



# Situation Analysis of Children and Women in Kenya, 2017

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and Women in Kenya, 2017**

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# List of Abbreviations

<b>ACSM</b>	Advocacy, Communication and Social Mobilization
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ARI</b>	Acute respiratory infection
<b>ART</b>	Antiretroviral therapy
<b>ASAL</b>	Arid and semi-arid lands
<b>BCG</b>	Bacillus Calmette–Guérin vaccine
<b>BMI</b>	Body mass index
<b>BMS</b>	Breast milk substitutes
<b>CBO(s)</b>	Community Based Organisation(s)
<b>CCI(S)</b>	Charitable children’s institution(s)
<b>CDF</b>	Capacity Development Framework
<b>CFR</b>	Case Fatality Rate
<b>CFA/FFA</b>	Cash for Assets / Food for Assets
<b>CHEW</b>	Community Health Extension Worker
<b>CHV</b>	Community Health Volunteer
<b>CIDP</b>	Country integrated development plan
<b>CLTS</b>	Community Led Total Sanitation
<b>CNAP(s)</b>	Community Nutrition Action Plan(s)
<b>CPiE</b>	Child Protection in Emergencies
<b>CPIMS</b>	Child Protection Information Management System
<b>CRA</b>	Commission on Revenue Allocation
<b>CRC</b>	Convention on the Rights of the Child
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities
<b>CSG</b>	County Steering Group
<b>CSPS</b>	Civil Service Pension Scheme
<b>CT-OVC</b>	Cash Transfer for Orphans and Vulnerable Children
<b>DALY</b>	Disability-adjusted life year
<b>DANIDA</b>	Danish International Development Agency
<b>DCS</b>	Department of Children’s Services
<b>DFID</b>	(United Kingdom) Department for International Development
<b>DVD</b>	Digital video disc
<b>EAC</b>	East African Community
<b>EARC(s)</b>	Educational Assessment Resource Centre(s)
<b>EDE</b>	Ending Drought Emergencies initiative
<b>EMIS</b>	Education Management Information System



<b>ENAC</b>	Emergency Nutrition Advisory Committee
<b>FAO</b>	Food and Agricultural Organisation
<b>FGM</b>	Female Genital Mutilation
<b>FNSP</b>	Food and Nutrition Security Policy
<b>GAVI</b>	Global Alliance for Vaccines and Immunization
<b>GDP</b>	Gross Domestic Product
<b>GER</b>	Gross Enrolment Rate
<b>HDI</b>	Human Development Index
<b>HIV</b>	Human Immunodeficiency Virus
<b>HSNP</b>	Hunger Safety Net Programme
<b>ICCM</b>	Integrated Community Case Management
<b>IMAM</b>	Integrated Management of Acute Malnutrition
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>IPV</b>	Inactivated polio vaccine
<b>ITN</b>	Insecticide-treated mosquito net
<b>KABP</b>	Knowledge, Attitudes, Behaviour and Practices
<b>KCPE</b>	Kenya Certificate of Primary Education
<b>KCSE</b>	Kenya Certificate of Secondary Education
<b>KDHS</b>	Kenya Demographic and Health Survey
<b>KEPSA</b>	Kenya Private Sector Alliance
<b>KFSSG</b>	Kenya Food Security Steering Group
<b>KHO</b>	Kenya Health Observatory
<b>KHSSP</b>	Kenya Health Sector Strategic and Investment Plan
<b>KNBS</b>	Kenya National Bureau of Statistics
<b>KSh</b>	Kenyan Shillings
<b>MDG(s)</b>	Millennium Development Goal(s)
<b>MEACLSP</b>	Ministry of East African Community, Labour and Social Protection
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>MODA</b>	Multidimensional Overlapping Deprivation Analysis
<b>MTCT</b>	Mother to child transmission of HIV
<b>MTP</b>	Medium Term Plan
<b>MTPII</b>	Second Medium Term Plan
<b>NACONEK</b>	National Council for Nomadic Education in Kenya
<b>NDMA</b>	National Drought Management Authority
<b>NER</b>	Net enrolment rate
<b>NGO(s)</b>	Non-Governmental Organisations(s)
<b>NHIF</b>	National Health Insurance Fund

<b>NNAP</b>	National Nutrition Action Plan
<b>NSNP</b>	National Safety Net Programme
<b>NSPP</b>	National Social Protection Policy
<b>OCHA</b>	Office for the Coordination of Humanitarian Affairs
<b>ODA</b>	Official Development Assistance
<b>OPCT</b>	Older Persons Cash Transfer
<b>ORS</b>	Oral Rehydration Salt
<b>PMTCT</b>	Prevention of mother to child transmission of HIV
<b>PPP</b>	Public-private partnership
<b>PWSD-CT</b>	Cash Transfer for Persons with Severe Disabilities
<b>RDT</b>	Rapid diagnosis test
<b>RMNCH</b>	Reproductive, maternal, newborn, and child health
<b>SAU</b>	Social Assistance Unit
<b>SDG(s)</b>	Sustainable Development Goal(s)
<b>SMART</b>	Standardized Monitoring and Assessment of Relief and Transitions
<b>SPS</b>	Social Protection Secretariat
<b>SUN</b>	Scaling Up Nutrition
<b>STI</b>	Sexually Transmitted Infection
<b>TSC</b>	Teacher Services Commission
<b>TVET</b>	Technical and vocational education and training
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations High Commission for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>US</b>	United States
<b>US\$</b>	United States dollar
<b>VSO</b>	Voluntary Service Overseas
<b>WASH</b>	Water, sanitation and hygiene
<b>WaSReB</b>	Water Services Regulatory Board
<b>WFP</b>	(United Nations) World Food Programme
<b>WHO</b>	World Health Organisation
<b>WSP</b>	Water service provider
<b>WWDA</b>	Water works development agency

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## Foreword

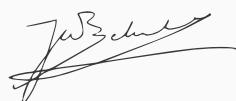
The 2017 Situation Analysis of Children and Women (SitAn) report provides a comprehensive overview of the key factors contributing to and hindering the realization of children and adolescents' rights in Kenya. The launch of the report comes at a critical time in terms of national planning for children: after the launch of the Sustainable Development Goals (SDGs) and while the Government is in the process of finalizing the Third Medium Term Plan 2018-2022 (MTP III) of the Vision 2030; the second generation of County Integrated Development Plans (CIDPs); and the United Nations Development Assistance Framework (UNDAF) 2018-2022. The 2017 SitAn aims to inform these planning processes by providing policy makers with a current and comprehensive overview of the needs of children and women in Kenya. The findings of the SitAn have been critical for Government and UNICEF Kenya in the planning of the 2018-2022 Country Programme Development (CPD), which identifies key priorities for the next 4 years of collaboration and UNICEF support.

Given the availability of rich data on children in Kenya conducted between 2014 and 2017, the SitAn report used secondary analysis of recent data on children and women in Kenya, and was also complimented by key informant interviews with Government technical departments, and technical input from the Kenya Bureau of National Statistics (KNBS).

The report highlights evidence on the various policies, legislation, legal frameworks and interventions adopted by the Government aimed at strengthening the realization of children's rights, including adolescents. It also presents an overview of the most recent data and analysis relating to the status of women and children in terms of poverty; health and nutrition; HIV and AIDS; water and sanitation; education; protection; inclusion in society and in emergencies, at both national and at county levels.

As the report shows, the Government of Kenya is committed in providing an enabling legislative and policy environment for addressing women and children's issues. Some of the finalized policies in key children's rights areas include (i) the education curriculum reform (ii) early childhood and development policy (iii) free secondary school scheme and (iv) FGM policy. The Children's Act is also being revised. The SitAn also notes that groups of children- particularly those living in the northern counties of the Arid and Semi-Arid Lands (ASAL); those living in informal settlements within growing cities; and many girls living within communities which practice harmful traditions- are being left behind in the realization of their fundamental rights and the opportunity to thrive.

The 2017 Situational Analysis reminds us that while Kenya is a middle-income country, which has enjoyed significant development advances and positive economic outlook, there is also an unfinished agenda from the 2015 Millennium Development Goals, particularly in the areas of maternal health; clean water and sanitation; reducing child mortality; eradicating extreme poverty and hunger; ending female genital mutilation and cutting; ending child marriage; and combating HIV/AIDs, malaria and other diseases such as Tuberculosis. The Government will address these gaps through the SDGs to ensure that no child is left behind. The report provides the much-needed evidence to design interventions for children in Kenya and as such we urge partners to use this report as a document for planning for children.



Werner Schultink  
Representative  
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## Acknowledgements

The Situation Analysis of Children and Women, (SitAn) in Kenya, 2017, is a culmination of the concerted efforts of various organizations and individuals. The report would not have been possible without the input of a wide cross-section of organizations and individuals, who contributed to the quality of data collected.

The compilation of the report was facilitated by technical support from the Kenya National Bureau of Statistics under the leadership of the Director General, Mr Zachary Mwangi, with final oversight and approval from the Principal Economic Secretary of the National Treasury and Ministry of Planning.

The technical sections of the report were produced in collaboration with the Ministry of Health; Ministry of Education, Science and Technology; Ministry of Water and Sanitation; and Ministry of Labour and Social Protection whose staff participated in key informant interviews and validated drafts of the report.

In addition to these Ministries, the report was produced with detailed technical input from the following departments: The Council of Governors; National Council of Children's Services; Department of Children's Services and the Anti-FGM Board.

The Situation Analysis of Children and Women (SitAn) 2017 is based on existing published data, collated through a comprehensive desk review. The report was presented to major stakeholders at UNICEF Kenya's *Strategic Moment of Reflection (SMR)* in October 2017, and International Stakeholders Meeting held in March 2018.

The Situation Analysis was drafted in consultation with the following non-governmental organizations, who provided reference materials on the status of children in Kenya: International Mercy Corps, Save the Children and World Vision.

Many UNICEF staff members also contributed to this report. Although not possible to mention everybody by name, their contribution and input is well recognized.

The report was drafted by UNICEF consultant Matthew Naumann.



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# Executive Summary

## Introduction

1. In September 2016, Kenya's Government launched its national implementation plan for the Sustainable Development Goals, and expressed commitment that 'no one will be left behind' in the economic and social prosperity of the country. This report, produced by UNICEF as part of its country programme, is intended to support the Government to meet this commitment.
2. The report presents an overview of the Situation of Children and Women in Kenya using the results of the most significant research and analysis between 2014 and 2017 in areas related to the wellbeing of children and women. It is the product of a desk review of key reports, studies, surveys and evaluations produced in the last three years in the area of child rights and associated issues in Kenya by the Government and its development partners, as well as a series of interviews with national and local officials and other stakeholders. By focusing on the key knowledge gaps related to inequities and child deprivations and promoting the broad engagement of all stakeholders, the Situation Analysis is intended to contribute to implementation of Kenya Vision 2030, to support achievement of national and child-related sustainable development goals.
3. The Situation Analysis is divided into several sections. The background section provides information on the geographical, political, economic and social situation in Kenya; and the Enabling Environment section looks at more specific aspects of governance for children in the country. This is followed by six sections that focus on key issues affecting the lives of children and women in the country today:
  - *Surviving*, which focuses on health and nutrition challenges
  - *Learning*, primarily looking at access to and quality of education
  - *Protection from violence, abuse, exploitation and family separation*
  - *Safe and clean environment*, looking at water, sanitation, housing and energy
  - *Children and emergencies*, covering the effects of natural disasters, security challenges, and refugee children; and
  - *Equitable chances in life*, highlighting the situation of children with disabilities, challenges ensuring birth registration, the social protection system and adolescent empowerment.

## Key findings

4. Kenya's GDP growth has been relatively strong in recent years: reaching an estimated 5.9 per cent in 2016 and expected to rise to 6.1 per cent by 2018. Kenya has also experienced some progress towards meeting its development goals. However, the country faces several challenges that complicate the country's efforts to fulfil the rights of women and children. In 2017, progress towards achieving children's rights was threatened by the drought declared in February in 23 of the country's 47 counties, which worsened food and nutrition security, and led to displacement of children and disruption to social services. Meanwhile, insecurity in areas affected by the conflict in neighbouring Somalia and instability associated with pasture in lands that have become increasingly arid as a result of the drought, have further aggravated population movement and barriers to service provision. Rapid population growth, coupled with the effects of climate change, has led to a growth in rural to urban migration and use of informal settlements. While prevalence of HIV has fallen in recent years, Kenya continues to be one of the countries most affected by the virus, and the number of new cases has been increasing recently, particularly among those aged 15 to 24. Poverty continues to hamper the full realisation of children's rights. 45% of children (9.5 million) are deprived in more than 3 basic rights areas.

5. Between 2000 and 2015 Kenya had mixed success in implementation of the Millennium Development Goals (MDGs). Successes included improved net enrolment rates in education, and greater promotion of gender equality and empowerment of women. However, targets were not met with regard to eradicating extreme poverty and hunger; reducing child mortality; combating HIV and AIDS, malaria and other diseases; ensuring clean water supply and sanitation; and improving maternal health.
6. There are some striking differences between development indicators across Kenya's 47 counties. Figures for poverty, education and healthcare, are particularly low in the arid and semi arid counties, and especially in Mandera, Wajir and Turkana Counties, which are affected both by security concerns and by ongoing drought. Groups of children in other areas of the country also face acute vulnerabilities. Increasing numbers of children are residing in rapidly growing informal settlements around the country's major cities, often in poor living conditions, with limited access to services, and heightened risk of violence and abuse. The high prevalence of HIV and large numbers of orphaned children in the southwest of Kenya (particularly Homa Bay, Siaya, Kisumu and Migori Counties) has contributed to specific violations of rights, and access to services for children living on islands on Lake Victoria is problematic.

## Enabling environment

7. The national legislative and policy framework in Kenya is generally favourable for children. The Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child have been brought into national law through enactment of the 2001 Children Act. Revision of the Children Act is currently in progress. Children's rights and their implementation are also enshrined in the Constitution and in Kenya Vision 2030, the national long-term development blueprint.
8. In 2013, significant powers were devolved to 47 county-level governments. This was intended to enhance local participation and service delivery to the most deprived populations. With devolution, county governments have become highly strategic entities, controlling more than 4.5 per cent of GDP in 2015-2016 (based on Government figures) and responsible for planning and delivering a range of functions, including health, water, sanitation, urban services, early childhood development, and other local infrastructure.
9. Following devolution, in some cases counties have struggled with insufficient resources to meet competing sector demands; weak systems; and challenges attracting and retaining competent or trained staff for planning, budgeting and participatory processes. Experience from the last three years appears to indicate that where county governments are committed to improving the situation of the population in their area, and have been provided with support to develop and implement strong county integrated development plans, significant improvements have been made to several key indicators in administrative data (for health, nutrition and sanitation for example). However, other counties appear to have struggled to spend their new annual budgets, partly because of delays to transfers from national Government, and have not seen similar rises in indicators.
10. The Government is committed to investing in improving quality of and access to free healthcare and education as well as the social safety net to reduce burdens on households and complement sustainable long-term growth and development. Including spending at county level, almost 40 per cent of government expenditure was on social sectors in 2015-2016, of which education accounted for more than half. However, efforts are still needed to allocate resources in sectors such as water, sanitation, nutrition and child protection, and planning for and monitoring child rights is constrained by a lack of disaggregated data. The Government is working to improve the capacity of Ministries to generate sectoral statistics.



11. In 2015, Kenya officially moved from a low income to a lower-middle income country. In this context, official development assistance has fallen and is expected to further reduce in upcoming years. The country is increasingly exploring how the private sector can be engaged in meeting development goals, through investment on social sectors, innovation, and sponsorship. However, care should be taken to ensure that the private sector is adequately regulated to prevent violations of children's rights.

## Surviving and thriving

12. According to the Kenya Demographic and Health Survey, the maternal mortality ratio in Kenya has improved from 520 per 100,000 live births in 2008-2009 to 362 per 100,000 in 2014. The main drivers of declines in maternal mortality are a reduction in maternal HIV and reduced mortality from giving birth, ranging from complications associated with abortion, haemorrhage, and obstructed labour. The United Nations estimates that one in 42 women will die of a maternity related cause, and that 8,000 women die every year in Kenya of maternity related conditions, the seventh highest figure in the world. Recent county figures for total maternal mortality are not available, but Mandera County had the highest figure at the time of the 2009 census.
13. Ministry of Health administrative data suggest that significant improvements have been made in skilled birth attendance since devolution, with the figure rising from 44.4 per cent in 2012 to 57.4 per cent in 2016. This is largely a result of making maternity services free of charge, and improved access to comprehensive obstetric maternal and newborn services. In some counties, the improvements are linked to stipends given to mothers for antenatal care visits and delivery at health facilities. The process has also been facilitated by the engagement of Community Health Volunteers, who continuous follow-up with mothers during pregnancy, and linkage with health facilities increasing the use of health services at the community level. However, in addition to being understaffed, dispensaries in the counties often lack basic equipment, facilities and access to water. In pastoral communities, distance to facilities also continues to lead to more deliveries at home.
14. Neonatal, infant and child mortality have also been steadily falling in recent years, though not enough to meet the MDG targets. However, for neonatal mortality the reduction is slower. Factors behind the downward trend in childhood mortality include high impact interventions, such as increased use of mosquito nets among children, immunization programmes and improvements in the health system, including community-based systems. Under-five mortality is generally higher in arid, semi-arid and rural areas, but 2014 Kenya Demographic and Health Survey data suggest that Nairobi also has high levels of under-five mortality.
15. Full immunization coverage fell from 83.8 per cent in 2012 to 79 per cent in 2014 and 76 per cent in 2016, according to Ministry of Health administrative data. This was as a result of underfunding for outreach for underserved populations, stock out of injection devices and vaccines, and frequent labour disputes in the health sector that led to closure of healthcare facilities. These problems arose from challenges linked to devolution of health services and reduced communication between healthcare facilities and communities to address demand side constraints. However, some counties that have been able to develop strong action plans (such as Turkana) have reversed this trend. With support from Gavi, UNICEF and the World Health Organization, the country managed to introduce new vaccines: the inactivated polio vaccine, rota, measles and rubella. Successful vaccination campaigns have been conducted, with 19 million children aged below 14 years vaccinated against measles and rubella in 2016 and nine million children aged below five years vaccinated against polio between 2013 and 2017. This has contributed to Kenya being free of polio since 2013.

Children in Kenya have been effectively protected against measles since the vaccination campaign. Successful mobilization of funds to strengthen effective management of vaccines, train cold chain technicians and procure cold chain equipment led to an increase in the number of healthcare facilities providing immunization from 5,300 to 6,900 between 2011 and 2016, and a reduction in the proportion of cold chain equipment not working from 17 per cent in 2011 to 8 per cent in 2016. In spite of challenges witnessed following devolution, Kenya continues to fully finance the procurement of all new vaccines and co-finance the procurement of new vaccines.

16. Retention and redeployment of healthcare professionals are significant challenges in Kenya, particularly in more challenging working environments, such as the arid and semi-arid lands. In recent years, the country has also had to contend with large-scale strikes over safety and conditions.
17. HIV prevalence was 5.9 per cent in 2015, slightly down from 6.5 per cent in 2013, but in real terms the fifth largest number of cases in the world. Notably, 46 per cent of all new HIV infections are among young people aged 15-24 years, with two thirds among girls and young women. However, mother to child transmission has fallen in recent years. The southwestern counties of Homa Bay, Siaya, Kisumu and Migori have rates between 26 and 14.3 per cent and contribute 53 per cent of all new HIV infections among adolescents aged 10-19 years in the country and 50 per cent of all new HIV infections nationally among 15-24 year olds. Poverty and reliance on fishing (which leads to high mobility and “sex for fish”) are key drivers of the virus in this region.
18. Adolescents in Kenya face challenges accessing health services due to cultural barriers and lack of appropriate services. There is a lack of mental health services for adolescents in the country, while sexual and reproductive health services are not tailored to the needs of young people.
19. Kenya’s pastoral and marginal agricultural communities are highly vulnerable to erratic rains and drought, and are almost completely dependent on rains to sustain their livelihoods. Their situation is further exacerbated by environmental degradation and rapid biodiversity loss. In some of these areas, tensions, conflicts and insecurity limit households’ capacity to engage in normal livelihood activities. Food insecurity is also high in Nairobi, where 96,356 households had poor or borderline consumption in 2016, because of dependence on markets for food among the urban population.
20. The 2014 Kenya Demographic and Health Survey revealed significant reductions in stunting, wasting and underweight children, as well as an increase in breastfeeding rates. However, high levels of nutritional vulnerabilities associated with chronic food insecurity; drought in much of the country, which has intensified in 2017; disease outbreaks; and chronic poverty are all holding nutritional advances back. Following the devolution of responsibility for nutrition, most counties have failed to scale up capacity to deliver needed nutrition services, though there are some positive exceptions.
21. Complementary feeding in Kenya remains sub-optimal. Complementary foods are limited in quality and quantity and do not meet the nutrient requirements of a growing child. Introduction to other foods and liquids start as early as the first months, with 13 per cent and 27 per cent of infants being given complementary foods by 2-3 months and 4-5 months respectively. Unfortunately, these complementary foods, which replace breast milk, are low in energy and micronutrients. Eighty per cent of breastfed children aged 6-8 months are fed solid or semi-solid foods in addition to being breastfed as recommended. However, only 22 percent of children aged 6-23 months consume acceptable diets to meet their nutritional needs. Unhygienic preparation and storage of complementary foods, which is common in many households in Kenya, further predisposes many infants to diarrheal diseases. In addition, cultural practices, family pressure, economic constraints and food insecurity influence complementary feeding. The poor performance of complementary feeding indicators could be due to a lack of scaling up of strategies and resources to support them, incomplete understanding of cultural and economic barriers, incorrect assumptions about determinants of poor feeding practices, absence of creative behaviour change communication (BCC) strategies and lack of clarity on programme approaches due to insufficient documentation of different ways to deliver results.

22. The coverage of severe acute malnutrition and moderate acute malnutrition is estimated at 50 per cent, with variations across counties. Counties that experience insecurity, such as Mandera, have lower coverage while others, like Kilifi, Kwale, Kitui and Narok, often report high levels of defaulting. Key gaps in management of severe acute malnutrition are poor health facility and community linkages, inadequate prevention of acute malnutrition, limited food security responses and lack of predictable long term funding. It is intended in the future for high impact nutrition Interventions to be a regular part of child healthcare service packages.
23. The latest research on micronutrients in Kenya, the Kenya National Micronutrient Survey of 2011, found that the population group with the highest prevalence of anaemia, iron deficiency and iron deficiency anaemia was pregnant women, at 41.6 per cent, 36.1 per cent and 26 per cent respectively. Pre-school children had a higher prevalence of anaemia, iron deficiency and iron deficiency anaemia (26.3 per cent, 21.8 per cent, and 13.3 per cent respectively) than school-age children (16.5 per cent, 9.4 per cent and 4.9 per cent respectively). National iodine deficiency prevalence was 22.1 per cent among school age children and 25.6 per cent among non-pregnant women. Finally, pre-school children had the highest prevalence of zinc deficiency (83.3 per cent) of all the population subgroups.
24. The nutrition sector has in the previous years invested in the capacity for nutrition information through training, development of data tools and web-based data management systems. Due to recruitment of new staff and mobility of staff across counties and implementing partners, capacity development still requires investment.
25. A Cost Benefit Analysis conducted by UNICEF, the World Bank and the Ministry of Health in 2016 found that each \$1 invested in scaling up high-impact nutrition interventions in Kenya had the potential to add \$22 to the economy. An investment of \$76 million could increase economic productivity by \$458 million per year over the productive lives of the beneficiaries.
26. In recent years, Kenya has suffered a range of health emergencies, including outbreaks of cholera, chikungunya, dengue fever, measles and kala azaar. To a large extent, health emergency prevention and response is reliant on external partners. The devolved health administrations at county level seemingly have failed to plan for or set aside funds for emergencies.

## Learning

27. Enrolment in pre-school facilities increased from 2.5 million in 2011 to 3.2 million in 2015. In 2015, 97 girls were attending for every 100 boys. Gross enrolment rose from 67 per cent in 2011 and 76.5 per cent in 2015. However, figures vary from 123.0 per cent in West Pokot (as a result of high overage enrolment) to 18 per cent in Mandera and 29 per cent in Wajir. The latter two have significantly more boys than girls at pre-school.
28. In 2015, an estimated 1,292,695 children (55 per cent girls) were out of school. Net enrolment at primary school in 2015, at 88 per cent, was the same as in 2011. Net enrolment in Bomet County was 99.8 per cent, compared to Mandera County's 27.2 per cent (and 18.2 per cent for girls) and Wajir County's 32.9 per cent (23.6 per cent for girls).
29. Large numbers of Kenya's out-of-school children have disabilities. However, lack of data makes it impossible to quantify the extent of the problem. The factors that keep children with disabilities out of school are found both in the home environment and in the education system. Children from nomadic communities face challenges including a perceived lack of value of schooling for pastoral societies, and the long distance to schools in some areas. Meanwhile, providing state education for children in the informal settlements around large cities such as Nairobi, Mombasa, Kisumu and Garissa is problematic if the Government does not recognize settlements: this opens the way to low-cost private schools that may not meet national quality standards.

30. The transition rate between primary and secondary school remains low at 86 per cent in 2014. The low number of secondary schools in the country (9,440, compared to 31,300 primary schools in 2015) is a major bottleneck to secondary enrolment. In addition, the language barrier dissuades pupils in areas where English and Swahili are not widely spoken, while costs are also a barrier for poorer families. In some communities, girls may fear losing their “marriageability” by entering secondary school, and face risks of sexual abuse, but many report their education leading to greater successes in life.
31. Relatively good national pupil: teacher ratios and regionally high teacher salaries mask significant regional disparities, which particularly affect arid and semi-arid areas. The pupil to teacher ratio is 30.4:1 nationally, but 77.3:1 in Turkana and 56.5:1 in Mandera. This is partly because teachers are paid the same throughout the country, despite conditions and the insecurity in northern Kenya.
32. Regionally comparable tests suggest that the quality of education has not improved in recent years. In 2014, only three out of 10 children in Class 3 could do Class 2 work, with the poorest outcomes in Wajir (9.9 per cent), Mandera (10.1 per cent), Turkana (11.4 per cent) and Garissa (12.9 per cent) Counties. In 2017 piloting began of a new National Curriculum that is intended to produce citizens equipped with relevant and quality knowledge, national values and social competencies and to equip them with twenty-first century skills.
33. In north-eastern Kenya, educational institutions, their students and their staff have been affected both directly and indirectly by recent acts of violence, including terrorist attacks on schools. This has led to teachers from other regions of the country refusing to work in these areas because of safety fears, meaning that children, adolescents and youths in the already marginalized north-eastern counties are further deprived of education. Meanwhile, drought has led to school closures, lower attendance (especially in pastoral communities) and reduction in water supply and school feeding. Refugee children in Dadaab and Kakuma struggle with large classrooms and insufficient teachers, as well as a prohibition on entering the workforce that reduces the incentive to study.

## Protection from violence, abuse, exploitation and family separation

34. Capacity gaps in the social welfare workforce, such as lack of personnel and knowledge and limited infrastructure, hamper their ability to provide the services children and their families need. The access gap is particularly acute in northern Kenya. Coordination at national level is challenging because different aspects of child protection are currently the responsibility of different government ministries and departments, and at times their mandates conflict.
35. The only national survey on violence against children in Kenya dates to 2010 and suggests that 79 per cent of boys and 76 per cent of girls experience physical, sexual and/or emotional violence before the age of 18. Although banned under the Constitution and in national legislation, violence against children in schools is a major concern, and corporal punishment appears to remain an accepted form of discipline among parents. Violence against children is also prevalent in all stages of the justice system: less information is available about private residential institutions for children and in boarding schools.
36. In the 2014 Demographic and Health Survey, 14 per cent of women and 6 per cent of men aged 15-49 reported having experienced sexual violence at least once in their lifetimes. While the Government has developed and adopted policies, enacted laws, developed and implemented educational programmes to combat gender-based violence, response is constrained by the lack of human capacity for prevention and protection, entrenched religious and cultural beliefs that perpetuate negative stereotypes, discrimination and gender inequality, and socio-cultural norms around gender and masculinity.

37. Prevalence of female genital mutilation has fallen significantly over the past decade, standing at 21 per cent among 15-49 year olds in the 2014 Demographic and Health Survey. However, among Somalis (94 per cent), Samburu (86 per cent), Kisii (84 per cent) and Maasai (78 per cent) the practice is still prevalent. The 2014 KDHS also suggests that the practice is now occurring at a younger age than previously. The Government has responded to the problem through the Prohibition of Female Genital Mutilation Act of 2011. It also established the Anti-Female Genital Mutilation Board, a semi-autonomous government agency, in 2013. The Board engages in awareness-raising work in areas with a high prevalence of Female Genital Mutilation, often sensitizing community members by working with chiefs and religious leaders.
38. In Kenya, marriage is illegal before the age of 18. However, child marriage is in practice accepted and recognized in many communities. The national average of child marriage prevalence has reduced slightly, from 26.4 per cent of 20-24-year-old females married by the age of 18 (2008/9) to 22.9 per cent in 2014. Prevalence is highest in northern Kenya (56 per cent), and the coast (41 per cent). The causes of child marriage include social economic factors, such as poverty, low education and the treatment of girls as economic assets. Capacity gaps among some police officers and court officials and cultural reluctance on the part of some community and religious leaders hamper efforts to delay marriage.
39. Approximately 3.6 million Kenyan children are orphans or otherwise classified as vulnerable. Of these, 646,887 children have lost both parents, while 2.6 million children have lost at least one parent (one million of these to AIDS). Other children are made vulnerable due to poverty, harmful cultural practices, family breakdown, abandonment, natural disasters, ethnic and political conflict, and/or poor care arrangements. Communities in Kenya have traditionally responded to children without parental care by placing them informally in the care of extended family or community members. However, with increasing socio-economic pressures and weakening family structures, this kinship care mechanism is under threat and many children are at risk of maltreatment. The predominant formal alternative care arrangements are placements in children's charitable institutions or other institutional care.
40. Amendment of laws and regulations on adoption, including relevant provisions under the Children Act (2001), is still pending. There is currently a moratorium on inter-country and adoption by residents of Kenya who are citizens of other countries, issued in November 2014. This was a response to concerns about possible cases of child trafficking through abuse of Kenya's adoption processes, and with the aim to review and improve the adoption system.
41. According to a 2015 study by the African Network for the Prevention and Protection Against Child Abuse and Neglect, children in Kenya are involved in the commercial sex trade with both tourists and Kenyan nationals who travel from other parts of the country. Sexual exploitation of children in travel and tourism is reportedly common in major tourist destinations, such as Nairobi, Mombasa, Kisumu, Kakamega, Nakuru, as well as in other major towns in Kenya. Children are also exploited in sex trafficking by people working in khat cultivation areas, near Nyanza's gold mines, along the coast by lorry drivers transporting stones from quarries, by fishermen on Lake Victoria, and at Lokichar in Turkana, where oil exploitation is underway. In most cases, victims of commercial sexual exploitation are not able to access support services because most organizations focus only on awareness raising activities rather than direct service provision.
42. In recent years, efforts have been made to increase the number of and to rehabilitate courtrooms, and to increase the number of magistrates to adjudicate on matters concerning children. The minimum age of criminal responsibility is still set at eight years of age, which is well below acceptable international standards. There is insufficient information on personnel with specialized training in juvenile justice, including lawyers, judges, prosecutors and public defenders, and correctional officers.

43. Children in contact with the law in Kenya can legally be housed in probation hostels, though there is a lack of such hostels in some counties. Conditions in children's remand homes have been found to be problematic in some cases, largely because of ageing infrastructure. Child victims of violence can lack access to justice, particularly in cases of sexual violence and harmful practices, due to social stigma, pressure from family members, low rates of investigation and prosecution, frequent delays in court proceedings, lenient sanctions imposed, the risk of revictimization in the justice system and the lack of legal aid and other support. In response to some of these concerns, the National Council for the Administration of Justice established a Special Taskforce on Children Matters in 2016 to improve the situation of children in contact with the justice system.
44. The number of children living and/or working on the streets in Kenya is not known, but estimates are high, varying from 50,000 to 250,000. Urban areas with high numbers of children in street situations and homeless families include Nairobi, Mombasa, Kisumu, Eldoret, Lodwar and Nanyuki. There has reportedly been a growth in recent years in children from informal settlements being drawn to the streets of Nairobi during the day, while numbers in Lodwar have reportedly increased because of the impact of the 2017 drought. Devolution has added further complexity to the issue, as county governments lack a constitutional obligation to allocate money for rehabilitation of children in street situations.
45. While internet use is on the rise, awareness of risk and the consequences of unsafe digital behaviour among these children and young people is very low. There is also a substantial gap between children's and young people's digital media skills and those of their parents (with that of parents being much lower). Many 12-17 year olds reported having encountered sexually explicit content via the internet. Many befriend people online they have never met, and receiving hateful messages online is prevalent. The system and its capacity to protect children from online abuse and exploitation are inadequate. The reporting and referral mechanism and targeted services for child victims of online sexual abuse and exploitation are in their infant stages of development.
46. Child protection risks have increased in drought- and conflict-affected areas in 2017. With increased movements of people in search of water and pasture, one of the key child protection concerns is the risk of children being separated from their families. Refugee children can also be separated from their families, and can face gender-based violence, harmful traditional practices, physical abuse, child labour, discrimination and psychosocial distress. They also generally do not participate in resettlement decisions. To build Government capacity to respond to child protection concerns in emergencies, the Department for Children's Services created a new Child Protection in Emergencies section in early 2017.

## Safe and clean environment

47. Under the devolution settlement, service provision for both water and sanitation has been devolved to county level, and the counties have established ministries with responsibilities for both. However, most counties lack the institutional and human resource capacity to deliver strategic planning and coordination. The Government has estimated that it requires Ksh 100 billion every year to achieve universal water access but only allocates KSh 40 billion annually, leading to high reliance on external finance. Budgeting for water is further constrained by the high prevalence of non-revenue water in the country.
48. Analysis of 2014 survey data found that sanitation, housing, and water were the largest contributors to child poverty for all children younger than 18 in Kenya. In 2015, access to improved water sources stood at 82 per cent of urban households, but only 57 per cent for rural households. In Sub-Saharan Africa, Kenya has the third largest number of people in absolute numbers and by percentage of population that rely on unprotected surface water. In 2014, for 21 per cent of children it took more than 30 minutes for a household member to collect water. When water is not supplied to the premises, responsibility for collecting drinking water usually lies with women and older girls.

Lack of ongoing support to water supply systems once construction is completed means that 25 to 30 per cent of recently-constructed community-managed rural water supply facilities in Kenya will become dysfunctional in the first three years following construction. Challenges ensuring water supply in Kenya are likely to be exacerbated in future decades because of the ongoing effects of climate change and population growth.

49. In 2015, only 9,000 of the country's 22,000 public primary schools were connected to safe water supplies. High proportions of schools had no water source at all in Wajir County (25.9 per cent), Tana River County (14.4 per cent), Taita Taveta County (13.5 per cent) and Mandera County (13.1 per cent). In this context, in 2016 the Government began a project to ensure that all schools in the country were connected with safe water supplies. In Kitui, for example, dispensaries were reported to lack access to safe drinking water, posing a major challenge to service delivery.
50. In informal urban settlements kiosks selling water privately were the major sources of water for 49 per cent of respondent households in 2015. Increased migration from rural to urban areas and a rise in the number of people living in slums will further aggravate the situation.
51. In 2015, 30 per cent of households had improved sanitation facilities. This is only 5 per cent more than the figure in 1990. Twenty-seven per cent used shared facilities, 31 per cent other unimproved sources, and 12 per cent practised open defecation. The revised Kenya Environmental Sanitation and Hygiene Policy 2016-2020, Kenya Environmental Sanitation and Hygiene Framework 2016-2020 and National Open Defecation Free Kenya 2020 Campaign Framework all commit the Government to ending open defecation in Kenya by 2020. By 2016, 8 per cent of villages in Kenya had been certified as open-defecation free. Busia County has been declared open-defecation free, and significant progress had also been made in Siaya County (56 per cent of villages), Isiolo County (33 per cent), Kitui County (26 per cent), and Kisumu County (21 per cent).
52. Among communities that do have access to sanitation, latrines are very few in number and are often used by many households especially in western counties where the latrines frequently collapse. Sanitation problems often led to contamination of water sources and increases probability disease outbreaks. Inability to afford facilities is the major bottleneck.
53. Availability of toilet facilities is reportedly sufficient in four urban informal settlements surveyed in 2015, although not necessarily accessible. Poor sanitation within the informal settlements leads to high prevalence of water-borne diseases, such as cholera, typhoid, amoeba infection and diarrhoea.
54. Access to sanitation is reportedly a problem in many schools, with the number of latrines insufficient given the population of pupils. In 2015 there were 35 boys per toilet and 29 girls per toilet in schools, below the national norms of 30:1 and 25:1 respectively. Turkana County had 107 boys per toilet and 75 girls per toilet, while Mandera County had ratios of 76:1 and 54:1. The quality of latrines is also an issue. As with water supply, there have been challenges for county and national level governments in understanding their roles and responsibilities about sanitation.
55. In Kenya, knowledge about hand washing and its importance is high. However, most Kenyans have limited understanding of the relationship between hand washing and diseases and how this affects the day-to-day lives of children and the community. For example, 82 per cent of caregivers believe that families would be healthier if they washed their hands with soap all the time. In communities where community-led total sanitation has progressed well (such as in Siaya where 64 per cent of villages are open defecation free), there has been a marked increase in households with simple handwashing devices and places for soap or ash, and people wash their hands more frequently, particularly after going to the toilet.
56. In 2014, 43 per cent of children lived in dwellings made of natural material, such as earth, sand, cane, mud, or grass, a rise from 2008-2009. Housing shortages mean there is a critical need to invest more in affordable housing in urban areas.

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57. According to the Kenya Health Policy 2014-2030, indoor air pollution is one of the top five leading risk factors contributing to mortality and morbidity in the country. An estimated 59 per cent of 19,000 child deaths due to acute respiratory infections are attributable to household air pollution, and there appears to be a relationship with cooking fuel used.
58. The poor conditions of the informal settlements and the casual and informal nature of most employment in households in these areas expose their residents to volatility and changes in food prices, insecurity, political intolerance, fires and environmental dangers. Children in informal urban settlements are particularly vulnerable to disasters, particularly man-made fires and flooding.
59. Electric power supply appears to be expanding in Kenya, increasing from 27 per cent in 2013 to 63 per cent in March 2017 and putting the country on course to achieve its goal of universal electrification by 2020. The rise potentially means that many more children can now do their homework with electric lights; medicine and food can be stored at home; water pumps can supply safe drinking water; and reduced use of paraffin lamps will improve indoor air quality and prevent many of the deadly fires that occur every day in the country. However, having access to electricity does not mean it is always available: in 2014, only 33 per cent of survey respondents stated that they had connections that worked most or all of the time.
60. Car exhaust fumes contribute to 40 per cent of the particulate matter air pollution (solid and liquid particles suspended in the air) in urban areas of Kenya. Meanwhile, air quality monitoring in Kenya is practically non-existent. In this context, Kenya legislated to prohibit the use of fuel with high sulphur content in January 2015. The open burning of waste – including plastics, waste tyres, and other materials – practised both in urban and rural areas, is a significant source of toxic air pollutants harming human health.
61. Kenya is already extremely susceptible to climate-related events, which pose a serious threat to the socio-economic development of the country. Droughts and floods in particular have devastating consequences on the environment, society and the wider economy. The 2013-2017 National Climate Change Action Plan was developed in 2012 to enable Kenya to reduce vulnerability to climate change and to improve the country's ability to take advantage of the opportunities that climate change offers.

## Children and emergencies

62. In Kenya, progress for children continues to face ongoing setbacks caused by multiple emergencies and the country is extremely vulnerable to shocks. Cholera outbreaks and other health emergencies significantly affect Kenya's development goals. Other emergency concerns include violence related to inter-clan conflict, radicalization, inequality and political tensions concerning elections. In all of these instances, children are affected, either directly (being caught in actual conflict and losing family members, being hurt or even losing their own lives), as well as indirectly (such as witnessing violence and living in fear).
63. However, drought has for decades been the single most disastrous natural hazard in Kenya, particularly in the arid and semi-arid lands. In addition to increased food and nutrition insecurity, drought-related displacement and water shortages have led to increased reports of disease outbreaks and conflict, as well as school closures. Kenya's response has been shaped by the country's Programme to End Drought Emergencies in 2012 that committed the country to ending drought emergencies within a 10-year period.
64. Kenya has experienced serious flooding incidents over the years, particularly in the Western lowlands around Lake Victoria, the coastal lowlands around the Indian Ocean and other areas with poor surface water drainage. These have caused major disturbances, destroying property and resulting in loss of life.



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65. In May 2017, there were 490,656 refugees and asylum seekers registered in Kenya. Of these, more than half were children. Most of the refugees and asylum seekers (308,643) were from Somalia, with other significant populations from South Sudan (95,283), the Democratic Republic of the Congo (29,560), and Ethiopia (27,291). Kenya's long-term encampment policy and certain proposals and responses to the heightened security situation do not fully respect and protect the rights of asylum-seeking and refugee children.

## Equitable chances in life

66. The certification of births in Kenya is 64 per cent. Efforts need to be put into promoting certification, as parents often do not see the value of birth certificates. Lack of certification is a particular issue for children in contact with the law, engaged in child labour or exploitation or otherwise in need of protection and access to age-appropriate services. There are some costs associated with certification for children: though these are minimal they can influence the decision of parents. Low birth registration rates correlate to poor access to healthcare. If children are born in hospital, they are automatically registered and it is relatively easy to receive birth certificates.
67. There is no national indicator of prevalence of childhood disability in the country, though a 2014 survey estimated prevalence among children and young people aged 0-21 years at 13.5 per cent. While some progress has been made in relation to early detection, prevention and mitigation of disabilities, there are still several concerns. Children with disabilities, in particular those living in rural areas, are often stigmatized, confined at home, denied opportunities for development or abandoned. There is a lack of disaggregated data necessary for designing a comprehensive strategy for the inclusion of children with disabilities.
68. Major geographical disparity exists in the enjoyment of the rights to housing, sanitation, food, nutrition, water and social security, with worse conditions particularly in arid and semi-arid lands and in informal settlements in peri-urban and urban areas. Forced evictions and displacements of people, including children, have taken place due to development projects and environmental conservation.
69. Between 2013-14 and 2015-16, the number of beneficiary households of the Government's four principal cash transfer programmes increased from 522,000 to 829,000, an average growth rate of 26 per cent per year. In 2016, it was estimated that more than 2.3 million children (over 10 per cent of those in the country) lived in households that received cash transfers. Of these, the Cash Transfer Programme for Orphans and Vulnerable Children covered 1.1 million. However, the programme's coverage of the poorest households that need financial support still continues to be low, and children under five years are particularly unlikely to be in receipt of benefits, while coverage of children with disabilities is only estimated to be 1 per cent. Introduction of universal pensions for all those over 70 years from 1 January 2018 will support more children living in households with elderly relatives.
70. In recent years, creation of the State Department of Social Protection at the Ministry of East African Community, Labour and Social Protection in 2015 and the Social Assistance Unit in 2016 have significantly strengthened social protection sector governance, though it remains somewhat fragmented across several ministries. The State Department faces challenges coordinating the sector, and implementation structures at local level need to be streamlined.



# Introduction

1. In September 2016, Kenya's Government launched its national implementation plan for the Sustainable Development Goals, and expressed commitment that 'no one will be left behind' in the economic and social prosperity of the country. This report, produced by UNICEF as part of its country programme, is intended to support the Government to meet this commitment.
2. The report presents an overview of the situation of children in Kenya using the results of the most significant research and analysis between 2014 and 2017 in areas related to the wellbeing of children. By focusing on the key knowledge gaps related to inequities and child deprivations and promoting the broad engagement of all stakeholders, the Situation Analysis is intended to contribute to implementation of Kenya Vision 2030, to support achievement of national and child-related sustainable development goals.
3. The 2017 Kenya Situation Analysis is the product of a desk review of key reports, studies, surveys and evaluations produced in the last three years in the area of child rights and associated issues in Kenya by the Government and its development partners. It was also informed by a series of interviews with national and local officials and other stakeholders conducted in April and June 2017, and follow-up internet-based correspondence with interlocutors. UNICEF subsequently validated the findings in liaison with key Government and civil society partners, and inputs from the validation process were used to strengthen the final report.
4. The Situation Analysis is divided into several sections, each of which is further divided into sub-sections to reflect the wide range of factors affecting the lives of children in Kenya. The initial *Background* section provides information on the geographical, political, economic and social situation in the country, while the second *Enabling Environment* section looks at more specific aspects of governance for children. This is followed by six sections that focus on some of the issues affecting the lives of children and women in the country today:
  - *Surviving*, which focuses on health and nutrition challenges
  - *Learning*, primarily looking at access to and quality of education
  - *Protection from violence, abuse, exploitation and family separation*
  - *Safe and clean environment*, looking at water, sanitation, housing and energy
  - Children and emergencies, covering the effects of natural disasters, security challenges, and refugee children; and
  - Equitable chances in life, highlighting the situation of children with disabilities, challenges ensuring birth registration, the social protection system and adolescent empowerment.
5. Analysis of the extent to which the rights of children are upheld was conducted using the following interrelated and mutually reinforcing tools, which are set out in the UNICEF Guidelines for Situation Analysis:<sup>1</sup>
  - **causality analysis**, examining the causes of shortfalls and inequities, probing beyond the immediate causes of non-realization of children's and women's rights to determine the underlying and structural causes of the problem; identifying the bottlenecks and barriers to the provision and use of essential interventions and services for children and women;
  - **role-pattern analysis**, delving into the roles and relationships between duty-bearers and rights holders in relation to specific rights; and
  - **capacity-gap analysis**, examining the capacity of key individuals and institutions responsible for respecting, protecting and fulfilling the rights of children.

1. UNICEF, Guidance on Conducting a Situation Analysis of Children's and Women's Rights, 2012, at <http://www.unicef.in/emergencies.com/downloads/eresource/docs/Rights%20based%20equity%20focused%20Situation%20Analysis%20guidance.pdf>

# Chapter 1:

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# Background



## Geographical and climatic overview

6. Kenya is located in East Africa, and is bordered by Tanzania to the south, Uganda to the west, South Sudan to the northwest, Ethiopia to the north, Somalia to the northeast and the Indian Ocean to the east.<sup>2</sup> The country has a territory of 582,64 kilometres divided into 47 administrative and political counties. Kenya's climate is diverse, ranging from tropical in southern, western and central regions, to arid and semi-arid in the north and northeast. Meanwhile, the country's central highlands have an equatorial climate.<sup>4</sup>

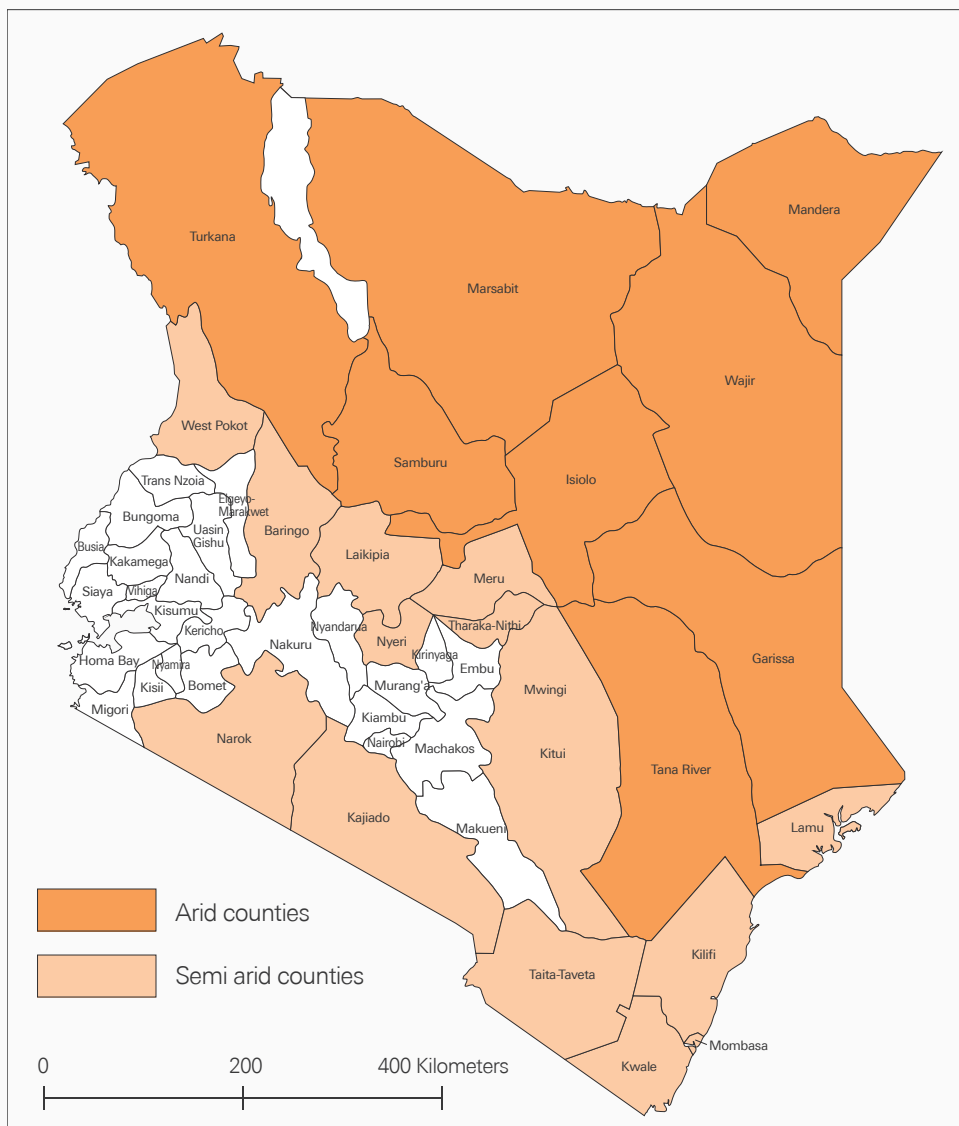


Figure 1: Counties of Kenya by climate

7. Rainfall and temperatures in Kenya are influenced by altitude and proximity to the Indian Ocean or to the country's lakes. In the coastal region both rainfall and temperatures are generally higher than the rest of the country throughout the year.<sup>5</sup> There are generally four seasons a year in Kenya: a dry period from January to March, a long rainy season from March to May, a long dry spell from May to October, and then short rains between October and December.<sup>6</sup>
8. Disparities in volume and distribution of rainfall have a significant effect on Kenya's population. Many parts of the country cannot produce sufficient food from rain-fed agriculture, and therefore are exposed to frequent food insecurity. The arid and semi-arid lands (see Figure 1) depend mainly on livestock production, which is often adversely affected by drought. Kenya has suffered a particularly acute drought in 2017, following failure of the two rains in 2016. On 10 February 2017, the Government declared the drought a national disaster.<sup>8</sup>

## Demographic overview

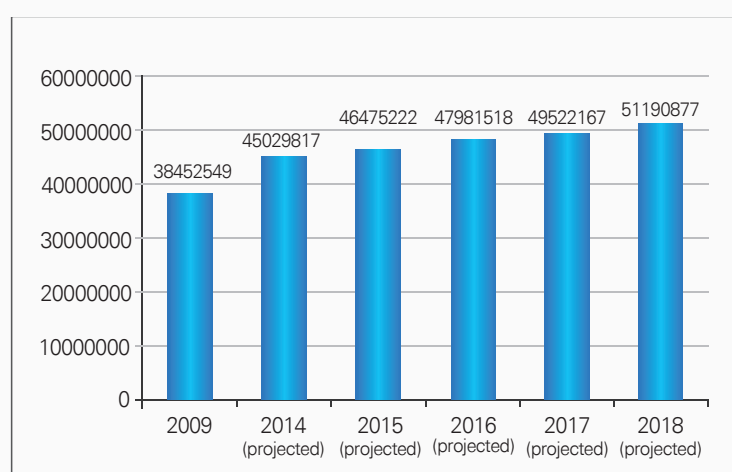


Figure 2: Population of Kenya by year, 2009 to 2018

9. Kenya's population in 2017 was estimated at 49.6 million, with a population growth rate estimated at about 1.5 million per year.<sup>9</sup> This is largely because in recent years the number of registered births has far exceeded the number of registered deaths<sup>10</sup> (it should be noted that in 2015, the most recent year that data is available for, birth registration coverage was 62.2 per cent and death registration coverage 45.8 per cent, and the Civil Registration Department is struggling to improve coverage<sup>11</sup>). Recent figures suggest that children aged 0-18 years accounted for 49 per cent of the total population and<sup>12</sup> adolescents aged 10-19 years make up about 24 per cent (9.2 million: 49 per cent male; 51 per cent female).<sup>13</sup>

2 Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>  
 3 UNDP, About Kenya, at <http://www.ke.undp.org/content/kenya/en/home/countryinfo.html>, accessed 11 March 2017  
 4 Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>  
 5 Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>  
 6 Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>  
 7 Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>  
 8 OCHA, Kenya Flash Appeal 2017, 16 March 2017, at <http://reliefweb.int/report/kenya/kenya-flash-appeal-2017>  
 9 UN Data, Country Profile: Kenya, at <http://data.un.org/CountryProfile.aspx?crName=kenya>  
 10 Kenya National Bureau of Statistics, Statistical Abstract, 2016, at [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=106&Itemid=1177](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=106&Itemid=1177)  
 11 Information provided by UNICEF based on Civil Registration Department, Annual Report for 2015  
 12 UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016  
 13 UNICEF, UNICEF – KCO MTR Report, 2016  
 14 Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

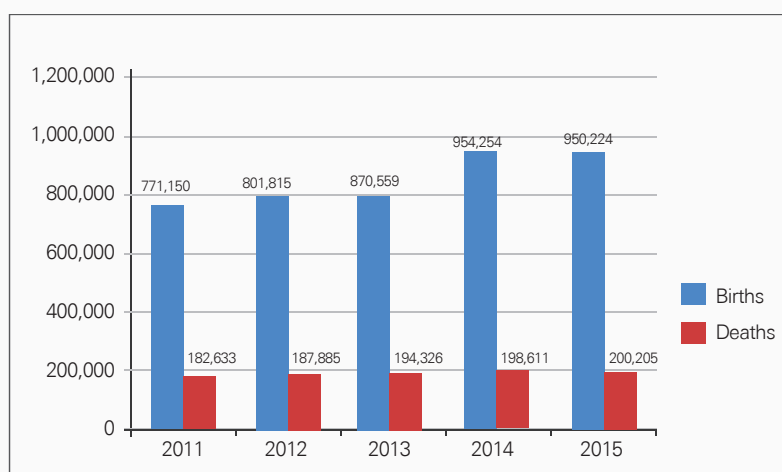


Figure 3: Number of births and deaths 2011-2015, Department of Civil Registration

10. The 2014 Kenya Demographic and Health Survey (KDHS) reports an average household size of 3.9 persons, and that females head 32 per cent of households. Households in rural areas are larger (4.4 persons compared to 3.2 in urban areas) and more are female-headed (36 per cent and 27 per cent respectively).<sup>14</sup>
11. Total fertility fell from 4.9 births per woman in the 2003 KDHS survey to 3.9 births per woman in 2014. Rural women had an average of at least one more child each than urban women. Half of all births occurred within three years of a previous birth, with 18 per cent occurring within 24 months.<sup>15</sup> Given that rapid growth in population size is seen as a constraint to national development, Kenya's Population Policy for National Development proposes a reduction in the fertility rate to two children per woman in 2050. If this is achieved, the population will increase to 59 million in 2030 and 75 million in 2050, with the proportion of the population aged below 15 years decreasing to 33 and 25 per cent respectively.<sup>16</sup>
12. Childbearing begins early in Kenya, with almost a quarter of girls giving birth by age 18 and nearly half by age 20, according to the 2014 KDHS survey. Eighteen per cent of adolescent females aged 15-19 are already mothers or pregnant with their first child. Between 2009 and 2014, teenage pregnancy rates remained unchanged.<sup>17</sup>
13. Kenya has a diverse population comprising 43 ethnic communities<sup>18</sup> that includes three of Africa's major sociolinguistic groups: Bantu (67 per cent), Nilotic (30 per cent), and Cushitic (3 per cent). Around 80 per cent of Kenyans are Christian, 10 per cent Muslim, and others follow traditional African religions, other faiths or none.<sup>19</sup>

14. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

15. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

16. National Council for Population and Development, Population Policy for National Development, July 2013, via [http://ncpd-ke.org/ncpdweb/Main\\_policies](http://ncpd-ke.org/ncpdweb/Main_policies)

17. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

18. The Makonde community were officially recognized as the 43rd tribe in Kenya in February 2017 [Daily Nation, Makonde Granted Kenyan Citizenship, 1 February 2017, at <http://www.nation.co.ke/counties/kwale/makonde-granted-Kenyan-citizenship/3444918-3796210-xx1iiv/index.html>]

19. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

14. The rapid urbanization experienced by Kenya over the last decade has increasingly affected the situation of children. More than a third of the population live in urban areas, and two thirds of the current urban population live in informal settlements.<sup>20</sup> It is projected that by 2033, half of the population will be residing in towns and cities.<sup>21</sup> Urban growth is driven by rural-urban migration as people seek employment and to escape the effects of climate change. High property prices in urban areas force many households into informal settlements without basic amenities such as safe drinking water, toilet/sewerage systems, drainage systems and other infrastructure.<sup>22</sup> These characteristics further increase vulnerability to natural hazards such as heat waves, floods and fires. In addition, informal settlements are often also located in areas particularly exposed to disasters.<sup>23</sup>

## Economic overview

15. With a per capita income of US\$1,455 in 2016,<sup>24</sup> Kenya is classified as a lower-middle income country. Kenya's Human Development Index (HDI) value for 2015 was 0.555, which put the country in the medium human development category and 146th out of 188 countries and territories. Kenya's HDI value is slightly higher than the average for Sub-Saharan Africa (0.523). When adjusted for inequality, the Kenyan figure falls to 0.391. Meanwhile, Kenya's Gender Inequality Index is particularly concerning: at 0.565 this is lower than the average for Sub-Saharan Africa, because of the low proportion of women in parliament and low female labour force participation.<sup>25</sup>
16. In recent years, Kenya has seen robust economic growth underpinned by a stable macroeconomic environment, continued low international oil prices and a stable Kenyan Shilling. Growth reached an estimated 5.9 per cent in 2016, and is expected to rise to 6.1 per cent by 2018.<sup>26</sup> However, this remains far below the 10 per cent target of Vision 2030, the Government's longer-term development plan.<sup>27</sup> In addition, Kenya is running a persistent current account deficit: in 2015, the current account deficit equalled 11.4 per cent of gross domestic product (GDP) – the highest deficit as a share of GDP in the East African Community (EAC) region, and far above the continental average. This deficit is financed increasingly through foreign exchange income, as a result of growing remittances from abroad.<sup>28</sup> The World Bank has warned that high borrowing rates may reduce the country's room to manoeuvre economically, but stresses that fiscal consolidation should not take place in a way that compromises critical public investments.<sup>29</sup>
17. According to official figures, in 2016 agriculture made up the largest share of Kenya's economy (32.6 per cent), primarily the growing of crops (25.9 per cent).<sup>30</sup> About 75 per cent of the workforce is engaged in agriculture, mainly as subsistence farmers, and most urban residents periodically leave the cities to assist on family farms.<sup>31</sup> Kenya's main agricultural products include tea, coffee, cattle, maize, and sugarcane.<sup>32</sup> The country's agricultural sector is facing major challenges, including stagnant or declining productivity levels, poor access to input markets and low value addition of most agricultural exports. Only about 6-8 per cent of Kenya's land has been irrigated, leaving smallholders highly vulnerable to droughts and floods.<sup>33</sup>

20. UNICEF, UNICEF – KCO MTR Report, 2016

21. African Development Bank, Kenya Country Strategy Paper 2014-2018, February 2014, at [https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/2014-2018\\_-\\_Kenya\\_Country\\_Strategy\\_Paper.pdf](https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/2014-2018_-_Kenya_Country_Strategy_Paper.pdf)

22. WFP, Comprehensive Food Security and Vulnerability Analysis (CFSVA): Kenya 2016, 2016, at <http://documents.wfp.org/stellent/groups/public/documents/ena/wfp285586.pdf>

23. Gencor E.A., "Natural Disasters, Urban Vulnerability, and Risk Management: A Theoretical Overview" in *The Interplay between Urban Development, Vulnerability, and Risk Management*. Springer, Springer, 2013, at [http://www.springer.com/cda/content/document/cda\\_downloaddocument/9783642294693-c2.pdf?SGWID=0-0-45-1404767-p174534183](http://www.springer.com/cda/content/document/cda_downloaddocument/9783642294693-c2.pdf?SGWID=0-0-45-1404767-p174534183)

24. World Bank, GDP Per Capita (current US\$), at <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD>, accessed 5 July 2017

25. UNDP, Briefing Note for Countries on the 2016 Human Development Report, 2016, at [http://hdr.undp.org/sites/all/themes/hdr\\_theme/country-notes/KEN.pdf](http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/KEN.pdf)

26. World Bank, Kenya Economic Update, April 2017, <http://documents.worldbank.org/curated/en/988191491576935397/pdf/114115-NWP-PUBLIC-add-series-86p-Kenya-Economic-Update-FINAL-Edition-15.pdf>

27. Government of Kenya, Vision 2030: the Popular Version, 2012, at [www.vision2030.go.ke/lib.php?f=vision-2030-popular-version](http://www.vision2030.go.ke/lib.php?f=vision-2030-popular-version)

28. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

29. World Bank, Kenya Economic Update, April 2017, <http://documents.worldbank.org/curated/en/988191491576935397/pdf/114115-NWP-PUBLIC-add-series-86p-Kenya-Economic-Update-FINAL-Edition-15.pdf>

30. Kenya National Bureau of Statistics, Statistical Abstract, 2017, [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

31. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

32. UNDP, About Kenya, at <http://www.ke.undp.org/content/kenya/en/home/countryinfo.html>, accessed 11 March 2017

33. WFP, Comprehensive Food Security and Vulnerability Analysis (CFSVA): Kenya 2016, 2016, at <http://documents.wfp.org/stellent/groups/public/documents/ena/wfp285586.pdf>



18. The 2016 official statistics also state that 4.4 per cent of GDP came from animal production, a slight fall from 2012, when it stood at 5.5 per cent. However, the KBS Statistical Abstract excludes earnings in the informal sector, rural small-scale agriculture and pastoralist activities.<sup>34</sup> A 2013 report by the Intergovernmental Authority on Development, using a total 'economic valuation framework', found that livestock's contribution to agricultural GDP was about two and half times greater than official estimates, at 13 per cent of GDP.<sup>35</sup>
19. Manufacturing accounts for 9.2 per cent of official GDP.<sup>36</sup> Other key economic sectors in Kenya include tourism, services, transport, communications and limited mining.<sup>37</sup>
20. Kenya is currently experiencing rapid electrification (for more see Housing and energy below). Nevertheless, a significant proportion of energy use still is made up of biomass, particularly wood fuel and charcoal.<sup>38</sup> Generation of energy comes from several sources, with the largest including hydropower, fossil fuels and geothermal energy.

## Social overview

21. In 2016, UNICEF conducted research into the prevalence of multidimensional child poverty in Kenya, using the Multidimensional Overlapping Deprivation Analysis (MODA) methodology to analyse six different dimensions of poverty. The research found that in 2014 only 13 per cent of children in Kenya were not deprived in any of the six dimensions analysed. Most children suffered from several deprivations simultaneously (though the average fell slightly from 3 to 2.7 dimensions between 2008-2009 and 2014), with problems affecting deprivation across sectors. This finding shows there is a need for an integrated approach to addressing the deprivations that children experience.<sup>39</sup> A total of 9.5 million children in Kenya experienced severe multidimensional child poverty (deprivations in at least three dimensions): this was 45 per cent of all children under age 18. This had fallen from 55 per cent in 2008/9.<sup>40</sup>
22. In 2014 there were large disparities in multidimensional child poverty rates across counties, from 7 per cent in Nairobi to 85 per cent in Turkana. In relative terms, the counties with the highest share of child poverty were Turkana, West Pokot, Wajir, Tana River, Samburu, and Mandera. In absolute numbers, the counties with the highest numbers of poor children are Bungoma and Kakamega with 661,660 and 515,842 poor children respectively.<sup>41</sup> This highlights the fact that poverty is also prevalent outside the arid and semi-arid (ASAL) counties.<sup>42</sup> Multiple deprivation is more likely for children with low educational attainment of the household head; low educational attainment of the mother; in rural areas; orphaned; with fathers without continuous employment or fathers who are self-employed agriculture workers; and in households with large numbers of children under five.<sup>43</sup>

26. World Bank, Kenya Economic Update, April 2017, <http://documents.worldbank.org/curated/en/988191491576935397/pdf/114115-NWP-PUBLIC-add-series-86p-Kenya-Economic-Update-FINAL-Edition-15.pdf>

27. Government of Kenya, Vision 2030: the Popular Version, 2012, at [www.vision2030.go.ke/lib.php?f=vision-2030-popular-version](http://www.vision2030.go.ke/lib.php?f=vision-2030-popular-version)

28. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

29. World Bank, Kenya Economic Update, April 2017, <http://documents.worldbank.org/curated/en/988191491576935397/pdf/114115-NWP-PUBLIC-add-series-86p-Kenya-Economic-Update-FINAL-Edition-15.pdf>

30. Kenya National Bureau of Statistics, Statistical Abstract, 2017, [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

31. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

32. UNDP, About Kenya, at <http://www.ke.undp.org/content/kenya/en/home/countryinfo.html>, accessed 11 March 2017

33. WFP, Comprehensive Food Security and Vulnerability Analysis (CFSVA): Kenya 2016, 2016, at <http://documents.wfp.org/stellent/groups/public/documents/ena/wfp285586.pdf>

34. Kenya National Bureau of Statistics, Statistical Abstract, 2017, via [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

35. IRIN, Pastoralism's Economic Contributions are Significantly Overlooked, 16 May 2013, at <http://www.irinnews.org/report/98052/pastoralism-s-economic-contributions-are-significant-overlooked>

36. Kenya National Bureau of Statistics, Statistical Abstract, 2017, via [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

37. UNDP, About Kenya, at <http://www.ke.undp.org/content/kenya/en/home/countryinfo.html>, accessed 11 March 2017

38. Institute of Economic Affairs, Situational Analysis of Energy Industry Policy and Strategy for Kenya, 2015, at [http://dspace.africaportal.org/jspui/bitstream/123456789/34928/1/Situational-Analysis-of-Energy-Industry-Policy-and-Strategy-for-Kenya%20\(1\).pdf?1](http://dspace.africaportal.org/jspui/bitstream/123456789/34928/1/Situational-Analysis-of-Energy-Industry-Policy-and-Strategy-for-Kenya%20(1).pdf?1)

39. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

40. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

41. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

42. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

43. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

23. When looking at income poverty in Kenya, most of those in the poorest wealth quintiles are children. Children made up 49 per cent of the population of Kenya in 2014 but 58 per cent of those in the poorest wealth quintile.<sup>44</sup> Meanwhile, the 2015 Malaria Indicator Survey found that 25 per cent of rural residents are in the poorest quintile, compared to 10 per cent of urban residents. It also found that the semi-arid zone has the largest proportion of households in the poorest quintile (42 per cent), while the malarial low risk area (broadly central Kenya) has the largest proportion of households in the richest quintile (37 per cent).<sup>45</sup>
24. Families in Kenya are continuously susceptible to poverty and falling living standards as they run the risk of being hit by a crisis or shock at any time. These crises can occur at any stage of life: it may be a sudden onset of illness or disability resulting from an accident; the growing challenge of ageing as people gradually become frailer and less able to provide for themselves and their families; unemployment; the birth of a child, while a joyful event, also means that family costs increase while their capacity to earn falls; the death of livestock; a drought or flood; or an economic recession. Any of these challenges can lead to falling living standards among Kenyan families and, the lower their incomes, the less able they are to cope with risks.<sup>46</sup>
25. Children and their families in pastoralist areas face a range of challenges in their everyday lives. They generally live in remote areas, with limited infrastructure and services. A dispersed population is scattered across a large area in relatively small settlements. Pastoralists, who generally live in an arid environment vulnerable to drought and climate impacts, rationally respond to their climatic conditions by migrating from place to place.<sup>47</sup>

## Gender overview

26. At national level, gender equality is enshrined in the 2010 Constitution, which provides the legal framework for the Government to fulfil basic rights, and for marginalized and vulnerable groups, especially women and children, to claim their rights. However, women still face challenges including barriers to participating effectively in decision-making and leadership. Meanwhile, according to UN Women there is no credible and vibrant women's movement to advocate for the gender equality gains in the 2010 Constitution to be upheld.<sup>48</sup>
27. In addition, most of the female members of the national parliament and county assemblies are new to the legislatures.<sup>49</sup> As of April 2017, no women have held County Governor positions, though this is likely to change in August 2017 elections.<sup>50</sup> In April 2017, the Constitutional Court ordered Parliament to ensure that women held at least a third of seats (as enshrined in the Constitution), or to risk dissolution. In April 2017 women made up 19 per cent of the National Assembly and 23 per cent of the Senate.<sup>51</sup>
28. Women face challenges due to the economy's vulnerability to shocks. For instance, while over 80 per cent of Kenyan women are engaged in smallholder farming, only 1 per cent own land in their own right; and women access less than 10 per cent of available credit, and less than 1 per cent of agricultural credit.<sup>52</sup>

44. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

45. Kenya Malaria Indicator Survey, 2015

46. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

47. Republic of Kenya, Vision 2030 Development Strategy for Northern Kenya and other Arid Lands, 2011, at [http://www.fao.org/fileadmin/user\\_upload/drought/docs/Vision2030%20development%20strategy%20for%20northern%20kenya%20and%20other%20dry%20areas%202011%20.pdf](http://www.fao.org/fileadmin/user_upload/drought/docs/Vision2030%20development%20strategy%20for%20northern%20kenya%20and%20other%20dry%20areas%202011%20.pdf)

48. UN Women, Kenya, at <http://africa.unwomen.org/en/where-we-are/eastern-and-southern-africa/kenya>, accessed 17 April 2017

49. UN Women, Kenya, at <http://africa.unwomen.org/en/where-we-are/eastern-and-southern-africa/kenya>, accessed 17 April 2017

50. Daniel Wesangula, Breakthrough as Kenya poised to elect first female governors, Reuters, 28 April 2017, at <http://www.reuters.com/article/us-kenya-politics-women-idUSKBN17U2GP>

51. Lily Kuo, Kenya's high court has ruled that a third of parliamentarians must be women, Quartz, 13 April 2017, at <https://qz.com/957712/kenyas-high-court-has-ruled-that-a-third-of-parliamentarians-must-be-women/>

52. UN Women, Kenya, at <http://africa.unwomen.org/en/where-we-are/eastern-and-southern-africa/kenya>, accessed 17 April 2017

29. In Kenya, the situation of women living in poverty is exacerbated by gender-based violence, including sexual violence, rape, physical violence and sexual harassment. Women's empowerment is hindered by polygamy, child marriage and harmful cultural and traditional practices, such as female genital mutilation. Traditional practices governing inheritance, acquisition of land and benefits accruing to land produce continue to favour men. Women face barriers to accessing the justice system, including legal costs, traditional justice systems, illiteracy and lack of awareness of rights. Women are also disproportionately affected by HIV and AIDS, with 6.9 per cent of women aged 15 to 64 affected, compared to 4.4 per cent of men in the same age group.<sup>53</sup>

## Political overview

30. The Government of Kenya is headed by President Uhuru Kenyatta, and Deputy President William Ruto, who were elected on 4 March 2013. The country's executive also includes 18 Cabinet Ministers, the Attorney General and the Director of Public Prosecutions. The bicameral legislature includes 337 Members of Parliament and 67 Senators. The judiciary is made up of the Supreme Court, the High Court and subordinate courts.<sup>54</sup>
31. In 2010, Kenya adopted a devolved system of governance. Forty-seven County Governors now oversee many areas of provision, including several social sectors. Through its funding formula and governance structures, the devolved system is intended to ensure equitable distribution of national and local resources and promote the participation of citizens in decision making on issues that affect them at local level.<sup>55</sup> Positive and negative aspects of the devolution process thus far are described in more detail below.

53. UN Women, Kenya, at <http://africa.unwomen.org/en/where-we-are/eastern-and-southern-africa/kenya>, accessed 17 April 2017

54. UNDP, About Kenya, at <http://www.ke.undp.org/content/kenya/en/home/countryinfo.html>, accessed 11 March 2017

55. UNDP, About Kenya, at <http://www.ke.undp.org/content/kenya/en/home/countryinfo.html>, accessed 11 March 2017

# Chapter 2:

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## The framework for children's rights in Kenya



## The Sustainable Development Goals and Kenya Vision 2030

32. Kenya had mixed success in implementation of the Millennium Development Goals (MDGs). Between 2000 and 2015 successes included improved net enrolment rates in education, and greater promotion of gender equality and empowerment of women. However, targets were not met with regard to eradicating extreme poverty and hunger, reducing child mortality, combating HIV and AIDS, malaria and other diseases, ensuring clean water supply and sanitation, and particularly improving maternal health.<sup>56</sup>
33. The Sustainable Development Goals (SDGs) came into effect in January 2016 to replace the MDGs. The SDGs build on the MDGs, while including new areas such as climate change, economic inequality, innovation, sustainable consumption, peace and justice, among other priorities.<sup>57</sup> While all the SDGs are important for children, the following are key:

SDG 1	No poverty
SDG 2	Zero hunger
SDG 3	Good health and wellbeing
SDG 4	Quality education
SDG 5	Gender equality
SDG 6	Clean water and sanitation
SDG 9	Industry, innovation and infrastructure
SDG 10	Reduced inequalities
SDG 13	Climate action
SDG 16	Peace, justice and strong institutions
SDG 17	Partnership for the goals

34. In September 2016, Kenya's Government launched its national implementation plan for the Sustainable Development Goals, and expressed commitment that 'no one will be left behind' in the economic and social prosperity of the country. The plan includes five thematic areas: to conduct extensive advocacy and awareness creation, to map out and engage all stakeholders, to mainstream the SDGs into the national development process, to domesticate and localize the SDGs agenda, to monitor and evaluate progress and to support building capacity for devolved governments to implement the process.<sup>58</sup>
35. On 5 May 2016, the Ministry of Development Planning was mandated to coordinate implementation of the SDGs in Kenya. Its focal point will liaise with national and local government, development partners, civil society and UN agencies to coordinate mapping and advocacy work, localization at county and sub-county level, resource mobilization, monitoring and evaluation and capacity building.<sup>59</sup>

56. SDG Philanthropy Platform, Investing in the Sustainable Development Goals in Kenya, 2016, at <http://sdgfunders.org/reports/investing-in-the-sustainable-development-goals-in-kenya/>

57. UNDP, Sustainable Development Goals, at <http://www.undp.org/content/undp/en/home/sustainable-development-goals.html>, accessed 18 May 2017

58. UNDP, #LeaveNoOneBehind: Kenya Government Gives Road Map to implementation of SDGs, 14 December 2016, at <http://www.ke.undp.org/content/kenya/en/home/presscenter/pressreleases/2016/leave-no-one-behind-kenya-government-gives-road-map-to-implement.html>

59. Benson Kimani, Overview of the SDGs in Kenya, presentation, Ministry of Devolution and Planning, 20 June 2016, at <http://www.devolutionplanning.go.ke/images/Overview%20of%20the%20SDGs%20in%20Kenya.%20Diani.pdf>

60. Benson Kimani, Overview of the SDGs in Kenya, presentation, Ministry of Devolution and Planning, 20 June 2016, at <http://www.devolutionplanning.go.ke/images/Overview%20of%20the%20SDGs%20in%20Kenya.%20Diani.pdf>

36. At national level, Kenya Vision 2030 is the country's long-term development blueprint, which is intended to create a globally competitive and prosperous country with high quality of life for all its citizens in a clean and secure environment by the year 2030. The vision of its social pillar is a "just and cohesive society enjoying equitable social development in a clean and secure environment", while the other pillars (economic and political) also have links to the SDGs.<sup>60</sup> Vision 2030 is being implemented through a series of Medium Term Plans (MTPs). The second MTP is due to conclude in 2017, and will be succeeded by MTP-3 for the years 2018-2022.<sup>61</sup>

#### Key issues

- The Government is committed to the SDG framework and launched its implementation plan in September 2016.
- Kenya Vision 2030 is also intended to support social development in the medium term.

## Children's rights framework

37. The national legislative and policy framework in Kenya is generally favourable for children. The Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child have been brought into national law through enactment of the 2001 Children Act. Revision of the Children Act is currently in progress. Children's rights and their implementation are also enshrined in the Constitution and in Kenya Vision 2030, the national long-term development blueprint. This document will refer where appropriate to the January 2016 Concluding Observations of the UN Committee on the Rights of the Child when considering Kenya's combined third to fifth periodic reports on implementation of the Convention.<sup>62</sup>
38. As part of its efforts to promote and protect the rights of children in Kenya, the Government has developed national plans of action for children in Kenya. The second Plan covers the years 2015-2022. It provides an operational framework to guide stakeholders and partners in coordinating, planning, implementing and monitoring programmes for the child. In addition, it outlines priorities and interventions necessary for the progressive realization of children's rights in Kenya. These priorities and interventions are designed to address the specific gaps identified by stakeholders.<sup>63</sup> In parallel, several laws and policies have been passed that address more specific areas of children's rights. Key documents are highlighted in the relevant sections of the report.

#### Key issues

- Generally favourable legislative and policy framework for children
- National Plan of Action for Children 2015-2022 currently being implemented
- Revision of Children Act still in progress

## Devolution

39. The constitutional shift made to devolve significant powers to 47 county-level governments in 2013 was intended to enhance local participation and service delivery to the most deprived populations. With devolution, county governments have become highly strategic entities, controlling more than 4.5 per cent of GDP<sup>64</sup> and responsible for planning and delivering all devolved functions, including health, water, sanitation, urban services, early childhood development, and other local infrastructure.<sup>65</sup> Article 104 of the 2012 County Governments Act<sup>66</sup> obliges counties to develop integrated plans, designate planning units at all county administrative levels and promote public participation and engagement by non-state actors in the planning process.

61. Republic of Kenya, Concept Note on Medium Term Plan 2018-2022, March 2017, at <http://www.mtp3.go.ke/assets/documents/mtp/CONCEPT%20NOTE%20MTP3.pdf>

62. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

63. National Council for Children's Services, National Plan of Action for Children in Kenya, 2015, at <http://www.childrenscouncil.go.ke/resources/category/3-policy-documents.html?download=5:national-plan-of-action-2015>

40. Although Section 15 (2) (a) (ii) of the Constitution provides for the enactment of legislation specifying how the national Government should 'assist county governments in building the capacity to govern effectively and provide the services for which they are responsible', these responsibilities were transferred quickly with little assessment of whether or not county administrations have the capacity to deliver.<sup>67</sup> Counties have also struggled with several issues, including insufficient resources to meet competing sector demands; weak county systems; and challenges attracting and retaining competent or trained staff to support planning, budgeting and implementing participatory processes. The counties are also face challenges interacting with central Government.<sup>68</sup> In this context, there have been teething problems in terms of counties having the capacity to produce planning and budgeting documents.
41. County governments are currently developing systems and structures to adopt and successfully carry out the tasks devolved to them. Counties which house previous provincial headquarters benefit to some extent from higher staff capacities and more developed infrastructure.<sup>69</sup>
42. Under Article 2013(2) of the Constitution, the central Government sets aside at least 15 per cent of its revenue for distribution to the 47 counties according to a set of predefined criteria established by the Kenya Commission on Revenue Allocation (CRA).<sup>70</sup> This "equitable share" allocation to counties is intended to assist counties to fulfil their devolved responsibilities. The Kenya CRA's allocation formula includes a basic equal share to guarantee minimal funding for key services, and variable amounts based on each county's population; poverty index; geographical size; access to water, electricity and roads; and the extent to which it optimizes capacity to raise revenue.<sup>71</sup>
43. A 2017 review of public expenditure finds that while the devolution process is moving in fits and starts, officials are broadly supportive. Nevertheless, a number of issues have been identified in initial county budget and planning processes that may affect county-level service delivery. Firstly, the very short timeframes for key parts of the budget planning and preparation cycle mean that annual development and financing strategies are delinked from medium-term planning, and participation in the budget process is limited. Secondly, high expectations of the devolution process, together with a lack of clear human resource guidance, have increased recurrent expenditure outlays and introduced ambitious development budget proposals. Thirdly, cash shortages and slow procurement procedures have led to low development budget execution and an accumulation of domestic payment arrears. Finally, over 70 per cent of county governments' revenues are from unconditional transfers from the national government. While county finances are normalizing following the initial years of devolution, service delivery could be made increasingly reliant on county budgets. A high degree of fiscal discretion for counties means the incentives will work against, for instance, efforts to improve accountability and revenue mobilisation.<sup>72</sup>

### Key issues

- Under devolution, counties have become the providers of many key social services, including health, water, sanitation, urban services, early childhood development, and other local infrastructure
- In some cases counties have struggled with insufficient resources to meet competing sector demands; weak systems; and challenges attracting and retaining competent or trained staff for planning, budgeting and participatory processes
- Ongoing support is required to improve service delivery at county level, particularly in counties that have not seen improvements in services in recent years, but also to address public finance management and coordination constraints that causes delays to provision of funds and prevent full utilization of allocated budgets

64. Calculated from National Treasury ([www.treasury.gov.ke](http://www.treasury.gov.ke)) GDP figures and Office of the Controller of the Budget ([cob.gov.ke](http://cob.gov.ke)) local government budget execution figures for the 2015-2016 fiscal year

65. UNICEF, UNICEF – KCO MTR Report, 2016

66. Act available at <http://kenyalaw.org/lex/rest/db/kenyalaw/Kenya/Legislation/English/Acts%20and%20Regulations/C/County%20Governments%20Act%20Cap.%20265%20-%20No.%2017%20of%202012/docs/CountyGovernmentsAct17of2012.pdf>

67. Agnes Cornell and Magnus D'Arcy, Devolution, Democracy and Development in Kenya, ICLD, 2016, at <http://icld.se/static/files/forskningsspublikationer/devolution-democracy-and-development-in-kenya-report-5-low.pdf>

68. IPE Global, Kenya: Investments in Social Sectors, 15 February 2017

69. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

## Financing and coordination of government policy on children and youth

44. Kenya's national budget has doubled in real terms since 2002-2003, and the public sector now makes up about a third of the economy. There has also been a significant shift in spending towards development goals over the last decade.<sup>73</sup> Government revenues were fairly consistent around 19 per cent of GDP between 2010 and 2015. Meanwhile, government expenditure has been four to five percentage points higher, at between 23.5 per cent and 25.9 per cent of GDP. This difference implies that some spending is financed by grants or loans, and is therefore less predictable.<sup>74</sup>
45. In 2015, Official Development Assistance (ODA) made up about 3.9 per cent of Kenya's Gross National Income (GNI), and amounted to US\$2.47 billion. This is a significant fall from the 6 per cent of GNI of 2013, and reflects Kenya's new status as lower-middle income country. For 2014-2015, the top donors of gross ODA for Kenya were the United States (US\$762.3 million), the International Development Association (US\$526.6 million), the African Development Fund (US\$248 million) and the United Kingdom (US\$235.2 million).<sup>75</sup>
46. In 2014-2015, the health and population sector accounted for 54 per cent of ODA, followed by other social infrastructure and economic infrastructure (11 per cent each). Humanitarian aid made up 10 per cent of ODA and education assistance 3 per cent.<sup>76</sup>
47. Recurrent expenditure – spending incurred in operating services provided by the national Government – receives around 70 per cent of government expenditure, with development expenditure – for the creation or renewal of assets – receiving the other 30 per cent. Development expenditure can be funded from government domestic revenues or relate to specific development partner-financed projects. Under the 2012 Public Financial Management Act, recurrent expenditure should be financed purely from domestic revenues over the medium term, and borrowing should only be used to finance development expenditure. The share of GDP allocated to recurrent expenditure fluctuated between 16.3 per cent and 17.6 per cent, well within Kenya's revenues. Development expenditure averaged about 7 per cent of GDP during the period.<sup>77</sup>
48. Under the Medium-Term Expenditure Framework 2017/18-2019/20, the Government is committed to invest in quality and access to free healthcare and education and the social safety net to reduce burdens on households and complement sustainable long-term growth and development.<sup>78</sup> However, efforts are still needed to allocate resources in sectors such as water, sanitation, nutrition and child protection. Late release of resources by the national treasury, and low resource mobilization capacities, including delays in procurement processes, have delayed progress in these areas.<sup>79</sup>
49. The share of total government spending on social sectors was close to 40 per cent in 2015-2016, of which education made up more than half. Health, environment, water and natural resources, and social protection accounted for much smaller proportions.<sup>80</sup> There have been increases in budgetary allocations to social sectors. However, the increases in certain areas, including education and social protection, still do not match the overwhelming needs in these sectors. Secondly, no measures have been taken on budget tracking from a child rights perspective, either at national level or at the level of devolved governments. Thirdly despite efforts made to eradicate it, corruption remains pervasive in Kenya and continues to divert resources needed to uphold the rights of the child.<sup>81</sup>

70. Constitution available at <http://www.kenyalaw.org/lex/actview.xql?actid=Const2010>

71. Committee for Resource Allocation, Brief on the Second Basis for Equitable Sharing of Revenue Among the County Governments, 10 March 2016, at <http://www.crakenya.org/cra-brief-on-the-second-basis-for-equitable-sharing-of-revenue/>

72. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

73. World Bank, Kenya GPE Primary Education Development Project (P146797), Project Document, 2015, at <http://documents.worldbank.org/curated/en/729261468038958395/pdf/PID-Appraisal-Print-P146797-02-18-2015-1424278256001.pdf>

74. Mamy Rakotomalala, Nicola Ruddle, Polycarp Otieno, Amos Kaburu, Analysis of Kenya's expenditure in education, future sector cost scenarios and benefits of curriculum reform: final report, Oxford Policy Management, November 2016.

75. OECD DAC, Aid at a Glance: Kenya, at [https://public.tableau.com/views/OECDDACAidataglancebyrecipient\\_new/Recipients?:embed=y&:display\\_count=yes&:showTabs=y&:toolbar=no?&:showVizHome=no](https://public.tableau.com/views/OECDDACAidataglancebyrecipient_new/Recipients?:embed=y&:display_count=yes&:showTabs=y&:toolbar=no?&:showVizHome=no), accessed 24 May 2017.

76. GIZ, Private Sector Development in Kenya, 28 March 2017, at [http://m.nairobi.diplo.de/contentblob/4310952/Daten/4553586/Factsheet\\_Private\\_Sector.pdf](http://m.nairobi.diplo.de/contentblob/4310952/Daten/4553586/Factsheet_Private_Sector.pdf)



50. Weaknesses in national and county monitoring and evaluation systems and limited technical capacity are major bottlenecks to monitoring progress and reporting results on children's issues. There is neither a comprehensive system to monitor and track the realization of all rights of the child at national and county levels, nor enough disaggregation of data on children to enable planning and resource allocation.<sup>82</sup> The national monitoring and evaluation policy has remained in draft form for over three years now. Capacity to analyse and package data for evidence-based decision making remains low, especially at county level. The legislative environment does not compel policymakers to use evidence in programming. For example, the budget law focuses on the timeframes for budget submission but is silent on use of evidence; and the current Kenya National Bureau of Statistics (KNBS) law focuses on generation of national level data but not county data.<sup>83</sup>
51. The Kenya National Commission on Human Rights has been re-established in line with the principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles). However, the Commission does not place specific emphasis on the rights of children in discharging its mandate.<sup>84</sup>

#### Key issues

- Kenya becoming a lower-middle income country in 2015 means that it loses access to some grants and concessional loans for social spending that should be replaced from other sources.
- The Government is committed to investing in improving quality of and access to free healthcare and education as well as the social safety net to reduce burdens on households.
- Including spending at county level, almost 40 per cent of government expenditure was on social sectors in 2015-2016, of which education accounted for more than half.
- Efforts are still needed to allocate resources in sectors such as water, sanitation, nutrition and child protection.
- Weaknesses in national and county monitoring and evaluation systems and limited technical capacity are major bottlenecks to monitoring progress and reporting results on children's issues.

## Information and data on children's rights

52. To identify and address barriers to upholding the rights of children, it is vital to produce and use accurate and timely disaggregated data on the issues that affect them. Under the Statistics Act of 2006,<sup>85</sup> the KNBS has been designated the principal agency of the Government for collecting, analysing and disseminating statistical data in Kenya and the custodian of official statistical information.
53. The KNBS relies on both special surveys and administrative data to compile statistics. It has produced several key publications in recent years at national level, and in June 2017 it published the first County Statistical Abstracts, highlighting key statistical indicators at county level.<sup>86</sup> There are currently challenges in several government ministries and departments with the provision of administrative data. Some Ministries do not have statistical units, which means that the people who collect administrative data are unable to assess their quality. In parts of government where statisticians are working, such as the health and education information systems and the police, much stronger data can be collected. Another challenge is the rapid turnover of staff responsible for data in ministries, which necessitates continuous retraining.<sup>87</sup> However, the Department of Children Services has made strides in developing Child Protection Management of Information System (CPMIS) to capture data on children's issues.

77. Mamy Rakotomalala, Nicola Ruddle, Polycarp Otiemo, Amos Kaburu, Analysis of Kenya's expenditure in education, future sector cost scenarios and benefits of curriculum reform: final report, Oxford Policy Management, November 2016

78. Government of Kenya, Guidelines for Preparation of the 2017/18-2019/20 Medium Term Budget, 13 July 2016, at <http://www.treasury.go.ke/annual-budget/guidelines.html?download=651:guidelines-for-the-preparation-of-the-2017-2018-2019-2020-medium-term-budget>

79. UNICEF, UNICEF – KCO MTR Report, 2016

80. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

81. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

82. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

83. UNICEF, UNICEF – KCO MTR Report, 2016

84. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5.

54. Therefore, a National Strategy for the Development of Statistics has been put in place, and a Cabinet memo has been passed to establish statistical departments in every planning unit. In addition, inter-ministerial technical working groups have been set up to look at issues such as governance and gender statistics. Under the National Strategy for Development of Statistics, stakeholders from sectors are being encouraged to develop sector statistical work plans.<sup>88</sup>

#### Key issues

- Planning for and monitoring child rights is constrained by a lack of disaggregated data.
- The Kenya National Bureau of Statistics is expanding its portfolio of key publications, and in June 2017 produced its first County Statistical Abstracts, which should support planning for children at decentralized level.
- The Government is working to improve the capacity of line Ministries to generate sectoral statistics.

## Role of private sector in development

55. Kenya's Government sees private sector organizations as potential partners to address financing gaps with less conditionality than ODA.<sup>89</sup> The private sector is a key driver of growth and development, with private businesses providing 70 per cent of jobs and income in the formal sector and contributing about 80 per cent of GDP. Kenya attracts regional offices of many international companies that bring capital, technology and know-how into the country. Between 2005 and 2015, foreign direct investment in Kenya increased by an average of 50 per cent.<sup>90</sup>
56. In this context, Kenya's public-private partnership (PPP) policy, which came into force in 2012, seeks to provide an enabling environment for PPPs through strong political will and robust legal and institutional frameworks.<sup>91</sup> PPP is currently being used across a range of sectors, including water supply: in 2016 six water service providers (WSPs) were selected by the Ministry of Environment, Water and Natural Resources to pilot PPP models to build the capacity of counties and ensure that residents have reliable access to quality water.<sup>92</sup>
57. The Government has recognized and promoted the interests of its private sector as the engine for growth and as a key partner in realizing Vision 2030.<sup>93</sup> One of the objectives of the Kenya Private Sector Alliance (KEPSA), alongside representing the interests of its members and promoting their vision of how to achieve economic growth, is *"To promote action-based best practices, CSR, conservation, protection and prudent use of Kenya's natural resources; ensuring dignified living conditions, quality of life, socio-cultural wealth, human development, growth and sustainable development for posterity"*.<sup>94</sup> In this regard KEPSA is promoting and influencing social budgeting to support early childhood education and maternal and newborn care.<sup>95</sup>
58. Recent years have seen increasing involvement of private sector organizations in corporate social foundation activities. For example, since 2003 the Safaricom Foundation has invested over KSh 1.8 billion in sectors including education, health, and disaster relief.<sup>96</sup> Chandaria industries promotes handwashing and donates washing and menstrual hygiene supplies to schools and children with disabilities.<sup>97</sup> Access Kenya and The Village Market use their billboards, light poles and marketing networks in strategic locations to promote child survival messages.<sup>98</sup>

85. Law 4 of 2006. Available at [http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/StatisticsAct\\_Cap112.pdf](http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/StatisticsAct_Cap112.pdf)

86. Kenya National Bureau of Statistics, County Statistical Abstract 2015, 6 July 2017, at <https://www.knbs.or.ke/county-statistical-abstract/>

87. Interview, Kenya National Bureau of Statistics, 22 March 2017

88. Interview, Kenya National Bureau of Statistics, 22 March 2017

89. Reality of Aid Africa, ODA and Private Sector Development in Kenya, November 2014, at [http://dSPACE.africaportal.org/jspui/bitstream/123456789/35545/1/ODA\\_and\\_Private\\_Sector\\_Development\\_in\\_Kenya.pdf?1](http://dSPACE.africaportal.org/jspui/bitstream/123456789/35545/1/ODA_and_Private_Sector_Development_in_Kenya.pdf?1)

90. GIZ, Private Sector Development in Kenya, 28 March 2017, at [http://m.nairobi.diplo.de/contentblob/4310952/Daten/4553586/Factsheet\\_Private\\_Sector.pdf](http://m.nairobi.diplo.de/contentblob/4310952/Daten/4553586/Factsheet_Private_Sector.pdf)

91. Reality of Aid Africa, ODA and Private Sector Development in Kenya, November 2014, at [http://dSPACE.africaportal.org/jspui/bitstream/123456789/35545/1/ODA\\_and\\_Private\\_Sector\\_Development\\_in\\_Kenya.pdf?1](http://dSPACE.africaportal.org/jspui/bitstream/123456789/35545/1/ODA_and_Private_Sector_Development_in_Kenya.pdf?1)

92. Kenya Markets Trust, Public Private Partnerships to Improve Citizen's access to Quality Water, 18 May 2016, at <http://www.kenyamarkets.org/press/public-private-partnerships-to-improve-citizens-access-to-quality-water/>

93. [https://www.unicef.org/kenya/partners\\_5221.htm](https://www.unicef.org/kenya/partners_5221.htm)

94. <https://kepsa.or.ke/our-focus/>, accessed 11 May 2017

95. [https://www.unicef.org/kenya/partners\\_5221.htm](https://www.unicef.org/kenya/partners_5221.htm)

96. Safaricom Foundation, Who We Are, at [http://safaricomfoundation.org/who\\_we\\_are](http://safaricomfoundation.org/who_we_are), accessed 24 May 2017.

59. Private sector companies in Kenya are also engaged in developing innovative products to meet the country's social challenges. Nairobi-based technology company BRCK Education has developed a system that provides a simple means of storing and charging 40 tablet computers to enable school classes to access the internet.<sup>99</sup> Meanwhile, Toto health enables organizations and counties to register parents to receive timely text messages, and facilitate the sharing of appointments, surveys and announcements with parents in a convenient and affordable way.<sup>100</sup>
60. In some cases, private sector products can be better tailored to meet the development needs of the population. For example, the National Food Fortification Alliance is engaging key corporate partners in salt iodization as well as flour, oil and sugar fortification.<sup>101</sup>
61. With funding from the Bill Gates and Melinda Foundation, UNICEF is modelling the baby-friendly workplace initiative, in a large tea estate in Kericho County, in partnership with Unilever Tea Kenya (UTK), the Ministry of Health, the Kenya Private Sector Alliance (KEPSA) and the African Population and Health Research Centre (APHRC), to encourage private sector companies to adopt better business practices for children, especially workplace support for breastfeeding mothers. KEPSA has identified ten champions in the private sector for better practices, including chief executive officers of large companies. As a result of the programme, Unilever revised their nursing break guidelines in November 2016 to support breastfeeding mothers to exclusively breastfeed and continue breastfeeding once they return back to work from maternity leave. The company renovated two rooms to form day care centres and breastfeeding rooms in two business units within the tea estate.
62. Nevertheless, in some cases, private sector engagement can be actively harmful for children's rights. Without adequate enforcement of regulations, the growing oil industry in Turkana County is in danger of exacerbating inequality, limiting household access to pastoral land and water supply, fuelling inter-clan conflict over jobs, and bringing new patterns of sexual networks,<sup>102</sup> which may include commercial sexual exploitation of children. Child labour is also a growing problem in mining areas of Turkana.<sup>103</sup>
63. Similarly, poorly regulated artisanal gold mining in Migori County has led to child labour, early pregnancy and prostitution,<sup>104</sup> as well as harmful effects of mercury poisoning on child labourers and unborn children.<sup>105</sup> Given that additional investment in extractive industries that can have negative effects on communities and the environment, there is a need for greater oversight and understanding of these issues in decision-making processes. There is also potential for resources leveraged from extractive industries to bring significant social and economic benefits to the citizens of Kenya, especially local communities, but this requires appropriate and inclusive mechanisms at community level, including the development of community development trusts, foundations and funds, and development of local capacity to engage in decision making processes.<sup>106</sup>

### Key issues

- In the context of its transition to lower-middle income status, stronger public-private partnership, innovation and charitable activities from the part of the private sector may help Kenya to achieve its social development goals, including for children,
- Sufficient Government oversight is required to ensure that children's rights are not infringed in the private sector: the extractive industries such as the oil industry in Turkana are a particular concern.

97. Chandaria Industries, Corporate Social Responsibility, at <http://www.chandaria.com/about-chandaria-industries/corporate-social-responsibility/>, accessed 24 May 2017

98. [https://www.unicef.org/kenya/partners\\_5221.htm](https://www.unicef.org/kenya/partners_5221.htm)

99. BRCK Education, Kio Kit, <https://www.brck.com/education/>, accessed 24 May 2017

100. Totohealth, About us, <https://totohealth.org/homepage#top>, accessed 24 May 2017

101. [https://www.unicef.org/kenya/partners\\_5221.htm](https://www.unicef.org/kenya/partners_5221.htm)

102. Kennedy Mkutu and Gerard Wandera, Conflict, Security and the Extractive Industries in Turkana, Kenya, USIU-Africa/KSG, 2016

103. Cordaid, Oil Exploration in Kenya: success requires consultation, 8 September 2015, at [https://www.cordaid.org/media/medialibrary/2015/09/Turkana\\_Baseline\\_Report\\_DEF-LR\\_Cordaid.pdf](https://www.cordaid.org/media/medialibrary/2015/09/Turkana_Baseline_Report_DEF-LR_Cordaid.pdf)

104. Milton Oboke, Child Labor in Nyatike Mines, Western Kenya, 16 September 2016, at <https://gnrc.net/en/blog/3716-child-labor-in-nyatike-mines-western-kenya>

105. IRIN, "Gold Mining Beats School Any Day", 2012, at <http://www.irinnews.org/report/94822/kenya-gold-mining-beats-school-any-day>

106. Cordaid, Oil Exploration in Kenya: success requires consultation, 8 September 2015, at [https://www.cordaid.org/media/medialibrary/2015/09/Turkana\\_Baseline\\_Report\\_DEF-LR\\_Cordaid.pdf](https://www.cordaid.org/media/medialibrary/2015/09/Turkana_Baseline_Report_DEF-LR_Cordaid.pdf)

# Chapter 3:

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## Surviving and thriving



64. Under the 2010 Constitution, “Every person has the right... to the highest attainable standard of health, which includes the right to health care services, including reproductive health care”.<sup>107</sup> Meanwhile “Every child has the right ... to basic nutrition, shelter and health care.”<sup>108</sup> The 2010 Constitution has led to devolution of health services. Following devolution, the national Ministry of Health is responsible for health policy, health regulation, national and referral facilities and capacity building and technical assistance to counties. Meanwhile, county governments are responsible for delivering health services at county level.<sup>109</sup>
65. The country has also developed a Health Bill that is intended to establish a unified health system; coordinate the inter-relationship between the national government and county government health systems; ensure regulation of healthcare service and healthcare service providers, health products and health technologies; and for related purposes. As of June 2017, the Bill is in Parliament awaiting enactment into law. The Bill states that every person has the right to the highest attainable standard of health, which shall include progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services, and every person has the right to be treated with dignity and respect and have their privacy respected in accordance with the Constitution and the Act.<sup>110</sup>
66. The Kenya Health Policy 2014-2030 is intended to guide improvements in healthcare in Kenya in the medium term, in line with the 2010 Constitution, Vision 2030 and Kenya’s global commitments. It demonstrates the health sector’s commitment, under the Government’s stewardship, to ensuring that the country attains the highest possible standards of health, in a manner responsive to the needs of the population. It focuses on ensuring equity, people centeredness and a participatory approach, efficiency, a multisectoral approach, and social accountability in healthcare service delivery, and embraces protection of the rights and fundamental freedoms of children, persons with disabilities, youth, minorities, the marginalized and older members of society.<sup>111</sup>

## Healthcare system

67. Devolution of responsibilities to counties has meant that decisions can be made closer to the point of need, but significant challenges remain. Even before devolution, health systems were quite weak, particularly in northern areas. When counties took over provision of healthcare, they received insufficient guidance for their new role, including guidance on budget lines.<sup>112</sup> Nevertheless, there have also been some successes in refocusing healthcare provision to the needs of local communities, and increasing the prioritization of preventive and promotive interventions rather than curative services.<sup>113</sup> Counties are currently at different levels of institutionalization, planning, prioritization and implementation, and this largely depends on the capacity and commitment of health managers.<sup>114</sup>

107. Article 43

108. Article 52

109. Ministry of Health, Ministerial Strategic and Investment Plan July 2014-June 2018,

Government of Kenya, The Health Bill 2016

111. Ministry of Health, Kenya Health Policy 2014-2030, 2014, at [https://www.afidep.org/?wpfb\\_dl=80](https://www.afidep.org/?wpfb_dl=80)

112. Interview, UNICEF, 20 March 2017

113. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

114. Information provided by UNICEF, May 2017

115. UNICEF, UNICEF – KCO MTR Report, 2016

116. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

117. UNICEF, UNICEF – KCO MTR Report, 2016:118.

68. Overall bottlenecks in the healthcare system include insufficient workforce; weak skills and experience of healthcare staff; and weak planning, management and financial systems resulting in barriers to health financing and efficient implementation. Weak and non-standardized logistics and supply systems and inefficient monitoring and evaluation compound these problems. There are also insufficient functioning health facilities, especially in northern under-developed counties. Many facilities lack electricity and water and continue to suffer persistent stock-outs of essential medical supplies. The quality of health services is low in many places: this in turn can also contribute to decreased demand for healthcare by the public.<sup>115</sup> Weak human resource management in the health sector has led to frequent strikes by healthcare workers that have affected service delivery including availability of services in public health facilities. These challenges faced by health facilities are repeatedly experienced by community units, which are the first tier of service provision in Kenya's health system.
69. On the demand side, long distances to health facilities decrease access to health services, particularly in rural areas (38 per cent of households in rural areas reported deprivations accessing healthcare in 2014, compared to 29 per cent in urban areas).<sup>116</sup> Other factors include high transportation costs and a number of socio-economic and cultural factors.<sup>117</sup> Children with mothers who are single, widowed, divorced, or separated have a higher probability of being deprived in accessing healthcare services.<sup>118</sup> Local knowledge about when to seek out health care is frequently another barrier. Shortages of Community Health Volunteers exacerbate these barriers, as without them the population can only learn about best practices at health facilities, which can prove expensive and difficult logistically.<sup>119</sup>
70. At a broader policy level, there are issues with the systems used to guide coordination in the health sector, health planning, financing and implementation. There is a weak link between national level policies/strategies and their use by counties, especially in relation to overall standardized management. Failures to make some policy decisions – such as not declaring cholera an emergency, delays in decisions pertaining to integrated community case management, and missed opportunities for leveraging funds – also hinder progress.<sup>120</sup>

#### Key issues

- Following devolution healthcare planning has generally been refocused to the needs of communities
- This is constrained to some extent by capacity challenges.
- Barriers to healthcare system improvement still exist at supply, demand and policy levels.

## Healthcare workforce

71. The WHO recommends a norm of 21.7 doctors and 228 nurses per 100,000 population. In 2016, Kenya had 14 doctors per 100,000 population and just 42 nurses per 100,000 population.<sup>121</sup> The country has not been able to fill all approved positions in all healthcare facilities, and the gap is much worse in primary healthcare facilities than in tertiary care. In total, only 15 per cent of approved positions were filled: 40 per cent in tertiary care facilities, and only 13 per cent at medical clinics and health centres.<sup>122</sup>
72. Retention and redeployment are a significant challenge, particularly in more challenging working environments, such as the arid and semi-arid lands.<sup>123</sup> For example in Turkana, the doctor to population ratio is 1:285,000.<sup>124</sup> Devolution has created an enabling environment for counties to employ more staff, and this has enhanced the health worker to population ratio, especially in hard-to-reach areas.<sup>125</sup> A number of counties, such as Turkana, Garissa, Homa Bay, Kakamega and Nairobi have conducted analysis of the situation of the health workforce,<sup>126</sup> and some have also started to work on motivation and retention mechanisms. For example, Garissa County has upgraded health workers' salaries and developed a retention package for its workers.<sup>127</sup> The same is also true of Turkana County.<sup>128</sup>

118. UNICEF, *Multidimensional Child Poverty in Kenya*, Draft, November 2016

119. UNICEF, UNICEF – KCO MTR Report, 2016

120. UNICEF, UNICEF – KCO MTR Report, 2016

121. Ministry of Health, *Health Sector Working Group Report*, Cited in Ministry of Health, *Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018)*, Final Report, November 2016

122. Ministry of Health, *Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018)*, Final Report, November 2016

123. Ministry of Health, *Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018)*, Final Report, November 2016

73. Between December 2016 and March 2017 doctors in public hospitals throughout Kenya went on strike to push for the implementation of a 2013 collective bargaining agreement that committed the Government to increase pay, restore dilapidated public health facilities, and address the country's huge shortage of doctors. The strike covered all public health facilities and hospitals in 47 counties, though some northern counties such as Turkana were able to keep some healthcare facilities open as they had their own mechanisms to retain doctors. The Government has stated that it does not recognize this agreement, following the devolution settlement that passed responsibility for healthcare to county governments. Administrative data indicates there was a decline in maternal, newborn and child health services, particularly in December, but that the most urgent services, such as Caesarean sections and treatment of childhood diarrhoea, were stable throughout the strike.

#### Key issues

- Kenya is significantly short of WHO norms for doctors and nurses per head of population: only 15 per cent of approved healthcare positions were reported filled in 2016
- Retention and redeployment are a significant challenge, particularly in more challenging working environments, such as the arid and semi-arid lands
- A doctors' strike between December 2016 and March 2017 highlights dissatisfaction in the sector, and led to a decline in maternal, newborn and child health services.

## Financing and planning

74. Following devolution, health spending by Kenya's national and county governments grew to KSh 110.3 billion in 2015-16 (equivalent to \$26 per capita).<sup>123</sup> In 2014, health spending as a proportion of total expenditure by national and county governments stood at 12.8 per cent, more than double the figure from before devolution in 2010 (5.8 per cent),<sup>133</sup> but still less than the 15 per cent rate that the Government committed itself to under the 2001 Abuja Declaration.<sup>134</sup> As a percentage of GDP, healthcare expenditure has also risen substantially, from 1.4 per cent in 2010 to 3.5 per cent in 2014.<sup>135</sup>
75. In recent years, nominal health sector budget allocations have increased, and larger shares are now being spent through counties than through the national Ministry of Health. In 2015-2016, the total health budget for the national Ministry of Health was KSh 46.7 billion, compared to KSh 63.5 billion by Kenya's counties.<sup>136</sup>
76. Of national Ministry of Health expenditure between 2013-2014 and 2015-2016, 30 per cent was spent on the two national hospitals (Kenyatta and Moi). A total of 35.7 per cent was spent on development activities, including 10 per cent on family planning, maternal and child health; and 7 per cent on district health services. Throughout the devolution period, development spending on district health services, and rural health centres and dispensaries has remained a large area of expenditure for the national Ministry, accounting for an average of 11 per cent of its expenditure over the three years. However, following the transfer of significant areas of healthcare spending to county governments, only 3.1 per cent of national level government spending (excluding transfers to counties) is spent on the healthcare system.<sup>137</sup>
77. At county level, the proportion of county budgets allocated to healthcare is over 20 per cent on average, partly because health is seen as a priority sector at county level, and partly because conditional transfers are a significant part of health budgets at county level. However, 10 counties reviewed for a 2017 study all suggested that their budget allocations were insufficient for the demands and needs of the local population.<sup>138</sup>

123. Interview, UNICEF, 20 March 2017

124. UNICEF, UNICEF – KCO MTR Report, 2016

125. Ministry of Health, Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018), Final Report, November 2016

126. Information provided by UNICEF, May 2017

127. Ministry of Health, Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018), Final Report, November 2016

128. Information provided by UNICEF, May 2017

129. Al Jazeera, Kenya Doctors End Strike after Deal with Government, 15 March 2017, at <http://www.aljazeera.com/news/2017/03/kenya-doctors-strike-deal-government-170314084246054.html>

130. UNICEF, Assessment of the Impact of the Doctors' Strike in Kenya, March 2017

78. A total of 81 per cent of county level spending in 2015-2016 was on recurrent expenditure. Few counties meet the Constitutional provision that a minimum of 30 per cent of the budget should be allocated to development spending. While detailed data is unavailable, it appears that recurrent healthcare spending in counties is increasing largely due to substantial personnel costs, which could amount to 60-70 per cent of recurrent expenditure. This means that funds available for operations and maintenance, for example, are severely limited.<sup>139</sup>
79. Like at national level, execution rates for development budgets are low. County health service delivery is strongly affected by delayed and lower-than-budgeted transfers of concessional and conditional transfers from the national Government to county level. Funds received late near the end of the year that cannot be spent must be returned to the National Treasury.<sup>140</sup>
80. There are similar challenges with conditional grants, including maternity grants. Counties report the number of maternity deliveries every month but are reimbursed by the national Government on a quarterly basis. Often disbursements are late. Counties and facilities struggle to provide free maternal healthcare given the consistent delays in funds to repay the cost of deliveries to hospitals and facilities. Meanwhile, problems using the National Treasury's integrated financial management information system have also slowed work at county level. The delays have led to reports that some facilities are threatening to charge fees for maternal care, or to withhold user fees to account for the delays and reduced grant payments. World Bank- and DANIDA-funded conditional grants, delivered directly to healthcare service facilities, are meant in part to ensure service delivery is not affected.<sup>141</sup>
81. External donor funding makes up just under 30 per cent of healthcare spending, and supports a wide variety of healthcare programmes in Kenya. The two largest donors to the health sector are GAVI and the Global Fund, which together account for 40 per cent of external finance to the sector. Donor-financed programmes typically cover HIV and AIDS, malaria, tuberculosis, and maternal and child health (including immunization and nutrition). Supply of drugs and capacity building are also common. However, much of this funding does not come through government budgets, and both national and county governments lack information about it. In addition, overreliance on external funding can generate real risks to sustainability of projects at county level and have a knock-on effect on county budgets. The national Ministry of Health is gathering data and information to map donors and track resources, to help identify areas of overspend and underspend and streamline external funding with national health priorities.<sup>142</sup>
82. Low public expenditure on health has significantly increased households' out-of-pocket expenditure. The 2014 out-of-pocket spending rate of 26 per cent is relatively high, given that the World Health Report of 2010 stated that direct payments of more than 15-20 per cent cause higher incidence of financial catastrophe and impoverishment.<sup>143</sup>
83. Private sector healthcare expenditure nearly doubled from Ksh 21.3 in 2011 to 39.0 billion in 2014. However, this expenditure accounts for only around 12 per cent of healthcare expenditure over this period.<sup>145</sup>

131. The Conversation, Why Kenyan health workers are on strike and what can be done about it, 14 December 2016, at <http://theconversation.com/why-kenyan-health-workers-are-on-strike-and-what-can-be-done-about-it-70221>

132. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

133. World Bank, Health expenditure, public (% of total government expenditure), at <http://data.worldbank.org/indicator/SH.XPD.PUBL.GX.ZS?contextual=aggregate&locations=KE>, accessed 21 July 2017

134. WHO, The Abuja Declaration: 10 years on, 2011, at [http://www.who.int/healthsystems/publications/abuja\\_declaration/en/](http://www.who.int/healthsystems/publications/abuja_declaration/en/)

135. World Bank, Health expenditure, public (% of total government expenditure), at <http://data.worldbank.org/indicator/SH.XPD.PUBL.GX.ZS?contextual=aggregate&locations=KE>, accessed 21 July 2017

136. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.

137. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.

138. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.

139. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.

140. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.



84. Despite disbursement delays, health outcomes at county level are improving. This suggests that health spending at county level has been largely able to support the county policy objectives for health. Administrative data indicate that county planning and budgeting have helped reduce maternal and infant mortality, and improve antiretroviral services for persons living with HIV, and has increased the resources put into preventative rather than curative healthcare<sup>146</sup> (at national level, spending is highly skewed towards curative health, with spending on administration, planning and support services also high).<sup>147</sup> Though health spending per capita has increased in 10 counties reviewed for a 2017 study, variations in health spending per capita have widened with devolution, suggesting that mismatches between resources and demand for healthcare persist.<sup>148</sup> Improved communication between the various levels and institutions involved in healthcare service delivery may help overcome service delivery planning issues.
85. While county budget cycles follow legal and procedural requirements, there are many improvements to be made. The 2017 Public Expenditure Review recommends that all counties undertake midterm reviews of their plans to ensure they are being implemented as expected, and to update priorities if necessary. Planning and budgeting for health at county level could be improved with better generation and review of quality, gender-disaggregated data. Capacity building and extra funding for staff would be needed to implement this effectively.<sup>149</sup>
86. Analysis of ten counties has revealed a weak correlation between per capita public health expenditure and provision of healthcare services (such as reaching the recommended target of four or more antenatal care visits and skilled delivery). This suggests that counties need to ensure that healthcare services are commensurate with public spending in the sector.<sup>150</sup>

#### Key issues

- Since devolution, public healthcare expenditure has risen substantially as a percentage both of GDP and of government expenditure
- County level healthcare expenditure is still reportedly insufficient for the demands and needs of local populations
- There is insufficient development expenditure at county level, largely because of substantial personnel costs
- Local level spending has been constrained by delayed and lower-than-budgeted transfers from national to county level
- The Ministry of Health is seeking to improve its information about donor expenditure and to streamline it with national health priorities
- Out-of-pocket healthcare expenditure remained high, at 26 per cent in 2014

141. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

142. Interviews with national Ministry of Health and development partners, September 2016. Cited in Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

143. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

144. Interviews with national Ministry of Health and development partners, September 2016. Cited in Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.

145. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.

146. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

147. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

148. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017.

149. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

150. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017.

## Health information

87. As counties are responsible under devolution for healthcare delivery, while the national Government is in charge of policy and setting standards, there is a need for a robust, harmonized and efficient health information system to cover all counties and the whole country, to track progress on health commitments, including the Sustainable Development Goals. However, sectional interests, focus among donors on their own data needs, and a lack of capacity to generate and analyse data, have led to a lack of trust in data or use of it for policy making at county level.<sup>151</sup>
88. There has been significant investment in Kenya since 2012 in strengthening the routine health information system.<sup>152</sup> Kenya is now one of 47 countries using an advanced DHIS2 system. In May 2016, the Kenya Health Data Collaborative was launched to raise the profile of the SDGs, rally stakeholder support, and agree a road map to improve the system.<sup>153</sup>
89. In May 2014, the Ministry of Health started developing a reproductive, maternal, newborn, and child health (RMNCH) scorecard for the country. The Scorecard should comprise of 27 national- and county-level indicators across six categories: pregnancy and newborn, early childhood, late childhood, adulthood, health systems, and the community. The Scorecard is intended to help healthcare administrators, stakeholders in health and the general public to know the state of health in their counties.<sup>154</sup> As of May 2017, data has been collected for two years on a quarterly basis.<sup>155</sup>
90. The components can be used for analysis by teams of health programme managers to reveal areas for concern in service delivery, find solutions, apply solutions, make changes and improve accountability. Several counties already use the tool to discuss progress in the lifecycle, including related health system issues, as well as to document and track actions for improvement. For example, information from the RMNCH scorecard to Garissa County was used to secure additional healthcare spending from the county assembly. The Ministry of Health intends to publish a half-yearly or annual update of the information received. However, implementation is not uniform across the country at sub-county level. While all counties have received training, some have stated that additional support is needed for implementation.<sup>156</sup>

### Key issues

- Since 2012 there has been significant investment in Kenya in strengthening the routine health information system.
- A reproductive, maternal, newborn, and child health scorecard for Kenya has been collecting quarterly data for two years and the information is being used to discuss progress in the lifecycle, including related health system issues, as well as to document and track actions for improvement.

151. Office of the Deputy President, Kenya Health Data Collective: experiences and challenges, presentation, 2017, at [https://www.healthdatacollaborative.org/fileadmin/uploads/hdc/Documents/WDF\\_session\\_Philip\\_Thigo\\_presentation.pdf](https://www.healthdatacollaborative.org/fileadmin/uploads/hdc/Documents/WDF_session_Philip_Thigo_presentation.pdf)

152. DHIS2, DHIS2 in Action, at <https://www.dhis2.org/inaction>, accessed 16 May 2017

153. Office of the Deputy President, Kenya Health Data Collective: experiences and challenges, presentation, 2017, at [https://www.healthdatacollaborative.org/fileadmin/uploads/hdc/Documents/WDF\\_session\\_Philip\\_Thigo\\_presentation.pdf](https://www.healthdatacollaborative.org/fileadmin/uploads/hdc/Documents/WDF_session_Philip_Thigo_presentation.pdf)

154. Measure Evaluation, Tracking Maternal and Newborn Health in Kenya, 2015, at <https://www.measureevaluation.org/pima/meval-pima-news/tracking-maternal-and-newborn-health-interventions-in-kenya>

155. Interview, Ministry of Health, 22 May 2017

156. Interview, Ministry of Health, 22 May 2017

## Community level healthcare

91. The Ministry of Health has had a Community Health Strategy in place since 2006. In 2014, a new Community Health Strategy was adopted for 2014-2019 that was intended to strengthen the delivery of integrated comprehensive and quality community health services for all population cohorts; strengthen community structures and systems for effective implementation of community health actions and services at all levels; strengthen data demand and information use at all levels; and strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services.<sup>157</sup>
92. Community health volunteers (CHVs) support a variety of essential health activities, such as maternal and newborn care, parent support groups, timed and targeted counselling, nutrition support, referral of children for immunization, and treatment of certain ailments, including common childhood diseases such as diarrhoea and fever.<sup>158</sup> The CHVs provide essential information and medical supplies, act as a referral mechanism for serious conditions, and inform community members about the health facilities in which they can access services.<sup>159</sup>
93. At sub-county level, according to quality standards, there should be five community health extension workers (CHEWs), responsible for supporting CHVs in their areas.<sup>160</sup> CHEWs are required to have some form of formal healthcare training, such as community development, health information, nursing, public health or laboratory science, and receive additional standardized training. While there are literacy, age, residency and other specifications, CHVs do not require any specific academic qualifications, and their educational attainment can vary depending on the status of the community.<sup>161</sup> Generally, groups of about 50 CHVs report to health centre based CHEWs.<sup>162</sup> Each CHV is supposed to cover 100 households, depending on the density of population in the area where they work (less households in areas where households are sparsely distributed, such as the ASAL, and more in urban settings where households are densely populated). In practice, the complement of staff varies significantly between counties, with a few that receive particular donor support having full complements.<sup>163</sup>
94. Certain counties have particularly developed CHV networks. In Turkana county, following the launch of its community health strategy in 2015, every village has a CHV, and a range of health indicators have improved. A meeting held in April 2016 that gathered Community Health Strategy workers and managers from all counties gathered the following information: since devolution, (i) twelve counties have made specific budgetary allocations towards community health, (ii) eight counties have hired CHEWs, (iii) five counties have provided kits for their CHVs, (iv) three counties are providing stipends for their CHVs, and (v) two counties are contributing towards the National Health Insurance Fund (NHIF) for their CHVs.<sup>164</sup> However, some counties that have received less support currently have much weaker community health strategies.<sup>165</sup>
95. CHVs treat and refer children for common childhood illness as per national policy guidelines, using Integrated Community Case Management (ICCM). ICCM is current best practice for areas lacking medical facilities and trained healthcare professionals, and ensures that more children have access to lifesaving treatments in their own communities. However, currently all ICCM services are donor funded and vary greatly from county to county. There is a need to integrate ICCM services with higher-level healthcare so that severely ill children can be referred to the appropriate healthcare facilities.<sup>166</sup> The Ministry of Health suggests a need for greater coordination between development partners to ensure that capacity is built across the country, and that best practices can be scaled up to meet needs in counties that have been left behind.<sup>167</sup>

157. Ministry of Health, Strategy for Community Health 2014-2019

158. World Vision, Kenya's Community Health Workers, 28 December 2015, at [http://www.wvi.org/sites/default/files/CHW%20Profile%20Kenya\\_0.pdf](http://www.wvi.org/sites/default/files/CHW%20Profile%20Kenya_0.pdf)

159. Interview, Ministry of Health, 22 May 2017

160. Ministry of Health, Kenya Quality Model for Health: Quality standards for community health workers, 2015, at [https://www.usaidassist.org/sites/assist/files/community\\_health\\_services\\_qi\\_standards\\_.pdf](https://www.usaidassist.org/sites/assist/files/community_health_services_qi_standards_.pdf)

161. Interview, Ministry of Health, 22 May 2017

162. World Vision, Kenya's Community Health Workers, 28 December 2015, at [http://www.wvi.org/sites/default/files/CHW%20Profile%20Kenya\\_0.pdf](http://www.wvi.org/sites/default/files/CHW%20Profile%20Kenya_0.pdf)

163. Interview, Ministry of Health, 22 May 2017

164. Community Health Development Unit, Survey of Community Health Strategy Persons; Community Health Policy Review Meeting April 2016.

96. Analysis of the Countdown to 2015 Report showed that countries with good investments in their community health system show the strongest progress in reducing under-five mortality: Brazil, Ethiopia, Nepal, Bangladesh and Rwanda. In Kenya, a study showed that community health contributed to an increase in women attending at least four antenatal care visits (39 to 62 per cent), increase in deliveries by skilled birth attendants (31 to 57 per cent), and increase in exclusive breastfeeding (23 to 57 per cent).<sup>168</sup>
97. It is also important to note that a strong community system does not only provide health benefits to the community but also provides an effective way to reach communities on various issues, as well as to empower them and mobilize them on various issues. Community structures provide platforms for integration of multi-sectoral services, such as nutrition; water, sanitation and hygiene; early childhood development; and child protection. For example, CHWs are often actively engaged in tackling gender-based violence and child marriage, as well as infanticide in Samburu.<sup>169</sup>
98. There are a number of challenges currently facing the community healthcare system in Kenya. While CHVs are officially volunteers, an income is needed to ensure that they can continue their work. While national policy states that they should receive KSh 2,000 per month, since the devolution process most have not received it, though a few receive stipends from their counties or from civil society partners. CHVs also face under resourcing challenges, such as lack of stationery to keep records; mobile phones to receive information and transmit data on diseases, deaths and births in their areas; and transportation to move around their areas, a particular challenge in sparsely-populated areas. At a wider level, there is a lack of resources in each population unit and among CHEWs to use and analyse data collected by the community healthcare system. This means that data collected is often not used for the intended purposes at county level, and not transmitted to be included in national health information reporting.<sup>170</sup>
99. One of the tasks of the community health system is disease prevention and health promotion. Disease prevention and health promotion activities are critical, especially in disease endemic communities regularly affected by outbreaks such as cholera. The Ministry of Health has stated that given the wide variety in cultures and disease burdens across the country, there is a need for targeted health promotion materials to be developed for each county. In addition, community members can have unrealistic expectations about the care and information that CHVs can provide: these also need to be addressed.<sup>171</sup>

### Key issues

- The Community Health Strategy for 2014-2019 builds on previous strategies to improve services
- Community health volunteers support maternal and newborn care, parent support groups, timed and targeted counselling, nutrition support, referral of children for immunization, and treatment of certain ailments by providing essential information and medical supplies, and acting as a referral mechanism.
- In practice, the complement of community health staff and volunteers varies significantly between counties, with a few that receive particular donor support having full complements and strong strategies
- The community healthcare system faces challenges including under resourcing, lack of coordination, and lack of capacity to use and analyse data generated.

165. Interview, UNICEF, 19 May 2017

166. Interview, UNICEF, 20 March 2017

167. Interview, Ministry of Health, 22 May 2017

168. Wangalwa et al, Effectiveness of Kenya's Community Health Strategy in delivering community-based maternal and newborn health care in Busia County, Kenya: non-randomized pre-test post test study, 2012, at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3587017/>

169. Interview, UNICEF, 19 May 2017

170. Interview, Ministry of Health, 22 May 2017

171. Interview, Ministry of Health, 22 May 2017

## Maternal and child health

### Maternal health

100. Modelled estimates by WHO suggest that the maternal mortality ratio was 510 in Kenya in 2015, a fall from a peak of 759 in 2000.<sup>172</sup> The 2015 figure was significantly higher than the midterm target of the Ministry of Health's *Kenya Health Sector Strategic and Investment Plan (KHSSP)* (300 in 2016).<sup>173</sup> International organizations estimate that one in 42 women will die of a maternity related cause; and that 8,000 women die every year in Kenya of maternity related conditions, the seventh highest figure in the world. A total of 2.3 per cent of maternal deaths in Kenya are indirectly related to HIV.<sup>174</sup> The last national statistics, from the 2009 census, showed that maternal mortality was highest in the former North-eastern Region (2,041 per 100,000) and reached 3,795 in Mandera County. Meanwhile, Nairobi and the former Central Region had the lowest rates at 212 and 289 per 100,000 respectively.<sup>175</sup> However, despite the low maternal mortality rate in Nairobi, given its large population the region is one of the 15 counties with the highest burden of maternal deaths in Kenya. By 2014, maternal mortality had reportedly fallen to 362 per 100,000 across Kenya. Maternal deaths account for 14 per cent of all deaths to women age 15-49.<sup>176</sup>
101. According to administrative data, the maternal mortality ratio among women who are admitted to give birth in healthcare facilities has fallen significantly, from 142 per 100,000 deliveries in 2012 to 106 in 2016, though there are important regional differences. In 27 of the 47 counties, institutional maternal mortality ratios are below the KHSSP target of 100 per 100,000 deliveries. In 2016, Lamu, Turkana, Kisumu and Tama River counties had institutional maternal mortality over 200 per 100,000 deliveries.<sup>177</sup>
102. The main driver of declines in maternal mortality is a reduction in maternal HIV and reduced mortality from giving birth, ranging from complications associated with abortion, haemorrhage, and obstructed labour. However, there is still much avoidable death and disability due to maternal haemorrhage, obstructed labour, and maternal sepsis. In 2013, the Government addressed high maternal death and injury and the lack of access to quality maternal health services (including antenatal, delivery, and post-natal services) by waiving all user fees for maternity services at all public facilities.<sup>178</sup>
103. KDHS figures on receiving antenatal care from a skilled provider increased from 92 per cent to 96 per cent of women with a live birth in 2014. In 2014, urban women (98 per cent) were slightly more likely than rural women (94 per cent) to receive antenatal care service from skilled providers. The former North-eastern Region, however, reported significantly lower care rates (67 per cent). Receiving antenatal care services from skilled providers increased with increasing education and wealth. Eighty-nine per cent of women in the lowest wealth quintile received antenatal care services from skilled providers, compared with 99 per cent in the highest wealth quintile.<sup>179</sup> However, administrative data from the Ministry of Health reveal that the proportion of pregnant women who received at least one antenatal care visit during pregnancy fell every year from 2012 (82.2 per cent) to 2016 (74.2 per cent). In Mandera (33.7 per cent) and Wajir (49 per cent) counties, less than half of women received skilled antenatal care.<sup>180</sup>
104. The 2014 KDHS found that 58 per cent of women made the recommended four or more antenatal care visits during their pregnancy, an increase of 11 percentage points from the 2008-09 KDHS.<sup>181</sup> However, this figure is significantly below the Ministry of Health's target of 80 per cent for 2018.<sup>182</sup> Again, administrative data show significantly lower figures, at 38.5 per cent in 2016, though this is higher than the 2012 figure of 33.2 per cent. At 11.6 per cent, the figure for Mandera County was again the lowest, though this is more than double the proportion in 2012 (4.2 per cent).<sup>183</sup>

172. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: Trends in maternal mortality: 1990 to 2015, 2015, at [http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf)

173. Ministry of Health, Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018), Final Report, November 2016

174. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, Trends in maternal mortality: 1990 to 2015, 2015, at [http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf)

175. KNBS, Analytical Report on Mortality, March 2012, available via <https://www.knbs.or.ke/2009-kenya-population-and-housing-census-analytical-reports/#266-analytical-reports>

176. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

105. According to the 2014 KDHS, 61 per cent of live births in the previous five years had been delivered in health facilities, and skilled providers assisted 62 per cent (compared to 44 per cent in 2008-2009). Assistance with birth by skilled providers was least likely for mothers who gave birth outside health facilities (2.8 per cent), those who had received no antenatal care visits (18.6 per cent), mothers who had received no education (26.4 per cent), and those in the poorest quintile (31.1 per cent). Mothers were least likely to have skilled assistance with birth in the former North-eastern (32.4 per cent) and Western (47.8 per cent) regions. Administrative data suggest that skilled birth attendance rose nationally from 44.4 per cent in 2012 to 57.6 per cent in 2016. However, the figure remained below 40 per cent in Mandera County (28.6 per cent), Nandi County (35.5 per cent), Trans-Nzoia County (38.3 per cent), Narok County (39.1 per cent) and Wajir County (39.9 per cent).<sup>185</sup>
106. Despite the increase in registered births as a whole, according to official statistics the number of births recorded at home halved between 2011 and 2015. However, the number in health facilities increased by 60 per cent. During this period, according to the figures, only Bomet County saw a significant increase in the number and proportion of births at home.<sup>186</sup> The overall increase in the proportion of deliveries in healthcare facilities was partly facilitated by a presidential initiative of free maternity services.<sup>187</sup> The increase occurred in 43 of the 47 counties, with many of low coverage counties, such as Tana River, Wajir, Mandera and Kwale, showing dramatic increases.<sup>188</sup>

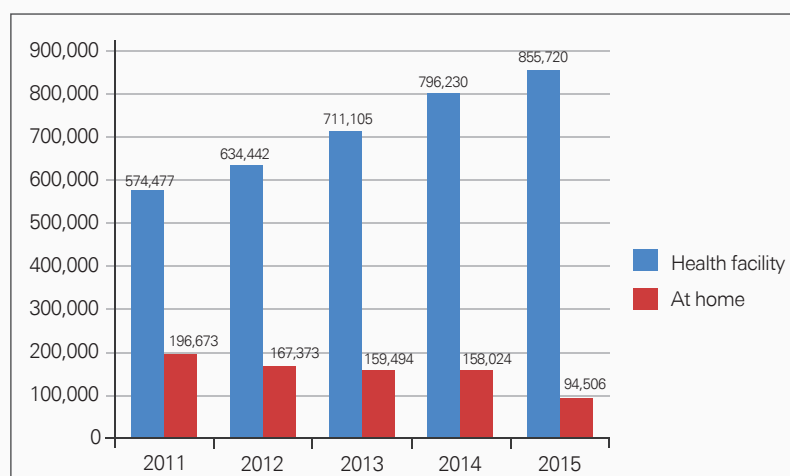


Figure 4: Number of births in health facilities and at home, 2011-2015, Department of Civil Registration

177. Administrative data from Ministry of Health for 2012-2016  
 178. Institute for Health Metrics and Evaluation and the International Centre for Humanitarian Affairs, The Global Burden of Disease: Generating Evidence, Guiding Policy: Kenya, 2016, at <http://www.healthdata.org/policy-report/global-burden-disease-generating-evidence-guiding-policy-kenya>  
 179. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>  
 180. Administrative data from Ministry of Health for 2016  
 181. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>  
 182. Ministry of Health, Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018), Final Report, November 2016  
 183. Administrative data from Ministry of Health for 2016  
 184. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>  
 185. Administrative data from Ministry of Health for 2016  
 186. Kenya National Bureau of Statistics, Statistical Abstract, 2016, at [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=106&Itemid=1177](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=106&Itemid=1177)  
 187. Set out in "Speech by H.E. Hon. Uhuru Kenyatta, C.G.H., President and Commander-in-Chief of the Defence Forces of the Republic of Kenya During the Madaraka Day Celebrations" (Nyayo National Stadium, June 1, 2013), <http://www.statehousekenya.go.ke>  
 188. Ministry of Health, Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018), Final Report, November 2016

107. Qualitative research in three counties for the 2016 Multidimensional Child Poverty Survey agreed that significant improvements have been achieved in skilled birth attendance since devolution. Making maternity services free of charge and providing stipends to mothers for antenatal care visits and delivery at health facilities was highlighted to have significantly contributed in this regard. In Turkana and Kitui, investments in infrastructure through building of new facilities and incorporation of maternity services at dispensaries (lower levels of healthcare provision) also played an important role. The process has also been facilitated by the engagement of Community Health Volunteers, who follow-up with mothers during pregnancy, and the linkage with health facilities increasing the use of health services at the community level. In a number of cases, the process has been facilitated by the involvement of traditional birth attendants as birth companions, responsible for referring and accompanying mothers to the health facilities when their labour begins, and on a few occasions assisting nurses during the birth.<sup>189</sup>
108. However, provision of maternity services remains a challenge, especially for dispensaries in the counties, which, in addition to being understaffed, often lack basic equipment, facilities and even essentials, such as access to water. Also, referral to higher levels of healthcare provision is hindered by insufficient vehicles for transportation, which typically cover very large areas in counties like Turkana and Kitui. It must also be noted that the quality of maternity services is compromised to an extent by understaffing in most dispensaries and health facilities as staff provide a wide range of services simultaneously to offering maternity services.<sup>190</sup>
109. Distance remains a major barrier to giving birth in health facilities in Turkana and Kitui, especially among poor women who cannot afford to pay for transportation in absence of public transport services.<sup>191</sup> Distance, poor roads, and difficulties obtaining and paying for transport have also been cited as key reasons why pastoralist women continue to give birth at home in Laikipia and Samburu counties.<sup>192</sup>
110. In addition, traditional practices of giving birth in the community remain rather prevalent in certain communities. In some instances, mothers reportedly prefer traditional birth attendants as they are not satisfied with the quality of the services in health facilities, citing unfriendly treatment from staff, lack of attentiveness, and “medicalization” of the birth process (in Turkana).<sup>193</sup>
111. More than half (53 per cent) of women who gave birth in the two years before the KDHS received a postnatal care check-up in the first two days after delivery. Thirty-six per cent of infants born in the two years before the survey had their first postnatal check-up within the first two days after birth.

#### Key issues

- According to KDHS, the maternal mortality ratio in Kenya improved from 520 per 100,000 live births in 2008-2009 to 362 per 100,000 in 2014. One in 42 women will die of a maternity related cause, and that 8,000 women die every year in Kenya of maternity related conditions, the seventh highest figure in the world.
- Recent county figures for total maternal mortality are not available, but Mandera County had the highest figure at the time of the 2009 census.
- The main drivers of the fall are a reduction in maternal HIV and reduced mortality from giving birth, ranging from complications associated with abortion, haemorrhage, and obstructed labour.
- Significant improvements have been made in skilled birth attendance since devolution, with the figure rising from 44.4 per cent in 2012 to 57.4 per cent in 2016
- Increased skilled birth attendance results from making maternity services free of charge, and improved access to comprehensive obstetric maternal and newborn services
- Provision of maternity services remains a challenge, especially for dispensaries in the counties, which, in addition to being understaffed, often lack basic equipment, facilities and even essentials, such as access to water
- Distance also remains a major barrier to giving birth in health facilities

189. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

190. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

191. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

## Newborn health

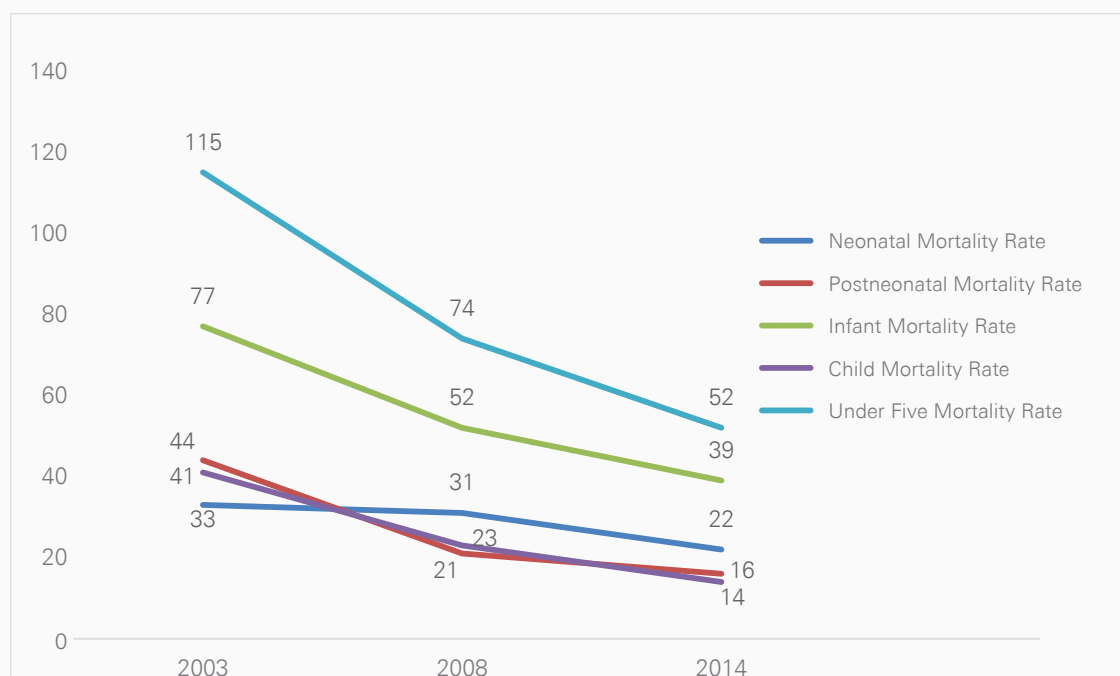


Figure 5: Trends in under five mortality by age group, 2003-2014, KDHS figures

112. Despite progress in reducing mortality among children of all ages in recent years, neonatal mortality has exhibited the slowest rate of decline. The neonatal mortality rate for 2009-2014 is 22 deaths per 1,000 live births (down from 31 per 100 live births in 2009), and 56 per cent of all infant deaths occur in the first month. Neonatal mortality is 24 per cent higher in urban areas than in rural areas (26 deaths and 21 deaths per 1,000 live births respectively). The highest rate is found in Nairobi (39 per 1,000). The perinatal mortality rate for the same reference period is 29 deaths per 1,000 pregnancies.<sup>195</sup>
113. An average of administrative data from the Ministry of Health for 2012-2016 suggests that at county level neonatal mortality is highest in Nairobi County. Unlike most indicators, the data suggests that the best situation is found in the ASAL counties, with the lowest figure in Mandera County. These data should be treated with caution, however.
114. Using UN estimates based on survey and census data, neonatal mortality fell by 2.7 per cent per year between 2005 and 2015. If this rate of decline continues neonatal mortality is projected to be 22 by 2016 (target met), 20 by 2018 (target of 15 will not be met), and 15 per 1,000 live births by 2030 (SDG target of 12 will not be met).<sup>196</sup>

192. Tanya Caulfield et al, "Factors influencing place of delivery for pastoralist women in Kenya: a qualitative study", BMC Women's Health, August 2016, at <https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-016-0333-3>

193. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016. In Lakipia and Samburu there are similar concerns [Tanya Caulfield et al, "Factors influencing place of delivery for pastoralist women in Kenya: a qualitative study", BMC Women's Health, August 2016, at <https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-016-0333-3>]

194. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

195. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

196. Ministry of Health, Mid-Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-June 2018), Final Report, November 2016

197. Institute for Health Metrics and Evaluation and the International Centre for Humanitarian Affairs, The Global Burden of Disease: Generating Evidence, Guiding Policy: Kenya, 2016, at <http://www.healthdata.org/policy-report/global-burden-disease-generating-evidence-guiding-policy-kenya>.



115. The highest rates of death and disability among children occur among newborns during the first month of life and especially during the first six days of life. In 2013, neonatal disorders accounted for the vast majority of disability-adjusted life years. Taken together, diarrhoea, lower respiratory infections (such as pneumonia), and other common infectious disorders were the second-leading causes of death and disability among newborns in Kenya after neonatal disorders.<sup>197</sup>

#### Key issues

- Newborn mortality has been falling slower than other childhood mortality rates from 31 per 1,000 births in 2009 to 22 per 1,000 in 2014. 56 per cent of all infant deaths occur in the first month
- Newborn mortality is higher in urban than rural areas, and highest in Nairobi (39 per 1,000)
- Neonatal disorders account for the vast majority of disability-adjusted life years among newborns, followed by diarrhoea and common infections, including pneumonia.

## Infant and child health

116. Beyond the first week of life, survival for infants is substantially better. In 2014, the infant mortality rate for Kenya was 39 per 1,000 live births, suggesting most infant mortality occurs in the first week after birth. All early childhood mortality rates declined between 2003 and 2014, according to KDHS surveys.<sup>198</sup> During the first year of life, the most common causes of death and disability are again neonatal causes, lower respiratory infections (pneumonia), malaria, diarrhoea, and other common infectious disorders.<sup>199</sup>
117. The under-five mortality rate in 2014 was 52 per 1,000 live births, down from 74 per 1,000 in 2009.<sup>200</sup> Much of the health loss among children between the ages of one and five years in Kenya is due to conditions such as lower respiratory infections (pneumonia), diarrhoeal disease, malaria and HIV and AIDS. While these conditions remain prevalent, there have been significant decreases in child deaths from HIV, malaria, and measles.<sup>201</sup> Factors behind the downward trend in childhood mortality include high impact interventions, such as increased use of mosquito nets among children, immunization programmes and improvements in the health system.<sup>202</sup> However, it is important to note that the reduction did not reach the MDG target of 32 per 1,000 live births. A lot more needs to be done to reach the SDG target of below 25 per 1,000 live births.
118. Regional disparities have increased for under-five mortality, with significantly higher mortality in arid, semi-arid and rural areas.<sup>203</sup> In 2009, the highest regional rate was found in the former North-eastern Region, at 111 per 1,000. Nairobi (46), the former Central Region (46) and the former Eastern Region (47) had the lowest regional figures.<sup>204</sup> There are severe regional disparities in the country: a child born in the former Nyanza Region is almost twice as likely to die before age five as a child born in the former Central Region. However, there are quite significant differences between administrative and survey data: according to the 2014 KDHS Nairobi has the second highest under-five mortality rate, following former Nyanza Region (82 deaths per 1,000 live births).<sup>205</sup>

197. Institute for Health Metrics and Evaluation and the International Centre for Humanitarian Affairs, *The Global Burden of Disease: Generating Evidence, Guiding Policy: Kenya*, 2016, at <http://www.healthdata.org/policy-report/global-burden-disease-generating-evidence-guiding-policy-kenya>

198. Kenya National Bureau of Statistics et al, *Kenya Demographic and Health Survey 2014*, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

199. Institute for Health Metrics and Evaluation and the International Centre for Humanitarian Affairs, *The Global Burden of Disease: Generating Evidence, Guiding Policy: Kenya*, 2016, at <http://www.healthdata.org/policy-report/global-burden-disease-generating-evidence-guiding-policy-kenya>

200. Kenya National Bureau of Statistics et al, *Kenya Demographic and Health Survey 2014*, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

201. Institute for Health Metrics and Evaluation and the International Centre for Humanitarian Affairs, *The Global Burden of Disease: Generating Evidence, Guiding Policy: Kenya*, 2016, at <http://www.healthdata.org/policy-report/global-burden-disease-generating-evidence-guiding-policy-kenya>

202. UNICEF, UNICEF – KCO MTR Report, 2016

203. UN Committee on the Rights of the Child, *Concluding Observations on the combined third to fifth periodic reports of Kenya*, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

204. KNBS, *Analytical Report on Mortality*, March 2012, available via <https://www.knbs.or.ke/2009-kenya-population-and-housing-census-analytical-reports/#266-analytical-reports>

205. Kenya National Bureau of Statistics et al, *Kenya Demographic and Health Survey 2014*, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

206. UNICEF, *Multidimensional Child Poverty in Kenya*, Draft, November 2016

119. Regional disparities are also observed in lack of access to healthcare, ranging from 15 per cent in Embu County and Tharaka Nithi County to 78 per cent in Mandera County (in the methodology of the study, children’s and their mother’s access to healthcare services is measured by vaccinations and skilled birth attendance for children aged 0-11 months, and by vaccinations and mothers’ knowledge about oral rehydration salts for treating diarrhoea for children aged 12-59 months). For more, see the map below:<sup>206</sup>

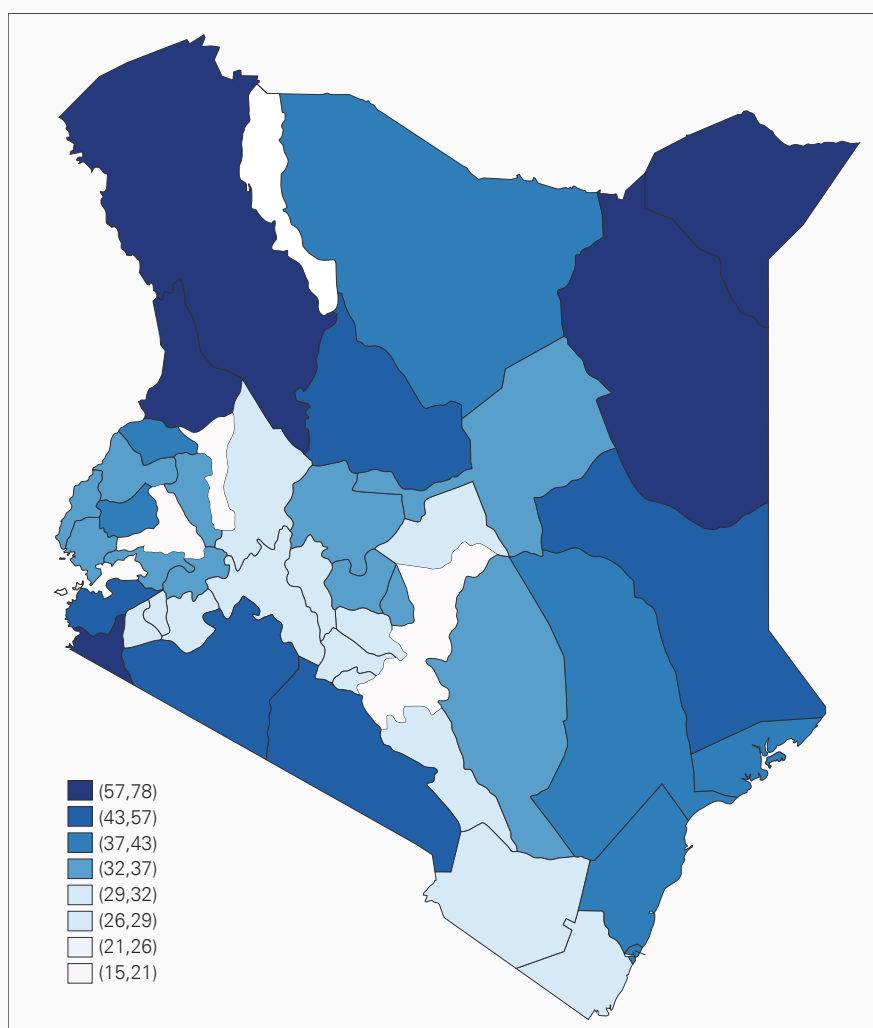


Figure 6: Regional disparities in access to healthcare, 2014

**Key issues**

- Under five mortality fell from 74 per 1,000 in 2009 to 52 per 1,000 in 2014
- Factors behind the downward trend in childhood mortality include high impact interventions, such as increased use of mosquito nets among children, immunization programmes, and improvements to the health system, including community-based systems
- Under-five mortality is generally higher in arid, semi-arid and rural areas, but 2014 KDHS data suggest that Nairobi also has high levels of under-five mortality.

## Immunization

120. Seventy-nine per cent of children aged 12-23 months received all basic vaccines in 2014: this was slightly higher than the 77 per cent observed in the 2008-09 KDHS.<sup>207</sup> Despite this, in 2014 Kenya had the second highest number of children who are not immunized in the Eastern and Southern Africa region, after Ethiopia.<sup>208</sup> Overall, according to the DHS, 27.5 per cent of all children under the age of 5 were not fully immunized in 2014. This is only slightly lower than in 2008-09 when 33 per cent of all children in this age group had not received all the necessary basic vaccines.<sup>209</sup>
121. However, administrative figures suggest that immunization coverage fell significantly between 2012 (83.8 per cent, or 1,112,635 children) and 2016 (75.6 per cent, or 1,098,256 children).<sup>210</sup> The Ministry of Health has identified several reasons for this. Firstly, there is a lack of specialists at county level for cold chain maintenance. Secondly, the cold chain can breakdown because of frequent power outages (for this reason vaccines are often taken to centralized locations and vaccination services cannot be provided on a daily basis in communities). Thirdly, the devolution changes led to significant restructuring of staff, and those now in charge of services sometimes lack capacity to manage the extended programme of immunization services, including ensuring the cold chain is well maintained, forecasting vaccine and devices required, and linking with communities. The practice at sub-county level of supportive supervision and health facility monthly meetings to deliberate on immunization performance has largely stopped in most counties due to lack of consistent financial support by the devolved governments.<sup>211</sup>

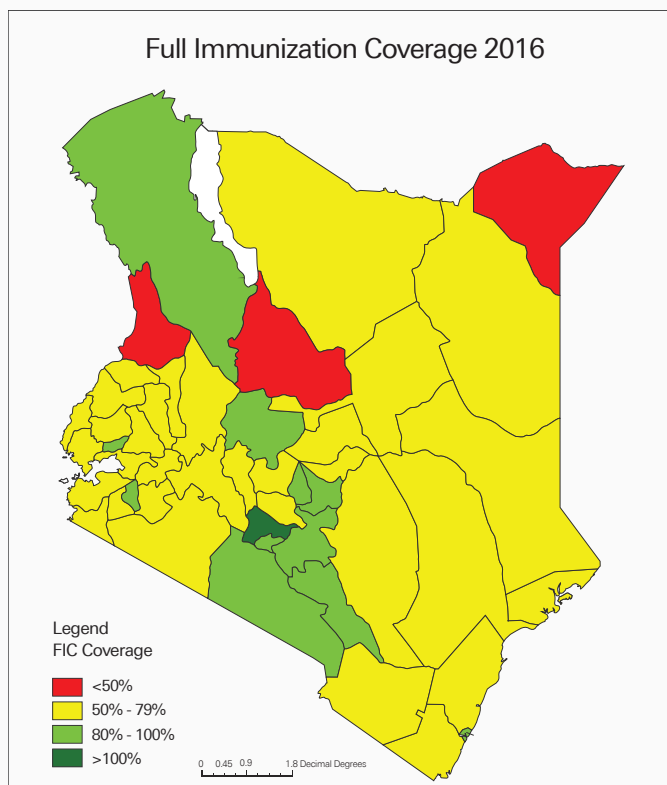


Figure 7: Full immunization coverage, 2016, administrative data

207. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

208. Interview, UNICEF, 20 March 2017

209. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

210. Administrative data from Ministry of Health for 2012-2016

211. Interview, Ministry of Health, 22 May 2017

122. Most unvaccinated children come from poor families, urban informal settlements and hard-to-reach parts of the country, particularly arid and semi-arid regions.<sup>212</sup> Immunization rates vary sharply by region. According to administrative data, only 31 per cent of children under one year in Mandera were fully immunized. However, the figures reflect a steady improvement from 2013 (17.9 per cent).<sup>213</sup> Reasons for low rates in Mandera include uncertainty of the accuracy of population to be targeted due to disputed census results, limited outreach services, lack of immunization facilities and staff turnover due to insecurity.<sup>214</sup> The other counties with rates under 50 per cent in 2016 were Kajiado (43.2 per cent) and Tharaka Nithi (47.3 per cent).<sup>215</sup>
123. The 2016 Multidimensional Child Poverty study found that children from families with mothers with lower educational attainment, lower income, non-married parents, and more children under the age of five in the household are all statistically less likely to be fully immunized.<sup>216</sup>
124. Qualitative research for the 2016 Multidimensional Child Poverty study indicated that coverage of immunization improved with devolution because of improvement in accessibility of health facilities, engagement of Community Health Volunteers and outreaches funded by donors. In some counties, such as Kakamega, devolution has also had a positive impact on supply of vaccines, with facilities rarely experiencing stock-outs.<sup>217</sup> Counties that have developed proactive development plans for immunization have seen sharp rises. For example, the full immunization rate in Turkana County rose from 45 per cent in 2015 to 75 per cent in 2016. In certain sub-counties bordering Ethiopia, Uganda and South Sudan, a Nomadic Health Strategy has been developed that addresses the need of persons who cross borders frequently and are thus are less likely to access community health systems. This has reportedly been very successfully at increasing immunization rates in Kibish sub-country, which stood at 20 per cent in 2015 and 80 per cent in 2017.<sup>218</sup>
125. However, 2017 research by the Results for Development Initiative and financed by the Gates Foundation suggests that child immunization coverage has in fact declined as a result of devolution. Under the devolved system, counties receive block grants and allocate funds as they see fit across sectors, including health. Health management teams in counties further allocate funds across the health sector. If county administrators do not see immunization as a priority, such programmes – or aspects such as outreach – may not get funded. This is because facilities have less control over their own funding. Previously, some operational costs for immunization and certain other activities were financed using income generated, retained, and allocated by the facility; these funds are now consolidated in county bank accounts for use across sectors.<sup>219</sup> Meanwhile, storage of vaccines remains a challenge in some counties due to limited access to electricity, gas and fridges, especially in remote areas and lower levels of healthcare provision (dispensaries). Healthcare providers reportedly stress the unavailability of vaccines due to storage issues and understaffing, which result in long waiting hours, thereby discouraging clients from returning.
126. There has been a decline in BCG vaccination coverage. This is largely caused by stock out of BCG syringes; most counties failed to budget and procure the devices. The stock out of syringes has had an additional negative effect on the coverage of other antigens (vaccines).<sup>220</sup>

212. WHO and UNICEF, Why Polio Campaigns Must Reach Every Last Child in Kenya, 20 January 2017, at <http://reliefweb.int/report/kenya/why-polio-campaigns-must-reach-every-last-child-kenya>

213. Administrative data from Ministry of Health for 2012-2016

214. Kenya Food Security Steering Group and County Steering Group, Mandera County, Mandera County: 2016 Long Rains Food Security Assessment Report, August 2016, at [http://reliefweb.int/sites/reliefweb.int/files/resources/Mandera%20County%202016%20LRA%20\\_Report.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Mandera%20County%202016%20LRA%20_Report.pdf)

215. KNBS, Economic Survey 2017. Available via [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

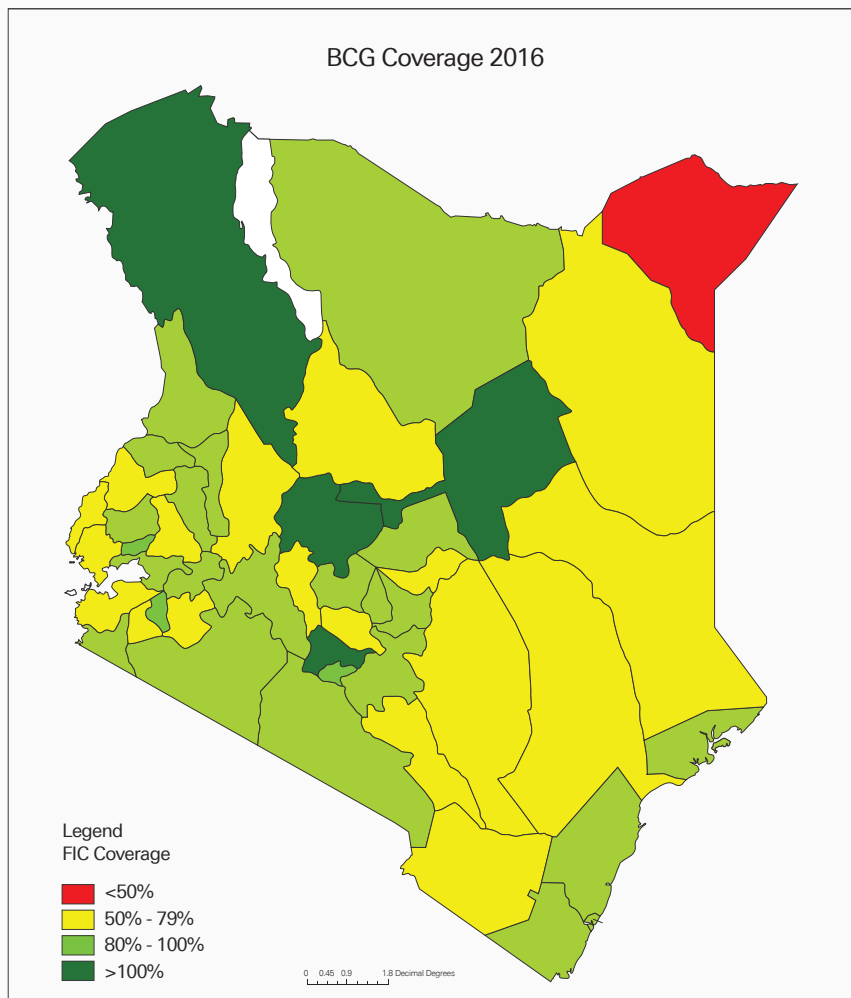
216. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

217. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

218. Kenya Health Information System data

219. Immunization Financing, Kenya: Decentralization and Immunization Financing, Research for Development Initiative, 23 February 2017, at <http://www.immunizationfinancing.org/country-case-studies/kenya-decentralization-and-immunization-financing/>

220. Ministry of Health, National Immunization Consultative Forum, Immunization Performance and Vaccine Cold Chain Summary Report, February 2017



**Figure 8: BCG coverage, 2016, administrative data**

127. In recent years, new vaccines have been introduced against common childhood illnesses in Kenya.<sup>221</sup> These include IPV, rota, measles and rubella. In addition, the country has been making successful progress towards polio eradication, and it has remained polio free since July 2013.<sup>222</sup>
128. Measles remains a public health concern in Kenya because of an accumulation of unvaccinated children. Although 19 million children were vaccinated in 2016 in a successful mass campaign, risks persist due to weak immunization systems in neighbouring Somalia and low vaccination coverage in counties that border Somalia (see the coverage map by county below).<sup>223</sup> For instance, while current immunization coverage among refugees at the Dadaab refugee camps was 95 per cent in May 2017, coverage in the host community in Garissa County was less than 60 per cent.<sup>224</sup>

221. Information provided by UNICEF, May 2017

222. WHO and UNICEF, Why Polio Campaigns Must Reach Every Last Child in Kenya, 20 January 2017, at <http://reliefweb.int/report/kenya/why-polio-campaigns-must-reach-every-last-child-kenya>

223. Information provided by UNICEF, May 2017

224. UNICEF, Kenya: Humanitarian Situation Report, 5 May 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20Situation%20Report%20-%2005%20May%202017.pdf>

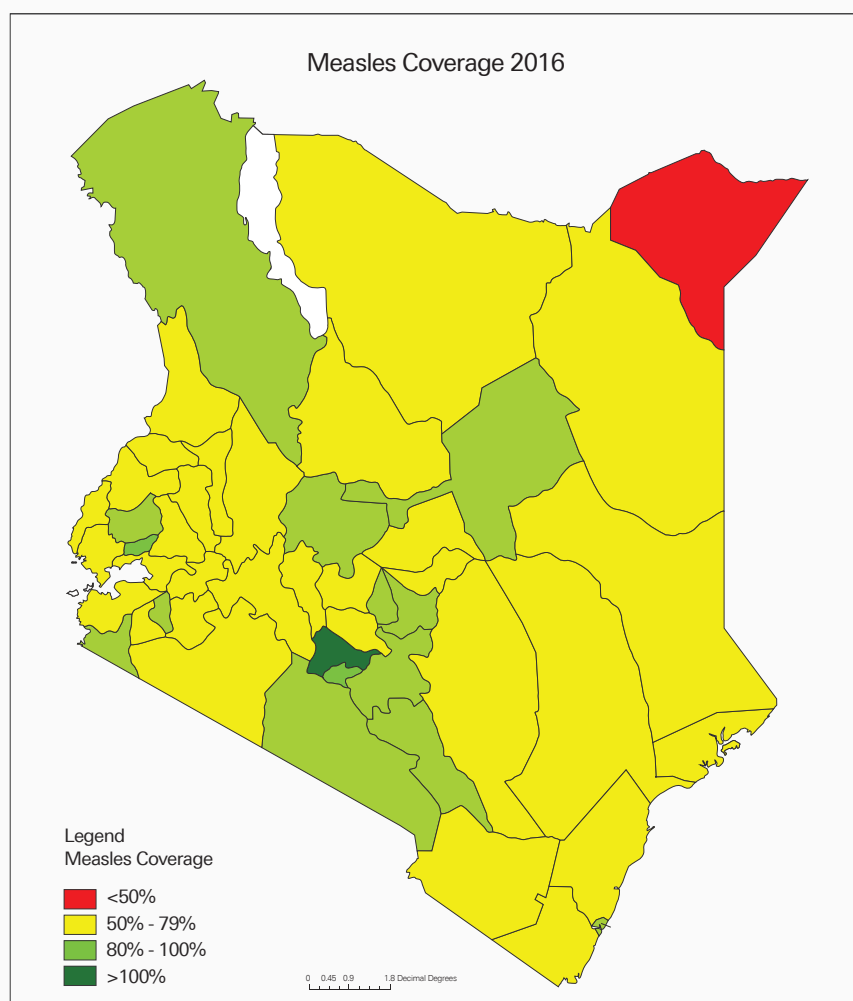


Figure 9: Measles vaccination coverage by country, 2016, administrative data

## Childhood disease and healthcare-seeking behaviour

129. Pneumonia causes the highest number of deaths among children, followed by diarrhoea and malaria. Timely access to recommended treatment remains a major challenge. Nine per cent of children under age five showed symptoms of acute respiratory infection in the two weeks before the 2014 KDHS, with higher prevalence reported in the former Western Kenya Region, which also reported a high burden of child deaths. Only 66 per cent of these children were taken to a health facility or provider for advice or treatment, while only 50 per cent received an antibiotic. Successful demonstration of the ability of CHVs to successfully identify and treat children with pneumonia in Homa Bay through ICCM has the potential to improve access to timely recommended treatment by sick children. In addition, the Government has adopted the 2010 WHO pneumonia treatment guidelines and is currently introducing Amoxicillin DT, a more efficacious formulation for treatment of pneumonia, in all healthcare facilities. However, underinvestment in pneumonia-related interventions is affecting efforts to reduce ill health and death among children.<sup>225</sup>

225. Brian I. Shaw et al, "Perceived Quality of Care of Community Health Worker and Facility-Based Health Worker Management of Pneumonia in Children Under 5 Years in Western Kenya: A Cross-Sectional Multidimensional Study", *Am. J. Trop. Med. Hyg.*, 94(5), 2016, pp. 1170–1176

226. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

130. Twenty-four per cent of children under age five had had a fever in the two weeks before the 2014 KDHS survey: 63 per cent of these children were taken to a health facility or provider for advice or treatment. Fifteen per cent of children under age five had had diarrhoea in the two weeks before the survey. The proportion of children with diarrhoea taken to a health provider for advice or treatment increased from 49 per cent in the 2008-09 KDHS to 58 per cent in the 2014 KDHS. The proportion of children with diarrhoea given fluid from oral rehydration salt (ORS) packets has increased over this period, from 39 per cent in 2008-09 to 54 per cent in 2014. According to KDHS findings, the percentage of women who know that ORS can be used to treat diarrhoea in children increased from 78 per cent in 2008-09 to 93 per cent in 2014.<sup>226</sup>
131. Childhood tuberculosis is increasingly becoming a major area for intervention globally and in Kenya because of the increase in the number of infected children and challenges in identifying and diagnosing these children. The Government has introduced new drug formulation to manage childhood tuberculosis and progress has been made to ensure treatment guidelines are integrated into integrated management of childhood illness (IMCI) and paediatric protocols. An integrated approach is required to address this leading killer.

#### Key issues

- Full immunization coverage fell from 83.8 per cent in 2012 to 76 per cent in 2016 as a result of underfunding for outreach for underserved populations, stock out of injection devices and vaccines, and frequent labour disputes in the health sector
- These problems arose from challenges linked to devolution of health services and reduced communication between healthcare facilities and communities to address demand side constraints
- Some counties that have been able to develop strong action plans on immunization (such as Turkana) have reversed this trend
- Kenya has managed to introduce new vaccines: the inactivated polio vaccine, rota, measles and rubella: 19 million children aged below 14 years were vaccinated against measles and rubella in 2016 and nine million children under five years were vaccinated against polio between 2013 and 2017
- The number of healthcare facilities providing immunization increased from 5,300 to 6,900 between 2011 and 2016, and the proportion of cold chain equipment not working fell from 17 per cent in 2011 to 8 per cent in 2016
- Kenya is continuing to fully finance the procurement of all new vaccines and co-finance the procurement of new vaccines.

## Malaria

132. In 2013, malaria accounted for an estimated 7 per cent of mortality among children aged 1-59 months in Kenya.<sup>227</sup> More than 70 per cent of Kenya's population live in areas at risk of malaria.<sup>228</sup> Of the at-risk population, 27 per cent (about 12 million people) live in areas of epidemic and seasonal malaria transmission. However, an estimated 28 million people live in endemic areas, and over a quarter (approximately 11 million people) live in areas where parasite prevalence is estimated to be equal to or greater than 20 per cent.<sup>229</sup>
133. In the 2015 MIS, 13 per cent of Kenyan children aged six months to 14 years tested positive for malaria by rapid diagnosis test (RDT), while 8 per cent tested positive by microscopy. Regardless of the type of test, malaria prevalence generally increases with age. Malaria prevalence is generally highest among children aged 10-14 years (15 per cent by RDT and 11 per cent by microscopy). Prevalence of malaria by microscopy among children aged six months to 14 years in rural areas (10 per cent) is much higher than among their urban peers (3 per cent). It is also generally less prevalent among the richest quintile (1 per cent). Childhood malaria is much more prevalent in the Lakes region in the southwest than elsewhere in the country (27 per cent prevalence: down from 38 per cent in 2010). The coastal region is the only other part of the country where it reaches the national average microscopy-based prevalence of 8 per cent, though this marks a doubling in prevalence from 4 per cent in 2010.<sup>230</sup>

227. WHO, Kenya: Neonatal and Child Health Profile, 2015, at [http://www.who.int/maternal\\_child\\_adolescent/epidemiology/profiles/neonatal\\_child/ken.pdf](http://www.who.int/maternal_child_adolescent/epidemiology/profiles/neonatal_child/ken.pdf)

228. Kenya Malaria Indicator Survey, 2015

134. In 2015, 63 per cent of households in Kenya owned at least one insecticide-treated mosquito net (ITN). The richest households were more likely (68 per cent) to have nets than the poorest households (49 per cent). Net ownership is similar in urban and rural areas, and both saw a rise of about 20 percentage points between 2010 and 2015.<sup>231</sup>
135. A 2015 survey found that children below five years of age in informal settlements around large cities were vulnerable to malaria, mainly because of stagnant water in the drains and an environment that enhances the breeding of mosquitoes. Over a fifth (20.4 per cent) of respondents stated that the disease was common in the settlements, including 30.2 per cent in Garissa, 20.6 per cent in Kisumu, 18.4 per cent in Nairobi and 17.3 per cent in Mombasa. However, in 27.2 per cent of households, children under five were not using mosquito nets. Non-usage of mosquito nets was highest in Nairobi's informal settlements (49 per cent), and less common in informal settlements in Mombasa (19.1 per cent), Kisumu (21.2 per cent), and Mombasa (12.7 per cent). Many reasons were advanced for not sleeping under the net; with most respondents indicating that the designs of nets they received from hospitals and other administrative units were not good.<sup>232</sup>

#### Key issues

- An estimated 27 million people live in malaria epidemic areas of Kenya
- In 2015, prevalence among children aged six months to 14 years was 8 or 14 per cent, depending on the type of testing
- Prevalence is highest in the Lakes region in the southwest (27 per cent), but doubled in the coast region to 8 per cent from 2010 to 2015.
- Prevalence is lower in urban areas and among the richest quintile of the population
- Mosquito net ownership rose by 20 percentage points from 2010 to 2015

## HIV and AIDS

136. Kenya's HIV prevalence was 5.9 per cent among people aged 15–49 years in 2015 (slightly down from 6 per cent in 2013). This is equivalent to 1.42 million people living with HIV, including 98,000 children (139,027 in 2010),<sup>233</sup> and makes the country one of the five with the largest number of cases in the world.<sup>234</sup> HIV and AIDS account for an estimated 29 per cent of adult deaths annually, 20 per cent of maternal mortality, and 16 per cent of deaths of children under the age of five.<sup>235</sup>
137. Notably, 46 per cent of all new HIV infections are among young people aged 15–24 years, with two thirds among girls and young women.<sup>236</sup> Population groups with particularly high prevalence rates include sex workers (29.3 per cent), men who have sex with men (18.2 per cent) and injecting drug users (18.2 per cent).<sup>237</sup>
138. The HIV epidemic in Kenya is also highly geographically concentrated. The four counties with more than 10 per cent prevalence – Homa Bay (26 per cent), Siaya (24.8 per cent), Kisumu (19.9 per cent) and Migori (14.3 per cent) – are all located in the south west of the country, on the shore of Lake Victoria. A recent secondary analysis of 2012 Kenya AIDS Indicator Survey data shows the former Nyanza Region, where these four counties are located, as one of the regions where migration impacts HIV prevalence. The migrant population had a higher HIV prevalence than the non-migrant population.<sup>238</sup> These four counties also see the highest estimated annual numbers of new infections among adults and children. The next highest prevalence at county level is in Mombasa on the Indian Ocean coast (7.5 per cent). At 6.1 per cent, the figure for Nairobi is slightly higher than the national average. Wajir County in the northeast has the lowest estimated prevalence (0.4 per cent).<sup>239</sup>

229. USAID, President's Malaria Initiative: Kenya –Malaria Operational Plan FY 2017, 2016, at <https://www.pmi.gov/resource-library/mops/fy-2017>

230. Kenya Malaria Indicator Survey, 2015

231. Kenya Malaria Indicator Survey, 2015

232. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

233. Ministry of Health and National AIDS Control Council, Kenya AIDS Response Progress Report, 2015

234. UNICEF, UNICEF – KCO MTR Report, 2016



139. Research conducted in 2014 and 2015<sup>240</sup> identified several driving factors behind the high rates of HIV in Homa Bay. Poverty was determined to be the most important, followed by cultural, sexual attitude and behaviour; fisher-folk and fishing industry networks, lifestyle related factors, health-seeking behaviour and professional related factors. Poverty leads to increased vulnerability to HIV through food poverty, poor nutrition, lack of school fees, and inadequate access to healthcare, clothing and shelter as well as risky behaviour to secure livelihoods, placing people at increased risk of acquiring HIV. The fishing industry drives the spread of HIV partially through transactional sex for fish, engagement with female sex workers on the islands of Lake Victoria, and the presence of fishermen, beach management and security personnel living away from their families for significant periods of time.<sup>241</sup> The factors are similar in the other lakeside communities. The response to HIV in recent years in these areas has been challenging because of the need to come to terms with understanding HIV response roles at county level in the context of devolution, though this has improved in the four years since devolution.<sup>242</sup>
140. Meanwhile, in Mombasa, groups particularly vulnerable to HIV include immigrant and mobile populations working in tourism and recreation centres, mining, construction, transport and fisheries industries.<sup>243</sup> Given the county's prevailing cultural and religious norms and values, issues of stigma and discrimination mean that sex workers and other key populations are reluctant to identify themselves to receive support. However, the county has a well-organized healthcare system, and overall prevalence has been falling in recent years.<sup>244</sup>

## Children and adolescents

141. Because of improved coverage and antiretroviral treatment, mothers living with HIV are today less likely to transmit the virus to their children during pregnancy, labour, delivery and breastfeeding. The mother to child transmission (MTCT) rate for 18-month olds fell from 16 per cent in 2012 and 14 per cent in 2013 to 8.3 per cent in 2015. Maternal antiretroviral coverage also increased from 66 per cent in 2014 to 75 per cent in 2015. Prevention of MTCT (PMTCT) services were available for 75 per cent of mothers living with HIV in 2015, compared to 60 per cent in 2013. However, less than 19 per cent were covered by PMTCT in the north-eastern counties of Wajir and Mandera.<sup>245</sup>
142. The number of new infections among children fell from 12,286 in 2013 to 6,613 in 2015. Twelve counties showed encouraging results with more than a 50 per cent reduction in new infections among children during this three-year period. However, in the same period, increases in new infections were recorded in 21 counties.<sup>246</sup>
143. In 2015, there were an estimated total of 133,455 adolescents aged 10-19 living with HIV in Kenya.<sup>247</sup> However, there are significant data gaps concerning adolescents, and data on younger children is poor. With 71,034 new HIV infections in 2015 among 15-49 year olds, slightly more than half of all new HIV infections (35,776) were in young women and men aged 15-24. Cultural and social norms, such as intergenerational sex between young women and older men, child marriage, poverty, gender-based violence, stigma and self-stigma continue to play a role.<sup>248</sup>

235. Ministry of Health and National AIDS Control Council, Kenya HIV County Profiles, 2016, at <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf>

236. UNICEF, UNICEF – KCO MTR Report, 2016

237. Ministry of Health and National AIDS Control Council, Kenya HIV County Profiles, 2016, at <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf>

238. IOM, 2017. Understanding the HIV/AIDS Epidemic among the Migrant Population in Kenya. Evidence from an National Population Survey (unpublished)

239. Ministry of Health and National AIDS Control Council, Kenya HIV County Profiles, 2016, at <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf>

240. Homa Bay County Government and National AIDS Control Council, The First Homa Bay County Multisectoral AIDS Strategic Plan, 2015 at [nacc.or.ke/?mdocs-file=3753&mdocs-url=false](http://nacc.or.ke/?mdocs-file=3753&mdocs-url=false)

241. Homa Bay County Government and National AIDS Control Council, The First Homa Bay County Multisectoral AIDS Strategic Plan, 2015 at [nacc.or.ke/?mdocs-file=3753&mdocs-url=false](http://nacc.or.ke/?mdocs-file=3753&mdocs-url=false)

242. Interview, UNICEF, 20 March 2017

243. Mombasa County Government and National AIDS Control Council, Mombasa HIV and AIDS Strategic Plan 2016-2020, 2015, at <http://nacc.or.ke/?mdocs-file=3502&mdocs-url=false>

244. Interview, UNICEF, 20 March 2017

245. Ministry of Health and National AIDS Control Council, Kenya AIDS Response Progress Report, 2016, at [http://nacc.or.ke/wp-content/uploads/2016/11/Kenya-AIDS-Progress-Report\\_web.pdf](http://nacc.or.ke/wp-content/uploads/2016/11/Kenya-AIDS-Progress-Report_web.pdf)

144. At the end of 2015, 71,547 children under 14 years were on HIV treatment (equating to an antiretroviral treatment (ART) coverage rate of 77 per cent).<sup>249</sup> Disaggregated ART coverage data is currently not nationally available for adolescents. However, programme data suggests limited access, disclosure and adherence problems inhibit uptake for the growing group of adolescents living with HIV. With 650,000 children (0-17 years) estimated to be orphaned due to AIDS, social protection interventions remain important.<sup>250</sup>
145. While the Government and partners have ensured availability of HIV commodities, and HIV services for adults are staffed, only 25 per cent of health facilities in the country provide paediatric ART. Limited early HIV testing, lack of disclosure and adherence to HIV treatment among children, adolescents and pregnant or lactating women have also posed challenges. Limited community and health facility links and lack of family support also play a role.<sup>251</sup>

## Awareness

146. Awareness of AIDS is universal in Kenya. However, according to the 2014 KDHS, only 56 per cent of women and 66 per cent of men (15-49 year olds) have comprehensive knowledge about HIV and AIDS prevention and transmission (that is, they know that both condom use and limiting sexual intercourse to one uninfected partner can prevent HIV, they are aware that a healthy-looking person can have HIV, and they reject the two most common local misconceptions about HIV: that HIV can be transmitted by mosquitoes and by sharing food). Seventy-two per cent of women and 62 per cent of men know both that HIV can be transmitted through breastfeeding and that the risk of mother-to-child transmission can be reduced by taking special drugs during pregnancy.<sup>252</sup>
147. A 2015 study of informal settlements found that children did not access drugs and were at the mercy of the caregivers to take them for healthcare, check-ups and follow up treatment, which is a key requirement for the control of the side effects of HIV. For young children, lack of care resulted in regular infections and re-infections with coughs and colds as well as pneumonia.<sup>253</sup> Meanwhile, stigma and discrimination against children living with HIV and AIDS remain persistent, leading to neglect and abandonment and treatment interruption, once they are aware of their status.<sup>254</sup>

## Policy and guidelines

148. Kenya has a robust legal and policy framework aimed at responding and protecting the rights of children and adolescents. Article 53(1)(b) of the 2010 Constitution states that every child has the right to free and compulsory education and (c) to basic nutrition, shelter and health care. The Government has expressed commitment to addressing HIV through the Kenya AIDS Strategic Framework 2014-2019. This has led to tailored County AIDS Strategic Plans.<sup>255</sup>
149. A second key policy document is the National Plan for Accelerating HIV Care and Treatment 2015-2017. It addresses issues both of demand for care and supply of services, setting out a framework for innovative testing at the point of care for early infant diagnosis and the use of child friendly ART treatment.<sup>256</sup> In 2016, the age of consent for testing for HIV has been reduced from 18 to 15. This means that adolescents who had previously been reluctant to seek treatment for fear of stigma from family and members of the community can now go for testing and maintain their anonymity.<sup>257</sup> A third key policy document is the Fast Track Plan to end HIV and AIDS among Adolescents, developed following the global launch of the ALL-In! Campaign by President Kenyatta, an initiative led by UNICEF and UNAIDS in recognition of the high number of untimely deaths and new HIV infections among adolescents.

245. Ministry of Health and National AIDS Control Council, Kenya AIDS Response Progress Report, 2016, at [http://nacc.or.ke/wp-content/uploads/2016/11/Kenya-AIDS-Progress-Report\\_web.pdf](http://nacc.or.ke/wp-content/uploads/2016/11/Kenya-AIDS-Progress-Report_web.pdf)

246. Ministry of Health and National AIDS and STI Control Programme, Framework for Elimination of Mother-to-Child Transmission of HIV and Syphilis, 2017.

247. Ministry of Health and National AIDS Control Council, Kenya AIDS Response Progress Report, 2016, at [http://nacc.or.ke/wp-content/uploads/2016/11/Kenya-AIDS-Progress-Report\\_web.pdf](http://nacc.or.ke/wp-content/uploads/2016/11/Kenya-AIDS-Progress-Report_web.pdf)

248. UNICEF, UNICEF – KCO MTR Report, 2016

249. UNICEF, UNICEF – KCO MTR Report, 2016

250. UNICEF, UNICEF – KCO MTR Report, 2016

150. Fourthly, policy has been updated on mother-to-child transmission of HIV. A new national strategic framework is in place for elimination of mother-to-child transmission of HIV and syphilis, along with guidelines for PMTCT to enable Kenya to qualify for validation of pre-elimination by 2021. The new strategic framework and guidelines place particular emphasis on the needs of adolescent mothers. Guidelines have also been issued for peer education and psychosocial support for mothers for PMTCT, through the “Kenya Mentor Mother” programme.
151. Nevertheless, gaps remain at policy level. The lack of focussed guidelines on HIV in emergencies means that population groups affected by emergencies, especially adolescent key populations, can be neglected in provision of effective prevention, treatment and care services. The challenges with life skills education at school (see Adolescent and Youth Sexual and Reproductive Health below) means that young people may be insufficiently informed about the risks they can be exposed to. There has been no clear country position/commitment on Comprehensive Sexuality Education and its roll out has been slow. Legislation preventing sexual health services (such as condoms) being provided in schools contribute to increased vulnerability of young people already engaged in sex, particularly where there are limited opportunities for accessing outside services.<sup>258</sup>

#### Key issues

- HIV prevalence in Kenya was 5.9 per cent in 2015, slightly down from 6.5 per cent in 2013, but in real terms the fifth largest number of cases in the world.
- 46 per cent of all new HIV infections are among young people aged 15-24 years, with two thirds among girls and young women.
- The southwestern counties of Homa Bay, Siaya, Kisumu and Migori have rates between 26 and 14.3 per cent and contribute 53 per cent of all new HIV infections among adolescents aged 10-19 years in the country and 50 per cent of all new HIV infections nationally among 15-24 year olds. Poverty and reliance on fishing (which leads to high mobility and “sex for fish”) are key drivers of the virus in this region.
- The mother to child transmission (MTCT) rate for 18-month olds fell from 16 per cent in 2012 to 8.3 per cent in 2015.
- Prevention of MTCT services were available for 75 per cent of mothers living with HIV in 2015, but less than 19 per cent in Wajir and Mandera Counties.
- The number of new infections among children fell from 12,286 in 2013 to 6,613 in 2015.
- Only 25 per cent of health facilities provide paediatric antiretroviral therapy

251. UNICEF, UNICEF – KCO MTR Report, 2016

252. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

253. UNICEF, Participatory Mapping of Children’s Risks and Vulnerabilities in Urban Areas, November 2015

254. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

255. UNICEF, UNICEF – KCO MTR Report, 2016

256. National AIDS and STI Control Programme, National Plan for Accelerating HIV Care and Treatment 2015-2017, October 2015, at <https://karp.or.ke/resources/National-Plan-for-Accelerating-HIV-Care-and-Treatment.pdf>

257. ICAP, In Kenya, a New Focus on HIV Care and Treatment for Adolescents, 30 August 2016, at <http://icap.columbia.edu/news-events/detail/in-kenya-new-approaches-put-focus-of-hiv-care-and-treatment-on-children-and>

258. Interview, UNICEF, 17 May 2017

259. UNICEF, UNICEF – KCO MTR Report, 2016

## Adolescent and youth health

152. Adolescents are vulnerable to poor access to contraception, early and unintended pregnancy, unsafe abortion, female genital mutilation (FGM), child marriages, sexual and gender-based violence, malnutrition and reproductive tract infections, including sexually transmitted infections (STIs) as well as HIV and AIDS.<sup>259</sup>

## Sexual and reproductive health

153. According to the 2014 KDHS, the median age at first sexual intercourse in Kenya was 18.0 years for women and 17.4 years for men, with little difference between age cohorts. Among 15-19 year olds, 10.7 per cent of girls and 19.6 per cent of boys reported having had sex by the age of 15. Women in rural areas initiate sexual activity slightly earlier than their urban peers. Among women aged 20-49, sexual activity begins earliest on average in the former Nyanza Region (16.4 years) and latest in Nairobi (19.3 years). The counties with the lowest median age are Migori (15.5), Homa Bay (15.7), Samburu (15.7), Kisumu (16.4), and Siaya (16.6).<sup>260</sup> Research in Nyanza published in 2013 found increased sexual activity amongst adolescents who sleep in a different home to the household head.<sup>261</sup> With respect to education, women with at least some secondary education begin sexual activity three years later than those with no education. Similarly, women in the richest wealth quintile tend to initiate sexual activity three years later than those in the poorest.<sup>262</sup>
154. The 2014 KDHS found that 14.7 per cent of girls and women aged 15-19 had already given birth and 3 per cent were pregnant with their first child. The figure was higher in rural areas (15 per cent) than urban areas (14 per cent). There has been a general decline in this indicator over the years that the KDHS has been conducted.<sup>263</sup>

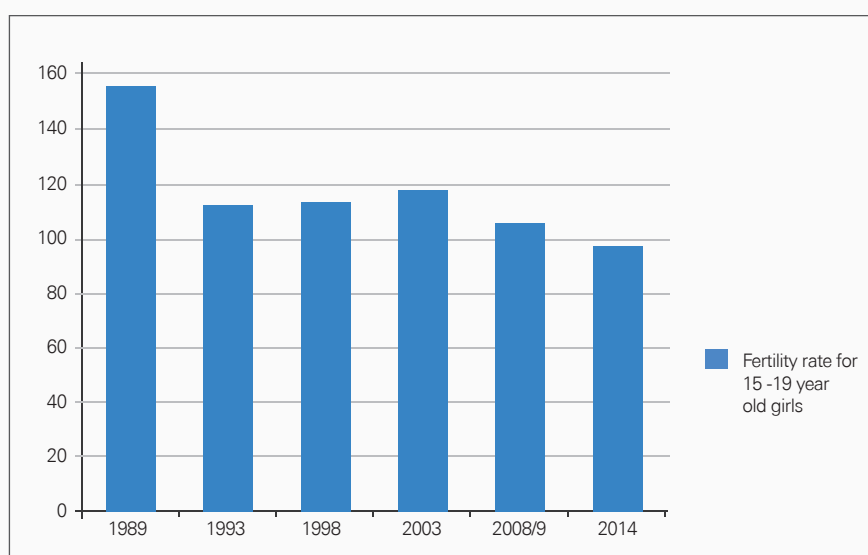


Figure 10: Fertility rate per 1,000 15-19-year-old girls, 1989-2014, KDHS figures

260. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

261. Juma, M., Alajii, J., Bartholomew, L. K., Askew, I., & Van den Borne, B. (2013). Risky Sexual Behavior Among Orphan and Non-orphan Adolescents in Nyanza Province, Western Kenya. *Aids and Behavior*, 17(3), 951-960. Cited in Rachel Bray with Andrew Dawes, Parenting, Family Care and Adolescence in East and Southern Africa: An evidence-focused literature review, UNICEF, June 2016, at [http://childprotectionforum.org/wp-content/uploads/2017/02/IDP\\_2016\\_02.pdf](http://childprotectionforum.org/wp-content/uploads/2017/02/IDP_2016_02.pdf)

262. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

263. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

264. Ministry of Youth Affairs (MOYAS), Youth Dialogue Tool, 2011. Cited in Ministry of Health, National Adolescent Sexual and Reproductive Health Policy, 2015, at [http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP\\_KenyaNationalAdolSRHPolicy.pdf](http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP_KenyaNationalAdolSRHPolicy.pdf)

265. Ministry of Gender, Children and Social Development, Kenya Violence Against Children Study, 2010

266. Chandra-Mouli V, McCarragher DR, Phillips SJ, et al. "Contraception for adolescents in low and middle income countries: needs, barriers, and access". *Reprod Health* 2013; 11:1. Cited in Ministry of Health, National Adolescent Sexual and Reproductive Health Policy, 2015, at [http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP\\_KenyaNationalAdolSRHPolicy.pdf](http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP_KenyaNationalAdolSRHPolicy.pdf)

155. Many adolescent pregnancies occur in the context of human rights violations, such as child marriage, coerced sex or sexual abuse.<sup>264</sup> Sexual and gender-based violence is high among girls and young women and increases vulnerability to HIV, reduces ability to negotiate for safer sex, with long-term psychosocial outcomes that impact risky sexual behaviour. According to a study on violence against children in Kenya in 2010 (VAC Report), 32 per cent of females experienced sexual violence during childhood.<sup>265</sup>
156. Broader socio-economic factors such as poverty, lack of education and limited economic opportunities among girls may also contribute to adolescent pregnancy rates.
157. A lack of reproductive healthcare services for adolescents, particularly a lack of comprehensive sexuality education, contraceptive education and affordable, available commodities, means contraceptive use among married and unmarried adolescents is generally low in developing countries.<sup>266</sup> Existing health providers may not feel comfortable serving sexually active youth, while young people may feel uncomfortable accessing existing services if the way the services are set up does not meet their needs. In addition, many communities in Kenya feel that unmarried youth should not be sexually active and therefore should not have access to reproductive health services. This suggests a need to invest in sexual and reproductive health services specifically for young people and adolescents.<sup>267</sup>
158. The 2014 KDHS estimated mortality rates among 15-19 year olds as 1.67 per thousand for females and 2.06 per thousand for males.<sup>268</sup> HIV is the leading cause of death for adolescents in sub-Saharan Africa, followed closely by road accidents.<sup>269</sup> However, estimates from developing countries indicate that pregnancy and delivery complications, including unsafe abortion, are the second leading cause of death for girls below 20 years.<sup>270</sup> A 2013 study conducted on the incidence and magnitude of abortions showed that girls under the age of 19 accounted for 17 per cent of all females seeking post-abortion care services and about 45 per cent of all severe abortion-related admissions in Kenyan hospitals in 2012.<sup>271</sup> In this context, the Committee on the Rights of the Child has expressed concern about the high rates of early pregnancy and of maternal mortality among adolescents, including mortality as a result of unsafe abortions, and linked this to a restrictive and inconsistent legal framework on abortion which undermines adolescents' access to safe and legal abortion and post-abortion care.<sup>272</sup>
159. In addition to physiological immaturity, delays in receiving medical attention or emergency obstetric care at healthcare facilities contribute to high rates of obstetric fistula among adolescents.<sup>273</sup> However, according to the 2014 KDHS, only 0.3 per cent of adolescent girls aged 15-19 had ever had fistula. Nevertheless, given that only a third of the respondents had heard of the condition, it is possible that it was underreported. According to KDHS 2014, 46.9 per cent of pregnancies among 15-19 year olds were unintended. Meanwhile, 61.7 per cent of girls aged below 20 reported that they delivered their babies in public or private health facilities (substantially higher than in the 2008-2009 KDHS).<sup>274</sup>

267. George Kamau, Invest in Youth-Friendly Sexual and Reproductive Health Services, Deutsche Stiftung Weltbevölkerung, 26 September 2016, at <http://www.dsw.org/en/2016/09/invest-youth-friendly-sexual-reproductive-health-services/>

268. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

269. UNAIDS, Global Estimates Monitoring Report, 2015

270. Mayor, S, "Pregnancy and childbirth are leading causes of death in teenage girls in developing countries". British Medical Journal Vol. 328 (2004). Cited in Ministry of Health, National Adolescent Sexual and Reproductive Health Policy, 2015, at [http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP\\_KenyaNationalAdoSRHPolicy.pdf](http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP_KenyaNationalAdoSRHPolicy.pdf)

271. African Population and Health Research Center (APHRC), Ministry of Health (MOH), Ipas, Guttmacher Institute, Incidence and Complications of Unsafe Abortions in Kenya: Key Findings of a National Study, Nairobi (2013). Cited in Ministry of Health, National Adolescent Sexual and Reproductive Health Policy, 2015, at [http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP\\_KenyaNationalAdoSRHPolicy.pdf](http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP_KenyaNationalAdoSRHPolicy.pdf)

272. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

273. UNFPA, Kenya Obstetric Fistula Needs Assessment Report, 2004, at <http://www.unfpa.org/sites/default/files/pub-pdf/fistula-needs-assessment.pdf>

274. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2008-2009, 2010 at <https://dhsprogram.com/pubs/pdf/fr229/fr229.pdf>

## Harmful substances

160. The level of drug and substance abuse among young people is high.<sup>275</sup> According to a 2012 rapid assessment of drugs and substance use in Kenya, about 18 per cent of adolescents aged 15-17 reported having ever used any drug or substance, including tobacco, Khat (Miraa), narcotics and inhalants. Additionally, about two per cent of females and four per cent of males aged 10-14 and about 11 per cent of 15-17 year olds reported ever using alcohol.<sup>276</sup>
161. Despite the need for services to address substance abuse, very few drug rehabilitation programmes and counselling centres specific for adolescents are available in Kenya, and these tend to be urban-based. For adolescents, substance use and abuse is associated with increased risk of early sexual debut, multiple sexual partners and early childbearing.<sup>277</sup>

## Mental health

162. A 2016 study of patients presenting to a tertiary-level child and adolescent mental health clinic in Nairobi found that the mean age of attendees was 13.6 years (for a clinic catering to 0-18 year olds). Substance abuse disorders were the most prevalent presentation (30.1 per cent) followed by depressive disorders (13.9 per cent).<sup>278</sup> Stigma has been associated with these disorders as it affects an individual's sense of self-worth and self-esteem, the ability to seek emotional and psychosocial support through disclosure to others, the confidence to adhere to treatment at school or in the workplace, and the willingness to seek health services on a continual basis. Self-stigma, another contributing factor, occurs when a person internalizes and accepts the stigmatizing attitudes of others toward him or herself - often with damaging effects on feelings of self-worth.<sup>279</sup> Most referrals to the clinic came from medical practitioners and teachers. The results are not indicative for the whole country, as most patients at the clinic come from Nairobi and the surrounding area.<sup>280</sup>
163. The 2016 research revealed a dearth of child and adolescent mental health specialists in Kenya. In 2016, there was only one in clinical practice and only two specialized child and adolescent mental health clinics catering specifically to the needs of children in the country, based in Nairobi and Eldoret. While there are also accessible mental health services serviced by psychiatrists in the coastal region, the northeast of Kenya lacks psychiatrists and is far from both the clinics.<sup>281</sup> This overall lack of child psychiatrists is consistent with the misconception in Kenya that children and adolescents do not suffer from mental illness and the fact that such illnesses are rarely diagnosed and treated in Kenyan youth.<sup>282</sup>
164. The Government is aware of this deficiency. The 2015-2030 Mental Health Policy identifies children and adolescents as vulnerable groups and emphasizes that children are often prone to mental disorders either at birth, where there might have been inadequate pre-natal care, or if their environment does not promote care, affection, love, stimulation for cognitive abilities or other emotional and social support. It also states that adolescents face behavioural challenges and exposure or pressure to risky behaviour, such as use of psychoactive substances, that makes them vulnerable to mental disorders and includes as a priority action "Establish special separate child and adolescent outpatient and inpatient facilities".<sup>283</sup>

275. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

276. National Authority for the Campaign against Alcohol and Drug Abuse (NACADA), Rapid Situation Assessment of the Status of Drug and Substance Abuse in Kenya, 2012. Cited in Ministry of Health, National Adolescent Sexual and Reproductive Health Policy, 2015, at [http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP\\_KenyaNationalAdolSRHPolicy.pdf](http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP_KenyaNationalAdolSRHPolicy.pdf)

277. Ministry of Health, National Adolescent Sexual and Reproductive Health Policy, 2015, at [http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP\\_KenyaNationalAdolSRHPolicy.pdf](http://www.fidakenya.org/dr7/sites/default/files/2015STEPUP_KenyaNationalAdolSRHPolicy.pdf)

278. Judy Wanjiru Kamau et al, "Who seeks child and adolescent mental health care in Kenya? A descriptive clinic profile at a tertiary referral facility", *Child and Adolescent Psychiatry and Mental Health*, 2017, at <https://capmh.biomedcentral.com/articles/10.1186/s13034-017-0151-x>

279. WHO, Adolescent Testing Counselling and Care, Implementation Guidance for Health Providers and Planners, 2014

280. Judy Wanjiru Kamau et al, "Who seeks child and adolescent mental health care in Kenya? A descriptive clinic profile at a tertiary referral facility", *Child and Adolescent Psychiatry and Mental Health*, 2017, at <https://capmh.biomedcentral.com/articles/10.1186/s13034-017-0151-x>

281. Judy Wanjiru Kamau et al, "Who seeks child and adolescent mental health care in Kenya? A descriptive clinic profile at a tertiary referral facility", *Child and Adolescent Psychiatry and Mental Health*, 2017, at <https://capmh.biomedcentral.com/articles/10.1186/s13034-017-0151-x>

**Key issues**

- There has been a general decline in births among 15-19-year-old females in Kenya: in 2014 14.7 per cent of girls and women aged 15-19 had already given birth and 3 per cent were pregnant with their first child
- Sexual and reproductive health services are not tailored to the needs of young people.
- Adolescents in Kenya face challenges accessing health services due to cultural barriers and lack of appropriate services.
- There is a lack of mental health services for adolescents in the country

**Food security**

165. Kenya’s pastoral and marginal agricultural communities in the ASAL area are highly vulnerable to erratic rains and drought, and are almost completely dependent on rains to sustain their livelihoods.<sup>284</sup> As can be seen in the map below, in research conducted for WFP before the 2017 drought emergency, Turkana stood out as being far more food insecure than any other county in Kenya. The next most food insecure counties were Samburu, Tana River, Baringo, West Pokot, Busia and Siaya. Apart from the last two, these are all arid or semi-arid counties. Four pastoralist counties (Marsabit, Mandera, Garissa and Wajir) were assessed as relatively food secure because of their high milk consumption. However, they have very low dietary diversity, and changes in food security can occur extremely quickly in milk-consuming areas because of storage problems and the impact of drought and season on milk production. These very poor counties, where the vast majority of household heads have little or no education, are highly vulnerable to food insecurity because of regular exposure to drought and food price inflation.<sup>285</sup>

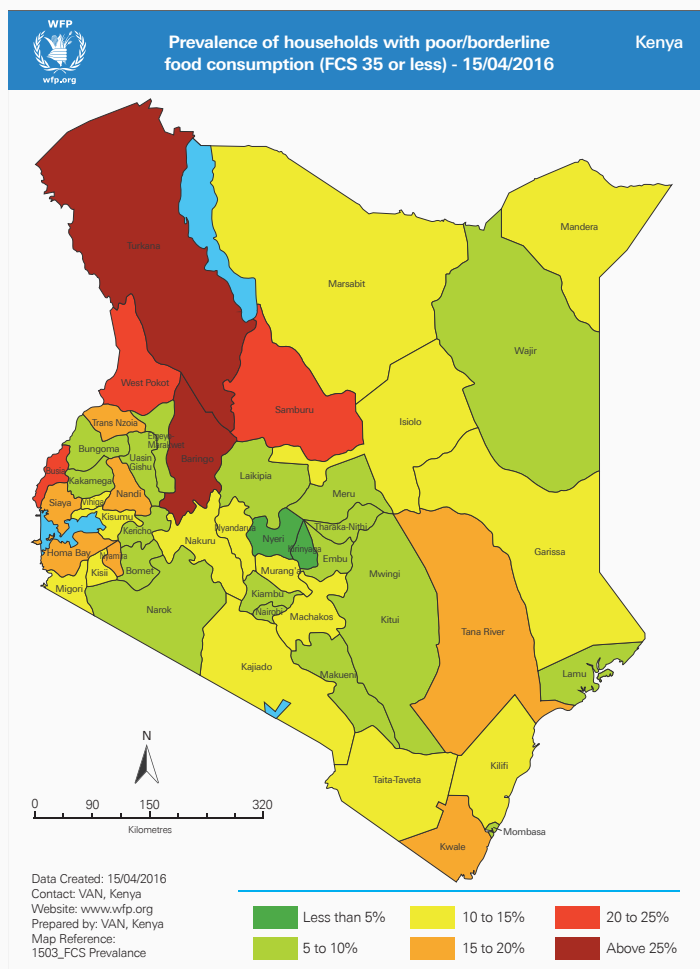


Figure 11: Prevalence of poor/borderline food consumption, WFP, 2016

166. 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. 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.<sup>286</sup>
167. While food insecurity prevalence was highest in rural counties, the highest number of food insecure households was in Nairobi, where 96,356 households had poor or borderline consumption.<sup>287</sup> Like those depending for their livelihoods on the land in the ASAL counties, the urban poor also face particular barriers to food security. Urban centres are dependent on markets to source food. In the 2015 *Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas* survey, many informal settlement residents reported buying 'ready-cooked' and fast foods to reduce costs. Some 97 per cent of households procured their food from markets. Rising food and fuel prices, conflict, and the primary or secondary effects of natural disasters directly affect food availability at household level. While 71 per cent of households consumed three meals, diets were often inadequate. For example, many parents usually fed their children tea without milk and mandazi (deep-fried wheat flour and baking powder), counting this as a meal. Food shortages were reportedly highest in January, December and February because of high food prices and loss of livelihoods in these months. Key coping strategies applied by households to deal with food shortages include consuming food on credit, skipping meals and borrowing money from relatives and friends to purchase food.<sup>288</sup>
168. On 10 February 2017 the Government of Kenya declared the national drought emergency, with 23 of the 47 counties affected.<sup>289</sup> The Government has warned that the number of food-insecure people could rise from 2.7 million people in January 2017 to 4 million by April 2017.<sup>290</sup> The most critical areas were identified as northern Turkana County, and Marsabit and Mandera Counties, with Baringo (East Pokot), Turkana (Turkana South, West and Central) and Isiolo Counties also identified as critical.<sup>291</sup> The May 2017 long rains mid-season assessment estimated that between three million and 3.5 million people in the pastoral, agro-pastoral and marginal agricultural areas would require assistance by August 2017. The long rains were delayed by two to four weeks across the pastoral and marginal agriculture areas, and were largely below average in cumulative amounts, mostly 50 – 75 per cent of normal, with poor and uneven temporal and spatial distribution.<sup>292</sup>
169. Food insecurity in early 2017 has been driven by late commencement and early conclusion of the short rains that normally fall between October and December. It has been aggravated by poor conditions in coastal areas, which normally provide food reserves in dry periods, and by cross-border migration linked to drought in neighbouring countries. Other drivers of food insecurity include crop pests and diseases, conflict and insecurity, hotter than usual land surface temperatures and the cumulative effects of previous poor rainy seasons.<sup>293</sup> For more on the 2017 emergency, see *Section 6: Children and Emergencies*.

282. Ampath, Mental Health Services, at <http://www.ampathkenya.org/our-programs/social-health/mental-health-services/>, accessed 15 April 2017

283. Ministry of Health, Kenya Mental Health Policy 2015-2030, August 2015, at <http://publications.universalhealth2030.org/uploads/Kenya-Mental-Health-Policy.pdf>

284. UNICEF, Situation Analysis of Children and Adolescents in Kenya: Our Children Our Future, 2014, at [https://www.unicef.org/kenya/SITAN\\_2014\\_Web.pdf](https://www.unicef.org/kenya/SITAN_2014_Web.pdf)

285. WFP, Comprehensive Food Security and Vulnerability Analysis (CFSVA): Kenya 2016, 2016, at <http://documents.wfp.org/stellent/groups/public/documents/ena/wfp285586.pdf>

286. UNICEF, Situation Analysis of Children and Adolescents in Kenya: Our Children Our Future, 2014, at [https://www.unicef.org/kenya/SITAN\\_2014\\_Web.pdf](https://www.unicef.org/kenya/SITAN_2014_Web.pdf)

287. WFP, Comprehensive Food Security and Vulnerability Analysis (CFSVA): Kenya 2016, 2016, at <http://documents.wfp.org/stellent/groups/public/documents/ena/wfp285586.pdf>

288. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

289. OCHA, Kenya Humanitarian Snapshot, 27 February 2017, at <http://reliefweb.int/report/kenya/kenya-humanitarian-snapshot-27-feb-2017>

290. UNICEF, Kenya Humanitarian Situation Report, 6 March 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20SitRep%20-%206%20March%202017.pdf>

291. Government of Kenya, The 2016 Short Rains Season Assessment Report, February 2017 at [http://reliefweb.int/sites/reliefweb.int/files/resources/Kenya\\_2016\\_SRA\\_NationalReport.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Kenya_2016_SRA_NationalReport.pdf)

292. WFP, Long Rains 2017 Mid-Season Food and Nutrition Security Assessment Findings, 18 May 2017

293. Government of Kenya, The 2016 Short Rains Season Assessment Report, February 2017 at [http://reliefweb.int/sites/reliefweb.int/files/resources/Kenya\\_2016\\_SRA\\_NationalReport.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Kenya_2016_SRA_NationalReport.pdf)

294. FAO, Linking farm diversification to household diet diversification: Evidence from a sample of Kenyan ultra-poor farmers, February 2017, at <http://www.fao.org/3/a-i6852e.pdf>



170. Recent evidence has shown that among very poor and labour constrained families in Kenya, diversification of agricultural production significantly improves household dietary diversification and nutrition. Poultry ownership and growing pulses are the most strongly correlated.<sup>294</sup>

#### Key issues

- Kenya's pastoral and marginal agricultural communities are highly vulnerable to erratic rains and drought, and are almost completely dependent on rains to sustain their livelihoods. Their situation is further exacerbated by environmental degradation and rapid biodiversity loss
- In some of these areas, tensions, conflicts and insecurity limit households' capacity to engage in normal livelihood activities.
- Food insecurity is also high in Nairobi, where 96,356 households had poor or borderline consumption in 2016, because of dependence on markets for food among the urban population
- Food insecurity has been sharply increased by the 2016-2017 drought.

## Nutrition

### Policy and coordination

171. The policy and coordination framework in Kenya remains conducive to improving nutritional outcomes in the country. Nutrition features in a number of key Government documents, including Kenya's Health Sector Strategic Plan II.<sup>295</sup> In 2011, the Government put in place the National Food and Nutrition Security Policy, which emphasizes that the right to nutrition is a constitutional right, provides policy directions, and stresses the importance of a multi-sectoral approach to addressing malnutrition in the country. The 2012-2017 National Nutrition Action Plan has 11 strategic objectives: Improve nutrition status of women of reproductive age (15-49 years); Improve nutrition status of children under five; Reduce the prevalence of micronutrient deficiencies in the population; Prevent deterioration of nutrition status and save lives of vulnerable groups in emergencies; Improve access to quality curative nutrition services; Improve prevention, management and control of diet related NCDs; Improve nutrition in schools and other institutions; Improve knowledge, attitudes and practices on optimal nutrition; Strengthen the nutrition surveillance, monitoring and evaluation systems; Enhance evidence-based decision-making through operations research; and Strengthen coordination and partnerships among the key nutrition actors. It also lists high impact nutrition interventions undertaken by the Ministry of Health, including exclusive breastfeeding; timely complementary feeding; iron folate, vitamin A and zinc supplementation; hand washing; deworming; food fortification and management of moderate and severe acute malnutrition.<sup>296</sup>
172. Other important policy documents for the nutrition sector include 15 County Nutrition Action Plans, the 2012 Breast Milk Substitutes (BMS) Act, the Kenya Social Protection Policy 2011, the 2014 National Social Protection Council Bill, the 2016 National Drought Management Authority (NDMA) Bill, and mandatory fortification of salt, flours, fats and oils under the 2012 Food, Drugs and Chemical Substances Act,<sup>297</sup> as well as the Kenya Strategy for Non-Communicable Diseases 2015-2020.

295. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

296. Ministry of Health (2012). National Nutrition Action Plan 2012-2017. Ministry of Health: Nairobi. at [https://extranet.who.int/nutrition/gina/sites/default/files/KEN%202011%20National%20FoodD%20anD%202020Nutrition%20Security%20Policy\(1\).pdf](https://extranet.who.int/nutrition/gina/sites/default/files/KEN%202011%20National%20FoodD%20anD%202020Nutrition%20Security%20Policy(1).pdf)

297. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

173. Internationally, Kenya signed up to the Scaling Up Nutrition (SUN) movement in 2012 and its current priorities and focus are on enhancing the multi-sectoral approach to addressing undernutrition at scale, ensuring adequate budgetary allocations for nutrition programming and monitoring progress at county level. While the key policy and strategy documents are in place in Kenya, high-level government multi-sectoral coordination structures and commitment still require scaling up. A structure has been articulated in the National Food and Nutrition Security Policy (FNSP) but has not yet been put in place, as there have been several leadership changes in the Ministry of Agriculture where this policy sits and a lack of clarity about where this structure will be housed. A draft SUN roadmap has been defined and is under review.<sup>298</sup> At the subnational level County Steering Groups (CSGs) meet regularly in each of the ASAL Counties and provide opportunities for multi-sectoral discussions, especially during the Long and Short Rain Assessments, which happen twice a year. However, the CSGs tend to be orientated to drought and whilst they are an immediately useful platform, the FNSP structures are required for longer-term development discussions nationally, as the legislation materializes. A draft SUN roadmap including the establishment of a multi-stakeholder platform has been developed, and is under review.
174. Over the last decade, the Ministry of Health has made significant changes to healthcare provision, including integrating nutrition interventions into disease management through the Ministry of Health's Kenya Health Policy 2014-2030, an evolution from more vertical programmes supported by partners, including UNICEF in the past.<sup>299</sup> Another major shift has been the devolution of Ministry of Health functions, including health management and nutrition budgets, to the Counties. Progress has been made and the 2015 Global Nutrition Report revealed that Kenya was the only one of 74 countries on course for all five World Health Assembly targets: a 40 per cent reduction of childhood stunting, a 50 per cent reduction of anaemia in women of reproductive age, a 50 per cent reduction of low birth weight, no increase in childhood overweight, increase in exclusive breast-feeding rates in the first six months up to at least 50 per cent, and reducing and maintaining childhood wasting to less than 5 per cent; all by 2025.<sup>300</sup>
175. The Government is also seeking to reduce micronutrient deficiencies by creating awareness about food fortification, supplementation and food-based approaches, and by improving knowledge, attitudes and practices on optimal nutrition.<sup>301</sup> Nevertheless, limited capacity in national and county governments; high levels of nutritional vulnerabilities associated with chronic food insecurity; drought in much of the country, which has intensified in 2017;<sup>302</sup>
176. The framework for partnership and collaboration is defined and led by the Government at national and county level. Nutrition and health activities are coordinated around the Government's commitment to end drought emergencies. The Ending drought emergencies initiative (EDE), SUN, and the newly emerging Food and Nutrition Council set out coordination structures at national and county levels. At the county level, various thematic committees feed into county EDE Steering Committees.<sup>303</sup>
177. Despite this progress, key challenges remain with the financing of nutrition work. As mentioned above, under the 2010 Constitution, healthcare delivery – including nutrition – is fully devolved to county-level governments. A 2016 report suggests that less than 15 of the 47 county governments had made positive progress in scaling up their nutrition response.<sup>304</sup> In Turkana County, for example, the number of nutritionists employed has increased from five before devolution to 81, as a result of decisions made following devolution using county budgets.<sup>305</sup>

298. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

299. Ministry of Health (2014). Kenya Health Policy 2014-2030. Towards attaining the highest standard of health. Ministry of Health: Nairobi

300. International Food Policy Research Institute, Global Nutrition Report, 2015, at <http://www.globalnutritionreport.org/the-report/the-report-2015/>

301. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

302. Information provided by UNICEF, May 2017

303. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

304. Jacob Korir, Nutrition advocacy in Kenya's newly devolved government system, ENN, 2016, at <http://www.ennonline.net/nex/6/nutritionadvocacykenya>

305. Interview, UNICEF, 18 May 2017

178. Nutrition stakeholders have to overcome limited resources, low awareness of the importance of good nutrition, inadequate policies and weak coordination mechanisms across sectors in order to reverse malnutrition trends.<sup>306</sup> Advocacy work to secure investment for nutrition has resulted in an increase in human resources and programmable resource allocations at national level, and firm commitments to prioritize nutrition within national and county budgets. However, the allocation of nutrition resources, both sensitive and specific, still remains low compared to the needs highlighted in the 2012-2017 NNAP, with less than 2 per cent of the health budget on average being spent on nutrition-specific interventions.<sup>307</sup>
179. Most counties have employed nutritionists, but their capacity requires enhancing. There are challenges in procuring commodities. For example, iron and folic acid supplements are now supposed to be procured by counties. However, not all the counties have the capacity for procurement, and following devolution national level procurement is no longer possible.<sup>308</sup>
180. The above policy efforts are in line with the SDG 2 focus on ending hunger and improving the nutrition of children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons.
181. A Cost Benefit Analysis conducted by UNICEF, the World Bank and the Ministry of Health in 2016 reported that every \$1 invested in scaling up high-impact nutrition interventions in Kenya has the potential for a \$22 return: this is higher than the global average of \$16-18. The research also found that scaling up 11 key nutrition-specific interventions in all counties of Kenya would cost \$76 million in public and donor investments annually, and produce tremendous health benefits: 455,000 disability-adjusted life years (DALYs or years of healthy life lost due to a health condition) averted, 5,000 lives saved, and almost 700,000 cases of stunting averted. The investment could increase economic productivity by \$458 million per year over the productive lives of the beneficiaries, and the package of interventions is highly cost-effective, at \$207 per DALY averted. Focusing the scale up on 10 cost-effective interventions in counties with stunting prevalence above 20 per cent would require \$48 million annually and would avert almost 295,000 DALYs and save more than 3,000 lives, with a cost per DALY averted of \$179.<sup>309</sup>

### Key issues

- Kenya has displayed commitment by joining the international Scaling Up Nutrition movement and implementing the National Nutrition Action Plan.
- However, allocation of nutrition resources, both sensitive and specific, still remains low compared to the needs highlighted in the Plan, with less than 2 per cent of the health budget on average being spent on nutrition-specific interventions.
- In 2016, less than 15 of the 47 county governments had made positive progress in scaling up their nutrition response.
- Nutrition stakeholders have to overcome limited resources, low awareness of the importance of good nutrition, inadequate policies and weak coordination mechanisms across sectors to reverse malnutrition trends.

306. Jacob Korir, Nutrition advocacy in Kenya's newly devolved government system, ENN, 2016, at <http://www.ennonline.net/nex/6/nutritionadvocacykenya>

307. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

308. Interview, Ministry of Health, 24 March 2017

309. UNICEF, the World Bank and the Ministry of Health, An Investment Framework for Nutrition in Kenya: Reducing Stunting and Other Forms of Child Malnutrition, 2016, at <https://openknowledge.worldbank.org/handle/10986/26282>

## Undernutrition

### Stunting

182. Between 2009 and 2014 the stunting rate among children aged less than five fell from 35 per cent to 26 per cent.<sup>310</sup> However, Kenya is unlikely to reach the target in the 2012-2017 National Nutrition Action Plan of 16 per cent by 2018.<sup>311</sup> In 2014, 8 per cent of children in the age group were severely stunted, compared to 14 per cent in 2008-2009.<sup>312</sup> The decrease in stunting seems likely to have been caused by multiple factors, including the scaling up of a package of high impact nutrition interventions within the health system by Government and development partners, and a renewed focus on community based programming to bring about behaviour change with regard to infant and young child nutrition and service utilization and other factors, including overall GDP growth and an increase in resilience programming.<sup>313</sup>
183. However, much remains to be done as stunting rates are higher in Kenya than in certain peer countries (see graph below).<sup>314</sup>

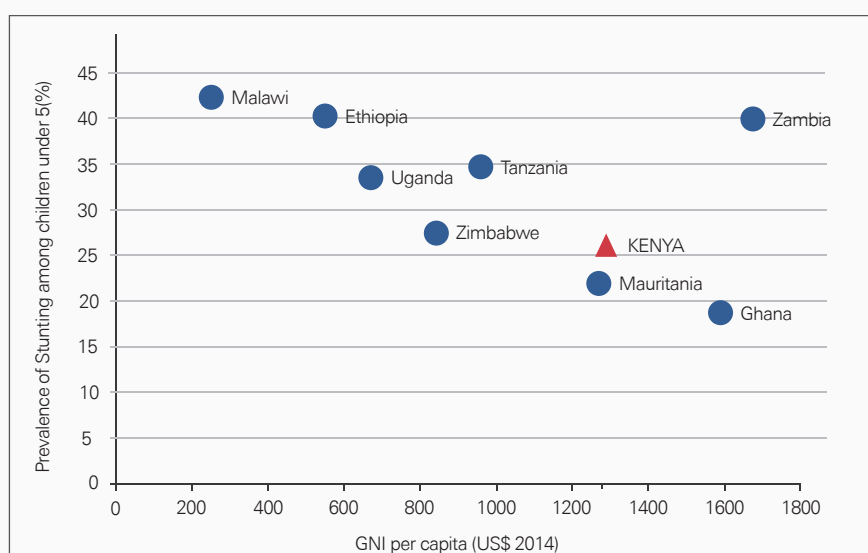


Figure 12: Percentage of stunting among children against GNI per capita, World Bank figures

184. In addition, large disparities exist between counties. Stunting rates vary from 15 per cent in Kiambu and Nyeri Counties in central Kenya to 46 per cent in Kitui County (in the east) and West Pokot Sub-county (in western Kenya). The data are represented in the map below. The data before 2014 are not disaggregated by county, so trends at county level cannot be determined.<sup>315</sup>

310. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

311. Ministry of Public Health and Sanitation, National Nutrition Action Plan 2012-2017, available online at <https://scalingupnutrition.org/wp-content/uploads/2013/10/Kenya-National-Nutrition-Action-Plan-2012-2017-final.pdf>

312. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2008-2009, 2010 at <https://dhsprogram.com/pubs/pdf/fr229/fr229.pdf>

313. UNICEF, UNICEF – KCO MTR Report, 2016

314. Julia Dayton Eberwein et al, An Investment Framework for Nutrition in Kenya: Reducing Stunting and Other Forms of Child Malnutrition, World Bank, December 2016, at <http://documents.worldbank.org/curated/en/437531489040369631/pdf/113243-WP-InvestmentFrameworkforNutritionKenya-PUBLIC.pdf>

315. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

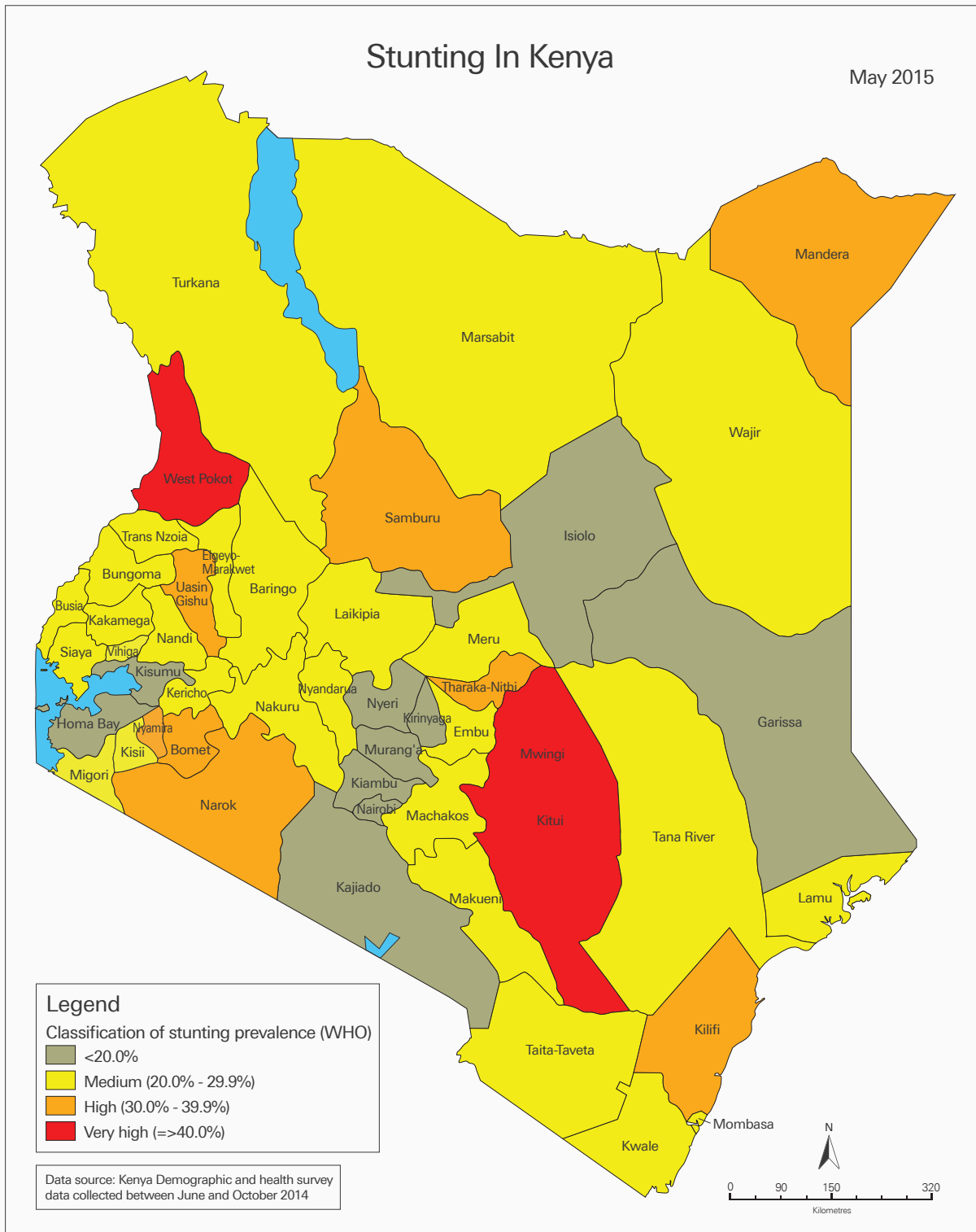


Figure 13: Stunting prevalence by county, 2014 (KDHS)

185. Stunting peaks in the age group 18-23 months (36 per cent stunting and 12 per cent severe stunting). A higher percentage of boys (29 per cent) than girls (22 per cent) under the age of five were stunted in 2014.<sup>316</sup>
186. There is a slight difference in stunting rates between children living in urban and rural areas. The stunting rate among children under five is 20 per cent in urban areas, and 29 per cent in rural areas. However, when accounting for other factors, such as household wealth, mother's educational attainment, and the number of children in household, multivariate analysis conducted for the Multidimensional Child Poverty study reveals that living in a rural area only increases the probability of stunting by 2 percentage points. This suggests that stunting may be associated not only with healthcare and nutrition service availability, market availability, or household income, but also with other factors, such as adequate knowledge and access to information on appropriate feeding and childcare practices.<sup>317</sup> A March 2017 Cost of the Diet Study in Turkana showed that to feed a family of eight with a nutritious diet costs KSh 1,132 per day, which is unaffordable for most households.<sup>318</sup> It should be noted that although stunting rates are highest in rural areas, the absolute number of stunted children is greater in urban areas, and particularly in Nairobi.<sup>319</sup> Meanwhile, targeted surveys conducted in urban informal settlements in 2017 have shown much higher stunting rates, in excess of 30 per cent in areas.<sup>320</sup>
187. Children from the lowest two wealth quintiles are eight percentage points more likely to be stunted than the average. In the 2016 Multidimensional Child Poverty study focus groups, it was claimed that because of monetary poverty households cannot afford to purchase food or diverse categories of nutritious food, and very few families can afford three meals a day. Therefore, children are primarily fed on tea, ugali, porridge, and potatoes. Nutrition officials also reported that treatment provided in the facilities is not as effective as intended because the supplements provided are consumed by the entire family due to poverty or sold at markets to pay for food for the whole family.<sup>321</sup>
188. Qualitative research has found that among children below the age of six months, stunting is also related to the introduction of complementary foods (see the sub-section below). For children older than six months, monetary poverty and lack of knowledge of good nutritional practice among mothers were emphasized as the key factors causing stunting.<sup>322</sup>

## Acute malnutrition

189. Nationally, according to the 2014 KDHS, 4 per cent of children were acutely malnourished and 1 per cent severely acutely malnourished.<sup>323</sup> This equates to a halving of the 2008-2009 figures (7 per cent and 2 per cent respectively).<sup>324</sup> In 2014, acute malnourishment levels were highest among children aged 6-8 months and 9-11 months (each 7 per cent). This is the period when children are introduced to complementary foods, which may vary in quality and quantity, and are more vulnerable to disease. Acute malnourishment was more prevalent (9 per cent) among children whose mothers were thin (BMI <18.5 kg/m<sup>2</sup>) than among other children.<sup>325</sup>
190. Geographically, acute malnourishment tends to be concentrated in the northern arid counties, where levels ranged from 11 per cent to 23 per cent.<sup>326</sup> The former North-eastern Region (13 per cent) has the highest levels, while the former Western, Nyanza, and Central Regions have the lowest (each 2 per cent). At county level, the highest figure is 23 per cent in Turkana and the lowest in Siaya and Kisumu (each 1 per cent or less).<sup>327</sup> The reasons for the sharp geographical discrepancies between stunting and acute malnourishment figures are unknown, but may be linked to the different dietary patterns of pastoralists and agriculturalists, or to physiological differences between the ethnic groups that inhabit different areas of the country.<sup>328</sup>

316. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

317. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

318. Claudia Damu, A Cost of the Diet Assessment in Turkana County, Kenya, Draft, Save the Children, April 2017

319. Julia Dayton Eberwein et al, An Investment Framework for Nutrition in Kenya: Reducing Stunting and Other Forms of Child Malnutrition, World Bank, December 2016, at <http://documents.worldbank.org/curated/en/437531489040369631/pdf/113243-WP-InvestmentFrameworkforNutritionKenya-PUBLIC.pdf>

320. Ministry of Health, Kenya Urban Nutrition Strategy 2012-2017, 2012

321. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

191. Acute malnutrition also peaks during the hungry season, which for the arid counties is June and July, and is also further exacerbated during periods of drought such as that experienced in 2017. According to the Integrated Phase Classification (IPC) for Acute Malnutrition conducted in February 2017, Turkana North, North Horr in Marsabit and Mandera counties reported a Very Critical Nutrition situation (phase 5; Global Acute Malnutrition  $\geq 30$  per cent). A Critical Nutrition Situation (Phase 4; Global Acute Malnutrition 15.0 - 29.9 per cent) was reported in East Pokot in Baringo County, Isiolo and Turkana South, West and Central. These rates of acute malnutrition are extremely alarming and highlight the severe crisis in 2017 compared to other years where more seasonal peaks are reported.

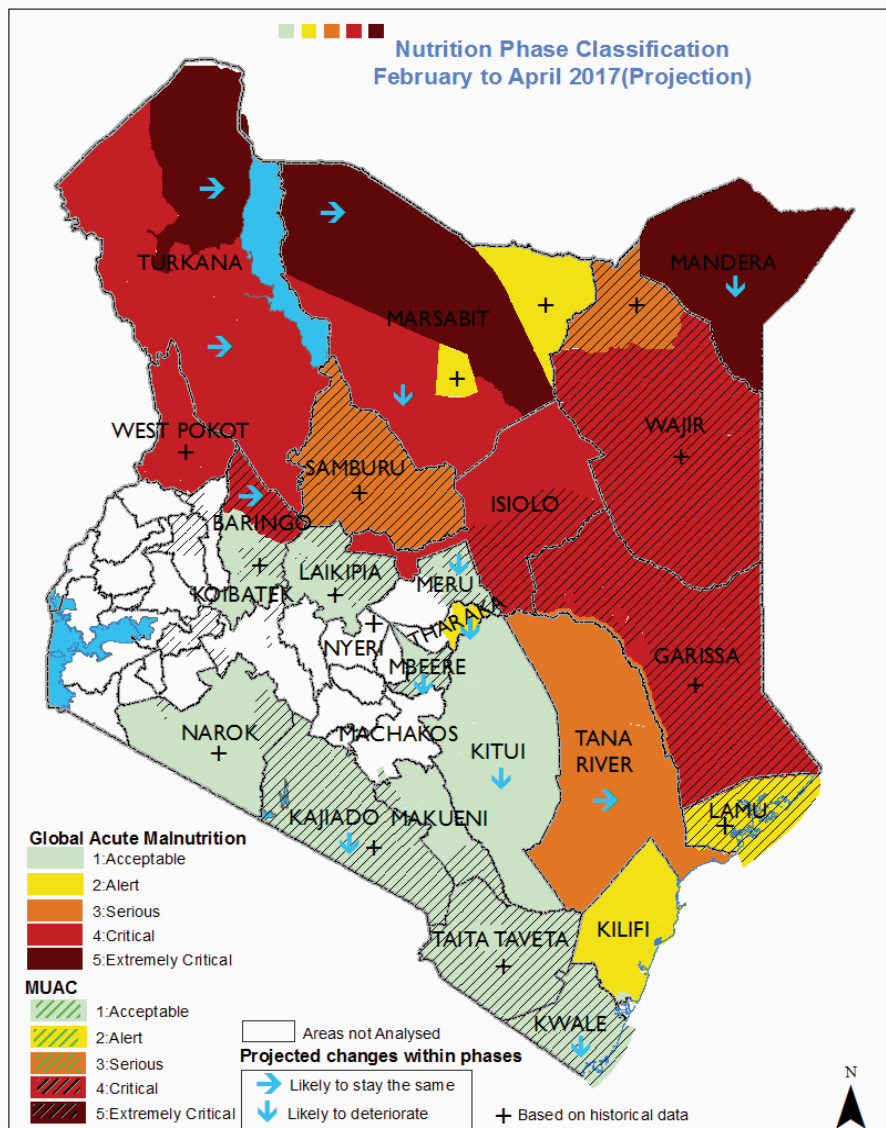


Figure 14: Nutrition Phase Classification, February to April 2017

321. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016  
 322. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016  
 323. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>  
 324. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2008-2009, 2010 at <https://dhsprogram.com/pubs/pdf/fr229/fr229.pdf>  
 325. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>  
 326. Julia Dayton Eberwein et al, An Investment Framework for Nutrition in Kenya: Reducing Stunting and Other Forms of Child Malnutrition, World Bank, December 2016, at <http://documents.worldbank.org/curated/en/437531489040369631/pdf/113243-WP-InvestmentFrameworkforNutritionKenya-PUBLIC.pdf>

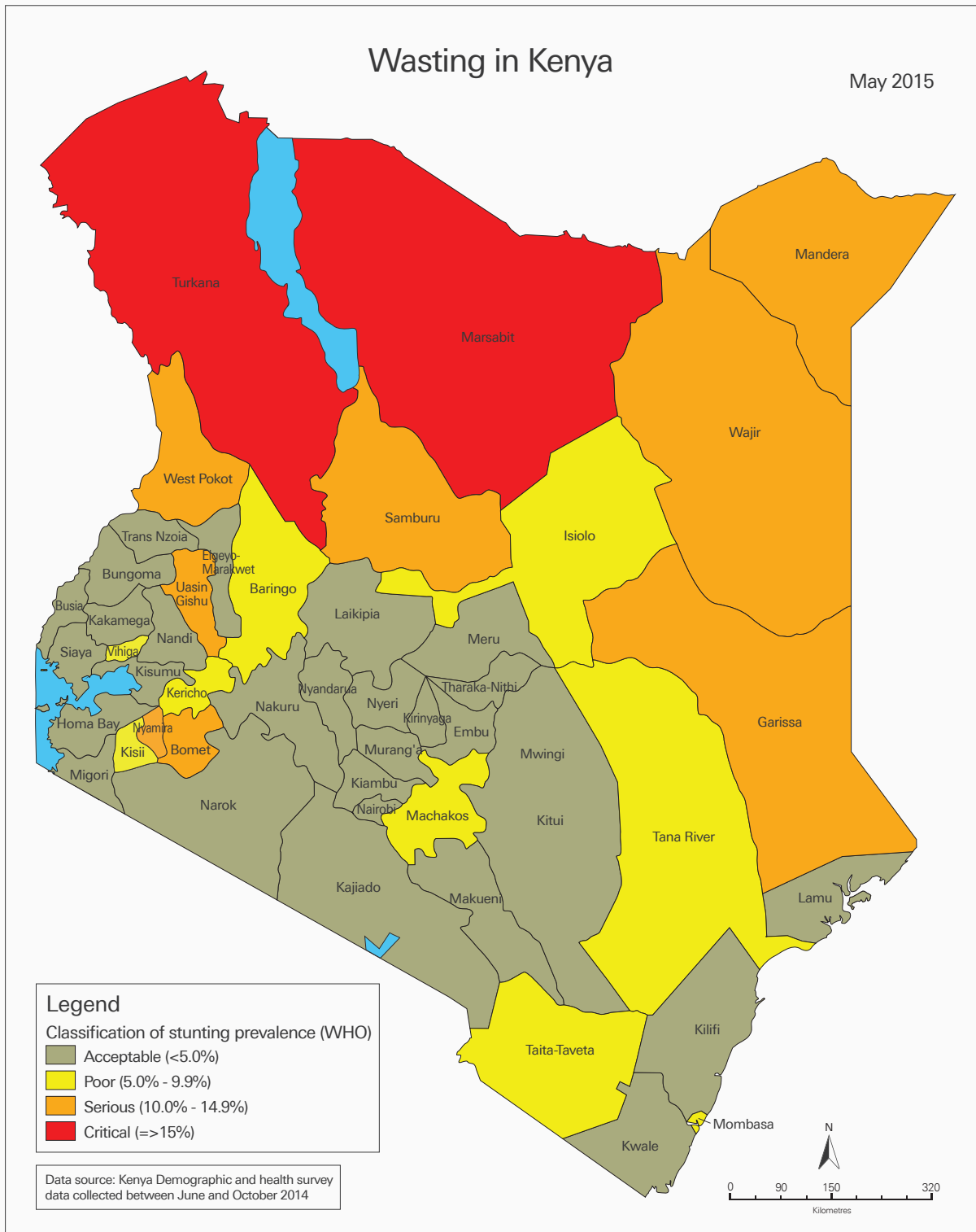


Figure 15: Acute malnourishment prevalence by county, 2014 (KDHS)



192. Acute malnutrition in children generally decreases with increasing household wealth. Children whose mothers have no education have a higher chance of acute malnutrition (10 per cent) than children whose mothers have some education (4 per cent or less).<sup>330</sup>

## Underweight

193. In 2014, 11 per cent of children under five years of age in Kenya were underweight. A higher percentage of children in rural areas than urban ones are underweight, at 13 per cent compared to 7 per cent; and boys are slightly more affected than girls (12 per cent and 10 per cent respectively). More than 25 per cent of children in three counties (Samburu, Turkana and West Pokot) in the Rift Valley region, as well as Marsabit County in the former Eastern region are underweight. In Nyeri and Nairobi 4 per cent or less are underweight.<sup>331</sup>

### Key issues

- The 2014 KDHS revealed significant reductions in stunting (8 per cent, from 14 per cent in 2009)
- Stunting rates vary from 15 per cent in Kiambu and Nyeri Counties in central Kenya to 46 per cent in Kitui County (in the east) and West Pokot Sub-county (in western Kenya)
- Acute malnourishment halved between 2009 and 2014, from 7 per cent to 2 per cent
- Geographically, acute malnourishment tends to be concentrated in the northern arid counties, where levels ranged from 11 per cent to 23 per cent
- Acute malnourishment peaks during periods of drought such as that experienced in 2017 in the ASAL counties
- In 2014, 11 per cent of children under five years of age in Kenya were underweight. At 12.1 per cent, boys in this age group were slightly more likely to be underweight than girls (9.8 per cent). Underweight is more common in rural areas than urban ones. More than 25 per cent of children in three counties (Samburu, Turkana and West Pokot) in the Rift Valley region, as well as Marsabit County in the former Eastern region are underweight.

## Overweight and obesity

194. Although some progress has been made in reducing malnutrition, Kenya now also faces increasing rates of obesity. In 2015, 27 per cent of Kenyans were either overweight or obese with the percentage being significantly higher in women (37.5 per cent) than men (17.5 per cent). The same survey also highlighted the increasing rates of non-communicable diseases in Kenya.<sup>332</sup> These figures for women are similar to those in the KDHS, which found that 33 per cent of women aged 15-49 were overweight or obese, a rise from 25 per cent in 2008-2009. Almost half of women in Nairobi (48 per cent) and Central Kenya (47 per cent) were overweight or obese in 2014. Urban women are more likely to be overweight/obese (43 per cent) than rural women (26 per cent). The 2014 KHDS also reported that approximately 7.2 per cent of preschool children were overweight or obese.<sup>333</sup> The causes of being overweight in Kenya include dietary and lifestyle changes, catalysed by processes such as the rapid urbanization in the country.<sup>334</sup>

326. Julia Dayton Eberwein et al, An Investment Framework for Nutrition in Kenya: Reducing Stunting and Other Forms of Child Malnutrition, World Bank, December 2016, at <http://documents.worldbank.org/curated/en/437531489040369631/pdf/113243-WP-InvestmentFrameworkforNutritionKenya-PUBLIC.pdf>

327. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

328. Interview, UNICEF, 20 March 2017

329. UNICEF, Kenya Humanitarian Situation Report, 20 February 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20SitRep%20-%2020%20February%202017.pdf>

330. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

331. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

## Maternal, infant and young child nutrition

### Maternal dietary diversity

195. Women play a major role in caregiving, household economic management and food production, and have principal responsibility for earning money to buy their children food (many of the basic complementary foods are purchased). Women are also responsible for ensuring that water and firewood are available and certain higher quality complementary foods are produced at home. As principal caregivers for young infants, opportunity costs of managing the households have immediate impacts on the quality of care of an infant - one of the key determinants of nutrition security.<sup>335</sup>
196. Women of reproductive age are often nutritionally vulnerable because of the physiological demands of pregnancy and lactation. Requirements for most nutrients are higher for pregnant and lactating women than for adult men. Women’s micronutrient status and dietary diversity in the ASAL areas is likely to be the worst in Kenya and this situation has changed little in the last two decades. During the severe drought of 2017, screening regularly reported 40-50 per cent of women as acutely malnourished in the arid counties. Minimal dietary diversity in women remains below target in many counties, as can be seen in the graph below.<sup>336</sup>

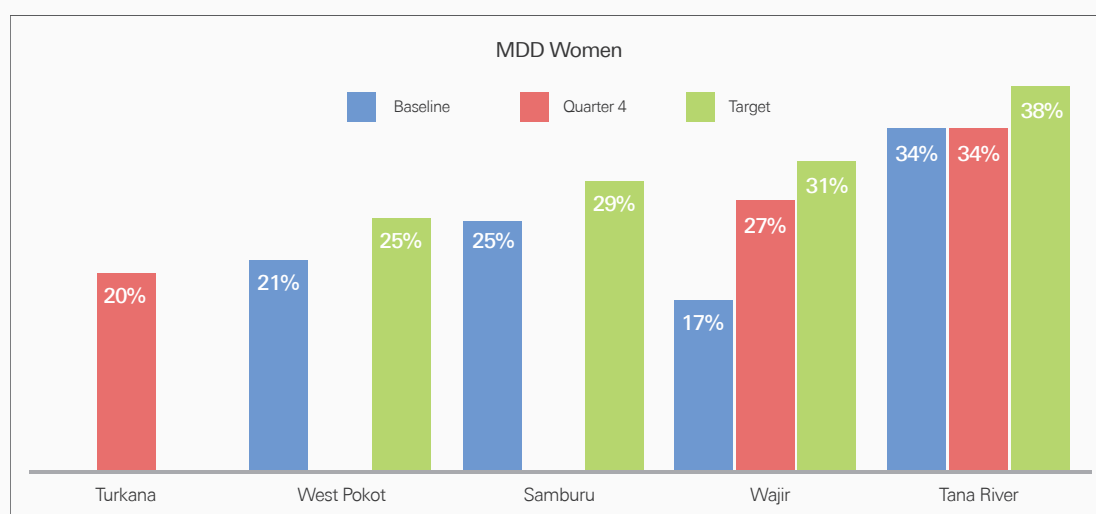


Figure 16: Minimum dietary diversity compared to targets, selected counties

332. KNBS. Kenya STEPwise Survey for Non Communicable Diseases Risk Factors 2015, 2016, at [http://www.knbs.or.ke/index.php?option=com\\_content&view=article&id=365:kenya-stepwise-survey-for-non-communicable-diseases-risk-factors-2015-report&catid=82:news&Itemid=593](http://www.knbs.or.ke/index.php?option=com_content&view=article&id=365:kenya-stepwise-survey-for-non-communicable-diseases-risk-factors-2015-report&catid=82:news&Itemid=593)

333. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

334. Elizabeth Kimani, The Nutrition Paradox in Kenya: What Are We Doing?

335. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

336. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

## Breastfeeding and complementary feeding

197. According to the 2014 KDHS, 99 per cent of children in Kenya had been breastfed in their lives. However, only 61 per cent of children under six months of age were exclusively breastfed.<sup>337</sup> This, however, represents a doubling of the figure since 2008-2009 (32 per cent).<sup>338</sup> Complementary foods are generally introduced at the recommended age: 81 per cent of breastfed children aged 6-9 months received complementary foods in the 24 hours preceding the survey.<sup>339</sup>
198. Breastfeeding has received increasing political support in recent years. A new Bill passed in parliament in June 2017 stipulates that all companies with 30 staff members or more need to have places for women to breastfeed or express breastmilk, and need to include changing facilities for infants and stimulation for young children.<sup>340</sup> Meanwhile, women working in the informal sector are not covered by the maternity leave regulation.<sup>341</sup> Most employees in the informal sector are casual labourers and lack entitlement to paid maternity / paternity leave. Such mothers generally report back to work earlier than the 14 weeks provided by the law, as employment provides their only source of income.<sup>342</sup> More broadly, regulations on breast milk substitutes are only partially being implemented.
199. Recent research has suggested that donated breast milk is the next best option in situations where mothers cannot feed their own children, particularly for low birthweight infants.<sup>343</sup> The NGO PATH is currently seeking funding to develop a human milk bank programme in Kenya for pre-term babies whose mothers are not ready to feed them, and as well as mothers with chronic illnesses or who otherwise cannot maintain exclusive breastfeeding.<sup>344</sup>
200. Complementary feeding in Kenya remains sub-optimal with complementary diets for young children limited in quality and quantity, and not meeting the nutrient requirements of a growing child. Introduction to other foods and liquids start as early as the first months, with 13 per cent and 27 per cent of infants being given complementary foods by 2-3 months and 4-5 months respectively. Unfortunately, these complementary foods that replace breast milk are low in energy and micronutrients. Eighty per cent of breastfed children aged 6-8 months are fed solid or semisolid foods in addition to being breastfed, as recommended. However, only 22 per cent of children aged 6-23 months consume acceptable diets to meet their nutritional needs.<sup>345</sup> Unhygienic preparation and storage of complementary foods, which is common in many households in Kenya, further predisposes many infants to diarrhoeal diseases. In addition, cultural practices, family pressure, economic constraints and food insecurity influence complementary feeding.
201. The poor performance of complementary feeding indicators is likely exacerbated by the lack of scale up of evidence-based strategies and resources to support them, incomplete understanding of cultural and economic barriers, incorrect assumptions about determinants of poor feeding practices, absence of creative behaviour change communication strategies, and lack of clarity on programme approaches due to insufficient documentation of different ways to deliver results.<sup>346</sup>

337. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

338. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2008-2009, 2010 at <https://dhsprogram.com/pubs/pdf/fr229/fr229.pdf>

339. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

340. Bill available at [http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2017/BreastfeedingMothersBill\\_2017.pdf](http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2017/BreastfeedingMothersBill_2017.pdf)

341. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

342. UNICEF, Maternity / Paternity Protection and Workplace Support for Breastfeeding in Kenya, presentation, September 2015, at <http://waba.org.my/stockholm-symposium/wp-content/uploads/2015/10/3.-Laura-Kiege-Workplace-support-for-breastfeeding-in-Kenya.pdf>

343. WHO, Donor human milk for low-birth-weight infants, August 2013, at [http://www.who.int/elena/titles/donormilk\\_infants/en/index.html#](http://www.who.int/elena/titles/donormilk_infants/en/index.html#)

344. Eunice Kilongo, Inside Kenya's Ambitious Plan to Build Human Milk Banks, Daily Nation, 26 June 2017, at <http://www.nation.co.ke/health/3476990-3988026-hrb6muz/index.html>

345. KNBS, ICF Macro, Kenya Demographic and Health Survey 2015

346. Piwoz, E., Baker, J., & Frongillo, E. A. (2013). Documenting Large-Scale Programs to Improve Infant and Young Child Feeding is Key to Facilitating Progress in Child Nutrition. *Food Nutr Bull*, 34(3 suppl2), S143-S145. doi:10.1177/15648265130343s201

**Key issues**

- Minimal dietary diversity in women remains below target in many counties
- During the severe drought of 2017, screening regularly reported 40-50 per cent of women as acutely malnourished in the arid counties
- A new Bill passed in parliament in June 2017 stipulates that all companies with 30 staff members or more need to have places for women to breastfeed or express breastmilk, and need to include changing facilities for infants and stimulation for young children
- According to the 2014 KDHS, 99 per cent of children in Kenya had been breastfed in their lives, but only 61 per cent of children under six months of age were exclusively breastfed
- In Kenya complementary foods are limited in quality and quantity and do not meet the nutrient requirements of a growing child.
- 13 per cent and 27 per cent of infants are given complementary foods by 2-3 months and 4-5 months respectively: these complementary foods, which replace breast milk, are low in energy and micronutrients.
- Only 22 per cent of children aged 6-23 months consume acceptable diets to meet their nutritional needs.
- Cultural practices, family pressure, economic constraints and food insecurity influence complementary feeding.

## Management of severe acute malnutrition

202. Support for nutrition service delivery in Kenya has historically arisen from years of emergency response in the ASAL counties (which have for a long time have reported the highest rates of acute malnutrition), with a largely parallel externally-driven approach, until 2008 when a concerted effort was made to strengthen systems using emergency funding under the leadership of the Ministry of Health. The National Nutrition Action Plan has further built on these gains, through the Integrated Management of Acute Malnutrition (IMAM). This has enabled the Ministry to take increasing ownership of the management of acutely malnourished children, and non-governmental partners are shifting from service delivery to supporting capacity development of the healthcare system.<sup>347</sup>
203. Coverage of severe acute malnutrition and moderate acute malnutrition is estimated at 50-60 per cent with variations between counties. Counties that experience insecurity such as Mandera have lower coverage while others, such as Kilifi, Kwale, Kitui and Narok, often report high levels of defaulting. Key gaps in management of severe acute malnutrition are weak linkages between health facilities and communities, inadequate prevention of acute malnutrition, limited food security responses, and lack of predictable long term funding. The long-term vision is for the High Impact Nutrition Interventions, including IMAM, to be a regular part of the child health service packages of care and delivered at community level: this should see a significant increase in coverage. Trial iCCM and SAM research is underway in 2017 and is intended to generate the evidence needed to amend the iCCM strategy to include treatment of severe acute malnutrition.
204. Several standing structures are in place within the Ministry of Health to oversee this integration and scale up key nutrition services, thereby ensuring systematic and regular stakeholder participation. Participatory mechanisms at national level include: Kenya Food Security Steering Group (KFSSG), the Intergovernmental Forum, the Emergency Nutrition Advisory Committee (ENAC), the Maternal, Infant, and Young Child Nutrition Working Group, the Capacity Development Working Group, the Nutrition Information Technical Working Group, the Nutrition Commodity Steering Group, and the Technical Advisory Group on iCCM-IMAM Integration.<sup>348</sup>

347. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

348. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

349. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

205. Recognizing the contribution of varying capacities across counties and across the various health systems' building blocks to the successful implementation of these initiatives, the Capacity Development Working Group of the Ministry of Health has developed the national Nutrition Capacity Development Framework (CDF) 2014-2019. The CDF is informing long-term capacity development initiatives for nutrition programmes at both national and county levels by outlining the key pillars of capacity and providing tools to assess existing capacities, while engaging health facilities and counties in actions to bridge identified capacity gaps.<sup>349</sup>
206. As several ASAL counties have recruited large numbers of new nutritionists since devolution, there is an enhanced need for capacity building of these newly qualified and inexperienced staff. To address capacity, duplication and information gaps caused by training by a range of development partners, the Ministry of Health has developed a standard package of competency-based nutrition training. This will minimize duplications in training, promote adherence to national standards and efficiency, planned supportive supervision and on-the-job training, and minimize time away from clinical care for nutrition officers.<sup>350</sup>

#### Key issues

- Coverage of severe acute malnutrition and moderate acute malnutrition is estimated at 50 per cent
- Counties that experience insecurity, such as Mandera, have lower coverage while others, like Kilifi, Kwale, Kitui and Narok, often report high levels of defaulting
- Key gaps in management of severe acute malnutrition are poor health facility and community linkages, inadequate prevention of acute malnutrition, limited food security responses and lack of predictable long term funding.

## Micronutrients

207. The latest research on micronutrients in Kenya, the Kenya National Micronutrient Survey of 2011, found that the population group with the highest prevalence of anaemia, iron deficiency and iron deficiency anaemia was pregnant women, at 41.6 per cent, 36.1 per cent and 26 per cent respectively. Pre-school children had a higher prevalence of anaemia, iron deficiency and iron deficiency anaemia (26.3 per cent, 21.8 per cent, and 13.3 per cent respectively) than school-age children (16.5 per cent, 9.4 per cent and 4.9 per cent respectively). National iodine deficiency prevalence was 22.1 per cent among school age children and 25.6 per cent among non-pregnant women. Finally, pre-school children had the highest prevalence of zinc deficiency (83.3 per cent) of all the population subgroups.<sup>351</sup>
208. Vitamin A is an important micronutrient for children's immune systems, and so healthcare facilities in Kenya provide Vitamin A supplements to children between the ages of 6-59 months to ensure that they do not suffer deficiency. However, analysis of the 2014 KDHS shows that among children aged 7-11 months, 23 per cent had not received vitamin A supplement in the previous six months. Among older children, this deprivation rate was higher: 28 per cent of all children aged 12-59 months in 2014 had not received a vitamin A supplement in the previous six months. This was significantly better than in 2008-09, when as many as 66 per cent of children aged 12-59 months had not received Vitamin A supplements in the previous six months. Gender-disaggregated data show no significant differences between boys and girls in terms of vitamin A supplement coverage.<sup>352</sup>

350. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

351. Ministry of Health, The Kenya National Micronutrient Survey 2011, 2017

352. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

209. Qualitative research conducted for the 2016 Multidimensional Child Poverty Survey found that provision of vitamin A commonly depended on the schedule of immunization; once the children have completed the immunization schedule, coverage rates drop as parents do not send their children to health facilities unless they are sick. Coverage was reportedly especially problematic in Turkana and Kitui, where the average distance to a healthcare facility is further. This is also the case for growth monitoring of children. While the Ministries of Health and Education organize twice-yearly vitamin A provision campaigns in Early Childhood Development (ECD) centres, children who do not attend these facilities appear not to be covered. County nutrition officials have also highlighted that irregular outreach, the lack of additional Vitamin A supplementation campaigns, and unsustainable structures for community level health provision when partner support is withdrawn have negatively impacted provision of vitamin A, particularly in hard-to-reach areas.<sup>353</sup>
210. Between February 2011 and September 2015, the Ministry of Health implemented Kenya's national food fortification programme, in order to reach 95 per cent of the population with fortified vegetable oil and 74 per cent of the population with fortified wheat flour.<sup>354</sup> The foods selected for mass fortification are found in most households. The Ministry recommended fortification of salt with iodine, maize and wheat flour with B vitamins, iron, folic acid, and zinc, and oils and fat with Vitamin A. Large scale food fortification is conducted in the industries, while Government creates a conducive environment through standards and regulations. In addition, the use of micronutrient powders at household level is an easy and highly acceptable strategy among families and children. In 2015, the Ministry reported that 4.7 million people had been reached with fortified maize flour, 18.2 million with fortified wheat flour and 38 million with fortified edible fats and oils.<sup>355</sup>

## Monitoring, evaluation and the nutrition information system

211. Strategic objectives nine and ten of the 2012-2017 National Nutrition Action Plan focus on nutrition surveillance, monitoring and evaluation systems and enhanced decision making through research. In recent years, the national nutrition surveillance and monitoring and evaluation systems have been refined and coordinated. A comprehensive monitoring and evaluation framework has been established with impact, outcome, output and process level progress monitoring tools. Data from the process monitoring tool, in addition to survey data, will be consolidated within a bottleneck analysis framework to ensure that county and health facility level staff are empowered to make key programme improvement decisions based on bottlenecks identified.<sup>356</sup>
212. In recent years the Ministry of Health and National Disaster Management Authority have been working with partners to generate and ensure timely use of quality nutrition information from surveys, assessments, and regular reports. Early warning surveillance has been critical for emergency preparedness to trigger appropriate emergency and surge response. In addition to the long rain and short rain seasonal assessments used for emergency preparedness and response, and incorporating seasonal outlooks of the nutrition and food security situation, other sources of nutrition information include the DHIS, SMART surveys, nutrition KABP surveys, coverage surveys and other assessments, quality assured through the Nutrition Information Technical Working Group, which has become the most important source of information on the severity of the 2017 drought emergency.<sup>357</sup>

353. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

354. GAIN, Kenya Food Fortification, at <http://www.gainhealth.org/knowledge-centre/project/kenya-food-fortification-initiative/>, accessed 18 April 2017

355. Save the Children, Micronutrient Deficiencies on the Decrease, 25 August 2015, at <https://kenya.savethechildren.net/news/micronutrient-deficiencies-decrease>

356. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

357. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

213. A programme dashboard is currently being finalized for the Ministry of Health's Kenya Health Observatory (KHO) to ensure that updated information on enabling environment, demand, supply and quality of services is easily available. The KHO is a web-based portal developed to improve the availability and use of information and evidence for policy and decision-making, following the same general structure as is used for the African Health Observatory (AHO). The KHO will enable collaboration and the bringing together of data in a single place, thereby reducing fragmentation, and improve monitoring on progress in the nutrition sector.<sup>358</sup>
214. In recent years, the nutrition sector has invested in developing capacity for nutrition information through training, and development of data tools and web based data management systems. Due to the recruitment of new staff and mobility of staff across counties and implementing partners, capacity development still requires ongoing investment. Training will still be required on Nutrition SMART methodology, KABP, administrative data and coverage surveys and evidence-based decision making. Investing in data quality assurance, the functionality of newly developed web based information systems, nutrition communication products and use of evidence in planning and implementation of programs will drive realization of results.

## Nutrition advocacy

215. The National Nutrition Advocacy, Communication and Social Mobilization (ACSM) Strategy was released in June 2016 with an Advocacy and Communications Toolkit, Messages and Tools. The documents underpin three strategic areas for advocacy in the country: governance, capacity to deliver, and behaviour and practices. The ACSM Strategy highlights some of the engagement tactics, strategies, activities, and expected outcomes for media engagement, with capacity building conducted for the media at county level through ongoing support and partnership with implementing partners. Sensitization on both documents and subsequent development of draft county specific advocacy plans was undertaken in over 30 counties. The Global Nutrition Report 2016 launch and World Breastfeeding Week (2016) events also served as high level advocacy events, with the First Lady of Kenya as the chief guest.<sup>359</sup>
216. At county level, nutrition advocacy has led to the development of County Nutrition Action Plans (CNAPs). Based on extensive consultations at county and national level and guided by the National Nutrition Action Plan, the CNAPs accurately determine sectoral budgets and contextualize the NNAP. There have also been county-level launches of national policy documents, such as Ending Drought Emergencies, and nutrition champions have been supported at county level as a resource to promote nutrition investment.<sup>360</sup>

## Health emergencies

217. Disease outbreaks can occur anywhere, anytime, with consequences that can shatter communities. In Kenya, health emergencies can occur as a result of outbreaks of a range of diseases, including cholera, chikungunya and dengue fever. Ebola is also a concern.

## Cholera

218. Cholera has been a serious threat in Kenya for many years. A recent outbreak began in December 2014 in informal settlements in Nairobi County. The outbreak was blamed on heavy rains combined with poor environmental sanitation and hygiene practices and the consumption of contaminated food and water in the informal settlements.<sup>361</sup>

358. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

359. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

360. UNICEF, Contributing towards the nutritional wellbeing of deprived children and women in Kenya: second annual progress report, January 2017

361. Ann Weru, Cholera highlights urban risk factors, UNISDR, 10 June 2015, at <http://www.unisdr.org/archive/44762>

219. From 2015, the cholera outbreak spread to affect 30 of the country's 47 counties. By 19 September 2016, 16,840 cases had been reported with 256 deaths recorded, a case fatality rate (CFR) of 1.5 per cent.<sup>362</sup> The cholera outbreak was particularly severe and long lasting in the northern and eastern counties of Tana River, Garissa, Wajir, Mandera, Isiolo and Marsabit.<sup>363</sup> Challenges in Mandera and Wajir counties that are particular risk factors include insecurity, lack of health professionals, poor sanitation and barriers to humanitarian access (discussed later in this report), as well as high levels of cross-border movement which, while positive for social and economic development, can spread disease and also make health information systems more challenging.<sup>364</sup>
220. After a short period of containment, cholera broke out again in October 2016 in Tana River County. In 2017, a total of 252 cases and 5 deaths (CFR of 1.2 per cent) were reported in Tana North Sub-county. Of these, 41 cases (16 per cent) are laboratory confirmed.<sup>365</sup> Risk factors identified in Tana River County include low latrine coverage, deep rooted social practices, widespread poverty and high illiteracy.<sup>366</sup>
221. A cholera outbreak was also officially declared at the Dadaab refugee camp on 2 April 2017, after a 10-year-old boy tested positive. Since then, a total of 55 cholera cases were reported, with 15 cases tested positive for cholera.<sup>367</sup> Most of the cases at Dadaab have been linked to newly arriving refugees from a village in Somalia and the households hosting them.<sup>368</sup> Following an earlier outbreak in late 2015, linked to pooled groundwater and poor hygiene, four cholera treatment centres were set up in the camps. Measures taken to address the outbreak included soap distribution, house and latrine disinfection and hygiene promotion campaign across all the five camps at Dadaab.<sup>369</sup> An outbreak of cholera was also reported at Kakuma refugee camp in May 2017, linked to significant cholera outbreaks in various parts of South Sudan: as of 16 June 2017, 115 cases had been reported at Kakuma and Kalobeyei.<sup>370</sup>

## Other health emergencies and response

222. In 2016, Kenya reported an outbreak of chikungunya that resulted in more than 1,700 suspected cases. Risk of the disease is highest where mosquito vector breeding sites are close to human habitation. In June 2016, it was estimated that 70 per cent of the population and 50 per cent of the health workforce in Mandera town were affected by chikungunya: this led to a need for significant surge support of health workers.<sup>371</sup> Most of the breeding of the chikungunya carrying vectors in Mandera town was found to be within domiciliary containers primarily for water storage.<sup>372</sup>
223. The chikungunya emergency in Mandera was aggravated by the porous border which challenged surveillance and active case finding activities. Patients from neighbouring areas of Ethiopia and Somalia also sought medical assistance in Mandera. Around 90 per cent of teachers were absent in some areas of the county, further affecting access to education, as well as critical health and nutrition services for children and women. The main gaps and challenges on response to the twin outbreaks were weak health, water, and sanitation systems at county level in terms of resources allocation, technical capacity and lack of policy guidance. In addition, communication and multi-sectoral coordination between county and national level were weak, with the outbreaks viewed as a 'health issue' only.<sup>373</sup>

362. UNICEF, Kenya Humanitarian Situation Report, September 2016, at [https://www.unicef.org/appeals/files/UNICEF\\_Kenya\\_Humanitarian\\_SitRep\\_Sept\\_2016.pdf](https://www.unicef.org/appeals/files/UNICEF_Kenya_Humanitarian_SitRep_Sept_2016.pdf)

363. UNICEF, Kenya: Cholera Outbreak Review, 2 May 2016, at [https://www.unicef.org/appeals/files/UNICEF\\_Kenya\\_Cholera\\_Outbreak\\_May\\_2016.PDF](https://www.unicef.org/appeals/files/UNICEF_Kenya_Cholera_Outbreak_May_2016.PDF)

364. IGAD and United Nations, Action Plan to Address Cholera / Acute Watery Diarrhea and Chikungunya Virus Outbreaks on the Kenya / Somalia / Ethiopia Border, August 2016, at <http://reliefweb.int/sites/reliefweb.int/files/resources/ACTION%20PLAN%20TO%20ADDRESS%20CHOLERA%20AND%20CHIKUNGUNYA%20VIRUS%20OUTBREAKS%20ON%20THE%20KENYA%20-%20ETHIOPIA%20-%20SOMALIA%20BORDER.pdf>

365. OCHA, Kenya: Drought Response. Situation Report 1, 13 April 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/Kenya%20Situation%20Report%20Number%201-%2013%20APRIL%202017.pdf>

366. UNICEF, Kenya Humanitarian Situation Report, 20 February 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20SitRep%20-%2020%20February%202017.pdf>

367. UNHCR, UNHCR Dadaab Bi-Weekly Update, 7 May 2017, at [http://reliefweb.int/sites/reliefweb.int/files/resources/30%20April%20UNHCR%20Dadaab%20bi-weekly%20Update\\_0.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/30%20April%20UNHCR%20Dadaab%20bi-weekly%20Update_0.pdf)

368. UNICEF Kenya, Kenya Humanitarian Situation Report, 5 May 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20Situation%20Report%20-%2005%20May%202017.pdf>

369. Assadullah Nasrullah, UNHCR battles cholera at world's largest refugee complex, UNHCR, 31 December 2015, at <http://www.unhcr.org/afr/news/latest/2015/12/5685137c9/unhcr-battles-cholera-worlds-largest-refugee-complex.html>

370. UNHCR, Cholera Outbreak Response Updates Kakuma Refugee Camp/Kalobeyei Settlement 16/06/2017 Week Three Of Cholera Outbreak, 16 June 2017, at <https://data2.unhcr.org/en/documents/details/57755>.



224. While particularly challenging in Mandera, given the particular situation there, capacity to respond to health emergencies more broadly in Kenya is a concern. To a large extent, health emergency prevention and response is largely reliant on external partners. The devolved health administrations at county level seemingly have failed to plan for or set aside funds for emergencies.<sup>374</sup>

#### Key issues

- In recent years, Kenya has suffered a range of health emergencies, including outbreaks of cholera, chikungunya, dengue fever, measles and kala azaar
- Cholera outbreaks have affected most of Kenya's counties in the last two years
- Areas particularly vulnerable to cholera and other health emergencies include informal settlements, with poor sanitation and hygiene practices; refugee camps, where people live closely together and the disease can be brought from neighbouring countries, and Mandera and Wajir counties that face particular risk factors including insecurity, lack of health professionals, poor sanitation and barriers to humanitarian access
- Devolved health administrations at county level seemingly have failed to plan for or set aside funds for emergencies

371. IGAD and United Nations, Action Plan to Address Cholera / Acute Watery Diarrhea and Chikungunya Virus Outbreaks on the Kenya / Somalia / Ethiopia Border, August 2016, at [http://reliefweb.int/sites/reliefweb.int/files/resources/ACTION%20PLAN%20TO%20ADDRESS%20CHOLERA%20AND%20CHIKUNGUNYA%20VIRUS%20OUTBREAKS%20ON%20THE%20KENYA%20\\_%20ETHIOPIA%20\\_%20SOMALIA%20BORDER.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/ACTION%20PLAN%20TO%20ADDRESS%20CHOLERA%20AND%20CHIKUNGUNYA%20VIRUS%20OUTBREAKS%20ON%20THE%20KENYA%20_%20ETHIOPIA%20_%20SOMALIA%20BORDER.pdf)

372. WHO, Chikungunya – Kenya, May 2016, at <http://www.who.int/csr/don/09-august-2016-chikungunya-kenya/en/>

373. IGAD and United Nations, Action Plan to Address Cholera / Acute Watery Diarrhea and Chikungunya Virus Outbreaks on the Kenya / Somalia / Ethiopia Border, August 2016, at [http://reliefweb.int/sites/reliefweb.int/files/resources/ACTION%20PLAN%20TO%20ADDRESS%20CHOLERA%20AND%20CHIKUNGUNYA%20VIRUS%20OUTBREAKS%20ON%20THE%20KENYA%20\\_%20ETHIOPIA%20\\_%20SOMALIA%20BORDER.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/ACTION%20PLAN%20TO%20ADDRESS%20CHOLERA%20AND%20CHIKUNGUNYA%20VIRUS%20OUTBREAKS%20ON%20THE%20KENYA%20_%20ETHIOPIA%20_%20SOMALIA%20BORDER.pdf)

374. Information provided by UNICEF, May 2017

# Chapter 4:

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# Learning



## Enabling environment

225. Article 53 of the 2010 Constitution of Kenya states that “Every child has the right to free and compulsory basic education”. Under the Sustainable Development Goals, Kenya has committed itself to ensure inclusive and quality education for all and promote lifelong learning. In this context, Vision 2030 calls for globally competitive quality education, training and research for sustainable development, which will position Kenya as a regional centre of research and development in new technologies. The following initiatives are envisaged:
- 1) Integrating early childhood education into primary education;
  - 2) Reforming secondary school curricula;
  - 3) Modernising teacher training;
  - 4) Strengthening partnerships with the private sector;
  - 5) Developing key programmes for learners with disabilities;
  - 6) Rejuvenating ongoing adult training programmes;
  - 7) Revising the curriculum for university and technical institutes to include more science and technology; and
  - 8) Increase public funding, in partnership with the private sector, to enable all these institutions to support activities envisaged under the economic pillar.
226. The 2013-2018 National Education Sector Plan emphasizes improving the quality of education and the governance and management of the education system. Its key priorities are:
- The enhancement of learner outcomes through addressing issues related to quality including introduction of a more relevant curriculum, enhancement of early grade literacy and numeracy, use of assessments, enhancement of teachers’ pedagogical skills and the establishment of robust oversight mechanisms.*<sup>375</sup>
227. The key legislation governing children’s education in Kenya is the Basic Education Act of 2013. The Act re-defined basic education to cover primary and secondary education, introduced a National Education Board and County Education Boards (CEBs) in the 47 counties and mandated the Government to provide free and compulsory basic education, including two years of pre-primary, eight of primary, and four of secondary or vocational education.<sup>376</sup>
228. There are a number of specific Ministry of Education policies to meet the needs of vulnerable groups and achieve equity goals. These include the 2016 Gender Policy in Education that aims to ensure that both boys and girls have equal access to education by guarding against the constraints girls face in accessing quality education; the 2013 HIV and AIDS Education Sector Policy; the 2015 revised Policy Framework for Nomadic Education in Kenya;<sup>377</sup> the 2014 Peace Education Policy; and the 2009 National Special Needs Education Policy<sup>378</sup> (which is currently being updated to meet the requirements of the Convention on the Rights of Persons with Disabilities). Other policy documents that have been recently finalized but not yet approved include the Education in Emergencies Policy and the ECD policy. These issues will be discussed in more detail later in this section of the report.

375. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

376. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

377. Available online at <http://www.education.go.ke/index.php/downloads/category/17-policy-documents?download=84:revised-policy-framework-on-nomadic-education-in-kenya>

378. Available online at <http://www.unesco.org/education/edurights/media/docs/446808882707702aaf616d3a2cec918bfc186fc.pdf>

## Governance

229. Kenya's education system includes two or three years of pre-primary education, eight years of primary school, four years of secondary education and (generally) four of university. There are also separate streams for vocational and technical education. Since 2013, the national Government is responsible for administration of primary and secondary education, education policy, standards, curricula and examinations and the granting of university charters. County governments are responsible for pre-primary education, village polytechnics and childcare facilities.<sup>379</sup>
230. The Government and its partners are currently basing their efforts to realize the right to education in Kenya on the National Education Sector Plan (NESP) 2013-2018. This Plan sets out plans to increase access to education in the country. In this context, over the last decade, there has been a substantial increase in the number of education facilities at all levels:<sup>380</sup>

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Primary schools	20,587	21,702	22,876	24,114	25,382	26,549	28,026	29,460	31,333
Secondary schools	4,663	5,128	5,639	6,201	6,257	7,174	7,834	8,747	9,440
Teacher training	69	132	179	233	236	245	256	267	271
TIVET institutions	540	568	597	627	630	701	753	755	874
Universities	28	28	31	32	34	35	52	53	53

Table 1: Number of educational institutions, 2007-2015

231. In spite of high budgetary allocations (5.3 per cent of GDP in 2015)<sup>381</sup> there are several challenges facing Kenya's education sector. This includes both concerns around the quality of education and the high number of out of school children, particularly in the north and east of the country. Curricular changes currently being formulated will be instrumental to address the quality of education by improving learning standards and the environment in schools.<sup>382</sup>
232. Governance issues, such as political patronage and financial irregularities, are perceived to hamper equitable provision of education services, weakening citizens' trust in the state and fuelling grievances that can undermine social cohesion and give rise to conflict.<sup>383</sup>
233. Between 2011 and 2015, the number of educational establishments at all levels, both publicly and privately owned, rose. The largest rises were seen in public primary and secondary schools and in private secondary schools (see the graph below).<sup>384</sup>

379. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

380. Kenya National Bureau of Statistics, Statistical Abstract, 2016, at [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=106&Itemid=1177](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=106&Itemid=1177)

381. World Bank, Government Expenditure on Education, total (% of GDP), <http://data.worldbank.org/indicator/SE.XPD.TOTL.GD.ZS>, accessed 27 June 2017

382. UNICEF, UNICEF – KCO MTR Report, 2016

383. Alan Smith et al, Exploring the Linkages between Education Sector Governance, Inequity, Conflict, and Peacebuilding in Kenya, UNICEF, 2016, at <http://eccnetwork.net/wp-content/uploads/10-Equity-Education-Peacebuilding-Governance-Kenya.pdf>

384. Kenya National Bureau of Statistics, Statistical Abstract, 2016, at [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=106&Itemid=1177](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=106&Itemid=1177)

385. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

386. Global Initiative for Economic, Cultural and Social Rights, The United Nation raises alarm about the lack of regulation and donor support in education in Kenya, 9 February 2016, at <http://globalinitiative-escri.org/the-united-nation-raises-alarm-about-the-lack-of-regulation-in-the-education-sector-and-sub-standard-schools-funded-by-development-aid-in-kenya/>

387. Ministry of Education, Basic Education Statistical Booklet, 2015

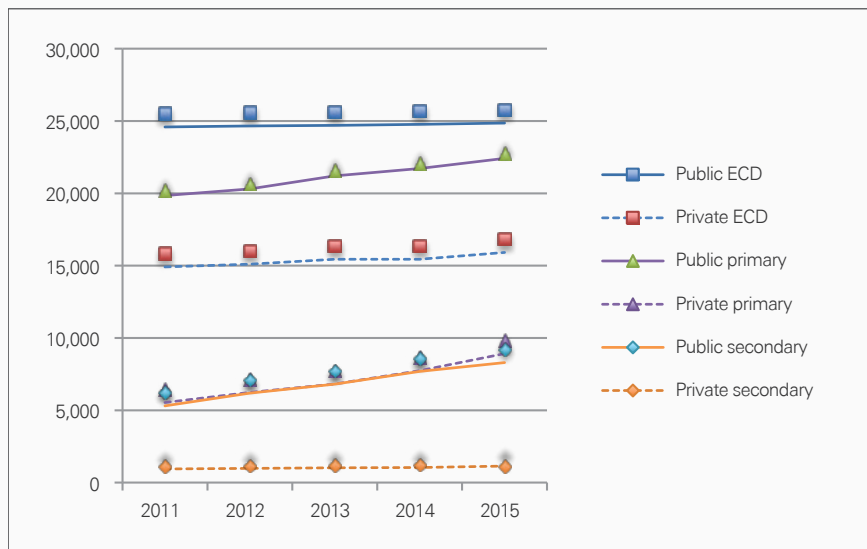


Figure 17: Numbers of educational institutions at various levels publicly- and privately-owned, 2011-2015

234. In 2015, the UN Committee on the Rights of the Child raised concerns about the, “low quality of education and rapid increase of private and informal schools, including those funded by foreign development aids, providing sub-standard education and deepening inequalities. It called on the Government to “guarantee the legal right to free mandatory education for all, without direct or hidden costs,” and insisted that Kenya should, in doing so, “regulate and monitor the quality of education provided by private informal schools in line with the Convention.”<sup>385</sup> Activists have stated that the growth of for-profit schools has institutionalized discrimination in the informal settlements where these schools are most prevalent, as the standards set for alternative schools are lower than those for normal public or private schools.<sup>386</sup>
235. Another governance concern in Kenyan education is the distribution of teachers. In some cases, schools with 500 pupils may have as few as five teachers or as many as 40 teachers. In some instances, 10 teachers can serve in schools with 100 or 1,000 pupils. According to the Education Management Information System (EMIS), the number of pupils only determines 52 per cent of distribution of teachers, with the remaining 48 per cent a result of other non-formal considerations.<sup>387</sup>
236. In Kenya, the education of children with disabilities is provided in special schools, integrated schools and special units attached to mainstream schools, as well as mainstream schools. In the context of the Basic Education Act of 2013, Government policy appears to favour institutionalization and segregated education for children with disabilities in special schools or specialized units.<sup>388</sup> There are with 2,713 special units within mainstream schools and around 300 special schools for children with disabilities.<sup>389</sup> A total of 102,749 students receive capitation grants for disabilities. Of these, 21,050 are in special schools and 81,649 are enrolled in integrated special units at both primary and secondary schools. However, the Ministry of Education recorded more than twice as many children with “special educational needs” enrolled at school in 2015 (224,159 at primary level and 11,219 at secondary level).<sup>391</sup> Many of these will not receive capitation grants. The Ministry of Education has provided capitation grants to 184 special boarding schools (167 primary schools, 8 secondary schools and 6 technical/vocational institutions) at the rate of Ksh 8,000 per year, per learner. In addition, the Department of Education has been providing financial and material support to 1,703 special units attached to regular schools and three primary teacher training colleges, which integrate student with disabilities at a rate of Ksh 2,000 capitation grant per learner per year for acquisition of assistive devices.<sup>392</sup>

388. African disability rights yearbook, 2014. Pretoria: Pretoria University Law Press, at <http://www.adry.up.ac.za/index.php/issues/volume-2-2014>

389. Information provided by Ministry of Education, Science and Technology, July 2017

390. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

237. However, this focus on separate educational provision for children with disabilities contradicts some of Kenya's other obligations under international treaties and national legislation. For example, the Convention on the Rights of Persons with Disabilities states that children with disabilities should be included in regular classrooms with support and accommodation. In the 2014-2018 National Education Sector Plan, inclusive education is an overarching principle, rather than special or segregated education.

## Pre-school governance

238. Following the devolution reforms of 2010, early childhood education is administered at county level. According to the Ministry of Education, this has led to significant improvements in facilities, teachers and meals for pre-school children.<sup>393</sup> Decentralization has created space for counties to allocate more resources to pre-school and explore innovative ideas, such as engaging with private providers and establishing model pre-school centres.<sup>394</sup>
239. At the same time, devolution has resulted in less central responsibility for pre-school education, creating the possibility of inequitable outcomes among regions, as counties with smaller tax bases have fewer resources of their own to scale up provision. No specific budget allocation from central Government is given to counties to provide pre-school services, and it is expected that it will be covered from the block grant to county governments. The resource requirements for these services may vary substantially between counties. Counties may use local tax revenue for pre-schools, but local revenue sources tend to be limited. In addition, anecdotal evidence indicates that the constitutional declaration of free pre-primary education has made many parents less willing to pay for this level of education.<sup>395</sup>
240. Governance arrangements between central Government and the counties are not clear. The central Government retains authority for pre-school policy, standards, curriculum, and assessment. Counties are responsible for implementing policies, developing programmes, training personnel, and providing infrastructure. In some cases, however, the legal lines of authority are unclear. For example, the authority to hire pre-school teachers has been a source of dispute. The national Teacher Services Commission (TSC) is constitutionally mandated to hire and oversee all teachers, including those at pre-primary level. This weakens counties' authority over pre-school services. It is unclear whether the TSC's budget for hiring pre-primary teachers should come from the central or county governments.<sup>396</sup> In this context, a draft Policy on Early Childhood Development and Education has been validated to address some of these issues.<sup>397</sup>

## Education financing

241. The Government allocates over 14 per cent of its total spending to education each year, although this share has fallen from over 20 per cent in 2011-2012. The absolute amount spent on education has increased year on year to reach Ksh 320 billion forecast for 2015-2016. This has stayed above 5 per cent of GDP over the last six years, which is slightly more than comparable neighbouring East African countries. Of government spending on education, around 92 per cent to 95 per cent tends to be on recurrent expenditure, with the rest on development.<sup>398</sup>
242. Primary education receives the largest share of recurrent education spending, at over 40 per cent over the last five years. Secondary education accounts for the second largest share, at around 32 per cent. Technical and vocational education and training (TVET) and university levels receive around 4 per cent and 14 per cent respectively, while administration takes 5-8 per cent. This leaves less than one per cent for early childhood education.<sup>399</sup>

391. Ministry of Education, Basic Education Statistical Booklet, 2015

392. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

393. Interview, Ministry of Education, 24 June 2017

394. World Bank, Scaling up preschool in Kenya: Costs, constraints and opportunities, September 2016, at <http://documents.worldbank.org/curated/en/762961482316633811/pdf/111215-BRI-ELPPolicyBriefKenya-PUBLIC.pdf>

395. World Bank, Scaling up preschool in Kenya: Costs, constraints and opportunities, September 2016, at <http://documents.worldbank.org/curated/en/762961482316633811/pdf/111215-BRI-ELPPolicyBriefKenya-PUBLIC.pdf>

243. Average spending per student in state educational institutions increases with the level of education. It costs three times as much to educate a student in secondary education for one year than it does in primary school, over four times as much in TVET and seven times as much in university. However, the gap between unit costs of TVET and university relative to primary school have reduced substantially in recent years, suggesting resource input has not kept up with enrolment at higher levels.<sup>400</sup>
244. In addition to public spending on education, a significant amount is financed from other sources, without coming into government budgets. Development partners spend around USD 190 million per year, roughly matching the amount the Government spends on development expenditure for education.<sup>401</sup>
245. Household spending on state is estimated to be Ksh 132 billion per year. If one assumes that the cost of private schools is equal to that of public schools, another Ksh 28 billion is spent each year on primary and secondary education. Compared to the approximately Ksh 280 billion spent by the Government on education, this suggests households are paying approximately half this amount again on top of government spend.<sup>402</sup>
246. While Kenya has moved to per capita financing of education facilities, the grants do not take equity issues into perspective. This means, for example, that capacitation grants received by schools do not consider the specific needs of each child, and assessment processes to receive the grant are rather slow.<sup>403</sup> Meanwhile, because low cost private schools have become the main education providers for children from the most disadvantaged backgrounds in informal urban settlements, these children do not receive public financing, further accentuating their vulnerability.
247. Notwithstanding concerns over the capacity of county governments to absorb development funds, devolution is already showing potential to bring infrastructural development to the most marginalized.<sup>404</sup> In ten counties selected for 2017 research, public expenditure on pre-primary education and skills development in 2015-16 varied from 12 per cent (Kilifi) to 3 per cent (Migori). Some counties (e.g. Kakamega, Kilifi, Kitui) have been supporting programmes that are not devolved to them, such as subsidising polytechnic fees, secondary education bursaries, scholarship and other educational benefits for secondary and tertiary education.<sup>405</sup>

## Education information

248. Kenya's Education Management Information System published annual statistical bulletins for 2014 and 2015, after a gap of several years. UNICEF supported these, but this funding stream has now come to an end. There is reportedly a lack of capacity in the Ministry of Education, Science and Technology to ensure the sustainability of data collection going forwards. Meanwhile, concerns have been expressed about the validity of some of the data produced, and also a lack of internal demand within the Ministry to use the data.<sup>406</sup>

396. World Bank, Scaling up preschool in Kenya: Costs, constraints and opportunities, September 2016, at <http://documents.worldbank.org/curated/en/762961482316633811/pdf/111215-BRI-ELPPolicyBriefKenya-PUBLIC.pdf>

397. Republic of Kenya, Concept Note on Medium Term Plan 2018-2022, March 2017, at <http://www.mtp3.go.ke/assets/documents/mtp/CONCEPT%20NOTE%20MTP3.pdf>

398. Mamy Rakotomalala, Nicola Ruddle, Polycarp Otieno, Amos Kaburu, Analysis of Kenya's expenditure in education, future sector cost scenarios and benefits of curriculum reform: final report, Oxford Policy Management, November 2016

399. Mamy Rakotomalala, Nicola Ruddle, Polycarp Otieno, Amos Kaburu, Analysis of Kenya's expenditure in education, future sector cost scenarios and benefits of curriculum reform: final report, Oxford Policy Management, November 2016

400. Mamy Rakotomalala, Nicola Ruddle, Polycarp Otieno, Amos Kaburu, Analysis of Kenya's expenditure in education, future sector cost scenarios and benefits of curriculum reform: final report, Oxford Policy Management, November 2016

401. Mamy Rakotomalala, Nicola Ruddle, Polycarp Otieno, Amos Kaburu, Analysis of Kenya's expenditure in education, future sector cost scenarios and benefits of curriculum reform: final report, Oxford Policy Management, November 2016

402. Mamy Rakotomalala, Nicola Ruddle, Polycarp Otieno, Amos Kaburu, Analysis of Kenya's expenditure in education, future sector cost scenarios and benefits of curriculum reform: final report, Oxford Policy Management, November 2016

403. Information provided by UNICEF, July 2017

404. Alan Smith et al, Exploring the Linkages between Education Sector Governance, Inequity, Conflict, and Peacebuilding in Kenya, UNICEF, 2016, at <http://eccnetwork.net/wp-content/uploads/10-Equity-Education-Peacebuilding-Governance-Kenya.pdf>

405. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

406. Tom Cassidy, Kenya. EMIS Design and Implementation: An Alternative Model and Way Forward, Powerpoint presentation following World Bank mission, May 2016

249. Limitations to pre-school data provide some context on education information challenges in Kenya. Basic data on the pre-school-age population and the large number of centres currently serving children is critical but currently not available. Very little is yet known about the children excluded from pre-school education, including where they live, their background characteristics, and why they are not enrolled. The mandate for collecting, storing, and publishing ECDE data remains with the national Government, and specifically with EMIS. Some counties have found the EMIS data inadequate for their planning needs, so they have conducted their own surveys. These local surveys have yielded detailed information, for example about the status of buildings and furniture in pre-school institutions, but their data also may overlap with, and are often inconsistent with, the data generated by EMIS. Many non-state pre-schools (which may be faith-based or NGO-run and include low-cost private centres) are not covered by official data collection but are captured by the local surveys. Such discrepancies impede local planning and policymaking and make coordination between the counties and the national Government difficult.<sup>407</sup>
250. Several attempts to develop new data collection systems have ended in failure, having focused largely on technology and supply-side issues rather than the organizational and capacity-building dimensions of EMIS. New county education offices have still less organizational, human resource and technical capacity to generate and use education information, but some are exploring innovative use of information technology for data collection.<sup>408</sup>
251. A 2016 consultant's report revealed wide agreement among key stakeholders about the critical need for better data and information in the education sector, and a widely-stated willingness among key internal and external stakeholders to work together to improve the quality of data and information available in the sector. The report proposes a model for education information management going forwards that will rationalize and integrate relevant technical systems and integrate counties and sub-counties as data providers and users.<sup>409</sup>

#### Key issues

- Between 2011 and 2015, the number of educational establishments at all levels rose, with the largest rises in public primary and secondary schools and in private secondary schools
- Teacher distribution is very inequitable, with schools with 500 pupils having as few as five or as many as 40 teachers
- Children with disabilities are still largely taught in separate schools or units, despite inclusive education being a principle of the 2014-2018 National Education Sector Plan
- Primary and secondary schools remain the responsible of national Government, but pre-school has been transferred to country governments
- At more than 14 per cent of total government expenditure, public spending on education is slightly higher than for comparable East African countries. Almost all this spending (92 to 95 per cent) is on recurrent expenditure, such as salaries
- There is a critical need for better data and information in the education sector, and a widely-stated willingness among key internal and external stakeholders to work together to improve the quality of data and information available in the sector

407. World Bank, Scaling up preschool in Kenya: Costs, constraints and opportunities, September 2016, at <http://documents.worldbank.org/curated/en/762961482316633811/pdf/111215-BRI-ELPPolicyBriefKenya-PUBLIC.pdf>

408. Tom Cassidy, Kenya. EMIS Design and Implementation: An Alternative Model and Way Forward, Powerpoint presentation following World Bank mission, May 2016

409. Tom Cassidy, Kenya. EMIS Design and Implementation: An Alternative Model and Way Forward, Powerpoint presentation following World Bank mission, May 2016



## Access to education

252. Access to school remains a major bottleneck to universal primary education in Kenya. According to the 2015 EMIS, an estimated 1,292,695 children (55 per cent girls) are out of school.<sup>410</sup> The hardest to reach include children with disabilities, children living in pastoral and nomadic communities and in urban informal settlements. Bottlenecks identified include low skill levels among teachers; inadequate deployment of teachers; lack of a conducive quality learning environment; insufficient infrastructure, including gender sensitive latrines; and the long distance to schools in some areas.<sup>411</sup>
253. The 2014 Education for All document identifies several groups of children that face challenges accessing quality education. These include those affected by disasters; communities in arid and semi-arid lands and pockets of poverty such as urban informal settlements and rural poor regions; children with disabilities; children engaged in child labour; orphans; adolescent mothers and sibling minders; children affected by and living with HIV and AIDS; and children discriminated against based on culture, religion and/or gender.<sup>412</sup>
254. There are very low school enrolment and completion rates in the arid and semi-arid areas and in urban informal settlements and a low retention rate of teachers in these areas, which undermines the quality of education.<sup>413</sup> A group of counties in the north and east (Mandera, Turkana, Garissa and Wajir) show clear indicators of poor educational development in terms of low enrolment rates, inequality of access by gender and inadequate provision of educational resources. These are precisely the counties where there has been the highest concentration of conflict events since 2007. However, educational inequalities are not only associated with conflict occurrence; the counties with poor educational indicators and high occurrence of conflict are also those with high poverty rates, indicating a strong relationship between the different dimensions of development.<sup>414</sup>

## Early learning

255. In the first five years of life, and particularly the first 1,000 days after conception, the brain develops rapidly, and children require a wide range of support development and learning. However, there is little information available about what parents in Kenya do with young children to support their development and preparedness for school. MICS surveys conducted in 2013-2014 in three counties (Turkana, Kakamega and Bungoma) appear to indicate that children are unlikely to receive significant support at home. The figures in Turkana County are the most striking. In the county, only 0.8 per cent of children aged 36-59 months have fathers involved in four or more activities with them, and the figure is 3.1 per cent for mothers. Only 0.3 per cent of the children have children's books available to them in their homes, while 19.4 per cent have two or more types of playthings to play with in their homes. A total of 54 per cent of children received inadequate care, either by being left alone or in the care of another child.<sup>415</sup>

410. The computation is based on Primary NER, EMIS 2015

411. UNICEF, UNICEF – KCO MTR Report, 2016

412. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

413. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

414. Alan Smith et al, Exploring the Linkages between Education Sector Governance, Inequity, Conflict, and Peacebuilding in Kenya, UNICEF, 2016, at <http://eccnetwork.net/wp-content/uploads/10-Equity-Education-Peacebuilding-Governance-Kenya.pdf>

415. KNBS and UNICEF, Turkana County Kenya: Multiple Indicator Cluster Survey 2013/14, February 2016, at [https://mics-surveys-prod.s3.amazonaws.com/MICS5/Eastern%20and%20Southern%20Africa/Kenya%20%28Turkana%20County%29/2013-2014/Final/Kenya%20%28Turkana%20County%29%202013-14%20MICS\\_English.pdf](https://mics-surveys-prod.s3.amazonaws.com/MICS5/Eastern%20and%20Southern%20Africa/Kenya%20%28Turkana%20County%29/2013-2014/Final/Kenya%20%28Turkana%20County%29%202013-14%20MICS_English.pdf)

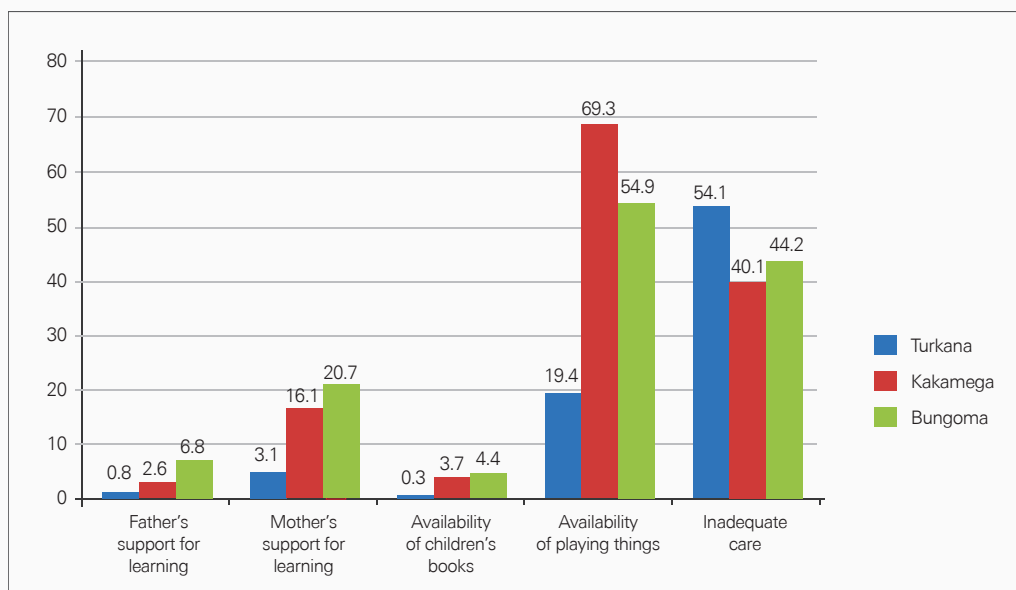


Figure 18: Parental support for learning by county, 2013-2014, MICS 5

256. Children in informal settlements face different challenges. Due to the economic constraints that face most mothers in these areas, children are often left in the care of caregivers at makeshift crèches or daycare centres. These centres have minimal facilities and are affordable for families residing in informal settlements. However, the conditions in the centres are often insanitary and cold. There are not enough caregivers per child. Therefore, some children are neglected, especially those who cry and are problematic.<sup>416</sup>

## Pre-school education

257. EMIS figures reveal that enrolment in pre-school facilities increased from 2.5 million in 2011 to 3.2 million in 2015. In 2015, 97 girls were attending for every 100 boys.<sup>417</sup>

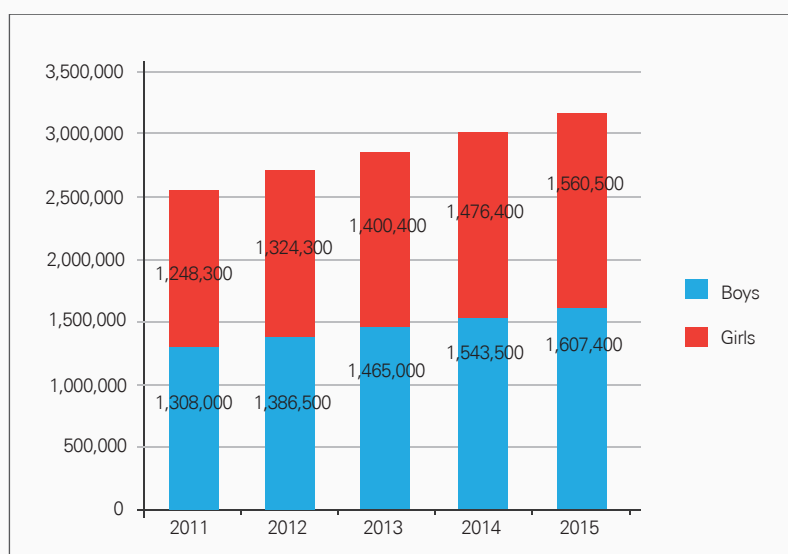


Figure 19: Pre-school enrolment 2011-2015, EMIS

258. This rise in real numbers also reflects growth in enrolment rates. The Gross Enrolment Rate (GER) rose from 57.6 per cent in 2004<sup>418</sup> to 67 per cent in 2011 and 76.5 per cent in 2015,<sup>419</sup> while the Net Enrolment Rate (NER) also rose, from 56.1 per cent in 2009<sup>420</sup> to 74.6 per cent in 2015.<sup>421</sup> There are large disparities between counties in enrolment rates, with the GER ranging from 123.0 per cent in West Pokot in the northwest (as a result of high overage enrolment) to 18.3 per cent in Mandera and 28.7 per cent in Wajir in the northeast (in every other county the GER was higher than 50 per cent). Mandera and Wajir counties, along with neighbouring Garissa County have the highest gender disparity in pre-school enrolment (GER in Garissa 93.0 per cent for boys and 63.2 per cent for girls (this figure includes learners at the Dadaab refugee camp and so is not accurate for the whole county); Mandera 24.3 per cent and 13.3 per cent respectively; and Wajir 36.2 per cent and 22.2 per cent respectively).<sup>422</sup>

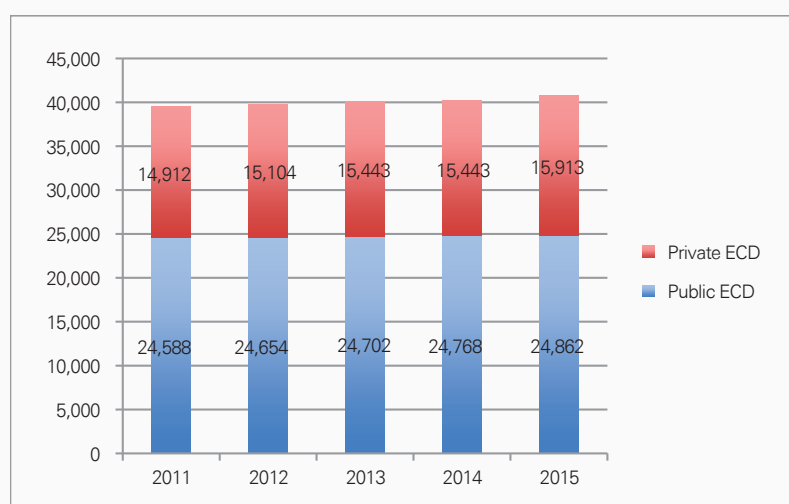


Figure 20: Number of pre-primary schools in Kenya 2011-2015, EMIS

259. The number of pre-primary schools in Kenya has continued to increase steadily since 2000.<sup>423</sup> In 2015, there were an average of 10 new private centres per county compared to an average of two new public centres per county. That year, 39 per cent of pre-schools were private, similar to the figures over recent years. However, the growth in the number of preschools has not kept pace with the rise in children attending: the average number of children attending each pre-school has increased steadily from 65 in 2011 to 78 in 2015.<sup>424</sup>
260. In Kenya, 57 per cent of the children enrolling at pre-school are aged four, which is the national standard. A total of 13 per cent enrol aged two or three, while 21 per cent of children at pre-school are aged over six and should be attending primary school.<sup>425</sup>

416. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

417. Ministry of Education, Basic Education Statistical Booklet, 2015/418. Ministry of Education, Basic Education Statistical Booklet, 2014, at <https://www.kicd.ac.ke/images/ICT/2014BasicEducationStatisticalBooklet.pdf>

419. Ministry of Education, Basic Education Statistical Booklet, 2015

420. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

421. Ministry of Education, Basic Education Statistical Booklet, 2015

422. Ministry of Education, Basic Education Statistical Booklet, 2015

423. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

424. Ministry of Education, Basic Education Statistical Booklet, 2015

425. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaweza.org/uploads/files/UwezoKenya2015ALARreport-FINAL-EN-web.pdf>

261. In total, 67 per cent of children in pre-school are at public institutions. However, the proportions of attendance of public and private pre-school institutions vary dramatically by county. In the largest cities, private pre-school is much more common: for example, 93 per cent of pre-schoolers in Nairobi attend private institutions, as do 85 per cent in Mombasa. By contrast, in Samburu, West Pokot, Mandera and Kitui counties more than 90 per cent of pre-schoolers are at public facilities.<sup>426</sup>

**Key issues**

- Enrolment in pre-school facilities increased from 2.5 million in 2011 to 3.2 million in 2015
- Gross enrolment rose from 67 per cent in 2011 and 76.5 per cent in 2015
- Gross enrolment varies from 123.0 per cent in West Pokot (as a result of high overage enrolment) to 18 per cent in Mandera and 29 per cent in Wajir
- In 2015, 97 girls were enrolled at pre-school for every 100 boys in Kenya, but some counties, such as Mandera, Wajir and Garissa, have significantly more boys than girls enrolled

## Primary education

262. As indicated above, the Basic Education Act of 2013 mandates the Government to provide free and compulsory basic education at primary and secondary level.<sup>427</sup> Kenya has been making progress towards universal primary education. At primary level, the GER stood at 103.6 per cent in 2015, and a reduced number of overage and underage children are being recorded in the figures. At 88.4 per cent in 2015, the NER for primary school had not substantially changed since 2011 (88.0 per cent).<sup>428</sup> There is no significant difference in attendance among children from the richest four quintiles: only primary-aged children from the poorest quintile are significantly less likely to be in education. The most recent national survey data on school attendance, the 2014 KDHS, gave a rather similar NER for primary education of 86.6 per cent. Girls were slightly more likely than boys to be in attendance at primary level (87.6 per cent and 85.5 per cent respectively).<sup>429</sup>

263. Figures from 2014 and 2015 show a sharp decline in children at school from Grade 7, the penultimate year of primary education.<sup>430</sup> Grade 8 is the year when children sit the exams to enter secondary school, and in the context of the limited number of secondary schools available, and the need in many remote areas for children to migrate from their own region to attend secondary, decisions to withdraw from formal education are relatively common at this stage.

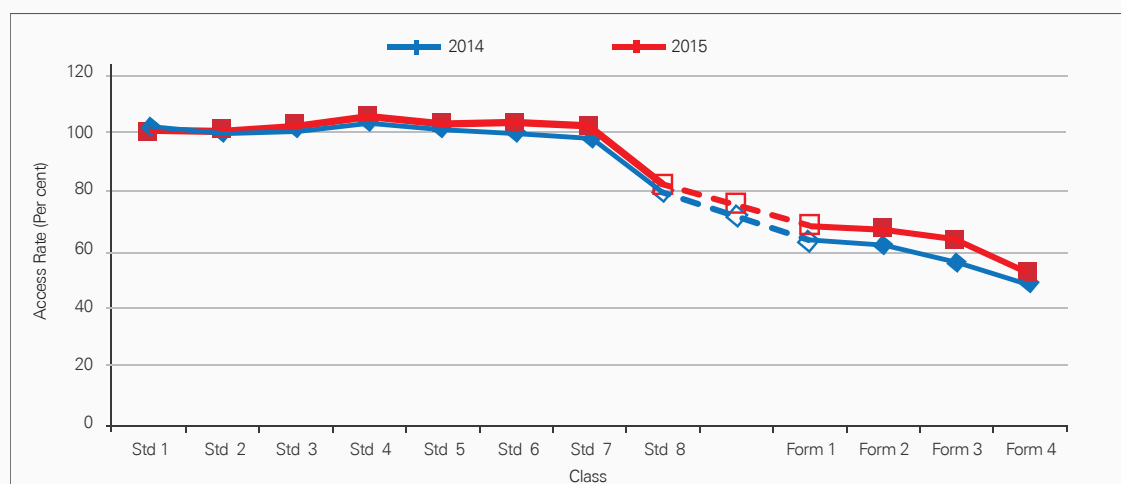


Figure 21: School access rate by grade, 2014 and 2015, EMIS

426. Ministry of Education, Basic Education Statistical Booklet, 2015  
 427. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>  
 428. Ministry of Education, Basic Education Statistical Booklet, 2015  
 429. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

264. Despite the relatively high enrolment rates, there are significant disparities between counties. According to EMIS, in 2015, the NER in Bomet county was 99.8 per cent. However, the figure in Mandera county was 27.2 per cent (and 18.2 per cent for girls) while in Wajir county the overall primary NER was 32.9 per cent (23.6 per cent for girls). The other counties with an NER significantly lower than the national average are generally in the north and east of the country. However, the NER in Nairobi is also relatively low, at 74.6 per cent.<sup>431</sup> This may be partly because some children from Nairobi attend school in neighbouring counties.<sup>432</sup>
265. Similarly, for all primary and secondary aged children (5-17), deprivation rates in education ranged from 7 per cent in Kiambu to 69 per cent in Mandera, 64 per cent in Wajir, 62 per cent in Garissa and 55 per cent in Turkana (see the map below).<sup>433</sup>

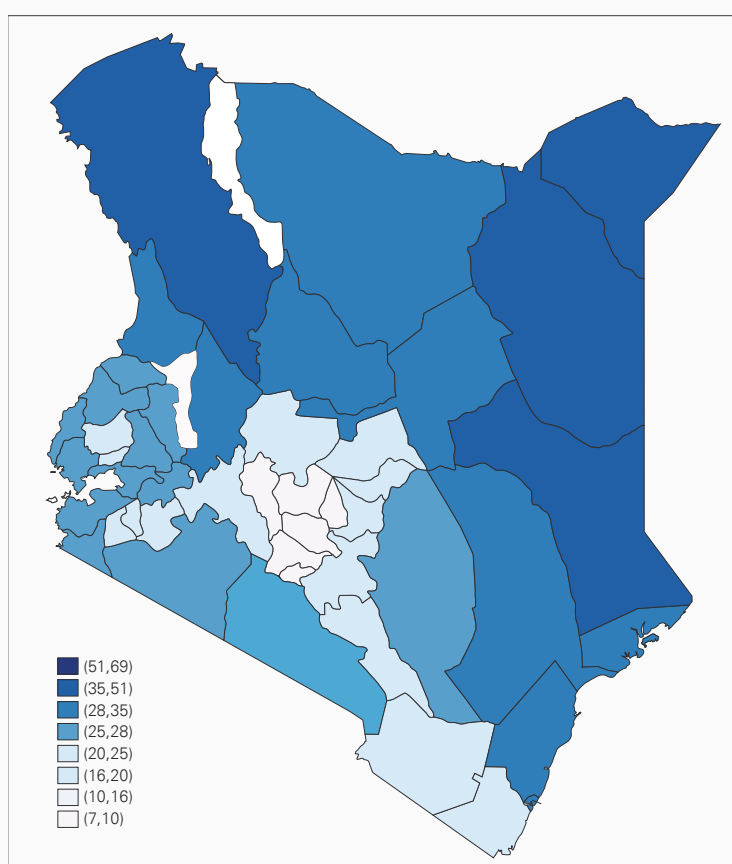


Figure 22: Deprivation rates in education, 2014, MDPS using KDHS figures

266. The total national pupil-per-teacher ratio at primary school level is 30.4 (35.2 for public schools and 16.8 for private schools). The figure is significantly higher in Turkana county (77.3; 84.1 public and 54.1 private), as well as in Mandera (56.5) and Wajir (49.0) counties.<sup>434</sup>

430. KNBS, Economic Survey 2016. Available via [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

431. Ministry of Education, Basic Education Statistical Booklet, 2015

432. Information provided by Ministry of Education, Science and Technology, June 2017

433. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

434. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

267. The profile per primary class varies significantly between counties. In most counties in 2015, there were more children in the middle grades (for example Primary 4 to 7) than in the first year.<sup>435</sup> This may reflect the fact that many children in the more senior classes were overage, taking advantage of new opportunities to receive education, while by the time new Primary 1 had started, there were fewer older children that needed to begin their education.<sup>436</sup> According to the 2014 KHDS, 25 per cent of children aged 8-14 years were two or more years behind their grade-for-age.<sup>437</sup>
268. The 2015 Uwezo report indicates that 15 per cent of pupils were absent from school on the day of the visit. A higher proportion of children from rural areas (16 per cent) were absent from school than those from urban areas (12 per cent). No gender difference was noted. The lowest attendance was found in the northwest, in Turkana (78 per cent) and Samburu (79 per cent), but no explanation was given for this.<sup>438</sup> Attendance data is only available from this one specific study at school level that is recorded by teachers and head teachers. No centralized data is available on attendance of students, making it hard to track and verify student numbers reported by head teachers to receive school grants, nor student progression across the system. The Ministry of Education is working to improve EMIS data and include individualized data.

## ASAL counties

269. In Kenya's northern and eastern ASAL counties, the profile of enrolment is different from the rest of the country. In Mandera, Wajir and particularly Turkana counties, enrolment numbers fall dramatically from first grade to eighth grade.<sup>439</sup> This is partly because more overage children are now entering the education system in these counties. A 2016 national study of children in Primary 3 by the Kenya National Examinations Council found that overage figures were particularly high in Garissa (98.3 per cent), Turkana (90 per cent) and Kwale (79.9 per cent) counties.<sup>440</sup>
270. However, retention rates are also low in the northern and eastern counties. In a 2015 study in the ASAL counties, parents gave the following reasons for their children not completing school: the child is unlikely to get a job at the end; the child may not pass the exams; the financial, social and moral costs are too high; the child is not safe or is exposed to 'poisonous' town culture; the child is needed to help at home; and/or, most commonly, the child needs to learn livestock production.<sup>441</sup>
271. Nomadic communities operate under very harsh climatic conditions, generally in the northern and ASAL counties,<sup>442</sup> and they have a myriad of competing needs but very limited resources. Lack of appropriate delivery methods and school infrastructure is one of the major barriers to improving access to primary education in nomadic areas. They face various problems relating to their geographical location and harsh ecological conditions. The mobility of nomadic communities, the hardships associated with the ASAL counties and the limited number of teachers with nomadic backgrounds makes recruitment, deployment and retention of teachers difficult. As current teacher management policies, including decentralization, have not adequately addressed staffing problems, there is a need to review the whole spectrum of teacher training, recruitment and deployment.<sup>443</sup>
272. Pastoralism is the economic mainstay in the ASAL region, yet little or no new understanding in academia on the value of pastoralism or on its technical and institutional requirements is being translated into curricula taught in formal schools. Instead, many portray a negative image of the livelihood.<sup>444</sup>

435. Ministry of Education, Basic Education Statistical Booklet, 2015

436. UNICEF, A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands, 2015

437. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

438. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaveza.org/uploads/files/UwezoKenya2015ALAREport-FINAL-EN-web.pdf>

439. Ministry of Education, Basic Education Statistical Booklet, 2015

440. Kenya National Examinations Council, 2016 NASMLA Class 3 Report, Powerpoint Presentation, 17 January 2017

441. UNICEF, A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands, 2015

442. In addition to families in the ASAL counties, there are also nomadic fishing communities on Lake Victoria whose movement in search of fish can also lead to irregular school attendance [Interview, UNICEF, 29 May 2017]

443. Ministry of Education, Science and Technology, Policy Framework for Nomadic Education in Kenya, Revised version, March 2015

444. UNICEF, A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands, 2015

273. In this context, the 2013 Basic Education Act established the National Council for Nomadic Education in Kenya (NACONEK) to expand educational opportunities for these groups. Meanwhile, parents, youth and community leaders are organizing a growing number of initiatives to secure the kind of education they want. Pastoralists, in particular, are starting schools that allow herding education and formal learning to take place hand-in-hand. In Mandera and Wajir, for example, in many cases parents clearly choose alternatives to formal education, such as pastoralist or religious education, and many express the opinion that these forms are more accessible and economically and culturally relevant.<sup>446</sup>
274. National statistics do not report what proportion of children in Kenya are boarding at school. However, most of the schools in Kenya (25,394) are day schools, with 532 full boarding schools and 532 mixed. The counties with the highest proportion of schools offering at least some boarding provision are Samburu (28 per cent), West Pokot (25 per cent), Marsabit (25 per cent) and Turkana (24 per cent) counties.<sup>447</sup> These are all ASAL counties, often with long distances to travel to school. The Government introduced the “Modelling of Integrated Nomadic Education, Child Friendly Schools and Water, Sanitation and Hygiene (WASH) Programme” in 2014; one of its aims was to improve access to education by the expansion of opportunities to study in low cost primary boarding schools.<sup>448</sup>

## Children with disabilities

275. The education of children with disabilities in Kenya is governed by the 2009 National Special Needs Education Policy, which is currently under review. In December 2016, the Ministry of Education created the Directorate of Special Needs Education, which has a mandate specifically to look into the issue of educating children with disabilities.<sup>449</sup> Policy is currently being amended to come into line with the Convention on the Rights of Persons with Disabilities (CRPD), under the National Plan of Action on the CPRD.<sup>450</sup>
276. Lack of data makes it impossible to quantify the number of children with disabilities not attending school. In 2015, the total number of primary school children registered with disabilities was 224,159, making up 2 per cent of primary school children in the country. Of these children with disabilities attending primary school, 43 per cent had intellectual impairments; with hearing (17 per cent), physical (15 per cent) and visual (16 per cent) impairments, or multiple disabilities (8 per cent) making up the rest.<sup>451</sup> Meanwhile, in August 2016, the Special School Heads Association of Kenya reported that more than 100,000 children with disabilities were out of school in the country.<sup>452</sup> However, on the basis of an estimated childhood disability rate of 13.5 per cent in Kenya (see *Children with Disabilities below*), the true number of out-of-school children with disabilities in the country may be as high as three million, and net enrolment less than 10 per cent.
277. Research has found several factors that make children with disabilities in Kenya more likely to be able to attend school. These include support from NGOs and CBOs, provision of assistive devices and educational institutions catering for the needs of children with disabilities, care and protection for the children, parents with high education levels, positive attitudes of parents and children, increased advocacy and availability of teachers trained to work with children with disabilities.<sup>453</sup>

445. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

446. UNICEF, A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands, 2015

447. Author's calculations, from Ministry of Education, Basic Education Statistical Booklet, 2015

448. Dennis Odunga, Low cost schools to boost pupil enrolment rates in ASALs, The Nation, 5 March 2014, at <http://mobile.nation.co.ke/news/Pupil-enrolment-and-completion-rates-set-to-increase-in-ASALS/1950946-2231310-format-xhtml-pwrb0b/index.html>

449. Ouma Wanzala, Ministry Sets Up Agency to Address Special Needs Education, Daily Nation, 19 December 2016, at <http://www.nation.co.ke/news/New-agency-to-address-special-needs-education/1056-3490750-11wyi3/index.html>

450. Ministry of East African Community, Labour and Social Protection, National Plan of Action on implementation of recommendations made by the Committee on the Rights of Persons With Disabilities in relation to the initial report of the Republic of Kenya, September 2015-June 2022, May 2016, at <http://www.udpkenya.or.ke/publications/national-plan-of-action.pdf>

451. Ministry of Education, Basic Education Statistical Booklet, 2015

452. Daily Nation, Over 100,000 Children With Disabilities out of School in Kenya, 30 August 2016, at <http://globalaccessibilitynews.com/2016/08/30/over-100000-children-with-disabilities-out-of-school-in-kenya/>

453. VSO, Kenya National Special Needs Education Survey Report, 2014

278. While national policy is relatively strong on disability, the Government has not invested sufficiently to empower these children. They are often marginalized, institutionalized and left behind if at school.<sup>454</sup> The factors that keep children with disabilities out of school are found both in the home environment and in the education system. Home-related challenges include parents keeping their children away from school for fear of exposing them to social stigma in the 'outside world', high levels of poverty, lack of assistive devices, such as wheelchairs, and lack of aides for children. Systemic factors included lack of adequate transportation to schools, inadequate numbers of special schools in the communities and lack of sufficient teachers and aides trained specifically to work with children with disabilities.<sup>455</sup>
279. Many of the children with disabilities who are attending school in Kenya study in special schools, or in special units attached to mainstream schools but segregated from other students. Funding mechanisms favour segregated education over inclusive education. For example, the stipend for teachers trained to work with children with disabilities is currently extended only to teachers in segregated schools; it does not reach teachers who teach children with disabilities in mainstream schools and who practice inclusive education.<sup>456</sup> In this context, the National Plan of Action on the CPRD has set out a timeline for changing legislation and policy and taking practical measures to ensure that children with disabilities can study alongside others at mainstream schools in inclusive education.<sup>457</sup>
280. There are mixed perceptions towards children with disabilities in the education system. While there are some favourable perceptions, there is a persistence of stereotypes, misconceptions, stigma and discrimination towards children with disabilities in schools and communities.<sup>458</sup> There is a lack of a specific inclusive education policy that covers funding, medical needs and adjustments for teaching, learning and examinations needs for children with disabilities.<sup>459</sup> Some children with disabilities face additional challenges. Among nomadic communities in particular, there is an issue of stigmatization of those disabilities and also a lack of capacity to effectively deliver inclusive education strategies in mainstream schools.<sup>460</sup>

## Other barriers to education

281. For children of primary-school age, the factor that has the highest effect on increasing the probability of being out of school is the educational attainment of the household head. Children living in households where the household head has had no education are 4 percentage points more likely to be out of school than children living in households where the household head has secondary or higher education. Four percentage points is a significant difference given that the total out-of-school rate among children aged 6-14 in 2014 was 5 per cent. Qualitative research found that parents without education are more likely to want their children to run house errands and assist them in economic activities, even if they are attending schools. Furthermore, parents with no formal education may not be able to follow pupils' homework and progress, leading to negligence due to illiteracy and language barriers among some of the parents.<sup>461</sup>
282. Qualitative research for the 2016 Multidimensional Child Poverty study found that monetary poverty was a barrier to school attendance because of the inability of parents to cover costs associated with sending their children to school, such as paying fees to hire additional teachers, purchasing desks and chairs, uniforms, textbooks and other school materials, sanitary towels for girls, and paying for meals. Monetary poverty is a particularly major barrier for children if they live too far from the school and would need to board to attend, if they are preparing for the national examination (children in Grades 6-8 of primary school), or if attending secondary school, as bursaries are small. Likewise, orphaned children and children living with only one parent are at a higher risk of being deprived of education as their grandparents/guardians may not be able to afford to send them to school.<sup>462</sup>

454. Interview, UNICEF, 21 March 2017

455. VSO, Kenya National Special Needs Education Survey Report, 2014

456. Global Campaign for Education, Accessing Inclusive Education for Children with Disabilities in Kenya, 2016, at <https://www.leonardcheshire.org/sites/default/files/Accessing-inclusive-education-children-disabilities-kenya-gce-appg-report-february-2016.pdf>

457. Ministry of East African Community, Labour and Social Protection, National Plan of Action on implementation of recommendations made by the Committee on the Rights of Persons With Disabilities in relation to the initial report of the Republic of Kenya, September 2015-June 2022, May 2016, at <http://www.udpkkenya.or.ke/publications/national-plan-of-action.pdf>



283. Another group of children facing particular barriers to education are children living on islands. Figures from the 2009 census and more recently indicate a total population of more than 80,000 on 10 islands in Lake Victoria, for example.<sup>463</sup> If national demographic projections hold true for the islands, this suggests that more than 40,000 of the population are children. Often the islands have no schools at all, or no secondary schools, and so to begin or continue their education children must leave their homes.<sup>464</sup> No research is available on the vulnerabilities that children are exposed to during the boat journey to and from school.
284. One of the greatest challenges for Kenya's education system is providing for children in the informal settlements around large cities such as Nairobi, Mombasa, Kisumu and Garissa. If the Government does not recognize settlements, provision of public schooling is problematic for the thousands of children who reside there.<sup>465</sup> For example, while there are 26 public schools serving Kibera and Langata, and informal settlements in the Nairobi area, parents of children living in the areas are often dissuaded from enrolling their children because they have to travel long distances to reach them. In this context, a number of private actors are operating schools in the communities for profit. The Ministry of Education recognized these non-formal schools in the 2016 Guidelines for Alternative Provision of Basic Education and Training but generally does not provide capitation funds as it does for other schools because they do not meet national standards.<sup>466</sup> This increases the cost for parents, who need to pay themselves.
285. In a 2015 survey, only 53 per cent of children aged 3-18 years in four informal settlements were enrolled at school. Dropping out and withdrawing children from school were noted to be common. Of those children who had dropped out, 66 per cent were boys and 34 per cent girls. Meanwhile, boys were also more likely to be withdrawn from school than girls (54 per cent and 46 per cent respectively). The reasons for withdrawal include lack of money to pay school fees, recuperating from accidents, drug and substance abuse, high poverty levels and opportunity costs, peer pressure and early pregnancies for girls.<sup>467</sup>
286. Families also face challenges affording menstrual protection and sanitary wear, especially when coupled with the lack of sanitation facilities in schools (which means that many feel they have to leave school when they reach puberty).<sup>468</sup> This is a particular issue at primary schools, because of lack of awareness. As of May 2017, the Ministry of Health is currently finalizing a new Menstrual Hygiene Policy that will address this issue, among others.

### Key issues

- Gross enrolment at primary school rose from 67 per cent in 2011 to 76.5 per cent in 2015
- In 2015, an estimated 1,292,695 children (55 per cent girls) were out of school
- The net enrolment at primary school in 2015 (88 per cent) was the same as in 2011
- There were wide regional disparities, with net enrolment in Bomet County was 99.8 per cent, compared to Mandera County's 27.2 per cent and Wajir County's 32.9 per cent
- As for pre-school education, there is gender parity for primary education enrolment with the main exception of the northeastern counties, which have a significantly larger proportion of boys enrolled
- While large numbers of Kenya's out-of-school children have disabilities, lack of data makes it impossible to quantify the extent of the problem, but according to estimates, less than 10 per cent of children with disabilities are enrolled at school
- The factors that keep children with disabilities out of school are found both in the home environment and in the education system.
- Children from nomadic communities face challenges including a perceived lack of value of schooling for pastoral societies, and the long distance to schools in some areas.

458. VSO, Kenya National Special Needs Education Survey Report, 2014

459. VSO, Kenya National Special Needs Education Survey Report, 2014

460. Ministry of Education, Science and Technology, Policy Framework for Nomadic Education in Kenya, Revised version, March 2015

461. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

462. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

463. Author's calculations, based on Isaiah Gwengi, Aspirants now troop to neglected vote-rich Lake Victoria islands, the Standard, 12 March 2017, at <https://www.standardmedia.co.ke/article/2001232348/aspirants-now-troop-to-neglected-vote-rich-lake-victoria-islands>

464. Interview, UNICEF, 29 May 2017. See, for example, NTV, Lack of School Killing Education Dreams for Sukru Children, Video, Youtube, 11 September 2016, at <https://www.youtube.com/watch?v=IPElgs-cWCw>

## Secondary education

287. Between 2012 and 2015, the number of children at secondary school increased, but the number of boys continued to be higher than the number of girls at this level of education.<sup>470</sup> According to the 2014 KDHS, however, in total, 40 per cent of boys and 34 per cent of girls aged 15-17 were deprived in education, meaning that they were not attending school, or attending school but with three or more years behind their expected grade-for-age, or had completed primary school but were illiterate. In total, 28 per cent of all children aged 15-17 were three or more years older than their expected grade-for-age.<sup>471</sup>

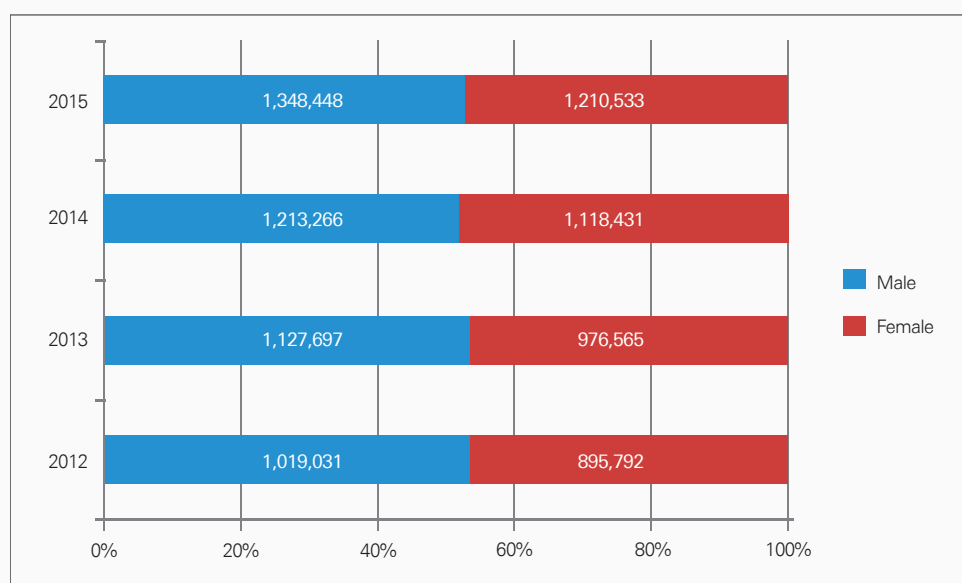


Figure 23: Number of boys and girls at secondary school 2012-2015, EMIS figures

288. The transition rate between primary and secondary school remains low, at 86 per cent in 2014. The low number of secondary schools in the country (9,440, compared to 31,300 primary schools in 2015) is a major bottleneck to secondary enrolment. Costs are also a barrier for poorer families, as well as lack of teachers (particularly in the ASAL counties), resource shortages and lack of quality to provide quality education. In this context, the Ministry of Education has established a KSh 6 billion Infrastructure Fund for Public Schools in order to increase the transition rate by ensuring that high quality facilities are available at an accessible cost. It has also suggested that there are significant levels of wastage in public schools, though school managements dispute this.<sup>472</sup>
289. In some communities, girls may fear losing their “marriageability” by entering secondary school, and face risks of sexual abuse, but many report their education leading to greater successes in life. Meanwhile, the exam barrier after Grade 8 is crucial: if children do not pass the exam, they cannot enter secondary education. In areas such as Turkana, where children and many teachers do not speak English or Kiswahili fluently as a mother tongue, passing the exam at the end of the academic year is difficult.<sup>473</sup>

465. Interview, UNICEF, 21 March 2017

466. MyGov, Ministry of Education Releases Guidelines for Informal Schools, 6 February 2016, at <http://www.mygov.go.ke/?p=6263>

467. UNICEF, Participatory Mapping of Children’s Risks and Vulnerabilities in Urban Areas, November 2015

468. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

469. Interview, Ministry of Health, 22 May 2017

470. Kenya National Bureau of Statistics, Statistical Abstract, 2016, at [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=106&Itemid=1177](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=106&Itemid=1177)

471. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

472. Kenya News Agency, Reforms in Education to Scale up Transition Rate, 26 April 2017, at <http://kenyanewsagency.go.ke/en/reforms-in-education-to-scale-up-transition-rate/>

473. Interview, UNICEF, 21 March 2017

290. For children of secondary school age, the main factor increasing the probability of being out of school is children living without parents. Single and double orphans are significantly more likely to be out of school than children with both parents alive, especially for older children aged 15-17, among whom orphans have an 8-percentage point higher probability to be out of school (this is significant given that the total out-of-school rate among children aged 15-17 was 12 per cent in 2014). For children of secondary school age, being from any quintile outside the richest significantly increases the probability of being out of school. Having an additional child under age five in the household also increases the probability of being out of school, especially for children of secondary-school age.<sup>474</sup>
291. Qualitative research in Kakamega found that child labour also has a negative effect on school attendance (no quantitative research was undertaken to estimate the scale of the effect). Because of urbanization in the county, there are more work opportunities available and the children are attracted by “quick money” jobs, such as driving boda-boda motorcycles (boys) or caretaking/cleaning jobs (girls). Orphaned children living with guardians, grandparents, or children who become household heads are more prone to engaging in labour activities due to poverty.<sup>475</sup>
292. For children aged 15-17, the difference in probability of being out of school between girls and boys is statistically insignificant, everything else being equal. Nevertheless, girls face different barriers to obtaining education than boys, because of heavy domestic workloads, adolescent marriage and pregnancies, and negative societal attitudes towards the importance of educating the girl child. Reportedly, when families have limited resources, boys will be given priority as they are considered the future caregivers for the family, while the girls will be married and will live with a new family. However, boys are more likely to drop out of school to work (on a farm for example) or as a result of peer influence.<sup>476</sup>
293. Some research suggests there are concerns that girls who have gone to school may lose their ‘marriageability’. Many girls are deeply insecure inside schools, enduring rape and other forms of sexual abuse. Yet many also report they are better able to choose whom they marry and feel they have more potential at home and in society as a result of attending secondary school.<sup>477</sup>
294. Children with disabilities are much less likely to be enrolled in secondary than primary school: only 0.4 per cent of children at secondary level are registered with disabilities as opposed to 2 per cent at primary level. The fall off is much more significant among children with intellectual disabilities and multiple disabilities than among those with hearing, physical or visual impairments.<sup>478</sup>
295. One of the key barriers for families trying to access inclusive education for their children with disabilities in Kenya is fees. Special Educational Needs schools are predominantly low fee-paying schools. While there is a pupil stipend for children with disabilities, children are only able to access these after being assessed in an ‘Educational Assessment Resource Centre’ (EARC). These EARCs are severely under-resourced, meaning there are gaps in meeting their role to identify, assess and refer children with disabilities. Meanwhile, the additional stipend given does little to cover the cost of the fees and additional support that is required.<sup>479</sup>

### Key issues

- The transition rate from primary to secondary school remains low at 86 per cent in 2014
- The low number of secondary schools in the country (9,440, compared to 31,300 primary schools in 2015) is a major bottleneck to secondary enrolment
- In 2014, children from the richest quintile were significantly more likely to be enrolled in secondary education than others
- Orphaned children are much less likely to attend secondary school
- Paid employment outside the home is more likely to keep boys out of secondary school, while girls are more likely to be out of school to care for younger siblings or for domestic work
- In some communities, girls may fear losing their “marriageability” by entering secondary school, and face risks of sexual abuse, but many report their education leading to greater success in life

## Technical and vocational education and training

296. Total enrolment in technical and vocational education and training (TVET) institutions rose by 4.7 per cent from 148,142 in 2014 to 155,176 in 2015 mainly due to the expansion of the youth polytechnics and infrastructure development by county governments.<sup>480</sup> There has been an increase to access of loans for TVET trainees with the number of beneficiaries increasing from 2,504 in 2013/14 to 12,148 students in 2015/16. A policy framework for the TVET sector is in place, which focuses on providing competency-based education and training that meets the need of the workplace and facilitates self-employment.<sup>481</sup>

## Quality of education

### Teaching

297. The pupil-teacher ratio is relatively good at national level (29.6 pupils per teacher at pre-school, 30.4 at primary and 20.1 at secondary school. For public schools, the figures are 31.9, 35.2 and 20.7).<sup>482</sup>
298. The national figures mask significant regional disparities, which particularly affect arid and semi-arid areas. For instance, in 2015, Turkana's pupil-teacher ratio was 77.3 at primary school and 30 at secondary school, while the primary school pupil-teacher ratio was 56.5 in Mandera, 49.0 in Wajir, 48.9 in Garissa and 43.0 in Bungoma.<sup>483</sup> In Mandera and Garissa counties, there were only six teachers per 10 classes in 2015, while in Turkana there were seven per 10 classes.<sup>484</sup> According to the 2015 EMIS report, only 52 per cent of teachers are deployed based on actual needs: the other 48 per cent are deployed due to other (unspecified) "non-formal conditions".<sup>485</sup>
299. One of the factors behind disparity in teacher ratios is that conditions are much harsher in the northern and eastern parts of the country, and yet teachers only receive a minimal hardship allowance of between KSh 5,700 and KSh 38,100.<sup>486</sup> Another concern is the insecurity in North Eastern Kenya, in Mandera County in particular, which has led to many teachers from outside the county leaving. In February 2017, it was reported that the county faced a shortage of 1,300 teachers. Because of this, schools were at risk of closure.<sup>487</sup> Similar problems are observed in Garissa and Wajir counties. The county governments are working with the Teachers Service Commission to provide funding for additional primary- and secondary-level teachers.<sup>488</sup>
300. According to the Uwezo study, in 2015 there were 1.2 teachers per class in the country, of whom 1.1 were recruited through the Teacher Service Commission, and 0.1 hired through the Board of Management (financed by parents).<sup>489</sup> This clearly has equity implications for low-income families who may be unable to afford to pay for additional teachers. When it comes to teachers registered with the Teachers Service Commission, schools in Baringo, Nyeri and Tharaka-Nithi have about four times as many teachers per pupil than those in Turkana or Mandera for the same size of school.<sup>490</sup>
301. Teacher attendance in schools appears to be a concern. The 2016 Uwezo report found that teacher attendance fell from 91 per cent in 2014 to 88 per cent in 2015. The lowest figure was found in Uasin Gishu (70 per cent), with Nairobi also low at 78 per cent. The report suggested that this may have been the result of an unsuccessful strike in 2015, and the consequent low morale among teachers.<sup>491</sup>

474. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

475. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

476. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

477. UNICEF, A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands, 2015

478. Ministry of Education, Basic Education Statistical Booklet, 2015

479. Global Campaign for Education, Accessing Inclusive Education for Children with Disabilities in Kenya, 2016, at <https://www.leonardcheshire.org/sites/default/files/Accessing-inclusive-education-children-disabilities-kenya-gce-appg-report-february-2016.pdf>

480. KNBS, Economic Survey 2016. Available via [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

481. Republic of Kenya, Concept Note on Medium Term Plan 2018-2022, March 2017, at <http://www.mtp3.go.ke/assets/documents/mtp/CONCEPT%20NOTE%20MTP3.pdf>

482. Ministry of Education, Basic Education Statistical Booklet, 2015

483. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

484. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaveza.org/uploads/files/UwezoKenya2015ALARReport-FINAL-EN-web.pdf>

485. Ministry of Education, Basic Education Statistical Booklet, 2015

302. Teacher salaries in Kenya are high compared to other countries in East Africa. However, there are no incentives in place for professional development and conditions are not in place to allow teachers to enjoy in-service training.<sup>492</sup>
303. At pre-school level, there are 107,187 teachers, 19 per cent male and 81 per cent female. Of all pre-school teachers, county governments employ 62.6 per cent in public facilities and 37.4 per cent practise in private centres.<sup>493</sup> According to the 2016 Uwezo study, 42 out of 100 preschool teachers in the surveyed schools are trained.<sup>494</sup>
304. National policy is under development to ensure training of teachers, curricula and quality assurance at pre-school level. Early childhood classes are located within primary schools. Although the Constitution states that pre-primary education should be free, pre-school education is funded differently from other levels of education, with teachers paid by counties.<sup>495</sup> Communities and parents often are also called upon to provide most of the financing, primarily through the fees they pay for teacher salaries.<sup>496</sup>
305. Quality assurance for pre-school is weak at county level. The quality of services varies significantly between centres (both public and private) and can be very low. The central Government previously provided quality assurance officers at District Centres for Early Childhood Education, but under the devolved system many officers have been given opportunities either to be employed by the TSC as classroom teachers or to join the county payroll to continue ECD quality assurance work but without TSC salaries and benefits.

## Infrastructure and learning materials

306. Infrastructural needs affect schools in several ways. Average class size in Kenya at primary level is 39 in public schools and 19 in private schools. At secondary level, the figures are 35 and 25 respectively.<sup>498</sup> According to 2015 EMIS figures, 25 per cent of secondary schools have a study library, (22 per cent state and 41 per cent private). Sixty-six per cent of public secondary schools have at least one science laboratory, compared to 72 per cent in private schools.
307. The 2015 school census indicates that 71.7 per cent of all primary schools are connected to electricity while 28.3 per cent are not connected. Just over half (57.5 per cent) of public primary schools are connected to electricity through the National Grid; 16 per cent use solar power or other generators; and 26.5 per cent are not connected to any source of power. Private primary schools are slightly less likely to have electricity supplies (33.2 per cent lack electricity) than public schools. At secondary level, 83.3 per cent of all secondary schools have electric power; with private schools (89.2 per cent) more likely to have electricity than public schools (76.1 per cent).<sup>500</sup> This lack of connectivity is affecting the equitable rollout of the Government's Digital Learning Programme, which seeks to equip every primary school learner with a tablet.<sup>501</sup> Access to water supply and toilet are also concerns in Kenya. For more on these, see the *Water, Sanitation and Hygiene* section of the report.

486. Tuko, Teachers Service Commission Reviews Allowances, 2016, at <https://www.tuko.co.ke/45376-teachers-service-commission-government-releases-new-allowances-for-teachers.html>

487. Daily Nation, Non-local teachers in Mandera still facing hardships, Knut says, 27 February 2017, at <http://www.nation.co.ke/counties/mandera/no-local-teachers-Mandera/1183298-3802936-pp8g1nz/>

488. UNICEF, A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands, 2015

489. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaveza.org/uploads/files/UwezoKenya2015ALARreport-FINAL-EN-web.pdf>

490. Ministry of Education, Basic Education Statistical Booklet, 2015

491. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaveza.org/uploads/files/UwezoKenya2015ALARreport-FINAL-EN-web.pdf>

492. Interview, UNICEF, 21 March 2017

493. Ministry of Education, Basic Education Statistical Booklet, 2015

494. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaveza.org/uploads/files/UwezoKenya2015ALARreport-FINAL-EN-web.pdf>

495. Ministry of Education, Science and Technology, Education for All: the 2015 national review, 2014, at <http://unesdoc.unesco.org/images/0023/002316/231637e.pdf>

496. World Bank, Scaling up preschool in Kenya: Costs, constraints and opportunities, September 2016, at <http://documents.worldbank.org/curated/en/762961482316633811/pdf/111215-BRI-ELPPolicyBriefKenya-PUBLIC.pdf>

497. World Bank, Scaling up preschool in Kenya: Costs, constraints and opportunities, September 2016, at <http://documents.worldbank.org/curated/en/762961482316633811/pdf/111215-BRI-ELPPolicyBriefKenya-PUBLIC.pdf>

498. Ministry of Education, Basic Education Statistical Booklet, 2015

499. Ministry of Education, Basic Education Statistical Booklet, 2015

500. Ministry of Education, Basic Education Statistical Booklet, 2015

308. Despite high access figures, classroom quality for pre-schools could still be significantly improved. A large number of teachers do not receive adequate in-service training, many pre-school classrooms lack adequate teaching and learning resources, and often the infrastructure is in poor condition.<sup>502</sup>
309. Research conducted in primary schools in Kakamega, Kitui and Turkana counties found that lack of teachers and infrastructure resulted in overcrowding, with 80-100 pupils in one stream, 4-5 children sitting on the same desk, 3-4 children sharing one textbook, and limited time available to teachers to attend to pupils individually or to give them homework and mark it.<sup>503</sup>

## Assessment results

310. Under Kenya's current curriculum, there are two key examinations: the Kenya Certificate of Primary Education (KCPE), taken at the end of Grade 8; and the Kenya Certificate of Secondary Education (KCSE), taken after Grade 12. Total KCPE candidature grew from 776,214 in 2011 to 927,789 in 2015, an annual growth rate of 4.6 per cent. The proportion of candidates who were girls increased over this period from 48.4 per cent to 49.6 per cent.<sup>504</sup>
311. KCSE candidature also increased from 410,586 in 2011 to 512,630 in 2015. The proportion of candidates who were girls rose from 44.3 per cent to 46.8 per cent. The number who reached the C+ grade needed to access higher education increased from 119,658 to 165,766, or from 29.1 per cent to 32.3 per cent of candidates in this period. The proportion of female candidates scoring C+ and above improved from 37.8 per cent to 42.4 per cent.<sup>505</sup>
312. In addition to the official tests, the quality of education is assessed in Kenya by the Uwezo initiative. Since 2009, Uwezo has implemented large-scale nationally representative household surveys to assess actual basic literary and numeracy competencies of school-aged children across Kenya, Tanzania and Uganda.<sup>506</sup>
313. The sixth national Uwezo report for Kenya, published in December 2016, indicates that the quality of education in the country had not improved over the period of research. The report states that only three out of 10 children in Class 3 can do Class 2 work. On average, one out of 10 children in Kenyan primary schools completes Class 8 without being able to complete Class 2 tasks. Generally, girls performed better than boys at both Class 3 and Class 8 in all the assessed subjects, with the gap wider for the earlier classes. The gap (in coverage of class 2 competences) between boys' and girls' performance is widest in the earlier classes of primary school. The 2016 report revealed statistically significant links between distribution of teachers and learning outcomes. It also found that learning outcomes are lower in rural areas, arid areas and poorer households. For poorer children, the gap in performance in English is the highest, but all gaps narrow by Class 8.<sup>507</sup>
314. There are also regional disparities in learning outcomes, which match the disparities found in access to education. In 2015, the poorest outcomes for Class 3 children being able to do Class 2 work were found in Wajir (9.9 per cent), Mandera (10.1 per cent), Turkana (11.4 per cent) and Garissa (12.9 per cent) counties. The highest figures were found for Nyeri (51.8 per cent), Nairobi (50.5 per cent), Mombasa (49.9 per cent) counties.<sup>508</sup>

501. For more on the Programme, see Ministry of Information, Communications and Technology, Government Officially Rolls Out the Digital Literacy Programme in Schools, 29 September 2016, <http://www.ict.go.ke/government-starts-distribution-of-1-2-digschool-devices-to-over-22-000-public-primary-schools/>

502. World Bank, Scaling up preschool in Kenya: Costs, constraints and opportunities, September 2016, at <http://documents.worldbank.org/curated/en/762961482316633811/pdf/111215-BRI-ELPPolicyBriefKenya-PUBLIC.pdf>

503. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

504. Ministry of Education, Basic Education Statistical Booklet, 2015

505. Ministry of Education, Basic Education Statistical Booklet, 2015

506. Uwezo, About us, at <http://www.uwezo.net/publications/reports/>, accessed 24 May 2017

507. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaweza.org/uploads/files/UwezoKenya2015ALAREport-FINAL-EN-web.pdf>

508. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaweza.org/uploads/files/UwezoKenya2015ALAREport-FINAL-EN-web.pdf>

## Barriers to quality education

315. In the ASAL counties, politically motivated teacher transfers, insecurity, uneven distribution of resources and poorly sited Constituencies Development Fund schools undermine education quality. This means that only those children whose parents have money and connections can access a high-quality state or private school education and hope for a good job at the end, and thus have strong incentives to ensure their children receive formal education.<sup>509</sup>
316. In Kenya's informal settlements, particularly in Nairobi, there has been a rapid rise in informal low-cost private schools, largely because of a lack of government provision of schools in these areas. A 2013 study found that 63 per cent of children living in Nairobi's slums attend private schools, which are often unregulated.<sup>510</sup> The UN Committee on the Rights of the Child has expressed concern about the rapid increase in such schools, including those funded by foreign development aid, suggesting that they provide substandard education and deepen inequalities.<sup>511</sup>

## Improving the quality of education

317. The Ministry of Education has been taking steps to improve the quality of education in the county. The Child Friendly Schools approach has been integrated in the Ministry of Education's 2013-2018 National Education Sector Plan. In 2015, the Tusome programme was introduced to improve reading among children in Classes 1 and 2, featuring a new approach to teaching reading, increased teacher support and supervision, and improved learning environments. Introduced at the same time, the Tayari programme works with pre-school children to improving pre-literacy schools, while PRIEDE aims to enhance numeracy in Classes 1 and 2.<sup>512</sup>
318. In 2015, Kenya developed a new National Curriculum Policy that is intended to produce citizens equipped with relevant and quality knowledge with national values and social competencies and to equip them with the twenty-first century skills. The curriculum is intended to be competency-based and envisages three different pathways for children through the education system: the traditional academic pathway, a life-skills and vocational training pathway, and a pathway of education specializing in arts or sports.<sup>513</sup>
319. A 2016 needs assessment for the new curriculum gives some ideas of the improvements that could be made to learning in Kenya. Respondents (including pupils, teachers and headteachers) called for the new curriculum to broaden out assessment from examinations to include practical assignments. They also wanted the curriculum to enhance peaceful co-existence, contribute to economic development, promote innovation, problem solving and self-reliance and combat corruption, tribalism and insecurity. Participants emphasized a need for use of participatory pedagogical approaches, experiments and field trips, and suggested that collaborative learning should be promoted. They also called for better provision of basics, such as classrooms, course books, toilets and teaching aids, as well as play, music and drama materials.<sup>514</sup> Based on the needs assessment, a new curriculum was developed and a pilot was launched in April 2017 to be undertaken in 470 schools in all 47 counties.<sup>515</sup>

509. UNICEF, A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands, 2015

510. African Population and Health Research Center, Quality and Access to Education in Urban Informal Settlements in Kenya, 2013, at <http://aphrc.org/wp-content/uploads/2013/11/ERP-III-Report.pdf>

511. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

512. Uwezo Kenya, Are Our Children Learning (2016)?, December 2016, at <http://www.twaweza.org/uploads/files/UwezoKenya2015ALAREport-FINAL-EN-web.pdf>

513. Policy available at <http://www.kicd.ac.ke/images/PDF/national-curriculum-policy.pdf>

514. Kenyan Institute of Curriculum Development, Highlights of Key Findings from the Needs Assessment Research for Curriculum Development in Kenya, Presentation, April 2016, at <https://www.slideshare.net/mjmwanzo/kicd-curriculum-reform-needs-assessment-findings-report-by-dr-julias-juang-kicd-ceo-april-2016>

515. KBC Channel 1, Ministry of Education Launches New Curriculum to Replace 8-4-4, 21 April 2017

**Key issues**

- The pupil – teacher ratio is relatively good at national level, at 30.4 to 1
- However, it reaches 77.3:1 in Turkana and 56.5:1 in Mandera, partly because hazard allowances for teachers are not commensurate to the difficult conditions and insecurity in northern Kenya
- In 2014, according to the Uwezo test only 30 per cent of Class 3 children could do Class 2 work
- The poorest outcomes were found in Wajir (9.9 per cent), Mandera (10.1 per cent), Turkana (11.4 per cent) and Garissa (12.9 per cent) Counties.
- Many children in informal settlements attend low-cost private schools that may not meet Government quality standards
- In 2017 piloting began of a new National Curriculum intended to produce citizens equipped with relevant and quality knowledge, national values and social competencies and equip them with twenty-first century skills

## Education and emergencies

320. Kenyan educational institutions, their students and their staff have been affected both directly and indirectly by recent acts of violence. The April 2015 attack on Garissa University claimed 147 lives. In November 2014, 17 teachers travelling home at the beginning of school holidays were among 28 passengers identified as non-Muslim and killed by al-Shabaab in a bus hijack in Mandera County. One consequence of this is that teachers from other parts of the country are refusing to work in these areas in fear for their safety. This means that children, adolescents and youths are further deprived of education in the already marginalized north-eastern counties.<sup>516</sup> Meanwhile, competition between tribes can lead to school closures or destruction, or else children being taken away by their parents to a location they perceive as safer.<sup>517</sup>
321. Drought also has a wide-ranging impact on children's education. Assessments conducted by the National Drought Management Authority (NDMA) in December 2016 found that some schools had closed because of the ongoing drought. Many pastoralist families have migrated further from schools in search of water and pasture, taking their children with them. The education system loses touch with some of these children because of the lack of tracking systems. Meanwhile, in some cases drought has led to water shortages and a suspension of school feeding programmes, which has again reduced the incentive for parents to send their children to school.<sup>519</sup> A March 2017 survey in 13 drought-affected counties found that 60 per cent of learners lacked access to school feeding and 51 per cent of learners did not have access to safe drinking water. According to the survey, the presence of both school feeding and safe drinking water increases school attendance by up to 22 per cent.<sup>520</sup>
322. Disease epidemics (such as cholera, chikungunya, dengue fever) have been recurrent in some counties, affecting learner's attendance and eventually their learning outcomes. For more on these, see *Health Emergencies* above.

516. Alan Smith et al, Exploring the Linkages between Education Sector Governance, Inequity, Conflict, and

517. Peacebuilding in Kenya, UNICEF, 2016, at <http://eccnetwork.net/wp-content/uploads/10-Equity-Education-Peacebuilding-Governance-Kenya.pdf>

518. Interview, UNICEF, 21 March 2017

519. World Vision, Impact of Drought on Education, 27 February 2017, at <http://www.wvi.org/kenya/article/impact-drought-education>

520. UNICEF, Kenya Humanitarian Situation Report, 6 April 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20SitRep%20-%206%20April%202017.pdf>



## Refugee education

323. Refugee education is very complex and poses major challenges, particularly as there is no national policy to galvanise and govern it. There are two fundamental problems with refugee education in Kenya. Firstly, the Government has never been involved in the decision-making process for refugee education. Secondly, refugees who complete school cannot enter the workforce.<sup>521</sup>
324. A 2016 survey at the Dadaab refugee camps found that enrolment in schools has gradually increased in recent years, partly due to sensitization of parents to the importance of education, as well as material support given to girl children to continue their education.<sup>522</sup> However, only an estimated 48 per cent of 3-17 year olds are in education.<sup>523</sup> This can be attributed to cultural practices, high illiteracy levels, parental negligence, negative attitudes towards education, cases of child-headed families, hot weather in Dadaab and inadequate facilities in the schools, all of which lead to cases of out-of-school children, drop-outs and absenteeism.<sup>524</sup>
325. At Dadaab, numerous efforts have been made to provide learning materials, construct classrooms and employ teachers, but these are still inadequate given the large number of students at the schools. There is an urgent need for more qualified teachers to be employed and more classrooms to be constructed to cater for the large student population. In additions schools do not have enough learning materials (textbooks, pencils, pens, solar lamps and school uniforms), teacher salaries are too low, and parental participation in their children's' education is insufficient.<sup>525</sup>
326. In Kakuma refugee camp in Turkana county, the pupil: teacher ratio is reportedly 120:1. Learning resources are limited, leading to low quality of education. Education is made more challenging by the wide diversity of languages spoken and previous school experience of the camp residents. A high proportion of the residents are separated from their parents. Many school pupils are over age, as a result of missing out on education earlier in their lives. Some children do not attend because the cost of school supplies, transport, uniforms and, in some cases, bribery by teaching staff can be difficult to meet or are not a priority for families. School attendance can also be seen as a loss of an income opportunity. Girls often do not attend because they are required to look after younger siblings. Cultural barriers to education include low value being placed on traditional education, delayed initiation of schooling, and leaving early because of marriage.<sup>526</sup> Child refugees also have very limited post-primary education opportunities.<sup>527</sup> Because of the persistent conflict in South Sudan, the influx of refugee children continues to put more pressure on the education facilities in the camps, further aggravating achievement of learning outcomes.<sup>528</sup>

### Key issues

- In north-eastern Kenya, educational institutions, their students and their staff have been affected both directly and indirectly by recent acts of violence, including terrorist attacks on schools.
- This has led to teachers from other regions of the country refusing to work in these areas because of safety fears.
- Drought has led to school closures, lower attendance (especially in pastoral communities) and reduction in water supply and school feeding.
- Refugee children in Dadaab and Kakuma struggle with large classrooms and insufficient teachers, as well as a prohibition on entering the workforce that reduces the incentive to study.

521. Interview, UNICEF, 21 March 2017

522. Daniel Wesonga et al, Out of School Children Assessment Report: Dadaab Refugee Camp, Draft submitted to UNHCR, January 2017

523. Joint Education Strategy for Dadaab (2016-2020). Cited in Daniel Wesonga et al, Out of School Children Assessment Report: Dadaab Refugee Camp, Draft submitted to UNHCR, January 2017

524. Daniel Wesonga et al, Out of School Children Assessment Report: Dadaab Refugee Camp, Draft submitted to UNHCR, January 2017

525. Daniel Wesonga et al, Out of School Children Assessment Report: Dadaab Refugee Camp, Draft submitted to UNHCR, January 2017

526. Lutheran World Federation, Rapid Assessment of Barriers to Education in Kakuma Refugee Camp, February 2015

527. Jennie Taylor and Boniface Karanja, Report on Joint Education Mission to Dadaab Refugee Camps, UNHCR and UNICEF, 2016, at [https://www.humanitarianresponse.info/system/files/documents/files/report\\_on\\_joint\\_education\\_mission\\_to\\_dadaab\\_refugee\\_camps\\_20160930.pdf](https://www.humanitarianresponse.info/system/files/documents/files/report_on_joint_education_mission_to_dadaab_refugee_camps_20160930.pdf)

528. See, for example, UNHCR, Kenya: Kakuma Operational Update 1-15 May 2017, May 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/57197.pdf>

# Chapter 5:

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## Protection from violence exploitation and family separation



## Enabling environment

### Legislation

327. The 2010 Constitution of Kenya (Article 53) recognizes the need for all children to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhumane treatment and punishment, and hazardous or exploitative labour. These provisions are aligned with those cited in both the Convention on the Rights of the Child and the Africa Charter on the Rights and Welfare of the Child, to which Kenya is a signatory.<sup>529</sup>
328. The country has developed a strong legal framework to protect children from violence, abuse and exploitation. This includes the Prohibition of FGM Act (2011), the Sexual Offences Act (2006, currently under revision), and the Marriage Act (2013), Children Act (2001), the Basic Education Act (2014) and others. However, in several cases, there is insufficient rules/regulations in place to fully implement these laws.
329. Corporal punishment is prohibited in several legal provisions, including Article 29(e) of the Constitution, and (in schools) the 2013 Basic Education Act. Government legal notice 56 of 2001 also bans corporal punishment in all learning institutions. However, Article 127 of the 2001 Children Act on cruelty to and neglect of children gives parents and others with lawful control or charge of a child to “administer reasonable punishment”. This Article is likely to be revised in the new Children Act to remove the ambiguity of this phrase, and the Article is in any case superseded by the Constitution.
330. Legislation and policy concerning child protection in emergencies remains particularly weak, and there is no child protection component to the National Disaster Management Authority (see the *Children in Emergencies* chapter below).
331. The Government is in the process of coming up with a new children law to align it with the Constitution of Kenya, 2010, and include emerging issues on children and who are the duty bearers in child<sup>530</sup> As of early 2017, consultations have been taking place throughout the country on the draft law involving the Government, the Judiciary, UNICEF and other stakeholders. Rules and regulations are also being developed concurrently.

### Policy

332. Child protection issues are broadly aligned with Vision 2030’s social pillar, though they are not specifically articulated. Within the Second Medium-Term Plan (2014-2018), child protection is one of the areas of intervention under the objectives for gender, youth and vulnerable groups. The child protection systems part of the plan focuses on establishing child protection centres, developing integrated data management systems and facilitating alternative family care services, as well as finalizing and implementing the National Community Development Policy. A specific focus is sexual and gender-based violence, including reducing FGM prevalence.<sup>531</sup>

529. Government of Kenya, UNICEF and Global Affairs Canada, Taking child protection to the next level in Kenya, 2015, at [https://www.unicef.org/protection/files/Kenya\\_CP\\_system\\_case\\_study.pdf](https://www.unicef.org/protection/files/Kenya_CP_system_case_study.pdf)

530. UNICEF, UNICEF – KCO MTR Report, 2016

531. Government of Kenya, UNICEF and Global Affairs Canada, Taking child protection to the next level in Kenya, 2015, at [https://www.unicef.org/protection/files/Kenya\\_CP\\_system\\_case\\_study.pdf](https://www.unicef.org/protection/files/Kenya_CP_system_case_study.pdf)

333. The Government uses several key documents to guide stakeholders to develop a stronger and more effective child protection system. The first, the Framework for the National Child Protection System for Kenya (2011), seeks to “promote linkages between different actors and provide coordinated interventions and responses through statutory mechanisms.” The second, the County Child Protection Systems Guidelines, spells out an agenda for “coordinated action at county level and provides work practice direction for all formal and informal actors.”<sup>532</sup> Meanwhile, in 2017 the Department of Children’s Services has endorsed Guidelines for Case Management and Referral for immediate use by DCS officers and other child protection practitioners as a blueprint for handling children or survivors of abuse. The Guidelines will be launched later in 2017.
334. A programme strategy with specific targets was also drawn up at the same time. *Strengthening Child Protection in Kenya: Programme Strategy 2011-2014* was developed by the Government under the leadership of the National Council of Children Services and the Department of Children Services, both of which are part of the Ministry of East African Community, Labour and Social Protection. A second strategy is now needed to help meet the targets set in the Second Medium-Term Plan (MTP II 2014-2018) of Vision 2030. The Government is committed to taking stock of progress made so far and to undertake a cost analysis of the key components of the child protection system envisaged in the new strategy.<sup>533</sup>
335. The Department of Children’s Services currently under the Ministry of Ministry of East African Community, Labour and Special Protection is the Government’s duty bearer for child protection. Meanwhile, the National Council for Children’s Services acts as the regulator, supervisor and monitor on child protection.<sup>534</sup>

## Capacity and financing

336. Capacity gaps in the social welfare workforce, such as lack of personnel and knowledge and limited infrastructure, hamper their ability to provide the services children and their families need. The number of children’s officers (mainly in sub-county headquarters) is inadequate and qualified social workers are lacking.<sup>535</sup> There are about 1,073 children’s officers in the 47 counties and plans are underway to recruit additional staff. The Department of Children’s Services considers this inadequate.<sup>536</sup> There are no institutional mechanisms in place to provide training on child protection issues: some personnel receive on-the-job training, but this is inadequate.<sup>537</sup> However, there is an increase of the number of qualified children’s officers over time. In addition, they are also offered periodic in-service trainings on various aspects of child protection.
337. These capacity gaps appear to reflect to some extent a lack of financing for child protection services in Kenya. However, no recent analysis has been undertaken to find out the extent of the financing gap. The DCS and UNICEF are currently undertaking a study to estimate the cost of providing child protection services and strengthening the institutional capacity of the child protection systems in the country. The study should be completed by the end of 2017, and it will highlight some of the financing gaps in the child protection sector in Kenya.
338. There is a national child helpline in place in Kenya run by the Department of Children’s Services with support from development partners including a local NGO Childline Kenya.
339. National legislation (Children Act 2001 section 37(j) 37 (k) provides makes the DCS the responsible agency for tracing the families of children who are lost.

532. Government of Kenya, UNICEF and Global Affairs Canada, Taking child protection to the next level in Kenya, 2015, at [https://www.unicef.org/protection/files/Kenya\\_CP\\_system\\_case\\_study.pdf](https://www.unicef.org/protection/files/Kenya_CP_system_case_study.pdf)

533. Government of Kenya, UNICEF and Global Affairs Canada, Taking child protection to the next level in Kenya, 2015, at [https://www.unicef.org/protection/files/Kenya\\_CP\\_system\\_case\\_study.pdf](https://www.unicef.org/protection/files/Kenya_CP_system_case_study.pdf)

534. Interview, Department of Children’s Services, 26 May 2017

535. Luisa Lopez, Laura Guyer and Plus Mutie, Situational Analysis: Kenya’s Social Welfare Workforce, USAID, March 2013, at <http://www.socialserviceworkforce.org/system/files/resource/files/Situational%20Analysis-%20Kenya%20Social%20Welfare%20Workforce.pdf>

536. Information provided to UNICEF by Department of Children’s Services

537. Oxford Policy Management, Functional Review of Kenya National Safety Net Program (NSNP) Cash Transfer Programs, 2014. Cited in World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

## Coordination

340. Various aspects of child protection, such as legal protection of children, social welfare services, and children and families in street situations, are the responsibility of different government ministries and departments. While this is a normal phenomenon, at times their mandates conflict and coordination needs to be improved at national, county and sub-county levels. While Area Advisory Councils have been established at the County and sub-County levels, these are not fully operational everywhere. There are Child Protection Centres in some counties, managed jointly with the Department of Children's Services, UNICEF and NGO implementing partners.
341. The Government launched the National Child Protection Management Information System (CPIMS) in May 2017 following a successful pilot in 13 counties. The database is expected to enhance the data collection process and enhance coordination amongst stakeholders. One major challenge facing the system is the limited resources within the Department of Children Services, as well as poor internet connectivity, which makes it impossible for some counties and sub-counties to utilise the system.

### Key issues

- The Department of Children's Services considers the number of child protection personnel at county level to currently be inadequate
- Capacity gaps in the social welfare workforce, such as lack of personnel and knowledge and limited infrastructure, hamper their ability to provide the services children and their families need.
- The access gap is particularly acute in northern Kenya.
- This capacity gap appears to reflect to some extent a lack of financing for child protection services in Kenya: research is to be completed in 2017 to identify the level of financing
- Coordination at national level is challenging because different aspects of child protection are currently the responsibility of different government ministries and departments, and at times their mandates conflict.

## Violence and abuse

### Violence and children

342. The only major national survey on violence against children in Kenya dates back to 2010. According to the report, violence against children is a serious problem in the country, with lifetime consequences for victims. An estimated 79 per cent of boys and 76 per cent of girls experience physical, sexual and/or emotional violence before the age of 18: 73 per cent of boys and 66 per cent of girls experience physical violence before this age; while 32 per cent of girls and 18 per cent of boys had experienced sexual violence. The report concludes that sexual and physical violence occurs irrespective of ethnicity or socio-economic status. The perpetrators of violence against children are mostly persons close to them, such as parents, relatives or teachers. Over 50 per cent of children report that their parents have physically abused them before the age of 18, indicating that violence in a family setting is a considerable problem and seems to be accepted.<sup>539</sup> Meanwhile, qualitative research in informal urban settlements in 2015 suggests that significant numbers of children in that setting experience extreme punishments, including burning of fingers and being denied food, medication and the opportunity to attend school.<sup>540</sup>
343. Despite the legislative prohibition on corporal punishment, violence against children in schools remains a major concern. In 2010, of females and males who reported being punched, kicked, whipped or beaten with an object by an authority figure before the age of 18, teachers accounted for 99.9 per cent of perpetrators reported by females and 96.2 per cent of perpetrators mentioned by males.<sup>541</sup>
344. Corporal punishment also appears to remain an accepted form of discipline among parents, despite the constitutional and legislative provisions. A 2014 study of parents' perceptions of the use of corporal punishment in pre-primary institutions in Kenya found that 78 per cent of parents agreed that teachers should use corporal punishment to modify deviant behaviour; 78 per cent agreed that reasonable punishment is beneficial to preschool learners; 70 per cent disagreed that corporal punishment should be abandoned and 76 per cent disagreed that corporal punishment degrades the parents. Most parents (87 per cent) indicated that they never viewed corporal punishment as child abuse, while 63 per cent of parents agreed that teachers should be allowed to use corporal punishment with discretion.<sup>542</sup>
345. Socio-cultural practices and beliefs continue to underpin child protection violations. These include the belief that violence is an effective discipline method, that institutional care is not detrimental to children, and that FGM is necessary for girls and prepares them for early marriage, and that the child's right to seek support when abused is not encouraged. These issues are explored in more detail below.

### Gender-based violence

346. In the 2014 DHS, 14 per cent of women and 6 per cent of men aged 15-49 reported having experienced sexual violence at least once in their lifetimes. Overall, 39 per cent of ever-married women and 9 per cent of ever-married men aged 15-49 report having experienced spousal physical or sexual violence. Among women and men who have ever experienced spousal violence (physical or sexual), 39 per cent and 24 per cent respectively, reported experiencing physical injuries. Forty-four per cent of women and 27 per cent of men have sought assistance to stop the violence they have experienced.<sup>543</sup> A 2015 survey of informal settlements confirms high prevalence of gender-based violence, states that this is often by triggered by financial arguments, alcohol abuse and men having multiple partners, and highlights that children are often caught in the middle of such confrontations.<sup>544</sup>

539. UNICEF, Division of Violence Prevention, National Center for Injury Prevention and Control, U.S. Centers for Disease Control and Prevention, and the Kenya National Bureau of Statistics, *Violence against Children in Kenya: Findings from a 2010 National Survey. Summary Report on the Prevalence of Sexual, Physical and Emotional Violence, Context of Sexual Violence, and Health and Behavioral Consequences of Violence Experienced in Childhood*. 2012, at [https://www.unicef.org/esaro/VAC\\_in\\_Kenya.pdf](https://www.unicef.org/esaro/VAC_in_Kenya.pdf)

540. UNICEF, *Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas*, November 2015

541. UNICEF, Division of Violence Prevention, National Center for Injury Prevention and Control, U.S. Centers for Disease Control and Prevention, and the Kenya National Bureau of Statistics, *Violence against Children in Kenya: Findings from a 2010 National Survey. Summary Report on the Prevalence of Sexual, Physical and Emotional Violence, Context of Sexual Violence, and Health and Behavioral Consequences of Violence Experienced in Childhood*. 2012, at [https://www.unicef.org/esaro/VAC\\_in\\_Kenya.pdf](https://www.unicef.org/esaro/VAC_in_Kenya.pdf)

347. The Government has developed and adopted policies, enacted laws, developed and implemented educational programmes, carried out advocacy and enhanced the capacity of its public officers to address gender-based violence. Non-state actors have also carried out advocacy, and created awareness and implemented capacity building programmes designed to prevent and respond.<sup>545</sup>
348. However, response to gender-based violence is constrained by the lack of human capacity for prevention and protection, entrenched religious and cultural beliefs that perpetuate negative stereotypes, discrimination and gender inequality, and socio-cultural norms around gender and masculinity. Availability and accessibility of these services is limited, especially for adolescent girls, and women and girls who experience multiple and intersecting forms of discrimination, such as those from marginalized communities and refugees, elderly, sex workers, those living with HIV and with disabilities. Responses are constrained by a lack of services and poor referral systems. Prosecution is unlikely because of late reporting (or non-reporting) because of stigma and fear of reprisals, and lack of capacity and resources to support victims among the police, the justice system and the healthcare system.<sup>546</sup>

## Violence against children in institutions of care and protection

349. A 2015 survey indicates that violence against children is prevalent in all stages of the justice system. A total of 79.8 per cent of respondents reported having witnessed violence against other children and 72.2 per cent having been subject to it. Perpetrators included personnel, peers and adult inmates. Violence reportedly occurred in police stations, and across all statutory child institutions, including remand homes, reception and rescue centres, rehabilitation schools, probation hostels and borstal institutions. The least affected environment appeared to be the Courts. Physical abuse was most common from the side of justice personnel. Girls were proportionately twice as likely to experience sexual violence as boys.<sup>547</sup>
350. The study also found that the victims' coping strategies including running away, getting married, or engaging in criminal activities or violence themselves. Positive coping mechanisms (such as talking with friends or family) were cited less, suggesting a lack of services to meet the needs of victims.<sup>548</sup>
351. No studies appear to be currently available about violence and abuse in children's charitable institutions or in boarding schools.

### Key issues

- No national survey on violence against children in Kenya has been conducted since 2010, when 79 per cent of boys and 76 per cent of girls were found to have experienced physical, sexual and/or emotional violence before the age of 18.
- Although banned under the Constitution and in national legislation, violence against children in schools is a major concern, and corporal punishment appears to remain an accepted form of discipline among parents
- Violence against children is also prevalent in all stages of the justice system: less information is available about private residential institutions for children and in boarding schools
- In the 2014 KDHS, 14 per cent of women and 6 per cent of men aged 15-49 reported having experienced sexual violence at least once in their lifetimes
- While the Government has developed, and adopted policies, enacted laws, developed and implemented educational programmes to combat gender-based violence, response is constrained by the lack of human capacity for prevention and protection, entrenched religious and cultural beliefs that perpetuate negative stereotypes, discrimination and gender inequality, and socio-cultural norms around gender and masculinity

542. Kimengi, I. N. & Mwaj, B. K. (2014), "Perceptions of parents on the use of corporal punishment in pre-primary institutions in Kenya", *International Journal of Education and Research*, 2(10), 663-680. Cited in Global Campaign to End Corporal Punishment, Kenya Country Report, 2016, at <http://www.endcorporalpunishment.org/assets/pdfs/status-reports/Kenya.pdf>

543. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

544. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

545. Government of Kenya and United Nations, Joint Programme on Gender-Based Violence 2017-2018, Project Document, 2017

## Harmful practices

### Female genital mutilation

352. According to the 2014 KDHS, 21 per cent of women age 15-49 have been affected by female genital mutilation (FGM). This represents a significant reduction from the KDHS surveys in 2003 and 2008-2009. Of these, 2 per cent of affected women aged 15-49 had cutting with no flesh removed, and 87 per cent had their genital area sewn closed after cutting (a procedure known as infibulation). Girls aged 0-14 were more likely to experience FGM/C if their mothers had, and were more likely to be infibulated if their mothers were also infibulated. Eight per cent of girls aged 0-14 had had their genital area sewn closed. Among 15-19 year olds, the percentage who had undergone FGM fell from 14.6 per cent at the 2008-2009 KDHS to 11 per cent at the time of the 2014 KDHS.<sup>549</sup>
353. Despite general reductions in prevalence of FGM nationwide in recent years, the DHS revealed that several ethnic groups continue to have much higher rates than the national average. These include Somalis (94 per cent), Samburu (86 per cent), Kisii (84 per cent) and Maasai (78 per cent).<sup>550</sup> Other smaller ethnic groups that are not disaggregated in the DHS that also have high prevalence of FGM include the Kurya.<sup>551</sup> Among the Maasai and Samburu, it appears that prevalence has fallen sharply in the last 20 years, though this is not the case for the Somali community. However, the prevalence of infibulation, the most serious form of FGM, has reportedly decreased in recent years among the Somali community.<sup>552</sup>
354. A 2016-2017 survey among communities with high prevalence of FGM found four main rationales for the practice of FGM. The most popular was readiness for marriage, better prospects for marriage if cut, and prevention of premarital sex. This was followed by social acceptance; personal hygiene, including enhanced attractiveness if cut; and religious identity. The rationale varies between regions, with marriageability the chief reason for practicing FGC in Pokot and Samburu communities, and personal hygiene in Somali areas. In Maasai and Rendille areas, social acceptance is the most popular reason for practicing FGC. Among the surveyed communities, 31 per cent in the surveyed Muslim communities believed that FGM was a religious requirement, compared to less than 10 per cent in Christian communities. The main negative consequences of not undergoing FGM, according to respondents, are ostracism, not being able to marry, and ridicule by other community members.<sup>553</sup>
355. Key complications as a result of FGM for girls and women include: continuous bleeding, difficulty during child birth, infection, pain during sex, reduced sexual satisfaction and relationship problems with the husband and trauma and depression. When there are complications following FGM, these are mainly referred to traditional practitioners (54 per cent) (traditional circumcisers, traditional birth attendants and witch doctors) and health professionals (46 per cent).<sup>554</sup>
356. There is some evidence of a trend over time for the cut to be performed at younger ages. Twenty-eight per cent of circumcised women aged 20-24 experienced FGM/C at age 5-9, as compared with 17 per cent of those aged 45-49. About 73 per cent of Somali girls and 50 per cent of Kisii girls are cut at age 5-9.<sup>555</sup> There are several reasons for the early cutting. Firstly, young girls do not have enough information about the dangers and reporting mechanisms, so are less likely to report cases. Secondly, it is believed that younger girls do not cry during the procedure.<sup>556</sup>

546. Government of Kenya and United Nations, Joint Programme on Gender-Based Violence 2017-2018, Project Document, 2017

547. CESVI, Violence Does Not Fall on One Roof Alone, 2015, at [http://www.cefaonius.it/uploads/files/2061it-vac\\_in\\_the\\_kenya\\_jjs\\_survey.pdf](http://www.cefaonius.it/uploads/files/2061it-vac_in_the_kenya_jjs_survey.pdf)

548. CESVI, Violence Does Not Fall on One Roof Alone, 2015, at [http://www.cefaonius.it/uploads/files/2061it-vac\\_in\\_the\\_kenya\\_jjs\\_survey.pdf](http://www.cefaonius.it/uploads/files/2061it-vac_in_the_kenya_jjs_survey.pdf)

549. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

550. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

551. Rachel Horner, FGM in Kenya: 'Girls are being paraded openly in the streets', The Guardian, 23 December 2016, at <https://www.theguardian.com/society/2016/dec/23/fgm-in-kenya-girls-are-being-paraded-openly-in-the-streets>

552. Information Research Solutions, A Draft Baseline Study Report on Female Genital Mutilation or Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya, UNICEF, March 2017

553. Information Research Solutions, A Draft Baseline Study Report on Female Genital Mutilation or Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya, UNICEF, March 2017

554. Information Research Solutions, A Draft Baseline Study Report on Female Genital Mutilation or Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya, UNICEF, March 2017

556. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>



357. In the high-prevalence communities where the 2016-2017 research was conducted, only half the surveyed girls and women (50 per cent) and boys and men (46 per cent) were aware of risks associated with FGM. By ethnicity, it appears that the Maasai, the Somali and the Samburu have significantly lower levels of awareness of the risks of FGM than the Pokot and the Rendille. However, no significant differences were observed across rural and urban areas.<sup>557</sup>
358. The Government has responded to the problem through the Prohibition of Female Genital Mutilation Act of 2011. Survey results appear to indicate that this has been at least partially successful, though less so in ethnic Somali areas.<sup>558</sup> As a result of the tightened legislation, in recent years, more girls have been crossing into Tanzania, Ethiopia and Uganda to be cut, because of the relatively stronger enforcement of anti-FGM rules in Kenya.<sup>559</sup>
359. However, in the 2016-2017 research only 77 per cent of surveyed girls and women and 81 per cent of surveyed boys and men in the target regions were aware that FGM has been outlawed in Kenya. The proportion is again lower among the Somali community. Particularly in the Somali community, many administrative officials and community leaders perceive FGM as a cultural practice that must be respected: this means that they are not able to objectively uphold their mandate about the 2011 Act.<sup>560</sup> The Government's Anti-FGM Board (see the paragraph below) is working with imams and madrassa teachers in the Somali community to try to overcome these barriers.<sup>561</sup>
360. The Government has also established the Anti-FGM Board, a semi-autonomous government agency, in 2013. Under the 2011 Prohibition of Female Genital Mutilation Act<sup>562</sup> the Board is mandated to:
- a) Design, supervise and co-ordinate public awareness programmes against the practice of female genital mutilation;
  - b) Generally advise the Government on matters relating to female genital mutilation and the implementation of this Act;
  - c) Design and formulate a policy on the planning, financing and coordinating of all activities relating to female genital mutilation;
  - d) Provide technical and other support to institutions, agencies and other bodies engaged in the programmes aimed at eradication of female genital mutilation;
  - e) Design programmes aimed at eradication of female genital mutilation;
  - f) Facilitate resource mobilization for the programmes and activities aimed at eradicating female genital mutilation; and
  - g) Perform such other functions as may be assigned by any written law.
361. The Board receives a budget from the exchequer for programme implementation under the mandate prescribed in the Prohibition of Female Genital Mutilation Act. To ensure effective implementation of Board activities, the Government has deployed highly qualified and skilled staff from line government departments to the Board. In addition, five of the eight members of the Board are drawn from practising communities. Members have been drawn specifically from Kisii, Somali, Samburu, Taita, Borana and Masai communities. In line with the two-tier government, the national Government works closely with County Government in service delivery to citizens.<sup>563</sup>

557. Information Research Solutions, A Draft Baseline Study Report on Female Genital Mutilation or Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya, UNICEF, March 2017

558. Information Research Solutions, A Draft Baseline Study Report on Female Genital Mutilation or Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya, UNICEF, March 2017

559. Interview, Anti-FGM Board, 23 March 2017

560. Information Research Solutions, A Draft Baseline Study Report on Female Genital Mutilation or Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya, UNICEF, March 2017

561. Interview, Anti-FGM Board, 23 March 2017

562. Part II – The Anti-Female Genital Mutilation Board, Section 5: Functions of the Board, 2011.

563. Information provided by Anti-FGM Board, June 2017

362. The Board engages in awareness creation in areas with high prevalence of FGM, sensitizing communities by working with chiefs, religious leaders and opinion leaders. While in some places, they have been received well, in other areas, such as Kuria in Migori County, there has been some resistance. To mitigate this, the Board has strengthened and supported local CBOs, for example, Msichana Empowerment, to build the capacity of community members on matters of FGM. The Board's engagement with local leaders and professional has also been scaled up.<sup>564</sup>

## Child marriage

363. In Kenya, marriage is illegal before the age of 18. The Marriage Act 2014 categorically outlaws marriage for persons below the age of 18 years and underage marriages are null and void. Section 14 of the Children's Act prohibits any person from subjecting a child to marriage and other harmful practices such as FGM. Responsibility for ensuring the child's safety and security lies with the parents. The Sexual Offence Act 2006 deters early marriage through prohibition of sexual acts with minors, and makes the offender liable to imprisonment. The 2015 Protection Against Domestic Violence Act prohibits child and forced marriages. The November 2014 National Policy for Prevention and Response to Gender Based Violence seeks to accelerate efforts towards the elimination of all forms of gender-based violence, including child marriage, in Kenya.<sup>565</sup>
364. However, child marriage is in practice accepted and recognized in many communities. The national average of child marriage prevalence has reduced slightly, from 26.4 per cent of 20-24-year-old females married by the age of 18 (2008/9) to 22.9 per cent in 2014. The percentage of 20-24 old females married before the age of 15 also fell from 6.2 per cent in 2008/9 to 4.4 per cent in 2014. Prevalence of child marriage is highest in Northern Kenya (56 per cent), followed by the coast (41 per cent), Nyanza (32 per cent), Rift Valley (30 per cent), Western (27 per cent), Eastern (18 per cent), Central (17 per cent) and Nairobi (7 per cent).<sup>566</sup>
365. While legislation is a necessary starting point for delaying marriage, enforcement is also needed at local level. However, a range of capacity gaps persists. There is a general lack of understanding about the harmful effects of child marriage among the public, including officials. For example, the police lack sufficient training to address the issue, do not see it as their job to prevent child marriages, or defer to the parents' wishes. Birth and marriage registration are rarely produced or verified at the point of marriage. Some cases taken to court for prosecution are delayed or not completed because of corruption. In some instances, community or religious leaders who align child marriage with customary practices and religious beliefs resist laws and their enforcement. In addition, there are no specific child protection programmes in place in Kenya that directly focus on protecting children from child marriage,<sup>567</sup> and referral pathways are very weak with a lot of compromise on the way.
366. The causes of child marriage include social economic factors, such as poverty, low education and the seeing of girls as economic assets. Low household incomes can make marrying off a daughter seem like the most viable choice to support the family and end household poverty. Girls living in poor households are twice as likely to marry under the age of 18 as girls in higher income households. Girls are frequently either seen as an economic burden or valued as capital to be exchanged for goods, money and livestock.<sup>568</sup>
367. Many parents in rural Kenya marry off their children, particularly girls, as young as 14, due to stigma associated with teenage pregnancies and children being born out of wedlock. Children born to informal marriages have lower status in the eyes of the community and their families.<sup>569</sup> Among the Luhya people in the former Nyanza Region, child marriage is frequently connected to child pregnancy, as the family believe that the mother and child will have a more protective environment following marriage.

564. Information provided by Anti-FGM Board, June 2017

565. Ministry of Public Service, Youth and Gender Affairs, Draft National Plan of Action for Ending Child Marriages in Kenya, 2016-2025

566. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

567. Ministry of Public Service, Youth and Gender Affairs, Draft National Plan of Action for Ending Child Marriages in Kenya, 2016-2025

568. Ministry of Public Service, Youth and Gender Affairs, Draft National Plan of Action for Ending Child Marriages in Kenya, 2016-2025

569. UNICEF, Family Assets: Understanding and Addressing Child Marriage in Turkana, February 2016, at [https://www.unicef.org/kenya/Family\\_Assets\\_-\\_Understanding\\_and\\_Addressing\\_Child\\_Marriage\\_in\\_Turkana.pdf](https://www.unicef.org/kenya/Family_Assets_-_Understanding_and_Addressing_Child_Marriage_in_Turkana.pdf)

368. In Kenya child marriage is common among all religious groups, including traditional religions. More conservative religious practices, however, can often reinforce patriarchal norms that are harmful to women and girls. Religious and cultural leaders often have the power to perpetuate child marriage or promote change in attitudes and practices within their communities.<sup>570</sup>
369. In geographical areas where FGM is prevalent, child marriage is also more common, as FGM is seen as a rite of womanhood. Many communities often view FGM as a gateway and pre-requisite to marriage and as a way of preserving a girl's purity. For communities who cut girls aged 12–14 years, child marriage is the next step after the cut. In these traditional communities, adulthood is not only determined by biological age but by the rites of passage from childhood to adulthood, which from a community perspective automatically translate into marriage, irrespective of the biological age of the girl. Girls are withdrawn from school to undergo FGM and subsequently married off.<sup>571</sup>
370. Child marriage is both a cause and consequence of gender inequality. Girls are seen as having little importance outside of their roles as wives, while boys are given preference in the belief that they will look after their parents in the future. Girls are viewed as a financial burden if retained in the family but an economic asset or gain if married off early. Girls are either seen as an economic burden or valued as capital for their exchange value in terms of goods, money and livestock. Gender inequality is often endorsed by socio-cultural traditions and religion. The view that women have the right to choose when and with whom to marry is inconsistent with most Kenyan community norms, which see them as the property of fathers and husbands.<sup>572</sup>
371. In some places, such as Kuria, boys are also in danger of being subjected to child marriage. In certain sites, boys drop out of school more frequently than girls, and most of those who do drop out are married as children.<sup>573</sup>
372. Child marriage rates often increase during conflict or natural disasters, such as drought and famine, as natural support systems, family structures, and physical and institutional protections are reduced. Most of the counties with the highest prevalence of child marriage in Kenya are insecure, marginalized and deprived economically and politically. Child marriage can be seen as a form of social protection or poverty reduction in crisis due to disrupted family structures, social networks, and support institutions. During ethnic conflict, where the likelihood of rape and sexual abuse increases, child marriage is viewed as a form of protection. Most of these marriages are spearheaded by elders (men and women) and formalized usually through customary procedures, such as the payment of a bride price to the girl's family. This worsens in times of drought or other emergencies when girls are an easy means of re-stocking family livestock that has perished. In these circumstances, girls are married off irrespective of their biological and childhood age.<sup>574</sup>

## Child beading

373. Child beading is a cultural practice in the Samburu community. Although limited studies or surveys have been done on this harmful practice, it is estimated that three in four girls in the 8-12 age group are beaded. Young Samburu warriors (known as "morans") are not allowed to marry before the age of 35, and girls as young as nine years old are assigned to male relatives by use of red traditional beads. The mother of the beaded girl builds a hut where the male relative visits the beaded girl to engage in sexual activity at any moment he wishes. The 'couple' is allowed to have sexual intercourse but pregnancy and use of contraceptives are forbidden. If pregnancy occurs, it should be terminated using herbs or crude abortion. Any baby born is abandoned in the forest as an outcast,<sup>575</sup> or else given to another ethnic community for adoption.<sup>576</sup>

570. Ministry of Public Service, Youth and Gender Affairs, Draft National Plan of Action for Ending Child Marriages in Kenya, 2016-2025

571. Ministry of Public Service, Youth and Gender Affairs, Draft National Plan of Action for Ending Child Marriages in Kenya, 2016-2025

572. Ministry of Public Service, Youth and Gender Affairs, Draft National Plan of Action for Ending Child Marriages in Kenya, 2016-2025

573. Information provided by ADRA, June 2017.

574. UNICEF, Family Assets: Understanding and Addressing Child Marriage in Turkana, February 2016, at [https://www.unicef.org/kenya/Family\\_Assets\\_-\\_Understanding\\_and\\_Addressing\\_Child\\_Marriage\\_in\\_Turkana.pdf](https://www.unicef.org/kenya/Family_Assets_-_Understanding_and_Addressing_Child_Marriage_in_Turkana.pdf)

374. Beading has the potential of spreading HIV in the community. Girls having sex at a young age can be cut during intercourse with older men, who may have sexual relations with other partners, thereby creating pathways for HIV transmission and increasing their vulnerability.<sup>577</sup> Meanwhile, the practice also indirectly encourages FGM, as parents who do not want to bead their daughter take them to undergo FGM, as after this they are considered ineligible for beading and ready for marriage.<sup>578</sup>

#### Key issues

- Prevalence of female genital mutilation was 21 per cent among 15-49 year olds in the 2014 KDHS, a significant fall in recent years
- However, among Somalis (94 per cent), Samburu (86 per cent), Kisii (84 per cent) and Maasai (78 per cent) the practice is still prevalent.
- The Government has responded to the problem through the Prohibition of Female Genital Mutilation Act of 2011 and by establishing the Anti-Female Genital Mutilation Board, a semi-autonomous government agency, in 2013, which engages in awareness-raising work in areas with a high prevalence of Female Genital Mutilation, often sensitizing community members by working with chiefs and religious leaders.
- Though marriage is illegal before the age of 18 in Kenya, child marriage is in practice accepted and recognized in many communities.
- The national average of child marriage prevalence has reduced slightly, from 26.4 per cent of 20-24-year-old females married by the age of 18 (2008/9) to 22.9 per cent in 2014.
- Prevalence is highest in northern Kenya (56 per cent), and the coast (41 per cent).
- Causes of child marriage include social economic factors, such as poverty, low education and the treatment of girls as economic assets.
- Capacity gaps among some police officers and court officials and cultural reluctance on the part of some community and religious leaders hamper efforts to delay marriage.

## Children without parental care

375. Approximately 3.6 million Kenyan children are orphans or otherwise classified as vulnerable.<sup>579</sup> Of these, 646,887 children have lost both parents,<sup>580</sup> while 2.6 million children have lost at least one parent (one million of these to AIDS).<sup>581</sup> Other children are made vulnerable due to poverty, harmful cultural practices, family breakdown, abandonment, natural disasters, ethnic and political conflict, and/or poor care arrangements.<sup>582</sup> The Government has put in place cash subsidy programme to assist orphaned and vulnerable children. There has been a significant increase in the number of children covered by the Cash Transfer Programme for Orphans and Vulnerable Children (CTOVC). Currently, 353,000 households are benefitting from Ksh 8,472,000. There is also a President Bursary for poor orphans in schools benefitting 50 children per constituency. Each constituency receives Ksh 1.3 million per year. However, CTOVC does not cover the cost of health care except with respect to children less than 5 years of age, and allocates benefits by households regardless of the number of children in each household. Its coverage has not been extended to children with disabilities, children in street situations, children in care institutions and refugee children. Information on the programme is not well disseminated among beneficiaries.
376. The Department of Children's Services in the Ministry of Labour, Social Security and Services is currently the Government's duty bearer for child protection. Meanwhile, the National Council for Children's Services acts as the regulator, supervisor and monitor on child protection.<sup>583</sup>

575. Samburu Girls Foundation, Child Beading, <http://www.samburugirls.foundation/issues/beading/>, accessed 25 May 2017

576. Bridget Job-Johnson, Girl Child Beading, Community-Sanctioned Child Exploitation And Abuse Among The Samburu Tribe Of Kenya, UNICEF, 2013

577. Samburu Girls Foundation, Child Beading, <http://www.samburugirls.foundation/issues/beading/>, accessed 25 May 2017

578. Zaina Kombo, Beading: the Undefined Offense in Kenya, LLM Dissertation, Parklands School of Law, 2016

579. Government of Kenya, Ministry for Planning, National Development and Vision 2030, Kenya Social Protection Sector Review, June 2012. The exact figure for orphans and vulnerable children is 3,612,679. Cited in Government of Kenya, UNICEF and Global Affairs Canada, Taking child protection to the next level in Kenya, 2015, at [https://www.unicef.org/protection/files/Kenya\\_CP\\_system\\_case\\_study.pdf](https://www.unicef.org/protection/files/Kenya_CP_system_case_study.pdf)

580. HIV Estimates, UNAIDS, 2015. Cited in Government of Kenya, UNICEF and Global Affairs Canada, Taking child protection to the next level in Kenya, 2015, at [https://www.unicef.org/protection/files/Kenya\\_CP\\_system\\_case\\_study.pdf](https://www.unicef.org/protection/files/Kenya_CP_system_case_study.pdf)

581. UNICEF, State of the World's Children 2014 in Numbers: Every child counts, revealing disparities, advancing children's rights, 2014

582. UNICEF and the Government of Kenya, Guidelines for the Alternative Care of Children in Kenya, October 2014, at <http://www.bettercarenetwork.org/sites/default/files/Guidelines%20for%20the%20Alternative%20Family%20Care%20of%20Children%20in%20Kenya.pdf>

583. Interview, Department of Children's Services, 26 May 2017

377. National legislation is unclear concerning which government agency is responsible for tracing the families of children who are lost (with the Department of Children's Services, the Child Welfare Association of Kenya, the police and the Adoption Society all having roles to play).<sup>584</sup> There are 854 registered Charitable Children institutions (CCIs) holding approximately 43,000 children in Kenya. Not all facilities holding children in residential care operate in line with set regulations and as such the Government is in the process of closing non-compliant CCIs.
378. In Kenya's practice, children aged 14 or older are considered capable of heading households and eligible for cash transfers. If child officers come across households with no members over the age of 14, they should indicate that the family is in need of care and protection and link to services.<sup>585</sup> Despite the Government's policy to prioritize family-based care for children, a significant proportion end up in residential charitable children's institutions (CCIs).<sup>586</sup> As of May 2017, there are 811 CCIs registered, with a total resident population of about 40,000 children.<sup>587</sup> However, not all CCIs in Kenya are registered with the authorities. In some cases, CCIs are reportedly unwilling to be registered because they do not want their practices and funding to be monitored. Some CCIs have been instructed to close following investigations by the authorities.<sup>588</sup>
379. Communities in Kenya have traditionally responded to children without parental care by placing them informally in the care of extended family or community members (kinship care).<sup>589</sup> There is currently no way of determining the number of children in this group. With increasing socio-economic pressures and weakening family structures, this kinship care mechanism is under threat and many children are at risk of maltreatment. Meanwhile, while guardianship is a formal status given by parents in a will, or else through a court, under the 2001 Children's Act,<sup>590</sup> this is not very common in Kenya because in most cases parents do not denote a guardian in their wills, and children and their informal carers are often reluctant to go through a court process.<sup>591</sup> In this context, there is an urgent need to recognize and strengthen informal care arrangements, especially kinship care and *kafaalah* (voluntary sponsorship of or care for children without parental care in the Muslim community).<sup>592</sup>
380. The predominant formal alternative care arrangements are placements in CCIs or other institutional care.<sup>593</sup> Officially there are about 43,000 children living in 831 registered institutions in Kenya.<sup>594</sup> While there are 28 "statutory institutions" which receive most of the Government's funding for alternative care,<sup>595</sup> the majority of childcare institutions, such as the Charitable Children's Institutions, are not yet registered, the inspection and monitoring of the care provided at childcare institutions are weak, and there is no complaints mechanism through which children can denounce violence in the institutions.<sup>596</sup> This means that the total number of children living in institutions in Kenya is unknown.<sup>597</sup>

584. UNICEF and the Government of Kenya, Guidelines for the Alternative Care of Children in Kenya, October 2014, at <http://www.bettercarenetwork.org/sites/default/files/Guidelines%20for%20the%20Alternative%20Family%20Care%20of%20Children%20in%20Kenya.pdf>

585. UNICEF and the Government of Kenya, Guidelines for the Alternative Care of Children in Kenya, October 2014, at <http://www.bettercarenetwork.org/sites/default/files/Guidelines%20for%20the%20Alternative%20Family%20Care%20of%20Children%20in%20Kenya.pdf>

586. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

587. Information provided by National Council of Children's Services, 26 May 2017

588. Interview, Department of Children's Services, 26 May 2017

589. Tulinde Wwototo Wwetu, Kinship Care Research, Save the Children, 2015, at [https://resourcecentre.savethechildren.net/node/9790/pdf/sci\\_kinship\\_report\\_kenya\\_final.pdf](https://resourcecentre.savethechildren.net/node/9790/pdf/sci_kinship_report_kenya_final.pdf)

590. UNICEF and the Government of Kenya, Guidelines for the Alternative Care of Children in Kenya, October 2014, at <http://www.bettercarenetwork.org/sites/default/files/Guidelines%20for%20the%20Alternative%20Family%20Care%20of%20Children%20in%20Kenya.pdf>

591. Information provided by UNICEF, March 2017

592. UNICEF and the Government of Kenya, Guidelines for the Alternative Care of Children in Kenya, October 2014, at <http://www.bettercarenetwork.org/sites/default/files/Guidelines%20for%20the%20Alternative%20Family%20Care%20of%20Children%20in%20Kenya.pdf>

593. UNICEF and the Government of Kenya, Guidelines for the Alternative Care of Children in Kenya, October 2014, at <http://www.bettercarenetwork.org/sites/default/files/Guidelines%20for%20the%20Alternative%20Family%20Care%20of%20Children%20in%20Kenya.pdf>

594. Information provided by Department of Children's Services, May 2017

595. Interview, Department of Children's Services, 26 May 2017

596. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

597. Stahili, Time is NOW to get the kids home, 14 December 2016, at <http://www.stahili.org/time-now-get-kids-home/>

## Adoption

381. Amendment of laws and regulations on adoption, including relevant provisions under the Children Act (2001), is still pending.<sup>598</sup> On 4 November 2015, the then Ministry of Labour, Social Security and Services appointed a Steering Committee to review a framework for child adoption in Kenya, as is in the gazette notice No. 8902 of 2015.<sup>599</sup>
382. There is currently a moratorium on inter-country and adoption by residents of Kenya who are citizens of other countries, issued in November 2014. The moratorium was instated in order to review the entire adoption process with the aim to improve it; better safeguard children and identify and fill any gaps that could leave room for malpractices or illegal adoptions, including the international trafficking of children.<sup>600</sup> This was a response to concerns about increased cases of child trafficking through abuse of Kenya's adoption processes by foreigners. Kenya was ranked at Tier 2 Watch List for non-compliance with minimum standards for elimination of human trafficking, based on the 2014 US State Department report on trafficking in persons.<sup>601</sup>
383. According to a report by the Better Care Network, court records show that hundreds of children have been taken out of the country under intercountry adoption laws over the years, and a sharp rise in the numbers occurred in 2005 when the law allowed private adoption agencies to operate.

### Key issues

- Approximately 3.6 million Kenyan children are orphans or otherwise classified as vulnerable
- Of these, 646,887 children have lost both parents, while 2.6 million children have lost at least one parent (one million of these to AIDS)
- Other children are made vulnerable due to poverty, harmful cultural practices, family breakdown, abandonment, natural disasters, ethnic and political conflict, and/or poor care arrangements
- While communities in Kenya have traditionally responded to children without parental care by placing them informally in the care of extended family or community members, with increasing socio-economic pressures and weakening family structures, this kinship care mechanism is under threat and many children are at risk of maltreatment
- The predominant formal alternative care arrangements are placements in children's charitable institutions or other institutional care
- Amendment of laws and regulations on adoption, including relevant provisions under the Children Act (2001), is still pending
- There is currently a moratorium on inter-country and adoption by residents of Kenya who are citizens of other countries, issued in November 2014 in response to concerns about possible cases of child trafficking through abuse of Kenya's adoption processes, and with the aim to review and improve the adoption system.

598. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

599. Republic of Kenya, Kenya Gazette Volume 133, 4 December 2015

600. Republic of Kenya, Kenya Gazette Volume 17, 20 February 2015

601. Thiong'o Mathenge and Rawlings Otieno, Kenyan Government bans adoption of children by foreigners, The Standard, 29 November 2014, at <https://www.standardmedia.co.ke/article/2000142876/kenyan-government-bans-adoption-of-children-by-foreigners>

## Commercial sexual exploitation of children

384. In its 2016 Concluding Observations, the UN CRC Committee expressed concern about the high level of child prostitution and child pornography in Kenya, particularly in the tourism and travel sector.<sup>602</sup> According to a 2015 study, children in Kenya are involved in commercial sex trade with both tourists and Kenyan nationals who travel from other parts of the country. Study findings indicated that 81.2 per cent and 94.8 per cent of children and adults respectively reported having heard of children being involved in sex with tourists and travellers. Typical offenders were identified as originating from the USA, the United Kingdom, Italy, Germany, Canada, South Korea and China, as well as South Africa, Nigeria, Ethiopia, Somalia, Uganda, Tanzania, Rwanda and Sudan, as well as Kenya itself.<sup>603</sup>
385. Sexual exploitation of children in travel and tourism is reportedly common in major tourist destinations such as Nairobi, Mombasa, Kisumu, Kakamega, Nakuru, as well as in other major towns in Kenya.<sup>604</sup> Children are also exploited in sex trafficking by people working in khat cultivation areas, near Nyanza's gold mines, along the coast by lorry drivers transporting stones from quarries, and by fishermen on Lake Victoria.<sup>605</sup> Typically Kenyan offenders come from wealthier areas, while the victims live in poor neighbourhoods. The most vulnerable children are believed to be orphans, girls, children from child-headed households, and children of single parents.<sup>606</sup>
386. Reportedly, in some coastal regions, such as Malindi and Kilifi counties, sexual exploitation and violence against children is becoming accepted, as parents encourage their children to bring maize meal home from school with the tacit understanding that this is received as a result of commercial sexual exploitation. In the coastal regions, commercial sexual exploitation of children is particularly related to tourism. There is also concern about the engagement and use of children in drug trafficking: in some cases (particularly in Mombasa) parents use their own children as "collateral" for drugs.<sup>607</sup>
387. Although 64 per cent of respondents to the 2015 study on sexual exploitation of children were found to be aware of services aimed at helping victims of commercial sexual exploitation in travel and tourism, in most cases, victims of commercial sexual exploitation were not able to access support services. This is because most organizations focus only on awareness raising activities rather than direct service provision. This is a major gap in efforts to assist victims and address the commercial sexual exploitation of children in Kenya. NGOs, faith groups and the Government provide most services. Commercial sex workers have also established informal associations for protection. These informal associations help commercial sexual workers to avoid being arrested and are beneficial in promoting the welfare of their members.<sup>608</sup>
388. Commercial sexual exploitation of children in Kenya also affects those from other countries. According to the US Department of State, some children in Kenya's refugee camps may endure sex trafficking, and lorries transporting goods from Kenya to Somalia reportedly have returned to Kenya with girls and women subsequently placed into brothels in Nairobi or Mombasa.<sup>609</sup>
389. The Government has in place a National Plan of Action for Combatting Trafficking for 2013-2017. It aims to ratify the Second Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography by 2019.<sup>610</sup>

602. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

603. African Network for the Prevention and Protection Against Child Abuse and Neglect, Global Study on Sexual Exploitation of Children in Travel and Tourism: Country Specific Report Kenya, 2015, at <http://www.anppcan.org/wp-content/uploads/2016/12/SECTT-Kenya.pdf>

604. African Network for the Prevention and Protection Against Child Abuse and Neglect, Global Study on Sexual Exploitation of Children in Travel and Tourism: Country Specific Report Kenya, 2015, at <http://www.anppcan.org/wp-content/uploads/2016/12/SECTT-Kenya.pdf>

605. US Department of State, 2016 Trafficking in Persons Report, 2017, at <https://www.state.gov/j/tip/rls/tiprpt/countries/2016/258795.htm>

606. African Network for the Prevention and Protection Against Child Abuse and Neglect, Global Study on Sexual Exploitation of Children in Travel and Tourism: Country Specific Report Kenya, 2015, at <http://www.anppcan.org/wp-content/uploads/2016/12/SECTT-Kenya.pdf>

607. Information provided by UNICEF, March 2017, based on evidence from field trips and implementing partners.

608. African Network for the Prevention and Protection Against Child Abuse and Neglect, Global Study on Sexual Exploitation of Children in Travel and Tourism: Country Specific Report Kenya, 2015, at <http://www.anppcan.org/wp-content/uploads/2016/12/SECTT-Kenya.pdf>

609. US Department of State, 2016 Trafficking in Persons Report, 2017, at <https://www.state.gov/j/tip/rls/tiprpt/countries/2016/258795.htm>

610. UNICEF, UNICEF Kenya Country Office Annual Report 2016, 20 January 2017

### Key issues

- A 2015 study reports that children in Kenya are involved in the commercial sex trade with both foreign tourists and Kenyan nationals who travel from other parts of the country in major tourist destinations, such as Nairobi, Mombasa, Kisumu, Kakamega, Nakuru, as well as in other major towns in Kenya
- Children are also exploited in sex trafficking by people working in khat cultivation areas, near Nyanza's gold mines, along the coast by lorry drivers transporting stones from quarries, by fishermen on Lake Victoria, and at Lokichar in Turkana, where oil exploitation is underway
- In most cases, victims of commercial sexual exploitation are not able to access support services because most organizations focus only on awareness raising activities rather than direct service provision.

## Other specific groups of children at risk

390. In its 2016 Concluding Observations, the UN CRC Committee expressed serious concern about killings of, and trafficking of, children with albinism for body parts, including such acts that are committed by family members.<sup>611</sup>
391. The UN CRC Committee is concerned about evictions of indigenous peoples from their lands under the pretext of national development and resource conservation, which have resulted in serious violations of the rights of indigenous children, aggravated by poverty, insecurity and conflict among indigenous communities.<sup>612</sup> For example, according to an advocacy NGO, the eviction of the Sengwer people from Embobut in the Cherangany Hills has resulted in disruption to education, a rise in early marriage, family separation and childhood malnutrition.<sup>613</sup>

## Children in contact with the law

392. Article 53 of Kenya's Constitution provides that every child has a right not to be detained, except as a measure of last resort, and when detained, to be held for the shortest appropriate period, and separated from adults and in conditions that take account of the child's sex and age.
393. Section 18 of the Children Act forbids unlawful arrest or deprivation of liberty of children, and that no child should be subjected to capital punishment or life imprisonment. In addition, a child who is arrested and detained should be accorded legal and other assistance from the Government and family contact. Under Section 73(b) and 185-5, the Children Act also established Children's Courts to hear cases against child offenders other than charges of murder or when a child is charged together with adults. Section 186 provides additional safeguards for children. Rule 10(6) of the Child Offender Rules in Schedule 5 of the Children's Act recommends the use of alternatives to remand custody if possible, such as 'close supervision or placement with a Counsellor or fit person determined by the Court on the recommendation of a Probation Officer or Children's Officer.'<sup>614</sup>

## The children's court system

394. In recent years, efforts have been made to increase the number of and to rehabilitate courtrooms, and to increase the number of magistrates to adjudicate on matters concerning children. In Nairobi, specific Children's Courts have been established.<sup>615</sup> Concerns have been raised that it may be inappropriate that the Children's Courts concurrently handles charges against children, care and protection, as well as crimes against children.<sup>616</sup>

611. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

612. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

613. Milka Chepkorir Kuto, Sengwer Women's Experiences of Evictions and their involvement in the struggle for Sengwer land rights, Forest People's Programme, October 2016, at <http://www.forestpeoples.org/sites/fpp/files/publication/2016/10/sengwerwomenreportweb.pdf>

614. National Council on the Administration of Justice, Criminal Justice System in Kenya: An Audit, pp. 46-47

615. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5. Interview, UNICEF, 21 March 2017



395. In addition, the minimum age of criminal responsibility is still set at eight years of age, which is well below accepted international standards. Meanwhile, children are still treated as adults and held together with adults; there is insufficient information on personnel with specialized training in juvenile justice, including lawyers, judges, prosecutors and public defenders, and correctional officers.<sup>617</sup> Children have to go through multiple interviews that are not coordinated with each other during the investigation process. However, some improvement has been achieved in this area of justice for children. Although not adequate, some juvenile justice stakeholders have been trained through CCPO programme. The government has also established Child Protection Unit (CPUs) and Gender and Children's Desk at some police stations.<sup>618</sup>
396. Analysis of court registers from two Children's Courts in 2013 and 2014 found that the most common charges against children were property offences (primarily theft) and sexual offences (mainly "defilement") – each amounted to over 30 per cent of the cases. Consensual sex between two 16 year olds was upheld as a crime perpetrated by the boy in 2013 by Kenya's High Court. Of the cases analysed, 43 per cent resulted in probation, while 27 per cent were discharged or withdrawn. Eleven per cent were committed to a borstal or children's home, usually for a period of three years. The review also found that significant delays of up to three years occurred in some cases, far beyond the maximum period of 90 days for non-death penalty offences.<sup>619</sup>
397. Ensuring justice for children is made more difficult by community practices to resolve child protection violations through informal legal mechanisms, rather than seeking justice, i.e. chiefs or parents settling for payments, even marriage of girls to perpetrators of child abuse.<sup>620</sup> The constitutional right of the child to have his or her best interests taken as a primary consideration is often not respected in informal justice systems or in dispute resolution outside of courts of justice, in particular with regard to cases of sexual offences.<sup>621</sup>

## Remand

398. Children in conflict with the law in Kenya can legally be housed in probation hostels, rehabilitation schools, borstal institutions and children's remand homes. The remand homes house children before determination of cases by the court, and they managed by the Department of Children's Services. Research conducted in 2016 found that the number of children on remand in the homes appeared to be much less than the number of arrests of children by the police. Although children detained in remand homes should be transferred to other relevant facilities or integrated with families within three months, there are cases where children spend more than the stipulated time period as per the relevant legislation. Finally, concern was expressed that remand homes house child perpetrators, child victims and children in need of care, in the same facility and even the same rooms.<sup>622</sup>
399. Conditions in the children's remand homes were problematic in some cases, largely because of ageing infrastructure. In most cases, there was too little available floor space per child. In remand homes in Nyeri and Murang'a children lacked enough clean space outside to play. In some cases, ratios of toilets to children were too high, and in four homes showers were not in operation, because they were not fitted, vandalized or not used because of water rationing. In only one of the remand homes, Kisumu, did children receive education: given that in many cases children are held for long periods in remand, this violates the right to education. Insufficient attention was paid to preventive and promotive medicine in the remand homes, and not enough attention was paid to ensuring continuity of treatment for tuberculosis and HIV and AIDS.<sup>623</sup>

616. National Council on the Administration of Justice, *Criminal Justice System in Kenya: An Audit*, pp. 46-47

617. UN Committee on the Rights of the Child, *Concluding Observations on the combined third to fifth periodic reports of Kenya*, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

618. UN Committee on the Rights of the Child, *Concluding Observations on the combined third to fifth periodic reports of Kenya*, 21 March 2016, UN Document CRC/C/KEN/CO/3/5. Interview, UNICEF, 21 March 2017

619. National Council on the Administration of Justice, *Criminal Justice System in Kenya: An Audit*, pp. 164-169

620. UNICEF, UNICEF – KCO MTR Report, 2016

621. UN Committee on the Rights of the Child, *Concluding Observations on the combined third to fifth periodic reports of Kenya*, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

622. National Council on the Administration of Justice, *Criminal Justice System in Kenya: An Audit*

623. National Council on the Administration of Justice, *Criminal Justice System in Kenya: An Audit*

- 400. The 2016 research found that in late 2015 and early 2016 there were 427 male under-18s held in remand in prisons, more than the 350 being held in remand homes at the same time. Of these, 18 per cent were charged with “preparation to commit a felony” and 15 per cent with “defilement”. The researchers were informed that these boys were held in the prison because they were a danger to other children in remand homes, even though this contravened national legislation.<sup>624</sup>
- 401. The 2016 research also found that 3 per cent of those being held in adult prisons were under the age of 18, in contravention of national legislation. This appears to reflect a need for additional remand homes in counties where they do not currently exist.<sup>625</sup> There is also a need to improve security in the remand homes to accommodate high risk cases.
- 402. The number of children in prison in Kenya fell in 2015, after rising sharply in 2014. Almost all the children in prison are boys aged 16 or 17.<sup>626</sup>

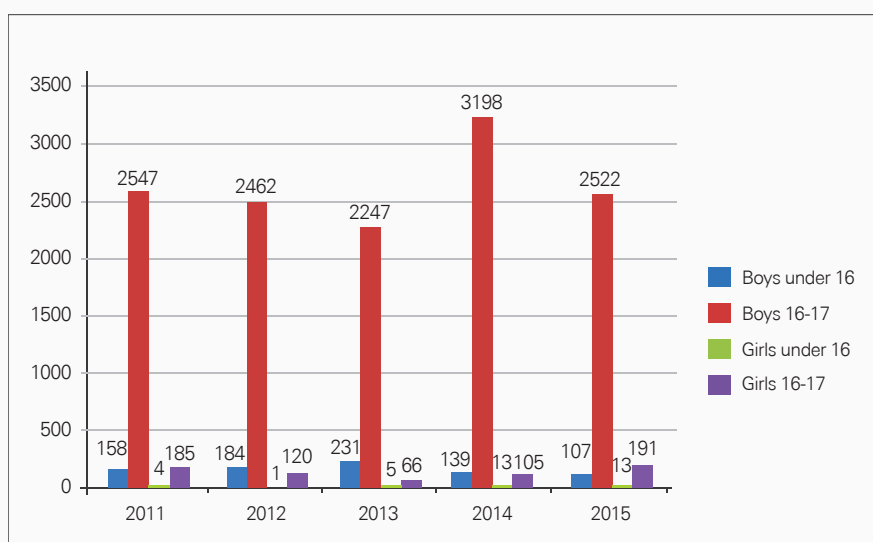


Figure 24: Number of children in prison by age and sex, 2011-2015

## Other children in contact with the law

- 403. Child victims of violence face lack of access to justice, particularly in cases of sexual violence and harmful practices, due to social stigma, pressure from family members, low rates of investigation and prosecution, frequent delays in court proceedings, lenient sanctions imposed, the risk of revictimization in the justice system and the lack of legal aid and other supports. Limited support is available for child victims of violence and girls escaping from harmful practices, including the provision of safe accommodation and support for access to education.<sup>627</sup>
- 404. Other children in contact with the law include child witnesses of crime, children living in prison with imprisoned mothers, children rescued and taken to police stations, and children caught in custody disputes during marital conflicts. All these groups are at particularly high risk of violations of their rights. Unfortunately, research is currently not available on these issues.<sup>628</sup>

624. National Council on the Administration of Justice, Criminal Justice System in Kenya: an Audit

625. National Council on the Administration of Justice, Criminal Justice System in Kenya: an Audit

626. KNBS, Economic Survey 2016. Available via [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

627. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

628. Information provided by The Cradle, June 2017

405. In response to some of these concerns, the National Council for the Administration of Justice established a Special Taskforce on Children Matters in 2016 to improve the situation of children in contact with the justice system.<sup>629</sup>

#### Key issues

- In recent years, efforts have been made to increase the number of and to rehabilitate courtrooms, and to increase the number of magistrates to adjudicate on matters concerning children.
- The minimum age of criminal responsibility is still set at eight years of age, which is well below acceptable international standards.
- Children are still treated as adults and held together with adults; and there is insufficient information on personnel with specialized training in juvenile justice, including lawyers, judges, prosecutors and public defenders, and correctional officers.
- Children in contact with the law in Kenya can legally be housed in probation hostels, though there is a lack of such hostels in some counties.
- Conditions in children's remand homes have been found to be problematic in some cases, largely because of ageing infrastructure.
- Child victims of violence can lack access to justice, particularly in cases of sexual violence and harmful practices, due to social stigma, pressure from family members, low rates of investigation and prosecution, frequent delays in court proceedings, lenient sanctions imposed, the risk of revictimization in the justice system and the lack of legal aid and other support.
- In response to some of these concerns, the National Council for the Administration of Justice established a Special Taskforce on Children Matters in 2016 to improve the situation of children in contact with the justice system.

## Child labour

406. Estimates show that 773,697 children were involved in child labour in Kenya in 2008. Of these, about 2.5 per cent were engaged in hazardous work, with eight in every ten of those children engaged in hazardous work being boys.<sup>630</sup> The worst forms of child labour in Kenya include illicit drug trafficking, commercial sexual exploitation of children, and human trafficking for child labour, along with begging and scavenging. There are also reports of increased employment of children as domestic workers.<sup>631</sup> Given the high numbers of children of school going age out of school in Kenya, these children could be working and not enjoying their constitutional right to education and holistic development.<sup>632</sup>
407. In this context, the Ministry of East African Community, Labour and Social Protection (MEACLSP), and its partners, in consultation with children affected by child labour, developed the National Child Labour Policy in 2016. The Policy targets three broad groups of children: children at risk, children already harmed by exposure to child labour, and children in the worst forms of child labour requiring immediate direct action. A key component of the policy is the strong institutional framework and integrated implementation, monitoring and evaluation mechanism.<sup>633</sup> The Government has introduced free basic education leading to a fewer children being engaged in gainful employment, especially in the domestic sector.

629. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5. Interview, UNICEF, 21 March 2017

630. ILO, Kenya's National Assembly Adopts the National Policy on Elimination of Child Labour, 8 October 2016, at [http://www.ilo.org/addisababa/countries-covered/kenya/WCMS\\_532340/lang-en/index.htm](http://www.ilo.org/addisababa/countries-covered/kenya/WCMS_532340/lang-en/index.htm)

631. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

632. ILO, Kenya's National Assembly Adopts the National Policy on Elimination of Child Labour, 8 October 2016, at [http://www.ilo.org/addisababa/countries-covered/kenya/WCMS\\_532340/lang-en/index.htm](http://www.ilo.org/addisababa/countries-covered/kenya/WCMS_532340/lang-en/index.htm)

633. ILO, Kenya's National Assembly Adopts the National Policy on Elimination of Child Labour, 8 October 2016, at [http://www.ilo.org/addisababa/countries-covered/kenya/WCMS\\_532340/lang-en/index.htm](http://www.ilo.org/addisababa/countries-covered/kenya/WCMS_532340/lang-en/index.htm)

## Children in street situations

408. The number of children living and/or working on the streets in Kenya is not known, but estimates are high, varying from 50,000 to 250,000.<sup>634</sup> Urban areas with high numbers of children in street situations and homeless families include Nairobi, Mombasa, Kisumu, Eldoret, Lodwar and Nanyuk, and there has reportedly been a growth in recent years in children from informal settlements being drawn to the streets of Nairobi during the day.<sup>635</sup> The Government is in the process of carrying out a survey of children and families on the street in all counties that will provide information on numbers of families and children living on the street, critical drivers and consequences which will inform a more coordinated programme approach.<sup>636</sup>
409. Children in street situations are the responsibility of the State Department on the Special Programme under the Ministry of Devolution and Planning, and the Street Family Rehabilitation Trust Fund (the Fund) – in practice this means that there are coordination gaps with the Department of Children’s Services.<sup>637</sup> Under the Fund, more than 80,200 former street children and youth have enrolled in primary and secondary schools countrywide, while 18,000 former street children have been re-integrated with their families.<sup>638</sup>
410. Devolution has added further complexity to the issue, as county governments lack a constitutional obligation to allocate money for rehabilitation of children in street situations. However, in some cases county governments do provide budgetary funds to support street children. There have been cases of children in street situations being taken away by local officials to neighbouring counties.<sup>639</sup>

## Child online protection

411. Internet use in Kenya is on the rise. As of December 2016, total internet subscriptions in Kenya stood at 26.7 million, and 39.7 million people (92.5 per cent of the population) had internet access in one form or another. Mobile data internet made up 99.4 per cent of the total internet subscriptions in Kenya.<sup>640</sup>
412. The changing media landscape in Kenya, due in large part to the increased availability of cheap web-enabled mobile phones, has changed the way young Kenyans seek information and news, make new connections, and entertain themselves. Most respondents to a 2013 study consider digital and social media to be an integral part of their lives. They use the internet regularly and most have access to a shared phone or their own personal phone, with internet access.<sup>641</sup>
413. Mobile phones are the main point of access to the internet and many children and young people switch fluidly between using the internet and the phone. Awareness of risk and the consequences of unsafe digital behaviour among these children and young people is very low. There is also a substantial gap between children’s and young people’s digital media skills and those of their parents (with that of parents being much lower). Even those parents who were active internet users appeared to have little knowledge of the risks their children might be exposed to when using the internet.<sup>642</sup>
414. In the 2013 study, many of the 12-17-year-old participants reported having encountered sexually explicit content via the internet on computers and mobile phones, with some sharing it on DVDs and hard drives. Many befriend people online they have never met, and some may try to meet them in person. Meanwhile, receiving hateful messages online, calling each other hurtful names or inappropriate posts on social media platforms is prevalent. Awareness of the risks and consequences of engaging in unsafe behaviour online is low and these young people only have an abstract sense of the risks and safety issues surrounding their digital and social media use.<sup>643</sup>

634. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

635. Elvis Ondieki, Nowhere to call home: Plea for street families as rehab projects stall, The Nation, 16 April 2016, at <http://www.nation.co.ke/news/-Plea-for-street-families-as-rehab-projects-stall/1056-3162682-k6wt7z/index.html>

636. Information provided by UNICEF, May 2017

637. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

638. Elvis Ondieki, Nowhere to call home: Plea for street families as rehab projects stall, The Nation, 16 April 2016, at <http://www.nation.co.ke/news/-Plea-for-street-families-as-rehab-projects-stall/1056-3162682-k6wt7z/index.html>

415. In response to these concerns, in 2015 the Communications Authority conducted a campaign on Child Online Protection to raise awareness of the types of crime that children are exposed to in the cyberspace. The campaign highlighted the role that parents, guardians and teachers need to play to protect children in cyberspace and at the same time provided avenues of redress should one encounter cyber-crime.<sup>644</sup> Thanks to the campaign, the level of awareness and knowledge of around 10,000 key stakeholders around the country, including children, parents and teachers, on child protection risks associated with internet use by children was enhanced. As a result, the issue of online child protection is being included in new legal and policy frameworks in relation to children, as well as part of the broader violence against children agenda.<sup>645</sup>
416. The system and its capacity to protect children from online abuse and exploitation is inadequate. The reporting and referral mechanism, and targeted services for child victims of online sexual abuse and exploitation are in their infant stages of development. However, there are some positive recent developments. The Cyber Crime Units of both Kenya National Police and the Communications Authority of Kenya are paying increasing attention to issues of child online protection. Industries such as Safaricom, Orange, Airtel have shown commitment to fighting online sexual abuse and exploitation and are all also part of the ongoing awareness raising campaign on child online protection by the Communications Authority of Kenya.
417. There is currently a need to strengthen coordination at national level on child online protection. The Ministry of Labour and East African Community Affairs is the lead ministry on child protection issues, and the Department of Children's Services under the Ministry has included a chapter on online sexual abuse and exploitation in its booklet for children on violence against children. However, more broadly, the Communications Authority of Kenya, under the Ministry of Information, has thus far been the leading body on child online protection. A draft national framework for action was developed through a multi-stakeholder conference on child online protection held in December 2015.

#### Key issues

- While internet use is on the rise, awareness of risk and the consequences of unsafe digital behaviour among these children and young people is very low.
- Many 12-17 year olds reported having encountered sexually explicit content via the internet. Many befriend people online they have never met
- Receiving hateful messages online is also prevalent among adolescents
- The system and its capacity to protect children from online abuse and exploitation are inadequate, with the reporting and referral mechanism and targeted services for child victims in their infant stages of development.

## Child protection in emergencies

418. Child protection risks have increased in drought- and conflict-affected areas in 2017. An estimated 480,000 children will be negatively affected by the drought. The number of children on the street in urban centres has increased, and more cases of child abuse have been reported to the police. With increased movements of people in search of water and pasture, one of the key child protection concerns is the risk of children being separated from their families.<sup>646</sup>
419. Physical, sexual violence and other forms of gender based violence, including psychological and sexual violations often also increase during emergencies, as evidenced during the 2011 Horn of Africa crisis and following elections in 2007. Violations increase during emergencies, with children and women more affected than men. Based on this experience, an effective prevention, surveillance, reporting and response mechanism in times of crisis is imperative.<sup>647</sup>

639. Elvis Ondieki, Nowhere to call home: Plea for street families as rehab projects stall, The Nation, 16 April 2016, at <http://www.nation.co.ke/news/-Plea-for-street-families-as-rehab-projects-stall/1056-3162682-k6wt7z/index.html>

640. Communications Authority of Kenya, Quarterly Sector Statistics Report, October to December 2016, at <http://www.ca.go.ke/images/downloads/STATISTICS/Sector%20Statistics%20Report%20Q2%20FY%202016-17.pdf>

641. Intermedia, A (Private) Public Space: Examining the Use and Impact of Digital and Social Media Among Adolescents in Kenya, UNICEF, 2013, at [http://www.voicesofyouth.org/files/A%20Private%20Public\\_Voices%20of%20Youth%20Kenya%20study\\_54b5689adc61f.pdf](http://www.voicesofyouth.org/files/A%20Private%20Public_Voices%20of%20Youth%20Kenya%20study_54b5689adc61f.pdf)

420. In order to build Government capacity to respond to child protection concerns in emergencies, the Department for Children's Services created a new Child Protection in Emergencies (CPIE) section in early 2017. It is working to implement guidelines for alternative child family care in emergencies, which state that communities, organizations on the ground and the Government should work in liaison with each other to make sure that unaccompanied and separated children are protected and recorded, and that family links can be established. As of May 2017, the current draft of the new Children Act includes a small section on protection of children in emergencies.<sup>648</sup>
421. In 2017 the CPIE working group, led by the Department of Children Services, has developed an emergency preparedness and response plan, and has been working at national and county levels, and with wards in counties, to build local capacity for information management, data management, and to follow international standards for the protection of children in emergencies.<sup>649</sup>

## Protection of refugee children

422. A group of children at particular risk in Kenya are children living in refugee camps. Concerns in the family and the wider community include gender-based violence, harmful traditional practices, physical abuse, discrimination and psychosocial distress. Children can be unaccompanied, separated from their families or living with abusive families.<sup>650</sup> In addition, child labour is a major concern in refugee camps. For example, at Dadaab, children work to support elderly and unwell caregivers or are forced by caregivers to work to provide for the family. Boys engage in shoe shining, fetching firewood for sale from the forests, and collecting rubbish from hotels, while girls engage in paid domestic work.<sup>651</sup>
423. NGOs work with refugee communities and local authorities to support case management and provide foster support for children in need of a safe family environment, as well as safe areas for children.<sup>652</sup> One of the major challenges in dealing with child abuse cases (particularly sexual abuse) among the Somali refugee community is the traditional Maslaha justice system, in which a group of mainly male elders may resolve the case by forcing the victim to marry the perpetrator or paying male members of the victim's family compensation while ignoring the needs of the child survivor.<sup>653</sup>

642. UNICEF Kenya, UNICEF Global Programme to Build Capacity to Tackle Online Child Sexual Exploitation (CSE): final narrative report, March 2016

643. Intermedia, A (Private) Public Space: Examining the Use and Impact of Digital and Social Media Among Adolescents in Kenya, UNICEF, 2013, at [http://www.voicesofyouth.org/files/A%20Private%20Public\\_Voices%20of%20Youth%20Kenya%20study\\_54b5689adc61f.pdf](http://www.voicesofyouth.org/files/A%20Private%20Public_Voices%20of%20Youth%20Kenya%20study_54b5689adc61f.pdf)

644. Elisha Kamau, Communications Authority Launches Child Online Protection Campaign, Standard, 4 May 2015, at <https://www.standardmedia.co.ke/business/article/2000171625/communications-authority-launches-child-online-protection-campaign>

645. UNICEF Kenya, UNICEF Global Programme to Build Capacity to Tackle Online Child Sexual Exploitation (CSE): final narrative report, March 2016

646. OCHA, 2017 Flash Appeal: Kenya, March 2017, at [http://reliefweb.int/sites/reliefweb.int/files/resources/Kenyan\\_Flash\\_%20Appeal\\_15%20March%202017%20final.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Kenyan_Flash_%20Appeal_15%20March%202017%20final.pdf)

647. OCHA, 2017 Flash Appeal: Kenya, March 2017, at [http://reliefweb.int/sites/reliefweb.int/files/resources/Kenyan\\_Flash\\_%20Appeal\\_15%20March%202017%20final.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Kenyan_Flash_%20Appeal_15%20March%202017%20final.pdf)

648. Interview, Department of Children's Services, 26 May 2017

649. Interview, Department of Children's Services, 26 May 2017

650. Save the Children, Our Child Protection Work in Kenya, at <https://kenya.savethechildren.net/what-we-do/child-protection>, accessed 7 July 2017. Terre des Hommes, Uncertain Situation for Refugee Children in Kenya, 10 June 2016, at <https://www.tdh.ch/en/news/refugee-children-kenya>

651. Daniel Wesonga et al, Out of School Children Assessment Report: Dadaab Refugee Camp, Draft submitted to UNHCR, January 2017

652. Save the Children, Our Child Protection Work in Kenya, at <https://kenya.savethechildren.net/what-we-do/child-protection>, accessed 7 July 2017. Terre des Hommes, Uncertain Situation for Refugee Children in Kenya, 10 June 2016, at <https://www.tdh.ch/en/news/refugee-children-kenya>

653. Maryam Hassan Abdi, Assessment of Sexual and Gender Based Violence Reporting Procedures among Refugees in Camps in Dadaab, Kenya, Masters Thesis, University of Nairobi, November 2016, at [http://erepository.uonbi.ac.ke:8080/xmlui/bitstream/handle/11295/99932/Abdi\\_AssessmenT%20of%20sexual%20anD%20gender%20baseD%20violence%20reporting%20procedures%20among%20refugees%20in%20camps%20in%20Dadaab%2C%20Kenya.pdf?sequence=1&isAllowed=y](http://erepository.uonbi.ac.ke:8080/xmlui/bitstream/handle/11295/99932/Abdi_AssessmenT%20of%20sexual%20anD%20gender%20baseD%20violence%20reporting%20procedures%20among%20refugees%20in%20camps%20in%20Dadaab%2C%20Kenya.pdf?sequence=1&isAllowed=y)

424. Meanwhile, there are also protection concerns for children affected by the ongoing efforts to promote the voluntary repatriation of refugees from the Dadaab refugee camps. Children returning to Somalia have faced violence and forced recruitment,<sup>654</sup> and emerging protection concerns that were previously low-risk, such as family separation and custody disputes.<sup>655</sup> Meanwhile, children are not being included in the decision making process for repatriation,<sup>656</sup> and in some cases girls and young women have returned independently from Somalia to Dadaab after their families have attempted to marry them off.<sup>657</sup> Meanwhile, other cases have been reported of families returning to Somalia while their children remain behind to stay in school.<sup>658</sup>

### Key issues

- Child protection risks have increased in drought- and conflict-affected areas in 2017.
- With increased movements of people in search of water and pasture, one of the key child protection concerns is the risk of children being separated from their families.
- Refugee children can also be separated from their families, and can face gender-based violence, harmful traditional practices, physical abuse, child labour, discrimination and psychosocial distress. They also generally do not participate in resettlement decisions
- To build Government capacity to respond to child protection concerns in emergencies, the Department for Children's Services created a new Child Protection in Emergencies section in early 2017.

654. Save the Children, Thousands of Vulnerable Children at Risk as Closure of World's Largest Refugee Camp Looms, 21 October 2016, at <http://www.savethechildren.org/site/apps/nlnet/content2.aspx?c=8rKLXMGlp4EGb=9357111&ct=14927489>

655. UNICEF, EU humanitarian aid of €800,000 for education and protection of refugee children in Kenya, 20 June 2017, at [https://www.unicef.org/kenya/media\\_20131.html](https://www.unicef.org/kenya/media_20131.html)

656. Jennie Taylor and Boniface Karanja, Report on Joint Education Mission to Dadaab Refugee Camps, UNHCR and UNICEF, 2016, at [https://www.humanitarianresponse.info/system/files/documents/files/report\\_on\\_joint\\_education\\_mission\\_to\\_dadaab\\_refugee\\_camps\\_20160930.pdf](https://www.humanitarianresponse.info/system/files/documents/files/report_on_joint_education_mission_to_dadaab_refugee_camps_20160930.pdf)

657. Jacqueline Kubania, A Girl's Education Dream Ends as Dadaab Shut, 19 June 2016, at <http://www.nation.co.ke/news/a-girl-s-education-dream-ends-as-Dadaab-shut/1056-3256030-9a1ry1z/index.html>

658. Jennie Taylor and Boniface Karanja, Report on Joint Education Mission to Dadaab Refugee Camps, UNHCR and UNICEF, 2016, at [https://www.humanitarianresponse.info/system/files/documents/files/report\\_on\\_joint\\_education\\_mission\\_to\\_dadaab\\_refugee\\_camps\\_20160930.pdf](https://www.humanitarianresponse.info/system/files/documents/files/report_on_joint_education_mission_to_dadaab_refugee_camps_20160930.pdf)

# Chapter 6:

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## Safe and clean environment





## Water, sanitation and hygiene

425. In 2015 the deadline passed for achieving the MDGs. Kenya failed to meet both of its targets for water and sanitation. Currently, under SDG 6, Kenya has committed itself to achieve by 2030 universal and equitable access to safe and affordable drinking water for all; access to adequate and equitable sanitation and hygiene for all and an end to open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

## WASH policy framework

### Policy environment

426. Kenya's national legislation and policy contains the same aspirations as the Sustainable Development Goals. Under Article 43(1)(d) of Kenya's Constitution, every person has the right to clean and safe water in adequate quantities. Vision 2030 states that the country should provide water and modern sanitation facilities to her citizens. According to the Government, this will be realized through specific strategies, such as: (i) raising the standards of the country's overall water, resource management, storage and harvesting capability; (ii) rehabilitating the hydro-meteorological data gathering network; (iii) constructing multipurpose dams across the country; and (iv) constructing water and sanitation facilities to support a growing urban and industrial population.<sup>659</sup>
427. The 2016 Water Act was passed and gazetted for implementation in April 2017.<sup>660</sup> Kenya's last National Water Policy was published in 1999. As of May 2017, a new National Water Policy is currently in the late stages of development, and it is intended that the Policy will be rolled out and implemented at county level along with the Water Act in upcoming months.<sup>661</sup> The Ministry of Health is also currently developing a menstrual hygiene policy.<sup>662</sup>
428. As of May 2017, a Sanitation Bill for Kenya is in the final stages of development. As Kenya's National Environmental Sanitation and Hygiene Policy from 2007 had become outdated, it was revised and a new version launched in April 2016. Implementation of the new policy, along with the linked Kenya's National Environmental Sanitation and Hygiene Action Plan for 2016-2020 and the Open-Defecation Free campaign for 2016-2020, has been hampered by the lack of capacity to familiarize local government with the campaign, and to adapt it to county settings. Few counties are reported to have developed actions plans to achieve open-defecation free status.

### Planning process

429. Under the devolved governance framework, service provision for both water and sanitation has been devolved to county level, and the counties have established ministries with responsibilities for both. However, most counties lack the institutional and human resource capacity to deliver strategic planning, monitoring and coordination.<sup>663</sup> Despite this, some counties are taking a lead on certain water and sanitation related issues. For example, Isiolo, Turkana, West Pokot and Kakamega each committed several million shillings towards community-led total sanitation in 2016-2017, while Migori County committed KSh24 million in both 2016-2017 and 2017-2018 to improve water supply in schools.<sup>664</sup>

659. Electronic Project Monitoring Information System, Vision 2030 Pillars, at <http://e-promis.treasury.go.ke/portal/development-strategy/vision-2030/pillars/>, accessed 17 May 2017

660. Law available at [http://kenyalaw.org/ki/fileadmin/pdfdownloads/Acts/WaterAct\\_No43of2016.pdf](http://kenyalaw.org/ki/fileadmin/pdfdownloads/Acts/WaterAct_No43of2016.pdf)

661. Interview, Ministry of Water and Sanitation, 22 May 2017

662. Interview, Ministry of Health, 22 May 2017

663. UNICEF, UNICEF – KCO MTR Report, 2016

664. Letters sent by County Governments to UNICEF in 2016 and 2017

430. County integrated development plans (CIDPs) should by law contain specific goals and objectives, costed implementation plans, provisions for monitoring and evaluation and clear reporting mechanisms.<sup>665</sup> However, several county CIDPs reviewed for UNICEF's 2017 Public Expenditure Review do not contain specific county-level access targets for WASH. As such, for these counties it is not possible to assess the degree to which the county policy is aligned with national objectives. Where CIDPs do set targets, these are ambitious, generally meeting national policy goals. However, despite numerous monitoring initiatives, there are few sources of data for comparative analysis. County monitoring systems are weak, with most dependent on using project-related data. That counties do not use common indicators to monitor progress on core WASH indicators is also problematic.<sup>666</sup>
431. Sector coordination and monitoring remains poor at county level despite the initiation of WASH forums since 2014. County water departments, water service boards and water utilities do not adequately plan together to avoid duplication, foster collaboration and enhance impact. UNICEF's 2017 Public Expenditure Review noted that at present the planning processes for county governments, water service providers, water service boards and the Ministry of Water and Irrigation are not linked.<sup>667</sup>
432. The Cabinet Secretary for Water has the authority to establish one or more water works development agencies (WWDAs). These will replace the eight water services boards. Currently the Ministry, in consultation with stakeholders, is developing criteria for creating the WWDAs.
433. A budget is allocated for WASH under the free education capitation system, but the allocation of resources is inadequate. There is also inadequate coordination between ministries to ensure that schools have basic WASH facilities. Increasing access to WASH in schools is made more problematic by the fact that three ministries have key mandates: water, health (with responsibility for rural sanitation), and education. The problem is further compounded by the fact that, while line ministries for water and health have been more or less fully devolved, the national Ministry of Education is still responsible for all aspects of education except early childhood development.<sup>668</sup>

## Budgeting

434. To achieve its target of universal access to water, the Government has estimated that it requires KSh 1.754 trillion by 2030,<sup>669</sup> amounting to Ksh 100 billion every year. However, the national budget only allocates KSh 40 billion annually.<sup>670</sup> In this context, the WASH sector is heavily reliant on external finance. Aid accounts for 40 per cent of the national Ministry of Water and Irrigation's expenditure funding, with additional external finance channelled through loans. External finance is heavily skewed towards loans as opposed to grants. For the following three years external finance is projected to account for over 80 per cent of public sector budget requirements.<sup>671</sup> Nevertheless, there is limited ODA for rural water supplies.<sup>672</sup>
435. Since devolution, county governments have found themselves with substantial financial resources and the mandate to deliver basic services including rural sanitation and water supply.<sup>673</sup> Most counties spend more than 75 per cent of their water budget on developing water service infrastructure.<sup>674</sup> However, much of this infrastructure does not meet the needs of the unserved population, while in addition sufficient resources are not allocated for sustaining services.<sup>675</sup>

665. The Institute for Social Accountability, What You Need to Know About County Integrated Development Plans, 2013, at [http://www.tisa.or.ke/images/uploads/What-You-Need-to-Know-About-the-County-Integrated-Development-Plan\\_2013.pdf](http://www.tisa.or.ke/images/uploads/What-You-Need-to-Know-About-the-County-Integrated-Development-Plan_2013.pdf)

666. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

667. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

668. UNICEF, UNICEF – KCO MTR Report, 2016

669. Ministry of and irrigation baseline report

670. Interview, Ministry of Water and Irrigation, 22 May 2016

671. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

672. UNICEF, UNICEF – KCO MTR Report, 2016

673. UNICEF, UNICEF – KCO MTR Report, 2016

436. While the national Ministry of Water and Irrigation saw a nominal reduction in budget allocations between 2013-2014 and 2015-2016, the budgets of county ministries responsible for water have increased. However, growth in public WASH funding is lower than the growth of total government expenditure.<sup>676</sup> In 2015-16, expenditure on water services by the State Department for Water and Regional Authorities was Ksh 16 billion, 1 per cent of total expenditure by national ministries, departments and agencies, and 0.3 per cent of GDP. Development expenditure made up nearly 97 per cent of this, but this was insufficient to meet the sector's investment needs.<sup>677</sup> Budget execution rates for development expenditure at county level is generally lower than recurrent expenditure, and for many counties the development expenditure rate is falling.<sup>678</sup>
437. There is no separate budget line for sanitation which makes it difficult to track expenditure. In most counties, sanitation-related activities are allocated under promotive health lines, which makes accessing these funds more challenging. A few counties have allocated funds for sanitation as a result of advocacy by development partners, but there has been gap between commitments and actual releases. Consequently, sanitation programming is still dependent on external funding from development partners such as the World Bank, UNICEF and the Global Sanitation Fund. The Ministry of Health has not been allocated a budget for sanitation programming. This has implications for the functions that it retains under the devolution framework, in terms of reaching the global and national milestones for allocation and ultimately achieving results for the sector.<sup>679</sup>
438. Budgeting for water is further constrained by the high prevalence of non-revenue water in the country. In 2014-2015, non-revenue water – the proportion of water put into the distribution system that is not billed to consumers – amounted to 43 per cent, far above the sector benchmark. The problem affects utility companies of all sizes, with the Kahuti company in Muranga county not receiving revenue for 83 per cent of its supply.<sup>680</sup>
439. Kenya's classification as a low-middle income country, the SDG framework's emphasis on mobilizing domestic resources and the private sector have all brought about changes among bilateral donors.<sup>681</sup> The Ministry of Water and Irrigation is now encouraging public private partnership for water service provision.<sup>682</sup> There is also increased interest in Kenya in water utilities using performance based contracts to contract out works or services to private sector parties that receive remuneration based partly on the achievement of pre-determined outputs or outcomes and partly on completion of works defined in their contracts.<sup>683</sup> However, private sector funding may be directed at 'bankable' investments that improve service quality for those who already have access, rather than meeting the needs of unserved populations, who are often in rural areas where profits are unlikely because of the lack of an economy of scale.<sup>684</sup>

### Key issues

- Under the devolution settlement, service provision for both water and sanitation has been devolved to county level, and the counties have established ministries with responsibilities for both.
- Most counties lack the institutional and human resource capacity to deliver strategic planning and coordination.
- The national Government has estimated that it requires KSh 100 billion every year to achieve universal water access but only allocates KSh 40 billion annually, leading to high reliance on external finance.
- Budgeting for water is further constrained by the high prevalence of non-revenue water in the country.

674. Oxford University, *Water Policy Choices in Kenya's 47 Counties*; Policy Brief, February 2016, at [http://www.smithschool.ox.ac.uk/research-programmes/water-programme/Policy%20Brief\\_VWater%20Policy%20Choices\\_JKoebler\\_Feb2016.pdf](http://www.smithschool.ox.ac.uk/research-programmes/water-programme/Policy%20Brief_VWater%20Policy%20Choices_JKoebler_Feb2016.pdf)

675. UNICEF, UNICEF – KCO MTR Report, 2016

676. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, *County Public Expenditure Review for the Health and Wash Sectors in Kenya*:

Draft for validation, Oxford Policy Management, January 2017

677. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

678. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, *County Public Expenditure Review for the Health and Wash Sectors in Kenya*: Draft for validation, Oxford Policy Management, January 2017

679. Information provided by UNICEF, May 2017

680. Water Services Regulatory Board, *A Performance Review of Kenya's Water Services Sector 2014-2015*, at [http://www.nyewasco.co.ke/wp-content/uploads/2017/03/wasreb\\_impact\\_report9.pdf](http://www.nyewasco.co.ke/wp-content/uploads/2017/03/wasreb_impact_report9.pdf)

681. UNICEF, UNICEF – KCO MTR Report, 2016

682. Interview, Ministry of Water and Irrigation, 22 May 2016

## Water supply

440. According to the Joint Monitoring Programme report, access to improved water sources in 2015 stood at 82 per cent of urban households, but only 57 per cent for rural households. The urban figure had fallen from 92 per cent in 1990, though in absolute terms, as a result of urbanization, the number of urban residents with improved water supply rose from 3.7 million to 10 million. In 2015, 33 per cent of households did not have access to improved sources of drinking water. Meanwhile, 22 per cent had water piped to their homes and 41 per cent had other improved water sources.<sup>685</sup> In 2014, for 21 per cent of children it took more than 30 minutes for a household member to collect water.<sup>686</sup> In total, the 2014 DHS revealed that 45 per cent of children either lacked access to improved sources of drinking water or lived in households that had to walk more than 30 minutes for water (together considered “deprived of water”).<sup>687</sup>
441. More than half of all children living in rural areas in 2014 suffered from deprivation in water (55 per cent); this was true of 21 per cent of children in urban areas. There are also large disparities between counties (see the map below), with deprivation rates in water ranging between 7 per cent in Nairobi and 80 per cent in Kitui, Marsabit, and Migori. In Turkana, for example, the water source is often located very far from many communities and women (at times also children) often have to walk for hours and kilometres to obtain it. Many families in this county obtain water from nearby rivers, either because of their nomadic lifestyle, working far from home, or because rivers are typically the nearest source.<sup>688</sup>

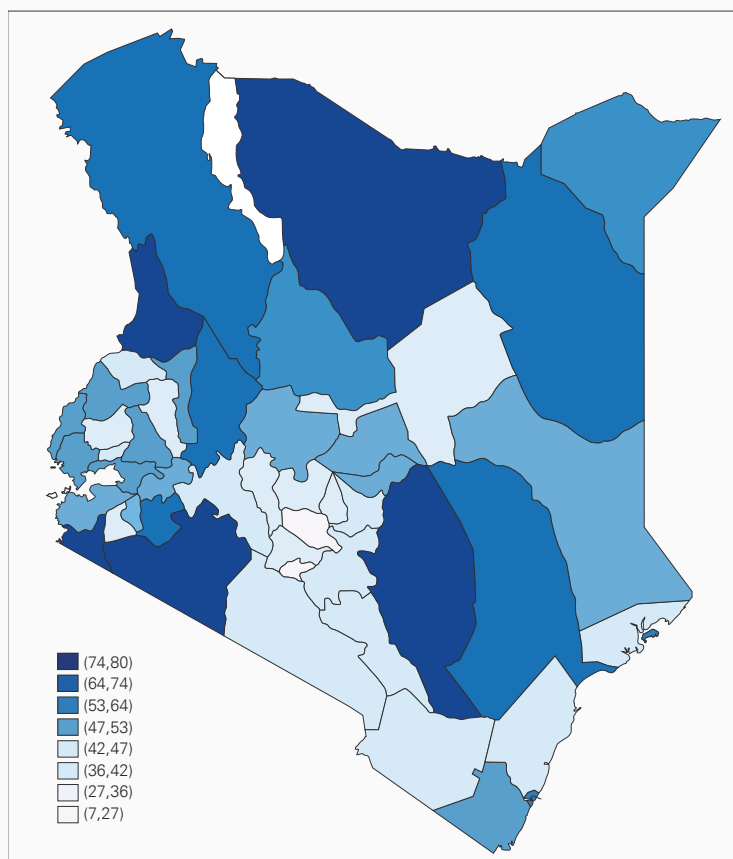


Figure 25: Proportion of children deprived of water by county (KDHS 2014 data)

683. Kenya Markets Trust, Innovations for Reducing Non-Revenue Water, 26 September 2016, at <http://www.kenyamarkets.org/press/innovations-reduced-non-revenue-water/>  
 684. Interview, Ministry of Water and Irrigation, 22 May 2016  
 685. UNICEF and WHO, Progress on Sanitation and Drinking Water: 2015 update and JMP Assessment, 2015, at [https://www.wssinfo.org/fileadmin/user\\_upload/resources/JMP-Update-report-2015\\_English.pdf](https://www.wssinfo.org/fileadmin/user_upload/resources/JMP-Update-report-2015_English.pdf)

442. When water is not supplied to the premises, responsibility of collecting drinking water usually lies with women and older girls. Forty-five per cent of households reported that a female aged 15 or older usually collects the drinking water for the household. Among rural households the figure is 57 per cent, as these households are much less likely to have their water source on the premises.<sup>689</sup>
443. The quality of water used by households is a serious concern in Kenya. Twenty-two per cent of households in 2015 (28 per cent in rural areas) used surface water from rivers, ponds, dams, lakes, streams, canals or irrigation channels, while a further 15 per cent used other unimproved sources such as unprotected dug wells, unprotected springs, tanker trucks or bottled water.<sup>690</sup> In Sub-Saharan Africa, Kenya has the third largest number of people in absolute numbers and by percentage of population that rely on unprotected surface water. This seems to be in contradiction with Kenya's status as a middle-income country.<sup>691</sup>
444. The authorities in Kenya are taking steps to address water quality concerns. In 2011 the water services regulatory board (WaSReB) began rolling out water safety plans to cover quality from source to consumer. As of May 2017, 36 of the country's 95 water service providers have water safety plans in place.<sup>692</sup> WaSReB issues an annual performance review of the country's water services sector. In 2014-15, a total of 50 of the 84 public-owned water utilities were not providing acceptable levels of water quality. Of the eight very large utilities, Mombasa fell in this category. It should also be noted that only 55 per cent of the population is covered by water supply utilities.<sup>693</sup>
445. According to 2015 EMIS data, at least 94 per cent of all primary schools had access to a water source, ranging from tap or borehole to river and rain water. Eighty per cent of public primary schools had access to piped or borehole water compared to 46 per cent of private primary schools. Ninety-five per cent of secondary schools had water sources, while only 10 per cent of public secondary schools relied on sources other than piped water, compared with 34 per cent of private secondary schools.<sup>694</sup> However, in total, only 9,000 of the country's 22,000 public primary schools were connected to safe water supplies.<sup>695</sup>
446. While 6.4 per cent of schools had no water source at all, data at county level revealed a much higher proportion of schools with no water source in Wajir county (25.9 per cent), Tana River county (14.4 per cent), Taita Taveta county (13.5 per cent) and Mandera county (13.1 per cent).<sup>696</sup> In this context, in 2016 the Government began a project to ensure that all schools in the country were connected with safe water supplies, and began the project in Wajir county.<sup>697</sup>
447. Qualitative research for the Multidimensional Poverty Survey found that children are asked to take water from their homes to schools, as the schools either experience shortages, have dysfunctional infrastructure, or cannot purchase water due to the limited budget. This water is used for drinking, hygiene, and cooking food. In the absence of water treatment or any quality assurance mechanisms, this practice poses a great health risk in schools where meals are cooked with the water that the children bring to school.<sup>698</sup>
448. Access to clean water is also problematic for healthcare service providers. In Turkana and Kitui, for example, dispensaries were reported to lack access to safe drinking water, posing a major issue to service delivery. Many dispensaries access water through roof catchment, boreholes, and rivers, and therefore they need to treat it before use.<sup>699</sup>

686. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

687. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

688. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

689. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

690. UNICEF and WHO, Progress on Sanitation and Drinking Water: 2015 update and JMP Assessment, 2015, at [https://www.wssinfo.org/fileadmin/user\\_upload/resources/JMP-Update-report-2015\\_English.pdf](https://www.wssinfo.org/fileadmin/user_upload/resources/JMP-Update-report-2015_English.pdf)

691. Interview, UNICEF, 17 May 2017

692. Interview, Ministry of Water and Irrigation, 22 May 2017

693. Water Services Regulatory Board, A Performance Review of Kenya's Water Services Sector 2014-2015, at [http://www.nyewasco.co.ke/wp-content/uploads/2017/03/wasreb\\_impact\\_report9.pdf](http://www.nyewasco.co.ke/wp-content/uploads/2017/03/wasreb_impact_report9.pdf)

694. Ministry of Education, Basic Education Statistical Booklet, 2015

695. Presidency, Governments launches ambitious project to supply 13,000 schools with safe water, 15 August 2016, at <http://www.president.go.ke/2016/08/15/governments-launches-ambitious-project-to-supply-13000-schools-with-safe-water/>

696. Ministry of Education, Basic Education Statistical Booklet, 2015

449. According to official figures, between 2012-13 and 2014-15, coverage of water supply by official utilities providers increased from 53 to 55 per cent. This is far below the national target of achieving 80 per cent by 2015.<sup>700</sup> In informal urban settlements, for example, water kiosks were reported to be the major sources of water for households by 49 per cent of respondents in a 2015 study. These kiosks are reportedly illegal, with vendors having connected their systems to the main water pipes. The price of water occasionally increases dramatically, especially during the dry and rainy seasons. Key challenges to accessing water include rationing (34 per cent), price/cost (30 per cent) and competition (14 per cent). A total of 28.4 per cent of households in the informal settlements did not treat water before drinking.<sup>701</sup> Increased migration from rural to urban areas and a rise in the number of people living in slums will further aggravate the situation.<sup>702</sup>
450. There is currently a lack of capacity at county level to plan strategically for water supply, to set county level targets for increasing supply or to monitor the situation. Most counties lack databases setting out where water supplies are in place, or registers of NGOs and international organizations working in the area on water supply. There is also a lack of planning of investment at county level, with budgets typically divided equally between sub-counties without any criteria to prioritize the more vulnerable areas.<sup>703</sup>
451. Most people in Kenya live in rural areas and they mostly depend on local sources or small-scale piped systems managed by communities themselves for their own water needs. National water policy has prioritized networked supplies in urban and peri-urban areas and their management on commercial lines by formally established Water Service Providers. These providers operate under license from the Water Service Boards, which retain ownership of the assets. In the absence of any separate provisions, the same policy applies (in theory) to small rural water supply schemes, but in practice cannot realistically be applied to small point sources such as hand dug wells and boreholes with hand pumps, especially in sparsely populated areas.<sup>704</sup>
452. The lack of ongoing support to water supply systems once construction is completed means that 25 to 30 per cent of recently-constructed community-managed rural water supply facilities in Kenya will become dysfunctional in the first three years following construction. A 2015 sustainability study by UNICEF found that 23 per cent of projects that had been completed were not functional for technical, social and/or financial reasons, and therefore not rendering the planned services. County governments lack capacity to restore broken water supplies. In some cases they do not know where to purchase spare parts or understand the pricing system, while in other cases, technical capacity to maintain the facilities is missing. This can result in water services being out of action for several months. This is partly because counties have low budgets for and few qualified staff working in operations and maintenance units, and because of the low-quality design and construction of rural water supplies.<sup>705</sup>
453. According to the Water Services Regulatory Board only 25 per cent of water supplies in Kenya are sustainably managed,<sup>706</sup> while, according to KDHS 2014, 54 per cent of households do not treat their drinking water.<sup>707</sup> Unlike urban areas, data on the status of these point sources and small-scale systems is hardly available, making it difficult to present a comprehensive picture on the current status of water services provision in rural areas.

697. Presidency, Governments launches ambitious project to supply 13,000 schools with safe water, 15 August 2016, at <http://www.president.go.ke/2016/08/15/governments-launches-ambitious-project-to-supply-13000-schools-with-safe-water/>

698. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

699. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

700. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

701. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

702. Brian McSorley, Improving Sanitation in Kenya: toilets have become an obsession, Oxfam, 13 May 2016, at <http://policy-practice.oxfam.org.uk/blog/2016/05/improving-sanitation-in-kenya-toilets-have-become-an-obsession>

703. Interview, UNICEF, 22 March 2017

704. UNICEF, Sustainability Check and Verification of WASH Projects Funded under the Dutch Programme, February 2015

705. UNICEF, Sustainability Check and Verification of WASH Projects Funded under the Dutch Programme, February 2015

706. Sanjay Wijesekera, MDGs to SDGs Kenya sector round, November 2016

707. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

454. A serious concern for the sector is the low budget absorption rate of 70 per cent.<sup>708</sup> This is partly a result of slow disbursement of donor funds, the sector being targeted for cuts in supplementary budgets and slow procurement procedures.<sup>709</sup> Weak leadership, coordination and the lack of good current data on existing assets can also lead to delays in financing.<sup>710</sup> The situation in Turkana county appears to be particularly problematic. Because of the size of the county and its high poverty level, it received an allocation of 638 million shillings from the national budget for WASH spending in the 2015-2016 fiscal year. However, its actual spending that year was only 232 million shillings, a drop of 48.6 per cent from the previous year.<sup>711</sup> Turkana County is now coming to terms with its larger budget for water and sanitation, and 80 new boreholes have been dug, resulting in an increase in water supply in the county from 39 per cent in 2014<sup>712</sup> to 59 per cent in June 2016.<sup>713</sup>
455. While the Water Services Regulatory Board regulates urban water utilities, it is not clear which body is responsible for regulation of rural water schemes and small town utilities. This has meant that the increased non-functionality of water schemes has gone unnoticed. Counties are unable to tackle the current problems facing the sector, because of inadequate capacity of the devolved units and a lack of dedicated funding from external actors. For example, envisaged service delivery models have not been anchored in policy and regulation.<sup>714</sup> Reportedly sub-counties are already complaining of a 'centralisation' of resources at county government level, a replication of the complaint made about national government by local government.<sup>715</sup>
456. Challenges ensuring water supply in Kenya are likely to be exacerbated in future decades because of the ongoing effects of climate change, as well as population growth. In 2017, Nairobi's water supplies reservoirs went down to 25 per cent of capacity, the lowest in record. New water works should resolve that capacity gap for Nairobi by 2020. However, in areas where there is insufficient water, even if funds are available, new solutions will have to be found. Kenya suffers from catchment degradation as farmers plough and plant along rivers. Water quality in certain sources (such as rivers) can also be affected by use of fertilisers and environmental pollution. Finally, given the use of pit latrines and septic tanks by much of the population, there is an ongoing danger of overflow into water sources.<sup>716</sup>

### Key issues

- In 2015, access to improved water sources stood at 82 per cent of urban households, but only 57 per cent for rural households
- Kenya has the third largest number of people in sub-Saharan Africa in absolute numbers and by percentage of population that rely on unprotected surface water
- In 2014, for 21 per cent of children it took more than 30 minutes for a household member to collect water, and when water is not supplied to the premises, responsibility for collecting drinking water usually lies with women and older girls.
- Lack of ongoing support to water supply systems once construction is completed means that 25 to 30 per cent of recently-constructed community-managed rural water supply facilities in Kenya will become dysfunctional in the first three years following construction.
- Challenges ensuring water supply in Kenya are likely to be exacerbated in future decades because of the ongoing effects of climate change and population growth.
- In 2015, only 9,000 of Kenya's 22,000 public primary schools were connected to safe water supplies, with high proportions of schools without any water sources in Wajir County (25.9 per cent), Tana River County (14.4 per cent), Taita Taveta County (13.5 per cent) and Mandera County (13.1 per cent)
- In 2016 the Government began a project to ensure that all schools in the country were connected with safe water supplies
- In informal urban settlements kiosks selling water privately were the major sources of water for 49 per cent of respondent households in 2015.

708. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

709. Laura Giles Álvarez, Florian Kratke, Zach White, Alexandra Murray-Zmijewski and Stanley Karuga, County Public Expenditure Review for the Health and Wash Sectors in Kenya: Draft for validation, Oxford Policy Management, January 2017

710. Interview, UNICEF, 17 May 2017

711. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

712. Interview, UNICEF, 18 May 2017

## Sanitation

457. According to the Ministry of Water and Irrigation (2017) 48 per cent of households had improved sanitation facilities. 22.8 per cent used shared facilities,<sup>717</sup> 31 per cent other unimproved sources, and 12.5 per cent practised open defecation. While there was little difference in 2015 in the figures for improved sanitation in rural and urban areas, urban residents were much more likely to use shared toilets (48 per cent compared to 19 per cent in rural areas), while rural residents were more likely to practise open defecation (15 per cent compared to 3 per cent) or use other unimproved sanitation facilities (40 per cent versus 18 per cent).<sup>718</sup>
458. In 2014, 57 per cent of children lived in households that used unimproved toilet facilities. There has been almost no reduction in this indicator since 2008-2009, when it stood at 60 per cent. Access to improved sanitation differed considerably across counties, with rates of unimproved toilet type used by children under age 18 in 2014 ranging between 1 per cent in Mombasa and 87 per cent in Samburu, Tana River, and Turkana.<sup>719</sup>

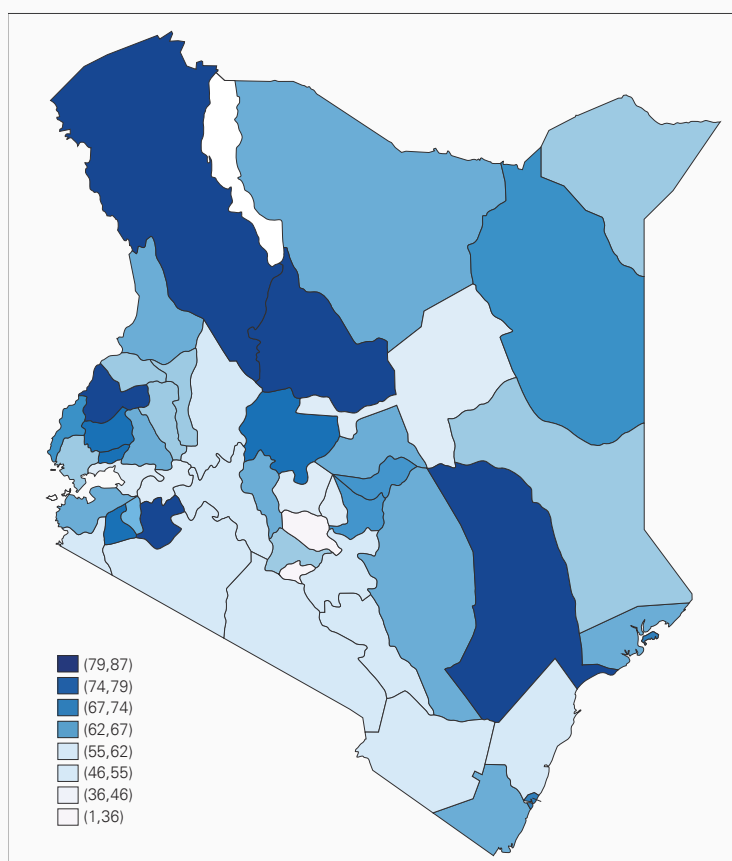


Figure 26: Proportion of children deprived of sanitation, 2014 (KDHS data)

713. Turkana County Department of Health, Turkana SMART Nutrition Survey, June 2016

714. Information provided by UNICEF, May 2017

715. UNICEF, UNICEF – KCO MTR Report, 2016

716. Interview, Ministry of Water and Irrigation, 22 May 2017

717. These figures were provided by the Ministry of Water and Irrigation (2017) as per letter to UNICEF Reference Number MWI/WSP/UNICEF/Vol.111 (38). The figures are obtained from the SDG 6 Baseline report for Kenya.

718. UNICEF and WHO, Progress on Sanitation and Drinking Water: 2015 update and JMP Assessment, 2015, at [https://www.wssinfo.org/fileadmin/user\\_upload/resources/JMP-Update-report-2015\\_English.pdf](https://www.wssinfo.org/fileadmin/user_upload/resources/JMP-Update-report-2015_English.pdf)

719. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2008-2009, 2010 at <https://dhsprogram.com/pubs/pdf/fr229/fr229.pdf>



459. The revised Kenya Environmental Sanitation and Hygiene Policy 2016-2020, Kenya Environmental Sanitation and Hygiene Framework 2016-2020 and National ODF Kenya 2020 Campaign Framework all commit the Government to ending open defecation in Kenya by 2020. This is largely to be conducted using local resources, such as community health workers (for more, see *Community healthcare system* above).<sup>720</sup> However, the national Ministry of Health lacks funds to communicate the policies to counties.<sup>721</sup> County budgets generally have no specific budget line for sanitation, thereby limiting ability to plan and leverage.<sup>722</sup> While CIDPs tend to have good problem analysis, often no funds are allocated. However, over the last two years eight counties have committed specific budgets for community-led total sanitation, which may suggest a growing awareness of the need to allocate budgets.<sup>723</sup>
460. By 2016, 8 per cent of villages in Kenya had been certified as open-defecation free. Busia County has been declared open-defecation free, and significant progress had also been made in Siaya County (56 per cent of villages), Isiolo county (33 per cent), Kitui county (26 per cent), and Kisumu County (21 per cent). Of the counties particularly affected by cholera in 2016 and 2017, Mandera County and Wajir County had no villages certified as open-defecation free, while in Tana River county only five out of 548 villages had been certified.<sup>724</sup>
461. Among communities that do have access to sanitation, latrines are very few in number and are often used by many households.<sup>725</sup> In western counties they also frequently collapse. This is because the water table is generally high, flash flooding is common and soil formation is loose, while poorer households have limited capacity to construct raised sanitation facilities. These problems often led to contamination of water sources and increases probability of WASH-related disease outbreaks.<sup>726</sup> While there has been improvement in terms of educating the communities on the importance of improved sanitation through community-level activities, inability to afford facilities is the major bottleneck.<sup>727</sup> The percentage of children whose stools are disposed of safely increased from 78 per cent in 2008-09 to 83 per cent in 2014.<sup>728</sup>
462. Given rapid urbanization in recent years, many people live in informal settlements for which disaggregated figures are not available.<sup>729</sup> Availability of toilet facilities is reportedly sufficient in four urban informal settlements surveyed in 2015, although not necessarily accessible. Most of the available toilet facilities were shared among households living in the same tenancy blocks. Hygiene in toilets was inadequate, and children could not use them because of the poor conditions. The informal settlements in Nairobi and Mombasa had some sanitation blocks operated by individuals charging user fees of between Ksh 5 and 10, reportedly beyond the reach of most residents. In the absence of toilets, many households confirmed using designated communal defecating areas such as rubbish tips, riverbanks, ocean shores, open sewer trenches, railway lines, forests, bushes, and roadsides. Disease was most prevalent in the rainy season. Poor sanitation within the informal settlements leads to high prevalence of water-borne diseases such as cholera, typhoid, amoeba infection and diarrhoea.<sup>730</sup>
463. Access to sanitation is reportedly a problem in many schools, with the number of latrines insufficient given the population of pupils. In 2015 the Ministry of Education reported a ratio of 35 boys per toilet and 29 girls per toilet in schools: this is below the national norms of 30:1 and 25:1 respectively. In some counties, the figures are much poorer: Turkana County had 107 boys per toilet and 75 girls per toilet, while Mandera County had ratios of 76:1 and 54:1.<sup>731</sup> The quality of latrines is also an issue. School principals and county education officials have reported that school budgets are too restricted to even empty latrines at times, let alone set up new structures. As a result, in many areas open defecation remains the only alternative.<sup>732</sup>

720. Ministry of Health, National ODF Kenya 2020 Campaign Framework 2016/17 – 2019/20, 2016, at [http://www.washwatch.org/uploads/filer\\_public/2c/8f/2c8f15cb-70f7-4387-a648-0cb440a8df95/odf\\_open\\_defecation\\_free\\_2020\\_campaign\\_framework\\_kenya\\_2016.pdf](http://www.washwatch.org/uploads/filer_public/2c/8f/2c8f15cb-70f7-4387-a648-0cb440a8df95/odf_open_defecation_free_2020_campaign_framework_kenya_2016.pdf)

721. Interview, Ministry of Health, 22 May 2017

722. UNICEF, UNICEF – KCO MTR Report, 2016

723. Interview, UNICEF, 17 May 2017

724. UNICEF and Ministry of Health, Realizing Open Defecation Free (ODF) Rural Kenya: achievements and the road ahead, December 2016

725. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

726. Information provided by UNICEF, May 2017

727. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016. Information provided by UNICEF, May 2017

728. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

729. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

464. National policy making on sanitation issues seeks to take account of the challenges of persons with disabilities accessing facilities, and organizations of persons with disabilities are involved in planning processes. However, the lack of disaggregated data at village level about the numbers of persons with various disabilities makes it difficult to plan for provision.<sup>733</sup>
465. As with water supply, there have been challenges for county and national level governments in understanding their roles and responsibilities regarding water supply. Coordination is also a challenge, with structures at county level often not corresponding to those in the national Ministry of Health. In addition, communications from the Ministry of Health concerning sanitation issues often take a month to be issued because of bureaucratic procedures.<sup>734</sup>
466. A web-based system has been established for monitoring progress on sanitation at county level. Two of the indicators – the number of households with latrines and with handwashing facilities – have been incorporated into the Health Information System. The system is currently being rolled out across the country, with Siaya and Kitui, followed by Garissa, Turkana and Kakamega counties, the most advanced in implementation.<sup>735</sup>

#### Key issues

- In 2015, 30 per cent of households had improved sanitation facilities, only 5 per cent more than the figure in 1990, with 27 per cent using shared facilities, 31 per cent other unimproved sources, and 12 per cent practising open defecation
- The revised Kenya Environmental Sanitation and Hygiene Policy 2016-2020, Kenya Environmental Sanitation and Hygiene Framework 2016-2020 and National Open Defecation Free Kenya 2020 Campaign Framework all commit the Government to ending open defecation in Kenya by 2020.
- By 2016, 8 per cent of villages in Kenya had been certified as open-defecation free with Busia County has been declared open-defecation free, and significant progress also made in Siaya County (56 per cent of villages), Isiolo County (33 per cent), Kitui County (26 per cent), and Kisumu County (21 per cent).
- Among communities that do have access to sanitation, latrines are very few in number and are often used by many households, and they also frequently collapse In western counties,
- Sanitation problems often lead to contamination of water sources and increase the probability of outbreaks of disease. Inability to afford facilities is the major bottleneck
- Poor sanitation in informal settlements leads to high prevalence of water-borne diseases, such as cholera, typhoid, amoeba infection and diarrhoea
- Access to sanitation is reportedly a problem in many schools, 35 boys per toilet and 29 girls per toilet in schools in 2015, below the national norms of 30:1 and 25:1 respectively.
- Turkana County schools had 107 boys per toilet and 75 girls per toilet, while Mandera County had ratios of 76:1 and 54:1

730. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

731. Ministry of Education, Basic Education Statistical Booklet, 2015

732. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

733. Interview, Ministry of Health, 22 May 2017

734. Interview, Ministry of Health, 22 May 2017

735. Interview, Ministry of Health, 22 May 2017

## Hygiene

467. In Kenya, knowledge about hand washing and its importance is high. However, most Kenyans have limited understanding of the relationship between hand washing and diseases and how this affects the day-to-day lives of children and the community. There also appears to be lack of knowledge about proper hand washing. One study found the use of recycled water, and almost 50 per cent of primary caregivers dried their hands on the clothes they were wearing. In some cases, people wash only one hand instead of rubbing both hands with water and soap.<sup>736</sup>
468. Most studies indicate that Kenyan households accord low priority to hand washing with soap; behind bathing, laundry and washing dishes and personal care. Hand washing with soap is most frequent after toilet use or potential contact with faeces but very low at other critical times and is almost non-existent in schools.<sup>737</sup>
469. Studies show however that Kenyans have a positive attitude towards hand washing. For example, 82 per cent of caregivers believe that families would be healthier if they washed their hands with soap all the time. Teaching children hand washing is considered good manners.<sup>738</sup> In Moheto community in Migori country, community health volunteers have organized groups to construct simple handwashing devices to generate incomes while at the same time enhancing handwashing practice at homes, schools and churches.<sup>739</sup>
470. In the 2014 DHS, a place for hand washing was only observed in a third of households (43 per cent in urban areas and 27 per cent in rural areas). The figures ranged from 17 per cent in the former Nyanza Region to 56 per cent in former Central Region. The wealthiest quintile was most likely to have places for hand washing, with 53 per cent, compared to 18 per cent for the poorest quintile. Both water and soap were available in 50 per cent of the households where a place for hand washing was observed (60 per cent in urban households and 38 per cent in rural households). Presence of soap and water increases steadily with increasing wealth, from 19 per cent in the lowest quintile to 67 per cent in the highest quintile. In about half of households in the former Coast, North Eastern, and Western Regions where a place for hand washing was observed neither water nor soap was available.<sup>740</sup> In communities where community-led total sanitation (CLTS) has progressed well (such as in Siaya where 64 per cent of villages are open defecation free), there has been a marked increase in households with simple handwashing devices and places for soap or ash, and people wash their hands more frequently, particularly after going to the toilet.<sup>741</sup>
471. A 2015 UNICEF study found that the community-led total sanitation scheme had resulted in sustained open-defecation free (ODF) practice in more than 95 per cent of surveyed households. However, because of continued practice of open defecation by a few households in each community, more than 70 per cent of villages had partially or fully lapsed from ODF status. The main reasons for households reverting to open defecation are lack of access to their own (not shared), safe and functioning toilet and young children's defecation practice; while demonstrated health benefits are the main motivating factor for households sustaining latrine use.<sup>742</sup>

736. UNICEF, 10 Key Child Survival Development and Protective Behaviours, April 2016

737. UNICEF, 10 Key Child Survival Development and Protective Behaviours, April 2016

738. UNICEF, 10 Key Child Survival Development and Protective Behaviours, April 2016

739. UNICEF, Hygiene promotion – the Moheto way, 2016, at <https://www.unicef.org/kenya/17905.html>

740. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

741. Information provided by UNICEF, May 2017

742. UNICEF, Sustainability of ODF Practices in Kenya, November 2015, at <https://www.unicef.org/esaro/UNICEF-FN-ODF-Sustainability.pdf>

## Housing and energy

472. In the Multidimensional Child Poverty study standards, children are considered deprived when living in a dwelling where both floor and exterior walls are made of natural material, such as earth, sand, cane, mud, or grass. The percentage of children living in dwellings with such conditions in 2014 was 43 per cent (54 per cent in rural areas and 16 per cent in urban areas). This is a higher figure than 2008-2009, when 39 per cent of all children under 18 lived in dwellings with floor and walls made of natural material.<sup>743</sup>
473. In Kenya, there is an estimated accumulated housing deficit of over 2 million units, and nearly 61 per cent of urban households live in slums.<sup>744</sup> This is because 244,000 housing units in different market segments are needed annually to keep up with demand, while current production is less than 50,000 units.<sup>745</sup> This means there is a critical need to invest more in affordable housing in urban areas.
474. According to the Kenya Health Policy 2014-2030, indoor air pollution is one of the top five leading risk factors contributing to mortality and morbidity in the country.<sup>746</sup> This is largely connected to the lack of electric or gas power supply to the home. In this context, wood and kerosene are the dominant fuels used by the poor for cooking and lighting. In 2007, biomass energy, such as firewood, charcoal and agricultural waste met up to 70 per cent of Kenya's energy demand and almost 90 per cent of rural households' energy needs.<sup>747</sup>
475. The percentage of children exposed to indoor air pollution from solid cooking fuel used inside the house in 2014 was 17 per cent (15 per cent in rural areas and 20 per cent in urban areas), with no change since 2008-2009.<sup>748</sup> Widely used figures from 2004 state that 14,300 people in Kenya die every year from diseases attributable to indoor air pollution (such as pneumonia).<sup>749</sup> There appears to be a relationship between cooking fuel used and acute respiratory infections (ARIs) among under-fives in the two weeks prior to the KDHS. ARIs were more common among families that use wood or straw (9 per cent) or charcoal (8.4 per cent) and less common among those using paraffin or kerosene (6.2 per cent) or electricity (6.7 per cent) for cooking.<sup>750</sup>
476. The total proportion of children deprived either through housing material or air pollution was 52 per cent in 2014. The lowest figure was 10 per cent in Machakos, while the highest were found in West Pokot (87 per cent), Samburu (85 per cent), Busia (83 per cent), Tana River (82 per cent), and Bungoma (81 per cent).<sup>751</sup>
477. The poor conditions of the informal settlements, and the casual and informal nature of most employment in households in the areas expose their residents to volatility and changes in food prices, insecurity, political intolerance, fires and environmental dangers, including floods. In addition, children's vulnerabilities resulting from fragile livelihoods were attributed to high levels of unemployment and under-employment, high house rents and threats of evictions from landlords and county authorities, fluctuations in food prices. January and February are reportedly the most challenging months when casual work is difficult to come by. Food prices increase significantly in the months of December, January and partly in February when the festive seasons are over and resources constrained. Evictions are most common between January and June, potentially because of accumulated unpaid house rent or because landlords intended to raise the rents at the beginning of the year.

743. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

744. Habitat for Humanity, KUR, MDG definition of a slum. Cited in World Bank, Kenya Economic Update, April 2017, <http://documents.worldbank.org/curated/en/988191491576935397/pdf/114115-NWP-PUBLIC-add-series-86p-Kenya-Economic-Update-FINAL-Edition-15.pdf>

745. World Bank, Kenya Economic Update, April 2017, <http://documents.worldbank.org/curated/en/988191491576935397/pdf/114115-NWP-PUBLIC-add-series-86p-Kenya-Economic-Update-FINAL-Edition-15.pdf>

746. Ministry of Health (2014). Kenya Health Policy 2014-2030. Towards attaining the highest standard of health. Ministry of Health: Nairobi.

747. UNEP, Kenya Air Quality Catalogue, 2015, at <https://wedocs.unep.org/bitstream/handle/20.500.11822/17228/Kenya.pdf?sequence=1&isAllowed=y>

748. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

749. WHO, Country Profile of Environmental Burden of Disease, 2009, at [http://www.who.int/quantifying\\_ehimpacts/national/countryprofile/kenya.pdf](http://www.who.int/quantifying_ehimpacts/national/countryprofile/kenya.pdf)

750. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

751. UNICEF, Multidimensional Child Poverty in Kenya, Draft, November 2016

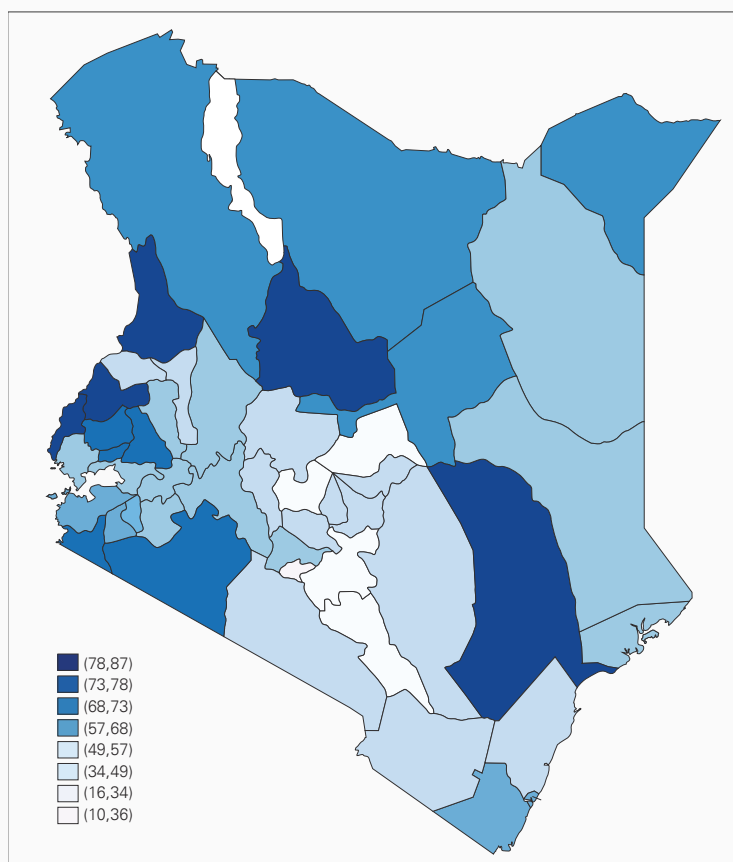


Figure 27: Proportion of children deprived in housing, 2014 (KDHS data)

478. Children in informal urban settlements are particularly vulnerable to disasters, particularly man-made fires and flooding. Research conducted in 2015 confirmed fires to be the major man-made risk in Nairobi's informal settlements. Fifty per cent of households in the informal settlements use paraffin stoves for cooking and either candles or paraffin tin lamps for lighting. The small dwelling units, which also served as cooking areas, exposed children to burns, as they play near the fireplaces. In addition, paraffin storage and use were a risk to children. Many of the household fires were blamed on children playing with the flammable fuel. Within the slums, by-laws on storage of paraffin for sale were not observed. Many of the outlets that stocked this flammable fuel were adjacent to household units with no protective measures. The paraffin outlets also did not have fire extinguishers. Therefore, households suffered major losses in case of fire outbreaks. Fire is common in the months of December, January, April and August. The fire incidences were attributed to dry weather conditions experienced in these months and lack of caregivers for children during school holidays. Floods, on the other hand, were common in the months of April and May when the country experiences long rains. Informal settlements in Nairobi, Mombasa and Kisumu experience heavy losses during these months, as many of them are located in areas condemned as inhabitable, such as road reserves, flood catchment areas along rivers and along the ocean shore.<sup>753</sup>

752. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

753. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

479. Electric power supply appears to be expanding in Kenya. According to figures from Kenya Power, the proportion of the population with access to electricity at home increased from 27 per cent in 2013 to 63 per cent in March 2017, putting the country on course to achieve its goal of universal electrification by 2020.<sup>754</sup> This rise appears to be backed up by figures from the KDHS (23 per cent in 2008-2009 and 36 per cent in 2014)<sup>755</sup> and the MIS (42 per cent in 2015).<sup>756</sup> The rise potentially means that many more children can now do their homework with electric lights; medicine and food can be stored at home; water pumps can supply safe drinking water; and reduced use of paraffin lamps will improve indoor air quality and prevent many of the deadly fires that occur every day in the country.<sup>757</sup> However, it should be noted that having access to electricity does not mean it is always available: in the 2014 Afrobarometer survey, only 33 per cent of respondents stated that they had connections that worked most or all of the time.<sup>758</sup>
480. Meanwhile, survey figures also indicate inequity in supply of electricity. According to DHS figures for Kenya in 2014, most households in urban areas had electricity (68 per cent), compared to only 13 per cent in rural areas.<sup>759</sup> In informal settlements, illicit connections to electricity lines has been a problem in recent years, but this is reportedly being reduced by a World Bank supported project to subsidize official connections in these areas.<sup>760</sup>

#### Key issues

- Housing shortages mean there is a critical need to invest more in affordable housing in urban areas.
- In 2014, 43 per cent of children lived in dwellings made of natural material, such as earth, sand, cane, mud, or grass, more than in 2008-2009.
- According to the Kenya Health Policy 2014-2030, indoor air pollution is one of the top five leading risk factors contributing to mortality and morbidity in the country, with an estimated 59 per cent of 19,000 child deaths due to acute respiratory infections attributable to household air pollution
- Electric power supply appears to be expanding in Kenya, increasing from 27 per cent in 2013 to 63 per cent in March 2017 and putting the country on course to achieve its goal of universal electrification by 2020, and potentially meaning that many more children can now do their homework with electric lights; medicine and food can be stored at home; water pumps can supply safe drinking water; and reduced use of paraffin lamps will improve indoor air quality and prevent fires
- However, having access to electricity does not mean it is always available: in 2014, only 33 per cent of survey respondents stated that they had connections that worked most or all of the time

754. Kenya Power, Kenya Power confirms 5.9 Million customers connected to the grid, 20 March 2017, at <http://www.kplc.co.ke/category/view/31/press-releases>

755. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2008-2009, 2010 at <https://dhsprogram.com/pubs/pdf/fr229/fr229.pdf>

756. Kenya Malaria Indicator Survey, 2015

757. Neil Ford, Shining a light on Kenya's electrification: African Energy, 8 February 2017, at <http://blogs.platts.com/2017/02/08/shining-light-kenya-electrification/>

758. Afrobarometer, Off-grid or 'off-on': Lack of access, unreliable electricity supply still plague majority of Africans, 14 March 2016, at [http://afrobarometer.msgfocus.com/files/amf\\_afrobarometer/project\\_164/Electrification/Electricity-in-Africa-dispatch\\_AD75-Afrobarometer-ENG.pdf](http://afrobarometer.msgfocus.com/files/amf_afrobarometer/project_164/Electrification/Electricity-in-Africa-dispatch_AD75-Afrobarometer-ENG.pdf)

759. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

760. Rael Ombuor, Power at Any Price in Kenya's Kibera Slum, VOA, 28 June 2016, at <http://www.voanews.com/a/power-any-cost-kenya-kibera-slum/3395757.html>

## Environmental pollution and climate change

481. Car exhaust fumes contribute 40 per cent of the particulate matter in air pollution in urban areas of Kenya. Imported second hand vehicles and frequent traffic jams in urban areas, along with poor vehicle maintenance have exacerbated air pollution in the country. Motorised transport is one of the fastest growing sectors in Kenya, with an average growth rate of 12 per cent per year for light duty vehicles. Most other outdoor emissions are connected to combustion facilities within industries, such as boilers and standby power generators. Industrial emissions contribute less than 7 per cent of the particulate matter concentration in the atmosphere.<sup>761</sup> Climate change and prolonged and more frequent periods of droughts also increase the likelihood and intensity of wildfires, which are a major source of air pollution, including across large distances.<sup>762</sup> Meanwhile, air quality monitoring in Kenya is practically non-existent.<sup>763</sup> In this context, Kenya legislated to forbid the use of fuel with high sulphur content in January 2015.<sup>764</sup>
482. Kenya is already extremely susceptible to climate-related events, which pose a serious threat to the socio-economic development of the country. Recurring droughts and floods in particular have devastating consequences on the environment, society and the wider economy. These impacts are likely to continue to affect the country in the future and undermine coping capacities.<sup>765</sup> Many diseases occurring in Kenya that disproportionately affect children are climate sensitive: these include malaria, dengue fever, cholera, dysentery, typhoid fever and leishmaniasis. With climate change, malaria prevalence is expected to expand to higher altitudes, and the intensity and length of the transmission season in areas where it already occurs is expected to increase. The ASAL counties are likely to see an increase in respiratory infections.<sup>766</sup>
483. The negative impact of climate change, combined with population growth and unsustainable development projects, is adding further pressure on children's access to water and sanitation and on their food and nutrition security in arid and semi-arid lands.<sup>767</sup> The urban poor living in slums that are flood-prone and the rural poor who rely on ground water for water supply and rainfall for food production are particularly vulnerable.<sup>768</sup> Children in urban slums are also particularly vulnerable to increasingly occurring heat waves, which are more devastating in urban areas because of the "heat island effect", while young children's and babies' bodies are less able to regulate their body temperature.
484. The 2013-2017 National Climate Change Action Plan was developed in 2012 to enable Kenya to reduce vulnerability to climate change and to improve the country's ability to take advantage of the opportunities that climate change offers.<sup>769</sup> The national climate change response strategy recognizes that "population displacement and migration from climate disaster-prone areas (such as drought-prone northern Kenya and the coastal region where sea levels are rising) are expected to increase. It is expected that most of those on the move will head towards urban agglomerations where assistance, income opportunities and infrastructure may be perceived to be more accessible and readily available. This will create an enormous social, health, infrastructure and management challenge for cities, subjecting them to unplanned population growth."<sup>770</sup>

761. UNEP, Actions on Air Quality, 2015. Cited in Daily Nation, 14,000 die annually in Kenya due to air pollution: report, 24 May 2016, at <http://www.nation.co.ke/news/air-pollution-kenya/1056-3217116-jbb1psz/index.html>

762. UNICEF, Clean the Air for Children, 30 October 2016, at [https://www.unicef.org/publications/files/UNICEF\\_Clear\\_the\\_Air\\_for\\_Children\\_30\\_Oct\\_2016.pdf](https://www.unicef.org/publications/files/UNICEF_Clear_the_Air_for_Children_30_Oct_2016.pdf)

763. UNEP, Actions on Air Quality, 2015. Cited in Daily Nation, 14,000 die annually in Kenya due to air pollution: report, 24 May 2016, at <http://www.nation.co.ke/news/air-pollution-kenya/1056-3217116-jbb1psz/index.html>

764. UNEP, Actions on Air Quality, 2015, at [oceanscoalition.org/sites/default/files/resources/AQ\\_GlobalReport\\_Summary.pdf](http://oceanscoalition.org/sites/default/files/resources/AQ_GlobalReport_Summary.pdf)

765. Government of Kenya, National Climate Change Action Plan 2013-2017, 2012, at <https://odkn.org/wp-content/uploads/2013/03/Kenya-National-Climate-Change-Action-Plan.pdf>

766. WHO, Climate Change Adaptation to Protect Human Health, 2016, at <http://www.who.int/globalchange/projects/adaptation/PHE-adaptation-final-Kenya.pdf>

767. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

768. Government of Kenya, National Climate Change Action Plan 2013-2017, 2012, at <https://odkn.org/wp-content/uploads/2013/03/Kenya-National-Climate-Change-Action-Plan.pdf>

769. Government of Kenya, National Climate Change Action Plan 2013-2017, 2012, at <https://odkn.org/wp-content/uploads/2013/03/Kenya-National-Climate-Change-Action-Plan.pdf>

770. WFP, Comprehensive Food Security and Vulnerability Analysis (CFSVA): Kenya 2016, 2016, at <http://documents.wfp.org/stellent/groups/public/documents/ena/wfp285586.pdf>

## National priorities for addressing climate change

485. The National Climate Change Action Plan sets out several adaptation measures that will increase the resilience of children and their communities to climate change. Some of these are summarized below:<sup>771</sup>

- **Water and sanitation:** Water resource management is important for addressing drought. Re-forestation in water catchment areas has proven critical for sustaining water availability, which is needed for generation of hydropower, drinking water and water for irrigation. Priority adaptation actions to improve water management include increased domestic water supply and improved sewage systems. Expanded flood management is required in high-risk areas, including in slums, which need upgrading to increase the resilience of the poor. Importantly, increased access to water and sanitation can improve disease vector control. A low carbon action is the use of water filters that provide access to clean water while reducing demand for firewood used to boil water, therefore slowing deforestation.
- **Energy:** Increased generation of renewable energy, including off-grid provision, also has the benefit of improved energy security by reducing reliance on fossil fuel imports. Improved cooking stoves can better the lives of individuals, particularly women and children, in rural and urban areas by reducing the time it takes to collect fuel wood, reducing indoor air pollution, and potentially introducing cost savings to households.
- **Livelihoods:** Climate-proofed infrastructure development in the ASALs, investment in sustainable livelihoods that are adaptive to climate change (such as crop farming with drought resistant seeds, dryland forestry and community-based livestock systems) and education programmes are priority elements of a climate resilient pathway. Research is needed to assess migration as an adjustment or coping mechanism for climate variability, and to identify alternatives to allow people to remain in their communities.
- **Health:** Improved community-level health care and dissemination of information on changing health risks can enhance the response to climate-related diseases.

771. Government of Kenya, National Climate Change Action Plan 2013-2017, 2012, at <https://cdkn.org/wp-content/uploads/2013/03/Kenya-National-Climate-Change-Action-Plan.pdf>



# Chapter 7:

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## Children and emergencies



## The humanitarian context

486. In Kenya, progress for children continues to face ongoing setbacks caused by multiple emergencies and the country is extremely vulnerable to shocks. Cholera outbreaks and floods significantly affect Kenya's development goals.<sup>772</sup> Children and women are also affected by violence related to inter-clan conflict, radicalization, terrorism, and political tensions concerning elections.<sup>773</sup> However, drought has for decades been the single most disastrous natural hazard in Kenya, particularly in the arid and semi-arid lands (ASAL). It has destroyed livelihoods and caused hunger, disease and fatalities. Droughts can lead to a decline in food production, affect the migratory patterns of pastoralists, exacerbate resource-based conflict, and cause substantial loss of assets, triggering acute food insecurity among vulnerable households and placing a heavy strain on both the local and national economies.<sup>774</sup>
487. All of these emergencies have a serious impact on children. This can include becoming direct victims of violence, loss of carers, psychosocial distress and family separation. Physical, sexual violence and other forms of gender based violence, including psychological and sexual violations often also increase during emergencies. Food insecurity and malnutrition disproportionately affect children. Drought and conflict lead to displacement of the most vulnerable groups. Acute water shortages, absence of school meals, displacement and teacher shortages because of conflict and hardship affect school enrolment and attendance.

## The impact of the 2016-2017 drought

488. The most serious humanitarian event of recent years in Kenya has been the drought of 2016-17, and this is likely to have repercussions for the country going forwards. On 10 February 2017, the Government declared a national drought emergency, with 23 of 47 counties affected.<sup>775</sup> Despite a return of rains in April, rainfall has been below average and drought is continuing to blight the ASAL counties. By June 2017, the total food insecure population in Kenya had risen to 3.5 million.<sup>776</sup>
489. Screening in February and March 2017 in Turkana and Marsabit identified significant numbers of children as acutely malnourished. The assessment confirmed a major shortage of water and pasture with a large number of visible animal carcasses. Community members' feedback indicated that there had been an inadequate food access response in terms of both food and cash.<sup>777</sup> As of May 2017, the drought had contributed to an increase in the number of children in the ASAL counties requiring treatment for acute malnutrition to 344,750.<sup>778</sup>
490. Assessments by the Kenyan Red Cross Society show that the distance to water points in affected areas has been much longer than average in recent months. This has had an impact on up to 70 per cent of the community, who may be traveling three times further than average to collect water.<sup>779</sup> Meanwhile, maize production in coastal areas decreased in 2017 by 99 per cent compared to the long-term average, and there were reports of large numbers of animal deaths in Turkana, Marsabit, Samburu and Mandera counties.<sup>780</sup>

772. UNICEF, UNICEF – KCO MTR Report, 2016

773. See, for example, Alan Smith et al, Exploring the Linkages between Education Sector Governance, Inequity, Conflict, and Peacebuilding in Kenya, UNICEF, 2016, at <http://ecnetwork.net/wp-content/uploads/10-Equity-Education-Peacebuilding-Governance-Kenya.pdf>

774. Government of Kenya, Drought Risk Management and Ending Drought Emergencies: Second Medium Term Plan 2013-2017, 2013, at <http://www.ndma.go.ke/resource-center/ede-reports/send/43-ending-drought-emergencies/4271-ede-medium-term-plan-2013-2017>

775. OCHA, Horn of Africa: a call for action, 17 February 2017, at [http://reliefweb.int/sites/reliefweb.int/files/resources/HOA\\_CALL\\_FOR\\_ACTION\\_Leaflet\\_Feb2017\\_1.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/HOA_CALL_FOR_ACTION_Leaflet_Feb2017_1.pdf)

776. NDMA, National Drought Early Warning Bulletin, June 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/National%20Drought%20Early%20Warning%20Bulletin%20-%20June%202017.pdf>

777. UNICEF, Kenya Humanitarian Situation Report, 6 April 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20SitRep%20-%206%20April%202017.pdf>

778. WFP, Long Rains 2017 Mid-Season Food and Nutrition Security Assessment Findings, 18 May 2017

779. IFRC, Emergency Appeal Revision: Kenya Drought, April 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/MDRKE039rea2.pdf>

780. OCHA, Horn of Africa: a call for action, 17 February 2017, at [http://reliefweb.int/sites/reliefweb.int/files/resources/HOA\\_CALL\\_FOR\\_ACTION\\_Leaflet\\_Feb2017\\_1.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/HOA_CALL_FOR_ACTION_Leaflet_Feb2017_1.pdf)

491. The drought has also had a range of secondary effects. Drought related displacement and water shortages have led to increased reports of disease outbreaks and conflict. New cholera cases were recorded in Garissa (the Dadaab refugee camp), Nairobi, Muranga, Turkana (the Dadaab refugee camp) and Nakuru between March and June 2017.<sup>781</sup> Resource-based conflict has resulted in school closures in East Baringo.<sup>782</sup>
492. It was also more difficult for displaced populations to access education: in 10 affected counties, close to 175,000 children were not attending early pre-primary and primary schools, primarily due to the drought's impact.<sup>783</sup> A March 2017 UNICEF SMS survey of 2,812 head teachers, County Directors of Education and implementing partners in 12 counties in the drought-affected areas found that 1,274 schools/pre-school centres with an enrolment of about 246,000 children had no access to water. Ninety per cent of the schools did not have school feeding programmes, and this had reduced school attendance by about 14 per cent.<sup>784</sup>

## Flooding

493. Kenya has experienced several serious flooding incidents over recent years, in various parts of the country. These have caused major disturbances, destroying property and resulting in loss of life. Some are the result of natural phenomena (though influenced by climate change), such as flash floods, river floods and coastal floods. Floods may also occur as a result human manipulation of watersheds, drainage basins and flood plains. For example, in some cases floods have occurred in river basins even with normal rains because of excess surface water runoff following deforestation and land degradation upstream. Floods following torrential rainfall force thousands of people living in the lowlands to move to higher grounds, particularly in western and Nyanza provinces and in Tana River district. However, slum dwellers in cities such as Nairobi who have erected informal structures near rivers can also be affected. As well as destruction of shelters and household assets and displacement of people, floods can also destroy irrigation infrastructure and crops, delay planting, contaminate water sources as a result of submerged sanitation facilities, destroy water supply systems and increase the density of mosquitoes and other vectors leading to outbreaks of malaria, measles and rift valley fever.<sup>785</sup>
494. The Western lowlands around Lake Victoria, the coastal low lands around the Indian Ocean and other areas with poor surface water drainage are particularly prone to flooding.<sup>786</sup> In parallel to the drought in 2017, floods killed 26 people and forced almost 25,000 from their homes in Kenya in May, and swept away almost 9,000 heads of cattle in northern and coastal pastoralist areas. The floods also affected the Dadaab refugee camp in Garissa County.<sup>787</sup> The hardest hit counties included Kilifi, Kwale, and Taita Taveta counties in the southeast, as well as Marsabit in the north.<sup>788</sup> However, all areas of Kenya are prone to flooding, with Western Kenya having been identified as particularly vulnerable.

781. UNICEF, Kenya Humanitarian Situation Report, 19 June 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20Situation%20Report%20-%2019%20June%202017.pdf>

782. UNICEF, Kenya Humanitarian Situation Report, 6 April 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20SitRep%20-%206%20April%202017.pdf>

783. OCHA, Horn of Africa: a call for action, 17 February 2017, at [http://reliefweb.int/sites/reliefweb.int/files/resources/HOA\\_CALL\\_FOR\\_ACTION\\_Leaflet\\_Feb2017\\_1.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/HOA_CALL_FOR_ACTION_Leaflet_Feb2017_1.pdf)

784. UNICEF, Kenya Humanitarian Situation Report, 20 March 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20SitRep%20-%2020%20March%202017.pdf>

785. Paul Owuor, The Disaster Profile of Kenya, University of Oviedo, 2015, at [http://www.uniovi.net/uid/Emergency\\_and\\_Disaster\\_Reports/EDR\\_2\\_3\\_2015\\_Kenia.pdf](http://www.uniovi.net/uid/Emergency_and_Disaster_Reports/EDR_2_3_2015_Kenia.pdf)

786. Development Initiatives, Assessment of Kenya's preparedness to disasters caused by natural hazards: Floods, drought and disease outbreak, January 2017, at <http://devinit.org/post/assessment-of-kenyas-preparedness-to-disasters-caused-by-natural-hazards-floods-drought-and-disease-outbreak/#>

787. Daniel Wesengula, Deadly flash floods set to worsen poverty and hunger in Kenya, experts say, Reuters, 18 May 2017, at <http://news.trust.org/item/20170518160528-ob3ra/>

788. FEWSNET, Below-average long rains bring about short-lived improvements, May 2017, at <http://www.fews.net/east-africa/kenya/key-message-update/may-2017>

## Social cohesion

495. There is a range of security challenges affecting children in various parts of Kenya. These include inter-clan conflict, violent extremism (including terrorism), and the threat of violence at the time of elections.

## Inter-clan conflict

496. A particular concern in some pastoral communities is the exposure of children to inter-clan violence. In 2016 this, and a lack of safety measures, continued to destabilize people's lives leaving more than 309,000 displaced across Kenya.<sup>789</sup> Inter-clan conflict can also lead to a decrease service delivery because of insecurity and staff deserting their services. For example, in June 2017, conflict in East Pokot Sub-County (of Baringo County) was severely constrained as a result of ongoing intercommunal conflict and security operations by government forces. In mid-June about 15 health facilities in the area were closed, while the remaining nineteen facilities were operating sub-optimally.<sup>790</sup> Humanitarian organisations have also experienced growing difficulty reaching some of the areas most in need of assistance.<sup>791</sup>
497. Boys are sent from a young age to protect herds of animals. Seen as "warriors", adolescents often have access to guns. Research from Turkana in 2015 reveals that boys face the danger of being killed by bandits or attacked by wild animals while migrating with their herds, and are encouraged to participate in raids and cattle rustling: this can place them at the centre of often-violent conflicts with other communities. Meanwhile, girls face the risk of being abducted for marriage.<sup>792</sup>
498. Children can sometimes become direct victims of inter-clan conflict. For example, four children were killed in March 2017 in Baringo County during inter-clan skirmishes that resulted from a cattle rustling incident.<sup>793</sup>

## Violent extremism

499. The UN CRC Committee is also concerned about the "radicalization" of children and their recruitment into non-State armed groups, mainly due to the social and economic marginalization of certain religious or ethnic groups.<sup>794</sup>
500. Kenya continues to face violent extremism by radical militarist groups, especially in areas along the coast and in Nairobi. Al-Shabaab has been one of the main violent extremist groups in East Africa for several years, and has expressed aspirations to recruit fighters from across countries in eastern Africa who understand their respective countries' vulnerabilities. Al-Shabaab also inspired the creation of several affiliated jihadist groups and autonomous networks, which have also organized attacks.<sup>795</sup> Meanwhile, school leavers from the north-eastern counties feel economically and politically marginalized from the rest of Kenya. Most of the young people leaving secondary school are not finding secure jobs, yet feel unable to return to the rural areas. Instead, many are 'hustling' in town. A rising number of young people who have been to school have reportedly turned to drugs and crime, or joined Al-Shabaab and other insurgent groups.<sup>796</sup>
501. Hard military and security counter-terrorism approaches have not successfully addressed the threat of violent extremism.<sup>797</sup> The CRC Committee has also raised concerns about certain counter-terrorism and security measures, such as mass raids, which do not comply with international human rights standards, including the CRC, and which have caused family separation, arbitrary detentions of children, and negative psychological impacts on children affected by the measures, such as fear and feelings of collective punishment.<sup>798</sup>

789. UNICEF, UNICEF – KCO MTR Report, 2016

790. UNICEF, Kenya Humanitarian Situation Report, 19 June 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Kenya%20Humanitarian%20Situation%20Report%20-%2019%20June%202017.pdf>

791. UNICEF, UNICEF – KCO MTR Report, 2016

792. Mercy Corps, *Wealth and Warriors: adolescents in the face of drought in Turkana, Kenya*, April 2015, at [https://www.mercycorps.org/sites/default/files/MercyCorps\\_AdolescentsDrought\\_FullStudy.pdf](https://www.mercycorps.org/sites/default/files/MercyCorps_AdolescentsDrought_FullStudy.pdf)

793. APA News, *11 Dead from Inter-Clan Clashes in Kenya's Rift Valley*, 15 March 2017, at <http://apanews.net/en/news/11-dead-from-inter-clan-clashes-in-kenyas-rift-valley>

502. In this context, a new countering violent extremism approach has emerged that promotes preventive programming that aims to address drivers of violent extremism. Research in communities in Nairobi and Mombasa has found that radicalization often takes place in the context of local factors, such as social change and rising inequality, marginalization in terms of social services, and lack of employment opportunities, which are exploited by radical groups for their own purposes. Weak intergenerational relations, particularly in poorer neighbourhoods where local institutions struggle to provide for their young populations, can also be exploited. In addition, recruiters for extremist groups have increasingly focussed in recent years on recruiting women and girls.<sup>799</sup>

## Electoral violence

503. Kenya faces challenges ensuring safety during elections. Following national elections in 2007, prolonged violence left 1,000 people dead.<sup>800</sup> In 2007 and 2008 thousands of children (along with adults) were displaced by the violence. Displaced children faced barriers to continuity of education and healthcare. Sharp rises in gender-based violence against children, particularly girls, were noted.<sup>801</sup> Research conducted with child survivors of the violence found that more than a year later children who had been exposed to the violence showed increased delinquent and aggressive behaviour, including bullying, vandalism, stealing and not attending school.<sup>802</sup>

504. Concerns have been raised about a return to violence in the context of 2017 elections taking place in a situation of political polarisation, growing distrust and lack of communication between parties.<sup>803</sup>

## Child refugees and internally displaced persons

505. In May 2017, there were 490,656 refugees and asylum seekers registered in Kenya. Of these, more than half were children (see the graph below). Most of the refugees and asylum seekers (304,892) were from Somalia, with other significant populations from South Sudan (101,713), the Democratic Republic of the Congo (29,894), and Ethiopia (27,640).<sup>804</sup>

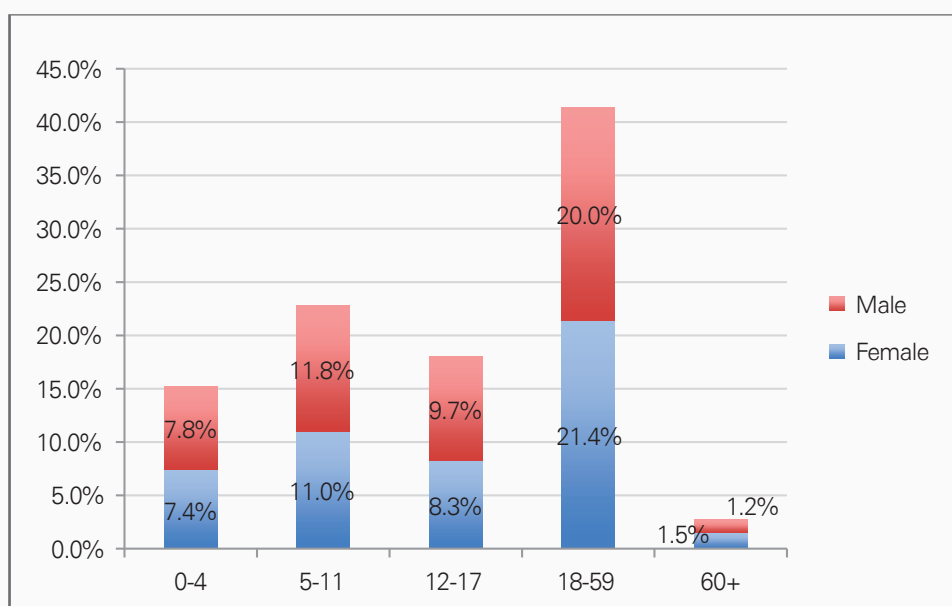


Figure 28: Percentages of refugees in Kenya by age and sex, May 2017

794. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

506. In March 2017, refugees and asylum seekers were concentrated in three locations. The largest number was found in the Dadaab and Alinjogur camps in Garissa County (246,617). In Kakuma camp in Turkana there were 176,872, and in Nairobi 67,267.<sup>805</sup>
507. The Dadaab refugee camps were established in 1991, following the outbreak of civil war in neighbouring Somalia. Their population reached a peak of more than 460,000 in October and November 2011, following drought and an upsurge of conflict in Somalia.<sup>806</sup> At the time, this made Dadaab the largest refugee complex in the world. On 6 May 2016, Kenya's Government announced its intention to close Dadaab, maintaining that the camp was a threat to national security and that the country had not received adequate support from the international community to maintain the camp.<sup>807</sup> However, in February 2017, Kenya's High Court blocked the closure, ruling that the decision was tantamount to an act of group persecution.<sup>808</sup> In recent years, the camp population has fallen below 250,000, partly as a result of voluntary repatriation to Somalia.
508. UNHCR registered more than 90,000 refugees from South Sudan in Kakuma between 2013 (when civil war erupted) and June 2017.<sup>809</sup> By June 2016, the reported population was over 190,000, well beyond the camp's maximum capacity of 125,000.<sup>810</sup> This influx led to overcrowding and water scarcity.<sup>811</sup> Between 2015 and 2017, acute malnutrition in the camp rose from 7.6 per cent to 13.5 per cent, despite improvements in therapy provided, because of the influx of refugees. Challenges included an erratic pipeline to bring cash for use at the camp.<sup>812</sup> There are also serious challenges ensuring water and sanitation for refugee camps. In Kakuma, latrine coverage stood at 78 per cent in December 2016.
509. Kenya's Government has allocated new land in Turkana (Kalobeyei) with capacity for 60,000 refugees and host community representatives, with the objective of having an integrated approach that would allow refugees to become self-sustainable through development of livelihood activities.<sup>814</sup> However, there are challenges ensuring sustainability at the Kalobeyei settlement. The site has faced severe water shortages, and has been forced to rely on trucking of water: a 2017 survey identified the potential for roof water catchment, as well as harvesting water from surface and underground water runoffs.<sup>815</sup> Another challenge is the large proportion of vulnerable refugees housed at the site, including separated and unaccompanied children.<sup>816</sup> This will make it challenging for the settlement to achieve self-sustainability.
510. The UN CRC Committee is concerned that Kenya's long-term encampment policy and certain proposals and responses to the heightened security situation do not fully respect and protect the rights of asylum-seeking and refugee children. These include proposals to encamp all asylum seekers and refugees in refugee camps and suspend registration of asylum seekers in urban areas; proposals to close refugee camps; and relocate and deport refugees without due process. While "refugee identity passes" have been issued to refugee children, individual identification cards, which are used as a basis for accessing social services such as education or health care, are issued only to those who are living in urban areas and are over 16 years old or recognized as unaccompanied or separated children.<sup>817</sup>

795. Shilpa Guha, *Violent Extremism in Kenya: Risk and resilience*, Rift Valley Institute, February 2017, at <http://riftvalley.net/publication/violent-extremism-kenya#WKRwffkr12x>

796. UNICEF, *A Study of Education and Resilience in Kenya's Arid and Semi-Arid Lands*, 2015

797. Shilpa Guha, *Violent Extremism in Kenya: Risk and resilience*, Rift Valley Institute, February 2017, at <http://riftvalley.net/publication/violent-extremism-kenya#WKRwffkr12x>

798. UN Committee on the Rights of the Child, *Concluding Observations on the combined third to fifth periodic reports of Kenya*, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

799. Shilpa Guha, *Violent Extremism in Kenya: Risk and resilience*, Rift Valley Institute, February 2017, at <http://riftvalley.net/publication/violent-extremism-kenya#WKRwffkr12x>. Alan Smith et al, *Exploring the Linkages between Education Sector Governance, Inequity, Conflict, and Peacebuilding in Kenya*, UNICEF, 2016, at <http://ecnetwork.net/wp-content/uploads/10-Equity-Education-Peacebuilding-Governance-Kenya.pdf>

800. International Crisis Group, *Kenya: avoiding another electoral crisis*, 3 March 2017, at <https://www.crisisgroup.org/africa/horn-africa/kenya/kenya-avoiding-another-electoral-crisis>

801. UNICEF, *The Hopes of Kenya's Children Hanging in the Balance*, 25 January 2008, at [https://www.unicef.org/media/media\\_42664.html](https://www.unicef.org/media/media_42664.html)

802. Duke Today, *The Effects of Political Violence on Children*, 1 July 2013, at <https://today.duke.edu/2013/07/polviolence>

803. International Crisis Group, *Kenya: avoiding another electoral crisis*, 3 March 2017, at <https://www.crisisgroup.org/africa/horn-africa/kenya/kenya-avoiding-another-electoral-crisis>

804. UNHCR, *Refugees and Asylum Seekers in Kenya*, May 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/57231.pdf>

805. UNHCR, *Refugees and Asylum Seekers in Kenya*, May 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/57231.pdf>

806. UNHCR, *East & Horn of Africa Update: Somali Displacement Crisis at a glance*, 17 October 2011, at <http://reliefweb.int/report/kenya/east-horn-africa-update-somali-displacement-crisis-glance-17-october-2011>

807. Amnesty International, *Kenya: Nowhere Else to Go: Forced Returns of Somali Refugees from Dadaab Refugee Camp*, Kenya, 14 November 2016

808. BBC, *Kenyan closure of Dadaab refugee camp blocked by high court*, 9 February 2017, at <http://www.bbc.co.uk/news/world-africa-38917681>

511. Some of the challenges faced by child refugees in Kenya are outlined in other sections of this report. Insufficient basic services and overcrowding have worsened an already stressful environment for children. In addition, the ongoing voluntary repatriation of refugees from Somalia has resulted in emerging protection concerns that were previously low-risk, such as family separation and custody disputes.<sup>818</sup> Other challenges in 2017 include outbreaks of measles (in Dadaab) and cholera (in Dadaab and Kakuma),<sup>819</sup> limited educational opportunities and motivation to learn (particularly after primary level),<sup>820</sup> ongoing child protection concerns including violence and abuse,<sup>821</sup> and flooding (in Dadaab).<sup>822</sup>
512. While the Prevention, Protection and Assistance to Internally Displaced Persons and Affected Communities Act (2012) has been passed to resettle people displaced by the 2007-2008 post-election violence, some internally displaced persons in Rift Valley, including children, remain in need of durable solutions and legal protection. Reconstruction of houses and public facilities has reportedly not begun for persons displaced before the 2007-2008 violence, such as those in Moyale and Marsabit.<sup>823</sup>

## Resilience of children to disasters, shocks and crises

513. While multiple definitions exist, resilience can be understood as “the ability to withstand threats or shocks, or the ability to adapt to new livelihood options, in ways that preserve integrity and that do not deepen vulnerability”.<sup>824</sup> To be resilient, service delivery options need to be flexible and capable of scaling up, while household should have capacity not only to withstand adverse changes in their environment but also to be positively transformed by them.<sup>825</sup>
514. 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, and interruption of access to basic services, such as health and education, have significant impacts on already vulnerable children, further perpetuating their deprivations.<sup>826</sup> Those most likely to be affected by drought include the youngest children, who are dependent on adults for their survival, the children of poor mothers and female-headed households, and vulnerable out-of-school adolescents.<sup>827</sup>
515. Many households resort to harmful coping strategies during drought. The Ending Drought Emergencies strategy includes a commitment to develop guidelines on child-focused drought risk management and a stronger system for child protection in drought emergencies.<sup>828</sup>
516. The 2011 drought crisis in the Horn of Africa hit the region after successive failed rains and coincided with rising food prices to have an impact on approximately 13 million people, around 3.75 million of whom lived in northern Kenya. This humanitarian crisis led to a step change in the approach of governments, donors and humanitarian organisations from emergency response towards resilience building. It was in this context that IGAD Member States and development partners convened to work together on a long-term approach to reducing drought vulnerability in the region.<sup>829</sup> Kenya’s Government tabled a Programme to End Drought Emergencies in 2012 that committed the country to ending drought emergencies within a 10-year period.<sup>830</sup> The Framework has three areas of emphasis: eliminating the conditions that perpetuate vulnerability, enhancing the productive potential of the region, and strengthening institutional capacity for effective risk management.<sup>831</sup>

809. UNHCR, New Arrival Registration Trends 2017 Sub Office Kakuma, 26 June 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/58144.pdf>

810. UNHCR, UNHCR Kenya Kakuma Operational Update, 01 - 15 June 2016, 15 June 2016, at <http://reliefweb.int/report/kenya/unhcr-kenya-kakuma-operational-update-01-15-june-2016>

811. WFP and UNHCR, Refugee Vulnerability Study: Kakuma, Kenya, May 2016, at [http://reliefweb.int/sites/reliefweb.int/files/resources/Refugee\\_HH\\_Vulnerability\\_Study\\_Kakuma\\_Refugee\\_Camp\\_Final\\_Report\\_2016\\_05\\_06.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Refugee_HH_Vulnerability_Study_Kakuma_Refugee_Camp_Final_Report_2016_05_06.pdf)

812. WFP Kenya, Food Assistance to Refugees Newsletter, January 2017, at [https://www.wfp.org/sites/default/files/WFP%20Refugee%20Newsletter\\_JAN2017.pdf](https://www.wfp.org/sites/default/files/WFP%20Refugee%20Newsletter_JAN2017.pdf)

813. UNHCR, Kenya Factsheet December 2016, at <http://www.unhcr.org/ke/wp-content/uploads/sites/2/2017/01/Kenya-Operation-Factsheet-December-2016.pdf>

814. UNHCR, Kalobeyei Settlement, at <http://www.unhcr.org/ke/kalobeyei-settlement>. Accessed 3 July 2017

815. WFP, Kenya Country Brief, May 2017, at <http://reliefweb.int/sites/reliefweb.int/files/resources/Kenya%20Country%20Brief%20May%20202017.pdf>

816. See, e.g. Danish Refugee Council, Fighting in South Sudan Forces Tens of Thousands to Refugee Camps, 23 August 2016, at <https://drc.ngo/news/news-archive/fighting-in-south-sudan-forces-tens-of-thousands-to-refugee-camps>

517. In 2011, the Government also established the National Drought Management Authority (NDMA) under the Ministry of Devolution and Planning to lead its drought preparedness and response efforts in the ASAL counties. The NDMA is responsible for policy, coordination of drought response, putting in place systems for early warning of drought and linking the country's drought management to international processes. A 2017 evaluation for DFID suggests that drought preparedness appears much better coordinated than flood and disease preparedness, and recommends that Kenya should consider replicating the NDMA approach for flooding and health emergencies.<sup>832</sup>

### Key issues

- In Kenya, progress for children continues to face ongoing setbacks caused by multiple emergencies and the country is extremely vulnerable to shocks
- All these forms of emergencies affect children directly and indirectly, causing malnutrition, displacement of children, disruption to essential services including education and healthcare, and protection concerns
- Drought has for decades been the single most disastrous natural hazard in Kenya, particularly in the arid and semi-arid lands
- In recent years floods, particularly in the Western lowlands around Lake Victoria, the coastal lowlands around the Indian Ocean and other areas with poor surface water drainage have caused major disturbances, destroying property and resulting in loss of life.
- Cholera outbreaks and other health emergencies significantly affect Kenya
- Other emergency concerns include violence related to inter-clan conflict, radicalization, inequality and political tensions concerning elections.
- In all of these instances, children are affected, either directly (being caught in actual conflict and losing family members, being hurt or even losing their own lives), as well as indirectly (such as witnessing violence and living in fear).
- In May 2017, there were 490,656 refugees and asylum seekers registered in Kenya. Of these, more than half were children.
- Most of the refugees and asylum seekers (308,643) were from Somalia, with other significant populations from South Sudan (95,283), the Democratic Republic of the Congo (29,560), and Ethiopia (27,291).
- Kenya's long-term encampment policy and certain proposals and responses to the heightened security situation do not fully respect and protect the rights of asylum-seeking and refugee children.

817. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

818. UNICEF, EU humanitarian aid of €800,000 for education and protection of refugee children in Kenya, 20 June 2017, at [https://www.unicef.org/kenya/media\\_20131.html](https://www.unicef.org/kenya/media_20131.html)

819. UNICEF, Kenya: Humanitarian Situation Report, 5 June 2017, at <http://reliefweb.int/report/kenya/unicef-kenya-humanitarian-situation-report-5-june-2017>. UNICEF, Kenya: Humanitarian Situation Report, 19 May 2017, at <http://reliefweb.int/report/kenya/unicef-kenya-humanitarian-situation-report-19-may-2017>

820. Daniel Wesonga et al, Out of School Children Assessment Report: Dadaab Refugee Camp, Draft submitted to UNHCR, January 2017

821. Save the Children, Our Child Protection Work in Kenya, at <https://kenya.savethechildren.net/what-we-do/child-protection>, accessed 7 July 2017. Terre des Hommes, Uncertain Situation for Refugee Children in Kenya, 10 June 2016, at <https://www.tdh.ch/en/news/refugee-children-kenya>

822. UNICEF, Kenya: Humanitarian Situation Report, 19 May 2017, at <http://reliefweb.int/report/kenya/unicef-kenya-humanitarian-situation-report-19-may-2017>

823. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

824. UNICEF, Resilience Building, at [https://www.unicef.org/esaro/5484\\_emergencies\\_results.html](https://www.unicef.org/esaro/5484_emergencies_results.html), accessed 13 April 2017

825. UNICEF, Country Programme Document Kenya 2014-2018, 2013, at [https://www.unicef.org/about/execboard/files/2014-PL6-Kenya\\_CPD-final\\_approved-English.pdf](https://www.unicef.org/about/execboard/files/2014-PL6-Kenya_CPD-final_approved-English.pdf)

826. UNICEF, Situation Analysis of Children and Adolescents in Kenya: Our Children Our Future, 2014, at [https://www.unicef.org/kenya/SITAN\\_2014\\_Web.pdf](https://www.unicef.org/kenya/SITAN_2014_Web.pdf)

827. Republic of Kenya, Ending Drought Emergencies Common Programme Framework, 2015, available via <http://www.ndma.go.ke/resource-center/ede-reports/category/43-ending-drought-emergencies>

828. Republic of Kenya, Ending Drought Emergencies Common Programme Framework, 2015, available via <http://www.ndma.go.ke/resource-center/ede-reports/category/43-ending-drought-emergencies>

829. Elizabeth Carabine et al, Kenya Ending Drought Emergencies Policy Review: Scenarios for Building Resilience in the ASALs, International Livestock Research Institute (ILRI), 2015, at [https://cdkn.org/wp-content/uploads/2017/01/Report-no-1-Kenya-Ending-Drought-Emergencies-Policy-Review\\_Scenarios-for-Building-Resilience-in-the-ASALs.pdf](https://cdkn.org/wp-content/uploads/2017/01/Report-no-1-Kenya-Ending-Drought-Emergencies-Policy-Review_Scenarios-for-Building-Resilience-in-the-ASALs.pdf)

830. Government of Kenya, Drought Risk Management and Ending Drought Emergencies: Second Medium Term Plan 2013-2017, 2013, at <http://www.ndma.go.ke/resource-center/ede-reports/send/43-ending-drought-emergencies/4271-ede-medium-term-plan-2013-2017>

831. Republic of Kenya, Ending Drought Emergencies Common Programme Framework, 2015, available via <http://www.ndma.go.ke/resource-center/ede-reports/category/43-ending-drought-emergencies>

832. Development Initiatives, Assessment of Kenya's preparedness to disasters caused by natural hazards: Floods, drought and disease outbreak, January 2017, at <http://devinit.org/post/assessment-of-kenyas-preparedness-to-disasters-caused-by-natural-hazards-floods-drought-and-disease-outbreak/#>



# Chapter 8:

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## Equitable chances in life



## Birth registration and documentation

518. According to the 2014 KDHS, 67 per cent of children under five years of age in Kenya had their births registered. This is a 7-percentage point increase on the 2008/9 level. Boys (67 per cent) and girls (66 per cent) are statistically equally likely to have their births registered, but birth registration correlates strongly with income: only 52 per cent of children under five in the poorest quintile have had their births registered, compared with 89 per cent of children in the richest quintile. Meanwhile urban children under five (79 per cent) are more likely to be registered than their rural peers (61 per cent).<sup>833</sup>
519. The certification of births in Kenya is less than 24 per cent. Efforts need to be put into certification, as parents often do not see the value of birth certificates. This is a particular issue for children in contact with the law, children suffering abuse or exploitation or other protection related issues where proof of age is important (such as marriage or labour). There are some costs associated with certification for children: though these are minimal they can influence the decision of parents.<sup>834</sup> Birth certificates are not needed to enter school, but they are needed to register for the Kenya Certificate of Primary Education (KCPE). While parents and head teachers at this stage try to find certificates, this can be problematic. Another point at which birth certificates are important is to receive national ID cards at the age of 18.<sup>835</sup>
520. National Bureau of Statistics figures show a lower rate of birth registration and, worryingly, that the rate fell slightly from 63.4 per cent in 2014 to 60.4 per cent in 2015. Disparities in birth registration were observed across counties, with Garissa recording the highest coverage rate (93.3 per cent) and Mandera the lowest (16.0 per cent); Wajir, and Turkana also had birth registration coverage rates of less than 20.0 per cent.<sup>836</sup> The reason why Garissa's figure is so high is that every refugee birth registration in the Dadaab camp is included, despite the fact that the children are not counted in the KNBS figures that act as the denominator.<sup>837</sup> Excluding the refugee population, birth registration coverage in Garissa County is about 30 per cent. Low birth registration rates correlate to poor access to healthcare. If children are born in hospital, they are automatically registered and it is relatively easy to receive birth certificates. In north-eastern Kenya, apart from the towns, most residents are pastoralists who move from place to place, further hampering their access to birth registration and certification services.<sup>838</sup>
521. Issuing of birth certificates is currently not devolved to county level, but to representatives of national Government around the country. Advocacy work with county governments and the national Government has resulted in increased issuance of certificates in county centres in in low coverage areas, but issuance at sub-county level is still poor (though in Mandera County birth certificates have been issued in sub-counties since 2016). As a result of advocacy and technical support, in Garissa County in 2016 1,000 birth certificates were issued when children entered pre-school institutions: this entry point is a new area of best practice.<sup>839</sup>
522. The 2011 Citizenship and Immigration Act (2011) provides for Kenyan nationality for all children born in the country, and recognizes the equal right of women and men to transmit Kenyan nationality to their children. However, a number of concerns persist. Free and universal birth registration has not been achieved. The proportion of births registered has been stagnating in recent years, with substantially lower rates of birth registration in rural and remote areas. Some groups of children, such as refugee children, children of Nubian descent, Makonde children, indigenous Somali children in Kenya, children with mothers in custody and intersex children, face difficulty in obtaining birth registration. Finally, children of stateless persons and migrants aged between eight and 18, including those who belong to the Nubian, Pemba, Gal'el and Makonde communities, may not have obtained Kenyan nationality despite the measures introduced in the Citizenship and Immigration Act (2011).<sup>840</sup>

## Children with disabilities

523. According to the Convention on the Rights of Persons with Disabilities:  
*“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with other.”*
524. The 2003 Persons with Disability Act defines disability as:  
 “A physical, sensory, mental or other impairment including any visual, hearing, learning, or physical incapability, which impacts adversely on social, economic or environmental participation.”
525. Together, these definitions recognise the aspects of impairments, activity limitations, and participation restrictions imposed on the individual as a result of the disability. This is an important recognition, especially, with regard to educational opportunities for children with disabilities.<sup>841</sup>
526. Children born with disabilities can be particularly disadvantaged if their impairment is considered the result of a curse and is a source of stigma. Often, husbands can abandon their wives and children after the birth of a disabled child, leaving them particularly exposed. Children with disabilities can also be hidden away, and find it impossible to access healthcare and education services. Meanwhile, disability can also only become apparent at a later age because of a lack of early intervention in childcare.<sup>842</sup>
527. In July 2015, the UN Committee on the Rights of Persons with Disabilities reviewed Kenya’s compliance with the CPRD. With regard to children with disabilities it recommended that (1) a strategy be adopted as a matter of priority to combat stereotypes against girls and boys with disabilities within families and in society and an early warning mechanism is implemented to prevent the abandonment of children with disabilities in urban and rural areas; (2) community-based services and assistance be provided for girls and boys with disabilities with a view to eliminating institutionalization, and to ensure that grants from the Transfer Programme for Orphans and Vulnerable Children reach children with disabilities in rural areas; (3) measures be taken to assess the situation of girls and boys who are deaf-blind and ensure that public policies and programmes are responsive to their specific needs; and (4) measures be taken, in partnership with organizations of persons with disabilities and other civil society organisations, to promote the right of children with disabilities to be consulted in all matters concerning their lives, and ensure that they receive assistance appropriate to their age and disability.<sup>843</sup>
528. In response, Kenya has developed the 2015-2022 National Plan of Action on the Implementation of the Convention on the Rights of Persons with Disabilities.<sup>844</sup> This includes a specific section solely for ‘children with disabilities’, setting out a planned response to the Committee’s recommendations, indicating activities, timeline and responsible parties. However, the activities in the National Plan of Action are not costed.
529. There is no national indicator of prevalence of childhood disability in the country. While measuring disability in a census or survey context is very challenging, international standards have been developed by the UN Washington Group on Disability Statistics that produce much more useful and reliable data and could be used in Kenya’s context.<sup>845</sup>

833. Kenya National Bureau of Statistics et al, Kenya Demographic and Health Survey 2014, 2015 at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

834. Interview, UNICEF, 21 March 2017

835. Interview, UNICEF, 23 May 2017

836. KNBS, Economic Survey 2016. Available via [http://www.knbs.or.ke/index.php?option=com\\_phocadownload&view=category&id=107&Itemid=1181](http://www.knbs.or.ke/index.php?option=com_phocadownload&view=category&id=107&Itemid=1181)

837. UNICEF, 10 Key Child Survival Development and Protective Behaviours, April 2016

838. Interview, UNICEF, 23 May 2017

839. Interview, UNICEF, 23 May 2017

840. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

841. VSO, Kenya National Special Needs Education Survey Report, 2014

842. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

843. Concluding Observations available via [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fKEN%2fCO%2f11&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fKEN%2fCO%2f11&Lang=en)

844. Plan available at <http://www.udpkkenya.or.ke/publications/national-plan-of-action.pdf>

845. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

530. A 2014 survey by Voluntary Service Overseas (VSO) estimated prevalence of disabilities among children and young people aged 0-21 years was 13.5 per cent. The prevalence by county varied significantly, from 29.1 per cent in Siaya County and 21.3 per cent in Kisumu County (both in western Kenya) to 6.2 per cent in West Pokot County and 6.9 per cent in Kwale and Nakuru Counties. It is possible that the vast differences may be accounted for by self-reporting, underestimating true prevalence because of stigma.<sup>846</sup> The Educational Assessment Resource Centres (EARCs), which are mandated to facilitate assessment and educational placement of children with disabilities, are limited in their ability to support local communities from a centralized location because of limited resources and number of staff, lack of outreach support and adequate budget provision to follow up on assessments to ensure that adequate support has been provided. Often the onus has been on teachers and social workers to refer parents to the EARCs, but this does not always lead to parents accessing this function. Parents often have other responsibilities, including employment, travel costs can be prohibitive and there remains a fear of the stigma associated with disability.<sup>847</sup> Ongoing efforts to improve microdata collection at village level by community health volunteers could provide an opening to understand better the prevalence of different disabilities around the country.<sup>848</sup>
531. While some progress has been made in relation to early detection, prevention and mitigation of disabilities, there are still several concerns. Children with disabilities, in particular those living in rural areas, are often stigmatized, confined at home, denied opportunities for development or abandoned.<sup>849</sup> Meanwhile, in informal settlements, children with disabilities can be locked up in houses, in some cases chained on a piece of furniture or tethered to a tree to stop them from roaming about and potentially straying. They are often considered “bad omens” and locked up to save families from the disgrace and stigma associated with having disability in the family. In areas with limited sanitation facilities, children with disabilities reportedly soiled themselves for the whole day without change of nappies or even clothing, while sometimes they were not fed.<sup>850</sup>
532. There is a lack of disaggregated data necessary for designing a comprehensive strategy for the inclusion of children with disabilities. Many mainstream schools are not equipped for inclusive education, some refuse admission to children with disabilities, and specialized schools are not available, accessible or affordable. In addition, healthcare and reasonable accommodation for children with disabilities are mainly unaffordable.<sup>851</sup>

## Children from families living in poverty

533. The rights to housing, sanitation, food, water and social security are explicitly recognized in the 2010 Constitution. However, many of the laws, policies and strategies to operationalize constitutional rights to housing, sanitation, food, water and social security have not been adopted and implemented. Major geographical disparity exists in the enjoyment of the rights to housing, sanitation, food, water and social security, with worse conditions particularly in arid and semi-arid lands and in informal settlements in peri-urban and urban areas. Forced evictions and displacements of people, including children, have taken place due to development projects and environmental conservation.<sup>852</sup>
534. Families with children in Kenya are particularly vulnerable when breadwinners stop working, through illness, disability or because of the birth of a child: family incomes suffer as does the wellbeing of children. A breadwinner becoming disabled can have catastrophic repercussions for families. Another significant challenge for families is that the birth of a child often leads to mothers reducing work in order to care for the child. Indeed, the more children that families have, the more likely they are to live in poverty. Women from households in the poorest wealth quintile have an average of 6.4 births, whereas women in the wealthiest quintile have an average of 2.8 births in a lifetime.<sup>853</sup>

846. VSO, Kenya National Special Needs Education Survey Report, 2014

847. Global Campaign for Education, Accessing Inclusive Education for Children with Disabilities in Kenya, 2016, at <https://www.leonardcheshire.org/sites/default/files/Accessing-inclusive-education-children-disabilities-kenya-gce-appg-report-february-2016.pdf>

848. Interview, Ministry of Health, 22 May 2017

849. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

535. Children living with grandparents in informal settlements are noted to be vulnerable as elderly grandparents often do not have the energy or resources to support them. This can lead to older children taking up the role of caregivers of their younger siblings and grandparents. In addition, most elderly grandparents did not benefit from the cash transfer safety net programme for the elderly, hence worsening the already dire situation.<sup>854</sup> There is weak enforcement of court orders on child maintenance within Kenya and abroad.<sup>855</sup>

## The social protection system

### Policy

536. Under Article 43(1)(e) of Kenya's 2010 Constitution: "Every person has a right to social security...[and] the State shall provide appropriate social security to persons who are unable to support themselves and their dependents." This gives the Government a firm legal basis to expand the social protection sector as required.
537. The country has designed and implemented a number of social protection interventions, including school bursaries, school feeding programmes, subsidized primary and secondary education under the Ministry of Education, user fee waivers and voucher schemes in the Ministry of Health, and cash transfer programmes under the Ministry of Devolution and Planning, and the Ministry of East African Community, Labour and Social Protection.
538. Other social protection interventions in Kenya include the Ministry of Devolution and Planning's Youth and Women Empowerment programmes that seek to address employment needs, and fertilizer and seed subsidy programmes. More formal and contributory social protection provisions include pension and employment benefit schemes under the Ministry of East African Community, Labour and Social Protection.
539. The National Social Protection Policy 2011 (NSPP)<sup>856</sup> also outlines the vision of gradually realizing the right to social protection as articulated in the Constitution. It aims to achieve this through (i) ensuring that the design and implementation of programmes are coordinated; (ii) strengthening and scaling existing social assistance programmes and; (iii) putting in place the institutional frameworks to ensure consistent and adequate level of support. It is expected that the NSPP will enhance the impact of social protection interventions through more strategic collaboration and synergy between programmes. Social protection is also a flagship programme in Vision 2030.<sup>857</sup>
540. As a first step in achieving these goals, the government established the National Safety Net Programme (NSNP) in 2013<sup>858</sup> with the aim of strengthening operational systems of the cash transfer programmes while also expanding coverage of the programs. The main objective of the NSNP was to improve the welfare and resilience of the beneficiaries of the four cash transfer programs, with the aim of reducing poverty and vulnerability in Kenya. To achieve these objectives, the NSNP aims to improve programme operations in several areas. The NSNP identified several key results to be achieved by 2017 and multiple activities to be implemented under each key result. Achieving these results would in turn greatly improve the social safety net in Kenya and help improve the lives of many vulnerable Kenyans.

850. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

851. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

852. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

853. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

854. UNICEF, Participatory Mapping of Children's Risks and Vulnerabilities in Urban Areas, November 2015

855. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

856. Ministry of Gender, Children and Social Development, Kenya National Social Protection Policy, 2011, at <http://www.socialprotection.or.ke/images/downloads/kenya-national-social-protection-policy.pdf>

857. See Ministry of State for Planning, National Development and Vision 2030, Kenya Social Protection Sector Review, June 2012, at <http://www.vision2030.go.ke/lib.php?f=kenya-social-protection-sector-review...report>

858. National Social Protection Secretariat, National Safety Net Program, at <http://www.socialprotection.or.ke/national-safety-net-program>. Accessed 10 July 2017

541. The Social Assistance Act of 2013 stipulated the establishment of a National Social Assistance Authority that, among other responsibilities, would identify and provide social assistance to persons in need of social assistance. Persons in need were defined as: 'orphans and vulnerable children; poor elderly persons; unemployed persons; persons disabled by acute chronic illnesses; widows and widowers; persons with disabilities; and any other persons as may from time to time be determined by the Minister, in consultation with the Board.'<sup>859</sup>
542. The specific focus on orphans as recipients of cash transfers has been challenged. A 2016 study by UNICEF, WFP and the Social Protection Secretariat argues that the definition of vulnerable children in Kenya should move away from a focus on orphanhood, since many non-orphans are also vulnerable and living in poverty. It concluded that children who have lost a parent are three times more likely to live in a household enrolled onto a cash transfer programme than their non-orphaned peers. This is to be expected as orphans are the explicit target group of the Cash Transfer for Orphans and Vulnerable Children (CT-OVC), while in addition orphanhood is a common proxy of vulnerability used in other cash transfer programmes. Girls appear to be slightly underrepresented among recipients, possibly suggesting gender bias in community-based selection processes. Children with disabilities are significantly under-covered, though it is challenging to produce estimates because no reliable data is available.<sup>860</sup> In 2016, the Committee on the Rights of the Child also highlighted the need to extend cash transfer coverage to children with disabilities, children in street situations, children in care institutions and refugee children. It also stated that information on the programme is not well disseminated among beneficiaries.<sup>861</sup>
543. Kenya's Government has chosen to build a lifecycle social protection system, combining both tax-financed and contributory mechanisms. In recent years, the country has made significant progress in building a larger, more effective and nationally-owned social protection system. There has been a significant expansion of its core social assistance schemes, which have replaced more ad hoc humanitarian programmes.<sup>862</sup>

## Governance

544. Kenya's four main cash transfer schemes are administered under the National Safety Net Programme, which was established in 2013.
545. In recent years, expansion of the National Social Protection Secretariat (SPS) in 2012, establishment of the State Department of Social Protection (SDSP) within the Ministry of East African Community, Labour and Social Protection in 2015, and the creation of the Social Assistance Unit (SAU) in 2016 have significantly strengthened social protection sector governance. However, sector governance remains somewhat fragmented across several ministries. The SPS faces challenges coordinating the sector, and implementation structures at local level need to be streamlined.<sup>863</sup>
546. Considerable progress has been made in strengthening the administrative processes and systems for social assistance schemes. This includes the building of a common operating framework to consolidate and harmonise programme delivery through the National Safety Net Programme. There have been significant improvements in programme and national management information systems, including the introduction of the Single Registry of beneficiaries of social assistance.<sup>864</sup>

859. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

860. B. Gelders, Assessment of the geographical and community-based targeting of WFP's Cash and Food for Assets programme in Kenya, Unpublished paper, WFP, UNICEF and Social Protection Secretariat, 2016. Cited in World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

861. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

862. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

863. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

864. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

547. The single registry is a single data depository of five major cash transfer programmes that identifies and verifies information on social protection beneficiaries for a more transparent and accountable system. The single registry has been an important step towards enhancing accountability, efficiency and transparency of these services. It stores information on 900,000 beneficiaries and 1.7 million children from the five main social safety nets.<sup>865</sup>

## Financing

548. National spending on the National Safety Net Programme doubled during the post-devolution period, from Ksh 8.7 billion in 2013-14 to Ksh 18.2 billion in 2015-16. However, cash transfers only accounted for 0.3 per cent of GDP over this period. The Government needs to scale up investment to increase coverage of safety net programmes.<sup>866</sup> The Government has made a commitment to increase national social protection spending (Equity, Poverty Reduction and Social Protection for Vulnerable Groups), in 2016-2017 the allocated budget was KSh 33.7 billion, 7 per cent higher than the 2015-2016 financial year (KSh 31.5bn)

549. In recent years, regular and predictable cash transfers have grown rapidly to make up 83 per cent of social assistance expenditure. The Government's own investment has driven this change, which marks a shift from the previous heavy financing by development partners such as the World Bank, DFID and UNICEF among others<sup>867</sup> and is positive for sustainability. In addition, scalable social protection has been developed to respond to droughts, through the Hunger Safety Net Programme: this has become an international model of best practice.<sup>868</sup>

550. Insufficient funding for social protection has obliged the Government to restrict the coverage of the categories of the population it can support. This creates challenges (as in all developing countries where it is always problematic to accurately identify beneficiaries). Most schemes target those living in poverty. There is no robust evidence on the effectiveness of the selection of beneficiaries across most programmes, but there is a general recognition that there are challenges in accurately identifying beneficiaries. The government is making efforts to strengthen targeting through a Harmonised Targeting Tool and the introduction of more inclusive schemes.<sup>869</sup>

551. In addition to reducing coverage, the value of cash transfers for CT-OVC, OPCT and PWSD-CT (see below) has also reduced over time. The size of the transfers was last revised in 2011. In 2015-2016, their real value stood at Ksh 1,515 compared to a nominal value of Ksh 2,000. It is imperative that the Government index the value of cash transfer to inflation.<sup>870</sup>

552. There are financing options to expand tax-financed social protection further. Over the next five years, it would be financially feasible to increase investment to one per cent of GDP. Adequate financing of social protection is crucial to achieving inclusive growth and development and realizing Vision 2030. Currently the National Social Security Fund and the National Hospital Insurance Fund each have a turnover of between 0.2 and 0.3 per cent of GDP, while the Civil Service Pension Scheme (CSPS) requires annual spending equivalent to 0.6 per cent of GDP.<sup>871</sup>

865. UNICEF, UNICEF Kenya Country Office Annual Report 2016, 20 January 2017

866. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

867. National Social Protection Secretariat, National Safety Net Program, at <http://www.socialprotection.or.ke/national-safety-net-program>. Accessed 4 July 2017

868. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

869. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

870. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017

871. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

## Expansion and coverage of children

553. The four key social assistance programmes – including the Cash Transfer for Orphans and Vulnerable Children (CT-OVC), the Older Persons Cash Transfer (OPCT), Cash Transfers for Persons with Severe Disabilities (PwSD-CT) and Cash For Assets / Food For Assets (CFA/FFA) – have expanded significantly since 2013. This demonstrates growing government commitment to the sector. Between 2013-14 and 2015-16, the number of beneficiary households under the four cash transfer programmes increased from 522,000 to 829,000, an average growth rate of 26 per cent per year. In 2016, it was estimated that 10 per cent of children lived in households that received cash transfers. Of these, about half (1.1 million) were receiving cash transfers through the Cash Transfers for Orphans and Vulnerable Children (CT-OVC) scheme. Meanwhile 39 per cent of the population can access the National Hospital Insurance Fund.<sup>872</sup>
554. The five cash transfer schemes are as follows:

Scheme	Year Launched	Coverage		
		Counties (November 2016)	Households (November 2016)	Children (end 2016)
Cash Transfers for Orphans and Vulnerable Children (CT-OVC)	2005	47	365,232	1,136,562
Older Person Cash Transfers (OPCT)	2006	47	320,556	518,150
Cash Transfers for Persons with Severe Disabilities (PwSD-CT)	2011	47	41,374	104,571
Hunger Safety Net Programme (HSNP)	2007	4	101,630	319,425
Food for Assets / Food for Cash	2010			238,735
Totals			828,792	2,317,442

Table 2: Estimated number of children living in households registered for regular social assistance programmes, 2016<sup>873</sup>

872. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017

873. Figures for coverage of counties and households from UNICEF, Draft Concept Paper for Comprehensive and Integrated Social Protection Program (Cash Plus). Figures for coverage of children from World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017. Calculations based on the number of households registered for each programme at the end of 2016, multiplied by the average number of children per household (as per the 2014 KDHS). Calculations are based on the average size and composition of households with orphans for the CT-OVC; households with older people 65+ years for the OPCT; households in the bottom two quintiles for the PwSD-CT; households in the four HSNP counties for the HSNP; and households in ASAL counties for the CFA/FFA. Estimates of the total population size in 2016 are derived from UN population projections by DESA.



555. While this coverage is impressive, given that the first core social assistance scheme only began in 2004, most of the population is still unable to access social protection. This impacts negatively on their wellbeing as well as national social cohesion and economic growth. A high proportion of the population on middle incomes – the so-called ‘missing middle’ – are unable to access benefits despite experiencing insecure livelihoods.<sup>874</sup>
556. Coverage of social protection schemes across lifecycle categories of the population is variable. Among children, the priority has been to reach orphans. However, the programme’s coverage of the poorest households that need financial support still continues to be low.<sup>875</sup> For example, the CT-OVC programme covers 61 per cent of poor households with orphans.<sup>876</sup> Meanwhile, the majority of children are excluded from the system, in particular the very youngest.<sup>877</sup> Recent research has shown that the disproportionate focus on orphans may not reflect the true nature of childhood vulnerability in Kenya, where children with disabilities, for example, are in many cases more vulnerable. In addition, young children under five are less likely to receive benefits because they are less likely to be orphaned. The underrepresentation of under-fives requires further attention, especially as global neuroscience and developmental psychology research shows that poverty during early childhood can have irreversible effects that last throughout adulthood.<sup>878</sup> The CT-OVC programme also does not cover the cost of healthcare except with respect to children under five years of age, and allocates benefits by household regardless of the number of children in each household.<sup>879</sup>
557. General food distribution, which was the largest programme in 2011-2012, is now one of the smaller programmes and to a large extent has been replaced by more regular and predictable cash transfers.
558. The number of beneficiary children of the school feeding programme has fallen slightly, from around 1.99 million in 2011-2012 to 1.69 million in 2015-2016. The Government has shared responsibility with WFP for the meals, with the proportion of children supported by government increasing from 38 per cent in 2011-2012 to 57 per cent in 2015-2016. The Government’s Home-Grown school feeding programme transfers funds to schools which procure food locally, thereby supporting local markets. However, while WFP school feeding offers children meals for 195 days per year – although, occasionally, pipeline challenges mean that is not possible – the Government’s school feeding programme only offers children meals for around 40-50 days per year, ostensibly because of insufficient funding.<sup>880</sup>
559. While all children in beneficiary schools receive meals, the schools are restricted to the ASAL areas and are selected based on educational factors, such as low enrolment rates and food insecurity within the zoned targeted areas. The forthcoming National School Feeding Strategy outlines a commitment to offering all school children a meal, which should also be a very effective means of including the poorest children.<sup>881</sup>
560. As part of its response to the 2016-2017 drought, the Ministry of Education distributed an additional KES 622 million (around US\$6 million) to bridge gaps in school feeding in the arid counties, while also extending the geographic coverage of its Home-Grown School Meals programme to reach further children in need.
561. The impact of social assistance programmes has grown in recent years as cash transfers have expanded and more ad hoc food-based transfers have reduced in size. Impact evaluations show positive effects in health, education (including reducing child labour), labour market participation, savings and credit, resilience to shocks and women’s empowerment. Programmes are increasing the capacity of the Kenyan labour force and have stimulated investment in assets and local economic growth. However, impacts would increase with higher coverage and improved targeting. Cost efficiency has improved and has been helped by increased coordination and consolidation of delivery. For the HSNP and CT-OVC schemes, cost efficiency is on a par with programmes in other countries. Administrative costs in contributory programmes have declined in recent years. Value for money of social assistance has been further improved in recent years as a result of the HSNP scheme successfully scaling up in response to drought, thereby reducing the need for less efficient and effective emergency support.<sup>882</sup>

562. Social assistance programmes have been directed to areas with the highest poverty rates, though not necessarily to the counties with the largest numbers of people in poverty. As a result, households in arid lands are three times more likely to be registered for social assistance schemes than those in rest of the country. There are also significant geographic disparities in the coverage of health insurance, with the highest prevalence in areas where the formal economy workforce is largest.<sup>883</sup>

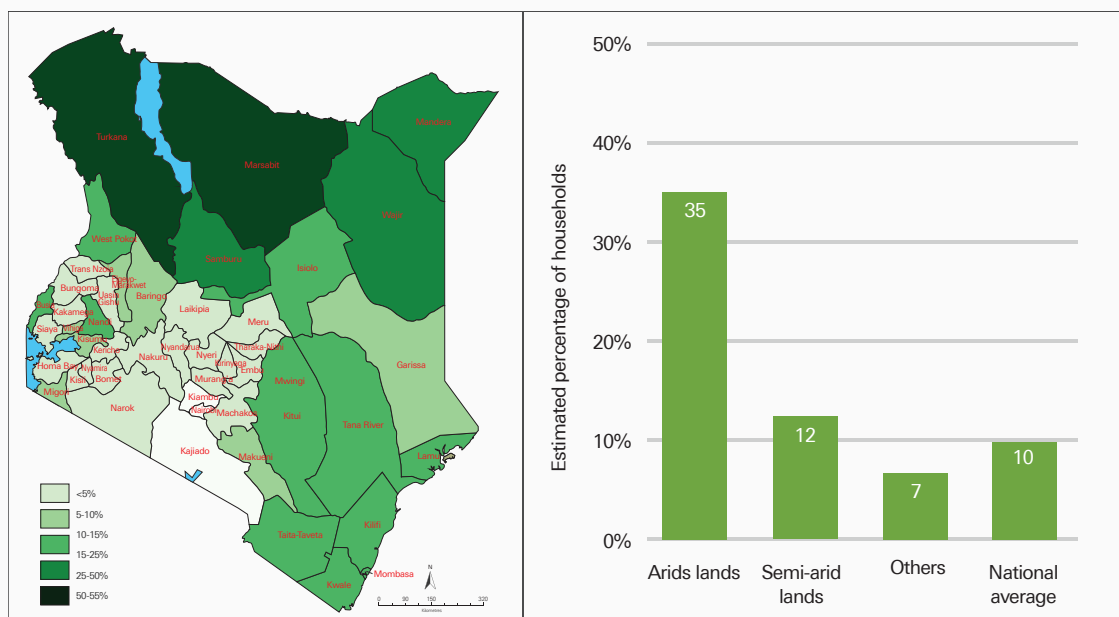


Figure 29: Proportion of households that are recipients of the main social assistance programmes, by county and by ASAL classification<sup>884</sup>

563. Persons with disabilities remain vastly underserved by the social assistance system, with an estimated coverage of less than 1 per cent among children.<sup>885</sup>

564. The National Safety Net Programme is only one part of the social protection system and the Government is now considering how to move towards a broader social protection system. A need has been identified to provide complimentary support for existing NSNP beneficiaries and also to think beyond the NSNP and identify potential areas for support to other vulnerable members of the population. The Government and its partners are considering designing a comprehensive and integrated social protection programme, which would include the existing cash transfer programmes and complementary support for the poor and vulnerable.<sup>886</sup>

874. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 875. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 876. UNICEF, Kenya: Investments in Social Sectors, 15 February 2017  
 877. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 878. B. Gelders, Assessment of the geographical and community-based targeting of WFP's Cash and Food for Assets programme in Kenya, Unpublished paper, WFP, UNICEF and Social Protection Secretariat, 2016. Cited in World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 879. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5  
 880. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 881. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 882. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 883. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 884. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017. Citing data from the Single Registry (December 2016) and Census 2009.  
 885. World Bank and Government of Kenya, Kenya Social Protection Sector Review, Draft, June 2017  
 886. UNICEF, Draft Concept Paper for Comprehensive and Integrated Social Protection Program (Cash Plus).

565. As cash alone is not always sufficient to reduce broad-based and interrelated social and economic risks and vulnerabilities, a “Cash Plus” system is envisaged, to combine cash transfers with other social protection interventions. It would also include a comprehensive poverty graduation programme to build stable livelihoods, build resilience and enable beneficiaries to support themselves.<sup>887</sup> Several “Cash Plus” interventions are being piloted in various parts of the country. The UNICEF-supported models include a nutrition intervention that increases the transfer and provides nutrition counselling for families with children aged under 24 months; an initiative to provide a separate cash transfer to poor and vulnerable pregnant and lactating mothers to improve maternal and neonatal health; and integration of existing cash transfers with HIV programmes targeted to adolescents.
566. A further step towards enhancing social protection in Kenya was the announcement by Finance Minister Henry Rotich on 31 March 2017 that from 1 January 2018 all citizens over the age of 70 years would be entitled to a pension fully funded by the state. Analysis by Development Pathways for the State Department of Social Protection – with support from WFP and UNICEF – has indicated that the universal pension will reduce the poverty rate among households with over-70s by a minimum of 16 per cent and the poverty gap by 29 per cent. This will also be an important step forward for younger generations, because older persons in Kenya are often carers of orphans and vulnerable children and, with pension support, they will be able to provide for the basic needs of children in their households, such as food, educational support and health care, while maintaining a decent standard of living.<sup>888</sup>

#### Key issues

- Between 2013-14 and 2015-16, the number of beneficiary households of the Government’s four principal cash transfer programmes increased from 522,000 to 829,000, an average growth rate of 26 per cent per year.
- In 2016, it was estimated that more than 2.3 million children (over 10 per cent of those in the country) lived in households that received cash transfers, of whom the Cash Transfer Programme for Orphans and Vulnerable Children covered 1.1 million
- However, the programme’s coverage of the poorest households that need financial support still continues to be low, and children under five years are particularly unlikely to be in receipt of benefits, while coverage of children with disabilities is only estimated to be 1 per cent
- Introduction of universal pensions for all those over 70 years from 1 January 2018 will support more children living in households with elderly relatives
- In recent years, creation of the State Department of Social Protection at the Ministry of East African Community, Labour and Social Protection in 2015 and the Social Assistance Unit in 2016 have significantly strengthened social protection sector governance, though it remains somewhat fragmented across several ministries.
- The State Department faces challenges coordinating the sector, and implementation structures at local level need to be streamlined.

887. UNICEF, Draft Concept Paper for Comprehensive and Integrated Social Protection Program (Cash Plus).

888. Krystle Kabare, *Pensheni Kwa Wote! Building the Social Protection Floor for Older Persons in Kenya*, Development Pathways, 24 April 2017, at <http://www.developmentpathways.co.uk/resources/pensheni-kwa-wote-building-social-protection-floor-older-persons-kenya/>

## Adolescent empowerment

567. Guidelines for child participation in Kenya recognize that meaningful children's participation ought to take place at various decision-making levels that include; home, school, community, national, regional and international platforms. The guidelines address rules to be followed in the process of child participation, such as mutual respect for the views of all children indiscriminately, access to information, equal rights to participation and use of appropriate methodologies to enhance child participation.<sup>889</sup>
568. While the 2010 Constitution guarantees freedom of expression, association and freedom of assembly to all Kenyans, the exercise of these freedoms by children is not always fully respected in practice, such as in cultural activities in which children may express their political view or in demonstrations organized by children.<sup>890</sup>
569. The Kenya Children's Assembly has been established at national, county and sub-county levels. However, the Children's Assembly is not open or accessible to certain groups of children, such as refugee children and children with disabilities.<sup>891</sup>
570. Other efforts include establishment of students' councils in secondary schools and children governments in primary schools to enhance child participation in management at school level. Other institutional activities are led by the Ministry of Education, Science and Technology through provision of extra-curricular activities to help children participate and harness their talents through sports, music, drama and music. School can provide a good opportunity for children and adolescents to be involved in decision-making and this can promote transparency and interaction between staff and the pupils or students.<sup>892</sup>

889. UNICEF, 10 Key Child Survival Development and Protective Behaviours, April 2016

890. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

891. UN Committee on the Rights of the Child, Concluding Observations on the combined third to fifth periodic reports of Kenya, 21 March 2016, UN Document CRC/C/KEN/CO/3/5

892. UNICEF, 10 Key Child Survival Development and Protective Behaviours, April 2016



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