ADDIS ABABA UNIBVSERITY
SCHOOL OF GRADUATE STUDIES

THE MULTIPLE CHALLENGES OF CHILDREN WITH DISABILITY IN ADDIS ABABA: COPING STYLES

NEMME NEGASSA YADATA

JULY 2006

ADDIS ABABA, ETHIOPIA

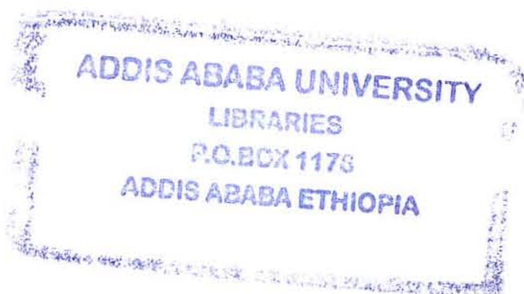
ADDIS ABABA UNIBVSERITY
SCHOOL OF GRADUATE STUDIES

THE MULTIPLE CHALLENGES OF CHILDREN WITH DISABILITY IN ADDIS ABABA: COPING STYLES

A thesis submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Masters of Arts in Special Needs Education

BY

NEMME NEGASSA YADATA



JULY, 2006

ADDIS ABABA, ETHIOPIA

ADDIS ABABA UNIBVSERITY
SCHOOL OF GRADUATE STUDIES

THE MULTIPLE CHALLENGES OF CHILDREN WITH DISABILITY IN ADDIS ABABA: COPING STYLES

NEMME NEGASSA YADATA

Approved By the Boards of Examiners.

Teka Zewdie (PhD)
Chairman of Graduate Committee

Signature

Tirussew Teferra (Professor)
Advisor

Signature

Wegayehu Tebeje(PhD)
External Examiner

Signature

Darge Wole (Professor)
Internal Examiner

Signature

ACKNOWLEDGEMENTS

I believe that the outcomes of every effort are the result of genuine cooperation and considerations. Few tasks might be achieved without others cooperation. This implies that the supports people of wisdom are always at the back of most successful stories. Hence, I would like to extend appreciation for respectful persons and different organizations for their valuable contributions and assistances to complete my Masters of Art (MA) degree in Special Needs Education at Department of Psychology, Addis Ababa University.

Foremost, I would like to extend my deepest and sincere gratitude to my advisor Professor Tirussew Teferra (PhD) for his constructive criticisms, insightful comments consistent guidance and technical supports rights from inception until the completion of my study in Special Needs Education. The professional guidance, he offered me, are eternal and long-lasting nature. I also extend my appreciation to Professor Darge Wole and Dr. Wegayehu Tebeje, Internal and external examiners respectively for their substantial guidance and contributions.

I would also to extend my profound gratitude to **Save the Children Sweden-Ethiopia** for providing technical and financial supports to conduct this research work in Addis Ababa. I also owe a great various organizations who were interested in working with my research project on the rights of children with disabilities particularly Ethiopian National Associations for Mentally Retarded Children and Youth, Cheshire services-Ethiopia, and Handicap National for children with disabilities and others.

My gratitude is also extending to all my classmates, lecturers, and staff members of the Department of psychology for their valuable assistance and in providing long- term knowledge in my life. Today, I am very proud since I have got substantial skills about human behaviors, Psychology.

Moreover, I would like to extend my great thanks to my family, wife and friends who have made valuable contributions during my study time. Last and most, I would like to dedicate my masters' thesis to my son, STEPHEN.

NEMME NEGASSA YADATA

ABSTRACT

The diverse socio-economic systems of children with disabilities have been creating different multiple life challenges at different ecosystems. Even though it had been assumed that favorable conditions shall facilitate or improve the existing life of persons with disabilities in general, the continual challenges in areas of trafficking, Streetism, HIVAIDS issues and other psychosocial problems including coping mechanisms are left untouched due to various reasons.

This study was undertaken to investigate the multiple challenges of children with disabilities in Addis Ababa. The study was a cross-section study that employed both quantitative and qualitative instruments. To assess and explore the aforementioned challenges, a sample of 251 children with disabilities were drawn randomly and analyzed using descriptive analysis and transcription approaches.

The study revealed that the multiple challenges of children with disabilities become very serious issues. More than one third of the children found being exposing to the problem of Traficking, and three out of ten children were living in/on street. One fourth of the children also found being exposing to sexual abuse /violence and more than two out of ten children did not have information about HIVAIDS issues. In addition to all these diverse challenges, they were found facing different psychosocial problems and have very limited coping styles to deal with the demanding life challenges.

Hence, the findings suggest that there is a great need for mainstreaming issues of children with disabilities into existing child-based projects/programs and encourage both concerned Non-governmental and governmental sectors to promote and advocate the rights of children with disabilities equally like non-disabled children in sphere of all programs. The study further suggests feasible and important interventions programs that give priority to creating awareness-raising programs and increasing the involvements of parents of children with disabilities, concerned partners, and community in general.

LIST OF TABLES PAGE

Table 1 Percentage distribution of street children population by types of disblties (MOLSA, 1995) 24

Table 2 Demographic characteristics of respondents by selected characteristics 43

Table 3 Percentage distribution of respondents by reason of leaving home 45

Table 4 Percentage distribution of respondents being trafficked by types of disabilities 45

Table 5 Percentage distribution of respondents by means of trafficking styles 46

Table 6 Percentage distribution of respondents by methods of deceptions 47

Table 7 Percentage distribution of respondents by perpetrators of child-trafficking 47

Table 8 Percentage distribution of respondents being trafficked children by activities 48

Table 9 Percentage distribution of respondents by types of problems they have faced 49

Table 10 Percentage distribution of respondents who have reported their status of street life by types of disabilities 50

Table 11 Percentage distribution of respondents who have reported living in street by types of disabilities 50

Table 12 Percentage distribution of respondents who have reported taking drugs by types of disabilities 51

Table 13 Percentage distribution of respondents who have reported that they have sexually abused by types of disabilities 52

Table 14 Percentage distribution of respondents who have heard of modern family planning services by gender 53

Table 15 Percentage distribution of respondents' status of knowledge of family planning by types of disabilities 53

Table 16 Percentage distribution of respondents who have ever heard of the virus HIV/AIDS by sources and types of disabilities 54

Table 17 Percentage distribution of respondents' information about HIV/AIDS by sources and types of disabilities 54

Table 18 Percentage distribution of respondents who have reported that they have heard means of avoiding HIV infection by types of disabilities 55

Table 19 Percentage distribution of respondents who have reported that they knew at least one means of HIV prevention by methods and types of disabilities 56

Table 20 Percentage distribution of respondents by status of their knowledge of STI's 57

Table 21 Percentage distribution of respondents who have reported having close friends or not by types of disabilities 58

Table 22 Percentage distribution of respondents who have reported experiencing social Problems by types of disabilities 59

Table 23 Percentage distribution of respondents who have reported experiencing some Psychological problem by types of disabilities 59

Table 24 Percentage distribution of respondents who have reported employing general Coping styles by types of disabilities 61

Table 25 Percentage distribution of respondents who have reported employing personal and social coping mechanisms in school settings by types of disabilities 62

Table 26 Percentage distribution of respondents who have reported employing personal and social coping mechanisms in-out school settings/community by types of disabilities 64

CONTENTS **PAGE**

ACKNOWLEDGEMENTS........i
ABSTRACT........ii
LIST OF TABLES........iii
CHAPTER **1**
1. INTRODUCTION...........1
1.1. Background........1
1.2. Statement of the problem........5
1.3. Justification........6
1.4. Objectives........7
1.5. Research Questions........7
1.6. Definition of Terms........8
1.7. Delimitation of the Study........9
2. REVIEW OF LITERATURE........10
2.1 Introduction........11
2.2 Theoretical Background........11
2.3 The Constitution and National laws of Ethiopia........12
2.4 .Convention on the Rights of Children (CRC)........13
2.5 African charter on the Rights and Welfare of the Child........15
2.6 United Nations protocol on Trafficking in Person........17
2.7 Multiple Challenges. of children with disabilities........19
2.7.1. Child-trafficking practices in Ethiopia........19
2.7.2. Street Children with disabilities........22
2.7.3. Awareness of STD and HIVAIDS issues........28
2.7.4. Sexual abuse/rape........29
2.7.5. The psychosocial problems........29
2.7.6. Coping mechanisms........30

3. METHODOLOGY...36

3.1. Study Sites..36

3.2. Target population..36

3.3. Study design and Sampling procedures..36

3.4. Instruments..37

3.5. Procedures of data collection..38

3.6. Recruitment, Training and Pilot study..38

3.7. Ethical Considerations..39

3.8. Data Analysis and interpretation..39

3.9. Limitation of the study..40

4. RESULT OF THE STUDY..41

4.1. Demographic Characteristics of Respondents..41

4.2. Child Trafficking Practices..42

4.2.1. Causes of Mobility..43

4.2.2. Prevalence of Child-Trafficking..44

4.2.3. Methods and Perpetrators of Child Trafficking..45

4.2.4. Occupations of trafficked Children..47

4.2.5. Consequences of Trafficking 47

4.3. Street Children with Disabilities..48

4.3.1. Prevalence of Streetism..48

4.3.2. The challenges of Street life..49

4.3.3. Substance abuse practices..50

4.4. Sexual abuse/ violence 50

4.5. Awareness of STDS and HIV/AIDS Issues..51

4.5.1. Knowledge of Family Planning Services..52

4.5.2. Knowledge on HIVAIDS..53

4.5.3. Sources of information on HIVAIDS..54

4.5.4. Knowledge on Means of HIV/AIDS Prevention..54

4.5.5. Knowledge on Sexually Transmitted Infections (STI's)................56

4.6. Psycho-Social problems..57

4.7. Coping Mechanisms..60

4.8. Programmatic Challenges..65
4.9. Case Studies..69
4.9.1. Case study 1..70
4.9.2. Case study 2..71
5. DISCUSSIONS..72
5.1. Trafficking of children with disabilities..73
5.2. Streetism and children with disabilities..75
5.3. Awareness of HIVAIDS issues s..76
5.4. Sexual Abuse and Rape..77
5.5. Psycho-Social Problems..77
5.6. Coping Mechanisms..78
5.7. Programmatic challenges..80
6. CONCLUSIONS AND SUGGESTIONS..82
6.1. Conclusions..82
6.2. Suggestions..84
6.2.1. Community Participations..84
6.2.2. IEC and Advocacy Programs..84
6.2.3. Intervention Programs..85
6.2.4. Co ordinations and networking..85
6.2.5. Good Governance..86
6.2.6. Research perspectives..86
6.2.7. Policy implementation perspectives..87
REFERENCES..88
Appendix A: Structured Questionnaire..93
Appendix B: Key Informant Interview Schedule..98
Appendix C: Guidelines for Focus Group Discussion..101
Appendix D: List of key informant organizations..103
Biography: 101
Signed Declaration..105

Chapter 1 INTRODUCTION

1.1. Background

The problems of children with disabilities are so diverse and complex. They are facing various life challenges due to the complex socio-economic factors including stigma and discrimination against them by the society in different time and places. Among others, the psychosocial problems, social maladjustments, child-trafficking practices, streetism, HIV/AIDS problems, sexual abuse and violence, and coping styles are the by-products of the existing socio-economic problems that come into existence over time.

Now a day, street children become an integral feature of urbanization in which children with disabilities believed to be one of the major groups. According to CYFWO (1989) estimation, 4,042,357 children live under especially difficult circumstances in Ethiopia. Among these it was expected that there were 100,000 children living in the street. Tocon (1991) has revealed that more than 500,000 children were extremely in high risk to involve in street life in Ethiopia. Confirming to this, Hirute (1996, cited in Habtamu, 1996) has revealed that among 250,000 homeless children and 100,000 street children only a small portion of them are getting limited welfare and rehabilitation services in Ethiopia. She further states that the socio economic services offered for these children covers only about 6 percent of the total affected children in the country.

One of the most catastrophic psychosocial problems of persons with disability is rejection. It provokes despair and retreat on them and further may produce social stereotype. The discrimination and prejudice towards persons with disability create a sense of being disabled that could lead to development of different psychosocial problems. The able-body people display these unfavorable attitudes due to ignorance, fear, and lack of familiarity with disabled people (Coleridge, 1993).

Besides, the other commonly cited problems includes self-esteem; inability to accept the role of being victim as the result, they face such problems and hence they are found in either institution or confined at home or become beggars. In most cases; however, persons with disability are not discouraged by the negative experiences they come across their lives. They rather attempt to cope up with forthcoming challenges.

Over long period of time, history tells us that the reactions of peoples toward with disability are characterized by liquidation and isolation (Millward & Dyson, 1995). These attitudes are largely influenced by the existing philosophy, socio-cultural factors and perceived causes of the disability (Rubin, 1995). Confirming to this, Rowltz (1992) has stated that one cannot analyze the future trends of persons with disability without perception of society as a whole. A surprising statement of Helen KELLER describes the situation better….. "Not blindness but the attitude of the society to the blind that is the hardest burden to bear" (Zahl, 1962). Tirussew (1998) revealed the social problems and negative attitude of both visually impaired and physically disabled children and those social problems including beliefs such as Blind cannot learn, cannot work and cannot improve their life, thus resulting in Neglect and exclusion of them from social relations at school.

In social perspectives, children with disabilities have also difficulties in major areas of academic achievement, socio-emotional adjustment (e.g. making and sustaining friendship), attaining a positive self concept and in physical activities (Reynolds, et al, 1987). These major psychosocial factors that have isolated disabled people from the general public and delayed their development society's ignorance, neglect, superstition and fear throughout history that are still exist within the general population.

One of recent growing problems of children with disabilities is the practices of trafficking. The concept of trafficking is primarily adopted by UN general assembly with purpose of developing convention against transnational organized crime. The objective of this UN trafficking protocol is to prevent, suppress and punish trafficking in persons, particularly on women and children, to fight against the smuggling of migrants by land, sea and air route across the world (UN, 2000, cited in Wang, 2005). Child trafficking is the act of recruiting, transportation, transfer, harbouring or receipt of the child for the purposes of labor exploitations or sexual abuse or as means of income using for begging. The trafficking practices involves the act of employing forces/coercion/deception and exploitation in order to gain profits by some body or actors on children with disabilities.

Various factors drive the actors and children themselves to participate in these slavery practices. The socio-economic inequalities including lack of access to existing public services and poverty are the frontline factors that mostly underlined in child trafficking history. For instance, most young girls and boys have been sold (trafficked) in Vietnam to China for marriage, commercial sex work, and Labour exploitation such for domestic workers, entertainers, and waitresses in bars, cafes and massage houses, etc.

Another area of concern about children with disabilities is about their awareness of HIV/AIDS issues. One of the objectives the policy on HIV/AIDS of Ethiopia are to empower youth and other vulnerable groups of the community, supporting orphans and surviving dependents of people living with HIV/AIDS and promoting research tasks directed towards the preventive, curative and rehabilitative aspects of HIV/AIDS issues (FDRE,1998).

However, there are no disaggregated data that show the situation of HIV/AIDS of children and young people with disability in Ethiopia. Some limited studies have shown the situation indirectly. According to Ministry of Health's report on AIDS, for instance, among the 2.2 million HIV positive populations in Ethiopia, adults and children consist of about 2 million and 200,000 respectively (MOH, 2002). One emerging problems about sexuality of children with disabilities at the HIV epidemic is a person with STDs and HIV/AIDS infection can rid of their infection if they have sexual relationships with a virgin of children with disabilities(UNICEF, 2005).

One of the ways of dealing with all life challenges is employing coping styles that assist to manage the demand and crises of stressful situations. Largely people who employ the coping mechanism are under difficult circumstance such as threat, harm, challenge and /or problematic situations. Hence, coping styles are purposeful efforts, a dynamic process, focused on the resolution of difficulties that are demand people for adjustment (Zautra, et al, 1991). An event that has no potential for producing any psychological distress may be considered as stressful situation. According to Folkman (1986) the transactional approach posits that person's interpretation of events play a unique role in adaptation of life stressors. This situation is also true with children with disabilities to cope-up with life challenges in the societies.

Non-disabled children who have little drive, sensitivity, autonomic reactivity along with too little parental protection, indulgence or restriction will have low potential of coping styles (Wolman, 1977). Wolman further states that children with stable family may have good ability to cope with stressful situation. Family stability, however, doesn't guarantee the best ability of coping with stressful events.

Similarly, physical illness at early life may have significant effect on children development progress and their coping skills. Children who were seriously ill during infancy become slower to be independent and less competent with the new ideas and experience of the environment (Wolman 1977).

In Ethiopia, however, there is no study that shows the status of trafficking of children with disabilities. The focus of this study is to describe the major problems of trafficked children with disabilities. This study is concerned to describe and investigate the major causes and driving factors, ways of trafficking, consequences, facilitating agents, problems of accessibility and supportive public services, psychosocial problems and coping styles of children with disabilities in Addis Ababa.

1.2. Statement of the Problem

In Ethiopia, there are many children who are living under the Children Especially Difficult Circumstances (CEDC) of which children with disabilities are the most vulnerable group. Among these, about 100,000 children were founding living in the street life (Tocon, 1991). According to MOLSA (1992) survey, the numbers of children with disabilities living in the street share the largest proportion. Besides, UNICEF (1993) reported that there were about 2.2 million children under the age 15 with disabilities who were living in street life.

However, the provision of adequate socio-economic services for children in general and children with disabilities are hardly non-existent in Ethiopia. For instance, Hurte(1996; cited in Habtamu, 1996) revealed that among 100,000 street children only a small proportion (6 percent) of them are getting limited welfare and rehabilitation services.

This situation is particularly worse for children with disabilities who may be exposed to trafficking problems as well as living in stressful street life. In addition to these problems, the nature disability believed to disturb the whole personality and strikes the core of personality-self-concept (Wolman, 1997). The effects of being trafficked and living in street might increase the severity of psychosocial problems such as stress and anxiety that probably leads to maladjusted behavioral and personality disorders.

1.3. Justification

Currently, due to various socioeconomic problems facing Ethiopia, there are a number of children with disabilities. The psychosocial problems of children who are disabled and at the same time trafficked and live in street are the most serious problem than any component of children categorized under "CEDC". Similarly, children with disabilities might be exposed to different forms of trafficking and forced to engage in Labour, or removal of organs for different purposes including begging activities, etc. All these practices show that children with disabilities are at high risk with regard to their welfare and overall socio economic development.

The primary rationale of investigating the psychosocial problems and other difficulties of children with disabilities is that children with disabilities are facing multiple challenges and they are the most vulnerable social group of our population. Due this fact, UN's declaration on person's disabilities promotes research endeavors and disseminations of relevant information particularly factors that affects the lives of persons with disabilities in general. In addition, person with disabilities are deprived of their basic human right to education, health, survival and proper health care and some of them are living in the street in very hazardous and painful environment that affect their physical, social and psychological development.

To this end, great attention should be given for systematic investigation of the rights and accessibility to available public services, psychosocial problems, child trafficking practices and coping styles of children with disabilities. This study will help implementing organizations, policy makers and funding agencies to uniquely address the problems of children with disabilities which require high priority in the provision of intervention programs. Besides, the result of the study may serve as a forum of discussion and provide better insights in designing programs. Therefore, it is necessary to investigate multiple challenges of children with disabilities including child trafficking practices, psychosocial problems and related issues in Addis Ababa.

1.4. Objectives

The overall objective of the study is to generate adequate information about the psychosocial problems, perceptions and self-esteem, child trafficking practices and attitudes, knowledge and practices (KAP) of prevention and control of HIV/AIDS issues, coping styles of children with disabilities. In light of these objectives, the study has the following specific objectives:

1. To explore the magnitudes and characteristics of child trafficking and Streetism
2. To identify the knowledge and practices about STDS and HIV/AIDS issues.
3. To examine sexual abuse and violence of children with disabilities.
4. To identify the prominent psycho-social problems and their coping styles.
5. To explore the provisions of services for these children.
6. To provide insight and possible recommendations for concerned bodies.

1.5. Research Questions

The forgoing evidence-based situations have revealed that the overall living conditions of children with disabilities seem at higher risk. They are forced to face diverse difficulties in their social adjustments, self-concepts and need to employ various coping mechanisms to manage their daily life.

Hence, this study is concerned with describing and identifying the major problems and co-concurrent psychosocial and coping styles of children with disabilities in Addis Ababa. Hence, the study will attempt to answer the following research questions:

1) What are the causes and consquesnces of trafficking of children with disabilities?
2) How many children with disabilities are sexually abused /raped?
3) What are the statuses of knowledge of children with disabilities about HIVAIDS?
4) What are the psychosocial problems and coping styles of children with disabilities?
5) What are the major coping styles of children with disabilities?
6) What are the determining factors for relevant implementing agencies?

1.6. Definitions of Terms

1) **A Child** According to Convention on the Rights of Child (CRC, 1989), a child means a person below the age of eighteen (18) years old.
2) **Street Children**. Conventionally, a person with the age group of 5-18 years who work, and live in/of the street as sources of livelihood with all the culture, values, norms and expectations without close supervision, assistance or control of adults, parents or caregivers (UNICEF,1993).
3) **Disability**. Refers to behavioral manifestations of individual with substantial evidences of gab between the actual and expected fulfillment of social roles including independent living and the roles of work; and in this study it includes children with certain impairments and considered as "blind, deaf, mentally retarded, and motor disorder people" in school, /training institutions/religious settings (Koshel and Granger,1978; cited in Wegayehu,1981).
4) **Child-Trafficking**. According to UN (2000), it refers to t*he recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of forces or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position, of vulnerability, or of the giving or receiving of payment or benefits to achieve the consent of a persons having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution others, or other forms of sexual exploitations, forced Labour or services, slavery or practices similar to slavery servitude or the removal of organs"*

5) **Prevalence.** It refers to the proportions/number of occurrences/cases of events in a certain particular population in at given point in time (Lwanga, et al, 1991).

6) **Psycho-social problems**. It refers to a difficut condition that might shatter the feeling of security, adequacy, emotional state, self-concept, social life and interactions, daily activities of children with disabilities within their environment (Nemme, et al, 2006).

7) **Coping Styles**. A deliberate way of attempting to manage the demands and crises or stressful life challenges.

1.7. Delimitations of the Study

This study is limited to schools/training institutions and religious settings where the largest proportions of children with disabilities are available. At these sites, it is feasible and manageable to conduct this study in terms of cost and time issues.

Chapter 2 REVIEW OF LITERATURE

2.1. Introduction

There are different laws, scientific theories, and conventions that may explain the problems of children with disabilities. For instance, the Constitution of Federal Democratic Republic of Ethiopia (FDRE) has ratified and accepted different human rights laws and related convention on children's rights. The prominent relevant declarations include the constitution of PDRE, Human Rights Convention, Convention on Rights of Children (CRC), African charter on the rights and welfare of the child, ILO's Convention, and other related proclamations and polices. These all rules and agreements have been issues to address the rights of children particularly vulnerable children.

There are various types of children who are living under Especially Difficult Circumstance (FSCE, 2005) include children living in street, children with disabilities, HIV/AIDS-orphan children, child prostitutes, juvenile delinquents, etc are still facing multiple life challenges in Ethiopia. This section shall review related studies, National and international conventions and treaties that are directly working against child trafficking practices, streetism, HIV/AIDS and other psychosocial problems in general and supports the rights of children with disabilities in particular. Moreover, the following sections shall give a detail picture of the theoretical background, the multiple challenges or the multidimensional problems of children with disabilities particularly with respect to child-trafficking, streetism, HIVAIDS issues and related psychosocial problems and their coping mechanisms.

2.2. Theoretical Background

The three most prominent theories this study and related to children with disabilities are ecological approach, transactional model/theory, and theories of coping styles. The ecological approach assumes that every child is part of the whole social system and significantly influenced by its interaction at different levels. The environmental influences upon the child occur at different levels and accordingly the challenges of these children are the by-product of the interaction at different levels such as at family, school,

community/society, etc (Smith et al, 1995). This means that ecosystem is made of the child, family, school, peer group, neighborhood, culture, community and society. For instance, when children join school, they go to school with diverse socio-cultural backgrounds and may be exposed to conflicting experiences and values in the environment. At this phase, unless these children get assistance from teachers and other significant people to understand the wide ranges of school's norm, rules and regulation and other expectations, they encounter difficulties in achieving better life adjustments. The ecosystem theory further states that any behavioral problems are the results of interactions between the child and his/her social system or environment (Kirk, et al, 1993).

Moreover, the life careers of children are not only determined by school situations but also by the significant community members such as service providers, governmental sectors, or policy makers. Many children with disabilities get supportive services from advocacy groups, educators, friends, and governmental leaders and at the same time influenced by the type resources and services they provide for them. This implies that most the programs or services that the aforementioned sectors offer often determine whether or not children with disabilities could get better service to make successful achievements in their life career (Kirk, et al, 1993; 6-9).

There are two well-known theories concerning coping strategies. The first type is dichotomous coping strategies (Lazarus and Folkman, 1984) that considers problem-focused and emotion- focused coping styles. The former one attempt to act on the directly stressor such as solving the problem where as the later tries to solve the problem emotionally by avoidance, distancing, etc. The other prominent theory of coping classifies the concept as primary versus secondary control strategies (Weisz, et al 1194 cited in Kirchner, 2000). The attempt to enhance, reward, or reduce punishment by changing objectives environmental conditions or altering the stressor (problem solving, emotional regulation, denial, avoidance and emotional expressions), and changing oneself such as one's belief about the stressor or cognitive restructuring (distraction, positive thinking, wishful thinking, and acceptance) are considered as primary and secondary

coping strategies respectively. An integrated approach of these two theories suggests that both problem-focused and emotional focused coping styles could be categorized as primary-control coping strategies (Rothbaum, et al, 1982). These primary strategies including problem-focused and emotional focused coping are more likely used with controllable stressors such as school or work problems. But, secondary control coping strategies are often used with uncontrollable stressors such as parental illness

Moreover, the transactional model considers coping styles of stressful situation as interactions between the given person and environmental triggers. The overall coping processes involve personal judgments the events (positive, controllable, challenging, or irrelevant, etc), the person evaluating capacities, and options to do; and actual regulation of the problems (Cohen, 1984). Cohen further states that the degrees of effects of stressors upon the given person are determined by the personal appraisal capacities, existing social and cultural resources to manage the difficulties at the disposal of the individual. The substantial factors that forces children with disabilities to employ coping styles might be the diverse condition of life and challenging social stigma and discriminations issues.

2.3. The constitution and National laws of Ethiopia

The legislative frame works of the country supports the right of human being and that of children. The FDRE constitution that deals with problems against in-human treatment states, "no one shall be held in slavery or servitude." Trafficking in human beings for whatever purpose is prohibited" (Art.18 (2)). In addition, article 36(1d) states that every child has the right " **NOT** to be subject to exploration practices, neither to be requested nor permitted to perform work which may be hazardous or harmful to his/her education , and health or wellbeing."(Daniel, 2005).

In Ethiopian penal code, the article that relates with trafficking is article 605 (cited in Daniel, 2005). This article states that it is an offence to seduce, entice, procure or induce women, infants or young person to engage in Prostitution. The corresponding punishment is a maximum of five years imprisonment or fine not exceeding 10,000 Birr. In addition, the punishment may be accelerated depending upon the following determining factors if the:-

- Victim is under 15 years old
- Victim is close family member or under the care and custody of the perpetrator.
- Offender has taken unfair advantages of the physical or mental distress of the victim (protector, employer, teacher, landlord or creditor).
- Offender used tricky, fraud, violence intimidation, coercion, or misuse of authority over the victim.
- Victim is intended for a professional procurer or has been taken abroad or has disappeared.
- Victim commits suicide out of shame, distress, or despair, etc (cited in Daniel,2005).

These aggravating factors/conditions may increase the penalty to a minimum of three to ten years imprisonment and fine not exceeding 20,000.Birr. In addition, participation in the offence in terms of making arrangement or provision entails imprisonment not exceeding three years and fins of not less than 500 Birr in grave cases (Daniel Yilma, 2005).

Moreover, the constitution of Ethiopia recently adopted family law that incorporates many of the principles and provision of Convention on the Rights of Child (CRC). The national policy on women also encourages the provision of specific child's rights of girls including access to education and health services. These evidences confirm that the constitution of Ethiopia specifically provides and creating conducive conditions for implementing the protections of children's rights. FSCE (2005) revealed that the government of Ethiopia is making practical progress in changing the CRC in implementation processes. One of these evidence-based tasks includes establishment of National Inter-Ministerial Committee until Regional, Zonal, Woreda and Kebele levels to coordinate and monitor the progress of implementation processes of CRC action plan.

2.4. Convention on the Rights of Child (CRC)

Understanding the principles and recognition of the inherent dignity and of equal rights of all members of the human family, the United Nation declaration upon the Convention on the Rights of Child (CRC, 1989) have paramount advantages to address different relevant program. It could assist in protecting the rights of children to grow within the sprit of peace, dignity, tolerance, freedom, and solidarity fully in atmosphere of happiness and loves environments.

The Government of Ethiopia has endorsed and accepted the Convention on the Rights of Child (CRC) in December 1991. This convention has introduced triangular relationships between the child, the family and the states. This means that it is expected to establish a balancing condition about the rights of child between parents and children within the framework of environmental and cultural milieu of the society. As children acquire enhanced competencies, there will be a reduced need for directions and greater capacity to take responsibilities for decision-making that might affect their lives (Lansdown, 2005). This shows that the degree of parental protection, participation and assisting in autonomous decision making could vary depending upon environmental and cultural conditions.

Different articles of the CRC (1989) encourage state parties to recognize children with disabilities in order to promote self-reliance, and active participation in the community, and provide special health care and available public services, education and vocational services, "free of charge whenever possible"(Article, 23). Accordingly, the state parties shall ensure and recognize that children with disabilities have access to the education, training, health care services, rehabilitation services and have to prepare children with disabilities for further employment opportunities. These measures should be taken in manner to achieve the fullest social integration and development in their life.

In addition, state parties shall take appropriate measures to protect the child from the illicit use of drugs and psychotropic substance, all forms of sexual exploration and sexual abuse such as inducement or coercion to engage in child prostitution or other unlawfully sexual practices (Article, 33 and 34) and also state parties should recover and rehabilitate children who have been exposed to victims of any form of neglect, exploitation and abuse, torture or any form of cruel, inhuman like child-trafficking or degrading treatment of punishment or armed conflict(article 39) . The expected psychical and psychological rehabilitation approaches should increase the child's health, self-respect and dignity (CYFW0, 1997).

Since 1996, Ethiopia has implemented a national program of action for children and women. During beginning of implementation of the action plan, different tasks were carried out successfully. The most notified and appreciated performances includes the establishments of the justice and legal system research institute, adoption of new family code, establishments of the commission on human rights and the office of ombudsman, the interim prohibition of corporal punishment in schools, establishment of AIDS awareness clubs in high schools, the establishments of child care and protection unit in police station in Addis Ababa, inclusion of child rights issues in systematic child participatory education with school curricula, the translations of Conventions on the Rights of Child(CRC) into local languages.

Moreover, the ratification of ILO convention No 138 (Minimum age for admission to employment) and No182 (prohibition and immediate action for the eliminations of the worst forms of child Labour), ILO (1999) and creating strong awareness raising campaigns and publicizing the convention in general through out the country, etc are the strong accomplishments of the implementation action plan of the country (Ethiopian CRC report, 2001, MOLSA, 2004).

However, the Ethiopian CRC committee has noted different deterring factors that have significant influences on the implementation of the rights of children. The committee noted that there is failure to enforce the legislation that could serve to protect the rights of

children from Harmful Tradition Practices (including female genital mutilation, early and abduction) and discrimination of children with disabilities. The committee has also noted limited relevant data on the situation of children in general and absences information and programs in favor of children with disabilities, and lack of non-discriminatory constitutional provisions in Ethiopia. Due to these problems, female children and other children with disabilities are forced to face extensive societal discriminations particularly in terms of opportunities and access to education in order to achieve full respect for their rights (Ethiopian CRC report, 2001, MOLSA, 2004).

2.5. African Charter on the Rights and Welfare of the Child

This Charter has been entered in force on November 29, 1999 underling the joint responsibilities of governments, parents, and children themselves and other guradians (Article31) in materializing the rights of children in general. The charter declares that all member states of the Organization of African Unity (OAU) must take appropriate measures to ensue the rights of children considering the unique factors prevailing within African socio-economic, cultural, natural disasters, armed conflicts, exploitation and hunger…physical and mental immaturity…(ACRWC,2005). The Government of Ethiopia has ratified both African charter on the rights of and welfare of the child and ILO 'S convention 182 on the elimination of the worst forms of child Labour in 2003. The African charter gives due attention to rights of the child with disabilities within the context of the following issues (ACRWC, 2005; 21-32):-

1) **Non-Discrimination and Child Labour**.

The African charter declares that without the child's national and social origin, race, ethnic group, sex, languages, religious, political, parental or legal guardians, fortune, birth, opinion or other status, every child is entitled to the enjoyment of rights and freedom (Article 3). Hence, "every child shall be protected from all forms of economic exploitation and performing any work that potentially interferes with the child's physical, mental, spiritual, moral, or social development" (Article 15).

2) Child Abuse and Sexual Exploitation

With respect to this, the African charter declare that state parties shall take legislative administrative ,social and educational measure to protect the child all forms of torture, in-human or degrading treatment and especially psychical or mental injury or abuse, neglect or maltreatment including sexual abuse (Article,16). In addition, the charter encourages state parties to protect the child from all forms of sexual exploitation or the use of children in prostitutions or pornographic activities (article. 27).

3) Sale, Trafficking and Adduction

The African Carter encourages state parties to prevent "the abduction, the sale or traffic of children for any purpose or in any form by any person including parents or legal guardians of the child and use of children in all form of begging" (article 29). To this effect, the charter encourages parents to ensure whether inter-country adoption or placements are not result in trafficking of children or not means of gaining financial supports (article, 14).

4) **Children with Disabilities**

The African charter has also encouraged state parties to provide special measure of protection for children with disabilities such as mentally retarded and children with motor disabilities in creating favorable psychological conditions(ensuing their dignity, self-reliance and active participations), allocating available resources to facilitate their moment and access to public highways, and creating recreational activities, training and employment opportunities that assist them in full social integrations and personal development(article, 13). Hence, the African charter is one of the regional laws that condemns child-trafficking practices including exploiting of person for all forms of begging.

2.6. UNITED NATION PROTOCOL ON TRAFFICKING IN PERSON

One of the world's growing organized crime practices that is violating the rights of human being and forcing them to live in slavery–like or exploitative condition across the world is the trafficking of women and girls. This practice is now become the third largest

sources of profit in organized crime after drugs and guns (FSCE, nd). In response to these increasing rapid global trafficking problems, the United Nation's has ratified a protocol to prevent, suppress and punish trafficking in person, especially women and children in 2000. This protocol working definition off trafficking as the following (UN, 2000 cited in WHO, 2003) shows that there are agents who employ coercion or some other forms of illicit influences in the recruitment and transportation processes of children to sought destination. There are two types of trafficking, in-country and external trafficking practices. The former largely practiced within the country where as the latter refers trafficking that is carried out around cross-border and involves trafficking persons from one country to other countries.

The act of child trafficking is a complex phenomenon that involves a series of acts such as recruiting and transporting children from her/his, birthplaces to new destination and exploitation of the children at some stages. The exploitation might take place at any stage of trafficking processes. In the process of trafficking, there are no informed consents among agents or facilitators, receivers and children being trafficked. The acts is involves complete deception of victims by some kinds of agents. In most cases, the victims of child-trafficking are unaware of that they are at risk when they agreed and join the journey. On the contrary, they believe that they are rather engaging in profitable career and think that they are going get benefits at destination. This shows that child trafficking comprises recruiting, transportation, transfer, harboring or receipt of the child for the purposes of exploitations. In addition, it involves practices of employing forces/coercion/deception and exploitation in order to gain profits by some body at the expense of the children's life challenges.

There are different driving forces that lead children to move and join the trafficking. The commonly known factors are 'push and pull" factors. The former typically refers to absolute poverty, family break down, violence, lack of job opportunities, low educational levels, social stigma and discriminations or marginalization including being a female in some countries. Where as the 'pull' factors at destination include economic differentials, unmet demand for cheap and malleable labour, demand for sexual services and shift of

supply of local women in sexual sector in some countries particularly in high HIVAIDS prevalence, etc(UNICEF, n.d).

In the world, there are several significant international treaties and agreements that have been promulgated to address the violation of human rights of including child trafficking. In addition to the United Nation's protocol and United Nations High Commissioner for Human Rights, the following are some of human rights conventions/agreements that oppose child-trafficking practices (UNICEF, n.d):

- Convention on the elimination of discrimination of Women (CEDAW) (1979)
- Convention on the Rights of Children (CRC) (1989)
- Convention on the protection of All migrants and their families (1990)
- The Hague convention on the protection of children and cooperation in request of inter-country adoption
- The Stockholm Declaration and agenda against commercial sexual exploration of children(1996)
- The Rome statute of the International Criminal Court (1998)
- International labour organization convention No.182
- The optional protocol to the CRC on the sales of children, child prostitution and child pornography.

These conventions and international agreements have played significant roles in changing the aptitudes of policy makers and program leaders in different countries. Due to the very serious violations of the rights of children, many countries are accepting the UN protocol upon trafficking in person and designing possible strategies and intervention to address the trafficking of children. However, the government of Ethiopia still did not sign upon the UN protocol to prevent, suppress, and punish the trafficking in persons. The reasons are not clear and remain unpublicized so far.

2.7. MULTIPLE CHALLENGES OF CHILDREN WITH DISABILITIES

There are many problems that encounter children with disabilities. In this section, however, the major challenges of children with disabilities shall be reviewed in order to understand better about their trafficking problems, street life, awareness of HIVAIDS issues, psychological problems and coping mechanisms.

2.7.1. CHILD-TRAFFICKING PRACTICES

One of the most degrading forms of exploitation threatening the lives of many children in different parts of the world is child trafficking. Due to this, the act of trafficking is equivalent to contemporary type of slavery. The prominent forms of trafficking are mostly carried out on women and children within and across different countries. The practices are largely depending upon deception or coercion for the purpose of exploitations (FSCE, n.d).

There are diverse causes for the trafficking issues. The leading factors are the existing socio-economic conditions such as poverty, unemployment, lack of socio-economic improvements, low economic conditions, drought, and famine, political instability, bad governance (AGRINET,2003). More specifically, other socio-economic inequalities that are mostly underlined in child trafficking history in driving the actors and children themselves to participate in these slavery practices are lack of access to existing public services and poverty (UNICEF, n.d). For instance, most young girls and boys have been sold (trafficked) in Vietnam to China for marriage, commercial sex work, and Labour exploitation such for domestic workers, entertainers, and waitresses in bars, cafés and massage houses, etc (Wang, 2005).

However, the driving forces of internal child-trafficking problem are largely attributed to rapid population growth and extreme poverty. Primarily, trafficked children are promised false opportunities at destination to move from their home place. The common ways of deceptions involve high payment as domestic worker, waitresses, sales clerk, etc. Due to these factors, trafficked children are simply lured by false promise of the traffickers who

promise to provide gainful employment and other relevant opportunities such as training or education (Daniel, 2005).

The types and severity of the problems that the victims encounter vary from time to time and one place to another. The trafficked children mostly suffers from extreme physical and psychological problems including rape, torture, starvation, imprisonment, physical brutality, and deadly disease including HIVAIDS (UNIFEM,2002 cited in USAID, 2003).

Ethiopia is believed to be the origin for international trafficked persons (FSCE, n.d). Mostly women and children are trafficked and recruited for domestic work in the Middle East countries particularly in Lebanon, Bahrain, Saudi Arabia and United Arab Emirate (FSCE, n.d). In Ethiopia, however, there is no study that shows the characteristics and magnitude of trafficking of children with disabilities. There are few studies that are concerned within-country and cross border trafficking of women and children in general.

There are limited studies on child-trafficking that are aggregated with data on women trafficking problems. For instance, USAID (2003) study revealed the prevalence of 24.4 percent trafficking problem among children and women in Ethiopia. This study has also found the prevalence of 26.8 percent of external child-trafficking. Most of the trafficked children were found to be aged 10-18 years old. Confirming to this, FSCE (2004) revealed that there were about 251 children who have been trafficked at the central bus terminal and at different places of Addis Ababa. Some evidence showed that the majority of these trafficked children were girls aged 10-18 years old (Daniel, 2005). USAID (2003) further showed that a small proportions of trafficked children and women in Addis Ababa, 17.9 percent.

With respect to the psychosocial problems, USAID (2003) revealed that the victims of trafficking particularly women and children suffered from various social problems such as becoming socially isolated, stigmatized, getting exposed to physical trauma and health hazards and face physical, economic, emotional and sexual abuse.

The study further showed that the practices have also exposed them to experiencing different psychosocial and emotional instabilities such as depression, low self-esteem, anxiety, and withdrawal/regression, aggression and self-destruction. In addition, most children trafficked were found to having facing various forms of maltreatment problems including sexual abuse, denial of salary, emotional and physical abuse, hunger, stress and trauma, overwork, etc. Moreover, FSCE (n.d) revealed that, from the records of police, children become victims of abduction getting maimed and impaired for the sole purpose of begging (FSCE, n.d; 4). However, one may say that the results of aforementioned studies have not specifically pin-pointed specific issues of person with disabilities in general.

Therefore, there are no studies that show the status of child-trafficking practices among children with disabilities in Ethiopia. This limitation has made it impossible to specifically address the problems of children with disabilities across the country.

2.7.2. STREET CHILDREN WITH DISABILITIES

In Ethiopia, over 50 percent of the total population lives below the poverty line MOLSA (1995). Confirming to this, UNDP (1998) human development report shows that living standard of Ethiopia stands at 169th out of 174 developing countries. In addition, about 35 percent of the economically active population of Ethiopia was reported to be unemployed (CSA, 1994). As the 1992 survey indicated, about 60 -70 percent of Addis Ababa's total population did not have the level of subsistence income necessary to secure basic needs such as food, clothing, and shelter (Solomon, 1993 cited in Habtamu,1996).

Therefore, as a result of these factors substantial numbers of children of these families are forced to live in especially difficult circumstances. The provision of adequate social services such as health, education, employment, child and family welfare are non-existant. As a result, such children are disproportionably exposed to persistent poverty and inadequate socio-economic development. Ultimately, they are forced to participate and live with unacceptable street life.

As one of the rehabilitation agency surveys (1974) indicates, there were 5000 street children aged between 5 and 18 years. A survey conducted by MOLSA and Radda Barnen (1988) has indicated that there were dramatic changes in the number of street population in Ethiopia. According to 1974 survey, street children comprise only 24% of the total population under study. Nevertheless, in the 1988 survey, the proportion of street children increased to 37% of the total population under study. This shows that there is one in every five children under the age of 15 who live under extremely difficult circumstance (UNICEF, 1991).

In the mean time, different advocates have made prediction about the forthcoming situation of streetism in Ethiopia. For instance, Tacon (1991) estimated that there were as many as 100,000 children taking part in street and in near future, there will be 500,000 children facing an extremely high risk of becoming street in Ethiopia. Confirming this, the official document of MOSLA (1993), indicates that there are 100,000 street children and over 1.6 million children are at high risk of involvement in the street. The document also indicates that the annual growth of street children population has reached 5 percent.

As a result, children are forced to engage in street in which they are without any intimate supervision of their parents or relatives. Among these street children, children with disabilities share the highest proportions of street population in Ethiopia (MOSLSA, 1992). In relation to this, UNICEF (1993) reported that were about 2.2 million children under the age of 15 with disabilities in Ethiopia.

There are limited data that specifically show the number of street children in general and that of children with disability across the country. CSA (1998) reported that the total population of persons with disability is 9978,853 people in the country. Among these population, both visually impaired (32.2%) and physically disabled (35.6%) together consist of the largest (67.9%) proportion of the total population with disability in

Ethiopia. A rigorous sample survey on persons with disabilities has shown (Tirussew, et al, 1995) that the prevalence of persons with disability across the country is 2.95 percent. According to this survey, the proportion of persons with visual impairment and person with motor disorders share the highest proportion (61.3 percent) of persons with disability in Ethiopia.

As far as the services and programs for street children is concerned, MOLSA (1995) states that from two million children with disability, only 3,000 of them are getting different services. Confirming this, (Hirute, 1996, cited in Habtamu, 1996) only a small proportion of them are getting limited welfare and rehabilitation services. This study has further explained that the prevision services so far offered cover only about 6 percent of the total affected children (Habtamu, 1996). Besides, the 1995 survey of MOLSA found out that about one-fourth (25%) of the total street children population were children with disability of different types: blind, partially blind, motor disorders and others with different types of impairments (Table 1).

Table 1 Percentage distribution of Street children Population by types of disabilities (MOLSA, 1995)

Health Status	Frequency	Percentage
Able bodied	1109	55.45
Blind & partially sighted	126	2.80
Serious Health problem	334	16.70
Motor disorders	126	6.30
Others	375	18.75
Total	2000	100

This survey concluded that children who were exposed to the highest risk of involvement in streetism are found more in the towns with the biggest size of population. The study further confirmed that Addis Ababa has the biggest share of street children population and the greatest magnitude of the problems of streetism. Confirming to this, Gobena (1995) found that the estimated number of street children in Addis Ababa reach around 20 - 40 thousand children.

The aforementioned surveys give a general picture of both the disability in general and street children with disability in particular. However, the total disability populations determined by these surveys are very low as compared to the WHO (10 percent) estimate of disable people in every countries (Tirussew et al, 1995).

The event of street life is almost an integral feature of urban phenomenon. The types of street children with disabilities who are forced to live in the street may include all types of disability. Generally, the prime causes of streetism, agreed are poverty and unemployment (MOLSA, 1993). Hence, throughout the history of streetism, children who have been found in the street are predominantly a product of poor families, whether they are in urban and rural areas (UNICEF, 1993).

2.7.2.1 Types of Street Children

Many studies have demonstrated clearly the causes, magnitude and trends of streetism in Ethiopia (MOSLA, 1993; Abeje, 1999). But, research findings that directed to types of street children with disabilities and their psychosocial problems are very rare. Most of the studies that are concerned with investigating streetism fail to disaggregate data with respect to types of street children with disabilities.

Nevertheless, MOLSA (1995) indicated that there are two types of street children with disability: visually impaired and motor disorders. This study has further revealed more specific types (but not mutually exclusive ones) of disability such as epilepsy, chronic skin disease, hand and leg disability, and totally or partially blind persons (see Table 1)

As already mentioned, the major causes of streeism are poverty and unemployment. MOLSA (1988) also indicate a high proportion of street children are pushed to the street due to economic reasons. This study has further explained that streetism as the product of urban poor families, instability and absence of family planning services. Besides, MOLSA survey (1995) showed that the major causes of streetism includes factors such as poverty, weakness and instability of family life that coupled with absence of family planning. Moreover, CEF- SCP (1996) states that as the social and economic conditions

of the major towns deteriorate, the poor families are forced to encourage their children to go to the street for survival. This study further underlined that the present urban poverty situation, particular in Addis Ababa, is neither possible nor realistic to prevent or remove children working in the street as far as thousands of children are unable to depend on the support and care of their parents (Habtamu, 1996).

In fact, it is true that due to lack of insufficient provision of socio-economic services within the family and community, children are forced to work/live in the street. For instance, Hecht (1998) has revealed the experience of a street girl who was forced to be on the street as the follows:-

> *I am street girl because I do not have a mother, or even though I do, she never helped me. When I needed her most kicked me out of the house and made me live with my grand mother (Lack of affection).*

In addition, when street children asked why they are on the street, particularly boys, typically respond to the blunt question with an equally blunt answer. For instance, they may respond as, "We felt it lit" (Hecht, 1998). Similarly, in explaining their reason for being in the street, boys often highlight their own defiant initiative, while girls state their ill -treatment at home. More often street boys typically reveal other home - centered problems such as beating, or a sense of rejection or boredom at home. The least cited cause of streetism among most children of streetism revolves around the shackness of home life and steeped hunger deprivation and violence around home environment.

2.7.2.2. Children with Visually Impairment

Over long period of time, history tells us that the reactions of peoples toward with disability are characterized by liquidation and isolation (Millward & Dyson, 1995). These attitudes are largely influenced by the existing philosophy, socio-cultural factors and perceived causes of the disability (Rubin, 1995). Confirming to this, Rowltz (1992) states that one cannot analyze future trends of persons with disability without the context of society as a whole. The following surprising statement of HElEN KELLER could describe better the argument, "Not blindness but the attitude of the society to the blind that is the hardest burden to bear (Zahl, 1962). Attitudes of people toward the disabled

people gradually generate a complex pattern of social inadequacy. Hence, visually impaired people will grow-up along the line of compulsive personality patterns. Still others may retreat to accept their feelings of in adequacy.

As the result of these factors, their behavioral or social patterns become so erratic, inconsistent, that they face difficulty in their social adjustment. Besides, due to these life styles, they are more prone to maladjustment behaviors. For instance, their restricted mobility and limited experience lead them to a state of passivity and dependency in their life (Kirk, et al, 1993).

Tirussew (1998) has also revealed the social problems of both children with visually impaired and motor disorders at school. Accordingly, the social problems of visually impaired children including negative attitude of society as follows:

- Blind cannot learn, work and improve their life
- Neglect: exclusion of them from social relations
- Absence of person who could understand their visual problem and appreciate their achievement.

Whereas the social problems of children with motor disorders include:

- Absence of interaction with non-disabled students in social affairs and games.
- Absence of social interaction in marriage heterosexual relations, and employment.

2.7.2.3. Children with motor disorders

Children with motor disorders are those whose physical or health problems result in an impairment of normal interaction with the larger community. The prevalence of Children with motor disorders is estimated to be two percent in the world (Smith et al, 1985). The primary problems of children with physical difficulties include chronic illness, weakness and pain (Taylor et al, 1995). By nature, there is no specific social or emotional behavior associated with physical disabilities. However, children with physical disabilities frequently have other disability such as language and speech, visual and hearing impairments and behavioral problems (Reynolds et al, 1987). For instance, children with motor disorders may show rigidity, stereotypic behavior patterns, behavioral problems, family stress, and lack of social integration (Ysseydke and Algozzine, 1995).

However, being withdrawal and living in a world of fantasy, they are become through coping up with inferiority by over developing skills that are unaffected by their disability (Wolman, 1977).

Moreover, children with motor disorders are found to be more dependent on adults and interact less with their peers. Thus, parents and teachers should adjust ways to facilitate the capacity of building independency and high self esteem. Other wise, they often display maladjusted behavior such as passive, less persistent, having short term attention span, engage in less explorative activity and display low motivation (Jennings et al, 1985; cited in Reynolds, 1987). This indicates that the major areas of intervention programs for Children with motor disorders are in social integration and self concept development. Generally, Children with motor disorders have difficulties in major areas of academic achievement, social /emotional adjustment (e.g. making and sustaining friendship), attaining a positive self concept and in physical activates (Reynolds et al, 1987).

A considerable number of street children are forced to live in street because when they come back home without income, parents get worried and frustrated. There is nothing to eat and hence parents forced to hit their children. As a result, street children are afraid to go back home and stay in the street sleeping and picking up vices such as sniffing, glue, and smoking pot (Hencht, 1998).

Therefore, any intervention program that could be designed to reduce the problems of street children should first and foremost consider best the question of "how to make the lives of street children with disability more rewarding and relatively convenient both socially and psychologically at home. Hence, declaring the street out of bounds will only make the home more viable. Hecht (1998) also stated regarding this that preventing poor street children just from working in the street may worsen the relationship of children with their parents.

2.7.3. Awareness of STD and HIVAIDS Issues

Another area of concern about children with disabilities is their awareness about HIV/AIDS issues. One of the objectives of the policy on HIV/AIDS of Ethiopia is to empower youth and other vulnerable groups of the community, support orphans and surviving dependents of people living with HIV/AIDS and promote research tasks directed towards the preventive, curative and rehabilitative aspects of HIV/AIDS issues (FDRE, 1998). One of the priority areas of the Ethiopian National action plan for children is combating HIVAIDS issues (MOLSA, 2004).

However, there are no data or programs that show the situations of HIV/AIDS issues particularly about children with disability in Ethiopia. However, some recent limited studies have shown the situation indirectly. According to Ministry of Health's report on AIDS, for instance, among the 2.2 million HIV positive populations in Ethiopia, adults and children consist of about 2 million and 200,000 respectively (MOH, 2002). MOLSA (2003; 23) has also revealed that the national prevalence of AIDS orphan to be 15 percent among child population that shows a substantial proportion of children are affecting by the HIV pandemic. Nevertheless, there are no programs or studies/reports that show the status of awareness of children with disabilities about HIVAIDS issues in Ethiopia.

Moreover, though there are very limited direct findings on children in general, Carr-Hill (2002; 42) has revealed research finding that show the effects of AIDS upon non-disabled children in reducing the number of school children by 22 percent in primary schools of Tanzania. This study further indicated that UNAIDS has estimated the number of children orphan due to AIDS at 1.1 million during 2000 years and shown evidence that about 14 percent of all children are living in family affected by HIVAIDS in general. Most studies, however, unable to show the status of awareness of children about HIVAIDS issues.

To get meager daily income, street children or trafficked children forced to engage in different activities such as begging, stealing, and prostitution. As street children live long in the street life and physically nature, the sympathy of people diminishes. Hence, they become older within life challenging environment, they physically become stronger and more daring. Consequently, they will also extend their life engagement into sniffing glue, fighting and do things that are simply are not good (Hecht, 1998).

To understand some of the psycho social problems of trafficked and street children with disability, this study will concern with the most frequently found or popular psychosocial problems of children with disabilities. Generally, the major psychosocial factors that have isolated disabled people from the general public and delayed their development includes ignorance, neglect, superstition and fear throughout history still exist with them on street life.

2.7.6. COPING MECHANISMS

By nature, coping styles are ways in which one attempts to manage the demand and crises of stressful situations. Largely, people employ them when they are under difficult circumstances such as threat, harm, challenge and /or problematic situations. Thus, coping styles are purposeful efforts, a dynamic process, focused on the resolution of difficulties that place demands on people for adjustment (Zautra et al, 1991). An event that has no potential for producing any psychological distress with one person may be considered as stressful situation by another people. According to Folkman et al (1986) the transactional approach posits that person's interpretation of events play a unique role in adaptation of life stressors. This implies that different people use different coping efforts with similar stressful events. Lazarus and his associates (1984) have also argued that coping styles are largely determined by the individual perception of the stressful situations (McCare, 1986).

Besides, there are different interacting factors that constantly determine the process of coping mechanisms including the demand of the specific situation, constraints, personality dispositions, lifestyle, etc (Woleman,1977). Several studies have

demonstrated that coping styles have different perspectives. They are different forms of coping styles ranging from global dichotomies (problem- focused to emotional coping) to lengthy list of coping and traditional defense mechanisms (McCrae, 1986). For instance, Lazarus and his associates (1984) have categorized five up to eight factors in their investigations. Monaghan (1983, cited in McCare, 1986), on the other hand, has offered a detailed discussion of coping effectiveness that consists of many alternative criteria: user perceived effectiveness, long term health or wellbeing, and rating of social functioning.

More specifically, some studies focused in selected types of stressors: Chronic illness, job related problems and marital instability (Felton, 1984; Pearlin, 1981; Meanaghan, 1982; cited in Mc Crae, 1986). Some studies have also investigated factors associated with poor performance and problem behavior. This study indicates that people who cope up with helplessness lack belief in personal control and are passive in achievement related situations rather than formulating task oriented goals (Diner and Deweck, 1978, cited in Eronen, 1997). Folkman et al, (1986) has designed a coping profile composed of eight coping strategies mostly used in stressful situations. Some researchers have also investigated the personality characteristics of coping styles (Wolman, 1977). Valliant (1977, cited in MCCare, 1986), for instance, systematically explored the relationship of personality characteristics and coping styles. He confirmed that both of them go hand in hand and coping styles are better understood by specific behavior.

On the contrary, research specifically related to children has revealed that coping mechanism depends upon a combination of different factors: learned responses, ability to integrate knowledge, self image, and emotional environment (Wolman, 1977). Besides, during child hood, coping styles are largely determined by four determinate factors such as drive level, sensitivity, autonomic reactivity, and development balance (Wolman, 1977). This implies that children who are active and sensitive enjoy a wide range of life experiences and are more likely cope up with conflicting situations than others.

In contrast, children who have little drive, sensitivity, autonomic reactivity along with too little parental protection, indulgence or restriction will have low potential of coping styles (Wolman, 1977). Wolman further states that children with stable family may have good ability to cope with stressful situation. Family stability, however, doesn't guarantee the best ability of coping with stressful events.

Similarly, physical illness at early life may have significant effect on children development progress and their coping skills. Children who were seriously ill during infancy become slower to be independent and less competent with the new ideas and experience of the environment (Wolman 1977). On the contrary, children who are physically adequate, loved, respected and granted dependent life cope up better with stressful situation than others (Wolman, 1997). Generally, coping styles are ecosystem that involves active interaction between an individual and environment influences within framework of available resources, potential, needs, and vulnerabilities (Eloff, cited in Coombe, 2000)

To this effect, Rossman (1992; cited in Varma, 1996) suggested that children should be helped to develop their own coping strategies that includes self-calming, ignoring some situations, showing anger in controlled ways and talking to friends, parents, or guards, etc(Varma, 1996). Among these, parents are normally expected to provide information and guidance that help them to cope up with stressful situations. Parents do have the access and potential skills to adopt coping styles in a calm and empathetic approach that may assist children to defend anxiety-inducing situations. Generally, the number and types of coping mechanisms used in research vary.

However, the main coping styles of street children were lie telling in order to keep people at a distance, to generate handouts and to preserve a sympathetic view of their auditory (Smart, 1990, cited in Abeje, 1998). The coping style of children with disabilities may be different form the aforementioned categories of peoples. **First**, they have marginal chance of getting to learn coping styles during their up bringing time. **Second**, when they start to live work on the street they are without any intimate assistance protection form

their parents/relatives. In any way, they are there in the street just employing coping strategies that enable them to manage the stressful situation of street life.

There are many studies that have concerned with coping styles of families of children with disabilities. The prominent studies have shown that some families fail to cope well and others found that divorce and suicide rate were found to be higher among families' of children with disabilities than among other families (Washington& Gallagher, 1986, cited in Kirk, et al, 1993).

Nevertheless, there are a few studies about coping mechanism of persons with disabilities within their demanding and stressful environment. This is also slightly true in Ethiopia. There are limited studies that reveal coping strategies of children with disabilities at school. Tirussew (1998) found that visually impaired children employ the following coping strategies.

- Finding willful students for help and creating close relations.
- Approaching teachers who have good attitudes
- Studying hard and regularly.
- Try to change attitudes of school community through teaching.

Similarly, children with motor disorders were found employing the following coping strategies to over come academic and social problems (Tirussew, 1998):

1) Patience, exposing self, creating an atmosphere of understanding.
2) Develop self confidence, spiritual strength to compensate and demonstrate ability to succeed.
3) Personal efforts to learn more and solve problems and teaching friend to hold positive attitude, efficient use of time and available money.

Moreover, Tirusssew(2005) found different coping mechanisms among person with three types of disabilities including hearing impaired, visually impaired and motor disabilities. This study revealed that they have employed different personal and social factors to cope up with stressful situations and achieve better success and overcome environmental stressors and difficulties across their life. The study further showed that persons with

disabilities have achieved good school performance mostly due to their personal strengths and social protective factors. But, the study did categorize with respect to type of coping mechanisms and disaggregated by gender

In addition, Kirchner (2000) has revealed findings typically conducted on primary control -coping strategies and secondary-control -coping strategies on non-disabled children. This study found out that child differs in their overall use of primary and secondary strategies. To cope up with parental depression, children were found often using secondary -control -coping styles such as emotional regulations and wishful thinking, where as other children were found using primary control coping styles including problem solving and positive thinking to cope up with school or work problems. This study, however, was largely limited with coping styles of children with parental depression.

With respect to children with disabilities particularly who are living and working in an extremely stressful situation like in street and trafficking environments, they need to learn how to deal with diverse life challenges. They are in the stressful situations and the environment demands to employ different coping styles to live and work effectively. Even though copying strategies have effects upon overall personality development, its effects, however, may not evident just at the venture of stressful events.

There are various advantages and disadvantages of coping mechanisms in the processes of managing stressful situations. In fact, coping styles are useful in helping people to cope up more effectively with life stressors. With respect to the major functions of coping styles, they are delineated as problem focused and emotional focused typologies. Many investigations have suggested that coping styles have a significant role in shaping the meaning and impact of stressful life events (Zautra et al, 1991). The disadvantages sides are that it mobilizes efforts to deal with new situation and drawing resources not typically employed. Then, it involves a set of ways or managing oneself and one's thought and feelings. At this time, however, daily life of the person may not be disturbed but the person's self- image may be profoundly altered.

However, there are side effect of coping styles that could be observable in the long run in many stressful encounters and arenas of living. Hence, there are ways in which coping styles might adversely affect them. Coping styles may fail to prevent or ameliorate the stressful/damaging events or regulate emotional distress of the stressful situations. Other side effects are that coping styles may increase the risk of mortality and morbidity. When people face these problems they engage in excessive use of injurious substances such as alcohol, tobacco, and other drug additions. Emotional - focused modes of coping can impair the health of people by adversely affecting the management of stress (Corsinc and Auerbach, 1996). For instance, denial or avoidance of thinking may succeed in lowering emotional distress. But, they concurrently prohibit people form critically addressing the problems.

In summary, hence, the advocates of the rights of children with disabilities who are seriously concerned may raise many questions about multiple challenges of children with disabilities. The queries might include the problems of streetism, trafficking, sexual abuse and rape, HIVAIDS, psychosocial problems, coping styles, etc. Alternatively, how do children with disabilities who are leading the most stressful life manage their lives? The realities are that multiple challenges of problems of children with disabilities particular those who have been trafficked and have lived in the street are not largely known as well as not well addressed. The challenges are still just like the water under an Iceberg.

Therefore, there is great need to investigate the problems of these children in order to make aware the community in general and design insightful intervention program in Addis Ababa.

3. METHODOLOGY

The following approaches were employed to generate information on the multiple challenges of children with disabilities in Addis Ababa.

3.1. Design of the Study

This study is a cross-sectional that directed to wards describing the desired events using both quantitative and qualitative approaches.

3.2. Study Sites

The location of the study was in Addis Ababa city administration particularly in schools, training institution/college and religious settings. The site of the study covered include AAU main campus, Vicktory primary school for the deaf, Menelik primary and secondary school, Amanueal church, German church school, Alpha primary school for deaf, Aniwar Mosque areas, Ethiopian National association for Mentally Retarded Children And Youth Center, Urael church areas, Makannisa Primary school for special needs and Yekatiti23 primary school.

3.3.Population and Sampling

The target population was the four major types of children with disabilities including blind, deaf, mentally retarded and children with motor disabilities who were living and/or working in schools, training institutions, and religious settings in Addis Ababa city administration.

The primary consideration in sample selection for the study was to include an adequate number of respondents to perform meaningful data analysis. Different approaches were examined to draw representative sample size of the target population. Hence, the study has employed the following appropriate formula and proportional to sample size sampling approaches to draw desired sample unit from each site. The overall sample size of the study was then determined using the following assumptions and formula: These assumptions include: 95% level of confidence, 80% power of test, an expected frequency of 50% since there was no previous study upon the topic under question, 5% risk and design effects of 0.80.

The formula is **N = (Z (P (1-p))}} D/d.** (Where n =total sample size, Z = 1.96, P =0.5, D = 0.80, and d = 0.05). Hence, the estimated sample size was 312 children with disabilities. The proportion of sample units to be included to overall sample size was determined depending upon the proportion to sample size of each school/training institution, religious setting at church or mosque sites. Each sample unit was drawn using systematic sampling methods. However, the key informants, FGD participants, and case study participants were selected purposively and administrated different desired instruments.

3.4. Instruments

Due to the variety of target group and illicit nature of the problems in question, the following different instruments or tools were prepared to generate reliable responses from children with disabilities. Moreover, most items of the instruments used in this study were adopted from previous relevant studies carried out on children with non-disabilities (USAID, 2003; Tirussew, 2005) for comparison purposes and other issues.

a) **Structured interview**. This tool was prepared in order to collect information about the personal background, psychosocial problems, HIV/AIDS issues, child trafficking practices and coping styles. The interview was designed comprising basic fact related to the objective of study and depends upon the existing supportive related literatures. Before the pre-test period, the finalized English version of the structured interview was translated into Amharic version by profession scholar. The pilot study was conducted on ten children with disabilities at Nazareth city. This instrument was then reviewed and refined depending upon observation made and forwarded for use during the actual data collection

c) **Key informant interview.** This tool was designed to collect programmatic and challenges of children with disabilities from child-based Governmental and NGO working on children issues.

d) **Focus Group Discussion (FGD)**.

A Tentative discussion guideline was prepared and translated into Amharic language version. During pilot study, two group discussions were conducted at Nazareth City. During actual data collection, a total five (5) group discussions were conducted that consist of homogenous types of disabilities by moderators.

e)**Case Studies** Two case studies were conducted on problems of children with disabilities including issues on sexual abuse and HIV/AIDS (See case study 1 and 2).

3.5. Procedures of Data Collection

Primarily, the lists of all schools /training institutions, bus stations, or religious settings in which children with disabilities were attending/most often found were identified in collaboration with Addis Ababa City Education Bureau's special education section and other related scholars. The principal investigator has identified all lists of sites and total children with disabilities with their respective sites.

Hence, these sites were used as primary preparations of fresh sample frame or list of all children with disabilities at their respective school/training institutions or religious settings. Every fresh list of children with disabilities was prepared in consideration of children's ages and types of disabilities in close supervision of the principal investigator. To take the sample unit from the fresh list of children with disabilities at each site, a random start number was given for enumerators using systematic random sampling technique. Then after each enumerator conduct the interview session with selected sample unit.

3.6. Recruitment, Training and Pilot Study

Most enumerators were recruited from same sites of target population schools/training institutions. Accordingly, two female and three male data collectors who have relevant theoretical and practical experiences in data collection pertaining to children with disabilities were selected. All of them were teachers or unit leaders of children with disabilities at primary schools

The training upon administration of structured interview for children with disabilities was given to these selected enumerators for two days. The content of the training was upon approaches of data collection in general and specifically conducting Focus Group Discussions (FGD) as moderators upon children with disabilities particularly giving attention to enumerators who had collected data from deaf and Mentally Retarded (MR) children. The field practices were held primarily in peer–wise as well as in the filed doing practical exercises

The pilot study was carried in early February 2006 in Nazareth Town. The structured interview was tried upon 10 children with disabilities. They were contacted at school and on streets. The main purpose of the pilot study was to improve some of important aspects of the interview questions. The advantages obtained through this study were how to phrase each item of the questions and checking the best sequences of each section and question.

The actual data collection was carried out beginning March to April 2006. Most selected data collectors were assigned their respective schools. At out-school sites; some familiar guides were selected for the purpose of identification and proper contact with children with disabilities. The guides have made a substantial facilitative work in going around and show places and arrange contact with children. Every guide has made some explanation about the purpose of the study to the respondents and requests their co-operation.

3.7. Ethical Considerations

The topic under investigation is a sensitive issue and it is illegal practices that are carried out secretively in the country. Due to these problems, information obtained from respondents and implementing organizations were kept confidential. The anonymity of children and confidentiality of their information were also given due considerations at the training followed by close supervisions. It also clearly outlined and expressed during the time of interview session for each respondents.

3.8. Data Analysis and Interpretation

Preliminary, data cleaning and editing were carried out. The responses of respondents of open-ended items were re-coded and entered into computer softer ware. Hence, the collected data were organized and analyzed using SPS+ as follows.

- Descriptive statistics such as percentage and mean were used to analyze data on general information.
- Other statistical procedures were used as required.
- Data obtained through FGDS, case studies and key informants interviews was transcribed and integrated into main body of this study.

The analyses of qualitative data were made through transcription of focus group discussions points made by moderators and information obtained from key informants. Some relevant secondary data were also taken and integrated into the main body of the findings.

3.9. Limitation of the Study

The major limitations of the study were the following:-

1) This study tries to show the diverse challenges of children with disabilities. Hence, it doesn't show these problems in detail or specifically.
2) Since the sample of the study was children with disabilities attending in schools/ training institutions, it might not represent the most severely exposed one to the sought multiple challenges of children with disabilities and living in general population. Hence, the study results are confined to the aforementioned target population.
3) The target population of the study was limited to the four major types of persons with disabilities and fails to cover other types of disabilities largely due to lack easy identifications and inaccessibility factors.
4) There are no/little similar comprehensive studies about child-trafficking and other issues of children with disabilities at site of the study and even across the world. Hence, it was hardly possible to make comparative analyses of the finding with others.
5) The mobility patterns and lack of effective language communication skills of some of the target groups have effects upon collecting reliable information.

CHAPTER 4 RESULTS OF THE STUDY

4.1. Demographic Characteristics of Respondents

A total of 251 children with disabilities responded to the structured questionnaire. The respondent rate was 80 percent. As shown in Table 1, age group, sex, religion, ethnic group, education levels and type of disabilities have been identified as the demographics characteristics of the respondents.

As shown in Table 1, the proportion of male and female respondents is equivalent. The age structure revealed that the majority of children with disabilities were adolescents (15-18 years old,) and followed by late childhood (11-14 years old). With respect to religion, the majority of the respondents was Orthodox Christians (76.5 percent) and followed by Muslim (12.7 percent). With regard to ethnic group, the majority of the respondents belongs to Amhara (48.5 percent) and followed by the *Oromo* ethnic group (23.8 percent).

Concerning education levels, most of the respondents were attending second cycle (grade 5-8) educational level and there were also children without education or illiterate (2.0 percent). A significant proportion of the respondents were single/ unmarried that might attribute to fact that they were attending school. The majority of the respondents were children with visually impaired/ blind children (50 percent) and the second largest proportion was belongs to children with hearing impaired/deaf children (45.4 percent).

Table 2 Demographic characteristic of respondents by selected characteristics

Background characteristics	Percent	N =251
Sex		
Male	53	133
Female	47	118
Age group		
7-10	2.8	7
11-14	37.0	93
15-18	60.2	151
Religion		
Orthodox	76.5	192
Muslim	12.7	32
Protestant	8.0	20
Catholic	2.0	5
Others	0.8	2
Ethnic group		
Amhara	47.4	118
Oromoo	23.1	56
Tigre	13.1	33
Gurage	11.1	29
Others	4.1	10
Marital status		
Single/unmarried	92.4	232
Married	2.4	6
Divorced	1.4	3
Widowed	0.4	1
Separated	3.2	8
Educational status		
No education(Illiterate)	13.9	35
Grade 1-4	23.1	58
Grade 5-8	42.2	106
Grade 9 and above	20.7	52
Type of Disabilities		
Visually impaired/Blind	40.2	101
Hearing impaired/Deaf	37.8	95
Mentally retarded(MR)	12.7	32
Physically disabled (Any type)	9.2	23

4.2. Child Trafficking Practices

This section shall present the causes, prevalence, methods, actors, and consequences of trafficking of children with disabilities.

4.2.1. Causes of Mobility

The majority of children who have been reported trafficking problems indicated that the underling causes are the aim of searching income for subsistence life. Most of the key informants have also reported that the major underlining forces of child-trafficking practices are the absolute poverty of the community in general. Besides, some key informants have also reported the causes of child-trafficking problems are related with existing socio-economic problems including using children as source of income, influences of social stigma and discrimination, and traditional practices/beliefs.

All respondents were asked the major reasons why they leave their home place. Some of children who have been once involved in trafficking gave the following reasons/information depending upon their testimony of life experiences. As shown in table 3 below, the majority of children were moved due to forceful problems (38%), followed by reasons of searching subsistence income (22.2%) and family violence (17.6 %). The aforementioned driving factors /reasons may attribute to poverty problems and sought trafficking intentions of out standers as also mentioned by some key informants. Among types of disabilities, the largest proportion of children with disabilities were moved due to forceful problems including visually/blind(43.5%), hearing impaired/deaf children(33.3%) and children with motor disorder(36.4%) and children with mentally retarded(33.3%). The next largest proportions of children with disabilities were moved due to family violence and lack of substance income, 23.9 percent of children with visually impaired and 22.2 percent of children with mentally retarded; and 23.8 percent of hearing impaired children and children with motor disorders respectively.

Table 3 Percentages distribution respondents by reason of leaving home

Major Reason of Mobility	Types of disabilities				Total
	Blind	Deaf	Motor Disorder	Mentally Retarded	
To seek employment	8.7	2.4	-----	11.1	**5.6**
Family violence	23.9	9.5	18.2	22.2	**17.6**
Death of caregivers	4.3	11.9	9.1	11.1	**8.3**
Lack of subsistence(income)	17.4	23.8	36.4	22.2	**22.2**
Escape from early marriage	-------	4.8	---	---	**1.9**
Forceful problems	43.5	33.3	36.4	33.3	**38.0**
City attractions	2.2	14.3	---	---	**6.5**
Total	**100(46)**	**100(42)**	**100(11)**	**100(9)**	**100(108)**

4.2.2. Prevalence of Child-Trafficking

The concept of trafficking refers to the act of intentional recruitment, transporting and exploitation of children with disabilities through different forms and being taken to certain destination. As shown in Table 4 below, data collected from respondents of children with disabilities has shown the proportion of child-trafficking. The prevalence of child-trafficking with disabilities was found to be **33.9** percent among the target population. The highest prevalence of trafficking is found in ascending order among children with visually impaired (15.1%) and followed by hearing impaired children (11.6%). The lowest trafficking problems were found among children with mentally retarded children (2.8%).

Table 4 Percentage distributions of children being trafficked by types of disabilities

Types of Disability	Yes	No	Total
Visually impaired/Blind	**15.1**	25.1	40.2
Hearing impaired/Deaf	**11.6**	26.3	37.8
Motor Disorder	4.4	4.8	9.2
Mentally Retarded(MR)	2.8	10.0	12.8
Total	**33.9(85)**	**66.1(166)**	**100(251)**

4.2.3. Methods and Perpetrators of Child Trafficking

The general means of trafficking of children with disabilities are various and it involves employing simple terms such as tricks and cheap materials such as biscuit, candy, etc. Hereafter actors can take them easily from one place to another for desired exploration than non-disabled children. As underlined in the UN protocol to prevent and suppress trafficking in person, the major components of child trafficking practices involves recruitment, transportation and explorations of children at destination in different forms.

The respondents in this study were asked what type of means that the perpetrators employ to move them from their birth place or to go out to the desired destination. The respondents were reported that they are triggered by a variety of factors as depicted in Table 5. The majority of children were convinced by different forms deceptions (49.9 %) and followed by parental consent (19.7%), other factors (18.1%), their intentions or personal interest that probably attributed to the existing social stigma and other determining factors.

Table 5 Percentage distribution of respondents by Means of Trafficking Styles

Means of trafficking	Percentage	Number of respondents
Abduction	5.3	7
Family consent/payments	19.7	26
Deception	46.9	62
Self-initiation/interest	9.8	13
Others	18.1	24
Total	100%	132

In addition, the respondents were asked in detail what forms off cheating/deception that perpetrators employ to move them from their place to another. As it is depicted in the Table 6 below, the majority of trafficked children had reported moved from their place through false promise of education/training (35.8 percent) at destination and followed by promise of employment (33.9 percent). The promises of high income, escape from early marriage and domestic violence were also found exposing children to trafficking problems.

Table 6 Percentage distribution of respondents by Methods of deceptions/cheating for trafficking

Forms of deceptions	Percentage	Number of respondents
Escape from early marriage	3.5	3
Promise of employment	33.5	37
Promise of education/training	35.6	39
Gaining more income/money	9.1	10
Escaping domestic violence	6.4	7
Others	11.9	13
Total	100%	109

The act of trafficking is never happen in vacuum. Most traffickers use different approaches of deception in order to exploit them for different purposes. There are different intermediate actors that facilitate the processes of trafficking practices. As it can be seen from Table 7 below, the majority of actors of child-trafficking with disabilities were found to be family/relatives (58.7percent) and followed by Brokers/*balukas* (16.8percent). Friend and Transport workers were also found to be the next driving actors, 12.9 percent and 9.7 percent respectively. Some key informants have reported the other major perpetrators or actors of child-trafficking practices are familiar persons within near living environment, and close family members such as mothers or close relatives. In addition, some key informants have also reported that mentally retarded children are the most cheated children by any means of trick due the status of cognitive capacities. For instance, they might be deceived easily by ways of promising to buy a single candy or other less costly issues.

Table 7 Percentage distribution of respondents by Perpetrators of child-trafficking and by types of disabilities

Types of Actors	Percentage	Number of respondents
Family/relatives	58.7	74
Brokers/Baluka	16.8	21
Friends	9.5	12
Transport workers	8.7	11
Others	6.3	8
Total	100%	126

4.2.4. Occupations of Trafficked Children

The UN protocol on trafficking that is directed to prevent, suppress, and punish trafficking actors states that the exploration of trafficking children involves being child prostitution, other forms of sexual exploitation, forced Labour, slavery or practices, similar to salivary , servitude or the removal of organs.

In this study, the respondents were asked in what type of activities/occupation they have been engaged after trafficking or while Living Street. As presented in Table 8 below, the largest proportion have reported that they have engaged in begging activities (30.5 percent) and followed by living in/on street life/ walking (20.7 percent). A smallest proportion of trafficked children with disabilities were found engaging in sex sector services and followed by working as a waitress and sex workers.

Table 8 Percentage distribution respondents by trafficked children and activities

Types of activities	Percent	Number of respondents
Daily Labour	15.8	13
Domestic Services	12.2	10
Waitress in Hotel/Bar	4.87	4
Keeping /cooking in Hotel	6.1	5
Sex worker in 'Baluka'	1.2	1
Street life/walkers'	20.7	17
Begging	30.5	25
Others	8.5	7
Total	100%	82

4.2.5. Consequences of Trafficking

The reported consequences that the children have faced are categorized into Psycho-social problems, sexual abuse/violence and health related consequences for better understanding as the following.

a) **Psycho-Social Problems**

The respondents were asked whether or not they have faced some problems after trafficking or living in street. The respondents have identified the following psychosocial problems as depicted in Table 9 below. The majority of them (28.4%) percent have reported that they encountered emotional violence. Others have also reported different psycho-social problems including overwork (24.2 percent) and physical violence (21.6%). The next lowest problems include denial of payment/salary, sexual exploitation and others. Some of the key informants of this study have reported that some children with mentally retarded have paid unexpected amount (such as 25 cents, etc)for the highly disregarded works such as cleaning dirty places and carrying out huge wastages.

Table 9 Percentage distribution of trafficked respondents by the types of problems they have encountered

Psycho-social problems	Percent	Number of Respondents
Physical violence	21.6	19
Emotional violence	28.4	25
Sexual exploitation	6.8	6
Overwork	21.6	19
Denial of salary	10.2	9
others	11.4	10
Total	100%	88

4.3. STREET CHILDREN WITH DISABILITIES

4.3.1. Prevalence of Streetism

All children with disabilities were asked whether they have ever joined or lived in a street life during their life time. As shown in Table 10, about 29.1 percent of the respondents were reported that they had lived in or on street at least once during their life time. This implies that the prevalence of streetism among children with disabilities who had reported living in/on street at least once was found to be **29.1** percent. Moreover, the results show that children with visually impairment constitute the largest proportion (12.7%) among children who were living in/on street and followed by children with hearing impairment/deaf (8.8%). The lowest proportion (2.7%) of children who have lived in/on street was found among children with mentally retarded.

Table 10 Percentage distribution of respondents who have reported their status of street life by types of disabilities

Types of Disability	Yes	No	Total
Visually impaired/Blind	12.7	27.5	40.2
Hearing impaired/Deaf	8.8	29.1	37.8
Motor Disorder	6.8	3.4	9.2
Mentally Retarded(MR)	2.7	16.9	12.7
Total	**29.1(73)**	**70.9(178)**	**100(251)**

4.3.2. The challenges of Street life

The experiences of children about life challenges of streestism were assessed by asking their first impression and other related issues. All respondents who had ever reported living on/in street were asked about their first impression when they have joined the street life. Table 11 below shows that the largest proportion (47.5%) of them was uncertain when they have joined the street life. This means that they did not have known image or unclear about their life perspective. This life challenging condition was followed by feeling of fear of the environment. It was surprising that a small proportion of children with disabilities particularly hearing impaired children had experienced pleasure (2.5%) being in/on the street during the first time. With respect to types of disabilities, children with visually impaired and motor disorder were the largest proportions who have faced life challenging of fear and uncertainty in/on street, 55.6 percent and 68.8 percent respectively.

Table 11 Percentages distribution of respondent's who had experience of street life by types of disabilities

First impressions	Blind	Deaf	Motor disorder	Total
Fear	55.6	50.0	31.3	45.0
Surprise	-----	-----	------	-----
Uncertainty	38.9	16.7	38.8	47.5
Pleasure	----	16.7	----	2.5
Others	5.6	16.7	----	5.0
Total	100(18)	100(6)	100(16)	100(40)

4.3.3. Substance Abuse Practices

One of the other problems of children in/on the street is the tendency of developing undesirable habits of taking drugs such as chat, alcohol, etc. All children who had reported living on/in street were asked whether they had take drugs. As depicted in Table 12 below, about 44.1 percent of children with disabilities had taken some types drugs while they have been on/in street. The results show that the practices were high among visually impaired/Blind (20.5%) and hearing impaired/Deaf (13.2%) children than other groups of children with disabilities. This shows that the probability of exposure of children with disabilities who were living in/on street to drug taking practices is 44 percent.

Table 12 Percentage distribution of respondents who had reported taking drug by types of disabilities

Types of Disability(N =68)	Yes	No	Total
Visually impaired/Blind	20.5	22.1	42.6
Hearing impaired/Deaf	13.2	14.7	27.9
Motor Disorder	8.8	19.1	27.9
Mentally Retarded	1.5	----	1.5
Total	**44.1(30)**	**55.9(30)**	**100(68)**

4.4. Sexual abuse/ violence

One of the underreporting cases in most research works is about sexual abuse/violence. As shown in Table 13 below, only 11.6 percent of children with disabilities have reported that they had encountered sexual abuse/ violence while they had been in one of the stressful situations. The highest prevalence was found among children with motor disorder, and visually impaired/Blind 43.5 percent and 13.9 percent respectively. With respect to gender, the highest proportion was found among female than male, 9.6 percent and 2.0percent respectively (Data was shown).These evidences have confirmed that how the problems of children with disabilities are multiple: trafficking, living on/in street, HIVAIDS issues, and sexually abused including the problems of their disability status.

One of the misconceptions that may expose these children with disabilities to sexual abuse/rape is that there is belief that children with disability are safe or free of HIV infection. Some of the key informants mentioned that most girl children with disabilities exposed to sexual abuse due that

fact that they are considered free of infection of all disease than their counterpart. Moreover, some of the case studies in this study have revealed that due to these misconceptions children with disabilities were found being frequently exposed to sexual abuse and even to the worst disease of HIV infections (See case study 2).

Table 13 Percentage distribution of respondents who have reported that hey have been sexually abused by types of disabilities

Types of Disability(N =249)	Yes	No	Total
Visually impaired/Blind	13.9	86.1	41.2
Hearing impaired/Deaf	5.3	94.7	37.8
Motor Disorder	43.5	56.5	12.7
Total	**11.6(29)**	**88.4(176)**	**100(249)**

4.5. Awareness of STDS and HIV/AIDS Issues

Availability inaccessibility of appropriate information on the types of family planning methods and HVAIDS issues has paramount advantages in promoting the reproductive health rights of couples and individual of persons with disabilities. This section presents finings on knowledge of family planning and proceeds to awareness abut on HIVAIDS. The volume of people affected by HIV/AIDS is increasing from time to time. This shows that the epidemic is posing serious challenges for all people of mankind of which children with disabilities are one of the liable groups in Ethiopia. Accordingly, in this study, some information on HIVAIDS and STIS was also collected.

4.5.1. Knowledge of Family Planning Services

All girls and boy were asked to state whether they have ever heard of family planning services or not. As shown Table 14 blow, over 62 percent of the respondents have reported to have heard about family planning methods. The proportion of boys who ever heard of at least one family planning methods was relatively higher than girls, 66.2 percent and 57.6 percent respectively. However, both girls and boys who have not heard about family planning method constitute a significant proportion, 42.2 percent and 33.8 percent respectively. This shows that there is great need for further intervention program among children/adolescents with disabilities.

Table 14 Percentage distribution of respondents who have heard of any modern family Planning s methods by gender

Sex	yes	No	Total
Male	66.2	33.8	53.0
Female	57.6	42.4	47.0
Total	62.2(156)	37.8(950	100(251)

Table 15 below shows the knowledge of children about family planning by types of disabilities. As depicted in the table below, the knowledge of family planning among children with disabilities seems moderate, 62.2 percent. A significant proportion of children with disabilities (37.8 percent) did not have information upon family planning methods. Among children with respect to types of disabilities, visually impaired (23.1%) and Hearing impaired (25.5%) children have more knowledge about family planning methods than other groups of children with disabilities in this study. One can say that there is need to increase the knowledge of children of with disabilities about family planning services.

Table 15 Percentage distribution of respondents' about knowledge of family planning by type of disabilities

Types of Disability	Yes	No	Total
Visually impaired/Blind	23.1	17.1	40.2
Hearing impaired/Deaf	25.1	12.7	37.8
Motor Disorder	6.0	3.2	9.2
Mentally Retarded(MR)	8.0	4.8	12.7
Total	**62.2**	**37.8**	**100(251)**

4.5.2. Knowledge on HIVAIDS

All respondents were asked whether they heard about HIVAIDS. As depicted on Table16 below knowledge about HIV/AIDS seems universal among children with disabilities, 77.5 percent. However, a significant proportion of children with disabilities (22.5 percent) did not have information upon HIV/AIDS issues. The findings have shown that the smallest proportion of all types of disabilities did not have knowledge about HIVAIDS. Hence, one can say that there is need to design possible intervention plan to increase the knowledge of children of with disabilities about the worst disease of HIVAIDAS in Addis Ababa.

Table 16 Percentage distribution of respondents who have ever heard of the virus HIV/AIDS by type of disabilities

Types of Disability	Yes	No	Total
Visually impaired/Blind	33.7	6.4	40.2
Hearing impaired/Deaf	33.7	4.4	38.2
Motor Disorder	4.8	4.4	9.2
Mentally Retarded(MR)	5.2	7.2	12.4
Total	**77.5**	**22.5**	**100(249)**

4.5.3. Sources of information on HIVAIDS

All respondents who have ever heard about HIVAIDS were asked to state the sources. As presented in Table 17, most respondents reported TV and Radio (22.5%) and school/college (20.4%) as the major socurces of information on HIVAIDS. These sources followed by clubs and peer groups. Similarly, there are no significant differences with respect to types of disabilities. This means that higher proportions of each type of children disabilities had got information from similar sources. It was found that only small proportion of them had reported getting information from health facilities, poster/leaflets and other sources. This shows that the accesses of children with disabilities in getting from other sources are very low.

Table 17 Percentage distribution of respondents' with some information on HIV/AIDS by sources and types of disabilities.

Sources of information	Types of disabilities				Total
	Blind	Deaf	Mentally Retarded	Motor Disorder	
TV/Radio	26.0	17.4	18.7	28.1	22.5
Social gathering	9.1	13.9	10.9	8.9	10.9
Health facilities	7.5	3.9	17.2	5.6	6.9
Church/Mosques	4.2	4.3	10.9	11.2	5.8
School/college	18.9	23.9	14.1	20.2	20.4
clubs	11.7	13.0	17.2	6.7	12.0
Peer groups/ relatives	15.8	14.8	-----	7.9	12.8
Poster/leaflet	4.2	6.9	10.9	3.4	5.7
others	2.6	1.7	----	7.9	2.8
Total	265	230	64	89	648

4.5.4. Knowledge on Means of HIV/AIDS Prevention

All respondents were asked two questions, about knowledge and methods to avoid HIV infection. Primarily, all respondents who have reported that they have heard about HIVAIDS were asked whether they have heard any methods to avoid HIV infections. As presented in Table 18 below, only 40.6 percent of the children with disabilities had knowledge about the means to avoid HIV infections. Among the four types of disabilities, the largest proportion of children with hearing impaired/Deaf and visually impaired/Blind had knowledge about the means (23.2 percent and 14.4 percent respectively) than other types of disabilities in this study.

Table 18 Percentage distribution of respondents who have reported that they heard at least one mean to avoid HIV prevention by types of disabilities.

Types of Disability	Yes	No	Total
Visually impaired/Blind	14.4	26.0	40.4
Hearing impaired/Deaf	23.2	14.4	37.6
Motor Disorder	2.4	6.8	9.2
Mentally Retarded(MR)	1.6	11.2	12.8
Total	**40.6**	**58.4**	**100(249)**

Moreover, all respondents who have reported that they have ever heard about the means of avoiding HIVAIDS infection were also asked to mention the possible ways that one has to take care to protect oneself from HIV infection. As presented in Table19, the largest proportion of respondents had reported abstinence from sex (37.8%) and limited to one sexual partners (16.2%) as major means of avoiding HIVAIDS infections. Though less common among respondents, some had reported avoiding blood transmission and avoiding infection with clean needles as means of avoiding it. However, the most recommended evidence based means HIV prevention of using condoms (10.5 percent) is not well-known among children with disabilities. This shows that the need of strong awareness-rising program on condom promotion among children with disabilities particularly among adolescents persons that may be sexually active.

Regarding the specific types of disabilities, the largest proportions of children with hearing impaired (25.6), mentally retarded (55.6 percent) and motor disorder (44.4 percent) had reported abstinence from sex as means of avoiding HIV infection. But, most children with visual impaired had reported limitation to one partner as the best means of avoiding HIV infections. These disparities may need further attentions among HIV/AIDS prevention and control programs.

Table 19 Percentage distribution of respondents who have reported that they Knew at least one means of HIV prevention by methods and Types of disabilities

Means of avoiding HIV infections	Types of disabilities				Total
	Blind	Deaf	Mentally Retarded	Motor Disorder	
Abstain from sex	51.2	30.3	55.6	44.4	37.8
Avoid blood transfusion	2.3	18.6	-------	31.5	14.1
Use of condom	14.7	8.5	16.7	5.6	10.5
Avoid I injection with unclean needle	2.3	22.8	5.6	9.3	13.4
Limited sex to one partner	25.6	11.2	22.2	9.3	16.2
others	3.9	8.5	----	---	5.4
Total	**129**	**188**	**18**	**54**	**379**

4.5.5. Knowledge on Sexually Transmitted Infections(STI's)

One of the diseases of that transmitted through sexual relationships and is believed to be a predisposing factor of HIV infections are different types of Sexually Transmitted Infections (STI's). The presence of STI's in a given population increases the pace of HIV expansion. Hence, since these issues are expected to have a strong bearing effect in determining what strategies to use in the fight against the spread of HIVAIDS prevention among the target population, they were asked whether they knew any types of STI's or not.

As presented in Table 20 below, about sixty four percent (64%) of the respondents reported that they have knowledge about commonly known STI's. With respect to types of disabilities, the largest proportion of visually impaired/Blind (34.3%) children knew the common types and followed by hearing impaired/Deaf (23%) children. The smallest proportions of both children with motor disorders and mentally retarded children have information about STI's, 2.9 percent and 3.4 percent respectively.

Table 20 Percentage distribution of respondents by status of knowledge of sexually Transmitted infections

Types of Disability	Yes	No	Total
Visually impaired/Blind	34.3 (70)	6.9 (14)	**41.2(84)**
Hearing impaired/Deaf	23.0(47)	19.1(39)	**42.2(86)**
Motor Disorder	2.9(6)	-------	**2.9(6)**
Mentally Retarded(MR)	3.4(7)	10.3(21)	**13.7(28)**
Total	**63.7(130)**	**36.3 (74)**	**100(204)**

4.6. Psycho-Social problems

The psychosocial problems that children with disabilities may face emanated from different milieu such as from the social stigma and discriminations of the community and from the environment in which they live such as in street life, trafficking situation and other related issues.

At early time, social interactions have significant contribution for overall cognitive and personality developments of children. To assess the social participation of these children at personal level, all respondents were asked whether they have classmate or a friend at school or other places. As shown in Table 21, the majority (73.4%) of children with disabilities have friends or classmates. But, three out of ten (27%) of children with disabilities did not have any friends or classmates. But, some key informants have reported that children with disablties have difficulties in making friendship in schools than around home environment.

However, with regard to types of disabilities, the largest proportions that have classmate or friend were visually impaired/Blind (79.0%) children and followed by mentally retarded children, 78percent. And yet, a significant proportion of children with motor disorders and hearing impaired/deaf children comprise the highest (65.2% and 24.7%) proportion among children who did not have classmate or friend. The smallest proportion of friendship was found among children with motor disorders, 34.5 percent.

Table 21 Percentage distribution of respondents who has close friends or not by types of disabilities

Types of Disability	Yes	No	Total
Visually impaired/Blind	79.0(79)	21.0 (21)	**40.3(100)**
Hearing impaired/Deaf	75.3(70)	24.7(23)	**37.5(93)**
Motor Disorder	34.5 (8)	65.2(15)	**9.3(23)**
Mentally Retarded(MR)	78.1(25)	21.9(7)	**12.9(32)**
Total	**73.4(182)**	**26.6(66)**	**100(248)**

Moreover, there are different psychosocial factors that might believe to play significant roles in delaying their progressive overall development of children. To assess these problems, all respondents were asked to mention separately the psychological and social problems they often encountered during their life time.

As presented in Table 22, most of the social problems that the four types of children with disabilities encounter were identified. The largest proportion of children with disabilities had reported difficulties in social problems of lack of interaction with others, and followed by difficulty of making friendships, 38.5 percent and 23.4 percent respectively. However, there are differences with respect to types of disabilities. The highest proportion of children with visual impaired, hearing impaired, mentally retarded and motor disorders had reported of social problems of difficulty of making friendships, lack of interaction with others, and isolation consequently, 37.9 percent, 38.5 percent,28.6 percent and 54.8 percent respectively.

On the contrary, the smallest proportion of all children with disabilities had reported aggressive behaviors as social problems. These underreporting tendencies may be attributed to the values and social influences upon being aggressive within the social environment.

Table 22 Percentage distribution of respondents' who have reported experiencing social problems by types of disabilities

Types of Social problems	Types of disabilities				Total
	Blind	Deaf	Mentally retarded	Motor disorder	
Lack of interaction with others	31.8	38.5	21.4	54.8	38.5
Being withdrawal from	12.1	16.7	14.3	9.5	13.8
Difficulty of making friendships	37.9	22.9	------	9.5	23.4
Isolation	10.6	15.6	28.6	21.4	16.1
Aggressive behaviors	1.5	5.2	14.3	2.4	3.7
others	6.1	1.7	21.4	2.4	4.1
Total	**66**	**96**	**14**	**42**	**218**

As presented in Table 23 below., some respondents were mentioned that the psychological problems that hey have experienced during their life time. Their experiences vary form on type of disability to another. The highest proportion children with visual impaired and hearing impaired had experienced neglect, 55.6 percent and 37.3 percent respectively. On the contrary, the largest proportion of children with mentally retarded and motor disabilities had reported being dependent upon others, 36.4 percent and 47.4 percent respectively. Generally, the major psychological problems among the four types of children disabilities were found to be feeling of neglect and being dependent, 38.1 percent and 26.1 percent respectively.

Table 23 Percentage distribution of respondents' who have reported experiencing of some psychological problems by types of disabilities

Types of psychological problems	Types of disabilities				Total
	Blind	**Deaf**	**Mentally Retarded**	**Motor Disorder**	
Negative attitude	17.8	27.1	18.2	21.1	22.4
Neglect	55.6	37.3	----	21.1	38.1
Dependent on others	15.6	25.4	36.4	47.4	26.1
Repetitive stereotyped behaviors	2.2	8.5	18.2	5.3	6.7
Lack of attaining positive self concept	8.9	16.9	27.3	5.3	6.7
Total	45	59	11	19	134

Table 25 Percentage distribution of respondent's who have reported personal and social coping styles in school settings by types of disabilities

Types of personal coping mechanisms In schools	Types of disabilities				Total
	Blind	Deaf	Motor disorders	Mentally Retarded	
Personal Orientations(in school)					
Hard work and effort	22.1	33.9	20.0	12.2	23.8
Commitment and willingness	12.1	5.8	10.0	17.1	10.8
Strong desire and devotion	12.1	5.8	15.0		9.7
Patience and tolerance	9.6	28.2	12.5	9.8	14.4
Spiritual strength	12.5	8.7	5.0	2.4	9.9
Good communicator	11.7	3.9	12.5	12.2	9.9
Developing self confidence	16.7	5.8	12.5	4.8	12.5
Accepting oneself	2.1	3.9	5.0	41.5	6.6
Others	1.3	3.9	7.5	—	2.4
Total	**240**	**103**	**40**	**41**	**424**
Social Orientations(in school)					
Peer group	18.5	35.7	14.3	16.2	21.8
Family members	19.5	23.8	9.5	48.6	22.3
related Association	12.5	—	11.9	.	8.3
Active in social activities	9.0	4.8	7.1	.	6.9
Religious people	7.5	13.1	14.3	10.8	9.9
Access to education	17.5	13.1	19.0	.	14.9
Successful person	1.5	3.6	7.1	2.7	2.8
NGOs and civil society	13.0	2.4	11.9	21.6	11.3
others	1.0	3.6	4.8	.	1.9
Total	**200**	**84**	**42**	**37**	**363**

The social coping mechanisms of children with disabilities in school setting are also presented Table 25 above. The largest proportion of children with disabilities (21.8%) were found coping with stressful situations in school through family members. The next higher proportions of children with disabilities who have reported using social coping mechanism such as peer groups in school, and access to education in dealing with stressful situations. As group of disabilities, except children with visually impaired and mentally retarded children, the largest proportions of the other groups (hearing and motor disorders) in this study were found employing different techniques of coping mechanisms. The latter two have reported using peer group and access to education as coping mechanism at time of streesful situations. In school, the largest proportion of children were found using primary–control-coping styles such as handwork, strong desire and devotion, self-confidence and accepting oneself and even with respect to types of disabilities.

Personal and social coping mechanisms in out school/in community

Table 26 below gives the personal and social coping mechanisms of children with disabilities in-out-school/in community settings. The common personal coping styles of children with disabilities were found to be hardworking and effort (18.9%), patience and tolerance (14.8%) and development of self-confidence (12.7%) within communities. Other personal coping mechanisms that children with disabilities had reported using as group were found to be different from one to another. The largest proportion of children with visually impaired and mentally retarded children had reported employing hard work and efforts and accepting oneself respectively. Similarly, children with hearing impaired and motor disorders in this study employ different techniques of coping mechanisms, being patience and tolerance, and developing self-confidences respectively.

In this study, however, the practices of using other techniques coping styles are minimal. Hence, further attentions seem necessary to assist children with disabilities in the community to able to develop various coping styles to deal with diverse life challenges effectively within their environments.

Table 26 Percentage distribution of respondent's who have reported personal and social coping styles in school settings by types of disabilities

Types of coping mechanisms	Types of disabilities				Total
	Blind	Deaf	Mentally Retarded	Motor disorders	
Personal orientation(Out of school)					
Hard work and effort	17.9	25.3	14.6	12.5	18.9
Commitment and willingness	11.8	9.9	8.6	18.8	11.3
Strong desire and devotion	9.6	9.9	11.4	.	14.8
Patience and tolerance	13.2	25.3	11.4	.	109
Spiritual strength	10.9	8.8	14.3	12.5	109
Good communicator	14.5	5.5	8.6	3.1	12.7
Developing self confidence	16.24.8	5.5	20.0	.	9.1
Accepting oneself	0.9	5.5	5.7	53.1	2.1
Others		4.4	5.7	.	
Total	**200**	**84**	**42**	**37**	**363**
Social orientations(Out of school)					
Peer group	14.2	15.1	11.3	11.8	13.4
Family members	18.0	43.0	12.1	44.1	22.2
related Association	12.6	4.6	10.6	5.9	10.3
Active in social activities	10.7	1.2	10.6	.	10.2
Religious people	9.6	10.5	12.1	5.8	10.2
Access to education	16.9	3.5	12.1	.	12.3
Successful person	7.3	3.5	11.3	.	7.3
NGOs and civil society	6.5	3.5	10.6	29.4	8.6
others	4.2	4.7	9.2	2.9	5.6
Total	261	86	141	34	522

Table 26 above presented the social coping mechanisms of children with disabilities in out-school/community setting. Like in school setting, the largest proportion of children with disabilities (22.2%) was found to be coping with stressful situations through family members. The next proportions of children with disabilities who have reported using social coping mechanism of peer groups and access to education programs.

By types of disabilities, except children with visually impaired and mentally retarded children, the largest proportions of the rest groups (hearing and motor disorders) in this study were found employing different techniques of coping mechanisms. The latter two who have reported using peer group and access to education as coping mechanism at time of streesful situations. As depicted in the table, a substantial proportion of children with visual impaired (18.0%), hearing impaired (43.0%), mentally retarded (12.1%) and motor disorders (44.1%) had reported using commitment and willingness as means of coping with stressful challenges in community. In addition, the next largest proportion of visually impaired children, hearing impaired, motor disorder and mentally retarded children have reported using good communication, hard work, spiritual strength and accepting oneself as coping styles respectively at times of streesful life challenges.

This finding shows that the majority of children were found employing primary-control –coping styles (hard work and efforts, self-confidences, accepting oneself, willingness, etc) than secondary –control-coping strategies (patience and tolerance). In both settings, the largest proportion of children were found coping with stressful situation through family members that shows their dependence around home environment. Even though some children with disabilities were using some coping mechanism, the proportion of using others still need further consideration in order to wide their capacities of coping styles within larger community.

4.8. Programmatic Challenges

One of the objectives of this study was to explore the programmatic intervention of the multiple challenges of children with disabilities. To assess theses issues, this study has employed interview guidelines and Focused Group Discussions (FGD) for selected key informants from some implementing organizations and target population respectively. The results of these qualitative data are consolidated as follows.

In Ethiopia, there are various children's rights-based local and international Non-Governmental Organization (NGOs) and governmental sectors that are closely working on children's rights and related programs in different parts of the country including in Addis Ababa City Administration. The degrees of involvement of these organizations have been examined through different discussion forums

The selected key informants and participants of group discussion have reported that the status of involvements of different concerned organization on the rights of children with disabilities compared to non-disabled children. They reported that even though all children are equally presented in all conventions, Africa's charters rights and welfare of children and in UN conventions including human rights conventions, there are shortcomings in addressing the rights of children with disabilities at program level. Hence, this next section shall present some of the existing problems why it becomes difficult to address the multiple challenges of children with disabilities in Addis Ababa.

Discrimination of the project for children with disabilities

Many local and international Non-Governmental Organization (NGOs) and governmental sectors have working on children's rights based programs (see Appendix E) in different parts of Addis Ababa. Some of the key informants from these organization have reported that the issues of these children are total discriminated from the projects/program either knowingly /unknowingly. However, it is confirmed from some key informants have reported, there is no organization either NGO or governmental sector that has planned program/projects particularly directed to wards fighting-against child-trafficking, streetism and HIV/AIDS programs of children with disabilities

in Addis Ababa. The major reasons are attributing to the following factors indicted by key informants:

1) Lack of awareness-raising program on multiple challenges of children with disabilities in general
2) Non-existence of sufficient information or studies on child-trafficking or streetism and other problems.
3) Lack of understanding of the degree of multiple challenges of children with disabilities.
4) Fear of addressing highly expensive and broad basic needs and related services of children with disabilities.
5) Lack of mainstreaming skills of the needs and provision of services for children with disablties within existing projects/program of non-disabled children.

Lack of Trained Personnel and Supports

Any organization need some qualified trained personnel and capacities to run sought programs/projects effectively. Some of the key informants of this study have mentioned that the following determining factors have played considerable roles in addressing or visualizing the multiple challenges of children with disabilities:-

1) There is clearly lack of trained personnel knowledgeable about issues of person with disabilities in most relevant organizations. In most children's right-based organizations, there is none or little qualified personnel who could design, understand and implement the vision, goals and other programmatic components of projects/programs that could deal with persons with disabilities.
2) There are none or minimal technical supports from concerned governmental sectors and NGOs to address the needs of children with disabilities in question. This problem may partially relate to the aforementioned problems.
3) There are no financial (budgets) supports from most local and international Non-Governmental Organization (NGOs) as well as governmental sectors to work and address the needs of children with disabilities.

Lack of Awareness-Raising Programs

In addition to the provision of basic public services, there are strong needs to create awareness and propagate the unique needs of children with disablties. To these effects, the key informants have reported that one of the deterring factors that hide the consideration of the basic needs of children with disablties includes the absence of the following important issues:

1) There are no strong awareness-raising programs within most relevant implementing agencies to consider the basic needs and problems of children with disabilities among public in general and in related forums of child rights issues. Some relevant organization do not have well-articulated understanding about needs and priorities issues of children with disabilities though they are working keenly upon child rights based programs..
2) The influences of traditional practices/beliefs upon children with disabilities are still playing considerable roles. Even though parents are expected to cooperate upon their children's overall development, some of them are still found to be refusal upon educational provision and rehabilitating children with disablties. This shows that there is gap in creating desirable awareness-raising programs to tackle the problem at grass root levels within the community.
3) There are social stigma and discrimination of children with disabilities at most public services such as in public transports, health facilities, education provisions, etc. Still, the attitudes of some community members towards children with disabilities are largely negative.

Misconceptions of Parents and Community

The members of community in general and the parents do have different misunderstanding about children with disabilities. To this end, some of the key informants have reported the following misconception about multiple challenges of children with disabilities:

1) Most parents have confusing views about their children with disabilities with respect to provision of services. Some believes that when somebody request to take care of their children with disabilities, for instance, to take the child for education or medication or for other issues, they consider as "*favor*" at any levels. The parents think that as if the person is helping them in getting relieve of their problem with disabilities, but they did not consider that such agents are completely improving the life challenges of the children with disabilities.

2) On the other hand, there are child-trafficking agents who take the children with false promise and expose them to various life challenges engaging in different activities. These conflicting misunderstandings among parents with disabilities have created confusion roles in the processes of assisting their children.

3) Nevertheless, some parents refuse when their children with disabilities are requested for rehabilitation or for other support since some them are dependent upon the child as a means of gaining income through different ways such as begging, etc.

4.9. Case Studies

This section presents two case studies that address sexual abuse/rape and HIVAIDS issues of children with disabilities in Addis Ababa. The cases shall show in detail how far the rights of children with disabilities are violated and make aware the degree of depth of the problems particularly for advocators and concerned bodies.

Case Study 1

Mrs. X is 18 years old. She has the problem of mental retardation. She has got the chance of being member of the Ethiopian National Association for Mentally Retarded Children and Youth on February 02/2001. Through being member, she received vocational training in handcraft in the school of the association found in Kazanches and Mekanissa. Since then the organization has been providing tremendous amount of assistance including guidance and other technical supports.

In the mean time, she has developed social skills and communications effectively. She become familiar with her social environment and started serving her family and neighborhood through buying different kinds of goods household properties. She also started going to church for worshiping and come back with no problems.

However, while she was doing aforementioned day-to-day activities, there was one person who was closely following-up covertly. Once upon time, in July 1994 E.C, while she was doing her usual work this person called and told her that he is going to buy her some biscuits. With the promise of this issue, the person takes her too far and covert place and abused her sexually. After this act, the girl said that he warned her not to disclose the information and to keep the information secrete properly. After this agreement, he brought her around her village at night and finally he disappeared. When she enters home, the family found her totally mixed with blood and highly disturbed. The family becomes shocked and too, curious about the case. However, she refused to let them know the secret of the act since she was strongly warned by the actor. The family members were disturbed and even reported the case to the Ethiopian National Association for Mentally Retarded Children and Youth and other concerned authorities.

Finally, the family has decided to take her to Yekatit 12 hospital for further Medical examination. She took the necessary medication examinations and it was surprising that the result of the health status indicates that she is victim of HIV infection.

Case Study 2

W/ro k is 18 years old. She was born to a poor family in a remote rural area of Ethiopia. She is visually impaired. Before ten years a go, her uncle brought her from the rural areas to Addis Ababa. He made her his servant and kept her in his solitary house. He did not want to send her to school due to various reasons.

In the mean time, while she was working in the kitchen of her uncle, she met one of the agents of Handicap National Association of Children with Disabilities (HNACD). Then after, she joined the HNACD Program. Through the HNACD's awareness raising program, she came to understand and become knowledgeable about her self and her community in general. Ultimately, she decided to leave the trafficking situation that compounded her with excessive labour exploitation of her uncle's house. In the mean time, she found an independent rent house and started living. The trafficking game ended up. Hereafter, the HNACD Program has extended its services to her in different ways. She has also received mobility and Braille training through the association's program.

The association continues taking the necessary measures to change her overall life perspectives. After these trainings, the association has assisted her to go to school. The association has supported and facilitated her education by providing educational materials, transportation fees, school uniform, clothing, etc. In addition, the association provides home-based services, counseling and tutorial services. Now, she is attending grade eight (8th) at Menelik Junior School. In her schooling, she become one of the outstanding students and mostly stood first from her class.

Last year (2005), she was married to a visually impaired person who is attending grade ten in Addis Ababa. This year, they had a baby born a month ago in 2006.

Chapter 5 DISCUSSIONS

This section shall present the explanations, implications, and evaluation of the results within the context of existing relevant studies and theoretical assumptions.

5.1. Trafficking of Children with Disabilities.

One of the multiple challenges of children with disabilities is exposure to trafficking problems. The act of trafficking comprises different phases including pushing or recruiting children, transportation to certain places, and various exploitations that might involve forcing children to engage in different activities such domestic labour, sex worker, sexual abuse, begging and in other task.

The prominent reasons for mobility of children are related to the existing social and economic situations. The key informants interviewed in different relevant organizations stressed that the major causes of trafficking children with disabilities are attributed to absolute poverty, using children with disabilities as means of income, influence of social stigma and discrimination, and factors related to traditional practices/ beliefs. Confirming to this, Tumlin(2000) revealed that increased poverty and food insecurity in South-East Asia has made children vulnerable to trafficking problems.

There are different actors/ perpetrators that facilitate the trafficking processes of children with disabilities. In this study, the major actors of child-trafficking with disabilities were found to be family/close relatives. Others include Brokers/ *balukas,* friends and transport workers. The actors employ different forms of cheating and deception in order to rap into their goals of trafficking. The majority of actors uses false promise of education/training at destination and followed by promise of employment opportunities, the promises of gaining high income, escape from early marriage and domestic violence.

This study reveals that more than one third of children with disabilities in study site were found to being exposed to trafficked problems. This shows that trafficking children with disabilities is a serious problem in the country. With respect to types of disabilities, the highest proportion

trafficking problems was found among visually impaired and hearing impaired children. A National study carried among Non-disabled children and women has revealed that the prevalence of trafficking problems throughout the country was 24.4 percent (USAID, 2003). This study has also shown that about 17.9 percent of non-disabled children and women were found to be trafficked in Addis Ababa. However, it is difficult to compare and explain the result of this study as compared to the national study since finding of the latter did not disaggregate the data into children and women, and by types of disabilities, too.

The act of trafficking is done for the purpose of exploration of children with disabilities for different purposes. This study revealed that trafficked children were forced to carryout different tasks at destinations. The most common and cheap employment opportunities in which children with disabilities were forced to engage are begging, domestic services, daily Labour and street life/walkers. Support to this fact, Tumlin(2000) have found that non- disabled children are trafficked from rural villages to work as begging gangs in Sir lank and Thailand.

According to the report of most key informants trafficked children suffer from different severe psychosocial, abuse and exploration while they have engaged in different activities at destination. The majority of them were found facing emotional violence and followed by overwork, denial of payment or underpayments/salary, sexual exploitation and others. Some of the key informants of this study have reported that some children with mentally retarded forced to overwork and made to be paid unexpected amount of wages.

Even though the degree of child-trafficking of both non-disabled and children with disabilities are largely unknown, the practices of trafficking seem widespread throughout the country (UASID, 2003). Nowadays, in whatsoever forms it takes place; it is not only a crime but also a serious violation of human rights, children's rights, labor rights, and fundamental freedom of human beings in general (UNICEF, nd). Even though Ethiopia did not sign upon the United Nations protocol to prevent, suppress, and punish trafficking in person, Especially Women and Children that supplement the former Unite Nation's Convention against Transactional organized crime (UN, 2000), currently, it seems mandatory to address the problems.

5.2. Streetism and Children with Disabilities

The problem of streetism is also one of the multiple challenges of children with disabilities. This study revealed that nearly one third of children with disabilities were found living in/on street life. More children with disabilities might suffer highly than non-disabled children due to different problems including being in/on the street life. The largest proportion of them was uncertain when they have joined the street life and followed by feeling of fear of the environment. It was surprising that a small proportion of children with impairment had experienced pleasure for the first time when they have joined the street life. Beyond these determining problems any person living in/on street are basically exposed to diverse problems such as harsh whether conditions, heat, rain harassment, communicable diseases, and social risks (Ayalew, et al, 1996). Moreover, the result shows that the largest proportions of children with disabilities who were living In/on Street are visually impairment and hearing impairment/deaf children.

Other difficulties of children with disabilities in street are sexual abuse/ violence. This study has indicated that one fourth of street children with disabilities encounter the problems of sexual abuse/violence. They mostly encounter these problems due to different reasons and misconceptions. Some of the key informants have reported that most female children with disabilities were exposed to sexual abuse/violence due strong misconceptions that they are "*free of infection*" of all sexually transmitted disease than their counterpart. This as also found true with non-disabled young children during the epidemic of HIV/AIDS in some countries of the world. Confirming to this, Tumlin (2000) has revealed that many men believe that having sex with young girls will cure STI's and HIVAIDS or make them more successful in business. These misunderstandings may affect the life of children with disabilities in general. Among street children with disabilities, children with visually impaired/Blind and Motor Disorder were found being highly exposed to the sexual abuse/violence problem than other categories in this study. Hence, once can easily deduce that the problems of children with disabilities are multiple: living on/in street, sexually abused and still with status of disability problems.

Street children with disabilities were found being exposing to undesirable habits of taking drugs such as chat, alcohol, etc. More than one forth of children who had reported living on/in street had experienced some types drugs. The funding further show that the practices were found being high among visually impaired/Blind and hearing impaired/Deaf children than other groups of children with disabilities.

5.3. Awareness of STDS and HIVAIDS issues

One of the devastating problems that Ethiopia has faced is the problem of HIVAIDS issues. In spite of this fact, there are no or little studies upon children with disabilities even though HIV adult prevalence is one of the highest in Ethiopia.

This study revealed that two-third of children with disabilities has heard about family planning methods. The proportion of boys who have ever heard of at least one family planning methods was relatively higher than among girls, 66.2percent and 57.6 percent respectively. However, the proportions of both girls and boys who did not ever heard about family planning method was higher, 42.2 percent and 33.8 percent respectively.

This study revealed that the knowledge about HIV/AIDS seems universal among children with disabilities. More than seventy seven percent of children with disablties had knowledge about HIVAIDS. In addition, higher proportions of visually impaired and hearing impaired children have more knowledge about HIVAIDS than other groups of children with disabilities. However, more than two out of ten children with disabilities did not have information about HIV/AIDS issues.

Another important factor that may play considerable roles in changing the knowledge of HIVAIDS is sources information about the epidemic. Children with disabilities who have ever heard about HIVAIDS were asked to state the sources of their information. Most of them mentioned TV and Radio as the major sources of information on HIVAIDS and followed by information obtained from the school/college and peer groups. This shows that the role of mass media has paramount importance in increasing the knowledge about HIVAIDS for children with disablties in combination with other followed sources of information.

There are relationships among child-trafficking issues, HIVAIDS and streetism and others. Primarily, HIVAIDS might be the cause and consequences of trafficking. The first point refers to the misconceptions of the fact that children with disabilities are free of HIV infection. Secondly, due to the influences of the socio-cultural factors such as sexual abuse/violence and misconception of young girl's sexuality, most children with disabilities including non-disabled particularly children become the victims of trafficking and consequently increasingly vulnerable to sexual exploitation and more likely to expose to HIV infections (EWA and IOM, 2001).

5.4. Sexual Abuse and Rape

The acts of sexual abuses/rapes among children with disabilities are driven by dual misconceptions. These beliefs include that persons with disabilities are incorrectly considered as sexual inactive and virgin. Some studies have revealed that before the advent of HIVAIDS epidemic, persons with disabilities suffered three times as much greater risk of abuse/rape than their counter non-disabled peers' (Nora, et al, 2004).

This study has shown that the more than one out of ten children with disabilities in study site were found sexually abused/raped. The degree of problem is more prevalent among children visually impaired/Blind and Motor Disorder. These acts show that how far the problems of children with disabilities are multiple than other non-disabled children. Besides, one of the case studies of children with disabilities has shown the higher risk exposure to HIV infections.

5.5. Psycho-Social Problems

The sources of different psychosocial problem of children with disablties are social stigma and discriminations, problems emanating from leading a street life, facing the trafficking situations and other related issues. Even though the majority of children did not have difficulties in finding friendships, key informants of the study have reported that some of them have difficulties in making friendship in schools than in home environments. Moreover, this study indicated that three out of ten children with disabilities did not have any friends or classmates during the study period.

Children with visually impaired/Blind children and hearing impaired/deaf children had the largest proportion of friendship formation than others. At the same time, Blind and Deaf children comprise the lowest proportion among children who did not have classmates or friends. A smallest proportion of friendship formation was found among children with motor disabilities and mentally retardation.

This study revealed that the most important interactions and influences upon children with disabilities were found with families, school, governmental sectors, child-based Non-governmental organizations, and community in general. The influences of these sectors upon children with disabilities were found significant and determine the degree of their challenges. Hence, concerned actors need to give due attention and create working relationships with these sectors in order to improve the multiple challenges of children with disabilities.

5.6. Coping Mechanisms

Coping styles is one of the techniques of dealing effectively with difficulties and stressful situation to managing the demands and crises occurred in one's life. Under normal circumstances, coping style are purposeful efforts directed towards searching desirable resolution for forthcoming difficulties to make acceptable for others or create favorable life adjustments.

This study has identified different types of coping mechanisms that children with disabilities were often employ to manage the difficulties happen to them either in general, in schools/home or out-schools/in community settings. In general, the majority of theses children employ coping with difficulty situations through directly solving the problems seeking social supports from significant people and accepting responsibilities in order to manage the problem in question.

However, in a school setting/home environment, the majority of children with disabilities manage difficulties personally by working hard with great efforts, developing great commitment and willingness to solve the encountered problematic situations. In social setting, children cope up with difficulties by using family members, following religious people and the model of successful persons. Moreover, this study revealed that in out-school and in community settings,

5.7. Programmatic challenges

The points of discussions what one should know about children with disabilities are their diverse or multiple challenges particularly child-trafficking, Streetism, STDs and HIVAIDS, and other psychosocial problems that they are uniquely encountered in their daily life. In Addis Ababa, there are no or little programs that address the problems of children with disabilities though the degrees of challenges were found significantly more than their non-disabled counterparts. Why their needs did not get attention?

The key informants have reported that the provisions of services for children with disabilities are discriminated from most projects/programs going on in some organizations. Nevertheless, the major priority areas of Ethiopian National Plan of Action for Children include protecting children against abuse/violence, preventing children from exploitation, and combating HIVAIDS issues (MOLSA, 2004).

However, there are no tangible intervention programs upon the aforementioned issues for children with disabilities across Addis Ababa city. Therefore, the major reasons for lack of programmatic consideration for children with disabilities need further investigations. These evidences show that there are various tasks that should be considered in order to address and minimize the acts of violation of the rights of these children including expansion of the number of trained personnel upon issues of disabilities, developing and supporting relevant projects/programs, continual awareness raising programs, and further research endeavors upon children with disabilities.

Chapter 6 CONCLUSIONS AND SUGGESTIONS

This study of multiple challenges of children with disabilities, by and large, bring about many points into the considerations of concerned bodies and may improve the understanding about trafficking, streetism, HIVAIDS and other diverse problems of children with disabilities. Based upon the findings of this study, the following conclusions are drawn and recommendations are forwarded for future actions.

6.1. CONCLUSIONS

The multiple challenges of children with disabilities are serious problems in Ethiopia. This study has shown the gravity of the problems in highlighting some of the visible and hidden aspects of children with disabilities. However, due to various reasons and explanations the voice of children with disabilities are not still heard and they are continuously exposed to violation of their basic rights.

According to this study, the most important sectors with respect to multiple challenges are family, school, concerned governmental sectors, child-based NGO's and community in general. The roles of these sectors were found having adverse effects either in improving or deterring the multiple challenges of children with disabilities.

The driving forces into child trafficking problems, streetism and other life challenges are many and complex. Different factors have played upon children with disabilities in exposing to such challenging problems. Hence, there is great need of urgent multidimensional interventions programs in collaboration and in active participation of persons with disabilities, individual advocators, relevant organizations, and concerned institutions starting at grass root levels.

Many local and international organizations and governmental sectors are working on child's rights based programs in Addis Ababa. This study has revealed that the issues of children with disabilities are totally discriminated from ongoing organizational projects/program. Though the major reasons include expensiveness of the projects related persons with disabilities, they are not

6.2. Suggestions

The multiple challenges of children with disabilities need the participation of diverse scholars and concerned organizations in order to tackle through strong national campaign, multi-sectroal approach and international cooperation. With respect to these points of views, due consideration should be given to community participations, feasible intervention programs, governmental supports, operational research works and, policy implementation issues.

6.2.1. Community Participations

The negative attitudes of public such as social stigma and discrimination in general and cooperation of governmental sectors should be expanded through strong awareness-raising program at different levels. These problems may be reduced by way of increasing the awareness and involvements of parents of children with disabilities, their neighborhoods and advocating governmental sectors those providing different public services such as education, health, transport, and private sectors in general. The ultimate goal of the increasing awareness and involvement of community members at large should be directed towards making these children able to benefit form the services of the society. These tasks may help these children to develop ownership like the non-disabled people.

6.2.2. IEC and Advocacy Programs

One of the approaches of increasing knowledge and understanding of the community about the problems of children with disabilities is through IEC and Advocacy programs. Hence, the following tasks should be in place:

a) Concerned organization sectors should disseminate information, education and other communications services for the public in general.
b) Basic advocacy programs should be forwarded in at appropriate places such as at public services, in schools and other relevant settings.
c) All concerned organizations should also create network for advocating and supporting the development of services for children with disabilities.

6.2.3. Intervention Programs

The possible intervention strategies for children with disabilities are so various and one needs to consider the following suggestion as components of the holistic approach:-

a) The overall desirable intervention programs should encompass sectors who have adverse effects in changing the life challenges of children including family members, schools, concerned governmental and Non-governmental organization and community in general.

b) The foreseeable intervention program should support parents of children with disabilities to alleviate their socio-economics burden to address and cope up with existing social life.

c) Most of these children enter schools at late age since there are no strong early intervention programs in the country. Hence, there is need to establish day care centers for children with disabilities that might accessible to and affordable to them.

d) A realistic intervention programs for children with disabilities should be in place considering the limited resources, existing traditional beliefs, social stigma and discriminations and poor infrastructures, negative public attitudes and other related factors within the community.

e) Like any non-disabled children, special priority should be given to children with disabilities at all levels of intervention programs including in Ethiopian national action plan for children.

6.2.4. Co ordinations and networking

a) It is useful to establish a national networking body whose members might be consist of relevant governmental, Non-governmental organizations and civil societies to address the problems of child-trafficking in general and that of children with disabilities in particular. This body may initiate, coordinate, monitor and supervise projects/programs that are designed to mitigate the problems of children with disabilities including child-trafficking practices in Ethiopia.

b) Alternatively, GOs and NGOs working upon children's rights in general and children with disabilities in particular should create a forum for coordination and networking activities and other issues.

6.2.5. Good Governance

Primarily, the governmental of Ethiopia has ratified and accepted international conventions about of the children's rights in general. However, currently, the involvements of concerned governmental sectors are very minimal. Hence, the governmental sectors at all levels need to perform the following tasks in collaborations with other implementing organization:

a) The government of Ethiopia has to make clear the reason for disagreement with UN protocol to prevent, suppress and punish trafficking in person, 2000.
b) Concerned governmental sectors should participate in awareness-rising programs and advocate for the rights of all children in general and for children with disabilities in particular.
c) Concerned governmental sectors should provide both financial and technical supports for children with disabilities at different public services such as in educational programs, health care and services, communication services, and at all levels.
d) Concerned governmental sectors should encourage and promote private sectors to invest their capital in this sector and also create forum for donation for children with disabilities.

6.2.6. Research perspectives

a) A further detail study should be in place to know and understand the magnitude and characteristics of the different multiple challenges of children with disabilities specifically. Hence, specific comprehensive studies are highly required at national and regional levels since they could give paramount importance for improvements of the life these children.
b) A comprehensive survey should be conducted to have disaggregated data on children with disabilities and non-disabled children to design holistic intervention projects/programs across the country.
c) In the mean time, action-oriented research works should be in place to understand and examine how the sought intervention programs are actively working and changing the livelihood of children with disabilities.

REFERENCES

Abeje Berhanu (1998). **The situation of survival strategist of Female Street children in Addis Ababa. Addis Ababa :** FSCE- Ethiopia.

Ayalew, et al (1996). **A study on the problems of street mothers and their children in** Addis Ababa. ANPPCAN- Ethiopian Chapter. Addis Ababa.

ACRWC(2005). African Charter on the Rights and Welfare of the Child In collaboration with save the children alliance. Addis Ababa: Andenet printers.

Brockner and Lioyd (1986). Self-esteem and liability: **Journal of Research in personality** 2014: 496 - 508

Byrne, L (1998). **The human right of street and working children.** London: ITP.

Carr-Hill, R, et al (2002). The impact of HIVAIDS on education and institutionalization preventive education. Paris: International Institution for educational planning (IIEP)

Coleridge, P (1993). **Disability, Liberation and Development**. Oxford: ADD.

Coombe, C (). **The new challenges to education**. A collection of Essays. Paris: IIEP

Cohen, (1984).

Corsini and Auerbach(1996).Concise Encyclopedia of Psychology. New York: John Wiley and Sons.

CSA (1998).**The 1994 Population and Housing Census of Ethiopia. Addis Ababa: CSA**

CYAO (1995). **Ethiopia Youth Basic challenges and prospects. Addis Ababa**: CYAO.

CYFWO (1997). **Convention on the Right of the Child. Addis Ababa .Norway Save the children.** Children, Youth, and Family Welfare Organization (CYFWO)

CYFWO (1997). **The situation of unaccompanied homeless children. Addis Ababa** Children, Youth, and Family Welfare Organization (CYFWO)

Daniel Yilma(2005). ANPPCAN-Ethiopia Chapter child-trafficking in Ethiopia: Situation Analysis. Paper presented on Eastern and Horn of Africa regional conference on human trafficking and forced Labour. Nairobi, Kenya

Dolan and white (1988) "issues of consistency and effectiveness in coping with daily Stressors: **Journal of Research in personality**. 22(3):397-407.

Eronen, R.L et al (1997). "Planned - oriented, Avoidant and impulsive social reaction style" **Journal of Research in personality** 31 (1) : 34-57

EWA and IOM (2001). Report of the National workshop on Traficking of Women form Ethiopia. Ethiopian women's affairs sub-sector and Internationals organization for Migration(IOM). Addis Ababa.

FDRE (1998). **Policy on HIV/AIDS of Ethiopia**. The Federal Democratic Republic of Ethiopia (FDRE). Master printing press. Addis Ababa.

FSCE (2005). Annual report 2004. Forum on Street Children-Ethiopia (FSCE). Addis Ababa: Central printing press.

Folkman, S .and Lazarus, R.S (1980). "An analysis of coping in middle-aged community Sample. **Journal of Health and social behavior**. 21:219-239.

FSC-Ethiopia (n.d).**Preventive and supportive program against child-trafficking**: Objectives and accomplishments. Addis Ababa: Ethiopia

FSC-Ethiopia (2005). **Annual Report 2004**. Addis Ababa: Ethiopia

Gobena Daneil (1995. **Children vice news letter of ANNPCAN- Ethiopian Chapter.** APPCAN: Addis Ababa.

Hecht, J (1998). At home in the street children of North east Brazil. New York: Cambridge University press.

Habtamu Wondimu (ed) (1996). **Research paper on the situation of children and Adolescents in Ethiopia.** Addis Ababa: A.A.U. Printing Press.

Halperin, D.S, et al (1996). Prevalence of child sexual abuse among adolescents in Schools: BMJ: London.

Kohala, H(1997).Providing special education. Helsinki: Uusimaaoy

Kirchner, Elizabeth (2000). Coping with Parental Depression. The UCI Undergraduate Research Journal. New York: 4: 31-36

Jackson, H(1993). Challenging Disability. Geneva: ILO

UN(1975). **Declaration on the Rights of Disabled Persons.** General assembly resolution 3447. December 9, 1975.

UNICEF(n.d). **Trafficking in Children for Sexual Purpose**: Analytical review. Paper Presented on 2nd world congress against commercial sexual exploration of children.

UNICEF (1991). **Special needs in classroom**. Paris: UNESCO.

UNICEF (1993). Study on the street children in four selected towns in Ethiopia. MOLSA: Addis Ababa.

UNICEF (2005). **Summary report on Violence against disabled children**. UN Secretary General Report on Violence against disabled children. UNCIEF: New York

UNHCR(1994). Refuge children: Guidance on protection and care. Geneva: UNHCR.

USAID (2003). Assessment of the magnitude of women and children trafficked within and outside of Ethiopia. USIAD: Addis Ababa:

Wang, Y(2005). **Anti-Human trafficking program in Vietnam**. Hanoi: Oxfam Quebec.

Wegayehu Tebeje (1981). Planning and delivery vocational rehabilitation training at the People's Heroes center. Addis Ababa University: Addis Ababa.

Wolman, B.B (1977). International encyclopedia of psychiatry, psychology, Psychoanalysis and Neurology. New York. Aescularius.

Ysseydke and Agozzine(1995). **Special Education**. Boston: Houghton Maffin Company.

Varma, V(1996). **Coping with Children in Stress**. Aldershot: arena

Zautra, A.j and Wrabetz, A.B. (1991).coping success and its relationships to Psychological distress for older adults. **Journal of personality and social Psychology.** 61(5): 801-810.

Zahl, P.A(1962). **Blindness.** Modern approaches of the unseen environment (Ed.) New York: Hafner Pub- Company.

Appendix A STRUCTURE INTERVIEW

This interview is designed to collect information on ***children with disabilities*** about different types of life challenges and experiences: Child-trafficking, Streetism HIV/AIDS issues and other life experiences. This study is directed to assess only some of the main problems. The outcomes of the study will serve children with disabilities and concerned stakeholders such as governmental sectors, NGOS and civic society who are addressing the problems question in designing intervention programs in Ethiopia. Due to these facts, your contribution has paramount importance for this study. Hence, you are randomly selected for this interview. Your identification (i.e. Name) and responses will be kept confidential. You have also the right NOT to give any response upon some question you did not want.

Section 1 Background Information

No	Question	Options and Codes	Skip
101	What is your gender?	1.Male 2 Female	
102	How old are you?	Age in completed years_______	
103	What is the highest grade you have completed?	1. illiterate 2.Grade_______	
104	What is your religious?	1. Orthodox 4. Muslim 2. Catholic 5. Other 3. Protestant	
105	To what type of disability do you belong?	1. Visually impaired/ Blind 2. Hearing impairments(Deaf) 3. Physically disability(any) 4. Mentally Retarded(MR) 5. Others(Specify)_______	
106	What is your current martial status?	1. Single(Never married) 2. Married 3. Divorced 4. Widowed 5. Separated	
107	To what ethnic group do you belong?	1. Amhara 4. Afar 2. Oromo 5. Gurage 3. Tigray 6 Others--------	
108	What is the estimated monthly income of your household or your family?	Monthly income birr________ Do not Know, record 96	
109	What is the size of your family size?	Total family size_________	
110	Do you have problems in getting health care and services	1.yes 2.No	
111	If you say yes to Qu .110, what are the problems	Write it	

SECTION 2 STREET LIFE

No	Question	Options and Codes	Skip
201	Have you ever lived /joined a street life?	1.Yes2. No	
202	How many years or months did you have live in the street?	Write in full______ Month/years	
203	If your response to Qes.401 is yes, what was the first impression about street life?	1.Fear 2. Surprise 3. Uncertainty 4. Pleasure	

		5. Others(Specify)_______	
204	How did you get food on the street?	1.Begging 2.Selling small articles 3.Daily Labour 4. Shoe shining 5.Others(specify)___________	
205	What is the common place for sleeping?	1.Open air 2. Plastic shelter 3. in some corridors 4. Communal living(others) 5. Others(Specify)__________	
205	On average, what is your daily income?	Birr_________ Cents_________	
208	Do you have any feeling of worry?	1.Yes 2. No	
209	Have you ever liked street life?	1.Yes 2. No	
210	Do you take drug addicts such as chat, alcohol, etc, in the street?	1.Yes 2. No	
211	If you say yes, how frequent was the practices of sexual abuse?	1. Once 2. Twice 3. several times	
212	Do you think that your relatives know that you are living on the street?	1.Yes 2. No	
213	Is there any possibility for you to go back home?	1.Yes 2. No	

Section 3 CHILD-TRAFFICKING

No	Question	Options And Codes	Skip
301	At what age did you leave your place of origin?	Age of leaving______ full During--------years	
302	What are the means used to convince or force you to come out from house or other city?	1. 1 Abduction 2. payment made to family 3. Deception 4. With my own interest 5. Others(Specify)_____	
303	What is the major reason for leaving your birth place?	1.To seek employment 2.Family violence 3.Death of caregivers 4.Lack of substances 5. Escape from early marriage 6. City attraction 7. others(Specify)____________	
304	Did you get consent of your from one of family to leave home?	1. yes 2. No	
305	If your response to Ques.303 is yes, what were your parent's reasons for agreement?	1. Sought financial supports 2. I forced to run away 3. Others(Specify)_______	
306	Did any one encourage/forced you to leave home?	1. yes 2. No	
307	Have you been forced to move or trafficked so far?	1.yes 2.No	

	How many times did you forced or trafficked so far?	Write : 1 time, 2, 3,4, 5,6, etc	
308	What are the means used to convince or force you to come out from house or other city?	1. Abduction 2. payment made to family 3. Deception 4. With my own interest 5. Others(Specify)_____	
309	During first time, who brought you to other place or Addis Ababa city?	1. Relatives 2. Brokers 3. Friends 4. Transportation workers 5. Others(Specify)_______	
310	If your response to Ques.302 is deception, what is the forms deception?	1. Escape from early marriage 2. Promise of employment 3. Promise of education/train 4. Promise of gaining money 5. Escaping domestic violence 6. Others(specify)__________	
311	What was /were the fist occupation/activities you were engaged when you first came to Addis Ababa or other places?	1. Daily Labour 2. Domestic Services 3. Waitress in Hotel/Bar 4. Keeping /cooking in Hotel 5. Sex worker in 'Baluka' 6. Street life/walkers' 7. Begging 8.others(Specify)__________	
312	What was the means in getting (Que.510) the aforementioned job/work?	1. Brokers 2. Balukas 3. Relatives 4. Friends **5.** Others(Specify)________	
313	Now, in what type of job/occupation do you engaged/ working?	1. Daily Labour 2. Domestic Services 3. Waitress in Hotel/Bar 4. Keeping /cooking in Hotel 5. Sex worker in 'Baluka' 6. Street life/walkers' 7. Begging 8.others(Specify)__________	
314	On average, how much birr do your earn per month?	1.Birr__________ 2. Other benefits______________	
315	Are you satisfied with your current work/job activities?	1.yes 2.No	
316	If your response to Ques.no 514 is No, what is the major reason?	1. Low income 2. Delay of payment 3. Physical abuse 4. Sexual exploitation(forced) 5. lack of free time 6. Overwork 7. Lack of sufficient food 8. others(specify)__________	
315	What is the major mal-treatment you have faced after you trafficked to other place or come to Addis Ababa?	1. Physical violence 2. Emotional violence 3. Sexual exploitation 4. Overwork 5. Denali of salary 6. others(Specify)____________	

SECTION 4 HIV/AIDS INFORMATION

No	Question	Options and Codes	Skip
401	Have you ever heard about sexual intercourse?	1.yes 2.No	
402	How old were you the first time you have had sexual intercourse?	Age___(full years) I do not know.......98	
403	Have ever heard of any planning methods so far?	1.Yes 2. No	
404	Have you ever heard about sexually transmitted disease of HIVAIDS	1.Yes, 2.No	
405	From what sources of information have you heard most about HIVAIDS?	1.TV/Radio 2. Social gathering 3. Health facilities 4.Church/Mosques 5. School/college 6.School club 7. Peer groups/ relatives 8.Poster/leafelet 9.others(Specify)______	
406	Have ever heard of any method to avoid HIV infections?	1. yes 2. No	
407	What can a person can do to avoid getting HIV virus? *(Don't read the following options, just listen to what she/he saying and circlet one).* 1. Abstain from Sex. 2. Avid blood transfusion 3. Use of condom 4. Avoid injection with unclean needle 5. Limited sex to one partner 6. Others(Specify)______________________		
408	Do you know any child (ren) whose parents have died from AIDS?	1. yes 2. No	
409	Other than HIV/AIDS, have you heard of any other infection that can be transmitted through sexual contact?	1.Yes 2. No	
410	Have been sexually abused?	1.Yes 2. No	

Section 5 Psycho-Social Problems

No	Question	Options and Codes	Skip
501	Do you have a classmate or a friend?	1.yes 2.No	
502	What are the most severe social problems do you face so far in school or out of school?	1.Lack of interaction with other 2.Being withdrawal from other 3.Difficuly of making friendships 4. Isolation 5. Aggressive behaviors	
503	What are the most severe psychological problems do you have or faced so far in school or out of school?	1. Negative attitude 3. Neglect 4. Dependent on adults 5. Repetitive stereotyped behaviors 6. lack of attaining positive self-concept 7. others(specify)_________	

SECTION 6 COPING MECHANISMS

No	Question	Personal factors	Social factors	
601	Which on of the following coping styles do you often employ in stressful situations in general?	1. problem solving 2. Accepting responsibility 3. confronting coping 4. escape 5. Avoidance/denial 6. positive appraisals 7. seeking for social support 8. other(specify)________		
602	Which one of the following coping styles do you often employ to overcome stressors and difficulties in school settings/home environment?	1. hard work and effort 2. Commitment and willingness 3. Strong desire and devotion 4. Patience and tolerance 5. Spiritual strength 6. Good communicator 7. Developing self confidence 8. Accepting oneself\ 9. Others__________	1. Peer group 2. Family members 3. related Association 4. Active in social activities 5. Religious people 6. Access to education 7. Successful person 8. NGOS 9. others__________	
603	Which one of the following coping styles do you often employ to overcome stressors and difficulties in out-school places/Community?	1. Hard work and effort 2. Commitment and willingness 3. Strong desire and devotion 4. Patience and tolerance 5. Spiritual strength 6. Good communicator 7. Developing self confidence 8. Accepting oneself 9. others__________	1. Peer group 2. Family members 3. related Association 4. Active in social activities 5. Religious people 6. Access to education 7. Successful person 8. NGOS 9. others__________	

Appendix B KEY INFORMANT INTERVIEW SCHEDULE

Dear/Madam: First of all I would like to thank you for cooperation and willingness to participate in this interview session.

The principal purposes of this study are to identify the major causes, consequences and problems of children with disabilities: Child-trafficking, Streetism, HIVAIDS, abuses and violence, and other psychosocial problems particularly in Addis Ababa city. The study will be useful for various professional, organizations and policy makers who could make valuable contribution in the area. You are selected for this study because you can provide additional information upon the issues. However, all information obtained will be kept confidential.

1) What do you know about UN protocol on trafficking in Person?

   ____

2) Do you know the problems of child-trafficking particularly of children of with disabilities in Addis Ababa city? 1. Yes 2. No

3) Who are the major perpetrators or facilitators/actors in child-trafficking practices among children with disabilities into city/town?

   ____

4) What are the major causes of child-trafficking practices among person with disabilities?

   ____

5) The commonly used/ types of deception approaches for child-trafficking with disabilities.

6) What are the major consequences of child trafficking particularly on children with disabilities?
   a) Physical violence
   b) Emotional violence
   c) Sexual exploitations
   d) Overwork
   e) Making a means of begging
   f) Making long-hours work
   g) Denial payment or salary
   h) Others(Specify)______________________________

7) What do you know about children with disabilities whoa are in/on the street?

   ____

8) Do you know the effects of HIV/AIDS issues on children with disabilities?

   ____

9) What do you about sexual abuse/violence of children with disabilities?

   ____

10) What is the level of involvement of your organization in combating child trafficking practices?

   ____

11) What measures (if any) are planned to be taken or ongoing by your organization to fight against the problems of child-trafficking practices?

12) Do you have plans to combat/minimize the problems of child trafficking in city of Addis Ababa? 1. Yes 2. No

____

13) What are the major viable measures that should be taken to minimize victims of child-trafficking of children with disabilities?

a) Providing broad skill training opportunities
b) Increasing employment opportunities
c) Providing better public services
d) Guidance and counseling services
e) Reunification with families
f) Developing integrated credit schemes
g) Other(Specify)__________________________________-

14) What are the possible intervention measures to be taken to minimize and rehabilitate child-trafficking problems?

10.1). To rehabilitate victims.

Type of services	Constraints	Observed outcomes

10.2). To Minimize the problems

Type of problems	Constraints	Observed outcomes

15) Do you know the major institutions (GOs, NGOs, civil societies, religious organizations, private people, etc) that are participating and should be involved against child trafficking practices at regional and National levels?

Name of the organizations	At regional level	At National levels

16) What are the major viable measure of combating the problems of trafficking of children with disabilities at different levels:

12.1) Local level:

a) National campaign
b) Research/survey

c) Promoting IEC/Advocacy Programs
d) Creating continuous awareness- raising programs
e) Building Networking
f) Others(Specify)________________________________

12.1) Regional l level:

g) National campaign
h) Research/survey
i) Promoting IEC/Advocacy Programs
j) Creating continuous awareness- raising programs
k) Building Networking
l) Others(Specify)________________________________

12.1) National level:

m) National campaign
n) Research/survey
o) Promoting IEC/Advocacy Programs
p) Creating continuous awareness- raising programs
q) Building Networking
r) Others(Specify)________________________________

17) Do you have any other comments to combat the problem of child-trafficking practices in this city?

____

THANK YOU FOR YOUR COOPERATION!

Appendix C Guidelines for Focus Group Discussion (FGD)

Dear participants:
This discussion form is conducted to get information upon multiple challenges of children with disabilities in Addis Ababa. Each participant is expected to participate actively and share hi/her experiences and opinions depending upon life experiences. All information obtained through this discussion will be kept confidential.

1) The major reasons of children of leaving their home places

____

2) The active facilitators/ actors in child-trafficking at all levels.

____

3) Current activities/occupations of trafficked children and levels of satisfaction

____

4) The major problems the trafficked-children have faced after leaving home.

____

5) What are the sexual/emotional problems that trafficked-children have faced?

____

6) Streetism and HIVAIDS of children with disabilities____________
7) What are the psychosocial and coping mechanisms of children with disabilities?
8) The current family relationships and future plans______________
9) Measures that should be taken to minimize multiple challenges of children with disabilities?____
10) Other comments____

Appendix D LIST OF KEY INFORMANT ORGANIZATIONS

No	Name of the organization	Position of informant	Location	Address(Tel)
1	Cheshire Foundation-Ethiopia /Addis Ababa Branch office	Assistant office head	Addis Ababa	011-156-6162
2	Cheshire Foundation-Ethiopia /Addis Ababa Branch office	Administrative head	Addis Ababa	011-156-6162
3	Handicap National for children with disabilities	Project supervisor	Addis Ababa	011-275-6356
4	Ethiopian National Association For Mentally Retarded Children and Youth/SOOM	Head of the office	Addis Ababa	011-663-1866
5	Ethiopian National Association For Mentally Retarded Children and Youth/SOOM	Mentally retarded teacher	Addis Ababa	011-663-1866
6	Forum on street children –Ethiopia	HIV/AIDS officer	Addis Ababa	011-55-4722
7	Forum on street children –Ethiopia	Child-trafficking head	Addis Ababa	011-55-4722
8	ANPPCAN-Ethiopian chapter	Program officer	Addis Ababa	011-
9	Ministry of Labour and Social Affairs(MOLSA), Family and Children Department			
10	Handicap international-Ethiopia	Deputy Country Representative	Addis Ababa	011618-1572
11	Cheshire Services-Ethiopia(CSE)	Project officer	Addis Ababa	011-123-4796
13	Addis Ababa city child protection Unit	Team leader	Addis Ababa	011-1118989
14	Addis Ababa Bus station Child-trafficking Office	Head	Addis Ababa	011-6541921
15	Medical Missionaries of Mary Center (MM)	Vice Administrative head	Addis Ababa	011-1221209
16	Medical Missionaries of Mary Center (MM)	Assistant to Disability Team	Addis Ababa	011-1221209
17	Misrach Handcraft Training &Rehabilitation Center	Assistant program head	Addis Ababa	011-1234528

BIOGRAPHY

Full Name **NEMME NEGASSA YADATA**
Date of Birth **JUNE 12/1966**
Place of Birth **ABUNNA/SHAMBU, ETHIOPIA**
Previous Educational Background
BA in Psychology, Dept Psychology,AAU, 1987
Certificate in Pop and RH Research, Mahidol Universiy, 2000, Bangkok, Thailand.
MA in Pop and RH Research, Mahidol University in 2003, Bangkok, Thailand
Certificate in Postgraduate Course in Reproductive Health/Sexual Health Research WHO's scientific committee/2005.

PREVIOUS POSITIONS AND EXPERIENCES

a) Teaching and Training Profession: Training/teaching kindergarten teachers, primary school Teachers and primary school directors at Asela, Harar, Adama and NeqemtTeachers'Training Institutes(TTIs).
Teaching Psychology course at Asela Nurse School, College of Commerce, School of Radiography, Centralized Nursing School and Undergraduate Medical Students of Faculty Medicine, Addis Ababa University, Ethiopia.
Teaching Demography course at DTRC and Population Health and Reproductive Health for MSC students at Centralized Nursing School, Faculty Medicine,AAU.

b) Leadership Positions:

- **Head,** Guidance and Counseling Office at Senior Secondary Schools, Arsi Zone Educational Department (1987-1995);
- **Head,** Department of Pedagogy, Asela TTI.
- Arsi Zone Branch **Manager,** Oromiya Development Association (ODA, 1996-1999);
- Reproductive Health **Team Leader**, National Office of Population (NOP, 2000-2002);
- **Administrative Manager** of health projects, Faculty of Faculty Medicine, Addis Ababa University (AAU, 2003-2004).

Present Occupations: **Secretary-General**, Ethiopian Society of Population Studies (ESPS)
Project Manager, AMREF-Ethiopia, Addis Ababa, August,2006.

Field of Study and Marks: Master of Art (M.A) in Special Needs Education, and **Excellent**

Present Educational Status: The first person with Psycho-Demographer's Specialization in Ethiopia: MA in Psychology and MA in Population and Reproductive Health Research.

August, 2006
Addis Ababa, Ethiopia

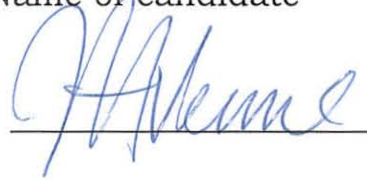
DECLARATION

(Singed)

The thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used for the thesis have been duly acknowledged.

Name: NEMME NEGASSA YADATA

Name of candidate

Signature: 

Date: JULY 17/2006

This thesis has been submitted for examination with my approval as university advisor.

Professor Tirussew Teferra		July 17/2006
Advisor	Signature	Date