

Poverty, HIV, and barriers to education:

street children's experiences in Tanzania

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This article discusses the links between poverty, HIV/AIDS, and barriers to education, based on the first-hand experiences of 'street children' in northern Tanzania. Within the context of national levels of poverty, 'cost-sharing' in health and education sectors, and the AIDS epidemic, poor families in Tanzania are under considerable pressure, and increasing numbers of girls and boys are consequently seeking a living independently on the streets of towns and cities. My research with street children shows that some children orphaned by AIDS are subject to rejection and exploitation by the extended family after the death of their parent(s). They are exposed to considerable risks of abuse, sexual violence and HIV within the street environment. Here, I discuss the links between poverty, HIV and barriers to education, which compound young people's vulnerability, and offer some policy recommendations in response to the young people's experiences.

The socio-economic and political context within which children live has a considerable impact on family life, in Tanzania as elsewhere. Levels of national poverty in contemporary Tanzania strain the relationships between household members, and, in particular, relationships between adults and children. The World Bank estimates that 43 per cent of the rural population and 19 per cent of the urban population live below the poverty line (Bendera 1999, 118). The global economic recession, and subsequent structural adjustment processes, have been felt by both the agricultural and urban sectors, each of which is increasingly unable to provide a livelihood for most households (Koda 1995). This has led to 'a great exodus of human labour from the agricultural to, predominantly, the service sector', with young girls and boys, in particular, migrating to urban areas in search of wage labour (ibid, 141).

The resources currently available to Tanzanian children – both material and in

terms of human care – are stretched very thin. It has been consistently demonstrated that the cost of structural adjustment is disproportionately borne by the poor, and by women and children (Taylor and Mackenzie 1992). Even before structural adjustment, there were few, generally lower paid, employment possibilities open to women. One of the features of structural adjustment is to reduce the size of the public sector, which sheds lower-paid, less permanent jobs first, where more women are clustered. Family livelihoods are therefore increasingly dependent on casual income-generating opportunities in the informal sector.

Children are also increasingly engaging in income-generation activities in both rural and urban areas, and especially in the informal sector. They bring in cash to meet the needs of their families and themselves. Children's own needs include school uniforms, pens, exercise books, school fees, and even food and clothing (Koda 2000). A recent study in Bagamoyo revealed that

55 per cent of boys and 37.5 per cent of girls were contributing to schooling costs through casual work (Bendera 1999, 124). Children are used on both a part-time and full-time basis as casual farm workers, hawkers of food stuffs, clothing, and miscellaneous items, house-girls, assistants in home beer brewing, and also in manufacturing and the mining industry, while the feminisation of child labour is mostly found in domestic labour and commercial sexual exploitation (Koda 2000). Researcher Bertha Koda concludes that, in contemporary Tanzania:

Depending on the degree of poverty, the educational level of parents and the general policy environment, most children are forced to sacrifice much of their recreational, schooling and social needs in order to meet the broader needs of the family unit (domestic chores, child care, productive work etc.)

(Koda 2000, 250).

The introduction of cost-sharing measures for health and education has had a devastating effect on social services in Tanzania. Cost-sharing in the education sector has resulted in sharply declining primary school enrolment rates, accompanied by high drop-out rates and very low performance, particularly of girls, because of the inability of parents and guardians to pay school expenses, combined with their need for children's labour at home (Bendera 1999, Kuleana 1999). Access to medical care is also now reduced. The Tanzanian public health service has also become conspicuously under-funded in absolute terms, spending about US\$3.50 per capita per annum, well below what is normally acceptable (Koda 1995, 142). This has led to a deterioration in staffing, infrastructure and availability of drugs and equipment in basic health care, reflected in increased mortality rates for children under five, high maternal mortality rates and AIDS deaths (Bendera 1999, 118; Koda 1995, 142).

The current AIDS epidemic is compounding many of the economic pressures facing Tanzania. There are an estimated one million AIDS cases in Tanzania, and 940,000 people have already died (Appleton 2000, 20). According to the Tanzanian Demographic and Health Survey in 1996, 64.6 per cent of the total population was under 25 years of age, with 47.2 per cent under 15 years of age, a situation which places an enormous burden on the economically active working population, now being gradually diminished by illness and death due to AIDS (UNICEF 1999a, 50). The majority of the 730,000 AIDS orphans in Tanzania are being cared for by extended family members. However, many guardians are either too old or too young to meet the orphaned children's material and emotional needs, and many older children leave their adoptive homes and make their way in the informal sector on the streets (Karlenza 1998).

This article is based on my doctoral research with street children¹ and former street children in northern Tanzania. Field work began in 2000, and is continuing.² In the next sections, I will explore young people's vulnerability to HIV infection and the linkages with education, showing how poverty, HIV/AIDS, gender inequalities and barriers to education all intersect to severely limit the potential of vulnerable young people in Tanzania. By way of conclusion, I offer some policy recommendations to address the inequalities and vulnerabilities discussed.

The impacts of poverty and AIDS on children

It is clear from the discussion above that poverty severely constrains families' abilities to provide for their children, and places great pressure on adult-child relationships within the family. In my research with street children, abject poverty affected the majority of the participants'

households. Indeed, 75 per cent of the young people interviewed cited the family's inability to meet their basic needs as a major factor forcing them to leave home. In over half the homes I visited, poverty was a major constraint on the household's ability to care for the children.

The young people's drawings also illustrated their experiences of poverty: Sophia³ was a former street girl, aged 17, who had a young baby. She lived with her mother and sisters, one of whom also had a baby. Her drawing (below) shows herself at home cooking food outside on a charcoal stove, with the words, 'Here I'm cooking food. We live with many problems. We don't have enough beds, we sleep on the floor, sometimes we overcome our hunger, other times we go to sleep hungry, we rely on selling fish so that we can eat. When we don't sell any we go to sleep hungry' (31/03/00). Her sister Halima's explanation of her picture reiterated Sophia's message, before adding, 'We play at home without any happiness' (interviews, 31/03/00).⁴

Members of staff at all three street children projects involved in this study cited extreme poverty as a major factor causing children to leave home. However, many of the children's stories tell of other problems within the household which compounded their experiences of poverty, and triggered their decision to move to town.

Orphaned children living in households in which one or both parents have died would appear to be particularly vulnerable to poverty and insecurity, and as the AIDS epidemic attacks the prime age adult population, the particular difficulties faced by 'AIDS orphans' have come to the attention of non-governmental organisations and international development agencies such as UNICEF. Women and girls often bear the greatest costs of adult ill-health and death, 'primarily because of the significant opportunity costs to them of their traditional roles as carers and nurturers of the ill or dying' (Godwin 1998, 3).

However, whilst women and girls may suffer most from the 'opportunity costs' of

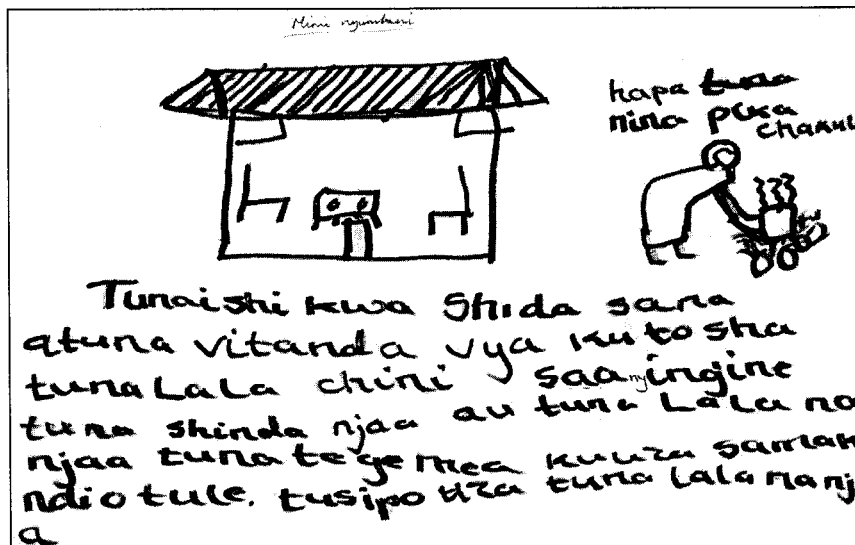


Figure 1: Sophia's (a 17-year-old mother) drawing of herself at home: 'We rely on selling fish so that we can eat. When we don't sell any we go to sleep hungry' (UCSC shelter, 31/03/00).

their carer role and increased domestic burden, orphaned children and the elderly are identified by Barnett as the most vulnerable to the long term impacts, as the survivors of AIDS-afflicted and/or AIDS-affected households (Barnett 1998). Experience in many African countries has shown that a large proportion of orphan caregivers are extended family members. However, capacity and resources are stretched to breaking point, and those providing the necessary care in many cases are already impoverished. Most are widows, who may themselves be ill, elderly grandparents, or even siblings running child-headed households (Karlenza 1998).

Orphaned children experience loss, sorrow and suffering long before the eventual death of their parents, due to the psychological trauma of a long-term fatal illness that afflicts their parents, combined with the increasing domestic burden of nursing their dying parents, caring for their siblings or elderly grandparents, and increased work in the fields (UNICEF 1999b). The distress and social isolation experienced by children, both before and after the death of their parent(s) is exacerbated by the shame, fear and rejection of the AIDS stigma. As a result, children may be denied access to schooling and health care, and their rights to inheritance and property may be denied, particularly in the case of girls (UNICEF 1999b; Barnett and Whiteside 2002). The rights of children are closely linked to those of the surviving parent. Thus, in Tanzania, as in other African countries, the customary laws which deny widows the right to inherit their deceased husband's land, can have devastating consequences for children after their father's death (UNICEF 1999b). According to Dr. Karlenza, Director of CREDO, a Tanzanian NGO working with AIDS survivors (orphans, the elderly and children in distress):

'Many orphaned children are traumatised, poorly socialised, lack emotional support,

receive little education, and are poorly equipped for adult life. Many older children leave their adoptive homes and seek a better life on the streets.'

(Karlenza 1998, 5)

The experiences of two of the street children participating in my study revealed that running away to the streets represents a survival strategy adopted by some children orphaned by AIDS when their families and communities fail to support them. Due to the stigma of the disease, people rarely mention AIDS. The experiences of children ostracised by their relatives following the death of their parents are likely to be linked to the stigma surrounding AIDS. The experiences of Simon,³ a fourteen year-old boy living on the streets at the time of the interview, illustrate the rejection and stigma AIDS orphans may face:

'I used to live in Babati with both my parents. My mama became ill with pneumonia and died in Babati. We moved to Arusha with my brother. Then my brother went away to Nairobi, and my sister got married and went back to Babati. Then my father too became ill, with TB, his lungs were rotten and he died. Then my [paternal] uncle treated us badly, I mean, we didn't have anywhere to stay. We had to leave. We left, the two of us, we went to a woman's house. We worked for her in her house but she refused to pay us. We left and my brother went to Morogoro and I came here. [...] At home, there were problems, but not that we had to go without food or school fees. But when my parents died, then we went without food a lot and school fees.'

(Simon, aged 14, living on the street at time of interview, 11/06/00).⁴

Simon's story shows how the rights of children from some AIDS-affected households are denied, with the extended family effectively disowning them. It also demonstrates the economic exploitation faced by child domestic workers seeking a

living independently, once they have left home for the street.

For Amina,³ a 14-year-old girl living on the streets at the time of the interview, 'home' also offered no possibility of support after her mother's death:

RE: At home, who would you go to/where would you go if you are ill?

A: At home, in Singida? In Singida, there's only grandma, and she can't look after herself, even if she's ill, there's no one to help her. She doesn't work at all. The year before last, her shamba [plot of land for cultivating] was grabbed from her and they are building a school there. She just lives there by herself. My younger brother has already died. Grandma is there with another relative of mine, my brother – we have the same mother but different fathers. He lives with his father and goes to school. My mama died last year. (Amina, aged 14, UCSC shelter, 09/06/00.)⁴

Amina's experiences testify to the rejection of orphans after the parent's death of AIDS:

A: When my younger brother died, my mama left and went to Dar es Salaam, and my father left for Mwanza. And me, I stayed with my grandmother.

RE: Why did mama go to Dar es Salaam?

A: Because of the famine. She went to find food and work. She got work as a bar-maid. I stayed with my grandmother; when grandma's land was taken away from her, then I left.

RE: Why did they take her land?

A: The land belonged to the government, grandma just got a place and cultivated there, she didn't know whose land it was, she just grew crops. We carried on living there, but grandma didn't have any food, not even a little, and we went hungry, we just picked fruit or vegetables, say, spinach, we picked it, boiled it, ate it and went to sleep. Then, grandma said to me, 'Go

and live with your brother, the relative of your father'. And I went and lived there in Singida. My brother was a fisherman, he went off fishing. I stayed with my sister-in-law, she harassed me and beat me again and again.

RE: If you did something wrong?

A: I mean, she harassed me, she didn't want me to stay there. [...] So I went back to grandma's. At grandma's, I met someone who offered to send me to school, and I went to live at boarding school.

RE: Someone paid your school fees?

A: Yes, for three years. Then at school one day, we were told that they'd run out of food. All the children had to be sent back home. So I stayed with my grandmother until mama came back. When she came, she was ill and I helped with the work at home, fetching water, for example, cooking, boiling water for mama, or relieving the pain with a cold press in the places she hurt. When she made it to the third month, yes, in the third month she died.

RE: I'm very sorry. What illness was it?

A: I don't know, she was just ill, with malaria, coughing, being sick, passing diarrhoea and blood. Once she was buried by my relatives, they hated me, because mama had died and there was no one to look after me. I had to go to my brother's and I lived there for about three months with my father's relatives. I was harassed as I had been before and I said to myself, 'I can't be harassed like this again', I'll have to start out on the streets (Amina, UCSC shelter, 09/06/00.)⁴

Amina's story not only illustrates the impact of AIDS on orphans and the elderly, but also highlights the linkages between poverty, gender inequalities and education. It reveals the increasing domestic burden Amina and her grandmother had to cope with in caring for and nursing her dying

mother and the rejection and harassment Amina faced from her extended family as an 'AIDS orphan'. It also shows the impoverishment her elderly grandmother and her mother faced due to underlying gender inequalities, such as the lack of independent access to land and lack of employment opportunities, leaving urban migration as the only alternative for poor female-headed households in rural areas.

In response to the fear, harassment and rejection they sometimes face due to the AIDS stigma, some orphaned children, like Amina and Simon, try to survive independently on the streets. However, orphaned children's emotional vulnerability and financial desperation living on the streets make them particularly vulnerable to sexual exploitation, abuse and survival sex. Thus, these young people are at a far greater risk of becoming infected with HIV themselves, thereby tragically perpetuating the cycle of poverty, HIV and AIDS which claimed one or both of their parents.

Simon and Amina's experiences also reveal the vulnerable situation of child domestic workers, where they are often subjected to exploitation, harassment, and physical or sexual abuse, representing a hidden violation of children's rights. The tradition of child fosterage in Tanzania leads to the recruitment of young children by relatives or non-related adults, particularly from rural areas, for domestic work in the homes of wealthier families. In Tanzania, a typical domestic servant is a young girl of between nine and eighteen years of age who may have been brought to her employer by a relative or a friend or a village-mate, or who has migrated to the urban area on her own (Koda 2000, 251). House girls work for long hours in house-keeping, cooking and child care, and are often vulnerable to patronisation, exploitation and sexual harassment from either the employer or his/her relatives, children and friends (*ibid*). As the experience of Simon shows, however, boys

are also vulnerable to exploitation of their labour and harassment as domestic workers.

The exploitation of girls as domestic workers is linked to the smaller proportion of girls living independently in the street environment. Studies on street children in Tanzania suggest that girls only represent an estimated 20–30 per cent of the total numbers of 'street youth' due to the fact that traditional cultural values restrict girls' freedom of movement compared to boys, thus girls are discouraged from migrating to urban areas; girls who are found on the streets are likely to be recruited into wealthier households as domestic servants; and female children represent a source of revenue for the family in the form of bride price when they get married, leading to forced early marriages (Mwakyanjala 1996). This reinforces the idea that girls' presence on the street subverts cultural norms and gender relations more than boys', since girls are responsible for reproductive duties within the home, while boys have more freedom to explore public space and engage in income-generation activities in urban areas (Koda 2000). Thus girls who do not conform to this conventional gender role, such as street girls, subvert norms of 'gender' as well as norms of 'childhood', and are sanctioned by society. This is also reflected in the lack of service provision for street girls – the majority of the twenty or so street children projects in Tanzania (most of which are located in Dar es Salaam) cater almost exclusively for boys.

While only two of the children participating in the study had clearly been orphaned by AIDS, seven others had lost one parent due to illness, and according to UCSC records of children at the Residential Centre, a quarter of the former street children staying at the centre had lost one or both parents (UCSC, February 2000). It is likely that some of these parental deaths were due to AIDS; however, as

Karlenza notes, experience from other countries suggests that it is important not to label children orphaned by AIDS as 'AIDS orphans', or single them out for development assistance, due to the stigma associated with AIDS and the fact that other children in poor communities suffer many of the same disadvantages (Karlenza, 1998, 4).

Indeed, my research with street children has revealed that children whom UNICEF defines as 'social' orphans (whose parents are not available to care for them) are just as vulnerable as 'biological' orphans (one or both parents have died). Parents in a discussion group conducted in Arusha as part of the UNICEF study 'Children in Need of Special Protection Measures: a Tanzanian Study' (1999a) suggested an all-inclusive definition: 'An orphan is a person [child] who does not have people to take care of him or her, or one who has lost his/her father or mother, or whose father and mother are unknown' (UNICEF 1999a, 116). Most of the young participants in my research are thus included in this definition of an orphan.

Barriers to girls' education and vulnerability to HIV

Within an environment of poverty, gender discrimination, and harassment at school, teenage girls are particularly vulnerable to HIV infection. Indeed, UNICEF notes that girls often become infected at a younger age than boys because they are biologically, socially and economically more vulnerable both to infection and to unprotected or coercive sex. Recent studies in Africa show that girls aged 15–19 are around eight times more likely to be HIV-positive than are boys their own age, and between the ages of 20 to 24, women are still three times more likely to be infected than men their age (UNICEF 1999b, 6).

Girls are often the first to be withdrawn from school (particularly secondary school)

when the household encounters economic pressures (Kuleana 1999). Thus, engaging in a sexual relationship with an older man may represent the only way for a girl to continue her education. Several of the girls interviewed as part of my research had never attended school, while many of the girls and boys had suffered corporal punishment and dropped out of primary school due to their parents' inability to pay school fees (UCSC shelter, 31/03/00).

As Amina's story implied earlier in this article, it is common for teenage girls to find a 'sugar daddy' – an older man who is often married – who can afford to sponsor her through school, in return for her sexual favours (ActionAid *et al.* 1997). This is reinforced by men's preference for younger girls, believing they are less likely to be HIV positive. Furthermore, in West and Southern Africa, some men believe that sex with a virgin will cure AIDS (Garcia-Moreno 1991). It has also been noted that within school settings in Tanzania, and in some other African countries, some male teachers sexually harass female students, and a girl's refusal to have sex can lead to public humiliation, unfairly low marks, exclusion from class or corporal punishment (Kuleana 1999, 56). Indeed, in focus groups with street children, the girls confirmed the issues raised in the literature on girls' education in Tanzania that schools provide a 'girl-unfriendly learning environment' (ibid), commenting that they were sometimes insulted, teased, beaten and discriminated against at school.

A study conducted amongst schoolgirls in Mwanza found that the most commonly cited problems experienced by schoolgirls were pregnancy (50 per cent), followed by sexual harassment by boys (37 per cent) (Kuleana 1999, 57). The official practice is to expel all school girls who are found to be pregnant, and Kuleana estimated that the number of expulsions due to school pregnancies may be as much as 39,000 per year, that is, thirteen times the official

record (Kuleana 1999, 58). While the girls in the focus groups did not mention pregnancy as a problem preventing their continued attendance at school, Sophia, the 17-year-old former street girl participating in the discussion group with her baby, had not been able to continue at the vocational training school she had been attending (sponsored by UCSC) due to her pregnancy, and in my later visit six months later, I found that her 14-year-old sister, Halima, (who participated in the discussion and in an interview), had also stopped attending the vocational training school during her pregnancy. The discrimination and harassment girls experience at school is clearly a violation of girls' right to education, which, though not recognised in the gender-blind language of the UN Convention on the Rights of the Child, is addressed explicitly in the African Charter on the Rights and Welfare of the Child (ANPPCAN 1999, Article 11:6).

Children's vulnerability to HIV on the street

My research with street children suggests that young people – both girls and boys – living on the streets are particularly vulnerable to HIV infection since they are often sexually exploited and abused, may engage in survival sex with adults in return for minimal payment, goods or security, or for intimacy amongst themselves. Male clients of sex workers often prefer young women, girls and boys, due to the belief mentioned earlier that they are less likely to be infected with the HIV virus, and due to the myth that sex with a virgin can cure AIDS. Paradoxically, however, young people are more biologically vulnerable to becoming infected and their low social and economic status places them in a weak bargaining position to insist on safer sex. The power imbalance governing relations between child commercial sex workers and their clients means that 'children have no power to ask for a high fee from adult

customers' (Ennew 1995, 206), or to negotiate condom use to protect themselves from STDs and HIV infection. Girls on the streets were perceived by street boys and girls to be at greater risk of sexual coercion, rape, survival sex, pregnancy and infection from sexually transmitted diseases, as one former street girl explained:

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

The perception that street girls face a higher level of vulnerability and risk than boys is also found in studies conducted in Latin America and the Caribbean (Green 1998), and Tanzanian studies on street children perceived this to be the case because commercial sex work seemed to be the only means of income for street girls (Yamamoto 1996). Indeed, my research showed that boys had more options available to them to earn money through casual work in the informal sector, and working in the mining industry, in addition to the survival strategies used by girls: begging, domestic work, commercial sex work and stealing. This is linked to the idea discussed earlier that girls' presence on the street subverts gender norms, and young women are forced into commercial sex work through a lack of alternatives and societal sanctions.

In response to the question, 'What are you afraid of?' a group of former street girls unanimously expressed their fears about suffering from AIDS and other sexually transmitted diseases, which groups of boys did not mention, demonstrating the girls' retrospective awareness that they were particularly at risk on the street. However, the cases of boys treated for STDs at the centre where I worked show that street boys are also vulnerable to HIV infection. On one occasion (noted in



Figure 2: Amina's (aged 14) drawing of herself on the streets. Top: 'I was begging from this bus'; below left: 'A boy was beating me'; below right: 'You whore, give me the money you were given by that man' (Amina, UCSC shelter, 31/03/00).

my fieldwork diary), an older youth was attacked when he was found raping a younger boy at the bus stand. Many of the boys at the centre knew of him, saying 'he does bad things to us' [phrase used to imply sexual abuse], and 'he persecutes us', testifying that he was a known child abuser, thus younger boys' vulnerability should not be overlooked.

Many of the street children interviewed perceived life on the streets as 'bad' because of the violence, harassment and sexual abuse they suffered. In response to the question, 'When do you feel safest?' 63 per cent of the participants said that they did not feel safe on the street, and in response to the question, 'When do you feel lonely?' 70 per cent said that they were lonely in town. Many of the young people's drawings of life on the streets depicted violence and other negative aspects of

street life. Both boys and girls drew violent images of figures being attacked and sexually abused, as illustrated in Figure 2.

However, the young people also drew positive images of street life, showing themselves employing survival strategies to earn money, with humorous captions. This reveals their resiliency and suggests that although they are exposed to violence and hardship on the street, they are not helpless victims and are able to often negotiate successfully for food and other goods.

In addition to facing considerable risks of violence and sexual exploitation in the street, the young people identified their lack of access to health care as a major problem of life on the street. They associated this with their inability to pay for medical treatment, demonstrating that the so-called 'cost-sharing' measures in the Tanzanian public health service, introduced as part of the IMF's structural adjustment policies, have devastating consequences for the poorest people at the grass-roots level. Ennew, however, suggests that street children's difficulty in accessing medical care may also be associated with their appearance and the stigma surrounding their existence, which can mean that they are chased away from hospitals and clinics (Ennew 1995).

In response to the question, 'Who would you go to/where would you go, if you were ill?' 40 per cent of the participants said that there was no one/nowhere to go, while 27 per cent said they would go to the hospital and 13 per cent mentioned a 'street children' project. Some children felt that the hospital might treat them, even though they were unable to pay for their treatment:

'I just go to hospital and ask for help, if they give me help, yes, if they don't, I just leave.

(Devi, aged 15, UCSC residential centre, 16/07/00)

Others felt that there was no point going to the hospital since they would be refused treatment:

'I couldn't go to anyone. There's no one. You can go [to the hospital] but they would say 'Pay the money first', or maybe you're seriously ill and they tell you, 'you should be admitted', when you've got no money for the bed.'

(Amina, aged 14, UCSC shelter, 09/06/00)

On a later visit, I learned that Amina had initially been refused hospital treatment following a dangerous abortion attempt, but had sought help from the UCSC project in paying the medical fees for her treatment.

The children's responses suggest that there were some options open to them to seek assistance if they became ill or injured on the street, although the street environment was not conducive to a speedy recovery. Street children's lack of access to health care, combined with the fact that they have often missed out on sexual health education at school, and often suffer from other sexually transmitted diseases which facilitate HIV transmission, all further constrain their ability to protect themselves from HIV infection.

Conclusion

Parents' and guardians' inability to provide for their children, both economically and emotionally, has a major influence on children's decision to leave home, and it is usually compounded by other factors which trigger the transition to life on the street. Children whose parent(s) died from AIDS, are vulnerable to rejection by relatives, due to the AIDS stigma, and are susceptible to exploitation and harassment as domestic servants within the extended family or in wealthier households in urban areas. Young people living on the streets, especially girls and young women, are particularly vulnerable to HIV infection themselves, due partly to the fact that their presence on the street subverts gender norms as well as norms of 'childhood', and

employment opportunities were limited to domestic work as servants in wealthier households and commercial sex work, which both expose them to a high risk of sexual exploitation and violence. Young boys were, however, also vulnerable to sexual abuse and exploitation within the street environment. My research suggests that poverty, HIV/AIDS, gender inequalities and barriers to education are all inter-linked, and severely constrain the ability of young people from poor communities to mitigate the risks and impacts of HIV/AIDS.

Policy measures aimed at assisting 'AIDS orphans' should be based on a wider definition of 'social orphans', that is, children whose parents and guardians are unable to provide for them, which includes other vulnerable children from poor communities. This would avoid labelling children orphaned by AIDS as 'AIDS orphans' due to the stigma and because many other poor children suffer the same hardships. It is generally recognised that compared to institutionalisation, community-based care for orphans is cost-effective, builds on local communities' own coping strategies and, because it keeps children in a familiar social, cultural and ethnic environment, reduces their distress (UNICEF 1999b). Whilst such community-based initiatives are proving the most successful way of coping with the orphan crisis, they are still in their infancy and need to be significantly scaled up and replicated in other sub-Saharan African countries in order to deal with the crisis effectively (UNICEF 1999b). This requires political will and the mobilisation of far more resources than are currently available.

Non-governmental organisations working with street children should develop services to provide for girls and young women, integrate gender analysis into their work, and remain sensitive to the gendered experiences, vulnerabilities and needs of street girls and boys as identified

by young people themselves. As well as addressing the 'practical' needs of street children to mitigate the impacts and vulnerabilities to HIV/ AIDS, young people's 'strategic' needs must be addressed in order to challenge the structural inequalities facing them. This includes advocacy to protect children's, particularly girls', rights to education, health care, protection from exploitation, violence and abuse, and rights to participate in all decisions affecting them, within the family, community and street environment.

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Notes

- 1 The term 'street children' is in itself problematic, since it sets up a dichotomy between children who use the street to live and work, and 'normal' children who live at home. However, the term is used here to discuss the particular situation of children and young people who live independently on the street in urban areas, supporting themselves, largely without adult supervision and with little or no family contact.
- 2 Based on findings from ethnographic research I conducted with street children, whilst working as a volunteer at a centre for street children in northern Tanzania during 1999–2000. A child-focused participatory methodology was undertaken, paying attention to gender and age differentials. Semi-structured interviews and focus group discussions were conducted in Swahili with girls and boys on the streets and at the centre, and with staff at local non-governmental organisations working with street children. Home visits to some of the children's families in the region were also combined with participant observation and participatory techniques with the children, such as drawings and photographic representation of their lives on the street.
- 3 In the interests of confidentiality, the names of the children have been changed.
- 4 Translated from Swahili transcripts of tape-recorded semi-structured interviews and focus groups conducted with street girls and boys, as part of the fieldwork detailed above (note 2) (June 2000).

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