Situation Analysis of Children and Adolescents in Kenya

“Our Children, our Future”

2014
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Glossary

AAC  Area Advisory Council
ACT  Artemisinin Lufenantrine Combination Therapy
ACRC  African Charter on the Rights and Welfare of the Child
ANPPCAN  African Network for the Prevention and Protection Against Child Abuse
APHIA  AIDS, Population and Health Integrated Assistance
ARHD  Adolescent Reproductive Health and Development
ARV  Anti-retrovirals
ASAL  Arid and Semi-Arid Land
CAAFAG  Children Associated with Armed Forces and Armed Groups
CCI  Charitable Children’s Institutions
CDF  Constituency Development Fund
CEDAW  Convention on the Elimination of All Forms of Discrimination against Women
CEWARN  Conflict Early Warning and Response Mechanism
CFE  Child-Friendly School
CHW  Community Health Worker
CHS  Community Health Structures
CHERG  Child Health Epidemiology Reference Group
CLAN  Children’s Legal Action Network
CLTS  Community-Led Total Sanitation
CMR  Child Mortality Rate
CRPC  Comprehensive Post Rape Care
CPU  Child Protection Units
CRC  Convention on the Rights of the Child
CRPD  Convention on the Rights of Persons with Disabilities
CPC  Child Protection Centre
C/UPC  Community-Urban Project Cycle
CPR  Contraceptive Prevalence Rate
CT-OVC  Cash Transfer Programme for Orphans and Vulnerable Children
CoK10  Constitution of Kenya
DCO  District Children’s Officer
DCS  Department of Children’s Services
DDO  District Development Officer
DFID  Department for International Development
DP  Development Partner
DPC  District Peace Committees
DPHKh  Development Partners in Health Kenya
DRR  Disaster Risk Reduction
ECD  Early Childhood Education
EFA  Education for All
EMIS  Education Management Information System
EMTCT  Elimination of Mother-to-Child Transmission
ESAR  Eastern and Southern Africa Region
ESOAC  Quality Assurance Council
FDS  Free Day Secondary Education
FGM/C  Female Genital Mutilation/Cutting
FHOK  Family Health Options Kenya
FPE  Free Primary Education
EYP  Education and Young People
GAM  Global Acute Malnutrition
GAUI  Global Alliance for Vaccines and Immunization
GRV  Gender-Based Violence
GER  Gross Enrolment Rate
GDP  Gross Domestic Product
GoK  Government of Kenya
HDI  Human Development Index
HDR  Human Development Report
HINI  High-Impact Nutrition Interventions
HPV  Human Papillomavirus
HWTs  Household Water Treatment and Safe Storage
ICPS  International Child Support
ICPD  International Conference on Population and Development
IDD  Iodine deficiency disorders
IDPs  Internally-Displaced Persons
IMAM  Integrated management of acute malnutrition
IMR  Infant mortality
IPPF  International Planned Parenthood Federation
IYCN  Infant and Young Child Nutrition
JICC  Joint Interagency Coordinating Committee
KAP  Knowledge, Attitude and Practice
KOHSS  Kenya Demographic Health Survey
KEMSA  Kenya Medical Supply Authority
KEPSA  Kenya Private Sector Alliance
KEPSHA  Kenya Primary School Head Teachers Association
KessaHA  Kenya Secondary School Head Teachers Association
KESSUP  Kenya Slums Upgrading Programme
KESSP  Kenya Education Sector Support Programme
KHHBS  Kenya Integrated Household Budget Survey
KNBS  Kenya National Bureau of Statistics
KNCHR  Kenya National Commission for Human Rights
KNPP  Kenya National Pharmaceutical Policy
KPHC  Kenya Population and Housing Census
KRCS  Kenya Red Cross Society
KSS  Kenya Health Sector Strategic Plan
KWSIP  Kenya Water Sector Investment Programme
LLITN  Long-Lasting Insecticide-Treated Nets
MOG  MDG Acceleration Framework
MDS  Millennium Development Goals
MED  Monitoring and Evaluation Directorate
MOGCSD  Ministry of Gender, Children and Social Development
MICS  Multiple Indicator Cluster Survey
MIS  Management Information System
MLM  Mid-Level Managers
MNC  Maternal, Neonatal and Child Health
MND  Maternal and Neonatal Death Audit
MOEST  Ministry of Education, Science and Technology
MONIDAL  Ministry of State for the Development of Northern Kenya and Other Arid Lands
MOH  Ministry of Health
MOPHS  Ministry of Public Health and Sanitation
MIC  Middle Income Country
MEOG  Ministry of Interior and Coordination of National Government
MIRP  Ministry of State for Immigration and Registration of Persons
MOWI  Ministry of Water and Irrigation
MOYAS  Ministry of Youth Affairs and Sports
MOSPASS  Ministry of State for Provincial Administration and Internal Security
The 2014 Situation Analysis of Children and Adolescents in Kenya points out the numerous policy regimes, legislative and legal frameworks, and programmatic interventions adopted by Kenya in recent years aimed at the realization of children's rights, including adolescents.

This report is meant to influence decision-makers to strive for equity in public policy and to go an extra mile for vulnerable children and adolescents. It looks into interventions and resources that support equitable access to survival, growth, development, protection and participation in the context of human rights.

The release of this Situation Analysis is timely as it coincides with the period when Kenya is in the process of implementing the 2nd Medium Term Plan (MTP) 2013-2017 of Vision 2030 and United Nations Development Assistance Framework (UNDAF) (2014-2018).

Indeed, the findings and recommendations of this report will help to inform the design of interventions by providing the basis for positioning the interests of Kenya's children, adolescents and women in development.

We wish to emphasize the Government's commitment to ensuring effective participation of children and achieving National Development Goals. The review of the 1st Medium Term Plan of Vision 2030 has shown progress in improving social service delivery, especially in the health and education sectors. The health indicators so far show that while there is greater potential for Kenya to meet the Millennium Development Goals' target on reduction by two-thirds of the under-five mortality rate, there are wide disparities across the regions/counties. The prospects for children in the education sector which has been credited for embracing spatial and gender equity are even brighter given that the sector's implementation framework has been a key instrument in influencing prioritization of resources and the sector's strategic focus. This enabling environment has undoubtedly led to the positive project assessment of meeting the MDG target for universal primary education in Kenya.

Yet, amidst this positive picture, high drop-out rates persist particularly in the arid and semi-arid land (ASAL) counties. Other challenges include inadequate implementation capacities within new county governments, HIV and AIDS, the "Brain Drain" in the health sector, unemployment and poverty, and inadequate access to public services. Socio-cultural orientations and weakening family support systems and their negative impact on the traditional social security system, especially in rural areas also affect the successful improvement of the situation of children and women in Kenya.

The focus for this analysis has been on different phases of childhood. While all children are equal rights-holders, the nature of their requirements and necessary conditions for them to claim these rights varies throughout childhood. It is worth noting that a gender lens was also applied to the different age groups to compare the situation between boys and girls. In addition, the impact of the mother's status on aspects of their children's lives was considered along with factors that have a bearing on women's own status. Furthermore, during the development of the Situation Analysis, conditions affecting different socio-economic groups such as populations in remote areas and pockets of poverty were considered.

The many achievements made for children in Kenya are also highlighted in the Situation Analysis to demonstrate how children's rights are implemented. It includes information and statistics on children's health, education and participation, in addition to child protection. We must keep in mind that poverty, poor health conditions and lack of education are all factors that deprive children of their dignity, threatening their lives and making them give up hope. At the same time, the report also proposes what still needs to be done and what the gaps are by sector.

Foreword

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This report thus presents valuable insights on the extent and depth of some of the challenges and also provides useful recommendations that the Government and its county counterparts and stakeholders could use in improving the situation of children, adolescents, and women at national and county levels. This Situation Analysis reinforces the need for all governments to continue prioritizing strategies to develop rural areas through county infrastructure and human capacity development to support core social service delivery.

Once this is achieved, the rural population especially children and women will share in the multi-sectoral opportunities that would uplift their livelihoods and improve their well-being. What is at stake here is not just the lives of children and adolescents, but the very future of Kenya as it strives to become a middle-income country by 2030. Every child’s, every adolescent’s life has to count.

Acknowledgements

The Situation Analysis of Children and Adolescents was prepared in an innovative and participatory way. It was a collaboration between the National Council for Children’s Services (NCCS) and UNICEF that entailed a wide range of consultations with governmental and non-governmental partners.

This partnership has helped to ensure that the report benefits from the most relevant and most recent facts from surveys. More importantly the update of the 2009 Situation Analysis also benefitted from specialists in the concerned ministries and agencies. Groups of adolescents, members of disadvantaged communities, Children Assemblies, children with disabilities participated in focus group discussions whose views enriched the content of the report.

This report is therefore, a product of concerted efforts and substantive contributions from many people with a broad range of expertise. Indeed, their participation was very crucial.

The 2014 Situation Analysis (SitAn) on children and adolescents in Kenya, contains ten chapters with recommendations that address the political and governance context for children’s rights, the economic context for advancing children rights, the legal and policy framework for children’s rights from 2009-2014, issues of gender equality in Kenya, child poverty and deprivation, the rights to survival, development, urbanization and migration, and the health and well-being of adolescents in Kenya. The source of the information on all the chapters is highly acknowledged.

We would like to express our appreciation for the valuable contribution of the Reference Group which was established during the SitAn development process; to provide regulation guidance, quality assurance and to act as a consultation mechanism. The Reference Group was comprised of the then Ministry of Planning and National Development, the Department of Children’s Services, the National Council for Children’s Services, UNICEF, the Kenya National Bureau of Statistics, the Ministry of Education, the Children’s Legal Action Network, the then Ministry of Youth Affairs and the Ministry of Health. Specific acknowledgement goes to Moses Ogola, Ahmed Hussein MBS, HSC, David M. Cheruiyot, Joanne Bosworth, Godfrey Nd’enge, Susan Govedi, Robert Ndugwa, Adelaide Ng’aru, John Wagai, Leah Ambwaya and the consultants and drafting teams who wrote the report and facilitated the process. In addition, we would like to acknowledge the participants of the Children’s Voices forum held at the Multi-Media University, Mbagathi, 17-20 February 2013 (see Annex I). The efforts of the technical group as well as the financial support from UNICEF during the entire process are highly acknowledged. Thanks to Rebeca Rios Kohn and Edita Nsubuga, UNICEF for providing additional editorial support and managing the publication production process.

Finally, all the stakeholders and individuals who are not mentioned here but who contributed their expertise to the development of this report are highly appreciated. It is the noble responsibility of all key stakeholders in the spirit of cooperation to ensure full implementation of the SitAn recommendations, and to strengthen the wake-up call for all duty-bearer institutions, organizations, professional and individuals.

Ms. Hellen Waweru, HSC
Chairperson, National Council for Children’s Services
For all stakeholders.
Executive Summary

This status report on children’s rights in Kenya looks back over the last five years, from 2010-2014. It identifies the key areas of progress towards the realization of children’s rights, as well as the remaining obstacles and challenges that prevent children in Kenya from enjoying their civil, political, economic, social and cultural rights. The report draws on the relevant data and analysis used in the 2009 Situation Analysis of Children, Young People and Women in Kenya and on new sources of information. It re-examines the major areas covered in the Situation Analysis that focused on the rights to health, nutrition, water and sanitation, education, participation, and child protection. In particular, it addresses child poverty and deprivations, and discusses how gender inequality is one of the critical drivers preventing children in Kenya from exercising their rights and hindering development efforts. Three important emerging issues are also covered in the report that merit greater attention namely, crises and disasters and their effect on children, growing urbanization and the situation of poor children in urban areas, and the period of adolescence.

Two recent positive developments that will help improve the lives of children in Kenya are underscored in the report. Firstly, Kenya’s progressive 2010 Constitution which provides a comprehensive legal framework that guarantees the rights and equality of citizens in all spheres of life. The constitutional guarantees establish a solid foundation for the realization of children’s rights in the country, triggering the review and alignment of policies, programmes and legal frameworks pertaining to children. Secondly, the adoption of a new devolved governance structure with the potential to ensure a more equitable distribution of power and resources. Devolution has important ramifications for children’s services located in the 47 counties throughout the country in terms of available finances, human resources, administrative services, built-infrastructure and essential commodities.

The 2010 Constitution recognizes some fundamental human rights, in keeping with the Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of the Child (ACRWC) and other international and regional treaties. Nevertheless, there is much more that remains to be done. Specifically, through the implementation of laws, policies and programmes, before all children in Kenya are ensured equal access to health care services, quality education, water and sanitation and child protection. Each chapter identifies the specific laws and policies that have been adopted, proposed or currently under review, that directly affect the realization of children’s rights in Kenya. The major causes and capacity gaps in the different sectors that prevent those actors responsible for children from fulfilling their duties and obligations are also underscored. In addition, specific recommendations are provided in most of the areas covered in the report. The status report provides an overall update of the situation supported by the available evidence to inform Kenyan policymakers, advocates, and the international development community working for children.

Kenya’s Economic Context

The report provides a snapshot of the economic conditions that impact on the laws, policies, programmes and budgetary allocations related to children. The Government’s capacity to protect and fulfill children’s rights through the adoption of such measures is closely linked to the country’s economy. Kenya began the year 2013 with an improved economic status and there are clear signs that the national economy is now stabilizing. The country experienced five years of economic difficulties due to an economic downturn in which GDP growth plummeted to 1.5 per cent in 2008 and then recovered to some extent to 2.7 per cent in 2009 in the wake of the global financial crisis and the post-election violence of 2008, reaching 5.8 per cent in 2010 and 4.6 per cent in 2012. Key domestic indicators such as interest rates, prices and inflation have also now stabilized.

Achievement of the Millennium Development Goals (MDGs)

Since 2009, Kenya has taken significant steps toward the realization of human rights by making progress in achievement of the MDGs. It has made advances in increasing educational enrollment (MDG2), gender parity in enrolments, particularly in primary education (MDG3), reducing child mortality (MDG4), and reducing the burden of HIV and AIDS (MDG6). However, despite progress in reducing child malnutrition, it is still insufficient to reach the 2015 target of 10 per cent of children under 5 underweight. There has also been insufficient progress in reducing maternal mortality (MDG5), and in ensuring access to safe water and sanitation (MDG7).

Progress towards MDG targets has been slower particularly where there are significant gaps in access to services between the poorest households and the wealthiest, for example in nutrition, access to skilled delivery care, and access to sanitation. This can be seen in a number of ways. A mother in the poorest quintile is four times less likely to receive skilled care during delivery than a mother in the wealthiest quintile, and a child in the poorest quintile is more than twice as likely to be underweight, and eight times less likely to access improved sanitation than a child in the wealthiest quintile.

Gender Inequality

Gender-based discrimination is one of the most pervasive forms of discrimination that children face in Kenya. Ending gender-based discrimination underpins the achievement of all human development goals, including universal primary education, reducing maternal mortality and control of HIV and AIDS. In regard to girls’ rights and gender equality, it is imperative to support the development of policies, legislative frameworks, institutions, budget mechanisms and service delivery systems that promote norms, services and protection for children. They must be in accordance with international human rights standards and the 2010 Constitution which includes a comprehensive Bill of Rights that guarantees equal protection for women and girls. The report underscores that the empowerment of women leads directly to multiple benefits for children in health, nutrition, education, and other ways.

A key finding is that gender inequality is one of the critical drivers of deprivations affecting children in Kenya. This is due to women in Kenya having lower economic status, lower access to formal employment, and the fact that female-headed households are more likely to belong to the poorest sector of the population. Women constitute half (51 per cent) of the Kenyan population and make up the majority of the poorest. In urban areas it was found that the poverty ratio for male-headed households was 30.0 per cent and for female-headed households 46.2 per cent.

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2 Middle Income Country (MIC) is a country with per capita GDP/GNI of at least $1,025. According to the World Bank, “Kenya could become a Middle Income Country by 2015.”


Another finding is that gender inequalities become more pronounced through the period of adolescence, and are manifested particularly in the high inequality in girls’ access to education and the drop-out rate from Primary 7 onwards. Specific protection concerns are linked to girls during this period that are associated with vulnerability to violence, early marriages and pregnancies. Children of mothers without schooling or incomplete primary education are also more likely to be deprived of their human rights.

Child Poverty and Deprivation

Poverty as it affects children, young people, women and other vulnerable groups is a human rights issue. Poverty impacts children in physical, emotional and social ways and its multi-dimensional nature is not always captured by monetary measurement. No matter how poverty is defined and what the causes may be, childhood poverty has carry-over effects that are absorbed at different stages during the life-development cycle. Kenya’s high poverty rate exerts its most extreme effects on the welfare of children,-limiting their right to access clean water, healthy food, medical care, education, and child protection. The situation is exacerbated by Kenya’s high population annual growth rate which strains the support capacity of state and non-governmental relief resources, particularly as the highest birth rates are recorded among the lowest income segments.

Poverty in children is manifest in multiple deprivations. The following figures demonstrate that approximately 80 per cent of all Kenyan children are deprived in one or more dimensions, with the largest deprivation in access to improved sanitation. In terms of absolute numbers, at the national level:

- 7.8 million children are deprived of access to safe drinking water;
- 15.8 million children are deprived of access to improved sanitation;
- 13.1 million children have inadequate shelter;
- 5.3 million children aged 6-17 years are deprived of adequate education;
- 1.1 million children under 2 years have not received all recommended vaccinations;
- 2.1 million children are stunted; and,
- 5.2 million children do not have access to information sources.

Regional imbalances of poverty remain prevalent, particularly those that are linked to access to shelter, sanitation and health. In terms of regional disparities, the North-eastern region was found to be by far the most affected in terms of deprivation, with every 6 out of 10 children reporting more than one deprivation, followed by the Western region (5 in 10 children). Children living in female-headed households, households with more than three children, the poorest households based on the 5-quintile wealth index, and those where the mother has no formal education are also more vulnerable to deprivations.

Since 2009, Kenya has piloted and implemented a wide range of social protection initiatives, many of which have benefited children. Examples include:

- Orphans and Vulnerable Children’s Cash Transfer
- Elderly Persons Cash Transfer
- Cash Transfer for Persons with Severe Disabilities
- Urban Food Subsidy
- Hunger SafetyNet Programme
- General Food Distribution
- Blanket Supplementary Feeding
- Scholarships and Bursaries (Northern Kenya Education Trust (NoKET), Constituency Bursary Scheme)
- OBA/Maternity Vouchers
- National Health Insurance Fund (NHIF)
- School Feeding and Home Grown School Feeding.

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Since 2009, all forms of social protection have expanded significantly in Kenya. Social protection programmes are effective in contributing to protection and realization of many children’s rights including nutrition and food, education, birth registration, sexual and reproductive health. However, coverage of social insurance, social health insurance and social assistance is only a fraction of the actual need and targeting of child vulnerability is currently limited to particular categories of children (e.g. orphans and severely malnourished). The constitutional recognition of the right to social security and the new social protection policy is an opportunity to develop a more systematic approach to social protection that extends coverage to more vulnerable children and improves links between core social protection programmes and other social services.

The Child’s Right to Child Survival and Development

During the period 2010-2012, there were important developments in relation to children’s rights to survival and development mainly in the area of health. Several significant policies and laws were adopted that were guided by the Constitution such as a Health Policy Framework and a Kenya Health Sector Strategic Plan III, and a Health Law was also drafted.

Another positive development is that child mortality fell significantly up to 2009, and there are indications that it continues to drop. The most recent estimate of child mortality is at 74 per 1000 live births, according to the 2008-2009 KDHS. During the period 2008-2011, under-five child mortality declined further in Nyarani region, which is the region that contributes the most to national mortality. To a large extent the mortality reduction is due to progress in preventing malaria deaths and to increasing immunization, based on the expansion of low-cost interventions. Kenya has recorded an increase of almost 20 per cent in immunization coverage over the past four years. According to administrative data provided by the Ministry of Health, 84 per cent of children less than one year of age have received all the scheduled routine vaccines. Nevertheless, appropriate and timely treatment of children with suspected malaria remains a particular challenge in Kenya. Fewer than one in six children with suspected malaria, including those in endemic regions, have access to treatment with the recommended Artemisinin Lufenantline Combination Therapy (ACT) on the same or following day of falling ill.

Despite some progress, major geographic, social and economic disparities remain in both mortality rates and rates of mortality reduction. Most of the child deaths in Kenya are concentrated in three former provinces: Nyanza, Rift Valley and Western. Neo-natal mortality stands at 28 per 1000 live births and has not changed substantially in the last decade but regional disparities in newborn survival have intensified.

Half of all child deaths are now due to newborn causes and pneumonia, with diarrhoea and HIV also constituting significant causes. While the recent introduction of new vaccinations offers some prospects for reducing the burden of diarrhoea and pneumonia, further sustained progress will require increasing mothers’ access to antenatal, skilled delivery and Elimination of Mother-to-Child Transmission (EMTCT) services and better newborn care. One of the key findings is that realizing children’s rights to survival, growth and development also requires paying more attention to extending access of the poorest children to low-cost community-based interventions, based on increasing awareness and uptake of services and behaviours among vulnerable and deprived populations.

While there has been some progress in reducing the maternal mortality rate over the past decade, the available estimates differ and, nevertheless, the MDG target is not being met. According to the Kenya National Bureau of Statistics (KNBS) and ICF Macro, (2010), and the 2008-2009 Kenya Demographic

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4 Refer to Table 10 for details of these figures.
6 Ibid.
and Health Survey (KHHS), the maternal mortality rate was estimated at 488 deaths per 100,000 live births. According to projections based on these figures the rate may now have decreased to 360 deaths per 100,000 live births. In Kenya, as in most other developing countries, the vast majority of maternal deaths take place during child birth and the immediate 24 hours following delivery. Most maternal deaths are attributable to just a few direct causes: haemorrhage, hypertension, sepsis and unsafe abortion.3-11 Virtually all of these conditions can be prevented or managed by basic healthcare services, including quality antenatal care, safe and clean delivery practices, and access to emergency referral facilities when needed. Similarly, neonatal mortality is closely related to the skills of health professionals to provide good care during and after delivery: a clean environment, effective resuscitation if required, keeping the baby warm, and taking proper care of the umbilical cord. Young mothers living in slums are identified as particularly vulnerable due to a lack of basic health services and inability to pay related obstetric costs.12 Survey findings (2005) identify substantial limitations in access to antenatal care in urban slums as compared to the overall population in urban areas.

Underlying causes preventing birth deliveries by a skilled attendant are related to geographic and financial access to services which constitute the most critical bottlenecks. The 2010 Kenya Service Provision Assessment Survey report indicates that out of 690 health facilities surveyed, 30 per cent offer normal delivery services, with a very wide range of 13-51 per cent depending on the region. Many of these facilities suffer from lack of resources such as staff shortages and insufficient materials, which constrain service delivery further.

Other significant disparities remain, in particular, high neonatal mortality in urban areas and highly uneven access to health services marked by high disparities in infrastructure and human resources between regions and between urban and rural areas, despite several equity-focused government policies in health. Although more resources are being dedicated to preventive and outreach services, for example through the Community Strategy, current resource allocations do not appear to be addressing geographical imbalances in access to services. The new revenue allocation formula under devolution and the Equalisation Fund is intended to begin to redress these disparities.

On a positive note, Kenya’s health facilities show good basic newborn care practices. It was found: 95 per cent support early initiation of breastfeeding, 92 per cent support rooming-in, 91 per cent examine the newborn from head to toe before discharge, and only 7 per cent give pre-lacteal feeds and full-immersion baths.

Child Nutrition

Malnutrition, including micronutrient deficiencies remains a significant public health problem in Kenya. The high burden of malnutrition is not only a threat to achieving the MDGs but also a clear indicator of unfulfilled human rights. There are significant regional disparities in nutrition indicators with the chronically food-insecure arid and semi-arid areas showing consistently higher levels of acute malnutrition. Recurrent food and nutrition crises in ASAL districts coupled with multiple and interlinked vulnerabilities such as poor access to functional social services, poverty and insecurity, have a significant impact on the nutrition status of under-five children and their capacity to withstand crisis. Persistent poor nutrition is clearly one of the underlying causes that prevent Kenya from making rapid progress in reducing neonatal, infant, child and maternal mortality.

As a consequence of malnutrition, Kenya is amongst the 12 high burden countries in Eastern and Southern Africa region in terms of stunting which is a serious national development concern that affects over 2 million children. There are wide disparities in child stunting throughout the country depending on wealth quintiles, gender and geographical characteristics. In response to the problem, the period 2009-2012 saw positive developments towards an enabling environment for improving maternal and child nutrition. This includes the adoption of key policies, strategies and guidelines in 2012 such as the Food and Nutrition Security Policy, a National Nutrition Action Plan for Kenya, and the Breast Milk Substitutes Regulation and Control Act, among others.

HIV and Prevention of Mother-to-Child Transmission

Despite huge strides in Kenya’s policy framework and strategies to prevent new HIV infections among children, adolescents and women, the national HIV prevalence was 5.6 per cent in 2012 (Kenya AIDS Indicator Survey, 2012), with some counties having infection rates of up to 22 per cent. As of December 2011, 1.6 million people (58 per cent female) in Kenya were living with HIV, placing continued demands on health and social services. The large number of sexually-acquired transmissions among women continues to be a risk for infections among newborns. In 2012, an estimated 10,300 babies were tested HIV positive.

Recent programme reviews showed persistent challenges in the prevention of mother-to-child transmission (PMTCT). They include:
- low PMTCT awareness
- weak health-seeking behaviour
- low-skilled delivery
- stigma and discrimination leading to low disclosure rates;
- weak PMTCT community-facility linkages
- social cultural beliefs and practices
- high unmet need for family planning
- low male involvement (less than 30 per cent).

By 2012, it was estimated that the mother-to-child transmission rate (MTCT) was 8.2 per cent with large regional disparities in overall transmission among the different counties.10 To accelerate progress in the elimination of mother-to-child transmission and keeping mothers alive, in November 2012, the Government of Kenya launched the new MTCT framework which sets important targets and strategies, a communication strategy, PMTCT guidelines and Kenya Mentor Mother Programme guidelines.

The report further identifies the major causes and capacity gaps that prevent the realization of the child’s right to survival, growth and development. They include the lack of human resources, poor access to health services, insufficient maternity services, poor quality of services, and others. Inadequate human resources (too few with insufficient training) is both one of the major causes that hinder the realization of the child’s right to survival and development, and a capacity gap issue. In short, this constitutes an ongoing nation-wide challenge, particularly in the arid and semi-arid land areas (ASAL).

Water and Sanitation

In recent years, there were important policy developments in the area of water and sanitation. The National Water Policy of 2012 was developed in line with the Constitution with regard to (i) consideration of water as public land, and (ii) the right to water by all, and it also informs the draft Water Act (2012). Currently, overall water coverage stands at 61 per cent but the rural/urban disparities are significant (83%
per cent urban compared to 54 per cent rural). Moreover, regional disparities persist, with lower than national average coverage rates in ASAL and peri-urban areas, amongst others. These disparities may continue to persist unless deliberate efforts are made to put more resources towards water coverage in the rural areas.

Kenya is also not on track to achieve the MDG target for sanitation and this represents one of the biggest development challenges in the country. In fact, poor sanitation costs Kenya Ksh 27 billion (US $324 million) each year. National sanitation coverage stands at 31 per cent; though disparities are not large between rural (32 per cent) and an urban area (27 per cent) because national coverage is low. However, more people in rural areas (18 per cent) practise open defecation compared to urban areas (2 per cent). In addition to geographical location, sanitation access varies significantly by wealth. The richest quintile is eight times more likely to use improved sanitation than the poorest, and the poorest quintile is seven times more likely to practise open defecation than the richest. Access to sanitation is the most serious deprivation for households and children, and represents the most significant inequity among counties.

The Child’s Right to Education

The legal and policy frameworks in Kenya are increasingly in harmony with the Convention on the Rights of the Child (CRC) and other international norms. The chapter on the Bill of Rights in the 2010 Constitution recognizes the right to education as a fundamental right of every child. Overall, as a result of the introduction of free primary education for all, there was an increase in enrolment in primary school and early childhood education. According to the Ministry of Education, Science and Technology, net enrolment in primary education increased from 76 per cent in 2002 to 93 per cent in 2009, and early childhood education from 57 per cent to 60 per cent. Nevertheless, significant inequalities remain on many levels regarding the realization of the right to education, based on geographical location, gender and wealth. Although net primary enrolment has continued to increase since 2009 to 95.7 per cent by 2012, primary completion rates remain at between 75 and 80 per cent, and pupil/teacher ratios have increased, suggesting that there are significant challenges with the quality of education and learning.

Education quality and completion rates for primary school have emerged as critical issues. More than ten years after the introduction of Free Primary Education (FPE), 20-30 per cent of Kenyan children are still not completing a full course of primary education – including around 400,000 who never enrol. In 2010, in five provinces only half or less than half of primary pupils had adequate levels of literacy and numeracy. Pupils in the arid lands are particularly deprived in access, quality and completion of primary education. Improving education quality will pay off for the economy and for individuals and households, yet Government expenditure on education and primary education in particular, is not keeping pace with other elements of the budget and has declined from 25 per cent to 20 per cent of the Government budget.

Since 2009, Kenya still has an estimated one million children out of school. Significant education disparities by geographical region, gender, and socio-economic group are found across the country. The report identifies the major causes and capacity gaps that prevent the realization of the right of the child to education such as gender bias, social norms, parental attitudes, costs, labour obligations and others. Like in other developing countries, the poor quality of education in Kenya may be one of the root causes that keep children from attending school.

The Child’s Right to Participation

The child’s right to participation is one of the guiding principles of the CRC and is recognized in several of the treaty’s provisions. In particular, Article 12 recognizes that children have the right to participate in decision-making processes that pertain to their lives and influence those decisions taken within the family, the school or the community. The enactment of the 2010 Constitution was a milestone in the right to participation in Kenya. According to the Constitution, public participation is looked to as one of the key national values and principles to promote citizen involvement.

The National Council for Children’s Services developed the Guidelines for Child Participation in collaboration with a broad range of stakeholders that were published in 2007. The Guidelines aim to establish, regulate and enforce procedures and standards for children’s involvement in the different spheres of life, while recognizing that child participation ought to take place at home, at school, in the community and at national level. The Guidelines reportedly contribute to a more supportive and favorable environment for participation.

More recently the Government has fully supported activities that are more child-focused including the Children Assembly through which children elect their own officials and hold an annual event and the creation of a Children’s Helpline. Significant Government resources were allocated to support participation particularly those targeting youths and women. To date, the most common forms of participation involving children and youth in Kenya are institutional-based participation, national consultations including children and youth, and events-based participation.

Child Protection

The Constitution and specific legislation have strengthened the framework for a child protection system in several areas. For example, in 2010 there was the adoption of the Counter Trafficking in Persons Act and the Alcoholic Drinks Control Act. The Prohibition of Female Genital Mutilation Act was adopted in 2011. The 2012 Family Protection Bill, which aims to reduce domestic violence, is currently undergoing internal review and stakeholder consultation. Protecting children against abuse, violence, neglect and exploitation is an obligation shared by many different actors, involving diverse government duty-bearers, as well as a broad array of civil society agencies and communities.

Other important recent developments aimed at strengthening the existing child protection programmes and services include:

• the creation of a national information management system with a case management database for all Government services;

• the expansion of core child protection services to several districts including Eldoret, Garissa, Kakamega, Malindi, Mombasa, Nairobi, Nakuru, and Siaya with child protection centres, child protection units in police stations and gender-based violence recovery centres;

• a significant increase in the number of children’s officers to 37826; and

• an increase (between 2005 and 2011) in the number of civil registration offices from 69 to 112 to improve access to birth registration services, though difficulties with long distances and accessibility gaps in rural districts are still a challenge.

The report highlights some of the key child protection concerns that constitute violations of human rights. Children in Kenya are vulnerable to a range of protection risks including abandonment, violence, child trafficking and sexual exploitation, hazardous labour, harmful traditional practices and harmful substances. Although the system for protection is beginning to take shape and respond to these child rights violations, there are still major capacity gaps that delay and hinder significant progress in this area.
The report points out some of the major causes and capacity gaps that are obstacles to ensuring child protection. For example, an inadequate birth registration system contributes to the problem leaving many children unregistered, thus creating barriers for children to access services. Many children have to cover long distances to reach health centres, child protection centres and child-friendly courts, as they are mainly located in urban areas. Access to child protection services is also hindered by the poor condition of the roads and long distances between towns/villages.

Capacity gaps found in the social work force are an important underlying cause of the poor child protection services. Inadequate personnel, knowledge and the limited infrastructure hampers the ability of this important group to provide the services that children and their families urgently need. There is still a low number of children’s officers and a limited back-up of qualified social workers. There are currently no minimum standards regarding experience and education for an officer working with children.

Other major obstacles are the poor child protection infrastructure and necessary budgets to create an adequate national system. There are also few institutional programmes funded and supported for training an adequate number of personnel, monitoring and reporting systems to track child protection cases nationally, as well as providing adequate service provision and forward planning. The need for inter-sectoral coordination in child protection is yet another issue that needs to be addressed.

Finally, poor implementation, monitoring and evaluation of laws and policies are hampering the protective effect of the current system. The Government is the main duty-bearer responsible for ensuring the child’s right to protection through an effective child protection system. The mapping and assessment of the existing components of the child protection system show that Kenya has a foundation to build on. However, there are numerous challenges, including limited human, financial and technical capacities. Inadequate funding prevents the creation of coordination mechanisms and key components such as child protection centres and Children’s Officers. It is hoped that the current devolution process will present a good opportunity for strengthening the child protection system.

**Emerging Issues**

The report covers important emerging issues namely, crises and disasters, urbanization, and adolescence. The first two warrant closer examination due to their enormous consequences on the lives of children in Kenya, and the period of adolescence merits greater attention as well, particularly from both a policy and programmatic perspective. It is pointed out that one of Kenya’s major development challenges is the ability to manage crises and natural disasters. Children in Kenya are particularly affected by natural disasters including droughts and floods, as well as by such crises as intra-communal violence. Natural disasters and violent conflicts are also undermining efforts toward the realization of children’s rights, especially in regard to those children who are already more likely to be subjected to multiple deprivations.

More specifically, crises and disasters deprive children of their rights to food and nutrition, education, water and protection. Drought and displacement particularly affect the most vulnerable children, those in ASAL regions and low-income urban areas, the youngest children who are totally dependent on adults for survival, children of poor mothers and female-headed households, as well as vulnerable out-of-school adolescents. A rigorous and child-focused disaster risk reduction and risk-informed approach to development and service delivery needs to be applied in high risk areas, and a stronger system for child protection in emergency contexts is urgently needed.

Kenya is currently host to more than 500,000 refugees residing in the Dadaab camp in the North Eastern Region22 and the Kakuma refugee camp. The majority of the refugees are from Somalia and over 250,000 are children. Children living in refugee camps are exposed to a number of serious child protection concerns, especially because many children are found separated from their families and unaccompanied Unaccompanied Asylum Seeking Children (UASC).

The Government has undertaken diverse measures and adopted a wide range of policies and programmes in response to natural disasters, internal displacement and refugees. However, important gaps in data collection and institutional responses are evident across the country, including in refugee camps. National systems and institutional reforms need to be more robust and of more utility in support of a plethora of new policies and programmes. Moreover, there is an urgent need for humanitarian assistance to meet immediate needs, and to address the dire living conditions and human rights deprivations.

Child deprivation in urban areas, particularly informal settlements, is an increasingly important issue. While urban children on the whole are less likely to be deprived, children living in poverty and residing in the urban slums areas face a range of vulnerabilities and disadvantages22. For example, in children in urban slums have three times the national rate of diarrhoea, one in two children in urban slums are chronically malnourished, and mortality rates are up to twice the national rate. The vulnerability of urban informal livelihoods, high food price inflation, and failure of governance, planning and delivery of services in urban informal settlements are key drivers of child vulnerability in urban areas. Also, fewer children belonging to poor urban households attend the higher grades of school and many slum areas have few or no public schools. As the population of cities, towns and municipalities are set to grow over the next decades, greater attention must be paid to measures and strategies to address children’s rights in urban areas, as a matter of priority.

The period of adolescence is another emerging issue that merits greater attention in policies and programmes. Although there is no internationally-accepted definition of adolescence, the United Nations defines adolescents as individuals aged between 10 and 19. Adolescence is a critical time in the life-cycle when an individual’s life and development are influenced by many external factors and when there are opportunities to break the intergenerational cycle of poverty.

Progress on the rights of adolescents can be viewed as a core element of realizing Vision 2030. Kenya’s adolescents are experiencing some progress in improved access to secondary education, increasing access to information and media, falling rates of child marriage and childbearing. However, only half of Kenya’s adolescents transition to secondary school, and four out of ten girls still begin childbearing by the age of 19, while 60 per cent are unable to access family planning and there is little progress to reduce HIV infections among adolescent girls. While there are adolescent programmes, they are fragmented and there is evidence that coverage is low in relation to need, so that many vulnerable adolescents are not able to access them.

In sum, general challenges faced by adolescents are: early pregnancies and marriages, child labour, poverty, drug and substance abuse, low school enrolment and high drop-out rates, and harmful practices such as female genital cutting. Adolescent girls, in particular, face severe obstacles when seeking employment, and struggle to overcome entrenched social, economic and gender inequality. They are also vulnerable to child marriage and pregnancy, HIV infection and gender-based violence. Moreover, without clear opportunities for income-generation, their families may see little value in supporting their education.

The report recommends acknowledging adolescents as positive assets and encourages their inclusion in national plans and programmes. It further underscores that adolescents can be agents of change in their communities and dynamic contributors to the country’s development.

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Recommendations for the Realization of Children’s Rights

The report makes a number of recommendations throughout, many related to the realization of specific rights. The following are the major recommendations targeted at Kenya’s policy makers and other duty-bearers at national and county levels.

1. Develop agreed measures of child deprivation and poverty based on children’s constitutional rights, and routinely monitor and report on progress. Utilize data and evidence on child deprivation for development of practical programmes and policies based on the best available evidence, and for targeting resources towards the most deprived children.

2. Extend the coverage and strengthen targeted social protection programmes, including among the urban poor, and incrementally scale-up the services in line with available budgetary provisions to achieve initial results in combating poverty.

3. Adopt a rigorous and child-focused, risk-informed approach to service delivery in high risk areas based on more comprehensive analysis of the impact of repeated natural and man-made disasters on children in Kenya, to serve as the basis for more rigorous child-focused disaster risk reduction and resilience strategies.

4. Enhance policy, planning and budget allocations for effective interventions to tackle the critical bottlenecks and barriers for reducing child and maternal mortality at national and county levels, including:
   - Strengthening the health system for prevention of maternal and newborn deaths.
   - Providing a multi-sectoral response to child stunting.
   - Scaling up of the community health strategy and a comprehensive communication strategy for child survival.
   - Develop and implement a policy for community-led sanitation.
   - Provide a complete WASH package of latrines, water supply, hand washing facilities and materials, as well as hygiene promotion, in schools and health centres.

5. Develop programmes to tackle structural gender inequalities and address the vulnerability of adolescents, in particular girls. Identify and address the barriers to keeping girls in school during adolescence. Identify and address the social, economic and cultural drivers of HIV, early marriage, and violence against adolescent girls.

Introduction

As Kenya embarks on the historic task of implementing the 2010 Constitution, this status report looks back at the last five years (the period 2010-2014) and identifies areas of progress towards fulfilling children’s rights, as well as the remaining obstacles and challenges. It draws on the relevant data and framework used in the “Situation Analysis of Children and Women, 2009” and on new sources of information. More specifically, it addresses emerging issues that are having a significant impact on the realization of children’s rights namely, rapid urbanization and urban poverty, violent conflicts including incidences of civil strife within the country, and the occurrence of natural and man-made disasters such as recurring droughts, floods and other forms of environmental degradation. It offers an overview of a critical period in children’s lives, known as adolescence, and underscores particular inequalities that contribute to the multiple and persistent deprivations found in the country that prevent many Kenyan children and adolescents from realizing all their human rights.

Multiple deprivations and disparities are often closely associated with specific forms of violations of civil, political, economic, social and cultural rights. This status report is intended to contribute to shaping national development strategies to accelerate achievement of child-related goals with equity. The obligation to address these issues arises from the principles and standards recognized in the major international human rights treaties to which Kenya is a signatory, such as the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and their Optional Protocols. They form the basis of the human rights-based approach which guides and informs this report. Moreover, Kenya’s 2010 Constitution prescribes a comprehensive legal framework that includes a Bill of Rights which guarantees the rights and equality of citizens in all spheres of life. The Constitution also endorses Kenya’s prior ratification of all human rights treaties such as the CRC and CEDAW, among others.

This status report points out the numerous policy regimes, legislative and legal frameworks, and programmatic interventions that have been adopted by Kenya in recent years aimed at the realization of children’s and women’s rights. It also identifies the major challenges that remain to improve children’s and women’s lives and well-being and analyzes some of the major causes that deprive children and women of their entitlements. Some of the capacity gaps found among the key duty-bearers that serve as obstacles to the realization of their human rights are likewise underscored. In addition, it offers timely recommendations to consider during this historic opportunity, as Kenya continues to implement its progressive Constitution under a newly elected Government.

Four fundamental approaches and perspectives inform the report:

1. A human rights-based approach: Addresses all children’s and women’s rights as recognized in the CRC, CEDAW and other relevant international treaties ratified by Kenya. Many of the principles and standards in the human rights treaties have been incorporated in the country’s national laws and Constitution. The rights-based approach aims to identify the major causes that deny children, who are the claim-holders, the enjoyment of their rights. It further identifies the roles and responsibilities of the duty-bearers at all levels of society to protect their rights and analyzes some of the capacity gaps that prevent them from complying with their obligations.

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2. An evidence-based approach: Uses data and analysis to accurately identify patterns, trends and incidences of rights deprivations (e.g., child mortality, violence against children); to consider the immediate, underlying and fundamental causes of rights deprivations; and to identify capacity gaps among duty-bearers, leading to recommendations that will address the critical bottlenecks and barriers to realization of rights.

3. A gender perspective: Based on the principles of gender equality and the empowerment of girls and women as recognized in CEDAW, Kenya’s National Gender and Equality Act of 2011 and the agenda and work-plan of the National Gender and Equality Commission. It looks at the extent to which the fulfillment or non-fulfillment of the rights of women affect overall inequalities and deprivations, including those affecting children. Gender equality is recognized as a pre-condition to the attainment of the Millennium Development Goals (MDGs) and integral to poverty reduction.

4. An equity perspective: Based on the principles of universality and non-discrimination, meaning that all children shall have an opportunity to survive, develop and reach their full potential, without discrimination in keeping with the CRC. This guarantees the fundamental rights of every child, regardless of gender, race, religious beliefs, income, physical attributes, geographic location or other status. An equity perspective requires identifying those population groups that are unfairly deprived of the enjoyment of their rights and focusing greater efforts on correcting the deprivations and disparities.

Significantly, the voices of children were also included in this status report to highlight the valuable insights and recommendations that emerged from the “Children’s Voices” consultation. Under the guidance of the National Council for Children Services (NCSC), the Department of Children Services and UNICEF, a consultation was organized that included forty (40) National Children Assembly Officials and members drawn from twenty counties to represent children in Kenya. The participants discussed a number of thematic issues, including economic development and children; urbanization, migration and children, maternal and child health; adolescence; crisis, conflict, disaster and children; and political and legal reform, including devolution.

One of the recommendations of the 2009 Situation Analysis was to ensure that routine situation updates and analysis are undertaken. Accordingly, this report benefits from the availability of significant new data and evidence in many areas. The current report focuses, in particular, on identifying the gaps in the enjoyment of rights of the poorest children and on the progress achieved in addressing deprivations and disparities since 2009.

The status report is divided into ten chapters:

1. Chapters I and II address the overall country context for advancing children’s rights and issues related to gender equality.

2. Chapters III through VII cover child poverty, health, nutrition, water and sanitation, education, participation, and child protection, building on some of the findings and recommendations of the 2009 Situation Analysis.

3. Chapters VIII through X focus on key emerging issues: crises and disasters, urbanization and migration, and the well-being of adolescents.

It should be noted that some challenges were faced during the preparation of this status report. Firstly, the new Government was undergoing a restructuring with many functions and titles being changed within ministries and new ones being created. Thus, there are many references to the former Government entities. Secondly, the full implications of a devolved government were also not yet widely known at the time of writing this report so as to be able to analyze the effect on children’s policies and programmes and the realization of their rights. Thirdly, there was lack of available current and reliable data in a number of areas.

The process of development and validation of the status report included:

- A Government Reference Group comprised of representatives of key Government and civil society agencies involved in the protection and promotion of children's rights.
- A Children’s Assembly consultation (Children’s Voices).
- A one-day consultation with stakeholders in Nairobi.
- A three-day workshop held in Nakuru with key Government representatives from various ministries.
Chapter I: Country Context

The political and constitutional reform firmly established children’s rights in the country, triggering the review and alignment of policies, programmes and frameworks affecting children...
Political and Governance Context for Children’s Rights

As of 2013, Kenya’s population is estimated at 44.1 million, whereas according to the country’s last census undertaken in 2009, it was at 38.6 million with an annual growth rate of 2.2 percent.25 Children within the age bracket of 0-18 years constitute about half of the Kenyan population. In 2012, the total child population was estimated at 21.3 million.26

Before the enactment of the Constitution on 27 August 2010, Kenya had a highly centralized system of governance, which some people believe was the root of unfair allocation of resources and development opportunities. Exclusion from Government services created feelings of marginalization in many parts of the country. High poverty levels and inequality, increased unemployment and high income disparities, coupled with low productive capacity fuelled perceptions that public office was the key to unlocking access to Government services and opportunities.27

Through a referendum, 67 per cent of Kenyan voters approved the 2010 Constitution. It contains many important new provisions that shape the governance structure in the country.28 The Constitution introduced additional checks and balances to executive power and significant devolution of power and resources to 47 newly-created counties. The legislature is composed of a two-tier system: tier one includes members of the National Assembly with women representatives from 47 counties; tier two includes one senator from each of the 47 counties. The Constitution “offered a wide-ranging set of reforms designed to break the cycle of corruption and violence, including a decentralized system of government, independent courts, a new citizens’ Bill of Rights and increased numbers of women in public office.”28 Kenya has a mixed legal system of English common law, Islamic law, and customary law.

The first presidential election under the new Constitution was held on 4 March 2013, which elected a President and a Deputy President who together with the Cabinet form the national Executive. With the exception of a few coastal skirmishes, the 2013 elections were peaceful, despite widespread fears of violence, winning praise from international observers.

Overall, these important developments provide strategic opportunities to make further progress for the fulfillment of children’s and women’s rights in Kenya. The political and constitutional reform firmly established children’s rights in the country, triggering the review and alignment of policies, programmes and frameworks affecting children, which are still under way.

Devolved Government and Its Implications for Service Delivery for Children

The Constitution specifies fundamental changes to the structure of Kenya’s government system by creating a new tier of county governments. Kenya’s eight provinces and over 280 districts have been replaced by 47 new counties, each with an elected Assembly, a Governor and Deputy, a Speaker, and an appointed Executive Committee. The Executive Committee and the Governor are not members of the Assembly, implying that there will be full separation of powers between the Legislature and Executive at both national and county level.

Devolution is the most profound and transformative dimension of the Constitution with significant impact on governance and public resource division and management. It has important ramifications for children’s services in the 47 counties in terms of available finances, human resources, administrative services, built-infrastructure and essential commodities. For Kenya’s children, devolution may be the key to the enjoyment of their human rights in the future. Devolution presents an opportunity for greater equity, self-governance and better service delivery particularly for the country’s poor, marginalized and vulnerable groups including children. Key institutions and individuals charged with such responsibilities, all primary duty-bearers, will need to seize the moment, retain the momentum and sustain citizens’ expectations of access to effective and efficient quality services that ensure children are not at risk of exclusion and multiple deprivations.

National and county governments have been assigned functional areas with protections against undue interference in the performance of their duties.29 If effectively implemented, this transformation could lay the foundation for the social and economic pillars articulated in Vision 2030. However, the reality is that devolution is a highly complex undertaking by the country. The challenge, therefore, will be to manage expectations of how much and how quickly the devolved system of governance can deliver. It must also ensure that the transition at all levels causes very little disruption to the delivery of services that are essential for the welfare of the people of Kenya, and the progressive realization of their human rights.30

First and foremost, devolution aims to ensure a more equitable distribution of power and resources amongst the country’s regions and in remote localities, with increased political, social and economic opportunities at all levels. Secondly, through county governments, functions and services are decentralized so that service delivery is more effective and brought closer to the people. A final objective of devolution is to enhance the responsiveness of government, governance structures and institutions through a more accountable, open, transparent, and participatory process, thus reducing corruption and enhancing the active role of citizens.31

24 UN DESA Estimates
25 UN DESA Estimates
29 Constitution of Kenya, Article 189.
30 Devolution without disruption: Pathways to a Successful New Kenya (World Bank).
Under the County Government Act, 2012, administrative divisions below the level of county have been revised and now comprise sub-counties (equivalent to districts) levels with Children’s Officers who are assisted at community level by Volunteer Children’s Officers (VCOs) deployed at location level. By 2010, there were 154 children’s offices and 581 Children’s Officers up from 400 officers in 2003.

The National Council for Children’s Services (NCCS) was established under Section 30 (1) of the Children Act to exercise general supervision and control over planning, financing and coordination of child rights activities and to advise the State on all aspects related to children. The Council is composed of representatives from relevant Government ministries, NGOs, FBOs, and the private sector and is independent in its operation. The functions of the NCCS are cascaded to the local levels through an Area Advisory Council (AAC) found at district, division and local levels. The AACs have similar membership as the NCCS. The operation of the AACs is guided by the principles of the best interests of the child, children’s participation, non-discrimination, and the right to protection, survival and development. The overall role of AACs is to co-ordinate children’s activities in their area of jurisdiction.

To date there are 153 AACs across the country. Plans are under way to ensure that AACs are part of the devolved government structure. In its effort to strengthen co-ordination, the NCCS has developed various regulations and guidelines. This includes the Child Participation Guidelines 2007, Charitable Children’s Institutions (CCI) Regulations 2005, and the Operationalization of the AAC’s Guidelines 2006.

The Ministry of Education, Science and Technology (MoEST) has primary responsibilities for the basic education system in Kenya to promote education access, quality, equity and relevance for all Kenyan children. It has a mission to provide, promote and co-ordinate lifelong education, training and research for Kenya’s sustainable development. To focus on priority areas within overall education goals, notably towards attaining ‘universal primary education’ by 2005, within the context of the wider objective of Education for All (EFA) by 2015.

The economic context is important for ensuring children’s rights considering that children live in households and communities that depend on the country’s economy for their overall well-being and prosperity. Moreover, the Government’s capacity to fulfill children’s rights through public services is closely linked to the country’s economy. As State Party to the CRC, Kenya has a duty to undertake all appropriate measures to the maximum extent of its available resources to protect and fulfill the rights of all children in the country (as per Article 4 of the treaty) and within the framework of international cooperation.

Kenya began the year 2014 with an improved economic status and there are clear signs that the national economy is now stabilizing. From 2008, the country experienced five difficult years due to an economic downturn. GDP growth plummeted to 1.5 per cent in 2008 and then recovered to some extent to 2.7 per cent in 2009 in the wake of the global financial crisis and the post-election violence of 2008, reaching 5.8 per cent in 2010 and 4.7 per cent in 2013. Key domestic indicators such as interest rates, prices and inflation also stabilized during this difficult period.

Kenya is the largest economy within the East African region with a Gross Domestic Product (GDP) of Ksh 3,798 billion (around $44 billion, current prices). Growth in 2013 was 4.7 per cent which is still well below Vision 2030’s 10 per cent target over the next period. Key economic drivers over this period were an increase in domestic consumption and the revival of cross-border regional trade.

Kenya’s per capita GDP in 2012 was Ksh 84,624, (around USD $985 at reported exchange rates) which means that the country, whilst steadily approaching middle-income status, still falls within the World Bank’s category of low-income countries (US$1,025 or less GDP per capita). With continued high population growth and inflation, however, growth is translating into only marginal increases in per capita real incomes, equivalent to around 7 per cent since 2008. There is evidence of widening income inequalities, according to the World Development Indicators which indicate that the Gini coefficient increased between 1992 and 2005, while the share of the poorest quintile in national consumption was estimated to have fallen from 4.8 per cent to 4.6 per cent in 2011.

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In recent years, the global economic crisis has had a major impact on Kenya’s national economy. As the global economy contracted, demand for Kenyan exports plummeted and domestic investment in manufacturing and agriculture, including horticulture, fell, with both sectors being badly affected. Apart from the public sector, the manufacturing and agricultural sectors provide work to the vast majority of Kenyan breadwinners. Tourism, a major national multiplier for local jobs and services, suffered severe losses to revenue and job cuts followed.\(^{41}\) Real wages declined by an average of 4.6 per cent per year.\(^{42}\) While overall inflation went up from 5 per cent in 2010 to 19.7 per cent in October 2011, food price inflation was even higher, reaching 26 per cent in October 2011. Households in the lowest income group saw their real incomes decline by 13 per cent during 2011, compared with only 8 per cent for the highest income group.\(^{43}\) Consequently, rising levels of poorly paid and unregulated employment in the informal sector of the economy, particularly of women and older children from poor families, were evident in both rural and urban areas. With the emergence of a more prominent ‘underclass’ in rural and urban areas, these urban or peri-urban ‘pockets of poverty’ are now evidently becoming ‘poverty sponges’, absorbing a new generation of mainly youthful migrants. This suggests a major structural shift towards a more urban economy in Kenya, with a new and distinctive demographic pattern.\(^{44}\)

Another factor that affected the national economy in recent years was drought. Estimated losses per capita due to drought between 2008 and 2011 ranged from Ksh 7,076 in Coast province to Ksh 43,699 (over $500 per person) in Rift Valley. Losses were mainly due to death of livestock.\(^{45}\) Many rural families in lowly productive, historically-marginalized and poorly-serviced regions in the Arid and Semi-Arid Lands (ASALs) were caught in the pincers of economic distress and drought. As a result, many resorted to harmful coping strategies involving extreme measures such as male household heads leaving women and children in stricken districts, and migrating long distances to seek grazing for livestock, the household’s key income-producing assets. It also involved extreme forms of on- and off-farm (heavy) child labour, for example, in harvesting river sand for cash and even child sexual exploitation.\(^{46}\)

During 2012, greater economic stability and Government action brought inflation and high food prices and other household expenses under control and the exchange rate stabilized. This was good news for Kenyan families faced with rising expenses, new costs and slow wage growth. With rising per capita GDP and substantial improvements in some key national indicators - such as child mortality - this is a positive environment for progress in realizing children’s rights. Nevertheless, concerns remain about the inclusiveness of growth and the share of development reaching the poorest families and children.

It should be noted that despite the challenges, public accounts remained sound throughout the difficult period with the Government of Kenya (GoK) able to secure sufficient funds from domestic sources to cover both ordinary and extraordinary spending in the national budget. By ensuring that Government expenditure remained aligned to the MTEF and by steadily maintaining fiscal discipline, basic social services continued to be available to ordinary Kenyans.\(^{47}\) However, during 2012, borrowing increased significantly related to the implementation of the Constitution.\(^{48}\)

In terms of overall progress in human development in the current economic environment, Kenya registered a minor improvement in both its ranking and its composite score in the Human Development Index (2012), due to its increasing GDP.\(^{49}\) Kenya’s 2012 HDI of 0.519 is above the average of 0.465 for countries in the low human development group and above the average of 0.475 for countries in Sub-Saharan Africa. Kenya’s HDI value for 2012 placed the country at 145 out of 187 countries and territories. Kenya’s human development index (HDI) score shows achievements in providing quality education, improving life expectancy and income per capita. Based on the HDI for 2013, Kenya has registered improvements in its HDI since 2000 but it has not yet managed to climb out of the “low human development” category. Progress in education has contributed the most to Kenya’s advances in human development but the country loses 33 per cent of its HDI value when its levels of inequality are taken into account. The trends in Kenya’s Human Development Index over the last 30 years are captured in the table below:

### Table 1: Trends in Kenya Human Development Index 1980-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Kenya</th>
<th>Sub-Saharan Africa</th>
<th>World</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>0.519</td>
<td>0.475</td>
<td>0.694</td>
</tr>
<tr>
<td>2011</td>
<td>0.515</td>
<td>0.472</td>
<td>0.692</td>
</tr>
<tr>
<td>2010</td>
<td>0.511</td>
<td>0.468</td>
<td>0.690</td>
</tr>
<tr>
<td>2005</td>
<td>0.472</td>
<td>0.432</td>
<td>0.666</td>
</tr>
<tr>
<td>2000</td>
<td>0.447</td>
<td>0.405</td>
<td>0.639</td>
</tr>
<tr>
<td>1990</td>
<td>0.463</td>
<td>0.387</td>
<td>0.600</td>
</tr>
<tr>
<td>1980</td>
<td>0.424</td>
<td>0.366</td>
<td>0.561</td>
</tr>
</tbody>
</table>


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Explanatory note on 2013 HDR composite indices.

33.6 per cent due to inequality in the distribution of the

Human Development Index (HDI) and the Inequality Adjusted Human Development Index (IHDI), which takes into account inequality in all three dimensions of the HDI by “discounting” each dimension’s average value according to its level of inequality. The HDI can be viewed as an index of ‘potential’ human development and the IHDI as an index of actual human development. The ‘loss’ in potential human development due to inequality is given by the difference between the HDI and the IHDI, and can be expressed as a percentage. Kenyan HDI for 2012 is 0.519, however, when the value is discounted for inequality, the HDI falls to 0.344, a loss of 33.6 per cent due to inequality in the distribution of the dimension indices.”49

Legal and Policy Frameworks

In 2008, the Government of Kenya was ranked among the ten most “child-friendly” governments in Africa for:50

• putting in place appropriate legal provisions to protect children against abuse and exploitation;
• promising to allocate a higher share of the national budget to provide for their basic needs; and
• making progress in children’s well-being.

The Government performed well according to other indicators related to child corporal punishment, free primary education and juvenile justice, the national plan of action for survival, protection and development of children, and establishment of a Government body for coordinating the national strategy for children, the National Council for Children’s Services (NCCS).


The 2010 Constitution incorporated a number of fundamental rights for children that are in harmony with the CRC including civil and political rights, as well as economic, social and cultural rights. According to Kenya’s State Party Report submitted in 2012, under the 2010 Constitution many new laws will be enacted and current laws amended within five years, some of which have a direct bearing on children’s rights. The 2010 Constitution represents a significant recognition and adoption of international human rights principles and standards and prescribes a comprehensive legal framework that guarantees the rights and equality of citizens in political, economic, cultural and social spheres of life. It also endorses Kenya’s prior ratification of all human rights treaties such as the CRC and CEDAW amongst others. Moreover, it goes beyond the provisions in both the CRC and the African Charter of the Rights and Welfare of the Child (ACRWC), by making the State obliged to respond to the needs of the vulnerable and pursue affirmative action for minorities and marginalized groups. However, while it recognizes the family and the child’s right to parental care, it does not clearly specify the duties and obligations of parents, and also does not make explicit the obligation of the State to support and promote the role of parents in the care and support of the child. It provides a framework for, but does not itself address, all areas of children’s rights which are addressed by the CRC and the ACRWC.

Overall, the Kenyan Constitution represents a significant achievement for advancing children’s rights in Kenya. Some highlights follow below:

• Chapter 3 (Citizenship), Article 14 (4) gives the right of citizenship and nationality to any child below the age of 8 years – inclusive of those whose parents are unknown.

• Chapter 4 (Bill of Rights), incorporates and recognizes the fundamental principle of the best interests of the child, whilst acknowledging children’s social, economic and political rights and safeguards against discrimination.52 Specifically, in article 43, the state must provide: appropriate social security


51 In 1998, Kenya submitted the initial State Party Report to the Committee on the Rights of the Child (CRC Committee), and the Second Periodic State Party Report was submitted in 2004. Thereafter, the Concluding Observations were issued to the State of Kenya by the international monitoring treaty body. Kenya also submitted a combined 3rd, 4th and 5th State Party Report in 2012 at the request of the CRC Committee. Kenya was due to submit the initial report on the Optional Protocol to the Convention on the Rights of the Child on 28 June 2012.

52 Constitution of Kenya, Articles 27, 43 and 53.

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to those who are unable to support themselves and their dependents; the right to the highest attainable standard of health; access to adequate housing and reasonable standards of sanitation; clean and safe water in adequate quantities; freedom from hunger and access to adequate food of acceptable quality; and education. Every child has the right to a name and nationality, to basic nutrition, protection from harm and to parental care and protection in equal measure from both parents.53

• Chapter 5 (Land and Environment) gives women rights to equitable access and ownership of land; this right if realized in practice is likely to enhance women’s security of livelihood with direct benefit to children.54

• Chapters 6 and 7 (Leadership and Integrity and Representation) requires that 33 per cent of all appointive and elective positions be held by female representatives. This is likely to increase the visibility and concern for gender and children’s issues.

• Chapter 11 addresses Devolved Government, and through articles 174 and 175 provides for social and economic development and provision of locally available, easily accessible services through county governments with adequate and reliable revenues and resources to govern and deliver effective services.

• Chapter 17 (General), article 260, a child is defined to include a person who has not attained the age of 18 years and removes any doubt as to the legal age of a child in Kenya.

While the 2010 Constitution recognizes some fundamental human rights, there is much more that remains to be addressed through legislation. Tables 2 and 3 below show specific legislation that has either been adopted in recent years or has been proposed that directly affects the realization of children and women’s rights in Kenya.

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**Table 2: Selected Acts and Bills of Parliament that were passed or are currently under way with implications for the rights of children and women**

<table>
<thead>
<tr>
<th>Act/ Bill</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>management service as a central body for the identification and registration</td>
</tr>
<tr>
<td></td>
<td>of persons, immigration matters, the issuance of identification and travel</td>
</tr>
<tr>
<td></td>
<td>documents, aliens management, integration of population registration data</td>
</tr>
<tr>
<td></td>
<td>and the administration and enforcement of all the laws relating to</td>
</tr>
<tr>
<td></td>
<td>registration and for connected purposes.</td>
</tr>
<tr>
<td>The National Gender and Equality Commission Act, 2011</td>
<td>An Act of Parliament to: establish the National Commission on Gender</td>
</tr>
<tr>
<td></td>
<td>pursuant to Article 59 of the Constitution; provide for the functions and</td>
</tr>
<tr>
<td></td>
<td>powers, qualification of, and appointment procedure for members of the</td>
</tr>
<tr>
<td></td>
<td>Commission; and for connected purposes.</td>
</tr>
<tr>
<td>The Kenya Citizenship and Immigration Act, 2011</td>
<td>An Act of Parliament to: make provision for the acquisition, loss and</td>
</tr>
<tr>
<td></td>
<td>regaining of citizenship, duties and rights of citizens; issuance of travel</td>
</tr>
<tr>
<td></td>
<td>documents; entry, residence and exit out of Kenya; and for connected</td>
</tr>
<tr>
<td></td>
<td>purposes.</td>
</tr>
<tr>
<td></td>
<td>Commission pursuant to Article 59 of the Constitution; and, provide for the</td>
</tr>
<tr>
<td></td>
<td>functions and powers, qualification of, and appointment procedure for</td>
</tr>
<tr>
<td></td>
<td>members of the Commission and for connected purposes.</td>
</tr>
<tr>
<td>The Commission on Revenue Allocation Act, 2011</td>
<td>An Act of Parliament to: make further provision as to the functions and</td>
</tr>
<tr>
<td></td>
<td>powers of the Commission on Revenue Allocation, the procedure for</td>
</tr>
<tr>
<td></td>
<td>appointments to the Commission and for connected purposes.</td>
</tr>
<tr>
<td>The Refugee Bill, 2012</td>
<td>A Bill for An Act of Parliament to make provision for the recognition,</td>
</tr>
<tr>
<td></td>
<td>protection and management of refugees and refugee affairs and for</td>
</tr>
<tr>
<td></td>
<td>connected purposes.</td>
</tr>
<tr>
<td>National Registration and Identification Bill, 2012</td>
<td>A Bill for AN ACT of Parliament to provide for the notification and</td>
</tr>
<tr>
<td></td>
<td>registration of births and deaths, for the identification of Kenya citizens,</td>
</tr>
<tr>
<td></td>
<td>the issuance of documents of registration and identification, and for</td>
</tr>
<tr>
<td></td>
<td>connected purposes.</td>
</tr>
<tr>
<td>Family Laws which include the Marriage Act 2014, Matrimonial Property</td>
<td>Marriage Act An Act of Parliament to amend and consolidate the various</td>
</tr>
<tr>
<td>Act, 2013 and the Protection Against Domestic Violence Bill 2013</td>
<td>laws relating to marriage and divorce and for connected purpose.</td>
</tr>
<tr>
<td></td>
<td>Matrimonial Property Act An Act of Parliament to make provision for the</td>
</tr>
<tr>
<td></td>
<td>rights and responsibilities of spouses in relation to matrimonial property</td>
</tr>
<tr>
<td></td>
<td>and for connected purposes.</td>
</tr>
<tr>
<td></td>
<td>Protection Against Domestic Violence Bill A Bill for An Act of Parliament</td>
</tr>
<tr>
<td></td>
<td>to make provision for the protection and relief of victims of domestic</td>
</tr>
<tr>
<td></td>
<td>violence; to make provisions for the protection of a spouse and any</td>
</tr>
<tr>
<td></td>
<td>children or other dependent persons, and to provide for matters</td>
</tr>
<tr>
<td></td>
<td>connected therewith or incidental thereto.</td>
</tr>
</tbody>
</table>


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53 Constitution of Kenya, Article 53.
54 Constitution of Kenya, Article 60 (1).
The bills were subjected to wide Stakeholders Consultations, and internal review procedures to ensure compliance with the Constitution and in the spirit of public participation in the implementation process.

Table 3: Selected Acts of Parliament that were passed or currently under way with implications for the rights of children and women.

<table>
<thead>
<tr>
<th>Act Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The County Governments Public Financial Management Transition Act 2013</td>
<td>An ACT of Parliament to: provide for, pursuant to section 15 of the Sixth Schedule of the Constitution, a framework for establishment and functions of Transition County Treasuries; the transition county budget process; transition revenue raising measures and expenditures for county governments; responsibilities of transition county accounting officers and receivers of revenue and for connected purposes.</td>
</tr>
<tr>
<td>The National Government Co-ordination Act, 2013</td>
<td>An ACT of Parliament to: establish an administrative and institutional framework for co-ordination of national government functions at the national and county levels of governance; to give effect to Articles 131(1) (b) and 132 (3) (b) of the Constitution and for connected purposes.</td>
</tr>
<tr>
<td>The Public Finance Management Act, 2012</td>
<td>An ACT of Parliament to: provide for the effective management of public finances by the national and county governments; the oversight responsibility of Parliament and county assemblies; the different responsibilities of government entities and other bodies, and for connected purposes.</td>
</tr>
<tr>
<td>The Urban Areas and Cities Act, 2011</td>
<td>An ACT of Parliament to: give effect to Article 184 of the Constitution; to provide for the, classification, governance and management of urban areas and cities; to provide for the criteria of establishing urban areas, to provide for the principle of governance and participation of residents and for connected purposes.</td>
</tr>
<tr>
<td>The County Governments Act, 2012</td>
<td>An ACT of Parliament to: give effect to Chapter Eleven of the Constitution; to provide for county governments powers, functions and responsibilities to deliver services and for connected purposes.</td>
</tr>
<tr>
<td>The Transition to Devolved Government Act, 2012</td>
<td>An ACT of Parliament to: provide for a framework for transitional arrangements and processes for the establishment and operationalization of devolved government; the phased transfer of functions and powers; and for connected purposes.</td>
</tr>
</tbody>
</table>

Source: Commission for the Implementation of the Constitution (http://cicke.co.ke/).

“A country where all the children’s standards of welfare and their quality of life meets globally competitive and acceptable standards.” Vision 2030

Kenya’s Constitution and its national development plan Vision 2030 are mutually reinforcing as the road map for political, economic and social equity and equality. Vision 2030 is a long-term development blueprint aimed at transforming the country into a globally-competitive middle-income country with a high quality of life by the year 2030. The plan aspires to meet medium term development goals including the Millennium Development Goals (MDGs) 2015. It seeks to reduce poverty, narrow inequalities through employment, empowerment and improving access to social services for all. The Kenya Vision 2030 and the Medium Term Plan (MTP) are aligned.

Second Medium Term Plan 2013-2017

Kenya’s Second Medium Term Plan for the period 2013-2017 prioritizes the implementation of devolution as a means to more rapid socio-economic development with equity. The plan aims to increase the pace and scale of social and economic transformation through modernization of infrastructure, restructuring the economy, employment creation, food security, wider access to better quality education and health care, and provision of improved water and sanitation. Policies to support youth and to promote gender equity, together with specific programmes for the vulnerable, are also priorities for this period.

Children Act 2001

In 2001 the Government of Kenya enacted the Children Act to harmonize the domestic laws pertaining to children and to domesticate the CRC and the ACRWC. The enactment of the Children Act was a landmark as it was the first law that domesticated an International Convention. In its Preamble, the Act makes provisions for parental responsibility, fostering, adoption, custody, maintenance, guardianship, care and protection of children; administration of children’s institutions; and giving effect to the principles of the CRC and ACRWC. The implementation of the Act is spearheaded by the Government ministry responsible for children’s affairs and the NCCS in partnership with stakeholders involved and engaged in working with children in the country. The Act has been undergoing review with the intention of harmonizing its provisions with the 2010 Constitution.


The Government of Kenya developed a National Children Policy in 2008. The Policy aims to create an environment in which all children’s rights will be fulfilled, safeguarded and protected in all sectors and in order to anchor the Children Act 2001. The Policy has been informed by the main principles and standards articulated in the CRC and the ACRWC namely civil and political, economic, social and cultural rights. Kenya also developed a National Plan of Action (NPA) for children 2008-2012 and plans are under way to develop a subsequent National Plan of Action 2013-2017.

Independent Monitoring of Children’s Rights

In regard to independent monitoring of children’s rights, the State Party report 2012 recently submitted to the CRC Committee indicates that Kenya does not currently have a comprehensive mechanism for monitoring implementation of the CRC although different State and Non-State Actors use agency-specific monitoring tools. There have been efforts to work with key stakeholders in order to disseminate the Concluding Observations of the treaty body and monitor implementation and progress at all developmental levels. The Kenya National Commission on Human Rights, the National Gender and Equality Commission and the Commission on Administrative Justice are three independent human rights bodies which are mandated “to act as watchdogs over the State in order to protect and promote human rights” in Kenya."
The Kenya National Commission on Human Rights and Gender and Equality Commission are mandated to oversee the promotion and implementation of human rights in Kenya and to promote equality and freedom from discrimination. The KNHRC also includes a Commissioner in charge of children’s affairs. According to the State Party report 2012, Kenya will develop and implement a National Monitoring and Evaluation Framework that will be under the auspices of the National Council for Children Services (NCCS). The NCCS is also developing a National Children Database to streamline monitoring and evaluation of children’s programmes and to review and assess performance and impact of various programmes and interventions.

**Child-Friendly Budgets**

There are a few key developments in regard to Government expenditure alignment to the Medium Term Expenditure Framework (MTEF) and allocations to social sectors. First, the share of expenditure allocated to social sectors fell from 36 per cent to 31 per cent from 2009/10 to 2012/13. Second, within social sectors, the proportion allocated to health and social protection increased while that to education fell. Third, most individual child-focused programmes did not change substantially, except for Early Child Development Education (ECDE), and Orphans and Vulnerable Children (OVC) Cash Transfer, which received significant increases, and Maternal and Child Health Care which saw a significant fall.

Kenya has continued to increase budgetary allocation to children’s services progressively as demonstrated over the period between 2005 and 2011, as shown in Table 4 below.

### Table 4: Budget allocation Department of Children’s Services (Kenya Shillings)

<table>
<thead>
<tr>
<th>Year</th>
<th>Recurrent expenditure</th>
<th>Development expenditure</th>
<th>Total Expenditure</th>
<th>External Receipts (Grants &amp; Loans)</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>323,370,584</td>
<td>88,500,000</td>
<td>411,870,584</td>
<td>89,659,090</td>
<td>501,529,674</td>
</tr>
<tr>
<td>2006/07</td>
<td>413,735,754</td>
<td>112,500,000</td>
<td>526,235,754</td>
<td>242,657,325</td>
<td>768,893,079</td>
</tr>
<tr>
<td>2007/08</td>
<td>563,682,019</td>
<td>109,500,000</td>
<td>673,182,019</td>
<td>453,044,460</td>
<td>1,126,226,479</td>
</tr>
<tr>
<td>2008/09</td>
<td>1,037,163,562</td>
<td>153,000,072</td>
<td>1,190,163,634</td>
<td>446,720,380</td>
<td>1,654,884,014</td>
</tr>
<tr>
<td>2009/10</td>
<td>1,324,348,055</td>
<td>234,325,000</td>
<td>1,558,673,055</td>
<td>1,957,493,272</td>
<td>3,516,166,327</td>
</tr>
<tr>
<td>2010/11</td>
<td>1,379,890,455</td>
<td>241,900,000</td>
<td>1,621,790,455</td>
<td>2,288,610,654</td>
<td>3,910,401,109</td>
</tr>
</tbody>
</table>

Source: Department of Children’s Services.
Regional disparities for some MDGs

Several recommendations have been made to accelerate achievement of the MDGs. The MDGs Acceleration Framework (MAF) will enhance achievement of those goals that are lagging behind. There is also a need to ensure mainstreaming of the MDGs in all counties, since there will be increased resources allocated to counties under devolved funds. County planning and budgeting process should prioritize and allocate more resources to sectors that can spur the achievement of the MDGs.

Data Collection and Dissemination

Kenya has made progress in data collection and dissemination through the Kenya National Bureau of Statistics (KNBS) and platforms such as KENINFO. KNBS has also contributed to and produced important publications and surveys such as the Violence Against Children Survey, Kenya Population and Housing Census, Kenya Demographic and Health Survey (KDHS), Persons with Disability Survey, Kenya Integrated Household Budget Survey, Kenya AIDS Indicator Survey and Multiple Indicator Cluster Surveys (MICS) and Labour Force Survey. The National Integrated Monitoring and Evaluation System includes several indicators of progress on children’s rights within the national indicator framework and the annual progress reports on the Medium Term Plan 2008-2012 include updates in core areas, including education and child health and mortality.

Achievement of the Millennium Development Goals (MDGs)

Since 2009, Kenya has made some progress in the realization of human rights through the achievement of the MDGs. It has advanced in increasing educational enrolment (MDG2), gender parity in enrolments, particularly in primary education (MDG3), reducing child mortality (MDG4), and reducing the burden of HIV and AIDS (MDG6). Despite progress in reducing undernutrition, it is still insufficient to reach the 2015 target. There has been also insufficient progress in reducing maternal mortality (MDG5), and in access to safe water and sanitation (MDG7).64

Progress towards MDG targets has been slower particularly where there are significant gaps in access to services between the poorest quintile and the wealthiest, for example in nutrition, access to skilled delivery care, and access to sanitation. This can be seen in a number of ways. A mother in the poorest quintile is four times less likely to receive skilled care during delivery than a mother in the wealthiest quintile, and a child in the poorest quintile is more than twice as likely to be underweight, and eight times less likely to access improved sanitation, than a child in the wealthiest quintile.

Table 5: Progress Towards MDG Targets According to Wealthiest and Poorest Quintile

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wealthiest Quintile</th>
<th>Poorest Quintile</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of children under 5 who are underweight69</td>
<td>9</td>
<td>25</td>
<td>0.4</td>
</tr>
<tr>
<td>Skilled attendance at birth60</td>
<td>81</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Proportion of households with access to improved sanitation (not shared)61</td>
<td>88</td>
<td>10</td>
<td>8.5</td>
</tr>
</tbody>
</table>

A number of challenges to achievement of the MDGs in Kenya have been identified, including62:

- Inadequate resources for financing MDGs in the country; a 2005 Needs Assessment found a funding gap of Ksh 4.1 trillion.
- High prices of foodstuffs and farm inputs.
- Inability of developed countries to avail 0.7 per cent of Gross National Income (GNI) in financial resources for MDGs in developing countries as agreed in the Millennium Declaration.
- Slow technological transfer especially in food production from developed countries to developing countries.
- Inadequate data for tracking and reporting on MDGs.
- Effects of climate change.

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60 Kenya National Bureau of Statistics, ICF Macro Kenya Demographic and Health Survey, 2009
Chapter II:

Gender Equality and Women’s Empowerment in Kenya

Gender inequalities become more pronounced through the period of adolescence, and are manifested particularly in the high inequality in girls’ access to education and the drop-out rate from Primary 7 onwards.
KEY FINDINGS

Gender inequality is one of the key drivers of deprivations in children’s rights in Kenya. Women in Kenya have lower economic status, lower access to formal employment, and female-headed households are more likely to be among the poor. Women have gained more access to political power through the recent affirmative action measures in the 2010 Constitution.

Gender inequalities become more pronounced through the period of adolescence, and are manifested particularly in the high inequality in girls’ access to education and the drop-out rate from Primary 7 onwards. Specific protection concerns arise for girls during this time, associated with vulnerability to violence, early marriages and pregnancies. Children of mothers with no schooling or incomplete primary education are also more likely to be deprived of their rights.

Gender Disparities

Gender-based discrimination is one of the most ubiquitous forms of discrimination that children face. Ending gender-based discrimination underpins the achievement of all human development goals, including universal primary education, reducing maternal mortality and control of HIV and AIDS. With regard to girls’ rights and gender equality, it is imperative to support development of policies, legislative frameworks, institutions, budget mechanisms and service delivery systems that promote norms, services and protections for children that reflect global human rights standards, including those relating to gender equality. Moreover, the empowerment of women leads directly to multiple benefits for children in health, nutrition, education, and their own empowerment and confidence.

Gender equality is important for both intrinsic and instrumental reasons and creates an environment for social harmony and society’s well-being. Gender equality has a potentially significant influence in policy formulation in various areas including education, poverty, labour, financial markets, political and economic empowerment, institutions and overall economic development. Gender inequality, on the other hand, has been found to undermine economic growth and social development.

Women and girls constitute half (51 per cent) of the Kenyan population and make up a majority of the poorest. Around one in every three Kenyan households is headed by a woman64,65,66,67,68,69,70. Households in Nyanza are most likely (36 per cent), while those in Nairobi are least likely (19 per cent), to be female-headed. The poverty rate for male-headed households (48.8 per cent) was slightly lower than for female-headed households (50 per cent).71 In urban areas it was found that the poverty ratio for male-headed households was 30.0 per cent and for female-headed households 46.2 per cent.

Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to risks and in differential access to utilization of development interventions. Gender disparities in Kenya still manifest themselves in various ways; the form of differential access in all areas including education, labour, financial markets, political and economic empowerment, institutions and overall economic development. There are significant differences between women and men, girls and boys in participation, mobility (within and between sectors and industries) and in distribution of benefits.

Some of the factors that constrain women’s and girls’ abilities to claim and exercise their rights and entitlements are:

- retrogressive cultural practices and ingrained patriarchal values;
- wide discrepancies in male/female rates of unemployment, particularly amongst youth;
- growing trends of violence and crime;
- widespread gender-based violence (both domestic and social) that affect women and girls disproportionately;
- differential in performance and participation of girls and boys in schools;
- increase in HIV/AIDS and subsequent vulnerabilities, particularly amongst girls and women;
- under-representation of women in decision-making positions;
- discriminatory practices related to citizenship/nationality, marriage, credit, property, inheritance inter alia; and,
- the high incidence of poor, female-headed household inter alia.72

Consequently, empowering women and girls and enabling them to actively participate and contribute to social, economic and political activities is important for sustainable development. Providing context-specific responses to address the needs and concerns of adolescent girls and boys pays dividends in empowering this age group and for them grow into confident and capable young adults.

The Legal and Policy Framework for Gender Equality

Since 2010 great strides have been made in anchoring gender equality as a national norm and principle. This progress was noted by the Committee on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) after reviewing the seventh periodic report of Kenya on 19 January 2011. In its Concluding Observations issued on 2 February 2011, the Committee welcomed the adoption of the new Constitution which provides for the immediate domestication of the CEDAW treaty.73 It also welcomed that the Constitution requires repealing many discriminatory provisions which existed in the former one, as well as the guarantee of non-discrimination with respect to all laws, including those in the areas of marriage, divorce, adoption, burial and succession. The Committee noted in particular that the Constitution includes a comprehensive Bill of Rights which enhances protection for women through, inter alia, the following provisions:

a) Article 2 (4) which provides that any law, including customary law, that is inconsistent with the Constitution is void to the extent of the inconsistency, and the fact that any act or omission in contravention of the Constitution is invalid;

b) Article 14 (1) (2) which guarantees equal citizenship rights for women, and in particular the direct applicability of the constitutional right of women to pass on Kenyan citizenship to their foreign spouses and children born outside of Kenya.

c) Article 19 (2) states that the purpose of recognizing and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social justice and the realization of the potential of all human beings.

d) Article 27 (3) establishes that women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres rights. It also recognizes that cultural practices which are harmful to women are unlawful.

e) Article 27 (4) which prohibits direct or indirect discrimination, inter alia, on the basis of sex, pregnancy and marital status;

f) Article 27 (6) which allows the State to take legislative and other measures including affirmative action to redress disadvantage;

g) Article 27 (8) which states that not more than two-thirds of the members of elective or appointive bodies be of the same gender in newly-established commissions crucial to the implementation of the Constitution.

Vision 2030 covers the period 2008-2030. Its first Medium Term Plan (2008-2012) identified the need to address gender concerns in order for the country to attain sustainable development. It also recognized that gender disparities in Kenya must be addressed to ensure both men and women equitable access to social, economic and political opportunities. It further identified various targets towards socio-economic and social development that include:

- ensuring gender mainstreaming in all Government policies, plans and programmes so that the needs and interests of each gender are visibly captured;
- collecting gender-disaggregated data to accurately portray the gender balance in all sections of the country and to form the basis for developing gender-sensitive policies, plans and programmes;
- ensuring that women have at least 30 per cent representation in recruitment, promotion and appointment at all decision-making levels;
- promoting campaigns to eliminate retrogressive cultural practices such as FGM and early marriages;
- reducing the rate of high-risk sex through increased access to safe sex methods; and,
- using de-centralized funds to provide social amenities at close proximity in order to reduce gender-based violence and human rights violations.

Kenya’s Ministries, Government Departments and Agencies have integrated “minimum gender compliance/thresholds” as part of their performance and are committed to developing sectoral gender policies.73 Beginning in 2010, a process to review and update the National Gender Policy on Gender and Development 2000 has been ongoing. The policy is being reviewed so as to institutionalize gender as a key concept in development, as well as to articulate specific sectoral policy measures in line with the Constitution. One of the notable features of the Revised Draft Gender Policy is the shift from the “women in development approach” to the “gender and development approach”.

On the face of it, the legal and policy terrain for women and girls has greatly improved – even though the actual practice and implementation of the gender equality dividends are yet to be institutionally-rooted.

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73 The Ministry of Education, The Ministry of Gender, Children and Social Development and the Ministry of Labour have as at 2011 developed their ministerial gender policies, whilst the Ministry of Medical Services and Public Health and Sanitation has submitted a stakeholders validation draft by the end of April 2012. Other Ministries have commenced but not concluded their policies.

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Social and Cultural Values and Practices Reinforce Unequal Status

Whilst the normative standards on gender equality and human rights are specifically articulated in the Constitution, patriarchal norms are still predominant in Kenya. They underpin relations between women and men, girls and boys thus producing and sustaining experiences of gender-based discrimination, with women and girls positioned in a subordinate relationship to men and boys respectively. The consequences of patriarchal norms have often been witnessed in unjust practices of resource control, law, policy and decision-making, which have resulted in unequal respect and inequities. Inequalities affect Kenyan boys and girls at a very early stage of their lives and sometimes in significantly different ways. Consequently, this can have long term negative implications on the fulfillment of rights and empowerment of children and young people in all stages of their lives.

Until the new Constitution was adopted in 2010, customary law irrespective of its discriminatory nature was applicable to a wide range of matters with numerous negative consequences for women in terms of inheritance, property rights, marriage, and adoption. The valuation of the boy child over the girl child has had a detrimental effect on girls’ pursuit and access to education, nutrition, security and inheritance. Control of women’s bodies and sexuality has resulted in diverse forms of gender-based violence including early marriage, FGM/C, wife inheritance, forced pregnancies, rape and abductions. Control of women’s labour and visualizing women as property has also helped to sustain practices such as dowry, polygamy, wife inheritance, restriction on mobility, and violence against women. Leadership is still perceived as a male domain, hence the insignificant number of women in decision-making throughout Kenya’s history.

Right to Reproductive Health Care

The 2010 Constitution recognizes the right to health of every individual, including reproductive health care. Reproductive health is an important component of overall health throughout the life cycle for both males and females. This requires individuals to be able to exercise control over their sexual and reproductive lives. The right to non-discrimination implies that reproductive health services should be accessible to all groups, including adolescents, unmarried women, migrants and refugees. It also implies that services should be available to meet the distinct needs of women and men, girls and boys. Thus, it calls for ensuring that adolescent reproductive health and rights are included in national agendas and translated into policies and actions.

National statistics indicate that coverage of access to family planning has improved, since 1967 when the Kenya Family Planning Programme was first established. Thus, the Contraceptive Prevalence Rate (CPR) among married women in Kenya has increased from 39 per cent in 1998 to 46 per cent in 2008-2009. Whilst the current trend is encouraging, the CPR is still more than 20 percentage points short of the target of 70 per cent for 2015 (NRHS 2009-2015). The KDHS 2008-2009 further shows a widespread desire among Kenyans to plan their families. Almost 25 per cent of all currently married women either did not want to have another child or had already been sterilized, while nearly 27 per cent would like to wait two years or longer before their next birth.
Table 6: Unmet Need for Family Planning 1998-2009

<table>
<thead>
<tr>
<th>Survey year</th>
<th>FP unmet need-Spacing (%)</th>
<th>FP unmet need-Limiting (%)</th>
<th>Total Unmet Need (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998 KDHS</td>
<td>14.0</td>
<td>9.9</td>
<td>23.9</td>
</tr>
<tr>
<td>2003 KDHS</td>
<td>14.4</td>
<td>10.1</td>
<td>24.5</td>
</tr>
<tr>
<td>2008-9 KDHS</td>
<td>12.9</td>
<td>12.8</td>
<td>25.7</td>
</tr>
</tbody>
</table>

Even if the CPR has gone up in the most recent decade, the total unmet need remains high. The unmet need for family planning continues to exist in roughly one-quarter of all currently married women. The role of men positively engaging and ensuring safe reproductive health for women and girls needs to be enhanced nationally. This requires the attention of all partners in the development arena as well as Government.

Table 7: Trends in Uptake of Family Planning and Method-Mix among Married Women aged 15-49 (1998-2009)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently using any method</td>
<td>39</td>
<td>38.3</td>
<td>45.5</td>
</tr>
<tr>
<td>Currently using any modern method</td>
<td>31.5</td>
<td>30.5</td>
<td>35.9</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>6.2</td>
<td>4.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Pill</td>
<td>8.5</td>
<td>7.2</td>
<td>7.2</td>
</tr>
<tr>
<td>IUCD</td>
<td>2.7</td>
<td>2.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Injectables</td>
<td>11.8</td>
<td>13.8</td>
<td>21.6</td>
</tr>
<tr>
<td>Male condoms</td>
<td>1.3</td>
<td>1.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Implants</td>
<td>0.8</td>
<td>1.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Traditional methods</td>
<td>7.5</td>
<td>7.8</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Disproportionate Impact of HIV on Adolescent Girls and Women

Kenya’s epidemic disproportionately affects women, who account for 59.1 per cent of adults living with HIV. Amongst people between 15-49 years of age, HIV prevalence of females is at 8 per cent, which is nearly twice that of males at 4.3 per cent in 2012.74 The odds of being infected increase during the transition from adolescence to adulthood.75 However, there are important differences between women and men, girls and boys in the underlying mechanisms of infection. These stem from biology, sexual behaviour and socially-constructed gender differences between women and men, girls and boys in roles and responsibilities, access to resources and decision-making power. Young women are particularly vulnerable to HIV; for example, 3 per cent of women aged 15-19 are HIV-infected, compared to less than one percentage of men of the same age. The HIV prevalence amongst pregnant women is 6.8 per cent and the average percentage of new infections among key-affected populations stands at 11 per cent.76 To date, many programmes have not yet addressed gender and age-specific vulnerabilities to protect the rights of women and girls affected by HIV.

74 The Kenya AIDS Epidemic Update 2012, National AIDS and STI Control Programme, p.4
75 The Kenya AIDS Epidemic Update 2012, p.6

Equality in Education

Gender disparities are evident in Kenya’s education sector at all levels of learning. Statistics from the Ministry of Education indicate a large increase in the number of total enrolments from the year 2007-2012 at all levels of learning.

At the Early Childhood Development Education (ECDE) level the Gross Enrolment Rate (GER) was 66.3 per cent for the year 2012 (53.3 per cent net enrolment).77 Total enrolment in 2012 at this level was 2,405,504 and there were more girls enrolled than boys.77

At the primary level there is a very high GER of 115.8 per cent.78 There has been steady progress towards gender parity in enrolments at this level, reaching 0.99 in 2012. However, girls are still more likely to drop out of primary school than boys. Of the pupils who joined Standard 1 in 2008, 98.5 per cent of the boys were still enrolled in 2012, compared with only 96.4 per cent of the girls. Drop-out rates tend to accelerate for girls from Standard 7.79

Table 8: Trends in Enrolment and Parity at ECDE, Primary and Secondary Levels

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls</td>
<td>814.93</td>
<td>834.93</td>
<td>946.68</td>
<td>1,092.18</td>
<td>1,194.52</td>
<td>1206.464</td>
</tr>
<tr>
<td>Boys</td>
<td>876.16</td>
<td>885.32</td>
<td>967.54</td>
<td>1,100.89</td>
<td>1,175.53</td>
<td>1199.041</td>
</tr>
<tr>
<td>Total</td>
<td>1,691.09</td>
<td>1,720.25</td>
<td>1,914.22</td>
<td>2,193.07</td>
<td>2,370.05</td>
<td>2,405.51</td>
</tr>
<tr>
<td>Parity</td>
<td>0.93</td>
<td>0.94</td>
<td>0.98</td>
<td>0.99</td>
<td>1.02</td>
<td>1.01</td>
</tr>
<tr>
<td>Girls</td>
<td>4,031.00</td>
<td>4,201.30</td>
<td>4,322.00</td>
<td>4,629.30</td>
<td>4,820.80</td>
<td>4,956.80</td>
</tr>
<tr>
<td>Boys</td>
<td>4,222.80</td>
<td>4,362.50</td>
<td>4,509.40</td>
<td>4,751.90</td>
<td>4,977.70</td>
<td>5,014.10</td>
</tr>
<tr>
<td>Total</td>
<td>8,253.80</td>
<td>8,563.80</td>
<td>8,831.40</td>
<td>9,381.20</td>
<td>9,857.90</td>
<td>9,970.90</td>
</tr>
<tr>
<td>Parity</td>
<td>0.95</td>
<td>0.96</td>
<td>0.96</td>
<td>0.97</td>
<td>0.98</td>
<td>0.99</td>
</tr>
<tr>
<td>Girls</td>
<td>541.58</td>
<td>615.41</td>
<td>684.69</td>
<td>767.85</td>
<td>819.01</td>
<td>895.79</td>
</tr>
<tr>
<td>Boys</td>
<td>638.69</td>
<td>720.50</td>
<td>787.94</td>
<td>885.54</td>
<td>948.71</td>
<td>1,019.03</td>
</tr>
<tr>
<td>Total</td>
<td>1,180.27</td>
<td>1,335.91</td>
<td>1,472.63</td>
<td>1,653.38</td>
<td>1,767.72</td>
<td>1,914.82</td>
</tr>
<tr>
<td>Parity</td>
<td>0.85</td>
<td>0.85</td>
<td>0.87</td>
<td>0.87</td>
<td>0.86</td>
<td>0.88</td>
</tr>
</tbody>
</table>


At the secondary level there is a much lower GER of 49.3 per cent as compared to the primary level.81 Girls’ enrolments are significantly lower than boys, and the gender parity index has progressed from 0.85 in 2008 to 0.88 in 2012. The more worrying factor is the increase in the difference of the number of enrolments at secondary level of girls as compared to boys. At the primary level the enrolment difference was 57,300 and at secondary level the difference is 123,239.

77 Kenya Facts and Figures 2012
79 Kenya Facts and Figures 2012
Gender-Based Violence

Women and girls are more likely to experience gender-based violence (GBV) than men and boys. Almost half (45 per cent) of women/girls 15-49 years of age have experienced one form of violence - either physical or sexual violence. The likelihood of experiencing either physical or sexual violence increases with the age of the women.82

One in five Kenyan women (21 per cent) has experienced sexual violence, representing an increase of 5.1 per cent since 2003.

The most prevalent form of violence is spousal violence.

There have been only minor changes in the level of marital violence since 2003. Except for physical violence, which declined slightly (from 40 per cent in 2003 to 37 per cent in 2008-09), the results indicate a slight increase in the magnitude of sexual and emotional violence (from 16 to 17 per cent and from 26 to 30 per cent, respectively).

Women whose spouses have completed primary school are less likely to have experienced some kind of violence than are those whose husbands have either no education or only some primary school.

The gender concerns around GBV emanate from social perceptions, largely captured in national statistics, which continue to regard such violence mainly as a female problem. This results in a growing profile that a survivor of GBV is female therefore “vulnerable” and “weak”, which further deepens the stigma, silence and lack of male-sensitive responses to the problem. Nevertheless, it is primarily women and girls who bear the larger burdens associated with GBV, which may lead to unwanted or unplanned pregnancies that are likely to cause unsafe abortions. There are also higher chances of contracting STIs including HIV and AIDS, as well as numerous gynecological complications. Identifying the prevalence of GBV is difficult particularly in so far as sexual violence is concerned, considering that rape is one of the most underreported crimes in the world.

Women, Employment and Work

The Employment Act 2007 was enacted to include sex and pregnancy as distinct grounds upon which one may not be discriminated against in employment matters. The Act stipulates that taking affirmative action measures consistent with the promotion of equality or the elimination of discrimination in the workplace does not amount to discrimination. It also provides that an employer is bound to pay employees equal remuneration for work of equal value. The Act provides for increased maternity leave for women (3 months) and paternity leave for men (2 weeks). In addition, it outlaws sexual harassment by or against either sex and requires employers to adopt sexual harassment policies in their respective places of work.

In 2006, a Presidential Decree was issued to implement affirmative action with a 30 per cent threshold in the recruitment and promotion of women in all public offices. This directive, however, still lacked an institutional and legal framework to ensure government compliance, though the 2010 Constitution has anchored the requirement. Statistics indicate women are still largely under-represented and make up 32.1 per cent of public sector workforce compared to 67.9 per cent of men. Women employed in Government Ministries are less than the 30 per cent stipulated in the affirmative action and 71.9 per cent of these women work in lower cadre jobs.83 Only 16 per cent of top positions in the public sector are occupied by women compared to 78 per cent of jobs in the lower job groups.84

The Presidential Decree of October 2006 on the implementation of Affirmative Action in recruitment and promotion of women in the public sector did not bring about substantive changes. The Ministry of Gender, Children and Social Development report (2009) on the implementation of the 30 per cent affirmative action revealed that:

- Employment and promotion is generally in favour of men.
- Out of the total labour force of 69,833 surveyed in 35 ministries only 0.5 per cent were women in top management position of P and above compared to 2 per cent of men.


In 2012-2013, the total enrolment in all universities increased by 21.3 per cent. Total female enrolment in all universities grew by 30 per cent compared to male enrolment of 15 per cent. Despite the 30 per cent increase, the total number of enrolments by females was still significantly below that of males, with over 30,000 more males enrolled than females. This is also the trend in all the previous years, showing that gender disparities are higher at this level of learning than in the others.

It is evident that girls have lower enrolment, transition and completion rates at all levels of learning. Various studies have indicated that this difference arises from the unique challenges the girl child faces in the society. They include:

- Lack of accurate information on how to deal with the growing up process;
- Unaffordable menstrual protection/sanitary wear;
- Lack of sanitation facilities in schools;
- Heavy domestic workloads;
- Child marriages and pregnancies; and
- Negative societal attitudes towards the importance of educating the girl child.

Therefore, in order to reduce the disparities the above challenges need to be addressed. The high drop-out rate by girls is highly manifested at the later stages of education at primary level and at secondary level. This can be attributed to the prevalence of the above factors at this stage of a girl’s life.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Public universities</td>
<td>62,753</td>
<td>37,896</td>
<td>49,615</td>
<td>52,945</td>
<td>53,839</td>
</tr>
<tr>
<td>Private universities</td>
<td>10,790</td>
<td>11,408</td>
<td>20,717</td>
<td>14,662</td>
<td>21,793</td>
</tr>
<tr>
<td>Total</td>
<td>73,543</td>
<td>49,304</td>
<td>70,332</td>
<td>67,607</td>
<td>70,632</td>
</tr>
<tr>
<td>Gender parity index</td>
<td>0.67</td>
<td>0.81</td>
<td>0.64</td>
<td>0.68</td>
<td>0.78</td>
</tr>
<tr>
<td>Grand Total</td>
<td>122,847</td>
<td>177,735</td>
<td>177,618</td>
<td>198,260</td>
<td>240,551</td>
</tr>
</tbody>
</table>

Table 9: Student enrolment in universities 2007/2008–2011/2012


82 Kenya National Bureau of Statistics (KNBS) and ICF Macro 2010 Kenya Demographic and Health Survey 2008-2009. Calverton, Maryland: KNBS and ICF Macro (AIDS) notes that “there is a culture of silence surrounding gender-based violence that makes collection of data on this sensitive topic particularly challenging. Even women who want to speak about their experiences of domestic violence may find doing so difficult because of feelings of shame or fear.” p. 245 and p. 250.

83 The Ministry of Gender report on the implementation of the 30 per cent employment and recruitment of women in the public service.


85 Ministry of Gender, Children and Social Development, Report 2009 on the implementation of the 30 per cent affirmative action.

86 Kenya National Bureau of Statistics (KNBS) and ICF Macro 2010 Kenya Demographic and Health Survey 2008-2009. Calverton, Maryland: KNBS and ICF Macro (AIDS) notes that “there is a culture of silence surrounding gender-based violence that makes collection of data on this sensitive topic particularly challenging. Even women who want to speak about their experiences of domestic violence may find doing so difficult because of feelings of shame or fear.” p. 245 and p. 250.
In State corporations overall numbers in the labour force show that women are 36.9 per cent compared to 63.1 per cent men.

Women in senior management positions comprise a mere 1.3 per cent of the workforce.

In Local Government women employees are 33.7 per cent of the workforce. However, women constitute only 10.2 per cent of top management including heads of departments.

The majority of women employees (97.7 per cent) in local authorities are low-level staff working as sweepers in offices, markets and revenue collectors in bus-parks and markets.65

Sex and gender disparities in wage employment are still evident and are reflective of women’s disadvantaged access to productive resources, labour markets and disempowerment at the household, community and national level. Distribution of wage employment by sex in 2007 revealed that women account for only 30 per cent of the total modern sector wage employment while men account for 70 per cent. The huge differentials between male and female wage employment limit women’s access to economic empowerment, therefore undermining equality of outcomes.66

The lower participation of women in waged employment activities in major sectors can be attributed to factors that curtail women’s mobility in the economic domain, namely: the demands placed on women with respect to domestic and reproductive responsibilities; the constraining nature of occupations where domestic and reproductive responsibilities cannot be easily combined with economic activity; and limited access to required skills, especially as provided to women in most education and training programmes. Misconceptions about women’s aptitudes, skills and dispositions, and reproductive responsibilities have also worked to hinder women’s participation in some production sectors.”67 The predominance of women in informal employment with poor working conditions, low salaries and no social protection leaves them open to exploitation and increases their vulnerability to poverty.68

Women and Public Life

Women often have limited participation at the decision-making table because they continuously face the challenge of allocating their time among domestic, reproductive, productive, and community work. Trends over time with respect to women’s political representation reveal great gender disparities despite an increasingly democratic environment. Statistics show that women in Parliament have not exceeded 10 per cent. For example, in the 2002 general elections, 64 (6.1 per cent) out of the 1,257 parliamentary candidates were women. Only 10 (4.8 per cent) were elected and 8 women were nominated by individual political parties in an attempt to increase women’s representation in Parliament. The 18 women represented only 8 per cent of the National Assembly Membership.

Kenya’s Constitution has laid a strong cornerstone for women’s empowerment by opening up more space and introducing a rule stating that no more than two-thirds of elected seats may be held by persons of either sex. This implies that neither women nor men could take more than two thirds of elected posts. The March 2013 elections have reinforced this and created a historical breakthrough in the numbers of women in the legislature elected or nominated. In fact 87 of the 416 seats in the newly-established National Assembly and Senate chamber are held by women compared to only 22 women out of 222 in the previous Parliament.

65 The biannual report on implementation of 30 per cent affirmative action on employment and recruitment of women in the public service is annexed to the Ministry of Gender report.

66 Formal equality is achieved when the law treats all persons, women and men equally. However, women and men are not the same or identical and have unequal access to resources and power which sustains disparity and inequality. Consequently, what is often required is the removal of the barriers that sustain inequalities. Substantive equality is the approach adopted to create equality of opportunity in order to attain real equality.


The trend of under-representation of women has also been manifested within the judiciary until new reforms under the Constitution. Prior to 2011, only two women were ever appointed to the Court of Appeal. Presently, about 20 per cent of High Court Judges are women while the highest representation of women (44 per cent) is among Resident Magistrates. In total, women represent 37 per cent of the judicial service establishments.69 With efforts to restructure and create gender balance within the new judiciary structure, the Constitution has incorporated a minimum threshold of at least one third representation of either gender.

Chapter III
Child Poverty and Deprivation

The high rate of poverty and the multiple deprivations affecting Kenyan children are undermining the realization of their rights.
KEY FINDINGS

Four out of every five Kenyan children are deprived in at least one of their rights. The largest single deprivation is in sanitation, where almost 16 million children lack access to improved sanitation. The poorest children are more likely to be deprived on all measures. Income inequality in Kenya has been increasing and children are more likely to live in households at the poorer end of the spectrum. They are more vulnerable to nutritional deprivation and their mothers are deprived of maternity health care. They also lack access to water and sanitation. Regional imbalances of child deprivation remain prevalent. Thus, the high rate of poverty and the multiple deprivations affecting Kenyan children are undermining the realization of their rights, Kenya’s progress on the MDGs and overall human development efforts.

Policies and Programmes to Reduce Child Poverty

The 2009 Kenya Census estimated there were nearly 20 million children under the age of 18 in the country. The proportion of poor children was estimated to be about 53.5 per cent which translates into about 10.3 million living in absolute poverty as of 2009.89

As was pointed out in the 2009 Situation Analysis, the impact and consequences of poverty are even worse for children. In response to a growing number of poor children, the Government adopted several policies and programmes that aim to protect the rights of children from extreme forms of poverty. These include Free Primary Education, Free Day Secondary Education, Constituency Development Fund (CDF), Cash Transfer for Orphans and Vulnerable Children (CT-OVC), Youth Funds, and Women Development Funds. Despite these efforts, poverty remains widespread across the country as was noted in the findings of the Kenya State Party report 2012 submitted to the Committee on the Rights of the Child, the international monitoring treaty body. The report stated that “despite these commendable efforts, poverty is still rampant among most of the population”.90 In recent years, however, there have been budget increases for social protection and particularly for orphans and vulnerable children.

In its Vision 2030 and respective social sector Medium Term Plans (MTPs), the Government acknowledges that macroeconomic growth and prosperity measured by increasing GDP are only meaningful if they propel positive social outcomes that lift the population from poverty. Moreover, tracking growth or aggregate income through growth in national GDP fails to capture poverty and inequality. A good example is the fall in income per capita during the period (2008-2011) when Kenya experienced the post-election crisis, food and fuel price rises, and drought emergency. In these circumstances social assistance programmes are necessary to bridge the gap and contribute to poverty alleviation.

Social protection is not to be limited to cash transfer programmes. The new National Social Protection Policy sets out clearly the role of contributory social insurance and health insurance mechanisms that provide income, employment and health protection for Kenyans working in the formal and informal wage sectors. Strategies for extension of these programmes will benefit many Kenyan children by protecting them and their families from economic hardship.

Child Poverty and Deprivation

Poverty as it affects children, young people, women and vulnerable populations is a human rights issue. Poverty affects children in physical, emotional and social ways and its multi-dimensional nature is not always captured by monetary measurement. No matter how poverty is defined and what the causes may be, childhood poverty has carry-over effects that are absorbed at different stages during the life cycle. Poverty has multiple effects on child growth and overall human and economic development. They range from effects on levels and standards of consumption that may be inadequate for nutritional and physical health,91 for safe and healthy living, for accumulation of knowledge and skills, for child care and protection, and as well as for advancement of the welfare of future generations. Poverty not only affects children at the time it is experienced, but may also have a serious long-term impact on the child’s development. Poverty also strikes children harder in times of emergencies, crisis, or when family livelihoods fail, by forcing them to drop out of school, take up early (paid or unpaid) or hazardous employment, and leading to neglect of health and nutrition, as well as overall development.

Kenya’s high poverty rate exerts its most extreme effects on the welfare of children, limiting their right to access clean water, healthy food, medical care, education, and child protection. The situation is exacerbated by Kenya’s high population growth rate, which strains the support capacity of state and non-governmental relief resources, particularly as the highest birth rates are recorded among the lowest income segments. Data from the 2008-2009 KDHS household wealth index confirms the strong relationship between wealth and child deprivation. It shows for example, that households with more children are more likely to fall in the poorest wealth quintiles. Results from the survey also show that while 35 per cent of households without children are classified as richest, only 7 per cent fall in the same category if they have three or more children. In general, children in the poorest households are more likely to be materially-deprived than those not at risk since having a relatively low income is an obvious source of deprivation.

Figure 4: Household distribution for children under five by household wealth index

Source: Computations from KDHS 2008-2009 data.

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Kenya has not undertaken a comprehensive national integrated household budget survey since 2006, when national poverty was estimated at 47 per cent. Recent estimates by the World Bank put poverty in Kenya at a rate between 34 and 42 per cent. 90

Current evidence shows provincial variations in poverty levels and the respective numbers of those affected by poverty. The true meaning and impact of poverty is reflected in the lack of access to services and in children’s rights that remain unfilled within the communities where they live.

The Bristol methodology was designed to measure child poverty.91 It is based on the understanding that measuring child poverty can no longer be carried out by poverty assessments that focus solely on income levels. It must take into consideration access to basic social services, especially nutrition, water, sanitation, shelter, education and information. According to an adaptation of the Bristol deprivation indicators for Kenya, child deprivation can be assessed using available data for seven indicators – shelter, sanitation, water, information, food, education, and health. The following Table identifies specific deprivation measures for Kenya and modified indicators to assess the severity of the deprivation.


### Table 10: Child deprivation indicators

<table>
<thead>
<tr>
<th>Age group</th>
<th>Deprivation</th>
<th>Children population</th>
<th>Indicator of deprivation</th>
<th>Indicator of severe deprivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-18 years</td>
<td>Water</td>
<td>20,035,430</td>
<td>Unprotected sources / wells / springs</td>
<td>Surface water</td>
</tr>
<tr>
<td></td>
<td>Sanitation</td>
<td>20,035,430</td>
<td>Unimproved or shared facility / open</td>
<td>No sanitation facility / open</td>
</tr>
<tr>
<td></td>
<td>Shelter</td>
<td>20,035,430</td>
<td>Dung floor</td>
<td>Earth / sand floor</td>
</tr>
<tr>
<td>3-17 years</td>
<td>Education</td>
<td>12,916,328</td>
<td>Enrolled but not currently attending</td>
<td>Never attended school</td>
</tr>
<tr>
<td></td>
<td>Information</td>
<td>16,512,627</td>
<td>No radio</td>
<td>No radio, TV or phone</td>
</tr>
<tr>
<td>0-4 years</td>
<td>Immunization</td>
<td>3,522,803</td>
<td>Received some but not all vaccines</td>
<td>Received no vaccination</td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>5,939,306</td>
<td>Stunted (between -2 and -3 SD)</td>
<td>Severely stunted (below -3 SD)</td>
</tr>
</tbody>
</table>

### Table 11: Percentage of children experiencing type of deprivation, by household headship, number of children, wealth index and mother’s level of education

<table>
<thead>
<tr>
<th>Variables</th>
<th>Housing floor is Earth/sand (%)</th>
<th>Have no toilet facility (%)</th>
<th>Source of drinking water=Surface water (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex of Household head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>38</td>
<td>18</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>45</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Number of children in house hold below 5yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td>39</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>3+</td>
<td>44</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>Wealth index based on 5 quintiles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorest</td>
<td>64</td>
<td>52</td>
<td>51</td>
</tr>
<tr>
<td>Richest</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Highest level of education for mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>70</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Primary</td>
<td>41</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td>Secondary</td>
<td>24</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Higher</td>
<td>8</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Calculations derived from 2008 KDHS.

These figures demonstrate that nearly 80 per cent or four out of five Kenyan children are likely to be deprived in one or more dimension, with the largest number deprived of access to improved sanitation.

In terms of absolute numbers, at the national level:

- 7.8 million children are deprived of access to safe drinking water;
- 15.8 million children are deprived of access to improved sanitation;
- 13.1 million children have inadequate shelter;
- 5.3 million children aged 6-17 years are deprived of adequate education;
- 1.1 million children under 3 have not received full immunization;
- 2.1 million children are stunted; and,
- 5.2 million children do not have access to information sources.

While further analysis of the causes and consequences of social deprivation experienced by children and youths is discussed in subsequent chapters of this report, millions of children suffer more than one deprivation.

Regional imbalances of poverty remain prevalent in Kenya, particularly those that are linked to access to shelter, sanitation and health. In terms of provincial disparities, the former North-eastern province was found to be by far the most affected in terms of deprivation, with every 6 out of 10 children reporting more than one deprivation, followed by the former Western region (5 in 10 children). Children living in female-headed households or households with more than three children, or poorest households based on 5-quintile wealth index, and those where the mother has no formal education are also more vulnerable to deprivation, as demonstrated by Table 11 below. Consequently, counties that largely fall in the former provinces with high levels of child deprivations and those that have been historically marginalized and hard-to-reach are known to have similar levels of deprivations. These include Mandera, Turkana, Wajir and West Pokot. Urban counties such as Nairobi have lower levels of overall deprivations, but there are areas of poverty and deprivation in urban informal settlements.

Findings also show that about 5 per cent of children were severely deprived of health services, which translates into 115,043 children. About 11 per cent of children were less severely deprived of health care services, which according to the 2009 Census figures accounted for 253,095 children. Health deprivation along the scale of severity was more prevalent in the regions that are predominantly arid and semi-arid lands.

Another way to analyze poverty is by using the qualitative approach based on various Participatory Poverty Assessments (PPAs) undertaken since 1994 that complement statistical studies of poverty. Thus it is clear that people define, view, perceive and experience poverty in different ways. In the third PPA of 2001, people mainly defined poverty as the inability to meet their basic needs. Poverty was associated with features such as lack of land, unemployment, inability to feed oneself and one’s family, lack of proper housing, poor health and inability to educate children and pay medical bills. Though different people and communities defined poverty differently, poverty was invariably associated with the inability to meet/afford certain basic needs. While many household surveys identify access to drinking water as a problem in some areas and less of a challenge in other areas, the PPAs have consistently documented that access to water is a major challenge facing the poor. In addition, the assessments show that in all districts except one, poor people reported access to safe water as a problem especially during the dry season when demand is high. Equally, the findings show that the poor are health-conscious and engage in a variety of health-maintaining strategies, and only visit Government health facilities when they are desperate and often as a last resort. Nevertheless, even with free health services offered for all, among the poorest, distances to health facilities and knowledge of lack of drugs at facilities prevents them from seeking care. Avenues such as Government-led social protection approaches can be important in bridging the gap in access to services between the wealthy and the poorest.

Poverty and Access to Information

Lack of access to information and services is one of the many challenges common to residents in Kenya, especially those who live in rural and resource-constrained locations. One way to reach out to isolated populations is by providing timely and locally-appropriate information about how to prevent disease, how to manage diseases at home, and how to access professional medical care when it is required, as well as raise awareness of educational Government programmes and social welfare programmes.

Access to information is essential for providing an opportunity to be informed, empowered and educated on issues ranging from health, nutrition, and other services that could help to overcome ignorance, poverty and disease. Today, many campaigns in hard-to-reach areas rely on radios, television or print media to transmit messages and to promote vaccination days and other programmes. Possession of a radio does not vary much according to the number of children in a household. However, real differences emerge in those who have electricity and a television set, and households with children are much less likely to access information through television. Increasingly mobile phones are emerging as a viable platform for sharing vital information on development to people including poorer households with children.
Since 2009, Kenya has piloted and implemented a wide range of social protection initiatives, many of which have benefited children. Examples include:

- Orphans and Vulnerable Children’s Cash Transfer
- Elderly Persons Cash Transfer
- Cash Transfer for Persons with Severe Disability
- Urban Food Subsidy
- Hunger Safety Net Programme
- General Food Distribution
- Blanket Supplementary Feeding
- Scholarships and Bursaries (Northern Kenya Education Trust (NoKet), Constituency Bursary Scheme)
- Output-Based Approach (OBA) / Maternity Vouchers
- National Health Insurance Fund (NHIF)
- School Feeding and Home-Grown School Feeding.

A review of social protection conducted in 2012 by the Ministry of Planning, National Development and Vision 2030 found that total spending on social protection had reached Ksh 50 billion by 2010, or 2.3 per cent of GDP. Social assistance (transfers in cash or in kind) had risen substantially from around Ksh 11.9 billion (bn) in 2005 to Ksh 20.5 bn in 2010. The largest element of social assistance was General Food Distribution (Ksh 10bn), followed by social cash transfers (Ksh 4.5bn), and education assistance (Ksh 3bn). The contribution of the Government to social cash transfers has risen from Ksh 48 million in 2005 to Ksh 2.43 bn in 2010, or 47 per cent of all transfers.97

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**Cash Transfer for Orphans and Vulnerable Children Programme**

This is an innovative programme in response to the growing levels of vulnerability and poverty associated with increasing numbers of orphans and other vulnerable children. From the beginning as a pilot in 2004, the Government led CT-OVC programme has expanded to 47 counties, 146,474 households98 (2013) and around 509,505 children (2012). The objective of the programme is to provide regular cash transfers to families taking care of OVC, to encourage fostering and retention of children and to promote their development. UNICEF and other development partners provided financial resources and technical assistance for the design, setting up of systems, implementation and scale-up process of a nationwide programme. The Government of Kenya is progressively implementing and sustaining the CT-OVC programme both technically and financially, and now provides 40 per cent of the total programme budget.

Emerging evidence confirms that the CT-OVC is having a significant impact on children as measured by improved school attendance, health visitations and household nutrition. There has been a significant reduction of on-farm child labour as a result of the cash transfer99. The programme has also shown that it has an effect on adolescent social behaviours. Young people who received cash benefits during adolescence were 7 per cent less likely to have had sex (indicating a postponement of sexual debut), as well as significantly less likely to have unprotected sex.100 Although the programme has had an important impact on OVC living standards, coverage remains low compared to the number of most deprived OVC in the country. It has a potential target group of over 500,000 poor households caring for OVCs, but is currently reaching around 28 per cent in 2013.

CT-OVC has become one of the flagship programmes in Vision 2030, and has also inspired the Government to start cash transfer interventions for other vulnerable groups (elderly, those with disabilities, etc.). Social Protection and cash transfer programmes are now part of the core strategies for poverty and vulnerability reduction in Kenya.

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Findings from the 2009 Census show that more than one million households in Kenya are caring for an orphan. Coverage rates vary around the country, from above 50 per cent in sparsely populated counties such as Isiolo and Tana River, to below 10 per cent in more densely populated areas including Kenya’s urban counties of Nairobi and Mombasa, and other more urbanized counties such as Nakuru and Uasin Gishu.

While orphans are one group of vulnerable children, they represent merely a fraction of the children in Kenya who are deprived of their rights. Current social protection programmes may also be systematically excluding other groups of vulnerable children. For example, children aged 0-4 tend to be excluded. Similarly, in order to qualify for the programme for those with disabilities it requires children to have severe disabilities; despite the fact that some children may have a disability that could be overcome with assistance, which would enable them to participate and develop their abilities.

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98 Ministry of Gender, Children and Social Development.
100 Handa, S., et al, 2012. Impact of the Kenya OVC-CT on the Transition to Adulthood, University of North Carolina, USA.
**Figure 6: Coverage rates of CT-OVC around the country**

**RECOMMENDATIONS**

- Monitor poverty routinely, and develop specific ways for measuring and monitoring child poverty and deprivation, to facilitate the development of practical programmes and policies based on the best available evidence.
- Continue supporting and strengthening targeted social protection programmes, and incrementally scale-up the services in line with available budgetary provisions to achieve initial results in combating poverty.
- Consider further the definitions of vulnerable children so that groups currently not covered may be addressed, within the context of the National Social Protection policy and the expansion of social assistance.
- Review other social protection programmes and consider how they can benefit children in order to develop a child-sensitive national social protection system (e.g. National Health Insurance Fund; NSSF; fee exemptions and others).
- Initiate and support programmes that reach out to isolated populations through innovative communications methods including use of mobile phones in order to provide timely and locally-appropriate information about how to prevent disease, how to manage diseases at home, and how to access professional medical care when it is required.

Source: UNICEF calculations based on KSHBS 2005-2006, Census 2009, and OVC Secretariat MIS.
Chapter IV

The Right to Survival and Development

Realizing children’s rights to survival, growth and development will also require more attention to extending access of the poorest children to low-cost community-based interventions.
The right to survival, growth and development encompasses several rights recognized in the CRC beginning with Article 6, which states that every child has the inherent right to life and obligates the State to ensure to the maximum extent possible the survival and development of the child. The right to health is one of these fundamental rights recognized in numerous international instruments including the CRC and CEDAW and is understood as the “right to the highest attainable standard of health.” This particular right is closely related to and dependent upon the realization of other human rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, privacy, access to information, and the freedoms of association, assembly and movement. “The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.”

Legal and Policy Frameworks

The period 2010-2012 saw several significant policy developments in the area of health that were guided by the Constitution. Major new policies include a Health Policy Framework, a Kenya Health Sector Strategic Plan III and a Health Law were also drafted. Significant policy developments in relation to children’s rights to health include:

- **An Essential Package for Health** has been defined for each level of care that recognizes the community level as the foundation for the service delivery system.
- **Kenya Health Sector Strategic Plan KSSP III 2013-2017** which clearly includes the 11 High-Impact Nutrition Interventions (HiNI) adopted by the nutrition sector in 2010 to address the problem of both acute and chronic malnutrition. The NHSSP III also re-defines most-deprived populations as those living in eight counties in Northern Kenya: Garissa, Isiolo, Mandera, Marsabit, Samburu, Turkana, Wajir and West Pokot as well as those in urban and informal settlements.
- **Kenya National Pharmaceutical Policy (KNPP)** replaced the Kenya National Drug Policy 2004 Artemisinin-based Combination Therapy (ACT) for managing uncomplicated malaria without prescription. Community-based treatment of diarrhoea with ORS and zinc has been approved and endorsed by the Ministry of Health and is promoted in the Community Health Policy. Community diagnosis and treatment for malaria using ACT is promoted in the malaria policy.
- **Haemophilus influenzae Type B and pneumococcal vaccines** were introduced to protect against childhood pneumonia and meningitis. In 2013, second dose measures and a demonstration project for HPV vaccine in Kitui County to protect against cervical cancer were introduced. A Rotavirus vaccine will be introduced in 2014.
- **The Food and Nutrition Security Policy** was adopted by Parliament in October 2012, and takes into account the rights enshrined in the Constitution. The policy and subsequent funding allocation for its implementation needs to be prioritized. The policy and draft strategy documents have rightly identified food and nutrition security as a basic human right; that the right to food includes not only sufficient numbers of calories but the right to nutritious foods that guarantee health, growth and development throughout a person’s lifecycle. The policy also focuses on the right of every woman and child to share equally or have greater shares of the available food because of the required needs for growth and development. The Government and partners will need to address past policy implementation bottlenecks, in particular inadequate budgetary allocations, sector and inter-ministerial coordination mechanisms.
- **The Breast Milk Substitutes Regulations and Control Act**, was passed into law in October 2012, after over a decade of efforts by the Ministry of Health and its partners, particularly International Baby Food Network (IBFAN), ILO, UNICEF, and WHO. A national assessment of CODE violations is being undertaken to establish a baseline for its implementation and monitoring.
- **The National Infant and Young Child Nutrition (IYCN) Strategy** has been reviewed to cover maternal, infant and young child nutrition with a focus on maternal nutrition in the prenatal period, maternal protection and workplace support for the period 2012-2017.
- **A National Nutrition Action Plan for Kenya** was launched in November 2012 during the Nutrition Symposium where the Government made the commitment to join the Global Scaling-Up Nutrition (SUN) Movement. This Plan serves as the strategic framework to operationalize the nutrition programme for the SUN movement, as well as for the National Food and Nutrition Security Policy.
- **Mandatory fortification of wheat flour, maize flour and oil with vitamins** was approved officially in 2012. The fortification mandate was introduced to protect against childhood pneumonia and meningitis. In 2013, second dose measures and a demonstration project for HPV vaccine in Kitui County to protect against cervical cancer were introduced. A Rotavirus vaccine will be introduced in 2014.
- **The National Water Policy 2012** has been developed in line with the Constitution with regard to (i) consideration of water as public land, and (ii) the right to water by all, and informs the new draft Water Act (2012).
The Water Bill 2013 is currently before Parliament. It obliges the Government to fulfill the right to water which embodies availability, accessibility, quality, and use. The Bill also provides guidelines for development and implementation of the national water services strategy, investment and financing plans for the progressive realization of the right to water for all in Kenya. The water sub-sector developed a Pro-Poor Implementation Plan, and ensures socially-responsible commercialization of water services, which are affordable even for the poor.

The Water Sector Strategic Plan was launched by the Ministry of Water. The plan rallies all sector stakeholders behind a common agenda, and by which intra and-inter-ministerial collaboration will be strengthened. In addition, the sector carries on strengthening its monitoring and evaluation through the establishment of various monitoring and evaluation information systems.

The Government adopted the Community-Led Total Sanitation (CLTS) approach in 2010 and the ODF Kenya 2013 was officially launched in 2011. It developed an ODF Rural Kenya 2013 roadmap to guide the process and there are plans to mainstream this approach in a revised national environmental sanitation and hygiene policy. To fast-track progress on sanitation provision, the Ministry of Water and Irrigation established a unit to influence, promote, and monitor policies on sanitation, as well as enhance cooperation with other sectors such as the Ministry of Health and institutions like the WSBs.

Both the Medium Term Plan I and the NHSSP II emphasized a strong community health system. Kenya’s Community Health Strategy (2006) now recognizes the community level as the lowest rank of the health system. This strategy aims to reverse the declining trends in key health sector indicators by: 1) empowering Kenyan individuals, households and communities to take charge of their health; and, 2) building the capacity of households to not only demand services from all providers, but to know and progressively realize their right to equitable, quality health care. While the Community Health Strategy is recognized as a major pillar in the child survival sector, its implementation has been slow and poorly supported. By 2010, 998 Community units had been established in the country and this rose to 2,512 in 2012, representing coverage of 29.6 per cent of planned (8,500) Community Health Units.

Maternal and Newborn Health

Maternal health and maternal mortality

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. The survival of mothers and newborns is often used as a barometer of success for communities and nations. Maternal mortality is said to represent the biggest disparity in health status between rich and poor countries (or rich and poor communities within the same country). Moreover, maternal and newborn mortality not only affect women and babies, poor health and health disparities contribute to preventing a nation from achieving human development and economic progress.101

Regarding the progress achieved in reducing maternal mortality over the past decade, the data available differs. According to the Kenya National Bureau of Statistics (KNBS) and ICF Macro, (2010), and the Kenya Demographic and Health Survey (KDHS) 2008-2009, the maternal mortality rate was estimated at 488 deaths per 100,000 live births. Projections based on these figures indicate that the maternal mortality rate has actually decreased to 360 deaths per 100,000 live births. The disparities in the country are of major concern with the maternal mortality rate in Northern Kenya estimated to be above 1,000 per 100,000 live births (administrative data).

Maternal mortality is generally acknowledged to be a failure of the overall health system. In Kenya, as in most other developing countries, the vast majority of maternal deaths take place during child birth and the immediate 24 hours following delivery.102 Most deaths are attributable to just a few direct causes: haemorrhage, hypertension, sepsis and unsafe abortion.103, 104 Virtually all of these conditions can be prevented or managed by basic healthcare services, including quality antenatal care, safe and clean delivery practices, and access to emergency referral facilities when needed. Similarly, neonatal mortality is closely related to the skills of health professionals to provide good care during and after delivery: a clean environment, effective resuscitation if required, keeping the baby warm, and taking proper care of the umbilical cord.

Infant mortality, antenatal and newborn care

Neonatal mortality stands at 28 per 1,000 live births and has not changed substantially in the last decade but regional disparities in newborn survival have intensified.105, 106 According to the 2010 Child Health Epidemiology Reference Group (CHERG) estimates, the most common causes of newborn mortality are pre-term delivery and low birth-weight (34 per cent of newborn deaths — equivalent to 12 per cent of all deaths in children under-five in Kenya), plus asphyxia and sepsis. One third of all deaths in children under-five occur in the first month of life and most of these deaths are in the first hours and days after delivery. Although frequently separated in studies and health programmes, it has been pointed out that “the health of mothers, newborns and children are so inter-connected as to make separate calculations of their needs misleading”.107

A major underlying cause of the infant mortality rate is the low percentage of birth deliveries by skilled attendants. During the period 2003-2008, deliveries by skilled attendants increased only slightly from 40 per cent to 42 per cent and institutional deliveries increased a little from 40 per cent to 43 per cent.

105 70 per cent of deaths take place during delivery.
Coverage was estimated to be closer to 60 per cent in 2012, according to administrative data, but this source is not always reliable. More importantly are the disparities in the coverage of skilled delivery; in the latest KDHS it is over 80 per cent in the highest wealth quintile and just 18 per cent in the lowest. In Turkana County, coverage of skilled delivery is estimated to be a mere 5 per cent. The met need for cesarean sections ranges from 20-100 per cent between the lowest and highest wealth quintiles. Underlying causes related to geographic and financial access to services that prevent birth deliveries by a skilled attendant constitute the most critical bottlenecks. The 2010 Kenya Service Provision Assessment Survey report indicates that out of 690 health facilities surveyed, 30 per cent offer normal delivery services, with a very wide range of 13-51 per cent depending on the province. Many of these facilities suffer from lack of resources such as staff shortages and insufficient materials, which further constrain service delivery.110

According to the same survey, normal delivery services are only available in three out of ten facilities, including 95 per cent of hospitals. Cesarean sections are available almost exclusively in hospitals. Half of the facilities have transportation support for maternity emergencies and private facilities are less likely to have transportation support than those managed by other authorities. All basic equipment and supplies for conducting normal deliveries (scissors or blade, cord clamps or ties, a suction apparatus, antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineum) are available in the delivery area in six of every ten facilities offering delivery services.

Although Kenya’s health facilities show good basic newborn care practices, in practice they are not consistent. Nevertheless, it was found: 95 per cent support early initiation of breastfeeding, 92 per cent support rooming-in, 91 per cent examine the newborn from head to toe before discharge, and only 7 per cent give pre-lacteal feeds and full-immersion baths. Only 46 per cent of babies observed for the Service Provision Assessment received all three essential newborn care interventions: dried and wrapped, placed skin-to-skin with their mothers, and encouraged to breastfeed within one hour of delivery.

Maintaining a continuum of care regime for maternal and newborn health is critical to pulling all the available interventions together and this requires effective community health services. A bottleneck analysis undertaken with counties demonstrated the gap between access (e.g. first antenatal visit over 90 per cent) and effective coverage (e.g. four antenatal care visits, or supervised delivery or fully immunized child). These bottlenecks have much to do with lack of effective communication with mothers and between them and health workers. Only 40 per cent of pregnant women make the recommended four antenatal visits. Consequently, Kenya is way off target to achieve the MDG 5 target of 147/100,000 by 2015 aimed at improving maternal health.

Young mothers living in low-income informal settlements are identified as particularly vulnerable due to a lack of basic health services and inability to pay related obstetric costs.111 Survey findings (2005) identify substantial limitations in access to antenatal care in urban slums as compared to the overall population in urban areas (see Figure 7 below).111 Although the trend in access to antenatal care worsened between 2003 and 2008-2009 for both urban and rural Kenya, being poor in an urban setting has evident disparities in access to essential health services that impact birth outcomes. With neonatal mortality upwards of 70 per cent higher in urban informal settlements as compared to other urban areas, ensuring access to maternal and newborn health services is essential.111 Reasons for the gaps in access to health care include poor living environment, poor quality health care, limited access to health services due to lack of income, transport and insecurity and variation in quality of unregulated health services.

110 Ministry of Medical Services & Ministry of Public Health and Sanitation, Kenya Service Provision Assessment Survey, May 2011
The leading causes of child deaths are pneumonia, malaria, and diarrhoea. However, according to WHO/CHERG 2010 estimates shown in Figure 8 below, neonatal causes and pneumonia contribute to an increasing percentage of under-five deaths, particularly in non-malaria endemic areas.116 These two conditions now account for about 35 per cent and 15 per cent of under-five mortality, respectively, or half of all under-five deaths. Diarrhoea and malaria contribute an additional 9 per cent and 3 per cent of under-five mortality, respectively. According to Kenya’s administrative data, the proportion of diarrhoea to under-five mortality is much higher than the CHERG estimates, and it is likely to be the leading cause of post-neonatal mortality. Malnutrition contributes to at least 35 per cent of these under-five deaths and HIV contributes to 7 per cent.117 Staya County has the highest under-five mortality rate with an estimated 167 per 1,000 live births for the ten year period preceding the survey. Counties that have a high HIV prevalence contribute to the high child mortality rate.

Figure 8: Causes of under-five and maternal mortality in Kenya

- HIV/AIDS 2%
- Meningitis 7%
- Neonatal 24%
- Other 24%
- Pneumonia 15%
- Injuries 5%
- Diarrhoea 9%
- Malaria 3%
- Measles 0%
- Other 24%

Globally more than one third of all child deaths are attributed to under-nutrition

Pneumonia is the main cause of death for about 21,000 Kenyan children under the age of five each year and it is the leading cause of childhood morbidity in areas with low prevalence of malaria.118 Less than one in two children with symptoms of Acute Respiratory Infections (ARI)/pneumonia receive antibiotics.119 A large proportion of the carers of these children only initiate treatment when their illness has become severe. Community-based treatment of pneumonia with antibiotics is under review but not yet permitted in Kenya.

Appropriate and timely treatment of children with suspected malaria remains a particular challenge in Kenya. Fewer than one in six children with suspected malaria, including those in endemic regions, access treatment with the recommended Artemisinine Lumefantrin Combination Therapy (ACT) on the same day or the following day of falling ill.120 This represents a slight improvement from 2008, when an estimated one in ten children had access to treatment within 24 hours.121 Fertility rates caused by malaria currently range from 3.5 to 8.5 per cent.122 As mentioned, one major milestone in the fight against childhood deaths caused by malaria has been the increased ownership and use of insecticide-treated nets (LLITNs). LLITN ownership in Nyanza province’s lake endemic region increased from 60 per cent in 2010 to 80 per cent, following the distribution of two LLITNs per household in 2011, in order to achieve universal coverage. Despite these substantial increases in LLITN availability, only one in three children in these regions living in households with at least one LLITN sleep under it regularly.

Diarrhoea is the third leading cause of under-five mortality in Kenya. Only one in three children with diarrhoea are provided with life-saving oral rehydration solution (ORS). This figure is virtually unchanged from 2003 estimates.123,124 The situation is of greatest concern in the ASAL counties, where only one in ten children with diarrhoea received oral rehydration therapy (ORT) and increased fluids. There is some evidence that presently health workers are less likely to promote ORS/ORT than they were a decade ago, even when a child shows clear signs of dehydration. Thus, this is an issue that merits further research and attention.125 Zinc is not commonly used for diarrhoea treatment at the moment, but coverage is expected to improve rapidly now that the national drug policy allows zinc to be provided without a prescription and the Ministry of Health has endorsed community-based treatment of diarrhoea with ORS and zinc.

Diarrhoea is one of the leading causes of morbidity in children under five and is up to three times higher in urban informal settlements compared to the general population. Furthermore, the proportion of children who had diarrhoea within the last two weeks is higher in urban as compared to rural areas across wealth quintiles. The exception is in the poorest126 informal settlements with the highest morbidity among children whose mothers were pregnant at the time of migration.

Immunization Coverage

Kenya has recorded an increase of almost 20 per cent in immunization coverage over the past four years. According to administrative data provided by the Ministry of Health, 84 per cent of children less than one year of age have received all the scheduled routine vaccines. This shows improvement from 65 per cent reported in the 2008-2009 KDHS survey. The number of districts reporting less than 80 per cent was also reduced to 27 per cent (49 out of 153 districts) from 41 per cent (61 out of 149 districts) between 2010 and 2011. Although the number of unimmunized children has declined over the years, an estimated 176,000 children did not receive any routine vaccines in 2011. The majority of the unvaccinated children live in the remote districts of Northern Kenya and other pastoral and mobile communities. The former Rift Valley and Nyanza provinces accounted for half of the children not vaccinated in 2011.

116 WHO/CHERG 2012.
118 WHO/CHERG 2010 estimates.
Measles outbreaks remain a major challenge in Kenya. In 2012, measles caused 67 child deaths. The accumulation of unimmunized children over the years led to a measles outbreak affecting children up to 15 years of age and an outbreak of polio in 2011 in western Kenya (Rongo District) and amongst the refugee population in Dadaab Camp in 2012. A successful measles vaccination campaign undertaken in November 2012 reached an estimated 97 per cent of children and is expected to boost population immunity significantly. Moreover, with the successful introduction of a pneumococcal vaccine in 2011, to protect against childhood pneumonia and meningitis and the planned introduction of Rotavirus vaccine in 2014, efforts will be strengthened towards significantly reducing child morbidity and mortality against measles, pneumonia and diarrhoea.

Neonatal tetanus is estimated to cause approximately 2 per cent of neonatal deaths with only 74 per cent of children protected at birth. Kenya is yet to achieve elimination status for maternal and neonatal tetanus.

**Equity in Health**

- **“Universal”** strategies including immunization and distribution of insecticide-treated nets have contributed to equitable improvements in child survival.
- Significant disparities remain, in particular with high neonatal mortality in urban areas, and high rates of child and overall mortality in the former Nyanza and Western provinces. This is exacerbated by the high HIV prevalence in the former Nyanza province. Reducing neonatal deaths is critical to improving progress towards national targets.
- Access to health services remains highly uneven with high disparities between regions (in infrastructure and human resources), and between urban and rural areas, despite several equity-focused government policies in health. Although more resources are being dedicated to preventive and outreach services, for example through the Community Strategy, current resource allocations do not appear to be addressing geographical imbalances in access to services.
- Some of the inequity in access to health services is related to demand-side barriers and behaviours.

**Child and Maternal Nutrition**

In terms of stunting, Kenya is amongst the 12 high-burden countries in the Eastern and Southern Africa region. Malnutrition, including micronutrient deficiencies remains a significant public health problem in Kenya. The high burden of malnutrition in Kenya is not only a threat to achieving the Millennium Development Goals (MDGs) but also a clear indication of unfulfilled human rights. Regional disparities in nutrition indicators are significant with the chronically food-insecure arid and semi-arid areas showing consistently higher levels of acute malnutrition. Persistent poor nutrition is undermining Kenya’s progress in reducing neonatal, infant, child and maternal mortality. With persistently high levels of under-nutrition in Kenya, vital opportunities to save millions of lives are being lost, and many more children are not growing and thriving to their full potential. Children born today could miss opportunities because of nutritional problems resulting from feeding practices for young children, growth faltering and iodine, iron and vitamin A deficiencies.

Kenya has made insufficient progress toward achieving the MDG1 (halving 1990 underweight rates to reach 11 per cent by 2015). National prevalence of underweight is at 16.1 per cent with an average annual reduction of 1.4 per cent only (below the >2.5 per cent target to be on track). This is attributed to extreme poverty that has not been reduced sufficiently and insufficient access to health services.\(^{132}\) The former Coast, Eastern and North Eastern provinces remain the areas with the highest underweight rate with a prevalence ranging from 20 to 25 per cent.\(^ {133}\) The prevalence of low birth weight babies (less than 2,500 grams) is estimated to be at 6 per cent.\(^ {134}\) These babies have low immune competence and are likely to suffer from non-communicable diseases such as being overweight.\(^ {135}\) Low birth weight is also a risk factor of infant mortality.

Wasting (low weight for height) among children under-five remains also a public health problem in Kenya with a national prevalence of 6.7 per cent,\(^ {136}\) the third highest rate in the ESA region. Acute malnutrition poses a direct threat to the reduction of under-five mortality in Kenya by increasing the risk, between four to nine times, of an acutely-malnourished child dying compared to a well-nourished child. Annually, between 300,000 to 400,000 Kenyan children suffer from this life-threatening condition. There are wide ranges of disparities in the prevalence of child wasting depending on the geographical area and wealth quintiles as shown in the graph below. The former North Eastern Province has an acute malnutrition rate of 19.5 per cent, which is about three times the national average. There is also important seasonal variability linked with the food security situation and other co-morbidity factors such as a diarrhea outbreak. Examining the impact of acute malnutrition through periods of drought has revealed that a child born during an episode of drought in the arid and semi-arid areas is 50 per cent more likely to be acutely malnourished than a child born before a drought.

Recurrent food and nutrition crises in ASAL districts coupled with multiple and interlinked vulnerabilities such as poor access to functional social services, poverty and insecurity, have a significant impact on the nutritional status of children under five years and their capacity to withstand crisis. For instance, while most affected areas recovered from the 2011 severe drought in terms of food insecurity, UNICEF noted that in many of the same areas like Wajir and parts of Mandera Counties, acute malnutrition rates failed to decrease significantly due to rooted and largely unaddressed multiple deprivations.

**Figure 9: Prevalence of Wasting among under-five children by region (2003-2008)**
During the decade 1998-2008, Kenya recorded no significant change in the stunting prevalence of children less than five years with the stunting stagnating between 33 and 35 per cent according to the KDHS in 1998, 2003 and 2008. This has resulted in a serious national development concern – in Kenya, 2.4 million children are stunted. There are wide disparities in child stunting throughout Kenya depending on wealth quintiles, gender and geographical characteristic. There is increasing awareness in Kenya and globally that stunting is one of the major public health problems affecting population development. There is growing evidence (WHO 2012) around the cyclical effects of poor nutrition on social capital – “poor linear growth or stunting in young children is associated with adverse functional outcomes, including short adult stature, reduced lean body mass, poor cognition and education performance, lower productivity and lower adult wage. Moreover, the women who were stunted as children are more likely to deliver lower birth weight infants, thus contributing to the intergenerational cycle of malnutrition”.

Figure 10: Prevalence of stunting in children under-five by province, 2003-2008

![Graph showing prevalence of stunting in children under-five by province, 2003-2008.](image)

Iron, vitamin A, iodine and zinc are the main four micronutrients of public health importance in Kenya. Vitamin A deficiency (VAD) is a severe public health problem in Kenya with a prevalence rate of 84 per cent.137 Vitamin A deficiency is a significant determinant of child mortality as 40 per cent of measles and 23 per cent of overall deaths can be reduced by vitamin A supplements alone.137

In Kenya the incidence of anaemia stands at 76 per cent among children less than 30 months. Iron deficiency anaemia is responsible for the increased burden of morbidity and mortality in children suffering from malaria, diarrhoeal disease, acute respiratory disease, HIV/AIDS, TB and hepatitis B and C, and parasitic diseases. Zinc deficiency and iodine deficiency and disorders (IDD) stand at 50 per cent and 6 per cent respectively, exacting a terrible toll on children’s intellect, development, growth and overall quality of life.118

Maternal nutrition

There is strong evidence that maternal nutrition significantly contributes to maternal and perinatal mortality, poor birth outcomes, obstetric complications and stunting. As mentioned earlier in the report, maternal deaths in Kenya remain high as well as neonatal deaths, accounting for approximately 60 per cent of under-five mortality. Kenya ranks fourth among the ESAR countries with the highest maternal underweight prevalence at 12.3 per cent.140 The prevalence of anaemia among pregnant and lactating women in Kenya is also worrying. The Kenya Micronutrient Survey, 1999 indicated the prevalence of anaemia among pregnant women to be high at 55.1 per cent and 46.4 per cent among non-pregnant women. On a positive note, the National Iodine Deficiency Survey (2006) reported a reduction in iodine deficiency from 16 per cent in 1994 to 6 per cent. An estimated 98 per cent of Kenyan households have access to adequately iodized salt (≥15 ppm). Iodine deficiency consequences include impaired fetal development, goitre and brain defects.

The Impact of Malnutrition in Kenya (Nutrition profile 2010)

- 19,000 children’s lives will be lost every year because of being underweight.
- 10,000 children’s lives will be lost every year because of vitamin A deficiency.
- 11,000 children’s lives will be lost every year because of inadequate child-feeding practices.
- 400,000 children suffer from mental retardation every year because of iodine deficiency.

Status of the priority nutrition actions

Kenya aims to create a globally-competitive and adaptive human resource base to meet the requirements of a rapidly industrializing economy.141 Achievement of these goals requires a healthy and productive labour force, which in turn, calls for the children who are born today to be well-nourished and well-cared for. It is recognized that the cost of not addressing child and maternal nutrition far outweighs the cost of the intervention required. There are nutrition interventions that have been demonstrated to be amongst the most cost-effective actions to address global problems such as child mortality, improving nutrition outcomes, and protecting human capital.142 However, without a deliberate and concerted effort, the cost of malnutrition in Kenya is estimated to reach Ksh 3.2 trillion and 527,000 lives will be lost in the next 20 years.143 The period 2009-2012 saw the development of a more enabling environment for improving maternal and child nutrition in Kenya. Key developments include the adoption of key policies, strategies and guidelines over the past four years.

Increased political commitment to adopt key nutrition-sensitive policies and strategies has been acknowledged. The total cost of the National Nutrition Action Plan over five years is approximately $824 million for which 88 per cent of the cost will cover nutrition-specific interventions. The nutrition budget is now aligned to the Government’s Medium Term Development Plan. The Government is committed to spending $70 million over the next five years to scale up nutrition.144 Currently, budgetary allocation to nutrition-specific interventions represents only 0.5 per cent of the annual health sector budget. The 2012

137 Kenya Micronutrient Survey Report 1999
155

141 Vision 2030 Declaration.
142 Hermes L et al UNICEF. Copenhagen Consensus, hunger and malnutrition. Copenhagen: Copenhagen Consensus Center.
144 Gutu, ADEMA Call for Commitment.
annual operating budget for the Department of Nutrition was around $10 million.\textsuperscript{145} Despite the funding being insufficient, the Government has progressively increased its contribution to the nutrition sector.

In 2013, the Government will procure 50 per cent of iron folate supplements and 7 per cent of micronutrient powders for national needs. More notably, the Government will procure over 90 per cent of the annual need of Ready to Use Supplementary and Therapeutic food through a $12.8 million credit from the World Bank. Humanitarian funds remain the principal source of funding for the nutrition sector predominantly targeting the arid and semi-arid lands (ASALs). In 2012, $17,269,671 million were received from donors under the Emergency Humanitarian Response Plan.

Despite continuous improvements in the coverage of high-impact nutrition interventions (HiNI), access to these essential nutrition services remains uneven across the country. In the ASALs essential preventive nutrition services (vitamin A) reached approximately 32 per cent (331,000) under-five children against a target of 1.1 million in 2012,\textsuperscript{146} while curative nutrition interventions reached an estimated 90 per cent (39,586) severely-malnourished under-five children against a target of 43,800. In addition, 60 per cent (88,175) of moderately malnourished were reached with curative services.\textsuperscript{147}

Out of the 11 HiNI, five are exclusively delivered through the health system for which coverage is constrained due to the weak health system. Exclusive breastfeeding, one of the most cost-effective preventive health practices, is practiced by only 32 per cent of mothers.\textsuperscript{148} The promotion of exclusive breastfeeding benefited from the scaling-up of peer support groups in parts of the country, however the recommended early initiation of breastfeeding continues to vary greatly between counties (45-89 per cent) compared to the national average of 58 per cent.\textsuperscript{149}

The Table below shows the expected impact if the 11 HiNI interventions were implemented at scale and the current HiNI coverage.\textsuperscript{150}

<table>
<thead>
<tr>
<th>HiNI intervention adopted in Kenya</th>
<th>Impact expected if delivered at scale</th>
<th>Current coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion of Exclusive Breast feeding for the first six months of life</td>
<td>13 per cent deaths prevented</td>
<td>31.9 per cent</td>
</tr>
<tr>
<td>Promotion of optimal complementary feeding for infants after the age of six months</td>
<td>6 per cent deaths prevented</td>
<td>53.3 per cent</td>
</tr>
<tr>
<td>Vitamin A Supplementation (2 doses per year for children 6-59 months)</td>
<td>2 per cent deaths prevented</td>
<td>30.3 per cent</td>
</tr>
<tr>
<td>Zinc supplementation for diarrhoea management</td>
<td>5 per cent deaths prevented</td>
<td>0.2 per cent</td>
</tr>
<tr>
<td>Multiple-micronutrients for children under five years</td>
<td>Prevents micronutrient deficiencies for populations not accessing micronutrient-rich foods</td>
<td>Not available</td>
</tr>
<tr>
<td>De-worming of children (2 doses per year for children 2-5 years)</td>
<td>Promotes physical growth and cognitive development while preventing anaemia</td>
<td>37.5 per cent</td>
</tr>
<tr>
<td>Iron-folic acid supplementation for pregnant mothers</td>
<td>20 per cent reduction in maternal mortality</td>
<td>47.1 per cent (proxy attending &gt;4 ANC visits)</td>
</tr>
<tr>
<td>Prevention and treatment of severe and moderate acute malnutrition</td>
<td>Life-saving intervention. Prevention of deterioration from moderate to severe stage</td>
<td>Not available</td>
</tr>
<tr>
<td>Promotion of improved hygiene practices including hand washing</td>
<td>The single most cost-effective intervention in preventing diarrhoeal diseases</td>
<td></td>
</tr>
<tr>
<td>Salt iodization</td>
<td>13 point increase in Intelligence Quotient (IQ)</td>
<td>97.6 per cent</td>
</tr>
<tr>
<td>Iron fortification of staple foods</td>
<td>5 to 17 per cent increase in adult productivity</td>
<td>Not available</td>
</tr>
</tbody>
</table>

\textsuperscript{145} Division of Nutrition-GoK.
\textsuperscript{146} Kenya Health Information System, 2012.
Elimination of Mother-to-Child Transmission of HIV and Paediatric HIV

Although huge strides have been made in Kenya’s policy framework and strategies to prevent new HIV infections among children, adolescents and women, national HIV prevalence was 5.6 per cent in 2012 (Kenya AIDS Indicator Survey, 2012), with some counties having infection rates of up to 22 per cent. As of December 2011, 1.6 million people (58 per cent female) in Kenya were living with HIV, placing continued demands on health and social services. The large number of sexually-acquired transmission among women continues to be a risk for infections among newborns. In 2012, an estimated 10,300 babies were tested HIV positive.

Recent programme reviews showed persistent supply and demand challenges in the prevention of mother-to-child transmission (PMTCT). Demand challenges include low PMTCT awareness, weak health-seeking behaviour, low-skilled delivery, stigma and discrimination leading to low disclosure rates, weak PMTCT community-facility linkages, social cultural beliefs and practices, high unmet need for family planning and low male involvement (under 30 per cent). Among the chief supply challenges are the slow adoption of new PMTCT guidelines, frequent commodity stock-outs, infrastructural and equipment challenges, data quality challenges, missed opportunities for follow-up of mother-baby pairs, mixed messaging on infant feeding and human resource gaps. Notably, ART coverage for children, adolescents and women remains sub-optimal.

### Table 13: Progress from 2009-2012

<table>
<thead>
<tr>
<th>Indicator/data element (Data source)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV incidence among women (Global Plan Progress 2012)</td>
<td>0.58</td>
<td>0.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per cent of pregnant women tested for HIV (NASCOP Program data)</td>
<td>65 per cent</td>
<td>84 per cent</td>
<td>80 per cent</td>
<td>80 per cent</td>
</tr>
<tr>
<td>Per cent of pregnant women whose partners were tested for HIV (NASCOP Programme data)</td>
<td>2 per cent</td>
<td>4 per cent</td>
<td>4.4 per cent</td>
<td>4.2 per cent</td>
</tr>
<tr>
<td>Unmet need for Family Planning (KDHS 08/09)</td>
<td>25.6 per cent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per cent males and females aged 15-49 yrs who had more than one sexual partner in the past 12 months reporting the use of a condom during last sexual intercourse (year of estimate)(Sentinel Surveillance 2011)</td>
<td>32 per cent (F); 37 per cent (M)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per cent of HIV-infected pregnant women who received efficacious ARV (prophylaxis or therapy) to reduce MTCT (disaggregated by regimen; includes breastfeeding coverage for 2011 &amp; 2012) (NASCOP Programme data)</td>
<td>74 per cent</td>
<td>76 per cent</td>
<td>69 per cent</td>
<td></td>
</tr>
<tr>
<td>Per cent ARV coverage for pregnant women's own health (Global Plan Progress Update 2012/UA reports/ NASCOP Programme data)</td>
<td>42 per cent</td>
<td>47 per cent</td>
<td>61 per cent</td>
<td></td>
</tr>
<tr>
<td>MTCT rate by PCR (year of estimate) (NASCOP Programme data)</td>
<td>12.7 per cent</td>
<td>10.8 per cent</td>
<td>10.1 per cent</td>
<td>8.2</td>
</tr>
<tr>
<td>Number/per cent of infants who receive EID by 8 weeks (NASCOP Programme data)</td>
<td>-</td>
<td>64 per cent</td>
<td>39 per cent</td>
<td>58 per cent</td>
</tr>
<tr>
<td>New HIV infections among children (including per cent decline by each year from 2009)(Spectrum estimates)</td>
<td>23000</td>
<td>19000 (17 per cent decline)</td>
<td>13000 (32 per cent decline)</td>
<td>13000 (20 per cent decline)</td>
</tr>
<tr>
<td>Per cent ART coverage among children under 15 (Global Plan Progress 2012/ NASCOP Programme data)</td>
<td>19 per cent (GP)</td>
<td>31 per cent (GP)</td>
<td>37 per cent (NASCOP)</td>
<td></td>
</tr>
<tr>
<td>Per cent HIV related deaths among children under 5 (UA reports/Global Plan Progress 2012)</td>
<td>8.9 per cent</td>
<td>7 per cent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
About 60 per cent of health facilities are providing PMTCT services, but only about 20 per cent provide a comprehensive PMTCT package.\textsuperscript{146} It is estimated that there will be 87,000 HIV positive pregnant women in Kenya each year. Currently, 80 per cent of pregnant women are counselled and tested for HIV and only 60 per cent of the HIV positive women receive anti-retrovirals (ARVs) for prophylaxis.\textsuperscript{147} However, a mere 13 per cent of women still receive single dose Nevirapine, a regimen being phased out in response to new WHO guidelines.\textsuperscript{148} In 2011, an estimated 61 per cent of HIV positive pregnant women received ART for their own health, indicating that renewed efforts are needed to ensure universal access.

From a review of the progress, it appears that children are losing out with only 56 per cent of exposed infants receiving ARV prophylaxis and a mere 35 per cent of the exposed infants receiving a PCR HIV test eight weeks after birth.\textsuperscript{149} Currently, many HIV-exposed infants are lost to the system and cannot be accounted for by 18 months. Of those infants who have not been lost and are followed up, merely 37 per cent receive ART, a glaring gap in the current HIV response.

By 2012, it was estimated that the MTCT rate was 8.2 per cent with large regional disparities in overall transmission among the different counties.\textsuperscript{150} To accelerate progress in the elimination of mother-to-child transmission and keeping mothers alive, in November 2012, the Government launched the new MTCT framework which sets out important targets and strategies, communication strategy, PMTCT guidelines and Kenya Mentor Mother Programme guidelines.

**Major Causes that Prevent the Realization of the Child’s Right to Survival, Growth and Development**

This section highlights some of the major causes that contribute to the high infant and maternal mortality rates including some gender inequality issues that must be addressed to achieve further progress.

**Inadequate human resources** - Kenya is one of the 57 countries globally and one of 36 within sub-Saharan Africa with a critical shortage of health workers.\textsuperscript{151} This absolute shortage is compounded by performance management issues and the persistent inability to attract and retain health workers in the public sector and particularly in deprived and rural areas. In addition, there is a regional imbalance in the distribution of health workers, who are mainly found in urban areas.

**Poor access to services** - Only one in three health facilities in Kenya offers basic maternity services and one in four is open at night; one in ten hospitals provides basic emergency obstetric care services and even fewer offer comprehensive emergency obstetric care.

Few of the new facilities offer maternity services – While there has been a big expansion in overall facilities, few of the new ones offer maternity services. As distance is still a barrier for many women, more facilities need to offer maternity services. Nationally, 42 per cent of women cite distance as a barrier to receiving healthcare; this figure ranges from 32.5 per cent (former Coast Province) to 46.4 per cent (former Northeast Province).\textsuperscript{152} According to the 1998 and 2010 Kenya Service Provision Assessments, the percentage of facilities offering maternity services has dropped since 1998, although supply availability in those facilities offering maternity services has improved.\textsuperscript{153} C-section availability has decreased slightly over the past decade even though the national C-section rate has increased, which means that women will go to extreme lengths to get a C-section when it is necessary.

**Poor quality of services** - This is an issue of insufficient quality control. Poor quality of services is cited more frequently than cost as the top barrier to care-seeking for maternal health in Kenya. Just 39 per cent of maternity facilities now conduct maternal death reviews and 38 per cent of facilities perform basic monitoring of delivery coverage. An estimated 37 per cent of health workers conducting deliveries have been trained in essential obstetric and life-saving skills, and half of them received their last training more than one year ago.

**Figure 11: Maternity services coverage**

![Graph showing percentage of health facilities offering services for normal delivery](image)

**Source:** Kenya Service Provision Assessment, 2010

The cultural and social context has a significant impact on the demand for some critical services: Cultural and behavioural factors contribute to low coverage of life-saving maternal health interventions. It may be one of the underlying or root causes that hinder the fulfillment of the right to health. For example, the use of a skilled attendant rather than a traditional birth attendant or contraceptive use is influenced by cultural traditions and practices.\textsuperscript{154} Statistically, Kenyan households are less likely to seek care for pregnancy and delivery-related concerns than for a sick child.\textsuperscript{155} In some more traditional societies, “heroic deliveries” done alone at home are still regarded as a badge of honour for women and there is a preference for child or teen marriages and large families.

\begin{itemize}
  \item Universal Access to Care Report 2010.
  \item 154  NASCOP Annual Programme Review, 2012.
  \item 155  Kenya Human Resources for Health Conference, 2011.
  \item 156  Kenya Demographic and Health Survey, 2008-2009
  \item 159  ICF Macro.
  \item 160  ICF Macro.
  \item 161  ICF Macro.
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  \item 168  ICF Macro.
  \item 169  ICF Macro.
\end{itemize}
Female genital cutting (FGC) is a known risk factor for maternal complications: It is encouraging to note that girls aged 15-19 are much less likely to undergo this practice than older women in Kenya. The practice varies greatly by area and ethnicity. In North Eastern, 98 per cent of women have undergone FGC, with 82.5 per cent having undergone the most severe form of it. Those from the Somali and Kisu ethnicities are most likely to have undergone it (97.6 per cent and 96.1 per cent respectively).\textsuperscript{161} Therefore, increasing demand for maternal health services through increased sensitivity to cultural and social contexts goes hand-in-hand with improving access and quality of maternal and newborn health services.

Gender-based violence is another risk factor for maternal complications: Over half of the women interviewed in the 2008-2009 KDHS believed that there were at least some grounds where wife beating was acceptable, such as when she neglects the children. Urban women under the age of 25 and over the age of 44 are more likely to accept beating, while women who have never been married or are employed for cash are least likely to accept beating as justified for any reason. Rural women or women from the poorest wealth quintile are approximately twice more likely to accept gender-based violence than those in urban areas or in the richest wealth quintile (59 per cent and 67 per cent, compared to 34 per cent and 32 per cent respectively).\textsuperscript{162}

Giving birth at a young age is significantly associated with increased childhood mortality rates: From the 2008-2009 KDHS survey, it was found that for mothers who gave birth before the age of 20, neonatal and infant mortality rates were 29 per cent and 30.8 per cent higher than the national average, and the under-five mortality rate was 35 per cent higher. Early marriage contributes to high rates of childbirth amongst adolescents in Kenya. According to the same survey, 11 per cent of adolescent girls are married, and when women aged 20-24 were asked their age when they first married, 33 per cent responded, by the age of 18. As for early sexual activity, when adolescent girls aged 18-19 were asked when they had their first sexual intercourse, 44 per cent of girls aged 18-19 reported it was before age 18 and nearly two-thirds had married.\textsuperscript{163}

Role and Capacity Gaps in Health

This section identifies the roles of key duty-bearers and some of the capacity gaps that exist within the health sector which hinder the pertinent duty-bearers at all levels from meeting their overall duties and obligations and carrying out their functions.

Community Health System: Kenya’s Community Health Strategy now recognizes the community level as the lowest level of the health system. There are currently 52,000 community health workers and 2,500 community health extension workers, who collectively serve 32 per cent of the target population. However, only 8 per cent of Kenyan households are receiving a full package of health services from a Community Health Worker (CHW), as defined in the Kenya Essential Package for Health. In the Northern regions of Kenya, where the need is greatest, fewer than 5 per cent of households are covered by a CHW and most of the established Community Health Units in these areas are not yet fully functional. Coverage is highest in Nyanza province, at approximately 54 per cent.

Health Access: Kenya has experienced a rapid increase in the number of health facilities in the past ten years due to increased investment in health through devolved funds. In spite of this progress, an estimated 18 per cent of the total Kenyan population lives more than 5 kilometres from a health facility.\textsuperscript{164}

The majority of the population in the ASAL region must travel more than 50 km to access basic health services. Data on health facilities collated for KDHS 2010 estimates that although 97 per cent of the health facilities provide treatment for sick children, only one in five (19 per cent) provide basic minimum services and operate for 24 hours/7 days a week.\textsuperscript{165}

Health Commodities: There has been an overall improvement in supply availability at health facilities over the past five years, according to the 2010 Service Provision Assessment and routine logistics reports. The Government and development partners have strengthened the performance of the Kenya Medical Supplies Agency (KEMSA), which now tracks and distributes health commodities to target health facilities based on need.

Human Resources: Inadequate human resources (too few and insufficient training) is both one of the major causes that hinder the realization of the child’s right to survival and development, and a capacity gap issue. It constitutes an ongoing nationwide challenge, particularly in the ASAL areas. Kenya is developing a Human Resources for Health Strategic Plan (2013-2017), which is expected to tackle some of the bottlenecks of health workforce development in line of the devolved system of governance. To improve health sector leadership, development partners are presently supporting leadership and governance training for health managers, particularly at the county level.

Health Services Coordination: Kenya’s health sector is well coordinated, principally through the Joint Interagency Coordinating Committee (JICC), which includes senior Ministry of Health officials and heads of Development Partner agencies. The role of JICC is to provide overall stewardship for the Sector and to provide a forum to discuss health issues that require policy guidance and support, and the implementation of the Kenya Health Policy Framework and the National Health Sector Strategic Plans. Other coordination structures include the Health Sector Coordination Committee, whose role is to provide a forum for policy and strategy discussion and to follow up on the implementation of agreed joint strategies and activities. There is also a DPHK and a number of Technical Working Groups that facilitate programme-specific coordination.

Nutrition Services Coordination: Coordination in the nutrition sector has been strengthened through the National Nutrition Technical Forum (NFT) and County Nutrition Technical Forum which ensure that information on programming and funding are shared and that national standards and guidelines are regularly updated, known and adhered to. However, there is a need to position the coordination of nutrition at a higher level, such as the Office of the President to ensure the multi-sectoral nature of nutrition is well-addressed in line with the Government commitment to the SUN movement. Coordination at county level requires strengthening, considering that counties will be making decisions on programmes to implement, as well as advocating part of the budget for Nutrition programmes. The NFT also plays a crucial role in the identification of capacity gaps and distribution of partners to support the Government in achieving its nutrition goals.

Progress since 2009 in Water, Sanitation and Hygiene

In addition to the laws and policies identified at the beginning of this chapter other important developments in water and sanitation deserve to be mentioned:

- The 2010 Constitution spells out, among other provisions, that (a) water is vested in the people, (b) water (supply) and sanitation (services) is a human right, (c) development of water resources is a function of national government and, (d) water and sanitation services provision is the function of county governments. Thus, the Constitution places an obligation on the Government to take steps to progressively realize this right (Section 21). In addition, the water sector has a new opportunity not

\textsuperscript{161} Ibid
\textsuperscript{162} Ibid
\textsuperscript{163} Ibid
\textsuperscript{164} KEMRI Welcome Trust Research Programme
\textsuperscript{165} Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010. Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro
only to carry the sector reform to a new and higher level (to reach the objectives of the Vision 2030) but also to make implementation of the reform more effective than in the past.

- The Ministry of Public Health and Sanitation launched a nationwide campaign in May 2011, dubbed Open Defecation Free (ODF) Rural Kenya by 2013. It provides a roadmap that has been aligned to the policy and will henceforth guide the process towards attainment of the national goals in the Vision 2030 blue print. The water sector’s priority now is to mobilize sufficient funding, attention, and political goodwill to accelerate the achievement of the target.

- WASH services coordination is being addressed as a well-coordinated and aligned sector critical to achieving the best results from the Sector-Wide Approach (SWAP) to planning. Several initiatives have been launched to improve the SWAP process and overall coordination, most notably the “Kenyan Water Sector Investment Programme KWSIP” (under MWI’s Sector Coordination Unit, established in 2010) and the formulation of the “National Water Master Plan.”

- The CPC (Community Project Cycle) and UPC (Urban Project Cycle) are the two main funding windows that have been instituted for addressing equity in WASH in rural and urban settings respectively. They can be applied at 3 levels: Water Services Trust Fund (WSTF) for pro-poor allocation based on poverty mapping, Water Services Board (WSB) for implementation of projects, and Water Services Providers (WSP) for service delivery targeting the poor. With devolution, the county WASH forums will become central to addressing equity issues in WASH.

- The Ministry of Water launched the Water Sector Strategic Plan, which rallies all sector stakeholders behind a common agenda, and through which intra-inter-ministerial collaboration will be strengthened. In addition, the sector carries on strengthening its monitoring and evaluation through the establishment of various monitoring and evaluation information systems.

- Hygiene promotion activities have concentrated on the training of trainers (ToTs) to train Community Health Workers (CHWs) provide household level training for hygiene promotion and Household Water Treatment & Safe Storage (HWTS) in line with the Community Health Strategy.

Water, Sanitation and Hygiene (WASH)

There are major inequalities in access to WASH services with poor households in rural and informal settlements receiving the least coverage. Consequently, the poorest and most vulnerable continue to be disproportionately exposed to pathogens that cause pneumonia and diarrhoea in particular, and are also more likely to develop severe illnesses as a result of other factors such as under-nutrition or co-morbidities.

The most recent monitoring indicated that Kenya is not on track to achieve MDG water targets. Moreover, regional disparities persist, with lower than national average coverage rates in ASAL and peri-urban areas, amongst others. Currently, overall water coverage stands at 61 per cent but the rural/urban disparities are significant (83 per cent urban compared to 54 per cent rural). These disparities may continue to persist unless deliberate efforts are made to put more resources towards water coverage in the rural areas. A survey undertaken in 2009, in 22 underserved districts highlighted significant disparities in quality and reliability of water supplies within districts. Low income urban areas and informal settlements receive poor water services yet pay higher costs relative to the level of services they receive (which are usually of poor quality). Costs to the poor are also higher in proportion to their incomes. Moreover, only 40.2 per cent of the rural population practise appropriate household water treatment methods compared to 57.1 per cent in urban areas.

Kenya is also not on track to achieve the MDG target for sanitation which represents one of the biggest development challenges in the country. Indeed, poor sanitation costs Kenya Ksh27 billion (US $324 million) each year which could be used for other development activities. National sanitation coverage stands at 31 per cent; though disparities are not large between rural (32 per cent) and an urban area (27 per cent) because national coverage is low. However, more people in rural areas (18 per cent) practise open defecation compared to urban areas (2 per cent). Since poverty is heavily weighted towards rural areas, the costs of poor sanitation fall disproportionately on the poorest with open defecation costing more per person than any other type of unimproved sanitation. Open defecation is common practice in the following regions: North Eastern (73 per cent), Coast (65 per cent), Rift Valley (34 per cent), Eastern (25 per cent), and Nyanza (23 per cent). In certain districts, more than seven of every ten households practised open defecation such as in Turkana (86 per cent), Wajir (76 per cent), Samburu (73 per cent), and Tana River (70 per cent).

In addition to geographical location, sanitation access varies significantly by wealth. The richest quintile is eight times more likely to use improved sanitation than the poorest, and the poorest quintile is seven times more likely to practise open defecation than the richest. Access to sanitation is the most serious deprivation for households and children, and the most significant inequities among districts.

Water Service Provider Boards’ track records on equity are mixed. Some progress has been made in addressing the challenges in the underserved areas of the country. However, new initiatives and mechanisms such as the WSTF have been also established as a window for channelling support to poor and vulnerable groups and the creation of special tariff structures for the vulnerable and poor by WSPs (e.g. Nairobi Water Company). The Trust Fund has three windows, two of which address water services issues in both rural and urban areas namely, the Community Project Cycle (CPC) and the Urban Project Cycle (UPC). About 1.3 million more Kenyans in the rural areas were reached with a water supply through the various interventions that included the WSTF CPC (rural financing) window, DP projects, NGOs and Government-funded programmes. These initiatives are still at an early stage and will take time to be fully operational.

Equity in WASH

- There has been progress in increasing access to water in a more equitable manner, with access in rural areas and in the provinces with the lowest access increasing faster than in urban areas and the less-disadvantaged provinces.
- There remain significant disparities between rural and urban areas and different provinces. Inequities are greater in access to sanitation, and although there is progress in increasing access to sanitation, this has been mostly among the wealthier sectors of the population.
- The Community Led Total Sanitation (CLTS) approach supported by UNICEF has generated some success in achieving improved sanitation with equity.

The overall budgetary allocations to the water sector have increased by more than 200 per cent in the last five years (2006-2007 to 2010-2011), with the development allocation increasing by 252 per cent, while the recurrent budget has maintained a lower growth rate of 93 per cent. The current allocation stands at 15 per cent as compared to the urban at 85 per cent. There is no dedicated budget for sanitation, and allocations are primarily for infrastructure purposes. Under Vision 2030/MTP 2 there are several water and sanitation infrastructure flagship projects.

Several large-scale infrastructure programmes in the fields of water and sanitation and storage are ongoing. Furthermore, numerous small-scale interventions in urban and rural low-income areas are being implemented and, some of them financed through the WSTF are achieving a quick and tangible impact.

In light of the vast investments needed to satisfy the demands of the growing population in Kenya, the sector revenues (water and sanitation tariffs, abstraction fees, etc.) need to be “ring-fenced”. Otherwise, the sector and its institutions may be missing out on the opportunity to attract investments through alternative markets (e.g. bond markets, commercial banks unlike for example, the energy sector). The “Water Bill 2013” already provides the way forward on this issue and therefore needs to be supported by all stakeholders.

Additional efforts are required to establish a coherent and harmonized planning and investment framework for the entire water and sanitation sector and/or selected sub-sectors, enabling development partners to further harmonize and align their interventions. In the context of the SWAp, inclusion of development partners and civil society in the sector budget process is a key element that still needs to be improved.

**Major Causes and Capacity Gaps in Water and Sanitation**

This section identifies some of the major causes and capacity gaps that prevent the realization of the right to water and sanitation.

**Poor access to water and sanitation services and inappropriate hygienic practices** are the main immediate causes of the two diseases that are major killers of children, pneumonia and diarrhoea. In 2010, an estimated 32,000 children under-five died from these two diseases. Some socio-cultural beliefs, taboos and misconceptions also militate against good and adequate sanitation and acceptable hygiene practices. Underlying causes of inequalities across child survival sectors include behaviour characteristics and lack of awareness and knowledge resulting in poor utilization of services even when they are available. At household level, most water is unsafe (especially susceptible to e-coli contamination) to drink or for preparing food; and, 75 per cent of primary child-caregivers and 71 per cent of secondary caregivers do not wash hands with soap at critical time.

**Inadequate budgetary allocation for the rural water supply** is one of the main underlying causes of poor access to safe water and sanitation.

**Inadequate data management and monitoring systems** impede effective planning and monitoring. Currently, there is no official guidance for defining affordability of water in general and for the poor in particular. The Water Service Trust Fund was established, under the Water Act 2002, to finance water supply projects for the most marginalized population/regions. However, progress towards achievements of pro-poor strategies/plans is not adequately monitored and evaluated.

**Insufficient attention to sanitation** despite its relevance for many health indicators. Sanitary conditions, particularly in urban low-income areas are critical. More efforts are required to scale-up sanitation-related activities and to improve effective inter-ministerial coordination.

**Sustainability of water supplies remains a major concern at community level.** Local water boards and governance structures often lack the capacity to efficiently steer maintenance systems to ensure long-term and continuous functionality. Sector reforms are necessary to align the sector with modern service provision models, where decision-making is decentralized to improve efficiency of water service delivery. The capacity-building of communities as well as the provision of technical assistance from an overseeing institution need to continue for efficient and effective service delivery.

**Health Sector Financing**

There were modest increases in the per capita Government expenditure on health from $9.9 in 2001/2002 to $11.4 in 2005/2006 and $12.1 in 2009/2010. The Government contribution to total Health Expenditure remained constant at about 29 per cent, while donor contributions continue to increase from 31 per cent in 2005/2006 to 35 per cent in 2009/2010. Private out-of-pocket expenditure has been decreasing from 54 per cent in 2001/2002 to 31 per cent in 2005/2006 and up again to 35 per cent in 2009/2010.

While the overall health sector budget for 2012/2013 at 8 per cent of the total Government budget is well below the Abuja target, it was a big increase from the previous year. However, the nutrition sector allocation is particularly insufficient. The nutrition sector has received 0.4 per cent of the health sector budget 2012/2013 financial year. Due to robust nutrition advocacy by partners, the Government has progressively invested in essential nutrition commodities. In the financial year 2012/2013, the Government procured 4 per cent (vitamin A capsules), 50 per cent (iron folate supplements) and 7 per cent (micronutrient powders) of the national needs. Furthermore in 2012, the Government borrowed USD12.8 million from the World Bank to procure essential nutrition commodities -- Ready to Use Therapeutic Food (RUTF), Ready to Use Supplementary Food (RUSF) and therapeutic milk. New opportunities have also arisen through the European Commission, and DFID who have committed to multi-year funding for the nutrition sector.
Actions to Improve the Right to Survival and Development

Address health budget equity and county allocations: Strengthening analysis and evidence for equitable and efficient resource allocation is a critical area. As more resources are allocated to counties during the transition to devolution, there is an opportunity to influence prioritization and budget allocations by providing evidence and advocating for funding of county child survival and development strategic plans.

Enhance the focus on reduction of maternal and neonatal mortality: Maternal and newborn health remains a serious challenge and is a health system issue. Post-neonatal child mortality could be reduced by scheduling interventions targeted at large populations often funded by donors (e.g., LLITN distribution, vitamin A supplementation, measles, immunization) and often delivered in campaign mode. The interventions required to reduce maternal and neonatal mortality rely on a functioning health system able to deliver services whenever needed (e.g., treating pneumonia, caesarean section, and giving blood).

Provide a multi-sectoral response to stunting as it remains one of the most serious national development concerns: High impact nutrition interventions will need to be recognized in the second Medium Term Plan of Vision 2030 to demonstrate the Government’s commitment to nutrition. While the National Food and Nutrition Security policy provides a sound basis for making progress, the Government and partners will need to address past policy implementation bottlenecks. This means paying particular attention to increasing budgetary allocations; involving the private sector; ensuring high level and effective coordination with clear government leadership; and implementing the food and nutrition security strategy.

Increase funding and support the development of creative and sustainable financing mechanisms for the community health system: The community health system is the fundamental basis for a strong health system in Kenya. The Government, with support from partners, has started to develop community health structures (CHS). Yet there is a fundamental element missing, without which the system cannot be sustained and the potential benefits maximized. While the Government identifies the CHS as a priority, its budget allocation is minimal, leaving most of the implementation to be funded by development partners.

Develop a comprehensive communication strategy for child survival: Social norms constitute major bottlenecks to child survival. Socio-cultural beliefs, taboos and misconceptions militate against good and adequate sanitation and acceptable hygiene practices, appropriate infant and young child feeding practices and other positive health-seeking behaviors.

Strengthen data-driven planning and programming for programme improvement: With a number of health services devolved to county levels, county structures must have the skills and capacities to plan and track progress of priority health and eMTCT interventions.

Strengthen efforts to reduce HIV infection among girls and women: This requires enhanced evidence-informed behaviour change communication, increased utilization of HIV services and, most importantly, addressing the underlying gender inequities and drivers for high HIV infections among girls and women.

Increase provision and quality of postnatal care, paediatric care and treatment: New point of care diagnostics for CD4, early infant diagnosis and viral load, strengthened integration of HIV services into MNCH, and improved retention in services are all urgently required. This will also contribute to an increased demand for services.

Reduce the unmet need for family planning: Urgent efforts are needed to ensure that a far greater number of women and men have access to contraception, in particular condoms. This includes ensuring access to condoms for adolescents and young people who are sexually active.

Increase efforts to protect and rehabilitate the catchment areas: Kenya is classified as a water scarce country, with a per capita endowment of about 500 to 640 m3 per year. The severe degradation of the main catchment areas contributes to the recurrent water crises which affect many parts of the country. Furthermore, measures must be undertaken to use the scarce resources more efficiently, for example, by reducing water losses and increasing water storage.

Develop a policy for community-led total sanitation (CLTS): There is an urgent need to upgrade the current Sanitation and Hygiene Policy (2007) in order to reflect the new CLTS approach. While the current policy recognizes access to sanitation as a human right, there is a lack of: clear guidance or mechanisms for poor households to access this right; specific promotional approaches for scale-up; and, guidance on provision and avoidance of hardware subsidies.

Provide a complete WASH package of latrines, water supply, hand washing facilities and materials, as well as hygiene promotion, in schools and health centres. This breaks the cycle of disease, primarily cholera and diarrhoea, and also sets a positive example for hygiene behaviour in early childhood influencing good practices in the home environment.
Chapter V
The Right to Education

Pupils in the ASALs are particularly deprived in access, quality and completion of primary education.

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Legal and Policy Frameworks

The right to education has been universally recognized since the 1948 Universal Declaration of Human Rights and is enshrined in various international conventions including the CRC (Articles 28 and 29), national constitutions and development plans. The right to education as defined by these instruments calls for: universal access to free and compulsory primary education and universal availability/accessibility of secondary education, through the progressive introduction of free education; and, equal access to higher education on the basis of capacity and by the progressive introduction of free education. Education is a fundamental human right and essential for the exercise of all other human rights.

The right to education has three dimensions:178

The right of access to education: The right of every child to education on the basis of equality of opportunity and without discrimination on any grounds. To achieve this goal, education must be available for, accessible to and inclusive of all children.

The right to quality education: The right of every child to a quality education that enables him or her to fulfil his or her potential, to realize opportunities for employment and to develop life skills. To achieve this goal, education must be available for, accessible to and inclusive of all children.

The right to respect within the learning community: The right of every child to respect for her or his inherent dignity and to have her or his universal human rights respected within the education system. To achieve this goal, education must be provided in a way that is consistent with human rights, including equal respect for every child, opportunities for meaningful participation, freedom from all forms of violence, and respect for language, culture and religion.

The legal and policy frameworks in Kenya are increasingly more in harmony with the CRC and other international norms. The chapter on the Bill of Rights in the new Constitution recognizes the right to education as a fundamental right of every child. Articles 43, 53 and 55 guarantee every child the right to free and compulsory basic education. Legal frameworks in the education sector are thus being realigned with the Constitution. The Basic Education Act and the Technical Vocational Education and Training Act recognize this right for both in and out-of-school children and adolescents. The Basic Education Act 2013 was enacted to ensure overall education access, quality, equity, relevance, effectiveness and for the institutional system enhancement in Kenya. It mainstreams ECDE into basic education, giving priority to ECDE as a key national programme.

The Sessional Paper No. 1 (2005) contains the overall education policies and guides the education sector in Kenya. The Paper states that “it will be necessary to take affirmative action to compensate for historical and emerging inequalities and disparities in all areas of our national life including gender.” In order to operationalize the priorities identified in the Sessional Paper, the Kenya Education Sector Support Programme (KESSPP) was developed. The KESSPP showed a strong commitment to addressing inequities in education including gender inequalities through specific policies on education in the ASALs. The Policy on Alternative Provision of Basic Education targets marginalized children in urban informal settlements and ASAL areas.

Early childhood development education (ECDE) has been included in recent education sector reforms. The Basic Education Act 2013 provides that ECDE be part of basic education and funded by Government. The Sessional Paper No. 14 (2012) also provides for free and compulsory pre-primary education for all 4-5 year olds, as well as health and nutritional support for under-five-year-olds attending day care centres and schools.

The National Education Sector Strategic Plan 2013/14-2017/18 expands the focus to both learning and quality as well as access. The Child-Friendly School (CFS) Strategy has evolved as a key Government approach to quality education. School-based CFS management and monitoring through head teachers and their peer network with the participation of parents, communities and school children has strengthened decentralization. National and district level, national trainers, District Education Officers, District Quality Assurance and Standards Officers and school cluster coordinators were targeted to create a foundation for district level support and for roll-out of the CFS system. Teacher training college tutors have been inducted to embed CFS in pre-service training for primary teachers.

Elements of a Child-Friendly School (CFS):

Schools should operate in the best interest of the child. Educational environments must be safe, healthy and protective, endowed with trained teachers, adequate resources and appropriate physical, emotional and social conditions for learning. Within them, children’s rights must be protected and their voices must be heard. Learning environments must be a haven for children to learn and grow, with innate respect for their identities and varied needs. The CFS model promotes inclusiveness, gender-sensitivity, tolerance, dignity and personal empowerment. The CFS model also builds partnerships between schools and the community. Since children have the right to be fully prepared to become active and productive citizens, their learning must be linked to the wider community.

Source: UNICEF Basic Education and Gender Equality/Child-Friendly Schools.

177 Primary completion rate was reported at 74.6 per cent for 2011 and 80 per cent for 2012 (Economic Survey, 2013); the proportion of pupils starting Grade 1 who reach the last grade of primary school is reported at 74.6 per cent in 2011 (MDG Status Report, 2011). None of these figures includes children who never enrolled in primary school.

178 A Human Rights-Based Approach to Education For All, UNICEF and UNESCO, 2007, p 6
Education Spending

Education spending has fallen over the period from 25 per cent of total Government expenditure in 2009 to 21 per cent in 2012, but remains the largest element in the social sector. At the same time, expenditure on secondary education has grown as a proportion of all education expenditure, in line with the policy of expanding access to secondary education.

Table 14: Proportion of the total Education Budget allocated

<table>
<thead>
<tr>
<th>Proportion of total Education Budget allocated to:</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and Administration(^{179})</td>
<td>69.0</td>
<td>68.2</td>
<td>68.5</td>
<td>62.9</td>
</tr>
<tr>
<td>Pre-primary and Primary Education</td>
<td>4.9</td>
<td>4.7</td>
<td>4.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Secondary Education</td>
<td>0.9</td>
<td>1.0</td>
<td>1.9</td>
<td>10.2</td>
</tr>
<tr>
<td>Tertiary Education</td>
<td>23.4</td>
<td>23.2</td>
<td>23.6</td>
<td>21.7</td>
</tr>
<tr>
<td>Other Education expenditure</td>
<td>1.9</td>
<td>3.0</td>
<td>1.5</td>
<td>1.4</td>
</tr>
</tbody>
</table>


Although the education expenditure has been increasing relatively with the poorest groups receiving a fair share of overall benefit, the share of the poor in secondary and in particular in tertiary education spending is much lower.\(^{180}\)

Donors to the education sector discontinued participation in KESSP and pooled funding which affected the development budget of the MoE. High inflation and reduced Government revenues also affected MoE funding for some critical programmes, for example, the discontinuation of grants for Most Vulnerable Children and reduced ASAL boarding grants for learners amongst others. Significant and sustained advocacy by key stakeholders resulted in leveraging funds from the Ministry for the Development of Northern Kenya and Other Arid Lands (MDKOL) which boosted education for nomadic communities. Over Ksh 200 million helped to improve access by nomadic children during the 2009-2011 emergencies in arid districts through improved infrastructure. This mainly involved the construction of school boarding facilities, additional scholarship trust funds and capacity-building. The MDKOL provided schools with emergency response support during the drought period such as tanked water. The infrastructure support to schools resulted in the construction of boarding units, which was a major boost for access and retention even during emergencies in arid nomadic districts.

Emmanuel Njeru, Embu County, 16 year old street child “My parents separated, I went with my mother, I was raised by my grandmother after my mother shortly passed on. My uncles took me in but mistreated me. I went to the street and a good Samaritan took me in paid my school fees, although I was like a house maid. I passed well and joined a national school, and in second term I was chased away. I started doing manual work, sleeping on the street, pay my school fees. I don’t even take breakfast and many times am without food”.

Source: Children’s Voices.

\(^{179}\) The figure for administration includes teachers’ salaries, which are not apportioned across the various education levels, Economic Survey, 2013.

\(^{180}\) Lionel Demery and Isis Gaddis, 2009, Social Spending, Poverty and Gender Equality in Kenya: a benefit-incidence analysis.

Early Childhood Development and Education, Primary and Secondary Education

Early Childhood Development Education (ECD) is an important strategy for increasing school readiness. Access to ECD is strongly related to wealth, with poorer families lacking the resources to enrol their children in these programmes. At the level of ECD, the net enrolment rate (NER) has slightly increased from 49.0 per cent in 2009, to 53.6 per cent in 2012.\(^{181}\) This is attributed to the fact that ECD has not been taken up as part of PFE by the Government to ensure that teachers are paid and per capita grants are provided. The Sessional Paper (2012) further proposes to provide free and compulsory pre-primary education for all 4-5 year olds, as well as provide health and nutritional support for under-five year olds attending day care centres and schools.

Overall, as a result of the introduction of free primary education for all, there was an increase in enrolment in primary school and early childhood education. According to the MoE, net enrolment in primary school has increased from 76 per cent in 2002, to 93 per cent in 2009, and early childhood education from 57 per cent to 60 per cent. Nevertheless, significant disparities remain on many levels regarding the fulfillment of the right to education, based on geographical location, gender and wealth. Although net primary enrolment has continued to increase since 2009, to 95.3 per cent by 2012, primary completion rates have only just reached 80 per cent, and pupil: teacher ratios have increased, suggesting there remain challenges with the quality of education and learning.

In recent years, the country has made strides in providing education for marginalized groups such as pastoralists but there are still key obstacles hindering the achievement of EFA targets in ASAL. For example, nationally, the primary GER has increased from 91.2 per cent (92.9 per cent boys and 89.6 per cent girls) in 2002, to 109.9 per cent (109.8 per cent boys and 109.9 per cent girls) in 2010. Despite these successes, there remain significant challenges in the realization of basic education rights for nomadic or pastoralist children as indicated in GER for NEP which is still below 50 per cent in 2012. The situation is similar for such children at ECDE level and for youth.

In urban areas children are slightly more likely to attend primary school than those in rural areas. Urban children are also much more likely to access secondary education compared to rural children. However, there are significant disparities in access to education in informal settlements. For example, the 2009 Census estimated around half a million low-income people living in informal settlements in Nairobi. According to the MoE, the overall enrolment rate in Nairobi primary schools was estimated at merely 60 per cent, with a large number of children in informal settlements attending low cost primary/community schools. These schools are not recognized by the MoE and the Education Management Information System which poses barriers to the students’ transition to secondary school.

Children belonging to the poorest households are less likely to attend school at all levels. The progress in increased attendance at secondary level is mainly concentrated in the wealthier social sector which shows the inequality in access to education. Similarly, a disaggregation of data by gender and wealth quintile indicates that for the most part, girls have been more disadvantaged than boys in accessing education. An estimated 40 per cent of girls in the lowest wealth group have never attended school compared to only 30 per cent of boys.

Since 2009, Kenya still has an estimated one million children out of school. Significant education disparities by geographical region, gender, and socio-economic group are found across the country. It is estimated that half of these out-of-school children are in ASAL districts of northern Kenya. Drought and security-related emergencies serve as barriers to education access for ECDE and primary school girls and boys in the arid districts of Kenya. Frequent man-made and natural disasters have affected the continuity of learning and access to schooling at all levels. Conflicts and clashes are common in some districts during elections. The flow of refugees from neighbouring Somalia and Sudan has overstretched education services in Dadaab and Turkana. These disasters affect children at all levels of formal schooling, as well as adolescents not attending school.

A number of education alternatives are provided and other initiatives have been undertaken to reach out-of-school children and youth:

- Alternative provision of Basic Education for most marginalized children in urban informal settlements has been boosted by the MoE provision of FPE grants to urban children in need.
- Children in Mobile schools benefited from improved quality of education through the provision of comprehensive school kits.
- Since 2009, the Government through an inter-ministerial programme (Education, MOYAS and the MOC) introduced the pilot talent academy concept as an alternative learning pathway for in- and out-of-school youth. The pilot programme reached close to 6,000 youth.
- As an alternative learning pathway, vocational training has also been harmonized with other education sector policies and institutionalized through the Technical Vocational Education and Training (TVET) Act (2013).

Improved access to education by children with special educational needs has been achieved by attaching special needs classes to primary schools. The challenge now is to provide for mild-to-moderate special education needs within regular classes, as a fully ‘inclusive’ and least restrictive option. This step has to be accompanied by well-trained teachers and support services.

Kenya’s education sector currently plays a role in shaping societal values and attitudes that promote a culture of peace and unity. However, peace education in schools has not been mainstreamed in counties prone to conflict, and public awareness and engagement in promoting peace is thereby limited. Violence and conflict between competing political factions and communities is not uncommon in urban informal settlements during which time children are often the victims and their access to schooling is prevented. Education for refugee children in the camps of Dadaab and Kakuma remains poor.

Major Causes and Capacity Gaps in Education

This section addresses some of the major causes and capacity gaps of the duty-bearers that prevent the realization of a child’s right to education.

Parental disapproval, labour obligations, costs, and disability or illness: At ECD level the primary causes that prevent children from attendance are the parents’ lack of resources and the distance to schools, particularly in rural areas. At primary school level, the primary causes that prevent children from attendance are parental disapproval, labour obligations, costs, and disability or illness. In Northern and ASAL counties the primary causes are the lack of parental support or labour obligations, whereas the costs incurred are most important in parts of Central, Coast and Western regions. Other specific groups of children including orphans and children with disabilities are likely to be more disadvantaged when it comes to attending primary school and to transitioning to secondary school. However, there is little data on school attendance in regard to children with disabilities.

Gender bias, social norms and parental attitudes: A number of other factors prevent children from attending school. When the gender factor is added, this suggests that there is a gender bias in social norms and parental attitudes towards education. The reasons found for the low attendance among girls, especially in higher grades, are pregnancies, early marriages and gender violence within communities and school environments. Girls, particularly as adolescents and young mothers are most affected by socio-cultural, economic and religious beliefs, attitudes and norms. In many cases, parents and communities actively take steps to hinder their full participation in education. Government policies are insufficiently sensitive to the different needs of boys and girls in schools and therefore, do not address the parents or community regarding the safety of girls.

Spatial Quality of Education: While there has been progress reported in improving access to school, significant inequalities in learning outcomes have been found and inequalities between different types of schools. At national level, less than half of Primary 3 students achieved the required competency in literacy, and only slightly more than half in numeracy. When it comes to total education achievement, children in former Central, Coast and Nairobi provinces are ahead of children in other provinces. The disparities between girls’ and boys’ attainment are particularly wide in North Eastern province. Issues of quality of education are further highlighted by the Primary School Completion Rate where the national average of 81 per cent is reached in only five out of eight provinces and the ASAL fall well below the average.

186 UNICEF Education Section, 2010.
Lack of latrines and sanitary pads for girls in schools in rural areas is one of the primary causes that meet the need. A particular challenge is the need for more training of multi-grade teachers. Another factor that affects the quality of education is the insufficient number of teachers recruited to the costs incurred.

Key factors that contribute to the slow improvement in access to quality education include a weak Education Management Information System (EMIS) combined with frequent natural and man-made disasters disrupting children’s schooling, rising cost of living, low political commitment to ensure equity, and critical studies will be needed to inform policy formulation and resource allocation, as well as confidence building for girls, particularly in communities that have strong negative cultural practices.

As in other developing countries, the poor quality of education may be one of the root causes that affect the right to education from being realized. The findings of the National Assessment System for Monitoring Learning Achievement report (National Assessment Centre, 2010) point out a number of significant relationships between school level factors and learning achievement indicating that the quality of education needs greater improvement. For example, children from smaller class sizes performed better, as well as pupils who had their own textbook or shared with only one other pupil. Inequities were also found in the availability of both qualified teachers and textbooks between provinces, and in pupil-teacher ratios. The former North Eastern province showed the largest shortage of teachers and the highest pupil-teacher ratios.

Key factors that contribute to the slow improvement in access to quality education include a weak Education Management Information System (EMIS) combined with frequent natural and man-made disasters disrupting children’s schooling, rising cost of living, low political commitment to ensure equity in resource allocation, and a backlog of cumulative historical inequalities. One of the specific capacity gaps identified is the lack of guidelines on costing of pre-primary classes, which leads to inequalities in resource allocation, and a backlog of cumulative historical inequalities. One of the specific capacity gaps identified is the lack of guidelines on costing of pre-primary classes, which leads to inequalities in resource allocation.

Another factor that affects the quality of education is the insufficient number of teachers recruited to meet the need. A particular challenge is the need for more training of multi-grade teachers.

Lack of latrines and sanitary pads for girls in schools in rural areas is one of the primary causes that prevent many females from attending school and contributes to the drop-out rate in secondary school.

Figure 12: Competency in literacy and numeracy


Geographic and gender inequalities in the ASAL districts are highlighted in Figure 13 below.

Figure 13: Primary School Completion Rate in Arid Lands

Source: Education Section ASAL Desk Review 2010

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**RECOMMENDATIONS**

- Improve access to basic education for most excluded children with a focus on nomadic and other most vulnerable children.
- Make ECDE a greater priority: Policymakers at national level, county officers and communities at county level need to appreciate the importance of ECDE particularly as it has now been recognized in the Basic Education Act. Capacities at national and county levels to implement quality ECDE programmes also need strengthening.
- Address the rights of out-of-school adolescents: There is a need to address the right to education of out-of-school adolescents through access to Technical and Vocational Education and Training (TVET) colleges, vocational education etc. in addition to other rights, such as to participation and to sexual and reproductive health, as well as HIV prevention, treatment and care services.
- Develop a national framework for quality education: The MoE has adopted the Child- Friendly School (CFS) approach and the Education Act 2013 which stipulate the establishment of Education Standards and a Quality Assurance Council (ESQAC). They will provide a national framework quality education strategy and ensure that CFS principles are mainstreamed in Basic Education. There is a need to fast-track establishment of ESQAC. ESQAC will also provide a framework to ensure consistency of standards, consistency and equivalence in the student experience, and a high-quality education whilst enabling appropriate diversity in local practices. The Ministry of Education, Science and Technology has developed a Meriting Tool which sets quality education standards for both primary and secondary education. The Meriting Tool will equip the Government to monitor whether all the rights related to education are fulfilled and to take informed actions.
- Promote gender equality in education programmes at all levels: There is a need to promote gender equality in education programmes at all levels beyond the simplistic data disaggregation, in order to focus on the holistic implications of gender norms and practices on education for boys and girls. Key partnerships and critical studies will be needed to inform policy formulation and resource allocation, as well as confidence building for girls, particularly in communities that have strong negative cultural practices.
- Strengthen knowledge generation and improve research and innovation: More research is needed to better inform the education sector, influence policies and advocate for the allocation of resources directed at all children across all levels. The education sector should undertake continuous knowledge generation, evidence documentation and sharing, including research of emerging issues.
- Provide peace education at all levels of schooling and at national level as it is a major gap that needs to be addressed by the education sector.
Chapter VI
The Right to Participation

...children’s participation ought to take place at home, at school, at the community and at national level.
Legal and Policy Frameworks

The child’s right to participation is one of the guiding principles of the CRC and it is established in several of the treaty’s provisions (articles 12, 13, 14, 15). In particular, Article 12 recognizes that children have the right to participate in decision-making processes that pertain to their lives and influence those decisions taken within the family, the school or the community. Children have the right to express their views in all matters that affect them and their views are to be heard and given due weight in accordance with the child’s age and maturity. Thus, children’s right to participate must be considered in all matters that affect them. The right to participation is also recognized in the African Charter on the Rights and Welfare of the Child (ACRWC). In its General Comment 13, (issued in 2011) the CRC Committee stated:

"Children’s rights to be heard and to have their views given due weight must be respected systematically in all decision-making processes, and their empowerment and participation should be central to child care-giving and protection strategies and programmes".

Taking children’s views and experiences into account within the family, at school and other settings helps develop children’s esteem, cognitive abilities, social skills and respect for others. Through participation children acquire skills, build competence and gain confidence. This contributes to personal development. Based on evolving capacities, children have a unique body of knowledge about their lives, needs and concerns together with ideas and views derived from direct experience.

The enactment of the 2010 Constitution was a milestone in the right to participation in Kenya. According to the Constitution, public participation is one of the key national values and principles to promote citizen involvement. These rights are to be realized through direct and engaged citizens’ participation in the prioritization, planning, ownership and sustainability of local and national development. Public participation is one of the principles that the Constitution stipulates will guide public finance. It complements other important financial management principles such as openness, transparency and accountability. It also ensures public expenditure is allocated and utilized prudently, responsibly and in a manner that promotes equitable development, including making special provisions for marginalized groups and areas. In addition, the County Government Act clearly spells out how citizens can participate in the planning and budgeting process.

The Constitution (Article 10) allows citizen participation which includes children. It has also set up two levels of government: National Government headed by the President, and County Government headed by a Governor in each of the 47 counties. Once the transition from the current system of government to the devolved system is complete, the provision on devolved government as laid out in Chapter 11 of the Constitution will take services closer to the people including children and also increase citizen participation in decision-making.

Another important development in Kenya in this regard is the Education Act 2013, which includes a provision requiring a student representative within the school board. A critical issue that has been addressed in Kenya is what constitutes active and meaningful ‘participation’. In response, the NCCS developed the Guidelines for Child Participation that were published in 2007. The Guidelines establish, regulate and enforce procedures and standards for children’s involvement in the different spheres of life, while recognizing that children’s participation ought to take place at home, at school, at the community and at national level. The Guidelines contribute to a more supportive and favorable environment for participation.

Kenya Guidelines for Child Participation

“These Guidelines are intended to address issues of child participation and involvement in all situations that affect and shape the well-being of a child. This is in recognition of the fact that child participation covers all aspects of a child’s life and that participation is not an event but a process. The aim is to enhance effective child participation at all levels within the family set-up, communities, organizations and institutions that work for children.

These guidelines provide direction with regard to participation of children with fellow children and duty-bearers such as parents/guardians, teachers, care givers, Government ministries and departments, organizations working with children such as faith-based organizations (FBOs), community-based organizations (CBOs) and NGOs, practitioners who include doctors, lawyers, counsellors, psychologists and public and private institutions of learning and research.”
The need to create an enabling environment for meaningful participation draws attention to factors underpinning the empowerment of children including important dimensions such as having access to decision-makers and information, and being able to make informed choices. These enabling factors are particularly relevant with respect to the participation of others specifically identified in the Constitution namely, youth and women and it is likely to be the same for other marginalized groups – the poor, nomadic populations, orphans, etc.

The National Children Policy (NCP): This policy incorporates child participation as an integral component, on its own and as a means to achieving other rights. It recognizes that children are ‘implicit’ participants, beneficiaries and targets in Kenya Vision 2030. The Government has also created institutions with specific mandates to lead the implementation of policies and programmes aimed at fulfilling children’s rights to participation. The establishment of the NCCS has offered institutional support to child participation, together with this policy and the Participation Guidelines. Thus, they represent the most important efforts since 2009 to institutionalize child participation in Kenya.

**Participation within the Family, School and Community**

**Dennis Mutui, 17 years, school going in Nyandarua County**

“We Children were to be seen and not to be heard, but currently we have gone a step higher by forming the Children Assembly so as to be seen to speak louder and be heard (the owner of the shoe knows where it pinches most)”.

Source: The Children Voices.

The Guidelines for Child Participation provide an understanding of how children’s participation is viewed within the family, school and community in Kenya. They state that “while the CRC spells out the rights of children, the ACRWC highlights the roles of children in society”. The roles and responsibilities of children are also provided for in Section 21 of the Children Act, 2001 which includes:

a) Working for the cohesion of the family.

b) Respect for parents, superiors and elders at all times and to assist them in case of need.

c) Serving the national community by placing their physical and intellectual abilities at its service.

d) Preserve and strengthen social and national solidarity.

e) Preserve and strengthen the positive cultural values of their community in relation with other members of that community.

Source: Roger Hart’s Ladder of Children’s and Youth Participation (1992)

Following Roger Hart’s Ladder of Participation in the figure above, the different degrees of participation can be seen as a stepladder rising from minimal forms of participation (manipulation, decoration, tokenism, etc.), which are the most commonly conceded forms of participation, to full and complete participation seen at the top rungs of the ladder. Considering the many challenges Kenya faces with broadening democratic rights now entrenched in the 2010 Constitution, understanding what constitutes meaningful participation of children is essential.

In regard to the participation of children within the family, this issue was addressed in the 2009 Situation Analysis acknowledging that child participation is yet to be practised in Kenyan society including within the family, the community and amongst policy-makers, as well as children themselves. The Situation Analysis provides the following observation: 187

“The concept of participation is particularly difficult for disadvantaged, poor parents to understand and practise, because they themselves are subject to (and products of) exclusion in a society where disparity has remained or even widened in political, social and economic opportunities. Totalitarian child-rearing methods are partly a natural reflex sometimes attributable to the misunderstanding of the ‘best interest of the child’, mirroring the pervasive culture in society, exploitation of inherent vulnerability of children, the deeply-ingrained notions of hierarchy in traditional culture, as well as lack of information and persisting poverty.”

To date, the most common forms of participation involving children and youth in Kenya are institution-based participation, national or local participation including children and events-based participation.

**Institution-based participation**

The Children Assembly is an official structure established by the Department of Children’s Services (DCS) to promote child participation in decision-making on matters that affect them through networking amongst themselves and to facilitate their best interests nationally and internationally. Its functions are to address issues of child participation and involvement issues; enhance and strengthen child participation in all processes; provide an opportunity for children to be involved in decision-making; and enhance cooperation and information-sharing. The membership is established through an election process from the county to the national level. Currently, there are 47 County Children Assemblies and the National Children Assembly. This is where children meet once a year to discuss issues and matters of importance to them. Discussions at the county forums are thereafter taken to the national level through the National Children Assembly.

Other institutional activities that promote children’s participation have been sustained over time through stakeholder support. For example, with regard to children, the Ministry of Education, Science and Technology (MoEST) provides for extra-curricular activities to help children participate and harness their talents through sports, music, drama and music. In schools, children are getting the opportunity to take up leadership positions in national school committees and to voluntarily participate in children’s clubs. Consequently, decisions in schools are gradually being informed by the children’s own perspective and have proved to be more relevant, more effective and sustainable. The MoEST has successfully introduced elective school councils that aim to be a real voice in public secondary schools as opposed to the adult/ teacher selected prefect system. Thus far, the adoption rate of these councils is at 42 per cent of the 7,000 public secondary schools which has greatly facilitated participatory management of the institutions resulting in a significant reduction in conflict and an improved school climate. Principals attending the recent conference in Mombasa acknowledged that involving children in management of schools prevents unrest and promotes harmony.

The primary schools have also adopted the elected pupil councils, though at a slower rate. Initiatives involving children in the middle years, such as adolescents in late primary and in secondary education, show signs of moving away from merely informing children of their rights towards promoting their more direct and genuine involvement in matters that impact their lives.

The MoEST also undertakes co-curricular activities, such as the national drama and music festivals in all ECD, primary and secondary schools. In 2008, the MoE conducted a baseline survey on children’s participation in school, and also sponsored the International Education Week. The Ministry of Gender, Children and Social Development (MGCD) through the National Council of Children Services (NCCS) and DCS facilitated the participation of children in national and international celebrations to mark important events such as the Day of the African Child, World AIDS Day, International Day of the Family and World Day against Child Labour.

**National or local participation**

Since 2009 various issue-based consultations with children have been facilitated by various child-serving organizations. Some notable successes include the national consultations with children for their inputs to the new Children’s Bill, the Constitutional Review, and the CRC State Party reporting process, which are more in accordance with the Participation Guidelines aforementioned.

More recently the Government has fully supported activities that are more child-focused including the Children’s Assembly established as an annual event and the creation of a Children’s Helpline. Significant Government resources were allocated to support participation particularly targeting youths and women. Government funds were provided to the Ministries of Education, Ministry of Gender, Women and Social Development, as well as to MOYAS, with specific budgetary provisions for the Youth Enterprise Fund, National Youth Council, the Women Enterprise Fund and NCCS, among others.

**Event-based participation**

At the lower levels of the participation ladder, child participation has continued in the form of annual meetings or special events to provide platforms for highlighting children’s interests and drawing attention to the need to celebrate and institutionalize participation. Events such as the International Day of the African Child and other national days are good examples of this type of participation in Kenya. Nevertheless, while this approach is commendable and attracts much needed media attention, it is nevertheless event-based and likely to constitute “tokenism” as noted earlier in Hart’s Ladder.

**Non-state actors in child participation**

**Non-Governmental Organizations:** The local and international NGOs have also supported initiatives geared towards promoting children’s right to participation:

- World Vision Kenya has set up children’s parliaments across counties each with 40 members.
- Save the Children Canada’s Kenya office has repeatedly sponsored the Day of the African Child and has in place Rights of the Child Clubs (ROC) in a number of schools with each club comprised of 40 children.
- Plan International has Mecki Bora Clubs in schools spread across a number of counties.
- ANPPCAN has developed a Child Participation Programme that seeks to build the capacity of young persons as advocates for the protection of rights of orphans and other vulnerable children in Kenya.

Kids Club in Kibera slums supports the participation of about 299 children and the club’s patrons are trained in post-trauma counselling. CBOS, NGOs, corporate entities, among others, are invited to contribute financial support in order to rebuild some houses.

**Role of the Media:** One of the recommendations from the 2009 Situation Analysis was the need to establish strategic partnerships amongst stakeholders to promote children’s rights including the right to participation. To this end, child programming has developed significantly over the last five years involving children in children-based programmes in various television and radio stations in Kenya. Strategic partnerships and support have emerged through private sector sponsorship such as Citizen TV children-focused programmes (e.g. Machachari), school debates, screening of musical festivals, national schools sports and youth-friendly media. The media has been highlighting some of the challenges faced by Kenya’s children and youth through consistent reporting on the issues and the success of various initiatives. This shows that the media has become a formidable partner in the promotion of children’s rights.
Actions to Improve the Right to Education

Develop a national programme to enhance the “voice” of children, adolescents and youth focusing on the most marginalized which would include components for:

- Child Participation – by supporting existing efforts by Government, NGOs and CSOs to ensure that genuine and meaningful participation is fostered and exercised by children. This includes children-led initiatives, such as the Children’s Assembly, School-based Pupil Councils in primary schools, co-curricular activities, the celebration of children’s achievements, and school clubs.

- Adolescent and Youth participation – by consolidating gains made through the establishment of secondary school councils and the National Youth Council for out of school youth. With the support and collaboration of NGOs and Government, make operational the elected school councils in all public secondary schools.

Strengthen County and local mechanisms for participation through continued support to the county children assemblies. Institutionalize child participation to supplement school-based participation at all levels especially at the nascent counties.

Strengthen Children Assemblies. Although efforts such as the Children Assemblies and the Youth Parliament are in place, they are not operating for optimal results. There is a need to revamp these forums and involve as many children and youth from different regions across the country. There is also a need to link the Children Assembly structures and discussions to the existing county legislation and development agenda. In addition, community empowerment is necessary so as to demand accountability from policy makers regarding children’s participation.

Support policy advocacy and information dissemination. The scarcity of data and lack of structured information and dissemination mechanisms has derailed implementation and adoption of the child participatory practices. Good interplay between policy-makers, the media and like-minded stakeholders has not been fully exploited. The information required for the familiarization of the content regarding child participation to the community has only been availed to a few individuals, who are directly dealing with the target groups, and has not yet reached everyone. More awareness campaigns on child rights could be employed through the media and Area Advisory Councils’ (AACs) programmes for their appropriate adoption.

Improve quality of youth-friendly services. There is evidence of lack of coordination between Government agencies that are implementing children’s participation, policies and programmes, all issues that must be addressed if meaningful participation is to succeed.

Create a clear framework for coordination of activities undertaken by the Government and those of non-state actors (e.g. where the non-state actors run parallel programmes to those of government).

Promote and document children’s participation by:

- Keeping records on the content of child participation;
- Creating a ‘constituency’ of children in Parliament;
- Identifying vulnerable and marginalized children with regard to participation;
- Enhancing youth participation for minors who drop out of school.
Chapter VII
The Right to Child Protection

...an inadequate birth registration system leaves many children unregistered and creates barriers for children to access services.
Legal and Policy Frameworks

Children in Kenya have the right to be protected from all forms of violence, abuse, neglect, exploitation and harmful cultural practices, as well as inhumane treatment and punishment. This right is enshrined in a number of articles of the UN Convention on the Rights of the Child (CRC)\(^{188}\) and the African Charter on the Rights and Welfare of the Child (ACRWC), as well as in national legislation including some provisions in the 2010 Kenya Constitution. These rights are further strengthened by the CRC’s Optional Protocol on the Involvement of Children in Armed Conflict.\(^{189}\) The Second Optional Protocol, on the sale of children, child prostitution and child pornography was signed but not yet ratified by Kenya. Child protection is also interrelated with the achievement of the Millennium Development Goals (MDGs) – from poverty reduction, child prostitution and child pornography was signed but not yet ratified by Kenya. Child protection is also interrelated with the achievement of the Millennium Development Goals (MDGs) – from poverty reduction, child mortality, and harmful cultural practices, as well as inhumane treatment and punishment, and hazardous or exploitative labour. The Kenya Citizens and Foreign Nationals Management Service Act enacted in 2011 provides a framework for the right to identity for all. The Counter Trafficking in Persons Act 2010 provides for the prevention, suppression and punishment for trafficking in persons. A National Plan of Action for Combating Human Trafficking 2011-2015 that provides protection from abuse, neglect, harmful cultural practices, all forms of violence, inhumane treatment and punishment, and hazardous or exploitative labour. The Kenya Citizens and Foreign Nationals Management Service Act enacted in 2011 provides a framework for the right to identity for all. The Counter Trafficking in Persons Act 2010 provides for the prevention, suppression and punishment for trafficking in persons. A National Plan of Action for Combating Human Trafficking 2011-2015 that addresses prevention, protection and regional cooperation was also developed. The Prohibition of Female Genital Mutilation Act which criminalizes FGM was passed on 30th September 2011 and enforced on 4 October 2011. The law is accompanied by a comprehensive National Policy for the Abandonment of FGM/C 2009 (Female Genital Mutilation/Cutting) which was approved by Kenya’s Cabinet in 2010.

Key developments in the national legislation and policies: (since 2009)

- Article 53 (1)d of the 2010 Constitution provides protection from abuse, neglect, harmful cultural practices, all forms of violence, inhumane treatment and punishment, and hazardous or exploitative labour.
- The Kenya Citizens and Foreign Nationals Management Service Act enacted in 2011 provides a framework for the right to identity for all.
- The Counter Trafficking in Persons Act 2010 provides for the prevention, suppression and punishment for trafficking in persons. A National Plan of Action for Combating Human Trafficking 2011-2015 that addresses prevention, protection and regional cooperation was also developed.
- The Prohibition of Female Genital Mutilation Act which criminalizes FGM was passed on 30th September 2011 and enforced on 4 October 2011. The law is accompanied by a comprehensive National Policy for the Abandonment of FGM/C 2009 (Female Genital Mutilation/Cutting) which was approved by Kenya’s Cabinet in 2010.

Prospective legal developments

- In 2012, the Government commissioned the development of Guidelines for Alternative Care to be in line with the 2009 UN Guidelines for the Alternative Care of Children. The guidelines emphasize the need to keep children within their families and when this is not possible, to ensure family-based care arrangements are available. The guidelines also spell out the role of different duty-bearers such as the Ministry of Gender, Children and Social Development, Ministry of Justice and other Government institutions including the police and those responsible for immigration, hospitals and schools.
- A Legal Aid Bill and Legal Aid Policy have been drafted.
- The 2012 Family Protection Bill, which aims to reduce domestic violence, is currently undergoing internal review and stakeholder consultation.
- The Refugee Act from 2006 is currently under review and the Refugee Bill 2012 will be aligned to international human rights and refugee law and the Constitution of Kenya.
- Draft Operational Standards for Child Protection Units and a draft Police Training Manual on Child Rights and Child Protection were developed in 2010, but are yet to be adopted.
- The Persons with Disabilities Bill (Amendments), 2012, seeks to review the Persons with Disabilities Act 2003 to align it with CRPD (signed 2008) and the 2010 Constitution. This review is ongoing.

Whilst these are all significant advances, Kenya still needs to adopt additional legislation to fully protect children’s rights in accordance with the international standards in the CRC and ACRWC and other treaties to which it is a signatory. As noted earlier, the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography is one key international human rights treaty not yet ratified. Among the national laws, the 2001 Children Act still awaits a review. Several challenges have been identified with the Act, which is the main steering document for children’s rights in Kenya. The major contested issues include, but are not limited to:

- Clarity of roles and responsibilities of the main Government institutions, especially those of the former Ministry of Gender, Children and Social Development (MGCSD), DCS and NCCS.
- The need to recognize and underline the roles and responsibilities of other Government ministries in child protection and the importance of them embracing a child protection system approach.
- Refocusing the language to reflect an emphasis on alternative family-based care as opposed to institutionalization.
- Care and maintenance of children, diversion, and corporal punishment.
- Legal representation of children within all court processes involving children.
- The age of criminal responsibility.

188 Relevant UN CRC articles are e.g. Article 2, 6, 9, 16, 26, 31, 32, 33, 34, 35, 36 and 39.
189 Kenya ratified the Optional Protocol on the Involvement of Children in Armed Conflict on 28 January 2002. It has yet to ratify the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, or the Third Optional Protocol to the CRC, which was adopted by the UN General Assembly in 2011 and allows for a complaints procedure for children.
The overview and analysis of the existing child protection-related policies and laws were put on hold as a consequence of the focus given to the development and implementation of the new Constitution. With the new government structure in place, the process will now restart. It is set to be done by August 2014.190 Discussions indicate that this should include a comprehensive review of the relevant children laws, including the Constitution, with a view to having a comprehensive piece of legislation that is sensitive to child rights.

Building a Child Protection System

A child protection system is defined as “a set of laws, policies, regulations and services, capacities, monitoring and oversight needed across all social sectors (…) to prevent and respond to protection-related risks”.191 Building a protective environment for children to help prevent and respond to violence, abuse and exploitation requires adopting a wide range of measures directed at:191

- strengthening Government commitment and capacity to fulfill children’s right to protection;
- promoting the establishment and enforcement of adequate legislation;
- addressing harmful attitudes, customs and practices;
- encouraging open discussion of child protection issues that includes media and civil society partners;
- developing children’s life skills, knowledge and participation;
- building capacity of families and communities;
- providing essential services for prevention, recovery and reintegration, including basic health, education and protection; and,
- establishing and implementing ongoing and effective monitoring, reporting and oversight.

Under the leadership of the former Ministry of Gender, Children and Social Development (now Ministry of Labour, Social Security and Services), the national child protection community has been working towards a strengthened child protection system – a comprehensive, sustainable, coordinated approach that recognizes that children can face multiple and simultaneous protection risks that require coordinated prevention and response services. Substantial progress has been made since 2009 towards strengthening Kenya’s child protection system, including cementing a joint commitment to this approach to protect children. A mapping and assessment of the current system was conducted in 2010 that identifies priority gaps that should be addressed. Based on this mapping a draft Child Protection System Strategy (May 2011) was developed. The strategy highlights the public sector contributions to the child protection system under Kenya’s Medium Term Expenditure Framework (MTEF), and emphasizes gaps that represent important opportunities for engagement by Kenya’s development partners and other actors.

Important recent developments aimed at strengthening the existing child protection programmes and services include:

- A national case management database for child protection cases was established, hosted within the Department of Children Services. This forms part of a planned national information management system.
- Expansion of core child protection services to several districts including Garissa, Eldoret, Kakamega, Malindi, Mombasa, Nairobi, Nakuru, and Siaya. This includes child protection centres, child protection units in police stations and gender-based violence recovery centres.
- A significant increase in the number of children’s officers to 378190.

Need for a Systems Approach to Child Protection

Protecting children against abuse, violence, neglect and exploitation is an obligation shared by many different actors, involving different elements of Government as well as a broad array of civil society agencies and communities. A number of countries in Sub-Saharan Africa are now actively promoting systems-strengthening as a means to achieve more effective and efficient child protection responses. A systems approach places emphasis on the use of a holistic strategy and strategic partnerships to increase protection for all children, and moves away from backing small scale, vertical projects that only target high visibility, at-risk categories of children. A “child protection system”, then, can be defined as a comprehensive and sustainable approach to preventing and responding to child protection issues, comprising the set of laws, policies, regulations and services required across all social sectors – especially social welfare, education, health, security and justice – to respond to and prevent protection-related risks.”


Also noteworthy are several programmes which have resulted in improved child protection outcomes. For example, the Department of Civil Registration has worked to raise the level of public awareness on the importance of birth registration, with the support of UNICEF and other partners.

In regard to human trafficking, the MGCSD has begun to collect information on trafficking cases from the police, media, foreign governments and United Nations Office on Drugs and Crime (UNODC) that will be used for designing more effective programming and interventions.194

190 As per the “Advice on the status of implementation of the constitution and system of devolution running for the period of June 2013 to December 2013” published in the Daily Nation 28th May 2013, the Children Act is set for review by August 2014.
193 Ministry of Labour, Social Security and Services, 2nd April 2014.
Child Protection Concerns

All children in Kenya are potentially at risk of violence, exploitation and abuse; however, some groups are particularly vulnerable due to their gender, social status or geographical location. Children without parental care lack the protective environment and supervision that adult care normally provides. Children in large families may also lack parental attention and can become victims of neglect. Although both boys and girls are victims of child protection violations, due to socio-cultural factors, cultural practices and economic constraints, girls are particularly vulnerable to violence, sexual abuse and harmful practices. The situation for children is sometimes worsened by the multiple deprivations that exist within population groups and communities, though data and studies on these issues are scarce. Violations of children’s rights occur daily across the country including physical violence, harmful traditional practices, sexual exploitation and abuse and neglect. This section addresses a number of child rights violations that are of major concern in Kenya.

The Right to an Identity: Both the CRC and the ACRWC provide that every child shall be registered immediately after birth (articles 7 and 6 respectively). Children who do not have a birth certificate are particularly vulnerable to child protection violations, as their age and identity cannot be determined. Thus, they are more vulnerable and may become victims of trafficking, be treated as adults in prison and have more difficulties in accessing social services. The right to identity is enshrined in the Kenya Citizens’ and Foreign nationals Management Service Act from 2011. This right was strengthened through a ruling in April 2013 which confirmed the right of adopted children to a birth certificate.

The most recent statistics for birth registration in Kenya states that overall 57.35 per cent of the children are registered, but only 24 per cent of under-five children have a birth certificate. However, there is significant national variation with 86.7 per cent of children registered at birth in Nairobi, while only 21.25 per cent registered in the former North Eastern region. Low awareness of the importance of birth registration may be an explanatory factor, as may the lack of access to health and registration facilities. Birth registration is not yet fully decentralized, which means there can be long distances to registration services. After the child is six months old, a penalty fee is required to register a child, and the procedures are more complicated. This may also deter some parents from registering their children. Cases of discrimination against children of certain descent have been noted, in clear violation of Kenyan laws, where they have not been allowed to obtain birth certificates.

Violence against Children and Neglect: According to the nationwide Violence against Children Report completed in 2012 (GoK and UNICEF), violence against children is a serious problem in Kenya with lifetime consequences for victims. An estimated 73 per cent of boys and 66 per cent of girls have experienced physical violence before the age of 18. The report concludes that sexual and physical violence does not discriminate on the basis of ethnicity or socio-economic status. Violence against children is most frequently being committed by persons who are closest to them, including their parents, relatives, figures of authority such as teachers and religious leaders, and other people unknown to them. Over 50 per cent of children report that they have been physically abused by their parents before the age of 18, showing that domestic violence is a considerable problem.

Exposure to violence has negative consequences for cognitive development, including language deficits and reduced cognitive functioning. Girls who reported experiencing sexual violence in childhood were significantly more likely to report feelings of anxiety, depression, suicidal thoughts, and fair or poor health. They were more likely to have multiple sexual partners in the past 12 months, thereby becoming more at risk of sexually-transmitted disease and HIV/AIDS.

Violence in schools remains a major concern. Among females and males who reported being punched, kicked, whipped or beaten with an object by an authority figure prior to age 18, teachers accounted for 52.1 per cent and 56.8 per cent respectively of perpetrators reported by females and 96.2 per cent of perpetrators mentioned by males. The recent Basic Education Act 2013 strengthens the legal ban of corporal punishment, clarifying that it is a criminal offence. The effect of this law is yet to be seen. The Government of Kenya has followed up the Violence against Children Study by developing a response plan, outlining several key strategies to combat and prevent violence. This plan is currently being finalized.

Figure 14: Violence against children in Kenya

<table>
<thead>
<tr>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced sexual violence prior to the age of 18</td>
<td>17</td>
</tr>
<tr>
<td>Experienced physical violence prior to the age of 18</td>
<td>73</td>
</tr>
<tr>
<td>Experienced emotional violence prior to the age of 18</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: Violence Against Children Study, GoK/UNICEF 2012

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196 Based on a ruling in the case of the Organization for National Empowerment versus the Principal Registrar of Birth and Deaths, Petition 269, 2012.


198 Annual Civil Registration Statistics Report 2010, Statistic Section, Department of Civil Registration, Ministry of State for Immigration and Registration of Persons, July 2011. According to the Republic of Kenya 2011, 4th and 5th State Party Report to the UNCRC Committee there was an increase in actual registration of children from 94.4 per cent in 2005 to 98.6 per cent in 2010. These figures include late registration that accounts for 57.2 per cent refugee and asylum seeking children. Nyeri Valley province recorded the highest birth registration (142.52 per cent) for the year 2010 followed by Western (132.49per cent), Eastern (106.25 per cent) and Narok (73.07 per cent). A total of 8.2 per cent and 12.2 per cent refugee and asylum seeking children were registered at birth in the year 2010 while 1.6 per cent and 1.5 per cent refugee and asylum seeking children were registered after six months. The overall figures are slightly different in the Annual Civil Registration Report 2010, however, the overall trend is the same, with 45.2, 2010 to 541,664 in 2005.

199 According to the Demographic and Health Survey 2008-2009 59.3 per cent of children under 2 were registered. According to the Republic of Kenya 2011, 4th and 5th State Party Report to the UNCRC Committee there was an increase in actual registration of children from 94.4 per cent in 2005 to 98.6 per cent in 2010. These figures include late registration that accounts for 57.2 per cent refugee and asylum seeking children. Nyeri Valley province recorded the highest birth registration (142.52 per cent) for the year 2010 followed by Western (132.49per cent), Eastern (106.25 per cent) and Narok (73.07 per cent). A total of 8.2 per cent and 12.2 per cent refugee and asylum seeking children were registered at birth in the year 2010 while 1.6 per cent and 1.5 per cent refugee and asylum seeking children were registered after six months. The overall figures are slightly different in the Annual Civil Registration Report 2010, however, the overall trend is the same, with 45.2, 2010 to 541,664 in 2005.

200 According to the Demographic and Health Survey 2008-2009 59.3 per cent of children under 2 were registered (Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010.

Cases of child neglect constitute the largest percentage of the caseload of the Department of Children’s Services, rising from 21,496 to 49,057 during the period 2005-2010. A majority of the cases involve neglect by fathers. A previous ambiguity in the Children Act 2001 regarding the conditions for acquiring parental custody has now been settled by the Constitution with both parents bearing responsibility regardless of their marital status. Many of the cases of neglect have led to children being removed from their families and placed in Charitable Children’s Institutions or alternative care institutions.204

The Figure below shows the number of violence and abuse cases that were reported by Kenya as a State Party to the Committee on the Rights of the Child. The data source includes the Department of Children’s Services, the Police and Child Rights Advisory Documentation and Legal Centre (CRADLE), a Kenyan non-governmental organization committed to the protection, promotion and enhancement of the rights of the child.

**Figure 15: Violence and Abuse in Kenya**

![Graph showing violence and abuse cases](source)

Source: The Republic of Kenya 3rd, 4th and 5th State Party Report to the UNCRC Committee

Children Living or Working in the Streets: It is estimated that in Kenya around 250-300,000 children live and work on the streets.205 Most of them come from rural areas and from large families or single parents. The overall root cause for them to reside on the streets is socio-economic factors, poverty and lack of care in the family setting. Many children list lack of food, being victims of abuse and lack of access to education as the direct causes for leaving their homes.206 The major pull-factor is the ability to make money.207

On the street most children face lack of food, shelter and harsh weather and face harassment from the police and other security agents. Child prostitution is high among these children, as they seek protection, money or food to sustain them. The number of children living in the streets has increased in some areas as a consequence of the drought forcing children to migrate to urban areas in search of a better life. About 12 per cent of the children currently living on the streets in Rift Valley area cite drought as the main reason for leaving home.208

**Figure 16: Child Labour caseload**

![Graph showing child labour caseload](source)

Source: DCS Casedalo distribution data 2012

Child Labour: The prevalence of child labour remains high in Kenya. The Kenya Integrated Household Budget Survey (KIHBS) 2005-2006 survey found that 1.01 million children aged 5-17 years were working in conditions for pay, profit or family gain. Furthermore, the survey established that there are 19,542 children working in conditions that fall within the definition of the worst forms of child labour.209

In 2012, research in the districts of Busia, Kilifi, and Kitui showed that between 46 and 64 per cent of children had worked for economic gain at some point in their lives. Most of these children lived with their parents, indicating that parents are not able to protect their children from engaging in labour.210 The majority of children work in the informal sector, for example, in subsistence and commercial agriculture, construction, mines or as domestic servants.211 The most recent information on child labour caseload is shown in Figure 16 above. However, it reveals only a fraction of the total estimated.

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** Trafficking and Sexual Exploitation:** Trafficking and sexual exploitation of children continues to be a major concern, especially in the tourism industry in urban centres. Kenya is a country of origin, transit, and destination for trafficked persons. Around 17,500 Kenyans are estimated to be trafficked annually212 for domestic work, forced labour, and commercial sexual exploitation. Judging from international estimations on child trafficking, about 50 per cent are likely to be minors.213 In 2011, the national Child Helpline received 46 reports of child trafficking and 19 concerning child prostitution.214 Internal human trafficking


210 Save the Children, 2012.


is the most identified form of trafficking in Kenya with women and children being the most commonly identified victims. Research indicates that it occurs primarily from rural to urban areas, particularly in towns such as Eldoret, Kisumu, Malindi, Mombasa and Nairobi.

The situation was exacerbated by the drought emergency of 2011 that affected large parts of the country. Displaced persons are particularly vulnerable to trafficking as they may more readily accept false offers of employment or education to escape the insecurity and instability inherent to displacement. The Government is making significant efforts to comply with the minimum standards for the elimination of trafficking, but several critical gaps exist, such as the full enactment of the anti-trafficking laws, and coordination of Government actors.215 Reporting cases continues to be a challenge since many children as well as adults lack confidence in the effectiveness of the authorities to handle reported cases.216

The 2006 Sexual Offences Act (SOA) provides strong legal protection for victims of sexual violence (rape, defilement, child trafficking, child prostitution, child pornography, and other related issues) clearly establishing that sexual offences are acts of violence and increasing the focus on bringing the perpetrators to justice. However, major steps need to be taken in terms of implementation, with increased coordination and resource allocation to enable actors to provide witness protection, awareness-raising about the SOA, improved investigative and prosecutorial capacity. Also needed is improved provision of psychosocial support for survivors of sexual offences in Kenya.217

Harmful Traditional Practices: Female Genital Mutilation/Cutting (FGM/C) is widely practised in many Kenyan communities. The practice is widely condemned as harmful because it potentially poses a great risk to the health and well-being of the women and girls who are subjected to it. It is also generally recognized as a violation of children’s and women’s rights (e.g. by the 2011 FGM Prohibition Act.). According to the Kenya Demographic Health Survey (KDHS) 2008-2009, 27 per cent of girls and women aged 15-49 years in Kenya have undergone FGM/C. The proportion of women circumcised increases with age, from 15 per cent of women age 15-19 to 49 per cent of those aged 45-49, signalling that the practice is decreasing. A higher proportion of rural women (31 per cent) than urban women (17 per cent) have been circumcised. The practice varies tremendously by province. The proportion of women circumcised ranges from 1 per cent in Western province to 98 per cent in North Eastern province.218 With regard to ethnicity, FGM/C is far more prevalent among the Somali (97.6 per cent), the Kisi (96.1 per cent), and the Maasai (73.7 per cent) than among other groups. It is least common among Luo and Luhya women.

There is a strong relationship between education and wealth level and circumcision status. Fifty-four per cent of women with no education report that they are circumcised, compared with only 19 per cent of those with at least some secondary education. Community education programmes and community dialogues on FGM/C are ongoing in areas where the practice is prevalent. In 2012, four years of community dialogues and engagement supported by community elders, Government departments, religious leaders and civil societies, culminated in three community public declarations and commitments to support abandonment of FGM/C in Meru, Moyale and Tana River counties.

Child marriage is another serious child rights violation. UNICEF Country statistics show 6 per cent of all girls are married by the age of 15 and 26 per cent by the age of 18. Among the pastoralist communities of Northern Kenya, child marriages are particularly common. According to UNICEF’s 2008 Multiple Indicator Cluster Survey (MICS) in Eastern province, 56.5 per cent of girls in the Moyale district were married before 18 years. In times of emergencies and disasters, there is a rise in the incidence of child marriage, as the economic pressure on the family increases. In Kenya, this phenomenon is called "famine brides".219

Children with Disabilities: Article 13 of the ACRWC provides that every child who is mentally or physically disabled shall have the right to special measures of protection in keeping with his physical and moral needs and under conditions that ensure his dignity, promote his self-reliance and active participation in the community. Kenya ratified the Convention on the Rights of Persons with Disabilities on 19 May 2008. As a State Party it has a duty to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.220

According to the Kenya Social Protection Sector Review 2012,221 the total number of children with disabilities is 349,086. Considering the stigma and shame associated with having a disability in Kenya, the real figure may be much higher. Children with disabilities may be deprived of child protection and are likely to become victims of human rights violations, due to the social attitudes, stigma as well as persistent discriminatory behaviour. Many of the charitable children’s institutions whose aim is to guarantee the rights of persons with disabilities lack the capacity to meet their obligations as duty-bearers. One improvement taking place since 2009 is the development of guidelines. In 2010 the Ministry of Health developed Guidelines on Identification and Referral of Children with Disabilities and Special Needs. The guidelines are aimed at health workers, as well as caregivers. A training manual for health workers on prevention, early identification and intervention on disability is currently being finalized by the Ministry. These two attempts show progress in realizing the rights of children with disabilities. However, challenges exist in relation to disseminating the documents and providing sufficient training for their application.222

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215 Ibid
217 Sexual Offences Act, Implementation Workshop, 26-27 May 2011. Summary Report, produced by the Task Force on the implementation of the Sexual Offences Act 2006. The Task Force was in place between 2007 and 2012 to ensure the implementation of the Act
218 Roughly one third of women in Eastern, Nyahururu and rift valley provinces have been circumcised compared with over one quarter of those in Central province, 14 per cent of those in Mombasa, and 10 per cent of those in coast province
219 Breaking Vines: Early and Forced Marriage and Girl Education, Plan UK 2011
220 See, articles 2 and 17 of the Convention on the Rights of Persons with Disabilities
222 Ministry of Health, Implementation, Validation Workshop, Nakuru 24 June 2013
Orphans and Children Affected by HIV: Approximately 3.6 million Kenyan children are orphans or otherwise classified as vulnerable according to the 2012 Kenya Social Protection Sector Review.223 An estimated 63.9 per cent of children (0-14 years of age) are living with both parents, 22.9 per cent with one parent, and 9.5 per cent with neither.224 Most children are separated from their parents due to parents’ death, poverty, natural disasters, and disintegration of families through separation and divorce. An estimated one million children have lost a parent to AIDS.225 Some parents believe that Charitable Children’s Institutions (CCIs) provide services which children lack at home and consequently many are placed in these institutions.

Orphan children who lack monitored adult care are particularly vulnerable, and may become victims of violence and abuse, including harmful labour, recruitment into gangs and sexual exploitation. Children who lose their parents suffer stress and trauma in addition to the loss of parental love, care and protection and often their inheritance. Children living with parents sick from HIV and AIDS, for example, are often given the responsibility to take care of the sick parent and their siblings. They are also particularly vulnerable to all forms of risks. These children are one of the main beneficiary groups of the OVC Cash Transfer programme (See Chapter III Child Poverty and Deprivation for information about this programme).

According to DCS September 2012 data,226 there are over 700 CCIs in Kenya housing approximately 40,000-42,000 children. However, the exact number of children residing in these institutions is unknown and may be higher. Out of 700 institutions, 591 are legally registered. Children in CCIs are denied parental nurturing and care, bonding and emotional development opportunities, and are at high risk of being abused.

There are currently five accredited adoption societies in the country. The number of local adoptions formed 60 per cent of the total compared to about 40 per cent for inter-country adoption in 2008.227 The internationally recommended good practice is to maintain inter-country adoptions at less than 30 per cent of total adoptions. Increasingly in Kenya, it is believed that it is more beneficial for children to live in alternative community-based care, instead of in institutions, and guidelines for this approach are being developed.

Children in Conflict with the Law: Children make up an estimated 4 per cent of the prison population, and most of them are accompanying imprisoned mothers.228 Only 15-20 per cent of children in police custody or in correctional facilities could be defined as being in conflict with the law. A majority of these have committed only minor offences that should not require incarceration.229 The age of criminal responsibility in Kenya remains at 8 years, although there is currently a proposal to raise this to 12 years as part of the review of the Children Act, 2001. Preliminary findings of the Situation Analysis of Children in the Justice System (UNICEF/GoK) indicate that children are continuously exposed to mistreatment by the police and are often confined with adults due to lack of child-friendly facilities. The existing 14 Child Protection Units (CPU) constructed at police stations around the country have varying degrees of capacity. A CPU is a child-friendly desk where cases involving minors are addressed at the policy station by officers in the Protection Units (CPU) constructed at police stations around the country have varying degrees of capacity. A CPU is a child-friendly desk where cases involving minors are addressed at the policy station by officers trained in a child-friendly approach.

Access to child-friendly legal services remains limited. Although there are five Children’s Courts in Eldoret, Kakamega, Mombasa, Nairobi and Nakuru, all other courts only have one or two Children’s Magistrates. Legal aid for children in the justice system is not systematically provided by the state. However, a pilot project by the National Legal Aid and Awareness Programme, under the Ministry of Justice, has been facilitating the provision of legal aid services for children in conflict with the law in Nakuru and children in contact with the law230 in Nairobi, which has benefited 9,462 and 967 children respectively (2010-2012). The project has been evaluated, and it will now be rolled out in the form of a national legal aid scheme through the enactment of the Legal Aid Bill. The figure below shows the number of children according to data of 2012 that were either in unlawful confinement, in conflict with the law, or regarded as delinquent.

**Figure 17: Children in conflict with the law**

Source: DCS Caudle Distribution Data 2012

Use of Illicit Drugs: Article 33 of the CRC provides that States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

According to the National Authority for Campaign against Alcohol and Drug Abuse (NACADA), the drug and substance abuse in Kenya is escalating including among children and youth and is considered “a major social and public health problem” by the same authority.226 Alcoholism, drugs and substance abuse is a common occurrence in Kenya among young people and youth in all communities.

In an attempt to address the problem of drug and substance abuse the Government created the National Agency for Campaign against Alcohol and Drug Abuse in 2001, which was later replaced by NACADA in July 2012 with a strengthened mandate to coordinate and harmonize drug abuse prevention, education and awareness. A toll-free phone number (1192) was established to assist persons, including children, who abuse drugs or are affected by drug and substance abuse. All Government ministries are required, through performance contracting, to report on drug-related activities undertaken with children and youth.

School management is supposed to ensure measures are in place making the schools drug-free areas and to educate children about the dangers of drugs. Teachers trained in counselling, including for drug abuse, have been deployed to schools.

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226 Provided by a Department of Children Services official during a telephone conversation, October 2012.
229 Save the Children Sweden, The Diversion Project in Kenya, An Internal Appraisal of the Period 2004-2007. An estimated 229,953 children were infected by HIV in 2010, according to the Government of Kenya’s State Report to the UNODC.
230 Children in conflict with the law are children who are suspected of committing a criminal offence, children in contact with the law may be children who used legal aid to obtain their basic rights, including food, clothing and shelter.
231 National Authority for the Campaign Against Alcohol and Drug Abuse, 2016.
In addition to the state, parents and families have a key role in protecting children from alcohol and drug-related concerns, including drug and other substance abuse. Another study conducted by NACADA in 2010 points out that 87.8 per cent of the parents participating indicated they had knowledge of children abusing alcohol and drugs, and 12.4 per cent acknowledged that these were children under their care. It is widely recognized that children living with parents with alcohol-related problems are more at risk of depression and low self-esteem and that substance abuse during adolescence is the single most predictive factor for being dependent on drugs as an adult.

Major Causes and Capacity Gaps in Child Protection

- Poverty remains the main underlying cause of a majority of child protection deprivations. Poverty aggravates already difficult conditions caused by, for example, chronic discrimination, violent conflict or drought. Economic instability may also cause parents to take their children out of school to work in hazardous labour. Some children are abandoned or orphaned while others leave their families due to their inability to provide and care for them.

- Gender inequality and inequity are among the root causes. When in dire situations, parents may choose harmful coping strategies, such as marrying their daughters off at a very young age. FGM and sexual violence are other examples of child rights violations with its origin in gender inequality. Children in Northern Kenya, and in rural areas, are another group that raises child protection concerns. On average they are more likely to live in extreme poverty, and hence, to experience the shocks and consequences arising from families choosing harmful coping strategies.

- Prevailing beliefs and behaviours, shaped by social norms and a lack of awareness of children’s rights leads to cases of abuse and violent acts against children go unreported or ignored. In many cases such acts are not considered unlawful by the victim or perpetrator. In fact, children are most at risk from violence at home and abuse committed by persons who are known to the victims or are responsible for their welfare. Social norms may explain why some practices remain despite an adequate legal framework which prohibits them. For example, in many communities that practise FGM/C, social approval or disapproval plays an important role, and following the tradition provides respect and maintains the social standing of the family. In these communities FGM/C is more than a social convention, it is a social norm.

- Lack of access to services is a cross-cutting underlying cause of children’s rights violations. The limited access to birth registration systems contributes to the problem leaving many children unregistered, thus creating barriers for children to access services. Many children have to walk long distances to reach health centres, child protection centres and child-friendly courts, as they are mainly located in urban areas. Access to child protection services is hindered by the poor condition of the roads and long distances between towns/villages.

- The capacity gaps found in the social work force are an important underlying cause of lack of child protection services. Lack of personnel, knowledge and the limited required infrastructure hampers the ability of this important group to provide the services that children and their families need. There is still a low number of children’s officers (mainly in district headquarters), and a lack of back-up of qualified social workers. Currently, there are no minimum standards for an officer working with children regarding experience and education.

- There is low availability of child protection infrastructure and budgets to create an adequate national system. There are also few institutional programmes funded and supported for training adequate numbers of personnel relative to the problem, monitoring and evaluation systems for child protection nationally, as well as links to adequate service provision and forward planning. Inter-sectoral coordination in child protection is another issue of concern.

- Poor of implementation, monitoring and evaluation of laws and policies is hampering the protective effect of the current system. The Government is the main duty-bearer responsible for ensuring the child’s right to protection through an effective child protection system. The mapping and assessment of the existing components of the child protection system revealed that Kenya has a foundation to build on. There are numerous challenges, including limited human, financial and technical capacities. Inadequate funding prevents the creation of coordination mechanisms and key components such as child protection centres and children’s officers. The current devolution process represents a good opportunity for strengthening the child protection system.

Equity in Child Protection

Lack of national and disaggregated data on many child protection issues makes an equity analysis difficult. There are ongoing exercises to improve the availability of data on violence against children and on children in the justice system. Great strides have been made in the formulation and roll-out of the child protection system. However, stronger equity considerations would improve the reach and the quality of the system. One major programme is the Cash Transfer for Orphans and Vulnerable Children (CT-OVC) which has significantly reduced poverty, improved diet and increased secondary school enrolment. Nevertheless, some aspects of the programme may not be equitable, including its geographic targeting, the uniform level of transfer for households of all sizes and its focus on orphans and chronically ill children as the primary target group, which excludes many other children living in poverty.
Actions to Improve the Right to Protection

Strengthen the legal and policy framework including improved coordination:

1. The relevant ministry and the Kenya Law Reform Commission should finalize the review and amendment of the Children Act, including addressing the main gaps identified in terms of clarification of roles, responsibilities and coordination.

2. The relevant ministry should strengthen the National Child Protection Committee so that it is able to fully resume its role as the key Government coordination body on child protection, and the management structure of the NCCS should be clarified.

3. Key legal developments pending such as the Legal Aid Bill and Legal Aid Policy, the Family Protection Bill, the Refugee Bill, the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, and the Persons with Disabilities Bill should be completed by assigned ministries. The VAC response plan should be finalized by the DCS and implemented under the leadership of the same.

Improve financial, technical and professional capacity of duty-bearers:

4. The National Treasury should increase the budget allocations for child protection, reflecting a systems perspective and include provisions for key components such as child protection centres with key service-providers including additional children’s officers and monitoring and evaluation systems.

5. The Ministry of Labour, Social Security and Services should increase the number of children’s officers, social workers and counsellors, distributing them across counties in a manner that ensures an equitable response.

6. The Ministry of Labour, Social Security and Services together with its partners, including UNICEF, should develop a capacity-building plan for all social welfare officers, especially in the Government based on the Social Welfare Workforce Analysis recommendations.

7. The Ministry of Interior and Coordination of National Government should strengthen the national training curriculum for both new and in-service personnel on child rights and child protection and train police officers to ensure the provision of child-friendly services, including functional Child Protection Units at Police Stations.

8. A diversion programme for children in conflict with the law should be implemented by the Ministry of Interior and Coordination of National Government in collaboration with the Department of Justice and Department of Children’s Services based on the information obtained from the Situation Analysis of Children in the Justice System.

9. The Department of Children Services should lead the roll-out of the new Guidelines on Alternative Care and Practice of Standards, accompanied with sufficient training to increase the use of alternative care solutions for separated and orphaned children.

Strengthen monitoring and evaluation and research for child protection:

10. The Department of Children Services should lead the development of a comprehensive information management system for child protection, including rolling out the child protection database on a national scale, linking it to other key data management systems, and complementing it with information-sharing mechanisms, joint indicators, baselines and targets.

11. Government of Kenya, UNICEF and NGO partners should invest resources in studying, engaging and strengthening the community-based approaches alternatives to child protection, and linking the informal and formal systems to each other.

12. Research on children with disabilities, child labour and other data/knowledge gaps should be conducted by UNICEF, GoK and other stakeholders.

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237 In the current structure of ministries within the Government of Kenya the Department of Children falls under the Ministry of Labour, Social Security and Services.
A rigorous and child-focused disaster risk and conflict-informed approach to development and service-delivery is needed in high-risk areas to systematically build community resilience to recurrent shocks.
In recent years, the concept of resilience has been gaining traction in the international aid community in light of the number of people being affected by disasters, conflicts, epidemics and other disasters throughout the world. This concept suggests that more attention needs to be paid to the importance of building the resilience of the most vulnerable communities exposed to recurrent and chronic emergencies as an integral element of sustainable development. UN, UNICEF Draft Position Paper on Resilience, drafted by the Regional Offices of East and Southern Africa (ESARO) and West and Central Africa (WCARO), Nov. 2012.

Legal and Policy Frameworks

One of Kenya’s major development challenges is the ability to manage disasters. Kenya continues to experience emergencies linked to natural disasters such as drought and floods, ethno-political and resource-based conflicts, and outbreaks of human and livestock diseases. Consequently, the country’s many disaster and conflict-related policies and programmes are currently under the spotlight. In addition, policies and programmes under consideration are those aimed more generally at improving the resilience of the country’s poor population to withstand ongoing crisis by strengthening livelihoods, health and other social assets.238

Since 2009, in response to on-going conflict and crises in the country, the Government developed and implemented a great number of important policies. It carried out a full range of actions intended to address the need for more durable approaches on a broader front. The key guiding document is the 2010 Constitution which requires the principles of ‘no child left behind’ and ‘the best interests of the child’ to be embedded in all national policies and legal frameworks. Kenya’s Vision 2030 provides the country’s medium to long-term objectives for reducing vulnerability across the country through poverty alleviation and more equitable growth, higher per capita incomes, and more diversified, productive economic activity and exports. These are all key structural requirements for a low income country like Kenya to move beyond the present context of high poverty, on-going crisis, ethnic and other conflicts based largely on low productive, resource-based ethnic/community competition.

The Government has undertaken diverse measures and adopted a wide range of policies and programmes in response to natural disasters, internal displacement and refugees, several of which are highlighted below:

- The Ending Drought Emergencies Kenya Country Plan (2012) and chapter of the Medium Term Plan II provide a national framework for resilience building efforts in the future. The formation of the National Drought Management Authority in November 2011, whose responsibilities include coordination and leadership in the prevention and mitigation of drought emergencies and in climate change adaptation, received support from a number of humanitarian actors in the form of technical advice and resources.

- The National Policy for the Sustainable Development of Northern Kenya and other Arid Lands (the ‘ASAL Policy’) provides for the institutional arrangements which will ensure effective management of drought risks, principally by means of the National Drought Management Authority and the National Drought and Disaster Contingency Fund, supported by the ASAL Secretariat.

- The National Policy on the Prevention of Internal Displacement and the Protection and Assistance to Internally-Displaced Persons in Kenya, was adopted in October 2012. It provides for a comprehensive approach to addressing internal displacement caused by conflict and other forms of violence, natural disasters and development projects, irrespective of IDPs’ location and ethnicity. It outlines the institutional framework, roles and responsibilities for state and non-state parties in all phases of displacement, and articulates measures to prevent, manage, and to mitigate against it and protect IDPs to find durable solutions.239

- The Prevention, Protection and Assistance to Internally-Displaced Persons and Affected Communities Act, 2012, establishes an institutional framework for IDPs’ protection and assistance. A new body, the National Consultative Coordination Committee on Internally-Displaced Persons, is responsible for coordinating and overseeing its implementation.240


238 In recent years, the concept of resilience has been gaining traction in the international aid community in light of the number of people being affected by disasters, conflicts, epidemics and other disasters throughout the world. This concept suggests that more attention needs to be paid to the importance of building the resilience of the most vulnerable communities exposed to recurrent and chronic emergencies as an integral element of sustainable development. UN, UNICEF Draft Position Paper on Resilience, drafted by the Regional Offices of East and Southern Africa (ESARO) and West and Central Africa (WCARO), Nov. 2012.

239 UNHCR, February 2013

240 Internal Displacement Monitoring Centre: Kenya, IDPs significant needs remain as inter-communal violence increases 28 December 2012 www.internal-displacement.org
National Disaster Management

The Government recognizes that resilience, risk reduction and disaster management, particularly community level capacity and response, are key components of national development policies and programmes, including the development blueprint, Vision 2030. Considerable effort has been made in exploring the development of an overarching national disaster management policy that would emphasize broad-based strategies such as resilience/risk preparedness, response and post-disaster recovery, community livelihood and risk response capacities – but with little effect to date. The Government acknowledges the need for a paradigm shift towards such a comprehensive risk reduction culture. This would include the capacity to better manage response and recovery at all levels through more holistic disaster management strategies involving all stakeholders in and beyond Government departments and agencies.

As a result of the lack of a unified policy framework, a recent Government report notes that “an adequate level of [disaster] preparedness required to address [Kenya’s] significant risk profile has not been achieved.” Initiatives have been undertaken in an inconsistent, inharmonious, reactive and uncoordinated manner, that has precluded meaningful action on proactive and preventive strategies. Notwithstanding the many policies and programmes already in place, the seriousness of disaster frequencies, complexity, scope and severity of impact has grown more acute in recent times as was recognized in both the country’s Disaster Risk Reduction Strategy (2006-2016) and National Disaster Response Plan (2009).

Resilience and Disaster Risk Reduction

Resilience: The ability of children, families, communities and systems to withstand, adapt to and recover from shocks and threats (e.g. natural disasters, epidemics, socio-economic instability, conflict) in ways that support economic and social development, preserve integrity, and do not deepen vulnerability (UNICEF Resilience paper, 2013).

Disaster Risk Reduction: The concept and practice of reducing disaster risks through systematic efforts to analyze and manage the causal factors of disasters, including through reduced exposure to hazards, lessened vulnerability of people and property, wise management of land and the environment, and improved preparedness for adverse events (UNISDR).

While there has been significant progress in addressing the policy and institutional framework for promoting drought resilience through the Ending Drought Emergencies Paper, the gazetting and formation of the National Drought Management Authority (NDMA) and the National Drought Contingency Fund, a comprehensive multi-hazard approach has still not been developed. However, the Government is still engaged in the search for an appropriate national institutional framework and overarching national policy response to disaster that would facilitate this shift from short-term relief towards more sustainable development, on-going risk reduction and preparedness.

Conflict/Peace Policies

The right to security – essential to the enjoyment of the right to life, as one of the most fundamental of human rights – has received the greatest attention recently.

Kenya has a well-established peace-building and conflict management architecture, with a National Steering Committee (NSC), provincial-level committees, and close to 200 sub-county peace committees (SCPCs). Nevertheless, the NSC has been hampered by inadequate Government funding, while the SCPCs lack capacity and resources and are not present in all areas that need them. Community peace agreements are not enforced, and the response to security emergencies is often late, inadequate and counter-productive. However, this architecture is being strengthened. Approval of the Peace-Building and Conflict Management Policy will ensure a more appropriate level of funding. County Peace Secretariats, and County Conflict Early Warning and Response Centres are being established to advise each Governor on peace issues, to take preventive action, and to act as a hub for information-sharing.

A National Action Plan is being developed to implement Kenya’s contribution to the Intergovernmental Authority on Development’s (IGAD) Conflict Early Warning and Response Mechanism (CEWARN), and its recently endorsed strategy for 2012-2019. It extends jurisdiction of the CEWARN mechanism beyond the current cross-border conflict clusters to the country as a whole. At the continental level, the African Union Policy Framework for Pastoralism provides a platform for Kenya to institutionalize a process to secure, protect and improve the lives, livelihoods and rights of pastoralist communities, for which peace is fundamental.

Policies Directed at Refugees

Major institutional and legislative reforms in the refugee sector were undertaken in recent years to further establish the country’s constitutional values and promote the Government’s vision of becoming a world leader in population registration and migration management, as envisaged in the Strategic Plan for the Ministry of State for Immigration and Registration of Persons (MIRP) 2008–2012. The Ministry of Interior and Coordination of National Government and its Department of Refugee Affairs are currently the Government’s primary agencies in refugee management. A new Government agency, the Kenya Citizens and Foreign Nationals Management Service was established in 2011 by an Act of Parliament, to take over the core functions of the Ministry of State for Immigration and Registration of Persons, including the Department of Refugee Affairs.

Notwithstanding these reforms, and a raft of new legislation including a proposed new Refugee Bill (2012), the situation on the ground has evolved dramatically since 2011. This has overtaken many of the intended reforms in Kenya which hosts such large numbers of refugees, the majority of whom come from Somalia. Current hopes for stability to take root in Somalia have led to certain expectations of the voluntary return of Somali refugees. However, with a population of nearly half a million and the third generation of children born in the camps, all durable solutions – voluntary return, third party resettlement and local re-integration – continue to be the basis of discussion between the Government and the international community.

More restrictive security measures have also curtailed humanitarian access to the camps and obliged the Government of Kenya, UNHCR, partners and the refugee leadership, to explore new ways to continue the delivery of assistance and protection. The outcome of this collaborative process is embodied in an Operations Continuity Plan (OCP), to guide the provision of coordinated and uninterrupted protection and life-saving services in the insecure Dadaab refugee complex. The OCP is empowering refugees by building the capacity of refugee leaders and refugee incentive workers so that they progressively take on key roles in the delivery of protection and assistance programmes, especially if the security situation does not allow humanitarian workers access to the camps. Sector Working Groups (WGs) have thus been established to continuously update the OCP and ensure standard readiness for sustained support to the refugee security situation. Current efforts in line with the OCP include: expanding the area of law and order; providing protection as a cornerstone of delivery of life-saving initiatives, improving social services with an emphasis on education, public health, nutrition and food security; improving infrastructure; focusing on provision of water and sanitation; constructing adequate housing; and, introducing low-cost, clean and renewable energy. The participation of the refugees in this initiative has so far been impressive.
Drivers of Children’s Major Deprivations during Crises and Disasters

In the ASAL, the main drivers of the major deprivations affecting children are recurring droughts, floods, food insecurity, and conflicts. Kenya’s pastoral and marginal agricultural communities in the ASAL are highly vulnerable to erratic rains and drought, and are almost completely dependent on rains to sustain their livelihoods. In some of these areas, tensions, conflicts and insecurity limit households’ capacity to engage in normal livelihood activities. Food security is also undermined by high food prices and the lack of adequate cash generating employment opportunities or other short-term work. During the rains, flooding and livestock diseases alternate with no or inadequate rains which further undermine food security across vast areas of the country. Flash floods lead to further loss of livestock to disease, loss and damage to social infrastructures such as water sources, health centres and schools, and contribute to epidemics of malaria, diarrhoeal disease, and cholera.

Kenya has experienced four episodes of severe drought over the past eight years (2004-2005, 2005-2006, 2008-2009, and 2010-2011).247 These recurrent droughts have impacted on some of the most vulnerable populations in the country, compounding and deepening their vulnerability. The Post Disaster Needs Assessment (PDNA)244 noted that the highest levels of per capita losses were sustained in areas with the lowest Human Development Indicators. “That is to say, individuals with the lowest human development in the country – and the most vulnerable against disasters – have sustained the highest socio-economic impacts caused by the drought.”245 The most recent Kenya Food Security Assessment of February 2014 indicates that there are 1.3 million food-insecure people in the country’s arid and semi-arid and other marginal areas, down from 3.75 million in January 2012.

Kenya’s natural hazard profile is also dominated by flooding with 72 per cent of all geophysical hazards between 1900 and 2010 resulting from floods associated with extreme rainfall and El Nino floods which are associated with massive destruction of infrastructure. Worst-affected were the Coast and parts of former Central and Coast Provinces, Nyanza, Rift Valley and Tana River. These cycles of regular flooding lead to recurrent asset losses including loss of housing, productive assets and crops; outbreaks of diarrhoeal disease and malaria; interruption of education; and damage to critical community infrastructure, including irrigation systems, water supplies, schools and health facilities.

Conflict and insecurity in the country has its roots in inter-communal ethnic tensions, ongoing political violence associated with national electoral competition, pending resettlement of internally-displaced populations, and continued urban slum clearances and urban upgrading initiatives. In rural Kenya, competition over access and use of scarce natural resources and unsettled land tenure persists and fuels conflict and insecurity.

Inter-communal conflicts in pastoral communities are sparked by increased competition for scarce grazing and water resources often leading to insecurity and limited access to markets and basic social services.248 Commercialization of cattle raiding has magnified the negative impact, especially through the notable increase in the number of small arms available.249

Who are the Most Vulnerable During Times of Crises and Disasters?

Infants and younger children are the most vulnerable. Research conducted by UNICEF and others has demonstrated that children, particularly infants and younger children in poor/refugee households are uniquely vulnerable during times of crisis and conflict. They are even more highly dependent on caregivers for their protection, safety and security during times of uncertainty when Government administrative services are put under great pressure. Moreover, their survival, food, health and education needs for which they rely almost entirely on their parents are often inadequate to sustain even minimal levels.

Poor mothers and female-headed households are particularly vulnerable as gender disparities are significant in Kenya, and highly correlated with levels of poverty. During times of crises and conflict, infants and younger children are the transmission belt for unequal household and wider social gender imbalances. For example, mothers who are the primary gives experience obstacles in their ability to access already constrained household income to ensure that children are fed and nurtured and covered by health-enhancing community and local health services. The gender-based inequities are well-evidenced in FGM, early marriage (often to older, marginally more secure men), early sex and onset of risky pregnancy, HIV and other heightened sexual and reproductive health issues. While the prevalence of gender-based violence is believed to remain high, it is difficult to provide accurate statistics due to the lack of a gender-based violence information management system to collect and analyze data.250

Young girls from poorer households are another highly vulnerable population group. The UN’s Special Envoy for Global Education, Mr. Gordon Brown cites Kenya as a country where child marriages sometimes increase during periods of crisis, a phenomenon referred to as “drought brides”.251 Rapid assessments and protection monitoring conducted in 2011 among pastoralist drop-outs and internally-displaced populations in Garissa and Kakuma and post-election violence areas demonstrate a high prevalence of female-headed families/households through family separation or death; increased rural-urban migration in search of employment opportunities, mainly by the bread-winners; and a high rate of female school drop-outs.

Impact and Consequences of Crises and Disasters on Children

In times of crises and disasters the most vulnerable populations have few resources at their disposal to cope with repeated shocks. The impact of these shocks on children is often unseen or poorly understood which results in inadequately designed prevention and preparedness initiatives and poor response. Family separation, early marriage, interruption of access to basic services, such as health and education, have significant impacts on already vulnerable children, further perpetuating their deprivations.

The 2011 drought in North and North Eastern Kenya increased the protection needs of children. Many parents migrated, leaving their children in the care of relatives and friends, or left alone to fend for themselves. Many children, especially boys, migrated to urban areas to look for work.252 The figure below provides a snapshot of the number of separated children in selected regions as a result of the drought emergency.

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245 PDNA, 2012.
246 The PDNA was undertaken by the Government of Kenya in 2011 with the support of the World Bank, European Union and the United Nations.
247 Ending Drought Emergencies, pg. 8.
248 Ending Drought Emergencies, pg. 9.
During periods of drought, girls are particularly vulnerable to sexual abuse, exploitation and early marriages. In Turkana, girls between 13-18 years old reported how they were pressured into sexual engagement with persons of authority for food and money, sent to local bars as sex workers, or married off to wealthy, elderly men in exchange of dowry.253

Assessments of the impact of the 2011 Horn of Africa drought on children revealed the following:

* The already vulnerable situation of many pastoralist and impoverished children had been exacerbated by the displacement of families and communities, loss of resources and livelihoods.
* Many families had migrated to urban centres in search of resources and new ways to survive.
* Children were being separated from their families and either left behind while parents sought work/food security, or placed in boarding schools or charitable children’s institutions (CCIs).
* Many children (primarily adolescent boys) had separated from their families and migrated to urban areas, thus becoming part of a burgeoning street children population in Eldoret and Lodwar.252

The impact of conflicts is greatest on children who are the main victims of ethnic violence, such as those in Moyale and Tana River. They are orphaned, separated from their families, suffer from physical attacks or become witnesses to extensive violence.251 The lack of child protection centres in Tana River and Moyale further exacerbates the situation, as orphaned and abandoned children cannot receive sufficient support. About 12 per cent of the children currently living on the street in Rift Valley attribute their situation to ethnic clashes.

Overall, the inability of food-insecure households to recover fully from recurrent shocks and hazards suggests the need for a mix of immediate and long-term food and non-food interventions that seek to mitigate urgent needs, restore livelihoods and build resilience. Again, children are impacted by these multiple shocks through the impoverishment of their families and communities but also through more direct impacts on their access to basic services, family separation and other negative coping mechanisms.

The impact of crises and disasters on children is also manifest in human trafficking. A counter-trafficking campaign evaluation report indicates that a lack of information on the risks of human trafficking and weakened community coping mechanisms are major contributing factors that need to be addressed.255 Furthermore, the affected communities have undergone events that may have provoked distress and weakened their emotional well-being. More pastoralist communities especially women, girls and boys continue to migrate from rural areas to urban centres, and without relevant skills to seek employment they remain susceptible to trafficking. The coastal region of Kenya and Nairobi are key destinations for internal trafficking. Victims are trafficked for domestic servitude, forced prostitution, street begging and labour exploitation. Many of the cases identified in the coastal region and Nairobi are from areas that are prone to natural disasters and man-made crisis.

Children affected by post-election violence (PEV) continue to suffer psycho-social distress. Many struggle to find alternatives to harmful coping mechanisms adopted during displacement, such as sex work. While many children affected may have returned home to their families under the umbrella of the Department of Children Services’ Reunification of Separated Children Programme over the course of 2008-2009, there has been a proliferation of street children in urban areas of the Rift Valley. During a profiling of over 2,400 street children conducted in five locations in 2011, thirty seven per cent of children reported that they were displaced as a result of PEV. The study highlights the long-term impact of emergencies, with a significant number of those displaced by PEV only joining the streets in 2011 (22 per cent). Almost half of the children interviewed had been affected in some way by an emergency (PEV, tribal clashes, drought or flooding). Food insecurity was by far the most significant push factor, with 59 per cent of children reporting hunger as one of the reasons for resorting to the streets.254

Many studies highlight the role of ‘youths’ and adolescents in times of conflict and inter-communal tension. During the PEV male youths constituted the ‘rank and file’ of community or ethnic militias whilst female youths undertook supportive tasks to keep competing groups in the field. Particularly in urban centres, youths constituted a large element of contending neighbourhood or community groups and gangs in the predominantly crisis-affected urban slums and low-income areas. The literature on the recent period of crisis and conflict in Kenya since 2009 is replete with examples of Kenyan children in adolescence experiencing heightened participation as productive household agents in their own right.

In times of crises, adolescents of both sexes in poor households are the first to be withdrawn from schools as their families minimize costs and require older children to contribute to household income and productive activities. Schooling is the most positive nurturing environment that many poor children experience and urgent withdrawal in times of crisis and conflict often results in the onset of a permanent downward spiral into unemployment, abuse, ill-health, and violence. Adolescent girls are especially vulnerable to withdrawal from schooling. They are viewed as essential to maintaining and nurturing their younger siblings as parents necessarily diversify their income-earning activities by seeking employment in local urban centres and in informal activities. In pastoral and mixed agricultural zones during the drought, older and younger males decamp with the stock seeking fresh pastures leaving adolescent daughters and wives to fend for the younger children and themselves.

Recent estimates indicate there are almost 400,000 school-age boys and girls out of school in the emergency-prone ASAL areas, although over one million are in school and participate in feedback programmes. This means one in three children are not in school, which represents a major driver of children’s deprivations in ASAL. Ensuring that schools remain open during times of stress has proven less difficult than providing

253 Kenya Prof fairy violence programme reports.
255 June 2016.
Children Living in Refugee Camps and Host Communities

Kenya is currently host to more than 550,000 refugees, with about 75 per cent originating from Somalia, and others coming from Burundi, the Democratic Republic of Congo, Ethiopia and South Sudan. About 256,000 of these refugees reside in the Dadaab camp in the former North Eastern Province\(^{257}\) and approximately 160,000 are in the Kakuma refugee camp. The Dadaab refugee camp is currently the largest one in the world with an estimated 252,889 of the refugees below 18 years of age.\(^{258}\)

There is ongoing concern about conflict between refugee and host communities as they compete for scarce resources and basic facilities, including water and accommodation. Children and youths constitute almost 55 per cent of refugees and asylum-seekers. Refugee children in Dadaab and Kakuma and a growing number amongst host communities are widely acknowledged to be amongst the poorest, most deprived children in Kenya due to their lack of access to education, health, WASH and protection services.

Conflict and food insecurity in neighbouring Somalia and South Sudan drive the arrival of new refugees to Kenya, who are in the camps isolated from their livelihoods and far from their homes. There are many ‘drivers’ of refugee vulnerabilities. Security issues are acute in the region of the camps and have deteriorated since 2011. Although international norms require that all refugees have adequate, appropriate and secure shelter, camp authorities presently estimate that only 30 per cent of refugees meet these standards and thousands of new arrivals are not provided with emergency shelter.

Adequate nutrition/nutrition services and food security in the camps is an on-going challenge, as is the provision of integrated management of acute malnutrition (IMAM) to address and reduce high morbidity and mortality rates. Infant mortality is 0.5 deaths per 1,000 live births; and neonatal mortality is 4.8 per 1,000 live births. GAM prevalence often exceeds 15 per cent in Dadaab peaking at close to 30 per cent during the 2011 crisis with prevalence of anaemia in young children reported to exceed the 40 per cent threshold of public health significance in Hagadera (44.5 per cent), Ifo 2 (45.5 per cent) and Kambioos (50.7 per cent) in 2012. Health facilities are rudimentary, and the provision of psycho-social counselling for a traumatized population is limited. Only 30 per cent of refugees have access to family latrines, which is a major concern for the protection needs of children and young girls.

Children living in refugee camps are exposed to a number of serious child protection concerns. Many children are separated and unaccompanied (UASC). As of August 2014, the Kakuma refugee camp was hosting over 13,000 UASC. Sexual and gender-based violence (SGBV) and exploitation of women and children in the camps was reported from 40 in May-June 2011 to 50-60 in July 2012.\(^{260}\) Harmful traditional practices such as female genital mutilation/cutting (FGM/C) and child marriage affect many girls in the camps.\(^{261}\) Children with disabilities face severe discrimination and are frequently harassed, neglected and abused. Child labour exists in all the camps and is most widespread among vulnerable groups such as new arrivals, poor families, single parent families, orphans and unaccompanied children. Trafficking of children and young girls is a worrying symptom of the lack of adequate protection.

The needs of refugees are high and in order to provide full legal protection in accordance with international standards, it should include protection for refugee children and women and other vulnerable people regarding SGBV. In both Dadaab and Turkana, refugee children lack access to the formal legal system and legal aid services. Most cases are settled at the community level through traditional justice mechanisms such as Mauahe courts or mediation, after which compensation (Ekichul in Turkana and dhvig in Somali) can be paid to the survivor’s family. In addition, there is a lack of resources and services available in the camps to support their needs.\(^{262}\)

There are over 215,000 school-age boys and girls in Dadaab, of which almost 130,000 are currently out of school. As of March 2013, only 86,401 children (44 per cent of them girls) were enrolled in school. According to EMIS data in Dadaab the pupil-classroom ratio is 137:1 for ECD, 58:1 for primary, and 22:1 for secondary. Girls are particularly affected as many are not in school and only a few of those who do attend continue to secondary school. The total transition rate in Kakuma to secondary schools is seven per cent, while in Dadaab it is a mere five per cent. Overall, about 26,283 girls (close to 60 per cent) and 20,760 of the boys (close to 40 per cent) are missing out on education.

Less than three per cent of the refugee population between 18-59 years of age is engaged in livelihoods activities, and fewer than 2.5 per cent of the population benefit from livelihood interventions in camps. There are limited livelihood opportunities for the host community around refugee camps, (e.g. Dadaab town, Fafi district and Lagadera) which often puts children in these communities at considerable risk for harmful cultural practices and child labour. As a result of the 2011 drought, in Kakuma, there was a notable increase in the number of children from the host community who provide labour by fetching water, cleaning, and other tasks for which they can be paid at the refugee camps.

The search for durable solutions to Kenya’s refugee problem is highly challenging. However the government of Kenya is confident that with the support and collaboration with its partners and the international community the refugees will continue to get protection while in Kenya or when they resettle back home.

Internally-Displaced (IDPs)

In May 2008, the Government launched Operation Rudi Nyumbani to facilitate resettlement and return of an estimated 350,000 registered IDPs and to close the camps in which many had sought temporary shelter through the post-election violence (PEV). A national humanitarian fund was established to support logistical arrangements for IDPs’ movements, re-establishment of livelihoods, provision of various non-food items and the construction of homes, with further assistance from the international community.

The lack of comprehensive registration and profiling data on IDPs, particularly in reference to the integrated IDPs and forest evictees, continues to challenge the protection and assistance environment in the country. There is also an urgent need for the provision of objective, reliable and accessible information targeting the affected populations, including illiterate people, at all levels for the population to better understand the ongoing relief, assistance and durable solutions programmes. Furthermore, addressing inter-communal tension and violence, as well as land and property related disputes are critical in facilitating durable solutions. Reintegration and/or resettlement are a key need across all affected provinces. There is continued need to ensure access to legal redress mechanisms and legal assistance encompassing restitution measures.

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\(^{259}\) Rapid Inter-agency Sexual and Gender-Based Violence Assessment, Dadaab Refugee Camps and Sub-counties, July – August 2011 (UNHCR supported).


\(^{261}\) Although no official statistics exist, FGM among Somali girls is expected to be close to 100 per cent and to the prevalence among Somali Kenyans.

to aid and document recovery and durable solutions. Psycho-social counselling for PEV IDPs has also been identified as a gap, especially amongst girls and boys where the need is deemed acute.265

Kenya lacks efficient and disaggregated data-collection systems. Although a comprehensive verification survey of IDPs has been conducted, the results are not yet available. Previous registrations of IDPs have not been accurate and, as result, many of those displaced, for example during the PEV, have not received assistance. A better understanding of the situation and needs of all IDPs is necessary. These include the so-called "integrated IDPs" in urban settings, people displaced by natural disasters, development or environmental projects, and pastoralist IDPs.

The UN concludes that in essence, no IDPs displaced before or after the violence of 2007 and 2008 have been profiled or registered in the national database.264 Given that unregistered IDPs are much less visible and in many cases barely recognized as internally-displaced, they have been largely excluded from assistance and protection programmes. Newly-adopted legislation on IDPs is a positive development in this regard, as it foresees the profiling of IDPs within 30 days of any crisis resulting in displacement.

The numbers of Kenyans displaced in urban centres through slum clearances and urban upgrading programmes have been acknowledged as a growing humanitarian challenge. Recent high urban migration is the result of households leaving disaster-impacted rural areas and overcrowded refugee camps for urban neighbourhoods, in many cases for good (urban refugees were estimated to number 64,000 persons in 2012). A recent report has drawn attention to the conditions of urban refugees in Nairobi who often experience the same challenges in everyday life as poor Kenyans in the city, including dire living conditions, poor access to basic services and exposure to criminal acts and other violence.265

The National Protection Working Group on Internal Displacement (PWGID) believes that IDPs are exposed to high levels of gender-based violence (GBV). Again, the lack of an adequate information management system means that accurate statistics are hard to come by, as is information regarding the location of water, sanitation and shelter facilities, since it is where such violence often occurs and therefore critical for preventing GBV.266

**Major Causes and Capacity Gaps in the Context of Crises and Disasters**

The Government is putting in place policy frameworks, mechanisms and institutions to address the root causes of conflict and crisis in the country and manifestations of human rights deprivations amongst children. However, the Kenyan population is also affected by multiple factors likely to exacerbate their circumstances, including more severe and frequent natural disasters, both sudden and slow onset, due to the effects of climate change and other factors; environmental conservation and development projects; land and resource-based conflicts; and forced evictions, especially in urban areas.

**Pre-existing conditions**, such as the high percentage of persons living below the poverty line, violations of human rights, poor access to services, and important challenges related to governance, render children less resilient and more vulnerable to internal displacement. The situation of many Kenya children impacted by drought, floods, political conflict, urban removals and internal displacement has revealed these vulnerabilities, which need to be addressed as part of ongoing national programmes and sustained throughout emergencies.

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263 This has been documented in KNCHR’s comprehensive and systematic monitoring of the situation of PEV IDPs and contained in KNCHR’s 2011 report titled Homeless at Home.
264 OHCHR, February 2012.
266 OHCHR, February 2012.
Actions to Build Resilience and Action Disaster Risk Reduction

Analyze in a more comprehensive manner the impact of repeated natural and man-made disasters on children in Kenya to serve as the basis for more rigorous child-focused disaster risk reduction and resilience strategies.

Apply a risk-informed approach to development programming and social service delivery in high-risk areas to ensure that a comprehensive, multi-sectoral and integrated approach is applied, including social protection, resilient social norms and behavioural practices and effective governance for risk management. Prevention, mitigation and preparedness measures must be integrated into all programming and services and assistance provided in a way that promotes community resilience.

Implement existing policies including effective planning and budgeting of cross-ministerial policies within Line Ministries and county governments. Ensure that Government, partner and community monitoring systems feed into future planning and policy development to strengthen accountability and the effectiveness of investments.

Provide better clarity on the division of labour and dedicated resources for disaster management functions at the national and county level. This should include a clear capacity assessment of critical institutions at county and national level and government-owned capacity development plans that can be collectively supported by partners. Integrated contingency planning systems, including clear accountabilities at all levels, information management systems and triggers for scaling up response need to be put in place to support response to residual risk.

Strengthen child protection in emergencies: Emergency coordination mechanisms for child protection and Gender-Based Violence (GBV) in drought-affected and refugee settings should be strengthened, including data-gathering systems. Strategic partnerships for the emergency response should be developed, with a focus on engaging with and strengthening community-based structures, providing support to Area Advisory Committees (AACs) to coordinate and monitor the child protection response. The capacity of service providers should be developed, particularly on GBV, to improve access to care and ensure that GBV is mainstreamed across humanitarian interventions. The child protection system approach should also be strengthened and applied in emergency settings, so that it is able to respond to humanitarian crises. In this context, local authorities remain key players in the sustainable response to child protection concerns.
Chapter IX

Urbanization

Urban areas are more diverse than rural settings, with the former harbouring pockets of severe poverty and deprivation, and exhibiting substantial concentrations of ill-health among the poor.
Child deprivation in urban areas, particularly informal settlements, is an increasingly important issue. Urban areas are more diverse than rural settings, with the former harbouring pockets of severe poverty and deprivation, and exhibiting substantial concentrations of ill-health among the poor.267 Children in urban slums have three times the national rate of diarrhoea, one in two children in urban slums are chronically malnourished, and mortality rates are up to twice the national rate. The vulnerability of urban informal livelihoods, high food price inflation, and weaknesses of governance, planning and delivery of services in urban informal settlements are key drivers of child vulnerability in urban areas. As the population of cities, towns and municipalities is set to grow over the next decades, greater attention to measures and strategies to address children’s rights in urban areas is necessary.

Legal and Policy Frameworks

Urbanization as a force of development should be emphasized as a national priority, particularly as the country implements the 2010 Constitution under a devolved system of governance. Currently the Government of Kenya is geared towards devolving political and fiscal governance, which may facilitate greater attention to the scale of urbanization and urban poverty in the country. While there is now a growing recognition on the part of the Government of the need to improve living conditions in the informal settlements, there are further causes for concern in relation to whether efforts to respond to urban poverty will be well-addressed within the new devolution structures. Previous efforts to bring funds to the local levels such as Constituency Development Funds (CDF) have had limited impact on urban development or addressing the immense challenges of urbanization.

Kenya’s 2010 Constitution and Vision 2030 take cognizance of Kenya’s growing urbanization and the need for urban development. A National Urban Development Policy (NUDP) has been drafted and an Urban Areas and Cities Act enacted in 2011. The National Urban Development Policy (NUDP) is intended to guide the spatial allocation of resources and to serve as a framework for the governance and management of urban areas. As a critical guide for policymakers aligned with a devolved system of governance under the Constitution, the policy focuses on:

(i) supporting an urban system that equitably serves the whole country and addresses the historically-neglected regions of the country;
(ii) reversing the marginalization of sub-national governments through devolution, decentralization and reforming local governance and finance systems as provided for in the Constitution of Kenya 2010;
(iii) introducing integrated land and environmental management practices that serve the demands of inclusive and sustainable urban development;
(iv) addressing infrastructure and housing backlogs, and improving service delivery;
(v) improving living conditions in informal settlements and opportunities for the residents;
(vi) improving urban safety; and,
(vii) protecting the rights of vulnerable and marginalized groups.

These policy frameworks provide a foundation for strengthening governance, productivity and inclusivity, both in Nairobi and the 46 other settlements classified as urban in the country. Vision 2030, highlights rapid urbanization as one of the four key challenges facing the country, and notes initiatives that address urban development as a national priority. However, there is concern that progress in implementation of policy in urban areas has been hampered by the existence of a number of parallel structures and systems, which are generally neither well-managed nor effective in bringing development to the local level.

Kenya Slums Upgrading Programme: The Ministry of Housing in partnership with UN-HABITAT is responsible for overseeing the implementation of the Kenya Slums Upgrading Programme (KENSUP)268. The programme was designed with a more holistic approach to improve conditions in the country’s informal settlements, including the upgrading of housing and related infrastructure such as water and sanitation, security, access roads, and lighting. Beginning in 2004, KENSUP marks a major shift in attitude by the Government of Kenya by recognizing that informal settlements are a reality and home to a large proportion of the country’s urban population. Furthermore, upgrading the houses of the urban poor protects them from environmental hazards such as floods. With a devolved governance structure, county governments will need to: introduce a more coherent resource mobilization process towards social infrastructure and services; and, pursue innovative and participatory/partnership approaches to the financing, provision, operation and maintenance of social infrastructure and services.

Targeted programmes to improve service delivery in urban informal settlements: Addressing the disparities in access to social services for all, especially among the poor and marginalized in urban informal settlements, is critical. This will enable the benefits of urbanization to translate into the realization of children’s rights. Programmes to tackle the specific needs of urban low-income populations are needed. One good example is the initiative of the Ministry of Health (since 2008) with support from UNICEF and Concern Worldwide which has accelerated targeted support for nutrition interventions in urban low-income settlements by strengthening health systems and ensuring a package of high-impact nutrition interventions reach children and mothers. Coverage has improved for Nairobi and Kisumu health centres and hospitals offering high-impact nutrition interventions from 26 sites in 2008 to 102 sites in 2012 (reaching more than 80 per cent of target sites in slums). Responding to the nutritional needs of children has involved wide scale-up of support covering 50 per cent of children through strengthening nutritional services in all locations serving households in urban low-income settlements. In 2011, by doubling the rates of exclusive breastfeeding by establishing a network of community support to 75 per cent, it has improved neonatal and child survival and helped to prevent malnutrition.

Growing Urbanization in Kenya

Urban centres, including unplanned urban settlements, account for a rapidly growing share of the Kenyan population. The capital Nairobi has seen a population increase from 120,000 in 1948, to 3,138,369 in 2009.269 Kenya’s urbanization in the next two decades will follow many of the trends and patterns found elsewhere in the developing world, with population growth taking place in urban and peri-urban areas and reversing long-term population patterns with a shift from rural to urban areas.

The latest Census estimated 19,147,737 children under the age of 18 in Kenya. Over 5 million children live in urban areas, with over 1 million each in Nairobi and in urban areas in the Rift Valley. In most provinces between 20 and 40 per cent of children are already living in urban areas, and projections indicate that around half of Kenya’s children will live in urban areas by 2030.

Urbanization can create positive development when matched with good planning and management. However, Kenya’s urban growth has already overstretched the available resources to support its inhabitants, creating more challenges for current and future generations. Currently, about 34 per cent of the population lives in urban areas and eventually the percentage is set to reach 44 per cent by 2030.270 Some of Kenya’s counties are already fully urban, Nairobi and Mombasa, for example, while several others (Kiambu and Kisumu) are rapidly transitioning into this category.271 (See Figure 20 below)

Urbanization is an engine for economic growth and may facilitate improvements in access to employment and services. However, urbanization can also create high inequalities. The majority of the populations living in informal settlements are classified as urban poor, when compared with those living in other parts of towns and cities. They face the chronic consequences of poor socio-economic development which includes: high unemployment and low incomes; inadequate housing together with tenure insecurity; and limited access to services such as health, education, safe water and sanitation, with limited physical and environmental infrastructure.272

Over half of urban populations live in low-income informal settlement areas with one in three children or 1.7 million children living in urban poverty. In the urban informal settlements, the rights of a majority of the children are not respected or protected and the violations of their rights to food, nutrition, water, health care and protection are experienced on a daily basis. Homeless children and those residing in slums are generally at greater risk of adversity, morbidity, and mortality than children living in other areas of the country.273 274

Poverty in Urban Areas

In keeping with the constitutional rights of every citizen, the state has the primary obligation to provide support for those who are unable to meet their basic needs. Notable urban improvement programmes including housing projects and urban food subsidy programmes have attempted to address these needs. However, between a third and half of the country’s urban population is living in poverty, and given the pace of urbanization, urban poverty will represent almost half of the total poverty in Kenya by 2020.275 While the urban poverty rate has been decreasing according to some measures, there are indications that the proportion of the urban population that constitute the poorest of all (the ‘food poor’ and ‘hard core poor’) has been on the increase.

Understanding the determinants of urban poverty and its impact on the well-being of children is essential in order to address the needs and inequities caused by urbanization and urban poverty in Kenya. For example, a number of factors have been associated with urban poverty and under-employment. These include limited diversity in livelihood opportunities, unemployment, involuntary part-time employment, and low wages which are the primary causes of poverty for the urban poor residents especially the youth.

Source: Republic of Kenya, Census 2009

Source: Computations from Census data

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Families with no workers, married couple families with one earner, and families with only a part-time worker have much higher poverty rates than all families with children. Women face lower wages and fewer job opportunities due to discrimination and are more likely to be unemployed and income poor. Moreover, urbanization is increasingly exacerbating the risk to injuries, mental illness and disability, affecting the ability to secure or maintain employment.

Poor urban-dwellers face an alarming (and growing) range of vulnerabilities that include:276

- Fewer children attend the higher grades of school in Nairobi than in Kenya’s rural areas, and many informal settlement areas have few or no public schools.
- Gender inequalities remain severe, with females being five times more likely to be unemployed than males.
- HIV prevalence in the informal settlements amongst those aged 15–49 is estimated to be about 11.5 per cent as compared to 9.9 per cent among the same age group for Nairobi as a whole.
- Infant, child and neonatal mortality rates in urban slums are above the national average.
- Children living in Nairobi’s low-income informal settlements are less likely than in rural areas to be immunized, as well as being more prone to diarrheaea and acute respiratory infection.277
- The inhabitants of the low-income informal settlements often pay around eight times as much for water as the wealthy sectors of the population, despite the fact that being at risk from contaminated water, and the lack of waste management and disposal in the slums breeds disease.
- Poor drainage/inadequate infrastructure contribute to a higher risk of urban floods, which is also being heightened by climate change.278
- Malnutrition and anaemia rank fourth out of the top ten causes of the mortality burden for children under five years of age in Nairobi, accounting for 8.4 per cent years of life lost.279
- Stunting affects more than one in two children in urban slums resulting in the cyclical effects of poor nutrition on social capital: “adverse functional outcomes including short adult stature, reduced lean body mass, poor cognition and education performance, lower productivity and lower adult wage.”280
- The difference in child malnutrition between the wealthiest and poorest households is twice as great in urban areas (vs. rural) highlighting high levels of inequality.

### Health Outcomes for Children and Women in Urban Areas

Poor health outcomes of low-income settlement residents at all life stages are related to several causal factors: poor environmental conditions and infrastructure, limited access to services due to lack of income to pay for treatment and preventive services, undernutrition and reliance on poor quality and mostly informal and unregulated health services that are not well suited to meeting the unique realities and health needs of slum dwellers.279 Vulnerability to child mortality is “far worse among new migrants and those with relatively low socio-economic status than among long-term residents and those who can afford reasonable amenities.”282

Challenges in health and survival of mothers and children in urban areas include:

- Infant and child mortality in urban informal settlements is up to twice the national level; thus these settlements are contributing disproportionately to national mortality.
- Neonatal mortality is 70 per cent higher in urban slums than in other urban areas.
- Despite greater availability of ante-natal and maternity services, utilization rates particularly among low-income settlement residents are still low.

### Table 15: Trends in mortality in Kenya

<table>
<thead>
<tr>
<th>Region/Survey</th>
<th>IMR</th>
<th>USMR</th>
<th>Prevalence of diarrhoea children under 3</th>
<th>IMR</th>
<th>USMR</th>
<th>Prevalence of diarrhoea children under 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya (All)</td>
<td>77</td>
<td>115</td>
<td>3</td>
<td>52</td>
<td>74</td>
<td>17</td>
</tr>
<tr>
<td>Rural</td>
<td>79</td>
<td>117</td>
<td>3.1</td>
<td>58</td>
<td>86</td>
<td>16.5</td>
</tr>
<tr>
<td>Nairobi</td>
<td>67</td>
<td>95</td>
<td>3.4</td>
<td>60</td>
<td>64</td>
<td>11.9</td>
</tr>
<tr>
<td>Urban</td>
<td>61</td>
<td>93</td>
<td>63</td>
<td>74</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Urban</td>
<td>57</td>
<td>84</td>
<td>1.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Informal Settlements in Nairobi**</td>
<td>91</td>
<td>151</td>
<td>11.3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kibera**</td>
<td>106</td>
<td>187</td>
<td>9.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Embakasi**</td>
<td>164</td>
<td>254</td>
<td>9.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mombasa*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70</td>
<td>91</td>
<td>19</td>
</tr>
</tbody>
</table>


*Based on Mombasa MIES 2008
**Based on 2002 NIES APHRC survey

Analysis of survey data for infants and children in urban low-income settlements shows that while at population level, infant mortality (IMR) and under-five mortality (USMR) for the broader Nairobi was much better than national average, in some urban slums, both infant and under-five mortality were more than double the national average and double that found in rural areas.283 284 285 286 In addition, the prevalence of diarrhoea among children less than three years of age in the settlements was shown to be more than three times the national average (11 per cent versus 3 per cent). Data from later surveys conducted around 2007-2009 in slums in Mombasa and nationally depicts similar vulnerabilities.287 USMR as a whole was estimated at 74 nationally, compared to the Mombasa informal settlements Multi-indicator Cluster Survey (MICS) estimate of 91 per 1000 live births (2009).
Nutrition Security, Child Growth and Development in Urban Areas

Challenges and solutions to nutrition security remain complex with almost half of the food-poor or insecure living in urban informal settlements, representing over 3.4 million people in Kenya. Children in urban areas are highly vulnerable to food insecurity and malnutrition. Urban informal settlements disproportionately carry the burden of child malnutrition with the associated impact manifesting in high levels of child morbidity and mortality. Fifty per cent of households are food insecure with households spending up to 75 per cent of their income on staple food. Urban livelihoods particularly in the informal sector are highly unpredictable, whilst nutrition and food security fluctuate with informal markets and inflation affecting the average households’ ability to cope with the food and nutritional needs of children. The figure below illustrates rates of undernutrition comparing the urban and rural population in Kenya.

Figure 21: Under-nutrition prevalence by urban and rural (KDHS 2008-2009)

It is important to note that Kenyan demographic surveys have not presented results for resource-poor informal settlements where levels of undernutrition could be higher when the effect of affluent families is removed.

A few studies have been carried out in Nairobi informal settlements. Olack et al (2011) conducted a nutrition survey in Kibera slums and reported the following prevalences: stunting (47 per cent), underweight (11.8 per cent) and wasting (2.6 per cent). The prevalence of stunting among boys was found to be more than girls. Abuya et al (2012) also reported similar findings in Korogocho and Viwandani slums of Nairobi in which stunting was found close to 40 per cent. Lango (2011) reviewed literature and reported that undernutrition in urban informal settlements was linked to poverty, lack of access to enough nutritious food or health services (including antenatal care and birth spacing), low levels of maternal education and poor child care practices.

Recent evidence from nutrition surveillance (MUAC data) in the slums of Nairobi shows that the numbers of children identified as acutely malnourished increased during 2011 and 2012. The proportion of children identified as severely acutely-malnourished increased significantly from 1.1 per cent in 2011 to 2.1 per cent in 2012. This means that the numbers of children severely malnourished in urban slums are equal to the numbers of severely malnourished in the most affected regions during the drought emergency of 2011. Households cope with increasing prices by reducing the number of meals per day and the quality of food purchased, by not purchasing safer water and using plastic bags called flying toilets instead of ‘pay as you go’ sanitation facilities. An emerging concern related to the nutrition of young children is related to ‘informal day-care’ arrangements in the settlements which keeps small children indoors for most of the day while the mothers search for casual work for income. Reduced exposure to sunlight leads to vitamin D deficiency and an increasing number of children are subsequently being identified with rickets. A further concern about the informal day-care centres is the lack of appropriate infant and young child feeding practices leading to increased nutritional vulnerability in the younger children. Eighty per cent of children being treated for severe acute malnutrition are under two years of age.

An Urban Nutrition Strategy 2012-2017 has been developed aligned with the National Urban Policy and the Kenya National Food and Nutrition Security Strategy to provide improved guidance for devolution and emerging areas of programme support. The work of UNICEF and Concern Worldwide on nutrition interventions in urban settlements in Nairobi and Kisumu from 2008 has demonstrated that it is possible to improve nutritional outcomes for acutely malnourished children. More children have been able to access nutrition services, a result that is linked to strengthening the health systems to deliver a package of high-impact nutrition interventions and establishing a network of community support to reach these children. Coverage assessments conducted in Nairobi and Kisumu in 2012, reported Outpatient Treatment Programme (OTP) point coverage of 39 per cent and 45.5 per cent which are still below 70 per cent expected in urban areas.

Water and Sanitation in Urban Settlements

In Kenya, about 61 per cent of the population uses an improved drinking water source, while only 29 per cent are using an improved sanitation facility. Coverage of safe water in urban areas is at 83 per cent in 2011, almost ten per cent lower than it was in 1990, while coverage of improved sanitation in urban areas has increased from 26 per cent to 31 per cent over the same period. A study in two informal settlements in Nairobi showed that diarrhoeal episodes ranged from 10-20 per cent among children under five years of age, and less than 6 per cent of residents reported washing their hands properly.

Within slums, almost 90 per cent of the population does not have a piped water connection which means they pay four-to-eight times as much as the wealthy residents for water, and are forced to buy from private vendors in the informal settlements. The majority of the residents use pit latrines that are communally owned, over-used and poorly maintained. An earlier study within one low-income area in Nairobi found that on average there were about 500 people to each toilet. In addition, as a result of such poor sanitation facilities, many urban informal settlement dwellers resort to the use of plastic carrier bags (referred to as ‘flying toilets’) as toilets, which are then casually thrown away into rivers or waste disposal sites.

dumping areas. Lack of proper latrines and the few inaccessible public latrines pose acute problems for young children and the overall human waste management in poor urban informal settlements. Findings from a study in two informal settlements showed that the most common practice for managing human waste for children under five was the use of in-door portable toilet containers or potties. Flooding is a frequent occurrence in urban slums, perhaps as a result of climate change and unplanned urban growth which compounds the already poor sanitation situation.

The poor environmental factors highlighted above expose slum inhabitants to particularly poor health, and consequently, they suffer from a high incidence of communicable diseases such as tuberculosis, diarrhoea and other waterborne diseases, as well as malnutrition. These factors in turn result in very high infant and child mortality rates.

Shelter and Migration Patterns of the Urban Poor

Traditionally urban areas have always had better housing structures and amenities. This characteristic has motivated many migrants to move from rural to urban areas. However, housing characteristics among the urban poor are not necessarily better than the rural poor. In many poor areas of Kenya’s cities, people do not own the land on which they reside on. Most people are at risk from crime and violence in their settlements, and this sense of insecurity is exacerbated by insecurity of tenure and the threat of eviction under which many of the urban poor live. It is possible that the poor state of the housing characteristics such as floor, wall and roof materials is not only a factor of non-affordability of better materials, but driven by the temporary nature of shelter access and provision, with the ease of transferring such housing materials elsewhere in the event of demolition.

Urban Informal settlements or slums are highly dynamic and heterogeneous settings. Longitudinal analysis through the Nairobi Urban Health and Demographic Surveillance System (NUHDSS) has shown that while settlement populations are highly mobile, approximately half of the population is more established as long-term residents of settlements for more than 10 years. Reasons for migration included better housing conditions (33 per cent), opportunities for work (21 per cent), increase in income (6 per cent), conflicts (6 per cent) and natural hazards (2 per cent).

Some households in urban informal settlements have been found to be particularly vulnerable, in particular: female-headed households, households lacking formal education, recent migrants, households caring for orphans or having an elderly caregiver of young children. This translates for women and children into insecurity highlighted by exposure to violence, insecurity associated with street residence, specific types of child labour, and gang culture affecting young women particularly through gender-based violence.

Social Protection for Vulnerable Urban Children

Social protection programmes aim to support families to cope with vulnerability and shocks and to enable them to access services. Existing programmes operating in urban areas include social insurance (SSPs) and health insurance (NHIF), and social assistance, including cash transfers such as the Orphans and Vulnerable Children Cash Transfer programme and the Urban Food Subsidy. The benefits of extending social protection to the vulnerable populace include reducing financial barriers associated with access to social services and protection from financial catastrophe and impoverishment related to expenses for such services.

Findings from a recent urban informal settlements study show that nearly one out of ten residents in informal settlements are without any type of insurance, which underscores the need for a social health insurance programme to ensure equitable access to health care among the poor and other vulnerable segments of the population. In addition, this study showed that only 10 per cent of the respondents were participating in the NHIF programme, while less than 1 per cent (0.8 per cent) had private insurance coverage. Females were twice as likely to participate in the NHIF programme than males.

Respondents working in the formal employment sector were four times more likely to be enrolled in the NHIF programme compared to those in the informal sector. Membership in microfinance institutions such as savings and credit cooperative organizations (SACCOs) and community-based savings and credit groups were important determinants of access to health insurance cover.

As the Kenyan Government moves toward transforming the NHIF into a universal health programme, it is important to harness the unique opportunities offered by both the formal and informal microfinance institutions in improving health care capacity by considering them as viable financing options within a comprehensive national health financing policy framework.

Access to Education in Informal Settlements

Schools that serve the informal settlement communities are mainly non-formal. These schools are characterized by shortage of staff, congested classrooms and lack of scholastic materials. It is usually difficult for these schools to attract and retain qualified staff due to the hardships associated with teaching in the slum schools. Some of the teachers find it difficult to deal with slum children who lack shelter, food and are constantly exposed to vices such as prostitution and drugs. Schools situated outside the slum communities are in many cases unaffordable to the slum dwellers.

On average, among the age group 6-15, school attendance is higher in urban areas than in rural. However, for the age groups 16-20 school attendance is higher in rural areas than in urban areas. The large gaps in school attendance for the age groups 16-20 was also noticeable in the 2003 KDHS and this has been suggested to reflect school attendance competing with events such as employment, early marriages and pregnancies.

Table 16: Percentage of the Population Aged 6-24 Years who were Attending School in 2008 by Age, Sex and Urban-Rural Residence

<table>
<thead>
<tr>
<th>School Attendance</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Age 6-15</td>
<td>96.7</td>
<td>96.2</td>
<td>92.5</td>
</tr>
<tr>
<td>Age 16-20</td>
<td>66.7</td>
<td>42.1</td>
<td>74</td>
</tr>
<tr>
<td>Age 21-24</td>
<td>19.2</td>
<td>10.7</td>
<td>29.8</td>
</tr>
</tbody>
</table>

Source: 2008-2009 KDHS
In addition, there is a high prevalence of alcohol and drug use, and early exposure to and engagement in sexual activity. For example, at 14 years of age, 50 per cent of girls in informal settlements have already had sexual intercourse. The corresponding age in rural areas is 17 years. These factors act as disincentives for children in the settlements to enrol or continue in school.

Young people in informal settlements face unique challenges as they transition from adolescence to adulthood in a hostile urban environment characterized by high levels of unemployment, crime, substance abuse, poor schooling facilities, and lack of recreational facilities. Overall, adolescents in these informal settlements of Nairobi initiate sex about three years earlier and they are twice more likely to have multiple sexual partners than adolescents in the city who do not live in these settlements. Other studies have demonstrated the central role of poverty in determining young people’s risky sexual behaviours and other sexual and reproductive health outcomes.

The Children’s Voices Consultation made a comparison between the lives of children in urban areas and those in rural areas:

1. Children in urban areas are more exposed to information than children in rural areas.
2. Children in urban areas are better off in terms of education, healthcare, security, technology.
3. Distance from school in rural areas is lengthier compared to urban areas and this has contributed to late enrolment of children.
4. Children live in poor sanitary conditions in rural areas and are more vulnerable to health problems than those in urban areas (e.g., Jigger infestation).
5. In urban areas children living in informal settlements are disadvantaged due to poverty. Such social economic pressures push children to social evils such as prostitution, drug abuse and trafficking.
6. Children in urban area have access to good recreational facilities, (e.g., swimming pools, parks and stadiums).
7. Children in rural areas are not exposed to protection measures compared to children in urban areas.
8. Culture and community rites are an impediment to legal implementation in rural areas.
9. Exposure to information for children in urban areas (e.g. Internet increases exposure to pornography).
10. In urban areas families don’t have enough time to interact compared to rural families.
11. In urban areas children are more exposed to the adult lifestyle and technology compared to those in rural areas, thus they mature faster.
12. In rural areas, children with disability lack facilities to assist them and they are discriminated against because they are perceived as a curse.

### Actions to Improve the Well-Being of Children in Urban Areas (Informal Settlements)

Ensure that the urban poor have access to health care under the NHIF: The Government needs to institute targeted subsidies and exemptions aimed at increasing their enrolment and participation. The large proportion of the urban poor is without health insurance which exposes them to a heavy financial burden associated with catastrophic out-of-pocket health expenditure. The inadequate coverage of the poor by the NHIF highlights the need for the Government to hasten the move towards social health protection by implementing a National Social Health Insurance Fund to guarantee access to quality healthcare services for the poor and vulnerable segments of the population, as well as offer protection against financial shocks associated with high medical costs.

Establish a framework for coordination between the various actors involved in urban development: This would provide coherence to the efforts of all the actors involved in addressing urban poverty. It would also facilitate debate about relevant development agendas such as scaling-up of successful interventions, pro-poor policies and house financing. In addition, it would encourage a multi-dimensional and multi-level approach towards urban poverty reduction and ensure more effective resource mobilization and allocation to the urban sector. One avenue by which to make the policy framework more responsive to citizens’ needs is to achieve greater community participation including children’s involvement in public policy-making.

Apply a holistic approach to the livelihood vulnerabilities of the urban poor: Another area where current efforts are lacking relates to support for urban livelihoods, taking into account the specific types of vulnerability faced by poor people in cities. Income security and food security regularly influence urban residents. While there are various initiatives in relation to the latter, there is little evidence of large scale approaches that explicitly address food security and other forms of food vulnerability. A more holistic approach to the livelihood vulnerabilities of the urban poor is needed that explicitly recognizes the degree of dependence on a cash economy, which would involve both supporting lower costs for basic services, as well as efforts to provide credit and savings schemes for the poor.

Implement nutrition interventions in major urban areas of Kenya (Kisumu, Mombasa and Nairobi) and monitor progress. Given a trend indicating growth in the urban population, issues of sanitation, unemployment and inflation affecting access to nutritious foods and health care, there is a need to monitor the nutrition status of urban children and women.
Chapter X

Health and Well-being of Adolescents

While there are adolescent programmes, they are fragmented and there is evidence that coverage is low related to the need so that many vulnerable adolescents are not able to access them.
Policies and Programmes for Adolescents

Overall, the policy framework regarding adolescent development is largely indirect and not specific to the age group. However, some legislation and policies have been put in place to support education, training, and health among adolescents. This section provides an overview of the key policies adopted and the programmes and services established in Kenya to date.

Adolescents and Health Policies

The International Conference on Population and Development (ICPD) held in Cairo, in 1994, set the agenda for adolescent health. During the Millennium decade there were key achievements in the creation of a facilitative policy and legislative environment for adolescent health in Kenya. The Adolescent Reproductive Health and Development (ARHD) Policy, Guidelines for Provision of Youth-Friendly Services (YFS) and Guidelines for Comprehensive Post Rape Care (CPRC) highlighted Kenya's commitment to enhancing access to services for adolescents.

Generally, there is inadequate access to health care services particularly in the rural areas and insufficient integration of health services which meet the needs of adolescents. Thus, most adolescents have little access to important reproductive health services and related information. At the same time, 94 per cent of adolescents do not have HIV and 83 per cent are not pregnant, so it is necessary to provide basic services that are sensitive to the specific needs of all adolescents. Furthermore, while access to HIV testing services has improved, access and utilization of ART, lack of follow-up and treatment adherence, limited disclosure and unmet sexual and reproductive health needs remain challenging for public health facilities (Source: NASCOP Adolescent Package of Care Programme Review 2013).

Adolescents and Education Policies

Education and adolescents has remained a key item on the policy agenda mainly as a means of providing subsequent employment and future livelihoods, as well as providing manpower for the country. Free Primary education introduced in 2003, and subsequently Free Day Secondary Education introduced in 2007, have benefited large numbers of adolescents. Nevertheless, there has been an emerging concern over quality and relevance of education, and that the education curriculum has largely focused on academic certification rather than on a curriculum to fit the job market. This contributes to the number of children dropping out of school, especially in ASAL areas and urban informal systems. Adolescents unable to continue with education at primary and secondary levels are exposed to further social and economic vulnerabilities such as child labour and early marriages.

Further concerns over access to education have been addressed by various policies, but education inequity and disparities have not been overcome, with poorer regions getting less access to education and hence, performing poorly in national examinations. Key gaps in the policy framework for education have been addressed by the education provisions in the 2010 Constitution, which guarantees every child and adolescent a right to education.

Employment Policies and Adolescents

Whilst the Government has continuously articulated the need to create sufficient employment opportunities to absorb the country’s growing labour force, unemployment and underemployment have been identified as Kenya’s most difficult and persistent problems. Discussion of employment or unemployment is relevant, particularly for late adolescents and those who enter the labour market after dropping out of school. Due to a mismatch between the skills of the unemployed and the skill requirements of potential employers, a significant proportion of trained youth tend to remain unemployed for long periods. This mismatch is more marked for school leavers and fresh graduates which partially explains the higher unemployment rate among younger people and new entrants into the job market. There is also a gender dimension with 45 per cent of females 20-24 found unemployed in 2009 within the previous 12 months and agriculture accounting for 44 per cent of the employment. In view of the escalating youth unemployment, there is a need to formulate and implement policies that foster youth employment.

KEY FINDINGS

Progress on the rights of adolescents can be harnessed and reinforced as a core element of realizing Vision 2030. The period of adolescence is a key time in the life-cycle when an individual's life is influenced and when there are opportunities to break the inter-generational cycle of poverty. Kenya’s adolescents are experiencing some progress in improved access to secondary education, increasing access to information and media, falling rates of early marriage and childbearing. However, only half of Kenya’s adolescents transition to secondary school, and four out of ten girls still begin childbearing by the age of 19, while 60 per cent are unable to access family planning and there is little progress to reduce HIV infections among adolescent girls. While there are adolescent programmes, they are fragmented and there is evidence that coverage is low related to the need so that many vulnerable adolescents are not able to access them.

Cultural and traditional practices such as early/forced marriages persist

Child marriage is a violation of human rights whether it involves a girl or a boy, and it represents one of the most prevalent forms of sexual abuse and exploitation of girls. Early marriage or any marriage where the bride is under the age of 18 years deprives women and girls of a number of basic human rights including the rights to education, leisure, health, freedom of expression, and freedom from discrimination. Child marriage leads to childbearing which is particularly detrimental to the health and well-being of adolescent girls. The law in Kenya states:

“No marriage shall be legally entered into without the full and free consent of both parties, such consent to be expressed by them in person after due publicity and in the presence of the authority competent to solemnize the marriage and of witnesses, as prescribed by law.”

Adolescents and Education Policies

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Adolescents Count Today (ACT) Project revolutionizing HIV interventions. Programmes catering to meet the diverse needs of adolescents in Kenya have been undertaken mainly by Government departments within ministries and complemented by a few non-governmental organizations and private sector actors. The Ministry of Devolution and Planning has assumed responsibility for youth affairs and has the overall responsibility of harmonizing, coordinating and mainstreaming youth issues in national development processes. Complementary work has been carried out by other Ministries such as Education, Health, and Culture.

The Ministry of Education has supported life skills education at both primary and secondary education level that also covers the rights of adolescents to education. However, life skills as a subject, is rarely taught in schools since it is not subject to examination. The previous Ministry of Youth Affairs and Sports (MDYSAS) focused on programmes to empower out-of-school youth through sports, training, livelihood programmes, micro-finance and leadership. Presently there is no coherent programme to tackle the challenges adolescents must face who experience early pregnancies or sexual violence. Various sector support programmes involving the UN, NGOs, FBOs and CBOs have been largely responsible for implementing programmes targeting adolescents. There are visible programmes around adolescent health, HIV and AIDS education and leadership. Major national programmes include: Yes Youth Can (USAID), HIV-Free Generation (USAID), Healthy Choices for Better Future (CDC), Church-Based Life Skills and Initiation Programmes, among others.

The Partnership for an HIV-Free Generation, Kenya (HFG/K), is a global public-private partnership championed by the US President’s Emergency Plan for AIDS Relief (PEPFAR) and supported by local and international private sector corporations. HFG/K’s vision is to inspire and provide opportunities for Kenyan youth to live healthy and productive lives and to contribute to the realization of a generation free from HIV. To achieve this, HFG/K will help accelerate the Government of Kenya’s (GoK) HIV Prevention strategy and contribute to a 50 per cent reduction of HIV incidence among youth aged 10-24 years by revolutionizing HIV interventions.

Adolescents Count Today (ACT) Project is sponsored by International Planned Parenthood Federation (IPPF) and Family Health Options Kenya (FHOK). This project targets adolescents within the ages of 10-19 years living with or affected by HIV, and their families. It tackles a number of challenges such as: high/disproportionate HIV rates among young girls, lack of access to sexual and reproductive health information, and the need for economic support to help provide tangible and sustainable solutions among young (particularly those living with and affected by HIV). Its activities include integrated, family-centred education and communication skills programme; HIV, sexual and reproductive health service delivery for adolescents; micro-credit and income-generating activities aimed especially at young women and girls; and skills and mentorship training.

Defining Adolescence

Adolescence in Kenya

Whilst the UN definition of adolescents includes persons between 10-19 years, this is largely for statistical purposes. It is recognized that the meaning of the term adolescents varies widely in different societies. Kenya has no specific nationally agreed definition for this age group; nonetheless, it is important to distinguish between the different phases of adolescence, characterized as early (10-14), middle (15-17) and late adolescence (17-19). Each phase is distinguished by different sociological, psychological and health issues and determines the evolving capacity during adolescence.

Adolescents constitute around 9.2 million or nearly a quarter of Kenya’s total population – 51 per cent males and 49 per cent females. An estimated 69 per cent of the adolescents live in the rural areas, the balance in urban areas, with many in the informal settlements and slums. According to the 2009 Census the highest numbers of adolescents are in Kakamega, Mandera, Nairobi and Nakuru counties.

There is growing recognition in Kenya that adolescents aged 10-19 years are important for development. This implies ensuring that their human rights are fulfilled and potential as individuals is realized in order for them to contribute to society and the country’s development. At the same time, there is concern that the marginalization and exclusion of adolescents from development efforts leads to negative social and economic outcomes, and can result in a minority of them engaging in harmful activities, including violence. To date, few development programmes in Kenya have explicitly targeted or measured outcomes for adolescent boys and girls. There is often a general assumption that programmes for children, youth or general development programmes will automatically benefit adolescents. This has led to a lack of specific targets on adolescents, and outcome data is rarely disaggregated for ages 10-19 years, meaning that adolescents have often fallen through the cracks of development programmes.
Today Kenyan adolescents face new opportunities and novel challenges. Acknowledging adolescents as positive assets reorients perspectives on this phase of life and encourages their inclusion in national plans and programmes. Adolescents can be agents of change in their communities and dynamic contributors to the country’s development. It is important to recall that the diverse stages of adolescence are a transition period from childhood to adulthood. These stages are often marked by life events such as leaving school, first sexual encounter, entering the labour force, leaving one’s parental home, getting married, and becoming a parent.

Kenya’s Constitution recognizes the rights of all children, which is understood as those persons between the ages of 0-18. Similarly, with the ratification of the CRC, the country accepted the obligation to meet the rights of children, including in their second decade of life. Yet many adolescents are not able to exercise their basic rights to quality education, health care, protection, and many are exposed to abuse and exploitation.

Aware of the need to turn this vulnerable age into a period of opportunity, Kenya has taken important steps and recognized adolescents in its Vision 2030, particularly in the health and education pillars. Empowering adolescents through active and meaningful participation is central to achieving Kenya’s Vision 2030. The absence of a systematic investment in the second decade of life represents a glaring need that must be fostered to inform national policies and programmes. A combination of determinants influence the health status of adolescents including individual and societal factors coupled with institutional and economic factors. Lifestyle changes and risk taking are some of the factors influencing the health status of adolescents during this particular period of life. However, access to correct information and services are equally (if not more) important as adolescents may have the best intentions to lead healthy lives, yet if they are deprived of information and services, they may have little choice. Structural barriers such as user fees, lack of confidentiality, opening hours and attitudes of health service providers pose substantial challenges and may impede their access and utilization of health services.

Among the critical health problems adolescents face are those associated with sexuality and reproductive health such as early and unprotected sexual activity. These have a significant bearing on both their current and future health status. Adolescents’ sexual and reproductive health is often determined by their age at first sex. As shown in the figure below, although trends have improved over time, in 2009 there were a significant number of girls (11 per cent) and boys (22 per cent) who had their first sexual intercourse before the age of 15 years.

Key Indicators for Adolescents

Adolescents in Kenya are not a homogeneous group. What they have in common is age, but they vary substantially by age segment, development, schooling attainment and enrolment status, work status, marital status, cultural affiliation, urban or rural and other factors. A richer understanding of the different needs of sub-groups of adolescents, as well as the contexts which pose risks to their healthy development must be fostered to inform national policies and programmes.

General challenges faced by adolescents are: early pregnancies and marriages, child labour, poverty, drug and substance abuse, low school enrolment and high drop-out rates, and harmful practices such as female genital cutting (FGC). Adolescent girls, in particular, face severe obstacles when seeking employment, and struggle to overcome entrenched social, economic and gender inequality. They are vulnerable to early marriage and pregnancy, HIV infection and violence. Without clear opportunities for income-generation, their families may see little value in supporting their education.

The 2008-2009 KDHS found the following:
- About one out of every five female teenagers has begun child-bearing (are pregnant or have ever given birth).
- HIV prevalence among those aged 15-19 years is about 2 per cent. The prevalence among females in this age group is about four times higher than that of males.
- About half of the women who have undergone FGC did so during their adolescence. Although generally there is data available for the age groups 15-24 years, there is less reliable data for young adolescents, especially for 10-14 years old. Data available in conventional datasets (e.g. KDHS) is disaggregated for ages 15-19 and must be used to provide evidence to inform policies and programmes for adolescent boys and girls. From a review of available studies and surveys, a number of inequalities emerge amongst boys and girls in this stage of life in Kenya. The most frequently highlighted in the available literature relate to education, health, access to employment, skills and training, urbanization and social protection.

Health and Well-being During Adolescence

A combination of determinants influence the health status of adolescents including individual and societal factors coupled with institutional and economic factors. Lifestyle changes and risk taking are some of the factors influencing the health status of adolescents during this particular period of life. However, access to correct information and services are equally (if not more) important as adolescents may have the best intentions to lead healthy lives, yet if they are deprived of information and services, they may have little choice. Structural barriers such as user fees, lack of confidentiality, opening hours and attitudes of health service providers pose substantial challenges and may impede their access and utilization of health services.
A person’s level of education is strongly associated with age at first sex, especially for women. In 2009, 67 per cent of women aged 18-24 with no education had experienced sex by the age of 18, compared to only 30 per cent among those with at least some secondary education. Similarly, early sexual debut seems to be associated with poverty levels. For example, 62 per cent of young women in the lowest wealth quintile had their first sexual intercourse by the age of 18 compared with 36 per cent of those in the highest wealth quintile. About one third (32 per cent) of out-of-school adolescents have begun childbearing, compared with only one-tenth (10 per cent) of those with some secondary education and above. Enabling girls to complete schooling, especially secondary education, yields substantial economic and social benefits.

Adolescents are up to three times more likely to experience pregnancy-related complications than older women. High fertility levels as well as high teenage pregnancy rates have serious negative consequences affecting adolescents’ health and education. Early childbearing in particular disrupts the pursuit of education and limits future opportunities for social and economic development.

Lifestyle choices are another cause of ill health and well-being among adolescents. For example, the likelihood of being obese or overweight increases with age for late adolescents and youth, and is twice as prevalent in urban (40 per cent) than in rural areas (20 per cent), and increases with level of education and wealth. Risk-taking such as use of drugs and alcohol is another factor influencing the health status of adolescents.

Despite increased investment in the health sector, utilization of health services by adolescents remains low. This can be attributed to the lack of integration of services which are supportive of adolescents needs. For instance, the Youth Fact Book 2010 estimated that only 12 per cent of health facilities provide youth-friendly services that would enable them to make informed choices and decisions regarding their health and general well-being.

**HIV and AIDS**

The impact of HIV still poses one of the greatest challenges in Kenya. The epidemic has changed the family landscape, resulting in a re-organization of roles and responsibilities, disrupting the lives of adolescents and driving up health care costs. Apart from increasing orphans, HIV infection and AIDS-related illnesses also contribute to the vulnerability of adolescents and put them at risk of exploitation. The disruption of family cohesion and the trauma associated is a serious threat to their mental health. In addition, the high burden on adolescents, usually young women, working as care givers to family members jeopardizes their ability to prepare for the future as some may have to leave school to be able to fund for themselves and their families. According to the Kenya AIDS Indicator Survey 2012 some 2.6 million children are either orphaned or vulnerable for other reasons. Notably, a third of these orphans and vulnerable children are in their early adolescence and between 10 and 14 years.

While HIV prevalence has decreased to an estimated national HIV prevalence of 6 per cent in 2013, the country is among the global priority countries with 1.6 million people living with HIV. With an HIV prevalence of 7 per cent among women, compared to 4 per cent among men, women continue to bear the brunt of the epidemic. The risk of HIV infection starts at a young age for girls, and increases rapidly as they grow up during their adolescence and youth, especially for girls.

**Figure 24: HIV prevalence among women and men aged 15-24 years, KAIS 2012**

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321 Lee, Veronica C. et all (2014): Orphans and Vulnerable Children in Kenya: Results From a Nationally Representative Population-Based Survey, JAIDS, Volume 66,


323 Youth Fact Book 2010

324 Ibid

325 Lee, Veronica C. et all (2014): Orphans and Vulnerable Children in Kenya: Results From a Nationally Representative Population-Based Survey, JAIDS, Volume 66,


328 UNICEF Secondary Data analysis of 2013 national HIV estimates and projections.

Adolescents and Education

Recent decades have witnessed enormous growth across all sectors of education in Kenya. By 2011 almost 9.9 million children were enrolled in primary school. However, 20-25 per cent of adolescents fail to complete primary schools whilst only two-thirds of those who complete are able to transition to secondary school. By 2010, completion of primary school was only at 76.8 per cent (79.2 per cent boys and 74.4 per cent girls). Transition rates from primary to secondary increased marginally from 59.6 per cent (56.5 per cent for males and 63.2 per cent for females) in 2007 to 72 per cent in 2010. Overall, only slightly more than half of all adolescents transition to secondary school.

**Figure 26: Need for ART by Age In 2013**

![Need for ART by Age In 2013](image)

**Summary:** Kenya urgently requires a more effective response to prevent new infections among adolescents, especially among girls 10-19 years who experience a high number of new infections. High-impact interventions, such as rapidly scaling up integrated HIV testing and counselling services, increasing consistent condom use and improved access and quality of treatment and care services for adolescent boys and girls are critical measures. Interventions must also seek to better address gender inequality and other structural drivers for new infections. Innovative programmes that test enhancing protection factors of social cash transfers coupled with complimentary interventions for highly vulnerable adolescent girls and their families may play an important role to better protect adolescents from HIV infection and enhance their wellbeing. New approaches should look at the local context, structural drivers and risk situations and seek to promote comprehensive approaches which recognize that adolescents are not one homogenous group and face multiple risks, including young key populations.

331 UNICEF Secondary Data analysis of 2013 national HIV estimates and projections.
332 UNICEF Secondary Data analysis of 2013 national HIV estimates and projections.
334 Youth Fact Book, 2010
335 Fraser and Hilker 2012
336 Recoup working paper 2010
337 UNICEF/GoK Violence against Children study 2012
Adolescents and Social Protection

A landmark 2012 study presents results of the impact of the national ‘Orphans and Vulnerable Children – Cash Transfer Programme’ (OVC-CT) on the health and demographic outcomes of young people aged 15-24 years. The study suggests that the programme has boosted the life chances of children to more safely navigate through their adolescence and facilitated their safe and healthy transition into adulthood. For instance, adolescents who benefitted from the programme in the 11-16 age group were less likely to have had their sexual debut than similar adolescents who had not benefited. In comparison, among those who had sex, those in receipt of cash transfers had fewer partners, and were less likely to have unprotected sex. Furthermore, young girls and women aged 12-24 in programme households were less likely to have ever been pregnant relative to their counterparts in non-programme households.339

The study offers several explanations for this. First, the OVC Cash Transfer has been shown to increase secondary school enrolment.340 Schooling in turn can affect sexual activity by changing peer groups and social networks, by directly providing knowledge about the costs and benefits of risky sexual behavior, or by simply reducing the available time that individuals have for socializing (Jukes 2008). Second, there is some evidence that young people, particularly those orphaned and vulnerable, may suffer from depression or other mental health illnesses which in turn lead to engagement in risky sexual behaviour, and the cash transfer may offer some protection from this.341 Since unprotected sex and multiple partners are related to HIV risk, the programme may be playing an HIV prevention role among young people in beneficiary households. The study confirmed that schooling is an important protective factor for sexual debut and for early pregnancy, especially for young women.

The study shows that social protection through the OVC-CT has greatly improved the life-chances of adolescents and young people in the target population by facilitating their healthy and safe transition into adulthood. For Kenya, the results indicate that the OVC-CT is an excellent investment by the Government in the welfare and development of vulnerable adolescents.

Actions to Promote the Rights of Adolescents

It is widely recognized that adolescence is a critical period to break the inter-generational cycle of poverty. The following are strategic recommendations for the Government and development partners to consider in order to seize the opportunities and address the inequalities that adolescent boys and girls face in Kenya:

- Conduct a more robust analysis of existing data, including geographical data, and generate disaggregated data for gap areas, recognizing the internal diversity among adolescents and geographical variations to develop a richer understanding of the different needs and contexts of risks. Such an analysis will be important to better identify those adolescents who experience multiple deprivations.

- Support interventions that target stages in the life-cycle in multiple environments. During these critical points in their life cycle -- early, middle and late adolescence -- children experience rapidly-changing physical, emotional, intellectual, and social needs. For instance, in early adolescents, the majority of Kenyan adolescents are in school, after which there is a large drop out. It will be important to determine the minimum knowledge and skills needed including in regard to sexual and reproductive health and other pertinent areas which should be acquired in early adolescence. For those who transition to secondary school, Government duty-bearers should consider a minimum package in terms of comprehensive sex education to be provided to this age group. As for middle to late adolescence, when sexual initiation and practice increases, the health sector needs to ensure that any interaction with an adolescent should be an occasion to reinforce a minimum package.

- Increase efforts in finding and supporting those adolescents who are not transitioning well to adulthood. This requires a community-focused protection response and must be based on locally analyzed data.

- Ensure that Government programmes and policies include explicit targets and outcomes for adolescent boys and girls, as without them the main inequities they face will not be changed. For instance, existing targets in the area of health and HIV need to be better age-disaggregated and combined with subsequent programming. It is also necessary to differentiate how best to reach and respond to the diverse mix of adolescents and their concerns.

- Increase education opportunities for girls by expanding access to primary, support for transition to secondary school and offering incentives to stay in school which reduces drop-out rates and can delay marriage.

- Make special efforts to address the gender inequalities experienced by adolescent girls. This will include working with boys and men to engage them in questioning traditional rigid forms of gender socialization. As the rights of adolescent girls and women are interrelated, fulfilling the rights of adolescent girls – to health, education, protection from violence and abuse – is the best way to ensure that they achieve their physical, emotional and social potential, and go on to become empowered women. This should include empowering and informing adolescents (both girls and boys) about their human rights, as well as their responsibilities.
• Support the participation of children during their adolescence phase. When adolescents have a say in programmes and activities, they can develop greater self-confidence and competence in different areas and activities. In recent years, there is also a phenomenal growth in Kenya in the use of the Internet and ICT among adolescents and young people. These new social networking tools provide enhanced opportunities for adolescents to connect and become involved in relevant activities.

• Scale-up social protection programmes which contribute to healthy adolescents and development outcomes. New evidence from cash transfer programmes has shown positive outcomes in adolescent healthy behaviours and in the area of education. Such approaches should be expanded with a view to supporting the most vulnerable adolescents. 342

Annex
The Children’s Voices

Over the past few years, there has been a steady rise in the number of structural mechanisms for children’s participation, where children can influence decisions about their lives and bring about real change. To this end, a deliberate effort was made by the National Council for Children’s Services, the Department of Children Services and UNICEF to engage the Children Assembly.
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Introduction:

1.1 Why this report

In 1990, the Government of Kenya ratified the UN Convention on the Rights of the Child (CRC). Under the CRC, all children and young people are guaranteed the right to freely express their views in all matters affecting them and for these views to be given due weight in accordance with the child’s age and maturity (Article 12). The aim of the Children’s Voices report is to provide an update on children’s insights and impressions in Kenya on diverse issues, ranging from economic development and conflict to maternal and child health, education and protection, to inform the 2014 Situation Analysis. This report would not have been complete without children’s inputs to the findings and recommendations.

The Children’s Voices report identifies priority issues that can help the Government to determine the most critical problems to address when designing programmes and interventions for the well-being of children.

1.2 Methodology

Over the past few years, there has been a steady rise in the number of structural mechanisms for children’s participation. By participation, we mean the type of participation where children can influence decisions about their lives and bring about real change. To this end, a deliberate effort was made by the National Council for Children’s Services, the Department of Children Services and UNICEF to engage the Children Assembly.

The Children Assembly is an official structure established by the Department of Children’s Services to promote child participation in decision-making on matters that affect them through networking and facilitating their best interest at county, national and global levels. Membership of the Assembly is established through an election process starting at the county level to the national level. At present, children at the county level sit and deliberate on issues that feed into the National Assembly discussions. The 40 National Children Assembly officials and members came from 20 counties. Although the participants were not representative of all 47 counties, the forum provided a tremendous opportunity for enhancing inter-county cooperation and information-sharing.

During the Children Assembly forum, measures were taken by the facilitators to ensure that no children’s rights were violated. Focus Group Discussions (FGDs) were conducted with the children in close cooperation with chaperones who were Children’s Officers from the Department of Children Services and NCCS. The UNICEF Consent Form was used to seek consent for the children’s participation from the parents/guardians. Before each session started, in the introductory remarks, the children were verbally asked for their consent to participate. They were also notified that they could opt out of the discussion at any time or refuse to respond to any specific question that might make them uncomfortable. All questions were asked in the form of “What do you think/What are your views with regard to certain issues?” Each group discussion lasted for about two and half hours with short breaks in the middle with refreshments.

The purpose of the group discussions was to enable children and adolescents to share aspects of their lives and thoughts with their peers, and for these views to be documented. Listening to the children was an opportunity for adults to see how children themselves saw their daily lives. Live interviews were carried out with selected children addressing specific rights and key thematic areas were identified. The consent of the children interviewed was sought and they were informed that their views would be included in the 2014 Situation Analysis on children’s rights.
Objectives of the participation

The children's input was required to review the recommendations of the 2009 Situation Analysis of Children, Young people and Women in Kenya; and to give their views on the current status of the rights to Education, Health, Participation and Protection; and to share their insights and knowledge of the thematic areas below:

1. Economic development and children
2. Urbanization, migration and children
3. Maternal and child health;
4. Adolescence; and
5. Crisis, conflict, disaster and children.

2.1 Economic context

Economic development and children

The children defined economic development as the allocation of funds to improve development, as Government's efforts to encourage development of marginalized areas, and also the way Government builds infrastructure and trains personnel. To further detail their understanding on the effects of economics on ordinary people, the children explained the differences between rich people and poor people in the community.

They described a rich person as a person who has property and a place to live, has a luxurious life and has money. A rich person's children don't suffer because he can afford to take them to good medical facilities. The rich man according to them also has good clothes, has cars and has the ability to help others.

On the other hand, a poor person was described as one who has children who are suffering, have inadequate food and clothes, and can't afford to rent a house. He/she struggles to meet basic needs for the family and he/she can't afford medication for his children and lives in a poor area.

The children made the following recommendations to boost the economy:

1. Sensitize the poor on family planning.
2. Promote charity and the act of giving in the society.
3. The Government should improve the economy to facilitate job creation.
4. Increase social facilities e.g. Hospitals, schools, markets etc.
5. Child labour should be abolished and children should go back to schools through law enforcement.
6. Corporal punishment should be abolished.
7. Children Officers should sensitize the community on child labour.
8. Children living on the streets should be provided for and also given equal opportunities.

2.2 Political context

Political, legal reforms and devolution

The children cited the steps that the Kenya Government has taken in a bid to protect children:

1. Implementation of the 4 pillars of children's rights as outlined in the four pillars
2. Ratification of international legal instruments
3. Establishment of the Children Act 2001
4. Partnership with international agencies
5. Capacity-building of the Justice system through training of police, judiciary, probation and Children's Officers
6. Establishment of rescue centres
7. Birth certificates registration
8. Free Primary Education and Medical Services
9. The Cash Transfer Programme for Orphans and Vulnerable Children

The children also indicated that they were aware of the legal instruments that are in place to protect them and cited the following:

1. Children Act 2001
2. Constitution 2010
3. African Charter on Rights and Welfare of Children
4. Sexual Offences Act
5. Anti-Female Genital Mutilation Act

The following however, were stated as the challenges facing the proper implementation of these laws:

1. Inadequate funds
2. Corruption
3. Adverse cultural practices
4. Ignorance of the law (impunity)
5. Discrimination
6. Political interference
7. Inter-communal conflicts
8. Illiteracy in the society
9. Unrealistic, open-ended laws.

Recommendations made towards overcoming these challenges were:

1. Allocate more funds to the Department of Children's Services.
2. Create more branches of Ethics and Anti-corruption.
3. Appoint strong leadership in powerful institutions to protect children.
4. Implement the laws well and adequately.
5. Create awareness of children's rights in society.
6. Involve children in the legislation process to capture their inputs.
7. Embrace and implement adult education to reduce illiteracy levels.
8. Make realistic rules.

It was noted that children and the community, being the major stakeholders, must be involved in the implementation of these laws for them to succeed.
3.0 Progress in realization of children rights

3.1 The right to survival, growth and development
Maternal health was defined as the well-being of a mother when she is expectant. It was also understood to be the period when the mother is pregnant until she gives birth and the process by which the mother gives birth to a child.

Child health was defined as the well-being of a child from a zygote to the time the child is born and grows. It was noted that child health is dependent on the mother. Child health was described as the well-being of a child in relation to nutrition, medication, environment, immunization, vitamin supplements, parental love and care.

The children discussed the importance of a mother’s health in relation to her child. It was noted that in the case of an expectant mother, her health will automatically affect her unborn child e.g. if her immune system is deficient. An expectant mother should sleep under a mosquito net to protect herself from malaria; while an expectant mother taking alcohol, drugs and smoking cigarettes leads to the birth of unhealthy or underweight babies.

An HIV positive mother can infect her children if she does not take necessary measures to protect him or her in food handling and the way she nurses her wounds (if she is carrying the child). She can also infect the unborn child if she doesn’t follow the prescribed measures during delivery and after delivery. She should eat nutritious food and visit a clinic regularly. She should go to a hospital for delivery and practise exclusive breastfeeding in the first six months.

The children knew that an unhealthy mother was unlikely to give birth to a healthy child and they stated that poor maternal nutrition makes a child malnourished. A mother who is unwell cannot fully take care of her children thus affecting their health. In some cases, the children end up taking care of their unhealthy mother, thus affecting them in various ways.

The following were termed as factors that contribute to a mother being unhealthy:
1. Surrounding environment
2. Diet
3. Social and economic status
4. Ignorance
5. Distance to a health facility
6. Misguided religious beliefs
7. Drug and alcohol abuse
8. Domestic violence
9. Adverse cultural practices e.g. FGM that affect delivery
10. Unqualified birth attendants
11. Diseases.

The children discussed ways in which the health of a newborn unhealthy baby can be improved:
1. Immunization
2. Growth monitoring
3. Proper nutrition
4. Proper medication
5. Good parental care
6. Proper hygiene and sanitation.

It was however noted that a healthy child could become unhealthy over time (before the age of 18) due to the following factors:
1. Immorality mainly associated with cyber/internet leading to sexual encounters and contracting HIV
2. Irresponsible parenting
3. Accidents
4. HIV infection through breastfeeding.

The following recommendations were made to improve maternal and child health in Kenya:
1. Give proper medication through accessible medical facilities
2. Provide proper nutrition
3. Give medical cover
4. Provide affordable and quality water and sanitation
5. Address industrial unrest of the doctors and nurses (strikes)
6. Create awareness of maternal healthcare and nutrition.

3.2 The right to education
Early childhood education was defined as the first formal education that a child is introduced to before joining primary level. Children receiving this form of education are normally between the ages of 3-6 years.

Cited challenges hindering early childhood education included:
1. Insecurity
2. Poverty
3. Financial status
4. Distance from school
5. Lack of ECD facilities
6. Disability
7. Culture and religion.

In regard to primary and secondary school education, the children believed that the number of children who enrol in schools is:
1. Primary – over 90 per cent enrolment because of the Free Primary Education policy.
2. Secondary – 10 per cent because of factors leading to school drop-outs e.g. displacement, lack of parental care and support, teenage pregnancy, early marriage, child labour and poverty.

The number of children who completed school was believed to be at:
1. Primary -- 75 per cent.
2. Secondary – 85 per cent due to the above-mentioned factors that cause drop out of the 15 per cent.

The percentage ratio of girls to boys who completed was believed to be:
1. Primary: girls: boys 42:58

There was also a discussion about children from nomadic communities and whether they were able to access formal education. The children stated that nomadic children have less access to Early Childhood Education. However, most of the nomadic children have access to primary and secondary education. Northern parts of Kenya were particularly highlighted in this discussion.
The challenges nomadic children were said to experience included:
1. Migration
2. Culture especially negative to girls
3. Famine and drought
4. Distance from home to school
5. Absence of mobile schools
6. Lack of boarding facilities in schools
7. Persistent insecurity.

The children came up with recommendations on how these challenges could be overcome:
1. Provide well-equipped mobile schools.
2. Sensitize the community on the benefits of education.
3. Increase number of mobile schools.
4. Increase number of boarding schools.
5. Enhance the school-feeding programme
7. Government should provide watering points especially for nomadic communities.
8. Diversify the economic activities of nomadic communities to avoid over-reliance on pastoralism, and find better methods of animal production.
9. Ensure extensive use of existing water supply for irrigation.

3.3 The right to protection

The children had discussions on the availability of laws and mechanisms protecting children in the country. Their discussions were based on the following protection issues:

a) Right to identity:
They stated that it is the right of every child to a name and identity as outlined in the Children Act, the Constitution, and other international instruments. A question was raised on the importance of birth certificates and it was established that a good number of the children had birth certificates. It was stated that it is currently easier and cheaper to get birth certificates than in the past.

b) Protection from violence, abuse, neglect and exploitation:
There are laws, a helpline (Childline), Child Protection Units, Children’s Courts and children’s services, but implementation is still a challenge.

c) Children living and working in the streets.
To prevent children from living and working on the streets, parents are encouraged to take parental responsibilities, while communities need to appreciate societal morals that discourage street life. There is need to allocate money to street children and families to rehabilitate them.

d) Child trafficking and sexual exploitation.
Legislation on sexual exploitation and abuse exist but there is still minimum reporting of such cases. Civic education of parents and children can help them to avoid exposing their children to kidnapping and trafficking. There is also a social protection factor. Such vulnerable children could be enrolled in the Cash Transfer Programme for Orphans and Vulnerable Children.

e) Protection from harmful practices e.g. FGM, early marriage, cattle rustling, karamu (Meru) etc. Legislation exists against FGM, but it is necessary to sensitize communities on the negative effects of such adverse cultural practices.

f) Right to parental care or alternative care
Adoption and foster care services exist, but long processes discourage prospective foster parents. One method to overcome this would be introducing parenting education in schools to instill family values in children.

g) Children in conflict with the law
Child Protection Units exist but they are still not enough. Court processes for children’s matters should be shortened, and Children Magistrates who deal with children’s cases only should be gazetted. Special courts for children’s cases only should be availed.

h) Protection from illicit drugs
The National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) are doing a commendable job on campaigns against drug abuse, and there is need to also curb drug-traffickers and their sources.

i) Protection from abuse through media such as TV, Internet, magazines, radio, etc.
Measures to curb child internet/cyber crime through the introduction of age limits or constraints in accessing the net should be adopted, and identification should be required before accessing of such material.

j) Non-discrimination of children with disabilities
All children have a right to be heard but it is difficult to reach children who are living with disabilities. It is important to find ways of directly seeking their views to improve their well-being and to give them a better quality of life.

Recommendations

1. Sensitize and educate parents to ensure registration of births and access to birth certificates.
2. Ban corporal punishment in Kenyan schools. Teachers, parents and children to be sensitized on the negative impacts of a cane and taken to appreciate and adopt alternative forms of discipline. Children should take the initiative of reporting such abuses to the authorities.
3. Make extensive use of the DCS and courts to resolve child neglect cases.
4. Enhance social protection mechanisms such as the CT-OVC to reach more families with children.
5. The Government should enforce strict measures on caregivers, companies and organizations employing children.
6. Government should fully implement Free Primary Education (FPE) so that no child is found working in order to raise school fees.
7. Follow-up on cases to avoid tampering with evidence and miscarriages of justice.
4.0 Thematic Analysis

4.1 Children in crisis and disaster
The terms conflict and crisis were understood to refer to unstable and dangerous situations affecting communities and have an impact on the entire nation. The children gave examples of conflicts and crises they have experienced. They stated that for instance, in some counties there exist extremist religious organizations that do not take children to hospital, e.g. the Kavonosya church in Kitui County. They also mentioned the Tana River violence, where many people were killed and thousands displaced, and children and women suffered. The post-election violence of 2007-2008 was also cited as another incident.

Crisis and conflicts were said to affect children in the following ways:
1. Children are forced to drop out of school.
2. Orphanhood
3. Exposure to child abuse.

The following recommendations were made in a bid to curb the negative effects of conflicts and crises. The following steps would be undertaken by the children themselves:
1. Reporting to authorities
2. Child awareness and sensitization forums including use of the Kenya Children Assembly to sensitize all children
3. Child Counsellors to be employed

4.2 Urbanization, migration and children
Urbanization was defined as the growth and development of towns and cities. The children stated that some towns and cities grow faster than others, e.g., Thika. A comparison was made of the lives of children in urban areas and rural areas. The following comparisons were made:
1. Children in urban areas are more exposed to information than children in rural areas.
2. Children in urban areas are better-off in terms of education, healthcare, security, and technology.
3. Distance from school in rural areas is further than in urban areas and this has contributed to late enrolment of children.
4. Children live in poor sanitary conditions in rural areas and are more vulnerable to health problems than those in urban areas e.g., jigger infestation.
5. In urban areas children living in slums are disadvantaged due to poverty. Such socio-economic pressures push children into social evils like prostitution, drug abuse and trafficking.
6. Children in urban area access good recreational facilities e.g., swimming pools, parks, stadiums.
7. Children in rural areas are less exposed to protection measures compared to children in urban areas.
8. Culture and community rites are an impediment to the implementation of laws in rural areas.
9. Exposure to information for children in urban areas e.g. internet increases exposure to pornography, for example.
10. In urban areas families don’t have enough time to interact compared to rural families.
11. In urban areas children are more exposed to adult lifestyles and advanced technology compared to children in rural areas, and thus mature faster.
12. In rural areas, children with disability lack facilities to assist them and they are discriminated against because they are perceived as a curse.

The children also examined the reasons behind rural to urban migration and the more recent urban to rural migration. They cited the following as the reasons for the migration:

Rural to urban migration:
1. Better job opportunities, which may lead to growth of slums
2. Better technology in urban areas
3. Better social amenities in urban areas
4. Negative perceptions about rural life
5. Food security perceived to be better in urban areas
6. Better quality schools in urban areas. Access to better facilities and equipment compared to rural areas
7. Poverty has led children to move to urban areas to earn a living, sometimes termed as the street economy

Urban to rural migration
1. Rising cost of living in urban areas pushes people back to the rural areas
2. Poor environmental conditions in urban areas, e.g., pollution
3. High competition for business and space/resources
4. Rise in insecurity and terrorism
5. Early retirement of parents results in a move to the rural areas
6. Decentralization of resources, jobs and other facilities especially with the introduction of County governments.

Child trafficking, erosion of culture, over-dependency, family break-up and drug abuse are cited as some of the negative impacts of migration.

The children made recommendations on how to curb the negative effects of urbanization and migration in the country:
1. Promote child participation and sensitize the community in all areas to abolish tribalism.
2. Sensitization in schools and community about the laws that address children issues, discourage child labour, child trafficking and early marriages.
3. Equal distribution of resources and opportunities.
4. Networking and interaction.
5. Ensure the standard and quality of education in both rural and urban areas.
6. Decentralization of the labour force and skills to rural areas.
7. Government to fully support scholarship programmes and bursaries for needy children e.g. Wings to Fly.
8. County governments to ensure equal development in all areas.
9. Ensure quality development of education in all rural areas.
10. Discourage negative cultural practices e.g. FGM.
11. Advocate for both boy and girl child empowerment.
12. Avoid idleness that encourages unnecessary migration; this will discourage development of gangs and misbehaviour.
13. The Government should reduce taxes on building materials to make them accessible to poor families to avoid inadequate shelter.
4.3 Adolescents

Adolescence was termed as the age between childhood and adulthood. It is a time of transition from childhood to adulthood. Most of the assembly members at the meeting admitted to being at this stage in their development. The changes they reported experiencing included: physical, mental, emotional, spiritual, and behavioural changes. The children reported that they had received information about adolescence from school teachers, school counsellors, parents and guardians; and programmes in special set-ups e.g. camps, churches, NGOs visiting schools, books and documentaries.

They discussed how adolescence has affected their relationships with people in their lives as well as their communities at large. The children stated that at first they would feel shy and did not wish to speak to anyone about what they were experiencing. However, with time, they felt that their views were being taken seriously -- a feeling that was instilled during counselling. Peer counselling clubs in schools were found to be particularly supportive.

The children discussed the opportunities for participation in decision-making, particularly in matters that directly affected them. They stressed that they wanted to be given room to make their own decisions. Regarding their choices of careers, while they appreciated the advice of their parents, the children wanted to make the final decisions about their careers. It was strongly felt that adults often did not take the trouble to explain to children the rationale for why a particular decision was reached without taking into account the child’s point of view. They also agreed that the involvement of a neutral third party when negotiating decisions that have an obvious impact on their lives, such as education and recreational activities, would be very helpful.

In addition, the children also looked at other opportunities for decision-making at home, in school and in the wider community. They noted that the views of students were being taken into account in school administration decisions. Increasingly, children are part of school students’ forums, -- but suggestions from these fora should also reach PTA meetings where decisions are taken to ensure that children’s views are supported and captured in the proceedings. Age groupings should be made clearer – it is confusing to be referred to as a “child” then next time as an “adult.”

Finally, the children advised teachers and parents to maintain good personal relationships with adolescents. “Being an adolescent means we are responsible – give us the freedom that allows us to become independent (freedom with responsibility).”

**CONCLUSION AND RECOMMENDATIONS**

Overall, children’s participation in and contribution to the 2014 Situation Analysis was effective in ensuring that the voices of young children were heard, even those from marginalized communities. It is hoped that in addition to the Children Assembly, a wider range of mechanisms will be made available for children to express their views. For the long-term, it is important to monitor and measure the impact of children's participation in decision-making and whether it eventually results in tangible outcomes for the fulfillment of children’s rights. In the meantime, we must continue to work with an even wider range of children to make the right to participation a reality.