

Running head: HEALTH SEEKING BEHAVIOR AND ACCESS TO HEALTH....

Health Seeking Behavior and Access to Health Care of Street Involved Children: The Case of  
Ambo Town, Central Ethiopia

A Thesis Submitted to School of Social Work for a Partial Fulfillment of the Requirements for a  
Degree of Masters in Health Care Social Work

By

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### **Declaration Letter**

I, undersigned hereby, declare that this thesis is my original work and has not been presented for a degree fulfillment to any university or other institution for any requirement, and that all sources of material used for this thesis have been duly acknowledged.

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This is to certify that this thesis is organized by Mesfin Minase which is entitled, “Health Seeking Behavior and Access to Health Care of Street Involved Children: The Case of Ambo Town, Central Ethiopia”. The thesis is submitted in the partial fulfillment of the requirement for degree of Masters of Social Work in line with the regulation of the University and meets the accepted standards with respect to originality and qualification.

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**Acronyms**

CRC	Convention on the Rights of the Child
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
MoLSA	Ministry of Labor and Social Affairs
n.d	No date
NGO	Non-governmental organizations
UNCRC	United Nations Convention on the Rights of child
UNICEF	United Nations international child's Emergency Fund
UNOHCHR	United Nations Office of the High Commissioner for Human Rights
WHO	World Health Organization

### ***Abstract***

*Street involved children underutilize health services worldwide despite their miserable health conditions and their frequent illness. Why health services do not reach the children and how they respond to illnesses, as a result, are critical research areas. Describing health risks to selected street involved children in Ambo town, this study explored their health seeking behavior and access to health care. The study was undertaken in the first half of the year 2017, and 33 children who aged 10 to 18 years participated in interview and focus group discussions. They were selected through no-random snow ball sampling technique. Key informant interview and observation were also employed in this qualitative study. Findings indicated that the children rarely visited health facilities despite their frequent illnesses and access entitlements.*

*Constrained by cost of payable health services and violation of their entitlements to wavier service, the children widely used sleeping off illnesses, medicine from pharmacies and traditional treatments when they got sick. Sensitivity towards the health plights of the children and commitment to realize their recognized health care entitlements are required to improve their health conditions.*

*Keywords- Street involved children, health seeking behavior, access to health care*

## CHAPTER ONE: INTRODUCTION

In this section of this study, three major issues are discussed. First, the context of the concern of study is figured out and its hubs are identified. Next, justification for the need of the study is substantiated from different standpoints to bear out the importance of this study. Lastly, where to carry out the study and its significances are discussed.

### 1.1 Background of the Study

The phenomenon of street involved children is highly attributed to the process of rapid urbanization (Fiasorgbor & Fiasorgbor, 2015; Nodjajim, 2000). Over 90 percent of urbanization is occurring in the developing world representing an estimated 70 million new residents to urban areas each year. Contrary to the hope that urbanization reduces deprivation; current conditions in many cities across the world make the lives of a range of inhabitants worse off (World Bank, 2011). Particularly, the urbanization process in Africa is presenting a hostile face to many millions of children inhabitants (Kopoka, 2000).

According to Garland, Massoumi and Ruble (2007), the paces of provision of infrastructure and services to urbanites are far behind urbanization pace and the consequences for the urban poor have been dire. Peters, Garg, Bloom, Walker, Brieger, and Rahman (2008) identified children and adolescents who are affected by the many hazards constitute almost half of the poor urban residents in developing countries. In showing the absolute majority of the problem of street involved children are happening in developing countries, Royal Tropical Institute (2002; in Shimelis, 2015) states that out of the estimated 100 million street involved children of the cities of the world 40 million live in Latin America, 25-30 million in Asia, and 10 million in Africa.

These children are among the most physically visible of the marginalized groups created in the urban centers, especially Africa (Nodjajim, 2000).

In Ethiopia, there is considerable variation of national figures that made the attempt to know the precise magnitude of street involved children in the country difficult. For instance, while the national Ministry of Labor and Social Affairs (MoLSA) estimated the overall numbers of street involved children in Ethiopia in 2007 to be around 150,000 amongst whom about 60,000 live in Addis Ababa (in Shimelis, 2015; Busutill, 2012). UNICEF and other international aid agencies on the other hand projected the number to be much higher, with nearly 600,000 street children country-wide and over 100,000 in Addis Ababa alone (Edwards, Guy-Walls, Jacinto & Franklin, 2015). Though the official magnitudes vary, all evidences suggest that there are an increasing number of street involved children in Ethiopia and it has become a major social problem (Tadis, Berihun & Nigusie, 2014).

The challenges of street life and the deprivation the street involved child suffers from are the fate of millions of street children in the developed and developing world (Rooyen & Hartell, 2002). Being homeless, these children work and live in difficult conditions (Karr, n.d) leading them to face multiple health problems (Elliot, 2016; Nodjajim, 2000). Though street involved children's wellbeing is the only pertinent resource at their disposal as their fate of survival is entirely dependent on the ability to work, they engage in risky health behavior in their survival struggle to survive (Edusei & Amoah, 2014).

Besides sharing the apparent vulnerability to illness that is common among the urban poor (Ray, Davey & Nolan, 2011), street involved children are particularly susceptible to health risks as a result of both their physical weakness and street life experiences (Peters et al., 2008).

Experiencing this special vulnerability, these street involved children are generally treated as one group of socially marginalized children (Ray et al, 2011). Moreover, children residing in streets are less likely than their more affluent peer counterparts in detecting and responding to illness symptoms, seeking medical care, and complying with directions of treatment. Their daily lives, socio-cultural factors and economic statuses affect their behavior by channeling their interpretations of illness incidences in some direction and how to cope with their health problems are sometimes harmful to their health (Chin & Noor, 2014).

Health-seeking behavior can produce different ideas across literatures; it is conceptualized in this study as the behavior held and activities carried out by the street involved children who perceive themselves to have a health problem for the purpose of finding a proper remedy (Afolabi, Daropale, Irinoye & Adegoke, 2013). This action is not confined to the end point of utilization of health system services; it is a sequence of remedial actions taken by the victims to rectify ill-health rather (MacKian, 2003).

This health seeking behavior of the street involved children affects and is affected by access to public facilities. The children's possibility of access to health facility affects their health seeking practices and vice versa, as entitlement to access in turn determines if, how and to what extent the children use the services (Musoke, Boynton, Butler & Musoke, 2014).

Access is thus central to the performance of health care systems around the world (Levesque, Harris & Russell, 2013) which has been conceptualized in numerous ways. Access hereby refers to the existence of the health services and their friendliness to the street involved children (Grundy & Annear, 2010). It is actual use of services focusing on user and service characteristics, and the notion of fit between the two (Peters et al, 2008). Thus, access to health

care stands for the functional relationship between the population and health facilities; it combines the attributes of the services and the users in the process of fitting each other.

Access to the health facilities, World Health Organization (WHO) (1978) affirms, is a fundamental human right and the attainment of the highest possible level of health is an important social goal. Today, however, providing access to health services according to need has become so complex (Grundy & Annear, 2010) and a significant number of urban children have no regular source of health care (Nanda, 2008; National Coalition for the Homeless, 2006). The health opportunity and right of street involved children, as a result, have become an empty promise (Levesque et al, 2013; Grundy & Annear, 2010).

Generally the immense and routine exposure of street involved children to diseases, their petty character to take care of themselves and knotty barriers to access to health care signal the health issue of street involved children require significant attention in terms of satisfying their basic health needs and protecting their human rights. Additionally, the need to work on the health conditions of street involved children is not a mere humanitarian action; it is rather a social responsibility to be respected. In tandem, this study looked into health-seeking behavior and access to health facilities of these children with a general inspiration of contributing to improvement of their health status.

## **1.2 Statement of the Problem**

Once children begin to live on street they grow up without guidance, companionship, love, protection, access to social services, and dignity. They become more vulnerable to all forms of challenges including health hazards. Consequently they develop prone to physical, social and emotional hazards (Mandalazi, Banda & Umar, 2009) showing that non-medical determinants of



the health of children must be considered in working on their health problems (Kelly & Caputo, 2007). Given the extent of these problems, the health of these children is a serious concern (Prinsloo & Ritcher, 2003).

Furthermore, responses of health facilities towards the health needs of street involved children are limited by factors beyond the personal decision of the children (Kelly & Caputo, 2007). The attention of government and other stakeholders to address the health needs of street involved children is too low especially in Africa (Edusei & Amoah, 2014; Muchinako, Chikwaiwa & Nyanguru, 2013; Amury & Komba, 2010) which in part stems from the fact that little is precisely known about these children (Kopoka, 2000).

A set of literatures show that the situation in Ethiopia is not exception to African countries' denial to accord attention to the health conditions of street involved children (Abrha, 2016; Mulualem, Kirubel, Mezinew & Hinsermu, 2015; Demelash & Addisie, 2013; Busutill, 2012; Sophia, 2010). In addition to the findings of these researchers, existence of only a thin number of researches on the health issues of street involved children in the country (according to my assessment) is one of the indicators of this denial. Yet, these few studies that have been carried out on the health conditions of these children in different cities and towns of the country have considerable gaps (discussed below) some of which were addressed by this study.

Mulualem et al (2015) studied the decision making challenges of homeless pregnant teens living in Addis Ababa by employing in-depth interview and focus group discussion methods. The study is specific in its concerns of study (pregnancy decision making), in studied population (pregnant teens), and in intention. A study carried out by Demelash and Addisie (2013) also focused on reproductive health state of street involved children in Addis Ababa. These

researchers focused on assessing the sexual and reproductive health needs, service utilization, and factors associated with sexual activity. The study was limited to the children who could speak Amharic language.

Close to the above studies Tadis, Berihun and Nigusie (2014) studied reproductive health behavior and needs of street youth residing in the streets of Gondar town. They focused on the reproductive health of youths particularly; they did not involve non-reproductive health concerns and behavior; they also involved only youths in their study. Ejigayew (2010) also assessed reproductive health behavior and needs of street youth in Dessie town. In her assessment, she focused on assessing sexual behaviors of street youth by exploring factors that influence their sexual behaviors, and their reproductive health service needs and utilization using survey method.

Another study that was carried out on health concern of street involved children of Ethiopia was a descriptive study by focusing on the etiology and types of illnesses the children face in Adama town (Yemane & Yemane, 2016). The perception of the children on health and illness, the ways they perceive and cope up with illness symptoms, and accesses to health facilities of the children patients were not studied. In his study of the situation of street children and their socio-economic problems in Hawassa town, Shimelis (2015) merely identified health need of the children as one of their basic needs but gave trivial weight to the details of the phenomenon.

Lastly, a study conducted using interview, focus group and participant observation by Sophia (2010) in Addis Ababa addressed the health seeking behavior of street involved children and whether their rights of access to health services were safeguarded. This research is closely related to my study but different in two important ways. First, she limited the health care options

that the children can access to public health facilities; I broadened this option to all accessible care options i.e., incorporating non-public health care options. Second, she did not explore the user-friendliness of waiver health system of Ethiopian government to the needs of these street involved children. In contrast, I explored the eligibility situation of the street involved children to use the national health protection system and their actual accessibility.

As I discussed above, the studies carried out with Ethiopian street involved children generally showed that the health condition of the children was not sufficiently studied. Additionally, the few existing studies still focused on the reproductive health aspect of the children. Some of them merely identified health needs of the children as in need of attention but lacked the whys and the hows. These studies, as a result, did explore the health seeking behavior of the children and their capacity to access health services. The study of Sophia (2010) fairly covered these issues but has vital gaps as identified above.

In a different way from the above studies, my study focused on the vulnerabilities of the children to diseases, the way they understood health, illness symptoms; the coping mechanisms they used to restore their health when they contract diseases; and their possibility of admittance to health facilities on illness incidents.

In addition to the gaps identified above in the studies undertaken in Ethiopia, there were other important grounds that substantiated the need to carry out my study. After undergoing studies/assessments, a number of researches carried out on the region where Ethiopia is located Ethiopia (Sub Sahara, Low Income Countries) have been recommending for further studies on the health seeking behavior and the access to health services of street involved children as seen below.

In their work of summarizing available knowledge and views of the health conditions of street involved children and youth in low and middle income countries Woan, Lin and Auerswald (2013) recommended that the health concerns of the children are understudied in need of further studies. These researchers identified few studies from their systematic search for articles published on the issues and between January, 1995 and September, 2011 to arrive at this recommendation.

Tsoka-Gwegweni and Cumber (2015) also recommended the need for further researches on access to health care services by street involved children particularly in Sub-Saharan Africa where the children carry the utmost disease burden. They uncovered that their assessment for studies that have been carried out on health care access of street involved children in sixteen Sub Saharan African countries yielded only two studies.

Dybicz (n.d) recommended for a need of further evidence based knowledge for interventions with regard to the health needs of street involved children ensuring that research on the issue is at its infant stage. Boivin, Roy, Haley and Fort (2005) similarly insisted for further epidemiologic research to better define the health needs of street involved children deeming this population segment as especially vulnerable population group in low income countries.

After showing that there are complex challenges that the health phenomena of street involved children have for policy makers in low and middle-income countries, UNICEF recommended that there is need to understand the drivers of health seeking behavior of street involved children. Studies analyzing this issue particularly help to develop need based and client centered health policy in appropriately meeting needs of the population (Shaikh & Hatcher, 2014).

The recommendations forwarded by the studies discussed above generally indicated that the health concerns of street involved children in Sub Saharan African countries in general and their health seeking behavior and access to health care in particular were under-researched.

Consequently, they insisted, further researches ought to be carried out on the area to make inputs in the attempts of getting the health conditions of these street involved children improved and their human rights respected. Utilizing recommendations of these studies, therefore, I studied the health seeking behavior of the street involved children and their health need satisfaction to make a contribution to the improvement of their health status and enhancement of social justice.

Lastly, I realistically combined the two concerns (health seeking behavior and access to health services) believing that if the health seeking behavior and access to health services of these street involved children were not studied in combination, the locus of no/under utilization of health facilities by the children could not be specifically located. Doing so, this study thumped both demand (will and ability of the children) and supply (provision) sides of the services. By identifying where the problem exactly lied, doing so is a key to show how to bridge the health needs of the children and health facilities.

Generally, all the above discussed evidences indicated that the current health condition statuses of street involved children were so pressing; their health-seeking behaviors and access to health facilities were under-researched; and the undertaken studies had considerable gaps. Standing on these grounds, my study aimed at achieving the objectives identified below.

### **1.3 Objectives of the Study**

#### **1.3.1 General objective**

The overall aim of this thesis project was to study the health seeking behavior of street involved children and their access to health care services.

### **1.3.2 Specific objectives**

In pursuit of the above general objective, this study had the following specific objectives.

- To describe the life situations of the street involved children in relation to their health connotations
- To describe how do street involved children understand health, illness and ill health
- To explore how do the street involved children recognize and respond to the illness symptoms they face
- To explore the conditions that influence street involved children to engage in different illness coping strategies
- To explore the realization of the health care access rights of the street involved children
- To identify the barriers to the street involved children in accessing health care services

### **1.4 Scope and Significance of the Study**

This study was confined to the town of Ambo municipality which is the seat of West Shoa Zone of Oromia regional state. The street involved children who were between age 10 and 18 were the population of this study. Among some groups of street involved children, children ‘of’ street was the group that participated in the study. Methodologically, my study was delimited to qualitative research approach triangulating the methods of in-depth interview, focus group discussion, key informant and systematic observation.

In its concern, my study was delimited to exploring the coping strategies that the children employed in overcoming perceived physical and mental illness symptoms. It did not cover the paths they went to fix their social health problems. Regarding secondary materials, I used the

literatures that have been written in twenty-first century except declarations/legal bodies/policies/strategies, and original works of theorists for which I went back to the second-half of twentieth century.

This study had a general aim of improving the health status of street involved children by providing evidence based findings and interpretation on the way the children handle illnesses and their possibility of admittance to use health facilities. Doing so, this study has vital potentials to provide different stakeholders with a plethora of critical inputs at its completion.

Providing knowledge on health seeking behavior and choices availing in the illness behavior of the street involved children, this study can be an input in promoting a change in individual illness behavior of the children towards more favorable health seeking behavior. This study also is significant in improving health service delivery to the street involved children who were in need of the service but could not from practical access.

This study also helps policy makers, implementers and direct health practitioners to understand the health seeking behavior of the street involved children such that it informs policy makings and direct practices. It also helps them in designing and implementing pro-poor health interventions that aim to tackle the health threats to the children.

The outcomes of this research can also be a crucial resource in improving the quality of life of the urban community as a whole for street involved children constitutes a significant portion of this community. Lastly, this study enables the voices of the voiceless children to be heard to concerned stakeholders.

## **1.5 Definitions of Operational Terms**

The following terms and phases were defined as they were applied to this particular thesis project

*Access to health care:* the possibility for the street involved children to identify, accept, accommodate, reach and use formal health services when they recognize that they get sick.

*Children 'of' street:* a group of street involved children who stay on street all day and night and have no family contact

*Etiology:* any state or process that causes ill health

*Health care seeking behavior:* the behavior of seeking formal health services by visiting health settings

*Health facilities:* settings where health services are provided by trained health workers

*Health seeking behavior:* the way the street involved children understand health and illness, and take actions to cope up with the illnesses when they get sick.

*Health threats:* conditions that jeopardize health status of the children

*Ill health:* any health problem

*Leftover food:* food that is remained after someone else eats some portion of it

*Menial work:* a type of works that need no skill and knowledge, and undertaken through natural labor and is barely gainful

*Meta analysis method:* it is a method of analyzing qualitative data that helps to analyze the findings of a study in relation to the findings of previous studies on the area

*Participatory interpretation:* interpretation of findings in which the ideas and perspectives of the data sources are emphasized

*Perceived illness symptoms:* illness symptoms that the victim feels and recognizes whether the symptoms are supported by medical examinations or other authorities or not



*Sleeping off an illness:* it is ideational illness coping up strategy in which the children hope that illness they experience leaves them by itself, through natural body cycle

*Street involved children:* the term I used in place of the term street children for it is more ethical

*Waiver health care/service system:* a system of providing health services through government expense that aims to protect the rights of indigent social groups to access health facilities when they get sick but cannot afford the services.

## **1.6 Organization of the Paper**

This paper has six chapters. The first chapter is an introduction that introduces the study concerns, specifies what was to be studied, why the study was required and the significances of the study outcomes. The second chapter deals with the knowledge that exists on the area of my study and how this body of knowledge can be input for this specific study. The third chapter depicts how the study was carried out from the beginning to the end. The fourth chapter presents the results of the study. In the fifth chapter, the findings of the study are discussed in relation to previous studies, and theoretical and legal frameworks. The last chapter concludes the study and forwards possible social work implications of the study findings, and recommendations.

## **CHAPTER TWO: LITERATURE REVIEW**

In this section, I discuss the knowledge that the existing array of literatures offer on the concern of my study. I present these systems of knowledge existing across the world (low income countries focused) synthesizing them into seven themes. First, I describe important concepts that are important for this study. Next, I discuss life of the children in street with its implication to their health conditions. In the third section, I discuss what does the context of Ethiopia look regarding the health concern of street involved children, followed by how do street involved children perceive and respond to illnesses they face. Fifth, I discuss the admittance of the children to health facilities in their act of responding to illness symptoms they face. The last section deals with the theoretical frameworks developed on the areas of this study.

### **2.1 Concepts: Child, Street and Street Involved Children**

Most global bodies disagree on deciding the age at which childhood ends, and they set the upper age edge of children differently (Pietkiewicz-Pareek, 2012). The UN (1989) defines all people up to 18 years of age as children.

Development of children is so groundbreaking in determining both immediate and long term well being of the child and the society (Mondal, 2013). Children have the right to grow in a constructive environment for the society and their growth is shaped by their surrounding world (Rioux, 2016). In spite its vitality, systematic evidences show that the conditions in which many children live today are becoming worse to which street involved children are typical group (Ayub, Kumar & Shora, 2015).

Street in the concept of street children are the spaces on roads, sidewalks, verandahs, railway terminals and platforms, bus stations, parks, religious centers, construction sites, around graveyards, under bridges and other open public places where the street involved children work and sleep. These spaces are used as home by the children (Uddin, Koehlmoos, Ashraf, Khan, Saha & Hossain, 2009).

Being heterogeneous population and their fluid usage of street, street children are not a clearly defined social group. Although usage of the term differs across literatures, there are a set of definitions in use (Ray, Davey & Nolan, 2011). According to Pietkiewicz-Pareek (2012), street children are children for whom the street more than their family has become their real home. The United Nations defines the term as:

Any boy or girl --- for whom the street in the widest sense of the word --- has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults (UN, 2012: p. 4).

Recently, the term ‘street children’ has become under increasing criticism as labeling and stigmatizing due to its connotations of delinquency in many societies, and for this reason it is disliked by researchers and children themselves. Considering this, writers have been arguing that the use of terms that stigmatize children should be avoided in order to preserve their dignity, and generate improved public and official attitudes towards them (Ray, Davey & Nolan, 2011). For this reason, the terms “children working and/or living on the street,” “children in street situations” “street involved children” and “children with street connections,” are in use (UN, 2012, p.5). Progressively thinking Ray, Davey and Nolan (2011) insist that rather than trying to

arrive at watertight definitions and argue on terminologies, programs should be based on a clear and contextualized analysis of the children who will be involved

In trying to classify street children, many researchers and practitioners (e.g. Mufune, 2000; Ali & Muynck, 2005; Nanda, 2008; Wargan & Dershem, 2009; Pietkiewicz-Pareek, 2012) used a grouping which is ascribed to UNICEF. These groups are children *on* the street, who work on the street and go home to their families at night; children *of* the street, who live on the street without family contact and support; children of street families, who spend nights (sleep) in the streets together with their adult family members.

There is general agreement that estimates the number of street involved children in the 1980s (100 million) were exaggerated though still widely quoted. But a rapidly urbanizing and growing global population together with increasing inequalities and migration suggest that numbers are generally increasing (UN, 2012). Though it is very difficult to establish the numbers of street involved children in each setting, program and policy works should be based on the most realistic available estimates of the numbers of street living and street working children (Ray, Davey & Nolan, 2011).

## **2.2 Life in Street and Illness Incidence**

Representing a typical case of urban poverty, millions of street involved children across the world are left to survive on their own. They face difficulties in maintaining their health on daily life basis and in accessing to healthcare. They are ill-treated, starved, ruthlessly abused, exposed to accidents, socially deprived, abandoned (Fiasorgbor & Fiasorgbor, 2015) and they are also the hardest to reach with vital services (Tsoka-Gwegweni & Cumber, 2015). Their entire life situations expose them to a long list of physical, social and psychological hazards (Tsoka-

Gwegweni, 2015; Amoah & Jorgensen, 2014; Gupta, 2012; Sophia, 2010; Mandalazi, Banda & Umar, 2009) than their counterparts (Gaston, 2001). Thus, these children experience a disproportionate amount of health problems (Tsoka-Gwegweni & Cumber, 2015; Barry, Ensign & Lippek, 2002).

The social wellbeing of street involved children is also highly disturbed. Public perceptions place street life as dangerous, destructive, sexualized and diseased. Media typify children on streets as antisocial, violent and associated with organized crime and drugs (de Benitez, 2008). Thus, their ability to trust and form attachments with society are severely damaged with potential effects for their development of future relationships. This attitude lastly ends in unbearable costs to the street involved children and society as a whole (UN, 2012).

Children in street also evidence frequent psychological distress to profound trauma. While the streets can offer respite from domestic violence, they expose children to settings that are adversarial to their emotional health including daily psychological violence through stigmatization, intimidation and violence (UN, 2012). When the withstanding capacity of the children is considered, they encounter health ills that they often are too young to understand which leads to other emotional distress. These experiences of stress through constant changes accumulate with time leading to a higher incidence of mental disorders, which become manifested in their behavior. Worst of all, such extensive exposure to violence underlies children's other challenges in the street and carries serious consequences for long-term health and personal development through adolescence into adulthood (de Benitez, 2003).

### **2.3 Local Context**

Living in street is common in the context of Ethiopia in the capital city, Addis Ababa, and towns (Yemane & Yemane, 2016; Abrha, 2016; Shimelis, 2015; Fekadu et al, 2014; Degwale, 2014; Sophia, 2010; Tatek, 2008; Tadesse, 2006). The findings of the study conducted in the town of Hawassa indicate that the most popular and usual sleeping places for street children of the town are roadsides and verandah (Shimelis, 2015). In such like sleeping spaces, Fekadu et al, (2014) indicated that the street involved children frequently report that they suffer life-size due to weather, environmental hygiene, and verbal and physical abuses.

For they live in street, children face several difficulties such as physical and sexual harassments, societal marginalization and abandonments of their rights to get the necessary services such as food, housing, education, and health care; their situation become worse by the negative attitude of the general public who are insensitive to their problems (Shimelis, 2015). According to Degwale (2014), street children lack recognition and respect from the community than ability to work.

Health problems are major problems of the street involved children in Ethiopia. Their hazardous street life exposes the children to a lot of acute health problems. Characterizing the street involved children living in Adama town as exposed to harsh environment; savage food from garbage bins; having very poor personal hygiene; being substance users; lacking family supervision and guidance; and engaging in unprotected sex, Yemane and Yemane (2016) concluded that they are exposed to miserable health hazards. Significant number of street youth in the town of Gondar also engages in high risk sexual practices (Tadis, Berihun & Nigusie, 2014).

These children's access to health facilities is bare (Yemane & Yemane, 2016; Sophia, 2010). Despite their heightened victim to diseases, they have extensive unmet needs (Sophia, 2010; Fekadu et al, 2014). Contrast to their expectations, Fekadu et al (2014) indicated that there is little support mentally ill homeless residents Addis Ababa obtain from even their family, local and international organizations, and the community. Although the health care facilities are available physically in Adama town, the street children's access to them is limited by their social status and economic constraints (Yemane & Yemane, 2016).

Standing on the findings he found out from his study in the town of Mekelle, Abrha (2016) call for all policy makers, community workers, special educators, and researchers to address the current difficulties and challenges of street children. There is poor dedication by the government in addressing the problems they face (Shimelis, 2015) in need of comprehensive health and social interventions (Yemane & Yemane, 2016).

## **2.4 Health Seeking Behavior and Street Involved Children**

### **2.4.1 Beliefs of street involved children on health and illness**

All street involved children are living in circumstances that shape their concepts about their health and illness (Nanda, 2008). These behaviors stem from their routine life experiences (Prinsloo & Ritche, 2003). For street children, the understanding and concept of health is a state that would allow them to work (Ali & Muynck, 2005; Nanda, 2008). They understand slight that health is an important element for wellbeing (Nanda, 2008; Prinsloo & Ritche, 2003).

According to Ali & Muynck (2005) and Nanda (2008), health is a prerequisite for work and is instrumental to survive. A great deal of findings emphasize that these children however are more preoccupied with the bothering for daily earning and survival than their health condition (Gupta, 2012; Amury & Komba, 2010; Rooyen & Hartel, 2002; Gaston, 2001).

Street children have a low self-perceived of diseases and illnesses. The illness recognition of street children relies on the gravity of the illness symptoms. Small injuries and minor illnesses are categorized as nothing but only a frailty which does not hinder their livelihood. Only major illnesses are identified as a disabling condition that would force them to stay away from work (Nanda, 2008) explaining the attitude of street children in engaging in medical treatment during the times of variety of illnesses (Gupta, 2012).

#### **2.4.2 Illness incidence and coping strategies of street involved children**

Illness coping strategies are composed of the varied behaviors depending on knowledge and perceptions of health, socioeconomic status, adequacy of health services and attitude of healthcare providers. These coping strategies are undertaken by individuals who perceive themselves as having a health problem for the purpose of remedy. But, there are differences on how people respond to illness symptoms. Some people may deny their illness symptoms and diseases; others may exaggerate (Chin & Noor, 2014). Furthermore, some measures are effective whereas others are ineffective or even harmful (Nayak, Sharada & Geroge, 2012).

There are various ways in which illness symptoms are evaluated and acted upon by street involved children (Chin & Noor, 2014). Some of them do nothing and others go to hospital (Yohannes, Yoel & Salwa, 2014) because health seeking behavior is associated with a set of factors (Young, 2004; Harding et al., 2002). The first response of street involved children to an illness is self medication using both homemade and commercially prepared remedies (Ali and Muynck, 2005; Prinsloo & Ritcher, 2003). According to Prinsloo and Ritcher (2003), street involved children first try to treat health problems themselves. Then, they would ask friends for advice. Substance use to get them through is also one strategy under this self medication.



Traditional healing is the other coping mechanism used by street involved children. They are considered economical and easily accessible by the children. These traditional healers hold the reputation of knowing secret cures for chronic and incurable diseases so that they are the preferred choice in situations where modern medicine fails or economic constraints become a key factor (Ali & Muynck, 2005).

The street children visit a spiritual healer, when they believe that illness is mainly due to evil spirit and when they fail/hate to use other services (Ali & Muynck, 2005). A study conducted by Fiasorgbor and Fiasorgbor (2015) in Accra (Ghana) showed that the act of sleeping off sicknesses is one of the responses the street involved children respond to illness incidents though it has serious implications for the health of the street children by delaying treatment.

When formal health care usage is concerned, street involved children delay seeking medical facilities (Prinsloo & Ritcher, 2003). They only seek health care in situations where illness persists longer; disable their survival struggle and when they can afford to pay (Ali & Muynck, 2005). If we aim to investigate the way in which people in particular places make decisions regarding their patterns of health seeking behavior, we should dig out the way in which they identify the merits and risks attached to that particular behaviors (MacKain, 2003) which is discussed next.

### **Conditions influencing the choice of coping strategies**

In trying to treat medical infirmity, people make choices from options of actions. This obviously depends on the number of choices available and ability to access the chose option (Rebhan, n.d). But, it is difficult to identify which determinants are most influential in the decision to utilize

health care (Prinsloo & Ritcher, 2003) though the presence or absence of these factors either initiate or restrain health behaviors (Amury & Komba, 2010).

There are a number of factors that determine the likelihood of engaging in a particular health seeking behavior. Culture, economics, access, perceptions, knowledge, belief in efficacy, age, social networks, roles, laws and regulations, and health care delivery system are all among the extensive list of factors influencing both the choice to seek health care and the assessment of which health care option to utilize for prevention and treatment of illness (Rebhan, n.d).

Street involved children view the health care system in a narrow biomedical context (Prinsloo & Ritcher, 2003). Their decision to seek medical advice depends mainly on gravity of the illness and financial situation (Ali & Muynck, 2005). These children most often cannot bear the cost of services (Prinsloo & Ritcher, 2003) and they affirm physicians as their choice when it comes to acute problems (Ali & Muynck, 2005).

Among the factors that have been associated with health seeking behavior is individuals' perceptions of their social location (MacKian, 2003). The first is perception of control. It is the subjective determination of the ability to determine or influence something that affects oneself (Wallston, n.d). The second perception is locus of control. It refers to the person's belief as to whether control over valued reinforcements is internal or external to the person. A person with an internal locus of control orientation believes that reinforcements are a consequence of either some action (s) in which the person engages. A person with an external locus of control orientation believes that reinforcements are the result of forces outside of the person (MacKain, 2003).

The influence of peers in the service seeking activities of street involved children shall not be overlooked (Ayaya & Esamai, 2001). Some adults on the streets serve as resource persons for the children in addressing their health problems and risks (Amoah & Jorgensen, 2014). They provide advices and lend money in times of need, but they are not always available, as they are busy in making livelihood (Ali & Muynck, 2005).

### **2.5 Access to Healthcare on Illness Incidence and Street Involved Children**

Health care is an essential service for street children and young people whose vulnerability to disease is exacerbated by life on the streets. Despite the essentiality, the circumstances of street children leave them without access to health services oftentimes (Fiasorgbor & Fiasorgbor, 2015; Ray, Davey & Nolan, 2011; Strehl, 2010; de Benitez, 2003). Worst of all, these children face barrier access to healthcare provided under governmental social aid programs for the majority of them lack a birth certificate and identity card (Strehl, 2010). There are multiple obstacles faced by street children bearing out this inaccessibility to health care services (Fiasorgbor & Fiasorgbor, 2015).

The study carried out on access to health care of street children in Addis Ababa (Ethiopia) indicates that no focus is given from government health care facilities in meeting their needs which range from disease prevention to care and treatment provision (Sophia, 2010). According to a research conducted in Canada recently, inadequate health care for street-involved youth is one of the country's great unmet needs (Elliott, 2016) underscoring the problem is rampant in the developed states even.

Authorities do quite little for street involved children; only under pressure as Kopoka (2000) argued on one of international conference on the health conditions of street involved children

living on streets of East Africa. Unfortunate of all, the practice of assessing unmet needs by service providers is almost absent (Uddin et al, 2009).

### **2.5.1 Legal and policy frameworks on access to health care of street involved children**

Working with street involved children in difficult circumstances is not a matter of humanitarian and charitable concern, but a legal responsibility at local, national and international levels (Panter-Brick, 2002). However, the mere existence of these legal frameworks cannot guarantee the protection of the health rights of the children. Mufune (2000), for instance, identified two problems in policy and programs targeted to benefits street youths and children. These are tendency that emphasizes compulsion in dealing with street people as against their understanding of their needs and promoting interventions that are so short term.

Specifically, African countries have many good national laws and some are specifically aimed at street children, but these policies are often not properly implemented or evaluated (UN, 2006 & UNICEF, 2009). Despite their implementation, it is worthwhile to see at the major legal frameworks that enshrine the rights of street involved children to access health services some of which I discussed hereunder.

#### **Global level**

##### **➤ United Nations Convention on the Rights of the Child (UNCRC)**

The most widely endorsed human rights treaty in history is the Convention on the Rights of the Child. It was adopted by the UN General Assembly in 1989 and has been ratified by 193

countries. Nonetheless the Convention makes no special reference to children working and/or living on the street, all its provisions are applicable to them (UN, 2012).

The UN (1989, p.1) states“...*everyone is entitled to all the rights and freedoms set forth herein, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.*” The definite article “*the*” defining the term child in the nomenclature of the convention itself signals its reference to all children of the world with no exception.

Accordingly, the UN (1989; p. 7), article 24/1 states:

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Article 24/2/b of the convention binds the states parties to pursue full implementation of this right (mentioned on article 24/1 of the convention) taking appropriate measures “*To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care*”(p. 7). While States play the role of the principal duty bearer for all children – including street-connected children – other non-State entities, professionals and individuals are also recognized by the Convention on the Rights of the Child as duty bearers in the fulfillment of children’s rights. They include parents and families, teachers, doctors and social workers, employers and/or probation officers. States have the obligation, as principal duty bearers, to ensure that the secondary duty bearers have the knowledge and means to carry out their specific obligations (UN, 1989).

## **Domestic level**

### ➤ **Constitution of Federal Democratic Republic of Ethiopia and health of street involved children**

Broadly speaking, the constitution of FDRE (FDRE, 1994) has enshrined statements that substantiate rights of children to access health care that can also extend to the health needs of street involved children of the country.

Every child has the right not to be subject to exploitative practices, neither to be required nor permitted to perform work which may be hazardous or harmful to his or her education, health or well-being” (Article 36/1/d); “All persons have the right to a clean and healthy environment” (Article 44/1/d) and article 92/2pursues “Government shall endeavor to ensure that all Ethiopians live in a clean and healthy environment.

### ➤ **Health Policy of Transitional Government of Ethiopia and health of street involved children**

The general objective of the National Health Policy of Ethiopia is to improve the health and wellbeing of all Ethiopians. Moreover from its preamble to the specific priority areas of the service, the policy states that it is committed to equity and justice in health service distribution (Transitional Government of Ethiopia, 1993).

The policy enshrines “*assurance of accessibility of health care for all segments of the population*” as one of its general policy areas and providing “*special assistance mechanisms for those who cannot afford to pay*” as one of its priority focuses. The policy identifies those hitherto most neglected segments of the population including the urban poor as one of the segment in need of special attention (Transitional Government of Ethiopia, 1993; p. 4-6).

➤ **National Health Care Financing Strategy of Ethiopia [2015-2035] and health care access of street involved children**

National Health Care Financing Strategy [2015-2035] is the revised version of Ethiopian Health Care Financing Strategy of 1998 which was developed and endorsed to increase resources for health, enhance efficiency in the use of available resources, improve the quality and coverage of health services, ensure equity and promote sustainability. This revision consists of ensuring universal health coverage through primary health care by the year 2035 as one of its goals.

In pursuit of its general objectives, this Health Care Financing Strategy has a set of specific strategic objectives. One of these specific objectives is “*reducing out of pocket spending at the point of use*” (p. 10). “Strengthening the waiver system and insurance coverage of indigents” has been mentioned as one of a strategic approaches used to meet the objective (p.11). The strategic approach states,

“... the government will enhance the effectiveness of waiver system through increasing the funding of waivers and increase the number of people covered by waivers by facilitating the setting up of different schemes like equity funds at federal, regional and woreda level; improving the targeting of waivers by setting up clear targeting/selection mechanisms based on best experiences within the

country and elsewhere; and Providing clearer regulations and mechanisms for reimbursement of health facilities and ensuring that these regulations are enforced” (MoH, n.d, p. 11).

On its discussion of the third objective of enhancing equity and justice, the strategy directly identifies street involved children as the prime beneficiaries of the waiver programs. It states, “Ethiopia will strengthen the current fee-waiver programs increasing its financing; improving its targeting and selection mechanisms. Federal Ministry of Health will work with and through other ministries to benefit and include special groups such as street children, and people with disabilities with waiver programs” (p.13).

### **2.5.2 Dimensions of health service access**

The factors determining access to health care could be broadly grouped under *spatial* and *aspatial* factors. Spatial factors embody factors relating to geographical barriers such as time or distance between health service providers and consumers. *Aspatial* elements however entail non-geographic factors including social class, age, sex, health seeking behavior, cultural traits, people's knowledge on health and health care as well as income levels as determinants of access to health care (Wang & Luo, 2005).

In line with these two broad factors, five dimensions have been identified in literatures with regards to the factors which influence ability and willingness of people to use a health service. These dimensions are availability, accessibility, accommodation, affordability and acceptability. The statuses of one or more of these factors either encourage or discourage people from accessing particular health service (Levesque et al., 2013; Edusei & Amoah, 2014; Peters et al., 2008; Sinha, 2008).



**Availability:** connotes the opportunities and options people possess with regards to health care. It refers to whether health services exist (Levesque et al., 2013) for its absence is one of the reasons why the poor in societies tend to use services of informal care providers (Peters et al., 2008). This situation also stands for street involved children (Edusei & Amoah, 2014).

**Accessibility:** Factors such as travel time, availability of adequate communication services, distance to facilities and quality of roads could determine when, where, and how people use particular health services (Peters et al., 2008; Sinha, 2008). It is also related to the notion of personal mobility, occupational flexibility, and knowledge about health services that would person to physically reach service providers. It is correlated that there is an inverse relationship between distance to health facilities and the use of health facilities depending on type and severity of ailment (Edusei & Amoah, 2014).

**Affordability:** Affordability connotes the economic capacity to spend resources and time to use relevant health services (Levesque et al., 2013). These include direct user charges and related costs such as transportation cost, cost of treatment drugs, lodging, and expenses on prescribed food. Studies have shown that, the poor are often deterred by user fees (Amury & Komba, 2010; Peters et al., 2008).

**Accommodation:** Factors such as appointment systems, hours of operation, waiting times, the amount of time spent in assessing health problems and in determining the correct treatment; and technical and interpersonal quality of the services provided may determine the accommodative nature of a given service (Edusei & Amoah, 2014). Accommodation is related to their capacity to communicate as well as notions of health literacy, self-efficacy and self management in addition

to the importance of receiving care that is actually appropriate for the person, given its resources, skills and willingness (Edusei & Amoah, 2014; Levesque et al., 2013; Sinha, 2008).

**Acceptability:** Acceptability relates to cultural and social factors determining the possibility for people to accept or reject aspects of a given health service. It embodies the expectations and perception of people with regards to the services that are provided (Edusei & Amoah, 2014).

Attributes such as type of facility, beliefs of clients, providers' relationship with clients; level of service and education or training of the providers determine the type and the rate at which clients utilize some health facilities (Peters et al., 2008). Thus, health care requirements should be appreciated in ways that will encourage their use of available health services (Edusei & Amoah, 2014).

### **2.5.3 Barriers to street involved children in accessing health services**

Literatures describe that there is little or no access to health care of street involved children (Tsoka-Gwegweni & Cumber 2015) because there are a number of barriers for street-dwellers to access the services (Amury & Komba, 2010; Uddin et al, 2009; Nanda, 2008; Gaston, 2001).

These barriers are similar to those faced by homeless youths and adults. However, street involved children are less able than their adult counterparts to overcome these barriers because of their age and lack of experience (Gaston, 2001 and Situmorang, 2005).

Several individual and systems level barriers to health care exist for this population (Elliot, 2016; Situmorang, 2005; Sophia, 2010). Health service cost is a primary barrier for street involved children who earn little/nothing on the streets experiencing extreme poverty (Tsoka-Gwegweni & Cumber 2015; Sophia, 2010; Nanda, 2008; Elliot, 2016; Nodjadjim, 2000) including the cost of public health facilities (Nodjadjim, 2000).

Psychological barrier is the other condition precluding the health care seeking behavior of the street involved children. They fear negative attitude and stigmatization the health staff may have towards them considering their minority status (Tsoka-Gwegweni & Cumber, 2015; Sophia, 2010; Nodjadjim, 2000; Elliot, 2016). They believe that the health providers may not take their needs seriously for they perceive themselves as minority group (Situmorang, 2005). They also have issues with trusting adults or authority figures (Elliot, 2016). According to the findings of Uddin et al (2009), many of the street-dwellers lack knowledge about available health services and the locations. They also lack knowledge to access appropriate health care (Elliot, 2016; Situmorang, 2005).

Fourthly, it is found out that the ways the children perceive health contribute to the less utilization of available health care services (Sophia, 2010); sometimes they deny to visit health service providers contemplating their health ills go away after a while (Gaston, 2001).

Sometimes, the street involved children fear social services for they identify them with authority involvements like police men (Situmorang, 2005). The last barrier discussed herein is confidentiality issue. The children distrust adults and professional agencies for they are not accustomed to and victim to the stigma of the society (Elliot, 2016; Situmorang, 2005; Gaston, 2001).

The task of helping street children with their health conditions is not an easy task; it cannot be achieved by simply injections of money or presence of laws, Kopoka argued (2000). When designing a health system, both real and perceived barriers to care (most of which have been discussed above) should be addressed. Having tailored services, low or no cost and specific to meet the needs of the target population may help to overcome the barriers (Gaston, 2001).

## **2.6 Theoretical Frameworks**

To facilitate the understanding of the complexities of health seeking behavior, health care utilization and the way service providers approach street involved children, I discussed three theories, three models and three approaches are discussed below. According to Strehl (2010), it is important to stress that these approaches are complementary in practice and that no single approach addresses the needs of the entire group of street children.

### **2.6.1 Theories on health seeking behavior and health care utilization**

#### **Sick role theory**

Sick role is one of the first theories of health care utilization which was proposed by Talcott Parsons. It elucidates that when an individual is sick, he/she assumes a role of being ill. Four components of this inquiry: 1) the individual is not responsible for their state of illness and is not expected to be able to heal without assistance; 2) the individual exempts from assuming routine roles; 3) generally recognized, being sick is an undesirable state; and 4) to facilitate recovery, the patient has to seek medical assistance and comply with medical prompt. This theory identifies typically seen behavior in the sick individuals (Ali & Muynck, 2005; Byrd, 2013).

#### **General theory of help seeking**

This was developed by Mechanic in 1978 taking a psychological sphere to health care utilization. The theory identifies ten conditions as determinants of illness behavior: 1) the salience of deviant signs and symptoms; 2) the individual's perception of symptom severity; 3) the disruption of the individual's daily life as caused by the illness; 4) the frequency of symptoms and their persistence; 5) the individual's tolerance of symptoms; 6) the individual's knowledge and cultural assumptions of the illness; 7) denial of illness as a result of basic needs; 8) whether or

not response to the illness disrupts needs; 9) alternative interpretations of symptom expression; and 10) treatment availability via location, economic cost, psychological cost and treatment resources. Additionally, the theory insists that illness response is influenced by the individual who makes decisions for treatment. Hence, autonomy and heteronomy influence health care utilization (Mechanic, 1979; Ali & Muynck, 2005; Sutton, 2002; Rebhan, n.d).

### **Stages of illness and medical care**

Developed by Suchman in 1965, it indicates five stages of decision making process to decide whether or not to utilize health care: 1) symptom experience of the person; 2) the assumption of sick role; 3) medical care contact. During this stage the individual seeks a professional health care system; 4) the assumption of a dependent-patient role via acceptance of professional health care treatment which is possible to be disrupted if the user and the care provider do not agree on the illness; 5) the individual's recovery from illness. The individual recovers upon relinquishing their role as patient. However, if an illness is not curable, a person may assume a chronically ill role (Suchman, 1965; Young, 2004).

## **2.6.2 Models on health seeking behavior and health care utilization**

### **Health belief model**

This model explains the individual's behavior to treat and prevent disease via synthesis of four major conditions the individual's perceived susceptibility to disease (Levesque et al, 2013; Ali & Muynck, 2005; Young, 2004; Sutton, 2002). 1) An individual will seek preventive health services if he or she believes they are susceptible to disease. 2) The perception of illness severity. If a person does not perceive the illness as serious, they will not seek treatment or prevention. 3) The individual's rational perception of benefits versus costs. An individual will not take action

unless the treatment or prevention is perceived as having greater benefits than costs. 4) The individual's cues to action. Media, friends, family, or well known citizens can provide an impetus for prevention. The absence of cues to action will reduce the likelihood of prevention. Thus, the individual's choice to utilize health services is context dependent.

### **Health behavior model**

Health behavior model forms three components with a linear relationship: 1) primary determinants; 2) health behaviors; and 3) health outcomes. Primary determinants are noted as the direct cause of health behaviors; these determinants include characteristics of the population (i.e., demographics), the health care system i.e., resources and organization, and the external environment i.e., political, physical, and economic influences (Levesque et al, 2013; Ali & Muynck, 2005; Barry, Ensign & Lippek, 2002; Young, 2004). In addition, the model explains that health behaviors determine health outcomes. Health behaviors include personal health practices (i.e., diet and exercise) and the use of health services. Health outcomes include perceived health status, evaluated health status, and consumer satisfaction (Ali & Muynck, 2005).

### **Choice making model**

This model was proposed based on ethnographic studies of health services utilization. This model incorporates four components that are most essential to the individual's health service choice: 1) perceptions of gravity. This category includes the individual's perception, their social network's consideration and their culture's definition of illness severity (Ali & Muynck, 2005). 2) The knowledge of a home treatment: If a person knows of an effective home remedy, they will be likely to utilize that treatment before utilizing a professional health care system. This is based on lay referral (Ali & Muynck, 2005; Young, 2004; Rebhan, n.d).

The third component is faith in remedy. This component incorporates the individual's belief of efficacy of treatment for the present illness. An individual will not utilize the treatment if they do not believe the treatment is effective (Levesque et al, 2013; Ali & Muynck, 2005; Sutton, 2002).

4) The accessibility of treatment: this incorporates the individuals' evaluation of the cost of health services and the availability of those services. Access may be the most important influence on health care utilization (Levesque et al, 2013; Ali & Muynck, 2005; Sutton, 2002).

### **2.6.3 Approaches to work with street involved children**

Strategies of street child services can be roughly divided into the reactive, the protective and rights-based approaches (Strehl, 2010). While the rights-based approach responds adequately to the legal responsibilities by governments upon ratification of the Convention on the Rights of the Child (CRC), Reactive and Protective approaches are also evident in practice in many countries. He insists children on the streets are one of the most disadvantaged sectors of urban youth. Their circumstances leave them without access to many of their human rights and excluded from mainstream society (de Benitez, 2003). Policies that affect these young people are influenced by the three approaches discussed below.

#### **Reactive approach**

This approach sees street children as a threat or potential threat to public safety that have to be corrected through imprisonment and punitive methods (Strehl, 2010; de Benitez, 2003). Since policy goal for this approach is to remove delinquents from the streets; the children can be arrested simply for living on the street. There are attempts at rehabilitation and instilling fear to prevent them from returning to street. However, evidence entail that the street involved children return to the streets since their problems are not uprooted (Consortium for Street Children, 2002).

**Protective approach**

It figures the children as victims and needing different treatment than adults suggesting their protection from potential social evils. Health care is considered a necessity although the priorities are identified via deductive reasoning than through grassroots method. Thus, street children are conceptualized as a residual category in health policies (Strehl, 2010; de Benitez, 2003).

This approach focuses on outcomes rather than means; on surface causes of problems instead of the underlying. It is charity-driven and sticks to residual approach. It lacks important elements of participation and empowerment (Canadian International Development Agency 2001; in de Benitez, 2003). Many democratic regimes, from neo-liberal to social conservative have this mindset (de Benitez, 2003).

**Right based approach**

To this approach, street involved children are groups whose fundamental rights have been violated and in need of legal protection (Strehl, 2010; de Benitez, 2003). To the rights-based approach, secured access to basic health services is recognized as entitlements of the children (de Benitez, 2003) and the children must be actively involved in programs aiming to fulfill these rights (Meincke, 2011; Richter & Rama, 2006; Sauvé, 2003; UNCRC, 1989). Thus states are responsible especially, not exclusively, for the protection of the rights and structural problem have to be highly emphasized in their efforts (Richter & Rama, 2006).

**2.6.4 The way the theoretical frameworks help this study**

All the above theories, models and approaches have important contributions in analyzing the findings of this study. First, the theories orient the concerns of this study to be studied



exhaustively by identifying vital issues in the process of health seeking behavior and access to health services of the street involved children. Second, the theories will be used in order to analyze the conditions behind different behavior of health seeking by identifying what forces exist behind each way of health seeking behavior.

Third, the models will be used to analyze whether street involved children have similar procedures of assuming illness roles and seeking help or not and why so. Fourth, the approaches will inform my research to study the approaches service providers apply in working with street involved children by identifying options of approaches that are underway across the world.

Generally the theories, models and approaches discussed above help the progress of this study by identifying its ladder and the rugs to go through.

## **2.7 Critical Gaps of the Literatures**

The literatures discussed above have explained a series of concerns in creating understanding of health conditions of street involved children, their health seeking behavior and access to health service. However, there are important gaps in the literatures that need further studies. First of all, most of the studies employed qualitative design which precludes them from transferability.

Hence their findings cannot stand for the specific conditions of street involved children in my specific area of study.

Second, the studies have been carried out either on the health seeking behavior of street involved children or their accessibility to health care services. Believing that these kinds of study fail in identifying the obstacles precluding the health care seeking behavior of the children, I combined the two concepts together to overcome the failures of the prior studies so that I precisely identified the factors why street involved children fail to access health services.

Third, the literatures fail to explain how and why the waiver health delivery systems in health policies of different states are not meeting the health service needs of street involved children. My study, thus, filled this gap by studying the implications of waiver health service system of Ethiopia to the health care seeking behavior of the street involved children who lived in Ambo town. In addition to discussing the existing body of knowledge and identifying the gaps that were to be filled by my study, the studies I reviewed shaped the way I went through to undergo the study.

### **2.8 The literatures and methodology of this study**

The literatures that are discussed above generated significant contribution for the methodology of my study. They supported me in important ways in designing the methodology of this study.

First, the literatures influenced the philosophy of my study to be in the tradition of relativism for the fact that the participants of this study have particular views and behavior influenced by their specific environment. Second, the literatures indicated that the characteristic of the population of this study is difficult to trace so that the relevant research approach has to be selected to reach the participants properly. This supported me to select a snowballing sampling technique in order to identify my study participants.

Third, the literatures assured that the concerns of my study should be studied through a design that helps to explicate data in-depth (e.g. Kroeger, 1983). They influenced my study by recommending that the participants have to be given longer time on data collection sessions so that they can elaborate their experiences adequately and freely than interfered by the data collector repeatedly. Thus, I selected data collection methods that give the participants longer time to share their experiences liberally and adequately. Lastly, the literatures indicated the scope of the concern of my study so that I developed my data collection tools comprehensively.

## **CHAPTER THREE: METHODOLOGY**

This chapter generally describes how the findings of this study were sought. It begins with discussing the research philosophy of this study. Next, the design of the study is described followed by identification of the study site and population. Then data sources, the methods of data collection and analysis are discussed. The last two sections of this chapter discuss the trustworthiness of the study, and how to protect the safety of the study participants.

### **3.1 Research Ontology and Epistemology**

Different ontological and epistemological positions in research often lead to different approaches towards even the same phenomenon. Regarding these research philosophies, researchers need to take a position regarding what things really are and how they work. Ontology is concerned with what reality is and its constituents (Creswell, 2014; Scotland, 2012) and there are different thoughts on the way realities are defined and understood (Creswell, 2014; Irene, 2014; Scotland, 2012; Porta & Keating, 2008).

This study was grounded on relativist ontology (Creswell, 2014; Irene, 2014). In line with this ontology, I assumed reality to be as embedded in specific time, space and culture contexts of the street involved children. The stuff of the children were understood from their own standpoint which was entirely dependent on their definition of the context in which they live, act, and behave.

Epistemology is about how we can know reality. It is the nature of relationship between would-be knower and what is to be known (Creswell, 2014; Porta & Keating, 2008; Cohen, Manion & Morrison, 2007; Grix, 2002). Scotland (2012) explained epistemology is concerned with how

knowledge can be created, acquired and communicated. Since this study aims to create spaces for thoughts of the participants in letting them speak up their experience in their specific context, I emphasized the weight of interpretative understanding, i.e. understanding the phenomena under study from the participants' perspective recognizing them as embedded in their historical and cultural contexts in which they inhabited (Creswell, 2009; Porta & Keating, 2008; Kalof et al, 2008).

In exploring the experiences and context of the experiences descriptions of the lived experiences of the study participants and making interpretations, I bracketed out my personal feelings, judgments and beliefs to the possible extent (Hancock, Ockleford & Windridge, 2007; Moustakas, 1994; in Creswell & Clark, 2006). Consequently, interpretations of all the experiences of the street involved children on the study area were done in sober and participatory manner (Van Manen, 2007).

### **3.2 Research Design**

This study was a qualitative inquiry. According to Grundy and Annear (2010), qualitative design provides more opportunity to explore motivations for different health seeking behavior and uncover contextual influences on understanding of care-seeking behaviors and coping mechanisms of the children. According to Kroeger (1983), there are two broad frameworks for looking at health seeking behavior: the pathway model which describes the steps of the process from recognition of symptoms to the use of particular health facilities which is studied qualitatively, and the determinants model which is studied via quantitative research design. Thus applying qualitative design, I studied the entire journey that the children went from how they defined health and illness to the coping up attempts they made in their activities of restoring their health.

In-depth interview, focus group discussions, key informant interview and observation were the data collection methods employed in this qualitative design are. Hence, the data presented in this research are the result of a set of anthropological and sociological fieldworks.

This study has the features of all exploratory, descriptive and qualitative explanatory research type. It is exploratory because it attempts to study the illness response of the children and their access to health services which are not known explicitly since it is under-researched (see chapter one of this paper). It is descriptive for the fact that this study describes the health seeking course of the children, accessible health services and the health needs of the children. It is also explanatory since the issues of how the street involved children react to illness incidences and why they prefer one coping mechanism to the others were among the questions of this study.

### **3.3 Study Location and Setting**

This study was undertaken in Ambo town, central Ethiopia. The town was selected for the fact that no research has been conducted on the health issue of the street involved children of the town so far, to my knowledge. Second, I was interested to conduct my study on the area for I have prior contacts with some street involved children of the town so that my engagement to the field was easier (Neuman, 2014).

The main study sites in the town were the three congregating areas of the town where the children gathered oftentimes. These sites were selected based on the suggestion of get keepers, social worker of Office of Labor and Social Affairs of Ambo town and early contacted children (Merckens, 2004). Shadow of a big tree which was found near to Huluka River was the place where the sessions of most data collection with the children took place depending on the choice of the children (Ruane, 2005). I made my first contact and introduction with the children of street

through the social worker who was an employee of Office of Labor and Social Affairs of Ambo Town (Cohen et al, 2007).

### **3.4 Inclusion Criteria and Justification**

In the absence of a homogeneity on the composition of the street involved children (Pietkiewicz-Pareek, 2012; Ray, Davey & Nolan, 2011), a specific group of the children participated in this study. The primary participants of this research were street involved children who were 10-18 years of age. Children of the age below 10 did not participate for the reason that research with children has to be ethically sound in line with specific methods selected for a study (Amury & Komba, 2010).

The other inclusion criterion of the participants was illness experience. The children who have experienced at least a perceived illness incident after they begin to live on the street participated in this study for they were in a position to share their own lived illness experiences (Whittaker, 2009; Flick et al, 2004). The third criterion for the children to qualify to participate in the study was family relation. Those street involved children who did not have family contacts or supervision participated in this study for they carried the heaviest health burden of street life above the other street groups (UNICEF, 2006). Hence, I selected to study the conditions of children *of* street separately to protect their hazardous conditions not to be overridden by the situations of those who are at less risk (relatively speaking) groups.

### **3.5 Data Types and Sources**

Both primary and secondary data types were used in this study. The sources for the primary data type were street involved children, and key informants from offices of labor and social affairs and municipality of Ambo town. Secondary data for the study were obtained from books, book

chapters, conventions, policies, strategies, journals, dissertations, thesis, and other relevant documents.

### **3.6 Data Collection Methods**

In order to enrich the study and maintain trustworthy and credibility, a number of qualitative methods of data collection were triangulated (Creswell, 2014; Boyce & Neale, 2006). In the triangulation of the methods of data collection, interviews were held first of all methods for it helps to provide context to the other methods. Focus group discussion and key informant interview followed the interview. Observation was done along all the other methods.

#### **3.6.1 In-depth interview**

In collecting data using this method, my interviewees were regarded as experts from whom I learned about the study topic (Mack, Woodson, Macqueen, Guest & Namey, 2005). This method was used for obtaining the interpretive perspective of the interviewees on the research themes (Lin, 2013; Matthews & Ross, 2010; Mack et al, 2005). Description of the living conditions of the children in relation to their health, their view on health, and illness; strategies they used to cope up with illnesses; their state of access to health services, and their health worries were the major themes on which the interview focused.

In carrying out the interviews, I applied the skills of attentive listening; a question at a time; natural development of conversation; seizing non-verbal expressions; probing; and interview tracking (Matthews & Ross, 2010; Whittaker, 2009; Mack et al, 2005). I conducted the interview sessions in a private location where the participants felt that comfortable and protected (Lin, 2013; Mack et al, 2005). The interview data were recorded on my recorder, and transcribed and

translated immediate to the sessions. The interviewees for this method were the children who had got sick more than a time.

### **3.6.2 Focus group discussion**

A focus group is a group of individuals selected to provide their opinions on a defined area of study, facilitated by a moderator who aims to create an open and relaxed environment by promoting interaction among the participants (Whittaker, 2009). Using this method, I explored a picture of how the study themes affected the children as a group. I also obtained a range of perspectives that existed among the children. Both the difference and consensus on the research themes in the group were obtained (Whittaker, 2009; Mack et al, 2005). Three FGD groups were handled, one from each congregating area of the children.

The views of the children on health, and illness; the conditions that influence their health seeking behavior; the conditions that influence their health and admittance to formal health organizations; health service feasibilities and their health worries were among the shared phenomena that was studied on the FGDs. Social life in street and its health connotation were also studied from the discussants. All the three sessions were handled under shadow of a tree that was located near to Huluka River where discussants selected (Mack et al, 2005).

In handling the FGDs, I employed the skills of working with group discussion. I set a round sitting arrangement and put ground rules at the beginning of the sessions; I acted friendly and made eye balling with the discussants. I did not coerce participants into responding to a question or responding in a certain way but I encouraged them to participate in the discussion (Mack et al, 2005; Krueger, 2002).



### **3.6.3 Key informant interview**

Key informant interviews were conducted with officials from two offices that were concerned with my research themes. These were from offices of Labor and Social Affairs and Municipality of Ambo Town (Hancock et al, 2007). Employing this method, access rights and status of the children to health facilities were studied. And the gaps that exist in meeting the health needs of the children and how they can be ameliorated were also elicited from the key informants. Thus, health service provision and structural side of the service accessibility and problems were gathered from these informants.

### **3.6.4 Observation**

Using this method, I obtained significant data from different sources including people, events and physical scenarios (Driscoll, 2011; Whittaker, 2010). The observation was non-participant in its nature. I employed this method in two ways; first, concerting with other methods; second, as an independent method. Concerting with other methods, I obtained data on the non-verbal expression (facial expression, body movements) of the participants on the courses of interview and focus group methods. It also provided me valuable information on the physical setting where the street involved children lived in relation to their health, and the health facilities accessible to the children. I documented the observation data through field notes (Corbetta, 2003).

## **3.7 Sampling Techniques and Procedures**

Lack of permanent address and wandering lifestyles make street involved children a difficult group to locate and develop their sampling frame. This indicates that identifying and locating the children who have experienced illness from all street involved children is even more difficult (Amury & Komba, 2010; Mufune, 2000). In addition, qualitative research requires fewer people

for the approach is more concerned with exploring full range of issues related to a phenomenon, focusing on the views of few people in greater depth (Bonde, 2013).

Non-probability sampling was used in selecting the participants of this study. Recruitment of interviewees for in-depth interview, discussants for FGD, informants for key informant and settings for observation methods were done via different non-probability techniques depending on the availability of the participants and data that are sought to be collected.

Snowball and judgmental sampling techniques were used to select interviewees. Using snowball technique, I identified a number of children who experienced illnesses through the help of the children who were initially located via gate keeper. After identifying these children, I judgmentally selected the children that have contracted diseases for more than a time as interviewees. Number of participants for the in-depth interview was determined by point of data saturation. I collected data until new theme emergence from the participant ideas stopped (Fusch & Ness, 2015; O'Reilly & Parker, 2012). Insuring this, I changed dimensions in the profile (e.g. congregating area) of the interviewees before deciding the status of saturation.

For recruitment of the FGD discussants, a non-probability sampling of snow ball was employed to identify the children who experienced illness. Fortunately, this was easy for me to do for the fact that I faced no child that did not get sick. For this method, I determined the sizes of each groups relying on the diversity that I observed on interview method and availability of the children (Hancock et al, 2007). The first two groups were composed of 8 children each and the third group had 9 discussants.

To select the two key informants from the two offices of Labor and Social Affairs and Municipality, critical case sampling (Hancock et al, 2007) was used. Using this technique, I

selected the officials because of the position they held. For the observation method, I observed important settings that provided me with input in answering my research questions and enriching the study. Thus, sampling of scenery for observation method was determined judgmentally considering the importance and gravity of settings that were resourceful for this study.

On interview and FGD sessions, I used tape recording mainly and field note hand in hand. Using the recorder helped to capture all data and to concentrate on probing my questions (Babbie & Rubin, 2011; Dawson, 2009; Hancock et al, 2007; Legard, Keegan & Ward, 2003). Additionally, I had had note book in case my tape recorder would have been failed (Payne & Payne, 2004) and in order to obtain the non-verbal expressions (facial expressions, body movement and voice tone) of the participants. Thus, I combined the strengths of both tape recording and note taking. I used only note taking for key informant interview and observation sessions.

### **3.8 Data Analysis Methods and Procedures**

Data analysis of this study began in constant interplay with my data gathering activities (Babbie, 2008) which followed inductive organizing process (Creswell, 2014; Bryman, 2008). Adhering to inductive reasoning, the report of this paper emerged out of the piecemeal ideas of the participants. They were analyzed in terms of the major themes that were adopted from the study objectives and their respective sub-themes that emerged from participants' expressions. This thematic analysis was undertaken manually.

First, I pooled all the data together and retained them in safe vicinity. Then, I transcribed the audio data and typed the data from my note book. After transcribing, I repeatedly listened to the audio records and go through the written notes once again. Next, I translated the typed data from

the Afan Oromo to English language. After completing the translation, I printed the data and read them repeatedly till I familiarized enough to them.

After developing acquaintance with the data contents, I highlighted significant statements, contexts, consistency, and quotes that provided me understanding of the views of the street involved children (Moustakas, 1994; in Creswell & Clark, 2006). After doing so, I coded the specific highlighted pieces of data depending on the research questions they feed and named them with 'identity symbols' to easily organize and retrieve them later on (Babbie, 2008). Then, I created catalogues (file folders) that were renamed after the major themes of the study. Then, I stored the coded piecemeal data in different catalogues I created according to their nature of relation to the study objectives (Babbie, 2008).

After storing all the piecemeal data in separate catalogues, I thoroughly went through the data. I organized the data according to their relation to the questions of my research tools in each catalogue. Repeatedly reading these organized data, different themes emerged at different levels. Then, I identified subthemes and sub of the subthemes that were presented under each major theme.

Next, I set the themes emerged at different levels as sub-topics to write the description and interpretation of this the report. After thematically setting the topics from the data, I proceeded to transfer the organized data from the catalogues to the report topics and sub-topics (Babbie, 2008; Moustakas, 1994 in Creswell & Clark, 2006). After presenting the primary data under the emerged themes, I discussed them relating to literatures, theoretical and legal frameworks. Lastly, I did the higher level of analysis i.e. interpretation, in which I explored and discussed the

patterns that occurred through the data (Babbie, 2008) i.e. latent level of analysis (Hancock et al, 2007) and their message for practices.

I employed meta-analysis method in synthesizing and discussing the findings of different literatures in relation to this study (Hancock et al, 2007).

### **3.9 Research Trustworthiness**

The credibility of a study is ensured if the findings are a true reflection of reality (Prinsloo & Ritcher, 2003). Credibility of this study was done at all junctures (before, while and after field works) of the study process. Before going to fields, consulting the study advisor and colleagues on research blue print was done. In the courses of data collection, analysis and interpretation, I bracketed out my personal beliefs, perceptions and perspectives in order to understand every issue in terms of insiders' perspectives.

Triangulating different research methods is used to ensure the research findings to be credible (Creswell, 2014; Babbie, 2008; Flick, 2004). For the fact that the research outcomes are the combinations of the data analysis elicited via various methods from a set of sources, they have no tendency to be opinion or freak arguments that can easily melt when other studies are conducted.

In this study, data were collected after establishing genuine rapport with all primary data sources indicating that a working relationship (openness, trust, willingness to collaborate and the lowest possible power-difference between researcher and the children) between researcher and the study participants was established. I also made possible long term engagements with the participants turning them acquainted so that they make no fraud (Creswell, 2014; Irwin & Johnson, 2005).

Member checking was also out at the end of the study. Sample of the previous research participants were asked to confirm the truth value or accuracy of the interpretation to check that the research statements really reflect their ideas and perspectives. If the findings ring true to these samples, then this study is considered authenticated (Creswell, 2014; Thorne, 2000; Prinsloo & Ritcher, 2003).

Lastly, external audit will be undertaken (Creswell, 2014). This happens when the finding is presented to audiences led by the task force of research advisors and examiners. On the tournament of the study presentation, the advisor and examiners will have say. I will gratefully incorporate the skeptics of this scientific community to scale up the trustworthiness of my study.

### **3.10 Presentation, Ownership and Dissemination of the Study Findings**

The findings of this study will be presented via audience presentation first. After the approval of the research findings by the task force of study advisor and examiners, the study will be public property under the copyright of the researcher. As the last stage of the study, the findings of this research will enter the wider scientific community through hard copy library storage at the University of Addis Ababa, and the findings will also be published on journals as soon as possible. Thus, the scientific community can access the findings of this study through one/more of these paths.

### **3.11 Ethical Considerations**

For social researches take place in a social context, researchers must take into account many ethical considerations alongside scientific methods in designing and executing their research (Creswell, 2014; Driscoll, 2011; Babbie, 2008). Researchers should take special care in respecting the dignity, well-being and rights of children who cannot protect themselves (Graham,

Powell, Taylor, Anderson, & Fitzgerald, 2013). Accordingly, I took important measures in order to safeguard the rights and safety of all participants of my study. Some of the cautions were:

First of all, the personal names of the street involved children that have been mentioned in this paper were pseudo names. Their original names were changed for anonymity and safety purpose. Respect for persons/autonomy was highly valued throughout this study. At all stages of this study, I treated all research participants with respect for their capacity for self-determination; I also protected participants with diminished autonomy properly. Before going to work together, I also informed all units of observation about the purposes and possible risks involved for their participation in the research project at the inception stage. I also informed the participants that they can withdraw from engagement at any time they like.

For the fact that street involved children may have different perspective from the researchers, I maintained cultural competence. I assumed my study participants as members of a unique cultural group though they share different ways of life with other groups. I did not impose any value onto the participants, I let them act and behave in the way they please instead. All contacts were performed in the language the participants were fluent with.

All participants are assured of the confidentiality of the information/data acquired. There was anonymity wherever desired. I ensured confidentiality by protecting the data they provide me from accessibility by other persons/organizations. I secured anonymity by disabling the likelihood that the statements of the participants can be traced with their respective identity. I prevented my bias from spoiling the data of my participants for it is little point in collecting data and learning about something if one already thinks he/she knows the answer. Thus, I was committed to avoid all types of bias.

Regarding data management and protection, I stored the field notes and any piece of data in a safe place, and as they are only accessible to the researcher of this study. In order to do this, I retained all hardcopy files in safe stores and secure the soft copies with computer passwords. In analyzing, interpreting and presenting data, I took serious caution to prevent distortion of the original data content.



## CHAPTER FOUR: RESULTS

Under this section, the findings that emerged from the primary data of this study are presented as they were reflected by the research participants and witnessed by my observation. The findings of this study are presented organized into major themes and their respective sub-themes and sub of sub-themes. The major themes were set from the objectives of my study with consideration of the viewpoints of the participants, and the sub-themes emerged from the patterns that emerged from the ideas of the study participants. Thus, the viewpoints of the study participants were stressed in this study from setting the topics/themes to quoting specific speeches of individual participants.

### 4.1 Description of Streetism in Ambo Town and the Street Involved Children

#### 4.1.1 Streetism in Ambo town

Ambo is the seat of the administration of West Shoa Zone. According to a key informant, for the town is largest in that specific zone, it attracted children from different parts of the area who could not afford to live in a family institution. The key informant added that the age of streetism in Ambo town is said to be as old as the emergence of the town and their size had been increasing constantly with the expansion of the town. The children who were living in the streets of the town came from rural and small towns of West Shoa Zone, the data indicated.

According to the observation I undertook accompanied by two street involved children who helped me as get keepers, there were three particular areas where the street involved children in Ambo town congregated most of their time. These congregating areas were bus station, *Gommista* and *Arada* areas. I observed that these areas where the children concentrated oftentimes were crowded of traffic movements and full of horrendous sounds.

According to a key informant from the Office of Labor and Social Affairs of Ambo town, it was a difficult task to learn and state the exact magnitude of children that live in the streets of Ambo town. He also confirmed that no attempt had been undertaken to enumerate the number of street involved children that live in the town.

#### 4.1.2 Description of the street involved children

The background information of the children that are presented hereunder has implications on the life aspects of the children that are central themes of my study. Thus, understanding these profiles of the street involved children supports the understanding the themes of this study.

**Table 1:** Sex profile of the street involved children

	<b>Category</b>	<b>Frequency</b>
<b>Sex</b>	Male	33
	Female	0
	<b>Total</b>	33

*Source: Field work, March, 2017*

All the street involved children that participated in this study were males. There was no female child (to the reach of this study) that qualifies for this study although there were female children that work in streets. According to the male participants, the female children returned to home at night after working in street during daylights. Thus, the male children were more exposed to street threats above the female street involved children, particularly to the risks that prevail at night.

**Table 2:** Religious Affiliation of the Street Involved Children

	<b>Category</b>	<b>Frequency</b>
	Orthodox	14
	Protestant	11
Religious affiliation	Wakeffata	4
	Jehovah	1
	No religion	3
	total	33

*Source: Field work, March, 2017*

Most of the children had religious affiliation. Orthodox, Protestant, Wakefata, Jehovah were the religions the children follow. The religiosity/non-religiosity of the children had influence on their health seeking behavior which will be discussed in the coming parts of this paper.

**Table 3:** Years the street involved children have lived in street

	<b>Categories</b>	<b>frequency</b>
	< 1 year	3
Years lived in street	1-3 years	11
	4-6 years	12
	> 6 years	7
	<b>Total</b>	<b>33</b>

*Source: Field Work, March, 2017*

For categorizing the year that the children lived in street, I set the categories to show the range of time the children spent in street and no standard category was used. Most of the children lived in

street for years while few of them lived for less than a year. It ranged from two months to the peak of ten years. This indicated that children could join street life either at early age or being adolescent. While living in street, the children had contracted disease from one to five times till the moment the data collection for this study took place.

Regarding the educational background of the children, only one of the street involved children was attending school. Around half (15 out of the 33 participants) of the children mentioned that they had begun school when they were at home and dropped when they were forced to live in street or before that incident. The schooling (although limited) of the children had influence on their understandings of health and illness, and their selection of illness coping strategy which will be explained in the coming sections of this paper.

**Table 4:** The congregating and sleeping areas of the street involved children

	<b>Categories</b>	<b>Frequency</b>
Congregating and sleeping areas	Bus station (including an abandoned kiosk)	15
	<i>Gommista</i>	10
	<i>Arada</i>	8
	<b>Total</b>	33

*Source: Field work, March, 2017*

The congregating area of the children was addressed to indicate the study participants were taken from all geographical location that hosts the children in the town. The children who participated in this study were purposefully picked from all their three congregating areas in the town. The first area of the town where the children concentrate was around the town's bus station which

was one of busy sites in the town. According to the children, the bus station was a place where travelers take and get off cars so that the children carry the stuffs of the travelers and obtain money. The second site was called '*Gommista*' area which was located approximately at 100m to the east of the bus station. The children that usually congregated at this site stated that the area had a number of shops with verandahs where they were used to sleep at nights.

The third congregating area for the children in the town was a place named as *Arada* i.e. market area. The children were attracted to this site to carry the goods that the market attendants transport to and from the market. In addition to these important sites where most of the children congregated, streets in the entire town sparsely harbored a number of children.

Regarding sleeping, most of the children that participated in this study slept on verandahs of trade house located in their congregating areas. Some participants mentioned that they slept in an abandoned kiosk that was found on the backside of the bus station. It was possessed by 02 *kebele* administration, according to the children. The kiosk they shared being up to twenty children per a night was not more than 6m<sup>2</sup>. One of the discussants challenged the children who slept in the kiosk insisting that this type of sleeping condition can cause easy transmission of air borne diseases.

In their job, most of the children passed most of their time as idles. In case they work, most of the children engaged in carrying bags and baggage including scavenging. Serving as messenger for people, and polishing shoe seasonally (in summer mostly) were the other activities of the children.

**Table 5:** Themes on Street living conditions of the children in relation to their health

<b>Sub-themes</b>	<b>Major-themes</b>	<b>Description</b>
Arriving on the street and Health	Vulnerabilities of the children to diseases	From all aspects of their regular life, the children were prone to illnesses. They were deprived of basic needs, they labored under hazardous conditions, unhygienic life, overridden by basic needs and abuses in street were daily incidents that suppressed their health conditions to unbearable level.
Working conditions and health		
Food in street life and Health		
Hygiene in street and health		
Substance use and abuse and health		
Preoccupation with basic needs		
Abuses in Street and health		

*Source: thematic analysis process of primary data*

#### **4.2 Vulnerabilities of the Street Involved Children to Diseases**

According to the children and my systematic observation, the living conditions in the streets of Ambo town were critically hostile to their health. From the discussions of the children, street living conditions severely hampered their wellbeing. Socialization, working conditions, food, hygiene, substance use and abuse, preoccupation with basic needs, and substance use and abuse are the seven themes that emerged from my study of the living conditions of the children in relation to their health connotations.

##### **4.2.1 Arriving on the street and Health**

The data generated by this inquiry indicated that threats to the health of the street involved children began as early as their arrival on street. Even though few of the children joined street life through support of their friends, most of the children mentioned that they faced health challenges at their street arrival. Except Yoseph (17 years old child), all of the children

mentioned that they felt frightened, unsettled, unprotected and normlessness on the moment they arrived at street.

*Moti*, a child aged 15 years stated,

When I came to street for the first time, I arrived in evening. After getting off from a bus, I sat at roadside around the bus station. Some street involved children came to me; they talked to me and asked me if I eat food. I agreed. They took six birr from me and opened the plastic bag they had on their hands. The food was leftover. I got shocked, refused to eat and walked away from them. After staying for two days without food, I cried...

Most of the children expressed that they were exploited by senior street population when they arrived at street. They were forced to bring leftover food from hotels for the senior street residents. They got kicked when they failed to get the leftover they were ordered to bring. According to the discussion of all the children, the senior street residents also made fun out of them on the time. And there was a time when a child was made to scavenge dead dog.

Some of the children participants mentioned that they were extorted and stolen their money and property by the senior street population on the time they joined street life from lacking awareness on the way street life functions.

*Namo*, 16 years old child stated,

On the first day I came to street... I was wearing a new pair of boots. At night of the day, I took off the boot, put beside me and slept on verandah. When I woke up after a nap, my pair of boots was stolen. I got shocked, angry and walked bare foot in the morning...

Contrary to most children that experienced challenges in their entrance to the street life, few children were welcomed by the senior street population and acquainted with the street life safely.

#### **4.2.2 Working conditions in street of Ambo town and health**

The life of the street involved children in Ambo town revolved around survival needs. As one of their survival struggles, they engaged in any menial works. They carried bags and baggage, and some others scavenged on their shoulder. Using the money they got, they bought their priority goods. The children did not choose job to generate money in order to purchase these goods. They undertook every kind of job they got available to them regardless of the health consequences of the activities.

Additionally, most of the children mentioned that they fell out with one another in competing for the limited available jobs. Lastly, the children stated that they had been underpaid for their labor by people especially the people that came from rural areas. *Mesfin*, 17 years old discussant, expressed his irritation as “...*Oh! Especially the people from rural areas! They are blood suckers! If we carry 100 kg load for them, they give us 2 birr. They are not human being...*” The children sometimes left their wage for the people by getting angry at the under-payment. Thus, the children experienced a number of immense challenges to their health in their working conditions.

#### **4.2.3 Food in street life and Health**

According to the children, street living standard lied far below hand-to-mouth. It was not only about healthy food that bothered the children but getting any type of stuff to be eaten. They sometimes lacked food at all and healthy food usually. Some of the children complained that they were hungry on the moment they were participating in this study. All of the children



mentioned that they usually relied on leftover food that they collected from the nearby hotels and restaurants.

Regarding its health consequences, there were children who preferred the unhygienic leftover food to that of the original (not leftover) *shiro* (local type of food and allegedly cheap) that they sometimes afford to buy from shanty restaurants. *Yoseph* described,

When I see the food we eat, we can be affected by diseases easily but God watches on us. We eat leftover that is unhygienic, mixed up with rubbish and infested with insects. The leftover food has multiple food items, and advantageous on that side but it is impure that much. However, I prefer the leftover food to original *shiro*.

Leftover food went worse in summer/rainy season, according to the children. They discussed that during rainy season, the leftover they collected from restaurants was quite unhygienic due to the moisture of the season and the waiters/waitresses arbitrarily stored the leftover food on dirty areas that were hit by rain. The worst thing was that the children used leftover food even when they were sick, most of the children discussed. Only sometimes, their friends and other sympathetic people bought them original food.

#### **4.2.4 Hygiene in street and health**

According to the street involved children and my observation, it was evident that the entire life aspects of the children were unhygienic. They wore dirty and ragged clothes day and night. They mentioned that they did not have adequate clothes to change and wash them. I observed, the body of most of the children was also unclean.

The hygiene of sleeping place of the children was critically disastrous. As it was evident via my observation, the sleeping areas of the children were so dirty (dusty or muddy) and infected with

fluids, rubbishes and infested with insects. The children indicated that dirtiness of their sleeping places was worst in summer/rainy season the time their sleeping areas turned muddy, smelly and harbored insects.

Some of the children also mentioned that they slept in abandoned kiosk which was found few meters on the backside of the bus station. According to my observation, the kiosk was dilapidated, too dusty, surrounded with rubbish, so narrow and had bad smell. The children stated that they shared kiosk (approximately 6m<sup>2</sup> size) crowdedly, being up to 20 attendants. Ganfure, 17 years old child, insisted that living together crowdedly in a room has adverse health impacts. According to the child, there are several germs that are transmittable in air, for instance, TB infection easily spreads among the children. For your consumption, food hygiene problem has been discussed earlier.

#### **4.2.5 Substance use and abuse among the children, and health**

Around half of the street involved children mentioned that they used and abused different substances. They usually abused *khat*, cigarette and *areke* (type of local alcohol) for different reasons.

The children associated their behavior of substance use and abuse with the life conditions they experienced in street. They compared that they lived in crisis relative to their counterpart children, those who live in family. They stated that they got anger of this condition and take the substances to cool down their anger. *Mesfin*, who was cigarette addict, stated, “*I get mental illness from my living conditions if I do not smoke. Smoking cools down my misery feelings and mood.*” Withstanding the chilly weather they experienced at night was another reason for the

children to use and abuse substances. *Areke* and cigarette were highly used among the children for this purpose.

Regarding the health consequences of the substances they abused, some of the children affirmed that it is harmful but they did not want to stop the behavior. *Barich*, a an interviewee of 18 years old narrated the case of his late friend as,

One of our friends recently was used to drink alcohol (*areke*). He was angry at his street life. He was used to drink the alcohol day and night. His appetite for food declined as a result. We were thinking to take him to hospital after he told us that his health was not good. Ultimately, we found his corpse in river. We could not learn what killed him, but we suspected that the alcohol damaged his organs.

This child felt unsettled narrating this case but he kept using *khat* and abusing cigarettes and alcohol.

#### **4.2.6 Preoccupation with basic needs among the children and health**

The street involved children mentioned that their primary intention of daily life was to satisfy their basic needs, specifically food and certain substances. They woke up early in the morning and wandered in the town in pursuit of jobs till late evening. For they were constantly deprived of basic needs, their mind was always overridden these needs and how to meet them.

*Jigsa*, a 17 years old discussant, described,

What worries us is the evening that we do not have coin for our drink (*areke*).

That is our big worry [other discussants laughed....! and agreed....!] when 6:00 in afternoon arrives. If we have coin, we enjoy; we do not have worry. If not, we ache. We struggle to death to obtain the money for *areke*.

#### **4.2.7 Abuses in Street and health**

According to the children, they encountered numerous abuses that came from other street population, policemen and other community members. These abuses happened to them both in day light and at night and unsettled and obsessed the children constantly.

##### **Abuse from other street population**

Almost all the children mentioned that they experienced abuse from other street population. There were gigantic members of street population (both from their own group and out groups) that abused the children. They extorted money from the children forcefully. Some other time, they denied sharing the money for the children that they got by waging together. The children also faced physical abuse, mostly at night.

The children stated that they had been experiencing stress from the abuse they could face at nights. The sometimes children slept besides river to escape from the potential night abuses. *Barich* stated, “...powerful street gangs often come to where we sleep at midnight and beat us. We sometimes sleep in rivers to escape from the gangsters.”

##### **Police brutality**

Police harassment was one of the big problems that most of the children mentioned repeatedly. The children asserted that policemen had been perpetrators that harm them. The children discussed that policemen hastily generalized as if every crime in street was committed by street involved children. In taking measures, they did not identify who is who. It was a sufficient condition for the policemen to be street involved children to be criminal, all the children agreed.

*Galata*, aged 14 child complained,

We have frequent contacts with policemen...we bear big challenge from them. If a person is a street child, he/she is regarded as antisocial by default. They blame us for all crimes that are committed in street. They hold us responsible for the problem committed by any person in street.

In addition to the arbitrary beatings, according to the children, the policemen were so brutal and ruthless. The policemen sometimes beat the children in midnight going to where they sleep. A discussant named Ganfure illustrated police brutality as *“I know several children that went insane when they were woken from deep sleep in mid-night and brutalized by policemen. The approach of the policemen in handling the street involved children is so ruthless and inhumane.”*

*Gashare*, a 15 years old discussant, added,

After we sleep at night, rain may hit us. We may get up in the midnight to search for a verandah that prevents rain from. If the policemen come to us in between this, they beat us to death assuming that we are attempting to steal peoples' property. They beat us with these like contemplations, without any evidence.

The policemen abused their power and at times extorted money from the children at night, according to some discussants. On their discussions on the actions of policemen (my observation), all the children felt anger and prey. The children also stated that the policemen intimidated them that they would dump them out of the town.

*Abba Shorro*, 15 years old interviewee described,

The policemen sometimes claim to clean us from the town. Once up on a time, they decided to harness and dump us outside the town. One judge intervened and

prevented the policemen from deporting us from the town. He explained to the policemen that we are not the criminal gangs that trouble the town. The policemen mistreat us by thinking that we are powerless and have no protector.

### **Community attitude and abuse**

The children mentioned that different social groups had different attitudes towards street involved children. There were groups of people that undermine the children seeing their being segregated group and their being street residents. Moti stated with tearful eyes, *“There are many people that undermine us and equate us to dog. Even, there are people who work in the bus station and look down on us.”* This negative attitude of the people was also evident in the name the street involved children were called by, *“duriyye”* (literal meaning: people that misbehave deviating from social norms).

According to most discussants, most people who had negative attitude towards them were people who came from rural areas. As part of community abuse, the children mentioned, there were times when people beat them to death taking them to unseen distant areas for the reason they did not know. Contrary to this, other discussants stated that community in which they live respected them as long as they served them in undertaking different tasks. According to some of the children, there were people who were critical in their outlook and felt sympathy for them. Particularly according to the children, urbanites and the people with whom the children were acquainted were humble and sympathetic for the children.

**Table 6:** Emerged Themes on the Health Seeking Behavior of the Street Involved Children

<b>Sub-themes</b>	<b>Major-themes</b>	<b>Description</b>
Health is ability to fulfill basic needs and undertake routine tasks	Health perception of the street involved children	The children understood health as a state that lets routines tasks and harmonious life with society and legal bodies
Health is having harmonious relation with people and legal bodies		
Illness is failure to handle routine tasks and deprivation of basic needs		
Illness is failure to intake food	Illness perception of the street involved children	The children defined illness as a state that stalls routine tasks, supporting oneself and stable life
Illness is failure to live with people and systems peacefully		
Sleeping off illnesses		
Buying medicine from pharmacy/shop	Illness coping strategies of the participants	Sleeping off illness, buying medicine from pharmacies, self and traditional treatments were widely employed while religious healings and health services were less employed.
Self and traditional treatment		
Religious treatment		
Visiting health facilities		
Believers	Beliefs of the children health facilities as a response to illness	Children that believed in the remedy exceeded the partial believers followed by the non-believers which were proportional to their usage of the services.
Partial believers		
Non-believers		

*Source: thematic primary data analysis process*

#### 4.2.8 Health perception of the street involved children

The entire street involved children explained that health is certain state of wellness that allows them to wander and work. They stated that one has to have organs that function properly for a person to be healthy; the person has to be able to undertake his/her routine activities and able to intake food. A discussant stated, *“I will be healthy if I can work and support myself. It depends on my ability to work and money I have.”* This point was supported by most of the discussants in that particular FGD.

In addition to the above concepts, some of the children defined health as it is fulfillment of basic needs. It is impossible to assume a person as healthy for he/she merely has physical wellbeing; his/her needs have to be met adequately. Notably, one discussant equated having money to having health. Jigsa illustrated this way, *“there was a guy who was living around the bus station. He developed insanity from poverty. He accidentally got big money from somewhere. He got cured instantly. He recovered from his illness because of the money.”*

Most of the children added that a person has to have harmonious relationship with other community members and legal bodies to have complete health. According to these children, a person who falls out with different people cannot maintain his/her health. Ganfure stated, *“The fight between most of these street involved children and our families has led us to live on street and we have become susceptible to unhealthy living condition. Thus, health involves social aspects of life.”* They also stated that the relation between the street involved children and legal bodies have to be stable to be healthy. As a result, the children did not assume themselves as healthy when they experienced police brutality and hostility.



#### 4.2.9 Illness perception of the street involved children

Most of the children defined illness as it is a state of condition that renders people incapable to undertake routine activities and support themselves. They discussed it is a health condition that takes people to bed and compels them to seek supports. If he/she is able to withstand the symptoms of a given condition and afford undertaking routine activities, he/she is not sick. Illness has to oblige people to cease what they undertake under normal circumstances, the children assured.

Yoseph described he is ill when,

I regard myself as sick when I am unable to move and work. If I am able to wander and work but feeling certain pain like headache, I do not regard it as illness. As far as I do not fall sleep of the sickness, I do not think that I am sick. I accept that I am sick when I fail to move and cannot handle my routine tasks.

The other understanding of the children regarding illness revolves around the food consumption of the person. A person has to virtually fail to intake food if he/she is sick. They insisted that if food consumption is kept up as usual, it is difficult to regard the person as sick. One other child defined illness as it is a condition that leads to death.

The children were also asked to rate their probability of getting sick. All the children agreed that all aspects of their living conditions rendered them frequent probability of contracting diseases. In the face of all the health hazardous situations in their living conditions, one interviewee exclaimed that the disease immunity of street involved children was so tough.

### **4.3 Illness Coping Strategies of the Street Involved Children**

What did the street involved children do on illness incidents they faced? From the discussion of the children, the strategies they employed in order to recover from their perceived illness vary from child to child. In engaging in one or the other illness coping strategy, the children reflected different explanations. Herein, I present the discussions concerning the coping strategies the children used on illness incidents and the explanations they associated the strategies.

#### **4.3.1 Sleeping off illnesses**

Sleeping off an illness is taking no action to recover from the happening illness. Sleeping off an illness was a common way of responding to illness in the illness courses of almost all the children. It was usual that most of the children practice sleeping off illness at least for some beginning days of their illness incidents. This mere tolerance of illness symptoms was also extended for weeks and months for some of the children.

Most of the children made an attempt of sleeping off their illness, but only a single child from the all participants' illness incident succeeded in recovering fully from illness without resorting to other strategy. For the absolute majority of children, sleeping off an illness did not let the children regain their health and ended up the children to resort to illness recovering actions.

Mesfin stated,

On my first illness case, I waited for two weeks thinking that I would recover with no action. I visited health center when I failed to recover from the illness. On my second illness incident, I waited for three months thinking that I would recover from the illness one day. After three months, I lost hope and visited health facilities.

The children that had ever tried to sleep off illnesses explained some important factors for the selection of the strategy. First, they did not give due attention for their health for their mind is constantly overridden by their basic needs. Entangled in quenching these basic needs, they gave trivial weight for health ills and tolerated to illness symptoms they experience.

Second, the children had a belief that infirmity ceases by itself and there is no need to take measures to recover from the symptoms. Third, the children stated that they could not afford to utilize other coping strategies, formal health facilities for instance. Notably, they stated that they did not have clue on the existence of waiver health service provision in the town. Shafi, 13 years old child, who was sleeping off illness on the time of the data collection of this study, took place stated, *“I need to visit health facilities for the illness I am experiencing but I do not have coin on my hand now. I have no parents or other relatives to help me. I have no alternative but waiting for what will happen to me.”*

#### **4.3.2 Self treatment and traditional medicines**

This study found out that there were several untypical self treatment methods via which the children treat themselves on illness incidents. These self treatment methods were often associated to long-established explanations of the community and that is why it is presented here merged to the traditional methods. This strategy had been employed by some children either separately or coupled with other methods. The children employed various self and traditional treatments in light of the illness symptoms they experienced and the social explanations attached to the illness symptoms.

First, the children treated abdominal aches with substances that have the nature of burning sensation. Pepper, garlic, ginger and *areke* were the major substances that were highly used

substances these symptoms. Barich stated, *“We use pepper from nearby hotels and restaurants and areke when we face stomachache.”* One child applied this strategy to treat malaria (malaria as the discussant perceived, not medically tested).

Second, there was a hot spring found at the Shore of Huluka River (the river that divides the town into two parts) that helped the children to treat illnesses. According to the children, there were some kinds of illnesses that were thought by the society as curable by the mineral of the spring, skin and cold (as mentioned by the children) illnesses for instance. According to the society (the children cited), this spring water had mineral content that cured illnesses. Third, other children treated their illnesses by taking some virtually ‘minor’ methods. One discussant used sunlight and fire to relief from pains that he experienced when he faced illness that made him chilly; and one other child applied bandage for headaches.

Lastly, there were different typical traditional medicines that had been used by the children on different illness incidents. They used this strategy when it is believed that the disease that contracted did not have modern treatment. The children, however, could not identify the name of the medicines. Abba Shorro stated, *“I faced an illness once up on a time. I heard that the illness has no modern medicine but traditional cures. My friends brought me traditional medicine. I applied the medicine to the disease through washing and I recovered from my illness totally.”*

### **4.3.3 Religious Healings**

As depicted under the demography of street involved children, most (except 3 of the 33 children) of the children had religious affiliation. The religious affiliation of these children influenced the responses they took on illness incidents. This strategy was used either solely or coupled with other strategy; either via intercessory or self prayers.

Abba Shorro stated,

After I got treatment from hospital and recovered in two months from an illness, I tried to return to my routine life. However, one of my legs stopped to function and my friends took me to holy water. I recovered totally then after.

#### **4.3.4 Buying medicine from pharmacy/shop**

In this context, this is a method of seeking and directly purchasing medicine form stores (pharmacies and rarely shops) with no medical prescription. This strategy was the other widely used strategy by majority of the children. Similar to the strategies discussed above, buying medicine from pharmacies or shops as illness curbing strategy had been employed by the children either immediate to the occurrence of the illness or following failed attempts of sleeping off illnesses.

According to the beneficiaries, buying medicines from pharmacies to cope illnesses had been employed for both new type of illnesses or for illnesses that had been happened to the children periodically. Ganfure described, *“I have gastric disease. I know the symptoms of this illness and I immediately go to pharmacies as I feel the pain and buy its medicine. I do not need to have laboratory examination for the reason that I know the illness and its cure.”*

In explaining the procedures of buying the medicine form stores, the children stated that they bought medicine from stores either by physically going to the store or via their friends. They asserted that the store keepers easily sold medicines if they were told the illness symptoms. The sellers, sometimes, asked some further questions regarding the illness and the patient.

Regarding their preference to use services from pharmacies the children discussed, first, the costs of medicines at pharmacies were affordable. It could be bought by the patient himself or at a

little support from friends. Second, the pharmacies functioned without exhaustive bureaucratic procedures. The children affirmed that they had been able to purchase medicine within minutes with no solid prerequisites. Lastly, the children had substantial belief in the remedy they used from pharmacies. From the illness cases that were treated by the medicine from pharmacies and shops, only a single discussant complained that he was not healed by the medicine.

#### **4.3.5 Visiting health facilities**

Visiting health facilities (excluding buying medicine from pharmacies without prescription) was the other strategy that some children employed to recover from their illnesses. Seeking health facility services was not the first alternative for almost all the children that participated in this study.

The health facilities that had been widely visited by the children were hospital, health centre and clinic respectively. Regarding the cost coverage of the treatments at health facilities, the children indicated that there was no case in which a single child visited health facilities at his own independent out-of-pocket payment. Fees for the treatment of the services were managed by the contribution from friends and other surrounding community members.

Most of the children that visited health facilities used this strategy as the last alternative after trying other strategies. One child described, *“I tried to sleep off my illness without taking any action for three days. At the night of the fourth day, I passed out and my friends took me to health facility by contributing money.”* Moti, in contrary, stated, *“I know my disease. If I do not get treatment early, I can die. I tell to my friends the symptoms of my illness early to take me to health facilities immediate to I feel illness symptoms.”*

Access to health facilities of the street involved children and its overall ambiance are discussed in the coming sections of this paper.

#### **4.6 Beliefs of the Street Involved Children on Health Facilities as Illness Coping Strategy**

The patterns generated from data indicate that the street involved children have various beliefs on using formal health facilities on illness incidents. This study has also explored that these beliefs highly influenced health care seeking behavior of the children. Three themes emerged from the beliefs that the children had on health facility as a response to illnesses. These are those who believe in health facilities, those who have conditional belief and the non-believers.

##### **4.6.1 Believers**

The data show that around half (15) of the children out of the total of thirty-three (33) believed that health facilities are important to cope up with illnesses. They explained that their faith in health facilities developed from their life experiences. The first group of children who believed in the importance of health facilities explained that their belief was developed from their own health service utilization history. Moti stated, *“I believe health facilities are helpful in recovering from illnesses..... I got sick once up on a time and got cured by using health care from Hospital...I have also learned at school and heard that health facilities are vital for patients.”*

Some other children mentioned that they had seen people who got cured using health care services. Their exposure to the people who recovered from illness using health services shaped their faith on the remedy. Some other children stated that they heard health facility was one of the strategies that helped in curbing sicknesses. These children emphasized that this remedy shall be used as the ultimate measure when other remedies fail.

Most of these children stated that they will visit health facilities in case they contract disease in the future. However, some of them stated that they will do that after employing other remedies.

#### **4.6.2 Partial believers**

Ten (10) children out of all (33) stated that they did not believe health facilities can address all health problems under any circumstance. The explanations of these children for their suspicion on health service remedies emerged from three explanations: The curing power of medical treatments, the treatment compartment and instability of the effects of treatment.

First, the moderate belief of some of the children was attributed the healing power of medical treatments. They stated that medicines sometimes fail to cure illnesses, deadly diseases for example. Second, most of these children affirmed that the cure of health facilities did not endure. They indicated that the relief help for certain time but the illness re-emerges after some time.

Ganfure insisted,

I do not think health facilities cure illnesses everlastingly. Medical treatments may curb illnesses for certain time. For example, I have gastric problem. If I take its medicine/treatment, it relieves me for around five days. My illness re-emerges after unsure number of days.

The other rationality for the children who had moderate beliefs was on the manner that health workers provide the treatments. They might not give due attention to their patients. This indulgence of the workers led to inadequacy of the treatments and maltreatment at times, these children explained.

Bariso, 16 years old child view, stated;



I do not think health facilities exactly cure illnesses. Once up on a time, I got sick and sought service from Ambo Hospital. The physician gave me medicine of kidney disease while my disease was gonorrhoea. The treatment did not help me. I think health workers lie. Their work is sometimes irrelevant.

#### 4.6.3 Non-believers

Eight (8) participants out of the all (33) stated that they did not believe in the remedy of health facilities. Most of these children who did not believe in the curing power of health facilities attribute their explanations to predestination. They believed that the healing performance of health facilities could not alter decision of God; it is God that cures illnesses not health workers.

Some of these non-believing children stated that they have not ever used the health facility on the past illness incidents. They also asserted that they will not visit health facilities in case they face health problems the future. Yoseph stated, *“I think that I have to be strong in my religion. I will not visit health facilities even when I face illness.”* The other child added, *“I have not ever visited health facilities and I do not think that I will do that in the future. If I get sick, I will take holy water. I do not think health treatments can cure me.”*

Some of the children were not certain whether they will visit health facilities if they get sick. They stated that they perhaps seek health care services if they cannot be supported by other coping strategies. Thus, the negative belief of the children in the curing power of health facilities led them to believe they will not seek health care services if they get sick.

**Table 7:** Themes on Access of the Street Involved Children to Health Facilities

<b>Sub-themes</b>	<b>Major-themes</b>	<b>Description</b>
Availability Accessibility Acceptability Affordability Accommodation	The access status of the street involved to payable health facilities	The access was affected by all the dimensions in which affordability and acceptability were the prime barriers and availability and accessibility were so favorable.
Limited waiver health program for the indigent Poor access of the children to waiver health service	Waiver health care system in Ambo town and the street involved children	Waiver system exists but inadequate and less known. No children has ever used the service for they were unaware and perceived marginalized
Irresponsibility of executive government offices The voicelessness of the children Absence of voices on behalf of the children	Why the Health Care Access Rights of Street Involved Children were Relinquished?	The waiver right of the children was violated for the implementers were so unresponsive and there was no pressure to get them responsive
Disease vulnerabilities Psychological problems How to cope up with illness Deprivations of basic needs Police brutality	What do the Children think/worry about their Future Health?	Deprivation of basic needs, proneness to illnesses and inaccessibility to health care are permeating the children's future.

*Source: thematic primary data analysis process*

## **4.7 The access Status of the Street Involved to Payable Health Facilities: the Five Access Dimensions**

The possibility of the street involved children to seek health services that are provided at payment is presented in this section. In order to make the access status exploration comprehensive, I present the current access status of the children putting into the themes of five aspects of health care access (Edusei & Amoah, 2014) the summation of which indicate the access status of the children to health facilities when they get sick. These sub-themes are availability, accessibility, acceptability, affordability and accommodation.

### **4.7.1 Access to health care: Availability**

Availability of health facilities is a mere existence of health services in the physical environment where the street involved children live. According to my observation and the discussions of the children, both public (health centers and Ambo general hospital) and private (clinics) health facilities were physically present in the town. All of the children knew the existence and location of the nearby health centers and Ambo General Hospital. They also knew the time (both on foot and by transport) and transport fee it takes to go to the facilities.

Likewise, my observational data indicate that private health facilities (clinics particularly) were present in the town. The children regularly wander by the doors of several clinics according to my observational data. Thus, the availability of health facilities (both public and private) is believed to be adequate regardless of the other factors that establish the actual access of the children.

#### **4.7.2 Access to health care: Accessibility**

According to my observation, health service settings (public) were available within the walking distance of 15 to 20 minutes from the children's congregating areas, and the roads that take the children to the facilities were favorable. Alternatively, the distance to several of the facilities can be travelled by two (2) birr taxi transport fee. Thus, the distance of most of the facilities needs neither long time nor big expenditure from the children to travel to them.

Beside to physical distance, working schedule of the children also determine the accessibility status of the children. According to the children, they always stayed the whole in street in order to obtain possible wage. They often sought job from early mornings to the late evenings to get possible income for their food and substances. Thus, the work schedule of the children embezzled the attention of the children from visiting health facilities even when they were in desperate health service need.

This overriding work schedule is not confined to the patient child; it also extended to the children that accompany a sick child to the facilities. To quote Barich's experience, "*Children including my closer friends did not stay with me when I was sick. Especially during days, the children got busy of searching for wage work and did not give me time.*" Beyond the working schedule of the children, other aspects of health care accessibility were favorable for the children to seek services from the health facilities.

#### **4.7.3 Access to health care: Acceptability**

On the side of the children, formal health service was less acceptable. Around 1/3 (8 from 33 children) of the children did not believe that health services cure diseases and around 1/3 of the children partially admitted the healing power of the remedy. Additionally from the children that

had faith in the remedy, some feared and some others hated the services. All these indicate that the acceptability of health facilities to the children was unfavorable to be sought by the children.

On the side of workers in the health facilities, acceptability was favorable to the children to seek health care services. Majority (3/4) of the children that had visited health facilities when they were sick stated that they were healed with the treatment they obtained but one child. Similarly, majority (3/4) of the children were affirmative on the way the health workers treated them. This majority stated that the service providers at the health facilities were so humble that they handled them friendly. One child added that the physician that treated him felt so sympathetic for him after hearing that he was child *of* street, and even made financial support for his treatment.

Abba Shorro, however, stated that male physician that treated him at Ambo General Hospital was not respectful to him unlike the female health worker with whom he was. This child said that the physician blamed him as he was the source of his illness and rebuked him.

#### **4.7.4 Access to health care: Accommodation**

In addition to the satisfaction of services provided and the way physicians treat the children, the manner the health organizations function was raised for the children. According to the children, there was no significant problem regarding the working hours of the health facilities. The children took the problem of schedule to themselves i.e. their own work search made them busy as discussed above, not the schedule of the facilities. Waiting time to use the services was also not a big concern in accessing the services, according to the children.

Differently, appointment system (the other aspect of accommodation) was a factor where few (2) children mentioned as challenging. They mentioned that the service providers at Ambo hospital scheduled patients even when the patient experiences severe illness. Regarding their

communication with the health workers, no children mentioned that there was a language problem regardless of their health literacy issue.

#### **4.7.5 Access to health care: Affordability**

The street involved children passed most of their time idle and undertook menial works sometimes although there is variety among them, according to the children. They used to purchase stuffs for their immediate consumption by the wage they sometimes got from their work. According to the children, it was a triumph for them if their wage could buy them food. Some of the children bought cigarette, *khat* and *areke* in addition to food. Thus, the children lived in severe absolute poverty that deprived them their basic needs.

For they live in absolute poverty, financial difficulty was the most challenging factor in access of health facilities. In their discussion, all the children assured that financial constraint was the most critical factor hindering them from seeking health care. And this factor was the most dominant force that suppressed the health facility access status of the children. All the children who visited health facilities on their illness incidents were financially supported by their friends and other people around them, at least partially.

### **4.8 Waiver Health Care System in Ambo Town and the Street Involved Children**

#### **4.8.1 Limited waiver health program for the indigent**

The tangible protection that was provided to access indigent social groups to health care on illness incidents was done through the financial provision of the municipality of the town. According to a key informant from municipality of Ambo town, the municipality had annual budget that was allocated for the office to cover the costs of health services that the indigent need but cannot pay on themselves. He added that destitute people from different social backgrounds

come to their office and claim to get the financial provision to use waiver health service from health facilities. Considering the number of applicants, the key informant mentioned that the budget allocated for this program was so inadequate that it could satisfy the needs of the poor to seek health services.

To support the applicants, the municipality needs some prerequisites to be fulfilled. The municipality requires the applicants to provide evidences of a cooperation letter that proves their being poor from their *kebele* administration, *kebele* identity card and three passport size photographs. These requirements that were required by the procedure of the office were so difficult for street involved children to fulfill, according to the key informant.

After fulfilling the requirements, the applicants are offered a cooperation letter from the municipality that certifies the mentioned person is indigent and the municipality will cover the expense for the health service he/she will utilize from the requested health facility. The applicants grab this cooperation letter and go to health facility that the municipality request to cooperate. After the patient utilizes the treatments, the receipt of the service expense will be sent to the municipality from the cooperating health facility. The municipality funds the service fee for the cooperated health facility retaining the receipt.

On the question he was asked if there is special consideration for street involved children on the requirements to be fulfilled to use the waiver service, the key informant assured that the guideline of the service does not have special consideration for the children. However, he suspiciously indicated that the personnel on the position may support the children without applying all the requirements if he/she believed in the eligibility of the children for the protection. He also mentioned that the children rarely claimed to use the service actually.

#### **4.8.2 Poor access of the street involved children to waiver health service**

A question was raised for the street involved children on whether they know and have ever used health services that were provided by government's expense, a waiver health service provision system. Accordingly, majority (27 out of 33) of the children mentioned that they did not have clue that free health services system exist in the town. All the children that had sought health care stated that they were helped by their friends and other community members in visiting health facilities on their illness incidents.

Only six (6) from thirty-three (33) participants had information on the existence of waiver health service provision in their town. From these six (6), four (4) children insisted that they merely heard the presence of the service from their friends. They certainly mentioned that the alleged free health services were not established in practice. Only one child tried to the health protection service from municipality but could not access the service for the day was Sunday and the office was closed on the day. The other child stated that he took another child to municipality and the municipality sent the child to hospital after long denial.

All the children who had information on the presence of the service resented that they feared the procedure of getting the service was so firm. In explaining the health protection service, the children regarded the service system as government's aid for them, not the rights they could claim to be protected. Most of the children generalized that there was no social structure that was voluntary to hear their concerns and they believed that they had no power to claim for the treatments.



Generally, waiver based health service in Ambo town was not reachable to the street involved children similar to the payable health facilities. This happened in the face of extreme poverty of the children and the existence of their legally protected rights to access the services.

#### **4.9 Why the Health Care Access Rights of the Street Involved Children were violated?**

The conditions in which the street involved children of Ambo town lived and worked were health hazardous, and they contracted diseases frequently as a result. On the other hand, only few of the street involved children visited health facilities when they got sick. All these conditions happened in the presence of legal bodies that stand to secure the health rights of the street involved children. Why so? Three major factors emerged on the reasons why street involved children were stalled from health facilities they were entitled to.

##### **4.9.1 Irresponsibility of executive government bodies**

###### **Labor and social affairs office of Ambo town**

The most significant problem in the access of the street involved children occurred at the Office of Labor and Social Affairs of Ambo town. Absolute majority of the street involved children did not have awareness on the presence of waiver health services in their town, the procedures and requirements to use the facilities, and their rights to access these facilities.

As most of the children confirmed that they did not know the presence of affordable health services, their lack of information hindered from the accessible health treatments. The office failed to create awareness for the street involved children on their health care rights, the existence of health service protection at government health facilities and how they could utilize these rights. In protecting the rights of the street involved children, the key informant at the

Bureau of Labor and Social Affairs, confirmed that the bureau did not make any intervention to make the children know their rights and claim waiver health care treatments when they get sick.

### **Municipality of Ambo town**

The municipality of Ambo town exerted effort that was attributed to it in order to implement the justice principle of health care system of Ethiopian health policy. However, the way the municipality provided assistance to destitute social groups had challenges, particularly for street involved children in the town. First, the municipality required significant prerequisites to be fulfilled from the potential beneficiaries. However, the street involved children were not in a position to fulfill the requirements to use the services. Second, the budget that was annually allocated to the waiver health service system was so little (as reported by the key informant) that it was far inadequate to meet the health needs of the indigent in the town including street involved children.

#### **4.9.2 The voicelessness of the street involved children**

It needed the street involved children to have knowledge about their health care rights, the existing services, and requirements and procedures to claim for utilization of the services. Absolute majority of the children did not have clue on the existence of the so called waiver health service provision. And the children who had clue on the waiver health services stated that the alleged payment free services did not exist practically.

Being in this unawareness, this study explored, that the children did not have the possibility to claim for their rights and how to go the claiming process. Second, the children understood that they were neglected social group such that they felt roughness towards formal social structures and process. This behavior of the children impacted their affinity to ask and reclaim their

violated health service rights. Third, the children believed that there was no social actor that affords to hear about their plight. They criticized that the alleged social servants in their surroundings always served the powerful citizens and repressed their concern.

Summation of all the above factors indicates that the street involved children were not in a position to speak up and press to get access to health care rights. As a result, the children did not have courage to quest their health service rights and enjoy them adequately.

#### **4.9.3 Absence of advocacy groups on behalf of the children**

The concerned governmental offices were not adequately responsive towards the health rights of the street involved children and also the children did not have audible voice to challenge these offices. Under these circumstances, support of other advocacy groups could help the problem of the children in order to bridge the gap that laid between the children and the executive government offices such that the children and their voices would be incorporated into the mainstream system.

When Ambo town is a concern, however, there was no single group that functions as either advocate or enablers for the street involved children, according to the children and key informants. The children mentioned that there were some organizations that aided them with clothes occasionally but no group/organization that worked on their health plight and rights. Thus, no group/organization was functioning to complement the rifts that happened from the unresponsiveness of government offices and the voicelessness of the children in order to realize the health service rights of the children.

#### 4.10 What did the Children think about their Future Health?

On the winding up of each data collection sessions of this study, the street involved children were asked on their worry about their future regarding their health conditions. First, most of the children mentioned that they had worries of all their physical, social and psychological health vulnerabilities to diseases. Most of the children described the conditions in which they were living exposes them to various and frequent health problems.

Some discussants mentioned that they may face psychological problems for they will see their old friends who succeed in their education and life in the future. Second, majority of the children stated that they worried what they will do if they get sick for the fact that their friends have helped them previously and got tired of supporting them repeatedly. They underscored that they will not have fee for health services and they could not think how they would respond to illnesses. Some other discussants mentioned that they were anxious about their basic need satisfactions. As discussed in the previous sections of this paper, some of the children stated that basic needs for them were extended to *khat* and alcohol. One discussant mentioned that he worried about his future fate of procreation family institution. He stated that he was worrying about unaffordability of marriage and family for him such that he may remain unmarried for his whole life.

Derara, 14 years old child, worries of police brutality,

We stay the day wandering here and there to pass our time. When evening comes, we begin to worry about police threat. Some of us sleep eating dinner, some others empty stomach. They come up to us and label us with certain crime we have even not heard. They beat us coming in the middle of our sleep. This makes us worry about the possibility to be threatened by the policemen.

As to most of the children, police brutality was among the primary challenges that upset the children and make instability and unsettlement the main features of their life.

Contrast to the above anxious children, around a fifth (6) of the children stated that they did not have worry in the future regarding their health. They mentioned they did not have worry in the face of their health hazardous living conditions.

Regarding the question on what can be done to improve their health conditions and facility access status, only one interviewee stated that concerned stakeholders have to support them to access health services when they encounter health problems. All the other children did not indicate that they were in need of interventions in order to enjoy better health conditions and status.

## **CHAPTER FIVE: DISCUSSION**

The findings of this study are discussed along the major themes of the study and analyzed data constitutes the discussions which are interpreted subsequently. Additionally, the findings that emerged from data are discussed with reference to the findings of earlier studies that have been conducted in low income countries (mostly African countries) and selected theories, models and approaches.

### **5.1 Streetism in Ambo Town and Profile of the Street Involved Children**

The history and nature of streetism in Ambo town has not been adequately studied which is supported by Kopoka's (2000) argument although it is believed to be as old as the town. This study, thus, put ground for other potential studies particularly on their health and health care access conditions. Likely, the size of the street involved children in the town is rising with the expansion of the town which is similar to the findings of Tadis, Berihun and Nigusie (2014), Fiasorgbor and Fiasorgbor (2015) and Nodjajim (2000). This trend indicates that there will be children victims from the expansion of the town so that cautions have to be taken in the course of growth of the town.

There were three specific areas in Ambo town where the street involved children mostly congregated albeit some of them lived dispersedly in the town. This indicates that some spots of the town have attracting scenarios for the children. The town hosted the children that came mostly from rural parts of West Shoa Zone which was indicative of the children's virtual similarity in social backgrounds so that they could get along one another easily.

On arriving on street, the children escaped the maladies they had been experiencing at home but entered into a new type of troubles which is supported by the findings of UN (2012); Fekadu et

al, (2014) and Peters et al, (2008). The life difficulties the children became exposed to on their coming to the street are so wide-ranging that they experienced a series of plights in each phase of their street life. This indicates that interventions that will be undertaken for the children need to be comprehensive.

## **5.2 Living in the Streets of Ambo Town: A Health Suffering**

Living conditions of the street involved children badly threaten the health state of the children which is parallel to the findings of several studies (e.g. Tsoka-Gwegweni, 2015; Amoah & Jorgensen, 2014; Gupta, 2012; Sophia, 2010; Mandalazi, Banda & Umar, 2009). Unmet basic needs and their force of preoccupation, health risky behavior of the children and systemic factors heightened the disease vulnerability of the children.

The basic need deprivations of the children affected their health in two major ways. Lack of the basic needs in itself led to multiple health problems. The food the children consumed regularly was perilous to their health, similar to the findings of most studies (e.g. Tsoka-Gwegweni & Cumber, 2015; Yemane & Yemane, 2016). Lack of shelter subscribed the children to extreme weather conditions, environmental rubbishes, physical abuses and stress that exposed them to health risks, similar to the findings of Fekadu et al (2014) and Shimelis (2015).

The clothing of the children exposed them to extreme weather and very poor personal hygiene, alike the findings of Yemane and Yemane (2016). Some of the children assumed *khat*, cigarette and *areke* as basic needs so that they were committed to work and satisfy these needs under any circumstance. Contrary to most studies (e.g. Shimelis, 2015, & Yemane & Yemane, 2016), the children did not mention sexual harassment as a problem to them.

Second, the persistent lack of the basic needs led to the preoccupation of the children with the needs so that they overlooked their health concern, parallel to the findings of Edusei and Amoah (2014), Gupta (2012), and Amury and Komba (2010). When surviving becomes a matter of struggle, the data indicate, the mind of the children gets overwhelmed with the satisfaction of these needs.

The second cluster of vulnerabilities was the self concept of the children and their substance abusive behavior. The image that most children gave for themselves lowered the weight they gave for their health condition which is supported with concept of individuals' perceptions of their social location of MacKian (2003). Substance abuse was habituated among half of the children and it affected their state of health in different ways. The substances affected various organs of the children; it led to addiction that obliged the children to grab the substances at any cost pushing them to engage in socially unapproved and culturally unaccepted strategies of generating income. This led to disturbance of the social health of the children. This implies that abusive behavior of the children needs attention in minimizing their vulnerabilities.

Third, there were systemic factors that suppressed the health state of the children. They lived in the physical environment that was unhygienic, infested with insects, and unprotected from harsh weather and abuses. This is parallel to the concept of primary determinants of health that are explained by Health Behavior Model in Levesque et al (2013). The children experienced ubiquitous abuse from street population, other community members and policemen indicating that their social environments were unhealthy. Thus, the social environment of the children is so peril to their health and in need of structural level interventions.



There was negative social attitude towards the children in the streets of the town which is parallel to the findings of Shimelis (2015) and Degwale (2014) which had emotional health effects, similar to the findings of de Benitez (2008). The way policemen dealt with the children was also unhealthy. These negative attitude and police brutality caused emotional health problems, similar to the findings of UN (2012). These imply that denial of the plights of the children is rampant to the level of mainstream society and even the legal structure.

### **5.3 Understanding of Health and Illness among the Children**

The street involved children understood health as it is a state of wellbeing that allows them able to wander and work which is similar to the findings of Ali and Muynck (2005) and Nanda (2008) and ability to meet basic needs. This definition indicates that illness recognition relies on the gravity of the illness symptoms, similar to the studies of Nanda (2008) and Prinsloo and Ritcher (2003). For the children, symptoms that do not disable functioning mentioned above do not amount to illness indicating that they delay in recognizing their state of health when they get ill.

These understandings of health and illness influenced whether the children detected and responded to the illness, responding methods and the time in which they made the response.

Most of the children recognized only severe illness and delayed their responses as a result which is supported by the findings of Gupta (2012). Few of the participants, however, detected and reacted to illnesses before they got disabled from routine activities fearing potential suffering.

Thus, obtaining health and illness understandings of the children is vital in understanding the health seeking behavior of the children and making interventions.

#### **5.4 Coping Strategies of the Street Involved Children on Illness Incidents**

On illness incidents, the street involved children employed different coping strategies. Sleeping off illness, buying medicine from pharmacies/shops, self and traditional treatments, religious healings and visiting health facilities emerged from the data that I collected on illness coping strategies of the children. These sub-themes along explanations behind are discussed below.

Parallel to the findings of Ali and Muynck (2005), most of the children tolerated illness pains expecting the restoration of their health via natural cycle instead of taking actions. This sleeping off illnesses was commonly practiced among the children but ineffective, similar to the study of Fiasorgbor and Fiasorgbor (2015). Mostly, the children exempted from routine tasks which corroborates with Sick Role Theory and the findings of Ali and Muynck (2005) but they mostly exempted at compulsion of the illness gravity. Sleeping off an illness of the children contradicts with most assumptions of Sick Role Theory (Byrd, 2013) and it was mainly attributed to unaffordability of treatments, preoccupation of the children with basic needs and their negligence on their state of health, similar to the assumptions of General Theory of Help Seeking Behavior. For it precluded their treatment seeking, sleeping off illness was lethal to the children.

Buying medicines from the nearby pharmacies/shops without prescription was the second widely employed strategy among the children. The children believed that pharmacies/shops were easily accessible, in line with the explanations of General Theory of Help Seeking (Mechanic, 1979) and findings of Ali and Muynck (2005), and effective which corroborates with the assumptions of Choice Making (Levesque et al, 2013; Ali & Muynck, 2005) and Health Belief Models (Levesque et al, 2013). Thus, solid reasons affected the children to employ the strategy implying that it needs tangible results that the children can easily recognize to alter their health seeking behavior.

Third, self treatment and using traditional medicines as illness coping strategy was also widely practiced among the children. In addition to typical traditional medicines, some of the children did self treatment by using substances of pepper, ginger, and onion for abdominal illnesses; and applying bandage for specific aching organ and hot mineral spring for skin and cold related illnesses. Alternative community interpretations of illness symptoms of General Theory of Health Seeking Behavior, Cues to action of Health Belief Model and home treatment of Choice Making Model support the explanations of the children on these methods. This implies that the children were influenced by common senses and relied on lay referral in the course of coping illnesses. Understanding and taking into account the community traditions that exist in a group, thus, are important in dealing with the health seeking behavior of the children.

Religious healing was also used among the children either independently or compounded with other strategies. Some of the children used for they had most faith in the strategy; some others assumed their specific illness was evil related and some others hated/failed to afford other strategy which is virtually supported by the study of Ali and Muynck (2005). The children who employed this strategy were those who reported that they had religious affiliations. Thus, this health seeking behavior of the children implies that having religious affiliation added one more alternative to illness coping strategies. It also indicates that any intervention in the health condition of the children needs to consider the religious beliefs of the children in relation to their health.

Similar to the findings of Ali and Muynck (2005), formal health facility was the least selected as the first alternative but the most selected as the last alternative in responding to illnesses by the children. Only few of the children who sought the facilities as the first alternative thought that it was the most effective strategy of coping illness. There were important conditions that

influenced the health care seeking behavior of the children which are discussed in the next sections of this paper.

### **5.5 Access of the Street Involved Children to Payable Health Facilities**

Only one-quarter of the children visited health facilities when they were sick. This access status of the children can be seen from two alternatives. Using the payable health services is the first alternative and accessing waiver health service is the second. Access of the children to the payable health service is discussed along the five access dimensions i.e. availability, accessibility, affordability, acceptability and accommodation that determine the possibility of the children to visit the facilities.

The physical availability and accessibility of the available health facilities in Ambo town were favorable for the children. Yet, the summation of mere availability and accessibility of the facilities did not guarantee the children to utilize a health service and this is similar to the findings of Yemane and Yemane (2016). Accordingly, actual access to the services requires other dimensions of access to be favorable indicating that presence of a service within ones nearby environment does not denote the real utilization of the services. This indicates that the children were isolated from the services that were available in their close settings implying that social justice regarding the service needs due attention.

Absolute majority of the children failed to visit health facilities on illness incidents for they could not afford the service fee; all the children that visited health facilities were supported by people around them. This indicates that financial ability chiefly influences the children's access to the facilities similar to the explanations of Choice Making Model (Ali & Muynck, 2005), General Theory of Help Seeking (Mechanic, 1979; Ali & Muynck, 2005) and the findings of

several studies (e.g. Yemane & Yemane, 2016; Elliot, 2016; Fiasorgbor & Fiasorgbor, 2015; Tsoka-Gwegweni & Cumber 2015; Ray, Davey & Nolan, 2011; Sophia, 2010; Strehl, 2010; Amury & Komba, 2010). Poverty, thus, represented an overriding force that need due attention in enabling the children to access health facilities.

Contrary to the findings of Elliot (2016), Tsoka-Gwegweni and Cumber (2015), Sophia (2010) and Nodjadjim (2000), most of health workers in the health facilities treated the children with respect and sympathy though there was a single case in which a health worker blamed a child for the illness incident. On the side of the children, however, formal health service was less acceptable which is similar to the findings of Gaston (2001). Some of the children had less faith in the remedy; some others feared the services; and some others hated them. In contrary, some of the children had positive health care seeking behavior. They visited the facilities as they saw illness symptoms. Thus, acceptability of health services had both favorable and unfavorable conditions for the children to seek health services indicating that it needs attention of practitioners on the area to identify where the hindrance lies.

Most accommodation elements of the health facilities: operation hours, walking-in-services, and the appointment system of the health facilities in the town were inviting for the experienced children. Appointing patients for another time, however, had disappointed a child. This implies that accommodation needs noticeable attention in accessing the children to health facilities.

### **5.6 Actual Access of the Street Involved Children to Waiver Health Care Provision**

Assuming access to health care as a human right, there are both global and national legal bodies that hold Ethiopian government to reach the indigent social groups (including street involved children) with health services. This government responsibility has been enshrined in UNCRC

(UN, 1989) (to which Ethiopia is a signatory), National Health Policy (MoH, 1993), and the National Health Care Financing Strategy [2015-2035] of FDRE (MoH, n.d). This attention (at least at paper level) of the government to waiver system is parallel to the assessment of Smith and Hanson (2012a) who insisted health care financing issue is a priority for many governments.

In line with the social responsibility of Ethiopian government, there is waiver health service that is provided in Ambo town which is run by the budget that is allocated for the municipality office of the town. The municipality is responsible to protect the health rights of indigent people of the town by the allocated budget. However, absolute majority of the street involved children were inaccessible to the waiver health services similar to the finding of the study of Strehl (2010). This implies that the rights of the children enshrined in different legal documents need to be protected practically.

The criteria that the guideline of the waiver health service requires the beneficiaries to fulfill to use the waiver services are unlikely to be fulfilled by the street involved children. Additionally, the children rarely visited the office to claim for the service. In the cases they claimed to use the service, they sometimes got the service at the good will of the officials. Thus, the human right of the children to access health facilities on illness incidents was hardly realized which has to be worked on by concerned government and non-government stakeholders.

### **5.7 The Violated Rights of the Street Involved Children to Access Health Facilities**

Herein, I discussed the way that the entitlements of the street involved children to access waiver health facilities were violated. I evaluated the actual access status of the children to health facilities in reference to their rights that are protected by UNCRC, FDRE Constitution, FDRE National Health Policy and FDRE National Health Care Financing Strategy.

Attention for children who live in adversarial circumstances is an obligation of state parties and states shall play the principal duty to ensure the provision of necessary medical assistance and health care to all children including the street-connected children (UN, 1989). The Convention (article 24/1) states, “*State Parties shall strive to ensure that no child is deprived of his or her right of access to ... health care services.*” Being the signatory of UNCRC, Ethiopia is responsible to protect the health rights of street involved children that are enshrined in the convention. But in Ambo town, little effort was underway to protect the health care rights of the children. Most of the children were denied of their rights that are enshrined in the UNCRC.

Constitution of FDRE (FDRE, 1994) enshrines rights that can protect the health wellbeing of all Ethiopian citizens irrespective of their identity.

Every child has the right not to be subjected to exploitative practices, neither to be required nor permitted to perform work which may be hazardous or harmful to his or her education, health or well-being (Article 36/1). All persons have the right to a clean and healthy environment (Article 44/1/d); Government shall endeavor to ensure that all Ethiopians live in a clean and healthy environment (Article 92/2).

Contrary to these constitutional rights, the street involved children were living on health-unfriendly basic stuffs: all their food, shelter, water, cloth are so hazardous to their health. Worst of all, no single effort that aims at improving the conditions of the children to be healthy was underway. Thus, the rights of the children that are enshrined in the supreme law of the land were violated.

Ensuring the health and wellbeing of all Ethiopians is among the general objective of the National Health Policy of Ethiopia (MoH, 1993) and the policy is committed to the philosophies

of equity and justice in providing health services. Particular to street involved children, the policy indicates that urban poor are among most neglected social segments that need special attention in health service provision. Practically however, most of the street involved children were not reached with health services through the principles of human rights and social justice.

The National Health Care Financing Strategy of Ethiopia [2015-2035] (MoH, n.d) indicates that the fees paid for health services have to take into account the social groups that are unable to afford the payment for the services. In promoting the access rights of the poor, the strategy states that it is a need to strengthen the waiver health service system through increasing funds for waiver and the number of people to be covered by the service. Notably, the strategy namely specifies that street involved children are among the social groups that shall be the beneficiaries of waiver health service provision. Practically however, most of the children were not accessible to waiver health care services that are promised in the strategy. Thus, the rights of the children on paper and the actual reality on ground remained two different worlds implying that efforts have to be exerted to realize the rights of the children that were left on shelf.

### **5.8 Barriers to the Street Involved Children to Access Health Facilities**

Utilizing health facilities either at user-fee or via waiver health care system were the two paths for the street involved children to seek health care. Majority of the children, however, were unable to take up either of the two paths. And the barriers that hindered the children from seeking health care when they get sick can be put into two bundles.

The first bundle of barriers is the financial inability of the children to access the payable health services. Regardless of the physical availability, easy accessibility and favorable health facility accommodative character, the children remained inaccessible to health care on their illness



incidents. All the children stayed idle usually and engaged in menial jobs some times. They lived in absolute poverty and failed to cover the health service expense which is similar to the studies of Yemane and Yemane (2016), Elliot (2016) Fiasorgbor and Fiasorgbor (2015), and Tsoka-Gwegweni and Cumber (2015).

In addition to critical financial difficulty, acceptability issue was also a condition that disables the children from seeking health care. Lack of faith in the remedy, fear and hate were acceptability factors that hindered the children from utilizing the services. This implies that enhancing the health care seeking behavior of the children needs to work on the acceptability of health care to the children and their motivation to seek the service.

The second bundle of barriers that hindered the children from seeking health care on illness incidents was the violation of their fundamental right to access waiver health services. There were three interrelated factors behind violation of these rights of the children. Unresponsiveness of the concerned government offices, voicelessness of the children to defend their rights and absence of advocacy groups with/on behalf of the children were the factors behind the violation of their rights.

The Office of Labor and Social Affairs of the town did not pay any attention to the health care entitlements of the children and violation of their rights which is similar to the arguments of Shimelis (2015), Yemane and Yemane (2016), Sophia (2010) and Kopoka (2000). Similarly, the municipality, health care office and *kebele* administrations of the town were not adequately committed to protect the health access rights of the children. This unresponsive behavior of the offices implies that executive organs of government failed to implement the legally bounded

rights of the children. This indicates that other stakeholders can help the children by putting pressure on the offices to be responsive to the rights of the children.

The children's inability to claim their rights to access health services, which is resulted from the first factor, was the second factor contributing for the violation of their rights to access health care. Most of the children had no clue on the rights they have regarding waiver health service and they felt weak to claim for their right. This indicates that the children have to be empowered to be able to speak for their rights.

Furthermore, there was no advocacy group that works with the children either to empower them or advocate with/on behalf of the children so that the children could claim their health care access rights. Had these groups or organizations existed, the health access of the children would have been improved. Thus, there is an opportunity for potential groups to advocate on behalf of the children in addressing the violation of their rights.

### **5.9 Where Do the Street Involved Children Go from Here?**

Standing on the prospects forwarded by the children, and interpreting their health seeking behavior and access status to health care, the future of the children regarding their health concerns will take certain direction. First, the street involved children will continue to live in unclean and unhealthy environment with no social services so that the children remain highly susceptible to physical, social and mental health problems.

Second, the street involved children will continue to struggle with illnesses outside the formal health care including inadequately inquired coping methods. Third, the children will continue barred from health facilities. Fourth, the children will continue being voiceless and marginalized from the basic health service system. Lastly, the rights of the children that are enshrined in

UNCRC (UN, 1989), FDRE Constitution (FDRE, 1994), National Health Policy (MoH, 1993) and the National Health care Financing Strategy (MoH, n.d) of FDRE will continue violated. Thus, the health condition of street involved children needs urgent attention particularly at policy/strategy implementation level.

## CHAPTER SIX: CONCUSSION, SOCIAL WORK IMPLICATIONS AND RECOMMENDATIONS

### 6.1 Conclusion

This study covered health seeking behavior and access to health facilities of selected street involved children living in the streets of Ambo town. In its exploration, the findings of this study corroborated with different literatures, theoretical explanations and prior studies. It also explored certain specificities on disease vulnerabilities of the children, their responses to illnesses and their admission to health facilities.

In their regular life, the street involved children are deprived of all basic needs. They live in street without shelter, on inadequate and unhealthy food, in a rag and dirty clothing, and with no protector. All these conditions and their resultants contribute to the health conditions of the children to be severe. Thus for the sake of their life conditions, the children are highly vulnerable to contract diseases and they are unlikely to engage in health behavior.

The street involved children respond in various ways when they get sick. They largely engage in sleeping off an illness, buying medicine from pharmacies and self treatment to recover from illnesses. Largely, the children visit health facilities at the help of their friends and other surrounding people when their illnesses turn severe. Gravity of an illness, affordability of an action, and faith in a remedy mainly affect the selection of illness coping strategy among the children. By adhering to one or the other illness coping strategy, the children have been experiencing both success and failure in their attempts of recovering from their illnesses.

The street involved children live in centre of the town where the physical availability of health facilities reach peak but inaccessible to them. Absolute poverty and violation of the right of the

children are the two bundles of factors that prevent the children from accessing health facilities that are available in the town. The children live in miserable poverty from all facets of life; thus, they are unable to afford the expense of health services.

Ethiopian government is legally responsible to provide health services for street involved children in case the children are unable to do on themselves. Practically, however, these legally enshrined health care rights of the street involved children are not adequately secured and social justice remains undone for the children. The concerned executive government offices in Ambo town are not committed to protect the health care rights of the children. The children's being unaware of their right to access health services and the absence of social agents that advocate with/on their behalf are the other conditions contributing for violation of the rights of the children.

The practical world of the rights of the children to access health services is in quest of attention, particularly from the views of human right protection and philosophy of social justice. There is an apparent opportunity for stakeholders who are liable and engrossed to work on the phenomenon. Existing legal documents that enshrine the rights of street involved children to utilize health services guarantee any action that aim to improve the conditions of the children to access health facilities.

## **6.2 Social Work Implications**

The findings of this study have important implication in contributing for improvement of the health conditions of street involved children. The implications of the findings of this study contribute to the knowledge of social work education and its practices, policy process, and future

researches. Thus, the implications discussed below are notably considerable by concerned stakeholders in the move of improving the health status of the children.

### **6.2.1 Implication for social work practice**

First of all, the views that are prevailing on the identity of the street involved children need to be transformed. Every individual, group or organization has to understand that the street involved children have untapped strengths that need to be recognized and tapped. Strengths of the children have to permeate the explanations, approaches and methods of any social work practice at its conception stage. The children, thus, will not be passive recipients of services but active contributing agents for interventions.

This study has seen that the street involved children have their own specific patterns of views, understandings and explanations on their life which entails that practitioners run over the children if their situations are not seen from internal points of view. Thus, the beneficiaries have to be the central source of inputs in planning and implementing social work interventions. Doing so, the efforts that are exerted to improve the health conditions of the children will be tailored, effective and enduring.

Third, enabling access of street involved children to health services on illness incidents should not be considered as a need of the children that needs humanitarian sympathy and aids. It is, and it has to be regarded as the right of the children so that the government is responsible to secure it. Any intervention that is undertaken on the health conditions of the children need to be regarded as the rights that the children have to enjoy for the sake they are human being; it is not an aid that is done at the sympathy of government or other stakeholders. This ultimately motivates the children to claim the services; it empowers them.

Fourth, social work practitioners are advised to exploit the opportunities that exist round their interventions. They have to be able to exploit the conventions, national policies and strategies that enshrine the rights of the children to access health services. Wise deployment of these guidelines is advisable so that their interventions can be easily justified legitimate and practitioners will be politically safe.

Fifth, the social workers have to lay emphasis on the executive branch of government in their attempts of improving the health status of the children. This is required for the fact that violations of the health access rights of the children are located at the practical world despite the legal guidelines that can guarantee the access of street involved children to health facilities. Thus, practitioners have to focus on where the problem revolves i.e. the social structures that are responsible but failed to implement the guidelines that are on the shelf of the government.

In addition to emphasizing on the fundamental barriers that hinder the children from accessing health facilities, reforms are required on other health care accessibility dimensions. Time needed to be served at health facilities, children's perceptions regarding health services and attitude of the health workers to the children need to be turned encouraging for the street involved children.

### **6.2.2 Implication for policy making, analysis and implementation**

Regardless of their implementation level, the global conventions that Ethiopia has adopted and the policies and strategies the country has ratified regarding the health care rights of street involved children has to be appreciated and supported.

Second, the health care access of the children was so limited practically albeit there are legal principles that entitle the children to have the accessibility. This has implication to assess and monitor the implementation of the policies and strategies and the consequences. This will help

by indicating something is to be done when the performance of the guidelines is so inconsequential.

Third, this study implies that policy analysis have to be sensitive to the practical side of policy documents to measure the level to which it is really achieving its goals. Achievements of a policy/strategy and the satisfaction of the beneficiaries shall not be evaluated on the mere existence and contents of a policy/strategy but also its actual effects shall be taken into account.

Fourth, the findings of this study indicate that policy/strategy monitoring/evaluation is not happening which is making the gap between the principle and practice aspects of the guideline to be unnoticed and overlooked. Thus, an agent that watches over the implementation of policy/strategy needs to be engaged and highlight the low performance of the policy/strategy.

Fifth, this study implies that it is so challenging to see a policy/strategy get enforced under the circumstances where the existence, contents and the way/how of a policy/strategy remain unknown to the potential practitioners and beneficiaries of the policy/strategy. Thus, policies/strategies have to be known to all concerned social structures, and the beneficiaries.

### **6.2.3 Implication for social work education**

First, lived experience of the same social groups across space and time can vary from one another so that their views, strengths, vulnerabilities, sufferings and needs will be different from one another. Thus, social work education shall discourse the specificities of realities, and the origin and consequences of these specificities.

Second, the study implies that the issue of justice and equity in social service provision can be violated practically while there are a series of standing legal documents that forbid the condition. Social work education needs to consider the paper and practical heights of social



policies/strategies in teaching how to understand the discontent of voiceless social groups, location of the discontent and how to protect them. Thus, lessons in social work education should reflect the practical reality and its importance in relation to paper level principles.

Third, social work education has to promote that holisticity is a vital lens in the efforts of dealing with the children's access to health facilities. The findings indicate that the barriers that are disabling the children from health facilities are located at the micro (individual children, health and other workers), mezzo (organizations and groups) and macro (community, policy practice and society) levels. Thus, any social work education needs to teach its learners to notice multidimensionality in understanding, explaining and working on social problems.

Fourth, this study reminds social work education that social structures are likely to be unresponsive to voiceless groups in the absence of voice-makers that seriously press them to rework on their approach towards the segregated social groups. Thus, social work education needs to reproduce skilled human power that is knowledgeable, skillful and artistic in promoting the concerns of voiceless social groups and empowering the voiceless groups to stand on their own feet and defend themselves.

#### **6.2.4 Implication for future studies**

This study was limited to a single town, children *of* street, pure qualitative research approach and curative health needs of the children. It is recommendable for other researchers to undertake studies on multiple towns, broader street community.

This study is limited to health service needs of the street involved children on the incidents they contract disease. Consequently, it is recommendable for future researchers to undertake studies

on how to minimize/prevent disease vulnerability of the children so that the disease prevention interventions will be promoted.

Studies are needed to be undertaken on identifying the strengths of the street involved children and how these strengths can be tapped in improving their living conditions generally and health conditions particularly.

The entitlement and the actual accessibility of the street involved children to other social services that are interconnected to their health conditions have to be studied so that their health implications will be identified and worked on.

Assessments are required on the types of required interventions and how to implement them in order to protect the rights of the street involved children to access health facilities that have been enshrined in the legal documents that the country has adopted and developed.

Studies have to be undertaken on the factors behind each illness coping strategies employed by the children in their order of weight so that priority areas of interventions are identified and worked on.

### **6.3 Recommendations**

In order to improve the health conditions of the street involved children in particular and their access to health facilities particularly, the following recommendations need to be considered.

The Office of Labor and Social Affairs of Ambo town has to approach the children and create awareness on their health care rights, the waiver health service system that exist in the town, the ways how they can afford the requirements to use the service and the procedures that they need to go through to use the service.

The municipality of Ambo town needs to reconsider the requirements that the street involved children are needed to fulfill to get their protection service to access health facilities for the fact that the children are not in a position to adequately fulfill the requirements. The municipality again has to make need assessment for the waiver health service and claim for adequate budget for the coming times.

*Kebele* administrations of Ambo town have to be sensitive to the street involved children living in their jurisdiction so that the children are recognized as residents of town when they seek the service of municipality office in getting access to the possible health facilities.

Health office of Ambo town needs to pay attention to the health conditions of the children that live in street on the town and facilitate their access to health facilities in collaboration with other offices identified above.

Advocacy groups, as a complementary, need to work with the street involved children for the fact that the children are not in a position to speak up their voice. These groups can work on creating awareness, mobilizing, and empowering the children by using the legal frameworks of UNCRC, Constitution of FDRE, National health policy of FDRE, national health care financing strategy [2015-2035] and others. These advocacy groups can also lobby the government offices mentioned above to be responsive to the health care rights of the children.

Higher government structural tiers have to decisively inflict pressure on the implementers of waiver health system in Ambo town so that they become responsive to the health care rights of the street involved children in line with conventions, policies and strategies that are mentioned above.

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**APPENDICES****APPENDIX I: Informed Consent Form for the Street Involved Children****Consent statement:**

The purpose of our stay is to collect information for the fulfillment of Master of Social Work at Addis Ababa University. The study is carried out on your coping strategies in the event of illnesses and your potential to access health care services. Your participation in this study is invaluable and the research cannot be successful without your contribution. There is no right/wrong answer; you are cordially requested to answer what you experienced genuinely. The researcher is fully responsible that no risk will happen to you by your participation in this study and there will be no immediate reward provided to you.

Please note that the information you provide in our stay will remain confidential and never be used for other purpose beyond this study. You can ask any question regarding this study and quit your participation whenever you like. Your participation is on voluntary basis. If you accept this statement, please give your consent on the spaces provided on the following form.

**Consent of the Participant**

I have read the foregoing information, or it has been explained to me. I have had the opportunity to ask questions which have been answered to my satisfaction. Agreeably, I hereby agree to participate voluntarily in this study which is carried out to explore the coping strategies I use when I face illness as well as my potential to access to health care services.

Name of the Participant: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of the Researcher: \_\_\_\_\_ Date: \_\_\_\_\_

Witness 1: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness 2: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

✚ If you have any query, contact the researcher (Mr. Mesfin Minase) at Tel. no: 0938-98-5370



**APPENDIX II: Research Tools****Tool A: Protocol for In-depth Interview Data Collection Method****About the Session**

Contact site	
Interviewer's Name	Mesfin Minase
Date of Interview	
Session duration	

**Introduction**

Well come and I am grateful to you for you gave me your consent to give me the data I need! My name is Mesfin Minase and I am a student of Master of Social Work at Addis Ababa University. The purpose why I need you here is to collect data for the study I am conducting for fulfillment of my master degree. This study is carried out on your health vulnerability to diseases, coping strategies on the event of illnesses and your potential to access health care services when you get sick.

Your participation in this study is invaluable and the research cannot be successful without your contribution. There is no right/wrong answer and you are cordially requested to answer what you experienced genuinely. I am fully responsible that no risk will happen to you by your participation in this study. Please note that the information you provide me will remain confidential and never be used for other purpose beyond this study. You can ask any question regarding this study and quit your participation if you like to do so. Thank you!

## I. Profile of the Interviewee Child

- Child Name (pseudo):\_\_\_\_\_
- Sex:\_\_\_\_\_
- Age:\_\_\_\_\_
- Religion:\_\_\_\_\_
- Job:\_\_\_\_\_
- Congregating area\_\_\_\_\_
- Sleeping place\_\_\_\_\_
- Number of years lived in street\_\_\_\_\_

## II. Questions

**Now, I Would Ask You Some Questions Regarding Your Living Condition In Relation To**

### **Its Health Connotations**

1. How did you get socialized into street life and health? explain its health implications
2. How is the meeting of basic needs in street affect your health?

**Probe:**

- a) Shortage of food, clothe and shelter, and health
- b) Hygiene of your meals, cloth, sleeping place and health
- c) Mind preoccupation with basic needs and health

3. How is your working condition affecting your health?

**Probe:** Lack of job, heavy works, unhygienic works

4. How is using and abusing substances affecting your health? (only if you engage)

**Probe:**

- a) the impact of the substances on health
- b) Measures taken to satisfy catering and
- c) Addiction and health

5. How is your mere identity and street social life affecting your health?

**Probe:**

- a) Abuses from other street population
- b) Abuses from other community members
- c) Streetism and social structures

**Now, I Would Ask You Some Questions Concerning your Health Seeking Behavior**

6. What is health for you?

**Probe:**

- a) your physical, social, emotional health status;
- b) the role of health in your life;
- c) the care you give to protect your health

7. How do you understand illness?

**Probe**

- a) meaning of illness;
- b) illness frequency in street life;

**8. Please describe your illness incident****Probe:**

- a) your immediate feeling;
- b) gravity of the symptoms;
- c) sleeping area during the illness;
- d) person that looked after you on the time;
- e) your daily bread on the time;

**9. What strategy did you employ to cope up the illness?****Probe**

- a) reason for your selection of the action;
- b) time gap in which you responded to the illness;
- c) persons participated in your decision to take the action;
- d) costs you incurred to take the action;
- e) the results of your actions;

**Now, I Would Ask You Some Questions Concerning Access to Health Care Services****10. If you have visited health facilities when you were sick,**

- a) In what time gap from inception your illness symptom?
- b) The health facility you visited
- c) Reason for selecting that facility
- d) Source of the fee for your treatment
- e) The way the workers treated you
- f) Any inconvenience you experienced

**11.** If you have not visited health facilities when you were sick,

- a) Explain your reasons;
- b) Your attempts to resolve the reasons.
- c) current status of the reasons

**12.** Have you ever used waiver health services?

**If yes, probe**

- a) Source of your information of the service
- b) The health facility you attended
- c) Offices that facilitated your access to the services
- d) The procedures you went through
- e) Requirement you were asked to use the service
- f) Inconveniencies you faced, if any
- g) Reasons of free health services for you

**If no, probe:**

- a) The reason and
- b) emerging points

**13.** Do you have any worry about your health condition?

If yes, what worries?

**Tool B: Outline of Focus Group Discussion (FGD)****About the Session**

Contact site	
Number of discussants	
Group moderator	Mesfin Minase
Date of the session	
Duration of the session	

**Introduction**

Well come and I am grateful for you gave me your consent to give me the data I need! My name is Mesfin Minase and I am a student of Master of Social Work at Addis Ababa University. The purpose why I need you here is to collect data for the study I am conducting for fulfillment of my post graduate degree. This study is carried out on your health vulnerability to diseases, coping strategies on the event of illnesses and your potential to access health care services when you get sick.

Your participation in this study is invaluable and the research cannot be successful without your contribution. There is no right/wrong answer and you are cordially requested to answer what you experienced genuinely. I am fully responsible that no risk will happen to you by your participation in this study. Please note that the information you provide me will remain confidential and never be used for other purpose beyond this study. You can ask any question regarding this study and quit your participation if you like to do so. Thank you!

## I. Profile of the Discussants

- a) Child Name (pseudo): \_\_\_\_\_
- b) Sex: \_\_\_\_\_
- c) Age: \_\_\_\_\_
- d) Religion: \_\_\_\_\_
- e) Job: \_\_\_\_\_
- f) Congregating area \_\_\_\_\_
- g) Sleeping place \_\_\_\_\_
- h) Number of years lived in street \_\_\_\_\_
- i) Number of illness incidents: \_\_\_\_\_

## II. Questions

**Now, I Would Ask You Some Questions Regarding Your Living Condition In Relation To  
Its Health Connotations**

1. How did you get socialized into street life and health? explain its health implications
  - a) About the food in street
  - b) In acquainting with the street population
  - c) In internalizing street norms
2. How is the meeting of basic needs in street affect your health?

**Probe:**

- a) Shortage of food, clothe and shelter, and health
- b) Hygiene of your meals, cloth, sleeping place and health
- c) Mind preoccupation with basic needs and health

3. How is your working condition affecting your health?

**Probe:**

- a) Lack of job
- b) Heavy works
- c) Unhygienic works

4. How is using and abusing substances affecting your health? (only if you engage)

**Probe:**

- a) the impact of the substances on health
- b) Measures taken to satisfy catering and
- c) Addiction and health

5. How is your mere identity and street social life affecting your health?

**Probe:**

- a) Abuses from other street population
- b) Abuses from other community members
- c) Streetism and social structures

**Now, I Would Ask You Some Questions Concerning your Health Seeking Behavior**

6. What is health for you?

**Probe:**

- a) physical, social, emotional health
- b) the role of health in your life;
- c) the care you give to protect your health



7. How do you understand illness?

**Probe:**

- a) meaning of illness;
- b) illness frequency in street life;

8. Please describe your illness incident

**Probe:**

- a) your immediate feeling;
- b) gravity of the symptoms;
- c) sleeping area during the illness;
- d) person that looked after you on the time;
- e) your daily bread on the time;

9. Please discuss on how social groups you belong to (if any) impact on health

- a) Social health (love, sharing ideas, protection, abuses, rebuke)
- b) Psychological health (protection, belongingness)
- c) Economic impact (before sickness, on sickness)
- d) Spiritual health

10. Please discuss on the strategy you did employ to cope up the illness

**Probe:**

- a) reason for your selection of the action;
- b) time gap in which you responded to the illness;
- c) persons participated in your decision to take the action;
- d) costs you incurred to take the action;
- e) the results of your actions;

**Now, I Would Ask You Some Questions Concerning Your Access to Health Care Services**

**when you were sick**

11. If you have visited health facilities when you were sick,
- a) In what time gap from inception your illness symptom?
  - b) The health facility you visited
  - c) Reason for selecting that facility
  - d) Source of the fee for your treatment
  - e) The way the workers treated you
  - f) Any inconvenience you experienced
12. If you have not visited health facilities when you were sick,
- a) Explain your reasons;
  - b) Your attempts to resolve the reasons.
  - c) current status of the reasons
13. Have you ever used waiver health services?

**If yes, probe:**

- a) Source of your information of the service
- b) The health facility you attended
- c) Offices that facilitated your access to the services
- d) The procedures you went through
- e) Requirement you were asked to use the service
- f) Inconveniencies you faced, if any
- g) Reasons of free health services for you

**If no, probe:**

- a) The reason and
- b) emerging points

14. Do you have any worry about your health condition?

If yes, what worries?

**Tool C: Key Informant Interview****Guiding Questions for Key Informant Interview: Official of Labor and Social Affairs of  
Ambo Town****About the Session**

Contact area	
Interviewer's Name	Mesfin Minase
Position of the official	
Date of Interview	
Duration of the session	

**Introduction**

I am grateful for you for you gave me your consent to stay with me! My name is Mesfin Minase and I am a student of Master of Social Work at Addis Ababa University. The purpose why I need you is to collect data for the study I am conducting for fulfillment of my master degree. This study is carried out on the health vulnerability of street involved children to diseases, their coping strategies on the event of illnesses and their potential to access health care services when they get sick. Thus, I ask you some questions on these concerns and you respond them on behalf of your office.

Your participation in this study is invaluable and the research cannot be successful without your contribution. I am fully responsible that no risk will happen to you by your participation in this study. Please note that the information you provide me will remain confidential and never be used for other purpose beyond this study. You can ask any question. Thank you!

## Questions

### First, Let Me Ask You Some Questions on Streetism in Ambo Town

1. When did street life begin in Ambo town?
2. What is the magnitude of children of below 18 years old in Ambo town?

**Probe:** recent assessment, if any

### Now, I ask you some questions regarding the health service that your office provide for street involved children

3. How does your office perceive street involved children?

**Probe:** As deviant, residual, victim category

4. What services do you provide for the street involved children, if any?

**Probe:** if yes, explain. If no, why?

5. What health service rights do street involved children have?

**Probe:** UNCRC, constitution, health policy, financing strategy

6. How do you see the realizations of the health service rights of the children?

**Probe:**

- a) your role in accessing the children to health facilities
- b) the children's usage level of your services

7. What barriers have you observed in realizations of the rights of the children?

8. Do you have any intervention plan that will be implemented on the health concerns of the children?

**Probe:** If yes, what? If no, why?

9. What do you recommend to improve health facility access of the children?

**Guiding Questions for Key Informant Interview: Official of Municipality of Ambo Town**

**About the Session**

Contact area	
Interviewer's Name	Mesfin Minase
Position of the official	
Date of Interview	
Duration of the session	

**Introduction**

I am grateful for you for you gave me your consent to stay with me! My name is Mesfin Minase and I am a student of Master of Social Work at Addis Ababa University. The purpose why I need you is to collect data for the study I am conducting for fulfillment of my master degree. This study is carried out on the health vulnerability of street involved children to diseases, their coping strategies on the event of illnesses and their potential to access health care services when they get sick. Thus, I ask you some questions on these concerns and you respond them on behalf of your office.

Your participation in this study is invaluable and the research cannot be successful without your contribution. I am fully responsible that no risk will happen to you by your participation in this study. Please note that the information you provide me will remain confidential and never be used for other purpose beyond this study. You can ask any question. Thank you!

## Questions

**First, I ask you some questions on work of the municipality office for people to access health facilities on illness incidents**

1. What services do poor people get from your office to visit health facilities when they get sick?
2. Which groups of people are eligible to use the services you mentioned above?
3. What criteria are required from an individual to qualify for the service?
4. Please explain the procedures that the people get the services?
5. What is the source of the finance for the services that the office provides?
6. What is the philosophy you depend on to provide this service for the poor?

**Now, I ask you some questions on how the services you described above in relation to street involved children**

7. How are street involved children eligible to use the services you described above?
8. To your experiences, are the children able to fulfill the requirements to use the services?  
**If no, probe:** so, how the children can access your services? Is there any affirmative action for them?
9. Do the children adequately come to your office to get the services?  
**If no, probe:** why?
10. What challenges are there in your providing the service to the children?
11. What do you recommend for the improvement of the provision of your services to street involved children to access health facilities?

**TRANSLATED VERSION OF THE RESEARCH TOOLS****Gumee I: Qajeelfama Af-gaaffii**

Bakka af-gaaffin kun itti godhame	
Nama af-gaaffii godhe	<b>Mesfin Minaasee</b>
Guyyaa af-gaaffii kun itti godhame	
Yeroo af-gaaffiin kun fudhate	

**Ibsa**

Baga nagaan dhufte. Ani maqaan koo Masfin Minaasee jedhama. Waamicha anis sii godheef tole jettee na wajjin turuudhaaf eeyyama waan naa kenniteef guddaa galatoomi. Osoo gara gaaffii kootti hin deemiin dura, seensa wayii siif godha. Af-gaaffiin kun kan qophaaye Masfin Minaaseetiin, barataa yuunivarsitii Addis Ababaattii barataa maastersii departimentii “Social Work.” Kaayyonsaas waraqaa qorannoo digrii maastarsii xumuruuf hojjetamurratti odeeffanno funaanuufidha. Haala jireenyaa ati karaarratti gootu, maloota yeroo si dhukkubu fayyuuf fayyadamtuu fi carraa ati tajaajila fayyaa fayyadamuuf qabdu dhimmoota gurguddaa af-gaaffii kana keessatti ka’an ta’a.

Hirmaannaan kee qorannoo kana keessatti bakka olaanaa qaba. Af-gaaffii kana keessatti deebiin kee sirrii dha yokiin sirrii miti jedhamee hin madaalamu. Gaaffii gaafatamteef ibsa qabatamaa ta’e duwwaa naaf kennita. Deebii ati naaf kennitu ebelutu naaf kenne jedhee maqaa kee faana hin kaa’u. Akkasumas ibsi ati kennitu, qaama biraaf tasumaa hi gabbaasamu. Deebiiin kee kaayyoo qorannoo kanaaf duwwaa oola. Gaaffii yoo qabaatte gafaachu ni dandeessa. Galatoomi!



**I. Ibsa hirmaatichaa/hirmattittii**

1. Maqaa (Kan jijjiirame): \_\_\_\_\_
2. Saala: \_\_\_\_\_
3. Umurii: \_\_\_\_\_
4. Amantii: \_\_\_\_\_
5. Hojii: \_\_\_\_\_
6. Bakka qubannaa: \_\_\_\_\_
7. Iddoo ciisaa: \_\_\_\_\_
8. Umurii karaarra jiraatte: \_\_\_\_\_

**Kutaa I: Amma Haala Jireenya kee Karaarraa Fayyaa Kee Faana Wal Qabsiisuudhaan**

**Gaaffii Muraasan Si Gaaafadha**

**1. Haala ati jalqabarratti jiruu karaarraa barte, fayyaakee miidhee ture?**

Eeeyyee, yoo ta'e, Akkamitti?

**2. Hanqinni fedhiwwan bu'uuraa kee akkamiin fayyaa kee miidhu?**

**Sakatta'aaf:**

- a) Dhabinsa nyaataa, uffataafi bakka ciisaa, fi Fayyaa kee
- b) Qulqullina nyaataa, uffataa fi ciisaa fi Fayyaa kee
- c) Dhiphina fedhiwwan kana guutuuf jiruu fi Fayyaa kee

**3. Haalli Hojii kee fayyaa kee akkamitti miidha?**

**Sakatta'aaf:**

- a) Hojii dhabuu
- b) Hojii humnaa olii

c) Hojii qushaashaa

**4. Araadni akkamiin fayyaa kee miidha? (yoo araada qabda ta'e duwwaa)**

**Sakatta'aaf:**

- a) Dhiibbaa araaduu qaamarratti
- b) Tattaaffii araada qabbaneffachuuf godhamuufi Fayyaa
- c) Dhiibbaa wantoota araadaman dhabuun fayyarratti qabu

**5. Jireenyi hawaasaa karaarra akkamiin fayyaa kee huba?**

**Sakatta'aaf:**

- a) Miidha hawaasa karaarra jiraatan irraa sirra gahu
- b) Miidhaa hawaasa biroorraa sirra gahu
- c) Miidhaa poolisootarraa sirra gahu

**Kutaa III: Amma Immoo Dhimoota Tarkaanfii Yeroo Si Dhukkubu Ittiin of Yaalte**

**Ilaallatun Si Gaafadha**

**6. Akka siif galutti, fayyaa jechuun maal jechuudha?**

Qabxiiwwan xiyyeeffannoo

- a) Fayyaa qaamaa, fayyaa sammuu, fayyaa hawaasummaa
- b) Sadarkaa fayyuummaakee
- c) Fayidaan fayyaa
- d) Kunuunsa fayyaa kee

**7. Akka keetti, yaadni dhukkuba jedhu maal jechuudha?**

Qabxiiwwan xiyyeeffanno

- a) Dhukkubaa fi hawaasummaa
- b) Dhukkubaa fi qaamota seeraa

- c) Babal'insa dhukkabbii naannoo kee keessti
- d) Haala jireenya keefi dhukkubbii wal bira qabi
- e) Carraa ati dhukkubsachuuf qabdu
- f) Miira kee yeroo dhukkubbiin si mudate

**8. Waayee dhukkuba si mudatee, naaf ibsi**

**Sakatta'aaf:**

- a) Akka si dhukkubbeen maaltu sitti dhagahame?
- b) cimina dhukkubichaa
- c) Nyaata fi dhugaatiikee si'a dhukkubsattetti
- d) bakka ciisichakee yeroo dhukkubsattee
- e) Nama yeroo dhukkubsatte si faana ture

**9. Yeroo si dhukkube fayyuudhaaf maal goote?**

**Sakatta'aaf:**

- a) Sababa tarkaanfii sanaa
- b) Yeroo keessatti tarkaanficha fudhatte
- c) Nama murtii tarkaanfikee murteesse
- d) Akkaataa tarkaanficha itti fudhatte
- e) Bu'aa tarkaanfiikee

**Kutaa IV: Amma Immoo Dhimmoota Yeroo Dhukkubsatte Tajaajila Fayyaa Argachuu  
yookiin Argachuu dhabuukee Ilaallatanan siif Kaasa**

**10. Yeroo dhukkubsatte mana yaalaa deemteetta yoo ta'e;**

**Sakatta'aaf:**

- a) Yeroo hammam keessatti deemtee?
- b) Maqaa mana yaalichaa
- c) Sababa achi deemteef
- d) Achi deemuuf eenyu mariisifte
- e) Madda baasii tajaajila argattee
- f) Haala ogeyyiin itti si kunuunsan
- g) Rakkoowwan kenninsa tajaajilichaarratti argite

**11. Yeroo dhukkubsatte mana yaalaa hin deemne yoo ta'e;**

**Sakatta'aaf:**

- a) Sababa kee ibsi
- b) gufuu sana darbuuf yaalii goote
- c) Ammahoo gufuun sun jiraa?

**12. Yeroo dhukkubsattetti, tajaajilaa Fayyaa bilisaan fayyadamtee beektaa?**

**Eeyyeen yoo ta'e, sakatta'i:**

- a) Madda odeeffanno kee
- b) Dhaabbata Fayyaa dhaqxe
- c) Waajjiraalee haala siif mijeessan
- d) Addemsa ittiin tajaajila argatte
- e) Haaldureewwan gaafatamte

- f) Wantootaa si quuqan
- g) Sababa maaliif tola argatta sitti fakkaata?

**Lakki yoo ta'e, sakatta'i**

- a) Maaliif
- b) Qabxiwwan achi maddanis sakatta'i

**13. Gara fuulduratti, waayee fayyaakee yaaddoo qabda?**

**Sakatta'i:** Yoo Eeyyeen ta'e, ibsi

**Gumee II: Qajeelfama Marii Garee****Waayee Garee kanaa**

Bakka mariin itti gaggeeffame	
Baayina mariyatootaa	
Maqaa mariisisaa	<b>Mesfin Minaasee</b>
Guyyaa fi sa'aatii marii	
Turtii marii	

**Ibsa**

Osoo gara gaaffii kootti hin deemiin dura, seensa wayii isiniif godha. Baga nagaan dhuftani. Ani maqaan koo Masfin Minaasee jedhama. Waamicha anis isiniif godheef tole jettanii na wajjin turuudhaaf eeyyama waan naa kennitaniif guddaa galatoomaa. Qajeelfamin kun kan Kaayyoo waraqa qorannoo digrii maastarsii “Social Work” Addis Ababa yuuniversityitti xumuruuf hojjetamurratti odeeffanno funaanuufidha. Haala jireenyaa isin karaarratti dabarsitanii, maloota yeroo sin dhukkubu fayyuuf fayyadamtaniif carraa isin tajaajila fayyaa fayyadamuuf qabdan dhimmoota gurguddaa marii kana irratti ka'an ta'a.

Hirmaannaan keessan qorannoo kana keessatti bakka olaanaa qaba. Marii kana keessatti deebiin keessan sirrii dha yokiin sirrii miti jedhamee hin madaalamu. Dhimma ka'e irratti ibsa qabatamaa ta'e duwwaa naaf kennitu. Deebii isi naaf kennitan iccitiidhaan kan qabamu ta'a. Akkasumas ibsi isin naaf kennitan, qaama biraaf tasumaa hi gabbaasamu. Deebiiin keessan kaayyoo qorannoo kanaaf duwwaa oola. Gaaffii yoo qabaattan gafaachu ni dandeessan. Galatoomaa!

## GAAFFILEE

### **Kutaa I: Duraan dursee dhimmoota akkaataa itti jiruun keessan karaarraa Fayyaa keessan miidhu irratti qabxii muraasa isiniifan kaasa**

#### **1. Yeroo gara jirenya karaatti dhuftan wantoonni isinitti ulfaatan turani?**

##### **Sakatta'i:**

- a) Nyaata irratti
- b) Ijoollee faana walbaruurratti
- c) Sosochii daandirraa baruurratti

#### **2. Mee Waayee fedhii bu'uuraa keessan guttachu akkamitti fayyaa keessan akka miidhu mariyadha?**

##### **Sakatta'i:**

- a) Hanqina nyaataa, uffannaa, bakka ciisaa
- b) Qulqullina wantoota fedhii bu'ura keessan guuttachuuf fudhattan
- c) Cinqii wantoota kana argaachuuf gootan

#### **3. Waayee jirenya hawaasa gootan irratti mariyadhaa**

##### **Sakatta'i:**

- a) Hiriyoota faana
- b) Jiraattota karaa warra kaan faana
- c) Uummata magaalaa biro fi baadiyyaa faana
- d) Polisoota faana

**4. Waayee araada fayyadamuurratti mariyadhaa**

**Sakatta'i:**

- a) Waantoota araadaaf oolan
- b) Haala ittiin argaman
- c) Yeroo wantoota san dhaban maal akka ta'u

**Kutaa II: Amma Immoo Dhimoota Tarkaanfii Yeroo Si Dhukkubu Ittiin of Yaalte**

**Ilaallatun Si Gaafadha**

**5. Akka keessanitti, Fayyaa jechuun maal jechuudha?**

**Sakatta'i:**

- a) Qaama keessan, sammuu keesan, hawaasa, qaamolee nageenyaa
- b) Faayidaa Fayyaa
- c) Kunuunsa fayyaa

**6. Dhukkubsachuun maali?**

**Sakatta'i:**

- a) Miiruma xiqqoo namatti hin tolle, Ciisuu, nyaata diduu, hojii dhaabuu
- b) Dhiphachuu, Waliigaltee namaa dhabuu, seera faana walitti bu'uu

**7. Waayee dhukkuba si mudate ibsamee**

**Sakatta'aaf:**

- a) Akka si dhukkubeen maaltu sitti dhagahame?
- b) cimina dhukkubichaa
- c) Nyaata fi dhugaatiikee si'a dhukkubsattetti
- d) bakka ciisichakee yeroo dhukkubsattee
- e) Nama yeroo dhukkubsatte si faana ture



8. Gareewwan addaa addaa isin qabdan Fayyaa keessan keessatti shoora maal qabu? [yoo qabaattan duwwaa]

**Sakatta'i:**

- a) Maallaqa wal gargaaruu
  - b) Waliin mariyachuu
  - c) Wal bira dhaabachuu
  - d) Wajjin taphachuu
  - e) Wal miidhuu
9. Mee gaafa dhukkubsatan, fayyuuf jecha maal gootani?

**Sakatta'i:** Homaa hin goone, Qorichan fayyadame, Tsabala/kadhannaa, Mana yaalaa, qoricha aadaa

**Kutaa IV: Yeroo Dhukkubsatan, Carraa Mana Yaalaa Deemuuf Qabdanirratti Qabxii**

**Muraasa**

10. Gaafa dhukkubsattan, yoo mana yaalaa deemtaniittu ta'e;

**Sakatta'i:** eessa, eenyu faana, kaffaltii, ilaalcha hakiimotaa, rakkina si mudate

11. Yoo mana yaalaa hin deemne ta'e;

**Sakatta'i:** Maaliif?

12. Tajaajila Fayyaa tolaan fayyadamtanii beektuu?

**Eeyee yoo ta'e, sakatta'i:**

- a) Madda odeeffanno kee
- b) Dhaabbata Fayyaa dhaqxe
- c) Waajjiraalee haala siif mijeessan
- d) Addemsa ittiin tajaajila argatte, haaldureewwan gaafatamte

- e) Wantootaa si quuqan
- f) Sababa maaliif tola argattan sitti fakkaata?

**Lakki yoo ta'e, sakatta'i:** maaliif?

**13. Gara fuulduratti, waayee Fayyaa keessanii yaaddoo qabduu?**

**Sakatta'i:** Yoo Eeyyeen ta'e, ibsaa

**Gumee III: Madda Odeeffannoo Furtuu****Qajeelfama Madda Odeeffanno Furtuu Waajjira Dhimma Humna Namaa fi****Hawaasummaa Magaala Amboof Qophaaye**

Bakka af-gaaffin kun itti godhame	
Nama af-gaaffii godhe	<b>Mesfin Minaasee</b>
Guyyaa af-gaaffii kun itti godhame	
Yeroo af-gaaffiin kun fudhate	

**Ibsa**

Ani maqaan koo Masfin Minaasee jedhama. Waamicha anis siif godheef tole jettee na wajjin turuudhaaf eeyyama waan naa kenniteef guddaa galatoomi. Osoo gara gaaffii kootti hin deemiin dura, seensa wayii siif godha. Af-gaaffiin kun kan qophaaye Masfin Minaaseetiin, yuuniversity Addis Ababaattii barataa maastersii “Social Work.” Kaayyonsaas waraqaa qorannoo digrii maastarsii xumuruuf hojjetamurratti odeeffanno funaanuufidha. Haala jireenyaa ijoolleen daandiiira jiraatan karaarratti godhan, maloota yeroo isaan dhukkubu fayyuuf fayyadamanii fi carraa isaan tajaajila fayyaa fayyadamuuf qaban dhimmoota gurguddaa af-gaaffii kana keessatti ka’an ta’a.

Hirmaannaan kee qorannoo kana keessatti bakka olaanaa qaba. Af-gaaffii kana keessatti deebiin kee sirrii dha yokiin sirrii miti jedhamee hin madaalamu. Gaaffii gaafatamteef ibsa qabatamaa ta’e duwwaa naaf kennita. Deebii ati naaf kennitu ebelutu naaf kenne jedhee maqaa kee faana hin kaa’u. Akkasumas ibsi ati kennitu, qaama biraaf tasumaa hi gabbaasamu. Deebiiin kee kaayyoo qorannoo kanaaf duwwaa oola. Gaaffii yoo qabaatte gafaachu ni dandeessa. Galatoomi!

**Kutaa I: Gaaffii Muraasa Waayee Karaa Magaala Amboo Irra Jiraachuu Ilaallatu Isiniif**

**Kaasa**

1. Magaala Ambootti, daandiiarra jiraaaachuun yoom eegale?
2. Ijoolleen waggaa 18 gadi karaa magaala Amboorra jiraatan, baayinni isaanii meeqa ta'u?

**Probe:** qorannoo yeroo dhihoo gootanii beektuu? Yoo lakki ta'e, maalif?

**Kutaa II: Gaaffii Muraasa Haala Waajjirri keessan Ijoollee daandiiarra Jiraatan wajjin**

**hojjeturrattin isin gaafadha**

3. Waajjirri keessan ijoollee daandiiarra jiraatan akkamiin ilaala?  
**Probe:** kuftoota, dadhaboota, yakkamtoota, gargaarsa barbaaddota, cimoota, dhiibamtoota
4. Tajaajila hawaasaa ijoollee daandiiarra jiraataniif gootan qabdu?  
**Probe:** Fayyaa isaanii faana wal qabatee hoo? yoo qabaattan, ibsaa. Yoo hin qabaanne, maaliif?
5. Mirga ijoolleen dandiirraa jiraatan tajaajila Fayyaa argachuuf qaban akkamiin ibsitu?  
**Probe:** UNCRC, FDRE Constitution, FDRE National Health Policy, FDRE National health care financing strategy
6. Mirgi ijoolleen kun tajaajila Fayyaa argachuuf qaban hammam eegameera?
7. Rakkinoota ijoollee kana tajaajila Fayyaa fayadamsiisuuf jiran ibsaa
8. Mirga daa'imman kun tajaajila fayyaa fayyaadamuuf qaban mirkaneessuuf, karoora yeroo dhihootti hojiirra oolu qabdu?
9. Akka mirgi ijoollee tajaajila Fayyaa gahaatti argataniif maal dhaamtu?

**Qajeelfama Madda Odeeffanno Furtuu Waajjira Mana Qopheessaa Magaala**  
**Amboof Qophaaye**

Bakka af-gaaffin kun itti godhame	
Nama af-gaaffii godhe	<b>Mesfin Minaasee</b>
Guyyaa af-gaaffii kun itti godhame	
Yeroo af-gaaffiin kun fudhate	

**Ibsa**

Ani maqaan koo Masfin Minaasee jedhama. Waamicha anis siif godheef tole jettee na wajjin turuudhaaf eeyyama waan naa kenniteef guddaa galatoomi. Osoo gara gaaffii kootti hin deemiin dura, seensa wayii siif godha. Af-gaaffiin kun kan qophaaye Masfin Minaaseetiin, yuunivarsitii Addis Ababaattii barataa maastersii “Social Work.” Kaayyonsaas waraqaa qorannoo digrii maastarsii xumuruuf hojjetamurratti odeeffanno funaanuufidha. Haala jireenyaa ijoolleen daandiiarra jiraatan karaarratti godhan, maloota yeroo isaan dhukkubu fayyuuf fayyadamanii fi carraa isaan tajaajila fayyaa fayyadamuuf qaban dhimmoota gurguddaa af-gaaffii kana keessatti ka’an ta’a.

Hirmaannaan kee qorannoo kana keessatti bakka olaanaa qaba. Af-gaaffii kana keessatti deebiin kee sirrii dha yokiin sirrii miti jedhamee hin madaalamu. Gaaffii gaafatamteef ibsa qabatamaa ta’e duwwaa naaf kennita. Deebii ati naaf kennitu ebelutu naaf kenne jedhee maqaa kee faana hin kaa’u. Akkasumas ibsi ati kennitu, qaama biraaf tasumaa hi gabbaasamu. Deebiiin kee kaayyoo qorannoo kanaaf duwwaa oola. Gaaffii yoo qabaatte gafaachu ni dandeessa. Galatoomi!

**Kutaa I: Waayee Waajirri Mana Qopheessa Magaala Amboo Namoonni akka tajaajila  
Fayyaa argataniif hojjeturratti Gaaffii muraasan isin gaafadha**

1. Namoonni yeroo dhukkubsatanii mana yaalaa deemuuf jedhan waajjira keessanirra tajaajila maalii argatu?
2. Namoonni tajaajila kana argatan namoota akkamiiti?
3. Adeemsa itti tajaajilli kun kennamu naaf ibsaa
4. Madda maallaqa tajaajila kanaaf oolchitanii naaf ibsaa
5. Tajaajila gubbaatti naaf ibsitan kana argachuuf, fayyadamtoonni ulaagaalee maal maal guutuu qabu?
6. Faalasamni isin namoonni humna hin qabne akka tajaajila fayyaa argatan gootaniif maali?

**Kutaa II: Amma Immoo Tajaajila Gubbaatti Naa Ibistan Kana Ijoollee Dandiirra  
Jiraatan Wajjin Wal Bira Qabeen Gaaffii Muraasa Isiniif Kaasa**

7. Ijoolleenn daandiirra jiraatan tajaajila gubbaatti naaf kaastan fayyadamuuf mirga ni qabuu?
8. Akka taajjabii keessaniitti, ijoolleen daandiirra jiraatan ulaagaalee barbaachisan haalaan guuttachuu ni danda'uu jettanii yaadduu?

**Yoo lakki ta'e, sakatta'i:** erga akkas ta'ee haala kamiin tajaajila keessan fayyadamuu danda'uree? Ilaalchi addaa ni godhamaafii?

9. Ijoolleenn daandiirra jiraatan, tajaajila kana fayyadamuuf yeroo hedduu ni dhufuu?

**Yoo lakki ta'e, sakatta'i:** akka ijoolleen kun dhufanii tajaajila keessan fayyadamaniif wanti gootan jiraa?

10. Tajaajila kana si'a kennitan rakkinoonni isin mudatan jiruu?

11. Ijoolleen dandiirra jiraatan akka baayinaan gara waajjira keessanii dhufanii tajaajila kana argataniif maal dhaamtu?

#### **Gumee IV: Qajeelfama Wantoota Daawwatamanii**

1. Bakkeewwaan ijoolleen qubatan, ciisanii fi Hojii isaanii Fayyaa isaani faana walqabsiisuun
2. Qulqullina dhuunfaa ijoollee fi naannoo isaanii
3. Dhaabbilee Fayyaa kennan kan naannoo ijoolleen sun jiraatanitti argaman
4. Waliitti dhufeenya ijoolleen waliinn qaban
5. Miirawwan fuula fi sosochii ijoolleen yeroo na wajjin turanitti godhan
6. Wantoota dirree hojii koo irratti barbaachisaadha jedhee arguu danda'u



### **ANNEX III: Glossary**

*Areke*: it is a local alcohol drink that is produced through small scale distillation chemical process

*Duriyye*: Amharic term commonly name used to address the street involved children which has the connotation of deviance from social norms

*Kebele*: a formal government administration structure/tier in Ethiopia which is subdivision of district

*Khat*: it is a type of leaf that is taken mostly through chewing, and has catalyzing and addiction effects

*Shiro*: it is a common food in Ethiopia which is allegedly identified with low income segments of society

*Waaqa*: Afan Oromo name for the concept of God