



Review of Progress towards the World Fit for Children +5 goals in Kenya



CONTENTS

1.	Introduction.....	5
1.1	Purpose of the review.....	5
1.2	Review Methodology.....	5
1.3	Report Outline	6
2.	Background of Kenya	6
3.	National policies, institutional and legal frameworks and resource allocation	9
3.1	Introduction.....	9
3.2	Social Policy Framework.....	9
3.3	Legal Framework	12
3.4	Sector specific resource allocations	13
4.	Review of progress of WFFC goals.....	14
4.1	Promoting Healthy Lives	14
4.1.1	<i>Context</i>	14
4.1.2	<i>Current Situation and trends</i>	15
4.1.3	<i>Policy and Legislative Framework</i>	21
4.1.4	<i>Main challenges</i>	22
4.2	Providing Quality Education.....	23
4.2.1	<i>Context</i>	23
4.2.2	<i>Current Status and Trends</i>	23
4.2.3	<i>Policy and legislative framework</i>	26
4.2.4	<i>Main challenges</i>	26
4.3	Protecting against abuse, exploitation and violence	28
4.3.1	<i>Context</i>	28
4.3.2	<i>Current Situation and trends</i>	28
4.3.3	<i>Policy and legislative framework</i>	30
4.3.4	<i>Main challenges</i>	31
4.4	Combating HIV/AIDS	31
4.4.1	<i>Context</i>	31
4.4.2	<i>Current status and trends</i>	32
4.4.3	<i>Policy and Legislative Framework</i>	33
4.4.4	<i>Main challenges</i>	33
5	Concluding Remarks.....	34

List of Tables and Figures

Table 1: Infant and Under Five Mortality 1989-2003	15
Table 2: Proportion of children below 1 year immunized 2001-2006	16
Table 3: Proportion of children born in 2000-2005 protected from tetanus	16
Table 4: Kenya's MDG Targets for Rural Water and Sanitation	21
Table 5: Expected Age for Grade and over age children by Grade	25
Table 6: Child Abuse Cases attended at Kenyatta National Hospital 2000-2005	29
Table 7 Number of Children by Age group and Gender involved in crime and convicted 2003-2006	30
Table 8: Kenya HIV/AIDS Prevalence 1999-2005	32
Table 9: Children infected by HIV 2003-2005	33
<hr/>	
Figure 1: Social sector allocations 2000/1 to 2004/5	14
Figure 2: Under Five mortality rates by region.	16
Figure 3: Malaria endemic areas	17
Figure 4: Trends in Children Nutritional Status	19
Figure 5: Wasting among children under 5 years	19
Figure 6: Intake of Vitamin A	20

Boxes

Box 1	Secondary School Scholarship programme for Girls from North Eastern Province	28
Box 2	Alleviating the Plight of Orphans: The Cash Transfer Program Initiative	34

Acronyms

AAC	Area Advisory Council
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CRC	Convention on the rights of the child
ECD	Early Childhood Development
EFA	Education for All
ERSWEC	Economic Recovery Strategy for Wealth and Employment Creation
FGM	Female Genital mutilation
FPE	Free primary education
GoK	Government of Kenya
GPI	Gender parity Index
GFATM	Global Fund for AIDS, TB and malaria
HELB	High Education Loans Board
HIV	Human Immune deficiency Virus
KDHS	Kenya Demographic Health Survey
KESSP	Kenya education sector support programme
KNASP	Kenya National Aids strategic plan
KSH	Kenyan Shillings
LLITN	Long lasting insecticide treated nets
MDG	Millennium Development Goals
MICS	Multi indicator cluster survey
MMR	Maternal Mortality ratio
MoE	Ministry of Education
MoH	Ministry of Health
MTEF	Medium term expenditure framework
NACC	National AIDS Control Council
NASCOP	National AIDS and STIs Control Programme
NEP	North eastern province
NCCS	National Council for Children's Services
NGOs	Non-Governmental Organizations
NPA	National plan of action
OVC	Orphans and vulnerable children
OPV	Oral Polio Vaccine
PMTCT	Prevention of mother to child transmission
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SWAPs	Sector wide approaches
UNCRC	United Nations Committee on the rights of the Child
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UPE	Universal Primary Education
UNGA	United Nations General Assembly
USD	United States Dollars
VCT	Voluntary Counseling & Testing
WFFC	World Fit For Children

1. Introduction

1.1 Purpose of the review

World leaders met at UN General Assembly in 2002 for the Special Session on Children and produced a Declaration called A World Fit for Children (WFFC). The Declaration outlines four themes to promote the well being of children everywhere. These are: promoting healthy lives; providing quality education; protecting against abuse, exploitation and violence; and combating HIV/AIDS. The UNGA at its 58th session in 2004 tasked UNICEF to assist national governments prepare the progress report. The UNGA also resolved in that session to convene a commemorative plenary meeting in 2007 devoted to the outcome and progress made in implementing the declaration and the plan of action, five years after the WFFC based on a report to be prepared by the Secretary General. This is the national progress report on the WFFC+5 for Kenya coordinated by the Permanent Secretary, Office of the Vice President and Ministry of Home Affairs, Government of Kenya in collaboration with UNICEF Kenya.

This assessment reviews progress made towards the realization of the World Fit For Children (WFFC) goals and target set in 2002. It highlights both the achievements as well as the challenge that Kenya faces in meeting the needs of children and makes recommendations for a way forward. The assessment also documents opportunities for improving the welfare and general well being of children over the past five years.

1.2 Review Methodology

This review combined a desk review with workshops and consultations. The process began with the development of a concept paper which was shared with the Government of Kenya (GoK) and the UN Country team (UNCT) in August 2006. The Permanent Secretary in the Office of the Vice President and Ministry of Home Affairs, Government of Kenya led the review process. The Department of Children's Affairs and the National Council for Children's Services (NCCS) in the Ministry of Home Affairs provided the support for the management of the review process. UNICEF contracted the services of the Centre for Study of Adolescents (CSA) to document the review and produce the report.

A matrix was developed translating the WFFC themes into relevant goals and indicators. This matrix was shared with key stakeholders during a national consultation held in October 2006 to discuss the progress of WFFC+ in Kenya. This consultation was extended to representatives from all sectors including private sector players and Civil Society Organizations (CSO). During the workshop stakeholders discussed progress and challenges of realizing WFFC goals and made recommendations towards accelerating the pace of meeting the WFFC and MDGs.

The literature review included, but was not limited to the Global Declaration of WFFC, regional and national commitments, periodic and complimentary reports of CRC including reports on the implementation of the Children Act (2001), key national policy and framework documents such as the Economic Recovery Strategy (ERS), the Sessional Paper on Education and the Health Sector Strategic Plan II.

Consultations were also held with children from various parts of the country to get their perspectives and understanding of what had changed over the past five years.

1.3 Report outline

Section One outlines the objectives of the assessment and the methodology. **Section two** provides an overview of the social-economic and political context of the period under review. **Section three** looks at the national legal, policy and institutional framework for the realization of the WFFC Goals. **Section four** highlights the sector specific strategies and activities, outlining progress made towards the realization of WFFC themes.

2. Background of Kenya

Kenya has an estimated population of 33 million, 75-80 percent of who live in the rural areas. The population distribution varies from 230 persons per km² in high potential areas to 3 persons per km² in arid areas. Only about 20 percent consists of high to medium potential agricultural land and supports 80% of the population. The remaining 20 percent of the population lives in 80 percent of the land, which is arid and semi arid.

The number of children in the population is estimated at 17.5 million, which is slightly more than a half of the total population. About 84.5% of the children live in rural areas while 15.5% live in urban areas. With over 50% of the population below 15 years of age, the country is faced with a high dependency burden. This not only creates a serious strain on basic social services such as education and health care; but also affects savings and wealth creation.

The past few years have seen mixed fortunes for Kenya. According to the Economic Survey (2006), there has been an expansion in the Gross Domestic Product (GDP) since 2003, which has been driven mainly by growth in Agriculture and Forestry, Wholesale and Retail trade and Transport and Communication. The economy maintained the momentum that began in 2003 with most sectors recording accelerated growth in 2005. Real GDP grew by 5.8 per cent in 2005 compared to a revised growth of 4.9 per cent in 2004. In 2006, the economy is expected to grow at a rate of 6.0 percent.¹

The country has experienced an increase in revenue collection which has translated into an increase in the financial allocation to the social sector since 2003. Total expenditure on social services increased from KSh 77.9 billion in 2001/ 2002 financial year to KSh 126.7 billion in 2005/06. This increase in expenditure reflects Government's commitment to improving access to basic social services. Recurrent expenditure rose by 10.1% from KSh 100.1 billion in 2004/2005 to KSh 110.2 billion in 2005/2006 financial year. Development expenditure rose by 21.9 percent during the same period.

The economic expansion has made available more funds for investment in children both from the state and from civil society. The Kenyan private sector's support for children include expanded activities by many companies including Celtel, Safaricom, Barclays Bank of Kenya, Standard Chartered Bank and Nakumatt.

While the economy has recorded growth for the first time after several years of an economic down turn, the cyclic pattern of natural disasters has had a negative impact on certain segments of the population including children. Persistent drought in certain parts

¹ Economic Survey 2006

of the country has been followed by severe food shortage which has adversely affected children. Apart from drought flooding has also been experienced in various parts of the country leading to destruction of property, displacement and even loss of life.

Opportunities for meeting WFFC goals: There have been significant opportunities for the realization of MDG and WFFC goals in terms resources. Revenue collection has improved significantly since 2003 making more resources available for social services. The total revenue grew by 15 percent from Ksh 252.7 billion in 2003-4 to Ksh 289.8 million in 2004-5. Total expenditures grew at a slower rate of 11.2 percent between 2003-4 and 2004-5. The fastest growing expenditure item was development outlay which increased by 32 percent. At the same time, additional funds have become available through devolution. The “devolved funds” include the road maintenance levy fund, bursary fund, local authority transfer fund (LATF) and the Constituency HIV/AIDS fund. Devolution has not only brought the financial decision making closer to the people but has led to increased participation in the decision making process. It has the potential to contribute to improved efficiency in the delivery of social services and match community needs and financial plans and allocations. It also has the potential to contribute to more flexibility and recognition of local innovations which in the end will be more beneficial to women and children who form the bulk of rural dwellers.

Availability of the LATF funds has also contributed to improved service delivery within the local government. Town and municipal councils have been able to improve the provision of social services such as health and education as well as infrastructure. In Nairobi the renovation of health facilities and schools has been undertaken as well as training of staff contributing to improved quality of health care services. In selected health facilities in Nairobi, training has been undertaken by the Ministry of Health (MoH) with support from UNFPA to strengthen the capacity of health care providers to improve the quality of reproductive health services provided to adolescents.

The introduction of the Constituency Development Fund (CDF) through an Act of Parliament in 2003 has brought additional funds for social services. The CDF Act provides that at least 2.5 percent of all collected ordinary revenue in every financial year shall be paid into the Fund. An estimated 32 percent of projects funded by CDF were for education; 26 percent for health; 18 percent for water and 8 percent for infrastructure.² The 2005 Kenya Millennium Development Goals (MDG) Report notes that more than 60 percent of all funds channeled at the constituency level are spent on education, water and health issues.

GoK submitted its Second Periodic Country Report on Implementation of the Convention on the Rights of the Child (CRC), covering 1998-2004. This report is complemented by a Supplementary Report prepared by Non-Governmental Organizations which includes developments up to July 2006. A pre-session was held by the Committee on the Rights of the Child in Geneva in October 2006, and the Plenary Session with the GoK took place in January 2007.

The GoK responded to the additional demand for information, and much of the information requested was made available. The CRC reporting process, including the Concluding Observations has proven to be an important opportunity to draw the

² Institute of Economic Affairs (2006) Citizen’s Report Card, IEA, September, Nairobi

attention of Government and civil society in Kenya to priority issues that need to be addressed.

There have also been significant improvements in data collection and information dissemination though a lot more needs to be done to ensure the availability of timely, desegregated data for monitoring and evaluation of progress towards meeting MDG and WFFC goals and targets. Over the past few years a number of surveys and assessments, both from government, CSOs and private sector have contributed to meeting the need for information and highlighting progress made as well as gaps.

The Kenya Integrated Household Budget Survey 2006 is expected to provide updated information on the levels of poverty in Kenya. The KenInfo socio-economic database launched by the Ministry of Planning in 2004 and updated in 2006 incorporates the harmonized MDG and ERS indicators. At the same time, the Kenya Service Provision Assessment conducted in 2004 and associated Kenya Demographic Survey (KDHS) 2003 have all contributed to updating trend and disparity assessments and analysis around progress made towards realizing the rights of children. In early 2007, the Ministry of Planning and National Development, with support from UNICEF conducted a MICS survey in the NEP, Dadaab and Turkana districts to determine the progress in social indicators for women and children in these areas; a second phase will include other districts. This initiative represents an effort to improve the resolution of trends and disparity analysis from province to district level.

The media in information dissemination has increased significantly. The widening reach of the mass media has been felt especially during drought and flood emergency appeals and in highlighting abuse of children.

Challenges to the realization of WFFC goals

Political uncertainty; Despite the up turn in economic growth, uncertainty in the political sector and inadequate policy and legislative framework to deal effectively with corruption coupled with rising insecurity and poor infrastructure kept investors away resulting in low levels of Foreign Direct Investment (FDI). Unemployment remained high and poverty levels remained unchanged in many Kenyan households. The wrangles that characterized the ruling party NARC slowed the momentum and the enthusiasm generated by the last elections in 2002 and shifted focus from development efforts to political issues.

High Levels of Poverty: Measured in terms of incidence, depth and intensity levels and persistence of poverty in households, poverty levels have now reached 56 percent of the population. A study conducted by the Central Bureau of Statistics (CBS)³ on poverty in Kenya revealed the poorest and wealthiest constituencies in the country. Among the 210 constituencies, the poverty headcount ratio ranges between 16.5 percent for the least poor constituency (Kabete in Central Province) to 84 percent for the poorest constituency (Ganze in Coast Province).

There are also major disparities between households and regions with the areas with low levels of poverty exhibiting the highest levels of inequality whereas the opposite is true of areas with highest poverty levels. This implication is that resources in poorer

³ Geographic Dimension of Well Being in Kenya: A Constituency Level Profile, Volume II

areas are more equitably distributed than in rich areas where the gap between the rich and poor are very wide.

Insecurity and Internal Displacement: Over the past few years, the country has experienced several incidents of insecurity resulting from inter tribal and clan wars which have left hundreds of people dead, and thousands displaced and homeless. The effect on displaced children goes without saying. Not only have children been direct victims of the violence, but the uncertainty and disruption caused by the death of parents and or guardians has had a negative impact on the development and well being of children in these areas. Since 2004 clashes between various clans in the northern parts of the country and the Rift Valley province have also led to rape of women and girls.

Poor enforcement of legislation and policies: Despite the enactment of legislations and development of policies, enforcement is often poor. The enactment of legislation has not always been followed by a corresponding budgetary allocation required to put the necessary structures in place to ensure implementation.

Natural disasters: Kenya has over the past few years experienced various disasters such as drought and famine and flooding. These natural disasters, for which the country has often been ill-prepared, have had a devastating impact on the lives of children. In the Northern and Eastern parts of the country where drought is common, malnutrition and ill health among children is widespread. Drought leads to death of animals among pastoralists increasing vulnerability and creating a cycle of poverty difficult to break.

3. National policies, institutional and legal frameworks and resource allocation

3.1 Introduction

A facilitative policy and legislative framework is critical to the realization of the MDG and WFFC goals. Since 2001 several policies and legislation have come into effect. In addition to new policies and legislation, review of old ones has also been undertaken by government to enable them integrate MDG issues in all sectors.

3.2 Social Policy Framework

Several new social policies are noted below. In many areas, policies have been, or are under development, to provide a framework for the enactment of legislation. Several statements of policy have therefore been followed by legislation which in most cases are still in draft form and are yet to be ratified by the legislative assembly. And others have been followed-up by the development of plans of actions, which even if not backed up by law, are the focus of intersectoral task forces that do their best to follow-up on the agreed actions. Below are some of the key social policies, action plans and legislations:

- Economic Recovery Strategy for Wealth and Employment Creation
- Sessional Paper No. 1 of 2005 and National Plan of Action on Education For All
- The Sessional Paper on HIV/AIDS and the associated Kenyan National AIDS Strategic Plan (KNASP) 2000- 2005 and 2005-2010
- National Health Strategic Plan 2000-2005 and 2005-2010
- National Reproductive Health Service Delivery Strategy (NRHSDS) 1997-2010

- Adolescent Reproductive Health and Development Policy and Action Plan
- Reproductive Health Strategy
- National Reproductive Health Service (NRHS) Delivery Strategy 1997 -2010
- Malaria Strategy
- National Gender and Education Policy
- Draft Complementary Non Formal Education Policy
- National Food Security Strategy
- Early Childhood Care and Education in Kenya. Early Childhood and Family Policy Series No. 11, 2005
- Policy on Orphans and Vulnerable Children (OVC) and the National Plan of Action
- Female Genital Mutilation (FGM) Eradication Strategy and National Action Plan
- Draft Arid Lands Development Policy
- Draft Disaster Management and Response Policy
- The National Food and Nutrition Policy

Economic Recovery Strategy for Wealth Creation: In 2003, the government reviewed and expanded its Poverty Reduction Strategy Paper (PRSP). Poverty eradication is a major focus of the government's human and socio-economic development efforts. The Economic Recovery Strategy for Growth and Wealth Creation (ERS) recognizes the need to tackle poverty and provides an overview of the poverty situation in Kenya. It outlines government commitment to poverty eradication and identifies key strategies and actions that need to be undertaken. It acknowledges the various dimensions of poverty and the greater vulnerability of children and proposes strategies and activities to be implemented over the next few years to deal with the situation. The ERS takes into note of human rights instruments and sets targets and goals in line with MDG goals and WFFC targets.

Sessional Paper No. 1 of 2005 and the National Action Plan on Education For All clearly outline governments plans to implement EFA goals and priorities in education. Both the ERS and the Sessional Paper highlight the government's commitment to ensuring equity in education and eliminating gender and regional disparities. Government priorities in basic education are in line with global EFA and MDG goals to which the government has pledged its commitment. The introduction of free primary education in 2003 further attests to the Government's commitment to meeting WFFC goals and targets in education. The introduction of Sector Wide Approach in education has also improved the overall commitment to the education priorities, partnership and coordination.

The Sessional Paper on HIV/AIDS: The policy provides a comprehensive overview on prevention, voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT) and Anti retroviral therapy (ART). The strategy recognizes the increased vulnerability of certain groups such as women, those serving in the armed forces, commercial sex workers and outlines proposals for addressing the needs of these groups.

Kenyan National AIDS Strategic Plan (KNASP) 2000- 2005 and 2005-2010: The KNASP highlights three main strategies for Kenya namely prevention, treatment and care and support. Following the development of the strategy several guidelines have been developed notably on PMCT and pediatric AIDS care. UNICEF partners with the Government of Kenya and other UN agencies to contribute towards seeing that the objectives of the KNASP are achieved.

National Health Strategic Plan 2000-2005 and 2005-2010: Both plans recognize the challenges facing Kenya in meeting the health care needs of children. MDG goals and targets are clearly integrated into the plan (2005-2010). While no mention of WFFC is made in the documents, WFFC goals and target are clearly integrated and indicators recognized. Government priorities in this sector reflect global priorities as outlined in both the MDGs and the WFFC as well as in other key international agreements and conventions. The use of Sector Wide Approaches (SWAs) in health will lead to better coordination and minimize duplication of activities in the sector.

Adolescent Reproductive Health and Development (ARH&D) Policy and Action Plan: Developed in 2003 through broad consultation with key stakeholders, the ARH&D policy provides a framework for implementation of activities aimed at improving the health and general well being of adolescents. It outlines government commitment to implementing relevant ICPD goals. The Action Plan outlines clear target and identifies key stakeholders in realizing the health and development needs of adolescents.

Reproductive Health Strategy: The reproductive health strategy provides an overview of the status of reproductive health in the country and outlines strategies for the realization of reproductive health and rights.

National Reproductive Health Service (NRHS) Delivery Strategy 1997-2010: The National Reproductive Health Services (NRHS) Delivery Strategy, 1997 – 2010 provides a framework for the promotion of safe motherhood and child survival, a key components towards the operationalization of comprehensive health care.

Malaria Strategy 2001-2010: It outlines the government strategies and commitment for reducing malaria related morbidity and mortality morbidity and sets clear targets for the 10 year period covered by the strategy.

National Gender and Education Policy: A gender policy has been developed but is still in draft form. The draft policy provides a framework for addressing gender inequalities and discrimination in key sectors such as education policy. The Gender and Education Policy (2005) has been approved and creates a road map for achieving gender parity at all levels of education. It provides a framework for the planning and implementation of gender responsive education and training.

Draft Complementary Non Formal Education Policy: This policy was drafted in 1996 but did not take off due poor political commitment. It was revived in 2004/05 after the implementation of Free Primary Education because of large number of out of school children who were not benefiting from the FPE strategy and the development of Kenya Education Sector Support Program (KESSP). The policy is currently being finalized and will cover alternative flexible education for out of school children and youth both at the primary and secondary levels.

Food Security Strategy: The strategy outlines government plans in the medium term for improving food security an ensuring adequate nutrition. While no reference is made to WFFC, related goals and targets are clearly integrated into the document. The Policy also recognizes the vulnerability of certain groups such as female headed households and children.

Early Childhood Care and Education in Kenya. Early Childhood and Family Policy Series No. 11, 2005: This policy developed in 2005 outlines government plans for improving ECD in Kenya. It highlights the challenges and makes recommendations for strategies and activities to be implemented to improve enrolment at this level. A comprehensive policy framework and service standards guideline for ECD was launched by the Government on January 23rd 2007. This policy framework paves the way for enhanced access and significant quality improvements for children age 0-5 in a cross-sectoral manner.

Policy on OVC and the National Plan of Action: Developed through a multi sectoral approach, the policy provides guidelines and outlines government plans on the plight of orphans in Kenya. It sets out clear strategies and highlights the challenges and opportunities for improving the lot of children made vulnerable through orphan hood.

FGM Eradication Strategy and Plan of Action: Developed in 1997, this strategy provides a framework for the eradication of FGM in Kenya and highlights government commitment to dealing with the issues of FGM. Despite this however implementation remains weak and many people are unaware of its existence.

Draft Arid Lands Development Policy: This policy, drafted in 2002/03 lays out a comprehensive plan for the acceleration of development in the arid districts of Kenya, the part of the country where emergency humanitarian programmes are routinely launched by government.

Draft Disaster Management and Response Policy: This policy drafted in 2001 is intended to replace the ad hoc coordination system developed in 1999 by Office of the President that carries on to this day. A criticism of the current system is that it overly focuses on distribution of free food hand outs to the detriment of a focus on alternative actions and on longer term issues around recovery.

The National Food and Nutrition Policy: This document was completed in February 2007, and considers the special concerns of children in relation to nutrition and development. The National Food and Nutrition Strategy will be developed in March 2007.

3.3 Legal Framework

Over the past five years, there have been major investments in legal reform leading to the enactment of key legislation to guide the implementation of activities in various sectors. The existence of a facilitative legal framework has contributed to the realization of children's rights and led to improved service delivery in some areas. The main draw back has been the slow pace of enforcement of existing legislation occasioned by among other things lack of adequate resources, both financial and human,. Some of the key legal reforms which have had a direct bearing on children include the following:

The Children Act 2001: The Act is the Government of Kenya's efforts to domesticate some elements of the Convention on the Rights of the Child (CRC). It provides a comprehensive legal framework for the realization of children's rights in Kenya. This has been followed-up with regulations regarding adoption in 2005 and the regulations on charitable children's institutions also in 2005.

Sexual Offences Act 2006: The Government enacted the Sexual Offences Act in 2006. The Act provides for the protection of women and children from sexual abuse, specifically; defilement, child sex tourism, child prostitution, child pornography and trafficking for sexual exploitation, incest, exploitation of prostitution and sexual harassment. It contains stiffer penalties than those provided for in the Children Act. Together with the Children Act, this Act will offer better protection for children who are victims of sexual exploitation. The Act also makes provision for the establishment of forensic laboratories to assist in collection, storage and analysis of evidence to assist during trials. This will increase the number of cases which are successfully prosecuted.

Persons with Disability Act 2003: In 2003, parliament passed *Persons with Disabilities Act*. The Act, which puts a strong emphasis on the rights of disabled children, also sets out clear recommendations and strategies for the implementation and monitoring of programmes for the disabled.

The Water Act 2002: The Water Act 2002 provides establishment of a water services regulatory board as autonomous institutions to regulate water services provision. The reforms also saw the establishment of a water services trust fund (WSTF) to harness resources for development of water and sanitation services in areas with water deficits. Water boards have been established in the provinces and independent water supply companies set up in most cities.

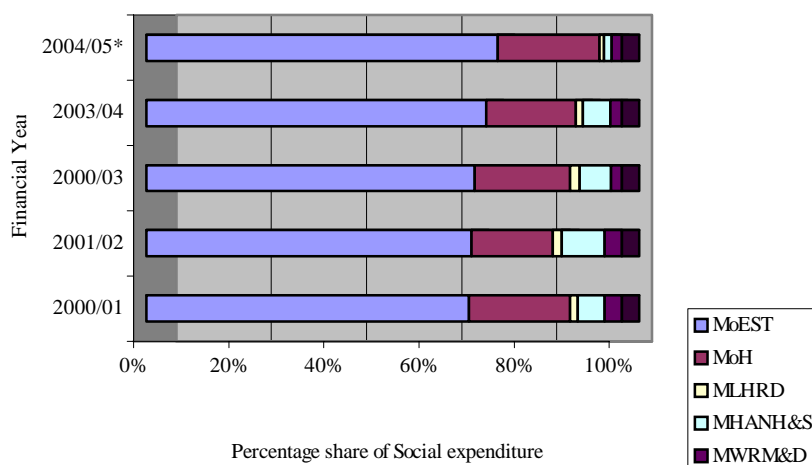
Review of legal instruments: A review of both the Children Act and the Education Act are currently underway. The main reason for review of the Children Act is to respond to the contradictions between the Act and other legal instruments including the Constitution and bring it in line with other key legal and international instruments.

For some of the policies outlined above, legislation has already been drafted. However in most cases, these laws are in draft form awaiting the enactment by parliament.

3.4 Sector specific resource allocations

Over the past few years significant progress has been made in improving access to basic social services in Kenya. In various sectors such as health, education, water and sanitation, education there has been increased investments both from public and private sector. Table 1 shows government expenditure on social services, 2001/02 – 2005/06 investments in key sectors.

Figure 1: Social sector allocations 2000/01-2004/05



At the social sector level, the total spending on education has been higher than in any other social sector spending – averaging 70 percent of the total social sector allocation. While the government commitment to free primary education is well reflected in the budgetary allocation to the education sector, the highest proportion of the education budget has been towards the recurrent expenditure. The allocation to the Ministry of Health though increasing over the years has not been matched with the needs although the highest proportion of the MOH budget has been directed towards development expenditure. The average allocation to the Ministry of Health (MoH) has been 19.75 percent over the same period. The share of the health sector budget to the total social sector budget has been declining, from 21 percent in 2000/01 to 18 percent in 2003/04 and back to 21.5 percent in the 2004/05 allocations.. The allocation to the Ministry of Labour and Human Resources Development, which enforces the labour laws and protects the rights of workers, has received an average of only 1.6 percent of the total social sector budget. This constrains its operations in child labour prevention and women rights protection in the working environment.

4. Review of progress of WFFC goals

This section of the report reviews the progress made towards the realization of WFFC goals. It highlights the achievements and the gaps in each of the four areas.

4.1 Promoting Healthy Lives

4.1.1 Context

In 2006/2007 period, the government allocated 43 billion Ksh to the health sector of which 33 billion Ksh went directly to the Ministry of Health while the remaining was allocated to various ministries and government departments to meet health related costs and activities. This represents an increase from 8.6 percent of total expenditure in 2005/06 to 9.4 percent in 2006. This however is still below the Abuja targets of 15 percent. A positive

development is the steady increase in the development budget over the past three years which has also resulted in increased investment in improvement of rural health facilities. Aggregate funding in this sector is very low, with public per capita expenditure on health totaling only US\$6.2, compared to the US\$34 recommended by the World Health Organisation (WHO). The allocations to health sector fall far short of the required MDG target and ERS costing for health sector. The outstanding expenditure requirements to meet health sector targets were estimated in 2005 to be an additional Ksh 126.4 million.⁴

The disease burden from preventive conditions is significantly high and subsequently costs more than the investment. The government acknowledges this in the Health Sector Strategic Plan II and makes an undertaking to invest more resources for the same. The financial allocations are in line with health sector priorities as outlined in Health Sector Strategic Plan II which puts an emphasis on prevention and health promotion. Investing more resources on prevention will ensure that more funds are available for immunization. Increasing immunization coverage is expected to contribute to reductions on the disease burden from immunization preventable illnesses. This in the long term is expected to help in meeting health related MDGs especially those related to child survival.

4.1.2 Current Situation and trends

Infant and child health: Over the past few years key health indicators in maternal and child health have declined relatively with wide variations as some areas show worsening trends than others. The right to health remains unfulfilled for many, particularly the poorest and most marginalized populations, including pastoralists. Infant and U5 mortality have increased steadily over the past few years. About 1 in every 14 babies born in Kenya will die before their first birthday and about 1 in 9 before their fifth birthday.

The main causes of childhood mortality are: malaria, diarrhoea, acute respiratory infections all exacerbated by high levels of malnutrition especially in the Northern areas. Both infant and Under 5 mortality were increasing with under 5 mortality rising from 112/1000 live births in 1998 to 115 per 1,000 live births in 2003.

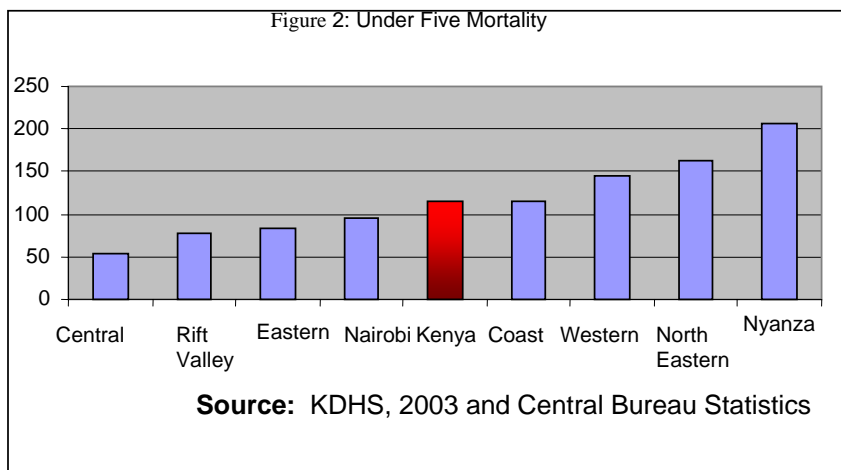
Table 1: Infant and Under Five Mortality 1989-2003

	1989		1993		1998		2003	
	Infant	Under Five	Infant	Under Five	Infant	Under Five	Infant	Under Five
Males	63	96	67	97	75	108	84	122
Females	54	86	59	89	67	103	67	103
Total	60	89	62	96	74	112	77	115

Sources: Ministry of Health and KDHS 2003

Data also shows major regional variations in U5MR ranging from 54 per 1,000 live births in Central province to 206 per 1,000 in Nyanza province. Other provinces such as North Eastern also record high U5 mortality rates. Figure 2 shows under five mortality rates by region.

⁴ McCord Anna: Overview of social protection systems in Kenya, 2006



Immunization coverage has also been declining from 1990 levels leading to increase in morbidity and mortality from vaccine preventable diseases. In all regions of the country, immunization coverage is lower than ten years ago. There has been a slow but steady increase in the immunization coverage since 2001. In 2005 and 2006 new cases of polio have been detected and polio immunization stepped up.

Table 2: Proportion of children below 1 year immunized (2001-2006)

Antigen	2001	2002	2003	2004	2005	2006
BCG	71	80	87	92	94	95
OPV3	58	62	72	73	68	74
DPT3	68	66	89	76	77	78
Measles	52	69	72	67	69	77
Fully immunized	42	46	57	59	61	69

Source: CBS, KDHS

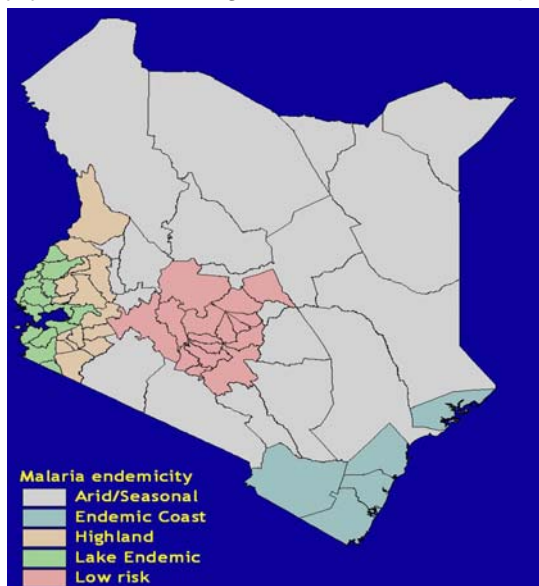
The number of children protected against tetanus by vaccination of their mothers with Tetanus Toxoid has increased since 2000 though figures remain lower than those in some countries in the region.

Table 3:- Proportion of children born in 2000-2005 protected against tetanus by vaccination of their mothers with Tetanus Toxoid (PAB)

Year	% of newborn infants protected against neonatal tetanus through maternal immunization with TT
2000	54
2001	54
2002	60
2003	66
2004	70
2005	72

Source: WHO / UNICEF Estimates, 2005

At the same time, malaria remains the biggest killer of young children in Kenya resulting in an estimated 34,000 deaths in under-fives every year, translating into 94 child deaths per day. Underlying factors include poor living environments, lack of access to Insecticide Treated Nets (ITNs), poor nutritional status of children, HIV/AIDS and poor access to health services. Deaths are also caused by lack of prompt, effective and affordable treatment. Figure 3 shows malaria endemicity.



Recent changes in the MoH official drug policy has led to the introduction of combination drug therapy currently being rolled out. This will no doubt contribute to more effective treatment thereby reducing mortality and morbidity especially among children. There has also been a significant scaling up of distribution of Insecticide Treated Nets (ITNs) in the endemic malaria areas which should also contribute to a reduction in malaria. The Government has put malaria control measures as indicated in the National Malaria Strategy (2001-2010). Intervention areas include management of malarial illness, vector control, control of malaria in pregnancy and control of malarial epidemics. Tax on imported mosquito nets has been waived and prices subsidized. The country has benefited from the Global Fund of Malaria, HIV/AIDS and TB (GFATM). A nation wide distribution of Long Lasting insecticide Treated Nets (LLITN) was conducted in 2006 as part of the integrated measles LLITN campaign in which a total of 1.7 million nets were distributed to children under five years in the high malaria risk regions. A stand alone LLITN distribution also took place in October 2006 and also covered 1.7 million making a total of 3.4 million nets distributed.⁵

Population Service International has also significantly scaled up ITN coverage through their social marketing programme, distributing over 4.57 million nets through clinics and commercial outlets between January 2005 and August 2006. Kenya is expected to be one of the first countries in Africa to achieve the 2010 Abuja ITN coverage target of 60 percent among the under five population.

A survey conducted by the Kenya Medical Research Institute/Wellcome Trust in 2005 in four sentinel districts showed an increase from 3 percent in 2002 to 24 percent in 2005 among children under five sleeping under a treated net.

Great progress is being made in scaling up treatment of HIV/AIDS in adults, currently 120,000 on treatment but treatment and care of children affected by HIV/AIDS lags far behind and particularly the use of cotrimoxazole which has been proven to be a cost effective in caring for pediatric HIV/AIDS.

Adolescent health: Child bearing begins early in Kenya putting many children at risk of maternal morbidity and mortality. Almost a quarter of young Kenyan women aged 15-19 years have begun child bearing, which means that they are either pregnant with their first

⁵ Division of Malaria Control, 2006

child or are already mothers (KDHS 2003). Teenage pregnancy leads to disruption of young people's education and reduces future potential of a good life. Currently DHS data show higher rates of fertility among adolescents. The proportion of adolescents aged 15-19 that are pregnant remained static since 2003 at around 21 percent.

There is also a high incidence of sexually transmitted infections among young people. Information about the incident of Sexually Transmitted Infections (STIs) is a useful marker of unprotected sexual intercourse. Tracking of STI epidemics, including HIV/AIDs, has mainly been from sero prevalence testing among pregnant women attending antenatal care clinics. The first population-based study carried out during the 2003 Kenya Demographic and Health Survey (KDHS) gave HIV prevalence rate of 6.7 percent. It is estimated that HIV prevalence rates dropped to 6.09 percent and 5.54 percent in 2004 and 2005, respectively. Women are disproportionately affected by the epidemic.

Maternal health: Maternal Mortality Ratio (MMR) is estimated at 414/100,000⁶ and remains the highest in the region. There is thought to be a decline from 670/100,000 in 1990 and 590 /100,000 recorded in the 1998 KDHS but this statistic is very unreliable and the decrease is not supported by the proxy indicator of skilled attendant at delivery which has declined from 45% to 42%. Approximately 14,700 women of reproductive age die each year due to pregnancy related complications, while between 294,000 and 441,000 suffer from disabilities caused by complications during pregnancy and childbirth.

Despite the strategies and policies designed to improve maternal health, the proportion of mothers assisted by skilled health personal declined from 51 percent in 1989 to 45 percent in 1993 and further down to 42 percent in 2003. Only 15 percent of the health facilities are able to provide Basic Obstetric care, while for emergencies a mere 9 percent of the facilities are equipped to provide comprehensive Essential Obstetric Care.⁷

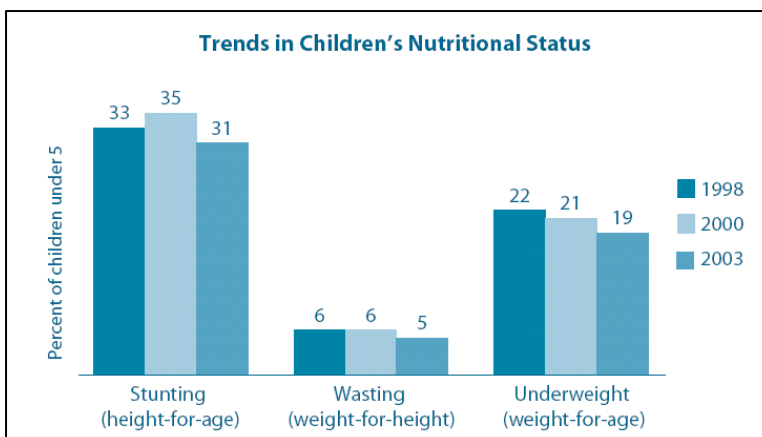
Northern Kenya has one of the highest Maternal Mortality Rates (MMR) in Kenya estimated at 1,000-1,300 deaths per 100,000 live births compared to the national average of 414 deaths per 100,000. Ninety five percent of deliveries take place at home with no skilled attendant compared to the national average of 40 percent (KDHS 2003). The commonest causes of maternal deaths are ante-partum and post-partum hemorrhage, hypertensive disorders of pregnancy, puerperal infection, malaria and HIV/AIDs related conditions.

Access to PMCT services is increasing rapidly with 40 percent of all pregnant women accepting to be tested but comprehensive PMTC has still low coverage of around 11 percent. Almost one in four babies born to HIV infected mothers is infected with HIV. According to National Aids Coordination Committee (NACC) 1,060 health facilities already provide PMCT services. This represents almost 50 percent of all health facilities providing Ante natal Care within the country. An estimated 10,660 health workers have been trained, half of the MoH target. Despite this, few women (10-22 percent) use PMCT. In some parts of the country, such as Northern Kenya, women are unaware of the existence and benefits of PMCT and therefore do not use the service. Also the high number of women delivering at home means that the benefits of PMCT are not available to them

⁶ Kenya Demographic and Health Survey (KDHS), 1998, 2003

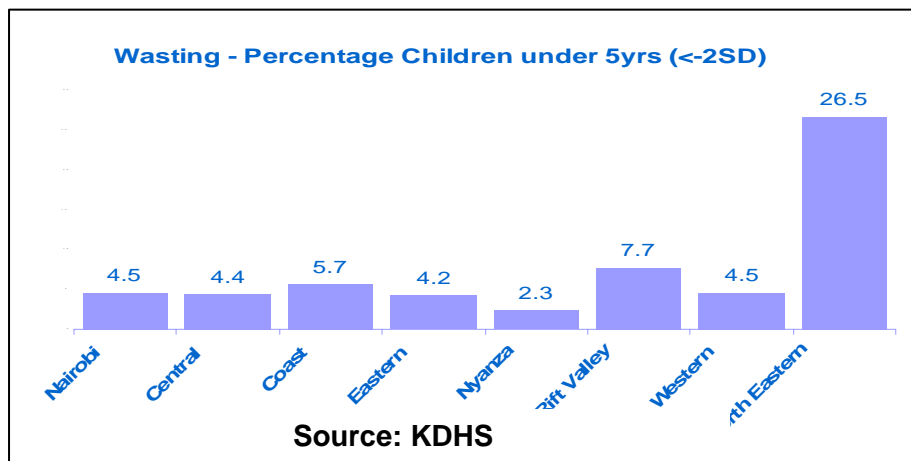
⁷ Millennium Development Goals, Status Report for Kenya 2005

Nutritional Status of Children and Women: The nutrition situation in Kenya has stagnated in the past 20 years. The results of the KDHS 2003 shows that levels of stunting are 31percent, underweight 19 percent and wasting 5 percent (**Figure 4**). The nutritional status of children under five years shows very little change during this five year period. The figures do not reflect the situation in North Eastern Province.⁸



There are significant regional disparities with the ASAL districts showing worsening trends than other parts of the country. **Figure 5**

illustrates the distinct regional disparities for wasting among children below 5 years of age. The proportion of children with wasting is the highest in the North Eastern Province (26.5 percent). During periods of food insecurity in Arid and Semi Arid (ASAL) districts in the past



Source: KDHS

year, levels of acute malnutrition have been as high as 37.3 percent in some divisions⁹.

Levels of micronutrient malnutrition are high with 43 percent of both under-fives and of women of reproductive age suffering from iron-deficiency anemia. 76 percent of pre-school children show vitamin A deficiency¹⁰ Kenya has shown some progress towards the elimination of Iodine Deficiency Disorders with goiter rates declining from 16 percent in 1994 to 6 percent in 2004.¹¹ This improvement is attributed to the increase in consumption of iodized salt by a large proportion of Kenyan households (91 percent)¹².

⁸ Anthropometric data was not been captured in 1993 and 1998 KDHS surveys

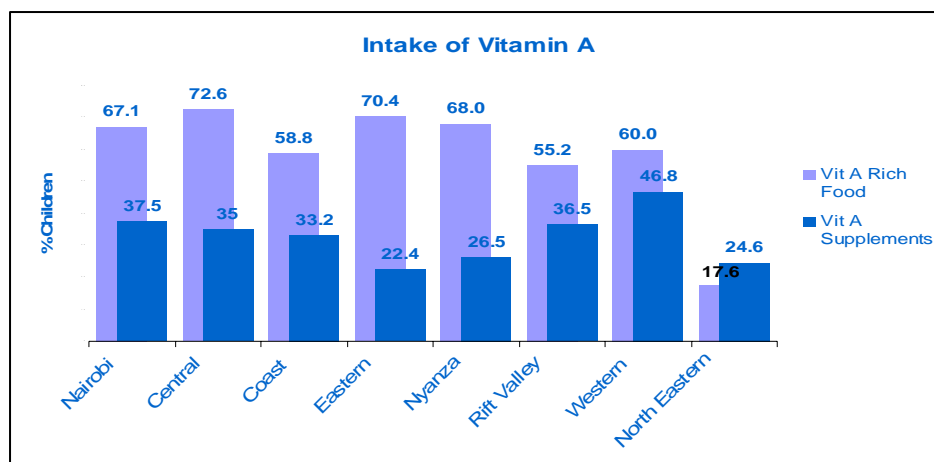
⁹ Survey conducted by World Vision in April/May of 2003.

¹⁰ MoH/University of Nairobi/KEMRI/SOMA-NET/UNICEF, Anaemia and the Status of Iron, Vitamin-A and Zinc in Kenya: The 1999 National Micronutrient Survey Report.

¹¹ Kenya Medical Research Institute (KEMRI, 2004).

¹² CBS/UNICEF Multi Indicator Cluster Survey or MICS 2000.

Vitamin A supplementation increased significantly between 2003 and 2006 due to the support of national supplementation campaign efforts. National level statistics do not however give clear picture of the regional disparities. According to KDHS data children under 5 years in the North Eastern Province are much more likely to have inadequate access to Vitamin A as part of a normal diet than those from other parts of the country. (Figure 6)



Safe and Adequate Water and Environmental Sanitation. The link between clean water and environmental sanitation and the health of children is clear. In Kenya water borne diseases are a common cause of illness among children. In some parts of the country, water borne disease account for almost half of all visits to the out patient department of health facilities.

Kenya is classified as a chronically water scarce country with a fresh water endorsement of 647 cubic meters per capita¹³ Since 1990, access to safe water and sanitation coverage has been increasing. In 2002, it was estimated that 43 percent and 46 percent of rural residents had access to safe water and sanitation respectively. Over that twelve year period, on average, the provision of safe water services was about 395,000 per year to new rural users and slightly over 348,000 per year for new rural sanitation users. Consequently, if Kenya is to reach its rural MDG by 2015 it must serve an additional 9.8 million persons with safe water supply and 9.9 million persons with sanitation services. It must speed up annual coverage by almost 25 times for water and 28 times for sanitation services.

According to the Ministry of Planning the capital development costs for this are estimated at US\$ 84.4 million for water supply and US\$ 27.3 million for sanitation. Likewise, costs for operation and maintenance of systems were estimated at US\$ 81.5 million for water and US\$ 31.3 million for sanitation. In addition, education and sensitization on hygiene promotion will cost the country approximately US\$ 16.6 million. This is a major challenge given the limited funding and other capacity gaps currently being experienced in the sector.

¹³ Economic Recovery Strategy Paper (2003 -2007)

Table 4: Kenya's MDG Targets for Rural Water and Sanitation					
	2005	2015	Total New Users by 2015 'millions	Total Capital Cost US \$ 'million	Total Operating Cost US \$ 'million
Safe Drinking Water(% population)	49	66	9.836	84.4	81.5
Use of Sanitation (% population)	76	89	9.949	27.3	21.3
Hygiene Education (country wide)				16.6	
Population 'millions	33.4	39.7			

Source: Millennium Development Goals Report, Ministry of Planning, November 2004

4.1.3 Policy and Legislative Framework

Since 2004 there has been considerable progress in the area of health sector reform with efforts directed at harmonizing co-ordination with the ultimate aim of adopting a Sector Wide Approach (SWAp). The second National Health Sector Strategic Plan (NHSP II) entitled “Reversing the Trend” was launched in 2005. The main focus is on provision of integrated and high quality curative, preventive, promotive and rehabilitative health care services for all Kenyans. In this new Strategic Plan, the government shifts its focus from the burden of disease to the promotion of individual and community health. The plan seeks to introduce the Kenya Essential Package for Health (KEPH) which focuses on the health needs of the individuals through the six stages of the human life cycle.

The MoH has adopted Primary Health Care (PHC) as the main strategy for the attainment of the overall goal of good health for all Kenyans, by clearly defining policies and guidelines for all components and regions. Policies and guidelines exist for the following; quality assurance, Kenya Expanded Program on Immunization (KEPI), Child Health, Sexual and Reproductive Health and Safe motherhood, Malaria Prevention and Control, Tuberculosis, HIV/AIDS/STD and Nutrition and Food Security.

The government launched the National Reproductive Health Services (NRHS) Delivery Strategy, 1997 – 2010 to promote safe motherhood and child survival, which is among the components towards the operationalization of comprehensive health care.

The food and nutrition policy document is in the final stages of development. There have been no major changes in the policy related to micronutrients. However, due to the high iodination levels of the salt produced in Kenya, the need to revise the legislation on iodation levels has been realized and the country is now moving towards this direction.

In recognition of the link between water and sanitation and the healthy of children, the country has made commendable progress in creating sound policies and enacting legislation for future water and sanitation sector development. Significant efforts have

been made to ensure that the necessary processes are put in place for institutional change and capacity strengthening to facilitate the realization of the relevant MDG, especially through the decentralization approach.

The government has made far-reaching water sector reforms through the promotion of modern services provision models using a variety of partnerships and technologies and by actively involving local level decision-making in this process. A Water Service Trust Fund, (WSTF) has also been established with plans to support water development for the MDG. Likewise, funds for school water, sanitation and hygiene will be channeled via the Kenya Education Sector Support Programme (KESSP), Ministry of Education.

4.1.4 Main Challenges hindering the realization of health related WFFC targets

Lack of adequate recognition to nutrition. Nutrition sector has suffered from lack of recognition and marginalization in the development agenda due to weak advocacy and coordination mechanisms at national and district level as well as the lack of a harmonized information system that provides continual evidence on the progression of malnutrition in the country and its consequences on human capital development.

Short term approach to arid areas. Short-term approaches in arid areas impact on the health and nutrition indicators. This has in part been a consequence of late interventions supported with short-term funding. Implementation capacity in these areas remains constrained through challenges in identifying adequate GoK personnel and NGO partners.

Low immunization coverage. In spite of the relative successes of the Kenya Expanded Programme of Immunisation since 2003, national coverage remains lower than the expected target of 85 percent. Kenya is among the 8 underperforming countries in East and South Africa region (ESAR) with coverage of below 80 percent. It is in the same category with countries in conflict or with underdeveloped health systems and infrastructure. The major constraint to increasing coverage has been the focus on immunization campaigns.

Lack of Adequate staff: Overall Kenya has sufficient health workers but there are problems in hiring more staff due to a budget ceiling on salaries , problems with equitable distribution of existing workforce particularly of doctors and a need to review the incentive system so that those staff working in hardship areas are better remunerated. One in 33,000 Kenyans living in rural areas is a practicing medical doctor compared to 1 in 1,700 urbanites. The government through the support from the constituency development fund and donors is working out modalities to employ over 600 health personnel to serve the population in the rural facilities.

Emergence of immunisable diseases - Poor health infrastructure in the countries neighbouring the north eastern parts of Kenya compounded by porous borders and influx of refugees has seen an emergence or upsurge of previously contained immunisable diseases like polio and measles. This has necessitated a lot of the health resources going to support campaigns as opposed to strengthening routine services.

Poor access to health care: particularly in Nairobi, has been exacerbated by under utilization or closure of Nairobi City Council facilities. Progress is being made in re opening

local government health facilities to reduce congestion at the main public referral hospital, Kenyatta National Hospital.¹⁴

The change in cost sharing policy to 10/20: The Minister moved away from full cost recovery and announced what is referred to as the 10/20 policy in July 2004 which included free health services for children. Initially utilization increased but it was not sustained due to insufficient supplies and the drop in local revenue from cost sharing. There is also no doubt that informal charges remain a problem and there is a need to increase the knowledge of communities to know that services for children should be free.

Widening disparities: There is evidence of widening gaps and disparities in access to health care, particularly between rural and urban and large regional disparities. Among nomadic and pastoralist communities mortality and morbidity from common and preventable illnesses still remain high compared to urban areas.

Weak linkages between environmental factors and child health: Historically the focus has largely been on curative services with insufficient support for prevention except immunization usually through campaigns. Since the development of the latest NHSP 11 the focus is changing to levels 1,2 and 3 to deliver a package of evidence based care including prevention, including large scale ITN distribution. It is now important that the policy is translated into practice and supported by a budget in order to see resources reach the lowest levels. A community strategy has been developed and in principle this is welcomed but more work is required on the details including lessons learnt from neighbouring countries and a realistic assessment of both human and financial cost.

4.2 Providing Quality Education

4.2.1 Context

The annual education allocation in 2005/6 is Ksh 96.7 billion, 28 percent of total government spending, significantly increased from 16.7 percent in 2000/01, in order to support the introduction of FPE. Expenses of primary schools take the highest share of the education sector allocations. This has been necessitated by the introduction of the free primary education. Early childhood development and education of children with disabilities sections are the lowest in the ministry's priorities as reflected in their budget share. The proportion of government allocation to education is expected to remain flat over the medium term expenditure framework ending 2008. The investment programme for ERS (2004) estimated total ERS requirements in the education sector at Kshs. 60 billion over the four year ERS period (2003-7). However, due to a financing gap between resources required in the ERS and resources available within the MTEF provisions, additional funds will be required from the private sector and civil society if the ERS objectives are to be met.

4.2.2 Current Status and Trends

The Government of Kenya is committed to meeting Education For All (EFA) and MDG goals by 2015 and has already taken a number of significant steps to increasing enrolment and improving the quality of education. The enrolment of 4 to 5 year old children to Early Childhood Development (ECD) nationally stands at 58 percent but at the regional levels like North Eastern Province it is only 19.7 percent.¹⁵ The causal

¹⁴ The People Newspaper, August 10 2003

¹⁵ Ministry of Education (2005)

factors include cost of ECD to poor households, community awareness on the value of school readiness programme, distance to ECD centres, availability of school feeding programmes and loss of parents (especially through HIV/AIDS) among others.

The introduction of Free Primary Education (FPE) in 2003 resulted in a dramatic increase in school enrolment levels for both boys and girls in Kenya. Enrolment increased from 5.9 million to 7.5 million children with the NER increasing from 77 percent in 2002 to nearly 84 percent in 2005. The primary completion rate has increased from 62 percent in 2002 to 76 percent in 2004 and more children are transiting to secondary education. However geographic and gender disparities persist mainly in the northern part of Kenya with less than 23 percent of the students enrolled in primary schools. Girls' Gross Enrollment rates in the North-Eastern part of the country revolved around 12 and 13% for five years, from 1999 to 2003. Most likely, due to the FPE, the figure jumped to 18.8% in 2003 and was at 18.5% in 2004. Net enrollment rates in 2004 were 23.6% and 14.9% for boys and Girls respectively. In 2005, boys' GER reached 36% GER while Girls' were at 20%--less than 2% increase. Given such a trend, it is obvious that the North-Eastern part of the country remains a challenge to the attainment of the EFA and MDGs and calls for specifically targeted interventions.

Out of school children: Despite the Free Primary Education (FPE) initiative declaration in 2003, there were 1.7 million children (1.5 million of them between 6 to 14 years of age) who were not able to access education through the formal school system in 2004. These included children mainly from pastoralist communities (see immediately above) in the northern districts where recurrent drought has accentuated the problem of school drop outs and children living in low income urban neighbourhoods where the supply of school places are not enough. There is need for an alternative Complementary Non Formal Education opportunity for children who cannot attend formal schooling including child workers, teenage mothers, nomadic children amongst others.

Gender Disparities: Low Enrolment and Higher drop out rates among girls: Free primary Education has resulted in increased school enrollments. In 2006, the Net Enrollment rates stood at 83.2% in 2005, from 67.8% in 2000. Overall, there is near parity at the primary level. Boys and girls were respectively 83.8% and 82.6% in 2005. However, the primary to secondary transition rates are at 60% in 2007. This is an encouraging progress from 43.3% in 2000 and 51% in 2004 but transition rates remain a concern especially for girls. Dropout rates are higher for girls as the advance in the system. Between the ages of 16-20 only 35 percent of girls are still in school compared to 47 percent of males.¹⁶

Teacher-pupil ratio: FPE resulted in the average teacher to pupil ratio to go from close to 1.30 to 1.40. The latter figure is the UN recommendation, so one could argue that previous to FPE too many teachers were employed but they were irregularly distributed nationally and that this was corrected by FPE. With international support, notably grants to buy text books and emergency teacher training to help cope with larger numbers of children in classes, the education system managed to cope with the influx. There is little evidence one way or the other of the effect of the influx on education quality. The increased numbers will have mitigated against quality but the massive increase in text book availability and the training will have helped to improve quality. Overall, there is

¹⁶ Ministry of Education Statistical Booklet

gender parity in the teacher body (49.5 percent are female) but geographic parity remains a challenge especially in areas requiring more teachers.

Age specific enrolment: Only a quarter of the pupils are actually in grade that is suitable for their age, while 44 percent are over aged by two or more years. This indicates that majority of the pupils are above the expected age for the grade. The new entrants in class 1 in 2004 were only 29.6 percent of the appropriate age. (Table 5).

Table 5: Expected Age for Grade and Over – aged children by Grade

Age for grade	Grade								
	1	2	3	4	5	6	7	8	Total
Expected	29.6	58.9	14.6	19.8	19.9	20.0	15.2	22.5	24.8
1+ year	34.2	16.3	50.6	29.6	28.3	29.6	26.2	34.6	31.8
2-3+ years	25.0	19.0	21.9	34.8	56.5	39.5	49.8	29.0	31.8
>4 years	11.2	10.7	12.8	16.3	15.4	11.5	8.9	3.9	11.6
Total	100	100	100	100	100	100	100	100	100

Source: UNESCO, 2005

Provision of Learning Materials: Most of the schools receive grants from the government for procuring instructional materials. Provision of instructional materials was identified as one of the major achievements for free primary education. Most of the schools have access to textbooks for core subjects such as Mathematics, English, Science and Kiswahili. Starting from a pilot programme in the mid nineties in Western Province the Ministry of Education developed a finance system that, now that it is scaled up, has enabled them to channel funds directly into bank accounts managed individually by each of the over 18,500 primary schools, giving the school management committee the power to decide in the use of the funds as long as guidelines are followed. The use of the funds then has to be posted in public for all to see to ensure accountability to the community.

Secondary enrolment: As for secondary school, official figures show a progress of 738,085 in 2000 to 934,255 in 2005 translating into a GER of 30.2 percent (31.3 for boys and 29.1 for girls). There were regional and gender disparities with the northern part of Kenya having only 9 percent of the students enrolled in secondary schools. Generally more boys were enrolled in secondary schools as compared to girls in all regions. As the wave of new entrants in the early grades moves through the system there will be an increasing issue of how to accommodate the larger numbers seeking places in primary schools in four or five years from now. This will require both additional classrooms and the recruitment of more secondary school teachers.

Although enrolment rates are almost the same at primary school entry, more girls drop out as they advance. Between the ages of 16-20 only 35 percent of girls are still in school compared to 47 percent of males.¹⁷ According to the latest economic survey (2006) girls make up less than half of secondary school enrolment. The figures are lower in districts where some examination classes have no female students. Drop out rates among girls in secondary schools between the ages of 13-18 is currently estimated at 45 percent as compared to 37 percent of boys.¹⁸

¹⁷ Ministry of Education Statistical Booklet

¹⁸ GOK/UNICEF estimates

One of the main reasons for school drop out among girls is pregnancy and early marriage. In the Coast, Rift Valley and Nyanza Provinces, these two reasons account for a significant number of drop out cases. KDHS data indicate that 1 in 5 adolescents have begun childbearing by age 17 and by 18 years 3 in 10 have begun childbearing. In total an estimated 390 babies are born to teenage girls every day, which works out to more than 142,000 babies annually.

4.2.3 Policy and legislative framework

The country's overall education goal is to achieve quality education for all (EFA) and the Millennium Development Goals (MDGs) by 2015 in line with the national and international commitments. The short-term sector goal of attaining universal primary education (UPE) by 2005 initially committed the government to implement the FPE in the year 2003. The Sessional Paper No. 1 of 2005 on education, training and research spells out the long-term objective of the Government – to provide every Kenyan with basic quality education and training, including 2 years of pre-primary, 8 years of primary and 4 years of secondary/technical education. The Sessional Paper stresses that provision of education to all Kenyans is fundamental to the success of the Government's overall development strategy. This vision is in line with the Government's plan as articulated in the ERS and MDG goal number 2 of achieving universal primary education.

The Government has developed a comprehensive policy framework to guide development in the education sector. The launch of the five year 2005-2010 Kenya Education Sector Support Programme (KESSP) in 2005 was a significant development. KESSP followed a broad based consultation with development partners that involved stakeholders from government, UN agencies, multilateral and bilateral donors, NGO and CBO partners in education, and benefited from a number of key policy documents. Under KESSP, several subsectors of the Education sector are developing specific policies and strategies to ensure key priorities adequately addressed. Political commitment to this SWAP remains strong and there is a sense of progress, ownership and coordination.

A gender and education policy has been developed approved by the Ministry of Education to provide a framework for planning and implementation of gender responsive education, research and training at all levels. The legal framework on Education and training has also been reviewed.

A Draft Complementary Non Formal Education policy is under review to provide learning opportunities to out of school children and youth both at basic and secondary education levels.

A review of the Education Act is currently being undertaken to bring it in line with other key policies in the sector and take into account changes that have occurred since the introduction of FPE in 2003.

4.2.4 Challenges affecting the achievement to education for children in Kenya

Lack of alternative complementary education program for out of school children and overage children: Kenya does not have a state/supported Complementary Non Formal Education program that addresses the learning needs of children who cannot

come to formal schooling including child workers, adolescent parents and nomadic children. The Non Formal Education Policy has been finalized and launched to address this issue and is expected to increase Kenya chances of achieving EFA by 2015.

Child Labour: Child labour is a critical factor that interferes with schooling in Kenya and is common among provinces where there are commercially viable plantations such as in Eastern, Coast and Central Kenya. Primary school drop-outs work in these plantations collecting tea, coffee and engaging in other informal sectors. The estimated number of street children is 700,000, with a concentration in Nairobi. This further calls for alternative methods and targeted interventions.

Cultural and Traditional Practices: FGM and early marriages are some of the harmful traditional practices which hinder the education of girls. In communities where FGM is practiced most girls leave school early to get married. According to available estimates, almost 13 percent of girls who leave school do so due to early marriage. Methods can however be further promoted that would enable young married women to attend non-formal and skill-building education.

HIV/AIDS and Orphanhood: HIV/AIDS is another cause for school drop-outs in Kenya as children leave school either to take care of their parents who are sick or manage household chores when their parents died due to HIV/AIDS. By the year 2020, the MoE estimates that 11.8 percent of all children below 15 years of age will be orphaned mainly due to AIDS.

Drought and Famine: In Arid and Semi Arid (ASAL) areas where drought and famine are common, school attendance is often lower than in other parts of the country. In the northern parts of Kenya, children do not often attend school due to famine. The introduction of school feeding programmes in these parts has contributed to keeping more children in school. But drought is not the only problem. Other adverse weather effects such as heavy rains often lead to floods, which not only make roads impassable, but also disrupt learning. In 2006, national examinations were interrupted in certain areas as heavy flooding displaced families and washed away key roads and bridges.

Inadequate learning materials: The dramatic increase in enrolment resulting from the introduction of FPE has caused a severe strain on existing facilities. In some parts of the country children learn in the open due to lack of physical facilities while some sit on the floor due to lack of furniture. Access to adequate text books has also been a major challenge although the situation has improved with the student book ratio declining for core subjects such as Mathematics and English.

Box 1: Secondary School Scholarship Programme for Girls' from North Eastern Province

Kenya made significant progress in ensuring Education For All with the introduction of the Free Primary Education in 2003. This resulted in an increase in the national Gross Enrollment Rates (GER) from 102 percent in 2003 to 107.2 percent in 2005 while national Net Enrolment Rates (NER) stands at 83.2 percent. However, among the nomadic and pastoralist communities living in the Arid and Semi Arid Districts of Northern Kenya, there has been little improvement in enrolment rates. NER for North Eastern Province (NEP) stands at 23 percent (18.8 percent girls and 26.7 percent boys).

With less than one in every five school aged girl accessing primary education and with national primary completion rates of less than 50 percent, transition to secondary education is extremely low further limiting the possibility of university education for girls. Only one girl from NEP enrolled for a regular university degree program in 2005 as a result of an affirmative action by the Ministry of Education. Since 1991, none of the ten girls' secondary schools in NEP of Kenya have sent a single girl to any public university for a regular degree program. In 2005, only three boys from 1,605 candidates and 25 secondary schools in the NEP qualified to join a regular state supported University degree course.

Although Kenya's regular university degree programme is highly subsidized and loans are available through the High Education Loans Board (HELB), no girl in the NEP has qualified to access a HELB loan in the last 12-15 years. The alternative cost of a parallel programme (i.e. without sponsorship) varies between Ksh. 200,000 to Ksh. 300,000 per year. With frequent droughts and subsequent famines, most households are too poor to afford the high fees. It is on this basis that UNICEF decided to initiate the scholarship programme to promote gender equity and gender parity in higher education in the NEP.

This project provides a scholarship scheme for bright and needy girls from four NEP districts to enable them access and complete good quality secondary education and achieve the subsequent examination results required to access a regular university education in Kenya. The bursary scheme comprises an annual scholarship package to 60 girls every year from four NEP districts for four years to complete secondary schooling (2006/2009). A total of 240 girls will benefit from the programme over a period of four years. The first cohort of 60 girls has been placed in 38 good national and provincial schools outside the province. The selection process is competitive and objective, relying on the National Examination Council results. The programme will be expanded to other ASAL districts in the future.

The programme is supported by the Ministry of Education and the local leaders. The bursary fund is managed at the district level by District Education Board (DEB) in each of the districts in collaboration with the Provincial Director of Education (PDE) and respective District Education Officers (DEOs). This increases community participation and ensures support for the programme.

The programme has faced certain challenges. For the girls who have never been away from home the culture shock sometimes leads to drop out. Also the low enrollment and the poor results at primary level hinders the selection process. In one of the districts, only 5 out of the 23 girls who sat for the KCPE attained the average score (above 250 and above)

This programme represents the first affirmative action for girls from a single region with a specific focus on increasing gender parity in both secondary and university education.

4.3 Protecting against abuse, exploitation and violence

4.3.1 Context

The national budget allocation to the Ministry of Home Affairs (MoHA) for OVC has increased from zero in 2004/2005, to Ksh 48 million in 2005/2006, to Ksh 56 million for 2006/2007. Bursary funds have increased from Ksh 770 million in 2004/2005 to 800 million in 2005/2006. Between 2003 and 2006 around USD 2.5 million (Ksh 182 million) were funded by donors for the CT-OVC programme. Advocacy on CT-OVC is expected to raise around USD 10 million (Ksh 730 million) between 2006 and 2008.

4.3.2 Current Situation and trends

Kenya continues to face serious child protection issues. While there is a lack of adequate data on the extent of abuse, there is ample evidence from surveys and media reports indicating an upsurge of violence and exploitation against children.

Table 6: Child abuse cases attended to at Kenyatta National Hospital 2000-2005

Category	2000	2001	2002	2003	2004	2005	Total
Neglect or abandonment	26	24	27	41	20	144	282
Physical abuse	7	9	8	5	5	25	59
Psychological abuse	0	0	0	1	0	0	1
Sexual abuse	83	73	87	69	13	52	377
Unspecified maltreatment syndromes	3	3	0	2	0	1	9
Grand total	119	109	122	118	38	222	728

Source: Report of the Government Response to UNCRC, November 2006

Increasing orphan hood also makes children more vulnerable to violence and exploitation. According to the National Policy on Orphans and Vulnerable Children, up to 6 million Kenyan children (40 percent of the country's total child population) require special care and protection. About 12 percent of households comprise orphans with no adult to take care of them.

There are approximately 2.4 million orphaned children (having lost one or both parents) in Kenya and the number of orphans and vulnerable children (OVC) is increasing according to the rapid analysis, assessment and action plan (RAAAPP) conducted in 2004. 65 percent of out of school youth are sexually active and have multiple partners and less than 10 percent use condoms according to the Behaviour Surveillance Survey conducted by the National AIDS Control Program, 2005.

Street Children: Due to increasing poverty levels, the number of street children has increased significantly over the years. There are no official numbers of street children, although it is a visible and growing problem. Current estimates total 700,000 with a concentration in Nairobi. Despite corporal punishment being banned, it is still practiced in schools, institutions and in homes. Media reports indicate that more than 61 percent of children have experienced violence at the hands of their guardians. Children are also exposed to sexual violence in schools and other institutions of learning, homes and on the street.

Child trafficking: Trafficking of children is also increasing. While there are no clear figures, there is anecdotal evidence that Kenya is fast growing as a source, transit and destination country for trafficking in persons (including internal trafficking). It is estimated that between 10,000 and 15,000 girls between the age of 12 and 18 are involved in sex work and sex tourism. More than 50 percent of these are engaged in part time sex work, when they need additional income to meet their basic needs.

Child labour: Child labour may be defined as the participation of school- aged children in the labour force on a regular basis. While government efforts to address child labour have been intensified, child labour persists in many parts of the country. This is mainly because of the prevailing poverty levels and the effects of HIV/AIDS. Given the current socio-economic situation prevalent in the country, children find themselves subjected to exploitative work. This has been compounded by the increasing incidence of child-headed households. Poverty reduction programmes and regulations in respect of periods of work and legitimate establishments for such work by children above the age of 16 years, are being looked at by the Minister of Home Affairs.

Children in armed conflict: In Kenya, children have been caught up in scarce resources-instigated clashes especially in the early 1990s and late 1990s. More recently

in 2005, inter-community conflicts have erupted in various parts of the country over the ownership and control of natural resources, especially water and grazing land. Cases in point include skirmishes in Marsabit, Nakuru (Mai Mahiu) and Trans Mara districts that led to internal displacement. In these conflicts, children lost parents, relatives and are unable to attend school. They were also traumatized by horrifying experiences. The National Council for Children Services (NCCS) in collaboration with other stakeholders is in the process of compiling statistics for children affected by armed conflict in Kenya.

Children in conflict with the law: There has been an increase in the number of children in conflict with the law. Newspaper reports indicate an increase in the number of children involved in violent crime. This could be attributed to high levels of poverty, HIV/AIDS which leads to orphan hood and increases vulnerability as well as breakdown in traditional structures of sanction

Table 7: Number of children by age group, gender involved in crime and convicted between 2003-2006

Year	2003		2004		2005	
Age	Male	Female	Male	Female	Male	Female
Under 16	1	-	166	-	511	11
16-17	5,465	644	3,706	351	4,486	506
Total	5466	644	3,872	351	4,597	517

Source: Economic Survey 2006

4.3.3 Policy and legislative framework

Since 2004, there have been some significant changes in Government policy affecting children, although much remains to be done. The Children Act is currently under review to address certain gaps, including the rights of children born out of wedlock. There is a need to harmonize existing laws with the Children Act to ensure effective implementation of the Children Act. A proposed revised constitution which would have harmonized with the Children Act was defeated in a national referendum in November 2005.

Currently Kenya has about 65 statutes which have a bearing on children under various circumstances. They include: the Employment Act (Cap. 229), the regulation of wages and conditions of Employment Act (Cap. 229). The Industrial Training Act (Cap. 234), the Trade Disputes Act (Cap. 234), the workmen’s compensation Act (Cap.236), the Education Act (Cap. 271) and the Children Act. The Sexual Offences Act was enacted in 2006 and offers increased protection for children against sexual violations.

In addition to legislation, several policies and National Plans of Action (NPA) addressing child protection concerns are in various stages of development, approval and implementation- including on youth, Orphans and vulnerable children (OVC) and Female Genital mutilation/ cutting (FGM/C). The GoK is also planning to develop a national policy and National Plan of Action (NPA) on Children. The capacity of the National Council of Children’s Services (NCCS) and the district-based Area Advisory Councils (AAC) are gradually increasing, although a few districts do not yet have AACs. The Governance, Justice, Law and Order Sector (GJLOS) reform programme is an ongoing SWAp addressing key child protection issues related to justice and child rights.

The draft Sessional Paper on child labour in Kenya, (GOK, 2000) summarizes the government’s commitment to fulfillment of it’s obligations under various international instruments towards the elimination of child labour and addresses the various

perspectives of child labour. The paper highlights the nature and magnitude of the child labour problem, the vulnerability of child workers, determinants and consequences of child labour, and the need to mainstream concrete intervention measures to fight child labour.

4.3.4 Main challenges

Pending Bills and Legislation: Several policies and bills are yet to be finalized or enforced. Below is a list of some pending legislative and policy agenda in the area of child protection:

- Refugee and Displaced Persons Bill recently enacted is expected to provide protection to refugees and internally displaced people including children is still awaiting enactment since being published in 2004;
- Proposed labour legislative framework also drafted in 2004 has not been published as a bill yet
- National Policy on Child Labour, drafted seven years ago is still pending
- A Joint Plan of Action between CSOs and the Government of Kenya for rehabilitation of street children has not been finalized more than three years since it was developed.
- The Counter Trafficking in Persons Bill
- The Domestic Violence (Family protection bill)

Weak implementation of Policies: Although several policies have been developed over the past few years, many remain unimplemented for various reasons key among them being the lack of financial allocation in. Also the lack of adequate personnel is hindering the implementation of policies.

Weak institutional framework: Several structures have been created through legislation, but their roles have remained unclear and are in conflict with existing structures.

Lack of adequate data: The lack of adequate data for decision making and monitoring is another major challenge. Lack of reliable and comprehensive data hinders planning and makes it difficult to review progress made towards the realization of both MDG and WFFC goals.

4.4 Combating HIV/AIDS

4.4.1 Context

Over the past few years, more resources have been invested in the fight against HIV/AIDS in Kenya. There have been efforts to strengthen institutional capacity of key institutions such as the National AIDS Control Council (NACC) to be able to co-ordinate and monitor activities better. During the last five years, the country has received support from the Global Fund for AIDS, Tuberculosis and Malaria, the Presidential Emergency Relief Fund for AIDS Relief (PEPFAR), the World Bank and other United Nations organizations, several bi-lateral aid programmes, numerous civil society organizations such as AMREF, World Vision and Care, and numerous private sector contributions

including the Bill and Melinda Gates Foundation, the Clinton Foundation and the Elizabeth Glaser Foundation.

4.4.2 Current status and trends

HIV/AIDS was first detected in Kenya in 1984. Since then about 1.5 million people in Kenya have died of AIDS-related causes. In 1999 the GOK declared HIV/AIDS a National disaster and established NACC. It facilitated development KNASP 2000-2005 and 2006-2010, which set out a multisectoral response to the epidemic, jointly agreed by stakeholders within Government, civil society, private sector and development partners¹⁹

The annual number of AIDS-related deaths has been increasing steadily. The death rate has doubled since 1999. The HIV/AIDS prevalence has fallen from an estimated 8.5 in the late 1990s to 5.9 percent in 2005 (Table 8). There are significant regional variations with prevalence rates of over 30 percent²⁰ experienced in certain parts of the country.

Table 8: Kenya HIV/AIDS Prevalence 1999-2005

Year	% Prevalence
1999	8.4
2000	8.2
2001	7.9
2002	7.1
2003	6.7
2004	6.4
2005	5.9

Source: NASCOP, Ministry Of Health

Infection rates are higher in urban areas and most new infections are occurring among youth, especially young women ages 15 to 24 and men under 30. According to UNAIDS, there is also a dramatic increase in infection rates among young women and girls. Currently prevalence among women is 7.7 percent compared to 4.0 percent of men. The difference by sex is most pronounced among young people in the 15-24 age range, female prevalence is nearly five times higher than the male prevalence.²¹

¹⁹ NACC (2006) Kenya National AIDS Strategic Plan (KNASP) 2005/06- 2009/10)

²⁰ Kenya Demographic and Health Survey (KDHS) 2003

²¹ National estimates of HIV/AIDS in Kenya in 2003, NASCOP, April 2004

Table 9 shows number of children infected with HIV since 2003.

Table 9: Children infected by HIV/AIDS, 2003-2005

Year	2003			2004			2005		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	34,914	34,777	69,691	31,719	31,595	63,313	28,869	28,756	57,625
5-9	26,210	26,718	52,928	23,812	24,273	48,086	21,672	22,092	43,764
10-14	1,274	1,428	2,702	1,157	1,297	2,455	1,053	1,181	2,234
15-17	10,799	28,552	39,351	9,811	25,939	35,751	8,929	23,609	32,538
TOTAL	73,197	91,475	164,672	66,499	83,105	149,605	60,523	75,638	136,161

Source: KDHS 2003 and CBS

There has been a rapid scale up activities in various areas such as VCT, PMTCT, and access to treatment. With support of The President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to fight HIV/AIDS ,TB and Malaria (GFATM), approximately 70,000 people are on HIV treatment through 120 treatment centers.

It is estimated that 11 percent of children below 15 years are orphans, defined as having lost one or both parents (KDHS 2003), and compared with 9 percent in 1998. Of the 2.4 million orphans in 2006, 1million is due to HIV/AIDS.²²

Despite this large number of children orphaned by HIV/AIDS, few programmes exist to mitigate the problems facing the children. Focus has been on providing the basics, while not much attention has been paid to their psycho-social and socio-economic needs of the children.

4.4.3 Policy and Legislative Framework

In the areas of HIV/AIDS, the Government has put in place various policies and guidelines to facilitate the implementation of activities. The Sessional Paper on HIV/AIDS provides comprehensive overview of government strategies in combating the HIV pandemic. It reiterates government commitment to mitigating the impact of HIV/AIDS on the socio-economic development of the country. The Kenyan National AIDS Strategic Plan (KNASP) 2000 - 2005 and 2005-2010 highlights the three main strategies for Kenya namely prevention, treatment and care and support.

Following the development of both the sessional paper and the strategic plan various guidelines have been developed to guide implementation in the following areas; PMCT, VCT, ART, training and pediatric AIDS care.

On the legislative front, the HIV/AIDS prevention and protection Bill has been pending before parliament now for several years and is yet to be enacted into law.

4.4.4 Challenges

Pediatric AIDS Care: What about treatment for children?: Paediatric HIV treatment and care is still low. Currently an estimated 44,000 children need treatment but only

²² Estimates from the KNASP 2005/6 – 2009/10

around about 5,500 are receiving treatment. There is need however to work urgently towards ensuring that more children are on treatment.

PMCT remains low: Access to Prevention of Mother to Child Transmission (PMCT) of HIV/AIDS services has progressed remarkably in the last few years mainly thanks to the increasing resources PEPFAR funding has applied to this area. PMTCT is offered at about 80 per cent of health centres nationwide. Despite expansion in facilities for PMTC, its use is extremely low in certain parts of the country such as Northern Kenya where many women are unaware of the existence of PMTCT.

Box 2: Alleviating the plight of orphans and vulnerable children: Scaling-up the cash transfer programme

The Office of the Vice President and Ministry of Home Affairs cash transfer programme started in December 2004 in three districts in Kenya, Garissa, Kwale and Nairobi. The inspiration for the programme are the cash transfer programmes existing in many developed countries and South Africa for decades and the new wave of programmes that have been developed in Latin America over the last ten years.

Implementation has come in stages included a pre-pilot phase undertaken to allow for learning of lessons on selected procedures, modalities and mechanisms, which were then put into the larger second pilot phase. The first cash disbursements were made to nine participating communities supporting 500 children. The programme has scaled up and is active in 17 districts with something like 10,000 children enrolled in 2007 rising to 30,000 in 2008. The government has a target of reaching somewhere between 300,000 and 1,000,000 children by 2010. The programme is supported through funds from Kenyan Taxes, DfID, Sida, UNICEF and World Bank. Families receive between 1,000 and 2,000 Kenya shillings per month.

At the local level the programme is managed by the District Children's Officer, with support from the Area Advisory Council (AAC), the body responsible for monitoring the implementation of the Children Act, oversees the project. Technical support and supervision is provided by the Children's Department and UNICEF.

With respect to affordability 750,000 children on cash transfers would cost approximately \$95 million if 10 per cent of the costs went into overheads. This amounts to only 2 per cent of government expenditure or 0.5 per cent of Gross Domestic Product. In the context of an expanding economy and more vigorous tax collection (tax revenues increased by 15 per cent in 2006), the projected scale-up is considered affordable by many policy makers.

5 Concluding Remarks

Over the past few years, Kenya has made tremendous progress in ensuring access to basic social services. While the result has been favorable in some sectors such as education, in others such as health, certain key indicators have worsened. Infant and Under 5 mortality as measured in the 2003 DHS survey were higher than in the 1998 survey. The 2003 DHS's latest mortality data is for a period about 2.5 years before the survey and so pertains to the period around 2001. Since that time there has been a

massive programme of bed net distribution. Since malaria is the main cause of under five mortality there is an expectation that under five mortality rates are coming down now. Early indications from the health management information system show that there are less cases of malaria in Kenya now. The massive drought and flood relief programmes have also made a major contribution in saving lives. Mortality and morbidity from malaria have continued with almost 94 children dying from malaria daily. Immunization levels have remained lower than ten years ago, while fewer women deliver in health facilities now than six years ago seriously compromising their own health and that of the new born babies.

In education, while an increase has been recorded in enrolment at all levels of primary education, regional and gender disparities persist and many children of school going age are still not attending school. Drop out rates especially among girls remain significant while harmful practices such as FGM hinder children from enjoying their rights.

High poverty levels and the HIV/AIDS epidemic have led to an increase in the number of children living under difficult circumstances. These categories include children who live and work on the streets; those abandoned and neglected; those abused and exploited and subjected to child labour.

The policy and legislative framework improved with the enactment of legislation and development of various policies and strategies to support government initiatives in various sectors. The existence of a facilitative policy and legislative framework no doubt contributed to the improvement of children's welfare in certain areas. However enforcement of existing legislation and implementation of policies remains weak in many areas, seriously compromising the rights of children as well as that of other citizens. For instance the government domesticated the UNCRC through the enactment of the Children Act 2001 in early 2002, but for several years corresponding financial allocations were not made to enable the relevant institutions such as the Children's Department and the National Council for Children's Services created through the Act function optimally.

A National Plan of Action (NPA) for children is expected to be developed by government and key stakeholders. This NPA will include budgets for various themes and will ensure the allocation of funds for their implementation. This report on the progress of WFFC+5 will contribute significantly to the NPA for children in 2007.

Bibliography

1. Central Bureau of Statistics. *Analytical report on population projections*, vol. 7. Nairobi:
2. Central Bureau of Statistics, Ministry of Health, ORC Macro. *Kenya demographic and health survey 2003*. Calverton, Maryland, USA: CBS, MOH, ORC Macro; 2004.
3. Central Bureau of Statistics, Ministry of Health, ORC Macro. *Kenya demographic and health survey 1998*. Calverton, Maryland, USA: CBS, MOH, ORC Macro; 1999.
4. Government of Kenya (2003) *Economic Recovery Strategy for Wealth Creation*, Government Printers, Nairobi
5. Government of Kenya (2005) *Gender Equality and Development*, Sessional Paper No.5 of 2005
6. Government of Kenya(2005) *A Policy Framework for Education, Training and Research: Meeting the Challenges of Education, Training and Research in the 21st Century*, Sessional Paper No. 1 of 2005
7. Government of Kenya. *Kenya Gazette Supplement No. 76 (Bill No. 22)*. Nairobi: Government Printer; 2003.
8. Government of Kenya. *Kenya national proposal to address and reduce the impact of HIV/AIDS, tuberculosis and malaria: submitted to the Global Trust Fund on AIDS, Tuberculosis and Malaria*. Nairobi: Government of Kenya; 2002.
9. Government of Kenya. *National report for the special session of the UN General Assembly on follow up to the World Summit for Children*. Nairobi: Government of Kenya; 2000.
10. Government of Kenya and UNICEF. *Impact of HIV/AIDS on education in Kenya and potential for using education in the widest sense for the prevention and control of HIV/AIDS*. Nairobi: UNICEF Country Office; 2000.
11. Ministry of Education, Science and Technology. *Education sector policy on HIV and AIDS*. Nairobi: UNESCO, USAID and the Mobile Task Team; 2004.
12. Ministry of Planning and Ministry of Health (2003) *Adolescent Reproductive Health and Development Policy*, MOPND, Nairobi
13. Ministry of Health (2005) *Guidelines for Provision of Youth Friendly Services*, Nairobi
14. Ministry Of Health (2005) *AIDS in Kenya: Trends, Impact and Challenges*, NASCOP, MOH Nairobi
15. Ministry of Health (2005) *Health Sector Strategic Plan 11*, Government printers, 2005, Nairobi
16. Ministry of Health. *AIDS in Kenya: background, projections, impact, interventions and policy*.6th ed. Nairobi: Ministry of Health; 2001.
17. Ministry of Health. *Curriculum for training health personnel on the rational use of ARV*
18. Ministry of Health. *Kenya health sector strategic plan 2005–2010*. Nairobi: MOH; 2005.
19. Ministry of Health. *National guidelines: prevention of mother-to-child HIV/AIDS transmission (PMCT)*, 2nd ed. Nairobi: MOH; 2002.
20. Ministry of Health. *National health accounts 2001/02*. Nairobi: MOH; 2005.
21. Ministry of Health. *National health sector strategic plan 1999–2004*. Nairobi: MOH; 1999.
22. Ministry of Health. *National Home-based Care Programme and Service Guidelines*. Nairobi: MOH; 2002.

23. Ministry of Health (1998) National Reproductive Health Services (NRHS) Delivery Strategy, 1997 – 2010, MOH. 1998
24. Ministry of Health. *National prevention of mother to child transmission strategic management plan, year 2003–2008*. Nairobi: MOH; 2003.
25. NACC (2006) Kenya National AIDS Strategic Plan (KNASP) 2005/06- 2009/10
26. UNESCO (2006) Quarterly standards and quality assurance in the basic education, experience from, Burundi, Eritrea, Rwanda, Uganda UNESCO, 2006
27. Jones, Sarah (2006) Extent and Effect of Sex Tourism and Sexual Exploitation of Children on the Kenyan Coast
28. The State of the World Children (SOWC) 2007: Women and Children. Double Dividend of Gender Equality. UNICEF 2006
29. UNICEF KCO Annual report of 2005
30. UNICEF KCO Mid-Term Review (MTR) Report 2006
31. Ministry of Planning and Nation Development (MOPND): Millennium Development Goals, Status Report for Kenya 2005