PSYCHOSOCIAL CORRELATES OF STREET CHILDREN IN KENEMA, EASTERN SIERRA LEONE: A DESCRIPTIVE SURVEY

By

Masah Mambu
Matriculation Number: 176755

A RESEARCH PROJECT SUBMITTED TO THE CENTRE FOR CHILD AND ADOLESCENT MENTAL HEALTH, UNIVERSITY OF IBADAN, NIGERIA IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE IN CHILD AND ADOLESCENT MENTAL HEALTH (MSC. CAMH), UNIVERSITY OF IBADAN, NIGERIA

May, 2014

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

ACKNOWLEDGEMENTS

My foremost appreciation goes to God, for safeguarding me that makes it possible for me to go through this project successfully. This exercise would have been unimaginable without financial support. I am therefore thankful to the John D. and Catherine T. MacArthur Foundation, for the full sponsorship that empowered me to be part of the pioneer group of this program.

The writing of this dissertation would not have been possible without a comprehensive supervision from Professor Olayinka. O. Omigbodun whose understanding and patience throughout the research provided me with direction and became more of a mentor, sister and a friend than a professor. I am also grateful to the other members of the supervision team, Dr. Bibi Oladeji and Dr. Babatunde Adedokun. They guided and supported me throughout my research.

I wish to acknowledge with deep appreciation the cooperation of Dr. Olurotimi Adejumo and Dr. Yetunde Adeniyi for their time and energy used in helping with my research supervision. Also, my sincere thanks and appreciation go to my dignified lecturers who impacted knowledge in me in the various course modules of the Masters program.

My sincere thanks also go to James F Sandy who provided me with insight, support and guided me throughout the entire project.

To the vice chancellor, Professor Red -Wood Sawyer, the dean, Dr. J. Edem Hotah of the Faculty of Nursing, University of Sierra Leone for giving me the opportunity to enrol into this training programme, I am grateful.

I also wish to record with appreciation the hard work of the field data collectors. My sincere gratitude, to my entire family and friends for their various supports towards this great achievement I thank you all!!!

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

TABLE OF CONTENT

	Page	Word
LIST OF TABLES	VIII	
ACRONYMS	X	
EXECUTIVE SUMMARY	XI	253
CHAPTER ONE		799
1.0 INTRODUCTION	1	
2.0 LITERATURE REVIEW	5	4,708
2.1 OVERVIEW OF PSYCHOSOCIAL CORRELATES OF STREET CHILDREN	5	
2.2 OVERVIEW OF CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES	7	
2.2.1 Definition of Children in Especially Difficult Circumstanc	7	
2.2.2 Family factors	8	
2.2.3 Social norms and cultural attitudes toward children	8	
2.2.4 Natural and manmade disasters	9	
2.2.5 Disease condition	9	
2.2.6 Poverty	9	
2.3.0 Health problems of children in especially difficult circumstances	10	
2.3.1 Children affected and infected by HIV/AIDS	10	
2.3.2 Children with disabilities and chronic illness	11	
2.3.3 Exploited or abused children	12	
2.3.4 Street children (homeless children)	13	
2.3.5 Child trafficking	15	
2.3.6 Commercial sex workers	15	
2.3.7 Children in disaster situations	16	
2.3.8 Children who migrate from rural to urban	18	
2.3.9 Children in contact with the law	18	
2.3.10 Orphaned and abandoned children	19	
2.3.11 Children in poverty	19	
2.4 STREET CHILDREN: HISTORY AND DEFINITION	20	
2.5 HEALTH PROBLEMS OF STREET CHILDREN IN WEST AFRICA AND SIERRA LEONE	21	
2.6 MENTAL HEALTH PROBLEMS OF STREET CHILDREN IN WEST AFRICA	23	
2.7 RELEVANCE OF THE STUDY OF MENTAL HEALTH PROBLEMS OF STREET CHILDREN IN KENEMA	25	
CHAPTER THREE		27
3.0 AIM AND OBJECTIVES OF THE STUDY	27	100
3.1 AIM	27	
3.2 SPECIFIC OBJECTIVES		
3.3 HYPOTHESIS	27	
CHAPTER FOUR		28
4.0 METHODOLOGY	28	1,246
4.1 STUDY LOCATION	28	
4.2 STUDY DESIGN	29	

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

4.3 SAMPLE SIZE DETERMINATION 29
4.4 STUDY POPULATION 30
4.5 SAMPLING TECHNIQUE 30
4.6 INSTRUMENT 31
4.7 TRANSLATION OF INSTRUMENT 32
4.8 ETHICAL APPROVAL 32
4.9 STUDY PROCEDURE 33
4.10 DATA MANAGEMENT 33
CHAPTER FIVE 34 1,770
5.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE STUDY POPULATION 34
5.2 PREVALENCE AND PATTERN OF PSYCHOSOCIAL FACTORS OF THE STUDY POPULATION 40
5.2.1 PATTERN OOF LIFE ON THE STREET 40
5.2.2 ECONOMIC ACTIVITIES ON THE STREET 42
5.2.3 PSYCHOACTIVE SUBSTANCE USE, SEXUAL BEHAVIOURS, TRAUMATIC EVENTS, WORRIES AND EXPOSURE TO VIOLENCE 43
5.2.4 EMOTIONAL AND BEHAVIOURAL SYMPTOMS EMOTIONAL SYMPTOMS: SELF ESTEEM ITEMS AND DEPRESSIVE SYMPTOMS 50
5.2.5 BEHAVIOURAL P*ROBLEMS* *47*
5.2.6 STRESS PROBLEMS *49*
5.2.7 PROBABLE DEPRESSION, OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER 49
5.3 SOCIO-DEMOGRAPHIC CORRELATES OF THE PSYCHOSOCIAL ISSUES OF THE STREET CHILDREN SAMPLED 51
5.3.1 SOCIO-DEMOGRAPHIC CORRELATES OF LIVING PERMANENTALY ON THE STREET 51
5.3.2. SOCIO-DEMOGRAPHIC CORRELATES OF LENGTH OF TIME LIVED ON THE STREET 53
5.3.3 SOCIO-DEMOGRAPHIC CORRELATES OF THE USE OF ALCOHOL, TOBACCO AND OTHER PSYCHOACTIVE SUBSTANCES SUBSTANCES 54
5.3.4 SOCIO-DEMOGRAPHIC CORRELATES OF BEING SEXUALLY ACTIVE 56
5.3.5 SOCIO-DEMOGRAPHIC CORRELATES OF BEING PHYSICALLY ATTACKED AND INVOLVED IN PHYSICAL FIGHT 58
5.3.6 SOCIO-DEMOGRAPHIC CORRELATES OF BEING OF HAVING PROBABLE DEPRESSION 60
CHAPTER SIX 62 1,481
6.0 DISCUSSION SECTION 62
6.1 SOCIO-DEMOGRAPHIC CORRELATES OF SREET CHILDREN IN KENEMA 62
6.2 PREVALENCE AND PATTERN OF PSYCHOSOCIAL FACTORS OF THE STUDY POPULATION 66
CHAPTER SEVEN 68
7.0 CONCLUSION 68 65

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER EIGHT 69 106
8.0 LIMITATION 69
CHAPTER NINE 70 66
9.0 RECOMMENDATION 70
REFERENCES 71
APPENDICES 78
ETHICAL APPROVAL 78
CONSENT FORM 79
INSTRUMENT 80

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

LIST OF TABLES

Table 1: Socio-Demographic Characteristics: Personal Information

Table 2: Socio-Demographic Characteristics: School Information

Table 3: Socio-Demographic Characteristics: Family Information

Table 3: Continued: Socio-Demographic Characteristics: Family Information

Table 4: Pattern of Life on the Street

Table 5: Economic Activities on the Street

Table 6: Psychoactive Substance Use, Sexual Behaviours, Traumatic Events, Worries and Exposure to Violence

Table 7: Self Esteem Items and Depressive Symptoms

Table 8: Oppositional Defiant Symptoms

Table 9: Stress and Problems: Help Seeking Behaviour of Respondents

Table 10: Probable Depression, Oppositional Defiant Disorder, Conduct Disorder and Self-Esteem problems

Table 11: Socio-demographic Correlates of Living Permanently on the Street

Table 12: Socio-demographic Correlates of Length of time lived on the street

Table 13: Socio-demographic Correlates of the Use of Alcohol, Tobacco & other Psychoactive Substances

Table 14: Socio -demographic correlates of being Sexually Active

Table 15: Socio-demographic Correlates of being physically attacked and Involved in Physical Fights

Table 16: Socio-demographic Correlates of having Probable Depression, Probable Oppositional Defiant Disorder and Probable Conduct Disorder

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CEDC	Children in Especially Difficult Circumstances
DDR	Disarmament, Demobilization and Reintegration
HANCI	Help A Needy Child International
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organizations
STIs	Sexually Transmitted Infections
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPA	Work Project Administration

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

EXECUTIVE SUMMARY

Street children are found in many cities around the world but most especially in regions with high rates of poverty and turmoil. Sierra Leone experienced an eleven year old civil war during which several children were separated from their parents and relatives. Eastern Sierra Leone where the war started was most severely hit in terms of destruction and breakdown of community life.

Kenema, the major city in Eastern Sierra Leone and third largest city in the country is reported to have a large number of street children. Despite this, the psychological and social correlates of street children in Kenema have never been reported.

Therefore this study aimed to determine the psychosocial correlates of street children in Kenema using a descriptive cross-sectional study design. A multi-stage cluster sampling of five market areas, five motor parks and two garages identified as densely populated areas where street children aggregate during the day and night was carried out. A total of 400 'street children' aged 5 to 19 years were interviewed utilizing the modified Global School Health questionnaire.

There were more boys (70.1%) than girls on the street and approximately, a quarter of children were living permanently on the street. Poverty was the main reason given for children staying on the street. Others reasons include family problems, a need for freedom and civil disturbances.

The Government in collaboration with non-governmental organization (NGOs) and other child care institutions should rehabilitate these children and initiate education and vocational training programmes to enable them enjoy a better future.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Chapter One

BACKGROUND

1.0 Introduction

"*Being poor is itself a health hazard; worse, however, is being urban and poor. Much worse is being poor, urban and a child. But worst of all is being a street child in an urban environment"* (Barra, 1998).

The existence of street children is a major phenomenon that cuts across several cultures. UNICEF (2005) has estimated that tens of millions of children live on the street all over the world. The dangers which these children are exposed to, and the challenges they face each day are a focus of increasing attention and concern, particularly on the African continent (Kopoka, 2000)

Several studies conducted in sub-Saharan Africa have identified factors peculiar to the region which contribute to the problem of street children. The rapid rates of urbanization in almost all countries in sub-Saharan Africa, is one major factor responsible for this trend (Mehta, 2000; Kopoka, 2000). Related to this are high rates of rural-urban migration, which complicates the situation of poverty and overcrowding in the major cities (Hecht, 2000). Other contributing factors specific to certain cultures in sub-Saharan Africa include family-related practices which create insecure and unsafe conditions within the home. Children, who are the victims of neglect, emotional, physical or sexual

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

abuse, or who experience various forms of exploitation such as child labour, are at risk of leaving home for the streets (Mallett and Rosenthal, 2009). Similarly, chaotic family settings as may arise from parental separation or divorce, polygamy, living in slums, or parental involvement in crime or substance use, are documented contributory factors to children moving out onto the streets (Rosenthal, Mallett and Myers, 2006; Katambwe, Kizanda, and Kyalemaninwa, 2009).

The effects of a life on the streets on child development have been extensively studied. Homelessness and exposure to various forms of adversity outside the protective environment of a stable home have been shown to adversely impact on children's emotional development and behaviour. Dibiase and Waddell (1995) reported lower levels of self-esteem and more deviant behavioural patterns in homeless children, when compared to pre-schoolers of the same socioeconomic status who lived in homes. Abdelgalil *et. al*, (2004); Mallett, Rosenthal and Keys (2005). Besides these, some studies have also reported a desire for "independence" or "freedom" as reasons given by sub-Saharan African children for leaving their families and homes. Similarly, Buckner *et al*, (1999) reported an association between internalising problem behaviours and homelessness in American children aged 6 years and above. Hunger is a very common experience of 'children in exceptionally difficult circumstances' (CEDC) and its severe forms have been documented in street children (Weinreb *et. al*, 2002). These conditions of deprivation have also been associated with increased rates of internalising behavioural problems like anxiety and depression, and exposure to stressful life events (Weinreb *et. al*, 2002). Furthermore, studies like those of Whitbeck *et.al* (2004) have demonstrated

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

significantly higher rates of psychiatric disorders like major depressive episodes, conduct disorder, posttraumatic stress disorder, and alcohol and substance abuse among adolescents on the streets, compared to same-aged respondents living with their families in the same communities.

Justification of the Study

Among countries in sub-Saharan Africa, Sierra Leone has experienced major social upheavals due to a major ten-year civil war. The war broke out in the eastern region of the country, and lasted for ten years between 1991 and 2001, a severely disruptive period during which her citizens witnessed considerable suffering. Kenema, the headquarter town of that region, witnessed a significant amount of bloodshed and chaos, with high records of death, family separation, and homelessness. These conditions are believed to be responsible for a large portion of the children found on the streets of Kenema following the war, as similar patterns have been reported in other post-war regions (Veale and Dona, 2003). An approximate figure of 250 street children was reported in 2011 in post-war Kenema (HANCI and The Ministry of Social Welfare, 2011) .While this is suspected to be a gross underestimate of the actual figures, these numbers may be at least partly made up of male and female child soldiers who remained on the streets after the war, for fear of stigma and rejection by their families and communities.

This study aims to examine psychosocial factors which relate to street children in Kenema, and to explore the relationships, if any, between these factors and their mental health. The findings will help to shed light on the socio demographic features which

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

characterise street children in this unique location, to highlight mental health problems which they may suffer, and to identify possible relationships between their socio demographic characteristics and mental health challenges. It is believed that this information will provide a basis for policy development to address the needs of these children, inspire effective interventions, and highlight areas of need for further research on this unique population of African children.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER TWO

LITERATURE REVIEW

This chapter focuses on the review of relevant literature specific to this study as outlined below:

2.1 Overview of psychosocial correlates of street children

2.2 Overview of children in especially difficult circumstances (CEDC)

2.3 Health problems of CEDC (social, physical, mental)

2.4 The street children phenomenon

2.5 Health problems of street children in West Africa and Sierra Leone

2.6 Mental health problems of street children in West Africa

2.7 Relevance of the study of mental health problems among street children in Kenema.

2.1 Overview of psychosocial correlates of street children

The term psychosocial refers to the relationship between different social factors and individual thoughts as well as behaviour (http://answer.ask.com/Health/Mental/What_is_psych....) Psychosocial matters involve both social and psychological behaviours of the individual or group. (http://answer.ask.com/Health/Mental/What_is_psych....) Psychosocial according to the psychologist, Erik Erikson, is a term used in describing an individual's psychological development, and in particular, the person's involvement with their social environment. The psychosocial theory states that a human should pass through eight stages of

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

development at certain ages in his or her life. These stages are hope, will, purpose, competence, fidelity, love, care, and wisdom (McLeod, 2008).

The latter definition implies that psychosocial correlates of street children refer to both psychological and social problems faced by street children. Since there is a correlation between social and psychological factors, one can deduce that each one could be as a result of the other. Children and adolescents on the streets face a range of emotional and psychological challenges that may have negative impact on their well-being (UNICEF, 2005).

Street children typically live in conditions of severe neglect, without access to education, good nutrition, safety, shelter, and appropriate health care (Le Roux, 1995).Several studies have highlighted the significant role that psychosocial factors play in the development of several psychiatric conditions in children (Omigbodun, 2004; Berden, Althaus *et al*.1990; Shaw, Vondra *et al*. 1994; Biederman, Milberger *et al.* 1995; Rey, Walter *et al*. 2000; Rubia and Smith. The absence of secure and nurturing family relationships place street children at increased risk of developing mental health problems like anxiety, depression, post traumatic stress disorder and behavioural problems such as conduct disorder (Bassuk and Rubin, 1987; Vostanis and Cumella, 1998). The harsh economic conditions on the streets also operate as predisposing factors to street children engaging in deviant behaviours such as stealing, shop-lifting, prostitution, illicit drug use, and many other behaviors that are against the norms of the society (Prince 2006).

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

2.2.0 Overview of Children in Especially Difficult Circumstances (CEDC)

2.2.1 Definition of Children in Especially Difficult Circumstances (CEDC)

'Children in especially difficult circumstances'(CEDC) are children who have extra-ordinary needs which are not met and who require specific protection to regulate their special needs' (Ritchie, 1999) Psychosocial support is a special need of children in difficult conditions (Nancy Mock and Buhr, 2009).

Millions of children around the world are living in especially difficult circumstances (UNICEF, 1993). Street children are one of the groups of children living under difficult circumstances as they experience difficulties in street life (UNICEF, 1993). Others include: Orphans and refugees or displaced persons, children of migrant workers and other socially deprived persons. These children are subjected to sexual abuse and other forms of exploitation and child labour (UNICEF, 1993). Most of them are exposed to chemical radiation as they work in factories and mining areas which are more hazardous and exploitative (UNICEF, 1993).

Children could live in such difficult circumstances as a result of family factors, social norms and cultural attitudes towards children, natural and man-made disasters, disease condition and poverty (UNICEF, 1986).

2.2.2. Family factors

Children need love, shelter, nourishment, a sense of identity and belonging as they rely on their family as the appropriate care provider (Cosgrove, 1990). Children in difficult

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

circumstances are socially deprived and some are abandoned and denied affection, education and assistance (Boukhari, 1997; Lugalla and Mbwambo, 1999; Foster, 2000).

Many children lack adequate protection either because they are separated from their families or because they belong to families who are also in difficult circumstances, such as situations of traumatic exposure, poverty, armed conflict or family conflict (UNICEF, 1986). Some children find themselves in neglectful or abusive families with no protection for their safety and see their families as threats (UNICEF, 1986).

2.2.3 Social Norms and Cultural Attitudes toward Children

Studies suggest that some children run away from their family's way of life due to traditional forms of cultural socialization (Lugalla and Mbwambo, 1999) and become street children.

Practices such as traditional and cultural beliefs preventing girls from attending school, early marriages where girls are bullied and abused by their husbands, girl child discrimination, female genital cutting, children being severely punished for rebellious or dishonourable attitude toward their families, Quranic school boys begging on the streets and denouncing children as witches in some cultures. These practices violate the Child Rights Act which states that children are entitled to care and protection putting them in difficult circumstances (UNICEF, 2009).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

2.2.4 Natural and Manmade Disasters

Disasters such as earth quakes, flooding or storms, and armed conflicts (UNICEF, 1986) these occurrences lead to situations where there are child soldiers, refugees and displaced persons.

2.2.5 Disease Condition

Disease conditions are another devastating factor that put children and adolescents in difficult situations (UNICEF, 1986). For example, children infected or affected by HIV/AIDS and children with disabilities and other chronic illnesses suffer from discrimination and stigma. This in addition to the suffering from their illness makes them vulnerable to emotional stress (UNICEF, 1997).

2.2.6 Poverty

Poverty is a key factor that may be responsible for many other factors such as manmade disaster, family separation and abandonment, insufficient provision of food that are responsible for the difficult life of children (UNICEF, 1997).

2. 3 Health Problems of Children in Especially Difficult Circumstances

The World Health Organization defined health, as "a state of physical, mental and social well-being" (www.who.int/about/definition/en/print.html, 2011). Children in especially difficult circumstances experience a lot of health problems affecting their physical, psychological and social wellbeing (UNICEF, 1986). They are far more susceptible to physical stress, under nutrition, fatigue, and disease (UNICEF, 1986). Any difficulty they

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

encounter will have negative effect on their health status. Discussed below are some of the categories of children in difficult circumstances.

2.3.1 Children Affected and Infected by HIV/AIDS

According to UNESCO (2002), HIV attacks and gradually destroys the body's defences. Children in difficult circumstances generally experience poor health (UNICEF, 2013). This combined with their difficult life, contributes to their lowered immunity and morbidity exposing them to debilitating diseases such as HIV/AIDS (Richter and Swart-Kruger, 1995).

HIV and AIDS greatly affect children at many levels. Parents might fall sick with HIV infection and will not be able to care adequately and properly for their children.

"As of 2011, more than 17 million children had lost one or both parents due to AIDS, almost 90% of which live in Sub-Saharan Africa" (UNICEF, 2013). These orphans continue to suffer in poverty and underachieve academically (UNICEF, 2013). HIV infection could lead to Acquired Immunodeficiency Syndrome (AIDS) if immediate intervention is not done. There are others who are not infected but are affected by HIV/AIDS such as orphans whose parents died of HIV/AIDS, abandoned children of infected parents and children in infected households (www.ci.org.za/depts/ci/plr/pdf/salrc_rprt_02/pr110chapter12.pdf).

Children infected with HIV encounter physical, emotional, social and educational instability (Richter & Swart-Kruger, 1995). They suffer discrimination in child care facilities, at home and in the society. Children who stay with HIV/AIDS infected parents are in stressful situations, sometimes abandoning their education to care for their sick

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

parents. The abandoned and orphaned children are the most vulnerable children affected by this disease condition. Nonetheless they all need special protection.

2.3.2 Children with Disabilities and Chronic Illness

Chronic illnesses may limit a child's activities a lot or a little. Children with disabilities may find it very difficult to take care of their personal daily living activities and in several societies the burden of care is wholly on their families (Allen, 1991).These children have a right to education and may need transportation to take them to school. Unfortunately, transport inaccessibility could be a big problem for the family and prevent the children from going to school. Some families cannot cope with the burdens and sometimes force the children into institutions established for the disabled, such as residential care facilities. This situation has often been documented to have a negative impact on the physical, social and mental health of these children as they are deprived of close parental interaction and supervision (Chandler, 1993).

2.3.3 Exploited or Abused Children

Exploitation includes the worst forms of child labour and child trafficking (UNICEF, 2003).

Working children (child labour)

Child labour has been in existence throughout history and since the industrial revolution in Europe where children were seen working in factories and mines in hazardous and exploitative conditions (UNICEF, 1993). Exploitative child work means children do work

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

at a young age, for long hours, with little pay in hazardous conditions and under slave – like arrangements (UNICEF, 1993). Child labour describes a stressful practice wherein children are engaged in certain activities not appropriate for their age and against their will (UNICEF, 1993). The hazardous job conditions (UNICEF, 1993) interfere with their education and also are detrimental to their health and development as they are exposed to accidents and infections. Such activities include street trading, agricultural activities, entertainment and modelling, domestic service and prostitution (UNICEF, 1997). Some families sell their children as labourers in exploitative circumstances such as prostitution that is detrimental to a young person's physical, mental, emotional or social development (UNICEF, 1997).

2.3.4 Street Children (Homeless Children)

Street children generally are in poor living conditions with an unhealthy life style associated with poor health and a lowered immune system (Rooyen and Hartell, 2002). They are exposed to illness and injury, increased rates of sexually transmitted, pregnancy, substance abuse, mental health concerns, mortality, poor nutrition, dental and periodontal disease and an increased future risk of diabetes, heart disease, arthritis and musculoskeletal disorders (Kulik *et al,* 2011). Street children encounter a lot of psychological and emotional problems with negative implications on their welfare and behaviour (Kulik, gaetz *et al.* 2011). Street children are known to survive by their own accord (Levenstein, 1996). As they strategize and work under hazardous and exploitative health conditions (Richter and Swart-Kruger, 1995), they engage in working, scavenging, begging, hawking, loading and unloading at railway stations, bus depots and market

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

places. They are also involved in prostitution and theft as a means of survival (UNICEF, 1993) and in the process they become victims of road traffic accidents, maltreatment, abused and eventually become malnourished (Levenstein, 1996) with an emaciated appearance. They are easily susceptible to wounds, infection and diarrhoea, anaemia, reduced levels of energy, impaired immune system due to chronic disease conditions such as HIV/AIDS with rapid regression (World Health Organization, 1991; Kelly 2001). Children who sleep on the street live in isolation and loneliness due to the strange and unfriendly street life (Richter and Swart-Kruger, 1995).

They sleep on cardboard and newspapers in small groups in hideouts like under bridges, dustbins, parks, cemeteries, old cars, junk yards, drainpipes, sports grounds, parking areas building sites, old store-rooms, dumping sites, religious places, corridors, pavements and or any other place that offers protection from the night and the harsh weather conditions, arrest by the security agents and other forms of opportunistic abuse. (Gebers, 1990; Swart, 1990; Connolly, 1990; Schurink, 1993; South African National Council for Child and Family Welfare, 1993; Geldenhuys, 1994; (Uddin *et al*. 2003). These places are generally unsafe, unhealthy and virtually unprotected (Lugalla and Mbwambo, 1999).

Street children are more vulnerable to HIV/AIDS as they engage in drug abuse, illicit sex such as unprotected commercial sexual activities, noncommercial high-risk sexual activities and sexual abuse (Haley, Roy *et al,* 2004); (Johnson, Aschkenasy *et al* 1996), which are as a result of their exclusion, stigmatization and discrimination (Swart, 1990a)

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

by the society. Furthermore, many street youth engage in substance abuse that causes running nose, sore throat, brain damage, bone degeneration, blotches on face, chapped lips, paleness, tired appearance, enlarged pupils and bloodshot eyes, headaches, weight loss and susceptibility to colds and flu (van Rooyen and Hartell, 2002).

Their poor physical health condition in combination with the difficult street life makes them vulnerable to mental health problems such as anxiety, depression and post-traumatic stress disorder (Richter and Swart-Kruger, 1995). They are also prone to anger, irritability, aggressiveness, mood swings, restlessness, poor sleep patterns, lowered immunity, poor memory; depression and hyperactivity (Holford, 1998).

2.3.5 Child Trafficking

Child trafficking is another form of child abuse and it is one of the most traumatic events children encounter as they are removed from their families and communities, and taken to strange and unsafe environments where they are forced into prostitution and child labour (UNICEF, 1997)

"Child trafficking is a modern form of slavery that involves displacing a child for the purpose of exploitation which implies the use of force, fraud or coercion; a legal or illegal entry into another country" (www.ibcr.org/eng/definition_child_trafficking.html).The use of force to engage in illicit work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children (www.santac.org/.../Human-Trafficking/Definition-of-Child-Trafficking) is child labour.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Children may be sold, kidnapped and forced into pornography and prostitution against their will (UNICEF, 1997) thereby creating a negative impact on the emotional and physical development of the victimized children.

2.3.6 Commercial Sex Work and Sexual Abuse

Children engage in commercial sex work due to poverty and the need to survive in harsh economic conditions (UNICEF, 1993). Commercial sex work often involves repeated sexual relations with multiple individuals, several of whom may be much older than the child worker. This situation puts the child at high risk of contracting dangerous diseases such as HIV/AIDS or other sexually transmitted diseases (Richter & Swart-Kruger (1997). Street children may also easily fall victim to violent psychopaths or be easily taken advantage of, resulting in sexual exploitation with severe emotional distress (Shanler, 1998).

Sexual abuse is frequently experienced by street children though it is also common among children who live with other relatives at home. Street children who run away from home are harassed by security agents and are the most vulnerable group for exposure to violence and sexual exploitation (White, Underwood, and Omelczuk, 1991). The children may suffer physical abuse if they refuse to comply and

the children may be ashamed to report the offence to avoid stigmatisation from the society. This means they bear the emotional distress alone.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

2.3.7 Children in Disaster Situations

Disasters may be the result of natural phenomena, or may be caused by armed violence. Disasters caused by armed violence are often more traumatic to children (UNICEF, 1986). War affected children often show symptoms of severe psychological trauma, sleeping disorders, problems of concentration, nightmares, withdrawal, aggression, clinging behaviour, depression, inability to form close relationships and bed-wetting (Sehgal *et al*. 2012). The reason is that children are sometimes abducted as hostages by armed men and subjected to torture. During the civil war in Sierra Leone, many children were forced to watch their family members being killed by rebel forces (Gupta and Zimmer, 2008) and were prevented from showing sympathy over the incidence. While some children remained silent, some were caught crying over the loss of their loved ones, and were also killed by the rebels. The war lasted eleven years and during this period created a recurrently life-threatening experience which affected the physical, emotional and social wellbeing of most children in the country. Disasters have long term effects on the psychological development of the children who survive it. Children who experience disasters are exposed to death, injury and displacement during emergencies and experience more health problems. War also affects the wellbeing of children through the destruction of infrastructure and their means of livelihood, thereby deepening poverty and disrupting the delivery of basic services.

In the aftermath of armed conflict, measures are sometimes put in place to rehabilitate perpetrators and rebel forces. Unfortunately, girl children are often not treated fairly during disarmament, demobilization and reintegration (DDR) Bentacourt (2011).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

processes. Following the peace agreement in Sierra Leone in 1999, many girls who had been involved in arm conflict during the civil war were left without support, and were either prevented from going home or rejected by their families. This situation forced them to the streets, and several began a life of commercial sex work Bentacout, (2011)

2.3.8 Children who migrate from Rural to Urban Areas

Children move from rural to urban areas in search of jobs and to flee from natural or manmade disasters (UNICEF, 1997). Such migration may also occur due to peer influence for socialization or to run away from family pressure. Rapid urbanisation usually takes place without planning, and causes overcrowding, unsanitary and polluted environments, stressful conditions and poor public services in urban centres. Most children live in slums due to overcrowding and are constantly under threat of eviction (UNICEF, 1997). Some migrate with their families in a rural-urban migration model thereby increasing the children's vulnerability to dropping out of school, exploitative work and a life on streets. Many of the migrant children become domestic helps, factory workers, shop attendants, prostitutes, and drug peddlers (UNICEF, 1997).

2.3.9 Children in Contact with the Law

In many societies in the world, children who come in contact with the law are subjected to harsh conditions in arrangements that range from foster home placements to placements in correctional institutions. These arrangements often disrupt a child's family connections and education, and can bring the child in contact with delinquent or antisocial peers, leading to cognitive, behavioural and mental health problems (Pennell *et al.*, 2011).

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

In some societies, child offenders are jailed for committing serious crimes. The experience of being in jail is traumatic because of cessation of freedom, the risk of subjection to sexual assault, and various diseases such as skin infections, venereal diseases, malaria, hepatitis and tuberculosis.

2.3.10 Orphaned and Abandoned Children

Orphans are children below 18 years who have no biological parents (George, 2011). Poverty, alcoholism and imprisonment are some of the factors responsible for families abandoning their children to become orphans (Dillon, 2008).

There are about 1.7 billion orphan children around the world (UNICEF, 2002). Many are in devastating and difficult life conditions in poorly managed orphanages (UNICEF, 2002). The children are exposed to diseases, deprived of adequate food and clothing that makes them go to the street to beg, work and hawk for survival. Orphans are at a high risk of encountering psychosocial problems of depression, anxiety, low self-esteem, and reproductive health problems when compared to non- orphans (Omigbodun, 2006) due to their impoverished and unhealthy living conditions.

2.3.11 Children in Poverty

Children who do not meet the minimum acceptable standard of life in the society where they live are said to be poor (UNICEF, 2014). Poverty is a generic problem which results from most other factors predisposing children to difficult situations, and it is also associated with most of the psychological and social effects children suffer in these

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

situations (UNICEF, 2014). Poverty can lead children to steal, kill and carry out other forms of destructive behaviour. Poverty can force children into difficult situations, whereby they have to leave home to go on the street to beg, work, hawk, and steal and in the process they can get physically, sexually and emotionally abused by adults. Poverty exposes children and their families to marginalization making them become vulnerable to social and economic pressures that result in children dropping out of school, engaging in hazardous and exploitative work (UNICEF, 2014).

2.4 Street Children: History and Definition

″The term ‘street children’ was first used by Henry Mayhew in 1851 when writing the London Labour and the London Poor. This term only came into general use after the United Nations Year of the Child 1979. Before this time, street children were referred to as “homeless, abandoned, or runaways" (Scanlon and Others, 1998).

In the twentieth century, there were reports of many homeless European children who were wandering in large numbers on the streets in the industrial centres of London, Paris and New York as a result of rapid industrialization and urbanization at the end of the two world wars. The situation worsened due to economic depression between the two wars. Nowadays, the majority of street children are found in growing urban areas of developing countries (UNICEF, 1986).

UNICEF and other agencies defined street children based on the frequency with which they sleep on the street and the degree of contact they maintain with their families (Knaul, 1995a). The various categories include (UNICEF, 2005):

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

- ***Street living children*:** (children who ran away from their families and live alone on the streets
- ***Street working children*:** (children who spend most of their time on the streets, fending for themselves or for their relatives, but returning home on a regular basis.
- ***Children from street families*:** (children who live on the streets with their families

The occurrence of street children has become a major social problem in many countries around the world. The situation is worsened by extreme poverty along with other factors as children and adolescents try to live in urban environment. Moreover, the prevalence of street children and their persistence to stay on the street is another problem observed (Gichuru, 1993).

2.5 Health problems of street children in West Africa and Sierra Leone

Street children are vulnerable to infectious and non- infectious diseases alike as they are exposed to harsh conditions and live in very unhygienic surroundings that are not conducive to their mental and physical health (Higgitt, Wigert *et al*. 2003). Street children generally tend to have severely cracked lips, sore eyes, sore throats, nasal problems and burns from cold, nausea, excessive thirst and rapid weight lost (Gebers, 1990). Many experiences dehydration, malaria, pneumonia and other contractible diseases associated with malnutrition and sexual behaviour (Campbell and Ntsabane, 1996). They experience general skin problems such as lice, scabies, facial blemishes, spot and sores around the mouth and nose (Schurink, 1993). Le Roux, (1995) found out that street youth and children experience cold and influenza, dental problems, tuberculosis, broken limbs often as a result of road accidents and assaults from gang fights and retaliation by older boys.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Study done by Winick, (1985) revealed that asthma and iron deficiencies have long term effects on the central nervous system. Molnar and Rath, (1990), in their study stated that a lack of vitamin 'A and B' result in a lower immune system leading to anaemia, a poor rate of healing and other diseases. The long-term effect of illness can include damage to the central nervous system, the brain and other major organs of the body like the heart, the liver, the kidneys and the vital blood producing function of the bone marrow. Consequently, street children are at a higher risk of death as well (Schurink, 1993).

Many street children are involved in psychoactive substance abuse (Kulik *et al*, 2011) increasing the risk of involvement in accidents, violence, unprotected sex and unwanted pregnancies (Kulik *et al*, 2011). The continuous use of substances can lead to complications such as brain and liver damage. Jansen, Richter *et al.* (1990) stated in their study, that street youth are at risk for neurological defects due to substance abuse. Glue sniffing for example, may lead to visual spatial difficulties, visual scanning problems, language deficiencies, motor coordination deficiencies, memory deficits and problems in attention and concentration. Abnormal cerebral signs and abnormal EEG readings with convulsive discharge were clearly evident in sniffers, (Jansen, Richter *et al.* 1990).

The health status of street children may depend on the age, gender and length of stay on the streets. For example, children who have been on the street at an early age are likely to be at higher risk of been malnourished than the new comers. Strong boys who are capable of earning enough money can afford to buy enough food to eat making them better nourished than some of their peers living in absolute poverty at home. Street children are

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

subjected to a number of specific physical, mental and sexual health risks. Children are constantly marginalized by adults who abuse their rights by using them as child labourers. They may also sustain injuries during fights among themselves or as a result of violence from the police or the public. They may have skin infections due to poor personal hygiene because of a lack of washing facilities.

2.6 Mental Health Problems of Street Children in West Africa

Street children and adolescents encounter a series of psychological problems such as depression and anxiety disorders, and post-traumatic stress disorders (Ayerst, 1999). These may have negative impact on their physical and social well-being thus leading to behavioural problems such as conduct disorders, substance use and abuse and other antisocial behaviours (Ayerst, 1999).

These psychological difficulties may arise from social problems that occur in their life. As they are frequently exposed to harsh environments and encounter traumatic events such as discrimination, marginalization and abuse, violence, social rejection and stigmatization making them vulnerable to having anxiety, depression, low self-esteem and post-traumatic stress disorder in their everyday life. Street children have to face daily violence from among themselves and police harassment and abuses. They are constantly migrating from city to city or from district to district hiding from the police, welfare authorities, gangs, and drug syndicates. This situation may cause social isolation and loneliness for them and may also make it difficult for them to develop social and emotional attachment with people.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Studies show that street children are more vulnerable to impaired psychological health than any other group of children Adlaf and Zdanowicz, (1999). They also found that between 30% - 40% of street youth reported depression, paranoid ideation, conduct disorder and attempted suicide.

Street children may also encounter developmental delays such as gross motor skills, personal and social impairment and learning difficulties. Co-morbid features such as conduct disorders, attention deficit hyperactivity disorders, and obsessive compulsive disorders are also common among street children (Bassuk and Rubin, 1987, Vostanis and Cumella, 1998).

Depression can be associated with homelessness and stressors such as abuse, pregnancy, HIV and other diseases, lack of social support which children encounter on the streets (Ayerst, 1999). Geldenhuy, (2001) also found that depression can be linked to inferiority, unhappiness, rebellion, feelings of uncertainty about life in general, anger, rejection and abandonment. Yates (1991) further argued that street youth are likely to have depression with suicidal ideation or attempt to put an end to their stressful situation. A quotation from one street child states "*I live on the street. I don't really have anyone. I die every day. I am not afraid of death. I am afraid of life* (Luna, 1991). In another development the study by Patricia Ray *et al.* (2011) shows that children cry and demonstrate nightmares out of distress.

Comparatively, girls are more vulnerable to mental health problems than boys, as they are more subject to rape, physical abuse and discrimination on the streets.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

2.7 Relevance of the Study of Mental Health Problems of Street Children in Kenema

The importance of this study is to provide information on the psychosocial factors associated with street children in Kenema, Eastern Sierra Leone and to make recommendations, based on the findings on useful interventions for this group of children. As stated by UNICEF (1986), children in difficult situations need adequate protection. Street children belong to the group of children in Especially Difficult Circumstances that need psychosocial support. The World Health Organization states that 'mental health is an essential part of overall health and mental health problems cause significant distress to the child, family, and community' (WHO, 2003). Also, mental health problems in children often lead to lifelong impairment, which has tremendous negative social and economic consequences (WPA, WHO et al. 2004).

In order to help children cope more effectively, more is expected to be known about which factors cause the worst psychological stress in children, how persistent that stress is, how it influences development, how children deal with it and how they could be helped to handle it better" (UNICEF, 1986). Therefore, understanding the mental health problems of street children and associated factors will help develop psychosocial interventions to tackle their physical and emotional well-being and social needs.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Chapter Three

AIM AND OBJECTIVES OF THE STUDY

3.1 Aim

The aim of the study was to investigate the socio-demographic characteristics, prevalence, pattern and correlates of psychosocial problems among street children in Kenema, Sierra Leone.

3.2 Specific Objectives

i. To determine the socio demographic characteristics of street children in Kenema, Sierra Leone.

ii. To determine the prevalence and pattern of psychosocial problems among street children in Kenema, Sierra Leone.

iii. To determine association between socio-demographic factors and psychosocial problems with street children in Kenema, Sierra Leone.

3.3 Hypothesis: Children do not encounter psychosocial problems in their adaptation to street life.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER FOUR

METHODOLOGY

4.1 Study Location

This study was carried out in Kenema, the third largest city in Sierra Leone from February to March 2014. As an ethnically diverse city, Kenema was chosen for its rapid population quarter town of Kenema District, which is located in the Eastern region of the country. Kenema district is at the border of Sierra Leone with Republic of Liberia. Hinterland, it shares boundaries with five districts, which include the Kailahun and Kono Districts in the East, while Bo and Pujehun Districts; and the Tonkolili District are in the south and north, respectively. There are sixteen (16) Chiefdoms in the District, each of which is headed by a Paramount Chief and they are as the local custodians of their communities. There are about fifteen primary schools, ten secondary schools and a polytechnic. Like at national level, the two main religions in Kenema are Islam and Christianity, Sesay, Karem, and Ngobeh, (2006). Republic of Sierra Leone: 2004 Population and Housing Census: Analytical Report on Population Distribution, Migration and Urbanisation in Sierra Leone. Published November, 2006.World Gazetter: Eastern-Administrative Divisions: *Per Geographical Entity*.

The main economic activity in the district is mining diamonds. The town is a major trade centre having local and international motor-parks, market centres and several mechanic workshops or garages. Five major market areas, two main motor-parks and three main garages were selected as data collecting sites since street children do aggregate in these areas with the day and at night.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

4.2 Study Design

A descriptive cross - sectional survey was carried out.

4.3 Sample Size Determination

The outcome of the study was the proportion of street children in Kenema who encounter mental health problems. Since there are no such records on the prevalence of mental health problems of street children in Sierra Leone, 50% estimate was used for **p** and **q** in the formula below for single proportion for sample size calculation.

$$N = \frac{(Z\alpha)^2 pq}{d^2}$$

$(Z\alpha)^2$ = Standard normal deviate corresponding to 5% level of significant (1.96)

P = Prevalence outcome of previous study which is not available so use 50% estimate

$q = 1 - p$

d = Level of precision (5%)

$$\frac{(1.96)(1.96)(50)(50)}{(0.05)(0.05)} = 384.16$$

Sample size from the above calculation is = 384.16 which was rounded up to 400 for those that did not respond or complete the questionnaire.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4.4 Study Population

The target groups were children and adolescents who were frequently found on the street such as those who were permanently staying, working, hawking and sleeping on the streets and those that spent the whole day selling, working and begging but retired to their families at home in the evening.

Inclusion Criteria:

Children and Adolescents age **5 to 18years** who were able to give assent.

Exclusion Criteria:

Children who were not able to give assent and those who refused to give assent.

4.5 Sampling Technique

Kenema town is divided into seven wards. In the selection method, a multi stage cluster sampling of the five major market areas, the two international parks and the three main garages that were identified was done based on the most densely populated areas that were selected as data collecting sites since street children do aggregate in these areas during day and at night.

4.6 Instrument (see appendix A).

A School Health Questionnaire with pertinent questions on socio demographic variables and indicators corresponding to the objectives of the study such as: society and family situation, shelter, housing and educational status, and economic activity of street children in Kenema was administered. The World Health Organization in collaboration with the Centre for Disease Control developed this questionnaire for the Global School-based Health Surveillance System.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

The questionnaire is structured to obtain information on aspects of the health of children and adolescents' health including their mental health such as depressive symptoms, oppositional defiant symptoms, symptoms of conduct disorder and self-esteem. The mental health rating scales were as follows:

The total of all positive responses to depressive symptoms less than five indicate no depression (Yes' scores <5 = no Depression) but the total of positive responses greater than or equal to five indicates depressive symptoms (Yes' scores >=5 = Depressive symptoms).

The total of all positive responses to Oppositional Defiant Symptoms less than five indicates no oppositional defiant symptoms ('Yes' scores <5 = no oppositional defiant symptoms) and a total of positive responses greater than or equal to five indicates oppositional defiant symptoms ('Yes' scores >=5 = oppositional symptoms).

A total of all positive responses to symptoms of conduct disorder less than three had no symptoms of conduct disorder ('Yes' scores <3 = no symptoms of conduct disorder) and a total of all positive responses greater than or equal to three had symptoms of conduct disorder (Yes' scores >= 3 = symptoms of conduct disorder).

A total of positive responses to self-esteem items greater than six indicate good self-esteem and less than six indicate poor self-esteem.

Children with 5 or more depressive symptoms, 5 or more symptoms of oppositional defiant disorder and 3 or more symptoms of conduct disorder were categorised as having probable depression, probable oppositional defiant disorder and probable conduct disorder respectively. Children with at least 1 negative response to the self-esteem items were categorised into poor self-esteem and those with all positive self-esteem responses were categorised at good self-esteem.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4.7 Translation of Instrument

The questionnaire was translated into the common spoken creole language in Kenema for respondents to understand and respond well to the questions. (see appendix)

4.8 Ethical Approval

Ethical approval was obtained from the College of Medicine and Allied Health Sciences, University of Sierra Leone. Permission was obtained from the local authorities in Kenema and assent was obtained from the street children themselves as their families were difficult to access. All the children who were involved in the study were provided with a Participant Information Sheet which stated the purpose of the study, the need for their involvement, what was required for their participation and issues pertaining to ethics and confidentiality. All information was kept in confidence.

4.9 Study Procedure

The questionnaire was interviewer administered. The researcher and trained assistants filled questionnaire through interviews. Two nurses and three public health/ community health officers who were also bilingual in the local languages, and English were employed and trained on how to use the research instrument using interactive training or learning methods. The research assistants were trained in the use of the instrument and given the opportunity to practice over time.

The data collection activity usually started at 8: am and ended at 9:00pm daily. Each child was interviewed one at a time to ensure privacy and confidentiality.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

A pre- test of the questionnaire was done in the main international park of the capital city Freetown with 20 participants who were not included in the actual study. The pre – test was used for the following purposes:

i. To test if the children could easily understand the research questions and their response to it
ii. To assess data collectors understanding of the study process.

Refreshments were given to all participants.

4.10 Data Management and Analysis

Data obtained from the street children were crosschecked and sorted for correct answers and completeness. The data were coded and analyzed using the Statistical Package for Social Sciences (SPSS version 22) in generating frequency distributions and cross-tabulations. Descriptive statistics was presented and Chi square was used to explore associations between categorical variables and t- test for continuous variables.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER FIVE

RESULTS

5.1. Socio-Demographic Characteristics of the Study Population

Analysis were done on398 completed questionnaires using statistical package for social sciences version 22 on data collected from 400 street children in Kenema, East of Sierra Leone. There were three sections on the questionnaires, thus the socio-demographic characteristics comprising of personal information, family type and school information.

The second section consists of the prevalence and pattern of psychosocial factors of respondents and the third section is the Socio-demographic Correlates of the Psychosocial Issues of the Street Children Sampled.

The socio demographic characteristics of the study sample are displayed in table 1 below. The mean age of children in this study was 13.7 (SD=2.9) years and just over half (50.5%) were aged 10-14years with ages ranging from 7 to 19 years. Majority of the children were male (70.1%) and over half (57%) reported they were of the Islamic faith. Over a quarter reported they had no religion (27.4%) and 26.6% were 'very much' guided by the teachings of their religion.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 1: Socio-Demographic Characteristics: Personal Information
N= 398

Variable	Frequency (n)	Percentage (%)
Age (years)		
5-9	27	6.8
10-14	201	50.5
15+	170	42.7
Gender		
Male	279	70.1
female	119	29.9
Religion		
Islam	227	57.0
Christianity	62	15.6
No religion	109	27.4
How much does the teaching of religion guide your behaviour?		
Very much	106	26.6
Much	133	33.4
Just a little	36	9.0
Not all	14	3.5
No religion	109	27.4

UNIVERSITY OF IBADAN LIBRARY

Table 2 displays the school-related information of the study sample. Almost half (45.2%) of the respondents reported that they were still in school and almost all (98.1%) worked for money before or after school. Four-fifths (43.5%) reported they had dropped out from school and 25.1% stated they would like to return school. One in ten (11.3%) reported they had never been to school.

Table 2: Socio-Demographic Characteristics: School Information
N= 398

Variable	**Frequency (n)**	**Percentage (%)**
Ever attended school		
Yes	353	88.7
No	45	11.3
Currently in school (n=353)		
Yes	180	45.2
Dropped out	173	43.5
Never attended	45	11.3
Level at which Child dropped out from school (n=173)		
Primary	70	17.6
Junior Secondary School	88	22.1
Senior Secondary School	15	3.8
Ever +never attended	225	56.5
Would you like to return to school (n=173)		
Yes	100	25.1
No	73	18.3
Ever attended +never attended	225	56.5
Had to work to earn money while at school (n=180)		
Yes	178	98.1
No	2	1.1

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Table 3 displays the family information of the study sample. Most (68.1%) of the children were from polygamous families and one in five (19.8%) stated their parents were separated or divorced. Nearly one third (29.1%) were double, paternal or maternal orphans and over half (54%) were brought up by their parents. Almost all the children studied (94.5%) had brothers or sisters. Over half (54.8%) reported their father as either having no formal education or attending Quranic school. Almost two thirds (60.6%) stated that their mothers had no formal education. Over one-third (36.9.0%) reported that their parents lived outside Kenema and nearly half (48.2%) were not living with their parents or grandparents. Almost half (48.2%) of the children stated their parents lived in rented houses and 8.0% had no contact with their parents/relatives.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 3: Socio-Demographic Characteristics: Family Information
N= 398

Variable	Frequency (n)	Percentage (%)
Family Type		
Monogamous	127	31.9
Polygamous	271	68.1
Siblings		
Yes	376	94.5
No	22	5.5
Place of abode of siblings		
At home	291	73.1
On the street	1	0.3
No sibling	23	5.8
Extended family system	83	20.9
Marital Status of Parents		
Married	203	51.0
Separated/Divorce	79	19.8
Father deceased	35	8.8
Mother deceased	36	9.0
Parent(s) deceased	45	11.3
Who child lives with		
Parent (s)	55	13.8
Mother	65	16.3
Father	30	7.5
Grandparent (s)	11	2.8
Grand mother	38	9.5
Grand father	7	1.8
Others	192	48.2
Brought up from childhood		
Parents	215	54
Mother	72	18.1
Father	13	3.3
Grandparents	23	5.8
Grandmother	42	10.6
Grandfather	2	0.5
Extended family system	31	7.8
Kind of House Parents/Guardian live in		
Owner of their home	158	39.7
Rented House	192	48.2
Others	48	12.1

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 3 Continued: Socio-Demographic Characteristics: Family Information N= 398

Variable	Frequency (n)	Percentage (%)
Frequency of contact with parents or relatives		
Frequently	204	51.3
Rarely	162	40.7
Never	32	8.0
Level of Father's Education		
No formal education	92	23.1
Koranic education	126	31.7
Primary school	22	5.5
Secondary school	87	21.9
Tertiary education	29	7.3
Don't know	42	10.6
Level of Mother's Education		
No formal education	241	60.6
Koranic education	7	1.8
Primary school	55	13.8
Secondary school	52	13.1
Tertiary education	10	2.6
Don't know	33	8.3
Location of parent's abode		
Kenema	245	61.6
Elsewhere	147	36.9
Don't know	6	1.5

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.2. Prevalence and Pattern of Psychosocial Factors of the Study Population

5.2.1. Pattern of life on the street

Table 4 displays the prevalence and pattern of life on the street. A quarter (25 .6%) of the children reported they were staying permanently on the street and 41.7% had been on the street for more than one year. The children gave multiple reasons for being on the street. While all (100%) of them stated a need for income as the main reason for being on the street, 20.9% mentioned family problems, 29.1% a need for freedom and 2.0% civil disturbances. Of the children who reported sleeping on the street, 17.3%) slept in public parks. Four-fifths (25.1%) of the children reported they would like to return to school.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4: Pattern of Life on the Street

N= 398

VARIABLE	Frequency (n)	Percentage (%)
Lives permanently on the street		
Yes	102	25.6
No	296	74.4
Length of time on the street		
Under one year	147	36.9
One year	85	21.4
More than one year	166	41.7
Reason for being on the street*		
Family problems	83	20.9
Need for income	398	100.0
Civil disturbances	8	2.0
Need for freedom	116	29.1
Where child sleeps at night*		
In dilapidated buildings	12	3.0
In public parks	69	17.3
In garage vehicles	21	5.3
In ghettoes (City slum areas)	14	3.5
At home	296	74.4
Ever been sick on the street		
Yes	205	51.5
No	193	48.5
Future plans when off the street		
Go back to school	100	25.1
Continue selling at home/shop	100	25.1
To be employed	46	11.6
Others	152	38.2

***Multiple Responses Occurred in place of sleep, reason for being on the street and future plans Category**

Others include:
To become drivers and mechanics

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.2.2. Economic activities on the street

More than half (50.3%) of the children reported they carried goods for money, 28.4% were engaged in scavenging and 31.9% were engaged in hawking. Just over a quarter (26.1%) were engaged in licit services such sweeping, car washing while 7.5% were engaged in illicit services such as sex work. Eight-three percent were beggars or leading their blind adult parents or relatives to beg. All (100%) of the children stated they bought already prepared food to eat when they felt hungry and 28.4% had one meal a day.

Table 5: Economic Activities on the Street
N= 398

Variables	Frequency (n)	Percentage (%)
Economic activities*		
Scavenging (searching for something usable)	113	28.4
Hawking (selling items in market)	127	31.9
Licit services (car washing)	104	26.1
Illicit services (sex work)	30	7.5
Carrying Loads for people for reward	200	50.3
Begging	33	8.3
Obtaining Food to eat		
I buy already prepared food to eat	398	100
Number of meals per day		
One meal	113	28.4
Two meals	156	39.2
Three meals	129	32.4

***Multiple Responses Occurred in this Category**

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.2.3. Psychoactive Substance Use, Sexual Behaviours, Traumatic Events, Worries and Exposure to Violence

Fifteen percent (15.3%) of the study sample admitted drinking alcohol and of those who drank alcohol, 39.3% reported getting drunk. Almost 17% stated they had 'ever had sexual intercourse' and of those who had sexual intercourse, more than half (56.7%) had first intercourse at below 15 years. Almost 6% had experienced forceful sexual intercourse and three- quarters (74.6%) did not use condoms. Half (50.3%) of the children had worries and (87.4%) had lost someone closed to them. One in five (20.4%) had been physically attacked more than four times.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 6: Psychoactive Substance Use, Sexual Behaviours,

Traumatic Events, Worries and Exposure to Violence
N= 398

Variables	Frequency (n)	Percentage (%)
Takes Alcohol		
Yes	61	15.3
No	337	84.7
Child usually get drunk (n=61)		
Yes	24	39.3
No	37	60.7
Uses Tobacco		
Yes	35	9.0
No	363	91.0
Psychoactive Substance Use		
Yes	51	12.8
No	347	87.2
Ever had sexual intercourse		
Yes	67	16.8
No	331	83.2
Age when child ever had sexual Intercourse -n=67		
<15 years	38	56.7
15yrs and older	29	43.3
Child ever had forceful sexual intercourse		
Yes	4	5.9
No	62	92.5
Condom use during sexual intercourse		
Yes	14	20.9
No	50	74.6
No response	3	4.4
Present worries		
Yes	200	50.3
No	198	49.7
Has anyone closed to you died?		
Yes	348	87.4
No	50	12.6
Physical attack		
0 time	111	27.9
1 time	116	29.1
2-3 times	90	22.6
>=4 times	81	20.4
In a physical fight		
0 time	127	31.9
1 time	117	29.4
2-3 times	98	24.6
>=4 times	56	14.1

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.2.4 Emotional and Behavioural Symptoms

Emotional Symptoms: Self Esteem Items and Depressive Symptoms

Table 6 reveals the responses to questions on self-esteem and depressive symptoms

Almost all (95%) the children agreed with the statement "I would change many things about myself if I could" and (92%) agreed with the statement "I can do things as well as other boys and girls". About half (47.7%) of the children agreed with the statement "My parents or guardians make me feel that I am not good enough" and (30.2%) agreed with the statement "I am a failure at school".

Almost three-quarters (71.9%) of the children agreed that at a point in time in the last year nothing made them happy and they were not interested in anything and more than three-quarters (84.1%) agreed that they had less energy at some point in time in the last year. Over three-quarters (77.9%) agreed that some time last year, they felt they could not do anything well or that they were not as good-looking or as smart as other people and 3.8% had thought of killing themselves in the last year.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 7: Self Esteem Items and Depressive Symptoms
N= 398

No.	Variables	Frequency	Percentage
	Self –Esteem Items	**n**	**%**
1.	My parents or guardians make me feel that I am not good enough Yes No	 190 208	 47.7 52.3
2.	I am happy most of the time Yes No	 108 290	 27.1 72.9
3.	I have lots of fun with my parents Yes No	 123 275	 30.9 69.1
4.	I would change many things about myself if I could Yes No	 378 20	 95.0 5.0
5.	My teacher feels that I am not good enough Yes No	 165 233	 41.5 58.5
6.	I can do things as well as other boys and girls Yes No	 366 32	 92.0 8.0
	Depressive Symptoms	**n (%)**	**n (%)**
		Yes	**No**
1.	Has there been a time when nothing made you happy and you just were not interested in anything?	287 (72.1)	111 (27.9)
2.	Has there been a time when you had less energy than you usually do?	335 (84.1)	63 (15.9)
3.	Has there been a time when you felt you could not do anything well or that you were not as good-looking or as smart as other people?	311 (77.9)	87 (22.1)
4.	Has there been a time when you thought seriously about killing yourself?	15(3.8)	383(96.2)
5.	Has there been a time when doing even little things made you feel really tired?	281 (70.5)	117 (29.5)
6.	Has there been a time when you couldn't think as clearly or as fast as usual?	278 (69.8)	120 (30.2)

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

5.2.5 Behavioural Symptoms

Oppositional defiant symptoms and Conduct disorder symptoms are shown in table 9.

Nearly half (41.5%) of the children answered yes to have carried out revenge by doing things like hurting people, spoiling their things or telling lies about them in the last year. Over a fifth (23.3%) confessed to have stolen from anyone when they thought they were not around or were not looking. More than half (56.5%) reported to have lied to get money or something else they wanted.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

TABLE 8: Oppositional Defiant Symptoms
N= 398

No.	Variables	Yes (%)	No (%)
	Oppositional Defiant Symptoms		
1.	In the last year, have you carried out revenge by doing things like hurting people, spoiling their things or telling lies about them?	165(41.5)	233 (58.5)
2.	Have you refused to do what your parents or teachers told you to do?	184 (46.2)	214 (53.8)
3.	Have you been irritable or easily annoyed?	194 (48.7)	204 (51.3)
4.	Have you done bad things to people on purpose?	211 (53.0)	187 (47.0)
5.	Have you blamed someone else for your mistakes or for things you did that you shouldn't have done?	193 (48.5)	205 (51.5)
6.	Have you done things just to annoy people or make them angry?	106 (26.6)	292 (73.4)
7.	Have people complained because you were swearing or used dirty language?	119 (29.9)	279 (70.1)
No.	**Conduct Symptoms**	**Yes (%)**	**No (%)**
1.	Have you shoplifted-that is, stolen something from a shop when you thought no one was looking?	2 (0.5)	396 (99.5)
2.	Have you lied to get money or something else you wanted?	225 (56.5)	173 (43.5)
3.	Have you snatched someone else's purse or jewellery?	20(5.0)	378 (95)
4.	Have you broken something or spoiled some place on purpose, like breaking windows, writing on a building, or slashing tyres?	63 (15.8)	335 (84.2)
5.	Have you stolen from anyone when they were not around or were not looking?	93 (23.3)	305 (76.7)
6.	Have you been physically cruel to an animal and hurt it on purpose?	243 (61.1)	155 (38.9)
7.	In the last one year, have you broken into a house, a building, or a car?	00 (00)	398 (100)

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.2.6. Stress problems

One in 5 children (21.6%) reported that they felt lonely and almost one-third (30.7%) reported sleep problems due to worry

Table 9: Stress and Problems: Help Seeking Behaviour of Respondents

N=398

Loneliness		
Never	86	21.6
Others	312	78.4
Total	**398**	**100.0**
Sleep Problems due to worry		
Never	122	30.7
Others	276	69.3
Total	**398**	**100.0**

5.2.7 Probable Depression, Oppositional Defiant Disorder & Conduct Disorder

Table 10: displays the prevalence of children with probable depression, oppositional defiant disorder, conduct disorder and poor self-esteem.

Children with 5 or more depressive symptoms, 5 or more symptoms of oppositional defiant disorder and 3 or more symptoms of conduct disorder were categorised as having probable depression, probable oppositional defiant disorder and probable conduct disorder respectively. Children with at least 1 negative response to the self-esteem items were categorised into poor self-esteem and those with all positive self-esteem responses were categorised at good self-esteem. Four-fifths (42%) of the children had Probable Depression, 1 in 5 had Probable Oppositional Defiant Disorder (18.8%) and Probable Conduct Disorder (21.4%). Virtually all the street children (98.7%) had poor self-esteem.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Table 10: Probable Depression, Oppositional Defiant Disorder, Conduct Disorder and Self-Esteem problems

N = 398

Variable	Frequency (n)	Percentage (%)
Depressive Symptoms5-9		
No Depression <5	231	58.0
Depression >=5	167	42.0
Total	**398**	**100.0**
Oppositional Defiant Symptoms		
No Oppositional Defiant Symptoms <5	323	81.2
Oppositional Defiant Symptoms >=5	75	18.8
Total	**398**	**100.0**
Conduct Symptoms		
None <3	313	78.6
Conduct Symptoms >=3	85	21.4
Total	**398**	**100.0**
Self Esteem		
Good	5	1.3
Poor	393	98.7
Total	**398**	**100.0**

5.3. Socio-demographic Correlates of the Psychosocial Issues of the Street Children Sampled

This section presents results of all socio-demographic factors statistically significantly associated with psychological and social aspects of the lives of the 'Street Children'.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.3.1. Socio-demographic Correlates of 'Living Permanently on the Street'

Table 11 displays socio-demographic factors significantly associated with 'living permanently on the street'. 'Street children' 15 years and above were twice as likely to live permanently on the street as those 14 years and below (35% vs. 19%, p=0.002). Males as opposed to females, those who had 'no religion' as opposed to those with religion, those who had lived with others as opposed to living with their parents and those from polygamous as opposed to monogamous families were more likely to 'live permanently on the street' ($p < 0.05$).

Table 11: Socio-demographic Correlates of Living Permanently on the Street

N= 398

	Lives permanently on the street				
	Yes	No			
Age Group in Years	**n (%)**	**n (%)**	**Total**	**x^2**	**p**
<10	5(18.5)	22(81.5)	27(100.0)	12.8	0.002
10-14	38(18.9)	163(81.1)	201(100.0)		
>=15	59 (34.7)	111(65.3)	170(100.0)		
Gender					
Male	88 (31.5)	191 (68.5)	279 (100)	17.1	<0.001
Female	14 (11.8)	105 (88.2)	119 (100)		
Practice Religion					
Yes	34 (11.8)	255 (88.2)	289 (100.0)	106.4	<0.001
No	68 (62.4)	41 (37.8)	109 (100.0)		
Family type					
Monogamous	23 (18.1)	104 (81.9)	127 (100.0)	5.5	0.02
Polygamous	79 (29.2)	192 (70.8)	271 (100.0)		
Whom do you live with					
Parent	16 (10.8)	132 (89.2)	148 (100.0)	27.1	<0.001
Other Relations	86 (34.4)	164 (65.6)	250 (100.0)		
Marital Status of parents					
Married	40 (19.7)	163 (80.3)	203 (100.0)	7.6	0.006
Others	62 (31.8)	133 (68.2)	195 (100.0)		

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

5.3.2. Socio-demographic Correlates of 'Length of time lived on the street'

Table 12 displays socio-demographic factors significantly associated with 'Length of time lived on the street'. Street children who were males (70%) versus females (48%), who did not practise a religion (72%) versus practising religion (60%), and from polygamous (66%) versus monogamous families (56%) were more likely to have lived on the street for greater than 2 years ($p<0.05$).

Table 12: Socio-demographic Correlates of Length of time lived on the street

N= 398

	Length of time on the street				
	<1year	**>=2years**	**Total**	**X^2**	**P/value**
Gender					
Male	85 (30.5)	194 (69.5)	279 (100)	16.8	<0.001
Female	62 (53.1)	57 (47.9)	119 (100)		
Practice Religion					
Yes	116 (40.1)	173 (59.9)	289 (100.0)	4.7	0.031
No	31 (28.4)	78 (71.6)	109 (100.0)		
Family type					
Monogamous	56 (44.1)	71 (55.9)	127 (100.0)	4.1	0.043
Polygamous	91 (33.6)	180 (66.4)	271 (100.0)		
Occupation of Father					
Trading	28 (37.3)	47 (62.7)	75 (100.0)	15.9	0.014
Corporate worker	25 (37.3)	42 (62.7)	67 (100.0)		
Crafts man	29 (43.9)	37 (56.1)	66 (100.0)		
Farming	18 (23.7)	58 (76.3)	76 (100.0)		
Begin	8 (36.4)	14 (63.6)	22 (100.0)		
Menial job	11 (26.8)	30 (73.2)	41 (100.0)		
Others	28 (54.9)	23 (45.1)	51 (100.0)		
Occupation of Mother					
Trading	66 (37.3)	111 (62.7)	177 (100.0)	10.7	0.03
Farming	23 (26.1)	65 (73.9)	88 (100.0)		
Housewife	13 (46.4)	15 (53.6)	28 (100.0)		
Others	18 (34.0)	35 (66.0)	53 (100.0)		
I don't know	27 (51.9)	25 (48.1)	52 (100.0)		

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

5.3.3. Socio-demographic Correlates of the Use of Alcohol, Tobacco & other Psychoactive Substances

Table 13 displays socio-demographic factors significantly associated with the Use of Alcohol, Tobacco & other Psychoactive Substances. Street Children older than 15 years were more likely to use alcohol, tobacco and other psychoactive substances than children younger than 15 years ($p<0.05$). Children from polygamous families, who do not practice any religion and who lived with other people were more likely to use alcohol, tobacco and other psychoactive substances ($p<0.05$).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 13: **Socio-demographic Correlates of the Use of Alcohol, Tobacco & other Psychoactive Substances**

N=398

DRINKS ALCOHOL	**n (%)** Yes	**n (%)** No	**n (%)** Total	x^2	p
Age Group in Years					
<10	3 (11.1)	24 (88.9)	27(100.0)	7.8	0.02
10-14	22 (10.9)	179 (89.1)	201(100.0)		
>=15	36 (21.2)	134 (78.8)	170(100.0)		
Practice Religion					
Yes	29 (10.0)	260 (90.0)	289 (100.0)	22.8	<0.001
No	32 (29.4)	77 (70.6)	109 (100.0)		
Family type					
Monogamous	11 (8.7)	116 (91.3)	127 (100.0)	6.4	0.012
Polygamous	50 (18.5)	221 (81.5)	271 (100.0)		
Who brought you up					
Parents	54 (18.0)	246 (82.0)	300 (100.0)	6.7	0.01
Other Relations	7 (7.1)	91 (92.9)	98 (100.0)		
TOBACCO USE	**Never smoked**	**Smoked**	**Total**	x^2	**p**
Age Group in Years					
<10	26 (96.3)	1 (3.7)	27(100.0)	15.6	<0.001
10-14	193 (96.0)	8 (4.0)	201(100.0)		
>=15	144 (84.7)	26 (15.3)	170(100.0)		
Practice Religion					
Yes	269 (93.1)	20 (6.9)	289 (100.0)	4.6	0.032
No	94 (86.2)	15 (13.8)	109 (100.0)		
Family type					
Monogamous	121 (95.3)	6 (4.7)	127 (100.0)	3.9	0.05
Polygamous	242 (89.3)	29 (10.7)	271 (100.0)		
Who do you live with					
Parent	143 (96.6)	5 (3.4)	148 (100.0)	8.6	0.003
Other Relations	220 (88.0)	30 (12.0)	250 (100.0)		
Who brought you up					
Parent	279 (93.0)	21 (7.0)	300 (100.0)	4.9	0.03
Other Relations	84 (85.7)	14 (14.3)	98 (100.0)		
Marital Status					
Married	193 (95.1)	10 (4.9)	203 (100.0)	7.7	0.005
Others	170 (87.2)	25 (12.8)	195 (100.0)		
DRUG USE	**No drug use**	**Drug use**	**Total**	X^2	**P/value**
Age					
<10	27 (100)	0 (0.0)	27 (100)	31.3	<0.001
10-14	193 (96.0)	8 (4.0)	201(100)		
15+	134 (78.8)	36 (21.2)	170(100)		
Contact with parents /relatives					
Frequently	195 (95.6)	9 (4.4)	204(100)	18.8	<0.001
Rare/never	159 (82.0)	35 (18.0)	194(100)		
Lives with					
Parents	141 (95.3)	7 (4.7)	148(100)	9.6	0.002
Others	213 (85.2)	37 (14.8)	250(100)		

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.3.4. Socio-demographic Correlates of being Sexually Active

Table 14 displays socio-demographic factors significantly associated with sexual behaviour. Street Children 15 years or older were more likely to have ever had sexual intercourse (37.1%) versus street

children who were within the age of 10-14years (5%), ($P < 0.001$). Street children who practiced no religion (24.8) versus street children who practiced religion (15.9) and Street children from polygamous families (21.8%) versus street children from monogamous families (11.0%), who lived with other people (22%), versus street children who lived with their parents (12.2%), were more likely to have ever had sexual intercourse ($p<0.05$).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 14: Socio-demographic Correlates of being Sexually Active
N= 398

	Ever had sexual intercourse				
	Yes	**No**	**Total**	**x^2**	**p**
Age Group in Years					
<10	0 (0.00)	27 (100.0)	27 (100.0)		
10-14	10 (5.0)	191 (95.0)	201 (100.0)	69.8	<0.001
>=15	63 (37.1)	107 (62.9)	170 (100.0)		
Practice Religion					
Yes	46 (15.9)	243 (84.1)	289 (100.0)	4.1	0.017
No	27 (24.8)	82 (75.2)	109 (100.0)		
Family type					
Monogamous	14 (11.0)	113(89.0)	127 (100.0)	6.7	0.010
Polygamous	59 (21.8)	212 (78.2)	271 (100.0)		
Whom do you live with					
Parent	18 (12.2)	130 (87.8)	148 (100.0)	6.0	0.014
Other Relations	55 (22.0)	195 (78.0)	250 (100.0)		
Occupation of mother					
Trading	23 (13.0)	154 (87.0)	177(100)		
Farming	15 (17.0)	73 (83.0)	88(100)	20.5	<0.001
Housewife	12 (42.9)	16 (57.1)	28(100)		
Others	16 (30.2)	37 (69.8)	53(100)		
I don't know	7 (13.5)	45 (86.5)	52(100)		
Where parents/guardian live					
Kenema	54 (22.1)	190 (77.9)	244(100)	6.0	0.014
Elsewhere	19 (12.3)	135 987.7)	154(100)		

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.3.5. Socio-demographic Correlates of being Physically Attacked and Involved in Physical Fights

Table 15 displays socio-demographic factors significantly associated with physical attack and physical fight. 'Street children who did not have or practice any religion, who were from polygamous families, who had rarely or never contacted their parents or relatives were more likely to have had physical attack as opposed to street children who are from monogamous families, who frequently contact their parents or relatives and practiced religion (p=0.05).

Street children who were 15 years or older were more likely to have involved into physical fight (75.3%) as opposed to street children who were younger than 10 years (51.9%) (p=0.013) and street children whose parents were not married (73.3%) versus street children whose parents were married (63.1%) were more likely to have involved in physical fight (p=0.028).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 15: Socio-demographic Correlates of being physically attacked and Involved in Physical Fights

N = 398

	Physical attack				
	No attack	**Attacked**	**Total**	**X^2**	**P/value**
Practice Religion					
Yes	91(31.5)	198 (68.5)	289(100)	6.8	0.009
No	20 (18.3)	89 (81.7)	109(100)		
What is your religion					
Islam	72 (31.4)	157 (68.6)	229(100)	6.8	0.033
Christianity	19 (31.7)	41 (68.3)	60(100)		
No religion	20 (18.3)	89 (81.7)	109(100)		
How much does the teaching of your religion guide your behaviour					
Very much	78 (32.6)	161 (67.4)	239(100)	6.7	0.010
Not all	33 (20.8)	126 (79.2)	159(100)		
Family type					
Monogamous	47 (37.0)	80 (63.0)	127(100)	7.7	0.005
Polygamous	64(23.6)	207 (76.4)	271(100)		
How often do you contact your parents/or relatives					
Frequent	66 (32.4)	138 (67.6)	204(100)	4.1	0.042
Rare/never	45 (23.2)	149 (76.8)	194(100)		
Level of mother's education					
No formal/Quranic education	69 (24.6)	212 (75.4)	281(100)	5.3	0.022
Primary to tertiary	42 (35.9)	75 (64.1)	117(100)		
	Physical fight				
	No fight	**Fight**	**Total**	**X^2**	**P/value**
Age Group in Years					0.013
<10	13 (48.1)	14 (51.9)	27 (100)	8.8	
10-14	72 (35.8)	129 (64.2)	201 (100)		
>=15	42 (24.7)	128 (75.3)	170 (100)		
Marital status					
Married	75 (36.9)	128 (63.1)	203 (100)	4.8	0.028
Others	52 (26.7)	143 (73.3)	195 (100)		
Level of mother's education					
No formal/Quranic education	78 (27.8)	203 (72.2)	2281 (100)		
Primary to tertiary	49 (41.9)	68 (58.1)	117 (100)	7.6	0.006

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.3.6. Socio-demographic Correlates of having Probable Depression, Probable Oppositional Defiant Disorder and Probable Conduct Disorder

Table 16 displays socio-demographic correlates significantly associated with probable Depression, probable Oppositional Defiant Disorder and probable Conduct Disorder.

Males (47.7%) as opposed to females (28.6%) were more likely to have depression ($p<0.001$). Also, males (23.3%) versus females (8.4%), who lived in garage/park or market environments (37.9%), who rarely or never contacted their parents (24.2%), were more likely to have oppositional defiant disorder ($p<0.05$). Street children who were younger than 10 years were more likely to have conduct disorder as opposed to street children who were older than 10 years, ($p=0.019$). Males (28%) versus females (5.9%), street children who had no siblings (40.9%) as opposed to street children who had siblings (20.2%) and whose mothers had some form of education (29.1%) versus street children whose mothers had no formal/Quranic education (18.1%) were more likely to have conduct disorder ($p<0.05$).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 16: Socio-demographic Correlates of having Probable Depression, Probable Oppositional Defiant Disorder and Probable Conduct Disorder

Depressive symptoms	No depression <5	Depression >=5	Total	X^2	P/value
Gender					
Male	146 (52.3)	133 (47.7)	279	12.5	<0.001
Female	85 (71.4)	34 (28.6)	119		
Oppositional Defiant Symptoms	**No Oppositional Symptoms <5**	**Oppositional Symptoms >=5**	**Total**	**X^2**	**P/value**
Gender					
Male	214 (76.7)	65 (23.3)	279	12.1	0.001
Female	109 (91.6)	10 (8.4)	119		
Where do you live					
Respective homes	244 (86.2)	39 (13.8)	283		
Ghettoes/Camps	25 (89.3)	3 (10.7)	28	26.7	<0.001
Garage/Park/Market	54 (62.1)	33 (37.9)	87		
How often do you contact your parents or relatives					
Frequently	176 (86.3)	28 (13.7)	204		
Rare/Never	147 (75.8)	47 (24.2)	194	7.2	0.007
Conduct Symptoms	**No Conduct Symptoms <3**	**Conduct Symptoms >=3**	**Total**	**x^2**	**p**
Age in years					
<10	18 (66.7)	9 (33.3)	27	7.9	0.019
10-14	169 (84.1)	32 (15.9)	201		
15+	126 (74.1)	44 (25.9)	170		
Gender					
Male	201 (72.0)	78 (28.0)	279	24.2	<0.001
Female	112 (94.1)	7 (5.9)	119		
Siblings					
Yes	300 (79.8)	76 (20.2)	376	5.3	0.021
No	13 (59.1)	9 (40.90	22		
Level of mother's education					
No formal education	230 (81.9)	51 (18.1)	281	5.6	0.013
Primary to tertiary education	83 (70.9)	34 (29.1)	117		

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER SIX
DISCUSSION SECTION

This chapter discusses results of the descriptive survey on psychosocial correlates of 400 street children in Kenema city in Eastern Sierra Leone carried out from February to March 2014.

The discussion of findings from the survey on street children in Kenema is categorized into three sections as follows:

1. Socio-demographic characteristics
2. Prevalence and pattern of psychosocial factors
3. Socio-demographic factors associated with psychosocial problems

Socio-demographic characteristics of street children in Kenema, Sierra Leone

Similar to research findings on street children from other parts of the world, this study found two distinct categories of street children. There were the children who came on the street to spend the day but return home at night and the children of the street who live permanently on the street in poor residential slums, motor parks, garages, market areas and other public places. Knowing and understanding their socio-demographic characteristics will help to understand factors responsible for children living on the street. This will also help in the design of policies that would have a positive impact on the lives of these children.

The age of the child played an important role in the lives of street children examined in this study. In this study, 'street children' were taken to be those up to the age of 19 years found on the streets as has been done in other studies. A study of street children in Zimbabwe studied all

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

children up to the age of 18 years. Another study involving Honduran street children (Connolly, 1990), took 'street children' to be all youth found on the street aged one to 22 years.

In this study, less than 1 in 10 were below 10years, over a half between 10-14years and the rest were aged 15 years and above, a clear indication that children aged 10 -14 years were in the majority. Children aged 10 to 14 years are in the early adolescent years and this is a critical age in which they want to experiment the world. They will have no regard or respect for rules both at home and in the society so they tend to do things as they like. This age group of adolescents is commonly seen hawking in Kenema. As they grow older they become conscious of the dangers of hawking and refrain from it.

The result shows gender differences in street life as boys were the larger proportion in this study (70.1%) which is in accordance with the world-wide higher proportion of boys as opposed to girls on the street. Almost all reports point towards a clear gender imbalance in street children as indicated by 75-90% of Latin and African street children who were boys (Abdelgalil, Gurgel, Theobald *et al,* 2004). Le Roux (1996) stated that street boys greatly outnumber street girls throughout Africa and gave the reason that girls are supposed to stay at home to care for children in Africa. Studies reveal that in Khartoum, Sudan and Maputo, Mozambique, girls reside in homes as domestic servants and are subject to be punished if they move to the streets (Dodge & Rundle, 1991). In the Sierra Leonean culture, as in most other sub-Saharan African countries, the girl-child is paid more attention to than boys due to her vulnerability to physical and sexual abuse. As a result, girls are subject to more controlled monitoring and supervision by their families. Also, boys are able to attain an early independent life and the opportunity to be on the

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

street with improper or no monitoring from family. Other reason why there are many more boys on the street than girls could be as a result of girls entering into early marriage where they are restricted to social interactions within the home. Girls are also more vulnerable to sexual and physical assault by big boys and men on the street making street life unpleasant and encouraging them to stay away from street life. All the above factors are possible contributors to the existence of fewer girls on the street.

Over half of the respondents were Muslims. This is no surprise as the Muslim population in Sierra Leone generally constitutes about 75% of the country's population (Houssain Kettani, 2010). Secondly, in Sierra Leone, children from Muslim families tend not live with their parents as they are been sent to Quranic schools at an early age making them more vulnerable to street life as they go on the street to beg or work to generate income for their Quranic teachers.

School is an institution meant for training and educating children under supervision. Observations made in Kenema as a provincial district are that majority of parents who send their children to school are educated parents who have the ability to pay for the education of their children. Education at all levels in Kenema, whether private or public is expensive and not many parents can afford to send their children to school. Over half of the street children in this study reported their fathers had no formal education and two thirds stated their mothers had no formal education. Having uneducated parents alongside poverty would have been responsible for the inability of the street children to attend school. Over half of the street children encountered in this study had either never attended school or had dropped out of school and a substantial number expressed a desire to either return to school or receive skill training such as to become a

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

driver or mechanic. Almost all the street children (95.5%) who were still in school, had to work for money in the morning hours before they could go to school or in the evening after school another indication of the problem of poverty. The children have right to food both at home and at school for cognitive development and growth. Their families cannot afford to provide for them enough food so they had to engage in working for income for their survival to continue schooling.

Street children were interviewed about their family type and siblings. Children from polygamous family settings face a lot more discord and strife than those from monogamous homes. Family problems were a reason given for being on the street. Two-thirds were from polygamous homes in this study. Orphans were also in high proportion in this study. Poverty is the reason many children stay on the street. Children from poor families are almost always found on the street begging or scavenging for survival and among the street children interviewed, almost 1 in 10 had no contact with their parents/relatives.

Prevalence and Pattern of Psychosocial Factors of the Study Population

Three out of every 4 street children in this study reported that they returned home every day to sleep. However, there are greater concerns about the 1 in every 4 who remain on and sleep on the street in public parks, dilapidated buildings, garages, old vehicles and in ghettoes. This could be as a result of the children having no home, being afraid to go home for fear of punishment or not wanting to be under parental control. Boys were more likely to live permanently on the street and to have been on the street for more than two years than girls.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Multiple reasons were given by the children for being on the street but all of them stated a 'need for income' as the main reason for being on the street. This appears to be a universal reason given by street children in almost all reports from Africa and Latin America. Family problems were also a common reason given by the children for being on the street. Studies suggest that in Sierra Leone, family discord and separation are common among married couples and as a result of the break up in the family, children end up having to live with other relations or on the street.

The findings of this study indicate that street children worked for their survival on the street. Some carried goods for money, some were engaged in scavenging such as scrap iron and other usable materials and other licit services such sweeping and car washing. Others were engaged in begging and some led their blind parents or relatives to beg. A few were involved in illicit services such as commercial sex work.

The result shows that fifteen percent (15.3%) of the study sample admitted drinking alcohol. Depression and stress or life style could also be a reason for this. Almost 17% stated they had 'ever had sexual intercourse' and of those who had sexual intercourse, more than half (56.7%) had first intercourse at below 15 years. Almost 6% had experienced forceful sexual intercourse and three- quarters (74.6%) did not use condoms. Poverty could be the main reason for this followed by sexual rape or incest by closed relatives. Street children have right to basic needs but they are poor and have no parental support will engage in sexual activities to survive.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

CHAPTER SEVEN

CONCLUSION

Poverty is a key factor driving these children to the street. Other problems include family problems, a need for freedom and civil disturbances. Street children engage in all sorts of hazardous activities for survival such as selling items on the street, scavenging and searching for usable items. They are prone to be exposed to traumatic experiences and are in need of support.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER EIGHT

LIMITATIONS

Some children were afraid to be interviewed by the researchers and were hesitant to discuss their personal experiences and behaviours.

There was a big challenge with privacy as there were distractions from onlookers on the street where the study process was conducted and therefore, the interview process had to be conducted in isolated and quiet places. Most of the children who were permanently staying on the street were only accessed at night so the interview process had to continue until late at night.

Some of the children could not understand the questions because not all of them understood the widely spoken Creole language.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER NINE

RECOMMENDATION

The existence of street children is a big social problem that affects every nation. Children are the future leaders of tomorrow so they should be well groomed to fit into the society.

The Government, NGOs and other child care institutions should come forward to re-establish these children and initiate education and vocational training programs to enhance their mental status for a better future.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

REFERENCES

A Rapid Assessment of the situation of street and other war –affected children in Sierra Leone. 2002.

Abdelgalil, S., Gurgel, R.G., Theobald, S., and Cuevas, L.E. (2004). Household and family characteristics of street children in Aracaju, Brazil. Archives of Diseases in Childhood; Sep; 89(9): 817-20.

Adlaf, E. M. and Y. M. Zdanowicz (1999). A Cluster Analytical study of substance problems and mental health among street youths. *American Journal of Drug and Alcohol Abuse, 10.*

Allen, K. E. (1991). The Exceptional Child: Mainstreaming in Early Childhood Education. Albany, N.Y.

Ayerst, S. L. (1999). "Depression and stress in street youth. Adolescence." Retrieved June 3, 2004: http://www.findarticles.com/p/articles: Date Accessed: November 5, 2013:

Bassuk, E. and L. Rubin (1987). "Homeless children: A neglected population." *American Orthopsychiatric Association,* **57 (2)**: 279-286.

Berden GF, A. M., Verhulst FC ((1990) "Major life events and changes in the behavioural functioning of children" J Child Psychol Psychiatry 31: 949–959.

Biederman J, M. S., Faranoe SV (1995). "Family environment risk factors for ADHD." Arch Gen Psychiatry 52: 464–470.

Boukhari S (1997). Not Just Street Smart. . UNESCO**:** 6-9.

Buckner, J.C., Bassuk, E.L., Weireb, L.F., and Brooks, M.G. (1999) Homelessness and its relation to the mental health and behaviour of low-income school-age children; Development Psychology Journal 35(1): pp 246-57.

Campbell, E. K. and T. Ntsabane (1996). "Health risk practices among street children in

Chandler, P. A. (1993). " Including Children with Special Needs in Early Care and Educational settings." A Place for Me:.Gaborone, Botswana." CHASA Journal of Comprehensive Health **7 (1)**,: 23-33.

Cosgrove, J. G. (1990). "Towards a working definition of street children." International Social Work, 33 (3).

DiBiase R., and Waddell S. (1995) 'Some effects of homelessness on the psychological functioning of preschoolers'. *Journal of Abnormal Child Psychology*. 23(6): 783-92.

Donald, D. and J. Swart-Kruger (1994). " The South African street child: Developmental implications." South African Journal of Psychology, 24(4): 169-174.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Dillon (2008). "The missing link." a social orphan protocol to the United Nations Convention on the Rights of the Child.

dM Kulik, s gaetz, et al. (2011). "homeless youth's overwhelming health burden:." a review of the literature. Paediatr Child health 16(6): e43-e47

Foster (2000). "The capacity of the extended family safety net for orphans in Africa." Psychology, Health & Medicine **5**: 55 -63.

Gebers, P. E. (1990). "Health of street children in Cape Town." Kinderversorger 8 (9).

Geldenhuys, J. L. (2001). "An investigation iinto possible development problems of African street adolescents in South Africa." Journal of Psychology in Africa 11 (2): 126-143.

George (2011). "State of orphans in the earthly paradise." Econ. Polit; Weekly 46(10): 1

Gichuru, F. (1993). Street Children, The Undugu Experience Nairobi, Kenyatta University /UNICEF AND ESAFO.

Gupta, L. and C. Zimmer (2008). "Psychosocial intervention for war-affected children in Sierra Leone." The British Journal of Psychiatry doi: 10.1192/bjp.bp.107.038182 **192**: 212–216.

Haley N, Roy E, et al. (2004). "HIV risk profile of male street youth involved in survival sex. " Sex Transm Infect **80**: 526-530. HANCI and G. a. C. A. Ministry of Social welfare (2011). "Street Children of Sierra Leone." Talk.

Hecht, T. (2000). In search of Brazil's street children. Abbandoned Children C. Panter-Brick and T. M. Smith. Cambridge Cambridge Univesity Press. http://answers.ask.com/Health/Mental/what_is_psych...).

Higgitt N, Wigert S, et al. (2003). "Operation Go Home. Experience of Street-Involved Youth in Winnipeg. ." Voices from the Margins:Winnipeg: Winnipeg Inner-City Research Alliance,.

Holford (1998). "The Optimum Nutrition Bible."

Houssain Kettani, (2010) "Muslim Population in Africa: 1950 – 2020" *International Journal of Environmental Science and Development, Vol. 1, No. 2, June 2010* http://answers.ask.com/Health/Mental/what_is_psych...)

Jansen, P., R. L. M. Richter, et al. (1990). "Glue sniffing: A descirption of social, psychological and neuropsychological factors in a group of South African 'street children'." Suid-Afrikaanse Tydskrift Sielkund 20 (3): 150-158.

Johnson TP, Aschkenasy JR, et al. (1996). "Self-reported risk factors for AIDS among homeless youth" AIDS Educ Prev 8: 308-322.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Kazi Saleh Ahmed, Dr. M. Mosleh Uddin, et al. (2003). A BASELINE SURVEY OF STREET CHILDREN IN BANGLADESH. T. B. B. o. Statistics, National Child-Labour Survey, t. F. Parishakhan Bhaban, (Block –1) and A. E-27/A, Dhaka. Parishakhan Bhaban, Agargaon, Dhaka

Klain, E. J. (1999). "Prostitution of Children and Child-Sex Tourism:." An analysis of domestic and international responses. Virginia: National Center for Missing & Exploited Children.

Knaul, F. (1995a). "Counting the street children of Bogota: defined away, missing or out of sight " Havard center for population and development studies working paper series No. 95/07.

Kopoka, P. A. (2000.). "The Problem of Street Children in Africa: An Ignored Tragedy." International Conference on Street Children and Street Children's Health in East Africa.

Le Roux, J. (1995). A comparison of the lifeworld experiences of street children in Thailand and South Africa, University of Orange Free State. Doctoral.

Le Roux, J (1996) “Street Children in South Africa: Findings from Interviews on the Background of Street Children in Pretoria, South Africa,” Adolescence 31, 122, 423431.

Luna, C. C. (1991). "Street youth: Adaptation and survival in the AIDS decade." Journal of Adolescent Health 12: 511-514.

Levenstein (1996). "Educating street children : innovative ideas and programmes in Brazil." South African Journal of Education, 16: 45-50.

Lugalla JLP and J. Mbwambo (1999). "Street children and street life in urban Tanzania: The culture of surviving and its implications." International Journal of Urban & Regional Research. 23: 329-345.

Luna, C. C. (1991). "Street youth: Adaptation and survival in the AIDS decade." Journal of Adolescent Health 12: 511-514.

M. Mudasir Naqshbandi1*, R. Sehgal, et al. (2012). "Orphans in orphanages of Kashmir “and their Psychological problems." International NGO Journal , **7(3),**: 55-63.

McLeod, S. (2008). "Simply Psychology." Developmental Psychology.

Mallet S., Rosenthal D., and Keys D. (2005) Young people, drug use and family conflict: pathways into homelessness. Journal of Adolescence; Apr 28(2): 185-99.

Mallett S. and Rosenthal D. (2009) physically violent mothers are a reason for young peoples’ leaving home. Journal of Interpersonal Violence; Jul; 24(7): 1165-74.

Molnar, J. M. and W. R. Rath (1990). "Constantly compromised: The impact of homelessness on children." Journal of Social Issues 46 (4): 109-124.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Nancy Mock and E. d. Buhr (2009). "Children in Difficult Circumstances " Maternal and Child Health.

Omigbodun, O. O. (2004). "Psychosocial issues in a child and adolescent psychiatric clinic population in Nigeria" Soc Psychiatry Psychiatr Epidemiol **39**: 667–672.

Omigbodun, O. O. (2006). "Psychosocial Attributes of Orphaned Youths in Ibadan Metropolis: Implications for Reproductive Health " Trop J Obstet Gynaecol, 23 (1).

Patricia Ray et al (2011). "Global Child Protection Services."

Petterson GR, D. B., Ramsey E (1989). "A developmental perspective on antisocial behavior. Amer psychologist." 44(2): 329 -335.

Prince, A. C. (2006). Factors Related to the Street Children Phenomenon in Major Towns in Sierra Leone: "A Comparative Study of the City's Street Children and Children in Normal Family Homes" St. Clements University.

Rey JM, Walter G, et al. (2000). "Family environment in attention deficit hyperactivity, oppositional defiant and conduct disorders." Aust N Z J Psychiatry: **34**: 453–445.

Ritchie, M. (1999). "Children in 'Especially Difficult Circumstances': Children Living On The Street. Can Their Special Needs Be Met Through Specific Legal Provisioning?" Consultative Paper Prepared For The South African Law Commission

Rooyen*, L. v. and a. C. G. Hartell (2002). "Health of the street child: the relation between life-style, immunity and HIV/AIDS a synergy of research." South African Journal of Education Copyright © 2002 EASA 22(3): 188 – 192

Rosenthal D, Mallett S, and Myers P. (2006). Why do homeless young people leave home? Australian and New Zealand Journal of Public Health; Jun; 30(3): 281-5.

Rubia S and a. A. Smith (2001). "Attention deficit hyperactivity disorder: current findings and treatment." Curr Opin Psychiatry **14**: 309–316.

Scanlon, F. (1998). "Street Children in Latin America " BRIT. MED. J. (1998) **316**: 1596, 1597.

Scharf, W., M. Powell, et al. ((1986)). "Street children of Cape Town. In S. Burman & P. Reynolds (Eds.), Growing up in a divided society: . ." The context of childhood of South Africa. Johannesburg: Ravan Press.

Schurink, W. (1993). "Street children, Pretoria:." Human Science Research Council Sesay, I.M., Karem, A.A., and Ngobeh, J.J. 2006. Republic of Sierra Leone: 2004 Population and Housing Census: Analytical Report on Population Distribution, Migration and Urbanisation in Sierra Leone. Published November 2006. World Gazetter: Eastern-Administrative Divisions: *Per Geographical Entity.*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Shanler (1998). "Sexual Abuse & Young Adult Reproductive Health. ." FOCUS on Young Adults.

Shaw DS, V. J., Hommerding KD,Keenan K, Dunn M ((1994)). "Chronic family adversity and early child behaviour problems: a longitudinal study of low income families." J Child Psychol Psychiatry 35: 1109–1122. Street Children in Zimbabwe, The international Child and Youth care network issues 35. December 2001

Swart (1990a). "Street Children: Their health and welfare.".

UNESCO (2002). Strengthning Partnership to combat HIV/AIDS and discrimination. Children in difficult circumstances.

UNICEF. (1986). "Children in especially difficult circumstances: Exploitayion of working and street children. New York:." United Nations Children Fund.

UNICEF (2005) Street Children.

UNICEF (2005) THE STATE OF THE WORLD'S CHILDREN

UNICEF(1993) Street and Working Children. INNOCENTI GLOBAL SEMINAR. M. Black. Florence Italy, UNICEF International Child Development Center Spedale degli Innocenti, Florence, Itally.

UNICEF (1997). State of the World's Children. **35:** 1109–1122.

Veale A. and Donà G. (2003) Street children and political violence: a socio-demographic analysis of street children in Rwanda. Child Abuse and Neglect; Mar 27(3): 253-69.

Vostanis, P. G. E. and S. Cumella (1998). "Mental health problems of homeless children and families: longitudinal study." British Medical Journal **3**.

Weinreb L, Wehler C, Perloff J, Scott R, Hosmer D, Sagor L, and Gundersen C. (2002) Hunger: its impact on children's health and mental health. Pediatrics Oct; 110(4):e41

Whitbeck LB, Johnson KD, Hoyt DR, and Cauce AM. (2004) Mental disorder and comorbidity among runaway and homeless adolescents. Journal of Adolescent Health; Aug 35(2):132-40.

WHO (2003). Caring for children and adolescents with mental disorders. Setting WHO directions. Geneva, Switzerland.

Winick, M. (1985). "Nutritional and vitamine deficiency states. In Molnar, J.M. & Rath, W.R (1990). Constantly compromised: The impact of homelessness on children." Journal of Social Issues 46 (4): 109-124.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Witumbula Katambwe V, Kizanda F, Wabatinga Kyalemaninwa G. [Street children in Bukava, Democratic Republic of Congo: causes for leaving home]. Medicine tropicale: revue du Corps de santé colonial. Jun 69(3): 303-5.

WPA, WHO, et al. (2004). Expanding Awareness of Mental Health in Childhood and Adolescence.www.ci.org.za/depts/ci/plr/pdf/salrc_rprt_02/pr110chapter12.pdf.

www.ibcr.org/eng/definition_child_trafficking.html.

www.santac.org/.../Human-Trafficking/Definition-of-Child-Trafficking.

Yates, G. L. (1991). "A risk profile comparison of homeless youth involved in prostitution and homeless youth not involved. In Klain, E.J. (1999). Prostitution of Children and Child-Sex Tourism:." An analysis of domestic and international responses. Virginia: National Center for Missing & Exploited Children.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

APPENDICES

CONSENT FORM FOR RESEARCH WITH HUMAN SUBJECT

Psychosocial correlates of street children in Kenema, Eastern Sierra Leone

I ………………………………………Have been fully informed and understood all contents of the proposed research study that:

- The study does not involved identification of participant by name or picture
- I have all rights to ask questions relevant to the study and to give correct answers to the designed questionnaire
- I have the right and free to withdraw from participating in the study at any time without any consequences
- I have been informed that data collected will be read by the CCAMH University of Ibadan, Ibadan , Nigeria
- I therefore agree to participate in the proposed research study.

Sign …………………….. Date………………

Principal Investigator for the research

Nurse Massah Mambu

Student of Center for Child and Adolescent Mental Health

Clinical Sciences, College of Medicine, University of Ibadan, Ibadan, Nigeria

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Instrument

Serial Number: __ __ __ __
today's Date: __ __/__ __/__ __

A MODIFIED SCHOOL HEALTH QUESTIONNAIRE IN ENGLISH & CREOLE FOR STREET CHILDREN

SECTION I

Personal Information

1. Where do you live? (Address of Present Abode):
1. Usai yu tap?

2. What is your date of birth?
2. Wetin nay u bat de?

3. How old are you?
3. Ɔmɔs ia yu ol?

4. Are you a boy or a girl? (a) Boy (b) Girl
4. Yu na bɔbɔ ɔ titi? (a) Bɔbɔ (b) Titi

5. Do you practise any religion? No Yes
5. Yu kin prey? Nɔ Yɛs

6. What is your religion?
6. Wetin na yu rilijɔn?
(a) Islam (b) Christianity (c) Others specify
(a) Muslim (b) Cristɛn (c) If na ɔda rilijɔn, duya nem am

7. How much does the teaching of your religion guide your behaviour?
7. Ɔmɔs tɛm yu rilijɔn tiching kin gyde yu wey?
(a) Very much (b) much (c) Just a little (d) Not at all
(a) Bɔku bɔku (b) bɔku (c) lili wan (d) natin atɔl

Family Information

8. Family Type:
8. Di kyn Fɛmili

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

(a) Monogamous (b) Polygamous
(a) Mɔnogɛmi (b) metmared / pɔligɛmi

9. Do you have bothers and / or sisters? Yes No
9. Yu gɛt brɔda ɛn sista dɛm?

10. If yes, where are they staying? At home On the street Others specify
10. If yu se yɛs, usai dɛn de? Na os Na trit If na ɔdasai, duya nɛm am

11. Marital Status of Parents:
11. Yu mama n papa dɛm mared kɔndishɔn
(a) Married (b) Separated/Divorced (c) Father is dead (d) Mother is dead
(e) Mother & Father are dead
(a) Mared (b) Dɛm bin dɔn pat (c) Mi papa dɔn dai (d) Mi mama dɔn dai (e) Den ɔl tu dɔn dai

12. Who do you live with presently?
12. Na to udat yu de naw?
(a) Parents (b) Mother (c) Father (d) Grandparents (e) Grandmother
(a) Mi mama ɛn mi papa (b) Mi mama (c) Mi papa (d) Mi granni en mi granpaa
(e) Mi granni
(f) Grandfather (g) Other [please specify] ________________
(f) Mi granpaa (g) If na ɔda pɔsin, duya nɛm am

13. Who brought you up from your childhood?
13. Udat brin yu kam ɔp frɔm wey u smɔl?
(a) Parents (b) Mother (c) Father (d) Grandparents (e) Grandmother
(a) Mi mama ɛn papa (b) Mi mama (c) Mi papa (d) Mi granni ɛn mi granpaa
(e) granmaa
(f) Grandfather (g) others [please specify] ________________
(f) Granpaa (g) If na ɔda pɔsin, duyaa nɛm am

14. What kind of house does your parent/guardian live in?
14. Usekyn os we yu mama ɛn papa ɔ di pɔsin we de luk afta yu dɛm tap?
(a) Owner occupied (b) rented house (c) others (specify)……..
(a) Dɛn yon os (b) Na rɛnt os (c) If na ɔda kyn os, duya nɛm am

15. How often do you contact your parents or relatives?
15. Ustɛm ɛn ustɛm yu kin go ɔ si yu mama ɛn papa ɔ fambul dɛm?
(a) Frequent (b) Rear (c) Never
(a) Fas fas (b) I kin te (c) A nɔ wan de go de

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

16. Level of Father's Education
16. Usai yu papa tap pa buk lanin?
(a) No Formal Education (b) Koranic School (c) Primary School (d) Secondary School
(a) I nɔ lan buk atɔl (b) Arabik skul (c) prɛmari skul (d) sɛkɛndri skul
(e) Post Secondary (Non-University) (f) University Degree and above (e) I do not know
(e) Post sɛkɛndri (f) univɛsiti digrii (e) ar nɔ no

17. Occupation of Father: I do not know
17. Uskayn wok yu papa de du? A nɔ no

18. Level of Mother's Education
18. Usai yu mama tap pa buk lanin?
(a) No Formal Education (b) Koranic School (c) Primary School (d) Secondary School

(a) I nɔ lan buk atɔl (b)Arabik skul (c)prɛmari skul (d) sɛkɛndri skul

(e) Post Secondary (Non-University) (f) University Degree and above (g) I do not know

(e) Post sɛkɛndri skul (f) univɛsiti digrii (g) a nɔ no

19. Occupation of Mother: I do not know
19. De kayn wok wey yu mama de du: a nɔ no

20. Where is/are your parent/s staying? (a) In Kenema (b) Elsewhere (c) Don't know parent/s whereabouts
20. Usai yu mama ɛn papa de? (a) Na Kenema (b) Na ɔdasai (c) A nɔ no usai mi mama ɛn mi papa de

School-Related Questions
21. Have you ever been to school? (a) Yes (b) No
21. Yu bin ɛva go skul? (a) Yɛs (b) Nɔ

22. Are you currently in school? Yes/ No
22. Yu stil de attɛnd skul ? Yɛs / Nɔ
a). If yes, Name of School b) If No, why do you drop out of school?

(c) Class

(a). If yu se yɛs, wetin na di skul in nem? (b) If yu se nɔ, wetin mɛk yu kɔmɔt skul?

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

23. What level did you stop/drop from school? Primary JSS Level SSS Level
23. Usai yu tap pan di buk lannin? Prɛmari JSS SSS

24. Would you like to go back to school? Yes No
24. Yu go lek for go bak na skul?

25. Do you do any kind of work to earn money before or after school? Yes No
25. Yu kin du eni kyn wok fɔ mɔni bifo yu go skul ɔ afta skul kɔmɔt?

26. If yes, please describe what you do ____
26. If yu se yɛs, duya tɛl mi wetin yu kin du

27. Why are you on the street?
27. Wetin mɛk yu de na trit?
(a) Family problems (b) Need for income (c) Civil disturbances (d) Need for freedom
(a) Fɛmili prɔblɛm (b) Fɔ fɛn mɔni (c) Civili wahala (d) Fɔ fri layf

28. How long have you been on the street?
28. Aw lɔng yu dɔn de na trit?
(a) Under One Year (b) One year (c) More than one year
(a) I nɔ rich wan ia (b) Wan ia (c) I pas wan ia

29. Do you return home every day?
29. Yu kin go bak na os ɛnide?
(a) Yes (b) No
(a) Yɛs (b) Nɔ

30. Do you permanently stay on the street?
30. Na trit yu de ɔltɛm?
(a) Yes (b) Nɔ
(a) Yɛs (b) Nɔ

31. Where do you sleep at night?
31. Usai yu kin slip na nɛt?
(a) At Home (b) On the Street (c) Others specify
(a) Na os (b) Na trit (c) If na ɔdasai, duya nem am

32. Which specific areas on the streets do you sleep?
32. Us pat na trit yu kin slip?
(a) In dilapidated buildings (b) In public parks (c) In garage vehicles (d) In ghettoes
(a) Na brok os (b) Na pak (c) Na garaj (d) Na gɛto

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

33. Have you ever been sick while on the street?
33. Yu bin dɔn ɛva sik we yu de na trit?
(a) Yes (b) No
(a) Yɛs (b) Nɔ

Usual activities
Economic:
34. What type of activities do you do to survive?
34. Uskayn wok we yu kin du fɔ yu livin?

(a) Scavenging (searching for something usable)
(a) A kin pikangrɔn

(b) Vending (selling items in markets)
(b) A kin sɛl tin dɛm na makit

(c) Licit services (e.g. car washing)
(c) A kin du sɔm kyn wok lɛk wass kaa

(d) Illicit services (e.g. sex work)
(d) A kin rarey fɔ mi livin

(e) Carrying Loads for people for reward
(e) A kin kɛrr lod go fɔ ɔda pipul dɛm fɔ pey

35. How do you eat while on the street?
35. Aw yu kin it wae yu de na trit?
(a) I buy already prepared food to eat
(a) A kin bai kuk chɔp ɛn it

(b) I and my peers prepare food together and eat
(b) Mi ɛn mi Kɔnpin dɛm kin kuk ɛn it na wan ples

(c) I eat remnant foods from adults
(c) A kin it di wɛrrɛ we big pipul dɛm kin lɛf

36. How many meals do have in a day?
36. Ɔmɔs tɛm yu kin it fɔ di dey?
(a) One meal a day (b) Two meals a day (c) Three times a day (d) Others specify
(a) Wan tɛm fɔ dey (b) Tu tɛm fɔ dey (c) Trii tɛm fɔ dey (d) ɔ ɛni ɔda tɛm, yu kin tɔkam

37. If you were to be removed from the street, what would you like to do?
37. If dɛm fɔ pull yu kɔmɔ na trit, wetin yu go lɛk fɔ du?
(a) Go back to school (b) Continue selling at home/shop (c) To be employed
(d) Others Specify
(a) Go bak na skul (b) Kɔntiniu fɔ de sɛl na ose/ shɔp (c) A go wan jɔb
(d) ɛni ɔda tin, na fɔ tɔkam

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Traumatic events and worries

Please tick in yes or no and give reasons for your answer
Duyaa tik insay yɛs ɔ nɔ en gi risin fɔ yu ansa

38. Do you have any present worries? Yes   Noɔ
38. Yu gɛt ani tin we de wɔri yu naw? Yɛs   Nɔ

Major Life Events

39. Has anyone close to you died? No   Yes
39. Ɛni yu klos pɔsin don dai?   Nɔ   Yɛs

40. Have you ever experienced a natural disaster such as flood or fire? Yes   No.
40. Yu bin dɔn ɛva gɛt ɔ de usai bibig trɔbul apin lɛk flɔdin ɔ faya? Yɛs   Nɔ

41. If yes, please describe ____
41. If yu se yɛs, duyaa tɛl mi we tin bin appin

Self-Esteem Questions: please tick in yes or no   Duyaa tik insai yɛs ɔ Nɔ

		Yes	No
42	I am a failure at school Mi na feliɔ na skul		
43	My parents or guardians make me feel that I am not good enough Mi mama ɛn papa ɔ di wan we de luk afta mi mɛk mi fil se a nɔ gud		
44	I am happy most of the time A gladi ɔltɛm		
45	I have lots of fun with my parents A gɛt plɛnti fɔn wit mi mama ɛn mi papa		
46	I would change many things about myself if I could A go chenj plɛnti tin bɔt misɛf if a yebu		

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

47	My teacher feels that I am not good enough Mi ticha fil se a nɔ gud		
48	I can do things as well as other boys and girls A kin du tin dɛm lɛk di ɔda bɔbɔ ɛn titi dɛm		

SECTION II : GLOBAL SCHOOL HEALTH QUESTIONNAIRE

Alcohol and Other Drug Use Module

The next 5 questions ask about drinking alcohol. This includes drinking beer, wine, ogogoro, opia-pia, burukutu, akpeteshi, oguro, palmwine or paraga. *Drinking alcohol* _does not_ *include drinking a few sips of wine for religious purposes. One drink is a glass of beer or palm-wine, a glass of wine or small glass of gin, ogogoro, burukutu, paraga, akpeteshi or opia-opia.*

49. Do you drink alcohol?
49. Yu kin drink rɔm?

50. Do you usually get drunk?
50. You kin chak?

51. How did you get the alcohol you drank?
51. Aw yu kin get di rɔm wae yu kin drink?

(a) I did not drink alcohol during the past 30 days (b) I bought it
(a)A nɔ drink rɔm insai dis 30 dey wae pass (b) a ba yam
(c) I gave someone else money to buy it for me. (d) I got it from my friends (e) I got it from home

(c) A gi sɔmbɔdi mɔni fɔ mɛk I ba yam fɔ mi (d) A gɛt am frɔm mi padi dɛm (e) A gɛt am frɔm os
(f) I stole it (g) I made it myself (h) I got it some other way

(f) A tiff am (g) A mɛk am fɔ misɛf (h) Na ɔda wey a gɛt am

52. During your life, how many times have you ever had a hang-over, felt sick, got into trouble with your family or friends, missed school, or got into fights, as a result of drinking alcohol?

52. Insai yu layf tɛm, ɔmɔs tɛm yu dɔn gɛt hang- ova ɛn fil sik, gɛt trɔbul wit yu femili ɔ paddi dɛm, yu mis skul da dey de ɔ fɛt bikɔs yu drink rɔm?

(a) 0 times (b) 1 or 2 times (c) 3 to 9 times (d) 10 or more times

(a)0 tɛm (b) 1 to 2 tɛm (c) 3 to 9 tɛm (d) I pas 10 tɛm

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

The next question asks about drugs.

53. During your life, how many times have you used drugs like Indian hemp (Taffie), heroin, cocaine, Chinese capsule, or smoked dried pawpaw leaves?

53. Insai yu layf tɛm, ɔmɔs tɛm u dɔn tek drɔg lɛk taffie, kokein, bran- bran ɔ pɔpɔ lif?

(a) 0 times (b) 1 or 2 times (c) 3 to 9 times (d) 10 or more times
(a) 0 tɛm (b) 1 ɔ 2 tɛm (c) 3 to 9 tɛm (d) I pas 10 tɛm

Protective Factors Module
The next 5 questions ask about your experiences at school and at home.

54. During the past 30 days, how often did your parents or guardians understand your problems and worries?

54. Insai dis 30 dey we pas so, ustɛm ɛn ustɛm yu mama ɛn yu papa ɔ di pɔsin we de luk afta yu kin undastan yu prɔblɛm ɛn yu wɔrri?
(a) Never (b) Rarely (c) Sometimes (d) Most of the time
(e) Always

(a) I nɔ wan dey bi (b) I nɔ kin bi nɔ mɔ (c) sɔmtɛm dɛm de (d) bɔku tɛm (e) ɔl di tɛm

Sexual Behaviours Module
The next 5 questions ask about sexual intercourse. [This includes vaginal intercourse (when a man puts his penis into a woman's vagina) and anal intercourse (when a man puts his penis into his partner's anus).]

55. Have you ever had sexual intercourse?
55. Yu bin dɔn ɛva du mami ɛn dadi biznɛs?
(a) Yes (b) No
(a) Yɛs (b) Nɔ

56. How old were you when you had sexual intercourse for the first time?
56. ɔmɔs ia yu bin ol we yu fɔs du mami ɛn dadi biznɛs?
(a) I have never had sexual intercourse (b) 11 years old or younger (c) 12 years old
(a) A nɔ wan de du mami ɛn dadi biznɛs (b) 11 ia ol ɔ yu nɔ rich so (c) 12 ia ol
(d) 13 years old (e) 14 years old (f) 15 years old (g) 16 years old or older
(d) 13 ia ol (e) 14 ia ol (f) 15 ia ol (g) 16 ia ol ɔ yu bin don ol pas so

57. During your life, with how many people have you had sexual intercourse?
57. Insai yu layf tɛm, ɔmɔs pipul dɛm we yu don gɛt mami ɛn dadi biznɛs wit?

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

(a) I have never had sexual intercourse (b) 1 person (c) 2 people (d) 3 people (e) 4 people

(a)A nɔ wan de du mami ɛn daddi biznɛs (b) 1 pɔsin (c) 2 pipul dɛm (d) 3 pipul dɛm (e) 4 pipul dɛm

(f) 5 people (g) 6 or more people

(f) 5 pipul dɛm (g) I pas 6 pipul dɛm

58. During the past 12 months, have you had sexual intercourse? (a) Yes (b) No
58. Insai dis 12 mɔnt we pas so, yu bin du mami ɛn dadi biznɛs? (a) Yɛs (b) Nɔ

59. The last time you had sexual intercourse did you or your partner use a condom?
59. Di las tɛm we yu du mami ɛn dadi biznɛs yu ɛn yu Patna bin use kɔdɔm?
(a) I have never had sexual intercourse (b) Yes, a condom was used (c) No, and condom was not used

(a) A nɔ ɛva du mami ɛn daddi biznɛs (b) yɛs a bin use wan kɔdɔm

(c) No, wi nɔ bin use kɔdɔm

60. Has an adult ever forced you to have sexual intercourse with them? No Yes
60. Big pɔsin dɔn ɛva fos yu fɔ du mami ɛn dadi biznɛs? Nɔ Yɛs

61. If yes, who was it? ____
61. If yu se yɛs, na bin udat?

62. Have you ever had any of these experiences since living on the street?
62. Yu bin dɔn ɛva ɛxpiriɛns ɛni wan pan dɛm waya frɔm we yu de na trit?
(a) Sexual abuse (b)Rape (c)child labor (d) Physical abuse (e) Emotional abuse
(a) Badɔf mami ɛn daddi biznɛs (b) Baifose mami ɛn daddi biznɛs (c) Dɛm attak yu bad bad wan? (d) Dɛm frɔstret yu?

63. Has an adult ever touched you on your breast, private part, or made you touch parts of their own private part? Yes No
63. Big pɔsin bin dɔn ɛva tɔch yu bɔbi, ɛn yu prayvet pat, ɔ mɛk yu tɔch I yon prayvet pat?
Yɛs Nɔ

64. If yes, explain
64. If yɛs, ɛxplen

Tobacco Use Module
The next 6 questions ask about cigarette and other tobacco use.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

65. How old were you when you first tried a cigarette?
65. Ɔmɔs ia yu bin ol we yu fɔs smok cigrɛt
(a) I have never smoked cigarettes (b) 7 years old or younger (c) 8 or 9 years old

(a) A nɔ ɛva smɔk cigrɛt (b)7 ia ol ɔ yu nɔ bin dɔn rich yet (c) 8 ɔ 9 ia ol

(d) 10 or 11 years old (e) 12 or 13 years old (f) 14 or 15 years old

(d)10 ɔ 11 ia ol (e) 12 ɔ 13 ia ol (f) 14 ɔ 15 ia ol

(g) 16 years old or older

(g) 16 ia ɔ yu bin ol pas so

66. During the past 30 days, on how many days did you smok cigarettes?
66. Insai dis 30 dey we pass so, ɔmɔs deys yu smok cigrɛt t?
(a) 0 days (b) 1 or 2 days (c) 3 to 5 days (d) 6 to 9 days
(a)0 dey (b) 1 ɔ 2 dey (c)3 ɔ 5 dey (d) 6 ɔ 9 dey

(e) 10 to 19 days (f) 20 to 29 days (g) All 30 days

(e) 10 ɔ 19 dey (f)20 ɔ 29 dey (g) ɔl di 30 dey

67. During the past 30 days, on how many days did you smoke any other form of tobacco, such as snuff?
67. Insai dis 30 dey we pas so, ɔmɔs deys yu bin smok ɛni ɔda kyn cigrɛt lɛk snɔf?
(a) 0 days (b) 1 or 2 days (c) 3 to 5 days (d) 6 to 9 days
(a)0 dey (b)1 ɔ 2 deys (c)3 ɔ 5 deys (d) 6 ɔ 9 deys
(e) 10 to 19 days (f) 20 to 29 days (g) All 30 days
(e)10 ɔ 19 deys (f) 20 ɔ 29 deys (g) ɔl di 30 deys

68. During the past 12 months, have you ever tried to stop smoking cigarettes?
68. Insai dis 12 mɔnt we pass so, yu dɔn ɛva trai fɔ lɛf fɔ smok cigrɛt?
(a) I have never smoked cigarettes (b) I did not smoke cigarettes during the past 12 months
(c) Yes, I tried to stop smoking (d) No; I did not try to stop smoking
(a) A nɔ ɛva smok cigrɛt (b) a nɔ bin smok cigrɛt fɔ di pass 12 mɔnt

(c) Yɛs, a bin trai fɔ tap fɔ smok (d)Nɔ, a nɔ bin trai fɔ tap fɔ smok

69. During the past 7 days, on how many days have people smoked in your presence?
69. Insai dis 7 dey we pass so, ɔmɔs dey pipul dɛm smok bifo yu?
(a) 0 days (b) 1 or 2 days (c) 3 to 4 days (d) 5 to 6 days
(a) 0 dey (b)1ɔ 2 deys (c)3 to 4 deys (d)5 to 6 deys
(e) All 7 days
(e)ɔl di 7 deys

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

Violence and Unintentional Injury Module

The next question asks about physical attacks. A physical attack occurs when one or more people hit or strike someone, or when one or more people hurt another person with a weapon (such as a stick, knife, or gun). It is not a physical attack when two students of about the same strength or power choose to fight each other.

70. During the past 12 months, how many times were you physically attacked?
70. Insai dis pass 12 mɔnts, ɔmɔs tɛm we yu bin gɛt fizikal attak?
(a) 0 times (b) 1 time (c) 2 or 3 times (d) 4 or 5 times
(a)0 tɛm (b)1 tɛm (c)2 ɔ 3 tɛm (d)4 ɔ 5 tɛm

(e) 6 or 7 times (f) 8 or 9 times (g) 10 or 11 times (h) 12 or more times

(e) 6ɔ 7 tɛm (f)8 ɔ 9 tɛm (g)10 ɔ 11 tɛm (h) I pas 12 tɛm

The next question asks about physical fights. A physical fight occurs when two or more students of about the same strength or power choose to fight each other.

71. During the past 12 months, how many times were you in a physical fight?
71. Insai dis pass 12 mɔnt, ɔmɔs tɛm yu fɛt wit pɔsin?
(a) 0 times (b) 1 time (c) 2 or 3 times (d) 4 or 5 times

(a) 0 tɛm (b) 1 tɛm (c) 2 ɔ 3 tɛm (d)4 ɔ 5 tɛm

(e) 6 or 7 times (f) 8 or 9 times (g) 10 or 11 times (h) 12 or more times

(e) 6 ɔ 7 tɛm (f) 8 ɔ 9 tɛm (g) 10 ɔ 11 tɛm (h) I pas 12 tɛm

Violence and Unintentional Injury Module

72. During the past 12 months, what was the most serious injury that happened to you?
72. Insai dis pas 12 mɔnt wetin na bin di soba wund we appin wit yu?

(a) I was not seriously injured during the past 12 months
(a) A nɔ bin wund bɛttɛ wan Insai dis pas 12 mɔnt

(b) I had a broken bone or a dislocated joint
(b) A bin gɛt brok fut

(c) I had a cut, puncture, or stab wound
(c) A bin gɛt kɔt, pɔnch, gɛt stab wund
(d) I had a concussion or other head or neck injury, was knocked out, or could not breathe
(d) Abin gɛt wund na mi ed, ɔ nɛk, dɛn bin hit mi ɛn a nɔ bin able fɔ blo

(e) I had a gunshot wound
(e) Dɛn bin shut mi

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

(f) I had a bad burn
(f) A bin ros badbad wan

(g) I lost all or part of a foot, leg, hand, or arm
(g) A lɔs ɔl ɔ pat ɔf mi fut, lɛg, ɔ mi And

(h) Something else happened to me
(h) ɔda tin bak bin apin wit mi

The next question asks about bullying, Bullying occurs when a student or group of students say or do bad and unpleasant things to another student. It is also bullying when a student is teased a lot in an unpleasant way or when a student is left out of things on purpose. It is not bullying when two students of about the same strength or power argue or fight or when teasing is done in a friendly and fun way.

73. During the past 30 days, how were you bullied most often? You can circle more than one option
73. Insai dis pas 30 dey, aw dɛn bin buli yu? Yu go tek pas wan ansa.
(a) I was not bullied during the past 30 days(
(a) Dɛn nɔ bin buli mi insai dis pas 30 deys

(b) I was hit, kicked, pushed, shoved around or locked indoors (
(b) Dɛn bin it, kik, push ɔ lɔk mi insai

(c) I was made fun of because of my ethnic group (
(c) Dɛn bin de laf mi fɔ mi trayb

(d) I was made fun of because of my religion (
(d) Dɛn bin de laf mi fɔ mi rilijɔn

(e) I was made fun of with sexual jokes, comments, or gestures (
(e) Dɛn bin de mɛk jok wit mi fɔ mami n daddi biznes, kɔment ɔ moshɔn

(f) I was left out of activities on purpose or completely ignored (
(f) A binlɛf awt pan plɛnty tin dɛm ɔ dɛn snɔb mi

(g) I was made fun of because of how my body or face looks(
(g) Dɛn bin de laf mi fɔ aw mi bɔdi ɔ fes luk lɛk

(h) I was bullied in some other way. (
(h) Dɛn bin buli mi pan ɔda wey

74. During the past 12 months, how often have you felt lonely?
74. Insai dis pas 12 mɔnt, ustɛm ɛn ustɛm yu bin fil we yu bin de yu wan gren?
(a) Never (b) Rarely (c) Sometimes (d) Most of the time (e) Always
(a) I nɔ wan de bi (b) I nɔ kin bi nɔmɔ (c) sɔmtɛm dɛm de (d) bɔku tɛm (e)ɔl di tɛm

75. During the past 12months, how often have you been so worried about something that you could not sleep at night?

75. Insai dis pas 12 mɔnt, ɔmɔs tɛm yu bin gɛt pɔɛl at tay yu nɔ ebul fɔ slip na net?

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

(a) Never (b) Rarely (c) Sometimes (d) Most of the time (e) Always
(a) I nɔ wan dey bi (b) (c) Sɔmtɛm dɛm de (d) Bɔku tɛm (e) ɔl tɛm

76. How many close friends do you have?
76. ɔmɔs padi dɛm yu gɛt?
(a) 0 (b) 1 (c) 2 (d) 3 or more

(a)0 (b)1 (c)2 (d)3 ɔ i pas

SECTION III

These questions are about feelings that young people sometimes have and things that may have happened to you IN THE LAST YEAR.			
77	Has there been a time when nothing made you happy and you just were not interested in anything? Ɛni tɛm bin de we yu nɔ bin gladi ɛn yu nɔ bin gɛt intrɛst pan ɛni tin?	Yes	No
78	Has there been a time when you had less energy than you usually do? Ɛni tɛm bin de we yu nɔ bin gɛt bɛtɛ ɛnaji lɛk aw yu blant gɛt am?	Yes	No
79	Has there been a time when you felt you could not do anything well or that you were not as good-looking or as smart as other people? Ɛni tɛm bin de we yu bin fil se yu nɔ go ebul fɔ du ɛnitin bɛtɛ, yu nɔ fayn, ɔ yu nɔ smat lɛk ɔda pipul dɛm?	Yes	No
80	Has there been a time when you thought seriously about killing yourself? Ɛni tɛm bin de we yu tinkam fɔ kil yusɛf?	Yes	No
81	Has there been a time when doing even little things made you feel really tired? Ɛni tɛm bin de we yu de du ivin smɔll tin sɛf kin mek yu taya?	Yes	No
82	Has there been a time when you couldn’t think as clearly or as fast as usual? Ɛni tɛm bin de we yu nɔ kin ebu fɔ tink bɛtɛ lɛk trade?	Yes	No

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

83	In the last year, have you carried out revenge by doing things like hurting people, spoiling their things or telling lies about them? Insai las ia, yu bin tɔn dɛt gi pipul dɛm lɛk yu du dɛm bad ɔ yu pwɛl dɛn tins dɛm ɛn yu lai pan dɛm?	Yes	No
84	Have you refused to do what your parents or teachers told you to do? Yu bin dɔn dinai fɔ du wetin yu mama ɛn yu papa tɛl yu fɔ du?	Yes	No
85	Have you been irritable or easily annoyed? Yu bin dɔn ɛva vex ɔ kwik fɔ vɛx?	Yes	No
86	Have you done bad things to people on purpose? Yu bin dɔn ɛva du pipul dɛm bad fɔ sɔntin?	Yes	No
87	Have you blamed someone else for your mistakes or for things you did that you shouldn't have done? Yu bin dn ɛva blem smbdi fɔ di mistek dm we yu du ɛn tin dm we yu nɔ sɔpos fɔ du?	Yes	No
88	Have you done things just to annoy people or make them angry? Yu bin dɔ du tin to pipul dɛm fɔ mɛk dɛm vɛx?	Yes	No
89	Have people complained because you were swearing or used dirty language? Pipul dɛm bin dɔn de kɔmplen yu bikɔs yu bin de swɛ ɔ uz dɔti languej?	Yes	No
90	Have you shoplifted-that is, stolen something from a shop when you thought no one was looking? Yu bin dɔn tiff na shɔp we yu fil se nobɔdi nɔ de wach yu?	Yes	No
91	Have you lied to get money or something else you wanted? Yu bin dɔn lai fɔ gɛt mɔni ɔ ɔda tin we yu bin want?	Yes	No
92	Have you snatched someone else's purse or jewellery? Yu bin dɔn jɔg sɔmbɔdi in pɔs ɔ jiwɛlri?	Yes	No
93	Have you broken something or spoiled some place on purpose, like breaking windows, writing on a building, or slashing tyres?	Yes	No

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

	Yu bin dɔn brok sɔntin ɔ pwɛl ples fɔ ɛni risin, lɛk fɔ brok windo, we yu de ryt pan bildin, ɔ yu bɔs taya?	
94	Have you stolen from anyone when they were not around or were not looking? Yu bin dɔn tiff ɛnbɔdi we dɛm nɔ bin de ɔ dɛm nɔ bin de luk?	Yes No
95	Have you been physically cruel to an animal and hurt it on purpose? Yu bin dɔn de wikɛd ɛn du bad to dɛn animal dɛm fɔ ɛn risin?	Yes No
96	In the last year, have you broken into a house, a building, or a car? Insai las ia, yu bin dɔn brok go insai os, bildin ɔ kaa?	Yes No

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT