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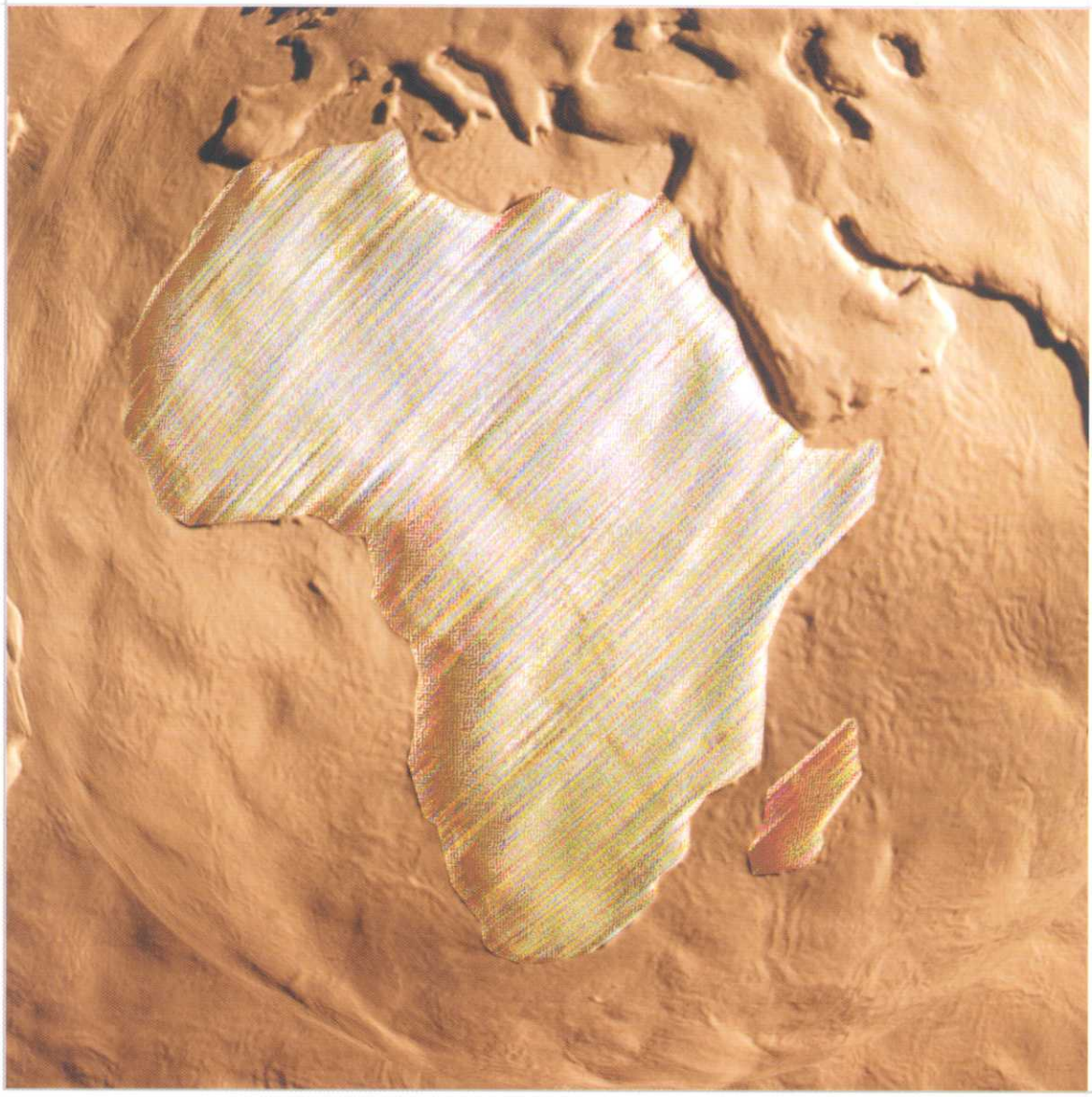
HIV/AIDS and child labour in Zambia: A rapid assessment

no. 5



IPEC - INTERNATIONAL PROGRAMME ON THE ELIMINATION OF CHILD LABOUR

HIV/AIDS and child labour in Zambia

A rapid assessment on the case of the Lusaka, Copperbelt and Eastern Provinces

Geneva-Lusaka, August 2002

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Paper No. 5*

Paper No. 1: Combating child labour and HIV/AIDS in sub-Saharan Africa.
Paper No. 2: HIV/AIDS and child labour in Zimbabwe: A rapid assessment.
Paper No. 3: HIV/AIDS and child labour in the United Republic of Tanzania: A rapid assessment.
Paper No. 4: HIV/AIDS and child labour in South Africa: A rapid assessment.
* **Paper No. 5: HIV/AIDS and child labour in Zambia: A rapid assessment.**
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Annex

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Executive summary

This rapid assessment examined correlations between the HIV/AIDS pandemic and child labour in Zambia. [1] The report aims at:

- assessing the extent to which HIV/AIDS has had an impact on child labour, both directly and indirectly;
- analysing the impact of HIV/AIDS-related child labour on the welfare of children in terms of their health, education, etc;
- assessing gender issues related to HIV/AIDS, as well as analysing the coping or survival strategies of girls and boys, including AIDS orphans;
- assessing the child labourers' awareness and knowledge of HIV/AIDS; and
- generating data that could assist policy and intervention strategies on behalf of child labourers.

This research was conducted in three provinces: Copperbelt, Eastern, and Lusaka. The sample included 306 child labourers: 211 boys and 95 girls in the five to 16-year age group. The study applied a triangulatory approach involving:

- 15 focus group discussions (FGDs) – five groups per study area, each involving ten participants;
- 34 in-depth interviews (13 on the Copperbelt, 11 in the Eastern Province, and ten in Lusaka); and
- a questionnaire survey of 122 children (41 each for the Copperbelt and Eastern Provinces, and 40 for Lusaka).

The relatively small study sample was sufficient for a rapid assessment which, as a qualitative study, seeks to provide insight into the respondents' lives. Even children involved in prostitution were interviewed in the places they frequented.

[1] This study complements rapid assessments in South Africa, United Republic of Tanzania, and Zimbabwe, each of which provided qualitative data on the links between child labour and HIV/AIDS in its own respective research areas. These studies, which address the complex relationship between health issues and exploitative labour, shed light on new dimensions of children's sufferings. Efforts are being made in all of these African countries to understand and respond to the issues, including those related to the worst forms of child labour as described in the ILO Convention on the Worst Forms of Child Labour, 1999 (No. 182). HIV/AIDS often affects the most vulnerable children, including those engaged in prostitution and other forms of hazardous work, as well as those working long hours in the streets in exploitative conditions. Convention No. 182, Article 3, defines the worst forms of child labour as: "(a) all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict; (b) the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances; (c) the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties; and (d) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety, or morals of children".

About one-third of the sample were single or double orphans (i.e. with either one or both parents deceased, respectively), a sizeable proportion of whom were engaged in prostitution. Many were also involved in other forms of child labour.

The non-orphaned children had parents whom they described, due to the 1970s-90s economic crisis, as being either poor or unemployed. Clearly, as parents became poor, their capacity to support their children was seriously compromised, and many children left to live on the street.

Given that the death of parents or guardians forced children out to work, the HIV/AIDS pandemic exacerbated the extent of child labour. Jobs included vending on the street and in markets, quarrying and stone breaking, fetching water, portering *(kuzezera)*, household chores or domestic work, digging wells and garbage pits, carpentry, cooking *nshima* in the markets, cutting grass, picking bottles, and prostitution. Child labourers were found in markets, streets, bars and pubs, shopping centres, bus stops, car parks, and resthouses/hotels.

Not all child labourers were orphans. Poverty was the major factor behind working children. For some, their meagre contributions were the only income their families had. Except for a few children in prostitution who earned about 30,000 kwachas (about US$6.30) per night, over 90 per cent of the child labourers earned as little as 15,000 kwachas (US$3.00) per month, especially in the Eastern Province.

Most children worked in hazardous environments, and were exposed to a variety of health problems. Among those mentioned by children were headaches, fatigue, chest pains, injuries/bruises (job-related and from fights), painful/swollen legs, painful ribs, coughing, stomach pains and diarrhoea, sore necks, sneezing, backache, waist ache, malaria, and sexually transmitted infections (STIs). Health care was irregular. The children claimed that health services were expensive and, for them, usually inaccessible. Self-medication combined with traditional therapies was often the only recourse, while on many occasions no care or treatment whatsoever was sought.

Education is a not priority among children who have to cope with poverty. Few of these children advanced beyond grade 7. In this regard, dropping out of school to work was more common a factor than failure to pass exams. Lack of money was cited by almost every child as the major obstacle to education. In most cases, the parents were too poor to pay for school fees, uniforms, or shoes. Among the total sample of 306, only 84 children (27 per cent) were in school. School attendance was reportedly difficult, since it required children to divide their time between work and school while struggling to find money for fees and supplies. The situation was even worse for orphans. Almost every child said that, if given an opportunity (i.e. someone to pay for them), they would return to school.

Commercial sexual exploitation (CSE) among children aged 14 to 16 years was common. Half of the 34 in-depth interviews (15 girls and two boys) were conducted with CSE victims. Children engaged in prostitution organized themselves into groups for purposes of security, and services were almost exclusively performed in exchange for money, although girls sometimes slept with men for beer. Girls claimed they slept with as many as four men per night and their earnings were meagre, ranging between 3,000 and 10,000 kwachas (US$0.63 and US$2.10) per act. Condoms were rarely used, since the children lacked the capability to negotiate safe sex. The girls interviewed expressed their awareness of the dangers of STI, including HIV/AIDS. Nonetheless, these girls accepted the risk of being infected so long as they could earn money.

Boys were also involved in prostitution. Their clients tended to be rich widows who paid in dollars. All of those children engaged in prostitution, except for one girl, were out of school.

Awareness of HIV/AIDS was reasonably prevalent, with over 86 per cent of the children recognizing the dangers related to unsafe sex. Awareness was low among younger children aged 5 to 11 years, however, most of whom failed to mention the principal cause of HIV/AIDS (i.e. unprotected sex). Moreover, many children failed to report at least three symptoms of the disease. Inconsistencies in knowledge about HIV/AIDS were related to geography, gender, and age, but were due even more to sources of information – most of the information was obtained from other working children – and the educational levels of respondents. Risk of HIV/AIDS was higher among children in prostitution than among other categories of child labourers, but all were prone to health risks in general.

HIV/AIDS victims in Zambia, according to most of the children, suffered stigmatization and discrimination resulting in social isolation. Infected people were commonly held responsible, since they had supposedly engaged in unprotected sex and "immoral activities". Only one child respondent reported having been discriminated against by relatives and neighbours because his parents had died of HIV/AIDS. Some of the child orphans – despite their having already described the dead parents/guardians as having suffered symptoms associated with the disease such as chronic illness, weight loss, and swollen legs – attributed the deaths of their parents or guardians to other causes. Others admitted that their parents or guardians had died of HIV/AIDS, but this fact was kept secret except from very close relatives. In the absence of HIV tests, the study could not determine how many of the children interviewed were themselves infected.

Abbreviations

AIDS	Acquired immune deficiency syndrome
CSO	Central Statistical Office
CSE	commercial sexual exploitation
FGD	focus group discussion
HIV	human immunodeficiency virus
ILO	International Labour Organization
IPEC	International Programme on the Elimination of Child Labour
NGO	non-governmental organization
PCI	Project Concern International
STI	sexually transmitted infection
UNDP	United Nations Development Programme
USDOL	United States Department of Labor

1. Introduction

This report is based on the results of a rapid assessment that examined links between the HIV/AIDS pandemic and child labour in Zambia. It complements similar rapid assessments undertaken in South Africa, United Republic of Tanzania, and Zimbabwe (see note above).

The introduction is divided into three parts:

- historical background;
- a review of the existing literature on HIV/AIDS and child labour in Zambia; and
- a description of the objectives, rationale, and sampling methods employed during data collection.

Background

Over the past 12 years, the number of street children in Zambia has increased at an alarming rate. [1] Indeed, Zambia is now said to have one of the highest numbers of orphans and street children in the world. [2]

Street children constitute an important segment of child labour. Children who feel vulnerable or abused in their own homes often seek alternative means of survival on the streets. The lack of a support net – which is in turn linked to weakening household cohesion owing mainly to poverty and HIV/AIDS – exacerbates the situation, further contributing to the vulnerability of these children.

The concept of "twin-risk" can help to understand child labour in Zambia. Many studies have indicated that economic crisis and HIV/AIDS are the two major factors behind the upsurge in child labour. The economic crisis, aggravated by the HIV/AIDS pandemic, appears to be the main impetus behind children, either as labourers or as beggars, trying to subsist on the streets.

The economic dimension has been documented by many researchers. In 1996, Opuku developed a general theory which categorized children according to three economic subgroups:

- children on the street;
- children of the street; and
- abandoned children.

[1] Mulenga, C.: *Orphans, widows and widowers in Zambia: A situational analysis and options for HIV/AIDS survival assistance*. A study conducted for the Ministry of Health's National AIDS Prevention and Control Programme (Lusaka, Dec. 1995); and de Burca, R.: *Study to identify individuals and organizations concerned with children in need, their activities and how to increase the benefits accruing to these children within the compounds of Lusaka* (July 1994).

[2] ILO and Central Statistical Office (CSO): *Zambia 1999 child labour survey: Country report* (Lusaka, 1999); and UNICEF: *Children orphaned by AIDS: Frontline responses from eastern and southern Africa* (Dec. 1999), p. 5.

The distinctions between these categories may be summarized as follows:

> Children on the street are those engaged in some kind of economic activity, ranging from begging to vending of manufactured commodities or food. Most go home at the end of the day and contribute part of their earnings for the economic survival of the family unit. They may be attending school and retain a sense of belonging to a family or household. Because of the economic fragility of their families, these children may eventually opt for a permanent life on the streets. Children of the street actually live on the street. Family ties may exist but are tenuous and maintained only casually or occasionally. Most of these children have no permanent residence and move from place to place and from town to town. Abandoned children are entirely without a home and have no contact whatsoever with their families. [3]

Several studies have demonstrated a strong relationship in Zambia between street children on the one hand, and poverty and child labour on the other. These include the works of Geoffrey Lungwangwa and Mubiana Machwan'gi (1996), the ILO (1999), Lemba (2002) and many others. [4] Lemba's study involved a sample of 1,232 street children drawn from both urban and peri-urban areas such as Lusaka and Nchelenge. These included single and double orphans (over 50 per cent) and children whose parents were alive (42 per cent).

> More than family status, life on the streets was revealed to be strongly linked to poverty. A majority of the children were currently living in, or had originated from, low-income compounds of Lusaka or other towns. Further, of those [children] with parents or guardians, the vast majority (over 90 per cent) indicated that their caregivers were unemployed. A majority of the children cited poverty or financial needs as the primary reason for being on the streets, with a significant portion also citing family problems or abuse. [5]

Zambia is now in economic crisis. The roots of the problem go back to the Second Republic (i.e. the early 1970s), when the Government introduced one-party rule and economic policies that placed the major means of production (i.e. mines and other industries) in the hands of the State. Ensuing problems included corruption, mismanagement, and a bloated workforce.

The country's economy was already experiencing major economic setbacks when change of government in 1991 reintroduced a pluralistic regime. The current crisis, however, can be traced to structural adjustment policies introduced since 1991. Economic liberalization under the supervision of the International Monetary Fund (IMF) and the World Bank has contributed to the collapse of major economic activities, resulting in massive retrenchment of workers and increasing poverty. Mining, for example, formerly the cornerstone of Zambia's economy, has suffered near-irreparable damage, with a number of mines closing or operating far below capacity. The Luanshya Mine, where fieldwork for this rapid assessment was partly conducted, was shut down, with severe economic consequences for workers and their families, as well as for those supply industries whose prosperity depended on the mining sector. The manufacturing and

[3] Cited by Lemba, M.: *Rapid assessment of street children in Lusaka*. A study conducted for Project Concern International (PCI) (Lusaka, Mar. 2002), p. 5.

[4] ibid., for full references.

[5] ibid., p. 2. This finding tallies with that of *Zambia 1999 child labour survey* (ILO and CSO), pp. 1-108.

farming sectors, where production has been at its lowest since independence in 1964, have suffered similar problems during the past 12 years. [6]

High levels of unemployment and poverty have ensued, especially among women and children. Current statistics estimate that about 80 per cent of the population live in degrading conditions. [7] Poverty has long ceased to be exclusively a rural phenomenon. Consequently, most children, adolescents and women have been pushed into the informal sector, where they subsist by selling their labour or vending a variety of goods. Many adolescents (especially girls), including those in school, have turned to commercial sex. As a result, prostitution has become rife in all major towns and peri-urban areas. This has in turn aggravated the HIV/AIDS pandemic [7] and associated social problems. Examples of unstable marital arrangements, for example, include abandonment of women by their husbands. Furthermore, the increasing numbers of merely informal marriage arrangements have released husbands from legal liability in cases of divorce.

Currently, Zambia is at the epicentre of the HIV/AIDS crisis in southern Africa. Most cases of HIV/AIDS morbidity and mortality in the country have occurred among the younger and more productive population (15-50 years of age), greatly affecting national productivity and economic growth. The loss has also had an impact on the social fabric, leaving the Zambian family and larger community increasingly vulnerable. The resilience of the African extended family is being challenged:

> As parents die of AIDS-related causes, their children become orphans and face uncertain futures. The ability to cope with the demands and consequences of HIV and AIDS is limited by the funds available for health care. [8]

After Uganda, Zambia has the highest number of AIDS orphans in the world. [8]

In 1997, studies targeting widows and orphans in Zambia estimated the number of orphans at more than 500,000. Between 1998 and 2001, levels of HIV infection in Zambia increased dramatically, with towns such as Livingstone suffering an infection rate of about 34 per cent, with eventual death of the victims virtually inevitable. [9] In 1999, the number of HIV/AIDS orphans in Zambia reportedly rose to 720,556 – a figure that may in fact grossly underestimate the real situation. [10]

Both HIV/AIDS and poverty have been important factors in the proliferation of working street children and child labour. Until recently, however, the relative impact of each factor on child labour was uncertain. A recent study commissioned by a number of NGOs found that AIDS orphans constituted only 22 per cent of child labourers in the study

[6] United Nations Development Programme (UNDP): *Zambia: Human development report, 1999/2000* (2001).

[7] ibid.

[8] Mushingeh, A.C.S.: *Family planning and sexual behaviour in the era of HIV/STDs: A multi-country study*. A study conducted for WHO, HRP (Sep. 1998), pp. 1-49.

[9] United Nations: "Countries most affected by HIV/AIDS are least able to pay for prevention and treatment", a press release (New York, United Nations, Department of Public Information, 11 June 2001), p. 1.

[10] UNICEF: *Children orphaned by AIDS*, p. 5.

area.[11] This analysis, however, relied exclusively on questionnaire-based data. Our study, on the other hand, applied both data triangulation as its methodological approach and multiple databases as its empirical foundation (i.e. from the questionnaire, FGDs, and in-depth interviews). Contributing further to its validity, an interdisciplinary team conducted the research.[12]

Objectives

Most of the relevant literature acknowledged high levels of poverty and rates of HIV/AIDS infection, on the one hand, and the proliferation of child labour on the other. In the absence of empirical evidence, however, the extent to which HIV/AIDS affected child labour was difficult to gauge. Neither was much known about the impact of HIV/AIDS on the quality and working conditions of Zambia's labour force. In this light, the ILO proposed the need for more research:

> The magnitude of the HIV/AIDS epidemic and the numerous implications that it potentially has for child labour make it of utmost urgency that research be conducted on the subject, so that knowledge can be acquired and appropriate measures taken so as to ameliorate the situation.[13]

It is in this context that this study has been conducted. Broadly speaking, the objective of the study is to examine the role of HIV/AIDS in the growing incidence of child labour in Zambia, and to explore avenues for possible interventions. Specifically, the study has sought to assess the extent to which HIV/AIDS has had an impact on child labour, both directly and indirectly:

- determining the extent to which the death of parent(s) or guardian(s) prompted children to engage in work on the streets;
- investigating factors such as stigmatization, illness-related costs, social impacts, and the burden of running the household; and
- analysing the impact of child labour on the welfare of children in terms of health and education, and, as part of this:
  - assessing the gender basis of child labour, and identifying the coping strategies of boys and girls;
  - determining awareness and knowledge of HIV/AIDS among child labourers; and
  - generating data upon which policy and interventions to reduce child labour could be based.

[11] Hira, S., and Nkowane, B: "Epidemiology of HIV in families in Lusaka, Zambia", in J*ournal of AIDS*, 3 (1990), pp. 83-86; and Mushingeh A.C.S.: *Voluntary counselling and testing for HIV in Zambia: Findings based on FGDs and in-depth interviews in Lusaka and Livingstone*. A study conducted for the Society for Family Health (Lusaka, 2001).

[12] See Mudenda, G. et al.: *A situational analysis of orphans and vulnerable children in Zambia* (Aug. 1999).

[13] Lemba: *Rapid assessment of street children.*

Study areas

The study centred on Lusaka, the Copperbelt and Eastern Provinces. On the Copperbelt, research focused on Kitwe, Luanshya, and Ndola.[14] In the Eastern Province, the study targeted Chipata, Petauke, Katete, and their surroundings.

The study areas were chosen for various reasons:

- Lusaka and the Copperbelt were two of the most affected cities, with HIV/AIDS transmission and infection rates among the highest in Zambia. The two areas also constitute the urban core of the country, and are severely affected by unemployment, street children, AIDS morbidity and mortality, and a concentration of orphans.[15]

- The Eastern Province was chosen partly because of HIV infection rates, and partly because of the greater potential for the employment of child labour, given the concentration of small-scale mining for precious stones (which relies on intensive labour) and limited financial capital on the part of the mine owners.

These areas were also important in terms of data triangulation between urban and peri-urban areas. A comparative study of urban and peri-urban areas was essential in producing a balanced view of the issues under study.

Target groups

The study focused on child labour and its relation to HIV/AIDS. "Child labour" was defined as harmful work undertaken by children that puts their mental, physical, social, and moral development at risk, and which prevents them from attending school.[16] For the purposes of this study, such work included the following:

- work conducted in an unhealthy environment that could expose children to hazardous substances, processes, agents, or temperatures (as defined in the ILO's Worst Forms of Child Labour Convention, 1999 (No. 182), and Recommendation No. 190);

- work conducted for long periods;

- work performed in the household (often without remuneration); and

- work involving the sexual exploitation of children.

[14] In the original proposal, Chingola was named as one of the research areas, but in the end it was omitted in favour of Luanshya. This town was chosen instead because it has suffered deep economic crisis due to the closure of a mine which was the source of employment for many people, and this balanced the research in Kitwe, Ndola, and Chingola, where mining continued and the economy was relatively better.

[15] Rapid assessment studies usually have the following characteristics: triangulation, inter- or multidisciplinary teams, and a mix of research techniques. Our team included a team leader with an interdisciplinary academic background, a labour expert, a gender expert, a health worker, and a social worker.

[16] ILO: *HIV/AIDS: A threat to decent work, productivity and development*, a document for discussion at the Special High-Level Meeting on HIV/AIDS and the World of Work (8 June 2000).

The study also took other forms of child work into account. Selected activities included street vending, quarrying, stone-breaking, domestic work (i.e. water fetching, house and crockery cleaning, cookery, etc.), portering, agricultural work, and commercial sexual exploitation (of both boys and girls). A child was considered to have performed an act of work if he or she was found to have been involved in any of the above activities, either for personal or family gain, prior to the time of the interview.[17] The sample selected was aged five to 16 years.[18]

The Zambia Employment Act, section 12,[19] considers 15 years to be the minimum age at which a person may work legally, provided the work is "non-hazardous". The 1990 Constitution of Zambia, section 24, also prohibits the employment of persons younger than 15 years of age. For the purposes of this study, the age of 16 years was chosen as the cut-off point.[20]

The most important criterion in selecting the sample was the respondents' engagement in child labour. Children who were either begging or simply roaming the streets were not considered to be working, and were therefore not included in the study. Only children who were working were interviewed. According to the initial framework, the study was required to draw a sample based on the following interrelated criteria:

- HIV/AIDS orphans;
- children living with AIDS or who suffered a high risk of HIV infection due to the nature of their work; and
- children affected by HIV/AIDS and forced to drop out of school to enter the job market.

[17] CSO: *Living conditions monitoring survey report, 1996* (Lusaka, 1997); Colling, J.A. and Sims, R.: *Seeking to address the needs of children in difficult circumstances: The case of eastern and southern Africa* (1996); and McKerrow, N. H.: *Implementing strategies for the development of modes of care for orphaned children* (Oct. 1996).

[18] LO/IPU: *Eliminating the worst forms of child labour: A practical guide to ILO Convention No. 182* (2002), p. 15; see also Kaunda, M. et al.: *Report on literature review done in preparation for the commissioned field research on HIV/AIDS and child labour in sub-Saharan Africa: The case of Zambia* (5 July, 2002), pp. 15-16. See also ILO and CSO: *Zambia 1999 child labour survey*, pp. 10-11; and McLeod, W.T. (ed.), p. 19. See ILO and CSO: *Zambia child labour survey*, p. 22. This definition only included children who had been working for a month or more.

[19] As the present study was of a qualitative nature, covering some of the worst forms of child labour as well, it was also considered useful to cover children over the general minimum age for admission to employment, which in Zambia is 15 years.

[20] ILO and CSO: *Zambia child labour survey*, p. 22. In a similar, upcoming study on child labour and HIV/AIDS commissioned by the Zambian Association for Research and Development and the Association of African Women in Research and Development, they define a "child" as a person aged 14 years or younger. The different perceptions of what represents a "child", especially for the purposes of "child labour", are not always clear in Zambia, despite the fact that this country has ratified the Minimum Age Convention, 1973 (No. 138), on 9 Feb. 1976 and the Worst Forms of Child Labour Convention, 1999 (No. 182) on 10 Dec. 2001. The Conventions have not yet been integrated into municipal law. Respondents gave many and varied reasons for deciding to work, these three among them. See Mturi, A.J. et al.: *ILO-IPEC rapid assessment of HIV/AIDS and child labour in South Africa: The case study of KwaZulu-Natal – A training manual* (Nov. 2001), pp. 1-22.

To avoid introduction of a sampling bias by taking these variables as the prerequisites for being interviewed, however, the main selection criterion was simply engagement in child labour and was, therefore, to a certain extent random. We wanted to see whether the respondents themselves would refer to the above three variables or characteristics as the reason for their deciding to work.

Design and methodology

The study was based on both secondary and primary data. The latter were the main sources, while the former provided supplementary information. In order to maximize data validity, data collection applied triangulation techniques, analysing target phenomena through the use of multiple methods, databases, and personnel.

Secondary data

Secondary data collection involved a review of unpublished and published documents, especially seminar and conference papers, reports, and books.[21] This served a number of objectives. First, it provided the baseline or foundation data upon which the study was built. Second, it provided a perspective for the study (i.e. how the issue of child labour has been approached by previous research). Third, the literature review helped to locate the study within a wider body of knowledge on the subject or on related issues, while helping to identify the gaps in available knowledge on HIV/AIDS and child labour in Zambia.

Secondary literature was gathered, providing a significant bibliography on the topic, from a number of libraries and organizations that conduct HIV/AIDS research. These included the University of Zambia, the Commonwealth Youth Programme, the Central Board of Health (Ministry of Health), the ILO Regional Office, and a number of NGOs, among them Project Concern International (PCI). (Among the works consulted was a recent PCI study of street kids and adolescent prostitution.)

Primary data

Primary data was collected through investigations in the three areas of study.[22] Sampling was conducted on the basis of a participatory and triangulatory approach.[23] Three research instruments – interview guide for in-depth interviews, interview guide for FGDs, and the questionnaire – were the main research tools. Person-to-person interviews were important in securing first-hand experiences and perceptions from respondents. FGDs were also important in capturing common respondent perceptions concerning various research issues.[24] The two interview techniques were complementary, compensating for each other's respective weaknesses. Data derived from interviews were cross-checked with those derived from the questionnaire.

[21] The literature review, conceived during preparation of the research proposal, was formally conducted 1-6 Mar. 2002.

[22] Field work was conducted between 13 Mar. and 7 Apr. 2002.

[23] See Mturi, A.J. et al.: *ILO-IPEC rapid assessment of HIV/AIDS and child labour in South Africa: The case study of KwaZulu-Natal – A training manual* (Nov. 2001), pp. 1-22. Also see footnote 16 above.

[24] ibid., pp. 5-6.

Fieldwork was preceded by a review of the research instruments originally prepared by the ILO (Geneva), adapting them to the local conditions and context. The instruments were also translated into Bemba and Nyanja, the two languages spoken in the study areas. Training of research assistants included systematic exposition of the issues involved, demonstration of interview techniques, and pre-testing of research instruments. Pre-testing included the administration of ten questionnaires as well as three FGDs and six in-depth interviews. Data were collected in the following order: Copperbelt, Eastern Province, and Lusaka. A total sample of 306 respondents was sampled, distributed as shown in table 1.

Table 1. Distribution by region

Region	Copperbelt Province	Eastern Province	Lusaka Province	Total
Questionnaires administered	41	41	40	122
FGDs (10 participants each)	5 (50 respondents)	5 (50 respondents)	5 (50 respondents)	15 (150 respondents)
In-depth interviews	13	11	10	34
Total sample	104	102	100	306

Although the researchers tried to strike a gender balance with the sample selection with the selected sample in Lusaka and Eastern Provinces, the subjects were predominantly boys, especially in the FGDs, since girls did not seem to be as comfortable with this set up (see table 2).

Table 2. Distribution by region and sex [25]

Region	Boys	Girls	Total
Copperbelt Province			
In-depth interviews	4	9	13
FGDs	3 (30 respondents)	2 (20 respondents)	5 (50 respondents)
Questionnaires	23	18	41
Eastern Province			
In-depth interviews	2	9	11
FGDs	4 (40 respondents)	1 (10 respondents)	5 (50 respondents)
Questionnaires	30	11	41
Lusaka Province			
In-depth interviews	8	2	10
FGDs	5 (50 respondents)	0	5 (50 respondents)
Questionnaires	24	16	40
Total sample	211	95	306

As mentioned above, the children were mostly sampled from markets, bus stops, streets, rest houses, car parks, shopping centres, bars, restaurants and other places offering opportunities for work. [26]

Data analysis

Quantifiable data from the questionnaires were analysed using Statistical Package for the Social Sciences (SPSS). Compared with other statistical packages, this programme allowed for easier data manipulation, creation of tables, and cross comparison of figures. Qualitative data analysis, on the other hand, involved tally sheet creation and coding of responses. Data analysis also involved the use of such techniques as description, interpretation, extrapolation, inference, and deduction. [27]

[25] These statistics can also be distributed by town as follows: *Kitwe:* 13questionnaires (eight boys, five girls), four in-depth interviews (girls), and one FGD (one boy); *Luanshya:* 14 questionnaires (five boys, nine girls), four in-depth interviews (two boys, two girls), and two FGDs (one boy, one girl); and *Ndola:* 14 questionnaires (ten boys, four girls), five in-depth interviews (two boys, three girls), and two FGDs (one boy, one girl); *Chipata:* 24 questionnaires (19 boys, five girls), nine in-depth interviews (all girls), and four FGDs (three boys, one girl); *Petauke:* eight questionnaires (six boys, two girls), two in-depth interviews (both boys), and one FGD (one boy); *Katete:* 9 questionnaires (five boys, four girls); and *Lusaka:* 40 questionnaires (24 boys, 16 girls), ten in-depth interviews (eight boys, two girls), and five FGDs (all boys).

[26] Lemba: *Rapid assessment of street children*, p. 2.

[27] See Feuerstein, M.-T.: *Partners in evaluation: Evaluating development and community programmes with participants* (London, Macmillan Publishers, 1988), pp. 103-106.

2. Characteristics and main activities of child workers

This chapter profiles the sample child labourers, and assesses the main factors shaping their lifestyles and self-perceptions. Key variables included family size and family relations; reasons for working; working conditions; education; health; commercial sexual activities; awareness and understanding of HIV/AIDS; and social stigma and discrimination.

Family size and family relations

Many of the children sampled in this study came from poor and underprivileged backgrounds. Apart from those engaged in commercial sexual activities, most of these children were poorly dressed and looked malnourished.

Families typically showed three important features:

- More than 95 per cent of their parents were unemployed,[1] and the children had to engage in informal subsistence activities. These included vending on the street and in the markets; domestic service; carpentry; and subsistence farming.

- The children came from families ranging from three to 11 people per household, suggesting six as a probable average size. The members of any given household might include the children themselves, their parent(s) or guardian(s), siblings, cousins, aunt(s) and uncle(s), and grandparents. The average number of children was four to five per family.

  In the regional context, these families were not overly large, but they were so in relation to the incomes of the parents or guardians. In communities where parents were struggling to provide for one child, having five children presented a serious burden.

  Typical responses, when asked with whom the children were living, included these:

  > There are nine of us in our family – mum, dad, six older sisters, and myself (girl respondent, Rescos Compound, Kitwe).

  > I live with my elder brother, my sister-in-law, and five of their children. In all, we are eight (girl respondent, Lusaka).

  > I live with my elder sister. She is married and they have three children. My sister is expecting another child. Altogether we are six (girl respondent, Chipata).

- Typically, family relations were weakening, mostly because of poverty, divorce/separation, and death of a parent/guardian or both parents/guardians. For instance, among the 122 children surveyed by questionnaires in all study areas, 46 said they had lost one or both parents, two said their parents were alive but sick, and 74 said their parents were alive but poor. In Luanshya, five children said that their parents had abandoned them (for a period of at least six months). The situation was similar among children involved in the FGDs and in-depth interviews. In short, the

[1] ILO and CSO: *Zambia 1999 child labour survey*, pp. 97-104. (In the Copperbelt, many parents had lost their jobs following economic decline in the mining sector.)

child labourers came from families who were poor mostly because of the death of one parent or both. [2]

Poverty and orphanhood have contributed significantly to the escalating numbers of working children. This, in turn, has strained the extended family to breaking point, as working relatives have to assume more responsibilities, given the great number of orphans living with members of the extended family.

Remarkably, although child labour involved a lot of intra-town movement on the part of children, this study detected no serious inter-town movement. About 80 per cent of the sampled children said they lived in the place of their birth. Those who had moved attributed this to the movement or death of parents or guardians. Older children also left in search of a better life, which meant seeking refuge with members of the extended family somewhere else.

Reasons for working, and working conditions

All 306 children, including those involved in commercial sexual activities, said that poverty had prompted them to work. The main reasons, all of them rooted in poverty, may be summarized as follows:

Table 3. Reasons for working (as presented by children interviewees)

(i)	Life became too tough after my parents died (boy child worker)
(ii)	Hunger (girl child worker)
(iii)	To assist parent(s)/guardian(s) (boy child worker/girl child worker)
(iv)	Needed money to buy clothes (girl child worker)
(v)	I wanted to avoid stealing (boy child worker)
(vi)	I needed money to buy whatever I wanted (girl child worker)
(vii)	I needed money for school fees (boy child worker)
(viii)	I needed money for books (boy child worker)
(ix)	I love money (girl in prostitution)
(x)	I wanted to be financially independent (girl in prostitution)
(xi)	After my parents died I had no one to look after me (girl in prostitution)
(xii)	I stopped school and didn't have money (girl in prostitution)
(xiii)	That is the only way I can have money (girl in prostitution)
(xiv)	I want to go back to school (boy child worker)

A few children also gave as reasons the wish to learn a trade, boredom, peer pressure, or the fact that they enjoyed what they did as reasons they decided to work. As mentioned in Chapter 1, the children engaged in occupations ranging from street and market vending to quarrying, stone-breaking, household work (including fetching of water, cutting grass, cooking, dish washing, babysitting, and sweeping the house), cooking *nshima* in the markets, agricultural work, cleaning fresh fish in the markets, digging wells, carpentry, picking up bottles at pubs, and commercial sexual services. Among these, the sample

[2] All the children in the sample, including orphans, came from poor families. There was no single orphan who claimed to have come from a rich socio-economic background, despite the fact that many rich people have died of HIV/AIDS. Single and double orphans included 18 girls and 28 boys.

broke down to 45 per cent engaged in street and market vending, 21 per cent in portering *(kuzezera)*, 21 per cent engaged in prostitution, 5 per cent in household work, and 8 per cent in other activities.

In all study areas, child vendors were found selling merchandise, either for themselves or for others, ranging from cooked food to vegetables, fruit, second-hand and new clothes, toys, and newspapers. Family or individual financial need was always the reason given for working. Those involved in household work for their parents or guardians said they were paid nothing, performing their services only for the welfare of the family. The small number who instead worked for neighbours said they were paid either in cash or in kind (mostly food). Apart from children who were involved in such activities as quarrying, stone-breaking, carpentry, and prostitution, a large majority also accepted general and casual work to meet immediate needs. As a result, they moved from one activity to another to earn money, mostly for food. They were often heard pleading with potential employers to engage them so that they could afford some food *(boss mpeniko fye iyakabwali)*.

Child porters *(ukuzezera)* were commonly found in all study areas, particularly around markets, shops, and bus stations. The goods carried (mostly on their heads) included bags of mealie meal, bundles of raw sugar cane, luggage, water buckets, firewood, and other items. Although girls were also involved in portering, the job was usually performed by boys. Some of the goods were very heavy, and the children carried them only with difficulty. Payment was usually extremely low – as little as 100 kwachas (US$0.02) per load. Stone-breaking and quarrying were not observed on the Copperbelt, being confined to Lusaka and Eastern Provinces. These activities were performed either as part of family work or as paid individual work along the roads and in areas suspected of having semi-precious stones.[3] This job was also predominantly performed by boys. In FGDs and in-depth interviews conducted in all study areas, respondents made it clear that their decision to work coincided with worsening economic conditions in Zambia during the previous 12 years (i.e. since 1991), partly attributed to the introduction of the structural adjustment programme (SAP). In an FGD with stone-breakers from Lusaka, the boys claimed that they started their work between 1997 and 2001. Asked to explain what their job involved, some of the boys had this to say:

> R1 (respondent 1): We go to Chimbotela to collect our own stones, carrying them either on wheelbarrows or on our heads. These are big stones, which we later break into small pieces with hammers. After this we start selling them.
>
> R4: As for us, our employers bring us the stones in trucks and then we break them into small pieces. The big stones are usually dropped on the road.

Ninety-five per cent of the child labourers (particularly those who did not go to school) said they worked an average of eight hours daily. Those who attended school divided their time between school and work. They usually worked for about four hours before going to school and, after school, returned to continue their job. As a result, many children, unable to continue both studies and job, found they had to drop out of school. One boy respondent from Lusaka put it this way:

> R: My main problem is how to divide time between selling here in the market and going to school. Most of the time I go home in the evenings tired.
>
> Interviewer (I): Could you describe your routine?

[3] ILO and CSO: op. cit., pp. 47-60.

R: I go to school at 12 o'clock and knock off at 5 o'clock. Before I go to school, I come here to the market to help my mother sell vegetables. After school, I join my mother at the market. I often get home around 7 o'clock.

The girls who did household work and street vending also divided their time between school and work. A later part of this report shows that it is this situation, together with difficulties in paying school fees, that is responsible for the large number of school drop-outs. Apart from spending long hours on their work, the majority of these children worked in otherwise harsh conditions, which had a telling effect on their health (see the section concerning health below).

Education

The difficult circumstances in which the children found themselves presented a considerable obstacle to their education. Poverty lay at the root of these problems, and was compounded by the death of parents or guardians, mainly because of HIV/AIDS, or by the divorce or separation of parents.

The study sample was overwhelmingly composed of children who had either dropped out of school or who had never attended. For instance, out of 150 children who participated in FGDs, only 30 (20 per cent) were attending school. The rest had either dropped out of school (more than 55 per cent) or had never attended. Among the 34 children who participated in the in-depth interviews, only six were attending school: three on the Copperbelt (one boy and two girls), and three in Lusaka (two girls and one boy). The rest had dropped out of school. The situation was almost the same among the 122 children sampled by questionnaire. On the Copperbelt, 24 (13 boys and 11 girls) of the 41 respondents had stopped school, while one girl respondent had never attended. In Lusaka, 17 respondents (11 boys and six girls) had dropped out of school, while four (two boys and two girls) had never attended. In the Eastern Province, only eight children out of the 41 sampled were in school, while the rest were not. Those not in school included 26 children (20 boys and four girls) who had dropped out of school and seven children (five boys and two girls) who had never attended.

This suggests the following observations:

- More children living in rural areas attended school than did their counterparts who lived in towns. In urban areas (e.g. the Copperbelt), where the economic crisis and poverty were approaching levels typical of rural areas, however, more children were out of school.

- Almost all of the children who had dropped out of school said they left because they could not afford school fees; their parents were either too poor or they had died.

- Almost all the children who had left school said they would return if there were someone to provide the necessary money. A girl respondent from Ndola who was engaged in prostitution put it this way:

  I: You told me that you don't go to school. Can you explain why?

  R: I don't have the money to pay, and there is no one to pay for me.

  I: Now you are 14 years old. Would you be interested in going back to school if given a chance?

  R: I would be very happy to return to school and stop prostitution because I am very young. I would completely stop what I am doing if I could know that someone would pay for

my education. Children in my age group do go to school and, when I am standing on the road doing nothing, I see a lot of my age mates in uniforms and speaking in English. It really hurts me, and I envy them.

- None of the children who dropped out of school had proceeded beyond grade 10. Almost 97 per cent of the children who were out of school had never gone beyond grade 7.

- Every child (including those 15-16 years of age) had left school in the previous ten years, a period which coincided with economic reforms and the introduction of school user fees.

- Only about 12 per cent of those who had left school said that someone in their family (parent or sibling) had also dropped out. All of these respondents, however, added that this was not the reason why they had left school. Most of the drop-outs left because of financial reasons.

Health

Their working conditions exposed a large majority of the children to a variety of health problems. Almost every job performed involved some kind of health risk, and a large majority of working children suffered poor health. This finding tallies with Lemba's *Rapid assessment of street children in Lusaka*:

> Life on the streets exposes children to a number of health risks, due to unhygienic environment, poor quality and/or inadequate food, low access to medical care, exposure to the elements, exposure to acts of violence, sexual risk-taking, etc. [4]

A direct relationship existed between the diseases and injuries suffered and the type of job the children were engaged in.

In all study areas, children complained about how their job affected their health. Among the quarry workers and stone-breakers of Lusaka and Eastern Provinces, children complained about constant headaches, chest pains, sore eyes, injury to fingers, and coughing and sneezing. The stone dust associated with these kinds of work can be especially injurious to health. The jobs also involved great physical exertion, the stones being broken with heavy hammers, and the children were often exhausted. An excerpt from one FGD held with boy stone-breakers in Lusaka illustrates this:

> I: If an accident happens at work, how do you deal with it?
>
> R9: Can you see how I injured my finger? The fingernail is gone because of breaking stones. I was injured by a hammer. Also, quarry dust affects our eyes.
>
> R6: That is why we drink milk – to protect ourselves from the effects of the dust we inhale everyday.
>
> R5: When you hit your finger with a hammer, the finger gets swollen and blood builds up inside.
>
> R3: The chest feels heavy and, if you don't drink milk, you get worse. We end up buying medicines to treat ourselves.

[4] Lemba: *Rapid assessment of street children*, p. 20.

R1: Even if you injure yourself, you don't stop, but continue. What you want is to make money.

I: Are there work-related illnesses or diseases? If yes, what are the common ones?

R1: Yes. We have such problems as coughing because of quarry dust.

R5: Our ribs are affected because of lifting and crushing heavy stones.

R7: If the quarry dust goes into the lungs, we even cough blood. That is why you should give us some money for milk.

In Luanshya, girls who cleaned and processed fresh fish at the markets also complained of frequent knife and fish injuries (stabbing fingers on dorsal fins). Constant exertion in the sun among many child vendors resulted in headaches, painful and swollen legs, fatigue, bodily pains, foot injuries, and falling. Porters often also reported sore painful necks, chest pains, headaches, backaches, and waist aches.

Working in harsh conditions created a survival-of-the-fittest ethos, and fights often erupted among child labourers, resulting in further injuries. Stomach aches also featured prominently among the ailments, most of them probably due to poor hygiene. Children frequently suffered from more than one disease. Work-related diseases and health conditions reported by the children are summarized, in order of frequency, in the following table. (The table does not include STIs, which are presented in a later section focusing on prostitution.)

Table 4. Most common diseases and health conditions among child labourers

Disease or health condition	Frequency
Headaches	Very common
Fatigue	Very common
Chest pains	Very common
Bodily pains	Very common
Injuries and bruises	Very common
Painful/swollen legs	Very common
Painful ribs	Very common
Coughs	Common
Stomach pains/diarrhoea	Common
Sore neck	Common
Sneezing	Common
Backache	Common
Fight-related injuries	Common
Waist ache	Sometimes
Malaria	Sometimes

These children strongly tended to allow disease or injury to heal itself. Self-treatment was commonplace. Respondents indicated that formal health clinics were the last resort (i.e. if their home remedies were not working). Common patent drugs procured from stores or chemists as painkillers included Panadol and Cafenol. Chloroquine was the most common drug used for malaria. Traditional medicines were also mentioned, especially by children engaged in prostitution. Children preferred self-treatment for two main reasons. First, their jobs rarely earned them enough money to pay for treatment in health centres.

Second, considerations of time were very important – to interrupt what they were doing to seek treatment was perceived as a loss of income. When asked to explain how they spent their money, expenditure on health was mentioned by less than 1 per cent of the total sample of 306. Money was mostly spent on personal food and clothes, as well as family expenditures.

Commercial sexual exploitation

To maintain confidentiality and to get detailed and reliable data, all the children exploited for commercial sex were sampled by means of in-depth interviews. Of 34 interviews, 17 were held with children engaged in prostitution (15 girls and two boys). There were more of these children in the areas we visited than the study could accommodate.

The main reason given for entering into prostitution was the need for money, although in some cases children mentioned that clients also bought beer for them. In one Chipata case, a girl in prostitution accepted payment in kind (second-hand clothes). Young girls in prostitution also associated with older ones, and sometimes worked in their company. [5] For instance, a 14 year-old girl in prostitution was always accompanied by her elder sister:

> I: Do you work alone or in groups?
>
> R: Because of the risks involved in this work [beatings by clients and fights with rival children commercially exploited for sex], I work with my elder sister. Every time I go to work, I am in the company of my elder sister. She is the one who even keeps the money I receive from clients. I always get paid before sex.

Although the motivations to enter prostitution were personal, the poverty of parents or poverty related to the death of parents or guardians lay at the root of the problem.

Typical responses regarding why they decided to engage in prostitution included these:

> My parents passed away and I had no one to look after me.
>
> We were suffering a lot in the household; most of the time we were hungry.
>
> Because I stopped school and my father neglected me.
>
> I did not have anyone to support me.
>
> Life became too tough for us.
>
> To get money for school fees.

Only three respondents said they were doing it because of peer pressure or because they enjoyed sexual activities.

[5] Owing to the risky nature of prostitution, children so engaged worked in groups for mutual security. See Mushingeh, A.C.S.: *Voluntary counselling and testing for HIV in Zambia: Findings based on FGDs and in-depth interviews in Lusaka and Livingstone*, A study conducted for the Society for Family Health (Aug. 2001).

There was also a relationship between prostitution, poverty, orphanhood, and school attendance, although often orphans did not resort to prostitution.[6] Only one child engaged in prostitution was attending school, and she achieved this only with great difficulty. Table 5 demonstrates the interrelatedness of commercial sexual exploitation with poverty, orphanhood, and school attendance. The grade attained is in brackets.

Table 5. Parental and educational status of children engaged in prostitution

Town	Gender	Age (years)	Attending school	Parental survival status
Ndola	F	15	No (G7)	Double orphan
"	F	14	No (G2)	Single orphan (father dead)
"	F	16	No (G9)	Double orphan
Luanshya	F	15	No (G7)	Double orphan
Kitwe	F	16	Yes (G10)	Double orphan
"	F	15	No (G7)	Alive but divorced
"	F	16	No (G7)	Alive but divorced
"	F	16	No (G7)	Alive but poor
Chipata	F	16	No (G8)	Single orphan (father dead and mother ill)
"	F	15	No (G5)	Double orphan
"	F	15	No (G3)	Single orphan (father dead)
"	F	15	No (G7)	Both parents alive but not living with the children
"	F	15	No (G7)	Parents alive but poor
"	F	14	Never attended school	Double orphan
"	F	14	No (G7)	Single orphan (father dead and lost contact with mother)
Lusaka	M	15	No (G9)	Double orphan
"	M	16	No (G9)	Double orphan

With the exception of boys, all children engaged in prostitution worked in bars and guest houses, and all (including boys) drank beer. Only six said they preferred to work at night, to maintain confidentiality, while the rest said they worked anytime. On the Copperbelt, some children in prostitution could be found in pubs and taverns as early as 8 a.m., drinking and dancing while waiting to meet clients. Their earnings ranged from 3,000 to 33,400 kwachas (about US$0.63 to US$7); few children got more than 20,000 kwachas (US$4.20). A large majority, especially younger ones, rarely earned 10,000 kwachas (US$2.10). Sometimes they slept with clients in exchange for beer. Two boys in prostitution from Lusaka said they were paid in dollars for sleeping with rich widows who drove big cars and lured them into hotels for sex.[7] In a single working day or night of a few hours to a whole night, each child in prostitution would sleep with three to four clients.

[6] For instance, 17 girl orphans were engaged in other activities such as street vending or cooking in the markets.

[7] This situation introduced a new form of commercial sexual exploitation in Zambia. The children engaged in prostitution claimed that, although they were aware of the possibility of HIV/AIDS in

Only two children engaged in prostitution reported the use of condoms during intercourse. Most children engaged in prostitution, therefore, were routinely exposed to STIs, including HIV/AIDS. Only three girls in prostitution (two in Chipata and one in Ndola) said they had suffered from syphilis. The rest reported friends as having had an STI. During the interviews, it was difficult to elicit accurate answers, given the sensitive nature of this topic.

Among the things children in prostitution hated in their job were STIs, violence from clients and rival gangs, and vaginal pain during sex (mentioned by most of the respondents aged 14-15 years). Treatment for STIs included both modern and traditional medicines. In cases of STI, traditional medicines were more frequently used because they were cheaper and, it was often believed, offered long-term solutions. One Ndola respondent reported this about her sister (also trapped in prostitution):

> She told me that she had syphilis and, since she had no money to go to the clinic, she went to a traditional healer who lives in our community. He gave her medicine which cured her. Healers are cheaper than modern doctors here in Ndola. They charge 3,000 kwachas [US$0.63] and the rest upon cure. My best friend has had chronic gonorrhoea, and her grandmother came to take her to the village for treatment.

Almost all children in prostitution mentioned that they hated their job because of the many risks involved. They did it, reportedly, only because of the money and lack of alternative economic avenues. Awareness of STIs, including HIV/AIDS (discussed in the next section), was high. The increasing incidence of children engaged in prostitution, in spite of this, indicates that awareness campaigns, in face of high poverty levels, are not very successful.

Some orphans engaged in prostitution reported symptoms that their parents had showed prior to death that suggested a probable link with HIV/AIDS. These included chronic illness, tuberculosis, weight loss, rashes, persistent diarrhoea and coughing, change of hair and skin colour, and boils.

Awareness and understanding of HIV/AIDS

HIV/AIDS awareness levels were reasonably high among both boys and girls involved in child labour. Most respondents from the FGDs, in-depth interviews, and questionnaire said they had heard about HIV/AIDS. All of the 34 respondents involved in in-depth interviews said that they knew that HIV/AIDS existed. Between seven and eight participants in each of the 15 FGDs conducted, an average of about 75 per cent, were aware of HIV/AIDS. In the questionnaire survey, 103 out of 122 (more than 84 per cent) said they were aware of HIV/AIDS.[8] Overall, more than 86 per cent of the respondents knew about the existence of HIV/AIDS. The most commonly reported mode of transmission was unprotected sex with an infected person. Few respondents cited other

the deaths of their clients' husbands, they did not use condoms because their partners did not like them. Being paid in dollars also deprived the boys of negotiating power.

[8] High levels of awareness regarding the existence of HIV are also referred to in many other studies. See, e.g., Mushingeh, A.C.S.: *An investigation of high-risk situations and environments and their potential role in the transmission of HIV in Zambia: The case of the Copperbelt and Luapula Provinces*. A study conducted for the Population Council (1991).

modes. The above figures are similar to those reported in other studies that have dealt with the same issue. [9]

Awareness levels were lower among the younger respondents, aged five to 11 years, especially among children not attending school. HIV/AIDS information sources differed regionally. On the Copperbelt, sources of information, listed in order of relevance, were radio, parents, friends, relatives, schools, and health facilities. The church, workplace, and neighbours were mentioned by few respondents. In Lusaka, the most important sources of information were friends, schools, radio, and parents. Relatives and community members were mentioned by a few people, while no one reported health facilities, workplaces, neighbours, or the church. In the Eastern Province, the most common sources were friends, radio, and schools; other sources did not feature prominently in the responses. Since most of the children were not going to school, and moved about in search of employment, they could not recall any HIV/AIDS prevention programmes in workplaces. Among those who went to school, few said their school offered an HIV/AIDS prevention programme.

Concrete knowledge, especially in terms of mentioning at least three symptoms of HIV/AIDS, was also high among both sexes in all areas of the study. About 85 per cent of the respondents between 12 and 16 years recalled the more common symptoms, while a sizeable proportion (about 35 per cent) of children between five and 11 years showed little or no knowledge of HIV/AIDS symptoms. In all sampling categories, the following symptoms (both symptomatic and behavioural) were given (in the order of responses).

Table 6. HIV/AIDS symptoms mentioned by child workers

1. Loss of weight/protruding shoulders
2. Chronic sickness
3. Persistent diarrhoea
4. Chronic coughing/tuberculosis/chronic flu
5. Pale or darker skin/rashes/herpes zoster
6. Loss of weight/loss of hair/permed-like hair
7. Milky white eyes
8. Boils
9. Persistent headaches
10. Too much talking/hallucinations
11. Easy tempered
12. Reduced appetite for food
13. Swollen legs
14. Ringworms

Despite the high levels of HIV/AIDS awareness, responses regarding knowledge of transmission modes were inconsistent. These inconsistencies transcended gender, geography and age, and were thus more likely due to the prevailing nature of HIV/AIDS education than other factors. Many children got their information from peers on the street, for example, and much of this information could have been incorrect. The following responses from the 122 children who answered the questionnaire illustrate the point.

[9] Lemba: *Rapid assessment of street children*.

Table 7. Child respondents' understanding of HIV transmission modes

	Response			Total
	Yes	No	Don't know	
Can one prevent HIV/AIDS infection?	69	10	43	122
Can one be infected with HIV/AIDS by supernatural means?	13	69	40	122
Can people protect themselves by using a condom?	42	16	35	93*
Can one get HIV/AIDS from mosquito bites?	41	50	31	122
Can a healthy-looking person be HIV-positive?	57	37	28	122
Can HIV be transmitted from mother to child?**	62	22	38	122

* Twenty-nine (29) would-be respondents were judged unsuitable for the question and excluded by the researchers because of their age. ** Although the question appeared in this form in the research instruments, it was qualified during interviews to refer to mother-to-child transmission during pregnancy.

These inconsistencies were also detected in the FGDs and in-depth interviews. As expected, none of the children had ever been tested for HIV/AIDS. This was in spite of the fact that a sizeable number of the respondents, particularly those between 14 and 16 years, knew where voluntary counselling and testing centres for HIV were located.

Stigma and discrimination

In Zambia, people infected with HIV/AIDS are subject to much discrimination. Many studies have revealed this stigmatization in the family, workplace, neighbourhood, community, and even institutions designed to combat the spread of HIV/AIDS.[10] Generally speaking, HIV-infected people are subjected to a variety of stereotypes:

> They are subjects of ridicule and are often perceived as hopeless or helpless people. Whatever they said or did, no matter how sensible, people would retort *aba balwele* [this one is sick]. … Even the sympathy shown towards the HIV/AIDS people was superficial and not genuine. It was sympathy shown in the presence of the infected person. Immediately that person left, they would be talking ill of them.[11]

Although the situation has changed slightly since that report, HIV/AIDS-infected people and their relatives still have to cope within this context. A Kitwe girl engaged in commercial sexual activities put it this way:

> People everywhere are generally hostile or uncaring towards people who have HIV/AIDS. Once they see that someone has symptoms associated with HIV/AIDS, they say *kalaye banoko* [go and say bye to your mother]. This is very sad. The problem is that there is no cure and once one has it, death is the consequence.

This scenario has conditioned people whose relatives have died of HIV/AIDS to deny this. In this study, many orphans and relatives of people who may have died of AIDS, said their parents or relatives died of something other than AIDS. Out of 306 respondents involved in the study, only two – one girl and one boy (himself suffering from TB) – admitted in the course of in-depth interviews that their parents had died of AIDS. The boy, when asked whether his friends knew that his parents had AIDS, shook his head in

[10] Mushingeh: *An investigation of high-risk situations*, pp. 122-127.

[11] Mushingeh: *Voluntary counselling and testing*, p. 123.

agreement. The girl also agreed. The rest either remained silent or attributed the death(s) to other causes. The following excerpt is one typical response:

> I: Did you or your friends know that your parents had HIV/AIDS?
>
> R: No, they did not die of AIDS. [Expression of anger on her face.] My mother died of high blood pressure. She fell ill after my father died (15-year-old girl respondent, Ndola).

In short, almost every respondent acknowledged the existence of stigma against those infected with HIV/AIDS. Most respondents were themselves prejudiced against these people. The following response from a girl in prostitution in Ndola in many ways sums up the position of many respondents vis-à-vis HIV/AIDS-infected people:

> I: Generally, how does your community react towards people with HIV/AIDS?
>
> R: The community does not like people with AIDS.
>
> I: Why is this?
>
> R: They get tired of chronic illnesses found in HIV/AIDS people. Personally, I do not like mingling with HIV/AIDS people, not because I fear being infected but because I do not want to be reminded of what I would look like if I fell ill. If I give water to an HIV/AIDS-infected person from my cup, I would immediately throw away the cup.

When one has HIV/AIDS, the reaction from the community is that one has brought the disaster upon oneself.

3. Findings

This chapter mainly presents a recapitulation and analysis, against the broad background of Zambia's socio-economic situation, of the main points and themes emerging from this study. Rather than emphasizing either child labour or the impact of HIV/AIDS per se on children, we focus here on the interrelationship between the country's economic crisis, child labour, and HIV/AIDS.

Child labour

This study and several others have demonstrated that child labour in Zambia is rife, and probably increasing. Child labourers were found distributed across the areas of study, especially in Lusaka, Luanshya, Kitwe, Ndola, and Chipata. More children than the study could accommodate presented themselves voluntarily to our team of researchers for interviews.

The working children interviewed were engaged in a wide range of activities including vending, stone-breaking, and prostitution. Child labourers came from underprivileged and deprived homes. They often worked in hazardous conditions, both on the street and in their respective activities. Although a sizeable number of child labourers were orphans, a large majority came from families where one or both parents or guardians were present. Poverty was the main factor forcing them into child labour.

A majority of the child workers lived on the streets with the full knowledge of their parents or guardians. The little money that these children earned represented, in some cases, the family's sole income. In the Eastern Province, we did not find any child worker (apart from children engaged in prostitution) who earned more than 15,000 kwachas (US$3) per month. Many children looked malnourished and were dressed in rags.

Although Zambian law prohibits children under the age of 18 years from working in hazardous occupations,[1] there is no government enforcement of this law. In spite of its formal commitment to eradicate child labour, the Government finds it difficult to implement this policy. As mentioned above, child labourers represented a mere fraction of the total number of street children, the majority of whom were constrained to subsist by begging. Instead of working for someone else, a lesser number of children aged 14-16 years tried to sustain themselves by vending all sorts of goods and performing all sorts of manual labour.

HIV/AIDS

AIDS has had a devastating impact on Zambia. HIV/AIDS infection rates across Zambia are high, comprising about 34 per cent of the adult population in such towns as Livingstone.[2] Indeed, Zambia is one of those countries at the core of the HIV/AIDS epidemic in southern Africa, with the United Nations reporting that, in five African countries – Botswana, Lesotho, Swaziland, Zambia, and Zimbabwe – at least one in five

[1] ILO and CSO: *Zambia 1999 child labour survey*, p. 22.

[2] Hira and Nkowane: *Epidemiology of HIV in families*, pp. 83-86.

adults has HIV or AIDS.[3] Zambia also ranks among the eight African countries which, by the year 2005, will have lost at least 17 years of life expectancy to the AIDS epidemic.[4] The welfare of Zambia's children, inevitably, will suffer even more.

The ever-increasing number of orphans, for one thing, is partly due to a high and rising HIV/AIDS mortality rate.[5] This had badly affected the resilience of the family:

- Of all the areas studied, Luanshya was probably most severely affected. Our team was constantly called upon by poor guardians either to offer financial assistance to orphans or even to take them with us to Lusaka. Our sample of 306 children included 30 children from single female-headed households, three from single male-headed households, and 15 from child-headed households. The latter group included two children whose parents were too sick to work. The nature of their parents' illnesses, as reported by the children themselves, led researchers to suspect that these illnesses or deaths were due to HIV/AIDS. Symptoms included chronic illnesses, swollen legs, persistent coughing and diarrhoea, and thinning hair.

- The epidemic is exacerbating what is virtually omnipresent poverty. The seriousness of the situation is partly reflected in the hundreds of thousands of children who, due to the death of their parents or guardians, have turned to the street as a means of survival.

- Together with adding greatly to the number of orphans needing care and to worsening household poverty, HIV/AIDS is seriously weakening the traditional extended Zambian family as a social welfare safety net. Our sample included, for example, orphans abandoned by their guardians (i.e. grandparents). What is more, the prevailing situation has created a vicious cycle, and things may be expected to get much worse.

It is important neither to exaggerate nor to underestimate the role of HIV/AIDS in pushing children onto the streets and into child labour. Our conclusion, however – one confirmed by other studies – is that HIV/AIDS has added as many as 23 to 30 per cent to the child labour force. (Although the Zambian streets are crowded with working children, a sizeable number of whom are orphans, we cannot assume that all of these are AIDS orphans.)[6]

It was also difficult for us to gauge how many of these children were themselves HIV positive, except in the case of one Luanshya boy (mentioned above) whose grandmother told us that he had TB and HIV. Many of the children sampled could be categorized as follows:

- HIV/AIDS orphans;

- children who were at high risk of HIV infection due to the nature of their work; and

[3] UN: *Countries most affected by HIV/AIDS*, p. 2.

[4] ibid., p. 2.

[5] ibid., p. 2.

[6] Lemba: *Rapid assessment of street children*; ILO/CSO: *Zambia 1999 child labour survey*; and CSO: *Living conditions monitoring survey report*, 1996 (Lusaka, 1997). According to the latter report, 78 per cent of current Zambian orphans are a product of the HIV/AIDS epidemic.

- children affected by HIV/AIDS and/or forced to drop out of school to enter the job market.

Some of the HIV/AIDS orphans, as we have seen in previous chapters, engaged in prostitution, while others came from families whose parents or guardians were alive but poor. The following section describes a marked correlation between poverty and HIV/AIDS, both of which factors produce conditions leaving children vulnerable to socio-economic insecurity, including lack of educational opportunities.

Economic crisis

Child labour in Zambia cannot be fully understood without considering the socio-economic context within which it has evolved.

The country has been in economic crisis since the early 1990s. Household poverty, owing to unemployment and lack of any serious economic income on the part of many adults, has had a severe impact on many children, especially the girls.[7] Poor families – many of them large – have found it increasingly difficult to care for their children, who increasingly often leave home to become beggars, loiterers, or child labourers. The street is both physically and psychologically dangerous for children. Children are forced, among other things, to steal and engage in prostitution.

The incidence of child labour has increased due to poverty and HIV/AIDS, both of which have forced children on to the street, where they themselves risk HIV infection in their attempts to survive. More than two-thirds of the child labourers sampled were on the street because of poverty. Indeed, many children were on the street because their impoverished parents or guardians expected them to make a financial contribution to the household. A significant number of children engaged in prostitution said they were so employed with the full knowledge of their parents or guardians.

More than three-quarters of the sampled children said that they worked to supplement family income; and many perceived their labour as a tangible contribution to the family rather than a denial of their rights.

Once on the street, most girls and boys had no chance of remaining in school. School attendance required a stable family background capable of providing such necessities as food, school fees, uniforms, and psychological security. But families struggling simply to put a meal together could not afford schooling for their children.

The interrelationship between poverty, HIV/AIDS, and child labour is complex, and the issues require a holistic solution involving multiple strategies. Any intervention measures must take into account the prevailing high rates of unemployment, for example. Unemployment has resulted in mass poverty, increasing vulnerability to HIV/AIDS infection through the adoption of risky behaviour (i.e. unprotected sexual activities). The Government and all stakeholders should explore methods of alleviating poverty, including job creation and training programmes. This would help to strengthen families. Currently, many households do not have the capacity to socialize their children properly or to care for AIDS orphans.

Not one of the child labourer interviewees came from a privileged social background. That in itself is evidence of the links between poverty, HIV/AIDS, and child labour. To

[7] UNDP: *Zambia: Human development report, 1999-2000*.

tackle HIV/AIDS effectively, households must be economically empowered. Children engaged in prostitution, for example, reported emphatically that they recognized the potential dangers of HIV/AIDS in their activities. They added, however, that they would prefer to risk AIDS-related death in the future, rather than stay at home and starve now. As one Ndola girl, when she was asked why she decided to engage in prostitution, said:

> We were suffering a lot in the household. Most of the time we were hungry, and neighbours would start laughing at us. They would be eating while we starved, as if we didn't want to eat. … You know, in our household we are three families, including my mother's sister and her children.

Conclusions and recommendations

In Zambia, poverty and HIV/AIDS are mutually reinforcing, and together they create fertile conditions for child labour. Merely counselling child labourers regarding the hazardous nature of their activities will remain ineffective as long as their families remain in poverty. The Government and other stakeholders must address the issue of child labour now, and any solution has to take into account the national socio-economic context.

HIV/AIDS has worsened the situation, creating a self-perpetuating cycle of suffering for many children. As long as poverty continues to afflict 80 per cent of Zambia's population, children will be involved in child labour, and they will continue to be affected, and infected, by HIV/AIDS.

On the basis of these findings, this report offers the following recommendations: [8]

- Child labour-related issues are many and varied, and they involve, among others, economic, social, health, and educational dimensions. This suggests the following approaches:
  - Policies and programmes designed to reduce child labour must apply a holistic approach, considering all of the above aspects in their interrelatedness.
  - Interventions must apply a multi-sectoral approach, involving all the government ministries, NGOs, the church, and multilateral organizations.
  - Solutions to child labour should address both the micro and macro levels. At the macro level, the Government, in conjunction with its "cooperating partners" and such multilateral organizations as the UNDP, WHO, and the ILO could combine efforts to formulate and implement strategies that focus on youth and their families. The starting point is the sourcing and pooling of finance specifically for child welfare. Within a broader context of cooperation, each organization can then focus on its own specialized activities.
  - Attempts to revive the economy should include empowerment of households through job creation and other activities. Although the root cause of child labour is household poverty, the Government cannot wait until it salvages the economy to focus on children. Paper legislation alone is not sufficient – tangible programmes are needed.

[8] These recommendations are very much in line with studies conducted in the recent past by the ILO and the Central Statistical Office (CSO), and by Dr. Musonda Lemba (see the bibliography).

- At the micro level, a multi-sectoral approach is required in which child labour issues are a top priority. Since these problems involve finance, education, health, and social welfare, government ministries (i.e. line ministries) dealing with these activities can combine efforts to formulate strategies that focus not only on the children, but on their households as well. Child labour prevention programmes can be implemented concurrently with attempts, probably on a cooperative basis, to strengthen families through economic empowerment. Parents and guardians should be trained in new skills such as microenterprise activities, thereby countering poverty's destructive effects on the family. Health issues, especially information concerning HIV/AIDS, could be incorporated in these programmes.

- Other sources of local power such as NGOs, the church, schools, and community leaders, should be integrated into programmes to combat child labour. Since these organizations and individuals deal with people at the grass-roots level, they offer special potential for making important contributions.

- Educational programmes are needed to focus on local communities and families, bringing parents to a better understanding and appreciation of their roles. Cases such as those encountered during this study where parents had abandoned their children might be thereby reduced.

- Peer education, involving peers selected from the street itself, could be of use, particularly in HIV/AIDS education.

- Educational programmes can aim at introducing children engaged in prostitution to contraceptives and condom use.

- Local governments should be asked to reintroduce welfare and recreational systems where children may acquire a variety of skills and enjoy other activities where, currently, working is too often the only option available to them.

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Annex

Child questionnaire

Background information

Sex	
Age	
Place of birth	

B1. Where do you live?		
B2. Have you always lived there?	Yes No	Yes > skip to Q/B5
B3. If no, why did you move?	Open	
B4. Where did you live before? *(Specify city or village only)*		
B5. How many people do you live with?		
B6. Does your _____live in your household? *(Check all persons that apply)*	Father Mother Sister(s) Specify younger/older Brother(s) Specify younger/older Guardians Employer Grandparents Uncle/aunt Non-relative Other (specify)	□ □ □ □ □ □ □ □ □

Interviewers should repeat questions B3-B4 as many times as necessary.

Educational section

E1. Are you currently attending school?	1. Never attended 2. Left school 3. Attending	1>skip to Q/E7 1>skip to QE4
E2. How regularly do you attend school?	Every day Once/week Twice/week Three times/week Four times/week Five times/week Depends on the season	
E3. Who pays for your education?	Myself Friends Parents or guardians Relatives Education is free Other (specify)	

Only if E1 = left school: E4. What is the main reason why you left school?	School is too far Cannot afford school Family does not allow schooling Not interested in school School not suitable or safe Illness or disabled (self) To help in household To take care of ill family members To work for wages To work in own business for income Other
E5. When did you leave school? (Check the year)	Open .....
E6. Would you like to go back to school?	Yes No DK
E7. What is the main reason that is preventing you from returning/going to school?	School is too far Cannot afford school Family does not allow schooling Not interested in school School not suitable or safe Illness or disabled (self) To help in household To take care of ill family members To work for wages To work in own business for income Other (specify)
E8. Did somebody (else) in your family drop out of school? *(Check all persons who drop out)*	Mother Father Sister(s) Brother(s) Nobody No other family member attends school Other (specify)

Parental survival status section

A1. Is your mother still alive	Yes No	Yes > skip to Q/A6
A2. What did she die from?	Open	
A3. Did she lie in bed for many weeks before she died?	Yes No	
A4. How old was she when she died? *(in years)*		
A5. When did she die? *(Check the year)*		> skip to Q/A8
A6. Is she working outside of the house?	Yes No	Yes> skip to Q/A8
A7. How does she spend her day?	Open.....	
A8. Is your father still alive?	Yes No	Yes> skip to Q/A13
A9. What did he die from?	Open.....	

A10. Did he lie in bed for many weeks before he died?	Yes No	
A11. How old was he when he died? *(in years)*		
A12. When did he die? *(Check the year)*		
A13. Is he working outside of the house?	Yes No	Yes > skip to next module
A14. How does he spend his day?	Open.....	

Housekeeping section

H1. Who are the people living in your house that take care of household chores?	Open	
Only if he/she performs domestic work: H2. What kind of domestic work do you perform? *More than one answer allowed.*	Cooking/serving food for household Cleaning utensils/house Minor household repairs Shopping for household Caring for the old Caring for the sick/infirm Child minding (feeding, child care, taking to school, etc.) Other (specify)	Yes No Yes No Yes No Yes No Yes No Yes No Yes No
H3. How many hours do you work each day?	Monday..... Tuesday..... Wednesday..... Thursday..... Friday..... Saturday..... Sunday.....	
H4. Do you perform domestic work in another household?	Yes No	No > skip to next section
H5. How many hours do you work each day?	Monday..... Tuesday..... Wednesday..... Thursday..... Friday..... Saturday..... Sunday.....	
H6. Are you paid for it?	Yes No	No > skip to next section
H7. How are you paid *For "in kind" give examples: shelter, food, school fees, etc.*	Cash In kind (specify).....	

Working status section

L1. Have you ever been involved in any work?	Yes No	No > skip to next section
L2. Are you currently working?	Yes No	No > skip to L5
L3. How long have you been working? *(Specify month/year)*		

L4. What is the main reason that you started working?	To gain experience/acquire training Supplement family income Help pay family debts Help in own household enterprise Earn money to establish own business There is no school nearby To pay school fees To be economically independent Others (specify)	
L5. What kind of work do/did you perform? *Leave it open, and use the following categories to probe:* *1. Mining and quarrying* *2. Agriculture* *3. Commercial sex worker** *4. Construction* *5. Handicraft* *6. Services including fetching water and firewood* *7. Domestic work* *8. Paid worker in own household-operated enterprise* *9. Self-employed* *10. Unpaid worker in own household farm or business* ** Adapt the phrasing to the local culture.*		
L6. What is the nature of your job?	Permanent Short-term/casual Seasonal/school vacation Worked for different employers on daily/weekly basis Other (specify)	
L7. Have you ever suffered any injury or illness as a result of your work?	Yes No	No > skip to L10
L8. What type of illness?	Open	
L9. How many times have you been injured or ill?		
L10. How do you spend your income?	Give it all to parents Give part of it to parents Pay for school fees and materials Buy medicine Leisure Others (specify)	

HIV/AIDS section

D1. Have you ever heard of the virus HIV or an illness called AIDS?	Yes No	If no, the module is over
D2. Who told you about it?	Parents Friends Relatives Media In school Medical facilities In the workplace Other (specify)	

D2a. *Only if the response to D2 is "school" or "workplace"* Are there prevention programmes within your workplaces/school?	Information Discussion/education Availability of condoms Voluntary testing Counselling Care and support services Other (specify)	Yes No Yes No Yes No Yes No Yes No Yes No
D3. Is there anything a person can do to avoid getting HIV, the virus that causes AIDS?	Yes No DK	
D4. Do you think a person can get infected with AIDS through supernatural means?	Yes No DK	
D5. *Only if interviewer deems that the age of the child is appropriate:* Can people protect themselves from the AIDS virus by using a condom?	Yes No DK	
D6. Can a person get AIDS from mosquito bites?	Yes No DK	
D7. Is it possible for a healthy-looking person to be HIV positive?	Yes No DK	
D8. Can HIV be transmitted from mother to child?	Yes No DK	
D9. I do not want to know the results, but have you ever been tested to see if you have HIV?	Yes No	No > skip to Q/D11
D10. I do not want you to tell me the results of the test, but have you been told the results?	Yes No	
D11. Do you know of a place where you can go to get such a test to see if you have AIDS?	Yes No	

Stigma and discrimination section

** Only for children with parents who have HIV/AIDS, or who are AIDS orphans, or those who themselves are ill or infected.*

S1. Have you ever been treated differently or badly because of your relationship with HIV/AIDS	Yes No DK	No > skip to next module
S2. How were you treated differently or badly?	Neglected, isolated, avoided Verbally abused, teased Physically abused Sexually abused Not allowed to go to school Made to do more chores Underfed, deprived Other (specify)	Yes No Yes No Yes No Yes No Yes No Yes No Yes No

Only if one of the answers to S2 was a "yes": S3. Who treated you differently or badly?	Other children Teachers The community in general Parents/guardians Step-parents Sisters/brothers Grandma/grandpa Employers/colleagues

Commercial sexual exploitation

Only for those who declared that they worked in prostitution in Q/L5 Working Status section.

** Experts recommend that better results in these cases are obtained if the interviewer is a woman.*

X1. What are the conditions of your activities? Probe with the following possibilities:· • Payments for sexual services • Working hours • Location of work	·
X2. Have you received any kind of information about the possible health dangers or diseases you could be exposed to in your job?	Yes No
X3. If yes, who provided the information? *(Read out list and mark all sources listed)*	Government health worker Other government officials NGO volunteers Colleagues in the same line of work Media (TV, radio, newspapers) Other (specify)
X4. Do you feel that you have adequate information on prevention and safety precautions?	Adequate Not adequate Never been given any information
X5. Do you regularly observe these prevention or safety precautions?	Yes No (why not?) .....
X6. How often do you have health/medical check-ups?	
X7. If regularly done, who arranges them?	NGO Yourself Other (specify) .....
X8. Have you ever had any illness related to your work?	Yes No
X9. If yes, what was the nature of the illness?	
X10. Who paid for your medical treatment?	Yourself Other (specify) .....
X11. Do you know about HIV/AIDS?	Yes No
X12. If yes, how did you learn about HIV/AIDS?	From the media (newspapers, radio, television) From friends From government officials From voluntary organizations Other (specify)
X13. Do you know what you can do to protect yourself against HIV/AIDS?	Yes No
X14. Have you heard of any ways that a person with HIV/AIDS can cure themselves of the disease? (Explain)	Yes No

X15. Do you carry a supply of condoms every time you go with a client?	Establishment provides and insists/enforces use of condom Establishment does not provide but insists/enforces use of condom Establishment does not provide but encourages use of condom Establishment does not care
X15. During the last five times you had sex with a customer, how many times was a condom used?	..... times
X16. If a condom was not used, why not?	Customer pays more Customer refused to use No condom available Did not know/care about use of condom Other (please explain) .....
X17. If you had sisters or girl children, would you encourage or discourage them if they wanted to enter this line of work?	Encourage them (why?) ..... Discourage them (why?) .....