ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF ALLIED HEALTH SCIENCES

DEPARTMENT OF NURSING AND MIDWIFERY

ASSESSMENT OF SEXUAL BEHAVIOUR, EXPLOITATION AND ITS DETERMINANTS AMONG ORPHAN AND VULNERABLE CHILDEREN IN ADDIS ABABA, ETHIOPIA, 2014

BY: AYANA CHIMDESSA (BSC)

RESEARCH THESIS SUBMITTED TO SCHOOL OF GRADUATE STUDIES, ADDISABABA UNIVERSITY, DEPARTMENT OF NURSING AND MIDWIFERY SCHOOL OF ALLIED HEALTH SCIENCE IN PARTIAL FULFILLMENT OF THE -- REQUIREMENTS FOR THE DEGREE OF MASTER IN CHILD HEALTH NURSING

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APPROVED BY THE BOARD OF EXAMINERS

This thesis by Ayana Chimdessa is accepted in its present form by the Board of Examiners as satisfying thesis requirements for degree of masters in child health nursing.

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Acronyms and Abbreviations

AIDS Acquired Immuno Deficiency Syndrome

CES-DC Center for Epidemiological Studies Depression Scale for Children

EDHS Ethiopian Demographic and Health Survey

EMOH Ethiopian ministry of Health

FDRE federal democratic republic of Ethiopia

FGD focus group discussion

HIV Human Immune deficiency Virus

HAPCO HIV/AIDS prevention and control office

NGO non-governmental organization

OVC orphan and vulnerable children

OAC orphan and abandoned children

STI Sexually Transmitted Infection

SSA sub-Saharan Africa

TS transactional sex

UNAIDS Joint United Nations Program on HIV/AIDS

UNICEF united nation

WHO World Health Organization

IGA income generating activities

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Abstract

Background: The increased sexual risk and exploitation among orphans and vulnerable children and its associated physical, psychological and social consequences is becoming a major public health concern globally. The number of orphans has risen significantly in recent years in Ethiopia. Understanding the magnitude of risky sexual behavior and exploring factors underpinning this behavior are pivotal to address the needs of orphan and vulnerable children (OVC) and mitigating the negative outcomes of the growing OVC population worldwide. However, there is paucity of information in this regard in Ethiopia.

Objectives: To assess the sexual practices, exploitation and its determinant factors among OVC in Addis Ababa city.

Methodology: community based cross sectional study and phenomenological qualitative methods was conducted from March to June 2014 in Addis Ababa, Ethiopia. Quantitative data was collected from OVC who were got community based care from three organizations, selected by systematic sampling using self administered questionnaire and phenomenological qualitative methods use focus group discussion (FGD) and interview of street children. Logistic regression and open code were used to analysis data.

Result : The study participants who were double orphans were about five times more at risky sexual behavior than the respondents who were maternal orphan only P=0.005, COR (95% CI) 5.455(1.674,17.770).

The multivariate risk sexual behavior shows that, orphans, who were living with others (non-relatives and far extended relatives) were about four times more at risky sexual behaviors than those who live with their mothers [(P=0.033, AOR (95%CI) 3.849(1.116,13.272)].

Many street children were forced to have coercive sex with strangers and older street children.

Conclusion: About 50 (44.6%) of OVC started early sexual intercourse to get basic need and followed by 39 (34.8%) of them start to facilitating social connection in their living environment.

About 96 (85.7%) of OVC did not use a condom regularly while they had sexual intercourse with their partner.

Sexual relationship among street children is widespread among the street groups and with outsiders, multiple partnerships is common.

Obviously, these findings suggest that orphan children were at high sexual risk behavior and exploitation next to the death of their income earner through their lack of basic needs.

Key words: orphan and vulnerable children, street children, risky sexual behavior, sexual exploitation, Addis Ababa.

Introduction ion

1.1. Back ground

The increased sexual risk and exploitation among orphans and vulnerable children (OVC) and its associated physical, psychological and social consequences is becoming a major public health concern throughout the world. An estimated 143,000,000 children worldwide had been orphaned. The number of orphan and vulnerable children is increasing in Sub-Saharan African countries. Studies showed that 12% of African children lost one or both parents(1)**.**Children who lost one or both parents may experience deepening poverty, school dropout, discrimination and stigma(1)**.**Orphaned children are at an elevated risk of early onset of sexual relations and sexual exploitation, which raises their risk of contracting sexually transmitted diseases, including HIV/AIDS (2).

The number of orphans has risen significantly in recent years in Ethiopia. The Ethiopian health and demographic survey revealed that from all children below the age of eighteen 28% were orphans among this 14% were paternal orphans 3% maternal orphans and 11% were double orphans (3).HIV/AIDS is one of the major cause of orphan hood. According to Federal Ministry of Health report of 2007, there were 5.4 million OVC in Ethiopia(6) and out of these, about 1 million were AIDS orphans**(2).**

Children from HIV/AIDS-affected households report experiencing stigma and discrimination on many levels and in all aspects of their lives (1).

Studies identified that OVC suffer from neglect and are vulnerable to STIs including HIV/AIDS, early pregnancy and poverty especially in Sub- Saharan Africa.(4).OVC are at increased risk of sexual exploitation, child labor, abuse and child prostitution to care for their sick family or younger brother and sister, and to win their daily life(3)**.**

Addressing the needs of orphans and vulnerable children and reducing the associated negative outcomes is a high priority for national governments and international stakeholders and it is becoming a social, economic, and human rights issue(4).

1.2. Statement of the problem

HIV/AIDS is a global challenge affecting people in their reproductive age and its effect on children, family and community is alarming. Globally, an estimated 35.3 (32.2–38.8) million people were living with HIV in 2012. There were 2.3 (1.9- 2.7) million new HIV infections in the world(5). In 2012 alone there were 1.4 million adult deaths from HIV/AIDS which resulted in increasing number of orphans. Studies indicated that there were 17.3 million orphans due to HIV/AIDS globally. Out of these majority of OVC (90%) live in Sub-Saharan Africa and Southern and Southeastern Asia (6).

There are an estimated 5.4 million orphans in Ethiopia, with around 25% of these believed to have been orphaned as a result of HIV/AIDS (6). According to 2007 census conducted in Ethiopia there were 145,052 orphans in Addis Ababa city administration, out of these 29,264 were double orphans, most of them are orphaned due to HIV/AIDS (6). It is indicated that one in five of the older children had lost one or both parents by age 15, and one in ten of the younger group by age 8 in Ethiopia. The number of children on the streets of Ethiopian cities is estimated at 160,000, and is expected to grow. Many become child laborers, beggars or even sex workers in a order to survive(6).

Children who lost their parents are at increased risk of physical, psychological, social, health, and economic problems. Orphan and vulnerable children may fall prey to sexual exploitation and abuse and may be forced to engage in high risk behavior that may predispose them to the risk of contracting HIV and other STIs (8). They may lack access to basic needs such as shelter, food, clothing, health care and education (8).

Orphaned adolescents are at a higher disposition for sexual risks compared to their non-orphan peers. A study of 1,694 South African youth found that14-18 year-old orphans were 1.38 times more likely than non-orphans to have engaged in sex(7). Different studies in Sub-Saharan Africa shown that orphan adolescents of age 15–19 are vulnerable to socioeconomic deprivations and sexual and reproductive health risks that are often associated with poverty, as they lose their income earners(7). Orphan and vulnerable children were most likely to experience physical and/or sexual abuse (8).

Studies conducted in southern Africa have documented higher rates of HIV among orphans. OVC have been found to have a higher likelihood of being sexually active, initiate sex at an earlier age, and have unprotected sex and multiple partners(9),Street children are highly prone to sexual abuse, rape, prostitution, sexual bartering and exchange, and casual sex that increase their risk of acquiring sexually transmitted infections including HIV(10).

Understanding the magnitude of risky sexual behavior and exploring factors underpinning this behavior are pivotal to address the needs of orphans and vulnerable children and mitigating the negative outcomes of the growing OVC population worldwide. However, there is paucity of information in this regard in Ethiopia. Therefore, it is the purpose of this study to assess the sexual practices and exploitation as well as its associated factors among OVC in Addis Ababa, Ethiopia.

1.3. Significance of the study

Understanding the sexual practices and sexual exploitation of OVC and identifying its determinant factors would be assist policy makers and program planners implementers to make evidence-based decisions about how best to direct program activities and maximize positive outcomes for children and their care takers. The study findings would help government, non government organizations and others to design better strategy to improve the right and care of OVC in the future. In addition, the findings add to the existing literature on the care and support of OVC. Furthermore, from this study, lesson can be drawn for designing gender responsive intervention for OVC in a national way. This study would also help to suggest concrete preemptive measures to reduce vulnerabilities of adolescent OVC to risky sexual practice, exploitation and thereby reduce STI and HIV/AIDS.

Finding of the study also provide valuable information to policy makers and other stake holders in the field of care and support for OVCs and also this study would enable academic and researchers to use the information as spring board for other related studies and also as a reference in their data banks.

II: Literature review

According to OVC Desk Review findings children orphaned and made vulnerable by the HIV/AIDS epidemic, malaria, TB, and other factors especially in Sub- Saharan African's and so afflicted by poverty, hunger, disease, pregnancy complications(11). HIV was contribute to vast increases in the numbers of AIDS-orphaned children and adolescents defined by the UN as peers Cons of age 0-18 years who have lost at least one parent to HIV/AIDS. Studies indicate that there were 17.3 million orphans due to HIV/AIDS globally. Out of these majority of OVC (90%) live in Sub-Saharan Africa and Southern and Southeastern Asia(12).

2.1. Sexual practice of orphan and vulnerable children

Studies suggest that orphaned adolescents are at a higher disposition for sexual risks compared to their non-orphan peers. A study of 1,694 South African youth found that14-18 year-old orphans were 1.38 times more likely than non-orphans to have engaged in sex(7). Different studies in Sub-Saharan Africa show adolescents of age 15–19 are vulnerable to socioeconomic deprivations and sexual and reproductive health risks that are often associated with poverty, as these children lose their parents especially due to HIV/AIDS, these risks increase adversely, as they lose their income earners(7).

The study conducted in south province of Rwanda shows that, 98.8% of respondents were aware that abstinence from sex was a prevention measure And also the same study that conducted in Rwanda indicate that only 57.9% reported use of condoms and 23.7% reported being faithful to one sexual partner as prevention measures (13). The study indicate that the large majority of respondents (85%) knew someone who had died of AIDS, however, more than two thirds (68.9%) indicated they had no risk or possibility of contracting HIV and only 3.2% believed they had a high risk of HIV infection In the study conducted in Rwanda Thirty-three percent of

respondents reported ever having had sex (n = 228) According to the study conducted in Rwanda condom use during intercourse was very low for both males and females (8.3%)(13).

According to research conducted in 5 low and middle-income countries, non-orphan sample experienced fewer event categories than the sample of orphaned and abandoned children, yet 87% reported at least one event; 13% experienced 4 or more types of events. Death of a family member (79%), physical and/or sexual abuse (70%), and witnessing family violence (50%) were the most commonly reported events.

Abandoned children were most likely to experience physical and/or sexual abuse (84%), followed by double orphans (79%). Double orphans were most likely to have witnessed family violence (59%) and to have had to leave home (42%)(8).

Four studies conducted in southern Africa have documented higher rates of HIV among orphans and these Studies suggest that increased rates of sexual risk behavior may help to explain this disparity. Orphans have been found to have a higher likelihood of being sexually active, initiate sex at an earlier age, and have unprotected sex and multiple partners(9), because of the majority of orphaned children live as street children where their living conditions makes them severe deprivation, which place them at all kinds of health risks. Several studies that exist on the sexual behaviors of street children show that these children engage in behaviors that put them at risk of sexually transmitted infections(10), specially the aspect of economy, most of the households accommodating orphaned adolescents in rural Uganda are particularly susceptible to poverty due to loss of one or more income earners, this makes them high risk for STI, because to get the basic need they become to sexually abused children(13).

The study conducted in Rwanda indicate that, logistic regression results indicate that youth under age 18 had a significantly lower adjusted odds ratio (AOR) of being sexually experienced (AOR = 0.60) and The study shows that respondents who moved more than two times during the last

five years, had a history of using marijuana, or perceived risk of HIV infection had a significantly higher likelihood of being sexually experienced (AOR = 1.85, 9.77, and 1.95, respectively).

Among the most serious threats to health of street children is the high degree of exposure to sexual abuse, rape, prostitution, sexual bartering and exchange, casual sex and romantic sexual relationships are among the factors that increase their risk of acquiring sexually transmitted infections. These factors, in addition to early exposure to both heterosexual and homosexual behaviors' place them at risk of STIs including HIV(10).

Throughout sub-Saharan Africa (SSA), transactional sex (TS) occurs to meet varied needs including cash, goods(14),or to gain social status. Power differentials leave women little room to refuse sex or negotiate condom use and can lead to sexual violence, early pregnancy, and HIV and sexually transmitted infection(15).

According to studies in Liberia, the transactional sex group, when compared with other student participants, reported greater increases in sex partnerships and frequency of sex and greater reductions in protective sexual attitudes and HIV risk perception at the nine-month follow-up, in both the intervention and control groups. The TS group was more likely to try to get pregnant (or get someone pregnant) and was more likely to ever engage in anal sex(16).

According to these research, Fifteen percent of the sample reported ever engaging in TS at the nine-month follow-up survey, among those who engaged in TS, 41% were female. Among this group of females, 52% were "promised something" in exchange for sex, 26% reported that they had been "promised something" and that they "promised something to someone else, "while 22% reported only "promising something to someone else" in exchange for sex. Among males who engaged in TS, 52% reported that they had engaged in both behaviors, while 30% reported only "promising something" to others while 18% reported being "promised something by someone else" in exchange for sex(16).The children who lose both parents especially leave the home and

live as street children, according to studies conducted in five low and middle-income countries, it indicates that orphaned children, especially double orphaned children have had to leave home 42% and these children live as street children(8).

There is existing evidence that these children engage in sexual activity either in exchange for money or seeking protection and sometimes either by being forced. One of the similar studies by Sharma, depicts that street children both at pre-puberty and puberty involved in unsafe sexual activity not only with the opposite sex but also with the same sex and mostly elder boys forcibly indulge in anal sex with the younger boys(17). Similar studies, also support that street children, (boys mainly) prefer homosexual relations and practice anal sex with fellow boys as boys are easily available(18). The study conducted in Malawi, suggests that, street children are a high risk group to HIV and STI, it revealed that boy/girl sexual relationship was widespread among the street children. These is due to, established the core business in these relationships was sexual intercourse. If there were no girls, boys involved in sexual activities with fellow boys; mostly the bigger boys would prey on the smaller boys or those boys that are new on the streets(10).

If orphans are at increased risk for HIV and if psycho-social and economic challenges contribute to this elevated risk, it becomes critical to target orphans for HIV and STI prevention efforts that aim to mitigate these factors(9),and introducing risk reduction programmes to their vulnerability would be of great importance. These practices might be amenable to brief cultural interventions and that the provision of night shelters to the homeless children can be a potential benefit to reduce the risk of sexual abuse and other risk sexual behaviors(10).

2.2. Sexual exploitation situation on orphan and vulnerable children

Studies have demonstrated ill effects of being an orphaned or abandoned child (OAC) in resource poor countries, including traumatic grief, poverty, impaired cognitive and emotional development, less access to education and greater likelihood of being exploited as child labor.

Other reports describe the challenges faced by families and communities in providing food, shelter, health care, and education for increasing numbers of OAC while the number of potential caregivers is diminishing due to increasing age-adjusted mortality(19).

Street children expressed experiencing sexual exploitation and view themselves as vulnerable to sexual exploitation that could predispose them to the risk of HIV/AIDS as well as other Sexually Transmitted infections. Furthermore, the street environment offers no protection against such vulnerability(10).

The streets have become the place where children orphaned and made vulnerable by HIV and STI and other causes, often turn to supplement lost wages, find refuge, and sometimes to find an escape from stigma. While on the street, children can be exposed to rape, drug abuse, child labor, including child prostitution, and other forms of exploitation, making them more vulnerable to contracting STI and HIV/AIDS. Children as young as nine years old have been found to be engaged in sex work(20).

Kenya has become infamous for its exploding population of street children, who lose their family to HIV/AIDS, who are known for committing petty crimes, like stealing cell phones and wallets, mostly because they have no other means of survival. Many analysts have expressed concern that the growing number of orphaned children and those on the streets are increasingly rootless, uneducated, under nurtured and traumatized, making them ready for recruitment for crime, military warlords and terrorists. Some are particularly concerned that orphans and other children affected by HIV/AIDS can become easy conscripts for warring factions, as they search for food, shelter, nurturing, and safety(20).There is also an existing evidence that these children engage in sexual activity either in exchange for money or seeking protection and sometimes either by being forced which makes them sexual abused(9).

One of the similar studies by Sharma depicts that street children both at pre-puberty and puberty indulge in unsafe sexual activity not only with the opposite sex but also with the same sex and mostly elder boys forcibly indulge in anal sex with the younger boys. Similar studies, also support that street orphan children, (boys mainly) prefer homosexual relations and practice anal sex with fellow boys as boys are easily available. The incidence of sexual abuse in form of homosexual and bisexual practice on the street is considered to be high**(21).**

Annual UNICEF report indicates that, Vulnerability is not limited to orphans; experience of violence and abuse is widespread. At least 21% of girls‟ first sexual encounter is forced and the perception that family violence is acceptable is shared by both women and men (48% and 37%, respectively). The combination of poverty, neglect and violence contributes to the large number of children on the move, resulting in unsafe migration and child exploitation(22).

Furthermore, they argue that children have lived among extended family members for some time, particularly in southern Africa, where a significant proportion of the populations are migrant laborers. Those that believe the family networks are strong and can support and adapt to the growing number of orphans point to a study conducted in Cape Town, South Africa, which found that before AIDS was a factor, at some point in their childhoods 18% of Africans surveyed were backed in households that were headed by neither their mother nor father(4).

One study found evidence of sexual abuse victimization associated with later forcing someone else to have sex. A negative sexual experience can also result in a host of negative psychological outcomes including sexual dysphoria, anxiety, eating disorders, substance abuse, depression and even suicide or attempted suicide(23).

A study in a township in Cape Town, South Africa found that women who had experienced coercion were significantly more likely to exchange sex for material needs, have multiple sex partners, engage in high rates of unprotected vaginal intercourse, and have more sexually

transmitted infections STIs and HIV/AIDS(24).Fear of violence can also impact a woman's willingness to take protective action during the time of sexual intercourse. A study among young women in South Africa found that partner violence and the fear of violence prevented girls from saying "no" to sex and compromised condom use(25).

Assumptions about women's sexuality ignore sexual violence. Research in South Africa found that girls' exhibition of sexual unwillingness, which maintains her respectability, opens the door to socially acceptable coercive sexual behavior including violence(26).

The study conducted in south Africa, found in their study of men and women in Cape Town, South Africa that 27% of participants across genders agreed that rape is usually a result of something a woman says or does, 18% felt that some cases of rape involve a woman who wants to have sex and 29% said that rape is often a woman's fault. Ideas such as these make it hard for women to convincing demonstrate to their partner that they do not want to have sex(27).

Sexual coercion has been found to be linked with sexual harassment and increasingly violent sexual behavior which reflect underlying structural factors that contribute to the oppression and exploitation of women(28). Authors of research conducted in Khayelitsha, Cape Town with adolescents conclude that "Violence was not limited to the first sexual act or to the first relationship, but was also reported to be a feature of all subsequent sexual relationships(25).

To the extent that sexual coercion including rape is just the most extreme manifestation of a pattern of gender oppression that includes sexual harassment and gender-based violence, the prevalence and experiences of unwanted sex at sexual debut can be heeded as a measurable manifestation of more widespread abuse and gender oppression(29).

Focus group discussions with 14–19 year olds in Burkina Faso, Ghana, Malawi and Uganda that were conducted as part of the same study as the results being presented in their research paper found that rape or forced sexual intercourse came up spontaneously in the context of a child

being forced to have sex (being "defiled") or in the context of what some men, after drinking alcohol or smoking hemp or marijuana, will do to young women. The latter context was related to men's "uncontrollable" urges or willingness to engage in unprotected sex when under the influence of alcohol or drugs**(30).**

According to the study conducted in sub-Saharan country, the percentage who were "not willing at all" at sexual debut was the lowest for Burkina Faso(15%), followed by Uganda at 23%, Ghana at 30% and Malawi at 38%. Turning briefly to the other response categories, between 20 and 30% were "somewhat willing" in all four countries(29).

Different research indicates that, there are significant associations between sexual harassment and a range of negative reproductive and as well as psychological and emotional health outcomes. The risks correlated with sexual coercion(an individual woman's lack of choice to pursue other options to avoid sexual interactions without severe social and physical consequence) include sexually transmitted infections (which can cause cervical cancer and infertility) including HIV, unintended pregnancy which can possibly lead to unsafe abortion and as a consequence morbidity and even mortality, as well as the onset of risk-taking behaviors including other nonconsensual sexual experiences, multiple partnerships and unprotected sex(31)**.** This condition leads the girls face an added risk of becoming pregnant and some proceed to deliver their infants and undergo the associated problems of early childbearing and motherhood, and the cycle of poverty and street life continues with making them risky to sexual exploitation and harassment.

Evidence from studies around the world shows that sexual abuse is frequently associated with a wide range of adverse health consequences including sexual dysfunction, low self-esteem, alcohol and drug use, depression, suicide attempts, and sexual risk taking

2.3. Factors affecting OVC to risk sexual behavior and exploitation in their life experience

Socio –economic status

Growing up as an orphaned child due to different condition poses psychosocial and economic challenges to these children and the households raising them. To resist the economic problem orphaned children are at an elevated risk for early onset of sexual relations and sexual exploitation, which raises their risk of contracting sexually transmitted diseases, including HIV/AIDS(32). Orphaned adolescents are at elevated risk of growing up in poverty owing to the loss of at least 1 family provider, and usually the deteriorating health of the second member will be occurred because of the death of the earner(33).

Children of parents, who die of whatever the case, suffer from the trauma of sickness, death, and associated hardships. The burden of caring for a sick parent, younger siblings, and of household subsistence often falls to adolescents, and many are forced to drop out of school and prematurely take on adult roles(34). Sexual behavior and abuse increases with school dropout, leaving adolescent orphans more vulnerable to sexually transmitted infection including HIV/AIDS(35).

In Malawi, for example, concerns were expressed about female orphans' spontaneous reporting of exchanging sex for money or goods. Transactional sex is particularly common in African street children among whom orphans may represent the majority(36).Studies in South Africa and Nigeria found that half of the street children have engaged in sex in exchange for money, goods or protection(37).In addition to increased chances of transactional sex, low socio-economic status appears to be associated with women having experienced physically forced sex(38). Sexual abuse is particularly of significance for orphans as studies have shown that forced and coercive sex is a major route for sexually transmitted infections, HIV, and pregnancy(39).

According to research conducted in Rwanda, 10% of females, compared to only 1.6% of males reported having exchanged sex for protection. Almost 7% of females also indicated that they received money or gifts in exchange for sex. Conversely, only 5.9% of males reported ever having been given money or gifts for sex(40). The proportion of condom use at regular sexual inters-course was low for both males and females with more males (14.6%) using condoms compared to females (11%). Among males, the most common reason given for not using condoms was the perception that there was no risk of HIV infection (30.7%). Sixteen percent of females reported that they were forced to have sex or raped and 7.5% indicated that their partner did not want to use condoms, as these children received money for sex they can't resist sex without condom(40). Females reported 46% of pregnancies occurred between the ages of 15-18 and 52% over the age of 18,these condition put these children in extreme poverty and as they remain on the street.

Although there may be various circumstances explaining early onset of sexual activity among YHH in Rwanda, poverty may be an important factor vis-à-vis survive(40). Randomized Controlled Trial study conducted in Zimbabwe, indicate that, by the end of the first year of high school, the intervention reduced school dropout rates by 82% and marriage rates by 63%. Study findings suggest that the intervention increased bonding with school and teachers, this study indicates the economy assaults on OVC on their education and their life(41).

Mental health

There is a clear pattern of higher internalizing problems among orphans in Sub-Saharan Africa (SSA) including more symptoms of depression, anxiety, and posttraumatic stress disorder(21). Data on externalizing problems are mixed, with higher conduct problems among orphans in studies in Uganda and Ghana(42). In the United States, both internalizing and externalizing

problems have been associated with high-risk sexual behavior(43). These both things may cause Poor mental health, lack of or negative caregiver social support, and inadequate economic resources have been cited as possible factors that may increase orphans' likelihood of engaging in behaviors associated with STI and HIV risk. Mechanisms may include compromised decision making, maladaptive coping, and low self-efficacy(43). According to the research conducted in South Africa one-third of the sample (30.3%) reported scores which met the threshold criteria (CES-D≥15) for clinical depression Orphan children tend to manifest more depression, personality disorder, and anxiety/insomnia tendencies than do non-orphans. These orphan children may present psychosomatic symptoms and health worries that may impede positive mental health(44).

Material and emotional supports from parents during childhood may have enduring psychosocial health benefits. These parental supports, which the orphan child may lack, fulfill the affective function of the family to its members(45). Orphans may encounter hopelessness, and frustration often owing to their new circumstance that may require them to not only fend for themselves but also for their younger ones, in some cases(46). (Other studies suggest that children orphaned by AIDS may be unique orphans. They tend to grief long before parental death(s) owing to the debilitating AIDS. Due to the moral shame associated with HIV infection, AIDS-orphaned children may encounter higher stigma/ social discrimination than do other orphan categories(47).

An especially important and distinctive characteristic of HIV/AIDS in regard to orphaning is that AIDS is more likely than other causes of death to create double orphans. With HIV/AIDS, if one parent is infected there is a higher probability that the other parent is or will become infected and that both will eventually die and Surveys consistently show that double orphans are more disadvantaged than single orphans(48). The study conducted in West Africa identifies several care options for the mental health need of the African orphan child. Prominent among them is the

“normative “fostering practice in which parents may allow their children to be reared elsewhere for kinship or economic gains(49).Foster children, however, tend to be unfairly treated in food allocation, domestic chores allocation, and school attendance that may adversely affect mental health(49).

Children orphaned by AIDS, in this study, show significant higher anxiety, lower self-esteem, lower social support, and lower positive mental health factors than do those in the control groups. Double orphans in this study, whether by AIDS- or other-causes show similar levels of psychological health(50).

Care giver and Social Support Systems

Loss of a parent disrupts interpersonal relationships, requiring children to build or shift relationships with new caregivers. In some cases, the death can also lead to decreased social support overall, particularly if children are required to move. Orphans may be more likely to engage in early sexual activity to facilitate social connections. Further, they may lack the communication with caregivers that has been identified as a potential protective factor(51). Qualitative evidence specifically from Nyanza indicates that community leaders, caregivers, and youth perceive that lack of caregiver supervision and emotional support are among the main reasons that orphans engage in risky behavior(52). (Orphans also may not receive the adequate caregiver monitoring that deters risky sexual behavior, female orphans with less supervision may be more likely to engage in transactional sex(53).

Parental death

According to qualitative research conducted in Uganda on 13 orphan children, Orphaned children spoke extensively about the loss of their childhood, their exposure to extended family conflict and their experiences of being socially stigmatized. They said “If my parent was alive, I would be

playing instead of digging, these indicate they are not well get their parents love and affection and economy which help them for basic need(54).

Parents' have importance in children's socialization and protective role in influencing adolescents' sexual risk taking, but orphaned children greatly lose these condition and love and affection of their parents. Studies demonstrate that better quality of family relationships, including parental warmth, support, and connectedness between a child and his/her parent, is associated with lower engagement in sexual risk behaviors, including delayed onset of sexual activity. Another important protective aspect of family support, and one that may be adversely affected by orphanhood, is parent-child communication. Adolescents with more frequent and open parent-child communication, including discussions about sexuality, have shown postponed sexual activity and higher likelihood of condom use(13). Orphaned adolescents, however, lack close parental support and supervision, these children engage in sexual activity either in exchange for money or seeking protection and sometimes either by being forced and these conditions make them more susceptible to sexual risks(13).

Street children who make the street their home and a source of livelihood are inadequately protected or supervised by a responsible adult(55), thus they might be children not necessarily homeless or without families, but are living in situations where there is no protection from responsible adults. Being a street child means going hungry, sleeping in insalubrious places, facing up to violence and sometimes becoming an expiatory victim. It means growing up without companionship, love and protection, having no access to education or medical services, losing all dignity and becoming an adult before even having been a child.

Facilitating Environment

Lack of safer places to spend the night especially for those children that are permanently on the streets predisposes the street children to sexual behaviors that put them at risk of contracting HIV and other sexually transmitted infections. This situation facilitates the sharing of sleeping quarters between boys and girls. At night the street becomes a 'heaven' of all sorts' of characters that include gangster, prostitutes (both male and female), security guards and other villains. This creation of characters prepares an enabling environment that is conducive to sexual exploitation to the street children.

The street becomes very unsafe to the point that street children would do anything just to survive. Some of the survival initiatives on the street by street children include sexual favours to the dominant 'scavengers' in exchange for protection, food, shelter and other favors that would facilitate the life of the street child on the street tolerable.

The main contributing factor as the study indicates was lack of safer places to spend nights especially those children that are permanently on the streets. This was because both boys and girls used the same sleeping place(10).

Theoretical Framework

This study uses the Ecological systems theory. The theory views different individuals as interacting systems (57). OVC, like any other human being within the environment, may be influenced by the environment in which they live and in turn the environment influences the OVC bringing in a reciprocal relationship.

The theory underlines that sexual behavior cannot be fully understood without considering the broader context the individual lives. It has the notion that sexual behavior is influenced by factors operating at individual, parent/guardian, school, community and organization levels.

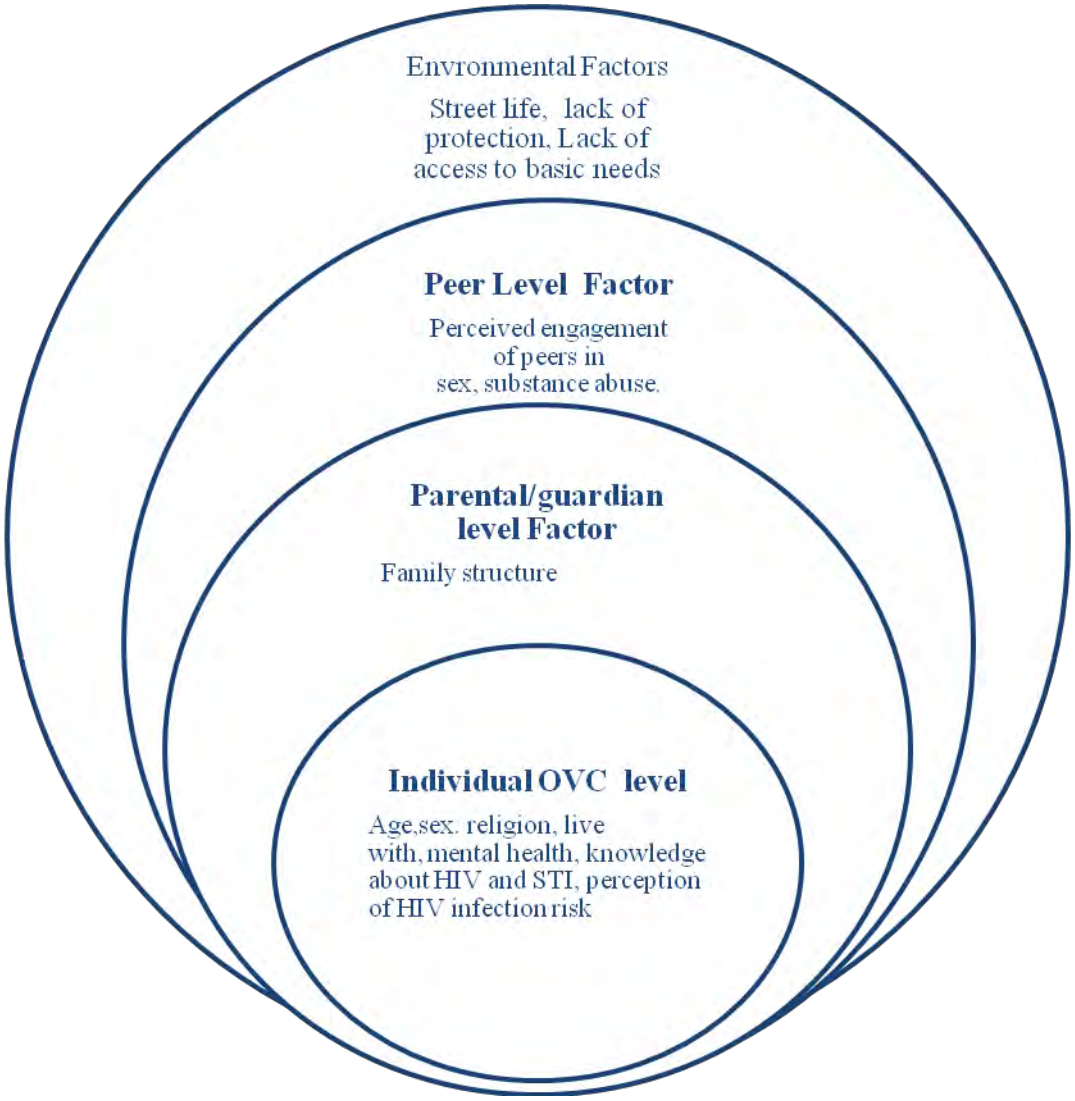

Figure 1: Urie Bronfenbrenner's levels or nested systems as related to the OVC's sexual practices.

III: Objectives

3.1: General objectives

The main objective of this study is to assess the sexual practices, exploitation and its determinant factors among orphan and vulnerable children (OVC) in Addis Ababa city.

3.2: Specific objectives

1. To assess sexual behavior of orphan and vulnerable children
2. To assess sexual exploitation of orphan and vulnerable children
3. To identify factors affecting OVC to risky sexual behavior and exploitation

IV: Methods and materials

4.1. Study area

The study was conducted in Addis Ababa, the Capital City of Ethiopia. The city is set up with 10 Sub-cities and 99 kebeles. It covers an area of 530.14 square km. According to the health and health indicator of Ethiopia 2006, its projected gross population size is 3,059,000. In Addis Ababa there are many governmental and non-governmental organizations that work with OVC. There are 90,000 orphan children due to HIV/AIDS in Addis Ababa city administration.

4.2. Study Design

The study employed a quantitative cross-sectional study triangulated with phenomenological qualitative study.

4.3. Source and study population

All orphan and vulnerable children who get community based care from three organizations (HAPCO, save the children and PACT)

Inclusion Criteria:

All orphan children found in the age group 13-18 years, who get community based care and orphan street children whose ages were between 15-18years were included in this study.

Exclusion criteria:

Orphan children of age below 13 years, and orphan street children whose age is below 15 years were excluded from this study. Orphan children who had hearing problem and acutely sick or unconscious during the study period were also excluded from this study.

4.4. Sample size and sampling techniques

Sample size

The sample size was determined using the following assumptions and formula.

1. Considering the absence of previous data on the specific study area and to obtain large sample size, this study assumed a prevalence of 50% of risky sexual practice among OVC (P= 0.5).

2. 95% confidence Interval (Z= 1.96)

3. A 5%margin of error (d=0.05)

4. A 10% allowance for non-response rate

$$N = (Z\alpha/2)^2 P(1-P)/d^2$$

Therefore: $$n = \frac{(1.96/2)^2 x 0.5\ (1-0.5)}{(0.05)^2}$$

384 +38 = 422

The phenomenological inquiry consisted of in-depth interview of orphan street children and FGD each group consisting of 5-10 male and female streets OVC aged between 15-18 years. Both FGD and in-depth interview for street children was conducted until the level of information redundancy or information saturation.

Sampling procedure

There are three organizations supporting OVC in Addis Ababa: Addis Ababa HAPCO, save the children and PACT as community based care. The determined sample size was assigned proportionate to the total orphan and vulnerable children population in these three organizations. Then, OVC for the study was selected using a systematic sampling method. The starting number was randomly chosen from the first three from the list of OVC in each of the organization. Every third OVC was taken from the three organizations until the assigned number was reached. The diagrammatic presentation of the sampling procedure is shown in figure 2.

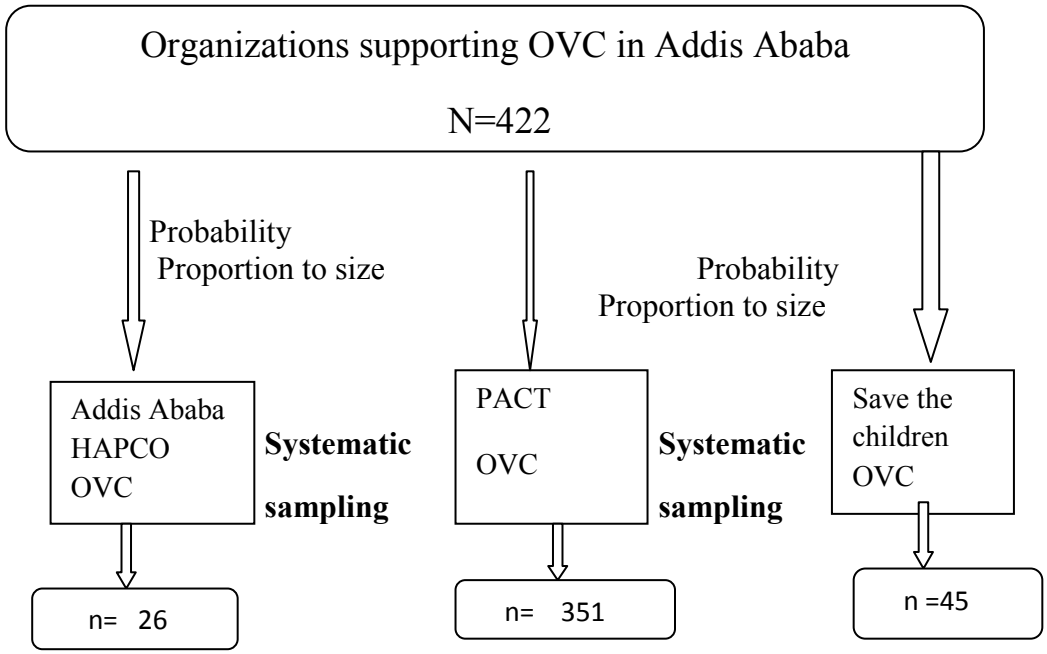

Figure 2: Diagrammatic representation of the sampling procedure

.4.5. Data collection procedures

Quantitative study: Closed ended structured Amharic questionnaire was used for data collection. The questionnaire was adapted from previous literature (58). The questionnaire was prepared in English and translated in to Amharic, then back to English to check for consistency of meaning. Finally the Amharic version was used for data collection. The main components of the questionnaire are: socio-demographic characteristics, sexual practices, sexual exploitation and determinant factors for risky sexual behavior and exploitation.

Six BSC nurses facilitated the data collection and two supervisors, who have experience on both qualitative and quantitative data collection, were recruited to supervise the data collection process and all of them took training for a minimum of two days on the objective and procedure of the study.

Qualitative study- Semi- structured open-ended questions were used to explore the life experience of orphan on street (age ranges between 15-18 years) on how they earn their daily wages, food, education, adapt themselves to new environment, make socialization with new person they get on the street, place they stay overnight, feeling and consequence after their family death, how they get protection while they are on street by in-depth interview, lasting for a minimum of 60 minute and FGD lasting 70 minute (each age category males and females had separate sessions) in order to get more insight in to the life experience of orphan street children, on risky sexual behavior, exploitation and factors affecting it. All interviews were conducted in a private place. Permission to use a tape recorder for the interviews was obtained from the participants prior to the interviews. The principal investigator moderated the discussion with the assistance of trained note taker and tape recorder.

4.6. Variables

Dependent variable– sexual behavior and sexual exploitation

Independent variables- Socio demographic variables (Age, sex, live with, religion), knowledge on STI and HIV/AIDS and perception of HIV infection risk, sexual practices, environmental factors, metal health, peer influence, substance abuse, access to basic needs.

4.7. Operational definition

Orphan and vulnerable children –are child who's their ages are 13-18 years, lost their family to different situation and has been in or are likely to be in a risky situation and are likely to suffer significant physical, emotional or mental stress that may result in children's rights not being fulfilled.

Sexual behavior/practice in this study sexual behavior is how the orphan children practice and behave that put them under a risk of STI including HIV/AIDs.

Exploitation- is the sexual abuse of orphan children through the exchange of food, shelter, protection, money, drugs, and other need of life for sexual acts or sex.

Orphan Children live on street: children who spend all their days and night on the streets and in public place.

Multiple sexual partner- More than one sexual partner at the different time

HIV/AIDS related risk factors- those who had sex earlier than 18 years of age, or have sex with non-regular partner or have more than one sexual partner or use condoms inconsistently or do not use condom at all.

Substance Abuse: Poor lifestyle that predispose to STI and HIV Infection including chat chewing, alcohol drinking, cigarette smoking and other drug use.

Poor knowledge- those participants who answer the asked question about HIV/AIDS less than 15 out of 30 question.

Good knowledge- those participants who answer the asked question about HIV/AIDS more than or equal to 15 questions.

4.8. Data quality assurance

The questionnaire was translated first into Amharic and back to English to assure its consistency. The questionnaire was pre-tested on OVC, at Adama town, Oromia region who are not included in the study to assess for clarity of questions, their sensitiveness as well as understanding of the study subjects about the questions. Discussion was held with advisor, principal investigator and data collectors, based on the result of the pre-test and accordingly, some amendments were made. Two days training were given to the supervisors and data collectors on the procedure. Data were checked for completeness, accuracy, clarity, and consistency by the supervisors and the principal investigator on daily basis. Any error or ambiguity and incompleteness were corrected accordingly.

In addition to assure the quality of data:

- Supervisors and data collectors was selected based on their abilities and skills
- Data collectors were trained by the principal investigator about the objective of the study and ways of data collection
- Data collectors were encouraged to have a field work diary to put all the notes of the field work for latter consideration.

- Each data collector and supervisors were checking the questionnaires for completeness before winding up the interview with each study participant.
- The principal investigator rechecks 10% of the questionnaires at the end of each data collection day.

4.9. Data Analysis procedures

Data were first interred to Epi Info 5.3.4 and exported to SPSS 20.0 Statistical package to clean and analyze the data. Frequencies, Proportions, mean and summery statics was used to describe the parameters investigated. Association between dependent and independent variables were assessed and presented using odds ratios and confidence intervals. Logistic regression was done to control possible confounders related to risky sexual behavior and exploitation.

The qualitative inquiry was analyzed using content analysis. The transcribed note was translated. Following this, coding was done using themes that were priory listed and those developed during translating and reading the transcript. Researchers identified and holding in any preconceived beliefs and opinions that may have about the phenomenon that is being researched and next to this intuiting the data. After this analysis of the data that include coding, categorizing and making sense of the essential meanings of the phenomenon. Researcher comes to understand and describe the phenomenon. Results were written by reorganizing, summarizing and quoting when needed.

Ethical consideration

Ethical clearance for the study was received from Addis Ababa University, College of Health Sciences, Department of Nursing and Midwifery. A formal letter was written to all concerned authorities and permission was secured at all levels.

Since the study subjects are younger than 18 years written assent was taken from study subjects and consent was taken from the care giver or guardians after explaining the purpose and procedure of the study.

Audio tape recording of the in-depth interview and FGD was made after getting informed consent from interviewees. Participation in the study was voluntary and information that was collected from the study subjects was in any way confidential.

V: Results

5.1. Results of the quantitative study

A total of 422 orphan children were interviewed and 407 orphan and vulnerable children were included in the analysis. Fifteen respondents were excluded from the analysis for gross incompleteness and inconsistency responses and made a response rate of 96.4%.

5.1.1 Socio demographic characteristics

More than half 231 (56.8%) of the respondents were female, and 176 (43.2%) of them were male. All respondents were teenagers whose age ranges between 13-18 years. Mean age of respondents was 16±1.22 years with minimum age of 13 and maximum age of 18.The largest proportion of the respondents 218(53.6%) were single orphans whose either mother or father were alive but unable to meet the needs of their children due to one of income earner death. Out of the respondents 161(39.8%) and 114 (28%) of the OVC were from Amhara and Oromo ethnic group respectively. The highest proportion 293(72%) of the respondents were orthodox Christians and 66 (16.2%) were followers of Muslim religion.

With regard to the living situation of OVC and their caregivers, from 407 OVC respondents, only 218 (53.6%) were currently living with their parents (they were either paternal orphans or maternal orphans) and 21 (2.7%) were cared for by relatives, (uncles /aunts and brothers or sisters) and 32 (7.9%) were living with non relatives and far extended relatives.

Table 1: Socio- Demographic characteristics of OVC in A.A, Ethiopia, 2014 (n=407)

S no	Characteristics	Frequency	
		Number	%
1	**Sex**		
	1.Male	176	43.2
	2. Female	231	56.8
2	**Age (mean:** 16±1.22)		
	1.13-15	152	37.3
	2. 16-18	255	62.7
3	**Religion**		
	1.Orthgodox	293	72
	2.Protestant	32	7.9
	3.Catholic	13	3.2
	4.Muslim	66	16.2
	5. other	3	0.7
4	**Ethnicity**		
	1. Amhara	161	39.6
	2. Oromo	114	28
	3. Tigre	32	7.9
	4. Gurage	58	14.3
	5. Silte	25	6.1
	6. Others	17	4.2
5	**Live with**		
	1. mother	192	47.2
	2. father	26	6.4
	3. grand father or mother	76	18.7
	4. relatives	70	17.2
	5. others	43	10.6

5.1.2: Sexual Behavior of orphan and vulnerable children

5.1.2.1. Knowledge about HIV among orphan and vulnerable children

Of the 407 study participants 392(97.3%) of them heard about HIV/AIDS. Almost 100% of the respondents had one or more misconceptions about HIV transmission and prevention. Of all 121(29.7%) had a close relative or close friend who is infected with HIV or has died of AIDS. Concerning about HIV transmission 129(31.7%) said a person can get the HIV virus from mosquito bites, 16(3.9%) said a person can get HIV by sharing a meal with someone who is infected and 398 (97.8%) indicated that a person can get the HIV infection by using a contaminated needle. In addition, 23(5.7%), 327(80.3 %), 331(81.3%) of the respondents reported that a person can get HIV from eating raw meat prepared by a person infected by HIV, and from HIV infected mother to her unborn child and through breastfeeding respectively (Table 2).

Regarding HIV prevention 310(76.2%) of orphans reported that correct and consistent use of condom protects from HIV. Furthermore, 338 (83.0%), and 356(87.5%) of the participants indicated that people can protect themselves from HIV by having one uninfected faithful sex partner, and by abstaining from sexual intercourse respectively (Table 2).

Table 2: knowledge of OVC about HIV/AIDS in A.A, Ethiopia, 2014 (n=407)

Serial no	Characteristics	Frequency	
		no	%
1	Heard about HIV /AIDS		
	1. yes	392	96.3
	2. no	15	3.7
2	Can people protect themselves from HIV/ AIDS by using a condom correctly every time they have sex		
	1. yes	310	6.2
	2. no	97	23.8
3	Do you have a close relative or close friend who is infected with HIV or has died of AIDS?		2
	1. Yes	121	9.7
	2. No	286	70.3
3	Can mosquito bites transmits HIV virus from person to person		
	1. yes		
	2. no	129	31.7
		278	68.3
4	Can a person get HIV by sharing a meal with someone who is infected?		
	1. Yes	16	3.9
	2. No	391	96.1
5	Can a person get the HIV infection by using a contaminated needle?		
	1. Yes	398	97.8
	2. No	9	2.2
6	Can a person get the HIV virus from eating raw meat prepared by a person infected by HIV?		
	1. Yes	23	5.7
	2. No	384	94.3
7	Can people protect themselves from HIV by having one uninfected faithful sex partner?		
	1. Yes	338	83.0
	2. No	69	17.0
8	Can people protect themselves from HIV by abstaining from sexual intercourse?		
	1. Yes	356	87.5
	2. No	51	12.5
9	Do you think that a healthy-looking person can be infected with HIV, the virus that causes AIDS?		
	1. Yes	266	65.4
	2. No	141	34.6
10	Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?		
	1. Yes	327	80.3
	2. No	80	19.7
11	Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?		
	1. Yes	331	81.3
	2. No	76	18.7

5.1.2.2. Knowledge about sexually transmitted infections (STIS) among orphan and vulnerable children

A total of 382 (93.9%) study participants heard about sexually transmitted infections. Concerning symptoms of STIs 337 (82.0%) of the participants said lower abdominal pain, 226 (55.5%) genital discharge, 223 (54.8%) burning sensation during urination and 59 (14.5%) itching in the groin (Fig 2).

Out of the total respondents 251 (61.7%) of them were not tested for HIV. The reasons cited for not being tested for HIV were, 132 (52.6) not at risk, 43 (17.1%) fear of might have HIV, 30 (11.9%) don't know where to go for such test and 46 (18.3%) and fear of other people's reaction if their test result is positive. From the total participants 22 (5.4%) of them know that they are HIV positive (Table 3).

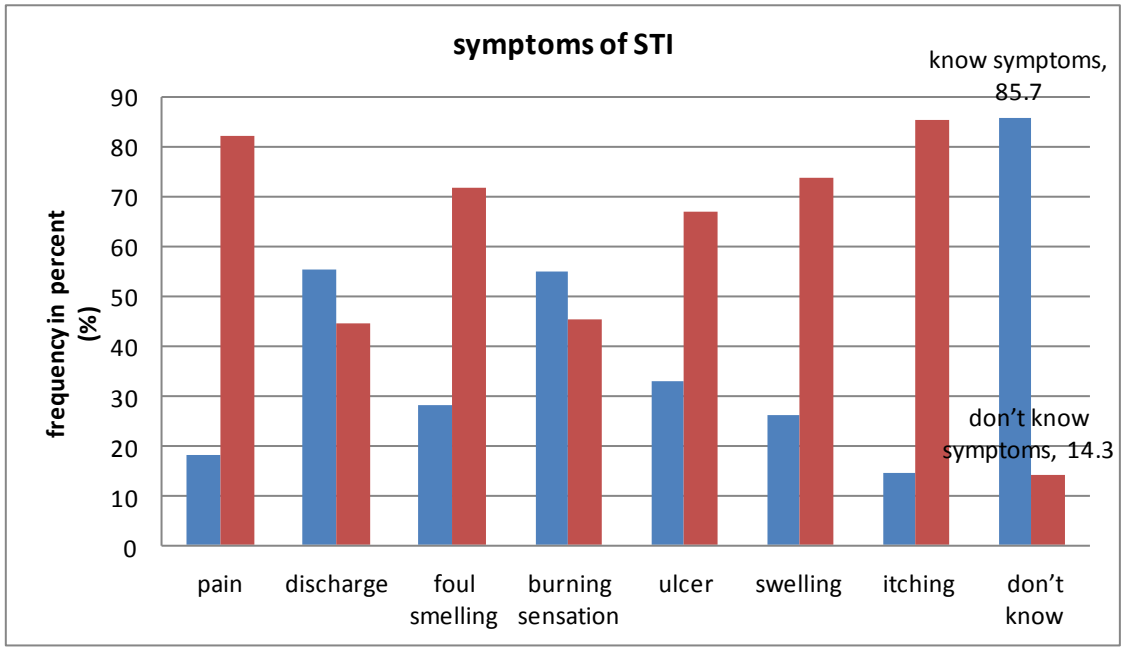

Fig 2: Knowledge of orphan and vulnerable children about STIs symptoms in Addis Ababa, Ethiopia 2014 (n=407).

Table 3: knowledge of OVC about STI in A.A, Ethiopia, 2014 (n=407)

S no	Characteristics	Frequency	
		No	%
1	Has anybody ever told you that you had a sexually transmitted disease?		
	1. Yes	29	7.1
	2. No	378	92.9
2	Have you ever been tested for HIV?		
	1. Yes	156	38.3
	2. No	251	61.7
3	If you are not tested why?		
	1. I am not at risk	132	52.6
	2. I fear I might have HIV	43	17.1
	3. Don't know where to go	30	11.9
	4. Fear of other people's reaction if	46	18.3
	5. my test result is positive		
4	Has anybody ever told you that you are HIV positive?		
	1. Yes	22	5.4
	2. No	385	94.6
5	Have you ever received treatment for HIV or HIV related symptoms?		
	1. Yes	22	5.4
	2. No	385	94.6
6	Have you ever had sexual intercourse?		
	1. Yes	112	27.5
	2. No	295	72.5
6	If you have started sex early, why you start early?		
	1. To facilitate social connection	43	38.4
	2. To get basic need	54	48.21
	3. To get protection	15	13.4
7	Did you or your partner use a condom regularly to protect yourself against HIV when you had have sex?		
	1. Yes	16	14.3
	2. No	96	85.7
8	Has anybody ever told you that you are HIV positive?		
	1. Yes	22	5.4
	2. No	385	94.6

5.1.2.3. Sexual practice of orphan and vulnerable children

Overall 112 (27.5%) of the respondents had sexual intercourse of these 50 (44.6%) started sexual intercourse before the age of 10 to get basic needs followed by 39 (34.8%) to facilitate social connection in their living environment. Out of OVC who started sexual intercourse the highest proportion 96 (85.7%) of them did not use condom regularly during sexual intercourse. The reasons for not using condom regularly during sexual intercourse were they hadn't money to purchase 43(38%), didn't have time to purchase 13(12%), their partner would not agree 13(12%) and they don't know they could get HIV 10(9.0%). (Table 3 and Fig 3)

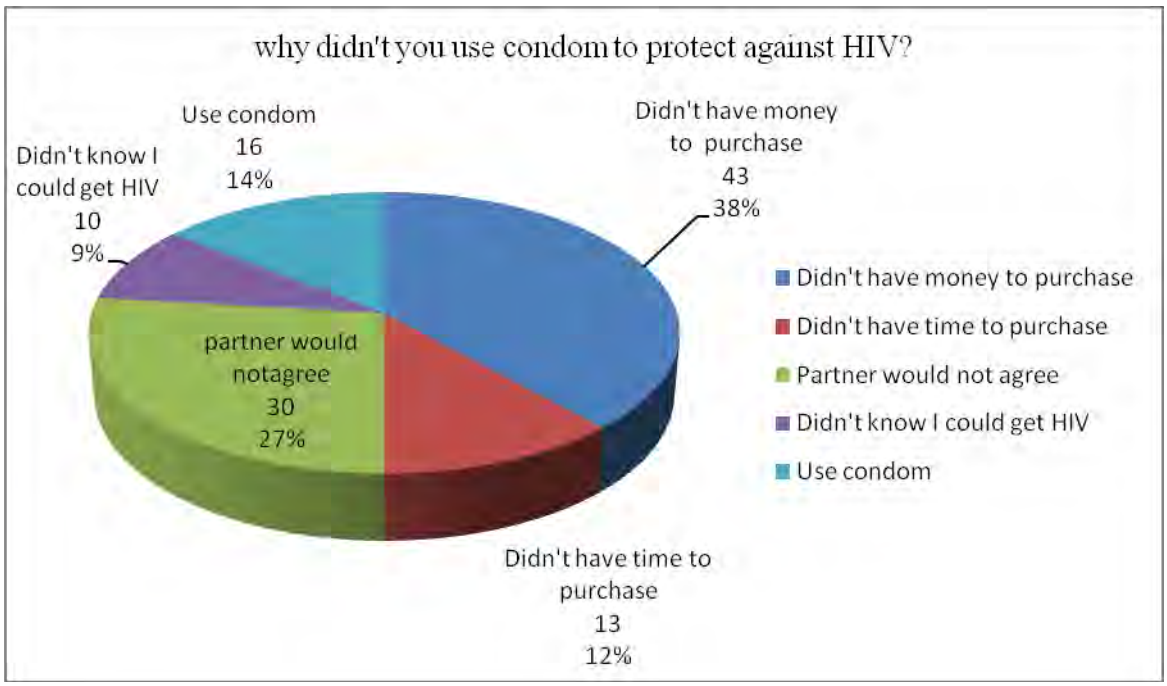

Fig 3: Reasons for not using condom during sexual intercourse among OVC in Addis Ababa, Ethiopia 2014.

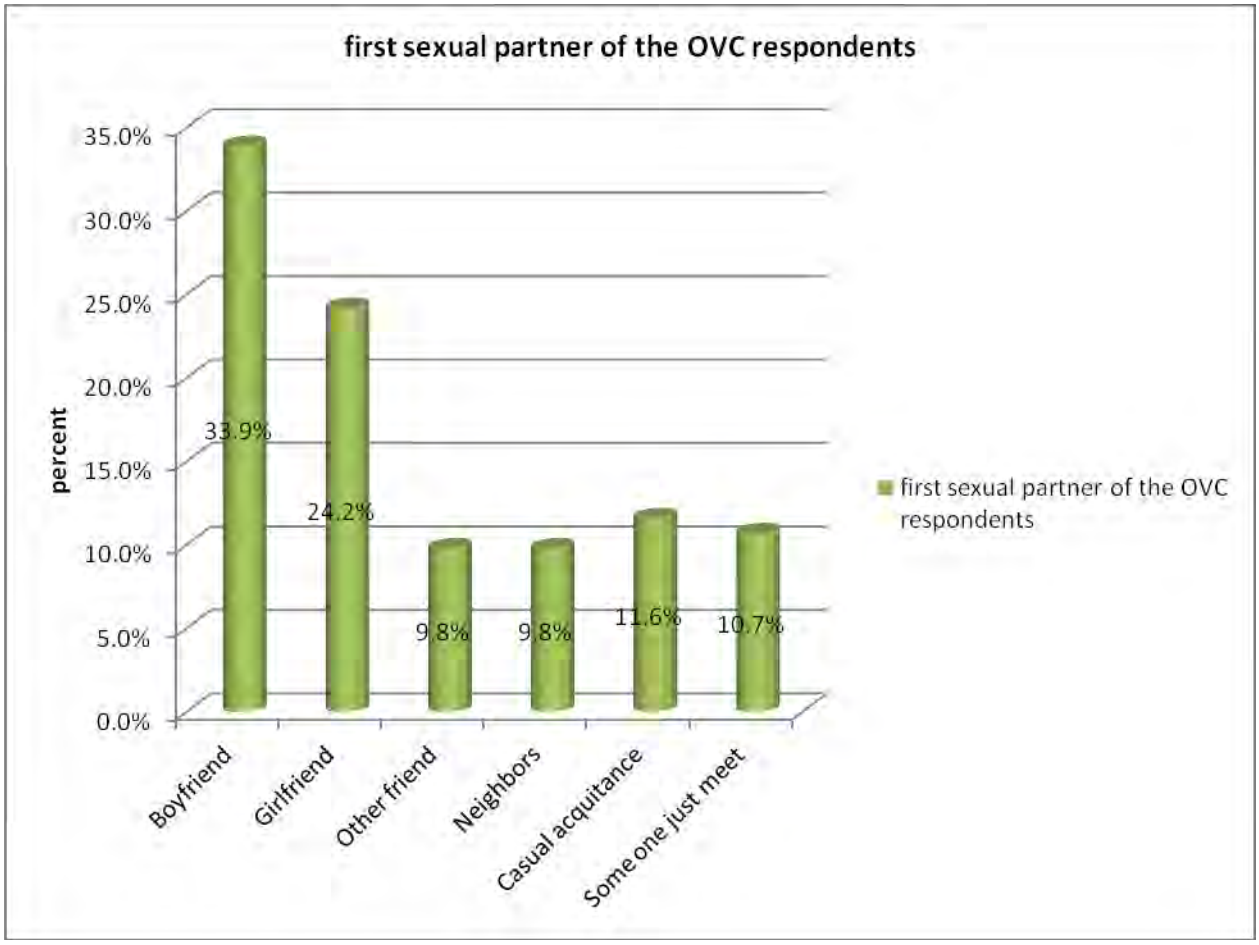

Fig: 3 First sexual partners of OVC respondents in Addis Ababa, Ethiopia 2014.

5.1.3. Sexual exploitation of orphan and vulnerable children

Of the 112 (27.5%) respondents who had sexual intercourse 33 (29.5%) of them reported that they were coerced to have sex in their first sex. Out of the total respondents 160 (39.3%) said that they have pressure to have sex. Of this 66 (16.2%) of the respondents, responded that this pressure comes from their boy/ girl friends, 61 (15%) from themselves, 15(3.7%) from teachers (those who attend school) and 5 (1.2%) from their parent or guardian.

More than half 264 (64.9%) of respondents said they are at risk of experiencing forced sex. With regard to receiving something in exchange of sex of those who had sex 94 (21.3 %) study participants received money, 21(5.2%) were invited alcoholic drinks, 14(3.4%) partners paid school fee, 11(2.7%) partners bought cloth and 3(0.7%) said the partner covered the house rent and 3 (0.7%) received ornaments to have sex. From the total participant 19 (4.7%) of the respondents have been forced to have sex with a person they don't know. Out of the respondents

who had engaged in sexual inter course 76 (67.9%) of their partners were not willing to use condom when they had sexual intercourse with the orphan children.

Table 4: Sexual exploitation of orphan and vulnerable children in Addis Ababa, Ethiopia 2014.

S. no	Characteristics	No	%
1	Was your first sexual intercourse forced (rape)?		
	Yes	33	29.5
	No	79	70.5
2	Do you feel pressure to have sex?		
	Yes	160	39.3
	No	247	60.7
3	Where does this pressure come from?		
	Myself	61	15
	Boyfriend/Girlfriend	66	16.2
	Teacher	15	3.7
	Parent/Guardian	5	1.2
	Other	13	3.2
4	How many of your friends have had sex as your opinion?		
	All	12	2.9
	Most	33	8.1
	Some	157	38.6
	None	205	50.4
5	Do you think you are at risk of experiencing forced sex?		
	Yes	264	64.9
	No	143	35.1
7	Have you given any thing by someone to had sex with him or her?		
	Yes	94	21.3
	No	313	76.9
8	What did they give you?		
	1. Money	31	7.6
	2. school fee	14	3.4
	3. drug	3	0.7
	4. alcohol	21	5.2
	5. house rent	3	0.7
	6. cloth	11	2.7
	7. ornaments	5	1.2
	8. helping home work	6	1.5
9	Have you ever been forced to have sex with a person you don't know?		
	Yes	19	4.7
	No	388	95.3
10	Is there your partner willingness to use condom when you get sex with him/her?		
	Yes	36	32.1
	No	76	67.9

5.1.4. Predictors of risky sexual behavior and sexual exploitation among OVC

The binary logistic regression in table 6 shows that, female respondents were about five times more at risky sexual behaviors than the male respondents (p=0.000, COR (95%CI) = 4.756 (2.697, 8.388). The study participants who were double orphans (maternal and paternal) were about five and half times more at risky sexual behavior than the respondents who were maternal orphan only P=0.005, COR (95% CI) 5.455(1.674,17.770)

Respondents who had no perception of risk of HIV/AIDs infection were about 51.3% more likely to involve in sexual risk behavior than respondents who had perception of risk of HIV/AIDs (p=0.002, COR (95%CI)= 0.487(0.306,0.776).

This findings showed that, participants who live with relatives and others (non-relatives, far extended relatives) were more likely to involve in risky behavior compared to their counterparts p=0.001, COR (95%CI) 3.237**(**2.697, 8.388**)** and p=0.044, COR (95%CI) 2.437**(**0.9924-4.969**)** respectively and also those who live with father were also significant compared to those who live with mother.

The respondents who were under the influence of alcohol during the first time they had sexual intercourse either the respondent only or both the respondent and their partner were about seven and three times more at risky sexual behavior than those who were neither of them under the influence of alcohol p=0.001, COR (95%CI) 7.029(2.143-23.055) and P=0.022, COR (95% CI) 3.195(1.180-8.650)respectively and also those whose partner were under the influence of alcohol alone were two times at risk behavior than those neither of them under alcohol influence.

In the multivariate analysis respondents who live with others (non-relatives and far extended relatives) were about four times more likely to engage in risk sexual behaviors than those who live with their mother P=0.033, AOR (95%CI) 3.849(1.116,13.272) and those respondents who hadn't the perception of HIV/AIDS infection were about two and half at risky sexual behavior than those who had the perception of HIV/AIDS infection p=0.021 ,AOR (95%CI) 2.564(1.153,5.703).

The respondents who were under the influence of alcohol during the first time they had sexual intercourse either the respondent only or both the respondent and their partner were about one

and half and two times more at risky sexual behavior than those who were neither of them under the influence of alcohol p=**0.033**, AOR (95%CI) 1.605(1.328, 8.325) and P=**0.048**, AOR (95% CI) 2.201(1.029-5.214) respectively.

Table: 5 Predictors of condom use among orphan and vulnerable children in Addis Ababa, Ethiopia 2014

Variables	Condom used N (%)	Not used N (%)	COR(95%CI)	AOR(95%CI)
Age				
13-15	12(37.5)	20(62.5)	0.467(0.201-1.082)	
15-18	45(56.2)	35(43.5)	1.00	
Sex				
Male	32(71.1)	13(28.9)	1.00	
Female	34(50.7)	33(49.3)	4.756(2.697,8.388)	
Orphan status				
Double	16(61.5)	10(38.5)	5.455(1.674,17.770	
Paternal	16(28.1)	41(71.9)	1.107(0.44,2.77)	
Maternal	19(65.5)	10(34.5)	1.00	
HIV/AIDS prevention knowledge				
Good knowledge	181(76.1)	57(23.9)	1.050(0.65,1.67)	
Poor knowledge	130(76.9)	39(23.1)	1	
Risk perception				
Yes	99(67.8)	47(32.2)	1.00	1.00
No	212(81.2)	49(18.8)	0.487(0.30,0.77)	2.564(1.153,5.703)
Age at first sex				
13-15	20(62.5)	12(37.5)	2.143(0.99-4-4.96)	
15-18	35(43.8)	45(56.2)	1.00	
Live with				
Mother	151(78.6)	41(21.4)	1.00	1.00
Father	20(76.9)	6(23.1)	1.540(0.17,3.68)	1.655(0.328,8.355)
Grandfather/ mother	64(84.2)	12(15.8)	1.379(0.12,2.13)	0.570(0.178,1.829)
Relatives	52(74.3)	18(25.7)	3.237(2.69,8.38)	0.839(0.271,2.599)
Others	24(55.8)	19(44.2)	2.437(0.99-4.96)	3.849(1.116,13.272)
Willingness first sex				
willing	27(57.4)	20(42.6)	0.213(0.055-0.821)	
Not willing	21(48.8)	22(51.2)	0.151(0.039-0.585)	
	19(86.4)	3(13.6)		
Under the influence of alcohol				
No	22(45.8)	26(54.2)	1.00	1.00
Me only	7(58.3)	5(41.7)	7.029(2.143-23.055)	1.605(1.328,8.325)
Partner only	11(32.4)	23(67.6)	2.401(1.099-5.244)	0.143(0.019,1.081)
Both of us	7(38.9)	11(61.1)	3.195(1.180-8.650)	2.201(1.029-5.214)

Orphan and vulnerable children whose age ranged between13-15 were less likely for sexual exploitation than those aged 15-18 p=0.002, COR (95%CI) 0.430(0.254, 0.729).

The study participants who were double orphans and only paternal orphan were about 94.1% 80.9% less likely at sexual exploitation than those who were maternal orphan p=0.000,COR(95%CI) 0.059(0.015,0.231) and p=0.006,COR(95%CI) 0.191(0.059,0.619) respectively.

Participants who live with relatives (uncle, brother sister) and live with others (non-relatives far extended relatives) were two and half and three times at sexual exploitation than those who live with their mother. p=0.001, COR (95%CI) 2.504(1.153, 5.602) and p=0.000, COR (95%CI) 3.261(2.126, 6.542) respectively.

The multivariate analysis showed that, participants who were paternal orphans were about 88.7% less likely at sexual exploitation than those respondents who were maternal orphan P=0.006, AOR (95% CI) 0.113(0.023, 0.542) and orphan children who had no any perception of HIV infection risk were about 55.4% less likely had sexual exploitation than those who had perception of HIV infection risk P=0.003, AOR (95% CI) 0.446(0.261, 0.764).

Those who live with others (non-relatives, far extended relatives) were two times to have sexual exploitation than those who live with mother P=0.025, AOR (95% CI) 0.376(2.3762(1.0.160, 3.882).

At the last the mental status of orphan were assessed by using depression measure using the Centre for Epidemiologic Studies Depression scale (CES-D), a 20-item measure designed to assess levels of depressive symptom logy (www.brightfutures.org). Scores range from 0 to 60, with a score of 15 or more used to indicate clinical depression in this study only 34(7.4%) orphans fit the threshold of clinical depression.

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Table: 6 shows binary and multivariate regression for sexual exploitation of orphan in Addis Ababa, Ethiopia 2014

Variables	exploitation	No-exploitation	COR(95%CI)	AOR(95%CI)
Age				
13-15	22(14.5)	130(85.5)	0.430(0.254,0.729)	
15-18	72(28.2)	183(71.8)	1.00	
Sex				
Male	37(21)	139(79)	1.00	
Female	57(24.7)	174(75.3)	0.813(0.508,1.300)	
Orphan status				
Double	19(73.1)	7(26.9)	0.059(0.015,0.231)	0.510(0.151,1.727)
Paternal	26(45.6)	31(54.4)	0.191(0.059,0.619)	0.113(0.023,0.542)
Maternal	4(13.8)	25(86.2)	1.00	1.00
HIV/AIDS prevention knowledge				
Good knowledge	57(23.9)	181(76.1)	1.123(0.702,1.799)	
Poor knowledge	37(21.9)	132(78.1)	1.00	
Perception of HIV infection risk				
Yes	51(34.9)	95(65.1)	1.00	1.00
No	43(16.5)	218(83.5)	0.367(0.229,0.589)	0.446(0.261,0.764
Age at first sexual initiation				
13-15	16(50)	16(50)	0.702(0.308,1.600)	
15-18	33(41.2)	47(58.8)	1	
Why early sex				
social connection	22(51.2)	21(48.8)	0.477(0.140,1.631)	
get basic need	23(42.6)	31(57.4)	0.674(0.203,2.241)	
get protection	5(33.3)	10(66.7)	1.00	
Live With mother				
father	28(14.6)	164(85.4)	1	1
grandfather/	7(26.9)	19(73.1)	0.463(0.178,1.204)	0.438(0.157,1.224)
mother	19(25)	57(75)	0.674(0.203,2.241)	0.664(0.314,1.405)
relatives				
others	23(32.9)	47(67.1)	2.504(1.153,5.602)	0.593(0.278,1.261)
	17(39.5)	26(60.5)	3.261(2.126,6.542)	2.3762(1.0.160,3.882)

5.2. Results of the qualitative study

In this interview and focus group discussion 30 n Orphan Street children, whose their ages range between 15-18 years old were participated, for the interview 5 orphans were participated and the rest 25 orphan were participate on FGD and out of this there were only 3 women.

5.2.1. Life in the street: Basic necessities and challenges

Reason for being in the street

The death of parents was one of the main reasons leading to street life. Discussants said ***"most of us joined street life after the death of one or both of our parents. If you don't have parents you will not have any one to fulfill the basic needs. You don't have anyone to take care of you, to support you, to protect you, to love you".***

One interviewee said" the death of a mother was more severe and affects your life a great deal. "***Following my mother's death my father married another woman. This woman was not friendly, she was unloving, she insults and beats me every day, and she was not giving me enough food. Because of this I run away. I joined a street life."*** The discussants and other interviewees also shared this idea. They said ***"loss of parents was the main reason for a considerable number of children to be in the street". If your parents die you lose everything: parental love, means of survival, shelter, security. You and you only, you have to struggle to survive".***

Context of being in the street

The context of the problem of living in the street was described by discussants as: ***"The Street is our home it is our social abode. We live in the streets we eat on the streets. Street life means hunger, deprivation of basic necessities, homeless, sleeping on the ground, passing the day on***

the sun and the night outside in the cold and begging, abuse, exploitation, lack of sense of belongingness, neglect, lack of protection, discrimination, social exclusion, drinking alcohol, drug addiction, and prostitution". The street is our world - a world characterized by miserable deprivation, subjected to physical, verbal and sexual abuse, and become victims of violence. Our life is utterly deplorable, but sometimes, we survive through the act of scavenging through the garbage"

All categories agreed that:" ***the most challenge of living in the street is hunger, cold, rain and police men. Children living in the streets are victimized on a daily basis. Police men consider us as criminals and they strike us without any reason and take our things (jalbo) and sometimes they take us to jail, but most street children are not criminals rather people who live with a problem on the street***".

As one interviewee stated" ***being out of school was the main thing that make me worried. I face different challenges by being on the street: hunger, cold, sleep on the street. The police men consider us pickpocket person but I am not pickpocket person rather searching for daily basic needs to survive***".

They said "***the other most challenge street children face is rain, during rainy season, there is no any roof to sleep under and no enough cloth to wear during the cold and rainy season***.

Income on the street

Three of the Interviewees said that, their main income on the street is through begging, sex work, exchange sex, participating in labor work. One interviewee stated that "you don't have option, ***I had anal sex with strangers in exchange with food, money and goods. If my parents were alive this would not happen to me. But I have to live this way and face the ugly life. The other said in order to survive I participated in heavy work in exchange with breads or cloth***".

Depression, mood fluctuation, stress, frustration and substance use

Three interviewees reported as "***life in the street is misery. You feel hopelessness, your current and future life is dark. We cry out for help but from where? There is no one in our side. At times we feel lonely, we suffer from lack of sleep, anxiety, isolation and face mood depression and to avoid these most of us use different types of substance: like glue, hashish, cannabis, chat and alcohol". The use of substance helps us to temporarily relieve ourselves from the hurdles we face in the street. Even dogs and cats have their shelter but we …we have to hide ourselves from our selves by taking substances.***

The other said ***"to temporarily mask our problem and relived from the cold we take substances"***

5.2.4. Risky sexual behavior, Sexual abuse and exploitation

There is no safe place for street children, "***no safer places to spend the night, both boys and girls sleep in the same place. All types of sexual relation exist in the street, heterosexual, bisexual and homosexual". Sexual relationship among street children is widespread among the street groups and with outsiders, multiple partnerships is common.***

All discussants and participants interviewed pointed that street children are involved in high risk sexual behaviors every day to survive. Participants in this interview described as***" we participate in risky sexual behavior for survival, if we do not involve in this, living on street is impossible. No one to provide you food, rather than dying from hunger we sell ourselves" .***

Non use of condom, inconsistent condom use is common among straight children during sex. ***Interviewees said*** "***condom use depends on our partner's interest. Most partners especially strangers prefer to have sex without condom.***"

Forced sex is common within the street group as well as from outside. Interviewees said***" the most difficult challenge we face is older people living in the street forces the younger one to have anal sex with them (homosexual sex). We street children had no one who can stand for us. As far as you are in the circle you cannot escape except accepting forced homosexual relationships. You don't have any one to protect you. For whom do you cry? ".*** Two groups agreed that***:" we tried to resist this condition by sleeping as a group".*** They reported as:' ***If we get a work and got money we street children spend the night at the bed room called DC which we pay 15 birr per night".***

Out of the three groups two of the group reported as***:"…the other most difficulty street children face was rich people who have car come and talk with us, give us cloth, food, money or other goods, and they take us to their home and after you reach home they force us to have sex (coercive) and transactional sex***". There were many street children who were forced to have anal sex with strangers. One group cited one example ***"One day one of our friends was taken by a rich person who drove his own car to his home after they reached home that rich person forced him to have a coercive anal sex with our friend. We waited for our friend and he come after some time and we asked him as why the rich person took him to his home? Our friend said that he gave him a blanket and one hundred birr. One of our friend who is older than us asked him as "what was the other thing you did with him?" The person who had forced sex was silent he wanted to hide as he had anal sex with the stranger. Our elder friend forced him then he disclosed what he did with the stranger, that he had anal sex with him and after that he gave a***

***blanket and one hundred birr as a transactional sex..*" the other hurt the females might face was 'gelbo' means forced sex on street while she sleep on street at night**.

Bisexual relationship and group sex is common among street children. From the three groups two groups reported as "***we have a girl friend or wife on the street. However, at the same time females also go for sex work with strangers to earn money for survival"***

5.2.5. Knowledge of STI and AIDs

From all categories two of them agree as" ***we know HIV/AIDs and STI".*** Among the group most of them said that:" these diseases can be transmitted by ***lice, sputum expectoration and they tried to list these diseases like relapsing fever, typhoid and typhus***". They said that." ***we street children were at high risk sexual behaviors because of anybody can abuse us as he/she like***". From one category one person said that:" ***these STI was transmitted if the female partner does not practice douching"***. Participants among group person agree that:" to prevent HIV/AIDS and STI I should use condom or other alternative means like' festal'".

Out of the three interviewees "two of them said we know HIV/AIDs and STI. Other participant said that" I heard about HIV/AIDs from kebeles, and he described as " ***it can be transmitted through having sex with infected female, sharp materials like needle and if I drink water with un cleaned (used)cup or nikel I my acquire HIV/AIDs. So, I protect myself from HIV through avoiding walk by bare foot, because sharp materials my pierce my skin, as the result whatever the means, either pickpocket or begging I should wear the shoes and oppositely the third respondent never heard about HIV and STI.***

5.2.6. Drug abuse of street children

All group have the same opinion on the drug abuse, they said that" **all of us use a drug like tej, chat, shisha, glue (mastish) and cigarette and almost all of us used these drugs to make** ourselves out of depression and anxiety". All group agreed that" ***this depression come from thinking the death of family, shortage of basic need and stopping of schooling"*** this idea is also the same for interviewee. ***When we use these drugs we will be in the mood and protect others who got sleep at night"***. All the group said that" ***If we hadn't money to purchase chat or other drug, we collect geraba (garbage) from dirty area mostly from Sumale tera, and chew it and got mood".*** All category said , ***glue ''mastish'' provide us a great pleasure as well it hazardious to our health similarly".***

VI. Discussion

This study provided the opportunity to look at sexual risk behaviors and sexual exploitation among children age 13-18 years living as an orphan in the Addis Ababa community. The results show striking finding on risky sexual behavior and sexual exploitation.

According to OVC Desk Review findings children orphaned and made vulnerable by the HIV/AIDS epidemic, malaria, TB, and other factors especially in Sub- Saharan African and also afflicted by poverty, hunger, disease, pregnancy complications(11). Also in this study the participants joined the street life because of their parental death.

Studies suggest that orphaned adolescents are at a higher disposition for sexual risks compared to their non-orphan peers. A study of 1,694 South African youth found that13-18 year-old orphans were 1.38 times more likely than non-orphans to have engaged in early sex(7) . This study showed similar findings in that, 27.5% of orphan children were engaged in early sexual intercourse.

In this study the respondent's knowledge about HIV/AIDS and risk perception is low compared to studies made elsewhere. (40) The sexual practice of the respondents is comparable with the finding of previous study. Four studies conducted in southern Africa have documented higher rates of HIV among orphans and these Studies suggest that increased rates of sexual risk behavior may help to explain this disparity. Orphans have been found to have at a higher likelihood of being sexually active, initiate sex at an earlier age, and have unprotected sex and multiple partners(9). This study showed that 22(5.4%) of participants are HIV positive.

The findings of this study concur with the results of previous studies. Participants who were under the influence of alcohol were about 1.5 and 2 times more at risky sexual behavior compared to their counterparts.

One of the factors that determine the sexual behavior of OVC is their knowledge about HIV/AIDS and sexually transmitted disease. OVC who had knowledge on sexually transmitted disease including HIV/AIDS protect themselves from risky sexual behavior (7).

The proportion of condom use at regular sexual inters-course was low for both males and females with more males (14.6%) using condoms compared to females (11%). Among males, the most common reason given for not using condoms was the perception that there was no risk of HIV infection (30.7%) and7.5% indicated that their partner did not want to use condoms, as these children received money for sex they can't resist sex without condom(40) but in this study from the respondents who had started sexual intercourse 112 (27.5%) and out of these respondents 50 (44.6%) of them started early sexual intercourse to get basic need and followed by 39 (34.8%) who start due to facilitating social connection in their living environment and out of OVC who had start sexual intercourse highest proportion 96 (85.7%) of them did not use a condom regularly while they had sexual intercourse with their partner and they reason out why they didn't use a condom regularly during sexual intercourse because of they hadn't money to purchase, their partner would not agree and they didn't know as they get HIV which were the indications for socio-economic deprivation of the OVC.

According to research conducted in Rwanda, 10% of females, compared to only 1.6% of males reported having exchanged sex for protection. Almost 7% of females also indicated that they

received money or gifts in exchange for sex. Conversely, only 5.9% of males reported ever having been given money or gifts for sex(40).

Depression Measure—Depression was measured using the Centre for Epidemiologic Studies Depression scale (CES-D), a 20-item measure designed to assess levels of depressive symptom logy (www.brightfutures.org). The CES-D is one of the most widely used self-report depression instruments and has been administered in various settings. Scores range from 0 to 60, with a score of 15 or more used to indicate clinical depression.

The research conducted in South Africa one-third of the sample (30.3%) reported scores which met the threshold criteria (CES-D≥15) for clinical depression while in this study only 34(7.4%) orphans fit the threshold of clinical depression this difference might be goes to the sample size and in this study the participants were most of them were parental or maternal orphan and also double orphans were cared for by community based care.

Loss of a parent disrupts interpersonal relationships, requiring children to build or shift relationships with new caregivers. In some cases, the death can also lead to decreased social support overall, particularly if children are required to move (10). Orphans may be more likely to engage in early sexual activity to facilitate social connections (12) and also this similarly shows that, from the respondents who had start the sexual intercourse 112 (27.5%), 39 (34.8%) of them start sexual intercourse early to facilitate social connection in their living environment.

Different studies shows that, 21% of girls‟ first sexual intercourse is forced and the perception that family violence is acceptable is shared by both women and men (48% and 37%, respectively). The combination of poverty, neglect and violence contributes to the large number of children on the move, resulting in unsafe migration and child exploitation(22). The study

conducted in south Africa, found in their study of men and women in Cape Town, South Africa that 27% of participants across genders agreed that rape is usually a result of something a woman says or does, 18% felt that some cases of rape involve a woman who wants to have sex and 29% said that rape is often a woman's fault(27) but in this study only 11 (2.7%) of them, their first sexual intercourse were rape and this discrepancy might be different local NGO like pact provide education on sexual behavior in the community.

According to the study conducted in sub-Saharan country, the percentage who were "not willing at all" at sexual debut was the lowest for Burkina Faso(15%), followed by Uganda at 23%, Ghana at 30% and Malawi at 38%. Turning briefly to the other response categories, between 20 and 30% were "somewhat willing" in all four countries(29), similarly in this study 19 (86.4%) of them were not willing at their first sexual intercourse and 21(48.8%) were somewhat willing and 27 (57.4%) were very willing.

According to studies in Liberia, Fifteen percent of the sample reported ever engaging in transitional sex (TS) at the nine-month follow-up survey, among those who engaged in TS, 41% were female. Among this group of females, 52% were "promised something" in exchange for sex, 26% reported that they had been "promised something" and that they "promised something to someone else, "while 22% reported only "promising something to someone else" in exchange for sex(9). Similarly this study shows that, 94 (21.3 %) orphan and vulnerable children were take something from somebody to had sex with them and out of the OVC who take something from their partner and enforced to had sex with them, 31 (7.6%) and 21 (5.2%) of the respondents were take money and alcohol from their partner respectively and out of the respondents the least 3 (0.7%) take ornaments from their partner. From the total participant 19 (4.7%) of the respondents were have been forced to have sex with a person they don't know. Out of the respondents who

had engaged in sexual inter course 76 (67.9%) of their partner were not willing to use condom when they had have sexual intercourse with the orphan children. The reason for unwillingness includes receiving enough money, coerced, and provided something to orphan children. Violence was not limited to the first sexual act or to the first relationship, but was also reported to be a feature of all subsequent sexual relationships in this study.

In this study, death of family or conflict with family (extended relatives) results in poverty as the consequence the context for transactional sex, and sexual exchange and risky sexual behavior among orphan street children. Lack of basic needs was perceived to lead directly to engaging in these behaviors as a survival strategy to meet such needs or indirectly through school dropout to engage in risky sexual behavior and exploitation whose environments and proceeds predisposed adolescents to sexual exchange.

Different studies suggest that orphaned adolescents are at a higher disposition for sexual risks compared to their non-orphan peers(7). Different studies in Sub-Saharan Africa show adolescents of age 15–19 are vulnerable to socioeconomic deprivations and sexual and reproductive health risks that are often associated with poverty, as these children lose their parents especially due to HIV/AIDS, these risks increase adversely, as they lose their income earners(7). Similarly this study also suggest that, poverty next to the death of family put the orphan street children hindrance to access to basic needs and findings also show how poverty contravene various basic child rights of adolescents leading to sexual risk behaviors.

Orphans have been found to have a higher likelihood of being sexually active, initiate sex at an earlier age, and have unprotected sex and multiple partners(9), because of the majority of orphaned children live as street children where their living conditions makes them severe deprivation, which place them at all kinds of health risks. Several studies that exist on the sexual

behaviors of street children show that these children engage in behaviors that put them at risk of sexually transmitted infections(10). Similarly this study was also show orphan street children participate in risky sexual behavior and exploitation for the survival of life as the respondents pick out to get basic need like food and cloth, they should participate in risky sexual behavior.

This study also supported by, the study conducted in Malawi, it suggests that, street children are a high risk group to HIV and STI, it revealed that boy/girl sexual relationship was widespread among the street children(10). Similarly, FGD and interview of orphan in this study also indicate that, there was no any separate space for female and male they spend over the night they slept as a group which put them on high sexual risk behavior.

Growing up as an orphaned child due to different condition poses psychosocial and economic challenges to these children. To resist the economic problem orphaned children are at an elevated risk for early onset of sexual relations and sexual exploitation, which raises their risk of contracting sexually transmitted diseases, including HIV/AIDS(32). Similarly this study also identify socio-economic factor as it place orphan children at elevated risk of sexual behavior.

This study also backup by the study, conducted in South Africa one-third of the sample (30.3%) reported scores which met the threshold criteria (CES-D≥15) for clinical depression Orphan children tend to manifest more depression, personality disorder, and anxiety/insomnia tendencies than do non-orphans(44). This study also show, Orphan Street children had more depression and anxiety than those who were get support in the community.

Loss of a parent disrupts interpersonal relationships, requiring children to build or shift relationships with new caregivers. Orphans may be more likely to engage in early sexual activity

to facilitate social connections(51). FGD and interview of orphan in this study similarly indicate that, loss of parent or conflict with step mother or father facilitates to leave the home.

Different study shows that, parents' have importance in children's socialization and protective role in influencing adolescents' sexual risk taking, but orphaned children greatly lose these condition, love and affection of their parents this make them susceptible to STI and HIV/AIDs(13). In this study also, orphans said "If my parent was alive, I would be playing instead of digging" this indicates as they were traumatized by the death of their family.

This study, identify these factors as they predispose orphan children to risky sexual behavior and findings also suggest that, poverty as a consequence of family death hinders orphan children access to education due to lack of food and school fee.

Most studies show that, serious threats to health of street children is the high degree of exposure to sexual abuse, rape, prostitution, sexual bartering and exchange, casual sex and romantic sexual relationships are among the factors that increase their risk of acquiring sexually transmitted infections(10). Similarly this study finding shows that, orphan street children were abused sexually, that was occurred as exchange with goods or forced sex. Also FGD group said that the other spoil females street children was 'gelbo' means forced sex on street while she slept on street at night.

Throughout sub-Saharan Africa (SSA), transactional sex (TS) occurs to meet varied needs including cash, goods(14),or to gain social status. Similar studies, also support that street children, (boys mainly) prefer homosexual relations and practice anal sex with fellow boys as boys are easily available(18). Most of the FGD group and interviewed group said that, street children were participate in risky sexual behavior and exploitation for the survival, unless living

on street was impossible, because we didn't get any basic needs, like food and cloth. Other study also shows that, which support this finding, says, If there were no girls, boys involved in sexual activities with fellow boys; mostly the bigger boys would prey on the smaller boys or those boys that are new on the streets(10).this study finding also indicate that, street children were enforced to have anal sex with strangers and elder person.

Limitation and strength of the study

This study used a cross-sectional design, thus causality cannot be ascertained. Because reporting about sexual experience is a sensitive issue it is likely that respondents may not disclose their experience fully.

Strength of the study

- ✓ The strength of this research was, it employed both quantitative and qualitative methods
- ✓ High response rate of the participants
- ✓ Included orphans getting community support and orphans living on he street

Conclusion

- ✓ More than a quarter of respondents 112 (27.5%) were sexually active of these 50 (44.6%) of them started sexual intercourse before the age of 10 to get basic needs and 39 (34.8%) of them started sex to facilitate social connection in their living environment.
- ✓ Out of OVC who started sexual intercourse highest proportion 96 (85.7%) of them did not use condom regularly while they had sexual intercourse because of partners refusal, lack of money to purchase, didn't have time, and they didn't know as they get HIV.
- ✓ The study participants who were double orphans (maternal and paternal) were about five and half times more at risky sexual behavior than the respondents who were maternal orphan only P=0.005, COR (95% CI) 5.455(1.674,17.770).
- ✓ The death of parents was one of the main reasons leading to street life. There is no safe place for street children, no safer places to spend the night, both boys and girls sleep in the same place. Sexual relationship among street children is widespread among the street groups and with outsiders, multiple partnerships is common. All types of sexual relation exist in the street, heterosexual, bisexual and homosexual. Both male and female street children face forced sex.

Generally, this study concludes that, orphan children were at high sexual risk behavior and exploitation.

Recommendations

Based on the finding of the quantitative and qualitative study the researcher recommends:

1. These study findings highlight pathways by which poverty next to the death of family contributes to sexual risk behavior and sexual exploitation among orphaned adolescents through their lack of basic needs, international NGOs like UNICEF and save the children should build IGA to take out of risky behavior and sexual exploitation.

2. Prevention policies and interventions targeting orphan adolescents in communities with generalized poverty reduction and sexual risk taking behavior should be provided by governmental and nongovernmental organizations.

3. Life skills targeting orphan adolescents, strengthening the existing social protection system implemented by the government that provides to encourage their fostering and retention within their families and communities, increase their knowledge on sexually transmitted disease should be implemented by ministry of women and child affairs and local and international NGOs.

4. At the national level, there should be reporting orphan trouble and a clear need for a vital registration system to assess the magnitude of orphan street children by ministry of women's and children affairs.
5. The importance of implementing HIV/AIDs and STI prevention programs that provide knowledge, enhance negotiations skills, target specific prevention-related social norms and increase the perception of risk sexual behavior and sexual exploitation and life-skills education programs may represent an effective strategy in targeting potential protective measures and alleviating risk sexual behavior and exploitation as a result should be

provided for orphan street children by international NGOs like UNICEF and save the children and ministry of health.

6. For street children health information dissemination (awareness creation on how the transmission of STI and HIV occurred) and build IGA to take out of risky behavior and sexual exploitation that provided by different local and international NGO.

7. Especially for those double orphans, increase social support system in the community to reduce the number of orphan street children.

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Annexes

Annex 1- consent form for family or care givers of children

Informed Parental/ Care giver Consent Form for Research Involving Children

This informed consent form is for the parents / guardians of children between the ages of 10 -18 years, who we are asking to participate in the study of risky sexual behaviors, exploitation and factors affecting it, here in Addis Ababa city administration.

Principal Investigator: Ayana Chimdessa

Organization: Addis Ababa University College of health science, school of allied health, department of nursing and midwifery.

Project name: Assessment of risky sexual behaviors, exploitation and factors affecting it among OVC in Addis Ababa city 2014, Ethiopia

My name is Ayana Chimdessa, Addis Ababa university post-graduate student, currently conducting research on risky sexual behavior, exploitation and factors affecting it among OVC here in Addis Ababa.

I am going to give you information and invite you to have your child participate in this research. You do not have to decide today whether or not you agree that your child may participate in the research. Before you decide, you can talk to anyone you feel comfortable with. There may be some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask me where ever and when ever.

The purpose of this study - is acknowledging the gaps that still exist in our knowledge and practice will assist policy makers and program implementers to make evidence-based decisions about how best to direct funding and program activities and maximize positive outcomes for children and their caretakers. The study findings will guide government, non-government organizations and others to design better strategy to improve the right and care of OVC in the future as well as used to forward comment on the existing care and support to revise the approach how to care for OVC. We are inviting your children to take part in this research because it is

important that to identify how orphan children may be affected as a consequence of their family death.

Voluntary Participation: Your decision to have your child participate in this study is entirely voluntary. It is your choice whether to have your child participate or not. If you choose not to consent, all the services you and your child receive from government and non-government will continue and nothing will change. You may also choose to change your mind later and stop participating, even if you agreed earlier, and the services your child receives from organization will continue).

Risks- by participating in this research there is no any risk your child will acquire. There has been nothing that has worried us at all that affects your child as they participate in this study. If anything unusual happens to your child, however, we need to know and you should feel free and call us anytime with your concerns or questions. The information your child provide us is confident in where ever and in whatever

Benefits- The research may not give a more concerns than the before but it later may used to revise the support system to modify it as it is preferable for orphan children all over in Ethiopia your child may get the advantage of this revise and more protection from government on exploitation. There may not be any other benefit for your child but his/her participation is likely to help us find the answer to the research question. There may not be any benefit to your children at this stage from this research, but near the future your children are likely to benefit.

Confidentiality- the information that we collect from this research project will be kept confidential. Information about your child that will be collected from the research will be put away and no-one but the researchers will be able to see it. Any information about your child will have a number on it instead of his/her name. Only the researchers will know what his/her number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except such as research sponsors, advisor.

Sharing of the results- The knowledge that we get from this study will be shared with you before it is made widely available to the public. Confidential information will not be shared. Afterwards, we will publish the results in order that other interested people may learn from our research. You do not have to agree to your child taking part in this research if you do not wish to

do so and refusing to allow your child to participate will not affect your child care. You and your child will still have all the benefits by organization. You may stop your child from participating in the research at any time that you wish without either you or your child losing any of your rights as a study subjects here.

If you have any question contact AyanaChemdissa:**e-mail: ayanayoom@gmail.com**
Cellphone: +251-920-42-30-69

Part II: Certificate of Consent

I have been invited to have my child participate in research risky sexual behavior and exploitation of OVC. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for my child to participate as a participant in this study.

Name of Participant_____

Name of Parent or Guardian_____

Signature of Parent or Guardian _____ Date ----------

If illiterate - literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

I have witnessed the accurate reading of the consent form to the parent of the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ Signature of witness _____Date _____

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the parent of the potential participant, and to the best of my ability made sure that the person understands all condition about the research. I confirm that the parent was given an opportunity to ask questions about the study, and all the questions asked by the parent have been answered correctly and to the best of my ability. I

confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the family or care giver

Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____ Date _____

Thank you!

Annex 2- assent form for children age between10-18

This informed assent form is for children between the age of 10-18years who attend this research and who we are invited to participate in assessment of risky sexual behavior, exploitation and factors affecting it on Orphan and vulnerable children.

Name of Principle Investigator: AyanaChimdessa

Name of Organization: Addis Ababa University College of health science, school of allied health, department of nursing and midwifery.

Name of Project: Assessment of risky sexual behaviors, exploitation and factors affecting it among OVC in Addis Ababa city 2014, Ethiopia

Part I: Information Sheet

Introduction

My name is AyanaChimdessa post-graduate student at AAU, and right now conducting a research on assessment of risky sexual behavior and exploitation of orphan children here in Addis Ababa city administration.

I have told to your family/care givers, as I have conducting research on this issue and not only you but also parental/caregivers consent necessary.

The purpose of this study - is acknowledging the gaps that still exist in our knowledge and practice will assist policy makers and program implementers to make evidence-based decisions about how best to direct funding and program activities and maximize positive outcomes for children and their caretakers. The study findings will guide the government, non government and others to design better strategy to improve the right and care of OVC in the future as well as used for forward a comment on the existing care and support to revise the approach how to care for these OVC.

Choice of participants/ study subjects- are selected because of they lose their family to whatever the case and in need of care and support from the government or nongovernment. You don't have to be in this research if you don't want to be. It’s up to you. If you decide not to be in the research, its okay and nothing changes, still your care from different organization; everything

stays the same as before. Even if you say "yes" now, you can change your mind later and it's still okay.

Risks: There are no any risks to you happen as you one of the study subjects. There has been nothing that has worried us at all. If anything unusual happens to you, however, we need to know and you should feel free and call us anytime with your concerns or questions. The information you provide us is confident in where ever and in whatever.

Benefit: Nothing really good might happen to you. The research may not give a more concerns than the before but it later may used to revise the support system modify it as it is preferable for orphan children all over in Ethiopia.

Incentives: Because you lose your perishable time to participate in this study, you will take 50 birr to componset your lost time after you have finished the question.

Confidentiality: information about you that will be collected from the research will be put away and no-one but the researchers will be able to see it. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except the researcher, Advisor and research sponsor.

Share the Findings: if you are in need of the result we can discuss with you after the research is completed. Afterwards, we will be telling more people, scientists and others, about the research and what we found. We will do this by writing and sharing reports and by going to meetings with people who are interested in the work we do

Part 2: Certificate of Assent

I know that I can choose to be in the research study or choose not to be in the research study I know that I can stop whenever I want. I have read this information (or had the information read to me) and I understand it. I have had my questions answered and know that I can ask questions later if I have them. I understand any changes to this will be discussed with me. (If illiterate: Children who are illiterate should include their thumb print as well).

I agree to take part in the research.

Name of child _____ Signature of child: _____ Date: _____

Witness: I have witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely (literate witness must sign (if possible, this person should be selected by the participant, not be a parent, and should have no connection to the research team).

Print name of witness _____Signature of witness _____Date _____

Researcher confirms it: I have accurately read or witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely.

Print name of researcher_____ ____Signature of researcher_____ __Date_____

Annex 3- questionnaire (English version)

Section1. The following questions are about your background characteristics. Please indicate your response by circling the number of your choice or by writing your response in the space provided accordingly

No	Questions	Coding categories
1.1	Sex of the respondent	1. Male 2. Female
1.2	Your age in years?	----------
1.3	What religion are you following Currently?	1. Orthodox. 2. Protestant 3. Catholic 4. Muslim 5. Others(specify) ----------
1.4	To which ethnic group do you belong?	1. Amhara 2. Oromo 3. Tigre 4. Others (specify)----------
1.5	With whom do you live?	1. With my mother only. 2. With my father only 3. With my grandfather/mother 4. With relatives 5. With friends 6. Alone 7. Other (specify)----------
1.6	**Currently are you student?**	**1. Yes 2. No** **If your answer is no, for what reason ----------**

Section 2: Knowledge about HIV and STIs

Please indicate your response by circling the number of your choice or by writing your response in the space provided accordingly.

No.	Questions	Categories
2.1	Have you ever heard of HIV or the disease called AIDS?	1.Yes 2.No 3.No response
2.2	Do you know anyone who is infected with HIV or who has died of AIDS?	1.Yes 2.No 3.I am not sure 4. No response
2.3	Do you have a close relative or close friend who is infected with HIV or has died of AIDS?	1.Yes, a close relative 2.Yes, a close friend 3.close friend and relative/both 4. No 5. No response
2.4	Can people protect themselves from HIV, the virus that causes AIDS by using a condom correctly every time they have sex?	1. Yes 2. No 3. Don't know 4.No response
2.5	Can a person get the HIV virus from mosquito bites?	1.Yes 2.No 3.Don't know 4.No response
2.6	Can a person get HIV by sharing a meal with someone who is infected?	1.Yes 2.No 3.Don't know 4.No response
2.7	Can a person get the HIV infection by using a contaminated needle?	1.Yes 2.No 3.Don't know 4.No response
2.8	Can a person get the HIV infection from eating food prepared by a person infected by the virus?	1.Yes 2.No 3.Don't know 4.No response
2.9	Can a person get the HIV virus from eating raw meat prepared by a person infected by HIV?	1.Yes 2.No 3.Don't know 4.No response
2.10	Can people protect themselves from	1.Yes 2.No

	HIV by drinking local hard liquor or eating hot pepper?	3.Don't know 4.No response
2.11	Can a person get the HIV virus from a curse by the elderly and religious leaders?	1.Yes 2.No 3.Don't know 4.No response
2.12	Can people protect themselves from HIV by having one uninfected faithful sex partner?	1.Yes 2.No 3.Don't know 4.No response
2.13	Can people protect themselves from HIV by abstaining from sexual intercourse?	1.Yes 2.No 3.Don't know 4.No response
2.14	Do you think that a healthy-looking person can be infected with HIV, the virus that causes AIDS?	1.Yes 2.No 3.Don't know 4.No response
2.15	Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	1.Yes 2.No 3.Don't know 4.No response
2.16	Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	1.Yes 2.No 3.Don't know 4.No response
2.17	How do you perceive using of condom while you get sex with your partner?	1. It is not acceptable culturally 2. No satisfaction when use it 3. Feel bad while I use it 4. Other specify

Section 3: Knowledge about STIs symptoms, reported STIS

Please indicate your response by circling the number of your choice or by writing your response in the space provided accordingly

	Questions	**Categories**
3.1.	Have you ever heard of diseases that can be transmitted through sexual	1.Yes 2.No 3.No response

	intercourse?	
3.2	Can you describe symptoms of STIs on women? (Please circle all that apply)	1. Lower abdominal pain 2. Genital discharge 3. Foul smelling genital discharge 4. Burning pain on urination 5. Genital ulcers/sores 6. Swellings in groin area 7. Itching on the genital area 8. I don't know 9. No response
3.3	Can you describe any symptoms of STIs on men? (Please circle all that apply)	1. Lower abdominal pain 2. Genital discharge 3. Foul smelling genital discharge 4. Burning pain on urination 5. Genital ulcers/sores 6. Swellings in groin area 7. Itching on the genital area 8. I don't know 9. No response
3.4	Have you ever had any of the symptoms on the right hand side? (Please circle all that apply)	1. Pain upon urination 2. Bad smell discharge from genitals 3. Itching in the genital area 4. Thick discharge from genitals 5. Genital ulcer 6. Swelling in the groin 7. Other----------
3.5	Did you receive treatment for these symptoms?	1.Yes 2.No 3.No response
3.6	If your answer to question 3.5 is **No**, why didn't you receive treatment?	Reasons for not seeking treatment_____

	Please indicate your reasons in the space provided.	_____
3.7	When did you receive treatment for the symptoms you indicted in 3.4?	1. Immediately the symptom appeared 2. After sometime 3. I don't remember
3.8	If your answer to question 3.7 is **after sometime**, why were you delayed to seek treatment? Please indicate your reasons in the space provided.	Reasons for delayed treatment_____ _____
3.9	By who were you treated for the symptoms you indicted in 3.4?	1. I bought myself the medicine 2. By health professionals 3. By traditional healers 4. Others(specify_____
3.10	Where did you go for treatment for these symptoms?	1. Private Health institutions 2. Government Health institutions 3. Traditional Healer 4. Pharmacy 5. Other_____
3.11	Has anybody ever told you that you had a sexually transmitted disease?	1.Yes 2.No 3.Don't Know/Don't Remember
3.12	Have you ever been tested for HIV?	1.Yes 2.No 3.Don't Know/Don't Remember
3.13	Why haven't you been tested for HIV/AIDS	1. I am not at risk 2. I fear I might have HIV 3. Don't know where to go 4. Fear of other people's reaction if my test result is positive 5. Other(Specify)_____
3.14	Has anybody ever told you that you are	1.Yes 2.No

	HIV positive?	3.Don't Know/Don't Remember
3.15	Have you ever received treatment for HIV or HIV related symptoms?	5. Yes 6. No
3.16	Where did you go for such treatment?	1. Private health institutions 2. Government health institutions 3. Traditional Healer 4. Other (Specify)_____

Section 4: Sexual behavior.

Now we would like to ask answer some questions about your own sexual experience.

We would like to remind you again that all of your responses will be kept confidential and your name is not attached to this questionnaire

	QUESTIONS	**CODING CATEGORIES**
	Is there any communication with your caregiver about sex, HIV, STIs, and puberty?	1. Yes 2. No If yes, how many frequency? Rare b. some times c. usually d. always
4.1	Have you ever had sexual intercourse	1. Yes 2.No
4.2	How old were you the first time you had sex?	1.Age In Years---------- 2.Never Had Sex
4.3	If you have never had sex, why haven't you had sex? **Please circle all that apply.**	1.I'm Too Young 2.No Opportunity/Partner 3. Fear Of Pregnancy 4. Fear Of HIV/Other Diseases 5.Fear Of Parents 6.Moral/Religious Purposes 7.Desire To Finish School Other(Specify)_____

4.4	Did you or your partner use a method to protect yourself against HIV the first time you had sex. (If f you have never had sex please skip to section 8)	1. Yes 2. No
4.5	If you have started sex early, why you start early?	4. To facilitate social connection 5. To get basic need 6. To get protection 7. Other specify……..
4.5	Why didn't you use a method to protect against HIV?	1.Didn't Know Where To Get One 2.Didn't Have Money To Purchase One 3.Didn't Have Time To Get One 4. Partner Would Not Agree 5. Didn't Know I Could Get HIV 6. I Was Already HIV Positive 7. Used A Method
4.6	What method did you use to protect yourself against HIV the first time you had sex? Please circle all that apply	1. Did Not Use A Method 2. Condom 3.Intera Uterine Device 4.Diaphragm/Foam/Jelly 5. Herbs 6. Withdrawal 7.Douching/Washing 8.Other (**Specify**)_____
4.7	Did you or your partner use a method to protect against pregnancy the first time you had sex?	1. Yes 2. No
4.8	Why didn't you use a method to	1.Didn't Know Where To Get One

	protect yourself against pregnancy?	2.Didn't Have Money To Purchase One 3.Didn't Have Time To Get One 4. Partner Would Not Agree 5. Didn't Know I Could Get HIV 6. I Was Already HIV Positive 7. Used A Method
4.9	What method did you use? Please circle all that apply	1. Did Not Use A Method 2. Condom 3.Intera Uterine Device 4.Diaphragm/Foam/Jelly 5. Herbs 6. Withdrawal 7.Douching/Washing 8. Other **(Specify)** _____
4.10	Who was your first sexual partner?	1.Girlfriend 2.Boyfriend 3. Husband/Wife 4. Other Friend 5.Relative 6.Neighbor 7.Casual Acquaintance 8.Someone I Just Met 9. Sex Worker/Prostitute 10.Other…….
4.11	At the time you first had sex, was this partner younger, older or the same age as you?	1. Younger 2. Same Age 3. Older 4. Don't Know/Don't Remember

4.12	At the time that you first had sex, how old was your first sexual partner?	1. Age In Completed Years---------- 2. Do not Know
4.13	What best describes the reason you had first sex at the time you did?	1. I Was Curious 2. Wanted To Get Pregnant 3. Partner Would Leave Me If I Did Not 4. All My Friends Were Having Sex 5. To Prove I Was Normal 6. I've Never Had Sex 7. Other(Specify)_____
4.14	Thinking back to the time you first had sex, how willing were you at that time to have sex?	1. Very Willing 2. Somewhat Willing 3. Not Willing 4. Don't Remember
4.15	Where you or your partner under the influence of alcohol the first time you had sex?	1. Neither Under The Influence 2. I Alone Was Under The Influence 3. Partner Only under The Influence 4. Both Of Us Were Under The Influence Don't Know/Don't Remember
4.16	How many people have you had sex with in the past 12 months?	1.None 2.Two 3.Three 4.Four 5.Five 6.Six 7.Seven 8.Eight To Ten 9.Eleven To Thirteen 10.More Than Thirteen 11.Don't Know/Don't Remember
4.17	How frequently do you have	1. I Have Never Had Sex 2. I am Not Currently Having Sex

	sexual intercourse?	3. At Least Once A Week 4. At Least Once A Month 5. A Few Times A Year 6. No More Than Once A Year
4.18	Which of the contraceptive methods have you ever used?**P**lease circle all that applies	1.Condom 2.Pill 3.IUD 4.Injectable 5.Diaphragm/Foam Tablet/Jelly 6.Implants/Norplant 7.Herbs 8.Male Sterilization 9.Female Sterilization 10.Periodic Abstinence 11.Withdrawal 12.Douching/Washing 13.Don't Remember Other(**Specify**)_____
4.19	How often do you or your partner(s) use condoms when you have sex	1. Never 2. Sometimes 3.Always If never use condom why?.....
4.20	How often do you or your partners use the pill and other methods (besides condoms) to protect against pregnancy?	1. Never 2. Sometimes 3.Always
4.21	What was your relationship to the person with whom you last had	1. Girlfriend 2. Boyfriend 3.Other Friend 4.Spouse

	sex?	5.Relative Neighbor 6.Casual Acquaintance 7.Someone Just Met 8.Sex Worker 9.Never Had Sex 10.Other_____
4.22	Was the person you last had sex with younger, older or the same age as you?	1. Younger 2. Same Age 3.Older 4.Don't Know/Don't Remember
4.23	Do you have intentions to engage in sexual risk-taking behaviors?	1. I believe it's OK for people my age to have sex with someone they've just met 2. I believe it's OK for people my age to have sex with someone they love, 3. I believe it's OK for people to have sex before marriage 4. I agree that it's OK to force a girl-friend/boyfriend to have sex even when they don't want to 5. I believe it's OK to have sex without protection with someone you know

Section 5: Sexual exploitation

Now we would like to ask answer some questions about your own sexual exploitation.

We would like to remind you again that all of your responses will be kept confidential

and your name is not attached to this questionnaire

5.1	Is your first sexual intercourse rape?	1. Yes 2. No
5.2	Do you feel pressure to have sex?	1. Yes 2. No
5.3	Where does this pressure come from?	1.Myself 2.Boyfriend/Girlfriend 3.Teacher 4.Parent/Guardian 5.Other Relative Other(Specify)_____
5.4	Would you say that all, most, some or none of your friends have had sex?	1.All 2.Most 3.Some 4.None
5.5	Do you think you are at risk of experiencing forced sex? Forced sex is sex that you do not participate in at your will	1. Yes 2. No
5.6	Have you ever given anything or done something for someone to get that person to have sex with you?	1. Yes 2. No 3. Don't Remember
5.7	What did you give?	1.Money Food 2.School Fees 3.Drugs 4.Alcohol 5.Shelter/Rent 6.Clothes 7.Ornaments 8.Help With Homework

		9.Never Given Anything 10.Other(Specify)_____ ___
5.8	Has anyone ever given you something to have sex with them?	1. Yes 2.No 3.Don't Remember
5.9	What did they give you?	1.Money Food 2.School Fees 3.Drugs 4.Alcohol 5.Shelter/Rent 6.Clothes 7.Ornaments 8.Help With Homework 9.Never Given Anything 10.Other(Specify)_____
5.10	Have you ever been forced to have sex with a person you don't know?	1.Yes 2.No 3.No response
5.11	Is there your partner willingness to use condom when you get sex with him/her?	1. Yes 2. No If your answer is no, why? 1. Give me enough money 2. Enforce me 3. As it is exchange with something he/she is unwilling to use condom 4. Other specify……..

Now we would like to ask, answer some questions about your own metal health.

We would like to remind you again that all of your responses will be kept confidential and your name is not attached to this questionnaire

Below is a list of the ways you might have felt or acted. Please check how much you have felt this way during the past week.(adapted from Center for Epidemiological Studies Depression Scale for Children (CES-DC)

DURING THE PAST WEEK Not At All A Little Some A Lot

1. I was bothered by things that usually don't bother me. _____ _____ _____ _____

2. I did not feel like eating, I wasn't very hungry. _____ _____ _____ _____

3. I wasn't able to feel happy, even when my family or

friends tried to help me feel better. _____ _____ _____ _____

4. I felt like I was just as good as other kids. _____ _____ _____ _____

5. I felt like I couldn't pay attention to what I was doing. _____ _____ _____ _____

DURING THE PAST WEEK Not At All A Little Some A Lot

6. I felt down and unhappy. _____ _____ _____ _

7. I felt like I was too tired to do things. _____ _____

8. I felt like something good was going to happen. _____ _____ _____ _____

9. I felt like things I did before didn't work out right. _____ _____ _____ _____

10. I felt frightened. _____ _____ _____ _____

DURING THE PAST WEEK Not At All A Little Some A Lot

11. I didn't sleep as well as I usually sleep. _____ _____ _____ _____

12. I was happy. _____ _____ _____ _____

13. I was more quiet than usual. _____ _____ _____ _____

14. I felt lonely, like I didn't have any friends. _____ _____ _____ _____

15. I felt like kids I know were not friendly or that _____ _____ _____ _____

they didn't want to be with me.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	___

In-depth interview of orphan street children age between 15-18 years old.

Now we would like to interview you about your life and experience on the street. We would like to remind you again that all of your responses will be kept confidential and your name is not attached to this response and we would also ask you to use tape recorder, your answers are more valuable for this study and also we think that this study may modify the rules for orphan on street and care for these orphan street children.

Background information

1. Name ---------- Sex ---------- Age ---------- Ethnicity------ Level of education-------
2. Are you born here in Addis Ababa? If no where is your born place? For what reason you come here?
3. Who helped you in your first arrival in this town?
4. What were the things you did in your first arrival?
5. Orphan means what it means for you? How you feel it
6. How you feel your family death? Is there any anxiety, depression and mood disorder within the past 12 months?
7. What makes you street children?-
8. Are you attending school? If yes, who sponsored your education? (Individuals, groups, organizations, community,) If you are not attending school, why not? If you are not attending school, what are you doing?

9. Have you been ill? If yes who take you to hospital
10. Looking at your history, can you tell us how your well-being/lifestyles kept while you experienced life on street?
11. While you join this street life how you get the socialization with other street children? What actions do you take to do this? Please describe it.
12. Where you spend over the night to sleep? Is there any separate place for girls and boys
    14. How you protect yourself? Is there any guardians for you?

This part is the interview to know your Knowledge about HIV/AIDS. To continue this part again we ask your permission for the tape recording. Again your responses are confidential in whatever and where ever.

1. Have you ever heard of HIV or the disease called AIDS? If you heard from what you have heard?
2. What are the most HIV/AIDS transmissions from person to person? If you know the way of transmission of HIV/AIDS how you protect yourself
3. Do you think that the mother who is pregnant or deliver baby can transmits HIV to her fetus/ baby? How it may occur?
4. Do you know diseases that can be transmitted through sexual intercourse? If you know them list some of them.
5. Can you describe symptoms of STIs on men and women? Have you ever had any of these symptoms within the past 12 months?
6. Did you receive treatment for these symptoms? If yes how you get the treatment? If you didn't took treatment, what are your reasons?
    1. Have you check your selves for sexually transmitted disease? If no what are the reason?

    This part is the in- depth interview to know your sexual practice while you have start street life. To continue this part again we ask your permission for the tape recording. Again your responses are confidential in whatever and where ever.

1. Have you ever had sexual intercourse? If yes with whom? When you start sex how many years old? How many age your partner at that time? What are the advantages you get from you partner?
2. When you start sex have you a full interest to have a sex with your partner? If no what enforce you to have sex with him/her?

3. What methods did you use to protect you self from STI and HIV/AIDS when you got sexual intercourse? If you didn't use any method what is the reason please describe it?
4. What methods did you use to prevent pregnancy? If you didn't use for what reason
5. Who was your first sexual partner? How you meet with him or her? Where you meet her/him?
6. What was your reason as you had first sex?
7. How frequently do you have sexual intercourse? How many partners do you have?

This part is the in- depth interview to know Sexual exploitation that happen against you while you have start street life. You appropriate responses are the heart for this study. To continue this part again we ask your permission for the tape recording. Again your responses are confidential in whatever and where ever.

1. We would like to know how you get the basic need like food, shelter, school fee, cloth, shoe that need for your life?
2. What is the core business to earn your daily life?
3. Did you have willingness to have sex with your first partner? If no are there any pressure to have sex with him/her? Where these pressures come from**?**
4. Do you think you are at risk of experiencing forced sex? If yes how you protect yourself?
5. Have you ever given anything or done something/take something or done something to have sex with him/her? If yes what you give/ take to/ from him or her?
6. Is there your partner willingness to use condom when you get sex with him/her? If no for what reason he/she unwillingness?
7. Do you think that is there high risk sexual behaviors take place among the street children on there every day life? Please describe them.

8. We would like to know more about your experiences of life difficulties associated with family death for whatever the case?
9. Can you describe what happened when you faced life difficulties?
10. Which resources [social and political networks and institutional] are available to protect against your right when any person act a crime against you?

Guide line for focus group discussion of orphan street children

1. What it mean street children?
2. As a group where is the street children spend over the night?
3. What are the challenges street children can face in their life experience?
4. What it seems the boy/girl sexual relationship is among the street children? And if no girls what happen on sexual relationship?
5. As a group do you know sexually transmitted disease? If yes to protect yourself what methods do you use while sexual intercourse?
6. As a group where you get basic need like food, school fee, cloth, shoe and others?
7. Is there sexual exchange with goods like drugs, money, food or others?
8. How you protect you self from criminal happened on you while you are on street?
9. We would like to know more about your experiences of life difficulties associated with family death for whatever the case?
10. Do you think that is there high risk sexual behaviors take place among the street children on there every day life?
11. Can you describe what happened when you faced life difficulties?
12. What have been the changes in your well-being/lifestyles after you experienced the life difficulties associated with orphanage?

Annex 4 questionnaires (Amharic version)

ክፈል 1፡- የሚከተሉትን ጥያቄዎች የአንተ/ቺን አጠቃላይ ሁኔታ የሚገልፀ ናቸው፡፡ እባኮዋን መልሶን ከተሰጥዎት አማራጮች በመክበብ ወይም በባዶ ቦታው ላይ በመሙላት ይግለፀ፡፡

ተ.ቁ	ጥያቄ	አማራጭ	
1.1	የተሳታፊው ፆታ	1.ወንድ	2.ሴት
1.2	ዕድሜ		
1.3	በአሁኑ ሰአት የሚከተሉት ሃይማኖት	1. ኦርቶዶክስ 2. ፕሮቴስታነት	3. ካቶሊክ 4. ሙስሊም
1.4	የየትኛው ጎሳ አባል ነዋት	1. አማራ 2. ኦሮሞ	3. ተጋሬ 4. ሌላ(ጋለፀ
1.5	ከማን ጋር ነው የሚኖሩት	1.ከእናት ጋር 2. ከአባት ጋር 3. ከአያት ጋር 4. ከዘመድ ጋር	5. ከጓደኛ ጋር 6. ብቻዬን 7. (ሌላ)ገለፀ

ክፍል 2፡- የHIV እና የአባላዘር በሽታዎችን እውቀት በተመለከተ እባኮዎን መልሶን ከተሰጦት አማራጮች በመክበብ ወይም በባዶ ቦታው ላይ በመሙላት ይግለፀ፡፡

ተ.ቁ	ጥያቄ	አማራጭ		
2.1	ስለ HIወይም ኤድስ ሰምተው ያውቃሉ	1.አዎ	2. የለም	3. መልስ የለም
2.2	በ HIV የተያዘ ሰው ወይም የሞተ ሰው ያውቃሉ	1.አዎ	2.የለም	3.እርግጠኛ አይደለሁም
2.3	በ HIV ወይም ኤድስ የተያዘ ሰው ወይም የሞተ የቅርብ ጓደኛ ወይም ዘመድ	1.አዎ የቅርብ ዘመድ 2. የቅርብ ጓደኛና ዘመድ 3.አዎ የቅርብ ጓደኛ		4.የለም 5.መልስየለም
2.4	ሰዎች ሁልጊዜ የግበረ ስጋ ግንኙነት ሲያደርጉ ኮንዶም በአግባብ በመጠቀም እራሳቸውን ከኤድስ አምጭ ከሆነው ከ HIV መከላከል ይችላሉ	1. አዎ 2. የለም		3. አላውቅም 4. መልስ የለም
2.5	አንድን ሰው HIV በወባ ንካሽ ሊይዘው ይችላል	1. አዎ 2. የለም		3.አላውቅም 4.መልስ የለም
2.6	አንድ ሰው HIV ከያዘው ሰው ጋር ምግብ አብሮ መብላት HIV ሊይዘው ይችላል	1. አዎ 2. የለም		3. አላውቅም 4. መልስ የለም
2.7	አንድ ሰው ከተበከለ መርፌ HIV ሊይዘው ይችላል	1. አዎ 2. የለም		3. አላውቅም 4. መልስ የለም

2.8	አንድሰው HIV በተያዘ ሰው የተዘጋጀ ምግብ በመብላት HIV ሊይዘው የችላል	1. አዎ 2. የለም	5. አላውቅም 3. መልስ የለም
2.9	አንድሰው HIV በተያዘ ሰው የተዘጋጀ ጥሬ ስጋ በመብላት HIVሊይዘው የችላል	1. አዎ 2. የለም	6. አላውቅም 3. መልስ የለም
2.10	ሰዎች ጠንካራ መጠጥ ወይም የሚያቃጥል በርበሬ በመመገብ ራሳቸውን ከ HIV መከላከል ይችላሉ	1. አዎ 2. የለም	3. አላውቅም 4. መልስ የለም
2.11	ሰው በታላላቅ ሰዎች እና በሃይማኖት አባቶች እርግማን HIV ሊያዘው ይችላል	1. አዎ 2. የለም	3. አዎ 4. መልስ የለም
2.12	ሰዎች አንድ ከ HIV ነፃከሆነች ጓደኛ ጋር በመተማመን እራሳቸውን ከ HIV መከላከል ይቻላሉ	1. አዎ 2. የለም	3.አላውቅም 4. መልስ የለም
2.13	ሰዎች ከግብረሰጋ ግንኙነት በመታቀብ ራሳቸውን ከ HIV መከላከል ይቻላል	1.አዎ 2.የለም	3.አላውቅም 4.መልስ የለም
2.14	ጤናማ የሚመስል ሰው ኤድስ በሚያመጣው የHIV ቫይረስ ሊያዝ ይችላል ብለውያስባሉ	1. እዎ 2. የለም	3. አላውቅም 4. መልስ የለም
2.15	አንድ በ HIV ወይም በኤድስ የተያዘች እናት ቫይረሱን ወደ ልጆዋ ልታስተላልፍ ተችላለች	1. እዎ 2. የለም	3. አላውቅም 4. መልስ የለም
2.16	አንድ በ HIV ወይም በኤድስ የተያዘች እናት ጡት ማጥባት ቫይረስ ወደ ልጂ ልታስተላልፍ ትችላለች	1. እዎ 2. የለም	3. አላውቅም 4. መልስ የለም

ክፈል 3፡-የአባላዘር ምልክቶች እውቀቶን በተመለከተ፡፡እባከዎን መልሶን አማራጮች በመክበብ ውይም በባዶ ቦታው ላይ በመሙላት ይግለፁ፡፡

ተ.ቁ	ጥያቄ	አማራጭ
3.1	በግብረ ስጋ ግንኙነት ስለሚተላለፍ በሽታ ሰምተው ያውቃሉ	1.አዎ 3.አላውቅም 2.የለም 4.መልሰ የለም
3.2	የአባላዘር በሽታ ምልክት በሴቶች ላይ ወይም በወንዶች ላይ መግለፅ ይችላሉ	1.የብልት ፈሳሽ 2.ከፍተኛ የሆድ ህመም 3.ሽታ ያለው መጥፎ የብልት ፈሳሽ 4. በሽንት ጊዜ ማቃጠል 5. የብልት ቁስለት 6. የብሽሽት አከባቢ ቁስለት 7. የብልት አከባቢ ማሳከክ 8.አላውቅም 9. መልስ የለም

3.3	ቀኝ እጅዎ ላይ የሚመለከቱትን ምልክቶች ኖረዎን ያውቃሉ	1. ከፍተኛ የሆነ ህመም 2. የብልት ፍሳሽ 3. ሽታ ያለው መጥፎ የብልት ሽታ 4. በሽንት ጊዜ ማቃጠል 5. የብልት ቁስለት 6. የብሽሽት አከባቢ ቁስለት 7. የብልት አከባቢ ማሳከክ 8. አላውቅመወ 9. መልስ የለም
3.4	በነዚህ ምልክቶች ህክምና ወስደው ያውቃሉ	1. አዎ | 2. የለም | 3.መልሰ የለም
3.5	ለተራ ቁጥር 3.5 መልስዎ የለም ከሆነ ለምንድነው እባክዎን መልስዎን በባዶ ቦታው ላይ ይፃፉ	ህክምና ያልወሰዱበት ምክንያት ----------
3.6	መቼ ነው በተራ ቁጥር 3.4 ለተገለፀው ምል□ት ህ□ም□ □□ረፈ□ት	1. ወድያውኑ ምልክቱን እንደታየ 2. ከተወሰነ ጊዜ በኃላ 3. አላስታውስም

3.8	ለተራ ቁ□ር 3.7 መልስክ ከተወሰነ ጊዜ በኃላ ከሆነ ለምድነው የዘገዩት እባክዎ በባዶ ቦታ□□□□ለ□□	□ህ□ም□ መዘግየት ምክንያቶች	
3.9	በተራ ቁ□ር 3.4 ለተፈለ□□□ ምል□ት ህ□ም□ □□ሰ□□ት በማዶ ነው	1.መድሀኒቱን በራሴ ገዛሁት 2. በፋ□ ባለመ□ 3.በባህል መድሀኒት አዋቂዎች 4. ሌሎች (ይግለፁ)----------	
3.10	በነዚህ ምልክቶች ህክም□ የወሰዱት ከየት ነው	1.□□ል □ፉ□ □ር□ት 2. ጀመዶ□ስት □ፉ□ □ር□ት 3. □ባህል ህ□ም□ አዋቂዎች 4.□ርማሰ□ 5.ሌሎች	
3.11	ሌላ ሰው የአባላዘር በሽታ እንዳለበት ነግሮት ያውቃል	1. አዎ 2. □ለም	3. አላውቅም /አላስታውስም/
3.12	□HIV ምርመራ አድርገው □□ቃለ□	1. አዎ 2. □ለም	3. አላውቅም/አላስታውስም/
3.13	ለምድንነው የHIV ምርመራ □ላ□ረፈ□ት	1.ተፉላ□ ስላልሆዶ□ 2. HIV ለ□ርብኝ ይችላል ብዬ 3. የት እንደምመረመር ስላለወኩ	

		4. ¬ ◪ ◰ +ve ቢሆን የሌሎችን ተፅእ• በመ□ራት	
3.14	ለ◰ ሰ¬ □HIV +ve እንደሆነ ነግሮት ያውቃል	1. አዎ 2. ½ላም	3. አላውቅም/አላስታውስም/
3.15	ለHIV ¬ □ም HIV ዶ ½ማ◪መሳስለ□ ምልክቶች ህክም • ¬ ስÃ¬ú ¿¬ ◪ቃለ□	1.Yes 2. No	
3.16	ለዘ◫ ህ¡ ም • ¬Ã½ ት ሃýÄú		

<u>ክፍል አራት</u> የግብረ ስጋ ጠባያት አሁን ስለ እርሶ የግብረ ስጋ ጠባያት በተመለከተ እጠይቆታለሁ።አሁንም የሚሰጡት መልስ ሚስጥራዊነቱ የተጠበቀ ሲሆን የእርሶም ስምም ከጥያቄው ጋር አብሮ አይያያዝም

ተ.ቀ	□¿ ቄ	አማራጭ
4.1	½□ብረስፉ □ዾኝነት አድርገው ያውቃሉ	1. አዎ 2. ½ላም
4.2	ለመጀመሪያ ጊዜ ግንኙነት ሳያደርጉ እድሜዎ ስንት ነበር	1. ---------- 2. የግብረ ስጋ ግንኙነት አድርጌ አላውቅም
4.3	ግንኙነት አድርገው ካለወቁ ለምድን ነው ¿ ለ□ረፈ◰	1. ልË ስለሆዶ□ 2. ጓደኛ ስለለ◪ኝ 3. እርግዝ• በመ□ራ 4. HIV እ• ሌሎችን በመፍራት 5. ወላጆችን በመፍራት 6. ህ□ማ• ት 7. ትምህርት ለመ× ረስ በመ□ለ□ 8. ሌሎች ካሉ----------
4.4	እርሶ ወይም ጓደኛዎ HIV ለመ□መረ¿ ጊዜ ግንኙነት ሲያደርጉ መከላከያ ተፋ.ቀመ¬ □	1. የት እንደሚገኝ ስለማላ¬ ◪ 2. ለመ□² ት ፈያዘብ ስለለ◪ኝ 3. ፈ◫□ስለለ◪ኝ 4. ጓደኛዬ ስላልተስማማች 5. HIV እንደሚይዘኝ ስለማላ¬ ◪ 6. HIV +ve ስለሆዶ□ 7. Used a method
4.5	ግንኙነት ቀድመው ከጀመሩ ለምድንነው ቶሎ ½□መሩት	1. ማህበራዊ ግንኙነት ለመጀመር 2. መሸረታ ð ልÑት ለማሟላት 3. መከላከያ ለማግኘት 4. ሌላ ካለ ይግለፀ----------
4.6	ለምድንነው HIV ለመጀላጀል መጀላጀ¿	1. የት እንደሚገኝ ስለማላ¬ ◪ 2. ለመ□² ት ፈያዘብ ስለለ◪ኝ 3. ጊዜ ስለሌለኝም 4. ጓደኛዬ ስላልተስማማች

	□ልተፋቀመ□	5. HIV እንደሚይዘኝ ስለማላ□□ 6. HIV +ve ስለሆኖ□ 7. Used a method
4.7	ለመጀመሪያ ጊዜ ግንኙነት ሲያደርጉ ምን አይነት መከላከያ ነው □ተፋቀመ□	1. አልተጠቀምኩም 2. ኮኖ□ም 3. በማህ□ዱ □ማ□ቀመ□ 4. □□□□ራም 5. ሰሃቀ□ል 6. ብልትዱ ማ□□ት 7. □□ብር □□ 8. ሌሎች----------
4.8	ለመጀመሪያ ጊዜ ግንኙነት ሲያደርጉ እርሶ ወይም ጓደኛዎ የእርግዝ□ መጀላጀ□ ተፋቀመ□□□□□ቃለ□	1. አዎ 2. □ለም
4.9	ለምድንነው የወሊድ መከላከያ □ልተፋቀመ□	1. የት እንደሚገኝ ስለማላ□□ 2. ለመ□□ት ፈሯዘብ ስለለ□ኝ 3. ጊዜ ስለሌለኝም 4. ጓደኛዬ ስላልተስማማች 5. HIV እንደሚይዘኝ ስለማላ□□ 6. HIV +ve ስለሆኖ□ 7. Used a metho
4.10	የትኛው ዘዴ ነው የተጠቀሙት	1. አልተጠቀምኩም 2. ኮኖ□ም 3. በማህ□ዱ □ማ□ቀመ□ 4. □□□□ራም 5. ሰሃቀ□ል 6. ብልትዱ ማ□□ት 7. □□ብር □□ 8. ሌሎች----------
4.11	ለመጀመሪያ ጊዜ ግንኙነት ያደረጉት ከማን ጋር ነው	1. የሴት ጓደኛዬ 2. □□ዶድ ጓደኛዬ 3. ጀባል/ማ□ት 4. ከሌላ ጓደኛ 5. ዘመ□ 6 □ረበ□ 7. በአጋጣሚ ካገኘሁት 8 ከሴተኛ አዳሪ 9.ሌሎች----------
4.12	ለመጀመሪያ ጊዜ ግንኙነት ሲያደርጉ ጓደኛዎ ከእርሶዎ በእድሜ ያንሳል ይበልጣል ወይስ እኩል ይሆ□ል	1. □ያሳል 2.እኩል ነው 3.ይበልጣል/ትበልጣለች 4.አላው□ቅም/አላስታው□ስም

4.13	ለመ□መሪ□ ፈ▣□ ግንኙነት ሲያደርጉ ጓደኛዎ ስንት አመት ይሆነዋል(ይሆ□ታል)	1. እድሜው---------- 2. አላውቅም
4.13	ለመጀመሪያ ጊዜ ግንኙነት ያደረጉበት ም□ያ□ት በ□ዶብ □መ□ለ□	1. ስለ□ለጀ□ 2. ነፍሰጡር መሆን ስለፈለግሁ 3.ካደረጉ ጓደኛዬ 4.ሀ▣▣ም □□ኞቼ ግንኙነት ስላደረጉ 5. ጤነኛ መሆኔን ለማረጋገጥ 6.ግንኙነት አድርጌ ስለማላውቅ 7.ሌላ ካለ ይጥቀስ□----------

4.14	ለመጀመሪያ ግንኙነት ያደረኩበት ለመጀመሪያ ጊዜ ግንኙነት ያደረኩበት /□ብቶዶ ፈ▣□ስታስታ□□ሽ/ለ□ ለምዶ ያህል ፈቃደኛ ነበርህ/ሽ ግንኙነት ለማ□ረ□	1.በጣም ፈቃደኛ 2. በመጠኑ ፈቃደኛ 3. ፈቃደኛ አልነበርኩም 4. አላስተውስም
4.15	ለመ□መሪ□ ፈ▣□ስታ□ርፈ□ እርሶ/ጓደኛዎ የባህል ተፅእ□ ነበረባችሁ	1. ማንኛችንም ከተፅእ□ ነፃ ነን 2. እኔ ብቻ በተፅእ□ ነበርኩ 3. ጓደኛዬ ብቻ በተፅእ□ ነበረ/ች 4.ሁለታችንም በተፅእ□ ነበርን 5. አላስታውስም/አላውቅም
4.16	ባለ□ት 12 □ራት □□ሽ□ ጀምዶ □ህል ሰዎች ጋር ግንኙነት አድርገዋል	1.የለም 4. አራት 7. ሰባት 2.ሁለት 5. አምስት 8. 8-10 3. ሶስት 6.ስ□ስት 10.>13 11. አላስታውስም
4.17	ስር ግንኙነት ለምን ያህል ጊዜ ያደርጋሉ	1. አድርጌ አላውቅም 2. በአሁኑ ሰአት እያደረጉ አይደለም 3. ቢያንስ በሳምንት አንድ ጊዜ 4. በአመት ጥቂት ጊዜ 5. ከአመት ከአንድ ጊዜ ያልበለጠ
4.18	የቤተሰብ ምጣኔ አገልግሎት አይነቶች የትኛውን ተጠቅሰው ያውቃሉ/እባክዎ በማ□በብ □መል□ቱ	1.ኮዶ□ም 7. ቅፋ ላቅፋ ል 2.እንክብል 8.የወንድ ማምጀዶ 3.ጀማህ□ዶ □ማ▣መ□ 9. □ስ▣ ማምጀዶ 4.በመርፌ የሚሰጥ 10.እንደሁኔታው መታቀብ 5.ዲያፍራም 11.የወንድ አልታ ማውጣት 6.በ□ዶ□ □ማ▣በር 12.□ብር □▣ 13.አላስታውስም

4.19	እርሶ ወይም ጓደኛዎ ግንኙነት ሲያደርጉ ለምዶ □ህል ፈ□ኮደ□ም □ፋቀማለ□	1. □ለም 2. አልፎ አልፎ 3. ሀ□ልፈ□ 4. ኮንዶም ተጠቅመው አላውቅም ለምዶ----------
4.20	እርሶ ወይም ጓደኛዎ እንክብል ከኮንዶም በተጨማሪ እርግዝ□ዶ ለመጀላጀል ለምዶ □ል ፈ□□ፋቀማለ□	1. □ለም 2. አልፎ አልፎ 3. ሀ□ልፈ□
4.21	ለመ□ ረሻ ጊዜ ግንኙነት ካደረጉበት ሰው ጋር ግንኙነቶት ምንድን ነው	1. የሴት ጓደኛ 7. ከሴተኛ አዳሪ ጋር 2. የወንድ ጓደኛ 8. ሌላ ካለ ይጥቀሱ---------- 3.□ለ□ □ደኛ ---------- 4.የትዳር ጓደኛ 5. ዘመ□ □ረበ□ት 6. ካገኙት ሰው ጋር
4.22	ለመ□ ረሻ ጊዜ ግንኙነት ካደረጉበት ሰው ከእርሶ ጋር በእድሜ ያንሳል፤ይበልጣል ወይስ እኩል ነው	1. □ያሳል 2. ተመሳሳይ ነው 3.□በል□ል 4.አላውቀውም/አላስታውስም
4.23	ተፉላ□ በማ□□ርፈ□□ሰ□- ባህሪ□ት ላ□ ለመሳተፍ ፍለጎት አሎት	1. በእኔ እድሜ ያሉ ሰዎች ጋር ግኙኝነት ቢያደርጉ ብዬ አም□ለሀ□ 2. በእኔ እድሜ ያሉ ሰዎችከሚያፈቅሩት ሰው ጋር ግንኙነት ቢያደርጉ ብዬ አም□ለሀ□ 3. ሰዎች ከጋብቻ በፊት ግንኙነት ቢያደርጉ ብዬ አም□ለሀ□ 4. የሴት/የወንድ ጓደኛ ግንኙነት እንዲያደርጉ ማስፈ□□ □ላፊ□ ባ□□ራቸው ጥሩ ነው ብዬ አም□ለሀ□ 5. ያለ መከላከያ ከሚያውቁት ሰው ጋር ግንኙነት በ□ረግ ጥሩ ነው ብዬ አም□ለሀ□

<u>ክፍል 5 ወሲባዊ ተጋላጭነት</u> አሁንም ሌላ ተጨማሪ ጥያቄዎችን የእርሶ ተጋላጭነት በተመለከተ እጠይቆታለሁ።አሁንም መልስዎ ሚስጥራዊ እንደሚሆን ስምዎም ከጥያቄው/ከመልሱ ጋር አብሮ እንደማይያዝ እንገልፅሎታለን።

5.1	የመጀመሪያ ግንኙነቶ አስገድዶ መድፈር ነው	1. አዎ 2. □ለም
5.2	ግንኙነት ለማድረግ የመገደድ ስሜት ይሰማዎታል	1. አዎ

		2. □ለም
5.3	□ህ መፈደድ ከየት ነው የመጣው	1. ጀራሰ□ 2. ከወንድ/ከሴት/ ጓደኞ 3. ጀመምህር 4. ለ□ ዘመ□ 5. ለ□----------
5.4	ጓደኞቸው ሁሉ አብዛኛው ጥቂቶ□ □□ም ማያም ግንኙነት አድርገው ያውቃሉ ብለው ያስባሉ	1. ህ□ል□ም 2. አብዛኞ□ 3. □ቂቶ□ 4. ማያም
5.5	ተፈ□□ ለመ□□ር ተፉላ□ ብለ□□ □ስባለ□ ተገድዶ መደፈር ማለት ያለፍላጎት ግንኙነት ማ□ረ□ ማለት	1. አዎ 2. □ለም
5.6	ግንኙነት ለማድረግት ብለው የሆነ ነገር ግኙነት ሳ□□ርፈ□ሰ□ ተ□□□□ቃለ□	1. አዎ 2. □ለም 3. አላስታውስም
5.7	ሌላ ሰው ግንኙነት ለማድረግ የሆነ ነገር ሰጥተው □□ቃለ□	1. አዎ 2. □ለም 3. አላስታውስም
5.8	ምዶ ሰ□ት/ምዶ ሰ□□	1.ፈያዘብ 6.ልብስ 2.□ት/በ□ □□□ 7.ፈ□ፈ□ 3.መድሀኒት 8.የቤት ስራ መስራት 4.አልኮል 9.ምንም አልሰጠሁም 5.□በ□ ጀ□ራ□ 10.ለ□ም----------
5.9	ከማያውቁት ሰው ጋር ግንኙነት ሊያደርጉ ተገደው □□ቃለ□	1. አዎ 2. □ለም 3. አላስታውስም
5.10	ግንኙነት ሊያደርጉ ኮንዶም እንዲጠቀሙ የጓደኞው ፍላጉት ነበር	1.አዎ 2.የለም መልስዎ የለም ከሆነ ለምን 1. በቂ □ዶ□በ□ ስለለ□ኝ 2.ስለተፈ□□ ጀ□ 3.ከሌላ ሰው ጋር ግንኙነት የማደርግ ስለሆነ 4.ሌላ ካለ ይጠቀስ----------

አሁንም ሌላ ተጨማሪ ጥያቄዎችን የእርሶ የአእምሮ ጤ□□በተመለከተ መልሰው አሁንም ሚስጥራዊነቱ የተጠበቀ ሲሆን ስምዎ ከጥያቄው/ከመልሱ ጋር አብሮ አያይዘው ከዚህ በታች የሚስቦት □□ም□ማ□ጀ□ውኑትን መንገድ ይሂል። እባክዎ እርስዎ ባለፈው ሳምዶት ምዶ □ህል በዘ□ መዶፈ□ እንዳሰቡ መልክት ያድርጉ።(ከሴንተር ፎር ኢፒሊ□ጂካ በተደረገ ዲፕረሽን ስኬል ፎር የተወሰደ)

ባለ□□□ሳምዶት

1	አብዛኛወን ጊዜ የሚያስደብሩኝ ነገሮች ደብሮኝ ነበር	ምዶም	በ□ቂቱ	በመጠኑ	በ□ም
2	እንደተባለው አይሰማኝም፤በጣም አልረበሽም				
3	ደስተኛ ለመሆን አልቻልኩም ምንም እንኳን ቤተሰቦቼ □□ኞቼ ደስተኛ እንድሆን ቢሞክሩም				
4	ለምሰራው ስራ ምንም ትኩረት እንዳልሰጠሁ አስብ ነበር				
5	ሀሳቤ ፎቶ ነበር				
6	ጥሩ ነገር እንደሚመጣ አስብ ነበር				
7	ለስራዬ በጣም እንደደከምኩ አስብ ነበር				
8	ድሮ የሰራሁት አሁን ላይ እንደማይሰራ አስብ ነበር				
9	□መ□ራት ስማ□ □ሰማኝ ነበር				
10	እንደሀፃን አስብ ነበር				
11	እንደድሮ አልተኛም ነበር				
12	ደስተኛ ነበርክ□				
13	ከድሮ በተለየ ዝምተኛ ነበርኩ				
14	ብቸኝነት ይሰማኝ ነበር				
15	እንደ ሀፍረት አስብ ነበር፤ሰው እንደማይወደኝ □□ም ከእኔ ጋር መሆን እንደማይፈልጉ አስብ ነበር				
16	ጥሩ ጊዜ ነበረኝ				
17	እንደማለቅስ እሩን ነበር				
18	ተከፍቼ ነበር				
19	ሰዎች አይወዱኝም				
20	ስራ መስራት ይከብደኛል				

DECLARATION

I Ayana Chimdessa the undersigned declare that this is my original work and has not been presented in this or any other University for a similar or any other degree award, and any partial or full sources of materials used should be fully acknowledged.

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