

HEALTH AND SOCIAL PROBLEMS OF
STREET CHILDREN IN NAZARETH
TOWN

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LIST OF ABBREVIATIONS

- MOLSA - Ministry of Labor and social affairs
UNICEF - United Nations Children's Fund
S.D. - Standard deviation
HIV - Human immune deficiency virus
AIDS - Acquired immunodeficiency syndrome
STD - Sexually transmitted disease

ABSTRACT

The exact number of street children in any given country is not known. To determine the number, health, and social problems of the street children, a cross sectional survey was conducted in Nazareth town, south eastern Ethiopia, from November to December 1994. Accordingly 5138 street children were counted during a one day census, by means of a systematic sampling. 597 subjects were selected into the study, 526(88.1%) Males and 71(11.9%) Females. The age ranged from 5 to 18 with mean age of 12.9 and SD of 3.16. (41.2%) of the children left their families when they were 10-14 years old, and 30.7% were separated in early childhood (0-4 years). Only (18.3%) were attending school currently, (54.6%) were children "on" the street and the rest (45.4%) were "of" the street children, (67.2%) of the children eat at least twice daily, (14.6%) of the children reported the use of at least one of the substances like Alcohol, cigarette, and chat. (61.6%) of the children reported an illness during the survey. The major health complaints were abdominal pain, cough and chest pain, eye and ear problems, headache and leg ulcer. This survey indicated that substance use, police arrest, sexual intercourse and STDs were reported more frequently among the "of" the street children. In conclusion, the street children have complex social and health problems which need to be addressed utilizing a multisectoral approach.

INTRODUCTION

The children of Ethiopia are among the most underprivileged in the world. They fare badly even in comparison with the children living in other parts of the impoverished African continent (1). Today there are millions of children in the world who are forced to seek survival on the streets of cities. They work and live alone without adequate food, shelter, education, affection, and social security (2).

Many factors contribute to the health problems of street children, including exposure to adverse weather, trauma and crime, overcrowding in shelters, uncomfortable sleeping accommodations, poor hygiene and nutritional status, alcoholism, drug abuse and psychiatric illness (3).

Street children are particularly vulnerable to malnutrition and health problems because of their extreme poverty. Girls in particular are exposed to sexual exploitation, rape, and prostitution. They remain disadvantaged for their lives, because they lack experience of life in normal society, like education and vocational training (4).

In Ethiopia where infant and maternal mortality rates are among the highest in the world, morbidity patterns indicate that preventable diseases are rampant

particularly among low socioeconomic groups like children and women.

Currently only 45% of the population is served by health services. Diarrhoeal diseases and acute respiratory infections are the major causes of childhood morbidity and mortality.

The synergy between malnutrition and infection is also evident in the child population. Other diseases like malaria, tuberculosis, parasitic infections and hepatitis occur with alarming frequency (5). Forty six percent of Ethiopian children are malnourished, 8% being affected severely. In general, factors related to malnutrition among children and women in Ethiopia include poverty, household food insecurity, lack of education, inadequate health, water and sanitation services and also traditional beliefs and practices (6).

At present Ethiopia is facing enormous difficulties in the aftermath of war and gross economic mismanagement. With the advent of the Transitional Government of Ethiopia in may 1991 bringing an end to the protracted civil war, and with a series of good harvests, the country is presented with an opportunity for economic recovery.

There is now the potential that with the governments' program of decentralization and increased self government at all levels, the situation in the

country is expected to improve, provided that the legacy of famine and warfare can be overcome.

With appropriate policies and strategies this should bring about an improvement in the situation of these children, together with UNICEF, and other Governmental and non Governmental agencies.

Ethiopia is also one of the signatory states for the UN convention on the right of the child from birth, and even those that are in the womb. On the other hand the penal code of Ethiopia of 1957 has two major functions of protection and rehabilitation of children. Child labor is also regulated under labor proclamation number 64/ 1975. The law prohibits child employment under 14 years of age (7). In general, even though the major Ethiopian laws are quite inadequate, they are not perfect. So far the problem with these laws is failure in their meaningful implementation like resource limitation, cultural factors and lack of good will on the part of the state.

This study was carried out with the purpose of describing the plight of street children in relation to the status of their health and social situation, in the Ethiopian context.

Despite the fact that the situation of these children is currently considered as a policy issue both at national and global levels, important data are not readily available.

Therefore it is assumed that this study will provide a base line information on the status of street children to policy makers and program developers who are involved in the evaluation and monitoring of the situation of the street children of Ethiopia.

LITERATURE REVIEW

Literature on street children is scarce particularly in the Ethiopian context. There are conflicting estimates about the number of street children at the global and national levels.

Although the number of street children is not accurately known, some figures are available that can give a sense of its size. For example the total population in developing countries is approximately 4.2 billion. Out of this, the urban population is about a third or 1.7 billion. Of these, 650 million are urban children aged 5-18 of whom, 100 million are street children. These include children on the street, of the street, and abandoned street children. About one third of these are girls. The percentage may be higher in Latin America, much lower in Africa and Asia, and somewhat lower in the Middle East bringing the total world street girl population to about 30 million (8).

Recent estimates have cited some 40 million in Latin America, and their numbers are said to be on the increase (9). In Brazil alone it is assumed that of the 36 million children living in poverty 7 million (20%) have moved away from their families and are street children (10).

Ethiopia, a country with a total population of 55 million has 23.5 million children under 16 years of age. It is estimated that there are more than 100,000 street children in the country. Furthermore it is estimated that there are 500,000 urban children and out of school who are at extremely high risk of becoming involved in street life. Another one million urban poor children are at high risk as well (11).

The counting of street children in many cases is difficult. In fact to date there is no valid and reliable numeric data for this purpose. Some of the major difficulties encountered are lack of clarity in the definition (it is not possible to count with out knowing what is to be counted), the enormity of some cities and urban areas, the impossibility to access certain zones "off limits" to strangers in the case of cities such as Lima, Rio, etc. and, the fact that the street children are constantly moving. There are different methods and techniques for counting street children.

A. Counting street children in their reference locations or focal points in the streets, by counting the number of street children in certain representative focal points or representative areas and obtaining the end result of street children present in the streets in their reference focal points (locations) by means of extrapolation. This

involves the following steps:

- i. Mapping the entire urban area under study, subdividing it into areas equal in size.
 - ii. Grouping the areas into categories with similar characteristics.
 - iii. Selecting one or more areas in each category which will be considered representative of the rest.
 - iv. Counting the focal points in the selected areas.
 - v. Counting the number of street children present in a certain number of focal points in each area which will be considered representative for the entire area.
 - vi. Calculating the extrapolation.
- B. Control methods for technique (a): Counting the children who are visible at first glance in some of the focal points previously visited. Conducting an in-depth survey to establish the number of those actually present, including those who were not visible at first glance. The technique (a) and its control (b) are particularly useful for counts undertaken in large and very diverse urban areas.
- C. Counting and subsequently extrapolating the cases reported of children who left their homes in a number of neighborhoods communities, or places of origin which are considered representative.

D. Use of censuses and surveys (12).

Since the twentieth century is considered as the age of urbanization, the number of street children living in complete or partial abandonment is bound to grow by tens of millions. By the year 2000, the world's urban population is expected to increase by half. For the first time it will exceed the number of those living in rural areas. If the present trend continues there will be 430 cities over 1 million population, in developing countries there will be 45 cities with over 5 million population. The population of cities is also becoming younger by the year 2000, half of the world's population will be under 25, where 35% of the total population will be under 14 (13).

Ethiopia has 23.5 million children under 16 years of age. Figures from the state of the world children 1992 show that 60% of Ethiopia's 6.2 million urban poor live below the absolute poverty line. 1.1 million urban children are victims of debilitating poverty. In rural areas the situation is similar and it is estimated that 65% of children live below the poverty line. Two thirds of all Ethiopians live on incomes below that required to meet the basic needs of a family. Throughout Ethiopia only 38% of children of the applicable age group are enrolled in primary school although the figure is probably higher in urban centers and lower in rural areas

(14). In the past 3-4 years this condition has worsened in most urban centers because of increasing inflation rates and lifting of restrictions on freedom of movements.

In Ethiopia there are no studies about the health status of street children, and there are only very few studies about the social aspects of these children, undertaken by The Ministry of Labor and Social Affairs (MOLSA), Radda Barnen and UNICEF.

A situation analysis of these children was undertaken by Ministry of Labor and Social Affairs and Department of Applied Psychology, University College Cork of Ireland in four regional towns namely Nazareth, Bahir Dar, Mekelle and Addis Ababa. These towns were selected because they were recognized as having large street child populations with different background characteristics. According to this study 62.5% of the Nazareth street children had left their families to come to the town, mostly from rural areas. In Nazareth the process reflects the Gurage custom of parents sending their children to the nearest big town to work. Nazareth was also reported to have the smallest percentage of children of the street, and many children were found to live with relatives or form households with peers. But Nazareth also had the highest proportion of school dropouts and also reported higher levels of family conflict when

compared to the other towns; possibly this may be related to the fact that a large proportion of the children were living with relatives (15).

A 1982 study by the rehabilitation agency for the disabled tried to identify the causes and effects of streetism. It also claimed to identify all known street children in Addis between the ages 5 to 18 and put the total count at 5,004 out of which 4,995 were boys and 49 were girls. 72.3% were from the rural areas. In this study the causes for migration were employment 78.4%, family displacement 8.8%, seeking educational opportunities 6.7%, family breakdown 2%, and other reasons 4.1% (16).

Another study conducted in 1984 by the Ministry of Labor and Social Affairs in ten major cities of Ethiopia considered the ages between 9 to 18 years. 841 youths were seen, out of which, 785 were boys, 31 girls and 25 unspecified. In this study 57% migrated due to broken families, which showed a huge difference with the previous study (17).

A study to assess the health status of homeless children on multiple dimensions through parental report was conducted in Los Angeles in 1987/88. 196 homeless families in 10 shelters in Los Angeles and 194 housed poor families were interviewed.

According to this survey, the homeless and housed poor children experienced high rates of illness symptoms, disability and bed days. Homeless children and housed poor children were frequently rated by their parents to be in fair or poor health. Homeless children had problems four times higher than housed poor children.

Homeless children also had high rates of other health problems such as developmental delay and disorders of nutrition. The diets of homeless children were frequently imbalanced, and characterized by repeated periods of deprivation.

It was also recognized that the importance of family functioning in the care and well being of children. Family problems were more common among the homeless, especially among single parent homeless families compared with single parent housed families. In conclusion, homeless children are at high risk for current and future nutritional, health, developmental, behavioral, and Academic impairments.

The complex confluence of family, economic, and social problems makes the task intervention seem overwhelming. However, demonstrations among similarly high risk and impoverished families have shown that comprehensive ecologically oriented interventions can dramatically improve the current and future health and other problems of the children (18,19,20,21).

A study on emotional and behavioral problems and severe academic delays among sheltered homeless children in Los Angeles county used standardized measures of depression, behavioral problems, receptive vocabulary and reading. The study has shown that the vast majority (78%) of homeless children suffered from either depression, a behavioral problem, or severe academic delay.

Among children having a problem, only one third of the parents were aware of any problem, and few of those children (15%) had ever received mental health care or special education (22).

Many factors contribute to the health problems of homeless persons like exposure to adverse weather, trauma and crime, overcrowding in shelters, unusual sleeping accommodations, poor hygiene and nutritional status, alcoholism, drug abuse and psychiatric illness.

It is common for homeless adults to have skin ailments, traumatic injuries and chronic gastrointestinal, vascular, dental and neurological disorders. Homeless children may have respiratory, ear and skin diseases, as well as special problems such as failure to thrive, developmental delay, neglect and abuse.

In the examination of these children, it is important to ask, during history taking, questions like

sleeping conditions, sources of food, past psychiatric problems, substance abuse, and sources of social support. Special attention should be given to examination of the skin, teeth, and feet. Supplemental food, immunizations, psychologic counselling and social service referrals should be considered for these patients (23).

A large study in 16 cities in the U.S.A. in 1987, showed that homeless children are at least twice as likely as children from a national sample to be seen in a clinic for infestational ailments, anemia, neurologic disorders, seizures, eye disorders, heart and circulatory problems, and serious and minor skin ailments. In addition, the incidence of trauma and chronic disease is notably higher for homeless children than others (24).

In a New York study, it was found that hospital admissions for homeless children, occurred at a much higher rate than for the comparison group, a domiciled low income population using the same clinic. Cases of abuse of homeless children were reported at a rate of 8.8/1,000 as opposed to 2.3/1,000 for the comparison group.

In a Massachusetts study of 151 homeless children approximately 50% were found to have psychosocial problems such as developmental delays, severe depression and anxiety, and learning difficulties. Nearly half required psychiatric evaluation (25).

Access to health care, particularly paediatric preventive health care, is impaired for homeless families. Health becomes a lower priority as parents struggle to meet the daily demands for food and shelter. Families are so often on the move that there is no opportunity to develop an ongoing relationship with a health care provider.

When there is an acute problem, hospital emergency rooms, and clinics usually provide episodic and fragmented care.

The best evidence of this is from the New York study and a study by another New York facility in which 27.2% and 49%, respectively, of the homeless children were delayed in their immunization schedule. These figures doubtless would be much higher in developing countries. Comparatively, only 8% and 12% of the domiciled group had immunization delays (25, 26).

A descriptive study of 76 homeless school age children to determine their level of depression was reported from Ohio. Mother and child were interviewed to collect demographic and background information, and the children's depression inventory used the instrument developed by Kovacs (1985), which is self rated, symptom oriented scale for school age children was used. In this study 57% of the subjects were girls and 43% were boys. They were between 8 to 12 ages with a mean age of 9.4

(SD=1.26). More than 40% of the subjects had scores above 9 on the children's depression inventory scale, indicating a need for further psychiatric referral, and almost one fourth of the children had scores of 15 or higher indicating frank psychopathology. This finding should sensitize health care providers to the intensity of the desperation and despair that children in these circumstances are suffering. In addition, it can alert them to the potential for self destructive behavior that exists in this group of children (27).

According to an indepth interview carried out by, Kevin Lalor with 32 street girls in Addis Ababa, between Oct. and Nov. 1992 who were aged 12 to 18, 50 % of the street girls have been raped at some point, often repeatedly. 80% of the street girls will be facing sexual attacks. 75-80% of sexually mature street girls are routinely solicited for sex by potential "clients". 40-50% of street girls will resort to prostitution (28).

OBJECTIVES

General:

To describe the health and social problems of street children.

Specific:

1. To determine the number of street children in the study area.
2. To assess the socio-demographic characteristics of the street children.
3. To identify health problems of the street children.
4. To examine the social problems of street children.

MATERIALS AND METHODS

The study utilized a cross sectional, descriptive design to assess the social and health problems of street children in Nazareth town during November, 1994.

Nazareth is located 100 kilometers south east of Addis Ababa, the capital of Ethiopia. This town has an estimated population of 147,094. According to the East Shoa Planning Office 47.8% of the town's population are males while 52.2% are females. There are 20 kebeles in the town. The town is a transit site for roads from Addis to the Eastern and southern parts of the country. The Ethio-Djibouti Railway also passes through this town. There are numerous food and drink establishments and bars which serve the transit population. A large number of commercial sex workers also reside and work in the town. Most of the transit population including the heavy truck drivers stop for a meal or may even spend a night in the town. Therefore the incidence of diseases like HIV and STD is currently considered to be high due to the above reasons. The Wonji sugar factory, the Wonji paper mill, and a large textile factories are found in and around the town. Currently this town is considered to be one of the fastest growing towns in Ethiopia. All of these characteristics attract street children to it.

STUDY POPULATION

Because the number, and the prevalence of health problems in these children is not known, an assumption of a 50% prevalence of health problems, a 95% certainty and an expected difference of ± 4 prevalence between the sample and the underlying population was done. A sample size of 600 street children was calculated. The study population was identified using the census registration, which was part of the study. Systematic sampling was utilized to select the study subjects. All street children up to the age of 18 years were considered for inclusion into the study.

DATA COLLECTION

The research team or staff consisted of eight interviewers, forty enumerators (data collectors), one coordinator who is a nurse and works in the Zonal health department, and who was trained by the principal investigator. Leaders of street children were also involved in the study as facilitator of the counting process. The 40 enumerators had all completed grade 12. A one week training was given to the enumerators by the principal investigator and a social worker from the local MOLSA office. The training focused mainly on introducing the purpose of the study, the different categories of street children and the exclusion and inclusion criteria.

Children who were found working or living in the streets were taken as study subjects. In addition training was given on how to approach and gain the trust of the children. The enumerators were also given identification papers during the course of the study. The interviewers were health assistants from the hospital and the health center. They were also given training on interviewing technique.

The original questionnaire which was in English was translated to Amharic after discussion with the interviewers and coordinator of the study. The Questionnaire had the following parts, background information, section on health and socio economic aspects of the children and their parents. Pretesting was conducted in Debrezeit town on 15 children, between November 24 to November 26, 1994. The pretesting was important in the subsequent correction and restructuring of some of the questions.

Before the commencement of the census, the town was mapped and the boundaries between the different kebeles were delineated. Each kebele was again subdivided into different parts depending on its size and population. A census of one day was conducted to determine the number of street children in the town on December 1. Each enumerator registered street children found in each subdivision. To avoid double counting each child's thumb

was painted with Gentian violet solution.

Every 6th child was referred to the health center for further interview. Interview was conducted in the following one week. Each interview lasted 45 minutes and two interviewers were assigned for each child. One interviewing and the other recording the results. All questionnaires were checked daily for completeness and other inconsistencies.

All the process was carefully monitored and supervised by the coordinator and the principal investigator to solve problems as they arise.

Ethical Considerations:

A Written permission was obtained from the local administration of the town before proceeding of the study. Verbal consent from all the study subjects was obtained during interviewing and examination of the children. The study did no harm on the study subject. Two hundred and five Children who have health problems were given free treatment. Some of the social problems of the children were also addressed. Lost work hours were also compensated.

DATA ANALYSIS

EPI-INFO version 5 software package was used in the entry, storage, and analysis of data. Rates, rate ratios, frequencies and 95% confidence intervals were used to present the results.

RESULT

A total of 5,138 children were registered during the one day census. 512 (10%) were girls while 4626 (90%) were boys. Street children to population ratio was 1:28. Out of the total 5138 street children 597 subjects were selected systematically for an in depth investigation of the health and social status of the street children.

Of the 597 subjects 526(88.1%) were males. The dominant age group was 10-14 accounting for 52.8% of the study population. The age ranges from 5 years to 18 years, with a mean age of 12.9 and S.D. of 3.16. Amhara was the majority ethnic group accounting for, 206 (34.5%) of the street children, followed by Oromo 139 (23.3%), ~~Garage~~ 151(25.3%) and others accounting for 40(6.7%). The birth order of the 447 (74.9%) of the children was below three. 255 (42.7%) of the children had up to 3 siblings and 309 (51.8%) had 4 to 7 siblings. 246 (41.2%) children left their home when they were 10 to 14 years old. While 183 (30.7%) were separated from their families in early childhood less than 4 years, the rest were separated from their families when they were 5-9 years old. Only 109 (18.3%) children reported attending school currently. 366 (61.3%) of the street children had primary school education and, 165 (27.6%) were totally illiterate.

Three hundred twenty six (54.6%) of the children were children "on" the street that is they have either a relatives or a family house to sleep at night, while 271 (45.4%) of the children were children "of" the street type meaning that they are completely homeless. Most of the children were involved in businesses like shoe shinning and working as a taxi driver's assistant 204 (34.2%), while 187 (31.3%) were involved in carrying and messanging, the rest were involved in vending, begging, and brokering, 15.4%, 12.7% and 5.4% respectively (Table 1).

Table 1. Socio-demographic Characteristics of Street Children, Nazareth, 1994.

Variable	Frequency	Percent
Sex		
Male	526	88.1
Female	71	11.9
Age Group		
5-9 years	84	14.1
10-14	315	52.8
>14	198	33.2
Ethnicity		
Amhara	206	34.5
Garage	151	25.3
Oromo	139	23.3
Tigre	61	10.2
Others	40	6.7
Birth order		
< 4 child	447	79.9
4-7	145	24.3
>7	5	0.8
Siblings		
< 4	255	42.7
4-7	309	51.8
>7	33	5.5
Age at leaving Family (years)		
< 4	183	30.7
5-9	129	21.6
10-14	246	41.2
> 14	39	6.5
Education		
illiterate	165	27.6
read & write	40	6.7
Primary	366	61.3
Secondary	26	4.4
Current school attendance		
Yes	109	18.3
No	488	81.7
Occupation		
Vendors	98	16.4
Brokers	32	5.4
Carriers & messengers	187	31.3
Beggars	76	12.7
Others	204	34.2

Regarding parental education 329(55.1%) of the fathers were illiterate, 99(16.6%) had primary school education, 94 (15.7%) could only read and write and 75 (12.6%) had secondary school education. Three hundred fifty two mothers (59%) were illiterate, 132 (22.1%) could only read and write, 70(11.7%) had primary school education and 43 (7.2%) had secondary school education.

Eighty nine (14.9%) of the children had reasonably good family who could support the children by providing clothing, shelter, and food. While 508(85.1%) children were not supported by their families. 391(65.7%) of the children reported that both their parents are alive. 106(17.8%) of the children reported that only the mother is alive. 39 (6.6%) of the children reported only the father is alive, 47(7.9%) children had both their mother and father dead (Table 2).

Only very few, 42 (7%), of the children save money from whatever they got. Of the total subjects 394(66%) did not wash their clothes at all, while the rest 203 (34%) wash their clothes as they see it dirty. 133 (22.3%) of the children reported they eat meals according to their income, 63(10.6%) eat once a day and the rest, 401(67.2%), eat at least twice a day (Table 3).

Table 2. Parental Characteristics of street children,
Nazareth, 1994.
n=597

Variable	Frequency	Percent
Alive parents		
Both parents	391	65.7
Father	39	6.6
Mother	106	17.8
Both dead	47	7.9
Don't know	12	2.0
Father Education		
Illiterate	329	55.1
Read and write	94	15.7
Primary	99	16.6
Secondary	75	12.6
Mother Education		
Illiterate	352	59.0
Read and Write	132	22.1
Primary	70	11.7
Secondary	43	7.2
Family Support		
Yes	89	14.9
No	508	85.1

Table 3. Feeding and Washing Habits of the Street Children, Nazareth, 1994.
n=597

Variable	Frequency	Percent
Body Washing		
no regular habit	432	72.4
Once in 15 days	114	27.6
Cloth Washing		
Wash when dirty	203	34.0
Don't wash	394	66.0
Meals		
As available	133	22.3
Once/day	63	10.6
Twice/day	133	22.3
Three/day	268	44.9

Majority of the children (72.4%) didn't have any regular body washing habit. only (34%) reported washing clothes as they see it dirty. 66% reported eating two or more times per day. 497 (83.2%) of the children reported no substance use (smoking cigarette, alcohol, and chewing chat). The rest 100 (14.6%) reported the use of at least one of these substances. 14.6% reported that they started the habits between the ages 10 and 14 years. 40(6.7%) reported that they were arrest by the police at least once.

In relation to sexual intercourse the majority 81.9% reported that they have not yet started sexual intercourse while 17.9% reported starting sex between 10 to 18 years of age. Few (1%) said they started sexual intercourse between the ages 5 and 9. 36 (6%) reported having sexually transmitted disease (Table 4).

Table 4. Substance use, Crime and Sex among Street Children in Nazareth, 1994. n=597

Variable	Frequency	Percent
Substance use		
Yes	100	16.8
No	497	83.2
Age at Start of Substance (years)		
No habits	495	82.9
5-9	9	1.5
10-14	87	14.6
>14	6	1.0
Police Arrest		
Yes	40	6.7
No	557	93.3
Police Arrest by cause		
Curfew	7	14.3
Quarrel	32	65.3
Theft	3	6.1
Don't know	7	14.3
Sexual intercourse		
Yes	93	15.6
No	504	84.4
Age at start of sex		
Not started	489	81.9
5-9	6	1.0
10-14	47	7.9
>14	55	9.2
Sexually Transmitted Diseases		
Yes	36	6.0
No	561	94.0

Table 5. Determinants of Family Attachment among Street Children, Nazareth, 1994.

Variables	"on" street	"of" street	OR (95% C.I.)
Age			
5-9	58	26	1.00
10-14	200	115	0.78 (0.45, 1.35)
15-19	68	130	0.23 (0.13, 0.42)
Sibling number			
0-3	131	124	1.00
4-7	177	132	1.27 (0.90, 1.80)
>=7	18	15	1.14 (0.52, 2.50)
Child's Education			
Illiterate	98	66	1.00
Read & Write	10	30	0.22 (0.10, 0.52)
Primary	195	171	0.77 (0.52, 1.13)
Secondary	22	4	3.70 (1.14, 13.34)
Alive Parents			
Both Parents	231	160	1.00
Father Alive	14	25	0.39 (0.18, 0.81)
Mother Alive	57	49	0.81 (0.51, 1.27)
Both dead	9	11	0.57 (0.21, 1.51)
Don't know	15	32	0.32 (0.16, 0.65)
Family Support			
Yes	62	27	1.00
No	264	244	0.47 (0.28, 0.78)
Age when leaving Family			
<5	120	63	1.00
5-9	73	56	0.68 (0.42, 1.12)
10-14	118	128	0.48 (0.32, 0.73)
>14	15	24	0.33 (0.15, 0.71)
Current School Attendance			
Yes	74	35	1.00
No	252	236	1.98 (1.25, 3.15)

Out of the 597 children included in this study 326 (54.6%) were "on" the street type and the rest 271 (45.4%) "of" the street type. Children "on" the street had a house to sleep at night whereas "of" the street children are completely homeless and had no contact with their families.

Older children, children from a small family, less educated, from a single parent family, who had better family support, who were relatively older when leaving home, and who currently attend school were found to be more likely to be "on" street type (table 5). The chances of washing clothes regularly and earning more than two Birr a day were significantly ($P < 0.05$) higher among the "on" the street children. The chances are 4 times and 6 times higher respectively. But children "of" the street reported eating more than one meal per day as compared to the "on" the street children (table 6).

Table 6. Living Conditions of Street Children, Nazareth, 1994.

Variables	"on" street	"of" street	OR (95% C)
Body Washing			
Never Wash	227	205	1.00
Once/15 Days	82	42	0.57 (0.37, 0.88)
Occasionally	17	24	0.64 (0.32, 1.28)
Cloth Washing			
Wash	274	120	1.00
Don't Wash	52	151	6.63 (4.45, 9.89)
Income (Birr)		203	
0-0.99	123	128	1.00
1-1.99	29	109	0.28 (0.17, 0.46)
2-2.99	62	12	5.38 (2.66, 11.09)
3-3.99	50	10	5.20 (2.42, 11.48)
4-4.99	16	4	4.16 (1.26, 15.19)
≥ 5.00	46	8	5.98 (2.59, 14.38)
Meals			
As Available	103	30	1.00
Once/day	50	10	1.54 (0.66, 3.67)
Twice/day	15	118	0.04 (0.02, 0.08)
Three/Day	155	113	0.04 (0.24, 0.66)
Financial Saving			
Yes	26	16	1.00
No	300	255	1.38 (0.70, 2.76)

Substance use, police arrest, sexual intercourse, and STD were reported less frequently among the "on" the street children. All differences were statistically significant ($P < 0.05$). Although not statistically significant sex as means of income was practiced more frequently among the "of" the street children (table 7).

Table 7. Substance use, Crime and Sex among Street Children, Nazareth, 1994.

Variables	"on" street	"of" street	OR (95% C)
Substance Use			
Yes	21	85	1.00
No	305	186	0.15 (0.09, 0.26)
Age Group (years)			
5-14	15	81	1.00
15-19	311	190	0.11 (0.06, 0.21)
Police Arrest			
Yes	4	36	1.00
No	322	235	0.08 (0.02, 0.24)
Sexual Intercourse			
Yes	11	82	1.00
No	315	189	0.08 (0.04, 0.16)
History of STD			
Yes	9	27	1.00
No	317	244	0.26 (0.11, 0.58)
Commercial sex			
Yes	5	11	1.00
No	321	260	0.37 (0.11, 1.16)

368 (61.6%) of the street children reported health problems during the survey time. Abdominal pain, cough and chest pain, eye and ear problems, headache and leg ulcer were the major complaints (Table 8).

Table 8. Frequency of reported Health Problems among Street Children in Nazareth, 1994.

	Frequency	Percent
No Complaint	229	38.4
Abdominal Pain	95	15.9
Cough & chest Pain	59	9.9
Headache	53	8.9
Leg Ulcer	49	8.2
Eye & Ear problems	38	6.4
Fever	34	5.7
STDs	16	2.7
Others	24	4.0
Total	597	100%

Children 10-19 years old were about twice more likely to be ill than children 5-9 years old which is a statistically significant association. All other variables studied which include: number of sibling, child's education, status of parents (alive or dead) , family support, age of the child at leaving the family and current school attendance did not show any significant association with illness (Table 9).

Table 9. Determinants of Ill-health Among Street Children, Nazareth, 1994.

Variable	Ill	Not Ill	OR(95% C)
Age			
5-9	42	42	1.00
10-14	199	116	1.72(1.03,2.87)
>14	127	71	1.79(1.03,3.10)
Siblings number			
0-3	164	191	1.00
4-7	190	119	1.86(1.35,2.57)
>7	14	19	0.86(0.39,1.86)
Child's Education			
Illiterate	127	37	1.00
Read and write	27	13	0.61(0.27,1.38)
Primary	199	167	0.35(0.22,0.54)
Secondary	15	11	0.40(0.16,1.02)
Alive parents			
Both parents	234	157	1.00
Father alive	23	16	0.96(0.47,1.98)
Mother alive	70	36	1.30(0.81,2.10)
Both dead	32	15	1.43(0.72,2.87)
Don't know	12	3	2.68(0.69,12.18)
Family Support			
Yes	47	42	1.00
No	321	187	0.65(0.40,1.05)
Age when leaving family			
0-4	114	69	1.00
5-9	73	56	0.79(0.49,1.28)
10-14	160	86	1.13(0.74,1.71)
15-19	21	18	0.71(0.33,1.50)
Current school Attendance			
Yes	69	40	0.92(0.58,1.44)
No	299	189	1.00

DISCUSSION

This study has revealed that large number of children are working and living in the streets of Nazareth town. The number obtained is larger than the number estimated by the local Ministry of Labor and Social Affairs (MOLSA) office by 20% (29). The reasons for this increase could be due to a previous under estimation or due the increasing number of children joining the streets of the town. In any case in a town of 150,000 population the number we obtained was very large. This huge size is attributed to the many attractions Nazareth has. The city is a major business center in Ethiopia so job opportunities for street children are plenty, and the warm weather in Nazareth makes street life easier than other towns at a higher altitude, which are cold. Similar situations were observed in Brazil with a high rate of increase as high as 90% with in three years (30).

The fact that considerable proportion (31%) of the children in this study had left their family before the age of 4 years has to be looked at seriously. A study in Colombia has shown that more than 50% of children left their home before 12 years (31). Another study in the same country by Felsman indicated that 60% left homes between 7-12 years (32).

Our finding showed that a large number of children are leaving their homes at an early age. This means that a large number of children are exposed to a harsh environment before they even start to understand the very simple games of life.

This shows that other factors like marital disharmony (apart from economic reasons) may be responsible. These children are not supervised by their parents on the street and could easily be hurt physically, mentally and economically. As observed in this study, these children would most likely do not attend school and their future as an adult would not be any different than the one they are leading now.

Out of the street children studied 45% were "of" the street type; meaning they are all in all homeless and do not receive any kind of family guidance and supervision. This figure is very high as compared to a Colombian study which put the maximum proportion at 30% for children "of" the street (30). The very high proportion of children "of" street in our study might be due to false information given by the children in anticipation of a material support. If the report is true it implies that these children would not get any chance to learn and adopt family and cultural values.

The absence of family ties and lack of cultural values may make them to get involved in crime and other

anti social activities. All these would make the small street children to grow without any social values, which will be ultimately a big source of social trouble for the society unless some corrective measure is taken timely.

According to this study some 15% of the street children are produced by the families who could support their children with the basic necessities in the form of food, shelter and clothing. This might be a small clue that the reason for the children to leave their home is not only because their family could not support them but that there are some other social problems which force them to do so. Other factors which cause family instability and breakdown need to be addressed (33). It is also important to note that the majority (65%) of the children had their parents alive.

Although most children claimed to eat at least twice in a day, this does not mean that they are getting adequate food. In fact most live on left-overs from the wide spread hotels in the town. The food available to them is inadequate in terms of quantity, the nutritional value and the safety of the food is also unsatisfactory.

Some of the children get their food by salvaging from a public garbage basket which makes the situation even worse. This may cause health problems which are related with the food (18). Washing and changing clothes were the major deficiencies observed which could be

mainly due to the unavailability or the less access of the facilities for washing. Substance use (16.8%) in this population seems low when we consider that they are very much exposed and free in terms of space and time without any supervision and control, though it is very much higher than those of high school adolescents in Addis Ababa who had a consumption rate of 9.2% (38). However, those who use substances do so when they are very young, which puts them at a higher risk of developing the complications and a high degree of dependence. These would possibly increase their demand for money and may in turn force them to get involved in anti social activities.

Majority of the children reported not being involved in Sexual intercourse, while 15.6% reported being involved in sexual intercourse in the past. Such sexual activity would contribute to an increasing risk of STDs particularly HIV/AIDS, and unwanted pregnancy with their complications. It may also contribute to the growing population of the street children. The effect of losing family and cultural values are reflected by the observations of a higher rates of substance use, arrest by police and sexually transmitted diseases among the "of" street children. Only 6.7% reported arrest by the police which is comparable to a study in Brazil (4%) (30) and very low as compared to an Indian study (39%) (34).

Out of all some 60% reported at least one symptom of a disease, considering their exposure to the harsh environment in the street it should not be surprising. The major complaints, which are almost similar to what has been reported else where (34), could also be related to their living conditions. This was substantiated by the fact that the "of" the street children were the once who reported health problems more than the "on" the street children.

Although the health care facilities are readily available physically in the town the children's access to them is limited by their status and economic constraints.

Generally the problem of street children is believed to increase due the declining economic status and the HIV/AIDS epidemic in most developing countries, particularly in the sub-Saharan African countries to which Ethiopia is not an exception. And as the problem is very complex any intervention directed to it must be a multisectoral effort involving all social sectors. Studies on street children are very rare world wide partly because of the difficulty of conducting a study among street children and partly because it was not considered as a public health/social problem until recently. Currently there is a growing interest about the street children world wide and also in Ethiopia. Hence this study is believed to shade some light in this field

which could lead to further study and hopefully to actions towards the improvement of quality of life of the street children. This study utilized probability sampling technique to select the study subjects, trained interviewers who used a standard and pretested questionnaire and applied a strong supervision system. Therefore the design and implementation of the study are believed to minimize bias, which could possibly distort the results.

Limitations of the study

This study is not without limitations. Some of the limitations are:

1. Lack of adequate reference materials was a major problem in the design and write-up of the study.
2. Classification of the children into "on" and "of" type was totally dependent on the children's report.
3. Although maximum care was applied not to include other children into the study it is a possibility that few poor children, who were not in fact street children, might have been included in the study.

CONCLUSION

The findings of this study indicated that the street children are at high risk of complex social and health problems. The children are faced with lack of education, shelter, and lack of basic health services. Comprehensive health and social interventions can improve the conditions of these children. Program for these children should include social, medical, and recreational services that simultaneously help to alleviate the family problems, and meet basic needs of the children.

RECOMMENDATIONS

1. Immediate attention should be given to this segment of the population which are found in a very desperate situations, exposed to many undesirable social and health conditions.
2. Ways to make the existing social services accessible to the street children must be explored.
3. Possibilities to rehabilitate and to rejoin them with their families should be explored.
4. Particular emphasis to the girl street children must be given since they have a special problem related to their gender.
5. Explore the possibility of providing street based health education in a way that is acceptable by the street children.
6. Further researches are recommended to elaborately indicate the health and social problems of the street children and also to identify effective intervention strategies.

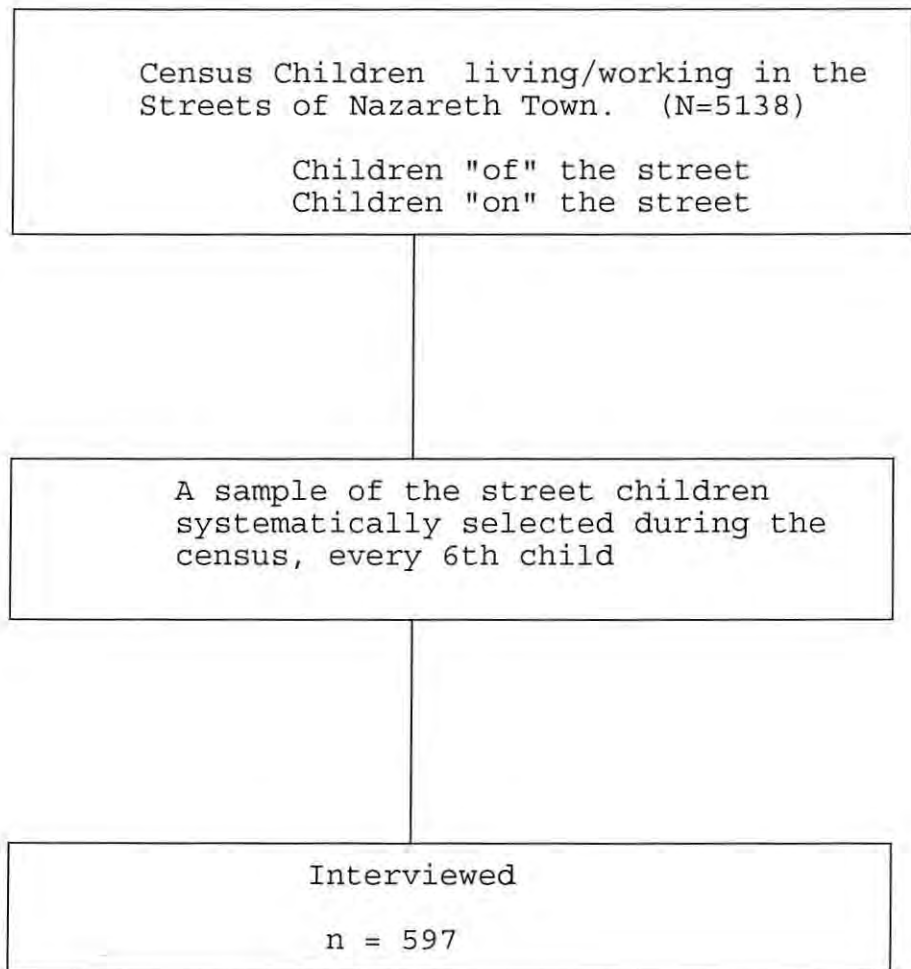
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Appendix 1



The Study Sample Selection Procedure

Appendix 2

Definitions

Street is a place where life goes on, it is a habitat a place of reference, the place to which the child will inescapably return between short or long stages of relative stability achieved away from the streets.

Street children are children and Adolescents up to 18 years old whose characterization comprises the following elements. They are located in Urban areas, their family ties if they exist are weak, ~~weak~~ ^{weak} they have developed survival skills. The street are their main habitat, essential for growing and socialization and their condition exposes them to considerable risks.

Children at risk are generally urban children who because of extreme poverty and deprivation in their homes, or inadequate care and supervision because parents are working, are at high risk of becoming involved in street-life.

Children "on" the street are children who spend most of their time in the streets or markets, usually as child workers. They maintain a strong family link, usually returning home at night, having spend all day away. The families are usually very poor and highly deprived, living in home

environments lacking basic necessities, and the children can be characterized as having primarily an economic involvement with street life, perhaps making a substantial contribution to the overall family income, or obtaining just the basic necessities for themselves. Few attend school regularly, the street being their main learning ground.

Children "of" the street, in contrast, are children who have in some sense chosen to fully participate in street-life not just at an economical level. They usually have a family accessible to them who they may visit from time to time, but the street is their principal home. There may be a developmental continuum from a child "on" the street to a child "of" the street, and any child may be located a point along this continuum and move along it. A key indicator of a child "of" the street is his or her place of sleeping.

Abandoned children are those who have no home to go to either because of the death of, or the rejection by, their parents and the unavailability or rejection of their extended family. Rejection may be a response to profound economic disadvantage as much as rejection of the child per se.

Appendix 3 Questionnaire

Part I Section on sociodemographic information

1. Respondents name-----
2. Respondents sex
Male---- Female-----
3. Respondents Age -----
4. Birth Place
Region----- Town-----
5. Ethnicity-----
6. Are your parents still alive
Yes---- No-----
7. Do you get support from your parents
Yes---- No-----
8. What type of support do you get from your parents
Food---- All of the above-----
Clothing----- None-----
Shelter-----
9. If your parents are not supporting you, what are the reasons
Poverty----- They are dead-----
Separation----- Others (specify)-----
10. Currently wit whom are you living
Father/Mother----- Other relatives-----
Step mother----- Other persons (specify) ----
Step father-----
Uncle/Aunt-----

11. You lived with your parents until the age of ___
12. Total number of brothers and sisters
- A. Same father/mother
- Number of brothers-----
- Number of sisters-----
- B. One father/ mother
- Number of brothers-----
- Number of sisters-----
13. Are your father and mother (both) alive
- Yes ----- No-----
14. Which one of your parents is dead
- Father----- Mother----- Both-----
15. When your father/mother died how old were you__
16. Your birth order is-----
17. When did you come to Nazareth town -----
18. Where were you living before coming to Nazareth town----
19. Why did you come to Nazareth town-----
20. Before coming to this town, what activity were you involved in -----
21. What is the name the location/street that you are living currently-----
22. Your parents are currently living
- In this town -----
- Out of this town-----

23. Do you frequently meet your parents

Yes----- No-----

24. You meet your parents

Daily----- Once in a year-----

Weekly----- Other (specify)-----

Monthly-----

Part II Section on Health and Education

26. Mother's education level

Illiterate-----

Literacy campaign up to 3rd grade-----

Primary ----- grade-----

Secondary-----grade-----

College-----

27. Father's level of education

Illiterate-----

Literacy campaign up to 3rd grade-----

Primary----- grade---

Secondary -----grade----

College-----

28. Respondent's level of education

Illiterate----- Koran school-----

Church school---- Primary school-----grade--

Secondary----- Grade--

29. Are you currently attending school

Yes-----

No-----

30. Reason(s) for school discontinuation

31. Do you have any health problems, please specify

Part III Section on income and occupation

32. What activity are you involved in currently

Vending-----

Brokering----

Carrying and messanging-----

Begging-----

Others, specify-----

33. Where do you sleep

Relatives house-----

Shilling house-----

Street-----

Others, specify-----

34. What is your daily income

35. How many times do you eat in a day

36. Except the ones you are wearing, do you have other
extra clothes -----

37. How frequent do you wash your clothes

38. Do you save money

Yes----- No-----

39. Where do you save your money -----

40. How much do you save -----

Part IV Section on sexual activity, habits, and crime

41. Do you have personal habits like smoking and chat chewing

Yes----- No-----

42. Which of the following habits do you have

Type	Age of start	Amount/day
Alcoholic -----		
Smoking-----		
Benzine sniffing-----		
All-----		
Others(specify) -----		

43. Have you been arrested by police/Kebeles

Yes----- No_____

44. If the answer to question 43 is yes, how many times have you been arrested in the past_____

45. What is the reason of your arrest

46. Have you been forced to commit sexual intercourse

Yes_____ No_____

47. At what age did you start sexual intercourse

48. To prevent STDs or unwanted pregnancy what method
do you use _____
49. (For females) How many abortions did you have in
the past

50. (For females) Have you given birth in the past
Yes _____ No _____
51. If the answer to Q. no 50 is yes, where is your
child now

52. Have you had sexually transmitted disease in the
past
Yes _____ No _____
53. Do you get income by performing sexual intercourse
Yes _____ No _____

Date of interview _____

Name of interviewer _____

DECLARATION

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other university and that all resources of material used for this thesis have been fully acknowledged.

Name : _____

Signature: _____

Place : Addis Ababa, Ethiopia

Date of Submission : May, 1995