subject covered with regard to public health and the marginalized populations. It forms a basis of carrying out research on unanswered questions regarding the street children phenomenon and health problems generated from their social circles.

6.1.2 Implications for Policy and Practice

The study outcomes on developmental aspects of street children will also alert policy makers regarding the evidence based factors that lead children into homelessness and what keeps them on the streets. This will guide policy making on setting up policies on the kind of programs that will truly accommodate the street children.

The study outcomes also speaks volumes on the emphasis of health in all policies approach and shows the link of health sector and other sectors such as the Ministry of Youth Sport and Child Development, the private sector, with the Ministry of Health.

6.2 Recommendations

- There is need for government and organizations developing programs for street children to understand the developmental aspects that happened for children living on the streets and a thick social circle that affect them.
- Interventions designed for street children's re-integration to families to consider addressing root causes and factors that obstruct forsaking of street attachments. I.e. by provision of drug withdrawal rehabilitation before admission to institutions or re-integration to families and also provision of psychotherapy in general.

- There is need for organizations and government to respond to children in a way that will truly accommodate and support them.
- Government and organizations involved in the care of street children, to consider involvement of cooperating partners that are already practicing withdrawal programs like the Street Outreach Harm Reduction Program (SHARPS) who do not currently target street children.
- Government and partners to consider designing and provision of key health services friendly to street children.
- Public learning and research institutions to consider participatory research on removal of street children.
- Government through the relevant sector to strengthen community parenting programs.

REFERENCES

Abdullah, Y.H.M and Bakar, N.R.H. (2008) Life History Approach: Fieldwork Experience. Journal e- Bangi volume 3, number 09, 2008 ISSN: 1823 884x.

Adrianse, HK. (2012) Timeline interviews: A tool for Conducting Life History Research. Qualitative Studies, 3 (1): 40-55.

Asante, K.O. (2015) Street children and Adolsecents in Ghana: A qualitative Study of Trajectory and Behavioral experiences of Homelessness. Global Social Welf. 2016. 3:33-43

Aptekar L, Ciano-Federoff LM. (1999) Street children in Nairobi: Gender Differences in Mental Health. New Dir Child Adolescents Dev 1999; 85:35-46

Anarfi JK, (1995) Street youth in Accra city: Sexual Networking in a High-Risk Environment and its Implications for the spread of HIV/AIDS. Health Trans Rev 1995; 5:131-52.

Barry M.S.W and Ensign J, Lippek S.H (2002). Embracing street culture, fitting Healthcare into the lives of street youth. Journal of Transcultural Nursing, Vol 13 No. 2, April 2002 145-152. Sage publications.

Basu, K and Tzannontos, Z. (2003). The Global Child Labour Problem: What do we know and what can we do? The World Bank Economic Reviewing Vol. 17, No.2

Bayden, J. Gibbs, S. (1997) Children and War Understanding Psychological Distress in Cambodia, UN; Genera

Boakye-Boaten, A. (2008) Street Children: Experiences from the streets of Accra. Research Journal of International Studies. Issue 8 (November, 2008).

Brandman, B. (2001) intervening in the lives of Street Children: A case for Zambia. Maxwell School of Citizenship and public affairs.

Buchanan, T.N, Donnel CM and Sosulsk RM. (2010) Life History and Narrative Analysis: Feminist Methodologies Contextualizing Black Women's Experiences with Severe Mental Illnesses. Journal of Sociology and Social welfare**,** September 2010, Volume XXXVII, No. 3

Catholic Action for Street Youth (2010). The Ghanaian Street Child. Accra Ghana: Catholic Action for Street children.

Central Statistics Office (2014) Social Statistics. Republic of Zambia Central Statistics Office, Nationalist Road, Lusaka.

Crombach A, Bombanye M and Elbert T. (2014). A Study on Reintegration of Street children in Burundi: Experienced violence and maltreatment are associated with mental health impairment and impeded educational progress. Frontiers in Psychology December 2016: doi: 10.3389.fpsych.2014.01441

Cumber S.N and Tsoka-Gwegweni J.M, (2015). The Health Profile of Street Children in Africa: Literature Review. Journal of Public Health Africa. Aug 17; 6 (2) 566. Pp. 566

Dahlgren, G and Whitehead, M. (1991). Policies and strategies to promote social Equity in Health: Stockholm, Sweden: Institute for future studies.

David L., Huezda J., Sullivan S and Plourde R. (1983) Maslow's Hierarchy of Needs And Psychological health. Journal of General Psychology 1983, 109, 83-85.

Dehne KL and Reidner G. (2005) Sexually Transmitted Infections among Adolescents. The need for adequate health services. Geneva, Switzerland: WHO; 2005.

Dhumpath R. and Samuel M. (2009) Life History Research. Epistemology, Methodology and Representation. Rotterdam: Sense Publisher.

Duyan V. (2005). Relationships between the sociodemographic and family characteristics, street life experiences and the hopelessness of street children. Childhood 2005; 12:445-59.

Etherington K. (2010). Narrative approaches to working with adult male survivors of childhood sexual abuse, London.

Imasiku M.L and Banda S. (2012). Mental Health Problems of Street Children in Residential Care in Zambia: Special focus on Prediction of Psychiatric Conditions in Street Children. Department of Psychology, University of Zambia.

Kayembe P.K, Mapatano M.A and Fatuma A.B (2008). Knowledge of HIV, Sexual Behavior and Correlates of Risky Sex among Street Children in Kinshasa, Democratic Republic Of Congo: East African Public Health Ass 2008; 5:186-92.

Kebende K.S. (2015) The Situation of Street Children in Urban Centers of Ethiopia and Role of NGO in Addressing their Social-Economic Problems: The Case of Hawassa City. International Journal of Academic Research in Education and Review Vol 3(3) April 2015. Pp. 45-57.

KidsRights (2012). Street Children Have Rights Too: KidsRights Foundation in Cooperation with the Child Law Department of Leiden University.

Kipyegon K, Nyachawa F.N Okirigitsi C.A, Kipchritchir I.K et al.(2015) Factors Influencing Rising numbers of Street Children in Urban Centers of Kenya: A Survey of Eldoret Municipality Kenya. European Open urban studies and Development Journal Vol. 1, 1 January 2015.pp.1-14

Lemba, M. (2002). Rapid Assessment of Street Children in Lusaka: Project Concern International Zambia, UNICEF, ZAMBIA.

Maslow A.H. (1970) A theory of human motivation. Psychological review, Vol. 50, 1943 370-396.

Menon, A. (2015). Adolescent Street Girl Children's Knowledge of STI, HIV/AIDS, Awareness of Contraceptives and Attitudes on Sexual health and Sexuality: International Journal of behavioral Social and Movement Sciences Vol. 02, July 2013. (Issue 03). 2277-7547

Mitchel M and Egudo M (2003) A review of Narrative Methodology: Land Operations Divisions- Australia. Edinburgh South Australia.

Mufune. P (2000) Street Youth in Southern Africa. UNESCO Oxford USA Blackwell publishers. 164/2000

Mumbi M.M.R, (2006). The Plight of Street Children and the Need for Participatory Communication between the Street children and Various Stake Holders: A Case study at the Fountain of Hope in Lusaka Zambia. School of Humanities and Social Sciences, University of Zambia.

Nanda S. (2008). Working Street Children's Perceptions of their health, Illness and health-seeking behavior: A Study in New Delhi, India. Royal Tropical Institute KIT Amsterdam.

Oduro G.Y (2012). Children of the Street: Sexual Citizenship and the Unprotected Lives of Ghanaian Street Youth. : Comparative Education, 48 (1), 41-46.

Patriasih R, Widiaty I, Dewy M and Sukandar D (2010) Nutrients Intake and Nutritional Status of street children in Bandung: Journal of Nutrition and Food, 2010, s (5): 177-183.

Pope, C., Ziebland S and Mays N. (2000) Qualitative research in Health care. British Medical journal 2000 Jan 8:320 (7227): 114-116.

Ray, P. (2011). Still on the Streets, Still short of Rights: Analysis of Policy and Programs Related to street Involved Children.

Rogers, C. (1995). On Becoming a Person. Boston: Mariner Books,

Rowe, A., McClelland A and Bellingham K (2001) Community Health Needs Assessment. Institute of General Practice and Primary Care, University of Sheffield, United Kingdom.

Seager, J.R and Tamasane T. (2010). Health and wellbeing of the homeless in South African cities and towns: Develop S Africa 2010; 27:63-83

Sherman, D. (1992). The Neglected health care needs of street Youth: Public health reports 107, 432-440.

Thomas de Benitez, S (2011). Street Children: Research Street Children Series 2. 2011

The People's Charter for Health www.phmovement.org accessed on 10/06/2016.

Turgut, N. (2015). Do I count if you count me? Street children and HIV/AIDS. Consortium for street children Briefing paper 2015.UNESCO, 2006. 2623-08021.

UNICEF, (2016). Zambia Cholera Outbreak report. United Nations International Emergence Children's Fund Zambia site Report number 5.

World Health Organization, (2000). Guidelines for Regulatory Assessment of Medicinal Products for use in Self-medication. Geneva, 2000. WHO/EMO/QSM/00.1.

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APPENDICES

APPENDIX I.

INFORMATION SHEET FOR INTERVIEW WITH STREET CHILDREN

Assent Form Version Date: 11th March 2016

Title of Study: Life Histories and Health Needs of Street Children in Lusaka City.

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Email Address: joelsimabwachi@yahoo.com

Introduction:

I would like to invite you to take part in a research study. This study is part of what is required for me to complete my Master of public health studies with the University of Zambia, School of Medicine Public Health Department. This document is the information sheet. I will explain all the information you need and anything else regarding research process. You are free to ask any questions at any time and you are also free to NOT answer questions that you may not be comfortable with. You are also free to withdraw from the study at any time without any penalty or any problems at all and I will not complain against you. You are also free to refuse participation in this study if you feel that you do not want to do so.

What is the purpose of this research?

The reason for carrying out this study is to provide information on the life histories and health needs of street children. The information will help to add more knowledge that will be useful in different ways including helping the street children to live healthy and better lives

Why are you being asked to participate in the focus group discussion/interview?

The people who will take part in discussion will help to raise useful information that may be helpful to improve programs for street children.

Procedures

If you allow me to talk to you, I will ask you to take part in an interview that will take about 1-2 hours. If you will allow me, I will record your voice with a tape recorder during the discussion so that it helps me to remember and write down exactly what you will be discussed. If there is some information you feel should not be recorded, you are free to say so. No name will be included in the tape recording and the typed documents.

Risks/discomforts

I do not expect you to have any problems during your participation in the interview discussion. However, some information I may learn from you may be personal and emotional. I would also like to assure you that the information I will get from you will not be shared with anyone outside the academic team, and will be kept confidential between all the participants and myself.

Benefits

If you agree that you participate in the interview, I will give you some refreshments (food) because of the time you will spend on this activity. Apart from this there will be no direct benefits to you, but what I will learn from you during the interview will help improve the programs aimed at helping street children.

Protecting data confidentiality

I have put up actions to protect the information I will get from you. Firstly, only members of the academic team will be able to see the information. Secondly, I will not put names on any information collected from you. Instead, I will use numbers for identification. Thirdly, I will destroy all tapes according to academic guidelines. I will keep copies of typed information on CDs in case I have a problem with the computer. All this information will be kept on a secure computer and in a secure room.

What happens if you do not want to participate or decide to leave the discussion early?

You are free to decide whether you want to take part in the discussion, and you are free to leave at any point during the discussion. You are also free not to answer any questions that you are not comfortable with and this will not bring any problem to you.

Who to call for questions or problems regarding the study?

You can call the Principal investigator

Investigator: Joel Zama Simabwachi (MPH student)

University of Zambia, School of medicine,

Department of Public Health,

P.O BOX 50110.

Lusaka.

Cell: +260977465223

You can also contact the

Supervisor: Dr Oliver Mweemba. PhD,

University of Zambia, School of medicine.

Department of Public Health,

P.O Box 50110

Lusaka.

Cell: +260971 194 852.

You may also contact the Ethics Committee

Biomedical Research Ethics Committee,

Ridgeway Campus,

P.O BOX 50110,

Lusaka, Zambia.

Telephone 260-1-256067

Email: unzarec@zamtel.zm

APPENDIX II

CONSENT FORM FOR PARTICIPATION IN THE STUDY ON LIFE HISTORIES AND HEALTH NEEDS OF STREET CHILDREN IN LUSAKA CITY.

Informed consent for street Children/parents/ Guardian /Representative.

What does my signature (or thumb print/mark) on this consent form mean?

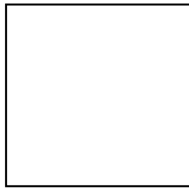
My signature (or thumb print/mark) on this form means:

- I have been informed about the purpose, procedures, possible benefits and risks of the interview.
- I have been given the chance to ask questions before I sign.

- I have voluntarily agreed to participate in this interview.
- That I am free to withdraw from the study or skip any question at any time without any consequences.
-

_________________________ ______________________________ __________

Name of participant Signature of participant Date

Ask the participant to mark a "left thumb impression" in this box if the participant is unable to provide a signature above.

___________________________ ________________________ ____________

Name of witness Signature of witness Date

(If the person giving consent

Cannot read and write)- -

AGREEMENT TO RECORDING

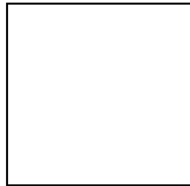
________ (participant initials) I agree to allow the interview I participate in to be recorded.

________ (participant initials) I do <u>not</u> agree that the interview I participate in to be recorded.

____ _________________

Signature of participant Date

____

Ask the participant to mark a “left thumb impression” in this box if she is unable to provide a signature above.

______________________________ ______________

Signature/ thumb print of Witness (if participant is illiterate) Date

____

Printed Name of Witness

If Illiterate: The content has been explained to me by the investigator or additional explanation given to me in my own language by another person other than the researcher.

Signature/Thumb print………………………………. Date……………………………………………

Witness 1…………………………………………………… Witness 2……………………………………

Signature of the person who explained the

Content in participant’s own language…….

………………………………………………………………..

Date……………………………………………………..

Witness 1………………………………………………..

APPENDIX III

ASSENT FORM FOR PARTICIPATION IN STUDY ON LIFE HISTORIES AND HEALTH NEEDS OF STREET CHILDREN IN LUSAKA CITY.

What does my signature (or thumb print/mark) on this assent form mean?

My signature (or thumb print/mark) on this form means:

- I have been informed about the purpose, procedures, possible benefits and risks of the interview.
- I have been given the chance to ask questions before I sign.

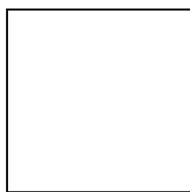
- I have voluntarily agreed to participate in this interview.
- That I am free to withdraw from the study or skip any question at any time without any consequences.

_________________________ _____________________________ __________

Name of participant Signature of participant Date

_________________________ _____________________________ __________

Name of person obtaining Signature of person obtaining assent Date



Ask the participant to mark a "left thumb impression" in this box if the participant is unable to provide a signature above.

___________________________ _______________________ ____________

Name of witness Signature of witness Date

(If the person giving assent

Cannot read and write)

AGREEMENT TO RECORDING

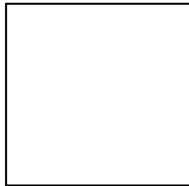
________ (participant initials) I agree to allow the interview I participate in to be recorded.

________ (participant initials) I do not agree that the interview I participate in to be recorded.

____ __________________

Signature of participant Date

____



Ask the participant to mark a "left thumb impression" in this box if she is unable to provide a signature above.

____ ___________________

Signature/ thumb print of Witness (if participant is illiterate) Date

____

Printed Name of Witness

If Illiterate: The content has been explained to me by the investigator or additional explanation given to me in my own language by another person other than the researcher.

Signature/Thumb print………………………………. Date……………………………………………

Witness 1…………………………………………………… Witness 2……………………………………

Signature of the person who explained the

Content in participant's own language…….

…………………………………………………………………..

Date……………………………………………………………..

Witness 1………………………………………………………..

APPENDIX IV.

INFORMATION SHEET IN CHI NYANJA

Information form for interview with street children translated in Nyanja.

Pepala la ciziwtso

Mutu wankhani: Nkhani za m’kalidwe ndi zofunikila za umoyo wa nthanzi kwa ana opezeka mumisewo ya mu Lusaka.

Wo fufudza dzina ndi: Joel Zama Simabwachi (wopunzila pa sukulu lalikulu ya univesiti yuku Zambia. Mu ciduswa ca Health.

Nambara ya foni: 0977465223

Email: joelsimabwachi@ yahoo.com

Choyambililа.

Ndili kukupempani kuti mutenge ko mbali mu nkani yopasa mayanko. Mayanko yanu niyo funikila kwambiri ndipo adza nditandizda ku kwanilitsa zdofunikila zones kuti ndithe mapunzilo yanga ku sikulu ya univesti ya mu Zambia muci duswa coyanganila pa za umoyo wa bantu. Ndidza fotokozda zonse zo mwe munga fune kudziwa ku nkhani ya zo fufuzda fufuzda zanga.

Inu muli omasuka kusatenga mbali ngankhale ku sayanka fusnso yomwe simunga fune ku yanka kopanda bvuto ili yonse. Muli omasuka nso ku chokapo nthawi iliyonse kopanda kupasidwa mulandu uli wonse ndipo sindidza kudandaulilani inu ngankale kukulesani inu.

Kodi Cholinga Cace Ca Kufufudza Fufudza kumeneku ndi Ca Bwanji?

Colinga cace caku fufuza uku ndicakuti mayanko ya dza tandidzila kudziwitsa anthu ambili pa nkhani ya m'khalidwe wa ana opezeka mumisewo omwe alibe manyumba ndi zofunikila zao za umoyo wanthanzi. Punzilo imene iyi idzatandidzila anthu ambili omwe angafune kupatsa tandidzo ku ana okhala mumiseo ngankhale mumindondomeko ya boma yothandizdila munjila imeneyi.

Kodi ndiciani muli pempedwa kuti mutenge ko mbali mu kufufuzdidwa kumeneku?

Anthu omwe akutenga mbali mukupasa mayanko adza tandidzila kuti anthu ambiri ankhale adziwa mkhalidwe wa ana amumisewo opanda manyumba ndopo nso azathanzdila kuti mindondomeko pa nkhani yo thandidzila ana ame wa idzi khala yolongosoka.

Ndondomeko Yathu

Ngati mwandi lola kuti ndilankhule ndi inu ndidza lankhula kwa ola limodzi kenaka maola yabili. Ndidzafunsa mufunso yosiyana siyana kuti munditandzileko kulingana ndi zomwe mukuzdiwa kulingana ndimafunso anga. Ndidzasebenzesa nso makina yotenga ndiku sunga mau yanu kuti ndisaibale zomwe tidzalankhula pano diponso ndidzakala ndili kulemba zomwe tizilankhula limodzi. Ngati simuli omasuka kuti ine ndisebenzese makina ya voice recoda kutenga mau yanu (Kutepinga) mungandidziwitse kuti ndisachite telo.

Mabvuto ndi zosanvesa bwino

Sindili kuyanganila kuti panga ngale vuto iliyonse pankhani yathu ayi koma zina zace zomwa tinzalankhula ndi inu zingankale zokukumbusani zintu zokumudwistsa zinachitika kale kale. Ndiponso ndilikufuna kukudziwitsani kuti zoonse zomwe tizalankhula pano imwe indi inu ndicisinsi chatu ife tilipano. Pa kulemba malembo yanga, sindidzachula maina yanu ndipo ndimau yomwe ndizda tepinga mumakina yanga ndidzayasunga mubisika kwambili.

Pindu.

Mukabvomela kuti ndilankhule ndi inu, palibe malipilo yomwe ndidza kupatsani inu koma cifukwa ca nthawi yanu yomwe tizasebenzesa ndidzakupatsani cakudya angakhale kadalama kangono kukuti mugule cakudya. Koma pindu inanso ndiyakuti nkhani yathu idzatandizila kuti kuti kupedzeke mau ambili omwe anga tandidzile kamindondomeko ya macitidwe yotandidzila ana osakhala ndi mabanja awo kumanyumba koma mu miseo.

Kasungidwe kwa mau yomwe tidza lankhula.

Nda ika matamphulo angapo yocingilidza mau aba omwe tidzalankhula pano. Choyamba nichakuti angakhale ndimphata wowona zomwe tidzalankhula panu ndi apunditsi anga oka ngankhale iwo sadzata kudziwa Mazina awanthu popeza kuti zomwe zi zdza falisidwa siziza sonyezdza kuti analankhula tele ndi ndani ngankhale madzina kulembedwa. Ndidza ika loco ya computer ku sebenzesa pass word. Ndiponso computer imeneyo idza ikidwa pobisidwa kuti anthu asankhale owelenga zomwe safunikila kuti adziwe.

Ma Nambala Yo Imbila Lamya ndi Keyala.

Ngati mwakhala ndibvuto iliyonse pa nkhani iyi kapena mafunso yochuluka, mungate kuimba lamya kuma nambala aya

Ofufudza: Joel Zama Simabwachi

Keyala: University of Zambia, School of medicine

Department of Public health

P.O BOX 50110

Lusaka.

Lamya: 0977465223.

Munga imbile Wondiyanganila Aphundzitsi

Dr Oliver Mweeba

University of Zambia, School of Medicine

Department of public health,

P.O Box 50110

Lusaka.

Lamya: 0971 194 852

Guulu yoyanganila pa Nkhani ya zo Fufuza (Ethics Committee.)

University of Zambia Biomedical Research Ethics Committee

Ridgeway Campus

P.O Box 50110

Lusaka, Zambia.

Telephone +260-1-256067

Email: unzarec@zamtel.zm.

APPENDIX V

FOCUS GROUP DISCUSSION GUIDE

Inclusion criteria; Street Children 12-18 years of age male and or females.

Copies of Consent/Assent and confidentiality to be provided to each participants and read aloud for the benefit of those that cannot read. Participants will be provided with an opportunity to ask any questions.

Before we start, I would like to remind you that there is no wrong answer in this discussion. We are interested in learning from you what you experiences are, what you feel and what you think. So feel free to be frank and to share your point of view regardless of whether you agree or disagree what you hear. It is important that we hear the general situation.

1. What do you think is the reason for our topic today? What do you think cause people to come to the streets and not be in homes like the majority of the people?

    - Contributing factors that you know
    - What stories have you heard as reasons for people to come to the streets

2. What are their challenges in living on the streets? If so what challenges do you face

3. What health challenges are faced on the streets by people who live on the streets?

    - What do you do when you get sick?
    - Challenges at clinics
    - Where to rest
    - Care who gives you food when you can't work or have time to beg?
    - Beddings and shelter

4. What health care services have you ever accessed while living on the streets
    - When and where?
    - Mass vaccinations say those that target people of age 15.
    - Free mosquito nets distributions
    - Vitamin A supplementations
    - Where you learn about health matters

5. How do you access water and sanitation facilities?
    - Toilets
    - Where to bath from
    - How often you bath
    - Where you wash from and dry your clothes
    - Your drinking water.

6. What do you consider to be your most felt health needs in general

- Considering access to treatment
- Health information
- What females go through
- What males go through
- The diseases you notice
- What you think if government or any organization did for your health you would appreciate.

7. Are there any street children or adults that have been affected with cholera or any epidemic before that you have observed? Say something on what you noticed if so (and please don't mention any names).

8. What diseases are commonly experienced by the majority of the street children?

APPENDIX VI

THE LIFE STORY TIME LINE INTERVIEW

Introductory Comments

This interview is all about your life story. I would like you to play the role of storyteller about your own life – to narrate to me story of your own past, present, and what you see as your own future (This interview is for research purposes only, and its sole purpose is the collection of data concerning people's life stories).

The interview will be divided into some of parts. In order to make the interview easier and to do it faster it will be important that you provide an overall outline of your story. The interview will starts with general things and then will move to the particular.

Questions

I. Life Chapters

Take it that your life is a story and taking into consideration that stories have characters, scenes, major events positive and negative ones, good and bad time, places and so on. What might things be in your story? Stories have chapters and parts I would suggest you name your chapters for example, your childhood days and life with your parents, good and bad times and events clear to you, challenging moments, pressure to leave home, going to live on the street etc.

You may mention the time when each event happened and the year or your age by then.

II. Critical Events

Now that you have given me an outline of the chapters in your story, I would like you to concentrate on a few key events that may stand out in bold print in the story. A key event should be a specific happening, a critical incident, a significant episode in your past set in a particular time and place. It is helpful to think of such an event as constituting a specific moment in your life story which stands out for some reason.

I am going to ask you about 8 specific life events. For each event, describe in detail what happened, where you were, who was involved, what you did, and what you were thinking and feeling in the event. Also, try to convey what impact this key event has had in your life story and what this event says about who you are or were as a person. Please be very specific here.

Event # Peak Experiences

A peak experience would be a high point in your life story -- perhaps the high point. It would be a moment or episode in the story in which you experienced extremely positive emotions, like joy, excitement, great happiness, up lifting, or even deep inner peace. Today, the episode would stand out in your memory as one of the best, highest, most wonderful scenes or moments in your life story. Please describe in some detail a peak experience, or something like it, that you have experienced some time in your past. Tell me exactly what happened, where it happened, who was involved, what you did, what you were thinking and feeling, what impact this experience may have had upon you, and what this experience says about who you were or who you are. [Interviewer should make sure that the subject addresses all of these questions, especially ones about impact and what the experience says about the person. Do not interrupt the description of the event. Rather ask for extra detail, if necessary, after the subject has finished initial description of the event.]

Event #2: Nadir Experience

A "nadir" is a low point. A nadir experience, therefore, is the opposite of a peak experience. It is a low point in your life story. Thinking back over your life, try to remember a specific

experience in which you felt extremely negative emotions, such as despair, disillusionment, terror, guilt, etc. You should consider this experience to represent one of the "low points" in your life story. Even though this memory is unpleasant, I would still appreciate an attempt on your part to be as honest and detailed as you can be. Please remember to be specific. What happened? When? Who was involved? What did you do? What were you thinking and feeling? What impact has the event had on you? What does the event say about who you are or who you were?

Event #3: Turning Point

In looking back on one's life, it is often possible to identify certain key "turning points" -- episodes through which a person undergoes substantial change. Turning points can occur in many different spheres of a person's life -- in relationships with other people, in work and school, in outside interests, etc. I am especially interested in a turning point in your understanding of yourself. Please identify a particular episode in your life story that you now see as a turning point. If you feel that your life story contains no turning points, then describe a particular episode in your life that comes closer than any other to qualifying as a turning point. [Note: If subject repeats an earlier event (e.g., peak experience, nadir) ask him or her to choose another one. Each of the 8 critical events in this section should be independent. We want 8 separate events. If the subject already mentioned an event under the section of "Life Chapters," it may be necessary to go over it again here. This kind of redundancy in inevitable.]

Event #4: Earliest Memory

Think back now to your childhood, as far back as you can go. Please choose a relatively clear memory from your earliest years and describe it in some detail. The memory need not seem especially significant in your life today. Rather what makes it significant is that it is the first or one of the first memories you have, one of the first scenes in your life story. The memory should be detailed enough to qualify as an "event." This is to say that you should choose the earliest (childhood) memory for which you are able to identify what happened, who was involved, and what you were thinking and feeling. Give us the best guess of your age at the time of the event.

Event #5: Important Childhood Scene

Now describe another memory from childhood, from later childhood, that stands out in your mind as especially important or significant. It may be a positive or negative memory. What happened? Who was involved? What did you do? What were you thinking and feeling? What impact has the event had on you? What does it say about who you are or who you were? Why is it important?

Event #6: Important Adolescent Scene

Describe a specific event from your teen-aged years that stands out as being especially important or significant.

Event #7: One Other Important Scene

Describe one more event, from any point in your life that stands out in your memory as being especially important or significant.

III. Life Challenge

Looking back over the various chapters and scenes in your life story, please describe the single greatest challenge that you have faced in your life. How have you faced, handled, or dealt with this challenge? Have other people assisted you in dealing with this challenge? How has this challenge had an impact on your life story?

IV. Influences on the Life Story: Positive and Negative

Positive

Looking back over your life story, please identify the single person, group of persons, or organization /institution that has or have had the greatest positive influence on your story. Please describe this person, group, or organization and the way in which he, she, it, or they have had a positive impact on your story.

Negative

Looking back over your life story, please identify the single person, group of persons, or organization/institution that has or have had the greatest negative influence on your story. Please describe this person, group, or organization and the way in which he, she, it, or they have had a negative impact on your story.

V. Stories and the Life Story

You have been telling me about the story of your life. In so doing, you have been trying to make your life into a story for me. I would like you now to think a little bit more about stories and how some particular stories might have influenced your own life story. From an early age, we all hear and watch stories. Our parents may read us stories when we are little; we hear people tell stories about everyday events; we watch stories on television and hear them on the radio; we see movies or plays; we learn about stories in schools, churches, synagogues, on the playground, in the neighborhood, with friends, family; we tell stories to each other in everyday life; some of us even write stories. I am interested in knowing what some of your favorite stories are and how they may have influenced how you think about your own life and your life story. I am going to ask you about three kinds of stories. In each case, try to identify a story you have heard in your life that fits the description, describe the story very briefly, and tell me if and how that story has had an effect on you.

Television, Movie, Performance: Stories Watched

Think back on TV shows you have seen, movies, or other forms of entertainment or stories from the media that you have experienced. Please identify one of your favorite stories from this domain -- for example, a favorite TV show or series, a favorite movie, play, etc. In a couple of sentences, tell me what the story is about. Tell me why you like the story so much. And tell me if and how the story has had an impact on your life.

Books, Magazines: Stories Read

Now think back over things you have read -- stories in books, magazines, newspapers, and so on. Please identify one of your favorite stories from this domain. Again, tell me a little bit about the story, why you like it, and what impact, if any, it has had on your life.

Family Stories, Friends: Stories Heard

Growing up, many of us hear stories in our families or from our friends that stick with us, stories that we remember. Family stories include things parents tell their children about "the old days," their family heritage, family legends, and so on. Children tell each other stories on the playground, in school, on the phone, and so on. Part of what makes life fun, even in adulthood, involves friends and family telling stories about themselves and about others. Try to identify one story like this that you remember, one that has stayed with you. Again, tell me a little bit about the story, why you like it or why you remember it, and what impact, if any, it has had on your life.

VI. Alternative Futures for the Life Story

Now that you have told me a little bit about your past, I would like you to consider the future. I would like you to imagine two different futures for your life story.

Positive Future

First, please describe a positive future. That is, please describe what you would like to happen in the future for your life story, including what goals and dreams you might accomplish or realize in the future. Please try to be realistic in doing this. In other words, I would like you to give me a picture of what you would realistically like to see happen in the future chapters and scenes of your life story.

Negative Future

Now, please describe a negative future. That is, please describe a highly undesirable future for yourself, one that you fear could happen to you but that you hope does not happen. Again, try to be pretty realistic. In other words, I would like you to give me a picture of a negative future for your life story that could possibly happen but that you hope will not happen.

VII. Personal Ideology

Now I would like to ask a few questions about your fundamental beliefs and values and about iy86fdiquestions of meaning and spirituality in your life. Please give some thought to each of these questions.

1. Consider for a moment the religious or spiritual dimensions of your life. Please describe in a nutshell your religious beliefs or the ways in which you approach life in a spiritual sense.

2. Please describe how your religious or spiritual life, values, or beliefs have changed over time.

3. How do you approach political and social issues? Do you have a particular political point of view? Are there particular issues or causes about which you feel strongly? Describe them.

4. What is the most important value in human living? Explain.

5. What else can you tell me that would help me understand your most fundamental beliefs and values about life and the world, the spiritual dimensions of your life, or your philosophy of life?

VIII. Life Theme

Looking back over your entire life story as a story with chapters and scenes, extending into the past as well as the imagined future, can you discern a central theme, message, or idea that runs throughout the story? What is the major theme of your life story? Explain.

IX. Other

What else should I know to understand your life story?

APPENDIX VII

INTERVIEW GUIDE FOR KEY INFORMANT INTERVIEWS

I would like to thank you for accepting to take part in this interview talking about Street children In Lusaka.

My name is Joel Zama Simabwachi a Public Health student at The University of Zambia carrying out a research on the life histories and health needs of street children in Lusaka city.

I am carrying out this interview with you because your organization has been carrying out programs for street children in Zambia including Lusaka and that you have some information concerning street children.

There are no wrong answers, please feel free to share your organization's point of view.

I have a recording device and I would like to request that you allow me to record this interview because I may not be fast enough in taking notes and I do not want to miss any important part of this discussion.

Let's Begin.

1. So generally what programs do you have for street children in Zambia?
    a) What programs do you have in Lusaka to be specific?
2. What information do you have generally regarding what pulls or pushes children to the streets?
3. What do think are the general health needs of street children in Lusaka City
    a) From your observations and lessons learnt in your service to them what their physical needs? I.e. shelter in rain seasons, warms, food, safe water
    b) What would you say are their psychological?
    c) What are their social health needs in general? I.e. how do they
    d) Access to health information?
4. What are the specific health needs in terms of health care needs
    a) Do they access health services easily?
    b) What do you know anything concerning street children's access to health care supplies and services as done to others members of Society? I.e. free Mosquito

nets, Vaccinations like cholera vaccination done during outbreaks (are they covered as well?)

c) Do they have access to family planning services, maternal and child health services?

5. Do you have programs that target street children's health needs in terms of the one's we have discussed?

   a) What specific activities do you have targeted against health needs of street children?

   b) What would you say is the impact of your programs regarding health needs of street children?

6. Are there any organizations in Lusaka have programs that cover health needs of street children known or working in partnership with this organization?

   a) Please give more detail if any.

End of Interview.

Thank you again for participating.