ASSESSMENT ON MALE STREET CHILDREN AND YOUTH VULNERABILITY TO HIV/AIDS IN ADDIS ABABA, ETHIOPIA

MSW DISSERTATION RESEARCH PROJECT REPORT

(MSWP-001)

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ENROLLMENT NO. 109100815

INDIRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

NOVEMBER 2014

ADDIS ABABA, ETHIOPIA

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NOVEMBER 2014
ADDIS ABABA, ETHIOPIA

PROFORMA FOR SUBMISSION OF MSW PROJECT PROPOSAL FOR APPROVAL FROM ACADEMIC CONSELLOR AT STUDY CENTER

Enrollment No. 109100815

Date of Submission: August 8, 2014

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DECLARATION

I hereby declare that the dissertation entitled "**ASSESSMENT ON MALE STREET CHILDREN AND YOUTH VULNERABILITY TO HIV/AIDS IN ADDIS ABABA, ETHIOPIA"** submitted by me for the partial fulfillment of MSW to Indra Gandhi National Open University (IGNOU), Addis Ababa is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirements for any other program of study. I also declare that no chapter of this manuscript in whole or in part is lifted or incorporated in this report from any earlier work done by me or others.

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ACKNOWLEDGEMENTS

First of all, I would like to thank my almighty God who gave me the courage, strength and wisdom to begin and successfully complete the long process of writing this thesis.

I would also like to sincerely thank Mr. Sebsib Belay, my thesis advisor, for his unreserved, brotherly and professional guidance with full commitment and concern throughout all the steps of producing the dissertation. On top of the technical and professional guidance, his encouraging and motivating words have been strengths for me to finish the research as per the schedule. In the absence of such a responsible and a truly helping advisor, my research would have never been possible.

My deepest gratitude also goes to my wife, Meseret Alemu for her all-round support with full understanding throughout the course and research works of my study in MSW. I would also like to appreciate my kids, Ananya and Kidanekal, for their tolerance and understanding when I was unable to give them time and attention for being busy with my studies.

The informal advice and close follow up of my brotherly friend, Dr. Wassie Kebede also has important place in this work. Therefore, I am more than happy to be able to recognize his supports in this acknowledgement.

Last, but does not mean least, I would like to extend my deepest thanks to all those who were involved, directly or indirectly, in this research. I am particularly grateful to the street boys who participated as informants, Street Children Rehabilitation Project staff at Yeka-Tinsae Village, Mr. Tesfaye Bogale and Mr. Abera Gemechu at Addis Ababa HIV/AIDS Prevention and Control Office as well as Mr. Bahiru Abebe and Mr. Berhanu Abera, at Labor and Social Affairs Bureau of Addis Ababa City Government Administration.

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ABSTRACT

The study on male street children and youth vulnerability to HIV/AIDS in Addis Ababa, Ethiopia, was conducted with the overall objective of assessing relationships between street life and vulnerability to HIV/AIDS. The research applied both quantitative and qualitative methods through collection and analysis of data from primary and secondary sources. Specifically, the research applied descriptive sample survey on 200 randomly selected male street children and youth aged 15-24 years. The finding of the study revealed that the study groups lack comprehensive knowledge about HIV/AIDS and appropriate changes in behavior. They experience significantly high level of vulnerability to HIV, with the self-reported prevalence of 9.7%. The major risk factors are unprotected and multiple concurrent sexual partnership, alcohol and substance abuse, infections with STIs, homosexuality and sexual abuse. The existing HIV/AIDS interventions for street children are inadequate both in scope and effectiveness. The study concludes that as the street boys continued living on the street, their likelihoods of exposure to HIV risk factors significantly increases, with steady declines in protective behaviors. The longer the duration of life on the street, the more street boys become desperate about their futures and the lesser they take protective measures against HIV/AIDS. The overall successes being registered in the HIV response has little or no implications on street children and youth. As a recommendation, it is not only necessary but also a top priority to halt the growing risk of young street people to HIV/AIDS in Addis Ababa. Interventions should focus on changes in behavior and practice, both prevention and treatment services and management of risk factors. Street children rehabilitation programs needs to be comprehensive, addressing their diverse needs and problems in a holistic manner. Any interventions against HIV/AIDS in street children should start with proper understanding of their situations. Addressing the big issue of street children phenomena is the long-term and sustainable solution to the problem. Additional studies of different nature on the subject matter are still required for evidence based interventions at policy and practice levels.

ABBREVIATIONS AND ACRONYMS

AAHAPCO:	Addis Ababa, HIV/AIDS Prevention and Control Office
ABC:	Abstinence, Being faithful, Condom use
AIDS:	Acquired Immuno Deficiency Syndrome
ART:	Anti-Retroviral Treatment
CDC:	Center for Diseases Control
CSA:	Central Statistics Agency
EDHS:	Ethiopian Demographic and Health Survey
EHNRI:	Ethiopian Health and Nutrition Research Institute
EMSAP:	Ethiopian Multi-Sectoral AIDS Program
FHAPCO:	Federal HIV/AIDS Prevention and Control Office
FMOH:	Federal Ministry of Health
HIV:	Human Immunodeficiency Virus
IDUs:	Injected Drug Users
IGNOU:	Indra Gandhi National Open University
KII:	Key Informant Interview
MARPs:	Most At Risk Populations
MDG:	Millennium Development Goal
MSM:	Men who have Sex with Men
NGO:	Non Governmental Organization
PMTCT:	Prevention of Mother to Child Transmission
PLHIV:	People living with HIV
SDPRP:	Sustainable Development and Poverty Reduction Program

SNNPR:	Southern Nations Nationalities and Peoples Region
STIs:	Sexually Transmits Infections
TB:	Tuberculosis
UN:	United Nations
UNAIDS:	The Joint United Nations Program on HIV and AIDS
UNESCO:	United Nations Education, Science and Culture Organization
UNHROHC:	United Nations Human Rights Office of the High Commissioner
UNICEF:	United Nations Children's Fund
USA:	United States of America
USD:	United States Dollar
VCT:	Voluntary Counseling and Testing
WHO:	World Health Organization

APPIENDICES

Annex A: Interview Schedule for Survey Respondents

No	Questions	Possible Responses	Move to No.→
Part one: Socio-Demographic Characteristics			
1	Age in years	Below 15 years ……1 15-19 years ……2 Don't know…..……99	
2	Sub City	Arada…….1 Yeka…….2 Bole ……..…3 Nefas Silk Lafto……4 Kolfe Kerane…….5 Adis Ketama…….6 Akaki Kaliti……7 Qirqos……8 Gullele……9 Lideta……..…10 Don/t know……99	
3	Have you ever been to school?	Yes…….……1 No…….2	→ 4 → 5
4	If your answer to question 3 is 'yes', what is the level of your education	Grad1-4…….1 Grade 5-8……..2 Grade 9-10…….3 Grade 11-12…….4 College/university dropout… ……5 College/university graduate……6	
5	Religion	Orthodox…….1 Islam…….2 Protestant ……3 Catholic……4 Other/Specify……5 No religion……6	
6	Ethnic Affiliation	Oromo…….1 Amahara…….2 Tigre…… Gurage……4 Sidama…….5 Wolayita……6 Hadya…….7 Kembata…..…….8 Gambella…..……9 Benishangul Gumuz…….10 Somale……..11 Afar……..12 Other /Specify/……13 Don't Know……99	
7	Have you ever been engaged in marriage?	Yes…….1 No…….2	→ 8-9 → 10

8	If your answer to question 7 is yes, where is the current address of your spouse?	Addis Ababa…….1 Out of Addis Ababa…….2 Don't know……99	
9	Do you have the plan to live together with your spouse, if you are not currently together?	Yes…….1 No…….2 Not decided…….3	
10	Is your mother alive?	Yes……1 No……2 Don't know……99	
11	Is your father alive?	Yes……1 No……2 Don't know……99	
Part two: Situation of Life on the Street			
12	Where had you been living before joining street?	Addis Ababa -Urban……1 Addis Ababa-Rural……2 Out of Addis Ababa-Urban……3 Out of Addis Ababa-Rural……4 Don't Know……9	
13	Had you been on street in other towns than Addis Ababa?	Yes.……1 No……..…2	
14	How long had you been on the street?	Less than 1 year…..……..1 1-2 years…….2 2-3 years…….3 3-4 years…….……4 4-5 years……..…5 5-6 years……..…6 More than 6 year…..…….7 Don't know/Don't remember……..……..99	
15	What was the cause/s for you to come out to the street ? *(responses can be multiple)*	Death of parents…….……1 Divorce of Parents……..…2 Conflict with family ……3 Family poverty……4 Search for job……5 Peer pressure……6 Other /please specify/….……7 Don't know……99	
16	How old were you when you began street life?	Below 7 years……..….1 7-9 years……2 10-12 years……..….3 13-15 years…….……4 16-18 years……..…..5 Above 18 years……6 Don't know/Remember……..99	
17	How had you been making a living while on the street? *(responses can be multiple)*	Casual Work……1 Street vending ……2 Shoe shinning……3 Car Washing……4 Begging……5 Theft……6 Other /Please Specify/……7	

18	What was your average daily income when you were on the street?	Below Birr 5.……1 5-10 Birr ……2 11-15 Birr ……3 11-20 Birr ……4 21-25 birr ……5 26-30 Birr……6 31-35 Birr ……7 Above Birr 35……8	
19	Living arrangement: How did you spend the night whon you were a street boy? *(responses can be multiple)*	Used to spend both the day & night on the street……1 Used to spend the night with family..……2 Used to live alone in a rented house.……..3 Used to live in group rented houses..……4 Other /please specify/……5	
Part three: Sexual History			
20	Have you ever had sex?	Yes…….1 No…….2	→ 21-25 → 26
21	If your answer for question 20 is "yes', how old were you at your first sex?	Below 10 years ……1 10-12 years ……2 13-15 years ……3 16-18 years ……4 Above 18 years old……5 Don't know/remember……99	
22	Whom you started your first sex with?	Girlfriend ……1 Spouse ……2 Female sex worker……3 Other/Please specify……4 Don't remember ……99	
23	How your first sex was initiated?	Own initiative/decision……1 Peer pressure ……2 As victim of rape ……3 Other /please specify……4 Don't remember……99	
24	Number of lifetime sexual partner?	Only one partner……1 2-5 partners……2 6-9 partners ……3 10-13 partners ……4 More than 13 partners ……5 Don't remember ……99	
25	Do you have regular sexual partners?	Yes……1 No……2	
26	Do you think that street boys practice homosexuality?	Yes……1 No……2 Not sure……3	→ 27-30 → 31
27	Have you ever come across with any homosexual street boy?	Yes……1 No……2	
28	Have you ever practiced homosexuality?	Yes……1 No……2	→ 29 → 31

29	If you answered question 28 is 'yes' how did you engage in homosexuality? *(responses can be multiple)*	Being raped by other …..……1 Committing rape ……..……2 Mutual consent with partner…..……3 Don't remember……..…99	
30	Which gender do you make sex with currently?	Only with same sex……1 only with opposite sex……..2 With both sexes……..…3	
Part four: Sexual Violence Against Street Boys			
31	Do you believe that street boys are victims of rape or other sexual violence?	Yes……1 No……2	→ 32 -33 →36
32	Have you ever come across with any street boy who was victims of rape?	Yes……1 No……2	
33	Have you ever encountered any rape or attempt of rape?	Yes……1 No……2 Don't remember ……99	
34	Have you ever committed rape in your lifetime?	Yes……1 No……2 Don't Remember ……99	→ 35 → 36
35	If your answer to question 34 is 'yes' on which gender did you commit rape?	On women/girls ……1 on boys ……2 Both genders……3	
Part Five: Use of Alcohol and Habit-Forming Substances			
36	Do you take alcohol drinks?	Yes……1 Not at all……2	→ 37 →38
37	If your answer to question 36 is 'yes', which alcohol do you often use? *(responses can be multiple)*	Local Beer /Tella/……1 *Filiter*……2 Areki /Home distled Liquer/……3 *Tej* ……4 Beer……5 Draft beer……6 Wine……7 Other /please specify/ ……8	
38	Do you have any practice of using habit-forming substances like Chat, Cigaret, Benzine, etc ?	Yes……1 Not at all……2	→ 39 → 40
39	If your answer to question 38 is 'yes', which substance/s do you often use? *(responses can be multiple)*	Chewing chat……1 Sniffing Benzine ……2 Sniffing Shisha……3 Smoking Cigarette……4 Other please specify ……5	
Part Six: Habits of Watching Pornographic Films			
40	Do you have any habit of watching pornography?	Yes……1 No……2	→ 41 →41-43
41	If your answer to question 40 is 'yes', how can you access the films? *(responses can be multiple)*	Small video house……1 Renting Video tapes……2 Using mobile phone apparatus ……3 Internet ……4 Other/ Please specify/……5	

42	Have you ever had sex due to the influence of sex film?	Yes……..…1 No……2 Don't Remember ……3	→ 43 → 44
43	If your answer to question 42 is 'yes', whom you often make sex with? *(responses can be multiple)*	With girlfriend……1 With commercial sex workers ……2 Committing rape ……3 Other /please specify/……4	
Part Seven: Knowledge, Awareness and Experience about STIs			
44	Have you ever heard about STIs?	Yes……1 Not at all…..……..2	→ 45-51 → 52
45	Would you please name a symptom/s of STIs what you know? *(responses can be multiple)*	Stomach ache……1 Unusual genital discharge…….2 Burning while urinating ….……3 Genital sore…..……4 Swallow around genitals…….5 Other/please specify/……6 Don't know…..…99	
46	Would you please mention the name of any STIs you know? *(responses can be multiple)*	Syphilis……1 Gonnoria……2 Chancroid ……3 HIV/AIDS.……4 Other/Please specify/……5 Don't know ……99	
47	Have you ever known any street boy contracted by any STI?	Yes……1 No……..2 I am not sure……3	
48	Have you ever been infected with any STIs?	Yes……1 No……....2 I am not sure……3	→ 49-51 → 52
49	If your answer to question 48 is 'yes', what was the name of the STIs you contracted with? *(responses can be multiple)*	Syphilis……1 Gonnoria……2 Chancroid ……3 HIV/AIDS.……4 Other/Please specify/……5 Don't know/remember……99	
50	Have you got medical treatment for the infection?	Yes……1 No……..2 I am not sure……3	
51	If not treated for the STIs, what was the reason? *(responses can be multiple)*	Not taking the problem as serious……1 Didn't know where to go for treatment……2 Financial problem……3 Being ashamed of……4 Other /Please specify/ ……5 Don't remember the reason.…….99	
Part Eight: Knowledge, Attitude, Practice and Behavior of about HIV			
52	Have you ever heard of HIV/AIDS?	Yes……1 No……..2	→ 53-83 → 69

53	If your answer to question 52 is 'yes', what is/are the source/s of your information about HIV/AIDS? *(responses can be multiple)*	Friends/peers……1 Family ……2 Health institutions…..……3 Radio/Television……4 Any print media……5 School……6 Church or Mosque……7 Other /please specify/……8	
54	Have you ever attended any HIV/AIDS Education?	Yes……1 No……..2 I am not sure……3	
55	Do you think that there is any difference between HIV and AIDS?	Yes……1 No……..2 I am not sure……3	
56	How HIV is transmitted from one person to another? *(responses can be multiple)*	Sexual Contact ……1 Using unsterilized sharp materials contaminated by HIV……2 From HIV mother to a child ….....……3 Through transfusion of infected blood……4 Other /please specify/……5 Don't know……99	
57	What are the ways of preventing the spread of HIV? *(responses can be multiple)*	Use of condoms ……1 Abstinence ……2 Being faithful to sexual partners……3 Not using contaminated sharp material…….. 4 Prevention of mother to child transmission…5 Other /please specify/……6 Don't know……99	
58	Do you think that HIV can infect everyone regardless of age, sex, color, wealth, etc?	Yes……1 No……..2 I am not sure……3	
59	Do think that it is possible to determine if a person is HIV positive or not by observing his/her physical conditions?	Yes……1 No……..2 I am not sure……3	
60	Do you think that AIDS has a cure?	Yes……1 No……..2 I am not sure……3	
61	Do you think that AIDS is a killing diseases?	Yes……1 No……..2 I am not sure……3	
62	Have you ever discussed about HIV/AIDS with friends or family members?	Yes……1 No……..2 I am not sure……3	
63	Have you ever discussed about HIV/AIDS with your sexual partner/s?	Yes……1 No……..2 I am not sure……3	
64	What is/are the way/s of knowing one's HIV status? *(responses can be multiple)*	Observation of the person's physical conditions...1 Blood testing ……2 Other/please specify/……3 Don't know……99	

65	Have you ever undergone HIV testing?	Yes……1 No…..……..2 I am not sure..……3	→ 66-60 → 72
66	If your answer to question 65 is 'yes', when did you make the testing?	During the last six month……1 During the last one year…..……2 Before a year……3 Don't t remember the time……4	
67	Have you received or known your HIV test result?	Yes……1 No……..2 I am not sure……3	→68-69
68	Are you willing to tell your HIV test result?	Yes……1 No……..2	
69	If your answer to question 68 is 'yes', what was your HIV test result?	HIV Negative……..1 HIV positive ……..2	
70	If never been tested for HIV, what was the reason/s? *(responses can be multiple)*	Being afraid of knowing the result……1 Lack of information as to where to go for testing…2 I did not give my attention to HIV/AIDS……3 I don't perceive myself as vulnerable to HIV..…4 Other /please specify/…….5	
71	Do you want to be tested for HIV in the future ?	Yes……1 No……..2 Have not decided……3	
Part Ten: Attitude towards People Living with HIV/AIDS			
72	Are you willing to share the same dish with HIV positive people?	Yes……1 No……..2 I am not sure……3	
73	Are you willing to shake hands with HIV positive people?	Yes……1 No……..2 I am not sure……3	
74	Are you willing to be taken care of or served by HIV positive people?	Yes……1 No……..2 I am not sure……3	
75	Are you willing to provide care and nursing an HIV positive family members or a friend?	Yes……1 No……..2 I am not sure……3	
Part Eleven: Self-Risk Perception			
76	Do you think that street boys are at risk of HIV/AIDS?	Yes……1 No……..2 I am not sure…..……3	
77	Have you ever come across with any HIV positive street boy?	Yes……1 No……..2 I am not sure……3	
78	Do you think that there were possibilities for you to be infected with HIV?	Yes……1 No……..2	→ 83
79	If your answer to question 71 is 'yes', what are the reasons for your perceived risks to HIV infection? *(responses can be multiple)*	Having ever had sex with multiple partners…….1 Having had sex without condoms…….…2 Suspect of sexual partner being unfaithful…….…3 Having ever used sharp materials that might have been contaminated with HIV ……4 Other /Please specify/…….5	

Thank you for your time and important information!

Annex B: Focus Group Discussion Schedule/Checklist

- **Introduction**
- **Discussion**

1. Sex and sexuality of male street children and youth

- How male street youth satisfy their sexual needs?
- Who are the most common Sexual partners of male street youth?
- To what extent homosexuality is practiced among male street youth?
- How male street youth start homosexuality?
- Do you think male street youth encounter sexual abuse such as rape?
- Who are the perpetuators of sexual abuse against male street youth?
- Do you think that male street youth watch pornography?
- What effects do you think pornographic films have on the sexual behavior of male street youth?
- Do you have any story of your own or that of your peers to tell me about homosexuality, sexual abuse, pornography & other related issues?

2. Alcohol and substance abuse

- Do you think male street youth are exceptionally exposed to alcohol consumption and substance abuse? Why?
- What are the most common substances used by male street youth
- Do you have any story of your own or that of your peer/s to tell me about alcohol consumption and /or substance abuse?

3. Sexually Transmitted Infections (STIs)

- Can you tell me what do you know about STIs?
- Do you think male street youth are vulnerable to STIs? Why?
- Do you have any story of your own or that of your peer/s to tell me about sexually transmitted infections?

4. HIV and AIDS

Knowledge and awareness about HIV and AIDS

- To what extent male street youth are aware of & knowledgeable about HIV & AIDS?
- What are the main sources of HIV information for male street children?
- Do you think that male street children have comprehensive knowledge about the modes of HIV transmission and prevention mechanisms? Why?
- Can you tell me any different or similarity between HIV and AIDS
- Do you think male street youth are being reached by HIV prevention and care services? Why?

HIV Testing

- To what extent male street youth are testing for HIV?
- What are the factors that either encourage or discourage male street youth to HIV testing

Use of condoms

- How do you judge the level of using condoms by male street youth?
- Why and under what circumstances male street youth fail to use condoms consistently?
- Do you have any story of your own or that of your peer/s to tell me about condom use?

Self-perception of vulnerability to HIV

- Do you think that male street youth are vulnerable to HIV infection
- What are the risk factors for HIV infection among male street youth?

What do you suggest to minimize the risk of HIV infection among male street youth? (10min)

Annex C: Key Informant Interview Guide/Protocol

1. To what extent street children in Addis Ababa are Vulnerable to HIV/AIDS?
2. Is there any established rate of HIV Prevalence among street children in AA?
3. What factors contribute to the vulnerability of Street Children in Addis Ababa?
4. To what extent street children are considered/recognized as high risk groups?
5. Are there any specific HIV/AIDS programs specific to Street Children?
6. What strategies and approaches are being used to address this risk groups?
7. Who is doing what on HIV/AIDS and Street Children in AA?
8. What has been achieved as the result of the intervention?
9. Does your office believe that the Issue of HIV/AIDS in street children is being addressed at satisfactory level?
10. Any other issues to be shared in relation to the topic.

Appendix D: Observation Schedule

- Conducting overall grand tour observations of each sub city in Addis Ababa

Appendix E: Documentary Analysis Template

- The concept of streetism and HIV/AIDS
- Global, regional, national and local levels: magnitude of street children and HIV/AIDS
- Vulnerability, Impact and Responses to HIV/AIDS, and Street Children
- Knowledge, Attitude, Behaviour and Practice among the Street Children
- HIV infection Risk Levels in different Contexts
- Contributory Factors to HIV/AIDS and related issues
- Interventions of the Rehabilitation Project to the lives of the Street Children
- Other Relevant Issues

CHAPTER ONE

INTRODUCTION

The World has faced with a number of problems such as poverty, HIV/AIDS, climate change, food insecurity and TB, but just to mention some. More than three decades, the epidemic of HIV/AIDS has been one of the critical problems which challenges the efforts of development at individual, family, community, national and global levels. Based on 0.8% prevalence rate, UNAIDS (2014) estimates that there were 35 million people living with HIV worldwide at the end of 2013.

In Africa, the Sub-Saharan Region is found to have a significant proportion (70.0%) of the World's new HIV infection occurred in 2012. It also accounted for seventy-four percent of AIDS related deaths in 2013 (UNAIDS, 2014). In 2013, there were an estimated 793,700 people living with HIV in Ethiopia; with approximately 45,200 AIDS related deaths; about 898,400 children orphaned by AIDS and an estimated 2.3% of young people aged 15-24 years were HIV positive across the country in 2012 (FHAPCO, 2014).

Much is not known about the degree of vulnerability of street children and youth to HIV and AIDS, yet they deserve more attention. Moreover, available few studies on street children and HIV/AIDS were conducted using sociological, psychological and public health orientations and perspectives. This means that there is little or no conclusive social work research on the vulnerability of street children and youth to HIV/AIDS.

Nevertheless, street children and youth are believed to be among those groups of young people who are considered as especially vulnerable to HIV. The increased vulnerability of street children and youth to HIV/AIDS resulted from their lack of understanding of the changes associated with adolescence, the lack of knowledge and skills which could help them to make healthy choices and their inability to access the appropriate services (Fuad Ismayilov, Suad Hasanzadeh and Nurlana Aliyeva, 2007).).

Scholars and professionals from different field of study in different parts of the world tried to study one aspect or other in relation to street children and HIV/AIDS. For example, Kidist Negash (2007) concludes that street children are at high risk of HIV infection given their often engagement in unprotected sexual intercourses under the influence of alcohol drinks and substances along with their low perception of having risk of acquiring HIV/AIDS. Besides, adolescents in general are a group of people that could be regarded as "most at risk" groups.

However, street children have been largely ignored in the fight against HIV/AIDS. While some initiatives exist, the nature of street life probably has not allowed effective interventions to be implemented. A study conducted in Hawassa found out that 64.5% of the street children in the town did not attend any kind of health education programs including HIV/AIDS awareness (Solomon Soressa, Tesfaye Kidane Mariam and Lopiso Erosie, n.d). Although a number of studies on street children, from different perspectives, their conclusions remain inconclusive on their vulnerabilities in various socio-cultural and economic contexts. Therefore, it is imperative for social work research to explore or assess

the vulnerability of male street children and youth to HIV/AIDS in Addis Ababa through social work practice perspectives.

Although there are no updated and recent data available, limited sources provide varying figures on the number of street children in Ethiopia. The Ethiopian Ministry of Labour and Social Affairs (2007) estimates the total number of children and youth at 150,000; among them, about 60,000 were living in Addis Ababa. The data generated from another sources estimate that there are between 150,000 and 200,000 children living and working on the streets (UNICEF, 2011). Habtamu Wondimu's Study (as cited in Heinonen, Paula Maria Luisa, 2000) noted that in Ethiopia, 75% of street children, aged 9 and above were boys. This is one of the justifications for designing the study by focusing on male street children and youth.

Despite their reasonable number and high degree of vulnerability, street children and youth are not believed to have been adequately addressed by HIV prevention and impact mitigation programs due to different factors, including lack of targeted interventions and isolation of the street children or youth from the mainstream community.

It is, therefore, appropriate to examine the level to which street children and youth are at risk of HIV as compared to the general population of the same age group. The data generated from this research will serve as inputs for policy formulation, program design and implementation, doing evidence-based advocacy, and undertaking further research on

the subject matter. The research also fills the existing gap in recent data with regard to street people and their vulnerability to HIV and AIDS.

1.2. Statement of the Problem

Street children and youth have mostly been overlooked in the fight against HIV in urban metropolis in Ethiopia. The nature of their life on the streets and their risky behaviors may put them at state of vulnerability to HIV/AIDS and related problems (like sexual exploitations and STIs). This is due to various factors which include low knowledge level of STIs and HIV?AIDS, high risk sexual practices, lack of safer places to spend their nights, rendering them vulnerable to sexual abuse and use of sex as means to secure protection and to be accepted, especially for the new comers to the streets to eke out their daily life.

Although a number of countries in Africa have implemented successful interventions to ameliorate the multi-faceted problems of street children and youth, in Ethiopia the efforts to address these problems have been limited. Therefore, there are complex factors that have coalesced to create a socio-economic and cultural climate conducive to the persistence of street children and youth. The survival of street children is substantially defined by severe socio-economic instability and deprivation leading to high risk coping strategies.

Street children are also involved in inhalant abuse; this combined with risky sexual behaviour and vulnerability to diseases makes them one of the most ostracized and marginalized social groups in the City of Addis Ababa. Therefore, those multi-dimensional problems related to street children and young people have made the difficult social

phenomena in the City. Here, one may pose questions related to their vulnerability levels, multi-faceted factors, their knowledge, attitude, and practice with regard to HIV and AIDS.

1.3 Research Questions

This research aims at answering the following key questions:

- What is the level of knowledge, attitude and practice of male street children and youth about HIV and AIDS?
- What is the degree of vulnerability of male street children and youth to HIV/AIDS in Addis Ababa?
- What are the most common factors that have put male street children and youth into the risks of HIV infection?
- To what extent, have male street children and youth been addressed in the HIV/AIDS programmes implemented by different actors in Addis Ababa?

1.4 Research Objectives

In order to answer the above-stated research questions and to achieve its purposes, this research aims at examining the relationship between street life and vulnerability of male street children and youth to HIV/AIDS in Addis Ababa. Specifically, it intends to:

i. Investigate the level of knowledge, attitude and practices of male street children and youth regarding HIV and AIDS;
ii. Examine the extent to which male street children and youth are at risk of HIV infection;

iii. Identify risk factors that would increase the vulnerability of male street children and youth to HIV and AIDS; and

iv. Assess the extent to which street children and youth are being addressed in the HIV/AIDS programmes implemented by different actors.

1.5. Operational Definition of Key Terms

- **Alcohol/Substance abuse:** It is a behavior and practice of using such stimulants and any sort of alcohol, chewing chat, sniffing benzene and glue, smoking which adversely influence the user to take informed decisions on matters related to his/her sexual life.

- **Comprehensive Knowledge:** Comprehensive knowledge means knowing that abstinence, consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV/AIDS. It also includes knowledge of all possible routs of HIV transmission.

- **Consistent use of condom:** It is a determination and practice of using condoms regularly and properly whenever having sex by the study participants.

- **HIV risk behavior:** A high risky behavior can be defined as a practice or habit of individuals or certain group of people which increases the likelihood of acquiring HIV. This may include unprotected sex, having multiple sexual partners, use of drugs, alcohol or other substances, frequent and unprotected sexual relation with sex workers and exposure to sexually transmitted diseases.

- **Living arrangement:** This term describes the condition how the study participants as street boys used to spend the night: with families, with group home, on the street or at the compounds of institutions such as churches and mosques, etc.

- **Male Street children and Youth:** For the purpose of this study, male street children and youth refer to those yang males aged 15-24 who until recently had been on the street, but currently admitted to a socio-economic rehabilitation project by Addis Ababa City Administration Labor and Social Affairs Bureau.

- **Number of Life time partner:** This term is used to know the total number of persons, mainly women with whom a respondent have had sex so far, until the date he completed the questioner for this study.

- **Orphanhood status:** The term orphanhood status is used in this study to describe the extent to which participants of the study have lost either one or both of their parents due to any cause of death.

- **Pornography films**: In this study, pornography films are defined as those movies, having sexual acts and intentions that trigger the desire for sex.

- **Rehabilitation Project:** It is a project initiated and implemented by the Labor and Social Affairs Bureau of Addis Ababa City Government towards ensuring the social and economic rehabilitation of young street people (both male and female) through cobblestone production. Respondents of the study are randomly drawn among this group of young people involved in the project.

- **Self-Reported HIV Status:** This concept refers to the HIV status of the respondents as reported by the person himself in the survey questionnaire. No proof or evidence is requested to validate the respondent's self-report on his HIV status.

- **Self-Reported STI infection:** It describes a situation whereby a respondent of this study has ever been infected with any sort of sexually transmitted diseases in his lifetime, excluding HIV/AIDS as reported by the person himself in the survey questionnaire.

1.6. Limitations of the Study

There are some limitations in the study which emanated from lack of clinical HIV test on the study participants, exclusion of street girls in the study, retrospective responses and the sensitive nature of the study. One of the purposes of this study is to assess the extent to which male street children and youth in Addis Ababa are exposed to the risk of HIV infection. However, the study is based on analysis of vulnerability factors and risk behaviors as well as self-reported HIV status of the study participants without undertaking any clinical HIV testing on the study group. The self-reported positive HIV status of some sample street children and youth have not been verified with medical certificates or other evidences. Thus, it could be difficult to establish an estimate on the rate HIV prevalence among the study population based on the data from this research. This limitation leads to a suggestion to conduct a clinical study that involves HIV testing among the study group.

The study exclusively targeted male street children and youth who recently abandoned street life and admitted to a socio-economic rehabilitation project. This is because of the fact that girls constituted insignificant proportion (1%) of the total number of street

children and youth involved in the rehabilitation project at the project site. Therefore, as extremely small number of girls is unlikely to be representative and lacks power for statistical analysis, the research focuses exclusively on boys and thus gender is not taken as a variable for the study. Although the exclusion of female street children and youth was made with the reason mentioned above, this may, on the other hand, be taken as a limitation of the study since it failed to cover certain group of the street children population.

The data for this research was collected some two months after the study group left streets and joined the socio-economic rehabilitation project. This means, the study participants were in a rehabilitation center but not any more on the streets. They were asked to tell the researcher what they remember about their past, but very recent lives and experiences on the streets. Although they had still fresh memory and even behavior of street phenomena, certain retroactive responses of the study participants may not be as accurate as the responses given on the spot. There could have also been respondents who did not have much interest in talking about their past experiences. In the opinion of the researcher, this might have limiting the data quality to a certain extent.

The subject matter of the study involve certain issues which are considered as sensitive to openly discuss about in the context of many Ethiopian cultures. Being part of these cultures and as any human being in general, there is a concern that the study participants might not have genuinely responded to some of the survey questions related to their sexuality as well as HIV/AIDS and other private issues. For example, some respondents

were reluctant to disclose their HIV status and some others were not happy to talk about homosexuality. These might have adversely affected the accuracy and quality of the data.

1.7 Organization of the Thesis

The research report is organized in five chapters. The first chapter presents the introduction part which deals with background of the study, statement of the problem, the research questions, objectives of the study, operational definitions of key terms, limitations of the study and the organization of the thesis. Chapter two presents and highlights review of related literature on concepts and empirical evidences on street children and youth and their vulnerability to HIV/AIDS. The third chapter deals with the design and methods. It describes about the research design and methods, study population, sample size, sampling methods, data collection tools and analysis. The fourth chapter presents the results of the study including data on the socio-demographic characteristics of study participants focusing on profile as well as socio-cultural background of male street children and youth who participated in the survey. This chapter discusses about the findings focusing on the sexual history, knowledge, attitude and practice about HIV/AIDS and STIs and HIV risk factors among the study participants. The fifth chapter, finally, tries to summarize main issues in the research. Based on the findings of the research, conclusions are drawn to answer the research questions and address those objectives of the study. In the end, those conclusive pieces of thematic findings will be drawn and put together which serve as social work practice and perspectives to suggest for professional interventions and/or networked refer to the necessary services and support.

CHAPTER TWO

REVIEW OF LITRATURE

2.1. Introduction

As already mentioned, the present study intended to assess the vulnerability of male street children and youth to HIV/AIDS in the City Government of Addis Ababa. Therefore, this chapter deals with review of available literature on HIV/AIDS in general and vulnerability of street children and youth to the epidemic in particular in the global and the Ethiopian contexts. It also aimed at supplying the current study with relevant background information from previous studies on the issues under investigation.

By reviewing the available literature, this chapter presents information on such specific issues as the global and the regional prevalence and consequences of HIV/AIDS with the review of the HIV/AIDS epidemic in Ethiopia. The chapter also reviews available literature on the state of street children and youth globally and in Ethiopia, and their levels of vulnerability to HIV/AIDS in relation to their sexual behaviours and other risk factors.

2.2. Global HIV/AIDS Epidemic and Its Effects: Overview

Since AIDS was first detected some three decades ago, it remained to be a worldwide epidemic and as one of the most challenging problems of the 21st century. Globally, there were an estimated 35 million HIV positive people with 1.5 million AIDS related deaths at the end of 2013 worldwide, according to UNAIDS (2014). The same source documents, in Western and Central Europe and North America, there were 2.3 million people living

with HIV; 27,000 AIDS-related deaths and 88,000 new HIV infections in 2013. The USA experiences the highest rate of HIV prevalence, constituting 56.0% of people living with HIV in the region. In the USA, the majority of new infection occurs among gay men and African-American heterosexual women.

In Eastern Europe and Central Asia, the number of people living with HIV covers 3.0% of the total HIV-positive population worldwide. The Report of UNAIDS also reveals that the HIV epidemic in Eastern Europe and Central Asia continues to grow with the highest prevalence in the Russian Federation and Ukraine. Those injected drug users, gay men and sex workers are the most vulnerable groups (UNAIDS 2014).

In Western and Central Europe, on the other hand, those injected drug users and their sexual partners, trans-gender people, prisoners, migrants and sex workers are the most affected groups. The Regional HIV rate of prevalence among the general adult population in Latin America is estimated at 0.4%, with a total of 1.6 million people living with HIV in 2013. More than one-third of new infections occur among young people aged 15–24 years. Gay men, trans-gender women, male and female sex workers and injected drug users are among the key populations most vulnerable to HIV. The prevalence of HIV among trans-gender women in Latin America is more than 49 times higher than the prevalence rate in the general population (UNAIDS, 2014).

Next to Sub-Saharan Africa, Asia and the Pacific Region is a part of the World most affected by HIV/AIDS with 4.8 million HIV-positive populations. Sex workers and their clients, men who have sex with men, trans-gender people and people who inject drugs are

the groups most affected by the epidemic. HIV prevalence rate among gay men and female sex workers together with widespread practice of drug uses and multiple sexual partnership are the major factors for the spread of HIV in the Region (UNAIDS, 2014).

According to UNAIDS (2014), the Caribbean still constitutes quite insignificant proportion (only 0.7%) of the global HIV positive population, yet infection rates (1.1%) remains high. In 2013, there were an estimated 11, 000 AIDS-related deaths and 12,000 new infections. Men who have sex with men experience high levels of HIV prevalence throughout the Region. In Jamaica, for example, one in every three gay men is living with HIV.

The Middle East and North Africa is characterized by the lowest HIV prevalence (UNAIDS, 2014). However, the impacts of the epidemic are still huge as the numbers of AIDS related deaths are increasing in many countries of the region. Injected drug use is one of the factors contributing to the spread of the virus in the Region. Those injected drug users, men who have sex with men and migrants constitute the key populations with high risk for HIV.

The prevalence and impact of HIV are declaiming since recent years in many parts of the world. Globally, new HIV infections and AIDS related deaths have declined by 13.0% and 19.0% respectively in the past three years (UNAIDS, 2014).

However, there are still growing concerns with the emerging sexual behaviours of young people which would aggravate HIV. Michel Sidibe expresses, “although several countries

registered significant decline in new HIV infections, the growing emergence of sexual risk behaviour among young people are challenging these achievements (UNAIDS, 2013).

According to the same source, only fifteen countries of the World (ten countries from Africa, including Ethiopia) account for three-fourth of all HIV positive people and seven of the ten African countries are from the Sub-Saharan Region of the continent.

As a region most affected by the epidemic, the Sub-Saharan Africa with an estimated 24.7 million HIV positive people, is a home for 70.6% of the global HIV positive population three-fourth ADIDS related deaths occurred in 2013 (UNAIDS). Within the Sub-Saharan Africa, Eastern and Southern Africa are the most affected sub-Regions where nearly half of the global HIV positive people were living. In these sub-Regions, there were 17.1 million people living with HIV, 1.2 million new HIV infections and 0.8 million AIDS-related deaths in 2011. During this year, more than half and over one-third of the global new HIV infections among children (1-14 years) and young people aged 15-24 respectively occurred in those sub-Regions. Unprotected heterosexual intercourse is generally noted to be the major mode of HIV transmission in Eastern and Southern Africa (UNAIDS 2013).

Like the cases with many parts of the world, HIV prevalence has been declining in the Eastern and Southern Africa. For example, thirty percent of reduction in new HIV infections was registered between 2001 and 2011 in the sub-Regions. However, knowledge of young men and women about HIV/AIDS is still considered low (UNAIDS, 2013).

2.3 HIV Epidemic in Ethiopia: Prevalence, Impacts, Responses and Challenges

Since 1986, when the first AIDS case in Ethiopia was reported (FHAPCO, 2012), the epidemic has been continuing as a major public health and development challenges of the country. Ethiopia is one of the ten Sub-Saharan African countries significantly contributing to the high rate of HIV prevalence in the Region (UNAIDS, 2014).

Based on HIV related estimates and projections by EHNRI (2012), slightly more than 87.0% of HIV positive in the country's population were living in the City Government of Addis Ababa (11.6%), and the prevalence rate in Amhara (25.8%), Tigray (7.7%), Oromia (28.4%), and SNNP (7.7%). The same document also reveals that the highest HIV prevalence rate (6.8%) is reported in Gambella Region, followed by Addis Ababa (5.2%) and Dire Dawa (4.0%). According to CSA (2011), the first three lowest HIV prevalence rates (0.9%, 1% and 1.1%) were registered in the SNNP, Oromiya and Somali Regions respectively.

As indicated above, the City Government is identified as one of the Regions with the highest HIV prevalence (5.2%). The City hosts 18.2% of the total urban and 11.6% of the National HIV positive population of the country. There were an estimated 91,682 HIV positive people living in the City with 2,154 new HIV infections and 4,532 annual AIDS related deaths in 2012. During the same year, there were a total of 28,261 children (aged 0-17 years) orphaned by AIDS which accounted for 52.4% of the total orphan population of the City (EHNRI, 2012).

The high rate of HIV prevalence in Addis Ababa is associated with labour migration and large scale construction projects, as well as a growing service industry in the City (FHAPCO, 2014). A literature review on migration in Ethiopia by Hunnes (2012) reveals that Addis Ababa is growing rapidly, partly due to rural-urban migration.

Studies indicate almost all Ethiopians have ever heard of HIV. However, it is only 24.0% of young women and 34.0% of men aged 15-24 years who were reported to have comprehensive knowledge about AIDS. Young women and men living in urban areas have better knowledge about HIV/AIDS than those living in rural areas. At National level, 36.0% of women and 38.0% of men tested for HIV (CSA, 2011).

Reviewing the knowledge and the practice, as well as sexual behaviour of young people (15-24 years) in Ethiopia is particularly important for the present study as it deals with a group of young people in the same age category, but living in different circumstances. A table below presents important data extracted from the recent EDHS Report in relation to HIV/AIDS and young people in Ethiopia.

Table 2.1: Major HIV indicators among young people (aged 15-24 years) by gender in Ethiopia

Indicators	Percent (%)	
	Women	Men
who never had sex	91.4	84.8
who started sex before the age of 15	11.6	1.3
who started sex before the age of 18	42.2	14.0
with two and above life time sexual partners	0.4	2.1
who ever had transactional sex with commercial sex workers	-	1.5
who consumed alcohol during last sexual intercourse	0.6	3.1
who chewed Chat/Kat during last sexual intercourse	3.6	14.7
with self-reported STIs infections	0.7	1.9
who ever heard of HIV/AIDS	96.4	98.0
who believe consistent & appropriate use of condoms prevent HIV	61.6	80.7
who used condoms at their last sexual intercourse	-	47.0
who assert that HIV can be prevented by limiting sexual partner into one uninfected person & using condoms properly	48.5	64.7
with comprehensive knowledge about HIV/AIDS	24.0	31.8
ever tested for HIV and received results	37.3	32.0
who tested for HIV Positive	0.6	0.2
who believe a healthy looking person might have acquired HIV	67.0	77.0
who were willing to care for a family member with HIV/AIDS	83.1	91.6

SOURCE: Ethiopian Demographic and Health Survey Report, 2011 (CSA, 2011).

In general, the gap between knowledge and behaviour was reported to be a common problem across different population groups in Ethiopia, reflected in low condom use, inadequate utilization of HIV counseling and testing as well as PMTCT services, and high level of stigma and discrimination.

There are a range of behavioural, socio-cultural and economic factors which are believed to exacerbate the spread of HIV/AIDS in Ethiopia. These include lack of comprehensive knowledge about HIV/AIDS, low self-risk perception, increased population migration, unprotected sex with multiple partners in a concurrent manner, intergenerational and transactional sex, high prevalence of STIs, alcohol and substance abuse, gender inequality, traditional harmful practices and poverty in general (FHAPCO, 2010a).

Based on a desk review on the drivers of HIV/AIDS epidemic and responses in Ethiopia, Getnet Mitike and Melese Tamiru develop a conceptual framework of factors affecting the spread of the epidemic in Ethiopia. According to the framework, the factors are classified into two major categories: underlying and immediate factors. The underlining factors are related to socio-cultural, economic, demographic and policy issues. Immediate factors are also concerned with behavioural and program factors which lead to sexual practices of individuals as key determinants of HIV epidemic in the country.

The impact of HIV/AIDS in Ethiopia is huge. AIDS has been recognized as the leading cause of adult morbidity and mortality in the country. In 2013, there were approximately 45,200 AIDS deaths throughout the country (FHAPCO, 2014). The other impact of HIV/AIDS is also reflected in the growing number of children orphaned by AIDS. There

were an estimated 429,860 children orphaned by AIDS, accounting for 52.0% of the total number of orphans in the country (EHNRI, 2012). Studies indicate that HIV/AIDS has had impacts on the livelihoods and food security of HIV affected households by creating higher dependency ratio and reducing household income (FHAPCO, 2010b).

HIV also has a sector wide impact affecting the agriculture, education, business and industry, and health sectors in Ethiopia. The fact that HIV prevalence is increasing in rural areas where about eighty-three percent of Ethiopians lives, has significant impact on the agriculture sector. The epidemic is also affecting the education sector by reducing the supply of teachers and school enrollment, and increasing dropout rates.

The morbidity and mortality resulting from HIV/AIDS reduced productivity, shortage of skilled human resources, increased absenteeism and rising medical costs for the industry sector. The impact in the health sector can also be seen in terms of the increased number of patients seeking medical care for HIV/AIDS related illness and opportunistic infections, burdening the already limited health care system of the country (Ethiopian AIDS Resource Center, 2005).

In Ethiopian context, there are specific groups vulnerable to HIV Infections. These high risk groups include: female sex workers, mobile workers, university and high school students, truck drivers, uniformed services (police and armed forces), sero-discordant couples and prisoners (FMOH, 2014). Street children were also identified as one of the most –at-risk populations (FHAPCO, 2010b).

Getnet Mitike and Melese Tamiru further identify four areas of HIV/AIDS risk network, namely, most at risk populations/groups, potential risk groups, risk conditions and hotspots. **Most at risk populations/groups** include female sex workers, in- school and out-of-school youth, uniformed service people, long distance drivers, cross-border and displaced populations, war affected people, and vulnerable women and adolescents. **Potential risk groups** are daily labourers, street children, merchants, migratory workers, teachers, rural administrators, men having sex with men, and uncircumcised males. **Risk conditions** include multiple sexual partnerships, non-use of condom, mobility, displacement, migration, commercial sex, alcohol abuse and drug use, sexually transmitted infections and harmful traditional practices. **Hotspots** include bars and hotels, streets, nightclubs and red-light houses, major cities/towns, small towns, market places, ceremonial occasions, long-distance transportation corridors, truck stop towns, road construction sites, coffee plantation areas, and agro-industries.

Data is hardly available with regard to the size of the population and magnitude of vulnerability to HIV among injected drug users (IDUs) and men who have sex with men in Ethiopia (FHAPCO, 2014).

Various measures have been taken by various actors mainly the government and civil society organizations to reduce the spread of HIV and mitigate its impacts in the country. The measures taken by the Ethiopian Government focused on formulation of policies and strategies, program designs, as well as putting in place institutional arrangements to HIV/AIDS response. The policies and strategies have been translated into actions through implementation of different programs at national level. On top of the above-stated

Government's measures, large number of local and international civil society agencies, faith-based organizations, community-based institutions, youth clubs and associations, associations of people living with HIV, networks and forums and the private sector have been actively involved in the HIV response (FHAPCO, 2010a, 2010b and 2014).

According to FHAPCO (2010), the following achievements have been registered as the result of the National HIV/AIDS response.

- Ignited public movement against HIV/AIDS deployment of over 30,000 health extension workers into all rural Kebeles of the country;
- Accelerated expansion of primary health care facilities with decentralization of HIV/AIDS services;
- Increased expansion of free ART program which improved the survival and quality of life for AIDS patients; and
- Mainstreaming of HIV/AIDS into core activities of public sectors, non-government and private sector organizations.

Encouraging results are being registered over the years in the HIV responses of Ethiopia. Recent reports show that Ethiopia is one of the sub-Saharan countries with more than 25.0% decline in new HIV infections (FHAPCO, 2012). UNAIDS (2013) reports that Ethiopia was included in the list of nations where new annual HIV infections declined by more than fifty percent since 2001.

While the above-mentioned results are considered as important milestones, there are still gaps and challenges in the fight against HIV/AIDS. The Federal HAPCO (2012) expresses its concern that HIV infections can expand to a newer population groups and

geographic areas in the country. The National Office in 2014 documents the following major challenges in the fight against HIV/AIDS:

- Limited scale and coverage of targeted interventions for key populations;
- Unsatisfactory coverage of PMTCT and low access to early infant diagnosis;
- Dependence on donors for direct HIV investment ;
- Emergence of new at risk populations, and inadequate intervention for the most at risk populations;
- Gender inequalities and power imbalances contribute to women's vulnerability; and
- Stigma and discrimination against people infected and affected by HIV/AIDS.

2.4. The State of Street Children and Youth: Global Overview

There are various definitions of the term 'street children' given by different international agencies. According to UNICEF's definition, street children are classified into three categories: (a) children who reside in the street, (b) children who work in the street and go back to their families at night, and (c) children from street families (UNICEF, 1997). In this definition, street children are generally categorized as children on the street and children of the street. Inter-NGO Group (as cited in DCI-PS, 2005) defined a street child or youth as any girl or boy who has not reached adulthood for whom the street has become her or his habitual residence and/or sources of livelihood, and who lack adequate protection, supervision and direction by responsible adults. This definition is considered as the most cited definition of the term street children.

In addition there is no universally agreed number of street children worldwide. An estimate of UNICEF (2002) put the numbers of street children around the world at 100

million. However, after few years, on its annual report on the State of the World's Children, UNICEF (2005) indicates that it is impossible to quantify the number of street children, albeit the figures are rapidly increasing across the world. Elena Volpi (2002) argues that all estimates on the number of street children should be used carefully and with caution as taking census of street children is so complex task and the results are often uncertain.

Various studies reveal that the numbers of street boys are greater than that of girls in many instances. In Bamako, 96.0% of street children were boys (Hatloy and Huster, 2005). Moreover, the great majority of street children are male is unrecognized since they are referred to as 'street children' and not street boys. Street children are really street boys. However, there are few exceptional cases where the proportion of female street children is larger than that of males. One example is the case of Accra, Ghana, where three –fourth of the street children were reported to be girls (Hatloy and Huster, 2005).

With regard to age distributions, the majority of street children globally are aged 10 or older. Many of them do not go to school or perform poorly with high risk of terminating school (Volpi, 2002). A study in Palestine associates the street children phenomena with dropping out of school (DCI-PS, 2005).

The flow of children into the streets depends on changes in socio-economic and political contexts, as well as availability of protection services and patterns of urbanization. Rapid urbanization, growing global population, increasing inequalities and migration can be mentioned are some of the socio-economic and political contexts (UNHROHC, 2012).

The phenomenon of street children can also be caused by the weakening of traditional social bonds and coping mechanisms, changes in the role and structure of the family (AFD, 2012). A study conducted in Palestine in 2005 documents such factors as economic poverty at family level, poor child-parent relation, migration, failure in schools, war and natural disasters as the major causes for street children phenomena (DCI-PS, 2005). The role of HIV in aggravating the street children phenomena is also documented. About eighty percent of street children in Malawi were orphaned by HIV/AIDS (Mandalazi, Banda and Umar, 2013).

2.5. The Situation of Street Children and Youth in Ethiopia

Limited sources provide conflicting figures on the number of street children in Ethiopia. The Ethiopian Ministry of Labour and Social Affairs (2007) estimates the total number of street children at 150,000 of which 60,000 living in Addis Ababa. UNICEF (2011), on the other hand, estimates their numbers between 150,000 and 200,000 children to have been living and working on the streets of urban centers in Ethiopia. According to an IRIN (2004), there were nearly 600,000 street children in the country and 100,000 of them were living in Addis Ababa. In any of the estimates, the number is considered to be significant.

As the case with most parts of the world, the numbers of street boys in Ethiopia is larger than that of girls. According to a study conducted on 998 street children by Kdist Negash (2007) in Adma town, 77.1% of the study participants were boys. Still another study conducted in Adama revealed girls constituted only 16% of the street children in the town (Kibrom Berhe, 2008). Similar finding was also documented in Addis Ababa and

attributed to the fact that boys have more opportunity for work and leisure in the street than girls (Heinonen, Paula Maria Luisa,2000)

The major factors for the phenomenon of street children in Ethiopia were identified to be poverty, family disintegration, neglect and violence at home, lack of educational opportunities, death of parents and sexual violence (FSCE, 2003). Heinonen Luisa (2002) also identify family's circumstances as the major causes for children to leave families for streets. In his assessment of Street Children and Orphans in Ethiopia, John Williamson (2000) notes poverty, drought, HIV/AIDS, war, and family violence as the leading factors for the phenomena of street children in the country.

Studies indicate that many of the street children in Ethiopia are orphans who lost either one or both of their parents. Kibrom Berhe (2008) indicates that 52.0% of the street children lost either of their parents, and less than half (46.0%) of them were school dropouts. In Dessie town, most of the street children in the town were orphans (Getnet Tadele, 2002). There are an estimated 429,860 children orphaned by AIDS which accounted for 52.0% of the total number of orphans in the country (EHNRI, 2012).

As a means of survival, street children engage in certain activities, including illegal practices. In Adama, higher proportions of street children were reported to have engaged in petty trade as a means of survival, while some others were involved in violent and risky practices like theft and robbery (Kidist Negash, 2007). Bagging has also been identified as one of the ways of making a living for street children in Adama (Kibrom Berhe, 2008).

The place where street children and youth often spend the night is another important area in assessing their situations. Review of available literature indicates that the proportions of children 'of the street' and children 'on the street' in Ethiopia varies depending on location and time. For example, fifty-eight percent of street children in Hawassa were reported to be homeless who were children of the street (Solomon Sorsa et.al., 1999). In contrary to the situation in Hawassa, nearly 70.0% of the street children in Adama were children 'on' the street, who worked on the street but had families to spend the night (Kibrom Berhe, 2008). Kidist Negash (2007) notes that half of the street children in Adama town were spending the night on the streets.

2.6. HIV/AIDS and Street Children and Youth

Being the main focus of this research, the issue of HIV/AIDS and street children is given special attention in this literature review. Therefore, this section deals with reviewing available documents on HIV/AIDS and Street children with special focus on degree of vulnerability and HIV prevalence, knowledge, attitude and practice of street children about HIV/AIDS, as well as sexual behavior and risk factors associated with the circumstances of street children and youth.

2.6.1. Level of Vulnerability and Prevalence of HIV among Street Children and Youth

Studies have confirmed that street children and youth are especially vulnerable to HIV/AIDS and other sexually transmitted infections. As young people, street children and youth have much in common with other adolescents, but some of their risk behaviours are more extreme (Kruger and Richter, 2003). A study in Malawi also confirms that street

children were vulnerable group whose ways of life on the streets placed them at greater risk of HIV infection and other STIs (Mandalazi et al., 2013). HIV infection among street children has become significant challenge in Kenya although progresses in HIV/AIDS prevention among the general population (Oino and Sorre, 2013).

The actual prevalence of HIV among street children and youth in many countries is unknown. However, findings of studies undertaken in few countries reported high HIV prevalence rate in this group of young people. A study conducted on a sample of 251 male street children and youth in Nepal documents nearly 20 times higher prevalence rate of HIV among street children than that of the general population in the country. According to this study, the HIV prevalence among male street children was 7.6% (Karmacharya et al., 2012). HIV prevalence rate among some sub-groups of street youth in Brazil was estimated at 35.0% (Rotheram-Borus, et al., 2003).

2.6.2. Knowledge, Behaviour and Practice of Street Children and Youth

As documented by several studies, street children are well aware of HIV/AIDS but with limited knowledge and understanding about the transmission routs and prevention mechanisms. In South Africa, for example, children living on the streets demonstrated low level of knowledge of HIV/AIDS as compared to children living with families (Kruger, 2003). Low level of knowledge about HIV/AIDS is considered as one of the factors that predispose street children in Malawi to high risk sexual practices (Mandalazi et al., 2013). A study in Pakistan also came up with a finding that the knowledge of street children on HIV prevention mechanisms was not very clear (Emmanuel et al., 2005).

In the Ethiopian case, almost all of street children participated in a study in Dessie town reported that they heard of HIV/AIDS and knew it was an incurable disease, but they lacked clear understanding on how HIV is transmitted and be prevented. In this town, street children who did not go to school were less knowledgeable about HIV/AIDS than those who attended street children in the town (Getnet Tadele, 2002). In Hawassa, 64.5% of the street children in the town did not attend any Health Education Programmes (Solomon Soressa et al, 2000) and nearly 11.0% of street children in Adama never had any information about HIV/AIDS (Kidist Negash, 2007).

Gaps are also observed in the behaviour and practices of street children with regard to HIV/AIDS. Because of the conditions they are living in, it seems abstinence in the majority of street children in different countries seemed impossible. For example, 94.0% and 88.0% of street children in Nepal (UNESCO, 2006) and Pakistan (Emmanuel et al., 2005) were sexually active. Regarding the situation of the children in Ethiopia, 53.0% of street children in Hawassa (Solomon Soressa, et. al, 2000) and 32.0% in Adama (Kidist Negash, 2007) were found to have started sex. Kidist concludes that the low percentage of sexually active street children reported in Adama could be due to reluctance of the children to disclose about their sexual behaviour.

In contrary to the principle of faithfulness, street children usually have multiple sexual partners (Hasanzadeh et al., 2007). Though their engagement in multiple sexual partnerships, street children often fail to use condoms. In Nepal, for example, 87.0% of street boys who participated in a study did not use condoms during their last sexual

contacts (UNESCO, 2006). In Pakistan, use of condom among street boys was reported as negligible (Emmanuel et.al, 2005).

All the undesirable behaviour and practices among the majority of street children could be attributed to their low self-risk perceptions. A study conducted by Hasanzadeh and Aliyeva (2007) in Azerbaijan establish that there was an underestimated personal risk of HIV infection by street children. In Malawi, the majority of street children were not considering themselves at risk of HIV and STIs (Mandalazi et al., 2013).

From the foregoing review of literature on the awareness, knowledge, behaviour and practices of street children, one can learn that the significant majority of street children are informed of HIV/AIDS. Nevertheless, their high level of awareness is not supported by comprehensive knowledge, practice and appropriate change in behaviour.

2.6.3. Sexual Behaviour of Street Children and Youth

Early sexual initiation has been documented by different studies as one of the features of sexual behaviour of street children. Based on those studies undertaken in Nepal (UNESCO, 2006), Azerbaijan (Hasanzadeh and Aliyeva, 2007) and Zimbabwe (Dube, 1997), the age at first sex of most street children are between 11 and 16 years.

Street children also indulge promiscuous sexual lifestyle with a large number of sexual partners. More than 37.0% of street boys in Nepal reported that they had sexual intercourse with more than one partners in a month time (UNESCO, 2006). Anarfi (1997), based on his study on the vulnerability of street children to sexually transmitted

diseases, found out that most of street children in Accra, Ghana had multiple sexual partners.

The nature of sexuality of street children can also be reviewed in relation to the type of their sexual partners. There is evidence that assert the street children often satisfy their sexual desires by having intercourses with commercial sex workers. The study of sexuality and HIV/AIDS among male street youth in Dessie showed that the children used any other options to meet their sexual needs except buying sex from prostitutes who are equally desperate for money (Getnet Tadele, 2002). Almost all the street boys participated in the Getnet's study reported to have ever had sex with female sex workers. Street children and youth also sell sex in exchange for money or materials benefits (Emmanuel et.al, 2005).

Homosexuality is the other aspect of sexual behaviour practiced by street children and youth. A study in Malawi reveals that street children, mainly boys, preferred homosexual relations with fellow boys (Mandalazi et al., 2013). Other studies conducted in Pakistan (Emmanuel et al., 2005), Azerbaijan (Hasanzadeh and Aliyeva, 2007) also report homosexuality as a common practice among street children. In Ethiopia, studies by Kibrom Berhie (2008) and Getnet Tadele (2002 and 2007) identify homosexuality as a feature of male street children's sexual behaviour. Getnet Tadele (2007) argues that it was not only their own peers, but also unknown persons, rich businessmen and Ethiopian Diaspora who have homosexual relation with street children in Addis Ababa.

It has also appeared that street children in Dessie and Addis Ababa often watch pornographic films and movies. Video houses play significant role in facilitating first-time sexual intercourse for street youth Getnet (2007).

2.6.4. HIV Risk Factors among Street Children

2.6.4.1. Sexually transmitted diseases: An STIs infected individual is up to five to times more likely than uninfected individuals to acquire HIV (CDC, 2010). According to this source, if an HIV-infected individual is also infected with another STIs, the possibility for this person to transmit HIV through sexual contact is higher than any HI other HIV positive persons. In Ethiopia, higher prevalence of HIV was observed among people with STIs than other people who had no any symptoms of STIs (CSA, 2011). Street children frequently suffer from sexually transmitted diseases mainly due to their indulgence in unprotected intercourse (UNESCO, 2006).

2.6.4.2. Substance and Alcohol Abuse: Street children often use drugs, abuse substances and take alcoholic drinks which enhance risky sexual practices (Dube, 1997). Globally, up to ninety percent of street children use psychoactive substances of some kind (WHO, 2000). Use of drugs and alcohol increases the vulnerability of street children to HIV infection by reducing their capacity to make rational decisions on sexual matters (Anarfi, 1997). The role of substances and alcohol beverages in hindering protected sex has also been noted in studies conducted in Ethiopia. For example, Abebe and others as cited in Getnet Mitike and Melese Tamiru document that there was a strong association between a chat chewing with subsequent alcohol drinking habit indulging in risky sexual practices.

2.6.4.3. Multiple Sexual Partnerships: As mentioned earlier, sexual intercourse with multiple partners is one of the features of street children's sexual behaviour. While the risk of HIV transmission grows with the increases in the number of lifetime partners, the risk reaches to the highest level when the there are multiple partnerships at a time (CSA, 2011). Street children often indulge in concurrent multiple sexual relations either as sex buyers from prostitutes or as sex sellers to others (Emmanuel et al., 2005). Transactional sex is always associated with a high risk of contracting HIV and other STIs due to multiple partnerships involved (CSA, 2011). The global HIV prevalence among sex workers is twelve times greater than that of prevalence among the general population (UNAIDS, 2014). In Ethiopia, data analyzed from mobile VCT clinics in 40 towns found that 25.3% of the sex female workers were HIV positive (FHAPCO, 2010a).

2.6.4.4. Homosexuality: HIV risk factors among street children are not only associated with their unsafe sexual practices with opposite sex, but also with their practice of homosexuality. As discussed in the previous sections, available literature confirms that homosexuality is a common practice among street children and youth (Mandalazi et al., 2013; Emmanuel et al., 2005; Hasanzadeh and Aliyeva, 2007). Global estimates indicate that men who have sex with men are 19 times more likely to be infected with HIV than the general population (UNAIDS, 2014).

2.6.4.5. Sexual Abuse: It is the other vulnerability factor that has placed street children and youth at special risk of HIV. (Getnet Tadele, 2007) indicated that the problem of sexual abuse against male children in Addis Ababa was quite common. Sexual abuse at younger age increases the likelihood to start sex at early age, engage in unprotected sex, have multiple partners and involve in transactional sex (SVRI, 2014).

2.6.4.6. Unprotected Sex: Having unprotected sex with multiple partners remains the greatest risk factor for HIV (UNAIDS, 2010). While street children are often involved in high risk sexual practices, many of them fail to use condoms (UNESCO, 2006; Emmanuel et al., 2005).

2.6.4.7. Low Level of Knowledge about HIV/AIDS: Street children and youth in many parts of the world lack the right knowledge of HIV/AIDS. Being denied of the opportunity to grow in family, community and school settings where they could go through process of socialization, street children lack the right understanding about HIV and other issues (Kruger and Richter, 2003). Perhaps, such a lack of comprehensive knowledge is the worst risk factor because all other risk factors are, in most cases, caused by lack of complete knowledge and inadequate change in behaviour.

2.7. Summary

The burden of HIV/AIDS differs from one region to the other, with disproportionately heights prevalence and huge impact in Sub-Saharan Africa. Whereas heterosexual intercourse is the main route of HIV transmission in Africa, other factors such as homosexuality and use of injected drugs appeared to be the most common modes of HIV transmission in the Caribbean, Asia Pacific, Latina America and Eastern Europe.

Since recent years, reduction in the prevalence and impacts of HIV/AIDS has been registered in many parts of the world. However, this achievement is being challenged by the emergence of new risk behaviours particularly among young people across the world.

Although HIV prevalence in Ethiopia is still considered high, the country has been able to register significant reductions in new HIV infections over the last decade. However, the growing spread of HIV/AIDS in small towns and rural areas, as well as the emergence of new risk groups has become an increasing concern. The gap between knowledge and change in behaviour is one of the challenges in the HIV response in the country.

Due to poverty, family disintegrations, domestic violence, HIV/AIDS, parental death and other socio-economic and political factors, tens of millions of children and youth across the world are living and working on the streets. Although the reported figures on the numbers of street children in Ethiopia are conflicting, the number is believed to be increasing with the growth these underlying factors.

Street children and youth in different parts of the world, including Ethiopia are especially vulnerable to HIV/AIDS and other STIs. Many of them lack comprehensive knowledge and understanding about the transmission routes and prevention mechanisms. Sexual initiation at early ages, multiple sexual partnership, unprotect sex, homosexuality and engagement in commercial sex, sexually transmitted diseases, substance and alcohol consumption are some of the HIV risk factors for street children and youth.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1. Description of the Study Area

The study was conducted in Yeka Sub Cities of the City Government of Addis Ababa where there are project sites for rehabilitation of street children and youth through cobblestone making. The specific name of the study area is commonly known as Yeka - Tinsae Village which is located in District 12 of Yeka Sub City. The study area is located specifically at the Eastern periphery of the City of Addis Ababa. The particular location of the study area is depicted in the map shown on next page (see Fig. 3.1).

Although the data collection was conducted at this project site, the study participants were collected from streets of all the sub-cities of Addis Ababa. In this case, the study covered the city of Addis Ababa in general and Yeka-Tinsae rehabilitation site in Woreda 12 in particular. The main reason why the researcher selected this rehabilitation site is that the site where the latest batch of rehabilitees with fresh memory and experience of life on the street were admitted.

It is important to give a brief highlight on the physical and socio-demographic characteristics of the city of Addis Ababa in general as well as Yeka Sub-city and Woreda 12 in particular. Addis Ababa is the capital city of Ethiopia and it hosts the offices of various continental and international agencies, including the Offices of the African Union and Embassies of many nations across the world.

The city is situated at an altitude of 2,300m above sea level in the central part of Ethiopia with a geographic coordinates of 9°1′48″N and 38°44′24″E. Addis Ababa has a sub-tropical highland climate . According to the projection of CSA (2008) based on the 2007 National Housing and Population Census, the City of Addis Ababa had a total population of 3,384,569 with annual growth rate of 3.8%. Administratively, the City is divided into ten sub-cities and 116 districts.

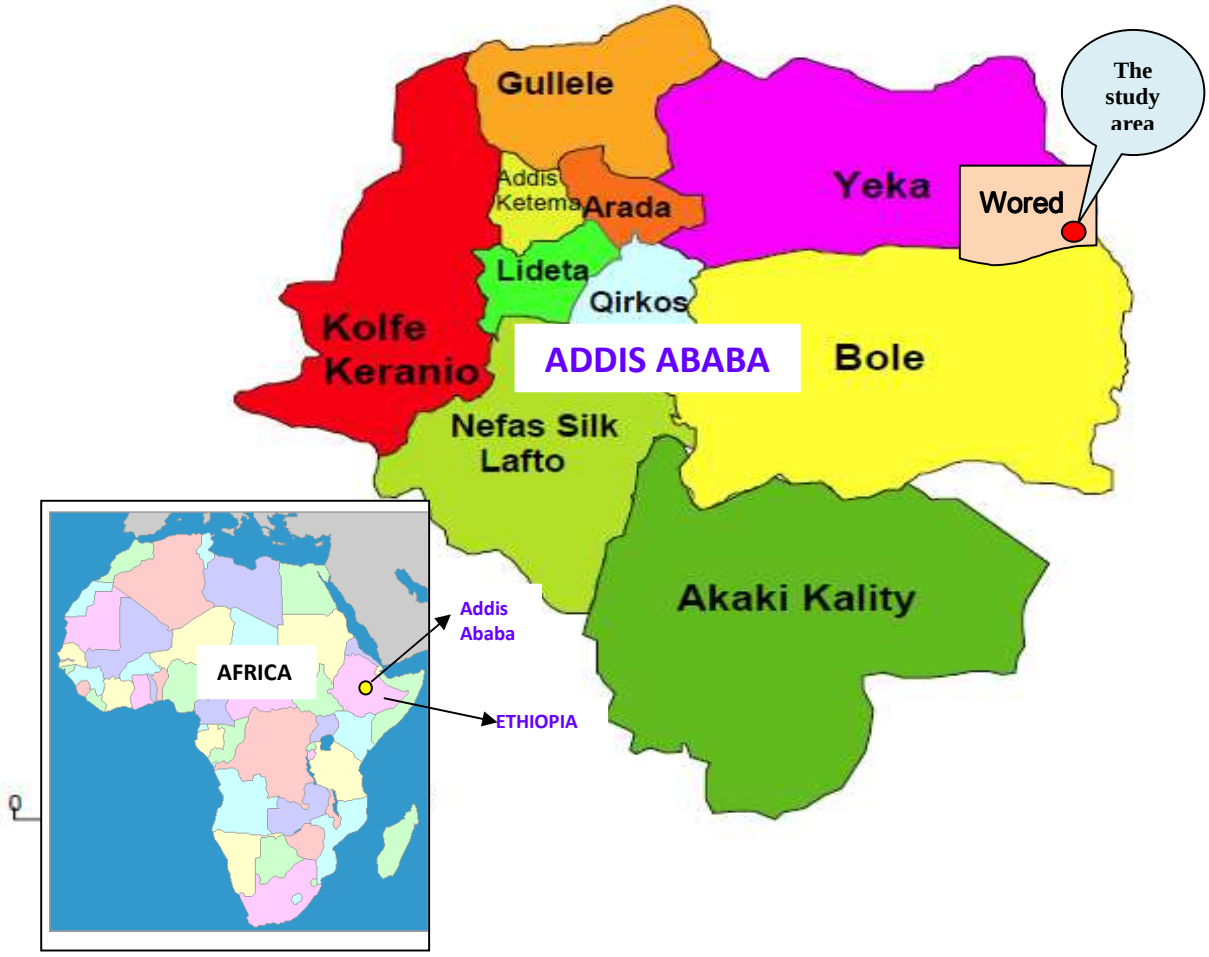

Figure 3.1: Map of the Study Area

Yeka sub-city is one of the ten cub-cities of the Addis Ababa City Government Administration. It covers the large portion of the North Eastern part of Addis Ababa. The sub-city shares borders with Bole Sub-City in the South, Gullele Sub City in the North West, as well as Arada and Qirkos Sub Cities in the South-West of Addis Ababa. The eastern and northern parts of the Sub City are fully boarded by the Oromiya Region.

Yeka Sub City, with a total area of 82.3 km2, is the third largest sub-city, next to Akaki-Kality and Bole Sub Cities. It is inhabited by a total of 346,486 people (CSA, 2008). The Sub City consists of thirteen districts, including Woreda 12 where the specific site of this study is located.

As already mentioned, Woreda 12 is located at the eastern tip of Yeka Sub City. Being one of the expansion corridors of the City, Woreda 12 is characterized by new residential settlements through construction of real-estates and condominium housings. It has vast area of uninhabited land endowed with plenty of underground soft rocks being used for production of cobblestones and construction of buildings in the City.

3.2. Research Design and Methods

In this research, the researcher employed non-experimental research design. The research used a combination of both quantitative and qualitative research methods. Specifically, the researcher applied descriptive sample survey in order to collect quantitative data on socio-demographic characteristics, sexual history and orientation, HIV/AIDS knowledge, attitude and practice, and exposure to STIs, use of alcohol and other substances, etc. Qualitatively, semi-structured interviews with key informants, focus group discussions

(FGDs) with a group of discussants, observations and documentary analyses were conducted to generate qualitative data from the key informants and the discussants, as well as from relevant potential documents on those issues under investigation.

3.3. Universe of the Study

The population in this study constituted male street children and youth in the city of Addis Ababa in general and those who joined the Rehabilitation Project which is initiated by Labour and Social Affairs Bureau under the auspices of the City Government of Addis Ababa in 2012/2013. The Labour and Social Affairs Bureau mobilized a total of 1800 (1781 males and 19 females) street children and youth from all the corners of the City into Yeka-Tinsae Rehabilitation Project site in the Eastern part of Addis Ababa for economic and social rehabilitation. Although these individuals were not any more street boys and girls, they had very fresh memory of their street lives to be utilized for purpose of research. Therefore, the universe of the study consisted of 1781 male street children and youth in the City Government of Addis Ababa, particularly Yeka –Tinsae village in Yeka Sub City in the years of 2012/2013.

3.4. Sample Size

The sample size of the study was 200 street children and youth who were randomly drawn from a total of 1781 study population gathered from all parts of Addis Ababa and temporarily settled at Yeka-Tinsae Rehabilitation site in the same City. The sample respondents constituted 11.3% of the total study population in the Rehabilitation site.

3.5. Sampling Methods

The researcher employed a total of 200 respondents who were drawn from 1800 persons in the above-stated Rehabilitation Project. Therefore, the sample size of the research was 200 male street children and youth who recently left street and joined into the cobblestone making project for social and economic rehabilitation at Yeka-Tinsae site in Yeka Sub City.

The sampling methods employed involved more than one sampling stage – multistage sampling methods. First, the researcher collected a complete list of male street children and youth from the Project Office as a sampling frame (1 to 1781) in the research. Second, the researcher used systematic sampling. For this purpose, a sampling interval was calculated (i.e. K=N/n; where N is the total size of the study population and n is the sample size which makes K to be approximately 9). Accordingly, the researcher randomly selected a number between 1 and 9 and started drawing the sample using systematic sampling with a random start. Third, a total of 200 male street children and youth were drawn from the population using the two stages at the Project site in 2012/2013. Here, the researcher also replaced the missing sample respondents and those respondents who were above the age of 24.

3.6. Tools and Procedures for Data Collection

Both primary and secondary sources were used to collect both quantitative data and qualitative data on those issues under investigation. In the study, the researcher employed combination of different tools and instruments for data collection from primary and

secondary sources. Interview schedule or structured questionnaires, interview guide/protocol, FGD schedule/checklist, observation schedule, and documentary analysis matrix/ template were employed. By administering the interview schedule or the questionnaire, the researcher managed to collect feedbacks and comments from experts in the area and by conducting pretesting and piloting study on similar social group in the research area. In addition, the interview guide, FGD schedule and documentary analysis template/matrix were pre-tested and feedbacks were incorporated for the actual study. Generally, the trustworthiness of those key informants and discussants were given due attention. The analysis of the survey data followed series of steps to ensure reliability and validity of the findings of the study.

3.7. Data Processing and Analysis

Having completed the collection of the quantitative and qualitative data, the questionnaires were checked for their completeness. The researcher engaged in coding of the close-ended questions in the questionnaires. These codes were used to prepare master chart and codebook which facilitated variable and data template design and data of steps. Each code for question item was entered into SPSS Version 19.0 software. This was followed by data clearing to make sure that no data is unnecessarily omitted or added. Mainly descriptive statistics was used in analyzing and interpreting the data. In order to examine the relationship between one variable with others in the data template, cross-tabulations were also applied as measures of association and correlation. The qualitative data was analyzed using thematic and content analysis. The findings of the data analysis are integrated into that of the quantitative while writing the thesis.

CHAPTER FOUR

FINDINGS OF THE STUDY

4.1. Socio-Demographic Characteristics of Respondents

The survey covered a total of 200 male street children and youth who were admitted to Yeka -Tinsae Rehabilitation Project site through cobblestone production implemented by Labour and Social Affairs Bureau of the City Government. The findings of the study on the major socio-demographic characteristics of the respondents are presented based on issues under investigation.

4.1.1. Age Structure: The ages of respondents fall between 15 and 24 years which is the youth age category. The ages of more than half (53.5%) of the study participants were found between 15 and 19 years of age. Those respondents in the age category of 20-24 years accounted for 46.5% of the whole respondents. Therefore, the respondents are youth who economically active section of the City residents.

4.1.2. Sub-City: The City of Addis Ababa is divided into ten sub-cities from which respondents of this survey were identified and selected for rehabilitation. Those respondents were asked about which sub-city of Addis Ababa they used to live on the street before joining the Rehabilitation Project. Out of 200 male street children and youth, about one-fifth (19.5%) of the respondents were from Addis Ketema Sub City, followed by Yeka, Bole and Lideta Sub Cities which contributed to 12.5%, 12.0% and 10.0% respectively. One can deduce that the children and youth in the Project are from the core of the City of Addis Ababa.

4.1.3. **Educational Background*:*** According to the survey results, 91.0% (n=182) of the street children and youth ever attended certain level of education, while 9.0% were not in schools at all. About two-third (63.5%, n=127) of the respondents achieved educational levels not higher than grade 8th. Twenty percent (n=40) of the respondents joined street life while they were in grades 9 or10. It was only 3.0% (n=6) of the survey participants who managed to join secondary education (grades 11-12). Only seven respondents (3.5%) reported to be drop-outs from their college or university education.

Table 4.1: Sub-City and Educational Status of Respondents

Name of Sub- City	Level of Education								
	Never been to School	**Grade 1-4**	**Grade 5-8**	**Grade 9-10**	**Grade 11-12**	**out from College or University**	**Collage or University Graduate**	**Total**	**Per cent**
Arada	2	3	6	4				15	7.5
Yeka	2	5	10	3	2	3		25	12.5
Bole	3	2	12	5	1		1	24	12.0
Nefas Silk Lafto	1	1	9	2	1			14	7.0
Kolfe Keraneo			9	5		1	1	16	8.0
Addis Ketema	4	8	17	8		2		39	19.5
Akaki Kaliti		6	8	4				18	9.0
Kirqos	1	2	6	6		1		16	8.0
Gullele	1	1	8	2	1			13	6.5
Lideta	4	4	10	1	1			20	10.0
Total	18	32	95	40	6	7	2	200	100
Percent	9.0	16.0	47.5	20.0	3.0	3.5	1.0	100	

SOURCE: Own survey findings, 2013

Further, there were also two respondents (1.0%) who graduated from colleges or universities. It has been unusual phenomenon in the Ethiopian context for the graduates form colleges and universities to become street boys. Other studies also associate the

street children phenomena with being dropouts of schools (DSCI-PS, 2005). Thus, majority the street children and youth have certain level of educated and they are economically active members of the society at large – a paradoxical issue in the Capital City of Ethiopia.

4.1.4. Ethnic and Religious Affiliations*:* Regarding religious affiliation, the significant proportion (72.5%, n=145) of the respondents were Orthodox Christians, followed by Protestants and Muslims who accounted for 14.0% and 12.0% respectively. In addition, only two respondents (1.0%) of them did not affiliate themselves with any of the religious categories. Like other studies in the City, most of the children and youth who have been eking out their daily loaves of bread are Orthodox Christians.

Table 4.2: Ethnic and Religious Affiliations of Study Participants

Ethnic Affiliation	Religious Affiliation					
	Orthodox Christian	Muslim	Protestant	No religion	Total	Per Cent
Oromo	39	9	6		54	27.0
Amhara	70	10	2	1	83	41.5
Tigre	15				15	7.5
Guraghe	8	3		1	12	6.0
Sidama	3		3		6	3.0
Wolayita	4	2	10		16	8.0
Hadya	1	1	6		8	4.0
Kambata			1		1	0.5
Beneshangul Gumuz	1				1	0.5
Afar	1				1	0.5
Others	2				2	1.0
Not specified	1				1	0.5
Total	145	25	28	2	200	100.0
Percent	72.5	12.5	14.0	1.0	100.0	

SOURCE: Results of own data analysis, 2013

As to ethnicity of the respondents in the study, 41.5% (n=83) and 27.0% (n=54) of them were from Amhara and Oromo ethnic groups respectively. Other ethnic groups included Wolayita (8.0%), Tigrie (7.5%), Guraghe (6.0%), Hadiya (4.0%) and Sidama (3.0%). Thus, there is no significantly dominating ethnic group among those street children and youth.

4.1.4. Marital Status: It might seem irrelevant talking about the marital status of street children and youth since they are not usually assumed to engage in marital arrangements. However, the study came up with the result that 12% of the respondents have ever married, although still the large majority (88%) was never married. This could be due to the fact that some of the street children and youth came from rural areas where early marriage is practiced. According to the findings, 58.3% of the ever married respondents reported that their ex-spouses were living out of Addis Ababa and 16.7% did not know the whereabouts of their ex-spouses by the time the survey was conducted.

4.1.5. Origin of Street Children and Youth*:* The study documented the origin of respondents as rural and urban. Before coming out to the street, the majority (68.5%) of the street children and youth had urban origin both outside and within Addis Ababa, but 51.0% of them found to be migrants from regional cities or towns. Those migrated from rural areas and started street life in Addis Ababa accounted for 28.5% (n=57) of the total respondents. It was only 19.5% of the respondents who were natives to the City of Addis Ababa. Pieces of information obtained from key informant interviews with experts at Addis Ababa Labour and Social Affairs Bureau also confirmed that a large majority of the

street children and youth in the City did not have roots in the Capital City. Therefore, the street children and youth in the Rehabilitation Project are migrants from elsewhere in the country. It also worth mentioning that 17.5% (n=35) of the street children and youth were street dwellers in other cities and towns of the country before coming to Addis Ababa. However, the significant proportion (81.5%) of the study participants began street lives in Addis Ababa.

4.1.6. Orphanhood Status: The survey also tried to assess whether the parents of the study participants were alive or not. Therefore, it appeared that 55% (n=110) of the respondents were orphans who lost one or both of their parents. Full orphans who lost both of their parents accounted for 14% (n=28) of the total study participants. Five respondents did not know whether their mothers or fathers were alive or not. Moreover, 53.3% of the respondents between the ages of 15 and 19 lost at least one of their parents, whereas 22.8% of them were double orphans. Generally, the street children and youth lose either one of their parents or both of them.

4.1.7. Duration of street life: Twenty nine percent (n=58) of the respondents had experiences of 3-6 years street life, and 13% (n=26) had been on the street for more than six years. More than one-third of the respondents (33.5%) experienced street lives for 1-3 years. Respondents with less than one year of life on the street accounted for 23.0% of the total respondents in the study. Therefore, the majority of the street children and youth have not lived on the streets for ten and above years.

4.1.8. Age of children and youth at the beginning of street life: More than half (54.0%) of the male street children and youth started street lives at their teen ages (13-18 years)

and 30.0% left their homes for streets at their ages of 19 years and above. Those children and youth who began living or working on the streets at their 10-12 years of ages accounted for 9% (n=18). One may thus conclude that majority of the street children and youth have started streetism at their teenage in Addis Ababa.

Table 4.3: Age of Children at Joining Street and Length of life lived on the street

Length of life on the street	**Age at Joining Street**								
	Below 7 years	**7-9 years**	**10-12 years**	**13-15 years**	**16-18 years**	**18 + years**	**Do not remember**	**Total**	**Per cent**
Less than one year				1	18	27		46	23.0
1-2 years		1	1	2	17	14		35	17.5
2-3 years			1	7	12	12		32	16.0
3-4 years	1		3	8	13	2		27	14.5
4-5 years		2	3	3	6	1		15	7.5
5- 6 years	1	2	1	8	2	2		16	8.0
More than 6 years	1	3	9	8	3	2		26	13.0
Do not know		1					2	3	1.5
Total	3	9	18	37	71	60	2	200	100
Percent	1.5	4.5	9.0	18.5	35.5	30.0	1.0	100.0	

SOURCE: Own survey results, 2013

According to Table 4.3, a significant majority (65.5%) of the children and youth joined streets at their ages of 16 years and above. The outputs of the cross tabulation data analysis also indicated that children who joined streets at their young ages were more likely to spend longer time on the street.

4.1.9. Causes for coming out to streets*:* Different factors forced the children and youth to get out of their family and live and/or work on the street. Slightly more than one-fourth (25.5%) of them became street boys after they had left their homes for search of jobs. Conflict with the family is the second most common factor that pushed the respondents out of their homes and to join streets. Parental death as a cause of street children phenomena was also reported by 11.5% of the study participants. Peer pressure, family poverty and parental divorce were the other factors as reported by 8.5%, 6% and 3% of the respondents respectively. Still, about one-fifth (20.5%) of them expressed that they joined streets due to a combination of two or three of the aforementioned factors. Further, three (1.5%) of the respondents stated that they did not know as to why they left their home and ended up on the streets. These findings are in line with the findings of many other previous studies conducted which have been conducted in different parts of the country so far (FSCE, 2003; Heinonen and Luisa, 2002).

4.1.10. Means of Living and Levels of Daily Income*:* While they were on the street, most of the children and youth used to engage in different activities to make a living out of it. The most common means of living were casual works, street vending, car washing and shoe shining as reported by 60.5% of the informants. About 27.5% of the children and youth used to engage in a combination of the above-stated activities. The rest (12.0%) of the respondents reported to use other means, including daily labour, begging, theft and pocket picking to make money for their daily breads.

With regard to their daily income, a considerable majority (66.5%) of the street children and youth earned a daily income of at least ETB 36.00 or nearly USD 2.00. Those

respondents who were used to earn a maximum amount of daily income of ETB 20.00 (nearly USD 1.00) accounted for 12.0%.

The daily incomes of the rest (21.5%) of the street children and youth were between ETB 21.00 and 35.00 (equivalent to USD 1.20 - 2.00). The expressions of the key informants during the semi-structured interviews, in some cases, indicated that some children and youth were found to earn up to ETB 200.00 (USD 10.80) daily.

Table 4.4: Means of Living and Amount of Daily Income of the Study Participants

Means of Living	Amount of Daily income in Ethiopian Birr									
	Below Birr 5	**5-10 Birr**	**11-15 Birr**	**16-20 Birr**	**21-25 Birr**	**26-30 Birr**	**31-35 Birr**	**Above 35 Birr**	**Total**	**Percent**
Casual Work /labor		4	2	4	4	14	9	53	90	45
Small business (Vending)	1							6	7	3.5
Shoe Shining			1	2	1		1	1	6	3.0
Car Washing				1		2	2	13	18	9.0
Beginning			1		1			1	3	1.5
Others including theft	1	1	0	1				18	21	10.5
Four of the above							1	4	5	2.5
Three of the above								8	8	4.0
Two of the above			2	1		6	4	29	42	21.0
Total	2	5	6	9	6	22	17	133	200	100
Percent	1.0	2.5	3.0	4.5	3.0	11.0	8.5	66.5	100	

SOURCE: Own survey findings, 2013

4.1.11. Living arrangement: The study participants were asked as to where they used to spend the night as street boys before joining the Rehabilitation Project. Accordingly, significant proportion (62.5%) of them responded that they spent both the day and the night

on the streets, sleeping under the bridges, around the fences and in the compounds of churches and other institutions. In addition, reasonable proportion (13.5%) of the children and youth reported to have lived in group by sharing rented rooms. Those children and youth who lived alone in rented rooms accounted for 7.0%. It was only 10.5% of the respondents who lived either with immediate or extended families who resided in the City. There were also 13 (6.5%) of the respondents who rented either open spaces or bed rooms on daily basis, depending on their earnings on that particular date, otherwise they used to sleep on the streets.

4.2. Sexual History

Sexual history and orientation of any person is one of the key factors that determine the level of his/her vulnerability to HIV infection. In view of this, the sexual histories of the study participants have been documented carefully.

4.2.1. Engagement in Sex: The study found out that 146 of the 200 respondents (73.0%) were sexually active when the interview was conducted. The remaining, 54 (27.0%) of the respondents did not start sex during the time of interviews. The finding of the current study is in line with other studies in Nepal (UNESCO, 2006) and Pakistan (Emmanuel et al., 2005) where the respective 94.0% and 88.0% of street children were sexually active. According to CSA (2011), 15.2% of young people (aged 15-24 years) among the general population of Ethiopia were reported as sexually active, which had significant difference from the findings of the current study.

4.2.2. Age at First Sex: Out of the 146 sexually active male street children and youth, 34.9% (n=51) of them started sex at their ages of 13-15 years. Among the general population, however, it was only 1.3% of young boys aged 15-24 years who experienced sex before the age of 15 years (CSA, 2011).

Table 4.5: Age of Study Participants at the beginning of Street Life and their Age at first Sex

Age at Beginning of Street life	Age at First Sex							
	Before 10	10-12	13-15	16-18	after 18	don't remember	Total	Percent
Less than 7 years				1			1	0.7
7-9 years		1	3	3		1	8	5.5
10-12 years	1	2	9	1	1	1	15	10.3
13-15 years		1	16	10			27	18.5
16-18 yrs		2	14	24	3	3	46	31.5
Above 18 years	1	1	9	30	8		49	33.6
Total	2	7	51	69	12	5	146	100.0
Percent	1.4	4.8	34.9	47.3	8.2	3.4	100	

Source: Own survey output, 2013

The current study also documented that the ages at first sex for about 47.3% (n=69) of the respondents were between 16 and 18 years. Those children and youth who experienced their first sex at the ages below 13 years and above 18 years accounted for 6.2% and 8.2% respectively. The rest, 3.4% (n=5) did not remember their ages at their first sex. Different studies around the world documented that most street children started sex at their ages of 11-16 years (UNESCO, 2006; Hasanzadeh and Aliyeva, 2007; Dube, 1997).

4.2.3. Sexual Partner at First Sex: Sexually active respondents were further asked as to whom they had their first sex with. Data analysis of their responses indicated that 47.3%

(n=69) of them started sex with their girl friends. Those who experienced their first sex with female sex workers were 35.6% of total sexually active participants. CSA (2011), however, indicates that only 1.5% of young people in the general population were reported to have sex with sex workers. The finding of this study on the sexual engagement of male street children and youth with female sex workers is also supported by previous studies. Getnet Tadele (2002), for example, documents that male street children in Dessie town had no other options to satisfy their sexual needs than buying sex from prostitutes.

The study also revealed that 5.5% of the respondents had their first sex with their spouses upon marriage. Still other eight children/youth (5.5%) had their first sexual contact with other groups of partners, including housemaids and neighbours. The remaining, nine respondents (6.1%) were not able to remember as to whom they had their first sex with.

During the focused group discussion, the study participants also confirmed that most of street boys went to commercial sex workers to satisfy their sexual needs. One of the FGD participants told the researcher, "….When we were on the streets, the only option we had was to go to the business women [female sex workers]. We had neither the interest nor the money to have girlfriend" (A 23 years old FGD participant).

Another FGD participant in the same group added:

……..Whenever we have money in our pockets, we usually went for sex with prostitutes. What we did when we had money was drinking, chewing [Chat] and smoking and eventually going to business women. What I am telling you is just the experience of myself. Anytime, I earn money, I went for sex, and nothing else came to my mind except sex (An 18 years old FGD participant).

It has also been learnt from the FGD that in rare cases, male street children and youth have girlfriends among street girls. They start living together as a kind of marital union and eventually have offspring on the street. Statements taken from the key informant interview at the Office of Labour and Social Affairs of the City Government could also show how promiscuous was the sexual life of street children and youth in Addis Ababa, as the key informant stated:

……..One day, one of the street girls in the Rehabilitation Project came to us and told that she had become pregnant. The girl explained that she had three boyfriends, all street boys, at a time. She was not able to know which of her boyfriends she conceived from. She argued that one of her boyfriends to whom the newborn might resemble would be the father. Similarly, each of the girl's boyfriends agreed to accept the newborn as their biological baby if he/she would resemble to themselves to a certain extent.

4.2.4. Initiation for first sex: The study participants were also asked as to what initiated them to experience sex for the first time. In response to this question, the majority (75.3%) of the sexually active study participants reported they had their first sex on their own decisions. The study also showed that street children and youth started sexual relations with the influence of peer pressures as confirmed by 20.5% of the sexually active respondents. Few respondents (2.1%) started sex by being raped and /or solicited by partners, whereas 6.2% did not remember how they experienced sex for the first time.

4.2.5. Number of Lifetime Sexual Partners: Sexually active study participants were asked about the number of sexual partners they had ever had until the date of the survey. Many of them expressed their concern about the difficulties to remember and count back the number of people they ever had sex with. They were however probed to tell what they could guess as there could not be perfection.

Therefore, 86.9% (n=127) of the respondents confirmed that they had sexual contact with multiple partners which ranged from 2 to more than 13 partners, while the proportion of young men (aged 15-24 years) with multiple partners were only 2.1% (CSA, 2011). Those respondents with single lifetime sexual partners accounted only for 17.1% (n=25). Nearly one-fourth of the respondents already had sexual contacts with 2-5 partners, whereas respondents with 6-9 lifetime partners accounted for 21.2%. Moreover, 11.6% and 15.8% of the respondents ever had 10-13 and above 13 sexual partners respectively. Besides, a reasonable proportion (10.3%) of the respondents was not able to remember the number of persons they ever had sex with. One reason for the failure of these respondents to remember their lifetime sexual partners could be their partners were too many to keep in mind or they felt ashamed of disclosing such a private issue.

During the semi-structured interviews, some key informants told the researcher that they ever had sex with tens and even hundreds of partners in their lifetimes. It also worth mentioning that 78.1% (n=114) of the sexually active respondents did not have regular sexual partners at the time they were interviewed.

The large number of life time sexual partners documented in this study is consistent with the findings of other studies on the subject matter. UNESCO (2003), for example, documents that street children indulged promiscuous sexual lifestyle with a large number of sexual partners. Studies in Nepal by UNESCO (2006) and in Ghana by Anarfi (1997) also reported that most of the street children had multiple sexual partners.

The engagement of male street children and youth in multiple sexual partnerships also confirmed that the focus group discussion participants in this study. When asked whether or not street boys went to the same prostitute every time they wanted to have sex, one of the participants quickly stated:

> ……...No! We never go to the same women while they are available from every direction, every place and every station. …. As to my interest, I don't want to repeat the same woman. As long as I pay, I want to change, unless and otherwise, the previous lady is exceptionally comfortable to me. Neither the business women nor street boys want to have regular partner. There is no as such regular partnership with business women [commercial sex workers] as it is a matter of doing business and making money (a 21 years old FGD participant).

4.2.6. Opinion and Practice of Homosexuality and Sexual Abuse: The study examined the sexual orientation of the male street children and youth in terms of their knowledge and experience regarding homosexuality. Accordingly, the respondents were asked few questions related to homosexuality and street life. Half of the respondents believed that homosexuality was widely practiced among male street children and youth. Different studies conducted in different countries also noted the widespread practice of homosexuality among male street children (Mandalazi et al., 2013; Emmanuel et al., 2005; Hasanzadeh and Aliyeva, 2007; Kibrom Berhie, 2008; Getnet Tadele, 2007).

In addition, fifty-nine percent of the respondents who had the view homosexuality is common among street boys stated that they personally knew some street boys who engaged in homosexual intercourse. About 3.5% (n=5) of the sexually active respondents ever experienced homosexuality during their lives on the street. Three of these respondents used to practice the act with the common consent of their sexual partner, but one of the remaining two was rapped and the other one committed rape against boys.

An act of rape against and among boys on the streets of Addis Ababa is a common practice. In this connection, a large majority (60.0%) of the study participants believed that street boys were victims of rape and other forms of sexual violence. Further, 31.0% affirmed that they came across with street boys who were raped. Moreover, eight percent (n=16) of the street children and youth ever encountered either actual rape or attempts of rape by others, including their peers and unknown adults. Four respondents (2.0%) committed rape against street girls (3) and street against boys (1).

The data obtained from the survey about homosexuality is also supported by the information generated through FGDs and KIIs. The FGD participants believed that many street children engaged in homosexuality. They explained, in most cases, the young boys and new comers are at special risk of rape. The abusers were not only older street boys but also other adults, mainly economically well to do business men and men who lived abroad. According the FGD participants, perpetuators applied force and even used weapons such as pistils and knives in intimidating the street boys for sex. They also either cheated or solicited the street boys with money or other material benefits. As mentioned by the FGD participants, it was hardly possible to come out of the practice once a street boy was raped and started engaging himself in homosexuality; he would rather continue raping others and expanding the practice.

Statements of FGD participants could help better understand the situation of homosexuality and sexual abuse among the study participants when they aired out:

…. Mostly, it is within the first one or two days of their street life that many boys are raped. Immediately after they left their families, these boys do not know much about what is going on in the streets. For this group of children, the possibility of being raped is very

high. Although some street boys are raped by abusers, there are also few street boys having sex with men on their own wish. This is mainly for the sake of earning money. They [abusers] give them [the victims] much money which they think the money would change their lives once and for all. …. Once they are raped, the boys repeat the practice by raping others even their friends on the street. This is common, especially in Piazza area of Addis Ababa.

The discussants continued,

Some men come to us driving their cars and ask us to let them show bedrooms for rent. As street boys, we are always in critical need of money. With the intention to get some money, we go with them in their cars to help them to find bedrooms. However, these persons lock the windows of their cars and drive us forcefully wherever they want. Even if we shout and cry nobody would heard of us. Then, they do whatever they want to do so.

A key informant interviewee who is working with the Street Children Rehabilitation Project also was of the view that the practice of *Gibre Sedom* (homosexuality) was quite common among street boys. Consequently, the expert stated that many street boys in the Rehabilitation Project used to visit clinics for treatment of anal cracks and tears that might have resulted from non-lubricated anal sex.

This study found out that sexual abuse against street boys in Addis Ababa not only committed by men but also by women. The FGD participants in all groups expressed that women often targeted street boys for sexual indulgence. The street boys in the FGD sessions argued that women, mostly older ones who appear to be economically well to do make sex with street boys. They stated:

…… There was a lady who used to come driving her car to the street at night where we usually sleep in Bole area. Then, she took two of our peers with the pretext that they could help her in doing some casual tasks. After certain hours, the boys came back to us having taken baths, changed their clothes with new ones and received good amount of money. When we asked them what they had done with the lady, they told us that the lady requested them to have sex with her and they did it accordingly. She used to come at least once in a

week. This was the case mostly on weekends and took the same boys for the same purpose (A 21-years -old street boy).

Another FGD participant aged 19 years also shared his own personal experience on how a lady solicited him for sex as follows:

…. Let me tell you frankly my own experience. One day, when I was on the street in Merkato area, an older woman asked me to carry for her a lot of food items (*Asbeza*) and went to her house. When we arrived at her home, no one was around and she asked me to stay with her and to have a lunch. ….After she had served me a lunch, she asked me to go to bed and to have sex with her which I did it without hesitation. She also invited me to come to her house some other times, but I did not go back again. …. The woman seemed a rich person as she had a good house and beautiful compound (A 19 years-old street boy in the FGD).

4.3. Exposure to Alcohol and Other Habit-Forming Substances

4.3.1. **Alcohol Consumption:** Street children and youth were asked whether or not they had had any habit of taking any sort of alcohol drinks while they were on the street. Seventy-nine (N=158) of the respondents had the habits of taking at least one type of alcoholic drink. Almost 38.0% of them expressed that they were using at least five types of alcohol drinks, many of which were home brewed ones. Those FGD participants also confirmed that almost all street children, and even those kids as young as nine and ten years old consume alcohol. The most common types of drinks consumed by the street children and youth participated in the study were t*ella* and *filiter* (home brewed beers), a*reke* (home distilled liquor), *tej* (a drink made of fermented honey and other ingredients, including malt). Other industrially brewed alcoholic drinks like beer and draft beer were rarely used, as they were considered expensive.

4.3.4. Use of Habit-Forming Substances: The study also came up with a finding that the children and youth involved in the study were consuming such habit-forming substances as *chat* (a stimulant locally grown green leaf served as it is), cigarette, benzene and *ganja* (a type of tobacco prepared from a dried and home packed green leaf). Of the total respondents, 65.0% (n=130) were taking at least one of those substances. Those respondents who were familiar with 3-4 types of substance accounted for 27.0% of the substance users. Chewing chat and smoking were the most common practices among the study participants. Of those substance users, 83.0% were chewing chat, 70.7% were smoking and 63.8% were both chewing and smoking. Smoking cigarette and using of *ganja*, sniffing glue and chewing chat were also the most common substances reported by the FGD participants.

High prevalence of alcohol and substance consumption among street children was also confirmed by other studies around the world. Dube (1997) and WHO (2000) indicate that street children often used drugs, abuse psychoactive substances and take alcohols.

The FGD participants stated three reasons for street children and youth often used alcohol and other habit-forming substances. Firstly, they used the substances and alcohol as their coping mechanisms with the cold weather mainly during nights and abuses by the police. One of the FGD participants who aged 18 stated: "In order to cope with the cold and the beating by the policy, it was a must for me to have one or two units of drinks, and if not alcohol, I had to use different stimulants such as chat, cigarette, hashish, Ganja, or else."

Alcohol and other substances are also used by street children as a means to get out of bad feelings such as depressions and frustrations resulted from the circumstances of street life. In this connection, a 17 years old participant expressed: "…. You know, there is always tension among most street children… and many of us drink alcohol to forget our frustration. I, myself take alcohol in times when I feel depressed or disappointed or getting tensioned." Thirdly, the street children and youth consume alcohol and other substances with the purpose of developing courage to engage in certain illegal acts such as theft, assault and robbery. According to one of the FGD participants (aged 18 years), some street children used substances like ganja when they want to do theft. He said, 'Ganja gives courage to do anything; there will be no fear at all in you once you take ganja."

4.4. Exposure to Pornography

Earlier studies noted the wide spread practice of watching pornographic films among male street boys in Dessie and Addis Ababa (Getnet Tadele 2002, 2007). About sixty-four (n=127) of the respondents were in the habit of watching sex films and significant proportion (31.5%) of them accessed these films from illegal video houses, whereas 24.4% watched the movies by downloading on their cell phones. This was also affirmed by an FGD participant who said, "we don't have to go to film houses for pornography, as we may not have the money; instead we simply download the films on our mobile phones." About thirty-one percent of the respondents reported that they used both small video houses and mobile phones to watch erotic movies.

Further questions were extended to the survey respondents if watching pornography had certain influence on their sexual behavior and practice. About forty-six percent (n=58) of

the respondents often went for sex immediately after watching the pornographies. Large proportion (86.2%) of this group of respondents indulged sex with female sex workers to satisfy their sexual desires provoked by the movies. The FGD participants also explained that many street boys engaged in sex immediately after they had watched sex films. Another FGD participant further confirmed that, “those street children around Sebategna area in Addis Ketema Sub City are having sex with prostitutes after they have watched out sex films. Getnet (2007) argues that pornographic films serve male street children and youth as the main initiators of rushing into sex with the intention to practice what they have seen on videos.

4.5. Knowledge and Experience of Respondents about STIs

The study participants were asked some questions related to their knowledge and experience about sexually transmitted infections. In this regard, the majority (85.0%) of the informants heard of STIs. Among those respondents, 66.1% of them cited the names of at least two STIs, including HIV/AIDS. Slightly more than half (53.0%) of the study participants mentioned at least two symptoms of STIs. Those participants who were able to name three and above symptoms accounted for 24.8%; and 22.4% were not able to mention any symptom of STIs at all.

Regarding prevalence of STIs, 18.3% (n=31) of the children and youth stated that they have ever been infected with STIs in their lifetimes. This finding shows that it is nine times higher than the proportion (1.9%) of young men (aged 15-24 years) in the general population with self-reported STIs (CSA, 2011). Nearly 68.0% of the respondents expressed that they experienced and underwent medical treatment for STIs, while 29.0% of

them did not get treated. According to the responses of the participants, little or no concern about the problem (55.6%) and financial constraints (22.2%) were the main factors for not attending medical treatment.

Nearly one-third (30%) of those respondents with information about STIs, reported they came across with at least one male street boy contracted by STIs. The information from the FGDs is consistent with the findings of the survey findings for the fact that many of the FGD participants have ever known peers infected with STIs.

On the other hand, some of the FGD participants were lacking information about STIs, including transmission routs. For example, when asked what he knew about STIs, a participant responded that "I think, but not sure, that the so called *Chebit* [gonorrhea] is a communicable disease that is it… I do not know much more". Another participant cited cloths and heat as transmission routes of STIs; he was not able to explain it further.

4.6. Knowledge, Awareness, Attitude and Behavior of Street Children and Youth about HIV and AIDS

4.6.1. Information and Awareness about HIV/AIDS*:* Almost all the study participants (99.5%) heard of HIV/AIDS. The main sources of information about HIV/AIDS for the participants were radio and television (12.0%), schools (8.0%) health institutions (5.5%), peers (3.0%) or a combination of two or more of these sources (71.0%). It was only 0.5% of the informants who reported to have had HIV/AIDS and related information from families.

A large majority (80.5%) had the notion that HIV/AIDS affects anyone irrespective of the person's identity and background. But, 7.5% (n=15) did not agree with the idea while the remaining, 12% (n=24) were not sure. Further, 4.5% of the respondents thought that it was possible to judge one's HIV status based on observation of his/her physical conditions, such as being skinny or fat. Moreover, 78.0% did agree that HIV/AIDS had no cure as opposed to 10.5% who believed HIV had a cure. The rest, 11.5% of them were not certain enough whether AIDS had a cure or not. Similarly, 13.0% of the respondents did not believe that AIDS is killing disease and 6.5% were not sure.

4.6.2. Access to HIV/AIDS Education: Slightly more than half (51.0%) of the respondents were found to attend awareness raising or HIV/AIDS education programs, while 2.5% were not sure if they received HIV/education or not. Similar finding was reported by a study in Hawassa (Solomon Soressa and Tesfaye Kidane Mariam, 2000) where 64.5% of the street children in the town did not attend any kind of health education during their stay in street contexts.

4.6.3. Knowledge about HIV/ AIDS*:* The participants of the study were asked few questions related to the difference between HIV and AIDS, routs of HIV transmission and prevention mechanisms, and their responses are summarized as follows.

With regard to knowledge of participants about the difference between HIV/AIDS, only 28.0% (n=56) believed that the two were somehow different, while 50.0% (n=100) did not think that there is difference between HIV and AIDS. Forty-four percent (22.0%) of the respondents were not sure whether or not there was any distinction between the two.

The study participants were asked as to which mode/s of HIV transmission they knew vis-à-vis sexual intercourse, and sharing sharp materials contaminated by HIV from HIV positive mothers to children, and transfusion of infected blood. Almost all (99.5%) of the participants mentioned at least one mode of HIV transmission. The proportion of respondents who cited only one mode of HIV transmission was 16.5% (n=33). Those participants who named two and three modes of HIV transmission accounted for 25.0% and 22.0% respectively. It was only 26.5% of the participants who cited all the four modes of HIV transmission mentioned above. Sexual intercourse and sharing contaminated sharp materials were the most commonly known modes of HIV transmission reported by 98.8% of the participants who provided multiple responses. On the other hand, transmission of the virus from HIV positive mother to child and infected blood transfusions were the least known modes of transmission because it was reported by only 37.8% of the respondents.

Concerning knowledge about HIV prevention mechanisms, significant proportion (98.0%) of the participants knew a minimum of one mechanism of preventing HIV transmission. However, the knowledge of reasonable proportion (42.0%) of the children and youth was limited only to a maximum of two prevention mechanisms, out of five possible answers given in the questionnaire: (1) abstinence (2) being faithful (3) condom use (4) prevention of mother to child transmission and (5) avoid using sharp materials contaminated by HIV. About 22.0% and 17.5% of the study participants could cite three and four of the above-mentioned prevention mechanisms respectively. It was only 16.5% who knew all the five means of HIV prevention stated above.

Using condom as a means of preventing HIV transmission was documented among the significant proportion (90.3%, n=177) of the male children and youth who reported knowing any HIV prevention mechanism. About 68.9% and 61.2% of the respondents included avoiding use of contaminated sharp materials and being faithful as mechanisms of HIV prevention in their responses.

Knowledge about ABC (Abstinence, being Faithfull and Condom Use): The study also assessed the knowledge and awareness of the study participants about ABC. The study found out that 34.2% were able to indicate all the three components and nearly 21% mentioned condom use and faithfulness only. Insignificant proportion (5.6%) combined condom use and abstinence in the responses about their knowledge of HIV prevention mechanisms. What was generally observed from the responses is that except condom use and avoiding use of contaminated sharp materials, the rest of HIV prevention mechanisms were not widely known by the study participants.

When asked about the ways of knowing one's HIV status, the majority (85.5%) identified blood testing as the only mechanism. Thirteen participants (6.5%) believed that HIV status of a person could be determined by observing his/her physical conditions. Those respondents who replied both blood testing and physical observation accounted for only five percent.

Knowledge and understanding of street children and youth about HIV/AIDS seemed to be shallow and inconsistent. Such a low level of knowledge about HIV/AIDS among street children has also been observed in other many countries such as Malawi (Mandalazi et al., 2013).

4.6.4. HIV/AIDS Practice and Behaviour

Nearly three-fourth (73.5%) of the male street children and youth were tested for HIV. Rate of HIV testing is significantly high among street boys compared with the rate among other young men in the general population which accounted for only 35.6% (CSA, 2011). According to their response, those respondents who reported their test result as HIV positive accounted for 9.7% (n=14). This means the rate of self-reported HIV prevalence among the study participants was 9.7%, excluding ten respondents (6.9%) who were not willing to disclose their status. The proportion of HIV positive young men (aged 15-24 years) in the general population in Ethiopia was estimated at 0.2% (CSA, 2011). In other words, the HIV prevalence among the participants of the current study is 48.5 times higher than the prevalence among young men in the general population. However, since it is not clinically confirmed, it may be difficult to take the self-reported data as a true prevalence of HIV among the study participants.

The key informant who is well-versed of streetism in Addis Ababa stated that some of the street children in the Rehabilitation Project were on ART although adherence remained to be a critical challenge. “Many HIV positive street children in the Project failed to take the ART on regular basis,” according to the key informant interview.

Other studies in different parts of the world also noted high HIV prevalence among street children and youth. For example, a study in Nepal and the USA respectively documented 20 and 10 times higher HIV prevalence among street children than the prevalence in the

general population (UNESCO, 2006 and Walter 1999). In Brazil, there was an estimated 35.0% HIV prevalence among street children (Borus, 2003).

Table 4.6: Practice of HIV Testing and Self-Reported HIV Status of the Study Participants

Variables	Responses	Frequency	Per cent
Have you ever tested for HIV? (N=200)	Yes	147	73.5
	No	53	26.5
	Total	200	100
Have you known the result of your HIV Test? (N=147)	Yes	145	98.6
	No	2	1.4
	Total	147	100
What was your test result? (Self-Reported HIV Status) (N=145)	HIV Negative	121	83.4
	HIV positive	14	9.7
	Not willing to disclose	10	6.9
	Total	145	100
What was your reason for not having been tested for HIV? (N=53)	Fear of knowing the test result	14	26.4
	Ignorant of where to go for testing	3	5.7
	Little or no concern about HIV	8	15.1
	Have no any risk of HIV	23	43.4
	Others	2	3.8
	Multiple reasons stated above	3	5.7
	Total	53	100
Are you willing to undergo HIV testing in the future? (N=200)	Yes	168	84
	No	19	9.5
	Not decided	13	6.5
	Total	200	100

SOURCE: Results of own survey data analysis, 2013

The main reasons for not undergoing HIV testing as reported by the participants were: low risk perception (43.4%), fear of knowing own HIV statues (26.4%), little or no concern about HIV (15.1%) and lack of information as to where to get tested (5.7%). When asked if they are ready for HIV testing in the future, 84% (n=168) showed readiness to get tested any time. The rest 9.5% were not willing while the remaining 6.5% did not decide yet.

The study also revealed that 86.2% (n=125) of the sexually active respondents used condoms. Less than fifty percent (47.2%) of the respondents expressed that they were mostly using condoms. Those respondents who used condoms very rarely accounted for 13.6%. It was only 39.2% (n=49) of the sexually active participants who claimed to use condoms consistently during each and every sex.

The qualitative data from the FGDs with street children and youth indicated that many street children and youth were aware of the importance of condom in preventing HIV infection. However their practice in using condom consistently and properly was limited. As indicated in the following statements quoted from the FGD participants, some street boys even did not want to use condoms at all, as they aired: "…. I personally know four or five street boys who never use condoms at all. They were not conformable to use condoms. Even, some may go to business women with condoms, but they do not use it actually."

There is consistency between the findings of the current study and that of previous studies as far as condom use among street children is concerned. In Nepal, for instance, 87.0% of street boys did not use condoms during their last sexual intercourse (UNESCO, 2006). Various purposes of using condoms by respondents were also documented. Slightly more

than half (50.4%) of the respondents used condoms mainly for HIV prevention. Other purposes were prevention of other STIs (1.6%) and prevention of unwanted pregnancies (2.4%). The proportion of respondents who reported to have used condoms for more than one purposes was 45.6%.

The respondents also cited certain factors that discouraged them from using condoms. The most common factors were perception of condom as a barrier to sexual pleasure (23.5%) and trust on sexual partners (23.5%). Such factors as having no interest to use condoms at all, lack of partner's consent, financial constraints to buy condoms and being ashamed of buying condoms, all together constituted 20.1% of the factors for not using condoms. Table 4.7 shows information on the practice and perception of respondents regarding condom use.

Still less than one-third (30.6%) of the respondents argued that they had sex without condoms due to the influence of alcoholic drinks. The role of substances and alcohols in hindering protected sex has also been documented in studies conducted in Ethiopia (Getnet Mitike and Melese Tamiru, 2008).

The study participants were similarly asked about their attitude towards HIV positive people. As shown in the Table, 23.1% of the study group was not willing to share the same dish and 13.6% showed reluctance to shake hands with PLHIV. The respective 3.5% and 4.0% of the male street children and youth were not sure to share the same dish and shake hands with PLHIV.

Table 4.7: Practice and Perception of Sexually Active Study Participants about Condom Use

Variables	Responses	Frequency	Percent
Have you ever used condoms (N=145)	Yes	125	86.2
	No	20	13.8
	Total	145	100
Consistency of using condoms (N=125)	Use condoms whenever having sex	49	39.2
	Use condoms most of the times	59	47.2
	Use condom rarely	17	13.6
	Total	125	100
Reported Purposes of using condoms by respondents (N=125)	HIV Prevention only	63	50.4
	Prevention of other STIs only	2	1.6
	Prevention of pregnancy	3	2.4
	Three of the above	21	16.8
	Two of the above	36	28.8
	Total	125	100
Reasons for not using or inconsistent use of condoms by respondents (N=98)	Perceiving condom as barrier to sexual pleasure	23	23.5
	Trust on sexual partner	23	23.5
	The influence of alcohol	30	30.6
	Lack of partner's consent	5	5.1
	Financial constraints to buy condoms	1	1
	Feeling ashamed of buying condoms	2	2
	Lack of interest with no clear reason	12	12.2
	Combination of two or more of the above factors	2	2
	Total	98	100

SOURCE: Own survey results, 2013

A considerable proportion (34.2%) of study participants expressed their unwillingness to be taken care of or served by HIV positive persons and 5.5% were not able to decide. On the other hand, the large majority (87.9%) reported willingness to provide care and support to any family members or friends who were AIDS patients.

Table 4.8: Attitude of Study Participants towards People Living with HIV

Variables	Responses	Frequency	Percent
Are you willing to share the same dish with an HIV positive people? (N=199)	Yes	146	73.4
	No	46	23.1
	Not sure	7	3.5
	Total	199	100
Are you willing to shake hands with HIV positive people? (N=199)	Yes	164	82.4
	No	27	13.6
	Not sure	8	4
	Total	199	100
Are you willing to be taken care of or served by HIV positive people? (N=199)	Yes	120	60.3
	No	68	34.2
	Not sure	11	5.5
	Total	199	100
Are you willing to provide care and support to any HIV positive family members or friends? (N=199)	Yes	175	87.9
	No	14	7.1
	Not sure	10	5
	Total	199	10

SOURCE: Own survey outputs, 2013

It was only 7.1% of the respondents who reported to be either reluctance or un sure to provide care and support for their HIV positive family members.

Regarding self-risk perception, the study also attempted to measure the extent to which male street children and youth perceived themselves to be vulnerable to HIV infection. The large majority (71.5%) of the respondents had the opinion that male street children and youth were vulnerable to HIV. Nearly, one-fifth (19.0%) of them did not perceive any risk, and the rest, 9.5% were not certain. Over half (55.0%) of the respondents stated that they knew HIV positive street boys.

The FGD participants also had the same perception about vulnerability of male street children and youth to HIV. Many of them also reported to have known at least one HIV positive street boy. They expressed their witnesses as follows:

…. I know many HIV positive street children, and one of them was my friend. He used to take alcohol every day. There was no single day when he did not get drunk. In cases where he had no money, he drank even with credit. He eventually became infected with HIV and started taking ART (A 16-years old participant in FGD).

When asked directly about themselves, more than one-third (35.0%) of the survey respondents replied that they were at risk of HIV infection, while about two-third (65.0%) never thought of any risk of HIV in their past lives. The main reasons for perceived risk of HIV infection, as reported by respondents, were having sex with multiple partners (15.7%), having had sex without condoms (15.7%), sharing sharp materials and tools that might have been contaminated with the virus (21.4%), unfaithful sexual partners (2.9%) or a combination of two or more of the above-stated factors (44.3%).

There is also evidence that show street children and youth prefer to avoid talking and thinking about HIV. Due to the present hardships of life on the streets, some were quite desperate about their future and did not want to be worried about HIV. The following expressions were taken from one of the FGD participants. "When I was on the street, I never worried about tomorrow. It didn't make any difference whether I live or die. …. As a street boy, I did not want to think about HIV/AIDS. Thinking of HIV/AIDS on the street was nothing, but adding more frustration to the already existing stress of street life" (a 20 years old FGD participant).

4.7. Duration of Stay on the Street and Exposure to Risk Behaviours

Data analysis using cross tabulations was run in order to check association or correlation between length of life on the street and other factors that may increase risks to HIV infection. The factors examined in the cross tabulation include age at first sex, number of life time sexual partner, experience of homosexuality, use of alcohol and other substances, the habit of watching pornography, sexual intercourse with female sex workers, knowledge about and experience in STIs, exposure to HIV education, as well as HIV/AIDS related awareness, knowledge and practices. The cross tabulation was analyzed by grouping respondents into two categories: (a) those respondents who have stayed on the street for two years or less and; (b) those respondents who have been on the streets for more than two years.

There were strong relations between duration of life on the street and HIV/AIDS risk behaviours or exposure to vulnerability factors. Those respondents who had longer duration of stay on the street were more likely to develop risk behaviours and/or experience risk

factors than those respondents with smaller numbers of years on the streets. For example, those street boys who have stayed two years and above on the street were more sexually active (81.5%) than those respondents with less than two years of life on the street (60.5%). Similarly, age at first sex decreases with the increase in the duration of street life. It was only 26.5% of street children who stayed two years or less on the street who started sex before the age of 16, whereas the proportions for those with more than two years of stay on the street was nearly double (48.4%). Respondents with longer stay on the street also had larger numbers of lifetime sexual partners than those who stayed shorter. Involvement in and exposure to homosexuality and sexual abuse, alcohol and substance abuse, chance of infections with sexually transmitted diseases and habits of watching pornographic films increased as the children and youth continued living on the streets.

On the other hand, awareness and knowledge about HIV/AIDS and risk factors, as well as the practice of taking protective measures appeared to be decreasing with the increase in the number of years passed on the streets. The male street children and youth with a maximum of two years of life on the street were better informed about the transmission routes and prevention mechanisms of HIV/AIDS than others.

Consistent use of condom was relatively higher among respondents with shorter duration of stay on the street than respondents who stayed longer. Moreover, the respondents with more than two years of life on street constituted larger proportions of people with self-reported infections with STIs and HIV positive status. The table below provides comparative data on duration of respondents on the street versus their exposure to risk behaviors and vulnerability factors.

Table 4.9: Total Number of Years Lived on the Street and their Experiences in HIV/AIDS Risk Behaviors and Vulnerability

Proportion of Male Street children and youth who:	Number of years lived on the street	
	2 years and less	Above two years
Were sexually active	60.5	81.5
Started sex before the age of 15	26.5	48.4
Had more than one life time sex partners	36.7	71.1
Believed homosexuality is practiced among male street children and youth	32.2	62.2
Ever practiced homosexuality	2	4
Reported to consume alcohol	66.7	87.4
Use habit forming substances such as chat, cigarette, Ganja, Shisha, Benzine	46.9	77.3
Had the habit of watching pornographic film	50.6	72.4
Went for sex with commercial sex worker after watching sex films	76.7	90.2
Ever heard of Sexually Transmitted Infections	80.2	88.2
Ever been infected with STIs	15.2	22.2
Ever attended any form of education about HIV/ AIDS	49.4	46.9
Were able to mention all possible ways HIV transmission given in the questionnaire	29.6	24.4
Were able to mention more than two possible ways of HIV transmission given in the questionnaire	19.8	14.3
Reported their self-reported HIV positive status	5.8	13.6
Reported to use condom consistently	53.6	32.1
Ever failed to use condom due to the influence of alcohol	25.8	32.8
Perceived themselves at risk of HIV	18.5	46.2

SOURCE: Survey outputs, 2013

It also appeared that as the duration of stay on the streets increase; the opportunity for street children and youth to know about HIV/AIDS from families, schools and communities got diminished.

Information from FGD participants also confirmed that as they continued living on the street, the male street children and youth became desperate about their current and future lives. They rather engaged in risky sexual behaviours and practices.

4.8. Interventions against the Spread and Impacts of HIV/AIDS on Street Children in Addis Ababa

The key informant interviews (KII) conducted with experts at HIV/AIDS Prevention and Control Office and Labour and Social Affairs Bureau of the City Government dealt with any interventions against the spread and impacts of the epidemic among street children. The findings of the study on this particular issue are presented.

According to the explanation of the key informant, the HIV/AIDS Prevention and Control Office (HAPCO) of the City Government recognized street children and youth as one of the groups, especially vulnerable to HIV/AIDS. Unprotected sex, exclusion from the mainstream community and low risk perception were reported as some of the factors which aggravated vulnerability to HIV/AIDS among street children and youth in the City.

Recognition of street children and youth as a group with high risk of HIV infection was a step forward by itself. However, there was no evidence that such recognition was supported by appropriate interventions to reduce vulnerability and mitigate impacts of HIV/AIDS among street children. Existing interventions are rather characterized by irregular

Behavioural Change and communication (BCC) Campaigns through distribution of materials with HIV/AIDS messages. According to the participant of the KII at Addis Ababa HAPCO, the interventions were not considered as sufficient and effective as compared with the degree of vulnerability of street children to HIV/AIDS in the City. In the views of the KII participant, success was being registered in the prevention of HIV/AIDS among the general population, yet there was no evidence to claim that this achievement applied to the MARPs, including street children.

From the key informant interview with the expert at the City's Labour and Social Affairs Bureau, it was found out that HIV/AIDS was not adequately integrated into the street children rehabilitation project. The Rehabilitation Project focused more on skills training and income generation activities, compulsory savings, counseling for confidence building and familiarization with the policies and strategies of the Government. The Project also provided the street children and youth with brief health education focusing on hygiene and sanitation promotion with the aim of preventing any outbreak of communicable diseases. HIV/AIDS related works were more of occasional campaigns aimed at mobilizing street children in the Projects towards VCT.

Both Labour and Social Affairs and HIV/AIDS Prevention and Control Offices of the City had the view that little was done to address the multi-dimensional problems of HIV/AIDS among street children, while they were either on the street or in the process of rehabilitation. Some of the challenges and drawbacks in relation to existing interventions against the spread of HIV/AIDS among street children and youth included:

- Frequent mobility of street children and youth from one town to another which made prevention and treatment programs difficult;
- Lack of research based data on most important HIV risk factors specific to street children;
- Lack of comprehensive and targeted interventions that took the realities of street children and youth;
- Lack of coordination and networking among different actors, including NGOs working on street children and HIV/AIDS;
- Existing interventions were sporadic that lacked continuity and systematic documentation of lessons and processes; and
- Absence of systematic mapping on the number, situations and overall background of street children in the City of Addis Ababa.

In general, both the quantitative and qualitative findings which have so far been discussed in this chapter show that street children and youth who participate in the study are very close to HIV/AIDS risk factors and behaviours. The circumstance they are living in and their lack of access to HIV prevention, as well as treatment and care services place the street children and youth at high risks of HIV infections and high level of susceptibility to its impacts.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1. Conclusions

The research on the vulnerability of male street children and youth was conducted on a total of 200 street boys aged between 15 and 24 years, who were gathered from all sub-cities of Addis Ababa and admitted to socio-economic rehabilitation project through cobblestone production in Yeka sub-city of Addis Ababa City Government Administration, Ethiopia.

Most male street children and youth are school dropouts mainly at primary level of education. One of the exceptional findings of this study is that dropouts and graduates from colleges and universities are joining streets, although their numbers are insignificant. Many of the male street children are categorized as “children of the street” and had no roots in the city, as many of them were migrated from other cities and towns outside of Addis Ababa. Thus, children with urban origins are more likely to join streets than children from rural areas.

The phenomenon of street children is strongly associated with death of patent. It also appeared that many children tend to join streets after their ages of 15. Poverty and lack of parental care and protection at home are the root causes for the study participants to become street boys. Street boys preferred streets as coping mechanisms for the hardships of life at home due to parental death, poverty or lack of peace and protection at home. Many leave homes for search of jobs, in times of crisis or conflicts within the family.

However, there is no one single factor responsible for the coming out of children and youth into the streets; and the factors are rather multiple and acing simultaneously.

In the study, it is also concluded that male street children and youth in the city of Addis Ababa become sexually active at their early teen ages. They experience their first sex with female sex workers, shortly after they started living on the streets. Pornographic films play significant roles in driving many male street children and youth into sex. It is hardly possible for the male street children and youth to have regular sexual partner, even on temporary basis. Multiple sexual partnerships are, therefore, one of the features of sexual behaviors of male street children and youth. Their sexual networks and contacts are diverse and multiple. Starting sex at early ages, frequent sex with female sex workers together with the overall distressing circumstances of street life are some of the factors that influence the study participants to engage in multiple sexual partnership.

For street boys, streets are not only the places to work and live, but also the grounds for learning and exercising new sexual practices. Street boys in Addis Ababa engage in homosexuality, and in most cases, they start the practice as victims of rape, and gradually they accept the act as a normal practice. Homosexuality also takes place in the form of transactional sex in exchange of financial, material or other forms of benefits. Street boys are being targeted by men who have sex with men. It seems that the phenomenon of street children, in the city, is becoming a ground for expansion of homosexuality and other risky sexual behaviors. There is also an emerging trend that street boys in Addis Ababa are being objects of sexual indulgence for women as well. However, the street boys tend to take this

as an opportunity, mainly because of the financial and material incentives involved in exchange for sex with the women.

Consumption of alcohol and other habit-forming substances is part of the daily routines of male street children and youth. For many of street boys, use of alcohols and substances usually followed by sexual intercourse mainly with female sex workers. The behavioral, health and other consequences of these habits are either unrealized or ignored by the children and youth.

The prevalence of self-reported infractions with STIs among the street boys is very high (18.3%). Nevertheless, their healthcare seeking behavior and practice for treatment of STIs is very low. Their knowledge about the transmission modalities and prevention mechanisms, however, lacks clarity and it is characterized by misconceptions.

The male street children and youth are quite informed of HIV/AIDS. However, their knowledge and understandings are shallow, superficial and inconsistent, mainly with regard to the modes of HIV/AIDS transmission and prevention mechanisms. Abstinence and faithfulness are not practically taken as HIV/AIDS prevention mechanisms among the study participants. Condom is perceived by many street boys as a barrier to sexual pleasure. Consistent use of condoms by street boys is affected by low risk perception behavior and the influence of alcohol and other substances. Many of them do not think that they have ever been at risk of HIV infections in their lifetime. In a nutshell, the level of awareness

and information of the male street children and youth about HIV/AIDS are not supported by comprehensive knowledge, appropriate practices and changes in behavior.

This study also concludes that male street children and youth in Addis Ababa experience considerably high level of vulnerability to HIV infection. The rate of self-reported HIV prevalence among the male street children and youth is 9.7%, which is nearly 49 times higher than the prevalence for other young men (aged 15-24 years) in the general population. Although subject to further research, it may be difficult to take this self-reported data as conclusive evidence and as a true prevalence of HIV among the study participants, as it was not clinically confirmed.

The factors that place male street children and youth at greater risk of acquiring HIV/AIDS are multiple and compounded which act jointly and simultaneously. The most common HIV/AIDS risk factors and conditions include limited knowledge about HIV/AIDS in general and prevention and transmission mechanisms in particular, multiple, unprotected and concurrent sexual partnership in most cases with prostitutes, low risk perceptions, alcohol and substance abuse, frequent infections with STIs, practice of homosexuality and sexual violence and high degree of mobility. The risk factors are related to the very nature and circumstances of street life experienced by the street boys. Poor access to HIV/AIDS prevention, treatment and care services also makes them vulnerable to the epidemic and its impacts. As the street boys continued living on the street, their likelihoods of exposure to these risk factors significantly increases. The longer the duration of life on the street, the more street boys become desperate about their futures and the lesser they are concerned with HIV/AIDS.

In Addis Ababa, the interventions against the spread of the epidemic among street children are considered insufficient both in scope and effectiveness. The interventions so far are characterized by fragmented and short-term actions with lack of research based data, in adequate coordination and networking among stakeholders, limited access to preventions, treatment and care services and absence of targeted interventions. The national successes being registered in reducing the spread of HIV and mitigating its impacts among the general populations have little or no trickledown effects on children and young people living and working on the streets .

5.2. Recommendations

As it is found out from this study, the factors that exacerbate the vulnerability of male street children and youth to HIV/AIDS are multiple and complicated. This shows any interventions towards protecting street children and youth from HIV/AIDS and its impacts should be holistic both in approach and practice. Within this general framework and based on the findings of the study, therefore, the researcher suggests the following specific recommendations.

It is noted that although the male street children youth have a good deal of information and awareness about HIV/AIDS, they critically lack change in behavior and practices. Therefore, it is crucial to design and implement quality HIV/AIDS programs that ensure comprehensive knowledge and appropriate change in behavior and practice among street children and youth. While awareness is important part of HIV prevention programs, changes in HIV-related risk behaviors is the most import outcome (Podschun, 1993).

On top of preventive programs, it is also crucial to intensively work towards mitigating the impacts of the virus on HIV positive street children and youth through creating adequate access to ART and treatment of opportunistic infections together with other psycho-social supports. The study also recommends the need for innovative approaches to ensure adherence to ART among HIV positive street children.

Any efforts against the spread of HIV among street children and youth should be able to incorporate strategies to address such risk factors as alcohol and substance abuse, other sexually transmitted infections; the practice of homosexuality and other undesired sexual behaviors prevailed in the population under study.

It is significantly important that HIV/AIDS prevention, care and treatment interventions for street children and youth should start with proper understanding of their unique situations and the circumstances they are living in. This would help not only to design and implement targeted interventions that can effectively address the root causes as well as the specific needs and problems of street children but also to make them part of the solution. Tailored interventions are believed to be effective to meet the specific needs and HIV risk profile of street children and youth (Greenberg and Neumann, 1998).

The focus and scope of the ongoing rehabilitation programs being implemented by the Labor and Social Affairs Bureau of Addis Ababa City Government Administration need not be limited to economic rehabilitation of the street children and youth. It is rather recommended the rehabilitation should be as comprehensive as possible, addresses such issues as HIV/AIDS, alcohol and substance de-addiction, sexual and reproductive health,

behavior modifications and correctional rehabilitations. The probability of achieving positive outcomes is maximized by combining a number of components in rehabilitating programs (Mcguire, 2001). This requires multi-disciplinary approach involving professional from the fields of social work, sociology, psychology, health, education and training, economics, social administration.

The findings of the study also suggest that ensuring legal protection of street children and youth against sexual exploitations, trafficking and other forms of abuse helps to reduce their vulnerability to HIV/AIDS. Therefore sensitizing law enforcement agencies to provide protection of the rights of children in general and protection of street children in particular, against sexual exploitation is fundamental. Protection of street boys from sexual abuse can also contribute towards preventing the emergence and spread of new sexual behaviors such as the practice of homosexuality as one of HIV risk factors.

Peer influence among street children is high, and such an influence can lead to both positive and negative outcomes (Greenberg and Neumann, 1998). It is therefore beneficial to capitalize on the positive aspect of the peer influence as an opportunity for behavior change communication among street children and youth towards HIV risk reduction behaviour. Andrew Malekoff (2004) emphasizes that helping people to explore their own strengths to improve their own situations is not an option for social workers but an obligation.

The long-term and sustainable solution for preventing children and young people from HIV/AIDS as the result of their engagement in street life could be tackling the underlying

causes of the street phenomena itself. As noted by University of California San Francisco [UCSF] (1994), it is hardly possible to conduct HIV prevention among street people without tackling the bigger issue of homelessness. Therefore, the need for child-protection based integrated community development and family empowerment programs are critically important.

In order to effectively address the problem of Street children and HIV/AIDS all actors including relevant government ministries at different levels, local and international NGOs, faith based and community based institutions need to work in networking and partnerships. This would help the stakeholders to broaden the scopes of their intervention, share experiences, mobilize recourses, tackle challenges together and maximize their powers for influencing policies and practices.

Finally, the researcher recommends further studies on the social epidemiology of HIV/AIDS among street children and youth to have clinically confirmed data on the prevalence of the epidemic among the study population. Comprehensive Social Work, behavioural and sociological research on the socio-demographic, risk factors and overall situations of street children and youth are still crucial to feed practitioners, researchers, policy makers and program designers, and even the knowledge reservoir.

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