Assessment of Sexual and Reproductive Health Problems of Street Youth in Addis Ketema Sub City of Addis Ababa, Ethiopia

MSW Project Work

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CERTEFICATE

This is to certify that Mrs Bezaye Ketema student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for her project work for the Course of **MSWP-001**. Her project work entitled

Assessment of Sexual and Reproductive Health Problems of Street Youth in Addis Ketema Sub City of Addis Ababa, Ethiopia

Which she is submitting, is her genuine and original work.

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Table of Contents

List of Tables

List of Figures

Acronyms and Abbreviations

AGOHELAMA	Abebech Gobena Yehetsanat Kebikabena Limat Mahiber
AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
CBOs	Community-Based Organizations
CSOs	Civil Society Organizations
FBOs	Faith-Based Organizations
FGC	Female Genital Cutting
GO	Governmental Organizations
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
MSW	Master of Social Work
NOGs	Non-governmental Organizations
RH	Reproductive Health
SC - USA	Save the Children – United States of America
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YRH	Youth Reproductive health

Glossary

- **Sexual health** WHO (World Health Organization) working definition 2002: Sexual health is a state of physical, emotional, mental and social well-being. In relation to sexuality, it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.
- Sexual health also encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own value'' SIECIS,2002.
- **Reproductive health** A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (DFID, 2004; United Nations, 1995).
- The definition of **street youth** in this study is modified from WHO's training module on Substance use, sexual and reproductive health including HIV/AIDS and STDs (World Health Organization (WHO), 2000. *Working with street children: A Training Package on Use, sexual and reproductive health including HIV/AIDS*). Street youth are defined as young people

    - Who are 'of the street', having no home but the streets. Their family may have abandoned them or they may have no family member left alive. Such youth have to struggle for survival and might move from friend to friend, or live in shelter such as abandoned buildings.

    - Who are 'on the street', those who visit their family regularly. They might even return every night to sleep at home, but spends most days and some nights on the street because of poverty, overcrowding, sexual or physical abuse at home.

- Who is 'a part of the street family'? Those who live on the sidewalks or city squares with the rest of their family. Family displaced due to poverty or natural disaster may be forced to live on the street.
- Who are in institutional care, having come from a situation of homelessness and at risk of returning to a homeless existence.

- **Youth -** In this study, youth is defined as people whose ages fall in range of certain intervals which range between age 15 and 24 years.
- **Problem** – is a perceived gap between the existing state and a desired state, or a deviation from a norm, standard, or status quo. Although most problems turn out to have several solutions (the means to close the gap or correct the deviation), difficulties arise where such means are either not obvious or are not immediately available. http://www.businessdictionary.com/ definition/problem.html#ixzz16hGsD5Ux.
- **Sub City** - Sub-cities are municipal functions within the bounds of the physical space located for them in accordance with the principle of decentralization and in conjunction with the center of the city.(Addis Ababa City Administration, Development Tuesday, 21 August 2007).
- **Kebele –** the lowest administration unit in the Ethiopian political system.

CHAPTER I

INTRODUCTION

Human beings in the world can be considered as a social group. In order to talk about social groups of different types, we can base our classification on various dimensions of social stratification such as age, sex, economic status, or wealth status. Disaggregated by age, we use different terms to refer to people from all walks of life. The terms, for example, we use to refer to people in the age range of 0 to 24 years: children (from birth to 18 years), adolescents (10 – 19 years), youth (15-24 years) and young people (10 – 27 years). However, these categories vary depending on the context and source of information (SC-USA and UNDP, 2009, p.6). Since youth make up a large proportion of the population, particularly in the developing countries, they have to give due attention to this section of their population. Youth can change the world in astonishing ways, making it a better place for themselves and everyone.

Young people who spend a considerable time on the street, often referred to as 'street youth'. They are increasingly present all over the world. The exact number of street youth is difficult to estimate. They are a transient and difficult to reach section of population. The estimated number of street children in the world ranges from 10 million to 100 million (WHO, 2000a, P. 7). Most are found in large, urban areas (metropolis) of developing countries including Sub-Saharan African countries like Ethiopia. In Addis Ababa, the estimated number of street children was between 50,000 and 60,000 in 2003. (MOLSA, 2004, p.1).

All people in general and the (street) youth have the right to sexual and reproductive health (SRH). Conversely, the fulfilment of women's and girl's reproductive right by providing access to quality SRH and HIV and AIDS education services would facilitate their enjoyment of other rights (UNDIPA, 2007, p.36). Sexual health is broadly a personal sense of sexual well-being as well as the absence of disease; infections… can hinder or enhance sexual expression (WHO, 2000b, p. 3).

RH is also a state of complete physical, mental and social well-being … the best chance of having a healthy infant (WHO, 19997, p. 1-8). There are basic package of sexual and reproductive health services (SRHs) in the nations of the world (NFPA, 2008; ECOSCO, 2009, p. 27). Comprehensive reproductive health encompasses adolescent reproductive health care, family planning (FP), maternal and newborn health care, safe abortion care, protection from and response to gender-based violence (GBV), and prevention and treatment of STI/RTI/HIV/AIDS (IAFM, 2010, p. 9).

Problems related to street youth are relatively recent and multifaceted phenomena in developing countries in general and in urban areas in particular. The vast majority of these people work and live along the streets. This group has personal sense of sexual well-being and social aspects of sexuality, which may influence its thoughts, feelings, etc., can be expressed in many different ways, and are closely related to the environment each street youth finds oneself in.

In Addis Ababa, like other parts of the developing countries, street youth have been facing multifaceted problems because they are involved in streetism - ways of life along streets. They are suffering from malnutrition, ill sexual and reproductive health, psychological and physiological disorder, lack of clothing, shelter, medical facility,

education, abortion, etc. the street youth also start sexual intercourse at younger ages willingly or as the consequence of coercion. They tend to engage in risky sexual behaviours (such as prostitution, multiple partners, infrequent condom use and unusual sexual intercourses).

However, street youth that are part of a large proportion of the youth population in the city face different types of ill sexual and reproductive health. The sexual and reproductive health (SRH) needs are largely unmet (SC-USA and UNFPA, 2009, p.6). Thus, the unmet needs for the comprehensive package of SRH services among youth in general and street youth in particular is more than that of married women (Population Council and FHI, 2005, p. 60). Such unmet needs affect the efforts for achieving certain MDGs set.

Since street youth, like other people, have the right to have access to SRH services; a number of indigenous international NGOs, CBOs, FBOs, CSOs in partnership with different UN agencies, embassies and so on have been serving their respective target populations, including street youth in Addis Ababa. The context services and practice of SRH services may vary in those organizations as each of them emphasize on one basic SRH services and/or no standardized tool kit for addressing the comprehensive SRH services to the street youth. Some services may be structured and practiced in line with the donors/partners' requirements and strategy and framework. Still other organizations may stick to the requirements on the part of the Ethiopian government and/or the city government Administration of Addis Ababa's full-fledged requirements. Some other providing organizations may clearly define what shall be the standardized toolkit, context and practice of the SRH services in a particular case, while other NGOs may leave the choice of the services for their respective client. It, therefore, becomes

imperative of to assess the existing sexual and reproductive problems of street youth in Addis Ketema Sub City of Addis Ababa, Ethiopia in the light of prevailing context, services package and existing achieve works.

1.1. Statement of the Problem

Street youth face lot of problems and encounter challenges in their daily routines of social life in different environments. Street youth engage in activities that may put them at risks for sexual and reproductive health problems such as alcohol, use of drug and other substances and risky sexual behaviours (like survival sex work, drug addiction, prostitution, and multiple partners for additional income without using condoms).

In addition, many of young street girls are sexually affected and harassed by street boys, police and other persons along the streets during daylight and/or at night. Street youth face these and other multidimensional SRH problems because they eke out their life along streets and they also start sexual intercourse at early ages willingly or unwillingly which in turn, result in sexual and reproductive health problems. These problems do have adverse effects not only on street youth but threaten the economic, social, political and cultural activities of the country. In general, the street youth's SRH problems affect directly or indirectly the development endeavours of the country, Addis Ababa, Ethiopia.

Professionals from different fields of study have attempted to study one aspect of the problem or another. Even some researchers focused on youth's SRH needs from their own fields of specialization. Still other professionals studied the street youth's SRH problems in health or medical or public health perspective without considering close investigation of the problems and their suggestions for action in practical manner at

different levels of social work intervention to alleviate their problems. Accordingly, adolescents' health service utilization pattern, domestic violence against girls premarital sexual practice among school adolescents, quality of family planning services, RH knowledge and attitude among adolescents, quality of care in FP services, post abortion care, fertility awareness and post-abortion pregnancy intention, determinants of condom use, obstructed labour, RH needs of out-of-school adolescents, social dimensions of female genital cutting (FGC), organizations' work and experiences in combating female genital cutting, young people's HIV/AIDS and RH needs and utilization of services, perception of the risks of sexual activities among out –of – school adolescents, and youth RH problems and service preferences were studied for decades (e.g. Berhane, Berhan and Fantahun, 2005; Lhoha et.al., 2003; Girma, Assefa 2006; Lindner, 2008; Mladonova, 2007; Ethiopian Public Health Association (EPHA), 2005; Dawud, 2003; Abudeker, 2004).

Nevertheless, the vast literature on the Ethiopian social work has been documenting and focusing on SRH problems and services in social research perspective, but not in social work perspective. For example, street children services in relation to NGOs activities (Hailu, 2006) and NGOs' responses to commercial exploitation of children (Tesfaye, 2007). Even some other studies in social work discipline in Ethiopia focused on NGOs' contributions to different aspects of NGOs' interventions to bring about development in different contexts. Surprisingly, the most recent studies also followed the same path as before years ago. Thus, the sexual and reproductive health problems of street youth in Addis Ketema Sub City of Addis Ababa, where there are a concentrated size of street children are found in the largest market (i.e. Merkato) and the biggest bus station are

located becomes relevant and researchable problem in social work perspective at this juncture.

1.2. Objectives of the study

This project aims at assessing sexual and reproductive health (SRH) problems of street youth in Addis Ketema Sub City of Addis Ababa, Ethiopia. The objectives of the study are thus the following:

- To assess and identify existing SRH problems among street youth (15 – 24 years) in Addis Ketema Sub City of the City Administration of Addis Ababa;
- To examine and identify factors that may contribute to and exacerbate street youth's SRH problems in the Sub City;
- To identify to whom the youth turn when they have faced with SRH problems, their utilization pattern of the SRH services, and
- To identify the existing gaps in the practices of NGOs and GOs, particularly Childe Aid – Ethiopia (CHAD –ET) which have been providing the youth with the services in their respective catchment areas of the Sub City in Addis Ababa.

1.3 Definition of Key Terms

- Sexual health is defined as a state of physical, emotional, mental and social well-being. In relation to sexuality, it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. (WHO, 2002).

- **Reproductive Health** is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (DFID, 2004; United Nations, 1995).

- **Youth -** is operationally defined as people whose ages fall in range of certain intervals which range between age 15 and 24 years.

- S**treet Youth** is defined as young people who are 'of the street', having no home but the streets, their family may have abandoned them or they may have no family member left alive. Such youth have to struggle for survival and might move from friend to friend, or live in shelter such as abandoned buildings; those who are 'on the street', those who visit their family regularly; they might even return every night to sleep at home, but spends most days and some nights on the street because of poverty, overcrowding, sexual or physical abuse at home; and/or Who is 'a part of the street family'? Those who live on the sidewalks or city squares with the rest of their family. Family displaced due to poverty or natural disaster may be forced to live on the street (WHO, 2000a).

- Adolescence is defined as the period between 10 and 19 years of age. It is a continuum of physical, cognitive, behavioural and psychosocial change that is characterized by increasing levels of individual autonomy, a growing sense of identity and self-esteem and progressive independence from adults (SC-USA and UNFPA, 2009, p.5).

1.4 Limitations of the Study

The main limitation, especially at the beginning, was to be accepted by the street children. At last, during my stay in the field setting, I got the chance to establish and very close relationships and frequent interactions with the street youth in Addis Ketema Sub City. Since the whole research was time limited, it required me a huge amount of tolerance, sensitivity, and tight pressure to get the necessary quantitative and qualitative data in different contexts. There were no other significant limitations which could be mentioned, apart from the problems arising due to lack of sufficient language knowledge in the youth's colloquial words or expressions, while they were discussing some sensitive issues in their day-to-day activities.

However, these problems could be more or less solved with the help of trustworthy, developing very friendly and cooperative socio-economic contacts with field assistants who guided me around, introduced me to the street youth that are dwelling in every pocket of the community. Here, I already got convinced that although I had been trying my best to learn few of the colloquial words or phrase or expressions which allowed me to engage in a basic conversation, it would have been impossible for me to conduct the descriptive survey in general and the interviews in particular on my own. Therefore, I am most grateful for the help and support I have received from the children. In this regard, it should be mentioned that the interviews which I have managed to hold in setting were interpreted by my well versed assistant, whereas interviewees who had exposure to such a research undertaking were interviewed by me.

In addition, I may gloss over some materials and do not incorporate possible arguments and counterarguments and even empirical findings which may substantiate some my

own findings due to time constraints. Generally, all of those problems and constraints on my part may shadow few of the findings of the study under consideration.

1.5 Organization of the Thesis

The MSW thesis is organized in to five chapters. The first chapter is an introduction which introduces the readers to statement of the problem, objectives of the study, and limitations of the study. The second chapter presents and discusses review of related literature. It also highlights both conceptual/theoretical literature as well as empirical literature. The third chapter describes the study area, design and methods, including sampling method, data collection tools and procedures, data processing and analysis, and even some of the ethical issues which were considered in the actual research undertakings. Chapter four presents data analysis, interpretation and discussion of the major findings of the study in the light of those of other relevant classical and latest literature on the issues under investigation which were conducted elsewhere in the world. Finally, the thesis presents conclusions and suggestions to be implemented by the NGOs in culture - and context-sensitive manner in the study area.

CHAPTER II

LITERATURE REVIEW

2.1 Conceptual/Theoretical Framework

There are some theoretical thoughts related to one's body, sexuality and identity resulting from this are very closely related terms and of paramount importance when dealing with sexual and reproductive health on the part of the youth. The body of humans, and especially women, is a medium of culture: The body, as Mary Douglas has argued, is a powerful symbolic form, a surface inscribed and, thus, reinforced through the concrete language of the body (Douglas, 1966 and 1982 cited in Bordo, 1997: 90).

The French scholars like Pierre Bourdieu and Michel Foucault have argued that the body is a practical, direct locus of social control and "female bodies become docile bodies - bodies whose forces and energies are habituated to external regulation, subjection, transformation, "improvement"' (Bourdieu, 1977, p. 94) and are surfaces for manipulation (Radnoth, 1999, p.74).

As stated earlier, men also have bodies and therefore are physical bodies common to all humans, while the social body is historically and culturally constructed and relative. Anthony Synnott (1990: 1 cited in Currie, 1992: 17) stated:

> We [must] discuss first the social construction of the body, i.e. the attribution of meanings to the body and therefore to the self: the way in which society models our construction of ourselves as tomb (Plato), temple (Paul), machine (Descartes) or self (Nietzsche, Sartre). These conceptual paradigms are no doubt of paramount significance for how people live their lives and regard themselves; but society has

> a very direct, immediate and physical impact upon people also. Our ideas do construct us, but so do our jobs, hobbies, lifestyles, and social roles. We are physically constructed by society, whether we like it or not; and in the end we are sometimes destructed by that same society.

Before we are constructing our body, it is firstly constructed by the value system of the society we are living in. Although we also have influence on what to do with our body, we are nevertheless guided by what others think, by what is expected from us to do, by what is society expecting from us how to look like. And therefore, the body is only "properly human" when it is culturally acceptable (Synnott, 1990, p. 11 cited in Currie, 1992, p. 18).

In order to understand human beings' health behaviours in general and youth section of the population in a certain society in particular, scholars have developed different theoretical models which are fundamentally guiding both our current and future understandings of health behavior, as well as providing direction for our studies and development interventions. Evaluation and comparison of the different theories reveals that they are not so different in terms of their differential predictions. Most differences really amount to emphasis on one construct over another. Cummings and Colleagues, therefore, conclude that theories which integrate ideas from other competing theories provide more explanatory power than other approaches (WHO, 1977).

The common health behaviour models generally include: health belief model, theory of reasoned action, theory of planned behaviour, social cognitive theory, health promotion planning matrix – precede-proceed model, and trans-theoretical model which , in turn, involves 5 major stages in an attempt of understanding health behaviours.

2.1. 1. Health Belief Model

The Health Belief Model (HBM) argues that someone's decision to take action to prevent illness depends upon the individual's perception that is personally vulnerable to the condition; the consequences of the condition would be serious; the precautionary behaviour effectively prevents the condition; and the benefits of reducing the threat of the condition exceed the costs of taking action. The Model's four key components are, thus, conceptualized as perceived susceptibility, severity, effectiveness, and cost.

2. 1.2 Theory of Reasoned Action

This is a widely used Theory as one of the behavioural prediction theories which represents a social-psychological approach to understanding and predicting the determinants of health-behaviour. There are two basic assumptions that underlie the TRA. These are: Behaviour is under volitional control; and people are rational beings. The TRA was also designed to predict behaviour from intention, and proposes quasimathematical relationships between beliefs, attitudes, intentions, and behaviour. Behavior is direct results of intention. Intention is also made up of attitudes and subjective norms. Attitudes are further based on beliefs. Finally, subjective norms are derived from what one believes others think one should do and motivate to comply.

2.1 3. Theory of Planned Behaviour

This Theory is a modification of the theory of reasoned action (TRA). It is concerned with and gives more emphasis on perceived behavioral control over the action, and self-efficacy.

2.1 4. Social Cognitive Theory

Social Cognitive Theory (SCT) is also referred to as Social Learning Theory. This Theory goes well beyond individual factors in health behaviour change to include

environmental and social factors. The Theory conceptualizes influences on behaviour as that involved the concept of person in terms of basic human capacities that are cognitive in nature. Key concepts associated with the person include: personal characteristics, emotional arousal/coping, behavioural capacity, self-efficacy, expectation, expectancies, self-regulation, observational/experiential learning, and reinforcement (IEJHE, 2003).

2.1 5. Health Promotion Planning Matrix – Precede – Proceed Model

The Matrixes operate either at primary (hygiene and health enhancement), secondary (early detection) or tertiary (therapeutic) stages of prevention. It may accurately be seen as an intervention whose purpose is to short-circuit illness or enhance quality of life through change or development of health related behavior and conditions of living. The Precede framework (*p*redisposing, *r*einforcing and *e*nabling *c*onstructs in *e*ducational/*e*nvironmental *d*iagnosis and *e*valuation) takes into account the multiple factors that shape health status and helps the planner arrive at a highly focused subset of those factors as targets for intervention. Precede also generates specific objectives and criteria for evaluation. The Proceed framework (*policy*, regulatory and *o*rganizational *c*onstructs in *e*ducational and *e*nvironmental *d*evelopment) provides additional steps for developing policy and initiating the implementation and evaluation process (Glanz, et.al., 2002, p. 99-100).

2.1.6 Trans-theoretical Model (TTM)

Tran-theoretical Model (TTM) is a model of intentional behaviour change that has produced a large volume of research and service across a wide range of problem behaviours and populations. The TTM is a model of intentional change that focuses on the decision-making abilities of the individual rather than the social and biological influences on behaviour as other approaches tried. This Model describes the

relationships among stages of change; processes change; decisional balance, or the pros and cons of change; situational confidence, or self-efficacy in the behaviour change; and situational temptations to relapse. This Model has several advantages over other Models. First, it describes behavior change as a process, as opposed to an event. Then, by breaking the change process down into stages and studying which variables are most strongly associated with progress through the stages. This model provides important tools for research and intervention development individualized, stage-matched, expert system interventions (see below) that target those variables most predictive of progress for individuals at each stage of change. One aspect of this model that often goes unrecognized is that it is the processes of change that drive movement through the stages of change. Thus, although commonly referred to as the "Stages of Change.

Model" since "stage" is the core construct around which other model constructs are organized; this is a misnomer since it focuses attention on only one construct from this multidimensional model. Naturally, model-based interventions are multidimensional as well. TTM research has found remarkable similarities across different kinds of behavior changes. We have found repeatedly that the stages of change have predictable relationships with the pros and cons of behavior change, confidence in behavior change, temptation to relapse, and the processes of change. The largest numbers of Trans-theoretical model related intervention studies have been for smoking and condom use.

Stages of Change

Individuals do not change their behavior all at once they change it incrementally or stepwise in stages of Change. The stages most commonly used across research areas include: Precontemplation, Contemplation, Preparation, Action, and Maintenance. Individuals do not typically move linearly from stage to stage, but often progress and

then recycle back to previous stage before moving forward again. This change process is conceptualized most meaningfully as a spiral, which illustrates that even when individuals do recycle to a stage they've been in before, they may still have learned from their previous experiences. Self efficacy is important for stage transition across all stage change.

Precontemplation describes individuals who for many reasons do not intend to change within the next six months. Some of these individuals may want to change at some future time, but just not within the next six months. Others may not want to change at all and, in fact, may be very committed to their problem.

Contemplation describes individuals who are thinking about changing their problem behaviour within the next six months. They are more open to feed back and information about the problem behavior than their counterparts in Precontemplation.

Preparation stages are committed to changing their problem behavior soon, usually within the next 30 days. These people have often tried to change in the past and/or have been practicing change efforts in small steps to help them get ready for their actual change attempt.

The ***Action stage*** includes individuals who have changed their problem behavior within the past six months. The change is still quite new and their risk for relapse is high, requiring their constant attention and vigilance.

Maintenance stage individuals have changed their problem behavior for at least six months. Their change has become more of a habit, and their risk for relapse is lower, but relapse prevention still requires some attention, although somewhat less than for individuals in Action stage.

Processes of Change

The processes of change describe the cognitive, emotional, behavioral, and Interpersonal strategies and techniques that individuals and/or change agents (therapists, counselors) use to change problem behaviors. The processes of change are also ideal tools for process-to-outcome research and in many ways provide the foundation for TTM expert system intervention. The processes of change are consistent with many SCT constructs and are quite similar to most conceptions of coping behaviors as well. Many studies across problem behaviors have found that the ten most used processes of change are organized into two higher order clusters of processes: the experiential processes—Consciousness Raising, Dramatic Relief, Self-Reevaluation, Environmental Reevaluation, and Social Liberation; and the behavioural processes—helping Relationships, Counter conditioning, Reinforcement Management, Stimulus Control and Self Liberation.

Decisional Balance

Decisional Balance, or the pros and cons of behavior change, describes the importance or weight of an individual's reasons for changing or not changing. The pros and cons relate strongly and predictably to the stages of change. The pros are the positive aspects of changing behavior, or the benefits of change (reasons to change).

In contrast, the cons include the negative aspects of changing behavior, or barriers to change (reasons not to change). These two dimensions have been consistently supported by studies across many different problem behaviors in TTM-based research. Characteristically, the pros of healthy behavior are low in the early stages and increase across the stages of change, and the cons of the healthy behavior are high in the early

stages and decrease across the stages of change. The pros and cons are particularly useful when intervening with individuals in early stages of change.

Decisional balance is an excellent indicator of an individual's decision to move out of the Precontemplation stage. The TTM pros and cons constructs are quite similar to those also proposed by both the HBM (benefits/barriers) and the TRA/TPB (benefits/costs); and the evidence presented by Prochaska and colleagues across problem behaviors does provide some support for all three models.

Situational Confidence and Temptations

The self-efficacy construct utilized in the TTM integrates the models of self-efficacy proposed by Bandura, and the coping models of relapse and maintenance described by Shiffman. These variables have undergone considerable elaboration over time, with situational temptation to engage in the unhealthy behavior often viewed as an equally important companion construct to the more commonly used situational confidence measures. Confidence and temptation function inversely across the stages, and temptation predicts relapse better.

Self-Efficacy

The concept of self-efficacy is recognized as one of Bandura's most important contributions to psychology and the field of health behavior change in general. Self-efficacy refers to the **confidence** an individual has in his or her own ability to successfully carry out a behavior. The importance of self-efficacy for behavior change has been widely recognized across multiple behaviors relevant to health risk reduction. An individual with low self-efficacy is likely to have lower expectations of successfully performing the behavior and be more affected by situational temptations that are counterproductive to promoting and maintaining behavior change.

In contrast, an individual who has High self-efficacy not only expects to succeed but is actually more likely to do so. Several factors influence an individual self-efficacy, including persuasion by others, observing others' behavior (modeling), previous experience with performing the behavior, and direct physiological feedback Self-efficacy exerts such a strong influence on behavior change that confidence has been found to outperform past performance in predicting future behavior. According to Bandura (2002), self-efficacy plays an important Role in the adoption of change and regulates human functioning through cognitive, motivational, affective and decisional processes. Therefore, assessment of the various socio-economic and cultural variables that contribute to low contraceptive practice is essential for promoting the use of contraception and lowering the birth rate.

2.2 Sexual and Reproductive Health

At the 1994 International Conference on Population and Development (ICPD) in Cairo, reproductive health care was defined as: “the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases”(Barroso and Girard, 2003).

Everyone has the right to enjoy reproductive health, which is a basis for having healthy children, intimate relationships and happy families. Reproductive health encompasses key areas of the UNFPA vision – that every child is wanted; every birth is safe, every young person is free of HIV and every girl and woman is treated with dignity and respect.

Reproductive health, which addresses the reproductive processes, functions and systems at all stages of life, is aimed at enabling men and women to have responsible, satisfying and safe sex lives, as well as the capacity and freedom to plan if, when and how often to have children.

Reproductive health does not start out from a list of diseases or problems - sexually transmitted diseases, maternal mortality - or from a list of programmes - maternal and child health, safe motherhood, family planning. Reproductive health instead must be understood in the context of relationships: fulfilment and risk; the opportunity to have a desired child or alternatively, to avoid unwanted or unsafe pregnancy. Reproductive health contributes enormously to physical and psychosocial comfort and closeness, and to personal and social maturation. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death.

2.3 Youth/ Street Youth

Throughout Sub-Saharan Africa, street youth are an undeniably growing population. Poverty, war, urbanization, disease, and broken homes are creating an environment in which millions of young people are turning to the streets. Street children comprise a vast range of often unheard voices— including abandoned children of poverty-stricken or abusive homes, children separated because of war, orphans who have lost their parents to AIDS, or youth who make the rational decision to be on the streets. The vast number of children on the streets is in many ways indicative of major government, public policy, economic, public health, and even moral breakdowns in societies.

Sub-Saharan Africa is faced with a complex web of factors which gravely heighten the risks for youth on the streets. In a continent in which 315 million people, or more than half

of the entire population, lives on less than one dollar a day, ("The Primacy of Pro-Poor Policies for Growth," *UNDP*, 2005, (1 May 2005). poverty threatens many families with the inability to adequately care for their children. In Accra, Ghana, for example, the population of street children has more than doubled in the last five years to 20,000 children and 6,000 babies (*Street Child Africa*, 1 May 2005). Previous and continuing conflicts, such as the genocide in Rwanda which claimed approximately 800,000 lives in 1994, or the continuing civil war in the Democratic Republic of Congo which to date has killed almost four million, 10 have left disasters such as the droughts in Ethiopia and the December 2004 tsunami which reached to Somalia, have also raised the vulnerability of many African youth. Additionally, disease is one of the many the risk factors for youth on the streets of Africa. By the end of 2003, 12 million children in Africa alone will have lost one or both parents to AIDS ("Launch of World Development Indicators 2005 Report," *The World Bank*, May, 2005).

In the nations of Zimbabwe, Zambia, Mozambique, Lesotho, Malawi and Swaziland, approximately 1 in 4 adults are infected with HIV/AIDS (UNICEF, 29 April 2005). In light of this, the outlook for youth is particularly bleak. There are now about 4 million children orphaned by HIV/AIDS in the Southern Africa region, with Zambia registering the highest number of orphans in the world (Ibid). Whether they are called *watoto wa mitaani* in Tanzania, *chokorra* in Kenya, or *moireaux* in the Democratic Republic of Congo, (Anthony Kopoka, "The Problem of Street Children in Africa," *University of Dar-Es-Salaam.* (2000): 7) street youth throughout Africa are a rising population who desperately cry for greater attention.

Reproductive health (RH) in general and adolescent reproductive health (ARH) in particular is of growing concern in most developing countries. Sub-Saharan Africa is the

youngest region of the world, with 44 percent of its population under age 15 in 2006 (PRB, 2007b). In Ethiopia, 11 percent of the population in 2007 is age 15-19, and 20 percent is age 15-241 (U.S. Census Bureau, International Data Base). Moreover, since Ethiopia is typical of a country with a youthful population (43 percent of the population of Ethiopia in 2007 is under 15 years of age [U.S. Census Bureau, International Data Base]), the number of adolescents have increased since then.

Lack of education, unemployment, and extreme poverty exacerbates and perpetuates the reproductive health problems faced by Ethiopian youth. The economic, political, and social situation in the country has given rise to fundamental concerns about the health and well-being of young mothers, the health and social development of children born to these young women, the well-being of young men exposed to sexually transmitted infections or who quit school early to support young families, and society's losses and obligations incurred because of adolescents and their children.

2.4 Street Youth SRH Needs and Problems

The UNFPA observes that concerns about reproductive health starts from childhood and lasts throughout the life-cycle. However, the needs of both men and women differ in each life stage. Women bear he greatest burden of reproductive health problems Research has shown that reproductive health problems account for approximately 36% of the total disease burden among women of reproductive age (15-45 years) compared to an estimated 12.5% in men in developing countries (World Bank, 1993). Sexual and reproductive health means more than just the reproductive organs and reproduction. The need to understand reproductive health within the context of relationships between men and women, communities and society is underscored. This is because reproductive and sexual health status of individuals is affected by complex web genetic predisposition, and economic,

cultural and psychological determinants (cook and Dickens, 2000). Sexual health can also be influenced by mental health, acute and chronic illness and violence (Butler, 2004)

The problem of street youth is worldwide phenomenon. Since these street youth exist in every part of the world. Large groups of youths, mostly unsupervised by adults found in almost every country of the world. The vast majorities of these children work and live large urban area of developing countries.

Global estimates indicate that every year about 3 million adolescents (one in every eight sexually active adolescents) are infected with an STD; and that the highest rates of Chalamydia are among the 15-19 year olds, mainly adolescent women (AGI, 1999' Bassett, 2000; RCAP). In many developing countries, more than half all new HIV infections are among young people 15-24 (UNFPA, 2000a). Early sexual debut and the prevalence of STIs in Africa are seen as some of he factors driving the spread of HIV infection. The WHO estimates indicate that STI rates are highest in sub Saharan Africa with 69 million new cases per year in a population of 269 million adults aged 15-49 years (Corbett, et al. 2002)

Reproductive health affects, and is affected by, the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures within which they live. Sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone. Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills.

The dimension of reproductive ill health encompasses problems such as female genital mutilation, malnutrition & anaemia, abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, Infertility, unregulated fertility, maternal morbidity & mortality, sexual & gender violence, and other related health problems (WHO, 2000, Ramakrishna Y, Karott M, Murthy RS, 2003*)*. Among women of reproductive age (15-49 years) in developing countries the burden of reproductive ill-health is far greater than the disease burden from tuberculosis, respiratory infections, motor vehicle injuries, homicide & violence or from war *(WHO, 1997; 42:1-8).*

Previous studies in many countries have indicated that street youth are particularly vulnerable of STDs and HIV infections because: most are sexually active (Lockhart C., 2002:294-311; Anarfi JK. 1997;7:281-306), have multiple sex partners, including prostitutes (Haley N, Roy E, and others, 2002), engage in homosexual activity (C. Kunyenga, 2002:294-311), provide sex in exchange for money without protection (Haley N, Roy E, and others, 2002, Swart-Kruger J, Richter LM.1997), are sexually abused (Black B, Farrington AP, 2004), rarely or inconsistently use condoms despite being aware of AIDS (Snell CL. 2002, Liverpool J, McGhee M, Lollis C, Beckford M, Levine D. 2002), are ignorant of other sexually transmitted diseases (STDs) against which they tend to self-medicate (Anarfi JK. 1997) and use illicit drug, including intravenous drug .

Ethiopian youth face many challenges. Sexual initiation often occurs at an early age due to traditions and poor living conditions. Traditional practices such as early marriage, marriage by abduction, and female genital cutting adversely affect the health and wellbeing of young people.

Rape and sexual coercion are common among young women in both urban and rural settings. Sexually transmitted diseases pose considerable risk to the youth population because of the practice of having multiple sexual partners and the limited use of condoms. Unintended pregnancies, pregnancies that occur within short intervals, and abortions pose serious health risks to young women. In addition, drug trafficking and drug abuse among the youth population continue to be of concern

In Ethiopia, our main country of focus, the plight of street children is also an increasing issue of concern in a nation in which 81.9 percent of the population lives on less than $1 a day (UNDP, 2001; 2003, p. 200).

According to UNICEF and actively engaged NGOs, there are approximately 500,000-700,000 street youth nationally, and according to the Ministry of Labour and Social Affairs, an additional 1 million are at risk for streetism.16 Moreover, with more than 1.5 million Ethiopians currently living with HIV, there is a heightened risk for AIDS orphans to end up on the streets unless they are cared for by other family members or community (UNAIDS, *Report on Global AIDS*, 2004). Broken homes and single parent families also appear to be a major push factor of children in the streets. It is estimated that fifty five percent of street youth in Addis Ababa have parents who are separated, widowed, or single (Radda Barnen, and MoLSA, 1998).

In addition to their abject poverty that has most commonly led them to the streets, most of the Ethiopian street youth are involved in unhealthy behaviours, such as smoking marijuana, drinking '*tela*' (local beer) and '*arake*' (strong spirit, similar to vodka), chewing *chat* (a stimulant and mild narcotic) and sniffing *Benson* (petrol) at the gas stations. Some work as taxi boys, and obtain these drugs and spirits in exchange for their

work. Many of the girls end up as prostitutes, sent by their families from the rural areas to find work, but who resort to commercial sex work in the absence of other forms of income. Many of the urban youth are particularly aggressive, often throwing stones, using profanity, having fist fights, or using sharp materials such as broken glass and scissors to attack each other (Interview, Emebet, March 2005). As a result, communities often ostracize street children and regard them as antisocial, dirty, and lacking in work ethic. Stigmatization compounds the street child's feelings of isolation and rejection and often becomes the major source of concern and distress, thereby dwarfing any initial trauma that may have necessitated life on the street.

According to Holly Dempsey, HIV/AIDS officer at USAID/Ethiopia, when asked if AIDS will bring down the country, she answered, "No, but street children will." (Interview, Holly Fluty Dempsey, *USAID Ethiopia*, 10 March 2005). Indeed, a significant number of young Ethiopians face daily realities of poverty and must fend for themselves on the streets without access to the necessary social networks and relationships that could lead them to an improved state of well-being.

Ethiopia's population is projected to increase to 108 million by the year 2025 (PRB, 2007a), becoming Africa's second-most populous country after Nigeria. This rapid population increase will continue to strain the government's ability to provide health care and education to young people and create conditions for even greater unemployment, poverty, and resource depletion.

Gender inequality is another major problem that affects youth reproductive health and wellbeing in Ethiopia. Gender inequality manifests itself in the low status of women and girls in the society as well as within the family, in the fewer educational opportunities

for girls, in the lack of participation of males in family planning and AIDS-prevention activities, and in the harmful traditional practices against young girls (FHI/Youth Net, 2004).

2.5 SRH Services and Utilization

The precise configuration of reproductive health needs and concerns, and the programmes and policies to address them, vary from country to country and depend on an assessment of each country's situation and the availability of appropriate interventions. Globally, however, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, STD prevention and management and prevention of maternal and prenatal mortality and morbidity. Reproductive health also address issues such as harmful practices, unwanted pregnancy, unsafe abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anaemia, and reproductive tract cancers. Appropriate services must be accessible and include information, education, counselling, prevention, detection and management of health problems, care and rehabilitation (UNFPA, 2009, p. 1).

There is consensus among the governmental and non-governmental institutions and agencies in Ethiopia that youth health and wellbeing relies on improved educational opportunities, improved economic opportunities, cultural expansion and the end of the long-held harmful traditional practices. Efforts have been made by the government and its partners to design and implement strategies, policies and programs to address the reproductive health, HIV/AIDS and gender issues of the most vulnerable age group of the country - youth.

In 2002, the Family Health Department of the MOH developed the Five-Year Action Plan for Adolescent Reproductive Health in Ethiopia (2002-2007). The main goals of the plan are to increase access and utilization of ARH services by youth, and to cause positive RH behaviour change among youth by providing better information and knowledge on reproductive health issues. Specific strategies to achieve these goals include: promotion of a positive policy and program environment; provision of knowledge and skills; and provision of quality reproductive health services for youth through youth centres, peer education, and counselling and service linkages through an efficient referral system (FHI/Youth Net, 2004).

In 2007, the MOH launched the Adolescent and Youth Reproductive Health Strategy (AYRH) designed primarily to address the problems associated with early marriage and pregnancies and abortions, polygamy, female circumcision, abduction and rape, and poor access to healthcare. The AYRH will be implemented over a period of eight years and is targeted at those age 10-24 years. This strategy calls for immediate tailored and targeted interventions to meet the diverse needs and realities of young people and reflects the commitment of the Ethiopian government to improving the reproductive health status of young Ethiopians (Plusnews Information Service07).

Youth friendly health services can be freestanding clinics or attached to existing clinics or recreational facilities. Ideally, they provide a full range of services and information to the youth. The services are provided under a setup where people are welcoming, confidentially is ensured, and services are conveniently located and affordable. Young people in Ethiopia are disadvantaged relative to older, in their lack of access to information and services for their reproductive needs because of the absence of youth friendly service delivery system. A study conducted in Kaliti and Akaki kebeles have

revealed that almost all discussants said that the media - TV, newspapers, magazines, books and especially radio - were their chief sources of information. Another study of adolescent reproductive health in East Gojjam revealed that the most common source of information on STIs/ HIV/ AIDS was the media (82%) and neighbours (67%) for urban and rural out of school adolescents respectively and more than half of the participants (55.2%) had reported that they had visited health institutions for reproductive health reasons. The majority (82.6%) have visited public health institutions and (11.5%) of them visited Family Guidance Association of Ethiopia' clinic and an equal proportion of them visited private for profit health institutions. The major reasons that prevent adolescents from visiting health institutions were reported to be too expensive services, too far health institutions, poor handling and failure to keep privacy and confidentiality by health workers, too much waiting time and it is shame for adolescents to visit health institutions.

Though youth are considered by the societies like Ethiopia relatively disease free, they are at greater risk of various health problems. There are also several misconceptions concerning HIV/AIDS, pregnancy, condom and contraceptive and they lack adequate sexual and reproductive health information to make appropriate decisions. Most of these problems were found to be more severe among out of school and street youth. In sum, the youth in general and the street youth in particular do have collective rights for sexual and reproductive health (SRH). The idea of sexual and reproductive health rights is inherent to the definition of reproductive health, and these rights are integral to globally recognized human rights. These include gender equality and the rights to education and health, including ARSH information and services appropriate to their age, capacity and circumstance. Actions to ensure implementation of these rights can have tremendous

practical benefits: empowering individuals, ensuring well-being, stemming the HIV/AIDS pandemic, alleviating poverty and improving socioeconomic prospects (UNFPA, 2004).

In Ethiopia, the Ministry of Health (2003, pp. 1-2) states that adolescence is a transitional period when a person is young and dependent. It is a period of high developmental changes in physical, mental and social conditions. In this period the adolescent youth fails to control his emotions, listen to parents' advice and begins to indulge him/her in unhealthy behavioral activities. The youth in Addis Ababa, Ethiopia is categorized in three age-groups 10 to 14 years old as teenage; from 15 to 19 years as early adolescent and 20 to 24 years as post-adolescent. These age groups face multi-faceted problems which arise from lack of understanding and proper response to the changes that occur during development, due to emotional behaviour, peer pressure and the lack of experience of the prevailing social system and its interactions. Consequently, most of the youth are exposed to casual sexual practices; unwanted pregnancy, child bearing at early age, high risk abortion, HIV/AIDS and other sexually transmitted diseases, rape unemployment, poverty and criminal acts. In addition, the adolescents don't receive adequate information and services on reproductive health. Even if services are available they don't utilize them. This situation has made the problems associated with adolescent reproductive health serious and complex. Therefore, the Adolescent Reproductive Health Programme is one of the priority components of the Ethiopian Health Extension Package.

CHAPTER III

STUDY AREA, DESIGN AND METHODS

3.1 Study Area

This study was conducted in Addis Ketema Sub City of the City Administration of Addis Ababa. The area of the Sub City is 7.41 square kilometre. It has a total population of 277, 786 persons (135,864 males and 141,922 females) in 2010(CSA, 2011, p. 44). The study area is a highly populated and slum area of Addis Ababa in which the density of population is 37,488.0 persons per square kilometre. In addition, on average, 4.2 persons per housing unit are dwelling in the area. The majority of the residents work in the Sub City as daily labourers, civil servants or businessmen and businesswomen. Prostitution is also common in Sub City due to the influx and arrival of more and more people from different parts of the country for various reasons. A total counted homeless children and youth who are living in this Sub City was 941; of which 899 were males and 42 were females in 2007 (CSA, 2010, p. 10). The same document also indicated that a total of 9,939 children; 3,131 children; and 3,302 children's mothers were only alive, fathers only alive, and both parents were died respectively in 2007. Due to these and many other reasons, the populations are highly vulnerable to HIV or SIT.

3.2 Design and Methods of the Study

This study used both quantitative and qualitative research methods. Regarding quantitative research approach, it employed descriptive survey method. Qualitatively, the present study used various types of methods under this approach such as semi-

structured interviews with key informants that was identified and selected among street youth and SRH services providing organizations in the study area. In addition, the study had conducted two focus group discussions (FGD) (one with female and one with male group). Physical observations have undertaken in some relevant contexts in the light of the study objectives. Similarly, the study was conducted documentary analysis at SRH services providing organizations in Addis Ketema Sub City.

3.3 Universe of the Study

The universe of this research project consists of street youth in Addis Ketema sub city, who have been living for at least 6 months in the study area. So far, the estimated number of street youth is 7000-10000. Street youths who have been living in Addis Ketema sub city and attending all or some types of the SRH services are included in the study.

3.4 Sampling Method

The present study used purposive sampling method due to approach and generate relevant from the street youth in the sub city, NGOs and GOs operating in the provision of SRH services. A sample of 60 street youth was selected and reasonable number of informants from the targeted youth and the organizations were approached and contacted to generate data on the issues under investigation.

Quantitative Part of the Study

Depending on the objectives of the proposed study and nature of data, different analytical tools were applied. Descriptive statistics like mean, variance, standard deviations, and frequency distributions, and percentages were used. Descriptive statistical tools are very important to have a clear picture of the respondents included in

the sample. Descriptive statistical techniques were employed for the purpose of describing the demographic and socio-economic structure of sample households in the study area.

Qualitative Part of the Study

The qualitative data collection method was utilized in order to generate information from reproductive health service providers, correctional setting, and women and children affairs office, in the study area and from female and male street youths, using focus group discussion (FGD) in order to supplement the result of the quantitative data that could not be quantified. Discussion was made with two focus groups and each group consisted of 10-12 participants. A semi-structured interview guide was used to facilitate the focus group discussion. A checklist was prepared to guide the discussion in such a way to generate relevant information. FGD was held in a quiet and comfortable place, and it took one and half hours with each group.

3.5 Data Collection Tools and Procedures

This study employed tools such as interview schedule, semi-structured interview check lists, focus group discussion check lists, documentary analysis check lists and observation check lists. The data for the quantitative section was collected using a interview schedule prepared by addressing all-important variables. These interview check lists were adopted from different literatures developed for similar purpose by different authors. It was reviewed to suit the local condition and translated to Amharic language and then back to English to ensure its consistency. These tools were first got pretested for reliability and validity of both quantitative and qualitative data to be

generated following the appropriate data collection procedures required for each method.

3.6 Data Processing and Analysis

The present study employed both quantitative and qualitative data analysis techniques respectively. The filled in and completed interview schedules was checked for completeness, verified, coded in code book, designed in master sheet, entered in to the computer and analyzed serially. Then, the quantitative data was processed and analyzed on the computer using data analysis software of SPSS version 17. In addition, the study employed univariate statistical data techniques (such as ratios, percentages, frequency distributions, bar graphs, pie charts, mean, median, range, minimum and maximum values as well as standard deviations). This survey further used logistic regression or logit model to assess and determine the association between an outcome variable that is a a categorical dichotomy (or a variable with only binary or two responses) and predictor variables that are continuous or categorical (Tarling, 2009, p. 64; Kleinbaum and Klein, 2010, p. 1).

Thematic data analysis was used to analyze the qualitative data collected. In so doing, categorization and re-categorization of relevant categories of qualitative data under relevant themes in the study was employed.

3.7 Ethical considerations

All the study participants were informed about the purpose of the study, their right to refuse and assured confidentiality and informed verbal consent was obtained prior to the interview. The instruments and procedures were not causing any harm to the study subjects, the community, and supervisor, which were involved in the study.

CHAPTER IV

DATA ANALYSIS AND MAJOR FINDINGS

This chapter presents data analysis and findings of the assessment study on sexual and reproductive health problems of street youth and then discusses the results accordingly. The aim of the chapter is to address the first, second, third and fourth specific objectives attempted to assess and identify existing SRH problems among street youth (14-25 years) in Addis Ketema Sub city of the City Administration of Addis Ababa; to examine and identify factors that may contribute to and exacerbate street youth's SRH problems in the Sub City; to identify those organizations which provide the youth who faced SRH problems, their utilization patterns; and to identify the existing gaps in the practices of the NGOs and GOs, particularly Children Aid–Ethiopia (CHAD-ET) which have been providing them with SRH services.

4.1. Socio-demographic and Economic Characteristics of the Respondents

This study was based on data collected from 60 street youth who had been clients of the Children Aid – Ethiopia in Addis Ketema Sub-City of Addis Ababa. The results of the descriptive data analysis shows that out of the total study respondents, 31 (51.7%) were males and 29 (48.3%) were females resulting in an overall male to female ratio of 1:1. The age structure of the sample respondents shows that the mean age of the respondents was 19.2 which was disaggregated by sex as 18.8 and 19.6 years for males and females; and . The age range in males was 14 – 24 years, while that of females was 14 -25 years resulting in the minimum age of 14 years for both sexes, but in different maximum ages. About half of the street youth (48.3%) were found to be in the age category of 15-19

years in the study area. In addition, from the cross-tabulation data analysis of SPSS, simple comparison of the mean age of female and male street youth reveals that the mean age of females was 19.6 years and that of males was 18.8 years. But all this tells us is that, on average, female street youth were older than males in the streets in the study area. Therefore, one may note that the males tended to be younger than the females in the streets of Addis Ketema Sub City. There were different percentages in both 14 – 19 and 20 – 25 age categories (i.e., both in the younger and older age categories). That is, 58 percent of males were in their 14s compared to 48 percent female youth, while 52 percent of females were in their 20s when compared with 42 percent of males in the streets within the territory of Addis Ketema Sub City in Addis Ababa, Ethiopia.

The majority of study participants were Orthodox Christians by religion comprising 51.7% and Muslims comprised 25.0%, but those respondents who were Protestants and without any religious affiliations constituted each 11.7%. Of the total respondents in the study, 30 (50.0%) were never married, and 20 (33.3%) were married, whereas the remaining 10 (16.7%) were divorced. The majority of the street youth in the study, 34 (56.7%) were Amhara and followed by Oromo young children, 14 (23.3%). Regarding the question on whether or not the respondents were attending school, the survey results indicated that the majority (66.7%) of the respondents had attended formal education, while 33. 3% had never gone to any kind of formal education system. However, among those who got enrolled in basic education, the highest grade reached was found to be grade 2; whereas those had been enrolled in formal education system, the highest and the lowest grade attended was grade 9 and grade 2 respectively.

Table 1 Socio-economic and Demographic Characteristics of the Respondents

Variables	Frequency	Percent (%)
Sex		
Male	31	51.7
Female	29	48.3
Age		
Less than 14	0	0.0
14 - 19	32	53.3
20 - 25	28	46.7
Marital status		
Never married	30	50.0
Currently married	20	33.3
Divorced	10	16.7
Ethnic group		
Amhara	34	56.7
Tigre	9	15.0
Oromo	14	23.3
Gurage	3	5.0
Religion		
Orthodox	31	51.7
Muslim	15	25.0
Protestant	7	11.7
No religion	7	11.7
School attendance		
Yes	40	66.7
No	20	33.3
Involvement in Income Generating Activities (IGAs)		
Yes	43	71.7
No	17	28.3

Source: Own survey results, 2011

Out of those street youth who responded affirmatively to the question about whether or not they had to work to earn their daily life along the street, the results showed that about 72 percent of them had been engaged in different income generating activities, while 28 percent had not engaged in any types of work for making a living. Table 2 depicts that 10 percent of the respondents had been engaged in shoe shinning; 25 percent in carrying small items; 6.7 percent in delivering messages; 1.7 percent in attending cars; 8.3 percent in exchange of money for sex; 21.7 percent in begging; 15 percent in peddling; 1.7 percent in both exchange for money and begging; 1.7 percent in carrying small items, attending cars and peddling; and 8.3 percent of them had not involved in any types of IGAs. Almost all youth in the study found to generate daily amount of income which showed a significant variability. The mean daily income generated from different types of IGAs on the part of the youth who eked out their lives along the street was Eth. Birr 8.68, while the minimum and the maximum income were Eth. Birr 2.00 and 18.00 in the order given. The majority (95 percent) of the respondents earned daily income less than the mean daily income. Therefore, the majority of the street youth found to earn less than USD 1 (which is poverty line as defined by the World Bank) which, in turn, clearly indicated that the street youth in the Sub City who are the clients of the CHAD-ET Organization are poor.

The survey indicated that 26 (43.3 %) of the street youth were found to be the local residents of Addis Ababa, but 34 (56.7 %) of them had come from different parts of the country. Thus, the significant proportions of the youth in the area are migrants from different corners of Ethiopia. There is a great variability in the duration of stay on the part of the respondents in the study Sub City. The minimum duration of stay in streetism was 1 year, whereas the maximum duration of street life for the youth respondents was surprising

13 years. In addition, on average, the respondents were found to reside on the streets for 3.5 years. A list of multi-faceted reason has contributed to compel the youth to experience streetism. The reasons for the respondents to become street dwellers ranged from peer pressure to looking for jobs. Therefore, about 32 percent of the respondents came out to street in order to looking for jobs, followed by 17 percent because of the death of their parents, and 10 percent due to their poor family background, 10 percent lack of peace in the family, and alcoholic family was accounted for being one of the reasons for about 12 percent of the respondents to come to streets. In the same vein, 3.3% due to displacement, 3.3% due to their change of life styles, 1.7% because of peer pressure, 10% due to illness of the bread-winner(s) in the family and 1.7% due to unwanted pregnancy. Thus, forced contextual factors at home and glittering and attractive factors in the social environments of the youth mostly force them to come out of their respective family and toil hard to eke out their daily loaves of bread on the streets.

Table 2 Type of Income Generating Activities the Respondents have been engaged in the Study Area

Type of IGAs	Frequency	Percent
Shoe shinning	6	10.0
Carrying small items	15	25.0
Delivering messages	4	6.7
Attending cars	1	1.7
Exchange of money for sex	5	8.3
Begging	13	21.7
Peddling	9	15.0
Exchange of money for sex and begging	1	1.7
Carrying small items, attending cars and peddling	1	1.7
No income generating activity at all	5	8.3
Total	**60**	**100.0**

Source: Field survey results, 2011

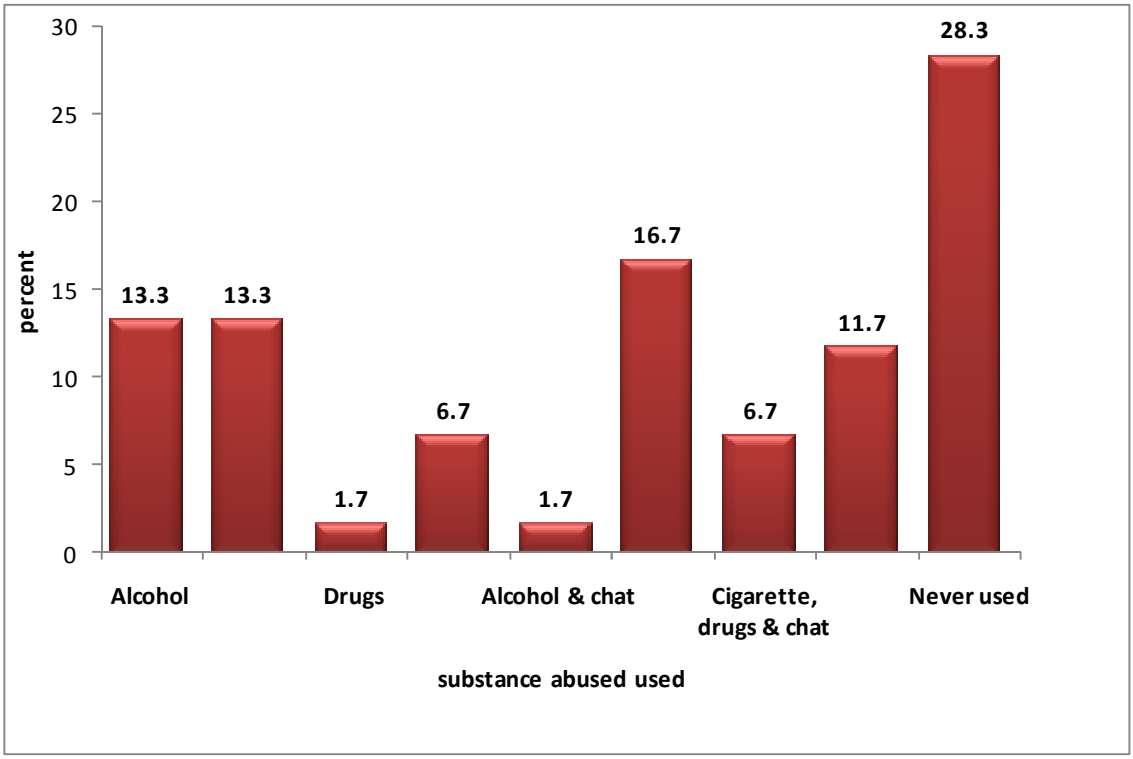
The housing conditions of the respondents as presented in Table 3 indicated that 30.0% of them had been living on the street. About 18 percent of the respondents were found to reside in small rented houses, whereas 40.0% of them had spent the nights in plastic shelters. On the other hand, 6.7% spent the day in the streets and went to their families' home to pas the nights. In contrast 5 percent of the street youth were found to live in a rental house just for the night. The majority (70 percent) of the respondents, therefore, are actually street youth, but the remaining (30 percent) are partially considered to be street youth in the study area. It can be deduced that there various ways of streetism in Addis Ketema Sub City of the City Administration of Addis Ababa.

Table 3 Places where the Respondents spent the Night in the Addis Ketema Sub City (A.A.)

Types of Residence	Frequency	Percent
On the street	18	30.0
Small rented house	11	18.3
Plastic shelter	24	40.0
Family house	4	6.7
Renting a house for a day	3	5.0
Total	**60**	**100.0**

Source: Own survey outputs, 2011

As to the issue of substance use of the street youth (Figure 1), the findings of the survey found out the majority (about 72 percent) of the study participants were addicts of one type of drug or a combination of different types of substance. Disaggregated by type, 13.3%t used alcoholic beverages, 13.3 percent smoked cigarettes, 1.7% were addicted to drugs, 6.7% chewed chat, while about 16.7 percent were found to be addicts of alcoholic drinks, cigarettes and chat, about 1.7 percent were in the category of alcoholic drinks and chat, about 6.7 percent were smokers of cigarettes, users of different types of drug and chat. Surprisingly, on the contrary, about 28.3 percent of them never used any type of substance and about 11.7 percent quite.



Source: Own survey, 2011)

Figure 1: Usage of Substance Abuse by the Street Youth in the Sub City

4.2 Sexual and Reproductive Health Practices

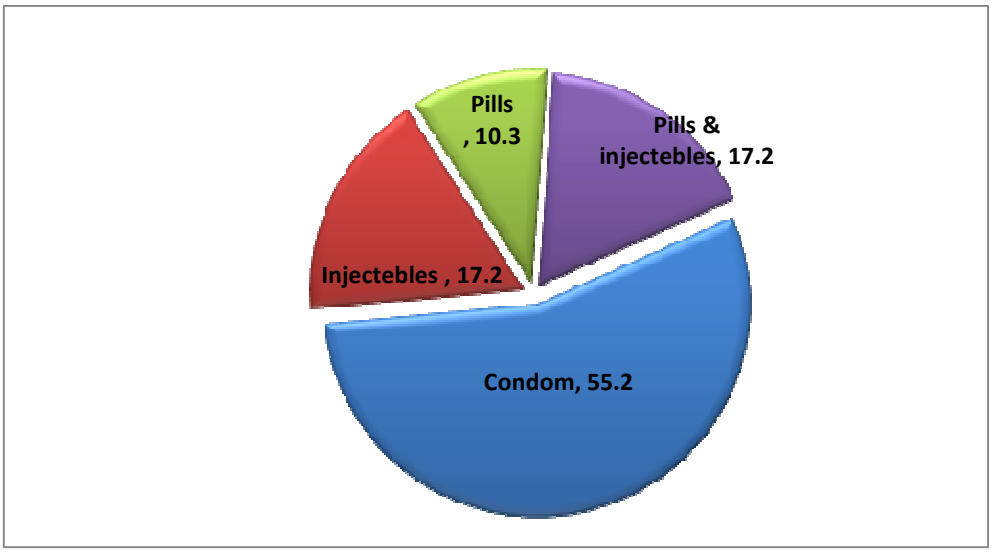
The data collected to know whether or not the respondents had had an experience of sexual intercourse in the study area had revealed that the majority of the youth in the streets experienced the sexual life. Eighty-five percent of the respondents were found to be sexually active, while fifteen percent were not sexually active as such. Among the sexually active respondents, the mean age at which the youth had begun their first sexual intercourse was 15.47 years, whereas the minimum and the maximum age at which they had first started sexual intercourses were 10 and 21 years respectively. The results of the study also showed the following reasons for their first sexual intercourses on the part of the youth: getting married (21.7%), being fall in love with someone in different contexts (6.7%),

personal desire (23.3%), being raped (11.7%), to generate daily income for making a living and in exchange of different types of gift for sex (3.3%), due to peer pressure (16.7%) and only 5% of them owing to substance influence.

The number of sexual partners the respondents has sexual partner(s) is consider as an indication of their vulnerability for sexually transmitted infections (STIs), including HIV/AIDS. More than half of the respondents had multiple sexual partners (i.e. which ranged from 2 to 5). The respondents, on average, were sexually involved with 2.38 persons. The study participants had encountered at least once a rape case. The study showed that out of the 60 sampled street youth, 43 (about 72 percent) of them were victims of rape. Among the forty-three rape victims, 23 were females and 20 were males. Rape is generally one of the many problems street youth have faced in their day to day life. This vividly proved the likelihood of being a rape victim is similar for both sexs. In addition, it throws a light in dark and shows the existence of homosexuality in their daily routines of social life in the streets in Sub-City.

With regard to the use of modern contraceptives, a significant percentage of the subjects do not use modern RH family planning methods in the study area. Only 47% of the respondents were found to utilize different types of modern contraceptives. According of their use of the types of the SRH methods, out of the total of 28 modern contraceptive users, 10.3% used oral contraceptive pills, 55.2%t utilized condoms, and 17.2% used Injectables. Moreover, about 17.2 percent used both pills and condoms. Nearly 53 percent of the respondents found not to utilize any types of the available modern contraceptives. As this finding creates a space in one's mind to engage in food for thought, the researcher further posed the question of why 53.3% of the respondents had not used any kind of contraceptives. The survey came up with the following 'discursive' reasons: religious

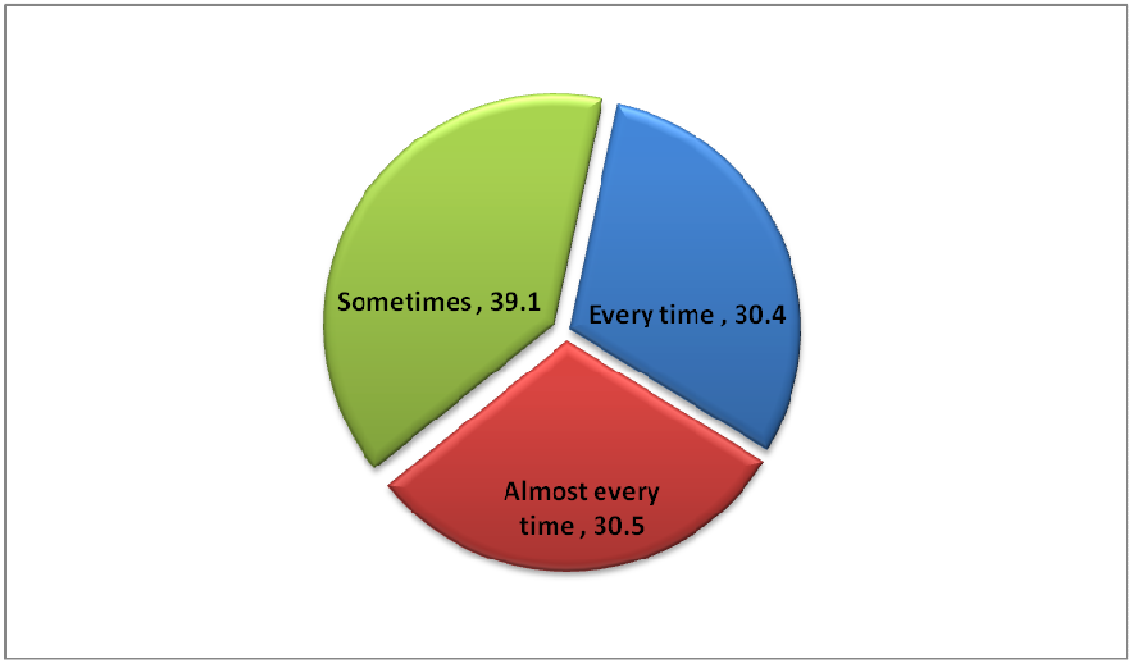
prohibition (16.7%), unwillingness to engage in unplanned sexual intercourses (30.0%), not being married youth (13.3%), lack of knowledge about modern contraceptives (13.3%), fear of side effects of the contraceptives (10.0%), lack of access or difficulty in getting the contraceptives (6.7%), and having infrequent sexual intercourses with partner(s) (3.3%). Generally, these reasons may constitute preventive factors not to utilize the contraceptives and/or SRH problems on the part of the clients of the Organization(s).



(Source: Survey results, 2011)

Figure 2: Types of Modern contraceptives used by the Street Youth in the Study Area

About 27 percent of the respondents were found to used condoms. Regarding the frequency of use of condoms, out of the condom users in the study, about 39.1 percent, 30.5 percent, and 30.4 percent were found to utilize condom sometimes, almost every time, and every time they engage in sexual intercourses respectively.



(Source: Own survey results, 2011

Figure 3: frequency of condom use by Street Youth for the last 12 months before the Study

Out of the total sampled female respondents, about 62 percent of the female street youth responded that they had been pregnant. Of the eighteen ladies who had responded as pregnant girls, 13 (72.2%) of them got pregnant one time, 2 girls (11.1%) twice, and 3 of them (16.7%) got pregnant three times before this study. Therefore, there is an insignificant average deviation (dispersion, i.e., SD=.784) in terms of their frequency of getting pregnant among the street youth. About 38 percent of the female respondents, on the contrary, reported that they had never got pregnant. The minimum age of the respondent at first pregnancy was 10 and the maximum is 20. The mean of the respondents at their first pregnancy was reported to be 15.33 years, while the standard deviation (SD=2.38) of the age at which they had got pregnant showed very little dispersion from the mean age of their first pregnancy. The outputs of the SPSS data analysis further revealed that 22.2% of the pregnancies were planned, but 77.8%t was unwanted pregnancies. Thus, these unwanted

and unplanned pregnancies appear to be one of the major SRH problems of the street youngsters.

As depicted in Table 4, not thinking of getting pregnant while engaging in sexual intercourse (50 percent), being raped (29 percent), inaccessibility of the contraceptive methods (14 percent) and failure of the contraceptive method(s) utilized (7 percent) in their decreasing order contributed their share to their unintended pregnancies. Therefore, personal problem(s) on the part of the street girls – internal factors, so to speak, are found to contribute more to their unwanted pregnancies than inaccessibility of the contraceptive methods in the study area.

Table 4 Reason(s) of the Female Street Girls for their unwanted Pregnancies

Reason(s)	Frequency	Percent (%)	Valid Percent	Cumulative Percent
Inaccessibility of contraceptive methods	2	3.3	14.3	14.3
Rape	4	6.7	28.6	42.9
Failure of contraceptive method(s)	1	1.7	7.1	50.0
I didn't think of pregnancy while engaging in sexual intercourse(s) /ignorance	7	11.7	50.0	100.0
Total	**14**	**23.3**	**100.0**	

Source: Own survey output, 2011

The findings of the survey indicated that 68 percent of the pregnant respondents had also given a birth to the babies before, but not for the remaining street girls. Out of those girls in the former category, 56% of them had given birth to only one child and 44% of them had got perpetuated by two kids before the unintended pregnancies. The mean age of giving birth was 16.75, while the minimum and the maximum ages were 11 and 21 years (with standard deviation of 2.57). Thus, on average, the street youth in the study area give birth at about their legally acceptable age category in Ethiopian case, but it seems that giving a birth early has not been identified as their SRH problem in the Sub City.

The study shows that induced abortion has not come up as a problem on the part of the street girls which requires attention. About 32 percent of the pregnant respondents went for induced abortion, whereas 68 percent of them did not resort to engage in that risky business. Of those who did abort their perpetuators, 14.3 % went to public health institutions twice for getting the induced abortions, but 85.7 % did it at their convenient venues or local contexts only once. Therefore, the significant majority of induced abortions are carried out in risky contexts, but not in a repeated manner. About 14 % of the pregnant girls discussed the issue with their husbands, 43% with boyfriends, 29% with their peers and about 14% of the female respondents had performed the induced abortion in consultation and discussion with the abortionists respectively. Thus, the significant proportions of the induced abortions are being performed by the street girls in consultation and discussion with their peers from either of the sexes.

4.3 Knowledge and Attitude towards selected Reproductive Health and HIV/AIDS Issues

Among the total study respondents, 54 (90%) of them had reported that they know at least one means of avoiding pregnancy. Regarding their specific knowledge of different ways of

preventing pregnancy, the street youth stated use of condoms (33 percent), taking pills and use of condoms (26 percent), use of oral contraceptives (16 percent), oral contraceptive pills, condoms and the practice of abstinence in combination (13 percent), Injectables (11 percent) and followed by use of condom and withdrawal (2 percent). These were the recognized contraceptive methods that had been used to avoid unwanted pregnancy. In sum, the study respondents are aware of the modern ways of preventing pregnancy.

Table 5 Respondents Knowledge of the Different Ways to avoid getting Pregnant

Ways of avoiding pregnancy	Frequency	Percent	Valid Percent	Cumulative Percent
Oral contraceptive pills	9	15.0	16.4	16.4
Using condoms	18	30.0	32.7	49.1
Injectables	6	10.0	10.9	60.0
Using pills and condoms	14	23.3	25.5	85.5
Oral contraceptive pills, condom and abstinence	7	11.7	12.7	98.2
Condom and withdrawal	1	1.7	1.8	**100.0**
Withdrawals	1	1.7		
Total	**56**	**93.4**	**100.0**	

Source: Own survey output, 2011

Out of the sixty sample respondents, ninety-seven percent of them stated that they had been aware of various types of sexually transmitted diseases and/or sexually transmitted infections. The awareness of the respondents about different types of STDs/STIs is

summarized in Table 6. About 35 % of the respondents were aware of Gonorrehea, about 28% knew about Gonorrehea, syphilis and HIV/AIDS, and about 16% gonorrehea and HIV/AIDS. Therefore, the street youth from both sexes are aware of most types of the STDs/STIs, but it appears that they still lack to be aware of the fact that HIV/AIDS is one of the STIs in the area.

Table 6 Knowledge of STDs/STIs among the Street Youth in Addis Ketema Sub City

Types of STDs/STIs	Frequency	Percent	Valid Percent	Cumulative Percent
Gonorrehea	2	3.3	3.4	3.4
Syphilis	3	5.0	5.2	8.6
Chanchroid	1	1.7	1.7	10.3
HIV/AIDS	20	33.3	34.5	44.8
Gonorrehea, syphilis and HIV/AIDS	16	26.7	27.6	72.4
Syphilis and HIV/AIDS	7	11.7	12.1	84.5
Gonorrehea and HIV/AIDS	9	15.0	15.5	100.0
Total	**58**	**96.7**	**100.0**	

Source: Own survey results, 2011

This study collected data on as to how understand the essence of safe sex as an effective way of preventing oneself from getting infected with STDs/STIs. Table 7 shows the different ways how the street youth's mind has conceive, processed and produced their understanding of the essence of safe sex in the light of preventing themselves from not getting infected with either of those STIs in the study area. The findings of the survey indicate that the youth in the streets have clearly associated safe sex with the frequent use of condoms. Thirty-nine percent of them were found to conceive of safe sex as the always

use of condoms while one had engaged in sexual intercourses. About seventeen percent of the respondents understood safe sex as a one to one sexual relationship, but without they had stated the issue of faithfulness as the basic that should be underscored in this context. In addition, insignificant proportions (15.3%) of the street youth were found to define safe sex as the utilization of not single mechanism but a combination of the mechanisms which would be believed to prevent them from those infections. These include: aabstinence, one to one sexual relationship, always use condoms, avoid unwanted sex, and don't sleep with prostitutes. Therefore, the street youth in the study area are not well-aware of the actual essence of safe sex albeit the issue has been in air and the media for years in different contexts.

Table 7 Meaning(s) of Safe Sex to the Respondents

Meaning of safe sex	Frequency	Percent	Valid Percent	Cumulative Percent
Abstinence	5	8.3	8.5	8.5
One to one sexual relationship	10	16.7	16.9	25.4
Always use condom	23	38.3	39.0	64.4
Avoid unwanted sex	4	6.7	6.8	71.2
Don't sleep with prostitutes	5	8.3	8.5	79.7
Abstinence, one to one sexual relationship, always use condoms, avoid unwanted sex, and don't sleep with prostitutes	9	15.0	15.3	94.9
One to one sexual relationship and using condoms	1	1.7	1.7	96.6
Abstinence and use of condom	2	3.3	3.4	100.0
Total	**59**	**98.3**	**100.0**	

Source: Own survey outputs, 2011

The survey also raised a question related to reasons for inconsistency of contraceptive uses, including use of condoms. Personal problems on the part of the respondents were found to far outweigh than external factors which had emanated from different sources not to use any types of contraceptives (see Table 8). The reasons for not using contraceptives on the part of sexually active youth in the streets were because of negligence (53.3%), lack of information (10.0%), being afraid to buy condom from shops (6.7 %), lack of information, religious reason, and negligence in combination accounted about 14.0%. External factors, on the other hand, were not that much influential on their part to decide not to put on the modern protective sheath. Generally, negligence, lack of information and fear for being labelled as those who use condoms to be sexy guys by people in their socio-economic environments significantly appear to be the major contributory factors on the part of the street youth not use the contraceptives.

Table 8 Reasons for Sexually Active Street Youth not using Contraceptives

Reasons for not using contraceptives	Frequency	Percent	Valid Percent	Cumulative Percent
Lack of information	6	10.0	10.0	10.0
Pressure from partners	4	6.7	6.7	16.7
Being expensive	3	5.0	5.0	21.7
Religious reasons	2	3.3	3.3	25.0
Afraid to buy it from shops	4	6.7	6.7	31.7
Not available	1	1.7	1.7	33.3
Negligence	32	53.3	53.3	86.7
Don't know	3	5.0	5.0	91.7
Lack of information and Negligence	4	6.7	6.7	98.3
Lack of information, religious reasons and negligence	1	1.7	1.7	100.0
Total	**60**	**100.0**	**100.0**	

Source: Own survey, 2011

With regard to whether or not there is access to different types of contraceptives in the setting, the study documented that significant level of easy accessibility to different types of contraceptives for the youth from both sexes. Sixty percent of the respondents stated that they had easy access to the contraceptives. One-fourth of them, however, had difficulty in accessing the contraceptives. The study further pointed out that some of the street youth had still remained in dilemma to clearly take their position concerning the level of access to the modern contraceptives in their locality. Fifteen percent of the youth did not know what to say regarding the level of accessibility of those devices.

Some reality on the ground may contribute to the street youth's lack of access to the contraceptives, including condoms as shown in Table 9. The study documented a mixed output concerning the reasons for difficult level of access to the modern contraceptives for both sexes. The street youth aired difficulty in buy the items (45.0%), the inconveniency of the places where the items are being distributed (30.0%), lack of financial resource together with the items being expensive (15.0%) and the provider disapproves the contraceptives, including condoms (5.0%). Thus, external socio-economic factors have contributed their share more than personal variables to the difficulty in accessing the above-sated devices.

Table 9 Reason(s) for Being Difficult to obtain SRH Services in the Study Area

Reasons	Frequency	Percent	Valid Percent	Cumulative Percent
Lack of money to buy the item(s)	2	3.3	10.0	10.0
Difficult to find the item(s)	9	15.0	45.0	55.0
Provider disapproves the item(s)	2	3.3	10.0	65.0
Distribution places are inconvenient for them	6	10.0	30.0	95.0
Expensive to buy the item(s)	1	1.7	5.0	100.0
Total	**20**	**33.3**	**100.0**	

Source: survey data, 2011

Table 10 Places where the Respondents can obtain condoms/contraceptives (SRH) services

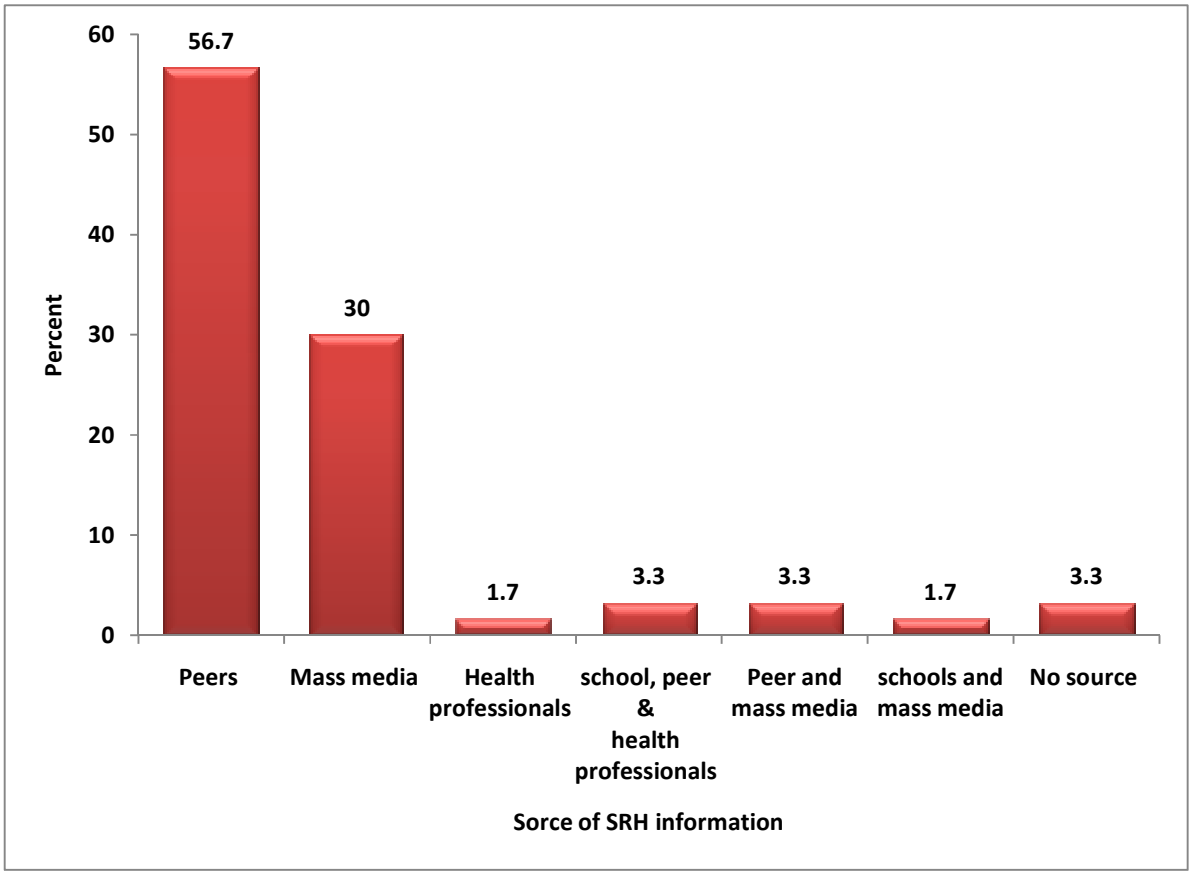
Places of SRH services	Frequency	Percent	Valid Percent	Cumulative Percent
Shop	14	23.3	23.3	23.3
Pharmacy	11	18.3	18.3	41.7
Market	1	1.7	1.7	43.3
Clinic	1	1.7	1.7	45.0
Hospital	3	5.0	5.0	50.0
EFGA/NGOs clinics	20	33.3	33.3	83.3
Bars/hotels	2	3.3	3.3	86.7
Peer	1	1.7	1.7	88.3
Shop, pharmacy and hospital	1	1.7	1.7	90.0
Shop, pharmacy, market, clinic and hospital	6	10.0	10.0	100.0
Total	**60**	**100.0**	**100.0**	

Source: Survey output, 2011

The youth respondents in the streets were found to get accessed to contraceptives, including condoms from clinics being run by EFGA/NGOs (33.3%), privately owned and run shops (23.3%), and pharmacies (18.3%). However, shops, pharmacies, hospitals, market places, clinics and/or bars/hotels were not places of the street youth's choices to access the devices in the study area – all together accounted for about 26 percent of the places to obtain the contraceptives and/or condoms for the youth.

As to the source(s) of information for the respondents about sexual and reproductive health to the street youth in the Sub City of Addis Ababa, the findings of the survey indicated that the common sources of information on SRH were found to be peers (56.7%), and the mass

media (30.0%). In contrary, health professionals; peers as well as the mass media; schools; schools, peers and health professionals; and schools and the mass media served as sources of information in the following order: (1.7%), (3.3%), (3.3%), and (1.7%). Surprisingly, 3.3% of the study participants, however, expressed that they had had nothing as their sources of information on SRH.



(Source: survey data, 2011)

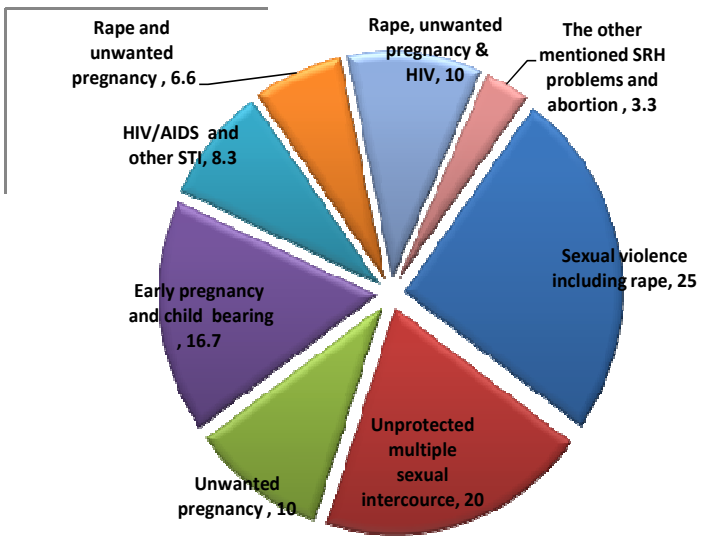
Figure 4: Sources of Information on Sexual and Reproductive Health, HIV/AIDS and other STIs of Street Youth

Level of awareness of the youth about a question on whether or not the respondents have thought that most street youth are well-informed about contraceptives/condoms (SRH services) came up mixed findings. Among the study subjects, only fifteen percent of them

responded that street youth were found to be well-informed about contraceptives, but about fifty-seven percent of them had had no information regarding contraceptives. Moreover, 28.4 % of the respondents were to add more puzzles to the problem by saying that they had not been aware of the matter under consideration.

4.4 SRH Problems among Street Youth

The study findings on the most common SRH problems among street youth put sexual violence, including rape on top with 25 percent. Twenty percent of the respondents considered unprotected multiple sexual intercourses as the major SRH problems for them. Early pregnancy and child bearing were viewed as the major SRH problems by 16.7 percent of the respondents. Unwanted pregnancy; rape; unwanted pregnancy; and HIV/AIDS were in fourth place with 10 percent each. About eight percent of the youth chose HIV/AIDS and other STIs as problems. About three percent of the respondents stated a combination of rape, multiple sexual intercourse, unwanted pregnancy, early pregnancy and child bearing, HIV and other STIs and abortion as the SRH problems on their part in the study area.



(Source: survey data, 2011)

Figure 5 SRH Problems among Street Youth

On the other hand, what about the relationship between the two variables (sex and SRH problems which faced the street youth in the Sub City)? Did each type of SRH problems similar to both female and male youth or were the SRH problems faced quite different proportions to female and male street youth? The results of the survey indicated that the types of sexual and reproductive health problems which had faced quite different proportions to female and male street youth in the Sub City. Females in the streets were found to face such SRH problems as early pregnancy and child bearing (24 percent); unprotected multiple sexual intercourses (24 percent); sexual violence, including rape (21 percent); unwanted pregnancy (14 percent); rape, unwanted pregnancy and HIV/AIDS (10 percent); and a combination of rape, unprotected multiple sexual intercourses, unwanted pregnancy, early pregnancy and child bearing, HIV/AIDS and other STIs and

abortion (7 percent). Male street youth in the study area, however, faced with sexual violence, including rape by the same sex (29 percent), and HIV/AIDS and other STIs (16 percent). Therefore, the types and proportions of SRH problems which had faced females were various and relatively considerable ones in comparison with those of the males in the area. Generally, female street youth suffered at least from the problems of early pregnancy and child bearing, unprotected multiple sexual intercourses, and sexual violence, including rape; whereas males faced with sexual violence, including rape by the same sex, and HIV/AIDS and other STIs.

The study also ran logistic regression for binary response variables – logit model. So far, this model has been interpreted in terms of odds and odds ratios. After the study had taken account of other variables (age, religion, marital status and school attendance), being a female rather than a male decreases the odds of being a victim of rape crime by .300. Thus, the odds of being raped are 30.0% less for girls than young boys in the street life in Addis Ketema Sub City of Addis Ababa. After considering of other variables (sex), the respondent who was being in single category of marital status compared with any other marital status category increases the odds of being raped by 5.00. On may wish to say, in other wards, that after the consideration of sex, the study subjects being from a marital status category of single increases the odds of being raped by 0.20. In the fitted logit model figure, it can be seen that marital status has a p-value (sig.) of .05 (or 5%) whereas sex has a p-value of .001 (or .1%). One can conclude that sex is highly significant, but marital status much less so – it is reaching or equal to the 5% threshold level.

After the researcher had considered other socio-demographic variables, being a female in preference to a male decreases the odds of being experienced unintended pregnancy by

.11. Therefore, the odds of being unintended pregnancy are 11.1% less for girls than boys. After taking into consideration of some other variables, being in the category of single marital status as compared with any other category of marital status increases the odds of being unintended pregnant woman by 1.00. In other words, one may conclude that after taking into account of sex, being in the single marital status category increases the odds of being unintended pregnant woman by 1.00. Thus, as the fitted logit model shows, it can be understood that marital status has a p-value of .002 (or .2%) while sex has a p-value of 1.00 (or 100%). It can be deduced that marital status is highly significant, but sex very much less so; however, quite transcending over the 5% level of threshold.

4.5. Factors that contribute to and exacerbate street youth's SRH problems

Factors that have contributed and exacerbated street youth's SRH problems in the eyes of the respondent street youth are summarized as follows in Table 11. The survey results show that a number of factors in combination have contributed to and exacerbated sexual and reproductive health problems of the street youth in the study Sub City, but at different levels of influence. Those factors in their order of magnitude of contributing and exacerbating the youth's SRH problems were the following: being street youth by itself accounted for 40 percent; lack of awareness about SRH (25 percent); unavailability of SRH provision system (10 percent); influences which had emanated from socio-cultural factors (about 8 percent); being street youth by itself and lack of awareness about SRH (about 7 percent); being street youth by itself and socio-cultural influence (5 percent); being street youth by itself, lack of awareness about SRH and unavailability of SRH system (about 3 percent); lack of awareness about SRH and unavailability of SRH system (about 2 percent).

Therefore, street ways of life (i.e., streetism) have relatively taken more of the share for causing SRH problems of the youth than other potential factors in the list.

Table 11 Factors which may contribute to SRH Problems of Street Youth in Addis Ketema Sub City

Types of factors	Frequency	Percent	Valid Percent	Cumulative Percent
Being street youth by itself	24	40.0	40.0	40.0
Socio- cultural influence	5	8.3	8.3	48.3
Lack of awareness about SRH	15	25.0	25.0	73.3
Unavailability of SRH provision of system	6	10.0	10.0	83.3
Being street youth by itself and socio-cultural influence	3	5.0	5.0	88.3
Being street youth by itself and lack of awareness about SRH	4	6.7	6.7	95.0
Being street youth by itself, lack of awareness about SRH and unavailability of SRH system	2	3.3	3.3	98.3
Lack of awareness about SRH and unavailability of SRH system	1	1.7	1.7	100.0
Total	**60**	**100.0**	**100.0**	

Source: Outputs of survey data analysis, 2011

A number of factors either separately or together in combined way has contributed to the street youth's SRH problems in Addis Ketema Sub City Administration, but different in their types and proportions on the part of the female and male respondents. These contributory factors on the part of the females in their descending order of proportion include: being street youth by itself (55.2%); lack of awareness of SRH by itself (13.8%); socio-cultural influence (10.3%); unavailability of SRH provision system in

place nearby (6.9%); a combination of being street youth by itself, lack of awareness of SRH by itself and unavailability of SRH provision system (6.9%); being street youth by itself and socio-cultural influence (3.4%). In contrast, males faced with SRH problems related to their lack of awareness of SRH (35.5%); their being street youth (25.8%); unavailability of SRH provision system (12.9%); and socio-cultural influences (6.5%). One can deduce that, based on these findings of the survey, the SRH problems of the females have mostly emanated from their street ways of life, but those of the males from more of low level of awareness of the essence of SRH.

Regarding main obstacles that have exacerbated the SRH problems of the street youth from both sexes, the study shows that fear was the outstanding factor which had played a significant role in accessing the SRH services and solving their respective problems. The exacerbating conditions resulted from fear (about 65 % for males and 31% for females); inconvenient conditions at the health institutions and/or organizations (24.1% for females and 6.5% for males); poor handling and scolding by health workers at the services providing institutions (9.7% for males and 6.9% for females); provision of too expensive services (10.3% for females and 3.2% for males); and failure on the part of the SRH service providers to keep one's privacy confidential (about 13% for males). On the whole, fear and inconvenient conditions that exist in the SRH services providing health institutions on the part of females, while fear and lack of one's privacy to be confidential on the part of males have been working to exacerbate their respective SRH problems in the area.

The survey further looked at some socio-demographic characteristics of the respondents to predict whether they were users of modern contraceptives in the study area. The

findings of the logistic regression analysis show that the overall goodness-of-fit of the new model which was found to be fitting very well as its value was 82.911 (which was less than -2L=96.124). This indicates that the logit model is predicting the outcome variable more accurately. Based on the value of the model statistic, how much better the model predicts the outcome variable (i.e., 96.124-82.911= 13.213) which is significant (.606) at a .05 level of significance. The estimates for the coefficients (Beta standardized) for the predictors was -.134 to be included in the model. Therefore, the values of Beta-standardized which were equal to -.134 indicate that the change in the logit of the outcome variable associated with a one-unit change in the predictor variable. These outputs of the logistic regression can be interpreted as follows. After the researcher had taken other variables (age), one could say that being a street girl rather than a male decreases the odds (or likelihoods) of being a user of modern contraceptive(s) by .605. The odds of being user of the contraceptives are 60.5% less for the girls than boys in the study area. After taking into account of other variable (sex) of the respondents in the study, being in age category of 14 -19 years compared with any other age bracket category increases the likelihoods of being user of modern contraceptives by 1.27. One, in other words, may wish to state that after the survey had considered of sex (female) being from a sex category of single increases the odds of the being modern contraceptives user by 0.79. One can see that age category has a p-value (sig.) of .63 (or 63%) while sex has a p-value of .53 (or 53%). Thus, it can be deduced that sex and age are found to be quite significant so much more, and transcending the 5% threshold level.

Based on the given socio-demographic features of the study samples such as sex, age, marital status, religious affiliation and school attendance, the survey assessed and

identified whether they had been condom users or not in the last 12 months prior the research undertaking in the area. After taking into consideration of other variables (religious affiliation, age, school attendance and marital status) being a female instead of a male decreases the likelihoods of being a frequent user of condom(s) by .067. Therefore, the odds of being a user of condom(s) are 6.7% of less for girls than being boys. On the other hand, after the student researcher had considered other variables, for the respondents who were users of condom(s) by being in the age category of 14 – 19 when compared with other age category increases the odds of being frequent user of condom(s) by 45.0. The other way round, one may wish to say that after taking into account of sex of the respondents, being female increases the odds of frequent being user of condom(s) by .02. One, in the output of the model, understands that age has a p-value of .047 or.05 (or 5%) whereas sex has a p-value of .053 (or 5.3%). One can, thus, deduce that both sex and age are not much so significant; so quite reaching or transcending over the 5% confidence level.

4.6. Utilization Pattern of the SRH Services

About fifty-seven percent of the respondents in the streets were found to turn their faces to health institutions to get reproductive health services. One-fifth of the street youth resorted to governmental organizations to get access to those services; while about thirteen percent of the respondents got the services from non-governmental organizations. Surprisingly, 10 percent of the street youth did not go anywhere and to kind of organization to seek help for their reproductive health problems (see Figure 6).

Regarding whether the study participants had visited the SRH service providing organizations or not during the last 3 months before the survey, the study documented, out

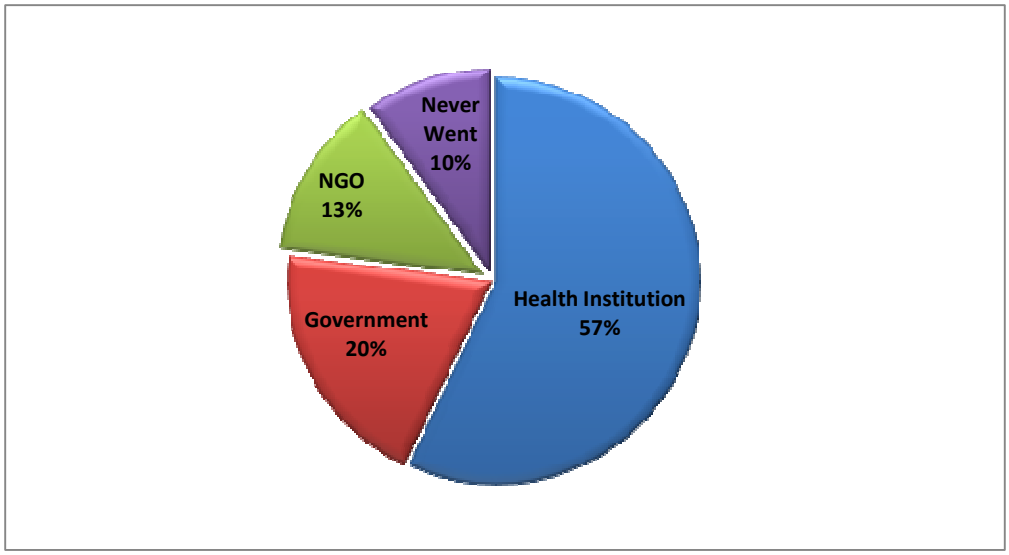
of the sixty youth, about 22 percent of them reported that they had visited those health institutions in the three months period prior to the study. Almost 78 percent of the respondents, on the contrary, had not visited the health institutions in the last 3 months before the survey was undertaken.

This survey further generated data on the street youth's reasons for visiting those SRH services providing health institutions. Among those street dwellers, about 54 percent of them reported that they had visited the institutions for oral contraceptives, followed by 23.1% to get abortion service, 15.4% for counselling, and 1.7% for delivery services. Thus, about four-fifth of the youth clients went to the health institutions in the locality to get help to their SRH problems of one sort or another. However, the majority (72.7%) of those who had visited the institutions found to visit public health centres and 18.2% and 9.1% of them visited the clinic under the auspices of the Family Guidance Association of Ethiopia and private health institutions respectively. In the study, the street youth aired their reasons to prefer one health institution to other. Accordingly, they stated such reasons as free of charge for treatment (50.0%), low cost of treatment (16.7%), effectiveness of treatment (8.3%) and proximity of the institutions (25.0%). Therefore, the street youth in the study area have mostly taken into account a combination of multi-faceted socio-economic and spatial variables before they decided where to get the SRH services and/or solve the problems.

Those street youth, according to the findings of the survey documented, managed to access the SRH services and solved successfully the related problems in unfavourable conditions. In addition, a number of barriers which have emanated from different sources and contexts seem to prevent them from getting easy access to the SRH services in the area. The major

barriers to utilizing health services were found to be inconvenient services at the health institutions (15.0%), not knowing where to seek help at the time of need (8.3%), poor handling and scolding by health workers (8.3%), too expensive services (6.7%), failure to keep privacy and confidentiality on the part of the by health workers (6.7%), too long duration of waiting time to get the services (5.0%), and the health institutions are located too far from their dwelling places (1.7%).

The findings of the study, however, indicated that there was gender difference in terms of whether or not the street youth had visited the SRH services providing health institutions and organizations in the last 3 months prior to the survey. More females (34.5%) than males (9.7%) visited various types of the service providers. However, more male street youth (90.3%) were found to be reluctant to go to those institutions and organizations than their counterparties. Therefore, female street youth show positive attitude towards visiting those health institutions and organizations which are providing the SRH services to the youth.



(Source: own survey output, 2011)

Figure 6 Utilization patterns of the SRH Services

In the same framework but through different window, the survey came up with the youth's preferences for one institution to other depending up on a number of factors. Although very few numbers of the street youth from both sexes had visited the SRH services providing institutions and organizations, the clients showed some degree of preference for some of them by considering some socio-economic factors. Females looked for proximity of the services provider (27.3%), low cost treatment (18.2%), and their respective parent's choices (9.1%), but all (100.0%) of those male youth who had visited the SRH service providers valued more free treatment and service provision than other factors. Thus, the females' preference is slightly based on proximity of the service providers, while that of males is totally based on free of charge. In sum, about seventy-four percent of males and thirty-eight percent of the females were clients of the health institutions for the last 3 months prior to the survey (see Table 12).

Table 12 Sex of the respondents by the institute(s) where they got SRH Services

		Types of Institute				
	Sex	Health institutions	NGOs	Governmental organizations	Never went to any place to get SRH services	Total
Male	Count	23	3	3	2	31
	Expected Count	17.6	4.1	6.2	3.1	31.0
	% within Sex of the respondent	74.2%	9.7%	9.7%	6.5%	100.0%
Female	Count	11	5	9	4	29
	Expected Count	16.4	3.9	5.8	2.9	29.0
	% within Sex of the respondent	37.9%	17.2%	31.0%	13.8%	100.0%
Total	**Count**	**34**	**8**	**12**	**6**	**60**
	Expected Count	**34.0**	**8.0**	**12.0**	**6.0**	**60.0**
	% within Sex of the respondent	**56.7%**	**13.3%**	**20.0%**	**10.0%**	**100.0%**

Source: Output of survey data analysis, 2011

The study further attempted to verify the above-stated findings in this section of the fourth chapter. After the student researcher had taken into account of some other predictors, being a female instead of a male decreases the odds of being visitor of SRH services providing institutions and organizations by 9.71. Therefore, the odds of being a visitor of those institutions are 97.1% greater for girls than boys. After considering other predictor variables in the study, being in the 14 – 19 age category, compared with any other age category increases the odds of being a visitor of the providers of the SRH services by .007. In other words, one may state that after taking into account of sex, being from age category of 14 -19 increases the odds of being visitor of the service

providers by 142.86. As a figure of the fitted model depicted, it is indicated that age category has a p-value of .006 (or .1%). Thus, it can be deduced that sex is highly significant, but age category much more, going beyond the 5% threshold level.

4.7. Existing Gaps in Provision of SRH Services

Both non-governmental and governmental organizations that provide youth with sexual and reproductive health (SRH) services have been faced and encountered with some obstacles and problems which, in turn, may contribute to create gaps in their provision of services to different clients in various contexts. One of these organizations is the Child Aid – Ethiopia (CHAD – ET) is a non-profit organization which was established to protect the rights and welfare of children in different parts of Ethiopia. The Organization had the following gaps: provision of limited access to the SRH services, no organized provisions of SRH services for the youth in relation to unintended pregnancy, early child bearing and STIs, not effective in facilitating to solve the street youth's SRH problems particularly being raped, lack of provision of the services in a user-friendly manner, not being efficient in bringing about behavioural change on the part of the street youth, gaps in consideration of the characteristics of the facilities, the design of services, and providers' attitudes and actions.

The participants in the focus group discussion stated that most of street youth in the area had had limited access to SRH services and had not known where to seek health services. Both informants in study clearly argued that the youth could not able to use modern contraceptive(s) as they had wanted due to limited access of SRH services.

The semi-structured interviews with key informants revealed that there had not been SRH services provided at the CHAD-ET's Branch Office which were provided in

organized manner for street youth in the Addis Ketema Sub City. Consequently, the youth were at risk of unwanted pregnancy, early child bearing and sexual transmitted infections (STIs).

According the Annual Progress Reports of CHAD-ET, it has been implementing an Adolescent Reproductive Health Project in few districts and sub cities in Ethiopia. The Project targeted adolescents in urban and rural areas. So far, the Project has undertaken the following major activities which were designed to empower local youth and adolescents to realize their rights and provide them with RH information. The Reports of the Organization indicated,

> The adolescent Reproductive Health services provided were composed of the mass educational shows to disseminate pieces of RH information, but no clearly stated street youth as participants in the sessions, best practice experience sharing visits by RH club leaders, conducting coffee ceremony within the local community for the same purpose, community conversations, storytelling and drama shows by drama and music group members, establishment of youth-friendly centres and equipping them with educational and other materials (like leaflets, posters and so on).

From the findings of the interview conducted with officials at the Correctional Centre, and Women and Children Affairs Office in the Sub City, being in street by itself had significantly contributed to their experience of to be at a high risk of sexual and reproductive health problems for street youth. The most reported cases of SRH were rape. Surprisingly, most of such cases did not getting any further solution from responsible bodies at different levels in the system.

The discussants in the focus group strongly argued that the objective of the Adolescent Reproductive Health Project had been to ensure availability and accessibility of reproductive health services for adolescents and youth and to work towards achievement a reduced fertility rate among adolescents and youth. Nevertheless, these services were found to be not user-friendly. The discussants suggested that SRH services should be user-friendly, especially for street youth in the area. In addition, the participants adduced that, "the peer educators in the Organization had been distributed condoms to young prostitutes in the age bracket between 14 and 19 years, including provision of sexual and reproductive health education and counselling to the street youth and the youth whom got involved in commercial sex work.

In the same framework, the Organization had gaps in participatory designing of the services. Various sources such as project documents and key informants expressed that it had not involved street youth in designing and running the SRH services. The potential clients may be more able than adults and project people who were far away from the street life to accurately identify the needs of their peers and could propose appropriate as well as user-friendly ways to meet those needs in the streets.

On the whole, the Organization has been attempting to address those SRH needs of the street youth with those existing gaps using RH Project components which are replica of both international and indigenous NGOs, but no use of an innovative approach in socio-culturally sensitive fashion. These gaps may, in turn, have their own contributory factors to serve as obstacles for efficient provision and effective utilization of the SRH services in the Addis Ketema Administration.

CHAPTER V

CONCLUSION AND SUGGESTIONS

This chapter presents conclusions which could be drawn from the major findings of the study and forwards some relevant suggestions for action in order to improve the practice and effectiveness of the social work in the contexts of those SRH services providing organizations and institutions. To reiterate, the general objective of the study is to assess the sexual and reproductive health problems of street youth in Addis Ketema Sub City.

5.1 Conclusion

The study indicates that there is no skewness in overall male to female ratio. However, female street youth, on average, is older than males in the study area. The majority of the youth are believers of Orthodox Christianity which is consistent with the findings of other studies conducted for some other purpose. Presently, the significant proportions of the street youth are single in terms of marital status. There is also a dominant proportion of Amhara ethnic group among the street youth in the Sub City. These youth in the locality are literate as the majority of them attended formal schooling at different levels. In addition, the youth are internal migrants from the four corners of Ethiopia, but their duration of stay in years in the Sub City shows a great variability. These are due to a variety of reasons like looking for job opportunities, parental death, poverty situation at household level, lack of harmonious interactions and relationships among family members which may partly emanate from alcoholic family members, Displacement, change in daily life styles, peer pressure, and unintended pregnancy. The study further shows that there exist different ways of eking out one's in the streets in the area. The

youth usually stay during the day light in the streets, but some resort to either plastic-roofed shelters or rented houses, so to speak, to pass the night. Thus, the street youth become addicts of alcoholic beverages, smokers of cigarettes, and hard drugs (like chat) partly as coping mechanisms to cope up the cold during the night. These risky behaviours are found either separately or in combined manner among those in the streets in Addis Ketema Sub City.

Both female and male street youth have to engage in different income generating activities (IGAs) or businesses (in their own colloquial expression) such as shoe shinning, being coolie/porter, message delivery, attending cars, commercial sex work, begging, peddling and/or a combination of two or more IGAs. Even though the proportion is relatively small, there are some young boys and girls who do not engage in any types of income generation endeavours. The latter category of the youth may depend on somebody's shoulder to earn their daily life in the Sub City. Therefore, most of the street youth live in below the World Bank's poverty line (i.e., 1USD) – they are members of the poor section of local communities in Addis Ketema Sub City.

Female and male youth in the street contexts have experienced sexual life and become sexually active, on average, at about their age reaches 16 years old which is too early to experience the sexual life compared what is stated in the Ethiopian Civil Code. However, the street youth start at least sexual life at the age of 10 years old. For this sexual engagement, such factors as personal desires fall in love with someone in different contexts, peer pressure, being raped, transactional sex and substance abuse may influence and pave the way for early start and experience.

The street youth are vulnerable to STIs, including HIV/AIDS as they have been experiencing multiple sexual partnerships. This study, based on an earth-shocking finding, argues that rape is no more females' case, but it is a reality among the young boys in their daily social life in the streets. This may, in turn, shade a ray of light on a very sensitive issue which shows the real existence of homosexuality in forced context in their routines of daily life.

The youth in the Sub City do not frequently use modern contraceptives. However, if they use the street youth mostly use condoms, followed by Injectables and oral pills. This may be because of some discursive reasons such as being reluctant not to engage in unplanned sexual intercourses. Nevertheless, the street youth sometimes put on the 'modern protective sheath' - Dr. Condom's scientific innovation for this purpose. This, therefore, leaves vacant entry points which results in pregnancy among female street dwellers at least once in their life prior to the present study. Generally, the socio-demographic and economic contexts of the street youth are mostly characterized as risk-prone ones.

Although the street youth are aware of different and modern devices of preventing pregnancy, their level of knowledge of all types of modern contraceptives is lower than the expected. They are more aware of condom(s) than other such devices. This reality may serve as a ground truth for what has been advertised using different means of communications and contexts for years. Thus, they do not vividly comprehend the essence of SRH services, problems and their constituent components of the rights-based package of the SRH services.

Moreover, the street youth are aware of the following types of STDs/STIs: HIV/AIDS, syphilis, gonorrehea and/or Chanchroid either serially or in combination, but in different proportions among them. The conception and understanding of safe sex is associated with the often-use of condom(s), but without underscoring the essence of faithfulness to one-to-one sexual relationship and proper use of the device(s).

As a result of the street youth's socio-economic and cultural contexts in their routines of daily life, they face sexual and reproductive health problems. The most common SRH problems are sexual violence (including rape), unprotected multiple sexual intercourses, but they also get experienced early and unintended pregnancy which may end up with either normal child bearing or induced abortion. There is a considerable variation in terms of the magnitude of the problems which have faced the female and male youth such as early pregnancy and child bearing, unprotected multiple sexual intercourses and sexual violence, including rape; while sexual violence including rape that seems homosexuality and HIV/AIDS respectively. Therefore, the types and proportions of the SRH problems which have faced the female youth are various and relatively considerable ones in comparison with those of the males in the study area. In this regard, sex of the youth is highly significant to predict the likelihoods of a girl in the street being raped, but her marital status has nothing to do that much to put her at stake. Besides, single females are more vulnerable to experience unintended pregnancy in the study area.

The street youth in the Sub City are inconsistent regarding the use of contraceptives, including the use of condom(s). For these to occur, there are a number of factors which lend their influential hands, but personal problems on their part far outweigh than external factors. These factors emanate from different sources like personal negligence,

lack of information on SRH services as well as fear to buy condom(s). However, there is a significant level of easy access to different contraceptives. In the contrary, there is still a dilemma about the level of access to the modern contraceptives in the study area which, in turn, dictates to evaluate the condition in place. This may be due to external socio-economic factors on the part of the youth. Anyways, the youth mostly access these devices from NGOs' clinics, shops and pharmacies in the locality.

The most common sources of information on SRH issues for the youth are their peers and the mass media, but they are also getting the pieces of information from two or more combined sources. However, although small in their proportion, the street youth seem to get confused over the appropriate source(s) of information about the SRH issues under consideration. In summary, they are not well-informed about SRH services in general, and about contraceptives or condoms in particular.

A number of multi-faceted factors either separately or together in combined way has contributed to and exacerbated SRH problems of the street youth from both sexes, but a t different level of influence. These include streetism (i.e., street ways of life in urban areas) lack of awareness of SRH issues, the exacerbating factor of unavailability of efficient SRH services delivery system and socio-cultural factors. Thus, among other factors, streetism stands out as a significant contributory and exacerbating factor which has relatively taken more of the share for causing the SRH problems of the youth than other factors in the list.

Those above-stated factors both separately or in combination, however, contribute to and exacerbate the youth's SRH problems of females and males in the streets in different proportion and order of influence in their routines of daily life. It can be concluded that these problems on the part of the females have mostly emanated from

their street ways of life, but for males from their low level of awareness of the essence of SRH services. Generally, the exacerbating and blocking conditions of their SRH problems emanate from their personal fear; but it accounts different proportion on the part of the street youth – the more on the part of the males than the females in the Sub City. On the other hand, the sex and the age of the street youth significantly determine their use of modern contraceptives. Both the sex and the age of the youth in the streets of Addis Ketema Sub City do not determine their frequency of condom use.

The street youth's utilization of the SRH services in the study are does not show any pattern in terms of the health institutions and organizations they have visited, the frequency of visit in the last 3 months prior to the survey, and even the types of the SRH services they wanted to get accessed. Surprisingly, unlike the NGOs, governmentally-owned health institutions and organizations are accessible to the SRH services in a limited extent of coverage and with very low level of visit to these service providers to get oral contraceptives, aborted, counseling and/or delivery service. The youth also decide where to go to get access to the SRH services based on some factors such as places where they thought could get services free of charge (particularly males) low cost, effectiveness of treatment and their proximity (particularly females). Therefore, they first get informed about a combination of those multi-faceted socio-economic and spatial factors and then make informed decisions on where to go and get their respective choice services to their specific problem(s). Finally, the youth utilize the services at those institutions in unfavorable conditions which, in turn, mostly seem to prevent them from getting easy access to the SRH services in the intervention area. However, there is gendered pattern of utilization of the sexual and reproductive services at both the non-governmental and governmental health institutions – as there are more females than

males who visit various types of the SRH services providers. In addition, the female youth show positive attitude towards the providers, but males appear to be reluctant to go to them. These findings are further verified and get supported by the output of the logistic regression.

Although those non-governmental organizations and governmental organizations have been providing them with the available SRH services and helping them to solve their respective problems in unfavourable contexts, there exist some gaps in their provision of the services. These include: limited and unorganized provision of the services, no commitment to facilitate and get solved the problem of rape cases in the context, lack of use of user-friendly services, ineffective services in terms of bringing about positive behavioural change on the part of the youth to prevent them from SRH problems, absence of giving due consideration to the characteristics of the facilities, to the design of the services, and to the providers' attitudes and actions in place in the intervention area.

By way of conclusion, the study argues that social policy makers at different levels in the existing system of governance should give due attention to the socio-demographic, cultural and economic characteristics, sexual and reproductive health problems, factors that contribute to and exacerbate these problems, multi-faceted gaps which exist in those services providing health institutions and organizations in comprehensive, integrated and culturally-sensitive tailored manner. These newly packed SRH services should be designed by considering the characteristics of the facilities and the design of the services which, in turn, contribute to the overall goal and objectives of the country in this regard through social work and social development perspective.

5.2 Suggestions

Based on the major findings and then conclusions drawn in the study, the following suggestions are forwarded for action:

- ✍ The Child-Aid Ethiopia Organization and its stakeholders should consult their beneficiaries or clients – street youth from both sexes – and fully involve them in the collection of feedbacks regarding the SRH services provided in the light of their problems and then in the packing of the services for them in socio-demographically, culturally and economically-tailored manner.
- ✍ All organizations and agencies which are working for the street youth from both sexes should begin to comprehend the differing responses according to the life styles of their clients or stakeholders. Thus, by so doing, the Organization could avoid a one-size fits all approach that patently does not respond properly to the 'aged out' (i.e., a term coined by Lorraine van Blerk).
- ✍ There should be guidelines for formulating and implementing advocacy and information, education and communication (IEC) Programmes/Projects on street girls' and boys' sexual and reproductive health problems assessment modules and then services provision.
- ✍ The Child-Aid –Ethiopia Organization as well as bold government organizations and agencies should take more additional steps to come up with innovative strategies to introduce SRH messages in their projects/programmes to reach the street youth in a socio-culturally tailored setting and to influence them into taking responsible decisions on their sexual and reproductive health behaviours.
- ✍ The Organization together with stakeholders at different levels in the intervention area should actively involve the street youth in developing local

policies and projects/programmes to meet their needs for good sexual and reproductive health.

- ✍ The NGO in close collaboration with concerned offices in the intervention are as well as its neighbouring areas should create a social forum at which they could one another and social policy makers about the SRH needs of the street youth and then lay the foundation for creating an enabling environment that may pave the way for networked and coordinated advocacy for social policy and project/programme changes(s).
- ✍ The Organization should work very hard to bring about positive change which may, further, advance the street youth's SRH through educating local policy makers, teachers, community leaders, teachers, religious leaders, opinion leaders and street youth on the human rights-based and multifaceted approach to meet the youth's SRH needs and to solve their related problems.
- ✍ Strategies should be enhanced with IE/BCC on HIV/AIDS/STIs and RH/FP, community counseling on HIV/AIDS/STIs and RH/FP, involving street youths in panel discussion and on different occasion, providing referrals for VCT /PMTCT and STIs diagnosis and treatment, and distribution of condoms for dual protection.
- ✍ The existing provision of SRH service should be strengthen with the training of public health service providers in service provision with the aim of increasing the availability of contraceptives of the street youth.
- ✍ Those concerned parties (i.e., the NGOs and its stakeholders as well as the GOs) should increase the street youth's access to accurate, complete and timely

information on SRH issues through different channels of communications in the locality on a continuous basis.

- ✍ Health education, especially sexual and reproductive health should be giving to street youth in order to increase and raise their awareness about reproductive health and family planning methods. Thus, the service providers should train youth as peer educators.
- ✍ In designing SRH facilities, the services providers should locate SRH clinics where public transportation is available and close to places where young people gather (such as schools, markets, and community centers).
- ✍ The Organization should, to assure the youth's privacy, set aside a separate space for their services, or, if that is not possible, set aside some hours just for youth, in the late afternoon and evening and on weekends. Within the space and times set aside for the youth, CHAID-ET could create an atmosphere that is welcoming, youthful, informal, and socio-culturally and economically appropriate for all the youth using the services.
- ✍ The organizations should offer youth free or low cost sexual and reproductive health services.
- ✍ CHAID-ET should schedule appointments to minimize waiting time and crowding in the waiting rooms. Otherwise, the Organization should permit youth to walk-in for services without an appointment and reserve appointment spaces for youth in the evening and on weekends.
- ✍ In designing the services, the Organization should ensure that counseling spaces are private and that others cannot overhear; maintain adequate supplies and a wide variety of contraceptive methods; provide, whenever possible,

contraception to young women without requiring a pelvic examination and blood tests; welcome young men. Recruit and train male staff to meet the sexual health needs of young men; welcome the clients' partners, when they wish their partners to accompany them; offer as many services as possible in a single location. If necessary, refer young people to youth-friendly facilities where they can obtain all the services they need; provide culturally appropriate information in the language and at the comprehension level of the client; and should make sure that information meets youth's needs and concerns.

- ✍ The NGO, in designing SRH services, should reach out with activities that make young people aware of the importance of sexual health care. Inform youth about available services and assure them of confidentiality.
- ✍ In order to address their attitudes, the service provider should treat street youth as respectfully as adults and avoid judging youth's behaviour. Generally, the NGO could work to develop solid, mutually trusting relationships with them.
- ✍ The Organization should provide all staff with ongoing training in adolescent development, understanding youth's needs and concerns, and treating them confidentially and respectfully. Its staff may need assistance in recognizing and changing attitudes that pose barriers to youth.
- ✍ The NGO should encourage counselors to spend as much time as necessary with each adolescent client in order to address all of her/his concerns.
- ✍ A concerted focus should be given in avoiding streetism by focusing on the detail multi-faceted influences of streetism.

- ✍ The study finally suggests the need for further comprehensive study on the overall aspects of the street youth's SRH issues through social work perspective and in participatory manner in the intervention area under consideration.

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Appendices

Appendix I: List of governmental and non governmental institution in Addis Ketema sub city

S.NO	Name of the organization	Address		Beneficiaries	Service
		Sub city	District		
1.	Woreda 5 Youth Association	Addis Ketema	5	All youths from the Woreda	• VCT service • ICT service • Training program
2.	Woreda 9 Youth Association	Addis Ketema	5	All youths from the Woreda	• VCT service • ICT service • Training program
3.	Amanuel Destitute children support organization	Addis Ketema	9	PLWHAs and OVCs	• Food support • ART • Prevention and rehabilitation
4.	CHADET	Addis Ketema	9	PLWHAs and OVCs	• Food support • IGA • Different skill trainings

5.	Merkato children and family welfare Association	Addis Ketema	6	OVCs	• OVC and youths
6.	OPRIFS (Organization for Prevention Rehabilitation and Integration of Female Street children)	Addis Ketema	9	OVCs and Servants	• Shelter home • Counselling • Educational and casual clothe support
7.	MAEDOT	Addis Ketema	5	OVCs and school age children	• Psychosocial support • Food support • Shelter and health service • IGA
8.	MAEDOT	Addis Ketema	4	OVCs and school age children	• Psychosocial support • Food support • Shelter and health service • IGA
9.	MAEDOT	Addis Ketema	9	OVCs and school age children	• Psychosocial support • Food support • Shelter and health

					service • IGA
10.	Addis ketema Health center	Addis Ketema	4	Woreda 1,2,3,7,8 and surrounding communities	• MCH • VCT and PMTCT • Impatient and out patient service • Laboratory service
11.	Woreda 7 Health center	Addis Ketema	9	Woreda 4,5,6,9,10 and surrounding communities	• MCH • VCT and PMTCT • Impatient and out patient service • Laboratory service
12.	MCDP (Mission Community Development Program)	Addis Ketema	6	Communities in the woreda, children and commercial sex workers	• Care and support • Health service • Saving and loan service
13.	Wogen Adin Association	Addis Ketema	2	PLWHA and OVCs	• Home based care • Psychosocial support • Food, educational

					and health support
14.	CHADET	Addis Ketema	9	OVC and PLWHAs	• Food support • IGA • Different skill training
15.	Youth Women Christian Association (YMCA)	Addis Ketema	8	Destitute women	Educational and health service
16.	Hope for all		7	OVC and Destitute women	Educational and health service
17.	Tibeb Adimas Anti AIDS and Reproductive Health Association	Addis Ketema	8	PLWHAs and surrounding communities	
18.	Propride	Addis Ketema	2	Low socioeconomic group of the community, OVCs and PLWHAs	• Peer education • Condom distribution • Community conversation • Skill training
19.	Addis ketema sub city youth Association	Addis Ketema	8	Surrounding communities,	• Different skill trainings

				youth, commercial sex workers and Low socioeconomic group of the community	• Care and support • Peer education • Community conversation
20.	Shoa Birhan committee Development	Addis Ketema	8	Youth, destitute women and OVCs	• Educational and health service • Care and support • Condom distribution
21.	Mary stops	Addis Ketema	1	Female and male	• Maternal health • VCT
22.	Lucy Positive Women Association	Addis Ketema	1	Female PLWHA	• Home based care • IGA • IEC/BCC
23.	Genet Church	Addis Ketema	3	PLWHA and OVCs	• Educational support • Financial support • Food and clothe support • Psychosocial support

24.	Woreda 3 Youth Association	Addis Ketema	3	Male and female youth	• Condom distribution • Peer education • Recreational service
25.	Woreda 3 Iddirs Association	Addis Ketema	1	Iddirs members and their families	• Care and support • Provision of School supplies • Psychosocial support • Legal aid • Food and shelter
26.	Woreda 1 Iddirs Association	Addis Ketema	1	Iddirs members and their families	• Provision of School supplies • Psychosocial support • Food and shelter
27.	Finoteamha Iddirs Voluntary service	Addis Ketema	1	Iddirs members and their families	• Care and support • Provision of School supplies • Psychosocial support • Legal aid • Food and shelter

28.	Woreda 6 and 7 Women Association	Addis Ketema	3	Children and female	• Legal aid • Reproductive health service • IGA • Saving and loan service • Food and educational support
29.	Addis ketema sub city Iddirs Associations	Addis Ketema	3	Iddirs members and their families	• Food support and health service • Provision of School supplies • Psychosocial support
30.	Woreda 4 and 5 Iddirs Associations	Addis Ketema	2	Iddirs members and their families	• Food support and health service • Provision of School supplies • Psychosocial support • IGA

PROFORMA FOR SUBMISSION OS MSW PROJECT PROPOSAL FOR APPROVAL FROM ACADEMIC COUNSELLOR AT STUDY CENTRE

Enrolment No. : **099111143**

Date of Submission: **February, 2010**

Name of the study centre: **St Mary University Collage**

Name of the guide: **Sebsib Belay**

Title of the project: **Assessment of Sexual and Reproductive Health Problems of Street Youth in Addis Ketema Sub City of Addis Ababa, Ethiopia**

Signature of the student: ----------

Approved /not approved

Signature: ----------

Name & Address of the student:

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Assessment of sexual and Reproductive Health problems of street youth in Addisketema Sub city of Addis Ababa, Ethiopia

MSW project proposal

(MSWP – 001)

Prepared by

Bezaye Ketema

Enrolment No. 099111143

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Submitted to

Indira Gandhi National Open University

School of Social Work

February 2010

Addis Ababa, Ethiopia

Table of content

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
CBOs	Community-Based Organizations
CSOs	Civil Society Organizations
FBOs	Faith-Based Organizations
FGC	Female Genital Cutting
GO	Governmental Organizations
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
MSW	Master of Social Work
NOGs	Non-governmental Organizations
RH	Reproductive Health
SC - USA	Save the Children – United States of America
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YRH	Youth Reproductive health

CHAPTER I

INTRODUCTION

Human beings in the world can be considered as a social group. In order to talk about social groups of different types, we can base our classification on various dimensions of social stratification such as age, sex, economic status, or wealth status. Disaggregated by age, we use different terms to refer to people from all walks of life. The terms, for example, we use to refer to people in the age range of 0 to 24 years: children (from birth to 18 years), adolescents (10 – 19 years), youth (15-24 years) and young people (10 – 27 years). However, these categories vary depending on the context and source of information (SC-USA and UNDP, 2009, p.6). Since youth make up a large proportion of the population, particularly in the developing countries, they have to give due attention to this section of their population. Youth can change the world in astonishing ways, making it a better place for themselves and everyone.

Young people who spend a considerable time on the street, often referred to as 'street youth'. They are increasingly present all over the world. The exact number of street youth is difficult to estimate. They are a transient and difficult to reach section of population. The estimated number of street children in the world ranges from 10 million to 100 million (WHO, 2000a, P. 7). Most are found in large, urban areas (metropolis) of developing countries including Sub-Saharan African countries like Ethiopia. In Addis Ababa, the estimated number of street children was between 50,000 and 60,000 in 2003. (MOLSA, 2004, p.1).

All people in general and the (street) youth have the right to sexual and reproductive health (SRH). Conversely, the fulfilment of women's and girl's reproductive right by providing

access to quality SRH and HIV and AIDS education services would facilitate their enjoyment of other rights (UNDIPA, 2007, p.36). Sexual health is broadly a personal sense of sexual well-being as well as the absence of disease; infections… can hinder or enhance sexual expression (WHO, 2000b, p. 3).

RH is also a state of complete physical, mental and social well-being … the best chance of having a healthy infant (WHO, 19997, p. 1-8). There are basic package of sexual and reproductive health services (SRHs) in the nations of the world (NFPA, 2008; ECOSCO, 2009, p. 27). Comprehensive reproductive health encompasses adolescent reproductive health care, family planning (FP), maternal and newborn health care, safe abortion care, protection from and response to gender-based violence (GBV), and prevention and treatment of STI/RTI/HIV/AIDS (IAFM, 2010, p. 9).

Problems related to street youth are relatively recent and multifaceted phenomena in developing countries in general and in urban areas in particular. The vast majority of these people work and live along the streets. This group has personal sense of sexual well-being and social aspects of sexuality, which may influence its thoughts, feelings, etc., can be expressed in many different ways, and are closely related to the environment each street youth finds oneself in.

In Addis Ababa, like other parts of the developing countries, street youth have been facing multifaceted problems because they are involved in streetism - ways of life along streets. They are suffering from malnutrition, ill sexual and reproductive health, psychological and physiological disorder, lack of clothing, shelter, medical facility, education, abortion, etc. the street youth also start sexual intercourse at younger ages willingly or as the consequence of

coercion. They tend to engage in risky sexual behaviours (such as prostitution, multiple partners, infrequent condom use and unusual sexual intercourses).

However, street youth that are part of a large proportion of the youth population in the city face different types of ill sexual and reproductive health. The sexual and reproductive health (SRH) needs are largely unmet (SC-USA and UNFPA, 2009, p.6). Thus, the unmet needs for the comprehensive package of SRH services among youth in general and street youth in particular is more than that of married women (Population Council and FHI, 2005, p. 60). Such unmet needs affect the efforts for achieving certain MDGs set.

Since street youth, like other people, have the right to have access to SRH services; a number of indigenous international NGOs, CBOs, FBOs, CSOs in partnership with different UN agencies, embassies and so on have been serving their respective target populations, including street youth in Addis Ababa. The context services and practice of SRH services may vary in those organizations as each of them emphasize on one basic SRH services and/or no standardized tool kit for addressing the comprehensive SRH services to the street youth. Some services may be structured and practiced in line with the donors/partners' requirements and strategy and framework. Still other organizations may stick to the requirements on the part of the Ethiopian government and/or the city government Administration of Addis Ababa's full-fledged requirements. Some other providing organizations may clearly define what shall be the standardized toolkit, context and practice of the SRH services in a particular case, while other NGOs may leave the choice of the services for their respective client. It, therefore, becomes imperative of to assess the existing sexual and reproductive problems of street youth in Addis Ketema Sub City of Addis Ababa, Ethiopia in the light of prevailing context, services package and existing achieve works.

1.3. Statement of the Problem

Street youth face lot of problems and encounter challenges in their daily routines of social life in different environments. Street youth engage in activities that may put them at risks for sexual and reproductive health problems such as alcohol, use of drug and other substances and risky sexual behaviours (like survival sex work, drug addiction, prostitution, and multiple partners for additional income without using condoms).

In addition, many of young street girls are sexually affected and harassed by street boys, police and other persons along the streets during daylight and/or at night. Street youth face these and other multidimensional SRH problems because they eke out their life along streets and they also start sexual intercourse at early ages willingly or unwillingly which in turn, result in sexual and reproductive health problems. These problems do have adverse effects not only on street youth but threaten the economic, social, political and cultural activities of the country. In general, the street youth's SRH problems affect directly or indirectly the development endeavours of the country, Addis Ababa, Ethiopia.

Professionals from different fields of study have attempted to study one aspect of the problem or another. Even some researchers focused on youth's SRH needs from their own fields of specialization. Still other professionals studied the street youth's SRH problems in health or medical or public health perspective without considering close investigation of the problems and their suggestions for action in practical manner at different levels of social work intervention to alleviate their problems. Accordingly, adolescents' health service utilization pattern, domestic violence against girls premarital sexual practice among school adolescents, quality of family planning services, RH knowledge and attitude among adolescents, quality of care in FP services, post abortion care, fertility awareness and post-abortion pregnancy

intention, determinants of condom use, obstructed labour, RH needs of out-of-school adolescents, social dimensions of female genital cutting (FGC), organizations' work and experiences in combating female genital cutting, young people's HIV/AIDS and RH needs and utilization of services, perception of the risks of sexual activities among out –of – school adolescents, and youth RH problems and service preferences were studied for decades (e.g. Berhane, Berhan and Fantahun, 2005; Lhoha et.al., 2003; Girma, Assefa 2006; Lindner, 2008; Mladonova, 2007; Ethiopian Public Health Association (EPHA), 2005; Dawud, 2003; Abudeker, 2004).

Nevertheless, the vast literature on the Ethiopian social work has been documenting and focusing on SRH problems and services in social research perspective, but not in social work perspective. For example, street children services in relation to NGOs activities (Hailu, 2006) and NGOs' responses to commercial exploitation of children (Tesfaye, 2007). Even some other studies in social work discipline in Ethiopia focused on NGOs' contributions to different aspects of NGOs' interventions to bring about development in different contexts. Surprisingly, the most recent studies also followed the same path as before years ago. Thus, the sexual and reproductive health problems of street youth in Addis Ketema Sub City of Addis Ababa, where there are a concentrated size of street children are found in the largest market (i.e. Merkato) and the biggest bus station are located becomes relevant and researchable problem in social work perspective at this juncture.

1.4. Objectives of the study

This project aims at assessing sexual and reproductive health (SRH) problems of street youth in Addis Ketema Sub City of Addis Ababa, Ethiopia. The objectives of the study are thus the following:

- To assess and identify existing SRH problems among street youth (15 – 24 years) in Addis Ketema Sub City of the City Administration of Addis Ababa;
- To examine and identify factors that may contribute to and exacerbate street youth's SRH problems in the Sub City;
- To identify to whom the youth turn when they have faced with SRH problems, their utilization pattern of the SRH services, and
- To identify the existing gaps in the practices of NGOs and GOs, particularly Childe Aid – Ethiopia (CHAD –ET) which have been providing the youth with the services in their respective catchment areas of the Sub City in Addis Ababa.

1.3 Definition of Key Terms

- Sexual health is defined as a state of physical, emotional, mental and social well-being. In relation to sexuality, it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. (WHO, 2002).
- **Reproductive Health** is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (DFID, 2004; United Nations, 1995).
- **Youth -** is operationally defined as people whose ages fall in range of certain intervals which range between age 15 and 24 years.

- S**treet Youth** is defined as young people who are ‘of the street’, having no home but the streets, their family may have abandoned them or they may have no family member left alive. Such youth have to struggle for survival and might move from friend to friend, or live in shelter such as abandoned buildings; those who are ‘on the street’, those who visit their family regularly; they might even return every night to sleep at home, but spends most days and some nights on the street because of poverty, overcrowding, sexual or physical abuse at home; and/or Who is ‘a part of the street family’? Those who live on the sidewalks or city squares with the rest of their family. Family displaced due to poverty or natural disaster may be forced to live on the street (WHO, 2000a).
- Adolescence is defined as the period between 10 and 19 years of age. It is a continuum of physical, cognitive, behavioural and psychosocial change that is characterized by increasing levels of individual autonomy, a growing sense of identity and self-esteem and progressive independence from adults (SC-USA and UNFPA, 2009, p.5).

CHAPTER II

LITERATURE REVIEW

At the 1994 International Conference on Population and Development (ICPD) in Cairo, reproductive health care was defined as: “the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases”(Barroso C, Girard, F. 2003. Reproductive Health and Gender Equality, Paper for the Taskforce on Education and Gender Equity UNDP).

Everyone has the right to enjoy reproductive health, which is a basis for having healthy children, intimate relationships and happy families. Reproductive health encompasses key areas of the UNFPA vision – that every child is wanted; every birth is safe, every young person is free of HIV and every girl and woman is treated with dignity and respect.

Reproductive health, which addresses the reproductive processes, functions and systems at all stages of life, is aimed at enabling men and women to have responsible, satisfying and safe sex lives, as well as the capacity and freedom to plan if, when and how often to have children.

Reproductive health does not start out from a list of diseases or problems - sexually transmitted diseases, maternal mortality - or from a list of programmes - maternal and child health, safe motherhood, family planning. Reproductive health instead must be understood in the context of relationships: fulfilment and risk; the opportunity to have a desired child or alternatively, to avoid unwanted or unsafe pregnancy. Reproductive health contributes enormously to physical

and psychosocial comfort and closeness, and to personal and social maturation. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death.

1.1. Youth/ street youth

Throughout Sub-Saharan Africa, street youth are an undeniably growing population. Poverty, war, urbanization, disease, and broken homes are creating an environment in which millions of young people are turning to the streets. Street children comprise a vast range of often unheard voices— including abandoned children of poverty-stricken or abusive homes, children separated because of war, orphans who have lost their parents to AIDS, or youth who make the rational decision to be on the streets. The vast number of children on the streets is in many ways indicative of major government, public policy, economic, public health, and even moral breakdowns in societies.

Sub-Saharan Africa is faced with a complex web of factors which gravely heighten the risks for youth on the streets. In a continent in which 315 million people, or more than half of the entire population, lives on less than one dollar a day, ("The Primacy of Pro-Poor Policies for Growth," *UNDP*, 2005, (1 May 2005). poverty threatens many families with the inability to adequately care for their children. In Accra, Ghana, for example, the population of street children has more than doubled in the last five years to 20,000 children and 6,000 babies (*Street Child Africa*, 1 May 2005). Previous and continuing conflicts, such as the genocide in Rwanda which claimed approximately 800,000 lives in 1994, or the continuing civil war in the Democratic Republic of Congo which to date has killed almost four million, 10 have left disasters such as the droughts in Ethiopia and the December 2004 tsunami which reached to Somalia, have also raised the vulnerability of many African youth. Additionally, disease is one of the many the risk factors for

youth on the streets of Africa. By the end of 2003, 12 million children in Africa alone will have lost one or both parents to AIDS ("Launch of World Development Indicators 2005 Report," *The World Bank*, May, 2005).

In the nations of Zimbabwe, Zambia, Mozambique, Lesotho, Malawi and Swaziland, approximately 1 in 4 adults are infected with HIV/AIDS (UNICEF, 29 April 2005). In light of this, the outlook for youth is particularly bleak. There are now about 4 million children orphaned by HIV/AIDS in the Southern Africa region, with Zambia registering the highest number of orphans in the world (Ibid). Whether they are called *watoto wa mitaani* in Tanzania, *chokorra* in Kenya, or *moireaux* in the Democratic Republic of Congo, (Anthony Kopoka, "The Problem of Street Children in Africa," *University of Dar-Es-Salaam.* (2000): 7) street youth throughout Africa are a rising population who desperately cry for greater attention.

Reproductive health (RH) in general and adolescent reproductive health (ARH) in particular is of growing concern in most developing countries. Sub-Saharan Africa is the youngest region of the world, with 44 percent of its population under age 15 in 2006 (PRB, 2007b). In Ethiopia, 11 percent of the population in 2007 is age 15-19, and 20 percent is age 15-241 (U.S. Census Bureau, International Data Base). Moreover, since Ethiopia is typical of a country with a youthful population (43 percent of the population of Ethiopia in 2007 is under 15 years of age [U.S. Census Bureau, International Data Base]), the number of adolescents will increase further in the future.

Lack of education, unemployment, and extreme poverty exacerbates and perpetuates the reproductive health problems faced by Ethiopian youth. The economic, political, and social situation in the country has given rise to fundamental concerns about the health and well-being of young mothers, the health and social development of children born to these young women, the

well-being of young men exposed to sexually transmitted infections or who quit school early to support young families, and society's losses and obligations incurred because of adolescents and their children.

1.2. Street youth SRH needs and problems

The UNFPA observes that concerns about reproductive health starts from childhood and lasts throughout the life-cycle. However, the needs of both men ad women differ in each life stage. Women bear he greatest burden of reproductive health problems Research has shown that reproductive health problems account for approximately 36% of the total disease burden among women of reproductive age (15-45 years) compared to an estimated 12.5% in men in developing countries (World Bank, 1993). Sexual and reproductive health means more than just the reproductive organs and reproduction. The need to understand reproductive health within the context of relationships between men and women, communities and society is underscored. This is because reproductive and sexual health status of individuals is affected by complex web genetic predisposition, and economic, cultural and psychological determinants (cook and Dickens, 2000). Sexual health can also be influenced by mental health, acute and chronic illness and violence (Butler, 2004)

The problem of street youth is worldwide phenomenon. Since these street youth exist in every part of the world. Large groups of youths, mostly unsupervised by adults found in almost every country of the world. The vast majorities of these children work and live large urban area of developing countries.

Global estimates indicate that every year about 3 million adolescents (one in every eight sexually active adolescents) are infected with an STD; and that the highest rates of Chalamydia are among the 15-19 year olds, mainly adolescent women (AGI, 1999' Bassett, 2000; RCAP). In many

developing countries, more than half all new HIV infections are among young people 15-24 (UNFPA, 2000a). Early sexual debut and the prevalence of STIs in Africa are seen as some of he factors driving the spread of HIV infection. The WHO estimates indicate that STI rates are highest in sub Saharan Africa with 69 million new cases per year in a population of 269 million adults aged 15-49 years (Corbett et al. 2002)

Reproductive health affects, and is affected by, the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures within which they live. Sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone. Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills.

The dimension of reproductive ill health encompasses problems such as female genital mutilation, malnutrition & anaemia, abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, Infertility, unregulated fertility, maternal morbidity & mortality, sexual & gender violence, and other related health problems (WHO, 2000, Ramakrishna Y, Karott M, Murthy RS, 2003*)*. Among women of reproductive age (15-49 years) in developing countries the burden of reproductive ill-health is far greater than the disease burden from tuberculosis, respiratory infections, motor vehicle injuries, homicide & violence or from war *(WHO, 1997; 42:1-8).*

Previous studies in many countries have indicated that street youth are particularly vulnerable of STDs and HIV infections because: most are sexually active (Lockhart C., 2002:294-311;

Anarfi JK. 1997;7:281-306), have multiple sex partners, including prostitutes (Haley N, Roy E, and others, 2002), engage in homosexual activity (C. Kunyenga, 2002:294-311), provide sex in exchange for money without protection (Haley N, Roy E, and others, 2002, Swart-Kruger J, Richter LM.1997), are sexually abused (Black B, Farrington AP, 2004), rarely or inconsistently use condoms despite being aware of AIDS (Snell CL. 2002, Liverpool J, McGhee M, Lollis C, Beckford M, Levine D. 2002), are ignorant of other sexually transmitted diseases (STDs) against which they tend to self-medicate (Anarfi JK. 1997) and use illicit drug, including intravenous drug .

Ethiopian youth face many challenges. Sexual initiation often occurs at an early age due to traditions and poor living conditions. Traditional practices such as early marriage, marriage by abduction, and female genital cutting adversely affect the health and wellbeing of young people.

Rape and sexual coercion are common among young women in both urban and rural settings. Sexually transmitted diseases pose considerable risk to the youth population because of the practice of having multiple sexual partners and the limited use of condoms. Unintended pregnancies, pregnancies that occur within short intervals, and abortions pose serious health risks to young women. In addition, drug trafficking and drug abuse among the youth population continue to be of concern

In Ethiopia, our main country of focus, the plight of street children is also an increasing issue of concern in a nation in which 81.9 percent of the population lives on less than $1 a day (UNDP, *Human Development Report*, 2001 statistics, New York, 2003, 200).

According to UNICEF and actively engaged NGOs, there are approximately 500,000-700,000 street youth nationally, and according to the Ministry of Labor and Social Affairs, an additional 1

million are at risk for streetism.16 Moreover, with more than 1.5 million Ethiopians currently living with HIV, there is a heightened risk for AIDS orphans to end up on the streets unless they are cared for by other family members or community (UNAIDS, *Report on Global AIDS,* 2004). Broken homes and single parent families also appear to be a major push factor of children in the streets. It is estimated that fifty five percent of street youth in Addis Ababa have parents who are separated, widowed, or single. (Radda Barnen, "Survey on Street Children-Selected Areas in Addis Ababa." *Ministry of Labor and Social Affairs*, 1998).

In addition to their abject poverty that has most commonly led them to the streets, most of the Ethiopian street youth are involved in unhealthy behaviors, such as smoking marijuana, drinking '*tela*' (local beer) and '*arake*' (strong spirit, similar to vodka), chewing *chat* (a stimulant and mild narcotic) and sniffing *Benson* (petrol) at the gas stations. Some work as taxi boys, and obtain these drugs and spirits in exchange for their work. Many of the girls end up as prostitutes, sent by their families from the rural areas to find work, but who resort to commercial sex work in the absence of other forms of income. Many of the urban youth are particularly aggressive, often throwing stones, using profanity, having fist fights, or using sharp materials such as broken glass and scissors to attack each other (Interview, Emebet, *Forum on Street Children Ethiopia*, 9 March 2005). As a result, communities often ostracize street children and regard them as antisocial, dirty, and lacking in work ethic. Stigmatization compounds the street child's feelings of isolation and rejection and often becomes the major source of concern and distress, thereby dwarfing any initial trauma that may have necessitated life on the street.

According to Holly Dempsey, HIV/AIDS officer at USAID/Ethiopia, when asked if AIDS will bring down the country, she answered, "No, but street children will." (Interview, Holly Fluty Dempsey, *USAID Ethiopia,* 10 March 2005).

Indeed, a significant number of young Ethiopians face daily realities of poverty and must fend for themselves on the streets without access to the necessary social networks and relationships that could lead them to an improved state of well-being.

Ethiopia's population is projected to increase to 108 million by the year 2025 (PRB, 2007a), becoming Africa's second-most populous country after Nigeria. This rapid population increase will continue to strain the government's ability to provide health care and education to young people and create conditions for even greater unemployment, poverty, and resource depletion.

Gender inequality is another major problem that affects youth reproductive health and wellbeing in Ethiopia. Gender inequality manifests itself in the low status of women and girls in the society as well as within the family, in the fewer educational opportunities for girls, in the lack of participation of males in family planning and AIDS-prevention activities, and in the harmful traditional practices against young girls (FHI/Youth Net, 2004).

1.3. SRH services and utilization

The precise configuration of reproductive health needs and concerns, and the programmes and policies to address them, vary from country to country and depend on an assessment of each country's situation and the availability of appropriate interventions. Globally, however, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, STD prevention and management and prevention of maternal and prenatal mortality and morbidity. Reproductive health also address issues such as harmful practices, unwanted pregnancy, unsafe abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anaemia, and reproductive tract cancers. Appropriate services must be accessible and include information, education,

counseling, prevention, detection and management of health problems, care and rehabilitation. **(**UNFPA)

There is consensus among the governmental and non-governmental institutions and agencies in Ethiopia that youth health and wellbeing relies on improved educational opportunities, improved economic opportunities, cultural expansion and the end of the long-held harmful traditional practices. Efforts have been made by the government and its partners to design and implement strategies, policies and programs to address the reproductive health, HIV/AIDS and gender issues of the most vulnerable age group of the country—youth.

In 2002, the Family Health Department of the MOH developed the Five-Year Action Plan for Adolescent Reproductive Health in Ethiopia (2002-2007). The main goals of the plan are (1) to increase access and utilization of ARH services by youth, and (2) to cause positive RH behavior change among youth by providing better information and knowledge on reproductive health issues. Specific strategies to achieve these goals include: promotion of a positive policy and program environment; provision of knowledge and skills; and provision of quality reproductive health services for youth through youth centers, peer education, and counseling and service linkages through an efficient referral system (FHI/YouthNet, 2004).

In 2007, the MOH launched the Adolescent and Youth Reproductive Health Strategy (AYRH) designed primarily to address the problems associated with early marriage and pregnancies and abortions, polygamy, female circumcision, abduction and rape, and poor access to healthcare. The AYRH will be implemented over a period of eight years and is targeted at those age 10-24 years. This strategy calls for immediate tailored and targeted interventions to meet the diverse needs and realities of young people and reflects the commitment of the Ethiopian government to

improving the reproductive health status of young Ethiopians (Plusnews Information Service, 2007).

Youth friendly health services can be freestanding clinics or attached to existing clinics or recreational facilities. Ideally, they provide a full range of services and information to the youth. The services are provided under a setup where people are welcoming, confidentially is ensured, and services are conveniently located and affordable. Young people in Ethiopia are disadvantaged relative to older, in their lack of access to information and services for their reproductive needs because of the absence of youth friendly service delivery system. A study conducted in Kaliti and Akaki kebeles have revealed that almost all discussants said that the media - TV, newspapers, magazines, books and especially radio - were their chief sources of information. Another study of adolescent reproductive health in East Gojam revealed that the most common source of information on STIs/ HIV/ AIDS was the media (82%) and neighbors (67%) for urban and rural out of school adolescents respectively and more than half of the participants (55.2%) had reported that they had visited health institutions for reproductive health reasons. The majority (82.6%) have visited public health institutions and (11.5%) of them visited Family Guidance Association of Ethiopia' clinic and an equal proportion of them visited private for profit health institutions. The major reasons that prevent adolescents from visiting health institutions were reported to be too expensive services, too far health institutions, poor handling and failure to keep privacy and confidentiality by health workers, too much waiting time and it is shame for adolescents to visit health institutions.

Though youth are considered by the societies like Ethiopia relatively disease free, they are at greater risk of various health problems. There are also several misconceptions concerning HIV/AIDS, pregnancy, condom and contraceptive and they lack adequate sexual and

reproductive health information to make appropriate decisions. Most of these problems were found to be more severe among out of school and street youth.

CHAPTER III

STUDY AREA, DESIGN AND METHODS

3.1. Study Area

This study will be conducted in Addis Ketema Sub City of the City Administration of Addis Ababa. The area of the Sub City is 7.41 square kilometre. It has a total population of 277, 786 persons (135,864 males and 141,922 females) in 2010(CSA, 2011, p. 44). The study area is a highly populated and slum area of Addis Ababa in which the density of population is 37,488 persons per square kilometre. In addition, on average, 4.2 persons per housing unit are dwelling in the area. The majority of the residents work in the Sub City as daily labourers, civil servants or businessmen and businesswomen. Prostitution is also common in Sub City due to the influx and arrival of more and more people from different parts of the country for various reasons. A total counted homeless children and youth who are living in this Sub City was 941; of which 899 were males and 42 were females in 2007 (CSA, 2010, p. 10). The same document also indicated that a total of 9,939 children; 3,131 children; and 3,302 children's mothers were only alive, fathers only alive, and both parents were died respectively in 2007. Due to these and many other reasons, the populations are highly vulnerable to HIV or SIT.

3.2. Design and Methods of the Study

The study will use both quantitative and qualitative research methods. Regarding quantitative research approach, it will employ descriptive survey method. Qualitatively, the study will use various types of methods under this approach such as semi-structured interviews with key

informants that will be identified and selected among street youth and SRH services providing organizations in the study area. In addition, the study will conduct two focus group discussions (FGD) (one with female and one with male group). Physical observations will be undertaken in some relevant contexts in the light of the study objectives. Similarly, the study will conduct documentary analysis at SRH services providing organizations in Addis Ketema Sub City.

3.3. Universe of the Study

The universe of this research project will consists of street youth in Addis Ketema sub city, who have been living for at least 6 months in the study area. So far, the estimated number of street youth is 7000-10000. Street youths who have been living in Addis Ketema sub city and attending all or some types of the SRH services be included in the study.

3.4. Sampling Method

The study will use purposive sampling method due to approach and generate relevant from the street youth in the sub city, NGOs and GOs operating in the provision of SRH services. A sample of 60 street youth will be selected and reasonable number of informants from the targeted youth and the organizations will be approached and contacted to generate data on the issues under investigation.

Quantitative Part of the Study

Depending on the objectives of the proposed study and nature of data, different analytical tools will be applied. Descriptive statistics like mean, variance, standard deviations, and frequency distributions, and percentages will used. Descriptive statistical tools are very important to have a clear picture of the respondents included in the sample. Descriptive

statistical techniques will be employed for the purpose of describing the demographic and socio-economic structure of sample households in the study area.

Qualitative Part of the Study

The qualitative data collection method will be utilized in order to generate information from reproductive health service providers, correctional setting, and women and children affairs office, in the study area and from female and male street youths, using focus group discussion (FGD) in order to supplement the result of the quantitative data that could not be quantified. Discussion will be made with two focus groups and each group consisted of 10-12 participants. A semi-structured interview guide will be used to facilitate the focus group discussion. A checklist will be prepared to guide the discussion in such a way to generate relevant information.

3.5. Data Collection Tools and Procedures

The study will employ tools such as interview schedule, semi-structured interview check lists, focus group discussion check lists, documentary analysis check lists and observation check lists. The data for the quantitative section will be collected using a interview schedule prepared by addressing all-important variables. The checklist will be reviewed to suit the local condition and translated to Amharic language and then back to English to ensure its consistency. The tools will be pretested for reliability and validity of both quantitative and qualitative data to be generated following the appropriate data collection procedures required for each method.

3.6. Data Processing and Analysis

The study will employ both quantitative and qualitative data analysis techniques respectively. The filled in and completed interview schedules will be checked for completeness, verified, coded in code book, designed in master sheet, entered in to the computer and analyzed serially. Then, the quantitative data will be processed and analyzed on the computer using data analysis software of SPSS version 17. In addition, the study will employ univariate statistical data techniques (such as ratios, percentages, frequency distributions, bar graphs, pie charts, mean, median, range, minimum and maximum values as well as standard deviations). The survey will further use logistic regression or logit model to assess and determine the association between an outcome variable that is a categorical dichotomy (or a variable with only binary or two responses) and predictor variables that are continuous or categorical (Tarling, 2009, p. 64; Kleinbaum and Klein, 2010, p. 1).

Thematic data analysis will be used to analyze the qualitative data collected. In so doing, categorization and re-categorization of relevant categories of qualitative data under relevant themes in the study will be employed.

3.7. Ethical considerations

All the study participants will be informed about the purpose of the study, their right to refuse and assured confidentiality and informed verbal consent will be obtained prior to the interview. The instruments and procedures will not cause any harm to the study subjects, the community, and supervisor, which will be involved in the study.

Chapterization

The MSW thesis will be organized in to five chapters. The first chapter will be an introduction which introduces the readers to statement of the problem, objectives of the study, and limitations of the study. The second chapter will presents and discusses review of related literature. It will also highlight both conceptual/theoretical literature as well as empirical literature. The third chapter will describes the study area, design and methods, including sampling method, data collection tools and procedures, data processing and analysis, and even some of the ethical issues which will be considered in the actual research undertakings. Chapter four will presents data analysis, interpretation and discussion of the major findings of the study in the light of those of other relevant classical and latest literature on the issues under investigation which were conducted elsewhere in the world. Finally, the thesis will presents conclusions and suggestions to be implemented by the NGOs in culture - and context-sensitive manner in the study area.

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Appendix III: Interview Schedule

Part 1: Socio-demographic characteristics			
Q. No.	**Questions**	**Alternative choices**	Code
1.	Sex	1.Male 2.Female	
2.	Age in years[enter number]	1.---------- years 2..Don't know/remember	
3.	Religion	1.Orthodox 2.Muslim 3.Protestant 4.Catholic 5.No religion 6.Others,specify----------	
4.	To which ethnic group do you belong?	1.Amhara 2.Tigray 3.Oromo 4.Others,specify----------	
5.	What is your current marital status?	1.Never married 2.Currently married 3.Divorced 4. Widowed 5.Others,specify----------	
6.	Have you ever attended school?	1.Yes 2.No	
7.	What is the highest level of school you completed?	1.Only read and write	

		2.1 to 8 grade 3.9 to 12 grade 4.Above grade 12 5.Others,specify----------	
8.	Do you work to earn money for yourself?	1.Yes 2.No -Skip to	
9.	What do you do to earn money?[multiple answers are possible]	1.Shoe shining 2.Carrying small items 3.Delivering messages 4. Attending cars. 5.Exchange of money for sex 6.Begging 7.Peddling 8.Others, specify----------	
10.	On average how much do you earn per day? enter number	1. Less than Five birr 2. 5 to 10 birr 3. 10 to 20 birr 4. Others, specify_____	
11.	Where is your former residence?	1.Addis Ababa 2.Out side Addis Ababa	
12.	Duration of street life [enter number]	1. ----------Years 2. ---------- Months 3. Don't know/remember	
13.	What was the main reason for you to go out for street life?	1.Peer pressure 2.Death of parents 3.Looking for a job 4.Due to alcoholic family	

		5.Lack of peace in the family 6.Displacement 7.Change of life style 8.Poor family 9.Illness of families 10.Others, specify_____ 11. Don't know/remember	
14.	Where do sleep during the night?	1.On the street 2.Small rented house 3.Plastic shelter 4. Families house 5.Others specify----------	
15.	Do use substance like..? Multiple answer is possible	1. Alcohol_____ 2. cigarette _____ 3. drug _____ 4. chat _____ 5. no, I have never used _____ 6. I had used, now I quite ___	

Part 2 : Concerning youth Sexual and reproductive health experience			
16.	Have you ever had sexual intercourse?	1.Yes 2. No	
17.	At what age did you first have sexual intercourse? (enter number)	1. -------- Age in years 97. Don't know/ remember	
18.	Why did you decide to have sexual intercourse the first time? (Multiple answers are possible)	1.I get married 2. Fell in love. 3. Personal desire.	

		4. Coercion (Rape). 5. To get money and other gifts. 6. Peer pressure 7. Influence of chat /alcohol 8. Do not remember 9. Other(s), please specify ----------	
19.	How many sexual partners have you ever had?	1. ----------Number of partners 2.Don't know / remember	
20.	Have you ever been raped without the consent of you?	1.Yes 2. No	
21.	Have you ever used modern contraceptives?	1.Yes 2. No –	
22.	If yes, what type? (Probe and indicate that all apply)	1. Oral contraceptive pills. 2. Condoms 3. Injectables 4. IUDs. 5. Norplant 6.Others, specify----------	
23.	If no, why not? (Multiple answers are possible)	1. Not married 2. I have infrequent sex. 3. Husband/partner opposed 4. Religious Prohibition 5. Lack of knowledge about contraceptives. 6. Fear of side effects 7. Difficult to obtain contraceptives	

		8. Method was expensive 9.Too far to get contraceptives(Not accessible) 10.Sex was unplanned 11.Others, specify---------- 12. Don't know/Remember	
24.	Have you ever used condom?	1.Yes 2. No-	
25.	With what frequency did you and your entire partner use condoms within the last 12 months?	1. Every time 2. Almost every time 3. Sometimes 4. Don't know /remember	

The following questions are only for female

26.	Have you ever been pregnant?	1.Yes 2.No	
27.	If yes, how many times have you been pregnant? (Enter number)	1. -----Times 2. Don't know/Remember	
28.	How old were you when you first became pregnant? (Enter number)	1. ---------- Age in years97. Don't know/ remember	
29.	If you have been pregnant, were all your pregnancies wanted?	1.Yes 2. No	
30.	If No, how did you become pregnant?	1.Contraceptive method not available 2.Coercion (rape) 3.Method failure 4.Didn't think of it	

		5. Other, specify_____ 6. Don't know/ remember	
31.	Did you give birth?	1 Yes 2. No	
32.	If yes, how many children do you born? [Enter number]	----------children	
33.	How old were you when you gave birth to your first child[Enter number]	1.----------years 2. Don't know/ remember	
34.	Have you ever had induced abortion?	1 Yes 2. No	
35.	How many times did you have abortion?	1. _____ Times 2. Don't know/ remember	
36.	To have induced abortion, with whom did you first discuss about the issue? (only one answer is possible)	1. Husband 2. My boy friend 3. My peers 4. My parents 5 Health workers 6. Traditional healers 7. For an abortionist 8. Others, specify ----------	
37.	Where did you get abortion service?	1. At public health institution 2. At private clinic 3. At abortionist's house 4. I have induced it myself by ingesting different drugs 5. Others, specify ---------- 6. Don't know/ remember	

Part 3: The following questions are concerning knowledge and attitude towards selected reproductive health and HIV/AIDS issues.			
38.	Do you know any ways to avoid getting pregnant?	1. Yes 2. No	
39.	If Yes to Q. No. 38, what are the ways to avoid getting pregnant? (Multiple answers are possible)	1. Oral contraceptive pills 2. Using condoms 3. Injectables 4. Norplant 5. IUDs. 6. Sterilization 7.Abstinence 8 Withdrawals 9. Washing the genitalia after intercourse 10. Safe period/abstinence 11. Others, specify-------	
40.	Have you ever heard of diseases that can be transmitted through sexual intercourse such as STDs/STIs?	1.Yes 2. No.	
41.	Which diseases (such as STDs/STIs) do you know about? (multiple answers are possible)	1. Gonorrhea 2. Syphilis 3. Chanchroid 4. Lymphogranuloma venerum 5. HIV/AIDS 6. Others, specify_____	
42.	What does safe sex mean to you?	1.Abstinence from sexual	

	(Probe and indicate all that apply)	intercourse 2.Having sex with a single faithful partner 3. Using condom in every sexual intercourse 4. Avoiding sex with prostitutes 5. Others, specify---------- 6. Don't know	
43.	Do you think that it is easy or difficult for street youth to obtain SRH services?	1. Easy - Skip 2. Difficult 3. Don't know	
44.	If it is **difficult**, why is it difficult? {Multiple answers are possible}	1. Lack of money to buy. 2. Difficult to find. 3. Provider disapproves. 4. Parents disapprove. 5. Distribution places are inconvenient for them 6. Too far to find 7. Expensive to buy 8. Others, specify------	
45.	Which places or persons do you know where you can obtain condoms/contraceptives?	1.Shop 2.Pharmacy 3.Market 4.clinic 5.Hospital 6.NGOs 7.Bar/Hotels 8.Peer	

		9. Others, specify ---------	
46.	From where do you think street youth obtain most of their information about sexual and reproductive health?	1. From school 2. From their peers 3. From their parents 4. From the mass media 5. From health professional 6.From different NGOs 7.No where 8. Others, specify_____ 9.Don't know	
47.	If sexually active street youth don't use condoms or contraceptives, what do you think is their most important reason?	1. They don't have information about condoms 2. Pressure from sex partners 3. It is expensive 4. Religious reasons 5. Being afraid to buy from shops/pharmacy 6. It is not available 7. Negligence 8. Other, specify_____ 9. Don't know	
48.	Do you think that most street youth are well informed about contraceptives/condoms?	1. Yes 2. No 3. Don't know	

Part 4: Concerning sexual and reproductive health problems.			
49.	What are the most SRH problems in street youths Multiple answer are possible	1. Sexual violence including Rape- 2. Unprotected (multiple) sexual intercourse---- 3. unwanted pregnancy ---------- 4. Early pregnancy and child bearing ---------- 5. HIV/AIDS and other STIs------- 6. Abortion --------- 7. Other specify ---------	

Part 5: Factors that contribute to street youth sexual and reproductive health problems.			
50.	What are the factors that contribute to SRH problems in street youths (Multiple answer are possible)	1. Being street youth by itself. 2. Lack of awareness about SRH 3. Unavailability of SRH service 4. Socio economic factor 5. Socio cultural factor 6. Demographic factor 7. Other, specify. _____	

Part 6: Concerning Sexual and reproductive health service utilization			
51.	Where do you go to seek SRH services?	1. Health facility 2. NGO----------, 3. GO---------- 4. Other ----------	
52.	Have you visited any SRH services providing institution(s) for the last 3 months?	1. Yes ---------- 2. No ----------	
53.	If yes, what was the reason for your visit?	1. I had STI. ---------- 2. For abortion ---------- 3. For delivery ---------- 4. For antenatal care ---------- 5. To get oral contraceptives------ 6. To get condom ----------	

		7. For counseling ---------- 8. Others specify----------	
54.	Where did you go for SRH services?	1. Pharmacy 2. Private clinic 3. Governmental health facilities 4. NGOs 5. Traditional medicine healer (s) practitioner(s) 6. Other, specify _____	
55.	Could you tell me why you prefer to seek health care in this place? [Multiple answers are possible]	1. Effectiveness of treatment 2. Free treatment 3 Low cost of treatment 4. Proximity 5. Relative works there 6. I prefer for confidentiality 7. Parents prefer the place 8. Others, specify----------	
56.	What are the main obstacles that prevent street youth from getting clinical and counseling services in institutions?	1. Too far institutions 2. Too expensive services 3. Providers fail to keep privacy and confidentiality 4. Poor handling and scolding by health workers 5.Too much waiting time to get the services 6. The health institutions are inconvenient. 7.Fear 8.Others, specify---------- 9. Don't know	

NB. This is the end of the interview schedule or questionnaire. Thank you very much for taking your time to answer the above-stated questions. I really appreciate your cooperation and help.

Source: Addis Ababa University, College of Health Sciences, Department of Community

Appendix V

ኢንድራ ጋንዲ ዩኒቨርሰቲ
ማህበራዊ ስራ

የስነ ተዋልዶ ጤና ችግርን አስመልክቶ በጎዳና ተዳዳሪ ወጣቶች ላይ ለሚደረግ ጥናት መረጃ ለማሰባሰብ የተዘጋጀ ቃለ መጠየቂያ ቅፅ

ክፍል አንድ፡ አጠቃላይ የግለሰብ መረጃ			
	ጥያቄዎች	አማራጭ መልሶች	ኮድ
1.	ፆታ	1. ወንድ 2. ሴት	
2.	እድሜ(በአመት)	1. ---------- አመት 2. አላውቀውም	
3.	ሀይማኖት	1. ኦርቶዶክስ ክርስቲያን 2. እስልምና 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሀይማኖት የለኝም 6. ሌላ ካለ ይገለጽ ----------	
4.	የየትኛው ብሄረሰብ አባል ነህ/ሽ?	1. አማራ 2. ትግሬ 3. ኦሮሞ 4. ሌላ ካለ ይገለጽ ----------	
5.	የትዳር ሁኔታ(በአሁኑ ወቅት)	1. አግብቸ አላውቅም 2. አግብቻለሁ 3. ተፋትቻለሁ 4. ባል/ሚስት የሞተበት/ባት 5. ሌላ ካለ ይገለፅ ----------	
6.	ትምህርት ቤት ገብተህ/ሽ ታውቃለህ/ ቂያለሽ?	1. አዎ 2. አላውቅም	
7.	እስከ ስንተኛ ክፍል ተምረሀል/ሻል?	1. ማንበብ እና መጻፍ ብቻ 2. 1-8 ክፍል 3. 9-12 ክፍል 4. ከ 12 ክፍል በላይ 5. ሌላ ካለ ይገለፅ ----------	
8.	ለራስህ/ሽ ገንዘብ ለማገኘት ስራ ትሰራለህ/ሽ?	1. አዎ 2. አልሰራም-	
9.	ገንዘብ ለማገኘት ምን አይነት ስራ ትሰራለህ/ሽ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ጫማ መጥረግ(ሊስትሮ) 2. እቃ መሸከም 3. መላላክ 4. መኪና ማጠብ 5. ሴተኛ አዳሪነት 6. መለመን 7. ጀብሎ 8. ሌላ ካለ ይገለጽ----------	
10.	በአማካኝ በቀን ስንት ታገኛ	1. ከ 5 ብር በታች	

	ለህ/ሽ?	2. ከ 5 ብር-10 ብር 3. ከ 10 ብር-20 ብር 4. ሌላ ካለ ይገለጽ----------	
11.	ከዚህ በፊት የት ነበር የምትኖረው/ኖሪው?	1. አዲስ አበባ 2. ክፍለሀገር	
12.	ጎዳና ላይ ከወጣህ/ሽ ስንት ጊዜህ/ሽ ነው?(ቁጥር አስገባ)	1. --------ዓመት 2. --------ወር 3. አላውቅም/አላስታውስም	
13.	ወደ ጎዳና የወጣህበት/ሽበት ምክንያት ምን ነበር?	1. በጓደኛ ግፊት 2. ወላጆች ስለሞቱ 3. ስራ ፍለጋ 4. ወላጆች የመጠጥ ሱሰኛ መሆን 5. በቤተሰብ ውስጥ ስምምነት ስለሌለ 6. በተፈናቅሎ 7. የአኗኗር ዘይቤ ለውጥ 8. ቤተሰቦቸ ድሀ ስለሆኑ 9. ወላጆቸ ስለታመሙ 10. ሌላ ካለ ይገለጽ---------- 11. አላውቅም/አላስታውስም	
14.	ሌሊቱን የት ታሳልፋለህ/ሽ?	1. በጎዳና ላይ 2. በአነስተኛአልቤርጎ 3. በላስቲክ ቤት 4. ቤተሰቦቸ ቤት 5. ሌላ ካለ ይገለጽ----------	
15.	የአልኮል መጠጦችን እንደ ጠላ፣ ጠጅ፣ አረቂ ፣ቢራ እና አደንዛዥ እፅ የመሳሰሉትን ትጠጣለህ/ሽ ?	1. አልኮል መጠጥ 2. ዲጋራ 3. እፅ 4. ጫት 5. ተጠቅሜ አላውቅም 6. በፊት እጠቀም ነበር አሁን ግን ትቼአለው	

ክፍል ሁለት፡ የጎዳና ላይ ወጣቶችን የስነተዋልዶ ተሞክሮ በተመለከተ የስነ ተዋልዶ ጤና ተግባርን በተመለከተ			
16.	የግብረ ስጋ ግንኙነት አድርገህ/ሽ ታውቃለህ/ሽ?	1.አዎ 2.የለም	
17.	አዎ ካልክ/ሽ መጀመሪያ የግብረ ስጋ ግንኙነት ስትፈጽም/ሚ እድሜህ/ሽ ስንት ነበር? (ቁጥር ይፃፍ)	1. ----------አመት 2. አላውቅም/አላስታውስም	
18.	ለመጀመሪያ ጊዜ የግብረስጋ ግንኙነት ለማድረግ ያነሳሳህ/ሽ	1. በትዳር	

	ምክንያት ምን ነበር?	2. ፍቅር ይዞኝ 3. በግል ወሲብ ፍላጎት 4. ተገድጀ/ተደፍሬ 5. ገንዘብና ሌሎች ሰጦታዎችን ለማገኘት 6. በጓደኛ ግፊት 7. አልኮል/ ጫት ተጠቅሜ 8. ሌላ ካለ ይገለጽ---------- 9. አላውቅም/አላስታውስም	
19.	የግብረ ስጋ ግንኙነት ከጀመርክ/ሽ ጊዜ አንስቶ በጥቅሉ ከስንት ሰዎች ጋር የግብረ ስጋ ግንኙነት አድርገሀል/ሽ? (ቁጥር አስገባ)	1. ---------- ሰዎች ጋር 2. አላውቅም/አላስታውስም	
20.	ባለፈው 12 ወራት ውስጥ አንተ/ች ሳትፈልግ/ጊ አስገድዶ የደፈረህ/ሽ አለ?	1.አዎ 2.የለም	
21.	አንተ/ች ወይም የወሲብ ጓደኛ ህ/ሽ ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴ ተጠቅማችሁ ታውቃላችሁ?	1. አዎ 2. የለም	
22.	አዎ ካልክ/ህ የትኞቹን ዘዴዎች ተጠቅማችኃል?(የተጠሩትን በሙሉ አክብቡ)	1. የሚዋጥ ክኒን(ፒልስ) 2. ኮንዶም 3. መርፌ(ዲፖ) 4. በመህፀን የሚገባ (ሉፕ) 5. ክንድ ላይ የሚቀበር (ኖርፕላንት) 6. ሌላ ካለ ይገለጽ----------	
23.	መልሱ የለም ከሆነ ምክንያቶቹ ምንድን ናቸው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ስላላገባሁ 2. አልፎ አልፎ የግብረ ስጋ ግንኙነት ስለማደርግ 3. ጓደኛየ/ባሌ/ሚስቴ ስለሚቃወም/ ምትቃወም 4. ሀይማኖቴ ስለማይፈቅድ 5. ስለ ቤተሰብ ምጣኔ ያለኝ እውቀት አናሳ መሆን 6. ያልተፈለገ ጉዳት ያደርስብኛል ብየ ስለፈራሁ	

		7. የወሊድ መቆጣጠሪያ ለማገኘት አስቸጋሪ ስለሆነ 8. ውድ ስለሆነ 9. ሩቅ ስለሆነ 10. ድንገት ያለ እቅድ ስለነበር 11. ሌላ ካለ ይገለጽ---------- 12. አላውቅም/አላስታውስም	
24.	ከዚህ በፊት ኮንዶም ተጠቅመህ/ሽ ታውቃለህ/ሽ?	1. አዎ 2. የለም	
25.	ባለፉት 12 ወራት ውስጥ በየስንት ጊዜው ኮንዶም ተጠቅመሀል/ሻል?	1. ሁልጊዜ 2. አብዘሀኛውን ጊዜ 3. አንዳንድ ጊዜ 4. አላውቅም/አላስታውስም	

ለሴቶች ብቻ የሚቀርብ ጥያቄ

26.	ከአሁን በፊት አርግዘሽ ታውቂያለሽ?	1. አዎ 2. የለም	
27.	አዎ ካልሽ ስንት ጊዜ አርግዘሻል?	1. ---------- ጊዜ 2. አላውቅም/አላስታውስም	
28.	ለመጀመሪያ ጊዜ ስታረግዢ እድሜሽ ስንት ነበር?	1. ----------ዓመት 2. አላውቅም/አላስታውስም	
29.	አርግዘሽ ካወቅሽ እርግዝናዎቹ በሙሉ ፈልገሻቸው ነበር?	1. አዎ 2. አይደለም	
30.	የለም ካልሽ እንዴት እርጉዝ ሆንሽ?	1. የወሊድ መቆጣጠሪያ ዘዴ ስላልነበር 2. ተደፍሬ 3. የወሊድ መቆጣጠሪያው ዘዴ እየወሰድ ተሳስቸ 4. ስላላሰብኩበት 5. ሌላ ካለ ይገለጽ---------- 6. አላውቅም/አላስታውስም	

31.	**ልጅ ወልደሽ ታውቂያለሽ?**	**1. አዎ** **2. አላውቅም**	
32.	**አዎ ካልሽ ስንት ልጅ ወልደሻል?**	**---------- ልጅ**	
33.	**ለመጀመሪያ ጊዜ ፯ስትወልጅ እድሜሽ ስንት ነበር?(ቁጥር ይፃፍ)**	**1. ----------ዓመት** **2. አላውቅም/አላስታውስም**	
34.	**ወጣት ሴቶች ሲያረግዙ አንዳንድ ጊዜ** **ለማስወረድ ይወስናሉ አንች አስወርደሽ ታውቂያለሽ?**	**1. አዎ** **2. የለም**	
35.	**አዎ ካልሽ ስንት ጊዜ አስወረድሽ?**	**1. ----------ጊዜ** **2. አላውቅም/አላስታውስም**	
36.	**አስወርደሽ ከነበር ጉዳዩን መጀመሪያ ለማን አዋየሽ?** **(አንድ መልስ ብቻ)**	**1 .ለባለቤቴ** **2. ለፍቅረኛየ** **3. ለአቻ ጓደኛየ** **4. ለቤተሰቦቸ** **5. ለጤና ባለሙያ** **6. ለባህል መደሀኒት አዋቂ** **7. ለመንደር ውርጃ ፈፃሚ** **8. ሌላ ካለ ይገለጽ----------**	
37.	**የት አስወረድሽ?**	**1 .በመንግስት ጤና ድርጅት** **2. በግል ጤና ድርጅት** **3. በመንደር ውርጃ ፈፃሚ ቤት** **4. እራሴ የተለያዩ መድሀኒቶች በቤት በመዋጥ** **8. ሌላ ካለ ይገለጽ----------** **9. አላውቅም/አላስታውስም**	

ክፍል ሶስት፡ የሚከተሉት ያሉት ጥያቄዎች ስለ ስነ ተዋልዶ ጤናና ስለ ኤች አይ ቪ ኤድስ እውቀት አመለካከትና እምነት የሚመለከቱ ናቸው፡			
38.	እርግዝናን ለመከላከል አንድ ሰው ማድረግ የሚችለው ነገር አለ?	1. አዎ 2. የለም	
39.	አዎ ካልክ/ሽ ምን ማድረግ ይቻላል? (አማራጭ መልሶች ይነበቡ) (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. የወሊድ መቆጣጠሪያ ክኒን መውሰድ 2. ኮንዶም መጠቀም 3. በመርፌ የሚሰጥ መከላከያ መውሰድ 4. በክንድ የሚቀበር መከላከያ ማድረግ 5. ሉፕ መጠቀም 6. ማህፀን ማስቋጠር 7. ከግብረ ስጋ ግንኙነት መታቀብ 8. ወንድ ዘርን ከሴቷ ብልት ውጭ ማፍሰስ 9. ከግብረ ስጋ ግንኙነት በኃላ ሴቷ ብልቷን መታጠብ 10. የቁም የግብረ ስጋ ግንኙነት ማድረግ 11. በተፈጥሮ እርግዝና የማይኖርበት ጊዜን ለይቶ የግብረ ስጋ ግንኙነት ማድረግ 12. ሌላ ካለ ይገለጽ----------	
40.	በግብረ ስጋ ግንኙነት የተነሳ ሊይዙ/ሊተላለፉ የሚችሉ በሽታዎች ሰምተህ ታውቃለህ/ሽ?	1. አዎ 2. የለም	
41.	አዎ ካልክ/ሽ የትኞቹን በሽታዎች ታውቃለህ/ሽ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ጨብጥ 2. ቂጥኝ 3. ከርክር 4. ባንቡሌ 5. ኤች አይ ቪ ኤድስ 6. ሌላ ካለ ይገለጽ----------	
42.	አንድ ሰው በአባላዘር በሽታ ወይም በኤድስ ላለመያዝ ማድረግ የሚችለቸው ነገሮች ምንድናቸው?	1. ከግብረ ስጋ ግንኙነት መታቀብ 2. ለአንድ ፍቅረኛ ታማኝ መሆን 3. የግብረ ስጋ ግንኙነት ባደጉ ቁጥር ኮንዶም	

		መጠቀም 4. ድንገተኛ ወይም ያልታቀደ የግብረ ስጋ ግንኙነት ማስወገድ 5. ከሴተኛ አዳሪዎች ጋር የግብረ ስጋ ግንኙነት አለማድረግ 6. ሌላ ካለ ይገለጽ-------	
43.	ኮንዶም ወይም ሌላ የወሊድ መቆጣጠሪያ ዘዴ ለማገኘት እንደ አንተ/ች ያለ ጎዳና ተዳዳሪ ወጣት ቀላል ነው ወይስ ከባድ?	1. ቀላል ወደ 2. ከባድ 3. አላውቅም ወደ	
44.	ከባድ ከሆነ ለምን ይመስልሀል/ሽ? (የሚስማማ መልስ ከተሰጠ አንድን ካልተሰጠ ሁለትን ክበብ/ቢ)	1. የገንዘብ እጥረት---------- 2. ለማገኘት አስቸጋሪ ስለሆነ-------- 3. አሰራጭዎቹ ስለማያምኑበት-------- 4. ቤተሰቦቸ ስለሚቃወሙ ---------- 5. የሚሰራጭበት ቦታ ለጎዳና ተዳዳሪዎች አመች ስላልሆነ 6. የሚገኝበት ቦታ ስለራቀ ---------- 7. ውድ ስለሆነ---------- 8. ሌላ ካለ ይገለጽ----------	
45.	የእርግዝና መከላከያ/ኮንዶም ሊገኝ ሚችልበት ስፍራ ወይም ግለሰብ ታውቃለህ/ሽ?	1. ሱቅ 2. ፋርማሲ 3. ገበያ 4. ክሊኒክ 5. ሆስፒታል 6. ቤተሰብ መምሪያ ክሊኒክ 7. ከቡና ቤት/ሆቴል/እንግዳ ማረፊያ 8. ከአቻ ጓደኞዬ 9. ሌላ ካለ ይገለጽ---------- 10. የሚገኝበት ቦታ አላውቅም	

46.	**የጎዳና ተዳዳሪ ወጣቶችአብዛኛውን ጊዜ ስለ ስነተዋልዶ ጤናና ኤች አይ ቪ ኤድስ መረጃ የሚያገኝ ት ከየት ነው ብለህ/ሽ ታስባለህ/ሽ?**	**1. ከትምህርት ቤት** **2. ከአቻ ጓደኞች** **3. ከቤተሰቦቻቸው** **4. ከመገናኛ ብዙሀን** **5. ከጤና ባለሙያዎች** **6. በአካባቢያችን ካሉ መንግስታዊ ካልሆኑ ድርጅቶች** **7. ከየትም** **8. ሌላ ካለ ይገለጽ----------** **9.አላውቅም**	
47.	**የግብረ-ስጋ ግንኙነት የጀመሩ** **የጎዳና ተዳዳሪ ወጣቶች ኮንዶም/ሌላ ዘዴ የማይጠቀሙ ከሆነ ዋነኛ አንድ ምክንያት ምንድነው ብለህ/ሽ ታስባለህ/ሽ?**	**1. ስለ ኮንደም ወይም ሌላ ዘዴ በቂ መረጃ ስለሌላቸው** **2. ከፍቅረኛ ግፊት ምክንያት** **3. ውድ ስለሆነ** **4. በሃይማኖት ግፊት ምክንያት** **5. ከሱቅ/ፋርማሲ ለመግዛት በማፈር** **6. ኮንዶም ስለማይገኝ** **7. ግድየለሽነት** **8. ሌላ ካለ ይገለጽ----------** **9. አላውቅም**	
48.	**በአንተ/ቺ እምነት አብዛሀኛ ቹ የጎዳና ተዳዳሪ ወጣቶች ስለ ኮንዶምና የወሊድ መቆጣጠሪያ ዘዴ በቂ መረጃ አላቸው ብለህ/ህታምናለህ/ሽ?**	**1. አዎ** **2. የለም** **3. አላውቅም**	

ክፍል አራት፡ የጎዳና ወጣቶችን የስነተዋልዶ ጤና ችግር በተመለከተ			
49.	**ዋና ዋና የስነ ተዋልዶ ጤና ችግር በጎዳና ተዳዳሪ ወጣቶች ላይ የሚታዩት**	1. **ወሲባዊ ጥቃት አስገድዶ መደፈር ጨምሮ** 2. **ያልተፈለገ እርግዝና**	

	ምንድናቸው	3. ያለድሜ ማርገዝና መውለድ 4. ኤች.አይ.ቪ ኤድሰና በግብረ ስጋ ግንኙነት የሚተላለፍ በሽታዎች 5. የፅንስ ማስጨንገፍ 6. ሌላ ተጨማሪ ካለ ግለፅ----------	

ክፍል አምስት፡ ለጎዳና ወጣቶችን የስነተዋልዶ ጤና ችግር አስተዋፅኦ የሚያደርጉ ምክኒያቶች በተመለከተ			
50.	ለጎዳና ወጣቶችን የስነተዋልዶ ጤና ችግር አስተዋፅኦ የሚያደርጉ ምክኒያቶች ምንድናቸው	1. የጎዳና ሕይወት በራሱ ለስነተዋልዶ ጤና ችግር ያጋልጣል 2. ስለስነተዋልዶ ጤና ግንዛቤ አለመኖር 3. የስነተዋልዶ ጤና አገልግሎት የሚሰጡ አካላት አለመኖር 4. ሌላ ተጨማር ካለ ግለፅ	

ክፍል ስድስት፡ የጎዳና ተዳዳሪ ወጣቶች የስነተዋልዶ ጤና አገልግሎት አጠቃቀምን በተመለከተ			
51.	የስነተዋልዶ ጤና አገልግሎት ለማግኘት የት ነው የምትሄደው/ጂው	1. የጤና ተቋማት 2. በአካባቢያችን ወዳሉት መንግስታው ያልሆኑ ድርጅቶች 3. በአካባቢያችን ወዳሉት መንግስታው የሆኑ ድርጅቶች 4. ሌላ ተጨማር ካለ ግለፅ	
52.	በዚህ 3 ወር ውስጥ ወደ የስነተዋልዶ ጤና አገልግሎት ሄደህ/ሽ ታውቂያለህ/ሽ?	1. አዎ 2. አልሄድኩም	
53.	አዎ ካልክ/ሽ ምክንያቶቹ ምንድናቸው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ለአባላዘር በሽታ 2 .ለማስወረድ 3. ለመውለድ 4. ለቅድመ ወሊድ ምርመራ	

		5. የወሊድ መቆጣጠሪያ ለመውሰድ 6. ኮንዶም ለመውሰድ 7. የምክር አገልግሎት ለማገኘት 8. ሌላ ካለ ይገለጽ----------	
54.	ለህክምና ሄደህ/ሽ ከነበረ የት ነበር?	1. ፋርማሲ 2. የግል ክሊኒክ 3. የመንግስት የጤና ድርጅት 4. መንግስታዊ ያልሆነ ድርጅት 5. የባህል መደሀኒት አዋቂ 6. ሌላ ካለ ይገለጽ----------	
55.	ወደነዚህ ቦታ ለመሄድ የመረጥከው/ሽው ለምንድነው?	1. ህክምናው ውጤታማ ስለሆነ 2. ነፃ ህክምና ስለማገኝ 3. የህክምናው ዋጋ ዝቅተኛ ስለሆነ (ርካሽ) 4. ቅርብ ስለሆነ 5. ዘመዴ እዚያ ስለሚሰራ 6. ምስጢር ስለሚጠብቁ 7. ቤተሰቦች ስለሚፈልጉ 8. ሌላ ካለ ይገለጽ----------	
56.	የጎዳና ተዳዳሪ ወጣቶችን የጤና ድርጅት ሄደው የምክር አገልግሎት ለማገኘት እንቅፋት የሚሆኑት የትኞቹ ናቸው?	1. የጤና ድርጅቱ መራቅ 2. የአገልግሎት ዋጋ ከፍተኛ መሆን 3. የሚያስተናግዱት ባለሙያዎች ሚስጥር አለመጠበቅ 4. ባለሙያዎቹ ሰው ስለማያቀርቡና ስለሚቆጡ 5. አገልግሎት ለማገኘት ብዙ ስለሚያስጠብቅ 6. የጤና ድርጅቱ ለእኛ አመቺ ስላልሆነ 7. ፍርሀት 8. ሌላ ካለ ይገለጽ----------	

ለትብብርህ/ሽ በጣም አመሰግናለሁ::

Appendix V: Focus Group discussion check list

Question for focus group discussion

1. What are the most frequent cases reported regarding sexual and reproductive health problems in street youths
2. What are the major sexual and reproductive health problems in street youths?
3. What are the factors that contribute to sexual and reproductive health problems?
4. What are the health services that are available for street youths so far regarding reproductive health?
5. What are the factors that influence sexual behavior of street youth?

Focus group 1: Health facilities, police, NGOs

1. What are the most frequent cases reported regarding sexual and reproductive health problems in street youths
2. What are the major sexual and reproductive health problems in street youths?
3. What are the factors that contribute to sexual and reproductive health problems?
4. What are the health services that are available for street youths so far regarding reproductive health?
5. What are the factors that influence sexual behavior of street youth?

Focus group 2: street youth female group

1. What are the factors that influence sexual behavior of street youth?
2. What are the major sexual and reproductive health problems in street youths?
3. What are the factors that contribute to sexual and reproductive health problems?
4. What king of SRH services you get form health facilities?

Focus group 3: street youth male group

5. What are the factors that influence sexual behavior of street youth?
6. What are the major sexual and reproductive health problems in street youths?
7. What are the factors that contribute to sexual and reproductive health problems?
8. What king of SRH services you get form health facilities?

Appendix VI: Observational check list

Name of Organization	
Contact Person and Position	
Contact details	
E-mail	
Established	
Staff Breakdown	
Geographical focus	
Organizational Summary	
Main activities or aims of the organization	
Main Activities undertaken in SRH	
Planned activities in SRH	
What are the current problems threatening SRH in the **CHAD-ETs'** focus area or target group?	

DECLARATION

I hereby declare that the dissertation entitled **ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH PROBLEMS OF STREET YOUTH IN ADDIS KETEMA SUB CITY OF ADDIS ABABA, ETHIOPIA** submitted by me for the partial fulfilment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfilment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

Place: **Addis Ababa, Ethiopia** Signature ----------

Date: **11/10/2011** Enrolment No: **099111143**

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