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The dynamics of women's homelessness in Ethiopia

Understanding the lives of women experiencing homelessness and the services and policies designed to meet their mental health and well-being needs

KALKIDAN YOHANNES

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Abstract

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This thesis aimed to gain a deeper understanding of the lives of women experiencing homelessness and the services and policies designed to meet their mental health and well-being needs by exploring lived experiences and multiple perspectives of both women of reproductive age and individuals providing homeless-focused mental health and psychosocial services in Addis Ababa, Ethiopia.

For **Paper I**, a photovoice study, women experiencing homelessness (n=9) were provided with cameras and asked to photograph their lives on the streets and discuss the images. Data from the photographs, interviews, and discussions were co-analysed with the women, and reflexive thematic analysis was also performed. Findings revealed that homeless women were deprived of basic needs, struggled with addiction, humiliated, and treated as social pariahs. Further, many children on the streets struggled with adversity from an early age, being subjected to violence and exploitation.

Based on in-depth interviews with 19 women who experienced homelessness, **Paper II** showed how the common threads of abuse, micro-level relational factors, and housing issues shaped women's trajectories through homelessness. The reflexive thematic analysis identified four main themes: trauma from childhood abuse, sexual violence, barriers to leaving street living, and sources of hope. The findings highlighted how re-traumatisation on the streets fuels these adverse traumatic experiences. However, although they faced personal, economic, and normative barriers, some women highlighted their resilience, willingness to seek support, and reliance on their strength and faith.

Papers III and IV recruited participants from government and non-government organisations. The findings of the inductive thematic analysis in **Paper III** demonstrated that contradictory beliefs and practices, problem−solution incompatibility, and mismatched resources all hindered the provision of psychosocial services to women experiencing homelessness.

The data collected for **Paper IV** were analysed using Shiffman and Smith's political prioritisation framework. The results indicated gaps in actors' power, how homelessness is portrayed in varying political contexts, and other issues of this topic (including lack of reliable indicators, effective interventions, and sufficient information on the problem's severity). Overall, the thesis identified that interventions targeting individual-level vulnerabilities to systemic-level challenges are needed to address the multifaceted aspects of women's homelessness.

Keywords: women's homelessness, trajectories through homelessness, health and well-being, photovoice, mental healthcare, psychosocial support, rough sleeping, qualitative study, dynamics of homelessness, Ethiopia, East Africa

Kalkidan Yohannes, Uppsala University, WoMHeR (Centre for Women's Mental Health during the Reproductive Lifespan), Box 256, Uppsala University, SE-75105 Uppsala, Sweden. Centre for Health and Sustainability, Akademiska sjukhuset, Uppsala University, SE-75185 Uppsala, Sweden.

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To my parents, my siblings, and everyone experiencing homelessness—especially women and children facing street homelessness: may your voices be heard and your faces seen. I hope this research inspires change and brings you the hope and action you seek.

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I. Yohannes K, Målqvist M, Bradby H, Berhane Y, Tewahido D, Herzig van Wees S. "Sleepless nights are a daily reality for us" How mothers experiencing homelessness in Addis Ababa, Ethiopia describe street life: A Photovoice study. Front Public Health. 2025;13:1488770.

II. Yohannes K, Bradby H, Herzig van Wees S, Berhane Y, Persson-Fischier U, Målqvist M: "I had no choice but to escape": Exploring women's early life experiences, drivers, and trajectories through street homelessness in Addis Ababa, Ethiopia. Submitted

III. Yohannes K, Berhane Y, Bradby H, Herzig van Wees S, Målqvist M: Contradictions hindering the provision of mental healthcare and psychosocial services to women experiencing homelessness in Addis Ababa, Ethiopia: service providers' and programme coordinators' experiences and perspectives. BMC Health Serv Res 2023, 23(1):821: (2023) 23:821:

IV. Yohannes K, Målqvist M, Bradby H, Berhane Y, Herzig van Wees S: Addressing the needs of Ethiopia's street homeless women of reproductive age in the health and social protection policy: a qualitative study. Int J Equity Health 2023, 22(1):80

Contents

Abbreviations

ACEs	Adverse Childhood Experiences
AMSH	Amanuel Mental Specialized Hospital
BICDO	Birhan Integrated Community Development Organisation
ICESCR	International Covenant on Economic, Social and Cultural Rights
MHPSS	Mental Health and Psychosocial Support
mh-GAP	Mental Health Gap Action Programme
MoLSA	Ministry of Labour and Social Affairs
MoWSA	Ministry of Women and Social Affairs
UDHR	Universal Declaration of Human Rights
UN-Habitat	United Nations Human Settlements Programme
WHO	World Health Organisation

Introduction

The growing importance of researching homelessness is becoming increasingly evident (1). To define homelessness, it is vital to understand what a 'home' means. Somerville (2) has argued that homelessness should be understood through the lens of the meaning of home, suggesting that the two concepts are interdependent. Beyond its physical attributes, namely space and place, a home is profoundly shaped by its social context (3). Therefore, it is a place of relationships, emotional connection, and belonging (3). Furthermore, the legal and security-based conception of the home is also crucial, as it emphasises a 'legal home' in which ownership and rights are assured (3). Hence, the multidimensional understanding of the term 'home' can help address the complex challenges faced by individuals experiencing homelessness.

Busch-Geertsema and his colleagues (4) have previously studied various definitions of homelessness from homelessness-focused organisations and studies, as well as definitions from low- to middle- and high-income countries. They have defined homelessness as 'living in severely inadequate housing' (4).

This definition considers the three domains of home including the security domain, physical domain, and social domain in different types of homelessness categories (i.e. people without accommodation, people living in temporary or crisis accommodation, and people living in severely inadequate and/or insecure accommodation) (4, 5). This thesis specifically focuses on the first category, addressing the situation of women who are experiencing homelessness; in other words, it concerns women who are 'without accommodation' or in a place not intended for human habitation. For example, these women sleep in the streets or other open spaces.

Women or households that live on the streets in regular spots, including those with makeshift covers, are included in this thesis. Hence, this thesis aimed to answer the following research question 'what experiences shape the lives and trajectories of homeless women of reproductive age, and how do existing services and policies address their mental health and well-being needs?'

Global figures on homelessness

Despite country-specific definitions of homelessness and household-level censuses, two organisations have presented global statistics on homelessness. These are the United Nations Human Settlements Program (UN-Habitat) global survey (6) and, most recently, the World Economic Forum's Global Homelessness Report (7). The UN-Habitat report showed that in 2022, there was a lack of adequate housing, and over 1.12 billion people lived in informal settlements and slums (6).

The World Economic Forum report previously stated that 150 million people were homeless worldwide (7), but the types of homelessness were not clarified. While these figures demonstrate how homelessness is a global issue, census data do not consider people who experience 'hidden' homelessness (8), in addition to the problems mentioned above.

Causes of women's homelessness

Among the driving factors that lead women to become homeless are individual-level risk factors; adverse relationships with parents; and structural, economic, and environmental factors (1, 9, 10)

Adverse childhood experiences- traumatic experiences

Adverse childhood experiences (ACEs) include physical and emotional neglect; physical abuse; verbal abuse; parental separation; sexual exploitation; and unstable households marked by domestic violence, parental substance misuse, mental health conditions, as well as criminal activity (11).

The absence of parental care during childhood, physical abuse, sexual abuse, and other immediate predisposing/triggering factors for homelessness not only act as risk factors for homelessness but also contribute to the cycle of homelessness (12). A review found that the lifetime prevalence of one or more ACEs among people experiencing homelessness was 89.8%, with 53% experiencing one or more ACEs in their lifetime (13). In addition, the high prevalence of ACEs is also positively associated with suicidal behaviour, depression, and substance abuse (13). Furthermore, a study of women across the United States, United Kingdom, and Australia found that childhood abuse was a leading cause of homelessness, with one in every three people having experienced childhood sexual trauma (14). In Ethiopia, 41.15% of children have experienced sexual abuse (15).

Unconducive family environments

The family environment may be defined as the perception each member has of their family (16), and a dysfunctional family refers to 'a family in which relationships or communication are impaired, and members are unable to attain closeness and self-expression' (17). The defining characteristics of dysfunctional family dynamics include drug or alcohol abuse, poor communication, lack of empathy, and excessive criticism (18).

An unhealthy family environment, especially one that includes family dysfunction, marital breakdown, or child abuse, has been proven to be the leading cause of homelessness (19, 20). In addition to the aforementioned individual vulnerabilities and unconducive family environmental factors, intimate partner violence and interactions with institutions have been reported to play a significant role in causing homelessness among women (9, 21).

In addition to homeless women experiencing various abuses and adverse exposures (10, 22), studies have demonstrated that women who have experienced sexual abuse and severe dissociation in childhood are highly vulnerable to further incidents of sexual violence (23, 24) and various challenges related to women's service engagement (23).

Similarly, studies have documented that various traumatic life experiences not only predispose women to future homelessness but also to multiple episodes of it (10, 23, 25).

Consequences of women's homelessness

Researchers have demonstrated that homelessness in women, especially for those with young children, has intergenerational and multifaceted impacts (26, 27). Experiencing a lack of access to basic human requirements (food, water, shelter, clothing, and sleep) due to street homelessness (28, 29), these women are forced to live on the streets in a state of extreme danger (30) and face unmet health needs (31). Such experiences are contrary to Articles 1 and 22 of the Universal Declaration of Human Rights (32) and Article 11 (1) of the International Covenant on Economic, Social, and Cultural Rights (33). In addition to being deprived of the basic needs for human survival, factors such as street life, hazardous environments, the lack of family nearby, the fact of their female gender, and friends who have engaged in sex work also expose women to a greater likelihood of further physical and sexual exploitation (34, 35), as well as criminalisation in law and isolation from a society with of individual and social othering (36, 37).

Moreover, studies have shown that certain health conditions can contribute to homelessness (38, 39). Women experiencing homelessness are often vulnerable to various psychiatric disorders, including major depressive disorders and anxiety disorders, with reported prevalence rates ranging from 15.8% to 53% (40-42). Other studies have reported a 29.1% to 40% prevalence of post-traumatic stress disorder among women experiencing homelessness and have

shown that dependency on alcohol and other drugs is also widespread among homeless women, including those without children (43).

A recent review has revealed a bidirectional association between substance addiction and homelessness (44). Furthermore, studies from Ethiopia have reported that the causes of substance misuse among individuals experiencing homelessness include peer pressure, distressing events, the need to conform to street culture, and the desire to cope with stress and improve performance at work (45, 46).

Additional studies have found a prevalence of addiction to crack cocaine, sedatives, alcohol, methadone, cannabis, heroin, and tobacco among this population (47, 48). Reports indicate that homeless women consume four times more alcohol and 12 times more drugs compared to the general female population (49). Women, especially those of reproductive age, face reproductive health- and service-related challenges when living on the streets (50, 51). These include unintended pregnancies, sexually transmitted infections (STIs), unmet family planning needs, and gynaecological problems (50-53).

Homeless Women's Coping Strategies

Coping refers to 'the thought processes and behaviours mobilised to deal with internal and external stressful situations' (54). The process of coping begins with appraisal (55), which involves assessing a situation to determine its meaning and how to respond to it. This first stage in the coping process is essential for deciding the best course of action (55). During the primary appraisal process, an individual encounters a potential stressor and must decide how to handle it (55). If the situation is deemed stressful and requires a response from the individual, a second appraisal is conducted. This appraisal determines the coping strategies applied (56, 57).

In general, there are four main categories of coping strategies. The problem-focused coping strategy highlights the underlying issue driving the distress; the emotion-focused approach seeks to reduce the negative emotions associated with the problem through positive reframing, acceptance, prayer, and humour; the meaning-focused approach involves using cognitive strategies to determine and manage the implications of the situation; and in the social coping approach, the individual reduces stress by seeking emotional or instrumental support from their community (54).

Individuals experiencing homelessness develop a variety of survival or coping strategies to fulfil their basic material needs (10). Many of these activities are common among disadvantaged people in general, such as using meal services (58); relying on social networks (59); scavenging (60); and engaging in bartering, informal labour, peddling, hustling, and petty crimes (61).

However, gender differences exist in the application of some of these strategies (61, 62). Women experiencing homelessness are less likely to engage in daily labour, peddling, or begging on the street compared to homeless men (61, 62).

Existing mental health issues can be exacerbated by a lack of access to healthcare (44). A study has found that a lack of social cohesion, service access barriers, and resource scarcity-related issues are factors in chronic homelessness (63). It is important to note that people experiencing homelessness lose more than just their homes; they also lose their social and family connections (10). Furthermore, such individuals often lack access to healthcare, education, and job opportunities (10).

Consequently, homeless women require support that explicitly addresses their mental health and psychological needs (64). Any assistance that aims to safeguard or promote psychological and social well-being and prevent or treat mental health conditions falls under the term 'mental health and psychosocial support' (MHPSS) (65).

This type of service is not limited to a single sector; instead, it requires a multisectoral approach involving collaboration among partners in health-, education-, and community-based protection; child protection; and protection against gender-based violence (65).

However, a lack of health insurance, service delivery impediments, poor service provision coordination, discrimination against people experiencing homelessness, and inadequate mental health outreach can also hamper mental health service provision for this section of society (66, 67).

Country context; Ethiopia

Situated in Northeast Africa, also known as the Horn of Africa, Ethiopia is the second-largest country in Africa in terms of population and has the 10th-largest total land area. It occupies 1.1 million square km², and its water bodies occupy 7,444 km^2 (68). Numerous ethnic groups reside in Ethiopia, where people speak over 80 languages. In 2024, Ethiopia's population was over 135 million, making it the 10th most populous country in the world (68, 69)

The government structure is a federal state comprising 12 regional states and two federal city administrations. In most cases, two hierarchical layers of subregional administrative units, known as zones and woredas, further divide the regional states and city administrations (Figure 1).

Figure 1. Map of Ethiopia (Source: Worldometer)

Policy frameworks and service delivery arena

In 1995, the federal government of Ethiopia passed a constitution (70) outlining the following rights: the right to honour and reputation (Article 24), the right to equality (Article 25), the rights of women (Article 35), the rights of children (Article 35), and the right to access justice (Article 37). Article 41.1 specifically addresses the rights of citizens to health, education, and social rights, which Article 90 (1) also underscores.

The healthcare system in Ethiopia

The Ethiopian government issued its first written national health policy in 1993 (71). The current health tier system comprises primary healthcare, which includes health posts, health centres, and primary hospitals; secondary healthcare, which includes general hospitals; and the highest tier, tertiary healthcare, which includes specialised hospitals (72).

The current health strategy envisions Ethiopia's path towards universal health coverage by strengthening primary healthcare (72). Ethiopia launched its innovative health extension programme in 2003 to address health issues in both urban and rural areas (73). Various guidelines, strategies, and programmes have been implemented to address the population's health needs in an organised way (74-77), including the mental health strategy (75).

Mental healthcare service delivery context

In Ethiopia, mental health services are available at healthcare centres, general hospitals, referral hospitals, and specialised hospitals (75). Mental health institutions specialising only in mental health treatment – St. Amanuel Mental Specialised Hospital, Geferssa Mental Rehabilitation Centre, and various hospitals – have served the community for many years (75, 78). In addition to institutions that provide mental and psychological services for children and adults, the establishment of institutions that offer addiction rehabilitation services has also improved service availability (79).

Psychiatric and psychological services encompass various modalities, such as individual, couple, group, and family therapies; inpatient care, including emergency management of acute cases; and outpatient services, with or without medication (80).

Ethiopia's governmental and non-governmental institutions provide outpatient and inpatient mental health services (75). Such services are provided by psychiatric nurses, psychiatric practitioners (With MSc degrees in integrated clinical and community mental health), and specialist doctors (75). However, there are far fewer psychiatrists than the World Health Organisation (WHO) recommends (81).

Furthermore, the fact that these psychiatrists are located in the country's capital, Addis Ababa, exacerbates this professional gap. One of the most significant efforts to enhance mental health service accessibility is the Mental Health Gap Action Programme (mh-GAP), launched by the WHO in 2008 to expand mental health services (82).

The WHO's mh-GAP aims to increase access to treatment for people in low- and middle-income countries, particularly for mental, neurological, and substance use disorders (82). The Ethiopian government's strong commitment to mental health services includes implementing the mental health strategy, increasing the number of mental health professionals, integrating mental healthcare into existing health extension workers' responsibilities, and allocating a dedicated budget for mental health services (83).

Although there are undoubtedly benefits to such programme integration and government commitment (83), particularly concerning the high prevalence of mental health conditions among people experiencing homelessness in various parts of the country (84, 85), no service delivery structure has yet been designed to reach this population group (84). In addition, inefficient planning and implementation capacity, a shortage of human resources, and low population demand for mental healthcare present barriers to mental health service delivery (83).

The context of social protection in Ethiopia

Formerly known as the Ministry of Labour and Social Affairs (MoLSA), the Ministry of Women and Social Affairs supports women (MoWSA), children,

youths, people with disabilities, and other marginalised segments of the population (86). Along with others that provide social support for people who are experiencing homelessness, this ministerial office works in collaboration with both governmental and non-governmental organisations to provide services and support (87).

The ministry has established a national social protection policy (88) and a national social protection strategy (89), explicitly describing the federal and local governments' roles and responsibilities in managing the country's social protection system. Views on social protection differ across countries and professions (90). In Ethiopia, the social protection policy comprises a set of rules intended to reduce social and economic risk, vulnerabilities, and deprivation while encouraging fair growth (88).

Moreover, besides the social protection policy, the national social protection strategy is based on four interrelated concepts (89). When viewed from an intervention lens, each concept has a particular focus: (1) protection, which involves ensuring that young people and those at risk, such as pregnant women, can obtain money and social opportunities; (2) prevention, which entails stopping vulnerable groups from dealing with their problems in an unhealthy way; (3) promotion, which relates to giving jobs to people in poverty to help them make a living; and (4) transformation, which comprises giving people more economic power and responding to and preventing human rights violations (89).

Although the term 'vulnerable' is frequently used in policy and strategy to refer to children, people with disabilities, and other vulnerable adults, these documents do not explicitly mention those individuals who are experiencing homelessness (88, 89). Nevertheless, the ministry and city administration have indicated that these population groups are the target groups of the ongoing services.

One international organisation supporting the urban poor is the World Bank, which provides opportunities for people to attain financial literacy through technical training and start-up grants. The World Bank's ongoing programmes in Ethiopia support people and aim to enhance resilience by focusing on social inclusion, institutional development, economic opportunities, job creation, and service delivery (91).

The rationale for the thesis

Women's homelessness is known to have gender-specific trajectories and impacts upon health needs, having multifaceted effects on women's health and wellbeing. Therefore, practical and context-specific support should be provided to address this pressing social and public health issue, which has not only multidimensional negative impacts on the women themselves but also profound intergenerational impacts on their children, families, and indeed the growth and development of the country. While the available literature points to the significant problem of homelessness in Addis Ababa due to the context of the civil war over the past few years, the rising urban migration rate, and the exceedingly high cost of living, there is nevertheless a paucity of evidence explaining why and how women become homeless and remain in this condition. In essence, our understanding of the circumstances surrounding women's homelessness in the capital of Ethiopia remains poor. Furthermore, there is a lack of understanding with regard to mental healthcare and the policy environment in terms of political priorities and the services available for homeless women. Additionally, there is also a lack of participatory research into the lives of women on the streets, which could promote proposals for the direction of social change. In summary, our understanding of the dynamics of women's street homelessness in Addis Ababa is limited. Therefore, the overall aim of this study was to gain a deeper understanding of the issues surrounding women's homelessness, which arise from individual- to systemic-level factors that affect the lives, mental health, and wellbeing needs of this marginalised group.

Aim and objectives

Overall aim

The overall aim of this thesis was to gain a deeper understanding of the lives of women experiencing street homelessness and the services and policy landscape designed to meet their mental health and well-being needs in Addis Ababa, Ethiopia.

Specific objectives

1. To describe women's experiences of street homelessness in their own terms and their suggestions for addressing their unmet needs.

2. To explore women's early life experiences, what drives them to homelessness, their trajectories through it, and the challenges inherent in their reintegration into the community.

3. To explore how service providers and programme coordinators perceive and experience the delivery of mental healthcare and psychosocial services to women experiencing homelessness.

4. To examine factors that have shaped the influence of policymaking for the health and well-being needs of homeless women of reproductive age.

Methods

Study area

The fieldwork for this thesis was conducted in Addis Ababa, Ethiopia. As the capital of Ethiopia, Addis Ababa has a population of 3,860,000 people (68). The city is one of the fastest-growing in Africa, with significant development projects underway (92). Data were collected from a local charity organization called Birhan Integrated Community Development Organization (BICDO) for the first two papers.

BICDO was selected based on several criteria: (1) The first study was participatory, involving participants from various neighborhoods within Addis Ababa and different parts of the country, all of whom had experienced varying durations of homelessness; (2) As women are the target population of the organization, they were given sufficient representation; and (3) Co-analysis presented challenges, making the researcher's convenience an important consideration.

Data for papers III and IV were collected from various governmental and non-governmental institutions. These included the MoWSA, the Addis Ababa City Administration, the Labour and Social Affairs Bureau, the Addis Ababa City Administration Health Bureau, Eka Kotebe General Hospital, Mekedonia Charity Association, Gergesenon Charity Organisation, Born Again Rehabilitation Center, Bureau of Women, Children and Youth Affairs, the Addis Ababa Mayor Office, St. Amanuel Mental Specialised Hospital and other charity organisations and associations. The selection of these institutions was based on the following criteria: (1) These institutions have been directly involved in the issues of street people and are governmentally mandated offices; (2) The Addis Ababa City Government is directly responsible for health and social issues and women's issues; (3) These are charity organisations that focus on street people and the mentally ill; and (4) Hospitals and associations that work with various governmental and non-governmental organisations are also included.

Study design

This thesis used a qualitative approach to capture multiple perspectives through different lenses. Qualitative research interviews are used to obtain an in-depth description of the participants' lived experiences based on their own interpretation. Blanche et al. (93) proposed four dimensions for selecting a research design: the research purpose, the theoretical paradigm informing the research, the situation or context, and the research method used to gather and analyse the data. Accordingly, we employed qualitative interviews, photographs, and focus group discussions involving individuals from government and non-government organisations and homeless women of reproductive age (18–49) in Addis Ababa, Ethiopia, to understand the dynamics of street homelessness among women.

Paper I utilised a participatory approach, conducting a photovoice study with women experiencing homelessness. According to research, a participatory approach promotes individual and societal change (94-96). Moreover, Caroline Wang and Mary Ann Burris (97) introduced photovoice as a community-based action research strategy that allows individuals to identify, represent, and enhance their communities. This method has been applied to various contexts (98), including people experiencing homelessness (99, 100). In this thesis, the participatory nature of photovoice allows women, especially those of childbearing age who have been living on the streets with their children for short or long periods in different neighbourhoods of Addis Ababa, to take photos that reflect their own lives to increase ownership of the research process. Taking photographs allows them to reflect on their perspectives and focuses, express their lives in their own terms (97), and become empowered (101), since photos are often richer than words (102). Since photovoice is a method that promotes social change (98), we believed that using it with women experiencing street homelessness would positively impact them and allow them to see their lives through different lenses.

Paper II used an exploratory qualitative study design. According to Blanche and his colleagues (93), an exploratory design seeks new insights into existing phenomena. Hence, this design was used to determine new understandings of women's homelessness in Ethiopia, specifically to understand women's lived experiences, from childhood throughout their journey to homelessness and their community reintegration challenges.

Papers III and IV used a descriptive, qualitative approach to capture the experiences and perceptions of employees and managers of various government and non-government organisations. This approach attempts to discover *"the who, what and where of events"* (103).

Study participants

Papers I and II involved women living on the streets with their children. **Paper I** focused on nine women who were of reproductive age (18−49) experiencing homelessness. It used photovoice to gain comprehensive insights into how they experience homelessness and depict their street lives through photographs. A criterion for this study was that the participants had to have been on the street for at least six months because these women tended to stay in different neighbourhoods over a few months, seeking safer places and better sources of income. Those who had been in a particular location for six months better understood the street context and could develop a more comprehensive picture of street life based on their lived experiences than those who had newly arrived. Moreover, people who were severely addicted to drugs, seriously ill, or grieving were not invited to take part in this study because it required a significant commitment to take photographs as a field researcher and participate in active dialogue, group sessions, a public exhibition of the photos, and an interview (97).

Paper II, which aimed to understand women's trajectories through homelessness, focused on 19 women of reproductive age (18−49) who were living on the streets in Addis Ababa, Ethiopia. Although the reproductive age group is 15−49 (following the standard demographic category, reproductive trends, and public and policy focus), for ethical reasons, only those aged over 18 were contacted to participate in the study. Women experiencing homelessness were chosen because this population is exposed not only to the same problems as men experiencing homelessness but also to highly gendered homelessness experiences. Although being a mother or living on the streets with a child was not a criterion for inclusion in the study, all the participants were mothers, and some had given birth to children after leaving the streets. Moreover, even though the duration of homelessness was not a criterion, being a current street dweller and being willing to participate in the study were key requirements.

Papers III and IV involved interviews with professionals from various government and non-government organisations, from low-level to high-level positions, including founders. These individuals were chosen because (i) they are founders and leaders of charity organisations that address the needs of people experiencing homelessness (although each organisation has a different target population); (ii) they work directly with government mandates or with institutions that are government-mandated, programme coordinators and directors from the MoWSA, and other organisations. All of the included organisations are directly or indirectly involved in the healthcare and social protection system; or (iii) they are healthcare professionals who directly provide people experiencing homelessness with mental health services and other psychosocial support at various organisations either as a volunteer or as a staff

member. Some of these professionals have previously participated in intersectoral campaigns to address the issue of co-morbid mental health and substance abuse among people experiencing homelessness.

Sample size and data collection

Qualitative studies often use a smaller sample size than quantitative studies (104). The sample sizes for the present studies were decided by considering factors listed in Patton (105) and Morse (106), namely how much valuable information could be obtained from each participant, the purpose of the survey, the type of qualitative study, the stakes involved, and the factors that would be credible and helpful for the study. Overall, fieldwork time was limited; I conducted and facilitated **Papers I and II** alone, which may have limited the number of participants that could be recruited. Six research assistants with backgrounds in mental health, public health, and developmental studies assisted with participant recruitment and data collection for **Papers III and IV**. However, determining a sufficient sample size in qualitative research is ultimately a matter of judgement (104). Various authors (15-17) have also stated that recruiting 15−30 participants is sufficient to identify patterns across the data in qualitative studies. Hence, 19 women experiencing homelessness were included in Paper II, and 34 government and non-government organisation employees from various professions participated in Papers III and IV. The photovoice study (**Paper I**) had a smaller sample size (nine) than the other three studies, based on Wang and colleagues' (18-20) recommendation of 7 to 10 participants for community-based participatory research.

Sampling and recruitment

Although various sampling techniques exist in qualitative studies (purposive, convenience, snowball, and theoretical sampling), purposive sampling techniques were preferred in this case as they help include different perspectives (93). Moreover, this technique helps generate '*insight and in-depth understanding'* of the subject under study (105). Accordingly, excluding the first study, the selection of participants from among both professionals and street women was based on the prepared inclusion and exclusion criteria (107) and because the selected people were *'information rich'* and could provide sufficient information, as described by Patton (105).

For the photovoice study, female street dwellers were selected using convenience sampling, a typical sampling technique in participant-based research (105). Women visited the local civil organisation from their makeshift shelters at 9 am to have breakfast and receive the life skills training assigned for the day before returning to their daily lives between 1 and 2 pm.

However, while availability and accessibility were a bonus, the two main criteria were that the women were over 18 and willing to participate in the study. The Amharic language was also a criterion, as sharing a language made it easier for them to talk to each other and me. For the second paper, the selected participants were women experiencing street homelessness, aged 18–49, with varying durations of homelessness, who had migrated to Addis Ababa from different areas or were born and raised in Addis Ababa.

For the third and fourth studies, the participants were included based on their knowledge of the health and social services provided to street women, as indicated by the institution in which they worked. Those interviewed suggested further contacts from government or charity organisations to be included in the study.

This snowballing, or friendship pyramiding (105), was used to identify individuals actively providing mental or other psychosocial assistance to people experiencing homelessness and had signed memoranda of understanding with government institutions. In addition, these two studies required diverse perspectives, also known as maximum variation or maximum heterogeneity sampling (108), regarding the research questions, which was considered when sampling participants.

Data sources and data collection procedures

In all studies, the interviews began with greetings and introductions. Before the participants agreed to proceed with the study, they were given an information sheet and consent form, and the purpose and scope of the study were explained. We also gave participants the chance to inquire about the process without any obligation to do so.

The research assistants and I emphasised that participants' views and work-life trajectories were crucial in addressing the research questions. However, we asked them to freely share their experiences of being homeless women and emphasised that there were no right or wrong answers. Moreover, when possible, the research assistants and I established a rapport with the women. For those women who could not read and write, the information sheet and the consent form were read to them calmly, and their spoken consent was recorded with an audio recorder. However, we did not take photos or record any identifying factors of the participants (Papers III and IV). Although 34 participants were included in the third and fourth studies, one refused to be recorded because she was in a position of responsibility and for other personal reasons; hence, we took only written notes.

Although semi-structured open-ended questions had been prepared for the data collection, especially for Papers II, III, and IV, the interview guide was used as a flexible tool rather than being followed verbatim.

The interview questions explored the situation of street people in Addis Ababa from different dimensions, ranging from the health and social welfare sector, through service provision and the country's policy environment, to the specific activities of the participants in the workplace. The street-dwelling women interviewed were often invited to expand on and clarify their answers by asking them, 'Please explain this to me', 'What does it mean when you see this?' and 'What made you cry? Please share it with me', as suggested by Braun and Clarke (107) and Rubin and Rubin (109), to help them open up further. In the second study, I showed interest in listening to the women as they shared their stories, including childhood memories, traumatic experiences, and the background of their homelessness. It was important to approach the women non-judgementally; whenever they started to cry, I gave them a soft tissue and allowed them a few moments of silence before restarting. Once they had calmed down, I asked what had made them cry. Some of the women relayed particularly disturbing stories and were given a few minutes to breast-feed their babies to calm them before continuing with the interview.

The design of the photovoice study (Paper I) was explicitly centred on the SHOWeD questionnaire (Figure 2).

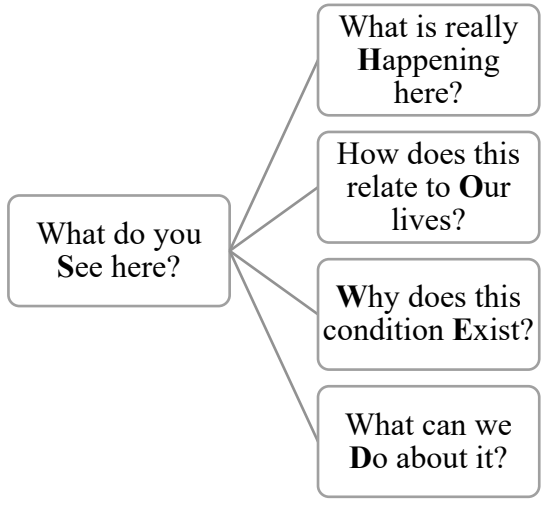


Figure 2: The SHOWeD technique (adapted from Wallerstein and Bernstein and Wang and Mary Burris (99, 110).

In all studies, in both individual interviews and group discussions, every participant was invited to ask about something they felt had been left unanswered, following Braun and Clarke's (107) guidelines on how to close qualitative interviews. We closed all interviews with a thank-you note and sent the published papers to the participants in the first study who had requested them.

Data quality management

During the fieldwork of **Paper I**, I introduced photovoice methodology, detailed the ethical considerations for photography and fieldwork, and explained our expectations from the participants. Subsequently, the research assistants and I transcribed and translated the audio-recorded interview files. During the transcription process, all verbal utterances from all speakers, both actual words and non-semantic sounds, were checked before analysis. In **Papers I and II**, women who had lived on the street for short and long periods were interviewed, and the languages they used while living on the street, called 'street languages', were transcribed verbatim and translated. Presenting made it easier for the participants to be seen and heard in the data. Previous research (111) supports this approach. A researcher from Addis Ababa University and I trained the research assistants on interview techniques and the ethical aspects of qualitative data collection for **Papers III and IV**.

Moreover, I acted as the photovoice facilitator and the principal investigator; participated in all fieldwork; and oversaw daily progress to ensure accuracy, completeness, and proper data management and storage. We handled all the data following the European General Data Protection Regulation (GDPR), while Professor Yemane Berhane (YB), Professor Mats Målqvist (MM), Professor Hannah Bradby (HB), and Sibylle Herzig van Wees (SHvW) supervised and guided all studies from conception to final submission.

Data analysis

Papers I−III were analysed using an inductive approach, while **Paper IV** was analysed deductively based on Shiffman and Smith's framework (112). In particular, in the photovoice study (Paper I), in addition to a reflexive thematic analysis, a co-analysis was conducted with the participating street women to categorise the photographs (97), as detailed in the co-analysis subsection below.

Reflexive thematic analysis − Papers I, II, and III

The inductive analysis of three of the four studies was inspired by Braun and Clarke's (113) six stages of thematic analysis. One-step after verbatim transcription and translation was 'familiarisation or data immersion.' As principal investigator, I listened to and read the transcribed files repeatedly to understand the data and how they were helpful in answering the research questions (107).

I kept a research journal and took notes on some transcriptions throughout this process. The second stage was coding, which Braun and Clarke (107) define as *identifying aspects of the data that relate to a research question.* The third stage entailed searching for themes and preparing a provisional theme and subthemes map (thematic tree); this stage led to much discussion, after

which many of the candidate themes were refined. The fourth stage was identifying the relationships and patterns between the themes and subthemes, while the fifth stage involved finalising each theme's definition and name. Although Braun and Clarke (107) named the final stage *'reporting of findings'*, this stage has not been given a separate explanation in any study but is included in the writing process of all studies. For **Papers II and III**, MM and I performed inductive thematic analysis using Braun and Clarke's six phases, while for **Paper II**, UF and HB were involved in different analysis stages.

Co-analysis combined with reflexive thematic analyses − Paper I

Unlike other research designs, photovoice analysis does not depend on the researcher's interpretation. It allows the triangulation of data, whereby the themes and content captured in the images can be compared with the information gathered via one-on-one interviews and focus groups (114). This technique was especially useful when conducting reflexive thematic analysis (107) after the initial co-analysis of visual data (115). Moreover, this method allows women experiencing homelessness to advocate for change beyond their personal perspectives (116). The photovoice study involved various data sources and data collection techniques – photographs, individual interviews, and group discussions, with the analysis following the three stages suggested by Wang and Burris (97). During the fieldwork, the participating women took photos that they thought showed different aspects of their street lives. Then, individually and in groups, they selected those that most accurately reflected the unmet needs of people experiencing street homelessness and those that depicted community assets (which they saw positively). This step formed the first stage of the participatory analysis. In the second stage of contextualisation, the participants explained the photographs using the SHOWeD technique (Figure 1) and told stories about how the images related to them.

Empowering the women to describe their daily struggles through images enabled us to gain a better understanding of their burdens – the aspects of street life women experiencing homelessness consider that but that have previously been neglected by researchers. The third and final stage entailed grouping photographs that showed similar content, determining relationships among them, and codifying the photos to facilitate further analysis (Figure 3). Subsequently, SHvW and I performed a reflexive thematic analysis following Braun and Clarke's six phases.

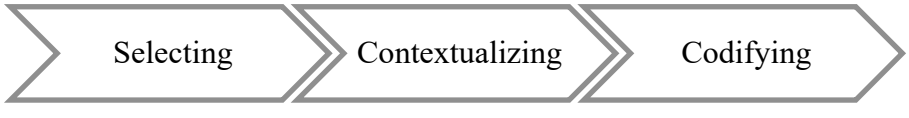


Figure 3: The participatory analysis process, adapted from Wang and Mary Burris (97).

Deductive analysis − Paper IV

As mentioned, the last study was designed to identify the factors shaping policymaking – or its absence – that led to street women's health and well-being being underrepresented in policy and service prioritisation. Shiffman and Smith (112) developed the framework to answer the main question, *"Why do some global health initiatives receive priority from international and national political leaders, whereas others receive little attention?"* This framework was deemed suitable for the present study and consists of four categories: actor power, ideas, political context, and issue characteristics, each with 11 factors that describe the primary category (112). The primary characteristic of this framework is power, viewed in various ways (112, 117).

The framework directs attention to the people involved in the issue being studied, the idea of power that is used to describe or explain the issue, the political environment in which power can attract or deny political attention, and the issue itself (117).

Despite its use in other health and issue research, we believe this is the first study to use this framework to analyse homelessness. I listened to and read the 34 participants' audio recordings and transcriptions several times to gain familiarity with the data. Subsequently, SHvW and I coded the data and allocated them to various categories and subcategories based on the framework. Through repeated discussions, we also identified the areas that needed correction.

Ethical considerations

As the fieldwork for all studies was conducted in Addis Ababa, the capital of Ethiopia, and as all four studies focused primarily on health – mental health services, multidimensional well-being, and broader social and community health − ethical approval was obtained from Addis Continental Institute of Public Health (Registration numbers ACIPH/IRERC/005/2023 for Papers I and II and ACIPH/IRB/009/2021 for Papers III and IV), which worked in collaboration with Uppsala University on this project, as well as from the Addis Ababa Health Bureau (Registration numbers A/A/7214/227- for Papers III and IV), which provides ethical review and approval for health-related studies conducted in Addis Ababa. We also obtained a letter of permission for all studies that involved both government and non-government organisations. Moreover, the Swedish Ethical Review Authority granted ethical approval for the analysis of personal data in Sweden (DNR 2024-05261-01). The second study, which used photographs, collected an additional consent form from participants, permitting the future use of the photographs in various publications and for research-related purposes. Sensitive data were handled in accordance with the GDPR, and for all studies, an Amharic information sheet explaining the purpose of the survey accompanied each interview. All interviews were conducted in an interview room that the institution approved to protect the

participants' privacy; since no one could overhear what was said in the interview room, the participants felt free to ask questions. In addition, the research reports used anonymised individual identities. In Paper I, the participants, especially those who shared traumatic life stories that they had not previously shared or who showed suicidal tendencies, substance abuse signs, or depression symptoms, were connected to a psychologist who provides psychological services to the organisation. We collected the data for Papers III and IV during the COVID-19 pandemic (August to September 2021). The precautionary measures issued by the WHO in all countries did not allow handshakes; hence, nodding greetings were used, and, when possible, masks and sanitisers were provided to all participants to protect their safety. We also maintained the recommended distance between researcher and interviewee during the interviews, adhering to health regulations and COVID-19 precautions.

Table 1: Summary of methodological and analytical features of papers I–IV.

Paper	Study Participants	Sample Size	Sampling Technique	Data Collection Methods	Data Analysis
I	Women of reproductive age (18−49)	(*n*=9)	Convenience	Photographs, interviews and focus group discussions	Reflexive thematic and co-analysis with women
II	Women of reproductive age (18−49)	(n=19)	Purposive	In-depth interviews	Reflexive thematic
III	Service providers and programme coordinators	(n=34)	Purposive and snowball	In-depth interviews	Inductive thematic
IV	Service providers and programme coordinators	(n=34)	Purposive and snowball	In-depth interviews and documents	Deductive thematic analysis using Shiffman and Smith's (2007) framework

Results

This thesis aimed to answer four research questions. Figure 4 summarises the key findings for each research question. The first research question focused on how women of reproductive age describe their experiences of street life in their own terms. The responses from this part of the study were further explained by the results of the second research question, which examined the factors that cause women to become homeless and examined their journeys through homelessness. Next, the third and fourth research questions explored the perceptions and experiences of employees and managers from governmental and nongovernmental organisations in order to better understand the mental health services and psychosocial support available, as well as the policy environment.

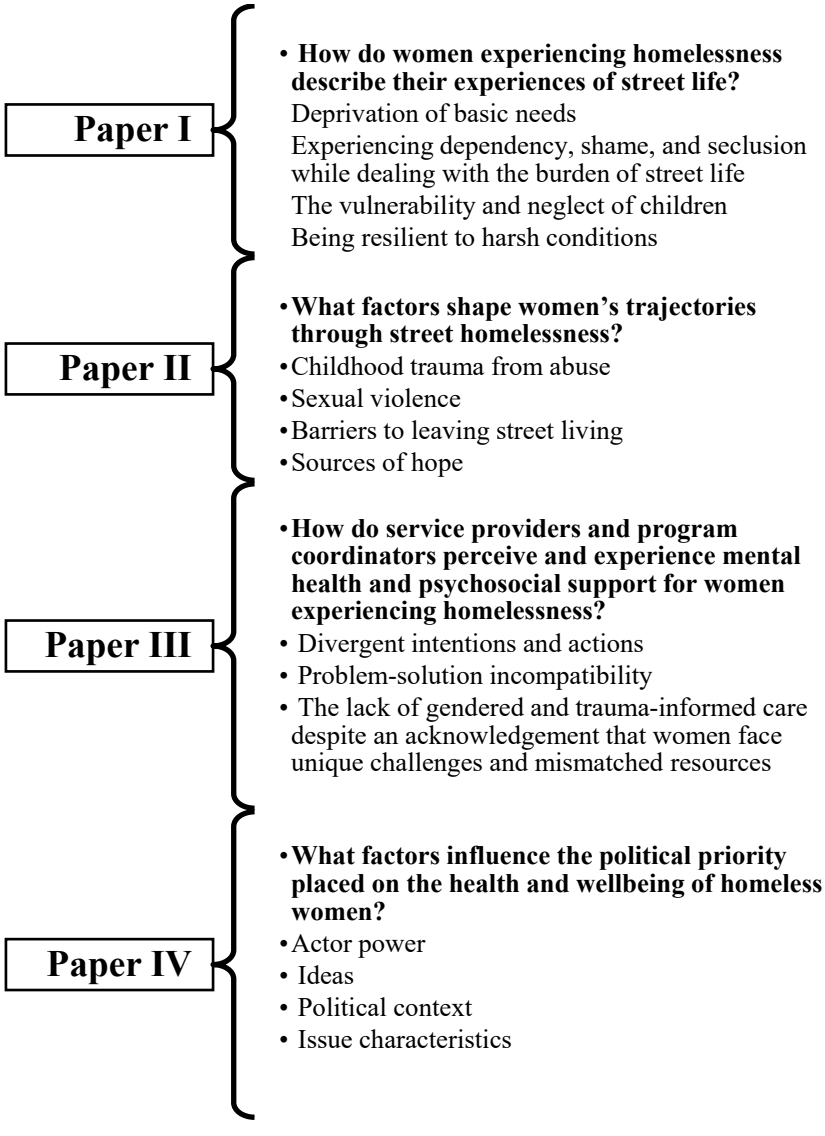


Figure 4. Research questions and main findings

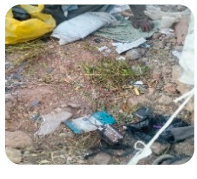
Paper I: How do women experiencing homelessness describe their experiences of street life?

Paper I comprises community-based participatory research, in the form of a photovoice study of women experiencing homelessness. This study examined the ways in which women describe and portray street life in Addis Ababa in their own terms. All of the participants had at least one child. Despite having children, all of the women were single, divorced, separated, and widowed. Four could not read or write and only one of the women had completed a secondary education. Chronic homelessness was highlighted among the experiences of most of the women. Four themes were identified from the data (Figure 5).

Theme I

Deprivation of basic needs

- Living off leftovers and unclean water
- Shelter demolishment and lack of safe housing
- Living in a world of fear



Theme II

Experiencing dependency, shape, and seclusion while dealing with the burden of street life

- Substance misuse
- A lonely and isolated life
- Everyday humiliation

Theme III

Vulnerable and neglected children

- Children's hardship
- Imitating parental street life
- Barriers to early childhood education

Theme IV

Being resilient to harsh conditions

- Normality in precarious circumstances
- Window of hope and faith
- Social cohesion

Figure 5. Themes and subthemes were identified from the photograph, focus group discussion, and interview analysis (from Paper II).

Theme I: Deprivation of basic needs

In the first theme, participants portrayed the ways in which they had suffered from the deprivation of their basic physiological needs (food, water, shelter,

clothing, and a safe place to sleep). Through photographs that they had taken, participants depicted how challenges relating to safety and security had endangered them. Neighbourhood issues and the built environment shaped the women's health and well-being in such a way that they were forced to live in unsafe and unstable shelters (see Figure 6).

Figure 6. ***A makeshift shelter in poor condition****. Addis Ababa, December 2023. "A homeless person's shelter is made of stones and plastic. Here, individuals reside in roofless shelters." (Image and quote credited to a 27-year-old woman experiencing homelessness.)*

Theme II: Experiencing dependency, shame, and seclusion while dealing with the burden of street life

Identified as the second theme, conversations around life on the streets and photographs were focused on portraying the challenges of streetlife that extended beyond a lack of basic needs to the issues of being subjected to stigma, feelings of humiliation, and shame while begging for survival.

The respondents revealed that although street people were visible to everyone, no action was taken.

Furthermore, the participants emphasised that it has become the norm to observe people struggling with addictions and mental health problems on the streets of Addis Ababa, as depicted in the photographs.

Many found the issue of sexual violence particularly challenging and disturbing. While some of the photographs portrayed people who had chosen self-isolation as a means of avoiding assault. Multiple participants focused on photographing people with substance misuse conditions living on the streets (Figure 7).

Figure 7. ***Addiction****. Addis Ababa, Ethiopia, December 2023. "Items visible in the photograph include a khat remnant, a cigarette butt, a plastic bag and a radio. Individuals often end up on the streets for a variety of reasons, and addiction is one of the most common factors." (Image and quote credited to a 26-year-old woman experiencing homelessness.)*

Theme III: Vulnerable and neglected children

In the third theme, participants expressed particular concerns about the struggles and worries faced by street children. In addition to the children's struggle with hardship, participants also explained that the children's safety was put at risk from the dangers posed by living under a construction building (Figure 8).

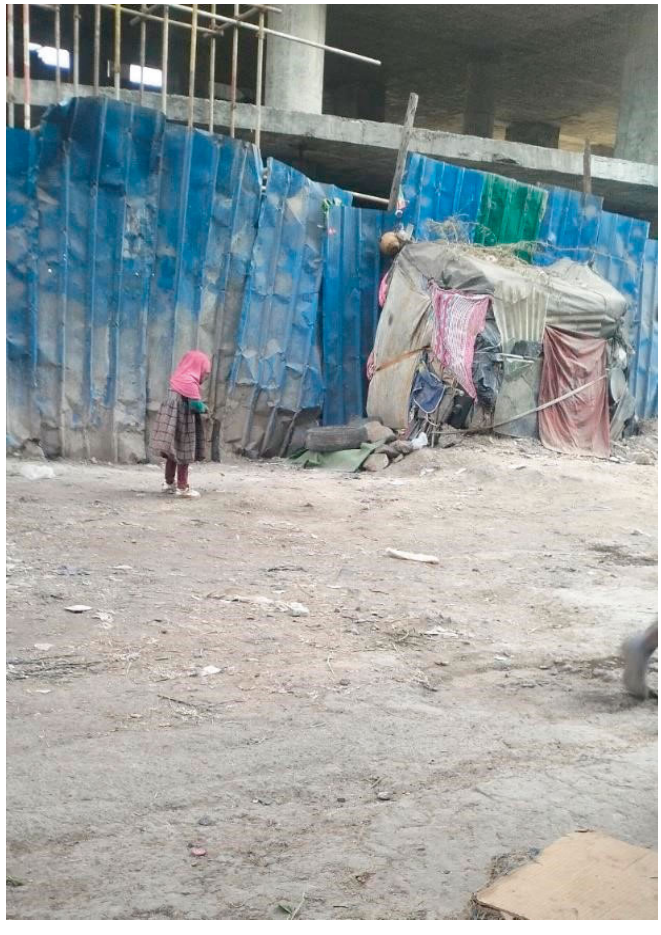


Figure 8. ***Safety risks for children.*** *Addis Ababa, Ethiopia, December 2023. "A little girl is standing next to her plastic shelter (Shera Bet), the type of shelter street dwellers live in. Construction above the shelter puts it at risk of attack from stone-throwing. This could endanger the little girl's safety. Sadly, controllers often destroy the shelter without prior warning, leaving the family with nothing to live in. I took the photograph to represent my situation." (Image and quote credited to a 28-year-old woman experiencing homelessness.)*

Theme IV: Being resilient to harsh conditions

Importantly, this theme highlights participants' portrayals of the resilience of people experiencing homelessness, the coping skills they employ to face the hardships of street life, and their generally positive outlook. Some participants demonstrated their positive observations in their images. One such example can be seen the following image, which emphasises social cohesion and shows communal eating practices.

Figure 9: ***Cohesion****. Addis Ababa, Ethiopia, December 2023. Here, a group of individuals experiencing homelessness eat rice from leftover foods (called 'bulle'). "This is how we survive on the streets. This photograph shows our culture's unity and how we eat food. While all we behave differently on the streets, there is a sense of caring among us." (Image and quote credited to a 26-year-old woman experiencing homelessness.)*

Paper II: What factors shape women's trajectories through street homelessness?

The study participants comprised 19 homeless women aged 18 to 49 years old; over half were aged 25−29. All but three of the women were single or separated. Regarding educational status, ten of the 19 women could not read and write. Only three of the participating women engaged in casual day labour, while 16 of them were panhandlers who subsisted through begging. Additionally, 12 of the 19 participants had lived on the streets for five years or more. The age range for first-time homeless people varied from seven to 29 years.

This paper examines the participants' experiences of street life since childhood, the particular aspects they currently encounter, the obstacles that prevent them from breaking the cycle of it, and the sources of hope they maintain for the future. In this paper, the main themes identified were 'childhood trauma from abuse,' 'sexual violence,' 'barriers to leaving street living,' and 'sources of hope,' as well as 'street life initiated and fuelled by unresolved wounds and re-traumatisation' as an overarching theme (Figure 10).

Table 2. Four themes and eleven subthemes emerged from the data

Street life initiated and fuelled by unresolved wounds and re-traumatisation	Theme I: Childhood trauma from abuse	Physical abuse
		Verbal abuse
		Parental neglect
	Theme II: Sexual violence	Widespread violence
		Silencing of victims
		Consequences of violence
	Theme III: Barriers to leaving street life	Norms and prejudice
		Destructive habits
		Poor health
	Theme IV: Sources of hope	Religion
		Self-belief

Drivers of and trajectories through women's homelessness

Although the causes of homelessness are complex, interrelated, and interconnected for individual women, this study found that the drivers of participants' homelessness included childhood-level traumatic experiences and gendered structural factors. For instance, the inability of women to pay rent was compounded by their economic dependency on husbands or partners, often resulting in them becoming homeless while expecting.

One 27-year-old participant described her trajectory through homelessness as follows: Her husband abandoned her while she was eight months pregnant and she was unable to pay the rent for housing. Consequently, she stayed with a married friend before ending up on the streets for three months.

Most women in this study had entered street life through chaotic routes. Among these, the pathways to homelessness participants' numbers 15 and 19 are described below.

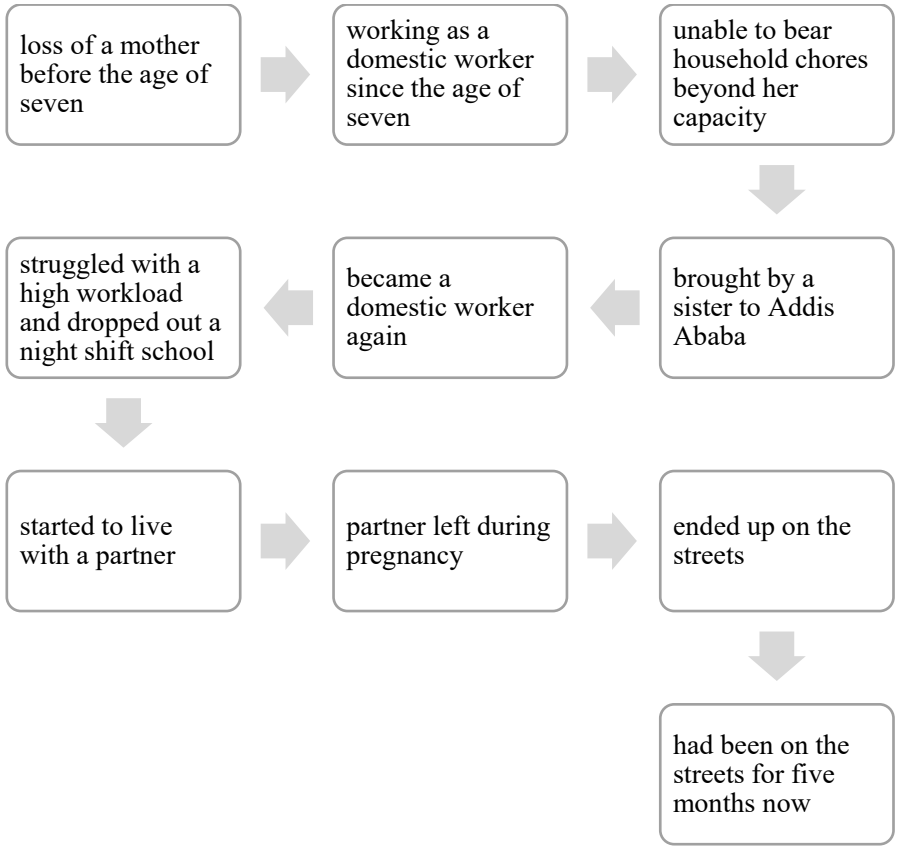


Figure 10. The pathway to homelessness of one 20-year-old woman (p15)

The other participant had experienced multiple forms of adverse childhood experiences and was re-traumatised on the streets:

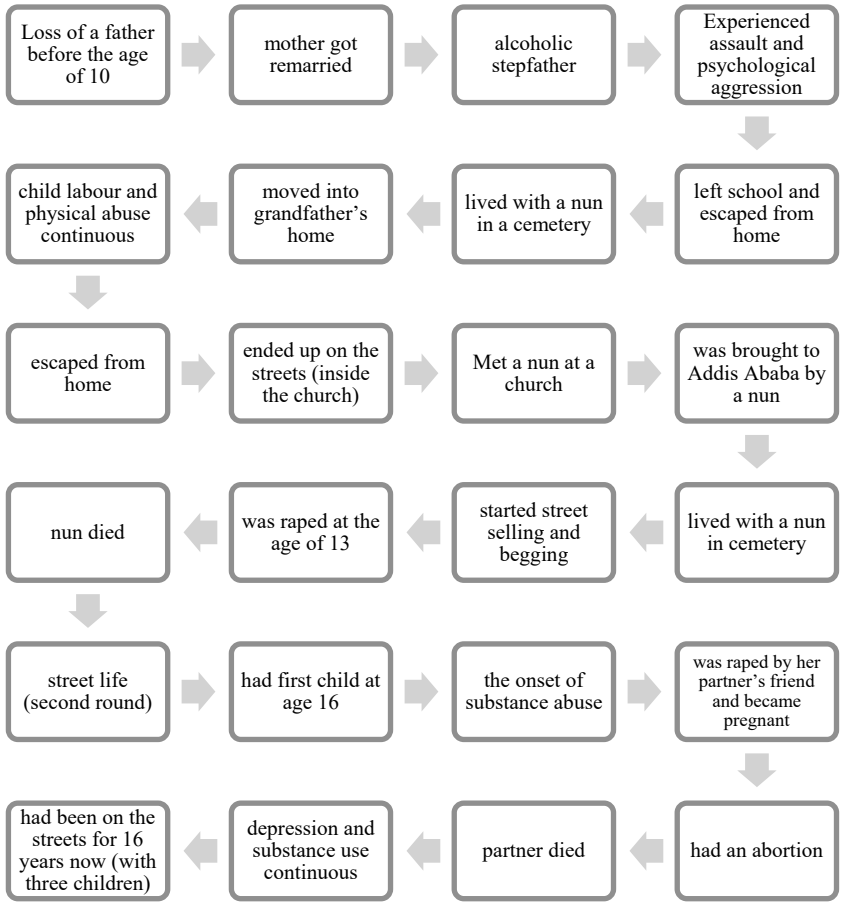


Figure 11. The pathway to homelessness of one 30-year-old woman (p19)

Abuse permeated participants' journeys to the streets, which were characterised by direct, indirect, and chaotic pathways. Participants revealed that adverse childhood experiences, being exploited at work, and having adverse relationships were among the factors that had set them on the path to living on the streets and kept them there indefinitely.

Furthermore, these problems prevented the women from breaking the cycle of living on the streets. For example, when single mothers remarried for economic or personal reasons, they left their children in the care of abusive relatives. Participants reported having experienced physical and verbal abuse, which had led to some of them becoming homeless. The participating women reported having experienced not only abuse from stepfathers but also rape by close relatives and others. One of the women shared her experience of gang rape:

> *'Then I just started spending the night in Giorgis [a neighbourhood in the city]. As I was starting to sleep in the middle, I got raped and gave birth to that lost child (her child was stolen a few years ago). I do not know who raped me; I got raped by six men (mumbling). They took me and raped me, then I gave birth to my child'. (P3)*

In order to make a living, some of the women had found work as domestic workers from a young age; they reported being beaten, forced to work without rest, punished for their inability to do hard work, and denied food by their employers (withholding food as a punishment).

Urbanisation challenges impact the city, causing pregnant women whose partners had abandoned to flee the streets as a result of high housing costs. The participants explained that they had tried to make a living as domestic workers but had failed, so they turned to street life to escape their employers. Despite the individual, financial, and cultural barriers they faced, various women highlighted how they had accepted the situation, looked for support, and relied on their strength and faith.

Paper III: How do service providers and programme coordinators perceive and experience services for women experiencing homelessness?

The third and fourth studies, represented by papers III and IV, used the same dataset. A total of 34 service providers and programme coordinators were involved in the studies. Their backgrounds were in medicine (general practitioners [GPs] and psychiatrists), health science (clinical and psychiatric nursing, public health, Master in Integrated Clinical and Community Mental Health [ICCMH], and Masters in Public Health [MPH].

Individuals with a social science background, such as sociologists and social workers, and those in leadership positions at various levels—including team coordinators, organisation founders, directors, and managers—participated in the study. The participants were aged between 22 and 61 years. Of these, 17 (50%) were aged 30−39. Regarding education, 15 participants (44.17%) had a master's degree, and 14 (44.1%) had a bachelor's degree. Moreover, 20 participants (58.82%) were healthcare professionals and psychologists, and five (29.4%) were social workers. Additionally, 24 out of 34 (70.58%) worked in governmental institutions, and only three (8.82%) were from an association. Indeed, three (8.82%) were the organisation's founders. Furthermore, a considerable proportion of the respondents (21; 61.76%) were male.

Paper III explored the perceptions and experiences of healthcare providers, programme managers, and service coordinators regarding mental health and psychosocial service provision in Addis Ababa. 'Divergent intentions and actions,' 'problem-solution incompatibility,' 'lack of gendered and trauma-informed care despite an acknowledgement that women face unique challenges' and 'mismatched resources' were the four themes identified from the data. Arising from these themes, there were 11 subthemes concerning the factors that facilitate or hinder mental health and psychosocial support for women experiencing homelessness, which ranged from individual to systemic. The service delivery gap exposed inconsistencies, acting as a unifying theme within the service delivery domain (Figure 12).

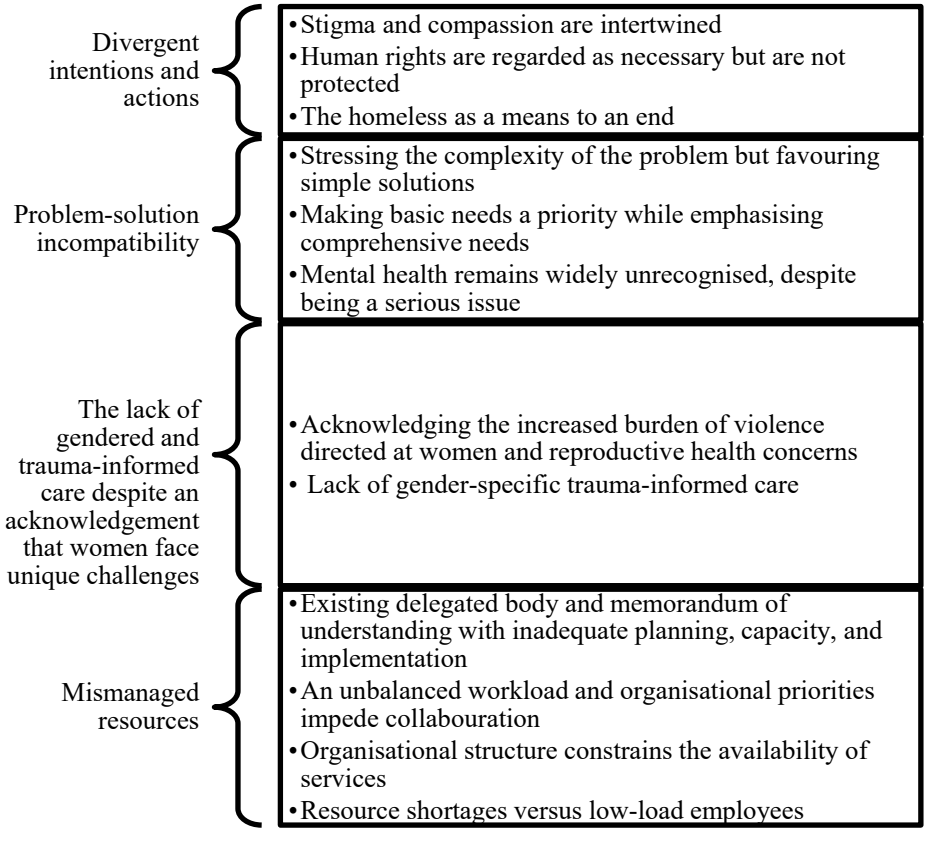


Figure 12. Themes and subthemes (from Paper III)

The first theme (Theme I) concerns the various beliefs and actions relating to public stigma, profound human rights violations committed against individuals with mental health conditions, and stigmas related to homelessness.

One participant, who had been working at a mental health hospital, indicated that mental health professionals were facing problems resulting from a lack of legislation that could support those with mental health conditions and could also enable service providers to assist homeless people with mental health problems.

> *'Other countries have a mental health law (the Mental Health Act) that outlines the rights of people with mental illnesses, while Ethiopia does not have one. Sometimes, we hesitate to assist homeless individuals with mental health conditions who have been seriously injured or damaged on the streets.' (IDI #7, service provider, public hospital)*

Participants emphasised the public health importance of addressing mental health issues and how they are currently neglected, highlighting the lack of tailored mental health services available to individuals experiencing street homelessness. Within Theme II, respondents emphasised homeless women's struggles in the city and their familiarity with sexual abuse and unmet basic needs (which were mainly witnessed during the mental health campaign and clinical work). One participant noted the multiple problems experienced by homeless women and the services they need:

> *'I agree that several problems need to be addressed. However, there is a high demand for basic needs, such as food, water, clothing, sleep, and shelter. Yes, the basics are necessary. However, they (people experiencing homelessness) also face economic difficulties.' (IDI #7, service provider, public hospital)*

There was a consensuses among the participants in terms of complicated concerns surrounding women's specific challenges. Most of them revealed that they had witnessed a multifaceted burden of unwanted pregnancies, unsafe abortions, reproductive health problems, marginalisation, and sexual abuse, as well as the added responsibility of raising children on the streets. One participant shared the health consequences of sexual violence, specifically rape against women, which resulted in reproductive health issues and untreatable health conditions.

> *'There are several psychological and physical consequences associated with sexual abuse. In particular, rape has a significant impact on women. Furthermore, sexual abuse may increase their risk of unintended pregnancy, HIV/AIDS and other sexually transmitted diseases.' (IDI #12, Healthcare provider, public hospital)*

Although the government-mandated office provides services only to institutionalised women who have experienced street homelessness, these services include necessities, medical assistance, and life skills training. This support helps the women to secure jobs based on their educational levels. In Theme III, participants talked about the unique reproductive health problems homeless women face, including their greater likelihood of contracting STIs or dying as a result of unsafe abortions. However, no structure exists to provide trauma-informed and gender-responsive care, and they did not discuss its importance.

The fourth theme, "mismatched resources", comprised of four subthemes that highlighted a delegated body and a memorandum of understanding, but gaps remained in terms of planning, capacity, and implementation. Furthermore, these subthemes also showed situational differences between the organisations' target groups, which was viewed as a sign that they would need to work together and that there was a shortage of resources, both human and financial.

At the same time, the respondents reported having low-load employees who were not doing much work at psychiatric units in primary healthcare centres. One social worker, who was working at a charity organisation that provides services to homeless people, shared his experience of those organisations from which the charity received support:

> *'St. Amanuel Mental Specialised Hospital provides psychotropic medications and mental health professionals. Additionally, St. Peter Hospital offers medical care for homeless individuals with the support of our charitable organisation. We often receive assistance from non-governmental organisations.' (IDI #20, social worker, charity organisations)*

Additionally, some participants talked about their experiences with campaigns that helped people experiencing homelessness and people with mental health problems. Topics included the good things that had happened and the willingness of professionals from various fields (e.g. psychologists, social workers, public health officers, and clinical and psychiatric nurses) to work together to solve the many problems that people experiencing homelessness face. However, hindrances to continuing such campaigns were also commonly mentioned, such as financial hardship and a lack of collaboration from other sectors. Moreover, the participants posited that the lack of free medical care, a health insurance system for people experiencing street homelessness and tailored mental health services to address them had both exacerbated and perpetuated the problem.

Paper IV: What factors influence the political priority placed on the health and well-being of homeless women?

Four themes emerged from the data, each focusing on the factors that shaped political priorities for addressing women's health and well-being needs. Figure 13 shows the themes and subthemes.

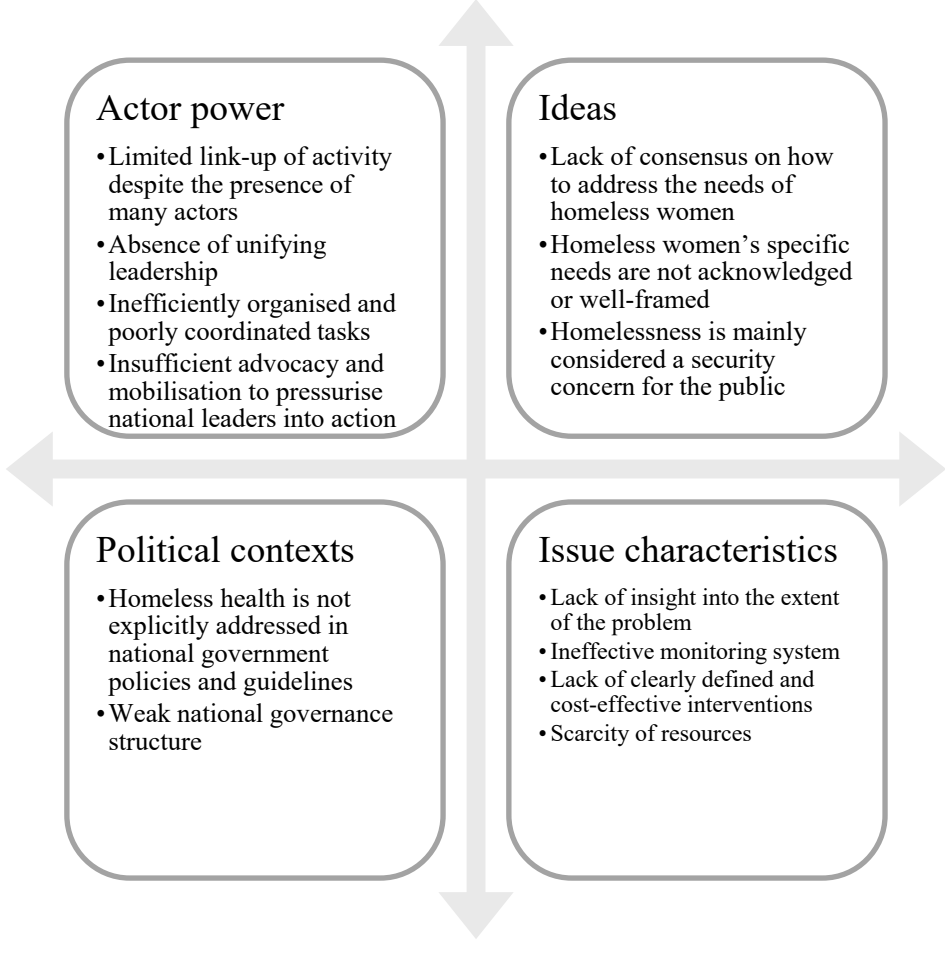


Figure 13. The themes and subthemes that emerged from the deductive analysis in Paper IV.

Under Theme I—actor power—participants generally talked about the existence of both governmental and non-governmental organisations. However, with no clear unifying leader in addressing homelessness, poorly coordinated tasks, and a lack of advocates, these groups did not link well together. Additionally, there was no strong push to persuade national leaders to address the needs of people experiencing homelessness.

Regarding internal and external framing of homelessness, under Theme II on Ideas, some participants described individuals experiencing homelessness as potentially posing a security risk to the community, which could be solved by the services their own organisation provided. Various forms of sexual violence against women were discussed, especially women's exposure to sexual assault and its consequences, along with some limited acknowledgement of the potentially serious effects of this on the women.

During conversations under Theme III on Political Context, concerns arose about the political and organisational context in Addis Ababa, and specifically the lack of explicit attention to the health and well-being of women experiencing homelessness. Some individual leaders' views notwithstanding, the mental health strategy and the service delivery structure were found to be limited to outreach services, thereby overlooking homelessness.

Under Theme IV on Issue Characteristics, participants stressed that there was insufficient information about serious problems, the organisation was not working well, and there were no precise, scientifically proven, and cost-effective ways to address homelessness. Engaging people in caring about homeless women's health and well-being was difficult, according to the respondents.

Discussion

In order to better understand the plight of homeless women in Addis Ababa, Ethiopia, this thesis drew on four studies that capture the lived experiences and perspectives of women of reproductive age as well as individuals involved in providing homeless-focused mental health and psychosocial services through governmental and non-governmental organisations. The findings revealed the effects of childhood trauma, gender-specific challenges, and human rights violations, such as abuse, unmet basic needs, addiction, humiliation, and social exclusion. Such traumatic experiences were further exacerbated by re-traumatisation on the streets. Many women endured early violence and exploitation, along with personal, health, economic, and normative barriers to leaving street life. Despite these challenges, some of the women demonstrated resilience, relying on their strong faith and maintaining their hope of breaking the cycle of homelessness.

Providers of services for people experiencing homelessness also faced substantial challenges. These included contradictory beliefs and actions, problem-solution incompatibility, service provision gaps, and mismatched resources, all of which hinder the provision of services to this population. Furthermore, the findings highlight multiple intersecting factors that have shaped women's homelessness and the service arena. These factors operate at the individual, interpersonal, organisational, community, and policy levels. Hence, the socio-ecological model, which considers influences across these levels, was used to discuss the findings (Figure 14).

Figure 14. Theoretical model for the interpretation of findings. Adapted from Bronfenbrenner's socio ecological model.

Individual level

Trauma and re-traumatisation

Before becoming homeless, the women interviewed in **Paper II** recounted having endured a variety of traumatic experiences. These included verbal and physical abuses (to the extent of being fumigated by chilli smoke, frequently beaten, and forced to work a domestic job). Some of them experienced physical and/or verbal abuse, while others endured a combination of verbal, sexual, and physical abuse, along with family neglect. This early exposure to trauma set them on the pathway to homelessness. Similar studies have found high rates of lifetime exposure to trauma and victimisation among women experiencing homelessness (11, 13, 118). Many of the women were economically dependent on their partners when they felt pregnant, so they could not afford to pay rent or buy groceries. This finding is echoed by a study from Ethiopia (119), which reported cases of psychological violence during pregnancy. Other women in this study had also experienced domestic violence, child labour violations, and sexual violence at the hands of their domestic employers. Such findings are aligned with previous studies that have demonstrated that homelessness constitutes a traumatic experience in itself and that homeless people are exposed to trauma and re-traumatisation (11, 13, 15, 118).

Some of the participants had experienced extreme sexual violence. One had been gang-raped by six men; one had been raped at just 13 years of age; and another was raped by unknown assailants in front of her children and forced to keep silent during the attack to prevent her children from being harmed. In addition to the sexual, physical, and verbal abuse they had suffered, the women also experienced shame and humiliation; this is also in line with similar findings in the literature (120).

Mental health conditions and substance misuse

None of the 19 women interviewed in Paper II were living on the streets because of mental illness or substance addiction. However, those who had been sexually assaulted (especially at a young age, whether by strangers, neighbours, or a close family member), who had experienced unwanted pregnancies, or who had been exposed to street violence were more likely to have experienced a variety of psychiatric conditions and symptoms.

These included self-loathing, feeling worthless and unloved, hitting their newborns and throwing them to the ground, and suicidal thoughts and unsuccessful suicide attempts. They were also more likely to have experienced substance abuse (whether or not they were diagnosed or on medication). In other studies —women, more than the general population— have reported a strong link between homelessness and significant psychopathology, particularly depression, anxiety, and alcohol/drug use (49, 121).

In addition, women who have been exposed to violence report high levels of medical problems and suicidal behaviour (suicidal ideation and attempts), as well as substance addiction (44).

Divergent intentions and actions

In Paper III, health and social support service providers displayed conflicting attitudes, beliefs, and behaviours. To make sense of this, we applied Festinger's (1957) cognitive dissonance theory (122), which explains the mental discomfort that arises from inconsistencies in behaviours, beliefs, and attitudes. The study revealed that employees and managers of governmental and non-governmental organisations held two distinct yet contradictory views: (i) 'women face various gender-specific challenges' (cognition); yet (ii) 'we do not provide gender-responsive care' (behaviour). Thus, their behaviour—in terms of implementing ongoing services for people experiencing homelessness, those with or without mental health issues, and those with substance use conditions—conflicts with their beliefs. This indicates that they were in a state of cognitive dissonance.

Due to the dissonance between the providers' attitudes and behaviours, it is recommended that one of these must change in order to resolve the inconsistency—either by altering their attitudes or by adjusting their actions. Respondents also stated that there were gaps in mental health and psychosocial services that were not meeting the needs of homeless women.

However, the participants added that these gaps were caused by things outside of their control, such as their organisation's lack of human and financial resources or collaboration among professionals.

Coping mechanisms

Many of the participants had fled from home to escape various forms of maltreatment, child marriage, and domestic violence. According to Lazarus and Folkman, coping means 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are seen as taxing or exceeding the person's resources' (55). It is the process through which the individual manages the demands of the person-environment relationship that they appraise as stressful and the emotions that those demands generate (55).

As demonstrated in **Papers I and II**, the women who participated in the study used a variety of coping strategies to navigate their unstable situations and life paths, especially when they were young or when their partners left them while they were pregnant. Eventually, these unpredictable and stressful events led to their homelessness, as well as the denial of their fundamental human rights and needs. In some cases, the women's coping strategies kept them homeless or addicted but, for other women, they helped them to gain autonomy and escape violence.

The women living on the streets reported finding it difficult to deal directly with the stressful demands placed on them, which often placed them in more trouble. Some of those who had escaped violence at home were then subjected to sexual violence on the streets; some were taken off the streets by strangers and forced into child labour without payment; and some were caught in addictions to khat, alcohol, glue, and cigarettes, as well as experiencing suicidal ideations and attempts and depressive symptoms such as feeling worthless. Prior research indicates an association between the use of avoidant coping mechanisms and mental health conditions and suicidality (123).

Hope, faith and resilience

A hopeful person seeks positive outcomes and is determined to overcome difficulties (124). According to Peterson and Seligman, 'Hope, optimism, future-mindedness, and future orientation represent a cognitive, emotional, and motivational stance towards the future' (125). In **Paper I**, the women portrayed life on the streets through photographs. As they shared their experiences of street life, they also expressed their hope and faith in God/Allah, whom they had found in their spiritual lives despite the difficulties of raising a child while living on the streets and being exposed to safety and security issues. Such positive psychological tools – resilience, hope, and seeking help – can help women to escape street life and become independent. Indeed, this is supported by other studies (126, 127).

Interpersonal level

Unconducive family environment

At the interpersonal level, ACEs and abandonment by their partners while they were pregnant were the main catalysts for the women's descent into homelessness.

According to the United Nations Children's Fund (UNICEF), 1.6 billion children endure corporal punishment and psychological aggression at the hands of their caregivers at home (128). Exposure to psychological aggression (being called offensive names, such as "bastard"), physical (corporal) punishment (e.g. being fumigated with berbere smoke (berbere is an Ethiopian red pepper spice mix), and child labour were driving factors that caused some of the women to escape from home. This is a plausible finding, given the high level of child abuse in the African region (129) and the fact that children in Ethiopia have a high risk of being punished harshly within the home (130). Participants reported that parental substance use disorders and witnessing parental IPV had worsened their conditions. This finding aligns with those of other studies that have reported the increased risk of child maltreatment by parents who use substances (131) and mothers who have experienced IPV (132).

Parental favouritism

According to Paper II, parental favouritism, in addition to structural and domestic violence, is an additional driver of homelessness. Discrimination from biological parents who favour other children or stepfathers who favour their own biological children can lead to physical violence against the child. Studies have shown that a non-favoured child faces overt or covert hostility from favoured siblings. Favouritism can cause attachment insecurity, feelings of inadequacy, or rejection. Additionally, the study showed that recurrent favouritism decreases siblings' closeness (133). Such emotional wounds erode the less favoured child's self-esteem and sense of belonging (134). Consequently, this can also lead to them distancing themselves from the rest of their family and putting themselves in vulnerable positions, such as the street.

Community level

Neighbourhoods

Deprivation of basic necessities such as food, water, clothing, sleep, and shelter complicates life on the streets of Addis Ababa for those who experience it. Deprivation of basic needs is a global phenomenon among rough sleepers (9). Studies from Ethiopia (135) and Kenya (136) support these findings. The authors emphasised that the neighbourhoods where homeless people lived were filled with hazardous waste and located in dangerous areas, where it was difficult for them to protect themselves and their children from health hazards, violence, and sexual abuse. Such hardships can lead women to turn to various substances, which perpetuates their cycle of vulnerabilities, making it less likely that they will eventually break free from violence and homelessness. For some, these substances even lead to recurrent homelessness after undergoing rehabilitation. One study (137) confirmed this finding, highlighting the recurrence of homelessness among substance users.

Social norms, customs, cultural beliefs

In looking at domestic violence through the lenses of culture and norms, as shown in Paper II, the women reported experiencing it prior to taking to the streets. Before they experienced visible street homelessness, however, they were already 'living in insecure housing', according to Busch-Geertsema's definition of homelessness (138), or were homeless within their own homes – which is a typical feature of hidden homelessness (8). In addition to the hidden nature of such types of homelessness, one of the obstacles to media narratives and political attention for these women is the role of cultural expectations, which suggest that women should be able to handle their husbands' abuses (139).

Among those experiencing homelessness, the vulnerability of women to sexual violence is high (9). The gender roles given to women in the home and harmful traditional practices that focus exclusively on women (child abduction and early marriage) are among the reasons for women migrating to the city and living on the streets (20). With regard to job opportunities, the participants in Paper I highlighted that employers looking for day labourers preferred to give jobs to men who were experiencing homelessness. Furthermore, the participants also reported that the community referred to them as 'hoodlums' and perceived them as irresponsible, assuming that they were homeless because of their addictive habits. Such perceptions may represent a gendered barrier to getting a job that could enable these women to leave street life.

Institutional/organisational level

Participants from the Addis Ababa City Administration Bureau of Labour and Social Affairs reported that rehabilitation-focused services are available to women who have been institutionalised after living on the streets. In addition, charity organisations—including homelessness-focused organisations such as the Born Again Mental Health Rehabilitation, the Healing Charity Association, the Mekedonia Humanitarian Association, the Gergesenon Mental Patients Aid Association, and others (87) — provide mental healthcare for people experiencing homelessness.

However, the participants indicated that there is a shortage of psychotropic medication. Furthermore, a shortage of mental health professionals is not uncommon in LMICs, including Ethiopia (140).

Paper III found contradictory reports of a shortage of professionals, difficulties reaching people who live on the streets, and low-loaded psychiatric nurses in health centres in Addis Ababa. This suggests an advocacy gap regarding where the community should go for mental health services. Also, resources are not allocated to those most in need, which is reflected in the organisation's information exchange, monitoring, and implementation gaps.

A previous study has shown that the public's mental health service-seeking behaviour is limited to health centres, which represents a health literacy gap and a service utilisation barrier (141).

Social support and healthcare: Women's experience

Although the women who participated in Papers I and II reported going to Mother Teresa Missionaries of Charity for treatment, they also described — especially in the photovoice study (Paper I)—their experiences at healthcare facilities during childbirth, noting how frequently their shelters were demolished, and how legal entities were a source of fear rather than protection (although some did say that the police had rescued them as they had hoped).

Furthermore, they described how Kebele administrative workers had unfairly treated them in terms of social services, with long waiting times, and perceptions of mistreatment by social support and healthcare providers. Similarly, previous studies have revealed that women experiencing homelessness have felt let down by homeless service providers and have reported negative experiences, which in turn exacerbates their feelings of being stigmatised, encountering barriers to receiving healthcare, social exclusion, and inability to find and maintain housing (37, 64, 66, 67).

Policy level

Paper IV elucidated the factors contributing to Ethiopia's inadequate focus on women's health and well-being needs. In Ethiopia, the national social protection policy (88) and the national social protection strategy (89) detail propoor policies and social welfare programmes that are being implemented to reach vulnerable population groups (although the notion of *vulnerability* is itself contentious, as the intended beneficiaries are not clearly identified.

With regard to actor power (112), Study IV showed that while many government and non-government organisations are working to help homeless people, directly or indirectly, there are few connections between them. Another study illustrated the impact of fragmented organisational collaboration on political prioritisation (142).

In Papers III and IV, the public and private sector participants' portrayal of homeless women was almost entirely sympathetic, with reproductive health issues and child-rearing responsibilities being placed on the battlefield of violence in the street. On the other hand, the proposed solutions are restricted to addressing basic survival needs and offering short-term training and rehabilitation. In the first two papers, many women demonstrated perseverance in overcoming various hardships. They showed both strength and resilience, both at a young age and as adults experiencing homelessness. Thus, while participants in Papers III and IV were sympathetic to the plights of these women, it is important to note that portraying them as "victims"—and in some quarters as "criminals" or "public threats"—rather than 'agents of social change' affects the services provided to them, especially, in terms of short-term charity-focused support, as well as the way in which they are perceived within the community. This finding is similar to that of a previous study on social stigma against people experiencing homelessness (143).

As shown in Paper IV, there is a lack of data on the total number of people experiencing homelessness in Addis Ababa, Ethiopia, or at the national level. The Addis Ababa City Administration Bureau of Social Affairs and participants from governmental organisations reported different numbers in their offices, making it difficult to obtain accurate data. Therefore, a comprehensive understanding of the scale of homelessness among women and the burden of disease among them remains elusive. Equally, the participants did not present

any further specific interventions, making it difficult to gain political attention in relevant policy areas or to spark policy discussions about homeless women's health and well-being needs.

Methodological considerations

Strengths of all papers

The strengths of this thesis lie in its addressing a hitherto ignored problem through multiple methods and including a range of voices. Indeed, the thesis is the first to use comprehensive qualitative methods to address women's homelessness in Ethiopia. It is notable for (i) collecting multiple perspectives by including women of reproductive age, service providers, organisation leaders, directors, and health professionals; (ii) using interactive data collection methods (face-to-face interviews, focus group discussions), different data sources, and visual methods; and (iii) involving women experiencing homelessness in the fieldwork and analysis. In addition, all of the studies were conducted in Addis Ababa, one of the largest cities in Africa, where street people migrate from other cities for various reasons and where major charity organisations and government institutions have focused their efforts.

Limitations of all papers

Because we included only women with dependent children in **Papers I and II**, the voices of other groups of people experiencing homelessness were not heard or considered. Furthermore, since the women included in the study were under one organisational umbrella, we could not capture those who were not receiving benefits from government or non-profit organisations. This could have impacted the results in terms of the lack of other perspectives. Moreover, time constraints prevented us from holding an exhibition, which could have offered an essential opportunity for interaction and shared learning among different stakeholders and women experiencing homelessness, in terms of helping them to find practical solutions to everyday challenges on the streets from a woman's perspective. The final limitation of the participatory study may be the exclusion of street-dwelling women who were not in good health during the data collection period. With regard to Papers III and IV, since we conducted the fieldwork during the COVID-19 pandemic, agencies with particular restrictions were not allowed to interview their employees; this meant that some pertinent individuals may have been omitted from the study, especially in two international organisations. Moreover, the study did not include national-level policymakers. However, deductive and inductive analyses, as described in the thesis, helped increase rigour and reliability.

Trustworthiness

Since all four of the included studies are qualitative, we evaluated them using Lincoln and Guba's (144) four trustworthiness criteria: credibility, transferability, dependability, and confirmability.

Credibility

Credibility primarily assesses how accurately the study's findings align with the participants' social world under study (144). To enhance credibility, I (as a principal investigator) engaged with the participating women over a long period and met them repeatedly—during the photography training, every time they came back from the fieldwork when discussing the photographs and again while categorising them. Spending long hours with the women—sometimes half a day—helped to build rapport, trust, and a broader understanding of the issues. Another factor that increased credibility is the triangulation facilitated by the use of different data sources, including photographs, interviews, focus group discussions, field notes (**Paper I**), and government documents (**Paper IV**). In addition, the researchers who checked and confirmed the data for all four papers came from a range of professional backgrounds, such as sociology, anthropology, epidemiology, global health, and mental health. This meant that each part of the data interpretation and analysis could be seen through the lens of a different field.

We checked the interpretations to ensure they accurately captured the women's voices and the experiences they wished to share. In addition, to ensure that peer debriefing was well-focused, the developing analyses were presented at various scholarly meetings, including the Welfare Research Group at Uppsala University (Paper IV) and during Uppsala University's Forum for African Studies seminar session (Paper II), as well as international conferences.

Transferability

Transferability involves gauging to how applicable the study's findings are to other settings, contexts, and population groups (144). To achieve this, a broad description of the characteristics of the participants selected from various institutions and organisations in Addis Ababa, the homeless women who participated in the study, and the methodology followed was given in each study. Each methodological step of each of the studies was described in detail for the benefit of anyone considering conducting a similar study in this research area. In Papers I and II, the national context of the study is shown using various legal framework documents, such as the constitution and endorsed universal legislation. These documents clarify the country's context and give a good explanation of the mental health service arena in Ethiopia. Papers III and IV provide a detailed description of the background context of health in Ethiopia in terms of social protection and gender policies, strategies, and guidelines. In

addition, the findings of these four papers were compared with results obtained in low-, middle-, and high-income countries to assess their resonance with broader global trends.

Dependability

Dependability refers to the extent to which the research process is consistent and can be replicated in similar settings (144). In Paper I, a researcher who had previously used a photo-elicitation method and knew a lot about the Ethiopian context went over the whole research process, starting with the proposal stage, with other research team members who had a lot of experience with qualitative methods and conducting studies in Ethiopia.

The local research team talked with this expert researcher regarding how to conduct community-based participatory research, how to conduct interviews, and what kind of analysis should be used. An audit trail demonstrates the implementation of each process in this thesis. The four building blocks that comprise this thesis follow a qualitative approach; each includes a code list that reflects the coding development of each dataset. The first study includes a code list based on an analysis of Shiffman and Smith's political prioritisation framework. Although the researchers involved in this thesis were from different disciplines, the leading researchers in the analysis varied from study to study; multiple researchers were not directly involved in the data management strategy, as suggested by Braun and Clarke. As the principal investigator in all studies, I performed all of the coding; however, I attempted to maintain inter-coder reliability by coordinating the code, categorising and re-categorising, and then returning to the data to reconstruct the thematic tree. In particular, in the second, third, and fourth studies, it was possible to rework the data by including different insights from the sociological, public health, anthropological, and mental health points of view put forward by researchers in different teams. When discrepancies were found, and flow was lost, the coding tree was reconsidered, and certain themes and sub-themes were merged. In terms of language, the three researchers in the first study were Ethiopians and the participants spoke Amharic. However, they were also accustomed to the 'Arada language' that prevailed on the streets, so additional glossary terms were included in the study to help with this (Paper I).

Confirmability

Lastly, confirmability is a strategy that helps maintain trustworthiness in qualitative studies. The degree to which study findings are influenced by participants' experiences and perspectives rather than researchers' biases is also measured. One of the ways to ensure this is reflexivity, which is explained in detail in the next section.

The other is peer review and collaboration, whereby repeated discussion with and input from a researcher who worked on using photovoice with homeless women in another setting (Paper I). In other studies, multiple viewpoints were considered, including presentations at seminars, conferences, and research centre meetings to obtain input on research design, methodology, and findings, as well as recommendations from those in the professional circles of scholars and service providers. In addition to the viewpoints of researchers and professionals, this study is rendered unique by its use of multiple perspectives. In order to reduce the impact of the researcher's perspectives, the researcher acted as a facilitator and allowed the participants to present their voices—including those of the street dwellers—through their photographs as much as they wanted. This helped to capture multiple perspectives. A 15-point checklist of criteria for good thematic analysis (113) and the consolidated criteria for reporting qualitative research (145) were also used in all of the studies.

Reflexivity

Understanding one's influence in research is crucial for maintaining quality control in qualitative studies (146, 147), and the reflexive approach guides readers to understand the researcher's role in shaping all research findings (147, 148). As the primary investigator in all four studies, I reflected on the ways in which the researchers' positions and experiences influence the research process. As an Ethiopian woman who is familiar with the cultural differences across the country, I understand gender roles and parental expectations, but I recognise my limited perspective on abuse survivors' experiences. Since I did not face negative family issues, homelessness, or traditional mistreatment, I positioned myself as an outsider in the first two studies. Listening to women's accounts of childhood trauma, shifting parental relationships, and life on the streets evoked deep emotions, including guilt over societal silence, and frustration over inadequate advocacy for vulnerable groups.

However, in later studies, power dynamics were unavoidable; some interviewees held high positions or were former teachers, which required careful navigation of my role as a student. In Paper III, my background as a psychiatric practitioner rendered me an insider, influencing interview design and focus. My prior knowledge of the health system may have limited deeper interview probing. The multidisciplinary team helped avoid bias, and the study's methodology sections ensured that the results were precise by connecting them to theories, laws, and previous research.

Conclusions

Findings from the four studies in this thesis demonstrate how the interplay of personal, relational, and community networks, along with institutional and systemic factors, have shaped the trajectories of homeless women of childbearing age. Collectively, these influences have contributed to neglect of their health and well-being in the health and social protection policy arena, thereby fostering health inequalities.

Firstly, the causes of women living on the streets range from multiple childhood abuses to economic instabilities, poverty, and dysfunctional family relationships. Within intimate relationships, violence is one of the immediate triggers for homelessness. Such experience of abuse was found to have continued on the streets and was compounded by re-traumatisation and a lack of social and legal protection and justice.

Second, these women were stuck in a cycle of poverty, trauma, bad health, and untreated drug addiction. This was in addition to a lack of access to basic needs and the effects of homelessness that were passed down from generation to generation.

Thirdly, this group of people had trouble accessing mental health and psychosocial care due to problems at both the individual and systemic levels. Such problems were exacerbated by differences between what people thought, what they did, and how resources were used, rendering services less effective and creating coordination gaps. From the policy perspective, although multi-organisational support is present the issue of women's homelessness and their neglected health and well-being needs remains.

Fourthly, the thesis showed clearly, why homelessness, and particularly the problems associated with women's homelessness, has not garnered significant political attention and how this group of people has become trapped within an inconsistent support system. The community-based participatory study (the photovoice) provided a platform for advocacy and practical suggestions that can amplify the voices of women experiencing homelessness, directly reflecting the needs of those affected by first-hand experiences of homelessness.

In summary, in order for homeless women of reproductive age and their children to navigate these multifaceted challenges, multi-level intersectoral collaboration and interventions are needed.

Recommendations

Policy and programme suggestions are based on the results of the four studies (Papers I–IV). These include areas that need more research, steps that need to be taken to improve current policy and healthcare, and psychological and legal responses to finally help women and other groups in Ethiopia who are homeless and living on the streets.

Policy and programme recommendations

1. Given that adverse childhood experiences are among the main factors contributing to women's homelessness, the focus should be placed on ensuring better law enforcement and social support programmes around child labour, violent punishments, and abuse by close family, other relatives, and domestic employers.
2. An essential priority area among policymakers and programmers, as well as legal enforcement workers in Ethiopia, should be to create social awareness and advocacy regarding the dangers of community-level normalisation and acceptance of child labour, harsh physical discipline, and harmful traditional practices.
3. Several steps can be taken to improve the lack of attention given to people experiencing homelessness, such as defining 'homelessness' within the Ethiopian context and assigning a leader who can unify the services and policy directions for issues of homelessness.
4. Advocating for politicians to address homelessness as a serious violation of human rights and important health and social issues can be effectively communicated through a gender lens.
5. Strengthening collaboration with the ministries and agencies working on homelessness and health is crucial.
6. A focus on adopting a mental health law in Ethiopia could address the service gaps, mental health stigma, and service mechanisms, particularly for hard-to-reach people.
7. Tailored approaches are vital for developing a service delivery strategy within the health system to ensure that mental health services reach people experiencing homelessness.

8. Trauma-informed care is needed in various mental health services packages to address both long- and short-term homelessness as well as other traumatic life events in a manner that is consistent with the needs of street dwellers.
9. Fragmented and inconsistent service delivery must be unified and strengthened.
10. Programme evaluation indicators should be designed and implemented to evaluate the ongoing interventions for people experiencing homelessness.

Future research recommendations

1. Large-scale studies should use a quantitative approach to examine the numbers of homeless individuals, their health burdens, and their unmet needs. Such a data-driven method would aid in developing resource requests, enhancing the understanding of homelessness issues in Ethiopia, and providing the necessary data for policymakers to create and enforce policies that protect people experiencing homelessness.
2. Further studies on the impact of homelessness on children should be conducted to document this problem and provide the appropriate evidence to guide policymaking.
3. In-depth, normative factors and traditional practices that affect the lives of children, girls, and women should be explored using various research methods (ethnographic, participatory, and prospective studies) to help understand the underlying factors that drive women into homelessness and develop solutions to help prevent it.
4. Participants in these studies (Papers I and II) faced issues of sexual and other traumatic experiences, as well as stigma, among their everyday experiences. Therefore, future researchers should conduct a study to measure the magnitude of trauma, the impacts of unaddressed trauma and social stigma, and strategies that could be implemented to address these effects.

Summary in English

The term ‘homelessness’ refers to a situation in which people lack adequate housing and physical, social, spiritual, legal, and private aspects of their lives. It is a pressing global concern that impacts individuals across high-, middle-, and low-income countries. The World Economic Forum and the United Nations reported that 2% of the global population is estimated to be homeless and that 1.6 billion people lack adequate housing. Based on their living conditions, individuals experiencing homelessness can be classified into four categories: people living in rough conditions (street homelessness), those who are houseless, those who have inadequate housing, and those with insecure housing.

This thesis focuses on the first category, ‘people living in rough conditions’ – which refers specifically those residing in places not designed for human habitation. This includes women who sleep in the streets or other open places and regularly occupy a specific spot, often with some form of makeshift cover.

Women experiencing street homelessness face multifaceted, gender-specific issues, in addition to the problems that both men and women face. These women are particularly vulnerable to violence, including sexual and physical assault, as well as exploitation and poor healthcare access. A lack of visibility makes it challenging to understand homeless women’s issues and implement policies to assist them.

While the available literature points to the fact that homelessness is a significant problem in Addis Ababa, Ethiopia, due to the context of the civil war in the past few years, rising urban migration rate, and exceedingly high cost of living, there is a paucity of evidence regarding why and how women become homeless and remain in this condition. Furthermore, the state of mental healthcare and the policy environment in terms of political priority and the services available for homeless women is unclear. In essence, the current understanding of the circumstances of these women in Addis Ababa, the capital of Ethiopia, is poor. Consequently, this thesis aimed to gain a deeper understanding of the lives of women experiencing street homelessness and the services and policy landscape designed to meet their mental health and well-being needs in Addis Ababa.

To address these independent but integrated aims, the thesis used a qualitative approach to capture multiple perspectives through different lenses focusing on homeless women of reproductive age (18−49 years; Papers I and

II), as well as health and social services providers, programme coordinators (Papers III and IV) at different levels.

For Paper, I, in addition to individual interviews, community-based participatory research was undertaken with women experiencing homelessness. This participatory research assessed how women living on the street in Addis Ababa, Ethiopia, describe their situations and their suggestions for addressing their unmet needs. In this study, the involvement of homeless women went beyond traditional data collection through interviews and included an analysis of photographs about *'life on the streets'*.

For Paper II, a study was conducted among 19 homeless women, exploring their early-life experiences, key drivers of homelessness, trajectories, and the challenges inherent to their reintegration into the community.

Paper III explored 34 health and social services providers' and programme coordinators' perceptions and experiences regarding the delivery of mental healthcare and psychosocial services to women experiencing homelessness.

Paper IV examined factors that have shaped political priority for the health and well-being needs of homeless women of reproductive age. Participants were recruited from governmental and non-governmental organisations for Papers III and IV.

Data were subjected to inductive thematic analysis for the first three studies (Papers I–III). For Paper IV, the data was analysed deductively using Shiffman and Smiths political prioritisation framework.

The results from Paper I indicated that in addition to being deprived of basic needs and caught in a cycle of dependency and solitude, as well as being prone to poor health and social exclusion, many of the women's children end up also becoming homeless, being subjected to violence and exploitation, and facing adversity at an early age. This reflects the extent of the violation of children's rights and the existing gap in child protection, as also portrayed in the photographs.

The most prominent finding of the second study was that rather than mesolevel systemic and structural factors, the drivers of women's homelessness, as well as their trajectories through homelessness, were shaped by individual and microlevel relational factors. The findings highlighted how the trajectories through homelessness were shaped by abuse as the common thread. Most of the women had been on the street for 10+ years and had physical, reproductive, and substance addiction issues. The four main themes identified were 'Childhood trauma from abuse', 'Sexual violence', 'Barriers to leaving street living', and 'Sources of hope'. Re-traumatisation on the streets fuels these adverse traumatic experiences.

In Papers I and II, although the darkness of street life was vividly depicted and shared, there were glimpses of hope and signs of resilience, self-esteem, and courage in the face of hardship; these are positive aspects that could foster reintegration and break the cycle of women's homelessness and its possible intergenerational impacts on children. While women identified and suggested

areas of improvement, they did not bring their deep-rooted issues, unresolved childhood traumatic experiences, and re-traumatisation from repeated rape and its aftermath to the fore (Paper I).

Contradictory beliefs and practices, problem-solution incompatibility, and resource limitations hinder the provision of services to women experiencing homelessness. Moreover, there is a mismatch between the services these women need and the ongoing service provision (Paper III).

From the perspectives and experiences of governmental and nongovernmental organisations' employees and managers, there are gaps in the actors' power, how homelessness is portrayed, and Ethiopia's health and social service provision structure. Further, the lack of attention to these women is evident through the gap in research on the extent of homelessness in Ethiopia, no indicators to measure the health and well-being issues, and the lack of explicit policy focus for this group (Paper IV).

Therefore, organisations focused on homelessness issues need to address the deep-seated individual circumstances related to dysfunctional family dynamics, as well as the increasingly gendered cultural and normative vulnerability of women to abuse. Women's economic dependency remains a critical concern, especially for chronically homeless women and their dependent children. This suggests the urgent need for strategies considering research-based assessments for situational and trauma trauma-focused needs and gender-responsive, multilevel, trauma-focused domestic violence interventions. Strategies should also include integrated rehabilitation campaigns, adopting internationally proven positive effects to address homelessness-focused policies, unmet basic needs, and denied human rights.

Summary in Amharic (ማጠቃለያ በአማርኛ)

‘ቤት አልባነት’ የሚለው ቃል ሰዎች በቂ መጠለያ እና አካላዊ፣ ማህበራዊ፣ መንፈሳዊ፣ ሕጋዊ እና የግል ሕይወት የሌላቸውን ሰዎች ሁኔታ ያመለክታል። ከፍተኛ፣ መካከለኛ፣ እና ዝቅተኛ ገቢ ባላቸው ሀገራት ውስጥ ያሉ ግለሰቦችን ተጽዕኖ የሚያሳድር አሳሳቢ ዓለም አቀፋዊ ጉዳይ ነው ። የዓለም የኢኮኖሚ ፎረም እና የተባበሩት መንግሥታት ድርጅት እንደዘገቡት ከሆነ ከዓለም ሕዝብ መካከል 2 በመቶ የሚሆኑት መጠለያ የሌላቸው ሲሆኑ 1.6 ቢሊዮን የሚሆኑት ደግሞ በቂ መጠለያ የላቸውም። በኑሮ ሁኔታቸው ላይ በመመስረት፣ ቤት የሌላቸው ግለሰቦች በአራት ሊመደቡ ይችላሉ:- በከባድ ሁኔታ ውስጥ የሚኖሩ ሰዎች (የጎዳና ላይ ኑሮ፣ ቤት አልባነት)፣ ቤት የሌላቸው፣ በቂ የሆነ መኖሪያ ቤት የሌላቸው እና ደህንነቱ ያልተጠበቀ መኖሪያ ቤት ያላቸው።

ይህ መመረቂያ ፅሁፍ በመጀመሪያው ምድብ ላይ ያተኮረ ነው፣ ‘በከባድ ሁኔታዎች ውስጥ የሚኖሩ ሰዎች’ – ይህም በተለይ ለሰው ልጅ መኖሪያ ባልተዘጋጁ ቦታዎች የሚኖሩትን ያመለክታል። ይህ ደግሞ በጎዳናዎች ወይም በሌሎች ክፍት ቦታዎች ላይ የሚተኙና አብዛኛውን ጊዜ ጊዜያዊ የሆነ መሸፈኛ ይዘው የተወሰኑ ቦታዎችን የሚይዙ ሴቶችን ያካትታል።

የጎዳና ቤት አልባነት ያጋጠማቸው ሴቶች ከወንዶችም ከሴቶችም ከሚያጋጥሟቸው ችግሮች በተጨማሪ ዘርፈ ብዙ፣ ጾታ-ተኮር ችግሮች ያጋጥሟቸዋል። እነዚህ ሴቶች በተለይ ለጥቃት ተጋላጭ ናቸው፣ ወሲባዊ እና አካላዊ ጥቃትን ጨምሮ፣ እንዲሁም ለብዝበዛ እና ለደካማ የጤና አገልግሎት ተደራሽነት ተጋላጭ ናቸው። የእይታ እጦት የቤት አልባ ሴቶችን ችግሮች ለመረዳት እና እነሱን ለመርዳት ፖሊሲዎችን ተግባራዊ ለማድረግ ፈታኝ ያደርገዋል።

ባለፉት ጥቂት አመታት በነበረው የእርስ በእርስ ጦርነት፣ ወደ ከተሞች እየጨመረ ያለው ፍልሰት መጠን እና እጅግ ከፍተኛ በሆነ የኑሮ ውድነት ምክንያት ቤት አልባነት በአዲስ አበባ፣ ኢትዮጵያ ከፍተኛ ችግር መሆኑን የሚጠቁሙ ጽሑፎች ቢኖሩም ሴቶች ለምን እና እንዴት ቤት አልባ እንደሚሆኑ እና በዚህ ሁኔታ ውስጥ እንደሚቆዩ የሚያሳይ በቂ ማስረጃ የለም። በተጨማሪም፣ የአዕምሮ ጤና አጠባበቅ ሁኔታ እና የፖሊሲ ምህዳሩ በፖለቲካ ቅድሚያ ከመስጠት አንፃር እና ቤት ለሌላቸው ሴቶች የሚሰጠው አገልግሎት ግልጽ አይደለም። በመሰረቱ በኢትዮጵያ ዋና ከተማ አዲስ አበባ ውስጥ ስለነዚህ ሴቶች ሁኔታ ያለው ግንዛቤ ደካማ ነው። በዚህም ምክንያት ይህ መመረቂያ ፅሁፍ ዓላማው በአዲስ አበባ ውስጥ የጎዳና ላይ ቤት አልባ ሴቶችን ሕይወት፣ የአእምሮ ጤንነት እና ደህንነት ፍላጎቶቻቸውን ለማሟላት የተነደፉ አገልግሎቶችን እና የፖሊሲ ገጽታዎችን በጥልቀት ለመረዳት ነበር ።

እነዚህን ገለልተኛ ግን የተቀናጁ ግቦች ለመምታት ፣ መመረቂያ ፅሁፉ በተለያዩ ዕይታዎች በመጠቀም በርካታ አመለካከቶችን ለማካተት የጥራት ስልትን ተጠቅሟል፣ ይህም በተለያዩ ደረጃዎች ላይ በቤት አልባ ሴቶች (ከ18 እስከ 49 ዓመት፤ ጥናታዊ ጽሑፍ 1 እና 2) እንዲሁም በጤና እና በማህበራዊ አገልግሎቶች አቅራቢዎች፣ በፕሮግራም አስተባባሪዎች (ጥናታዊ ጽሑፍ 3 እና 4) ላይ ያተኮረ ነው።

ለጥናታዊ ጽሑፍ 1፣ ከግለሰባዊ ቃለመጠይቆች በተጨማሪ፣ ቤት አልባነት ካጋጠማቸው ሴቶች ጋር በማህበረሰብ ላይ የተመሰረተ አሳታፊ ጥናት ተካሄዷል። ይህ አሳታፊ ጥናት በአዲስ አበባ፣ ኢትዮጵያ ውስጥ በጎዳና ላይ የሚኖሩ ሴቶች ሁኔታዎቻቸውን እና ያልተሟሉ ፍላጎቶቻቸውን

ለመፍታት ያቀረቡትን ሀሳብ ገምግሟል። በዚህ ጥናት ውስጥ የቤት አልባ ሴቶች ተሳትፎ በቃለ መጠይቆች አማካይነት ከተለመደው የመረጃ አሰባሰብ አልፎ ስለ 'በጎዳና ላይ ሕይወት' ፎቶግራፎችን ትንተና አካቷል።

ለጥናታዊ ጽሑፍ 2፣ በ19 ቤት አልባ ሴቶች ላይ ጥናት ተካሂዶ ነበር፣ ይህም ቀደምት የህይወት ልምዳቸውን፣ የቤት አልባነት ቁልፍ ምክንያቶችን፣ መንገዶችን እና ከማህበረሰቡ ጋር የመቀላቀል ተግዳሮቶችን የዳሰሰ ነው።

ጥናታዊ ጽሑፍ 3፣ በ34 የጤና እና ማህበራዊ አገልግሎት አቅራቢዎችን እና የፕሮግራም አስተባባሪዎችን ግንዛቤ እና ቤት አልባ ለሆኑ ሴቶች የአዕምሮ ጤና አጠባበቅ እና የስነ-ልቦና-ማህበራዊ አገልግሎቶች አቅርቦትን በተመለከተ ዳስሷል።

ጥናታዊ ጽሑፍ 4 መዉለጃ እድሜ ላይ ያሉ የቤት አልባ ሴቶች የጤና እና ደህንነት ፍላጎቶች የፖለቲካዊ ትኩረት እንዲሰጣቸው ያደረጓቸውን ምክንያቶች መርምሯል። ተሳታፊዎቹ ለጥናታዊ ጽሑፍ 3 እና 4 ከመንግሥታዊ እና መንግስታዊ ካልሆኑ ድርጅቶች ተመልምለዋል።

መረጃዎች በመጀመሪያዎቹ ሶስት ጥናቶች (ጥናታዊ ጽሑፍ 1-3) ለምልክታዊ አመክንዮ ጭብጥ ትንተና ተግባራዊ ሆነዋል። ለጥናታዊ ጽሑፍ 4 መረጃው በሺፍማን እና ስሚዝ የፖለቲካ ቅድሚያ መስጫ ማዕቀፍ በመጠቀም ተንትኗል።

ከጥናታዊ ጽሑፍ 1 የተገኘው እንደሚያመለክተው መሰረታዊ ፍላጎቶች ተነፍገው በጥገኝነት እና በብቸኝነት አዙሪት ውስጥ ከመግባታቸው በተጨማሪ ለጤና መጓደል እና ለማህበራዊ መገለል የተጋለጡ ከመሆናቸው በተጨማሪ የብዙዎቹ ሴቶች ልጆች ቤት አልባ ሆነው እየተዳረጉ ይገኛሉ፣ ለጥቃት እና ብዝበዛ፣ እና ገና በለጋ እድሜያቸው ችግሮችን ለመጋፈጥ ይገደዳሉ። ይህ በፎቶግራፎቹ ላይ እንደሚታየው የህፃናት መብቶች ጥሰት መጠን እና የህፃናት ጥበቃ ላይ ያለውን ነባር ክፍተት የሚያንፀባርቅ ነው።

የሁለተኛው ጥናት በጣም ጎልቶ የወጣው ግኝት የሴቶች ቤት አልባነት መንስኤዎች እና በቤት አልባነት ውስጥ የሚጓዙት በግለሰባዊ እና በማይክሮ-ደረጃ የግንኙነት ምክንያቶች እንጂ በመካከለኛ ደረጃ የስርዓት እና መዋቅራዊ ምክንያቶች እንዳልሆኑ ነው። ግኝቶቹ የቤት አልባነት መንገዶች እንደ አንድ ደም ስር እንዴት እንደተቀረጹ አፅንዖት ሰጥተዋል። አብዛኛዎቹ ሴቶች ከ10 ዓመት በላይ በመንገድ ላይ የቆዩ እና የአካል፣ የመራቢያ እና የአደንዛዥ ዕጽ ሱስ ችግሮች ሰለባ ናቸው። የተገለጹት አራቱ ዋና ጭብጦች 'የልጅነት ጉዳት በደል' ፣ 'ወሲባዊ ጥቃት' ፣ 'የጎዳና ላይ ኑሮ ለመተው ያሉ እንቅፋቶች' እና 'የተስፋ ምንጮች' ናቸው ። በጎዳናዎች ላይ ዳግም መጎዳት እነዚህን አሉታዊ የስቃይ ፈተናዎችን ያባብሳል።

ጥናታዊ ጽሑፍ 1 እና 2 ውስጥ ምንም እንኳን የጎዳና ላይ ሕይወት ጨለማ ቁልጭ ተደርጎ ቢገለፅም እና ቢጋራም፣ በፈተና ጊዜ የፅናት፣ በራስ የመተማመን እና የድፍረት የተስፋ ጭላንጭል ምልክቶች ነበሩ፤ እነዚህ ከማህበረሰቡ ጋር እንደገና መቀላቀልን የሚያበረታቱ እና የሴቶችን የቤት አልባነት ዑደት እና በልጆች ላይ ሊያመጣ የሚችለውን የትውልድ ተጽእኖ የሚሰብሩ አወንታዊ ገጽታዎች ናቸው። ሴቶች ማሻሻያ ማድረግ የሚኖርባቸውን ጉዳዮች ለይተው ቢጠቁሙም ጥልቅ የሆኑ ችግሮቻቸውን፣ ያልተፈቱ የልጅነት ጉዳቶቻቸውን እና በተደጋጋሚ ከተፈጸመባቸው አስገድዶ መድፈር እና ከደረሰባቸው መዘዞች ጋር በተያያዘ ያጋጠማቸውን ዳግም ጉዳት ግንባር ቀደም አድርገው አልገለጹም (ጥናታዊ ጽሑፍ 1)። ተቃራኒ እምነቶች እና ተግባራት፣ የችግርና-መፍትሄው አለመጣጣም እና የሀብት ውስንነት የቤት አልባነት ችግር ላለባቸው ሴቶች ለሚሰጠው አገልግሎት እንቅፋት ነው። ከዚህም በላይ በእነዚህ ሴቶች በሚያስፈልጋቸው አገልግሎቶች እና በቀጣይነት በሚቀርቡት አገልግሎት መካከል አለመጣጣም አለ (ጥናታዊ ጽሑፍ III)።

ከመንግስታዊና መንግስታዊ ያልሆኑ ድርጅቶች ሰራተኞችና ስራ አስኪያጆች እይታና ልምድ በመነሳት በባለስልጣናት፣ ቤት አልባነትን በሚገልጹበት መንገድ እና በኢትዮጵያ የጤና እና ማህበራዊ አገልግሎት አቅርቦት መዋቅር ላይ ክፍተቶች አሉ። ከዚህም በላይ ለእነዚህ ሴቶች ትኩረት አለመስጠቱ በኢትዮጵያ የቤት አልባነት መጠን ላይ በተደረገው ጥናት ክፍተት ፣ የጤና እና ደህንነት

ጉዳዮችን ለመለካት አመልካቾች ባለመኖራቸው እና ለዚህ ቡድን ግልጽ የፖሊሲ ትኩረት ባለመኖሩ በግልጽ ይታያል (ጥናታዊ ጽሑፍ 4)

ስለሆነም፣ በቤት አልባነት ጉዳዮች ላይ ያተኮሩ ድርጅቶች ከተቃወሰ የቤተሰብ ሁኔታ ጋር የተያያዙ ሥር የሰደዱ ግለሰባዊ ሁኔታዎችን እንዲሁም ሥርዓተ-ፆታዊነት እየጨመረ የመጣውን የባህል እና መደበኛ የሴቶች ጥቃት ተጋላጭነት መፍታት አለባቸው። የሴቶች ኢኮኖሚያዊ ጥገኝነት አሁንም አሳሳቢ ጉዳይ

ነው፣ በተለይም ሥር የሰደደ ቤት አልባ ሴቶች እና ጥገኛ ልጆቻቸው። ይህ የሚያሳየው በምርምር ላይ የተመሰረቱ ግምገማዎችን ለሁኔታ እና ለጉዳት ተኮር ፍላጎቶች እና ለጾታ ተኮር ምላሽ የሚሰጡ፣ ባለብዙ ደረጃ፣ ጉዳት ተኮር የቤት ውስጥ የኃይል ጥቃቶችን የሚመለከቱ ስትራቴጂዎች በአስቸኳይ አስፈላጊነት ነው። ስትራቴጂዎች በቤት አልባነት ላይ ያተኮሩ ፖሊሲዎችን፣ ያልተሟሉ መሰረታዊ ፍላጎቶችን እና የተነፈጉ የሰብአዊ መብቶችን ለመቅረፍ በዓለም አቀፍ ደረጃ የተረጋገጡ አዎንታዊ ውጤቶችን ያስገኙ ልምዶችን በመውሰድ የተቀናጁ የመልሶ ማቋቋም ዘመቻዎችን ማካተት አለባቸው።

Sammanfattning på svenska

Begreppet "hemlöshet" refererar till en situation där människor saknar adekvat bostad och lever under förhållanden som äventyrar deras fysiska, sociala, andliga hälsa och begränsar deras juridiska rättigheter och privatliv. Hemlöshet är en global kris som påverkar individer i så väl låg- och medel- som höginkomstländer. World Economic Forum och FN har rapporterat att två procent av världens befolkning är hemlösa och att 1,6 miljarder människor saknar adekvata bostäder. Baserat på levnadsförhållanden kan hemlösa individer delas in i fyra kategorier: gatuhemlöshet (när en person bor på gatan, utomhus eller på offentliga platser som inte är avsedda för boende), huslöshet (när en person vistas på tillfälliga boenden som härbärgen, natthärbärgen eller akutboenden utan ett permanent hem), osäkra boenden (när en person bor hos vänner, familj eller andra utan något långsiktigt avtal, ofta kallat att "soffsurfa"), och otillräckliga boenden (är en person bor i en bostad som är otrygg, överbelastad eller ohälsosam, exempelvis i slumområden eller byggnader som inte uppfyller grundläggande standarder).

Denna avhandling fokuserar på kvinnor i gatuhemlöshet i Addis Abeba, Etiopien, d.v.s. kvinnor som sover på offentliga platser som parker, järnvägsbankar, under broar, på vägkanter och vid flodstränder. Kvinnor i gatuhemlöshet möter mångfacetterade och könsspecifika problem utöver de utmaningar som både män och kvinnor står inför. Kvinnors hemlöshet är politiskt osynlig, vilket gör det svårt att förstå de problem som hemlösa kvinnor står inför och att implementera policyer som kan hjälpa dem. Även om hemlöshet påverkar alla samhällsgrupper, är orsakerna till kvinnors hemlöshet och de svårigheter och behov de möter starkt köns- och genusrelaterade.

Trots att litteraturen belyser vikten av kvinnors hemlöshet finns det lite kunskap om varför och hur kvinnor blir hemlösa och fastnar i hemlöshet, vilken roll psykiatrisk vård spelar samt hur policylandskapet ser ut med avseende på politiska prioriteringar och tjänster. Det saknas också forskning om kvinnors liv på gatan, forskning som skulle kunna möjliggöra förslag på förändringar och social utveckling. Sammanfattningsvis är vår förståelse av dynamiken kring kvinnors gatuhemlöshet i Addis Abeba bristfällig. Syftet med denna avhandling är därför att få en djupare förståelse för livsvillkoren och erfarenheterna hos de kvinnor som lever i hemlöshet och de samhällstjänster och riktlinjer som utformats för att möta deras behov i Addis Abeba, Etiopien.

Samtliga av avhandlingens fyra studier har en kvalitativ ansats för att fånga olika perspektiv och upplevelser om ämnet. Avhandlingen bygger på kvalitativa intervjuer med hemlösa kvinnor i reproduktiv ålder (18–49 år; artikel I och II), och vårdgivare och programkoordinatorer (artikel III och IV). För artikel I genomfördes, utöver individuella intervjuer, en samskapande övning med kvinnor som lever i hemlöshet genom att även använda en analys av fotografier om "livet på gatan" som kvinnorna själva tagit. Denna inkluderande forskningsmetod beskriver hur kvinnor som lever på gatan i Addis Abeba upplever sin situation och vilka förslag de har för att kunna hantera sina ouppfyllda behov.

För artikel II genomfördes en studie med 19 hemlösa kvinnor delgav sina tidiga livserfarenheter, de huvudsakliga orsakerna som drivit dem till hemlöshet, sina livshistorier och de utmaningar som är kopplade till deras återanpassning till samhället.

Artikel III undersökte 34 vård- och socialtjänstaktörers samt programkoordinatorers uppfattningar och erfarenheter av att erbjuda psykiatrisk vård och psykosociala tjänster till kvinnor som upplever hemlöshet.

Artikel IV analyserade de faktorer som har påverkat de politiska prioriteringarna runt hälsa och välbefinnande för hemlösa kvinnor i reproduktiv ålder. Deltagarna i artiklarna III och IV rekryterades från statliga och icke-statliga organisationer.

För de tre första studierna (artiklar I–III) användes en induktiv tematisk analys. För artikel IV analyserades data deduktivt med hjälp av Shiffman och Smiths ramverk för politisk prioritering.

Resultaten från artikel I visade att förutom att vara berövade grundläggande behov och fast i en cykel av beroende och ensamhet och utsatta för dålig hälsa och social exkludering, blir också många av kvinnornas barn också hemlösa. De utsätts för våld och exploatering och möter motgångar redan i tidig ålder. Detta speglar omfattningen av kränkningarna av barns rättigheter och den rådande bristen i barnskydd, något som även återspeglas i fotografierna.

Den mest framträdande lärdomen i den andra studien var att kvinnors hemlöshet och deras livshistorier formades av individuella och relationella faktorer snarare än av systemiska och strukturella faktorer. En genomgående röd tråd i resultaten betonade att de livsöden som drev kvinnorna till hemlöshet präglades av misshandel. De flesta av kvinnorna hade levt på gatan i över tio år och hade fysiska, reproduktiva och drogrelaterade hälsoproblem. De fyra huvudsakliga teman som identifierades var: "Barndomstrauma från övergrepp", "Sexuellt våld", "Hinder för att lämna gatulivet" och "Källor till hopp". Re-traumatisering på gatorna förstärker dessa negativa traumatiska upplevelser.

I artikel I och II fanns det glimtar av hopp och tecken på motståndskraft, självkänsla och mod i svåra tider trots den mörka bild av gatulivet som skildrades. Dessa positiva aspekter kan bidra till att bryta cykeln av hemlöshet och

dess potentiella inter-generationella effekter på barn och bidra till återintegrering i samhället. Även om kvinnorna identifierade och föreslog förbättringsområden, lyfte de inte fram sina djupt rotade problem så som olösta barndomstrauman och re-traumatisering från upprepad våldtäkt och dess efterverkningar.

I artikel III beskrivs hur motstridiga föreställningar och praktiker, såsom bristande länkning mellan problemformuleringar och lösningar samt dåligt utnyttjade resurser, hindrar tillhandahållandet av tjänster till kvinnor som upplever hemlöshet. Dessutom finns det en bristande överensstämmelse mellan de tjänster som dessa kvinnor behöver och de tjänster som faktiskt erbjuds.

I artikel IV uppgav anställda och chefer vid statliga och icke-statliga organisationer att det finns brister i de olika aktörernas makt och handlingsutrymme, hur hemlöshet porträtteras samt i Etiopiens hälso- och socialtjänststruktur. Vidare är bristen på uppmärksamhet för dessa kvinnor tydlig genom avsaknaden av forskning om omfattningen av hemlöshet i Etiopien, frånvaron av indikatorer för att mäta hälsa och välbefinnande samt den uteblivna explicita policyfokuseringen på denna grupp.

Resultaten från denna avhandling pekar på att organisationer som arbetar med hemlöshetsfrågor behöver arbeta med de djupt rotade individuella omständigheterna kopplade till dysfunktionella familjesituationer samt den alltmer köns- och genusrelaterade kulturella och normativa risken för kvinnor att utsättas för övergrepp. Kvinnors ekonomiska beroende förblir en kritisk fråga, särskilt för kroniskt hemlösa kvinnor och de barn som är beroende av dem. Detta understryker det akuta behovet av strategier som bygger på evidensbaserade bedömningar av situationen, möter trauma-fokuserade behov och introducerar könsanpassade, koordinerade, trauma-orienterade insatser mot våld i nära relationer. Strategierna bör även inkludera integrerade rehabiliteringskampanjer och tillämpa internationellt beprövade metoder för att skapa hemlöshetspolitik som möter ouppfyllda grundläggande behov och åtgärdar brister i mänskliga rättigheter.

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