CHAPTER ONE

INTRODUCTION

Background of the Study

The phenomenon of street children, an offspring of the modern urban environment, represents one of humanity's most complex and serious challenges. No country and virtually no city in the world today, is without the presence of street children (Le Roux, 1998). It is estimated that there are about 150 million street children worldwide (UN, 1990; Scanlon, Tomkins & Lynch, 1998). An estimated 10 million children in Africa live without families, mostly in towns as street children (Kopoka, 2000).

In 1993, the Human Science Research Council (HSRC) of South Africa put forward the following definition for the street child: A street child is any girl or boy who is under the age of 18 and who has left his/her home environment part time or permanently (because of problems at home and or in the school, or trying to alleviate those problems) and who spends most of his/her time unsupervised on the streets as part of a subculture of children who live an unprotected communal life and who depend on themselves and each other and not on an adult, for the provision of physical and emotional needs, such as food, clothing, nurturance, direction and socialization. As defined by UNICEF, there are three types of street children: 'Children at risk' who are defined as poor children with particular risk factors such as poverty and lack of schooling, 'children on the street'- those engaged in some kind of economic activity from begging to vending (most go home at the end of the day and contribute to the earnings of their families); 'children of the street' who actually live on the streets (or outside of a normal family environment; family ties are tenuous in nature and maintained only occasionally and casually (UNICEF, 1986).

Statement of the Problem

Statistics on the prevalence of street children in Nigeria are presently scanty or non-existent (Aderinto, 2000). However, a street child density study undertaken revealed an estimate of 414 children per street in Enugu, 1,959 per street in Kaduna, 1,931 per street in Ibadan. The street child density study was undertaken as follows: fieldworkers

were posted to the busy streets of Kaduna (in the North), Ibadan (in the West) and Enugu (in the East). An actual count of children below the age of 16 found working on the street was made. Those who were merely passing by or who were accompanied by adults were not included (Ebigbo, 2003).

Street children have a multitude of health problems such as malnutrition, respiratory infections, sexually transmitted diseases, including Human Immunodeficiency Virus infection, mental illness, and substance abuse. Health care, if available, is generally fragmented and often not relevant to their needs. Their high-risk existence leads to individual morbidity and has a negative effect on the health of the community. Presently, there is limited research on the health status and health care needs of street youth who are difficult to track and quantify (Sherman, 1992).

Street children continue to suffer a number of health hazards because of their lifestyle. The most common health risks associated with street children are skin diseases, coughs and cold, stomach ulcers, diarrhoea, brain damage mainly due to drug abuse and sexually transmitted diseases (Mehta, 2002). Little local information exists on the general physical health of street children. Trauma and certain infections are more common among children who are street based than among those based at home. In terms of nutrition, however, studies (Aderinto, 2000) have shown that street children fare no worse than other children from similar backgrounds. It has been suggested that astute begging and stealing might actually enhance the nutritional status of street children (Kopoka, 2000).

Justification of the Study

The current socioeconomic situation in the country, made worse in recent times by the economic 'meltdown' has led to an exacerbation of factors which push children to the streets. The phenomenon of street children is thus likely to get worse. Relatively little is known about the impact of street life on biological as opposed to psychological well being of street children (Greska et al, 2007) as most studies have focused on substance use and sexual networking behaviour. Hence street children are more prone to several physical problems, although most research has focused on adverse effects of sexual

activity and drug misuse (Scanlon et al, 1998). While some studies reveal no difference in the nutritional status and growth of street children (Kopoka, 2000), some record a high prevalence of underweight, wasting, stunting (Greka et al, 2007, Thapa et al 2009). Hence, this study aims to determine the physical health and substance use amongst street children in Ibadan municipality.

General Objective

To describe physical health and substance use amongst street children in Ibadan municipality.

Specific objectives

1. To assess the physical health problems of street children.
2. To describe pattern of substance use amongst street children.
3. To assess the association between socio-demographic characteristics and physical health problems of street children.
4. To describe life aspirations of street children.

CHAPTER 2

LITERATURE REVIEW

Introduction

It has been conventional belief that the care, support and upbringing of children and adolescents should be the duty of parents. Such belief has been predicated on age long tradition and norms of societies that at pre-adolescent and adolescent ages, children must be properly socialised at home and in school to prevent them from engaging in antisocial or improper behaviour. The phenomenon of street children contrasts with the culture of family cohesiveness that has been identified as providing a basis for the social structure of traditional societies such as Nigeria. An important strategy of child socialisation in Nigeria and other West African countries is responsibility training (Oloko, 1993). Traditionally, children helped their parents, particularly in those occupations that involve physical labour in rural and low income families. Today, the situation has changed drastically with the withdrawal of adult supervision.

Street children in Nigeria, are predominantly of "working street children rather than of children whose sole means of subsistence and existence is the street (Ebigbo, 2003). Socialisation and nurturance functions of the institution of the family are becoming difficult as rapid urbanisation, widespread poverty, and economic depression continue to plague and characterize the Nigerian situation. As a result, children receive inadequate care and attention from their parents (Ebigbo, 2003). Children are now being sent into the street alone to display or hawk and sell goods unsupervised. Thus while the earlier practice of children selling goods in the company or under supervision of parents could be excused, the current practice of loading children with goods and sending them out on their own is a strange departure from the familiar African experience.(Aderinto,2000)

Definitions of Street Children

In 1993, the Human Science Research Council (HSRC) of South Africa put forward the following definition for the street child: 'A street child is any girl or boy who is under the age of eighteen and who has left his/her home environment part time or permanently (because of problems at home and or in the school, or trying to alleviate those problems) and who spends most of his/her time unsupervised on the streets as part of a subculture of children who live an unprotected communal life and who depend on themselves and each other and not on an adult, for the provision of physical and emotional needs, such as food, clothing, nurturance, direction and socialization.' Inter-NGO Programme for Street Children and Street Youth in the early 1980s defined street children as "those for whom the street more than their family has become their home, a situation in which there is no protection, supervision or direction from responsible adults" (Ennew, 1994).

As defined by Shelter don Bosco a Non Governmental Organisation, A street child is one who: lives on the streets, waste land, or public space most of the time; works in the streets on jobs of low status and low income, lives in the exposed conditions of the street, has no or little parental supervision or other social protection, has either continuous, intermittent or no family contact at all, and is vulnerable to the hazards of urbanization and urban living (Shelter Don Bosco, 2003)

The United Nations adopted the phrasing: "any boy or girl...for whom the street in the widest sense of the word...has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults" (Panter-Brick, 2003).

Save the Children Fund adopts the following definition: A street child is any minor who is without a permanent home or adequate protection.

'Street children' is increasingly recognized by sociologists and anthropologists to be a socially constructed category that in reality does not form a clearly defined, homogeneous population or phenomenon (Glauser, 1990; Ennew, 2000; Moura, 2002). The term 'Street children' covers children in such a wide variety of circumstances and characteristics that policy-makers and service providers find it difficult to describe and target them. Upon peeling away the 'street children' label, individual girls and boys of

all ages are found living and working in public spaces, visible in the great majority of the world's urban centers.

UNICEF categorises street children into the following groupings: 'Children at risk' are defined as poor children with particular risk factors such as poverty and lack of schooling. The largest group in this typology is the "children at risk" category. These are the children of the urban poor and they form the reservoir from which street children emerge (UNICEF, 1984, 1992). 'Children on the street' are children that work on the street during the day and return home at night. They are usually engaged in some kind of economic activity ranging from begging to vending, menial labor such as shoe shining, washing and guarding cars or carrying goods. Most go home at the end of the day and contribute their earnings to their family. They may be attending school and retain a sense of belonging to a family. Because of the economic fragility of the family, these children may eventually opt for a permanent life on the streets. 'Children of the street' have a very limited family contact and live and sleep on the street with little, if any, adult supervision. Family ties may exist but are tenuous and are maintained only casually or occasionally. 'Children from street families' are children who live on the streets with their families. Another category of street children is the 'abandoned street children' who have no contact whatsoever with their parents. Very young children whose parents are abandoned street children are included in the definition of abandoned street children (UNICEF, 1992). The WHO also includes another category of street children called 'children in institutionalized care', who having come from a situation of homelessness are at risk of returning to a homeless existence.

While the distinction between children "on the street" and "of the street" has been useful, some overlaps and grey areas still remain. Some children "of the street" may have been abandoned and rejected by their families while others may have left their families due to prevailing circumstances. It has become increasingly clear that these categories are much more flexible and heterogeneous than originally envisaged, with children frequently moving from one category to the other (Greska et al, 2007). Currently, the focus on discrete categories of street lifestyles has fallen into disuse. Efforts to devise a suitable definition and an appropriate typology of street children

represented the first steps toward a useful conceptual framework to think about the children in question. A classification of street children is still useful, though, as long as it is understood that categories are neither discrete nor necessarily homogeneous, and that they may not always coincide with children's own views about their lives (Panter-Brick, 2003).

Street children are called chinches" (bed bugs) in Colombia, "pivetes" (little criminals/marginals) in Rio de Janeiro, as "pájaro frutero" (fruit bird) and "pirañitas" (little piranhas) in Peru, "polillas" (moths) in Bolivia, "resistoleros" (glue sniffers; Resistol is a major brand) in Honduras, "scugnizzi" (spinning tops). In Tanzania they are known as 'watoto wa mitaani', in Kenya they are known as 'chokorra' and in The Democratic Republic of the Congo (DRC) they are called moineaux or 'sparrows'(Kopoka, 2000). "Saligoman" (nasty kids) in Rwanda, or "poussins" (chicks), "moustiques" (mosquitos) in Cameroon and "balados" (wanderers) in Zaire and Congo (Wikipedia Encyclopedia). These names reflect the attitude of the general populace towards street children. It is apparent that street children are generally stigmatised and regarded as separate from society.

Magnitude of the Problem

According to estimates from the United Nations Department of Economic and Social Affairs, there were about 30 -170 million street children worldwide as at 1986. The large range illustrates how difficult it is to count street children accurately (Scanlon et al, 1998). In 1989, UNICEF estimated 100 million children were growing up on urban streets around the world. 14years later UNICEF reported: 'The latest estimates put the numbers of these children as high as 100 million' (UNICEF, 2002). As at 1990 the United Nations estimated that there were about 150 million street children worldwide. And even more recently: 'The exact number of street children is impossible to quantify, but the figure almost certainly runs into tens of millions across the world. It is likely that the numbers are increasing' (UNICEF, 2005). The 100 million figure is still commonly cited, but has no basis in fact. Similarly, it is debatable whether numbers of street children are growing globally or whether it is the awareness of street children within societies which has grown. While there are understandable pressures for policies to be informed by aggregate numbers, estimates of street child populations,

even at city levels, are often hotly disputed and can distract rather than inform policy makers (UNICEF, 2007). According to estimates from the United Nations, millions of street children live in the various cities around the world, with a large proportion residing in Latin America and Africa (United Nations, 1986) In 1996 it was estimated that there were 40 million children living or working on the streets of Latin America (UNICEF, 1996) and an estimated 10 million children in Africa live without families, mostly in towns as 'street children' (UNICEF, 1984)

According to the findings in the City of Mexico Report in 1991, there were 11,172 street children. 1,020 live in the street and 10,152 working there (City of Mexico Report, 1991). As at 1994, UNICEF estimated that there were 72,000 street children in Bolivia and about 200,000 street children are estimated to be found in the Philippines. Africa and Latin America are estimated to have the larger proportion of street children worldwide however; other continents are not totally empty of this scourge. According to UNICEF, in 1998 there were about 25 million children estimated to be living on the streets in Asia; 400,000 children are thought to live on Bangladeshi streets (Consortium of Street Children, 2007), In Lahore, Pakistan, there are estimated to be 5,000–7,000 street children (Towe, et al, 2009) In India, there are an estimated 11 million street children and in Vietnam 23,000 (Wikipedia Encyclopedia, 2003)

In Africa, there are about 32 million street children (Youth Advocate Programme International, 2004). Around 1 million children are believed to be on the streets of Egypt, most in Cairo and Alexandria (UNICEF, 2007). Kenya is estimated to have about 250,000 - 300,000 street children, while Egypt is estimated to have 200,000 - 1 million and Morocco 30,000 (Wikipedia Encyclopedia, 2003)

Street Children in Nigeria

The phenomenon of street children and its attendant the socioeconomic effects on society needs attention, as every major city in Nigeria has street children with numbers rising (Oloko, 1999, Ebigbo, 2003). The children either live on the street or derive their existence through hawking wares, stealing, or begging. In a density study carried out in Nigeria the following findings were reported over a one-week period, 414 children per street were counted in Enugu, 1959 per street in Kaduna, and, 1931 per

street in Ibadan. Considering a two-hour count per day for five days, this means that there is a street density population of 44.4, 195.9 and 193.1 working children per hour per street in Enugu, Kaduna and Ibadan. The findings also revealed that there was a 1:1 male/female ratio in Enugu; there were 20 percent more girls than boys in Kaduna and there was a 1:2 male/female ratio in Ibadan. In Enugu more children were observed on the streets in the evening, probably indicating that more children attended school in the morning and traded in the evening to supplement family income. In Kaduna and Ibadan there was no marked contrast in the number of children working in the mornings and evenings. This seems to indicate that a large number of children do not go to school at all but are engaged all day in active trading (Ebigbo, 2003).

Factors Predisposing to the Street Children Phenomenon

A recent International Labour Organization (ILO) report on child labour highlighted, three levels of causal analysis which must be taken into account when viewing the issue of street children. These are immediate, underlying and structural levels (ILO 2002). At the immediate level, the reason why a child may leave home and go to work or live on the streets could be as a result of a sudden drop in family income; loss of support from an adult family member due to illness, death or abandonment; or an episode of domestic violence (Ennew & Swart-Kruger, 2003). At the immediate level, community – or mezzo – factors include precarious living conditions, lack of community resources and basic services, low civic participation and social disorganization (Ferguson, 2006). Mehta (2000) corroborates the above construct, stating that the majority of street children originate from slum and squatter settlements. These settlements are generally characterized by lack of basic infrastructure such as water and sanitation, proper drainages means of waste management and roads.

Underlying causes could be chronic impoverishment; cultural expectations, such as the idea that a boy should go to work on the streets as soon as he is able; desire for consumer goods; or the "lure of bright city lights"(Ennew & Swart-Kruger, 2003). The fantasy world of the cinema often presents reasons for children from poverty-ridden rural areas to find themselves on the streets of an unfriendly urban metropolis. (Damodran, 1997)

Structural causes consist of factors such as development shocks, structural adjustment, regional inequalities and social exclusion. Current multi-level approaches to causality are supported and enhanced by a greater understanding of childhood, which incorporates both its constructed nature and the understanding that it is experienced in different ways by children at various ages and with diverse characteristics (Ennew & Swart-Kruger, 2003).

Societal Factors Predisposing to the Phenomenon of Street Children

It is widely believed that urbanization and economic growth are linked and they are regarded as important features of national economic development. However, rapid urbanization also poses enormous challenges for the urban social and physical environment, particularly in terms of the widespread poverty that results from the rapid urbanisation process.

Africa is one of the continents experiencing high population growth rates. With an estimated annual growth rate of 3.6 per cent, Africa's urban population will double from 174 million in 1985 to 361 million by the year 2000 (UNDP, 1990). Yet, Africa is the least urbanized region in the developing world with only 30 percent of its population presently living in towns and cities. However, it has the highest urbanization rates averaging around 4.6 percent per annum which is twice the growth of rural areas, with an annual growth rate of 2.0 percent (UMP Working Paper, 2000). According to estimates from the African Development Bank, 42 per cent of the total number of households in Africa are living in poverty. Many of the urban poor live in slum and squatter settlements with overcrowded, unhealthy housing and a lack of basic services. It is here that the majority of a city's youth and children live. Many children, in a bid to escape from these appalling living conditions, have turned to the streets in search for opportunities (UMP Working Paper, 2000).

The dramatic increase in the number of street children has been linked to societal stress associated with rapid industrialization and urbanization. Conversely, in industrialized countries, inner-city decay and chronic unemployment accompanying economic downturns are held responsible. In agricultural societies, drought and famine may be to blame (LeRoux& Smith, 1998). Poverty, overpopulation, a high rate of abandonment

by husbands, and political unrest are some of the major causes of the phenomenon in Latin America. In a study carried out in South America, poverty, domestic violence, drug abuse and encouragement from peers were the factors leading to street living as stated by the street children interviewed (Abdelgalil, Gurgel, Theobald & Cuevas, 2003)

Family Factors Predisposing to Street Children

The family is a key reference point when people conceptualize children and childhood (Ennew & Swart-Kruger, 2003). Economic and social upheavals have led to the breakdown of traditional family structures and values. Inadequate family incomes have forced children and adolescents into seeking employment in the informal economy. This has resulted in a rise in the number of street children (Ali, Shahab, Ushjima & Muynck, 2004).

Family pathology, which is linked to socioeconomic factors, drives many children from home (LeRoux & Smith, 1998). In a study carried out in Arcaju, Brazil, majority of the street children assessed were from single parent families, most of which are single female headed households. The higher number of female headed households reflects the traditional gender role of the mother maintaining responsibility for the child/children after separation of the couple. Many mothers had new unstable relationships and had themselves experienced adolescent pregnancies. In addition, most parents had started work at an early age and their teenage daughters had often left home and had become adolescent mothers themselves, perpetuating a vicious cycle of low education, low income, and unstable relationships. Also, most of the parents were unemployed with majority of the employed ones were low income earners (Abdelgalil, Gurgel, Theobald et al, 2003).

Matchinda (2000), in a study conducted in Cameroun, reported that there was a significant relationship between parents' income and children's decision to abandon the home in favour of the street. The lower the family income level, the more the children are exposed to the risk of abandoning the home to seek their needs in the street. Findings from a study done in Turkey also indicate that the street children's

familial system is characterized by high levels of conflict, abuse (sexual, physical, emotional), financial insecurity, parental substance abuse, parental divorce or separation and lack of communication (Duyan, 2005).

The Phenomenon of Street Children in Nigeria

The issue of street children cannot be related to a single cause in Nigeria as there are several causes of the problem; and this underscores the complexity of the issue. The phenomenon of street children which is regarded as one of humanity's most complex and serious challenges and has thus been generally attributed to a fall out of the modern environment with its multiple attendant problems, however there are several factors to be considered (Faloore & Asamu, 2009, National Institute on Drug Abuse, 2000).

Many factors have been linked to the proliferation of street children in Nigeria. These include: family disintegration, urbanisation, modernisation, and the impact of HIV/AIDS (Aransiola et al, 2009). While studies on the correlates of street children in foreign countries report such factors as poor communication with parents, single parenthood, incestuous relations and poor teacher-student relation, the situation is likely to be quite different in Nigeria where the problem of lower class poverty may be a significant factor (Aderinto, 2000).

In a study conducted in Bangladesh, 35% of street children indicated that they moved to the streets due to a change in the composition of their family (death of a parent, remarriage or desertion), 30% of the street children stated they were abused or oppressed in their home, 29% made the move to the streets for economic reasons like insufficient family resources and desire to earn money (Greska et al, 2007). However, not all children from impoverished families became street children. Suda (1995) notes, for example, that "a hungry child in an environment of love, care and peace can probably endure lack of material support and still find the home basically more secure than the streets". Therefore, the disintegrating nature of the urban family and the breakdown or the weakening of the African kinship systems in the urban setting could be the main contributing factors to the problem of street children in Africa (Mehta, 2000).

Religious factors are also implicated as a cause of the street children phenomenon. For instance in northern Nigeria where the Moslem religion is predominantly practiced and begging is allowed, young boys and girls lead handicapped adults about on the streets to beg. They receive a pittance for their services (Ebigbo, 2003). Also, there are the 'almajirai' who are enrolled in quranic schools and beg for alms for their feeding and sustenance.

The Problem of Street Children

The problem of street children is growing worldwide, more so in African countries. The presence of large numbers of children sometimes as young as 3 years old on the streets in urban areas was virtually unheard of prior to the transition to a market economy. However, it is now a growing problem in most African cities and towns (Kopoka, 2000). Decades ago, Africa witnessed rapid and wide ranging socioeconomic and political changes, such as rapid urbanization, population growth, wars, internal crises and increasing disparities in wealth.

It is instructive to note here, that, the emergence of large numbers of children on the streets of Africa today was partly a reflection of the extreme poverty and the lack of social services that are endemic in many highly populated urban areas in Africa (Faloore & Asamu, 2009). Kopoka in his paper on street children remarked: 'Strolling through a market or past a hotel or at the roadside of any major street in the center of most African capitals, towns or urban areas and you cannot fail to see them. They are stopping cars and people to beg or to ask for work. Others may be shining shoes, selling sundry articles of uncertain origin, or hurrying to wash the windscreens of cars stopped at traffic signals. Yet others would be roaming around or gathered in small groups waiting for something to do.' (Kopoka, 2000).

Socio-demographic characteristics of street children

Olley (2006), reports that few street youth in Ibadan had been raised by both parents. 27.8% had been raised solely by their fathers, 32.5% had been raised solely by their mothers and 30.2% by guardians and relatives with majority of fathers practicing

polygyny. Most parents were also poorly educated, having less than 6 years of formal education. These findings corroborate Abdelgalil, Gurgel, Theobald et al (2004) who reported that two thirds of parents of street children had high illiteracy levels, and only a few had completed elementary education. Findings reported by Aderinto (2002) also corroborate the above as it reveals that a higher percentage of fathers of non-street children had higher levels of formal education than their contemporaries on the street. He also reported that more than two-thirds of mothers of street children did not even have any formal education at all.

The typical age of a street child varies from place to place. In developing countries children as young as eight years, old live completely on their own. In developed countries, street children are usually over the age of twelve years old (WHO, 2000). The age profile of African street children varies between countries (Veale & Dona, 2003). Although street children are not a uniform group, research findings on African street children indicate that their ages range from two to eighteen years and, although the majority are boys, both sexes are represented. Surveys of street children in Latin America suggest that their ages range from eight to seventeen years, with the average age on entering the street being nine years.

Many Nigerian studies (Aransiola et al, 2009, Aderinto, 2000, Adebiyi, Owoaje & Asuzu, 2008) report that most street children in Nigeria are often aged between fourteen years and eighteen years of age, while few of them still are below 10 years of age.

Sex Distribution

Figures from population census conducted in a number of countries show that in general population, there are more females than males, however, almost all reports indicate a clear gender imbalance among street children: Scanlon et al (1998) reported that 75–90% of Latin American and African street children are male (Scanlon et al, 1998, Lalor, 1999). The proportion of females among street children was reported to be less than 30% in developing countries and about 50% in many developed countries (WHO, 2000)**.** Aderinto (2002) reported a male preponderance (91.6%) amongst the street children studied in Lagos and Ibadan. Aransiola et al (2009) also reported a majority of males among the street children studied. However, they noted a consistent rise in the proportion of female street children as one moves from the north (Kaduna),

through the southwest (Lagos) and to the southern part of Nigeria (Port Harcourt). It has been suggested that the higher representation of males among street children is because, while boys become independent from an earlier age and that girls are taught to cope with poverty while staying at home (Abdelgalil et al, 2004). In addition, alternative strategies open to females such as mothering younger siblings and domestic employment open to females might reduce their presence on the streets (Scanlon et al, 1998).The WHO has also suggested that street girls may be less 'visible' to researchers or educators than the boys.

Educational Attainment of Street Children

Most street children have had a chance to be enrolled in school, but later had to leave due to poverty; poor school performance etc. In a study among street children in Pakistan, almost all respondents had dropped out of school or were unable to continue with their schooling. Sixty percent of children had attended school at some time; however, fewer girls (7%) had ever been enrolled compared to boys (53%), with poverty being the main reason given for leaving school (Ali et al, 2004).A rapid assessment carried out by the United Nations in Alexandria, Egypt revealed that 70 percent of street children were school drop-outs and 30 percent had never attended schools in the first place. Data on educational level of street children in Nigeria revealed that 26.7% dropped out from primary school 23.6% completed primary school and 26.7% dropped out from secondary school, while 23.6% did not have any formal education at all, zonal disaggregation showed that a higher percentage of street children in the northern part of Nigeria (46.2%) did not have any formal education at all (Aransiola, 2009).

Social behaviour and characteristics adopted by street children

Street children as any social entity have a distinct culture with a structure that defines roles and responsibilities of each member. Street children depend less on their families or other people who they consider strangers and cannot share their experiences with them. Instead, they rely more on the meaningful ties they have established within their groups or gangs (Mehta, 2000). These gangs exist mainly for enhancing survival chances and often live and operate in designated territories. Most gangs manifest some kind of social structure, where there is likely to be a leader and other ordinary

members. The leader is usually recognized by other members for his authority and ensures security and safety of his gang members, organizes the gang and may assign responsibility to members. However, some gangs are not homogenous and lack any distinct social structure. In such gangs the decision-making process tends to be spontaneous (Mehta, 2000). Different gangs usually compete for territorial space and resources. Often they fight over who is supposed to dominate which area and who should have access to which resources. For instance, a gang involved in scavenging for waste materials in a given area would not allow a rival group to engage in a similar activity in their territory. Competition between groups tends to increase cohesiveness within a group i.e., the greater the cooperative effort within a group, the more likely it is to develop competitive friction with other groups pursuing similar objectives. In some cases, however, competitive gangs may coalesce in order to achieve super-ordinate goals that cannot be achieved by each group separately (Mehta, 2000)

Gangs/groups of street children also specialize in specific activities. Gangs involved in begging, pick-pocketing and prostitution operate in certain strategic areas e.g., the Central Business District. The differentiation of functions (roles) within a group normally provides for organized division of effort within the group and enhances group effectiveness.

Survival Strategies

Street children engage in a variety of economic activities in order to earn a living. Although predominantly concentrated in the informal sector, child workers in general encompass a broad range of labour environments, including agriculture, fishing, manufacturing, tourism, domestic service, construction and the street milieu. Majority of these activities are menial and include rag picking, hawking of various wares-sachet water, snacks etc. flower vending, scavenging, shoe shining, begging, head-loading, cart/truck pushing (porters), car washing, bus conducting. Older street children are also reported to be likely to engage in illegal activities like sex work, drug couriering and arson while younger ones may engage in stealing and pick-pocketing (Damodran, 1997, Aderinto, 2000, Ebigbo, 2003, Ali et al, 2004, Huang et al, 2004,Aderinto, Olley, 2006, Thakpa, Ghatane & Rimal, 2009).

However, most of these activities are not organized and lack any official recognition thus most are regarded illegal. As a result, many of these children are ignorant of any advancement opportunities for securing credit schemes and are ill organized to receive any financial assistance from recognized micro-enterprise financial institutions (Mehta, 2000).

Earnings

Research in Pakistan reveal street children may earn even less (no more than US 1$ - daily) despite the fact that more than 85% of the street children, particularly boys, were working for 8–12 hours daily and getting fewer than 8 hours of sleep (Ali et al, 2004). However, Thakpa, Ghatane & Rimal (2009) report earnings of between Rs 50-100 and above amongst street children in Nepal. Not only are most street and working children paid very poorly compared to adults undertaking similar jobs, their working conditions are more hazardous and they are less likely to be protected by the employment legislation (Mehta, 2000).

The average daily wage of a sample of street children studied in Ibadan is N239 (2 US dollars); however depending on nature of work youth could earn as much as N3000 (approximately $US 22) per day (Aderinto, 2000). Bus conducting as reported by Aderinto (2000) fetches the highest earnings reported by street children.

Furthermore, street children have been reported to engage in economic activities that are readily available hence they may change from one activity to another or engage in more than one economic activity at a time. It is also worthy of note that economic relationship among street children is often conflictual, intense competitive and antagonistic. Since their survival is so important, self interest becomes paramount as everyone tries to get engaged in one activity or the other (Aderinto, 2000).

Problems of Street children

The World Health Organisation classifies problems of street children into three broad categories: social, physical and psychological problems. Social problems are said to include poverty and illiteracy, discrimination and lack of available resources and violence. Physical problems include lack of adequate nutrition, injuries, common diseases and sexual and reproductive health problems. A transitory lifestyle, mental

health, substance use and a stressful past were labelled psychological problems (WHO, 2000).

However, street children's perception of their own problems and needs are less complex, not classified and basic. An analysis of focus group discussions conducted among street children in Ibadan, Nigeria showed that health related issues, accommodation and the problem of 'big boys' in other words, older street youth are the major challenges reported by street-based children. Other problems (mainly affecting boys) are issues with feeding, ritual makers and police (Faloore & Asamu, 2009).

Physical Health Problems of Street Children

Street youth worldwide are widely acknowledged as being particularly vulnerable medically and socially (Craig & Hudson, 1998). Street children have a multitude of health problems such as malnutrition, respiratory infections, sexually transmitted diseases, including Human Immunodeficiency Virus (HIV), mental illness, and substance abuse. Garbage dumps in particular attract many street scavengers. These pose a major health hazard, particularly because of the presence of hospital waste in these dumpsites (Mehta, 2000). In contrast, some studies conclude that children of the street are no less biologically fit or are actually somewhat fitter than other poor children (Panter-Brick et al, 1996, Kopoka, 2000). One possible explanation for the finding that children living on the streets may not be as vulnerable as originally assumed is that psychologically and biologically fitter children may be more likely to make the decision to move to the streets and/or once the decision to move to the streets has been made, may be more likely to remain there.

Trauma and certain infections are more common among children who are street based than among those based at home (Kopoka, 2000). Malaria is another major concern faced by street children in some regions. This is because they are exposed to mosquitoes while sleeping out in the open. Although malaria can be treated, these children are at greater risk because they lack access to health care and often suffer from prolonged malnutrition (Orme & Seipel, 2007). Studies assessing health problems of street children revealed that 80%- 100% of them reported at least one episode of illness (Olley, 2006, Thapa, Ghatane & Remal, 2009). In a study carried out

in Awassa, Ethiopia, malaria -like febrile illnesses (40.7%) followed by respiratory tract illnesses (31.6%) and diarrhoeal diseases (4.3%) were the major health problems reported (Sorsa, Kidanermariam, Erosie & 2002) .Greska et al (2000) also reported respiratory diseases and diarrheal diseases as the most frequently reported by street children in Bangladesh. A study conducted in Nepal reported skin problems (dry and scaly skin, 91.7%, head lice infestation, 81.2%), as the most common health problem in the 6 months prior to the study (Thapa, Ghatane and Remal, 2009). Mehta (2000) also reported that the most common health risks associated with street children in Africa were skin diseases, coughs and cold, stomach ulcers, diarrhoea. Research findings from Dharan municipality, Nepal revealed that all of the subjects had at least one or more health problems. The most common health problems were head lice infestation (81.2%), headache (66.7%), cut injury (60.4%), common cold (52.1%), burning micturition (47.9%), cough (47.9%), underweight (43.8%), abdominal pain (39.6%), joint pain (31.2%), leg cramps (25%), chest pain (18.8%), and skin lesions (16.7%) (Thapa et al, 2009). Olley (2006) stated in his findings that malaria-like/febrile symptoms were the most commonly reported illness amongst street children in Ibadan and majority of the respondents resorted to self medication as a treatment for these symptoms while fewer utilized to modern and traditional sources of health care.

Sorsa, Kidanermariam & Erosie (2002) also report a significant association between age and health problems as more (85.1%) of younger street children (below 10 yrs) reported health problems. However, although more (57.1%) of the homeless children reported health problems compared with those who still lived in houses (42.9%), the difference was not statistically significant.

Injuries

As regards injuries, in a study by Kudrati, Plummer and El Hag Yousif, 2008 carried out in Khartoum, Sudan most children reported having had injuries/wounds (77%). Also, females reported more safety concerns while ill and living on the streets than their male counterparts.

Street children's access to medical services is quite limited. Street and homeless are recognised as a medically underserved and vulnerable population (Ensign, 2004).

Health care, if available, generally lacks continuity and is often not relevant to their needs. Kudrati, Plummer & El Hag Yousif (2008), report that while about 70% of street children mentioned that their main source of health care was a hospital or clinic, slightly more than 12% reported primarily consulting traditional healers and sometimes, children used both modern and traditional medicines, particularly for illnesses which does not easily resolve. In a study conducted in Awassa, Ethiopa, findings stated that among the street children and women who reported health problems, 63.4% attended government health facilities (hospitals and health centers), 15.7% used traditional medicine and 9.1% attended private health institutions. Furthermore, 6.6% of those who reported health problems did not obtain medical treatment for economic reasons (Sorsa, Kidnemariam, Erosie, 2002). In Nigeria while 23.7% attended modern hospital, 7.7% attended traditional hospital, 62.7% self medicated and 5.9% did not use any treatment (Olley, 2006).

Their high-risk existence leads to individual morbidity and has a negative effect on the health of the community. Most street children are ignorant of the existence of health services or cannot afford them. Homeless adolescents experience a variety of health-related concerns, for which they rarely access health care services (Barkin et al, 2003; Sorsa, Kidnemariam, Erosie, 2002). Some barriers they encounter are fears that they will experience discriminatory attitudes and be negatively judged by health providers and/or inability to afford cost of treatment (Sorsa, Kidnemariam, Erosie, 2002).

It is possible that health professionals' negative and contemptous attitudes to homeless individuals and treat them with contempt thus dissuade this population from accessing needed health care and, in turn, contribute to their poor level of health. In view of the forgoing, the finding that street children keep away from medical facilities is understandable (Mehta, 2000, Haldenby, Berman & Forchuk, 2007). As a result of the type of life they lead compounded by lack of access to medical services, skin diseases, lacerations from fights, intestinal illnesses, and infections that street children suffer from often go untreated. Ensign and Bell (2004) concluded that health-seeking behaviours differed by gender. Female youth sought care more often and typically preferred to be accompanied by a friend.

Nutrition

Some studies report that street children are not any worse than other children from similar backgrounds and that begging and pilfering might actually enhance their nutritional status (Kopoka, 2000). Many reports(Sherman, 1992, Greska et al, 2007, Thapa et al, 2009) state otherwise, mentioning that nutritional problems: stunting and underweight to a greater extent usually plague street children and that most street children also suffer from malnutrition due to inadequate diet (Mehta, 2000). According to the causal model of malnutrition (UNICEF, 1998) caring capacity plays a central role in the nutritional status of children. The United Nations Office on Drugs and Crime (UNODC) reports that street children are a malnourished sub-population subsisting on an inadequate diet. In a study assessing the growth and health status of street children in Dhaka, Bangladesh, 67.6% of street children were stunted while 71.8% were underweight, thus indicating an overlap (Greska et al, 2007). Ali et al, 2004 in their research carried out amongst street children in Pakistan, showed that street children did not attain their full potential height for age; indeed, stunting was prevalent in 20% of the sample, 25% were underweight and 12% were wasted. This was attributed to insufficient food intake and frequent episodes of diarrhoea during early childhood. It was also noted that stunting was more prevalent among street boys than street girls.

Violence among Street Children

A report by the Consortium for street children shows street children accumulate a range of experiences of violence from an early age. The United Nations Office of Drug Control and Crime Prevention (ODCCP) reports that eighty percent of the children in Egypt are exposed to real or constant threat of violence from employers, hostile-abusive community members, and their peers(Mehta, 2002).

Evidence is strong that children who experience abuse at home,are in fragile families; live in poverty-afflicted neighbourhoods confront risks in the street, experiencing violence in their premature entry into the world of work. Their access to educational and health services is erratic, discriminatory and exclusionary. They also may be subjected to abuse and neglect in detention centres and welfare homes designed to protect them and may be stigmatized and shunned by mainstream society. Children

who work or live on the streets are recognized as being particularly at risk of violence (Pinheiro, 2006).

Lalor (1997) examined in some detail the victimization experienced by street children in Addis Ababa and reported that they experienced widespread abuse. Interviews with 28 street in boys revealed that being beaten was a weekly occurrence for approximately one third of the sample. More than half reported being "regularly" physically attacked on the streets. Injuries from stabbing, slashes from razor blades, fractured skulls, and broken bones were quite common even among this small sample. Such injuries are most often inflicted during fights with other street boys. Disputes were said to arise over "rights" to work in a particular area or perceived insults. Theft against street boys, particularly younger boys, is widespread. It is not an exaggeration to say that street boys are likely to be robbed of anything remotely valuable, usually by older street boys. Several street youths explained that they had been robbed, threatened, and ridiculed or forced to witness physical fights (Haldenby, Berman, Forchuk, 2007). Much of the violence experienced by street children in public spaces is attributed to police, and other risks of abuse come from street inhabitants and members of the public (Kudrati, Plummer, El Hag Yousif, 2008).

Younger girls are a particularly victimized group. Those in their early teens are routinely threatened, intimidated, and robbed by older boys. Those that refuse to part with their earnings are often beaten into acquiescence. Girls *on* the street who sleep at home experience considerably less victimization than those of the street (i.e. who sleep on the street) (Lalor, 1999). Sexual abuse, including rape and forced prostitution is a major problem experienced by girls on the streets (Kudrati, Plummer, El Hag Yousif, 2008)

Substance Use

Studies have found that between 25% and 90% of street children use psychoactive substances of some kind. The percentage of substance users among street children varies greatly, depending on the region, gender and age (WHO, 2000). Street children's relations with street gangs and drug use are amongst those areas which are

evolving rapidly, influenced by cultural change and drug availability (Thomas de Bénitez, 2007).

The types of psychoactive substances street children use can be many and varied and it may be difficult to determine what substances they are using. They include but is not limited to the following: Alcohol, which is found in wine, beer, spirits, home-brew, some medicinal tonics and syrups (e.g. cough syrups), some toiletries and industrial products.
Nicotine a stimulant found in cigarettes, cigars, pipe tobacco, chewed tobacco, snuff, nicotine gum, spray, skin patches. Opioids and hallucinogens e.g. LSD (Lysergic Acid Diethylamide), mescaline: made from the pulp of the peyote cactus; psilocybin, a hallucinogen found in some mushrooms, phencyclidine (PCP) which was used as an animal tranquilliser and preparations containing different concentrations of cannabis. Various forms of cannabis containing preparations include: marijuana the leaves and flowers of the marijuana or hemp plant, hashish (oil and resin), made from the resin of the flowering heads of the plant, tablets containing THC (Tetrahydrocannabinol, the main active ingredient in cannabis) etc. Other substances used by street children include hypno-sedatives e.g. benzodiazepines as well as inhalants- aerosol sprays, butane gas, petrol, glue, paint thinners, solvents, amyl nitrite (poppers). Also, stimulants, including caffeine, cocoa products like cocoa leaves and paste, cocaine, amphetamines, MDMA whose street name is ecstasy which has both stimulant and hallucinogenic effects (WHO, 2000).

Lalor, 1999 reported that drug use among street children would appear to be a relatively controlled activity involving drugs such as inhalants, alcohol, or hashish. Vulnerable children and youth frequently abuse inhalants. Unlike other drugs of abuse,inhalants are defined by their route of administration and are mostly legal substances (such as artand office supplies, industrial chemicals, or aerosol propellants) which are easily available, inexpensive, and used primarily by disadvantaged groups (NIDA, 2000). Younger street adolescents rarely use hard drugs or experience the addiction associated with them. Inhalants are often the first abused substance because they are inexpensive and mostly legally available, but in some communities the first drug of abuse is alcohol, tobacco, marijuana, or a coca product. Injection drug use was

reported most commonly in developed countries (Olgar et al, NIDA, 2000), probably because these vulnerable children and youth there tend to be older than their counterparts in developing countries, and injection drug use appears to be related to age and physical and emotional development. There is evidence that injection drug use is increasing among vulnerable children and youth in some regions of both transitional and developing countries NIDA, 2000).

Life Aspirations of Street Children

Most of the street children studied by Orme & Seipel (2007) in Ghana indicated that working through their present challenges was more important to them than recounting the events that brought them to the streets. Although all the children willingly disclosed their pasts, they did not elaborate or wish to focus on their childhood backgrounds. Moreover, Ali et al (2004) reports that most children were working for food on a daily basis; thus, when asked how they saw their future, the majority stated that they never had the time to think of the future. Those boys, who did, though, mentioned preferred professions of soldier, mechanic, and doctor while girls cited becoming a teacher or doctor. Approximately 44% of the street children thought that in order to achieve their ambition, education was an absolute must, and more than half were willing to rejoin school if given a chance.

CHAPTER THREE

MATERIALS AND METHODS

Study Area

The study area was Ibadan municipality, Oyo State with particular focus on areas where street children are predominantly present- motor parks, markets and major junctions and roundabouts. Ibadan is the largest traditional, urban centre in Africa with an estimated population of approximately 3.5million (National Population Commission, 2006). Ibadan municipality comprises five local government areas- Ibadan North, South-east, South-west, North-east and North-west. There are about 1,338,660 people Ibadan municipality (National Population Commission, 2006). Ibadan, which is an old city-state, constitutes many tribes, but is dominated by Yoruba-speaking people.

Study Sites

The respondents were recruited from two randomly selected local governments- Ibadan North-East and South-East Local Government Areas.

Ibadan North-East Local Government

Ibadan North East local government was created on 27th August, 1991. It was carved out of the defunct Ibadan Municipal Government and derived its name from the metropolitan nature of the area [12.5sqkm} it covered then (12km radius with the Mapo as the centre). The Local Government has its administrative headquarters located along the Iwo road axis of Ibadan. It has an estimated population of 340,972 comprising 168,861 males and 172,110 females (National Population Census, 2006).

The local government has 11 political wards with two State owned health facilities (St. Peter Maternity Hospital, Aremo and BCOS Clinic), 19 Primary Health Centers/Maternity center and 58 number of registered private health institutions.

There are a number of major motor parks within the LGA from where vehicles bound for neighbouring states take off.

There are several market places eg Gate and Oje markets. Those selected from Ibadan North-east include: Iwo Road junctions and motor parks, Oje, Gate and Labiran Markets.

Ibadan South East Local Government Area

Ibadan South East local Government, Mapo is one of the five local governments carved out of defunct Ibadan Municipal Government in May 3rd 1989. It covers an area of about 58.251 square km of land with an estimated population of 274,559: 134,755males and 139,804 females (National Population Census, 2006). The local government has 12 political wards with 7 Primary Health Centres/Maternity center and 44 registered private health institutions (Oyo State Health Facility Directory, 2008). The following sites were visited in Ibadan South east: Beere market, junction, Labo market, Oranyan market and junction, Orita-Aperin major junction, and Oja- Oba market. These areas are densely populated and people who reside around there are predominantly traders.

Study Population

The study population included street children which was defined as any girl or boy who is between the ages of eight and seventeen and who has left his/her home environment part time or permanently (because of problems at home and or in the school, or trying to alleviate those problems) and who spends most of his/her time unsupervised on the streets as part of a subculture of children who live an unprotected communal life and who depend largely on themselves and each other, for the provision of physical and emotional needs, such as food, clothing, nurturance, direction and socialization.

Study Design

The study was a cross-sectional study which utilized both qualitative and quantitative methods of data collection.

Study Instruments

Questionnaire/Interview Schedule

Data was collected using an interviewer-administered questionnaire containing structured and semi-structured questions which addressed each of the previously stated specific objectives. It was translated to Yoruba language in order to adapt it to the needs of a non literate respondent. The questionnaire was also back-translated to English to ensure that the questions retain their original meaning. The questionnaire was pre-tested in a local government area which was not used for the main study.

In-depth Interview Guide

In-depth interviews (two street children were interviewed) in each study of the locations, were carried out. Children found at data collection sites (markets, motor parks) without adult supervision with which the researcher established a good rapport were purposively selected. This was done with an interview guide comprising questions which were aimed at eliciting information to corroborate information yielded from the questionnaire on the pathways/reasons for being on the streets. The interview also aimed to elicit information on respondents' perception of safety and experiences of threats on the streets. The interview also aimed to corroborate information on health challenges experienced by street children. A tape recording of each account was made and transcribed. Transcripts were read and re-read after which responses were categorized into themes and summarised.

Sampling Technique

A two-stage sampling technique was used. First, two local government areas- Ibadan north east and south east were randomly selected from the five that fall under Ibadan municipality. A list of cluster sites comprising major markets, motor parks, junctions and roundabouts where street children are commonly found in each local government. Cluster sites reported to have the largest population of street children were visited in each LGA.

Then, a total population sample of all the street children present (seen) at each cluster site as at the time of data collection was taken. All street children present at each site were interviewed after informed assent had been obtained. The following cluster sites

were selected from Ibadan North east: Iwo Road junctions and motor parks, Oje, Gate and Labiran markets, while, Beere market, junction, Labo market, Oranyan market and junction , Orita-Aperin major junction and Oja- Oba markets were visited in Ibadan South east.

Sample Size Estimation

In a recent study done in Dharan Municipality, Nepal, it was reported that 93.8% of the street children reported having had at least one of the physical ailments in the last six months (Thaka, Ghatane & Rimal, 2009).

Using the sample size formula for single proportions:

$$\frac{(Z\alpha + Z\beta)^2 pq}{d^2}$$

Where, z= 1.96, standard normal deviate

α= level of significance

β=Type II error

Power=1-β, 80%, 0.84

q=93.8% 1-p=6.2%,

d= level of significance, 5%

$$S = \frac{(1.96+0.84)^2 0.5x0.5}{0.05^2} = 182$$

This was multiplied by 1.5 to adjust for clustering, (design effect),

182 x 1.5= 273

A minimum sample size of 273 respondents was calculated; however a total of 304 street children eventually participated in the study

Scope of the Study

The World Health Organization in the first module of the series of publications titled 'Working with Street children' identifies three categories of problems that street children encounter. They are: social problems (which include violence, social discrimination, poverty and lack of resources, substance use), psychological problems (which comprises their transitory lifestyle and mental health), and physical problems which include nutrition, injuries and common diseases (WHO, 2000).

This research elicited information on the physical health problems of the street child. These problems, for the purpose of this study included those in the following categories: nutritional problems, injuries, as well as common diseases. Nutritional problems were assessed using the following indices: dietary intake, stunting (height for age), wasting (weight for height), underweight (weight for age) and Body Mass Index for Age. Common diseases as defined by this study included febrile conditions marked by symptoms such as: fever, malaise, nausea and vomiting, diarrhoea, chest pain, joint pain and headaches. A serious injury as defined by this study was one that kept the respondent away from his daily routine for 24hrs or more and/or required the respondent to seek treatment.

Also, information on ever and current use of psychoactive substances was elicited

Inclusion criteria

Street children who were aged 8 to 17 years were included in the study.

Exclusion Criteria

Street youth older than 17years were not included in the study. This is in line with the United Nations definition of a child and anyone 18 and above would not be regarded as such. Those younger than 8 years were also excluded as they may have not been able to give adequate responses to questions posed.

Data Collection Instrument & Procedure

a. A semi-structured questionnaire which obtained information on the following was used

i. Socio demographic and family characteristics.
ii. Reasons for being on the streets and/or working on the streets.
iii. Physical health problems experienced in the three months prior to the study. These physical health problems include serious illness (A serious injury as defined by this study was one that kept the respondent away from his daily routine for 24hrs or more and/or illnesses/ailments for which treatment was sought), injuries. Nutritional Status assessed by obtaining and recording weight and height measurements
iv. Future plans and life aspirations.

b. An in-depth interview guide, which contained basic demographic information, reasons for being on the streets (leaving home), perception of safety and future plans was utilized. Interviews were tape-recorded and transcribed daily.

Weight measurements were taken with the use of electronic weighing scale which was standardised daily to ensure reliability. Weight was measured to the nearest 0.1 kg while participants were shoeless and wearing light clothing. Height was measured to the nearest 0.1 cm with mobile portable stadiometer. The scale and stadiometer were checked daily to ensure they were in good working condition.

Data Analysis and Presentation

After the data was collected, it was analysed using the Statistical Package for Social Sciences version 15.0. Frequencies were generated and chi square tests of association were carried out between selected socio demographic characteristics and the outcome variables (history of health problems in the last three months, history of at least one symptom in the last thirty days). Descriptive statistics- mean, median and range were computed for quantitative variables like age, earnings and cost of treatment.

Height for age, weight for height, weight for age, and Body Mass Index for age z-scores were calculated using Epi Info (Nutrition) statistical package and compared to the NCHS/CDC 2000 standard reference curves. Z-scores of the previously stated parameters less than 2 standard deviations were regarded as stunting, wasting and underweight respectively. Z-scores for Body Mass Index between -2 and +2 standard deviations were classified as normal, < -2 to -3 was classified as moderate thinness, while values less than -3 were classifies as severe thinness.

Each in depth interview account was tape-recorded and transcribed. Transcripts were read and re-read after which responses were summarised and categorised into themes and summarised in a narrative manner. Relevant quotes were cited.

Ethical Considerations

Ethical approval was obtained from the UI/UCH Institutional Review Committee (IRC).

1. *Confidentiality of Data*

The respondents' informed assent was obtained after provision of adequate, clear and complete information about what the study entailed. For street children who belonged to street families, consent was sought from their parents who were around the same vicinity. The researcher also ensured that confidentiality of information disclosed by respondents was strictly maintained as names were not written on questionnaires.

2. *Statement of Translation of Questionnaire and Consent forms to Local Language for Easy Communication*

The questionnaire and consent forms were translated to Yoruba language to cater for the needs of the non-literate respondents. They were also back translated to ensure that the original meaning was retained.

3. *Beneficence to Participants*

Incentives, (a face towel) were given to each participant. This was done to compensate for the time they might have spent away from the economic activities they usually were involved in. Asides this token benefit, results of this study will be communicated to stakeholders (Non-Governmental Organisations, Community-based Organisations and other relevant agencies), to give direction to interventions aimed at this category of children.

4. *Non-maleficence*

This study posed no harm and required only 15-25minutes of the respondents time to fill the questionnaires and obtain weight and height measurements.

Limitations of the Study

This study encountered the following limitations.

1. A proportion (about 25%) of the respondents did not know their exact dates of birth and some were not certain of their years of birth but gave estimations. Hence, the accuracy of the ages stated was affected.
2. Also, some mothers eight of prospective Hausa respondents in Iwo road declined to be interviewed as permission needed to be sought from their fathers who were unavailable.

CHAPTER FOUR

RESULTS

The results are presented in the following sections:

Section A: Socio-demographic and family characteristics of the street children

Section B: Respondents' experience of street life, survival strategies and life aspirations.

Section C: Physical health problems of street children

Section D: Factors associated with the occurrence of physical health problems among the street children.

Quantitative data are reported alongside quantitative data.

SECTION A: SOCIO-DEMOGRAPHIC AND FAMILY CHARACTERISTICS OF THE STREET CHILDREN

Of the 304 street children interviewed, 267 (87.5%) were male and 12.2% where females, 269 (88.5%) where in the age group 14-17years and the mean age was 15.2 $\pm$ 1.4 years (range, 9 - 17 years). Two hundred and ninety six (97.3%) were Nigerian, 1.6% from Niger and 1% Togolese. As regards ethnicity, 299 (98.4%) were Yoruba, 0.3% Igbo and 1.3% from other tribes; 233(76.6%) were Muslims and 70(23.3%) were Christians.

In-depth interviews revealed similar findings as nine males and one female were interviewed and with their ages ranging from 9 to 17 years. All the respondents were Yoruba and majority were Muslims. Most of the respondents were from polygamous homes while others were brought up by single parents, one was an orphan. Majority were not currently enrolled in school. They engaged in economic activities like scrap-picking, cart-pushing and hawking.

Table 4.1: Socio-demographic characteristics of respondents

Socio-demographic Characteristics	N(304)	%
Sex		
Male	267	87.8
Female	37	12.2
Age Group		
9-13	35	11.5
14-17	269	88.5
Nationality		
Nigerian	296	97.3
Togolese	5	1.6
Nigerien	3	1.0
Ethnicity		
Yoruba	295	97.0
Igbo	1	0.3
Other	8	2.6
Religion		
Christianity	70	23.0
Islam	233	76.6
Traditional African Religion	1	0.3

As regards family characteristics, 155 (51.1%) of the respondents reported being from polygamous home settings, i.e. their fathers had more than one wife. One hundred and sixty four (54.0%) stated that their mothers did not reside with their fathers, 16.4 % lived with both parents, 20.4% lived with a single parent (16.4%- mother alone, 4% father alone), 35.2% lived with friends, 19.8% lived with other relatives (8.6%- grandparent, 6.8%- aunt or uncle, 3.6%- older sibling, 1%- other relative).

Forty-three percent did not know their father's level of education, 28.7% of the fathers had secondary school education. Four (1.3%) fathers had tertiary education. About 30% of respondents' mothers had primary education. A quarter (25.3%) of their fathers were said to be artisans and 67.4% of the mothers were traders.

Table 4.2a: Family characteristics of respondents

Family Characteristics	N(304)	%
Family Type		
Monogamous	135	44.4
Polygamous	155	51.0
Not known	14	4.6
Mother lives with father?		
Yes	126	41.4
No	164	54.0
Not known	14	4.6
Both Parents Alive?		
Yes	229	75.3
No	62	20.4
Not known	13	4.3
Father's Level of Education		
No Formal Education	7	2.3
Vocational Training	10	3.3
Primary education	64	21.0
Secondary education	87	28.7
Tertiary Education	4	1.3
Not known	132	43.4

Table 4.2b: Family characteristics of respondents continued

Family Characteristics	N(304)	%
Mother's Level of Education		
No Formal Education	9	3.0
Vocational Training	7	2.3
Primary education	90	29.6
Secondary Education	56	18.5
Tertiary Education	3	1.1
Not known	139	45.7
Father's Occupation		
Artisan	77	25.3
Transport Worker	61	20.1
Trader	45	14.8
Civil Servant	22	7.2
Policeman/Soldier/Other Uniformed Personnel	14	4.6
Unskilled/Menial worker	13	4.3
Skilled/Professional	8	2.6
Islamic Cleric	4	1.3
Not known	27	8.9
Other**	21	6.9
Mother's Occupation		
Trader	205	67.4
Artisan	21	6.9
Housewife	20	6.7
Skilled/Professional	8	2.6
Civil Servant	5	1.6
Unskilled/Menial Worker	5	1.6
Farmer	2	0.7
Other***	8	2.6
I don't know	30	9.9

* Neighbour, parents' friend**Security/night guard, odd jobs, farmer***Maid, Odd jobs

Majority 293 (96.4%) of the respondents had been enrolled in school. However, only 79 (26%) were currently enrolled in school. Of those currently enrolled in school, 15.2% were in primary school 44 (55.7 %) were in junior secondary classes, 29.1% in senior secondary classes. Thirty nine (50.6%) of those currently schooling attended school five days a week, 37.9% thrice a week and 7.6% once or twice a week.

Table 4.3: School enrolment of respondents

School Enrolment	N(304)	%
Ever been in School		
Yes	293	96.4
No	11	3.6
Currently in School		
Yes	79	26.0
No	225	74.0
Class (if Currently in School) n=79		
Primary	12	15.2
Junior Class	44	55.7
Senior Class	23	29.1
Frequency of School Attendance n=79		
Once or twice	6	7.6
Thrice a week	30	37.9
Four times a week	3	3.8
5 days a week	40	50.6

The table below (4.4) presents respondents' reasons for dropping out of school. About half of the respondents, 109 (50.9%), stated lack of funds to continue as the reason for dropping out of school, while 38(17.8%) said they lost interest in schooling. Eighteen (8.4%) dropped out due to poor academic performance, 14(6.5%) due to abandonment by father or guardian and 9(4.2%) as a result of death of parent or guardian. Other reasons stated for leaving school include being sent of school for bad behaviour 7(3.3%), parental conflict or separation 6(2.8%), leaving to learn a trade 4(1.9%) and negative peer influence 2(0.9%). (Table 4.5)

Table 4.4: Reasons for dropping out of school

Reasons for leaving school	n(214)	%
Lack of funds to continue	109	50.9
Lost interest and dropped out	38	17.8
Poor academic performance	18	8.4
Abandonment by father or guardian	14	6.5
Death of parent/guardian	9	4.2
Other*	7	3.3
Sent out of school for bad behaviour	7	3.3
Parental Conflict/Separation	6	2.8
Left to learn a trade	4	1.9
Negative peer influence	2	0.9

*Other: School was closed down

SECTION B: EXPERIENCES OF STREET LIFE

As regards the reason why they were on the streets, 219(72%) stated financial constraints, 27(8.9%) lure from friends, 25(8.2%) neglect at home while 12(3.9%) reported being maltreated at home. One hundred and eighty-one (59.5%) respondents reported ever having slept on the streets. Amongst those who had slept on the streets, 46(25.4%) rarely did, 38(21.0%) sometimes did, 52(28.7%) slept on the street most times and 45(24.9%) always slept on the streets.

Qualitative data also revealed, as regards their living conditions, while few reported returning home occasionally most permanently reside 'on the streets' One of the participants reported thus-

'*I sleep at a nearby filling station with my friends'*

Majority stated that they did not enjoy living in their households. According to a participant

'*I left my home in Ilesha for Ibadan. My father's wife was treating me very badly my mother died, I don't want to go back there'*

Another respondent remarked '*The work at home was too much for me that is why I came here.'* and another, said

'My father started treated me badly after my mother died'

Table 4.5: Reasons for being on the streets

Reasons for being on the streets	**N (304)**	**%**
Financial/Economic Constraints	232	72.0
Lure from friends	27	8.9
Neglect at home	25	8.2
I chose to run away	12	3.9
Maltreatment from home	12	3.9
Unfavourable home condition	6	1.9
Ever slept on the streets?		
Yes	181	59.5
No	123	40.5
If yes, how often do you sleep on the streets n(181)		
Rarely	46	25.4
Sometimes	38	21.0
Most times	52	28.7
Always	45	24.9

Respondents were asked about the last time they slept on the streets, and the reasons for this included: 55(18.1%) stated financial reasons, 31(10.2%) just chose to, 26(8.6%) stated peer influence and 17(5.6%) reported being sent out of the house by parent/guardian/employer.

Table 4.6: Reasons for sleeping on the street (last time)

Reasons for sleeping on the Street (Last time)	n(181)	%
Financial/Economic reasons	55	30.3
I just chose to	31	17.2
Peer Influence	26	14.4
I had nowhere else to go to	19	10.5
Sent out by parent/guardian/employer	17	9.4
Party/Carnival	12	6.6
I can't remember	9	4.9
Unfavourable home condition	5	2.7
Maltreatment and/or Neglect at home	7	3.9

The average duration of time respondents spent on the streets is reported on table 4.8.Thirty-four respondents (11.2%) spent less than 6 hours on the streets, 128 (42.1%) spent 6-12 hours and 142 (46.7%) reported spending 12 hours and above on the average on the streets per day. More than half of the respondents 172 (56.6 %) reported that they return home daily while 44 (14.5%) rarely returned home. Twenty respondents (6.6%) could not remember the last time they went back home.

Table 4.7: Duration of time spent by respondents on the streets

Duration of time spent on the streets	N (304)	%
Average number of hours spent on the streets per day		
<6hrs	34	11.2
6-12hrs	128	42.1
12hrs and above	142	46.7
How often do you go home?		
Never	26	8.6
Daily	172	56.6
At least once weekly	34	11.1
Fortnightly	5	1.6
Monthly	17	5.6
Every 2-3 months	2	0.7
Occasionally/Rarely	44	14.5
Whenever/Anytime	4	1.3
When last did you go home?		
Yesterday	171	56.2
Within the last Week	47	15.4
Two Weeks Ago	9	3.0
1-5months	31	10.2
6-12months	7	2.3
1-2yrs	13	4.3
3-5yrs	6	2.0
I Can’t Remember	20	6.6

Regarding economic activities they were engaged in, 76(25.0%) of the respondents were bus conductors, 75(24.7%) engaged in hawking, 57(18.8%) in scrap-picking and selling, 45(14.8%) were porters and 19(6.3%) engaged in motorcycle/car/cart washing, 6(2.0%) in scavenging, 4(1.3%). Twenty-two (7.3%) engaged in other activities like shoe-shining, construction (labourers) (Table 4.8).

Table 4.8 Economic activities engaged in by respondents

Economic Activity	N(304)	%
Bus conducting	76	25.0
Hawking	75	24.7
Scrap-picking/selling	57	18.8
Porter	45	14.8
Motorcycle/car/cart washing	19	6.3
Scavenging	6	2.0
Begging	4	1.3
Other*	22	7.3

*Shoe-shining, labourer/construction, multiple chores, not engaged in any economic activity

History of Police Arrest

One hundred and twenty-five 125(41.1%) respondents had been arrested by the police since they commenced street life while 179 (58.9%) had never been arrested. Majority, 58 (46.4%) of those arrested were arrested during police raids, 21(16.8%) were roaming late at night when arrested, 10(8.0%) were arrested for theft, and 8(6.4%) for fighting. Seven (5.6%) respondents were arrested for being in possession of illicit substance and gambling. Most of those that had been arrested were detained in police stations 124 (99.2%) and only 1(0.8%) was detained in a borstal. Duration of detention was mostly a few hours 54(43.2%) and 1-7 days 62(45.6%). While 58(46.4%) were released by the police without bail, 30(24.0%) were bailed by parents/guardians, 20(16.0%) by employers and 9(7.2%) by older street youth.

Table 4.9: History of Arrest

History of Arrest	N(304)	%
Ever been arrested?		
Yes	125	41.1
No	179	58.9
Reason for arrest(n= 125)		
Police raids	59	47.2
Roaming late at night	21	16.8
Theft	10	12.5
Fighting	8	6.4
Gambling	7	5.6
Caught with illicit substance	7	5.6
Other*	13	10.4
Where were you detained(n=125)		
Borstal/Approved School	1	0.8
Police Station	124	99.2
Duration of Detention (n=125)		
A few hrs	54	43.2
1-3days	57	45.6
4-6days	5	4.0
1-2wks	8	6.4
Up to a month and above	1	0.8

***Late night partying, vandalisation

SECTION C: HEALTH PROBLEMS OF RESPONDENTS

Nutritional Status

The following categories of health problems were examined in this study: nutritional status, history of serious illness and injury in the three months prior to the study.

As regards frequency of meals, dinner was the most frequently eaten meal with 137(45.1%) of the respondents reporting that they always ate it. Breakfast was the least frequently eaten, 63(20.7%) reporting that they always had breakfast (Table 4.9).

Table 4.10: Frequency of meals in the 30 days prior to the study

Frequency of Meals (In the past 30 days)	N (304)	%
Breakfast		
Never	8	2.6
Rarely	38	12.5
Sometimes	89	29.3
Most times	106	34.9
Always	63	20
Lunch		
Rarely	12	3.9
Sometimes	64	21.1
Most times	133	43.8
Always	95	31.3
Dinner		
Never	4	1.3
Rarely	7	2.3
Sometimes	38	12.5
Most times	118	38.8
Always	137	45.1

The mean weight recorded was 43.13±8.29kg. Mean height recorded was 148.87±10.62cm. While none of the respondents were wasted, 166 (60.1%) of them were stunted, and 121(43.8%) were underweight. Majority 228 (82.8%) had normal Body Mass Index for age, 21 (7.5%) were moderately thin, 22 (7.8%) severely thin, and5 (1.9%) overweight

Table 4.11: Nutritional Status of Street Children

Nutritional Status	n(276)	%
Stunting		
Yes	166	60.1
No	110	39.9
Underweight		
Yes	121	43.8
No	155	56.2
Wasting		
Yes	0	0
No	276	100
BMI for Age		
Normal	228	82.8
Moderately Thin	21	7.5
Severely Thin	22	7.8
Overweight	5	1.8

History of Injury

Regarding history of injuries in the preceding three months, about two-thirds 199 (65.5%) reported having been injured; 84 (27.6%) had been injured once, 56 (18.4%) two to three times, 59 (19.4%) had been injured four times and above (table 4.11).

Table 4.12: History of injury among respondents

Frequency of Injury		
	N(304)	**%**
In the past 3months		
None	105	34.5
Once	84	27.6
2-3	56	18.4
4-5	36	11.8
6-7	21	6.9
8-9	2	0.7

A serious injury as defined in this study is one that kept the respondent away from his daily routine for 24hrs or more and/or required the respondent to seek treatment in a health facility. About two-thirds 119(65.5%) of the respondents been injured at least once in the three months prior to the study. Twenty three percent (70) of the last serious injuries were sustained by the respondent while performing their daily economic activity, 44 (14.5%) were sustained while playing, 37 (12.2%) in a car/motorcycle accident, 25 (8.2%) while performing a chore. The majority, 113 (52.3%), of the injuries sustained were cuts/ lacerations 113(52.3%) and bruises 69 (31.9%). The majority of the injuries sustained affected the upper 74 (34.3%) and lower extremities 93 (43.1%). (Table 4.13)

Table 4.13: Last serious injury three months preceding the study

History of serious injury sustained by respondents	n(304)	%
How Acquired		
At work(Daily Economic Activity)	70	23.0
Playing	44	14.5
In Car/Motorcycle Accident	37	12.2
Performing Chore	25	8.5
In a fight	14	4.6
Crossing/Walking by the road	8	2.6
Was Beaten/Attacked	5	1.6
Stepped on sharp object	1	0.3
None Stated	88	28.9
Other*	12	3.9
Type n=216		
Cut/Laceration	113	52.3
Bruises	69	31.9
Scald/Burn	8	3.7
Impact/Collision Injury	8	3.7
Puncture	5	2.3
Fracture	4	1.9
Dislocation	4	1.9
Other**	5	2.3
Part of the Body Affected		
Legs	93	43.1
Arms	74	34.3
Head and Neck	32	14.8
Chest/Trunk	7	3.2
Arms and Legs	5	2.3
All over the body	4	1.9
Trunk and Legs	1	0.5

*****Can't remember ******Bruise with dislocation, puncture and cut

One hundred and forty respondents 140(46.1%) sought treatment for their injuries, while 76 (25%) did not. As per treatment options, 75(53.6%) visited chemists or patent medicine stores, 22(15.7%) visited private hospitals, 12(8.6%) were treated at home. About a third, 49 (35.0%) paid for the treatment themselves, 43(30.7%) reported that their parents paid, 24(17.4%) stated that their employers paid.

Table 4.14: Injury management and payment modality

Treatment Sought for injuries	**n(216)**	**(%)**
Did you seek treatment?		
Yes	140	64.8
No	76	35.2
Treatment Centre n (140)		
Chemist &Patent Medicine Store	75	53.6
Private Hospital	22	15.7
At home	12	8.6
PHC	10	7.1
'Nurse'	5	3.6
Herbal Concoction	2	1.4
Medicine Hawker	1	0.7
Other	11	7.8
Person Responsible for payment n(140)		
Self	49	35.0
Parent/Guardian	43	30.7
Employer	24	17.4
Friend	6	4.3
Other	6	4.3
Was treated free of charge	4	2.9
Stranger/Good Samaritan	3	2.1
Sibling	2	1.4
Bus/Motorcycle Driver	2	1.4

History of Serious Illness among Respondents

One hundred and ninety four (63.8%) respondents had at least one serious illness for which treatment was sought in the 3 months prior to the survey. Of these, 55.7% reported having had febrile symptoms (fever, chills), 36(18.6%) stated gastrointestinal symptoms (nausea, vomiting, diarrhoea, abdominal pain), 15 (7.7%) musculoskeletal symptoms (muscular cramps, body pains), 7(3.6%) genitourinary symptoms (burning micturition) and 4(2.1%) reported central nervous system symptoms (headaches, dizziness). Majority (27%) sought treatment for their ailments from chemists and patent medicine stores and 25% used herbal concoctions, only 7.2% visited health facilities (comprising primary health care, secondary, tertiary centres and private hospitals). Other treatment options include medicine hawkers (1%), 'nurse' (2.6%), and church (0.7%). Cost of treatment mostly (29.3%) ranged from 100-300 naira, 8.9% paid less than 100 naira and 12.8% paid 500naira and above. Most (37.2%) of the children paid for the treatment themselves while 16.4% reported that their parents or guardians paid.

Qualitative data revealed that when asked about their health, most of the respondents reported having good health. However, when, asked about specific symptoms and injuries, majority reported episodes of headache, fever and 'malaria'.

Table 4.15: History of Serious Illness in the last 3 months

Serious Illness in the last 3 months		
	n(194)	**%**
Physical Ailment/Symptoms		
Febrile Symptoms	108	55.7
Gastrointestinal Symptoms	36	18.6
Musculoskeletal Symptoms	15	7.7
Respiratory Symptoms	11	5.7
Genitourinary Symptoms	7	3.6
ENT & Eye Symptoms	7	3.6
CNS Symptoms	4	2.1
Dental Problems	2	1.0
Other*	4	2.1
Where treatment was received n=194		
Chemist & Patent Medicine Store	82	42.2
PHC	3	1.5
Private Hospital	14	7.3
Secondary Centre	5	2.6
Tertiary Centre	1	0.6
Herbal Concoction	76	39.1
Medicine Hawker	3	1.5
'Nurse'	8	4.1
Church	2	1.1
Reason for choice of treatment		
Cost(Cheap)	13	6.7
Effective treatment	49	25.2
Proximity/Convenience	25	12.9
Preference for this option	60	30.9
Directed by friends	16	8.3
Taken by parent	20	10.3
Taken there by stranger/good Samaritan	2	1.1
Others*	9	4.6

Amount paid (n=168)		
<100 Naira	27	16.1
100-300 Naira	89	52.9
301-500 Naira	13	7.7
501-1000 Naira	17	10.2
Above 1000 Naira	22	13.1
Person who Paid		
Self	120	61.9
Parent/Guardian	50	25.8
Sibling	3	1.5
Friend	1	0.5
Stranger/Good Samaritan	4	2.1
Employer	8	4.1
Other *	8	4.1

*I have always used this method, I don't know ** Older street youth, cannot remember

When asked to rate their current state of health on a scale of 1-10, 1 being very poor health and 10 being very good health, 40.1% of the children perceived themselves as being in good health, 54.6% perceived themselves to be sometimes sick like anyone else, 4.3% reported falling ill often, 1% perceived himself as being seriously ill.

Table 4.16: Perception of General State of Health

Perception of general state of health	N (304)	%
Fully in good health(8-10)	122	40.1
Sometimes as sick as anyone else(6-7)	166	54.6
Falls ill often(4-5)	13	4.3
Seriously ill(1-3)	3	1.0

Substance Use

Data on ever use of substance revealed that about half (51.3%) of the respondents had ever used palm wine, 35.9% local gin, 26.3% marijuana 23% had used alcohol (beer), 28% kola nut, 3% had used cocaine and only 1.5% had used heroine.(Table 4.17)

Table 4.17: Ever Use of psychoactive substances by Respondents

Ever Use of Psychoactive Substances	N (304)	%
Palm wine		
Yes	156	51.3
No	148	48.7
Beer		
Yes	70	23.0
No	234	77.0
Local Gin		
Yes	109	35.9
No	195	64.1
Cigarette		
Yes	75	24.7
No	229	75.3
Kola nut		
Yes	85	28.0
No	219	72.0
Marijuana		
Yes	80	26.3
No	224	73.7
Cocaine		
Yes	9	3.0
No	297	97.0
Heroine		
Yes	5	1.6
No	299	98.4

The table 4.18 shows the association between current use of at least one psychoactive substance and history of illness, injuries and fights. A higher proportion (82.4%) of respondents who currently use at least one psychoactive substance had been arrested by the police than those who do not currently use a psychoactive substance (17.6%)(p=0.00, X^2=38.021). A higher proportion of current users (71.7%) had also experienced at least one episode of illness compared to those who were not current users(28.3%) of psychoactive substances. A similar trend occurs for history of injuries where (66.3%) of current users of psychoactive substances had sustained injuries while a smaller proportion (33.7%) of non-users sustained injuries (p=0.027, X^2=4.921). Also, a higher proportion (74.5%) of current users had engaged in one or more fights in the last 30days compared to the non-users (25.5%)(p=0.00, X^2=22.123)

In addition qualitative data revealed that respondents did not perceive the streets as a safe place. They also reported older street youth as threats. As reported by one of the respondents, who slept at a filling station in Iwo Road,

'*I don't feel safe in this place. At night other people steal our food and money. We're afraid of 'gbomo gbomo'(kidnappers) and ritualists'*

Most of the respondents reported having friends with whom they lived and they usually performed the same economic activities. Most of the respondents also reported that they've been threatened and taken advantage of before. A respondent remarked,

'The older boys sometimes threaten us. They demand that we give them our money, if we refuse they beat us'

Table 4.18 Association between current use of substance and history of illness, injuries and fights, police arrests

	None	At least one	Total	p	X^2
Previous Police Arrest					
Yes	22(17.6)	103(82.4)	125	0.00*	38.021
No	94(54.5)	85(47.5)	179		
Total	116	188	304		
History of Illness(3 months)					
No serious illness	62(54.9)	51(45.1)	113	0.00*	21.28
At least one Illness	54(28.3)	137(71.7)	191		
Total	116	188	304		
History of Injury(3months)					
None	49(46.7)	56(53.3)	105	0.027*	4.921
At least one	67(33.7)	132(66.3)	199		
Total	116	188	304		
Fights (In the last 30 days)					
None	76(51.7)	71(48.3)	147		
Fought at least once	40(25.5)	117(74.5)	157	0.00*	22.123
Total	116	188	304		

*Statistically significant

The table 4.19 reports current use of psychoactive substance i.e. use within the last 30days. Data revealed that majority 123(40.5%) had taken palm wine of which 114(92.6%) took less than five cups of palm wine per sitting. Majority 50(16.4%) of the respondents who took beer reported taking 1-3 bottles per sitting. Similarly, 70(23%) reported taking 1-3shots of local gin, 63(20.7%) took 1-3sticks of cigarette per sitting, 67(22%) took 1-3 pieces of kola nut, 77(25.3%) 1-3 wraps of marijuana.

Table 4.19: Current Use of Psychoactive Substance by Respondents

Current Use of Psychoactive Substances	N (304)	%
Palm wine n=123		
<5cups	114	92.7
5-10cups	9	7.3
Beer n=59		
1-3bottles	50	84.7
4-6bottles	9	15.3
Local Gin n=84		
1-3shots	70	83.3
4-6shots	13	15.5
Above 6 shots	1	1.2
Cigarette n=74		
1-3sticks	63	85.1
4-6sticks	10	13.5
Above 6 sticks	1	1.4
Kola nut n=75		
1-3pcs	67	89.4
4-6pcs	7	9.3
Above 6 pcs	1	1.3
Marijuana		
1-3wraps	77	97.5
4-6wraps	2	2.5

SECTION D: ASSOCIATION BETWEEN SOCIO DEMOGRAPHIC CHARACTERISTICS AND PHYSICAL HEALTH PROBLEMS OF STREET CHILDREN

The table 4.20 reveals that a higher proportion (43.9%) of street children aged 14 to 19years reported having had at least one health problem (illness and/or injury) than those between the ages of 9 and 13 years (37.1%)(p= 0.738 X^2= 0.112). A slightly higher proportion of males (43.4%) compared to females had experienced at least one health problem. This was not statistically significant. A higher proportion of those who live alone, with employer or other adult (84.6%) as well as those who live with other relatives (81.4%) reported having had at least one health problem than those who lived with either or both parents(72.3%). This finding was also not statistically significant.

Table 4.20: Association between selected socio-demographic characteristics and history of at least one Health Problem in the 3months prior to the study

	None	At least one health problem	Total	P	X^2
Age					
9-13	22(62.9)	13(37.1)	35		
14-17	151(56.1)	118(43.9)	269	0.738	0.112
Gender					
Male	151(56.6)	116(43.4)	267		
Female	22(59.5)	15(40.5)	37	0.45	0.571
With Whom do you Live ?					
Either or both	31(27.7)	81(72.3)	112		
parents	11(18.6)	48(81.4)	59		
Other Relative	28(26.2)	79(73.8)	107		
Friends					
Alone+ Employer + Other Adult	4(15.4)	22(84.6)	26	3.04	0.385

Table 4.21 shows the association between socio-demographic characteristics, living arrangements and frequency of sleeping on the streets and history of serious illness in the three months prior to the study. A slightly higher proportion (65.2%) of younger (9-13years) respondents reported having a serious illness in the 3 months preceding the study compared to the older age group (14-17years). This finding was however not statistically significant. Similar proportions of males and females reported experiencing at least one serious illness. A significantly higher proportion (71.1%) of those who always and often times sleep on the streets had experienced at least a health problem compared with those who occasionally (67.9%) and rarely did (52.8%) (p=0.011).

Table 4.21: Association between socio-demographic factors and history of at least one serious illness in the last three months.

	None	At least one serious illness	Total	X^2	P
Age					
9-13years	12(34.3)	23(65.7)	35	0.141	0.707
14-17years	101(37.5)	168(62.5)	269		
Gender					
Male	99(37.1)	168(62.9)	267	0.008	0.929
Female	14(37.8)	23(62.2)	37		
How often do you sleep on the streets?					
Never	58(47.2)	65(52.8)	123	9.023	0.011*
Occasionally (Rarely & Sometimes)	27(32.1)	57(67.9)	84		
Always &Most times	28(28.9)	69(71.1)	97		
With whom do you live?					
Either or both	45(40.2)	67(59.8)	112	0.801	0.849
parents	20(33.9)	39(66.1)	59		
Other Relative	39(36.4)	68(63.6)	107		
Friends	9(34.6)	17(65.4)	26		
Alone, with employer, other adult					

*Statistically significant

The table 4.22 shows the association between socio-demographic characteristics and living arrangements and current use of at least one psychoactive substance. A significantly higher proportion (63.9%) of the respondents who fell between 14-17years reported current use of at least one substance compared to those in the younger(9-13years) age group(45.7%) (p=0.037). A higher proportion (79.4%) of those who mostly or always slept on the streets were currently using at least one substance as compared to those who occasionally (76.2%) and never (38.2%) slept on the streets (p= 0.00). This was statistically significant. Also, a significantly higher proportion of those who lived with friends (79.4%), alone/with employer or other adult (61.5%) were currently using at least one substance compared with those who lived with either or both parents(50.9%) or with a relative(50.8%) (p= 0.00). (Table 4.20)

Table 4.22: Association between socio-demographic characteristics, living arrangements with current use of at least one psychoactive substance.

	None	At least one substance	Total	X^2	P
Age					
9-13years	19(54.3)	16(45.7)	35	4.360	0.037
14-17years	97(36.1)	172(63.9)	269		
Gender					
Male	89(33.3)	178(66.7)	267	21.630	0.00*
Female	27(73.0)	10(27.0)	37		
How often do you sleep on the streets					
Never	76(61.8)	47(38.2)	123		
Occasionally (Rarely &Sometimes)	20(23.8)	64(76.2)	84		
Always & Most times	20(20.6)	77(79.4)	97	49.08	0.00*
With whom do you live?					
Either or both parents	55(49.1)	57(50.9)	112		
Other relative	29(49.2)	30(50.8)	59		
Friends	22(20.6)	85(79.4)	107	22.57	0.00*
Alone/With Employer/With other adult	10(38.5)	16(61.5)	26		

*Statistically Significant

The table 4.23 shows the association between socio-demographic characteristics, duration of time on the streets and frequency of fights in the past thirty days. A higher proportion (33.3%) of street children who spent above 6 hours on the streets had engaged in two or more fights in the last thirty days compared to those that spent up to 6hours or less (14.7%)(p= 0.084). Also, a larger proportion (39.2%) of those who slept mostly/always on the streets had engaged in two or more fights than those who occasionally (31.0%) or had never (25.0%) slept on the streets (p= 0.01). This difference was statistically significant.

Table 4.23: **Association between socio-demographic characteristics, duration of time spent on the streets and frequency of fights in the last thirty days.**

	None	Once	Twice and Above	Total	X^2	P
Age						
9-13years	19(54.3)	6(17.1)	10(28.6)	35		
14-17years	128(47.6)	56(20.8)	85(31.6)	269	0.584	0.747
Gender						
Male	129(48.3)	55(20.6)	83(31.1)	267		
Female	18(48.6)	7(18.9)	12(32.4)	37	0.65	0.968
How many hrs do you spend daily on the streets?						
Up to 6hours	21(61.8%)	8(23.5%)	5(14.7%)	34		
Above 6hrs	126(46.7%)	54(20.0%)	90(33.3%)	270	4.961	0.084
How often do you sleep on the streets?						
Never	76(61.8)	16(13.0)	31(25.2)	123		
Occasionally	39(46.4)	19(22.6)	26(31.0)	84		
Most times & Always	32(33.0)	27(27.8)	38(39.2)	97	18.90	0.001*

*Statistically significant

SECTION E: EARNINGS AND LIFE ASPIRATIONS

The table 4.24 describes the approximate daily earnings and expenditure reported by respondents. One hundred and twenty-five (41.1%) of the respondents earned between N500.00 and N1000.00, 26.6% earned between N200:00 and N500.00, 14.8% earned between N1000.00 and N1500.00, 10.2% earned less than N200.00.

Regarding expenditure, majority earned 100 Naira to 400 Naira daily, 26.4% spent above 400 Naira and 14.5% spent less than 100 Naira.

Table 4.24: Reported approximate daily income and expenditure

Reported approximate daily income and expenditure	N (304)	%
Daily Income		
<200	31	10.2%
200-<500	81	26.6
500-<1000	125	41.1
1000-<1500	45	14.8
1500-<2000	18	5.9
Above 2000	4	1.3
Daily Expenditure		
< 100	44	14.5
100-≤ 400	180	59.2
401-<700	54	17.8
700 and above	26	8.6

The table 4.25 show the future plans stated by the respondents. About a third (35.5%) intended to become professionals, 21.4% planned to learn a trade or vocation, 12.8 % just wanted to be rich and successful, 11.5% wanted to be business persons or traders and 10.2% planned to become transport workers (bus owners or drivers).

In depth interviews showed that, when asked about future plans and goals, majority intended to go to school and pursue a career, hoping for a sponsor/benefactor. A few of the respondents stated that they didn't have plans but resigned to fate. One respondent remarked

'*I don't know what I'd like to be, fate determines what happens to anyone, I really don't know'*

Table 4.25: Future and career Plans of street children

Future Plans	N (304)	%
Become a professional	108	35.5
Learn a trade/vocation	65	21.4
To be rich and successful	39	12.8
Trader/Business person	35	11.5
Transport Worker	31	10.2
Sports & entertainment	10	3.3
Join the Police/Army	7	2.3
I don't know	2	1.6
Politician	2	0.7
Other*	2	0.7

*Not concerned, Acceptance of whatever occurs in the future

The table below shows the most important current need as stated by the respondents. One hundred and forty-four (47.4%) stated money as their most important need; education was stated by 19.7%. Other needs stated were apprenticeship and opportunity to learn a trade (5.9%), clothing and footwear (5.3%), shelter (3.9%) among others.

Table 4.26: Most important need specified by respondents

Most Important Need	N (304)	%
Money	144	47.4
Education	60	19.7
Apprenticeship	18	5.9
Clothing/Footwear	16	5.3
Sponsor/Benefactor	12	3.9
Shelter	12	3.9
Family/Parents	10	3.3
Car/Motocycle/Bus	10	3.3
School Supplies & Stationery	6	2.0
Food	6	2.0
Children/Marriage	3	1.0
Other*	7	2.3

*Friends, Cart/wheelbarrow, Phone

CHAPTER FIVE

DISCUSSION OF FINDINGS

This study was conducted to determine the physical health and substance use amongst street children in Ibadan municipality.

Of the 304 street children interviewed, there were significantly more males (87.5%) than females. This is consistent with other researchers (Aderinto, 2000); Olley, 2006, Greska et al 2009; Aransiola et al, 2009). Figures from other African countries also reveal a male preponderance namely 95 percent in Zimbabwe, 84 percent in Angola, 76 percent in Ethiopia, 70 percent in Zambia and 100 percent in Sudan (Veale and Dona, 2003). Universally, it has been seen that there are more boys than girls who are street children. This could be attributed to some reasons. First, families are more protective of female children, whereas boys are given a great deal of freedom to move around. In addition, it has been reported that, homeless runaway girl children are picked up very soon by antisocial elements and get caught in the prostitution web (Damodran, 1997). A consistent rise has however been observed in the proportion of female street children as one moves from the north (Kaduna), through the southwest (Lagos) and to the southern part of Nigeria (Port Harcourt) (Ebigbo, 2003).

Eighty-eight percent of the children interviewed were in the age group 14-17years. The mean age was 15.2 years, SD $\pm$ 1.4 years (range, 9 - 17 years). A study carried out in Namibia describes similar findings with street children aged between 6 and 18 years old, with the average age being between 12 and 13years, and the majority of street children being aged 10 to 15 years (Grudling & Grudling, 2005). Aderinto 2002, reports a majority between the ages of 15 and 18years.

This study revealed 16.4 % lived with both parents, about a fifth lived with a single parent, and about one-third lived with a friend. Olley (2006) reports similar findings reporting few (9.5%) street youth had been raised by both parents, 27.8% had been

raised solely by their fathers, 32.5% had been raised solely by their mothers, and 30.2% had been raised by guardians or other relatives.

While some street children did not know their parents' level of education, most fathers had secondary education, some had primary education, however very few had undergone tertiary education. Conversely, a lower proportion of mothers had secondary education, more had primary education, and much less had tertiary education. Duyan (2005), reports that majority of fathers of street children he studied in Turkey had at least primary education. This may point to the fact that parental education may influence degree of parental presence.

Few street children 11(3.5%) had never been in school, although, only about one quarter of the respondents were currently enrolled in school. These findings are corroborated by other studies conducted in Southwest Nigeria for instance Olley (2006), Aderinto (2000) and other countries Mathur (2009), revealed that a few street children currently enrolled in school and many infrequently attended school evidenced by school attendance less than 5 times a week. Regarding reasons for leaving school, about two-thirds of the respondents stated financial constraints as reason. These findings are similar to those reported by Ali et al (2004), Abdelgalil et al (2004). This implies that most street children are not in school, hence spend more hours on the streets which probably would have been spent in school

About three-quarter of the respondents reported spending more than six hours on the streets. Manthur (2009) reports a higher proportion of street children spending more than 6hours (90%) on the streets. More than half of the respondents reported going home daily. Grundling and Grundling (2005) also corroborate these findings with majority of the street children they studied as 'on the streets' i.e. those engaged in some kind of economic activity from begging to vending (most go home at the end of the day and contribute to the earnings of their families).

Nutritional status of the street children assessed in this study reveals that more than half of the respondents were stunted. Greska et al (2006) reports similar findings. However, lower proportions of stunting are reported by Alli et al (2004), Ayaya &Esamai (2001). Stunting reflects the presence of long-standing malnutrition, hence

indicating that most street children have been poorly nourished even prior to commencement of street life. The National Demographic Health Survey (2008) reports a similar trend reporting that stunting ranges from 22% in the South East zone to 53% in North West zone; almost one-quarter (23%) of Nigerian children are underweight, wasting, is less common (14%). This study records 43.8% of respondents were underweight and no wasting amongst respondents. Greska et al (2006) also corroborates this as their study in Dhaka Bangladesh did not report that any of the street children were wasted.

More than half of the respondents reported having experienced a serious injury at least once in the last thirty days. Majority of the injuries were sustained on the streets while performing their daily economic activities. Cut and wounds were the most commonly sustained injury. Thapa, Ghatane & Rimal (2009) and findings from the Ghana Child Labour Survey (2001) corroborate these findings.

Regarding substance use, this study reveals palm wine, kolanut, local gin, cigarette and marijuana in that order as substances most commonly used. This is probably attributable to the fact that they are cheap and most readily available. Abdelgalil et al (2004), Manthur (2009), Olley (2006), Kudratri, Plummer & El Hag Yousif (2008) report similar findings. However, an additional substance 'silision' ie glue is reported to be commonly used by street children Kudratri, Plummer & El Hag Yousif (2008).

A higher proportion of those who mostly or always slept on the streets were currently using at least one substance as compared to those who occasionally and never slept on the streets showing a significant association between frequency of sleeping on the streets and current use of at least one substance. More time on the streets results in less supervision by parent/guardian, hence these children are more likely to experiment with drugs

About two-thirds of the respondents reported having at least one illness for which treatment was sought in the last three months. Olley (2006) reports similar findings with 80.5% of the respondents reporting at least one illness. Febrile illness and gastrointestinal symptom were the most common symptoms reported by street children. Sorsa, Kidanemariiam & Erosie (2002), Thapa, Ghatane & Rimal (2009) and Olley (2006) record similar findings. However, Ayaya & Esamai (2001) as well as

Kelly & Caputo (2007) reported respiratory and dermal problems as the most commonly occurring health problem amongst street children. Street children mainly sought treatment by use of herbal concoctions and from patent medicine stores. Olley (2006), Faloore (2001) corroborated these findings with majority of street children street medicating rather than seeking health care from health facilities. However another study conducted in Kenya reports most street children seeking health care from mobile, government and private clinics (Ayaya & Esamai, 2001)

Majority of older street children (14-17years) reported having had at least one health problem in the last three months compared to the younger (9-13years) street children. Sorsa, Kidanermariam & Erosie (2002) corroborates this finding. This is probably because the younger street children were more likely to have more parental contact, hence parental care.

This study also revealed that a significantly higher proportion of those who most frequently (always and most times) slept on the streets had experienced at least one serious illness in the three months prior to the study compared to those who occasionally and rarely did. However, Sorsa, Kidanermariam & Erosie (2002) records no significant difference between street history of illness and frequency of nights spent on the streets.

When asked about most important need, about half of the respondents stated money, subsequently the need for education was the most stated. This finding coincides with that reported in a study carried out in Namibia (Grundling & Grundling, 2005) with physical needs such as money to purchase food and clothing rated as most important and schooling stated as second most important. Regarding future plans, majority either aspired to become a professional or learn a trade; also about one-tenth aspired to become transport workers (commercial drivers).

CONCLUSION

The cross-sectional study carried out to determine physical health and substance use among street children in Ibadan municipality revealed that street children experience health problems including febrile and gastrointestinal symptoms, injuries and malnutrition. While majority of them return home daily, most of them spend greater than six hours on the streets and are not currently enrolled in school. Those on the streets significantly experienced more illness 3 months prior to the study and engaged in current use of at least one psychoactive substance. Money for physical needs as well as education/schooling were the most important needs. The respondents aspired to become professionals, learn a trade or become transport workers.

This study clearly reveals that street children are at risk of physical health problems as well as substance use and violence. Street life exposes the child to a host of negative influences as stated above. Therefore the family, with the help the entire community remains the safest and most appropriate environment for raising a child. Hence, focus on preventing the influx of children on to the streets is essential.

RECOMMENDATIONS

In order to successfully address the problem of street children, interventions need to be aimed at reducing the 'push' and 'pull'factors that cause children to resort to street life, strengthen family ties of street children who still have family contact as well as rehabilitate street children who live completely on their own with no family contact. The following steps are essential.

1. Economic strengthening and community development aimed at assisting extremely poor families should be embarked upon to serve as a measure to reduce the influx of children on to the streets. The community at large and the family as a unit are largely responsible. When communities view child rearing as a collective responsibility and seek to nurture rather than stigmatise street children, the influx and proliferation of street children will reduce.
2. Designing interventions such as drop-in centres to cater for street children which provide health care, nutritional support, meet the immediate health needs of street children. Both governmental and non-governmental agencies can utilise this approach to ensure care and eventual rehabilitation of street children
3. Empowerment programmes offering formal education and vocational training are also useful in providing a platform for which delinquent behaviours can be substituted for beneficial activities which will be tools for legal income generation and livelihood both now and in the future.
4. Rehabilitative and/or residential facilities are necessary in interventions aimed that the small percentage of street children who have no family contact. Here, the immediate community can play a pivotal role in ensuring acceptance thus providing an alternative to street life

REFERENCES

Abdelgalil S, Gurgel RG, Theobald S, Cuevas LE (2004). Household and family characteristics of street children in Aracaju, Brazil *Arch Dis Child* 2004;89:817–820

Aderinto AA (2000). Social correlates and coping measures of street children: A comparative study of street and non-street children in south-west Nigeria. *Child Abuse and Neglect*, 24:9, 1199-1213.

Ali M, Shahab S, Ushjima H, Muynck A (2004).Street children in Pakistan: A Situational Analsysis of Social Conditions and Nutritional Status. *Social Science and Medicine*.2004:59, 1707-1717.

Ayaya, S O, & Esamai, FO (2001). Health problems of street children in Eldoret, Kenya. East African Medical Journal, 78(12), 624–629.

Craig, T. K. J., & Hudson, S. (1998). Homeless youth in London: Childhood Antecedents and Psychiatric Disorder. *Psychological Medicine*, 28, 1379–1388.

Barkin SL, Balkrishnan R., Manuel J, Anderson, R. M, & Gelberg, L (2003). Health Care Utilization Among Homeless Adolescents and Young Adults. *Journal of Adolescent Health*, *32*(4), 253-256.

Damodran A (1997). The Working Child and the Street Child: Effect on Future Child Development A Presentation at the *4th International Congress of Tropical Pediatrics.* July 7-11, 1996, Kuala Lumpur, Malaysia.

Duyan V (2005). Relationships between the Socio demographic and Family Characteristics, Street Life Experiences and the Hopelessness of Street Children. *Childhood* 2005, 12:445.

Ebigbo PO (2003). Street Children: The Core of Child Abuse and Neglect in Nigeria. *Children, Youth and Environments* 13(1), Spring 2003. Retrieved 14, February, 2009 from http://cye.colorado.edu.

Ennew J (1994). *Street and working children: a guide to planning*. London: Save the Children;

Ennew J and Swart-Kruger J (2003). Introduction: Homes, Places and Spaces in the Construction of Street Children and Street Youth. *Children, Youth and Environments* (1), Spring. Retrieved from http://colorado.edu/journals/cye.

Ensign J (2004). Quality of Health Care: The Views of Homeless Youth. *Health Service Research* 2004; 39: 695-708

Ensign, J., & Bell, M. (2004). Illness experiences of homeless youth. *Qualitative Health Research, 14*, 1239-1254.

Ferguson K (2006). Responding to Children's Street Work with Alternative Income Generation Strategies. *International Social Work* 2006:49, 705-716

Greska PL, Naganuma R, Rafiqul-Islam ABM, Maki U, Omori K (2007). Growth and Health Status of Street Children in Bangladesh. *American Journal of Human Biology,* 19:51-60.

Grundling J, Gundling I (2005). The Concrete Particulars of the Everyday Realities of Street Children. *Human Relations,* 58:173

Haldenby AM, Berman H & Forchuk (2007). Homelessness and Health in Adolescents. *Qualitative health Research* 2007;17;1232

Kelly K and Caputo T (2007). Health and Street Homeless Youth. *Journal of Health Psychology*, 2007:12; 726

Kopoka PA (2000).The Problem of Street Children in Africa; an Ignored Tragedy. A Paper presented at the International Conference on Street Children, and Street Children's Health, Dar-es-Salaam, Tanzania.

Kudrati M, Plummer ML, El Hag Yousif ND (2008). Children of the *sug*: A study of the daily lives of street children in Khartoum, Sudan, with intervention recommendations. *Child Abuse & Neglect* 2008:32, 439–448

Le Roux J, Smith S (1998). Causes and characteristics of the street child phenomenon: A Global Perspective. *Adolescence*, 33

Matchinda B (1999). Impact of Home Background on the decision of Children to Run Away: The Case of Yaounde City Street Children in Cameroun.*Cild Abuse and Neglect* 23:3, 245-255.

Mehta D. (2000). Street Children and Gangs in African Cities: Guidelines for Local Authorities. UMP Working Paper Series 18

Meena Mathur (2009). Socialisation of Street Children in India: A Socio-economic Profile, P*sychology Developing Societies* 2009; 21; 299

Moberly,C. (1999). Creating policies which address the "voluntary separation" of children in Angola. In A. Schrader & A. Veale (Eds.), *Prevention of street migration: Resource pack* (pp. 36–50).

National Institstute on Drug Abuse, NIDA (2000). Street Children and Drug Abuse: Social and Health Consequences

National Population Commission (NPC) and ICF Macro. (2009). *Nigeria Demographic and Health Survey 2008: Key Findings*. Calverton, Maryland, USA: NPC and ICF Macro.

Olley BO (2005). Social and Health Behaviors in Youths of the Streets of Ibadan, Nigeria. *Child Abuse and Neglect*, 2006:271-282

Oloko, S.B.A. (1999) 'Child Labour: The Hidden Workforce – Children Domestic Labour', *The Progress of Nigerian Children*, pp. 48–51. Lagos: UNICEF/Federal Office of Statistics.

Oloko SBA (1993). Children's Street Work in Urban Nigeria: Dilemma of Mordernizing Tradition. *Journal of Behavioural Development* 16:465-482

Orme J, Seipel, MO (2007). Survival Strategies of Street Children in Ghana: A Qualitative Study, *International Social Work*, 50:4, 489-498

Pinheiro, P., (2006) *World Report on Violence against Children.* New York: United Nations Secretary General's Study on Violence against Children.

Panter-Brick C, 2003. Street Children, Human Rights and Public Health: A Critique and Future Directions. *Children Youth and Environments*, 13:1, 147-172

Thomas de Bénitez S (2007). State of the World's Street Children: Violence. Retrieved from www.streetchildren.org/uk

Scalon TJ, Tomkins A, Lynch MA et al (1998). Street Children in Latin America. British Medical Journal. 1998:1596-600.

Shelter Don Bosco (2003). The World of street children. Retrieved from http://www.shelterdonbosco.org/index.html

Sherman DJ (1992). The Neglected Health Care Needs of Street Youth. *Public HealthReport*, 107(4):433-440.

Sorsa S, Kidanemariam T & Erosie L (2002). Health problems of Street Children and Women in Awassa, Southern Ethiopia. *Ethiopian Journal of Health Development*, 2002: 16(2): 129-137.

Thapa K, Ghatane S, Rimal SP (2009). Health problems among the street children of Dharan municipality, *Kathmandu University Medical Journal* 3(27): 273-279

Towe VL, Hasan SS, Zafar T, Sherman SG (2009). Street Life and Drug Risk Behaviours Associated with Exchanging Sex Among Male Street Children in Lahore, Pakistan. *Journal of Adolescent Health* 44(2009) 222-228

United Nations (1990). Children and Development in the 1990s: A UNICEF source book on the occasion of the World Summit for children. New York: United Nations.

UNICEF (1984). *Latin American Seminar on Community Alternatives for Street Children. Brasilia, Brazil*, November 12–15, 1984.

UNICEF (1986) *Children in Especially Difficult Circumstances: Supporting Annex, Exploitation of Working and Street Children*. New York: UNICEF.

UNICEF, (1992), Africa's Children, Africa's Future: Background Sectoral Papers. Dakar, Senegal, 25-27 Nov. 1992.

UNICEF (2002) State of the World's Children: New York UNICEF

Veale A, Donà G (2003). Street children and political violence: a socio-demographic analysis of street children in Rwanda. *Child Abuse and Neglect* (2003) 253–269.

WHO (2002). Working With Street Children. Module 1. A Training Package on Substance Use, Sexual and Reproductive Health including HIV/AIDS and STDs.

WHO (2002). Working with Street Children. Module 5. Determining the Needs and Problems of Street Children. A Training Package on Substance Use, Sexual and Reproductive Health including HIV/AIDS and STDs

WHO (2002). Working with Street children, Module 2. Responsibilities of Street Educators. A Training Package on Substance Use, Sexual and Reproductive Health including HIV/AIDS and STDs.

WHO (2002). Working with Street children, Module 3. Understanding Substance Use Among Street Children. A Training Package on Substance Use, Sexual and Reproductive Health including HIV/AIDS and STDs.

WHO (2002). Working with Street Children. Introduction. A Training Package on Substance Use, Sexual and Reproductive Health including HIV/AIDS and STDs.

Wikipedia Encyclopedia(2009). Street Children. Retrieved from http://en.wikipedia.org/wiki/Main_Page/streetchildren

Youth Advocate Programme International. May 2004. *Street Children and Homelessness*. Retrieved 19 Oct, 2009, from http://www.yapi.org/street/index.htm.

APPENDICES

QUESTIONNAIRE

TITLE OF SURVEY-Physical Health Problems of Street Children in Ibadan Municipality

YEAR CONDUCTED- 2010

CITY _____

REGION/ LGA _____

SITE _____

Introduction: "My name is _____ I'm working for _____.

We are interviewing people here in Ibadan for a study titled 'Physical Health Problems of Street Children in Ibadan Municipality. The purpose of this research is to describe the physical health problems which include nutritional, dermal and common diseases characterised by symptoms such as fever, headaches, nausea, vomiting, diarrhoea, headaches and body pains. I am going to ask you some personal questions, your weight and height measurements will also be taken. Your answers are going to be completely confidential. Your name is not going to be written on this form, and will never be used in connection with any of the information you tell me. You don't have to answer any questions you don't want to answer, and you may end this interview at any time you want to. Please note that some of the information obtained about you before you chose to withdraw may be used in reports and publications. . We would greatly appreciate your help in responding to this survey. It would take about 15-25minutes to ask the questions and take the measurements. Will you be willing to participate?

Signature of the interviewer certifying informed assent was given verbally by respondent.

Interviewer Name: _____

Date of Interview: _____

S/N	Questions	Coding Categories
SECTION ONE: SOCIODEMOGRAPHIC CHARACTERISTICS		
1.	Age	_____years
2.	Sex of Respondent	1. Male 2. Female
3.	Nationality	
4.	Religion	1. Christianity 2. Islam 3. Traditional 4. No Religion 5. Other (specify)_____
5.	To which ethnic group do you belong to?	1. Yoruba 2. Igbo 3. Hausa 4. Other(specify)_____
6.	Have you ever been in enrolled in school?	1. Yes 2. No
7.	Are you currently enrolled in school?	1. Yes 2. No
8.	If yes, what class are you in?	1. Primary4___ 2. JSS1___ 3. SS1____ 4. Primary5___ 5. JSS2____ 6. SS2____ 7. Primary6___ 8. JSS3____ 9. SS3____
9.	How often do you go to school?	1 .Everyday___ 2. Once or twice____ 3. Thrice a week___
10.	If you are not in school, what class were you when you stopped	1. Primary4___ 2. JSS1___ 3. SS1____ 4. Primary5___ 4. JSS2____ 6. SS2____

	school?	7. Primary6___ 8. JSS3____ 9. SS3____
11.	Why did you stop school?	…… …… …….....
12.	What do you do during the day if/when you are not in school?	……
13	Where do you live?	…….
14	With whom do you live?	1. Father Alone_____ 2. Employer_____ 3. Friends_____ 4. Mother Alone____ 5. Guardian_____ (please specify) 6. Both Parents_____ 7. Other (specify)_____
15	How often do you go home?	……..
16	Are both your parents alive?	1. Yes 2. No 3. I don't know because …… …….. 4. I never knew my parents
17	Does your father have more than one wife?	1. Yes 2. No 3. I don't know
18	If yes, how many?	……
19	Does your own mother stay with your father?	1. Yes

		2. No 3. I don't know
20	If no, why not?	……...
21	What is your father's highest level of education	1. None 2. Primary education(not completed) 3. Primary education completed 4. JSS3 5. SS3 6. Vocational Training 7. University education 8. I don't know 9. Other, specify……..
22	What is your mother's highest level of education?	1. None 2. Primary education(not completed) 3. Primary education completed 4. JSS3 5. SS3 6. Vocational Training 7. University education 8. I don't know 9. Other, specify……..
23	Father's Occupation	……
24	Mother's Occupation	…….
25	Has there been any occasion that you had to sleep out of the house?	1. Yes 2. No
26	Has there been any occasion you had to	1. Yes 2. No

	sleep out on the streets?	
27	If yes, how often?	1. Rarely ____ 2. Most times___ 3. Sometimes____ 4. Always____
28	Think of the last time you had to sleep on the streets. Why did you have to?	…… …… ……
29.	Think of the last time you had to sleep on the streets, where did you sleep?	…….. ……..
30.	What time of the day do you spend on the streets?	1. Daytime only_____ 2. Night time only____ 3. Both daytime and night time_____
31	How many hours do you spend daily on the streets?	1. Less than 6hrs 2. 6hrs-12hrs 3. 12hrs and above
32	When last did you go home?	…….....
33	How did you come about spending __ hrs on the streets?	…… …….....
34	Why are you here ie why did you leave home?	…… …… ……

35	Have you ever been arrested by the police?	1. Yes 2. No
36	If yes, why?	…… …… …….
37	Where were you detained?	……
38	For how long were you detained?	……
39	Who bailed you/ How did you get out?	…… ……
	Nutritional Status Weight	……kg
	Height	……cm
40	During the past 30 days how many times did you go hungry because you did not have enough to eat?	1. Never 2. Rarely 3. Sometimes 4. Most times 5. Always
41	During the past thirty days, how often did you eat breakfast?	1. Never 2. Rarely 3. Sometimes 4. Most times 5. Always
42	During the past 30 days how often did you	1. Never 2. Rarely 3. Sometimes

	eat lunch?	4. Most times 5. Always	
43	During the past 30 days how often did you eat dinner?	1. Never 2. Rarely 3. Sometimes 4. Most times 5. Always	
44	Which of the following substances have you EVER used?	1. Palm wine 2. Beer 3. Local gin 4. Cigarette 5. Kola nut 6. Marijuana 7. Cocaine 8. Heroine Other (specify)…….	
45	**Substance Use** Which of the following substances do you currently use (in the past 30 days)?	1. Palm wine 2. Beer 3. Local gin 4. Cigarette 5. Kola nut 6. Marijuana 7. Cocaine 8. Heroine 9. Other (specify)…….	Qty/time ……..cups ……bottles ……shots ……...sticks ……..pcs …….wraps ……. ……. …….

46	During the past 3mths, how many times have been seriously injured?	1. None 2. Once 3. 2-3times 4. 4-5times 5. 6-7times 6. 8-9times 7. 10times and above	
47	During the past 30days, how many times have been seriously injured?	1. None 2. Once 3. 2-3times 4. 4-5times 5. 6-7times 6. 8-9times 7. 10times and above	
48	Think about the most serious injury you suffered? What (activity) were you doing when the most serious injury happened to you?	…… …… ……	
49	What kind of injury was it?(type e.g. fall, cut, burn etc)	…… ……	
50.	What part of the body was affected?	…… ……..	
51.	Did you seek treatment for this injury?	1. Yes 2. No	

52.	If yes, where?	……..
53	Who paid for the treatment?	……
54	During the last 3 months, how many times were you physically attacked?	1. None 2. Once 3. 2-3times 4. 4-5times 5. 6-7times 6. 8-9times 7. 10times and above
55	During the last 30days, how many times were you physically attacked?	1. None 2. Once 3. 2-3times 4. 4-5times 5. 6-7times 6. 8-9times 7. 10times and above
56	Think about the last time you were physically attacked, a. What happened? b. Who attacked you?	a.…… …….. b.……... ……..
57	During the past 30 days how many times did you get into a fight?	1. None 2. Once 3. 2-3times 4. 4-5times 5. 6-7times 6. 8-9times 7. 10times and above

58	State the most severe physical ailment/illness you've experienced in the past three months	…….. …… ……
59.	Describe the symptoms you experienced.	…… ……
60	How would you describe your general physical health, on a scale of 10?	1. Fully in good health (8-10) 2. Sometimes ill as anyone else (5-7) 3. Falls ill often (3-4) 4. Seriously ill (0-2)
61	**Common Diseases** Which of the following have you experienced in the last 30days (Tick all that apply)?	1. Fever____ 2. Headache____ 3. Vomiting____ 4. Diarrhoea___ 5. Common cold___ 6. Cough____ 7. Blood stained feces___ 8. Mucus Stained feces____ 9. Joint pains____ 10. Chest pain____ 11. Leg cramps____ 12. Ear ache____ 13. Burning micturition___ 14. Eye pain___ 15. Tooth ache____ 16. Others, please specify_____
62.	Are the symptoms a part of the same episode of illness?	1. Yes 2. No
63.	Did you seek treatment	1. Yes

	for the last episode of illness?	2. No
64.	If yes, where?	1. Chemist 2. Patent medicine store 3. Private hospital 4. Secondary centre 5. Tertiary Centre 6. Took herbal concoction 7. Other, specify……..
65.	Why did you choose the above treatment option?	…… …… ……
66.	Who paid for the treatment?	……
67	How much was paid?	……
68	**Dermal(Skin) Problems** Have you had any skin problems in the past 6months?	3. Yes 4. No
69	If yes, which of the following?	1. Boils 2. Sores 3. Itchy rash 4. Non itchy rash
70	Do you currently have any?	1. Yes 2. No
71	If yes, where (on what part of the body)?	.....

		……..
72	Which of the following describes the skin problem?	1. Boils 2. Sores 3. Itchy rash 4. Non itchy rash
73	How much do you earn daily?	.....
74	What do you do with the money you earn?	…… ……. ……..
75	How much do you spend daily?	…….
76	What are your future plans?	…….. …….. ……..
77	Do you think getting an education will enable you attain this?	1. Yes 2. No
78	If so, how?	……. ……. …….
79	If you were asked to request for three things you needed the most, in order of importance, what would they be?	…….. …….. ……..

		…….. …… …….….

INTERVIEWER GUIDE FOR IN DEPTH INTERVIEWS CARRIED OUT AMONGST STREET CHILDREN IN IBADAN MUNICIPALITY.

Date: Location:

Interviewer: Start time: End time:

Participant Characteristics:

1. Age
2. Sex
3. Marital Status
4. Religion:
5. Tribe
6. Level of education

INTERVIEWER INSTRUCTIONS

- Obtain verbal consent
- Ask Permission to turn on tape recorder
- Turn on tape recorder, then...

READ TO VOLUNTEER: Thank you for agreeing to let me interview you today. Before we begin, I would like to confirm that you have given your voluntary consent to participate in this interview

- Do you agree freely?
- Do you have any questions?
- OK then, I'd like to begin.

INTERVIEW QUESTIONS

1. Describe your family type/setting?
2. How many siblings do you have?
3. What position are you?
4. Do/did you enjoy life within your household?
5. What do you think about the economic situation in Nigeria?
6. How did you start working here (antecedent factors, people involved in introducing you to the streets)?
7. How often do you go home?
8. When you don't go home, where do you sleep?

9. Do you feel safe here?
10. Have you experienced any health challenges? Describe your experiences
11. Do you have any friends?
12. Has anyone ever threatened by anyone? Has anyone ever taken advantage of you? Describe your experiences.
13. What are your future plans/goals/aspirations?
14. How do you hope to achieve them? Thank You.

AKOJOPO IBEERE LORI ISORO ILERA ARA AWON OMO TO MAA NWA/SISE/GBE LOJU TITI IGBORO ILU IBADAN

	Ibeere	**Idahun**
ABALA A: ORO NIPA ARA ENI		
1.	Ojo ori	_____
2.	Ako ni abi abo?	3. Ako 4. Abo
3.	Orile ede	
4.	1. Esin:	6. Omoleyin Kristi 7. Musulumi 8. Esin ibile 9. Mi o ni igbagbo ninu olorun 10. Iyoku, jowo so ni pato_____
5.	Eya	5. Yoruba 6. Igbo 7. Hausa 8. Iyoku, jowo so ni pato_____
6.	Nje o lo si ile iwe ri	3. Beeni 4. Beeko
7.	Nje o je omo ile iwe lowo lowo?	3. Beeni 4. Beeko
8.	Ti o baje beeni, kilaasi wo lowa?	1. Primary4___ 2. JSS1___ 3. SS1____ 4. Primary5___ 5. JSS2____ 6. SS2____ 7. Primary6___ 8. JSS3____ 9. SS3____
9.	Emelo loma n lo sile iwe ni ose?	Ojoojumo ☐ Ekan tabi eem☐ Eemeta ☐
10.	Ti o ko ba wa ni ile iwe bayii, kilaasi wo lo wa nigbati o dekun lati	1. Primary4___ 2. JSS1___ 3. SS1____ 4. Primary5___ 4. JSS2____ 6. SS2____ 7. Primary6___ 8. JSS3____ 9. SS3____

	maa losi ile iwe?	
11.	Kilode ti o ko fi lo si ile iwe mo?	……. ……. …….....
12.	Kilo maa nse ni oojo to o ko ba lo si ile iwe?	……
13	Nibo ni o n gbe?	…….
14	Tani o n ba gbe?	Baba nikan☐ Oga r☐ Iya nikan ☐ Olutoju/Alagbatoo (Jowo so ni patoo) _____ Obi mejeeji☐ Iyoku (so ni patoo)_____ Awon ore ☐
15	Emelo lo maa n lo sile?	……..
16	Se awon obi re mejeeji wa laye?	Beeni ☐ Beeko☐ Ti o ba je beeko, tani ninu won ni ko simo? Baba☐ Iya☐ Awon mej☐
17	Nje baba re ni ju iyawo kan lo?	Beeni☐ Beeko ☐ Mi o mo_____
18	Ti o ba je beeni, iyawo melo ni baba	……

	re ni	
19	Nje iya re ngbe pelu baba re?	Beeni ☐ Beeko ☐ Mi o mo_____
20	Ti o ba je beeko, kilode?	……...
21	Iwe melo ni baba re ka?	10. Won ko lo si ile iwe rara 11. Won ko pari iwe alako bere 12. Won pari iwe alako bere 13. Won ko pari ile iwe girama(iwe mewaa 14. Won pari ile iwe girama(iwe mewaa 15. Won lo si ile iwe ikose 16. Won lo si ile iwe giga yunifasiti I don't know 17. Iyoku, jowo so ni pato ……..
22	Iwe melo ni iya re ka?	1. Won ko lo si ile iwe rara 2. Won ko pari iwe alako bere 3. Won pari iwe alako bere 4. Won ko pari ile iwe girama(iwe mewaa 5. Won pari ile iwe girama(iwe mewaa 6. Won lo si ile iwe ikose 7. Won lo si ile iwe giga yunifasiti I don't know 8. Iyoku, jowo so ni pato ……..
23	Ise ti baba re nse	……
24	Ise ti iya re nse	…….
25	Nje o ti waye pe o sun sita gbanga, ni titi?	3. Beeni 4. Beeko
27	Ti obaje beeni, bawo lo se wopo si?	Osowon ☐ Lopo igba☐ Nigba n☐ Gbog☐gba
28	Ronu nipa igba ti o sun	……

	ni gbangba/tabi loju titi nigba akoko, ki lo se okunfa re?	…… ……
29.	Ronu nipa igba ti o sun ni gbangba/tabi loju titi kehin, ki lo se okunfa re?	…….. ……..
30.	Igba ojo wo ni o ma nlo ni gbangba/loju titi?	4. Ojumo_____ 5. Owo ale____ 6. Mejeeji_____
31	Wakati melo lomaa nlo loju titi ni ojoojumo	4. O kere ju wakati mefa 5. Mefa si mejila 6. Mejila ati jubeelo
32	Igbawo lolo sile keyin?	…….....
33	Bawo ni oseje ti o nlo wakati _____ loju titi	…… …….....
34	Ki lo de ti o wa nibi yi?	…… …… ……
35	Nje awon olopa ti mu o ri?	3. Beeni 4. Beeko
36	Ti o baje beeni ki lode?	……

		…… …….
37	Nibo ni won ti e mo?	……
38	O to igba wo ni won fi ti e mole?	……
39	Ta lo wa gba o sile?	…… ……
	Igbewon nipa to oro ounje: Osuwon	……kg
	Iwon ni giga	……cm
40	Lati ojo to koja, igba melo loti pebi monu tori wipe oko nito lati je?	Ko sele ri ☐ Lopo igba ☐ Osowon ☐ Gbogbo igba ☐ Nigba mii ☐
41	Lati ogbon ojo ti o koja, igba melo lo je ounje aaro?	Ko sele ri ☐ Lopo igba ☐ Osowon Gbogbo igba ☐ Nigba mii ☐
42	Ni ogbon ojo to koja emelo ni oje ounje	Ko sele ri ☐ Lopo igba ☐ Osowon Gbogbo igba ☐

	osan ?	Nigba mii ☐	
43	Ni ogbon ojo to koja emelo ni oje ounje ale?	Ko sele ri ☐ ☐ Osowon Nigba mii ☐	Lopo igba ☐ Gbogbo igba ☐
44	Melo ninu awon nkan ti o n pani lara lo ti lo ri?	9. Emu 10. Oti 11. Ogogoro 12. Siga 13. Obi 14. Igbo 15. Kokeeni 16. Iroini Iyoku(Jowo so ni pato	
45	Melo ninu awon nkan ti o n pani lara lo ti lo n lo lowo lowo(Ojo obon sehin)?	1. Emu 2. Oti 3. Ogogoro 4. Siga 5. Obi 6. Igbo 7. Kokeeni 8. Iroini 10. Iyoku(Jowo so ni pato	Osuwon loojo …….. …… …… ……... ……. ……. ……. ……. ……. ……..

IFARAPA

Ifarapa tole ni eyiti kii jeki ose nko ti o ma nse lojoojumo(ise oojo) fun ojo kan, tabi jubeelo ti o si je pe o nilo lati gba itoju.

46	Ni osu meta to koja seyin, emelo loti ni ifarapa tole?	Kosi rara ☐ Eekan ☐ Emeji tabi emeta ☐ Emerin tabi emarun ☐ Emefa tabi emeje ☐ Emejo tabi emesan ☐ Emewa tabi jubelo ☐
47	Ni ogbon ojo to koja, emelo ni otini ifarapa tole?	Kosi rara ☐ Eekan ☐ Emeji tabi emeta ☐ Emerin tabi emarun ☐ Emefa tabi emeje ☐ Emejo tabi emesan ☐ Emewa tabi jubelo ☐
48	Ki ni onse nigba ti ifarapa to le ju sele si o?	…… …… ……
49	Iru ifarapa wo ni?	…… ……
50.	What part of the body was affected?	…… ……..
51.	Nje o lo fun itoju nigbe ti o farapa?	5. Beeni 6. Beeko
52.	Ti o ba je bee nibo ni o ti lo fun itoju naa?	……..
53	Tani o sanwo fun itoju naa?	……

54	Ni osu meta ti o koja, emelo ni won se o lese?	Kosi rara ☐ Eekan ☐ Emeji tabi emeta ☐ Emerin tabi emarun ☐ Emefa tabi emeje ☐ Emejo tabi emesan ☐ Emewa tabi jubelo ☐
55	Ni ojo ogbon ti o koja, emelo ni won se o lese?	Kosi rara ☐ Eekan ☐ Emeji tabi emeta ☐ Emerin tabi emarun ☐ Emefa tabi emeje ☐ Emejo tabi emesan ☐ Emewa tabi jubelo ☐
56	Nigba ti won se e lese kehin, c. Ki lo sele? d. Talo se o lese?	a.…… …….. b.……... ……..
57	Ni osu meta seyin emeelo lo ti wo ijakadi?	Kosi rara ☐ Eekan ☐ Emeji tabi emeta ☐ Emerin tabi emarun ☐ Emefa tabi emeje ☐ Emejo tabi emesan ☐ Emewa tabi jubelo ☐
58	So aisan ti o le ju ti o se o ni osu meta sehin?	……..... …… ……
59.	Salaye awon apere bi aisan na se se o?	…… ……
60	Bawo lo se ri ilera re si. Ninu ookan si mewa? Bawo lara re se le si	5. Ara mi ya gaga (8-10) 6. Mo maa n saisan leekokan (5-7) 7. Mo ma n saisan lera lera (3-4) 8. Mo n saisan gidi gan (0-2)
61	**AISAN TO WOPO**	Iba ☐ Ara riro ☐ Eje ninu igbe ☐ Oju ara tita ti aba nto

	Ewo ninu awon eyi lo ti ni iriri re ni ogbon ojo to koja?	Ori fifo ☐ Yiya igbe sisan ☐ Ikun ninu igbe ☐ Bibi ☐ Iko ☐ Ese didun ☐ Eyin didun Ofikin ☐ Oju didun ☐ Eti riro ☐ Iyoku so ni patoo_____
62.	Se ni igba kan naa lo ri awon apeere to so loke?	1. Beeni 2. Beeko
63.	Nje olo fun itoju nigba too ri awon apeere wonyi?	1. Beeni 2. Beeko
64.	Ti o ba je beeni, nibo lo ti lo fun itoju?	1. Kemisti 2. Ile iwosan to je alabode ti ijoba 3. Soobu tiwon ti n ta oogun 4. Ile iwosan gbogbogbo to je ti ijoba 5. Ile iwosan aladani 6. Ile iwosan nla to je ti ijoba? 7. Omiran (so ni patoo)_____
65.	Ki ni idi ti o se lo si ibi to lo fun itoju?	…… …… ……
66.	Talo sanwo fun itoju re	……
67	E lo ni won san?	……

68	ISORO TO JEMO AWO ARA Nje oti ni isoro to jemo awo ara ni osu mejila seyin?	1. Beeni 2. Beeko
69	Ti o baje beeni, ewo ninu awon wonyi?	Egbo ☐ Oowo ☐ Ara sisu ti o n yun n ☐ Ara sisu ti ko yun ni ☐
70	Nje o ni isoro to jemo awo ara lowolowo?	1. Beeni 2. Beeko
71	Ti o ba je beeni, nibo laraa re lo wa?	..... ……..
72	Bawo ni isoro to je mo ti awo ara yii ti ri?	Egbo ☐ Oowo ☐ Ara sisu ti o n yun n ☐ Ara sisu ti ko yun ni ☐
73	Elo ni on pa lojumo?	.....
74	Kini o nse pelu owo ti o n pa?	…… ……. ……..

75	Elo ni o ma n na ni oojo	…….
76	Ki ni eto tabi eron gba re fun ojo iwaju?	…….. …….. ……..
77	Nje oro wipe ti o ba ni eko iwe, yio je ki o le mu erongba re fun ojo iwaju se?	3. Beeni 4. Beeko
78	Ti o ba je beeni, bawo?	……. ……. …….
79	Ti won ba ni ki o beere fun nkan Pataki meta to nilo julo, bi nkan meta naa se se Pataki si, ki ni won yoo je?	…….. …….. …….. …….. ……. …….....

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IMRAT)
COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN, IBADAN, NIGERIA.
Telefax: 234-805-0382048, 07028383980, 07028383039 /3310,3120,3114, 2451,Fax: 234-2-2413545
E-mail: Imratcomui@yahoo.com, gfalusi@yahoo.com
Ag. DIRECTOR: Professor Adeyinka G. Falusi, *B.sc (Hons), M.Phil., Ph.D.*

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Physical Health Problems of Street Children in Ibadan Municipality

UI/UCH Ethics Committee assigned number: UI/EC/09/0117

Name of Principal Investigators: Abiiann Modupeola

Address of Principal Investigator: Institute of Child Health,
College of Medicine,
University of Ibadan, Ibadan

Date of receipt of valid application: 28/09/2009

Date of meeting when final determination of research was made: 10/12/2009

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and *given full approval by the UI/UCH Ethics Committee.*

This approval dates from 10/12/2009 to 09/12/2010. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the UI/UCH EC assigned number and duration of UI/UCH EC approval of the study.* In multiyear research, endeavour to submit your annual report to the UI/UCH EC early in order to obtain renewal of your approval and avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. No changes are permitted in the research without prior approval by the UI/UCH EC except in circumstances outlined in the Code. The UI/UCH EC reserves the right to conduct compliance visit to your research site without previous notification.

UI/UCH EC
10 DEC 2009
APPROVED
COLLEGE OF MEDICINE, U.I.

Adeyinka G. Falusi, (FAS)
Professor/Chair, UI/UCH EC
E-mail:ethicsuichlec@yahoo.com