

African Women & Child Feature Service

Rights of the Child

Facts & Figures

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“Children who have lost their mother or both parents are society's most vulnerable members. Socially isolated because of the stigma of Aids, they are less likely to be immunised, more likely to be malnourished and illiterate, and more vulnerable to abuse and exploitation”

Unicef 1999

Foreword

In 1989 when the world's leaders and senior state officials pledged to pursue an agenda that would secure the well-being of children, they were making a commitment to children. They agreed to be guided by the principle of “first call for children”, which gives priority to the needs of children in the allocation of resources irrespective of other national priorities.

For the media, making this commitment a reality for children and youth needs to be prioritised. In the news sense, children and youth issues tend to be lost because of the passive manner in which reporters have handled their stories. Similarly reporting the status of children often ignores the impact on their lives of policies and decisions made in their name.

This booklet, “Facts and Figures on the Rights of the Child” aims to reach media practitioners who

are actively engaged in encouraging the national dialogue on topical issues that are central to Kenyans. It is our hope that this booklet will give deeper insight on the issues that affect the children beyond the statistics.

*The Editor,
African Women and Child Feature Service.*

Chapter 1: Defining Rights of the Child

Rights of the child have been defined in various conventions, declarations and other international instruments as human rights.

The most notable instrument that gives a comprehensive definition of the rights of the child is the Convention on the Rights of the Child (CRC). Adopted in 1989 by member states of the United Nations (UN) it is the world's most universally embraced human rights instrument.

In Africa, there is the African Charter on the Rights and Welfare of the Child. It is an instrument of the Organisation of African Unity (OAU) and was adopted by OAU members in 1990. This charter also defines the rights of the child.

The CRC defines a child as all persons under 18, unless a country's law gives a lower age of majority (the age at which one is considered an adult).

In Kenya, a Children's Bill, whose aim is to make into domestic law the CRC, is waiting for the Attorney General to present it to Parliament for debate and adoption.

Chapter 2: Highlights of the 1989 Convention on the Rights of the Child

When the Convention on the Rights of the Child was adopted by UN member states in 1989 it heralded a new era in the lives of the world's children. It is the first human rights instrument to specifically address children's rights.

It became international law on September 2 1990, and by mid-September 1997, 191 states had ratified it, making it the most widely ratified human rights document in the world. Kenya ratified the CRC in 1990.

Not only does this Convention address children's rights such as survival, protection and development, but also widens its scope to conform with the reality that children share the same spectrum of rights as adults: civil and political, social, cultural and economic.

The Convention is divided into three parts and is made up of a total of 54 articles. Part 1 describes what children's rights are. Part 2 describes the composition and work of the United Nations Committee on the Rights of the Child. Part 3 details the steps to be taken by states to ratify the Convention as well as the steps necessary for the Convention to become international law.

Some of the rights of the child as described in Part 1 are as follows:

A child should not suffer any form of discrimination (Article 2) and a child should be free to associate (Article 15), has a right to have a name and nationality from birth (Article 7), and his/her best interests should be taken care of in all situations (Article 3).

The Convention calls on state parties to recognise every child's inherent right to life and to ensure to the maximum extent possible the survival and development of the child (Article 6).

Accordingly, Article 27 provides that the child has a right to benefit from an adequate standard of living in all aspects of his/her life. Also Article 24 also states that a child is supposed to enjoy the highest attainable standard of health.

Article 28 affirms the child's right to education, and calls on the state parties to ensure that primary education is made free and compulsory.

Such education should be directed at developing the child's personality and talents, and fostering respect for basic human rights (Article 29).

The Convention calls on states to recognise the right of handicapped children to special care, education and training so as to live a full and active life in society.

Article 14 observes that children have rights to freedom of thought, conscience and religion,

subject to appropriate parental guidance and national law.

The state parties should therefore protect the rights of children of minority communities and indigenous populations (Article 30), to enjoy and practice their own culture, religion and language.

Article 18 affirms the principle that both parents have a joint primary responsibility for bringing up their children, and that the state should support them in this task.

In instances where children are deprived of family environment, it is the obligation of the state to provide special alternative protection for such children (Article 20).

Article 21 adds more weight to Article 20 by stating that, in cases where adoption is recognised and/or is allowed by a state party, alternative family care or institutional placement should be made available. And it is

the child's right (Article 25) to have all aspects of such placement evaluated regularly.

The Convention also protects children from all forms of abuse, exploitation and neglect, perpetrated by parents, other custodians or other persons.

Article 34 protects children from sexual exploitation and abuse, while Article 32 protects them from engaging in work that constitutes a threat to their health, education or development, by setting minimum ages for employment, and prevention of the sale, trafficking and abduction of children (Article 35).

In appreciating the escalation of armed conflicts and their effects on children, Article 22 calls on state parties to ensure that special protection is granted to children who are refugees or seeking refugee status.

Article 38 obliges state parties to respect and

ensure respect for humanitarian law as applies to children. To this end, children who are alleged to or have committed an offence, have a right to benefit from due process of law (Article 40).

As a step in ensuring the realisation of Articles 22, 32, 35, and 38 of the Convention, Article 39 affirms the state's obligation to ensure that victims of armed conflicts, torture, neglect, maltreatment or exploitation, receive appropriate treatment for their recovery and social reintegration.

In Part 2 of the Convention, for the purpose of monitoring the implementation and examining the progress made by state parties in achieving its provisions, the Convention in Article 43 calls for the establishment of a committee on the rights of the child.

This committee consists of 10 experts of high moral standing and recognised competence in the field covered by the Convention (Article 44).

It will receive comprehensive reports from states which have ratified the Convention. In these reports, states will show the steps they have taken to comply with the Convention, and progress made on the implementation of the child's rights.

And to foster effective implementation of the Convention, specialised agencies such as United Nations Children Fund (Unicef), shall be entitled to be present at the consideration of implementation of such provisions.

Also, Unicef and other NGOs may present alternative reports to complement official reports to the committee with respect to the children they deal with.

Article 44 requires the state parties to make such reports widely available to the public in their own countries.

Chapter 3: Child Labour

Child labour is any work carried out by persons less than 15 years of age, and which is likely to be exploitative, interfere with the child's education or be hazardous to the child's health or physical, mental, spiritual, moral or social development.

According to the 1998 *Situational Analysis Of Children And Women In Kenya* (SACWK; a government of Kenya and Unicef document), child labour refers to working children who earn a living for themselves, and to some extent for their families, and thus forego the opportunity to go to school.

Generally, child labour is a serious global problem and a violation of children's rights. The International Labour Organisation (ILO) estimates that 250 million children from 5-14 years old work, mainly in developing countries.

That is, one out of every 4 children in the developing world is at work.

In some countries, up to 80% of working children work the whole week. About 60% of child workers are in Asia, 7% in Latin America and 32% in Africa (ILO figures).

In Kenya, no survey has been conducted to establish the magnitude of the problem. However, estimates based on school dropout rates indicate that child labour is on the increase, according to *SACWK 1998*.

Causes of child labour

Child labour is both a consequence and a cause of poverty. Societies characterised by poverty and inequality tend to record higher levels of child labour, as children work to supplement their parents' income.

Child labour is also a consequence of the Structural Adjustment Programmes (SAPs) imposed on developing countries since the late

seventies. Specifically the splitting of costs between parents and governments - otherwise known as cost sharing in Kenya - has made education more expensive for the average family who are already unable to meet their other basic needs. As a result many children drop out of school and work to supplement their parent's income.

Its Manifestations

The State of the World's Children 1997 catalogues forms of child labour such as domestic service, forced and bonded labour (virtual enslavement of children to repay debts incurred by their parents or grandparents), commercial sexual exploitation and industrial and plantation work. (*The State of the World's Children* is an annual two-part report done by Unicef. The first part of the report usually focuses on a given theme and the second part of the report is made up of statistics regarding children's wellbeing in the world.)

In Kenya, child labour is rampant in tea and

coffee plantations, areas where *miraa* (khat) is harvested, such as Meru, salt pans in Malindi and in the soapstone quarries of Kisii, among other areas.

Research done by the University of Nairobi between 1982 and 1985 based on a sample of 863 child workers showed that 60% of these children were working in homes. 90% of these domestic workers were girls aged between 7-17 years.

ILO estimates that 150 million to 200 million children, most of them girls, do unpaid domestic work for their families. And even when involved in paying jobs, girls, on average, earn less than boys doing the same job.

Interventions and progress

In 1919, the Minimum Age Covenant No. 5, which established 14 years as the minimum age for children to be employed in industry, was adopted by ILO.

ILO went a step further in 1973, when it adopted the Minimum Age Covenant No. 138, which requires members to pursue national policies designed to ensure the effective abolition of children labour.

Article 32 of the Convention on the Rights of the Child (CRC) calls on state parties to protect children from exploitative and hazardous child labour.

The fight against child labour does not just stop at covenants and conventions. In 1998, children and adults in more than 100 countries participated in the global march against child labour.

Chapter 4: Child Sexual Violation

Documented information on sexual violations in general and on children in particular is scant, if not non-existent. This can be attributed the stigma attached to rape and other sexual violence making it difficult for victims to report it.

Child sexual violation is manifested in various forms. Child incest, female genital mutilation (FGM), forced early marriage of girls, and rape are some of the forms.

Child incest is rarely discussed publicly because it is considered taboo among many Kenyan communities.

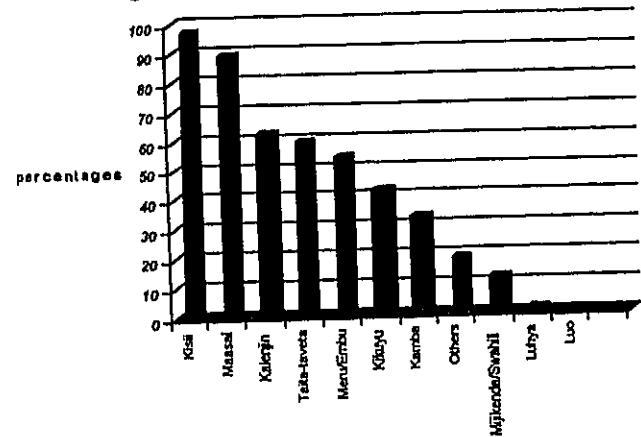
Other child sexual violations such as FGM, forced early marriages and rape are more widely discussed. Apart from FGM, little or no statistics exists on the other two forms of abuse. Female Genital Mutilation is the partial

or complete cutting away of a woman's external genitalia. However, the severity of the procedure varies from one community to another.

Female Genital Mutilation prevalence also varies from one ethnic group to another. According to the *Kenya Demographic and Health Survey* (KDHS), 1998 - prepared by planning ministry and Macro International Inc of the United States of America - Kisii leads with 97% of the girls undergoing FGM. Maasai follows next (88.8%), then the Kalenjin (62.2%). The rate of FGM prevalence among other ethnic groups is: Taita/Taveta (59.2%), Meru/Embu (54.2%), Kikuyu (42.5%), Kamba (33%), Mijikenda/Swahili (12.2%), Luhya (1.6%), Luo (1.2%) and Others (19.2%) - *see bar graph*.

Information available on child rape shows that it is prevalent in primary and secondary schools and in other institutions of learning. In primary and secondary schools, female students are sexually harassed and abused by

Prevalence of Female Genital Mutilation among Kenyan ethnic groups



either their teachers or fellow male students. Between 1986 and 1990, 650 cases relating to teachers' sexual conduct were reported to the Teachers Service Commission (TSC).

In July 1991, the mass rape of seventy girls occurred at St. Kizito's Mixed Secondary by their male counterparts. Nineteen girls died in the tragedy. Rape of female house-help by their

employers or male relatives is also an issue in many forums.

Laws relating to sexual violation are, to say the least, inadequate. The rape of a girl or woman over the age of 13 by her father, grandfather, brother or son carries a mere maximum sentence of five years imprisonment.

Under the Penal Code Chapter 63 of the Laws of Kenya, rape, incest, sexual harassment and other forms of sexual assault are considered offences "against morality", and not offences against the person.

Chapter 5: Child Health

Immunisation

In line with the World Health Organisation (WHO) guidelines, in order to be fully vaccinated a child should receive:

- A dose of BCG to protect against TB, given at birth or at first clinic contact.
- Polio
- DPT to protect against Diphtheria, Pertussis and Tetanus. (Both DPT and Polio vaccines are given at approximately 6, 10 and 14 weeks of age.)
- The Measles vaccine is given soon after the infant's 9th month.

Note: WHO recommends that children receive the entire schedule of vaccinations before they are 12 months of age.

"A child who is not immunised is more likely to become undernourished, to become disabled and die."

Facts for Life, Unicef

About 2 million children worldwide under the age of five still die every year from six vaccine-preventable illnesses: diphtheria, measles, pertussis, polio, tuberculosis and tetanus.

There has, however, been a tremendous improvement in the general trend as compared to two decades ago, when just 5% of infants in developing countries were being immunised against these six diseases. Now about 80% of the 125 million children who reach the age of one are immunised.

In Kenya the Ministry of Health runs a successful immunisation programme, the Expanded Programme on Immunisation (EPI) as a means of providing immunisation services. The main objective of the programme is to reduce deaths and illness that result from childhood immunisable diseases.

The Kenya Expanded Programme on Immunisation (KEPI) in collaboration with UNICEF and other NGOs has improved

immunisation coverage throughout the country. This has seen a reduction in the incidence and prevalence of childhood diseases.

Measles

Measles still claims more than 800,000 children in developing countries each year.

Two thirds of all countries have reached the year 2000 goal of cutting the number of measles deaths by at least 95% over 1990 levels. In Kenya illness and death from measles has been reduced by 90% and 95% respectively.

Polio

A major WHO global polio eradication campaign is nearing its year 2000 goal. However, the disease still cripples thousands of children each year.

In Kenya, the move towards eradicating polio has been implemented through the National Immunisation Days (NIDs) which have so far

seen great success. The 1996 and 1997 NIDs reached a total of 4,000,000 children under the age of five out of the targeted 5,000,000.

Malaria

Alone or in conjunction with other illnesses, malaria kills over one million children under the age of five every year - one child every 30 seconds - in about 100 malaria-endemic countries.

"90% of the estimated annual 300 million to 500 million malaria cases afflict people in sub-Saharan Africa and children are victims of over half of all malaria episodes."

Unicef 1998

In Kenya malaria cases number more in high prevalence areas and account for 30-50% of childhood illnesses in these areas. However, the highland areas which otherwise have a low prevalence rate are home to what has come to be known as 'highland malaria' - a more virulent form of malaria, which strikes sporadically but leads to numerous deaths.

In order to reduce death and illness from malaria, effective case management, personal protection and vector control are required. In Kenya, the National Malaria Control Programme is doing this in selected districts where malaria prevalence is high.

Diarrhoeal Diseases

About 2.2 million children in developing countries die from diarrhoeal diseases each year mainly due to dehydration.

In Kenya, diarrhoea is amongst the major childhood illnesses with the annual incidence of diarrhoea at 3.5 - 4.6 episodes per child.

Oral rehydration therapy (ORT) and continued feeding involves the prompt increase of fluid intake in response to dehydration; it is used to control diarrhoea and is simple and cost-effective. ORS (Oral Rehydration Salts), which are commercially prepared, or alternative fluids prepared in the home, are used in ORT, and are administered by the child's caregiver.

The use of ORT could prevent as many as 90% of all child deaths from diarrhoeal diseases.

Oral Rehydration Therapy in the developing world has been successful with 3/4 of households using it. It saves over 1.5 million lives each year - 4,500 every day.

In Kenya the Control of Diarrhoeal Diseases (CDD) Programme, which aims at reducing morbidity and mortality using ORT, runs its operations in 17 districts. Current use of ORT in the treatment of dehydration due to diarrhoea is 76% and has seen the reduction of child deaths due to diarrhoea from 14% to nine percent.

Acute Respiratory Infections

Acute Respiratory Infections (ARIs) in children include the common cold, coughs, bronchitis, difficulties in breathing, ear and sinus infections, asthma and pneumonia. ARIs account for 19% of all childhood deaths in the developing world.

In Kenya ARIs are the second leading causes of childhood morbidity, accounting for 30.2% of the total morbidity in 1996.

Incidences of ARIs are more prevalent in highlands, arid areas and slum dwellings.

"Low birth weight, malnutrition and exposure to air pollutants both at household level and in the environment are some of the factors that have been associated with the increased risk of ARI leading to death."

Situation Analysis of Women and Children in Kenya 1998

Key Primary Health Care Programmes Implemented in Kenya:

Bamako Initiative

CDD (Control of Diarrhoeal Diseases)

ARI (Acute Respiratory Diseases)

EPI (Expanded Immunisation Programme)

MCH/FP (Mother and Child Health/ Family Planning)

Malaria Control

Nutrition

Child Nutrition

Nutritional well being is not merely a result of sufficient food-intake. Nutrition or the lack of it is a result of several factors.

Malnutrition

Causes of malnutrition include poor diet, common and preventable infections, inadequate care and lack of sanitation.

Breastfeeding

Breast milk contains all the nutrients needed by children in the first four to six months of life. Babies who are breastfed are less likely to suffer from common childhood illnesses and malnutrition.

If exclusive breastfeeding was practised by all, this could save the lives of 1.5 million children each year.

In Kenya, about 97% of the infants are breastfed at birth, 90% are still breastfed at one year and 49% at two years. Despite the relatively large

percentages of infant breastfeeding, exclusive breastfeeding goes on for only up to two and a half months for the majority, with less than 20% of the infants being exclusively breastfed by the fourth month.

The use of bottle-feeding as a substitute for breast milk, especially in poor communities, poses a significant threat to the infant's health and nutrition. Poor communities often cannot afford sufficient quantities of milk powder to meet the children's nutritional requirements and may lack knowledge of cleanliness and sterilisation procedures required in handling the equipment, the result of which is increased incidences of diarrhoea.

However, with the raging HIV/AIDS scourge, exclusive breastfeeding is no longer the 'best option' in all cases. The pandemic has necessitated the need for facilities to enable women to learn of their HIV status and the provision of relevant information with which they can make informed choices on whether

or not to breastfeed should they be HIV positive.

Micronutrients

Micronutrients are essential to the good health and development of an individual. They are noted below:

Iodine

Insufficient iodine causes mental and physical disorders. Due to this insufficiency, about 1.6 billion people (30% of the world's population) risked these disorders in 1990. An estimated 43 million people worldwide suffer varying degrees of brain damage and physical impairment because of iodine deficiency. Approximately 760 million people have goitre.

Progress: The global campaign against iodine deficiency disorders has achieved iodisation of nearly 60% of the world's edible salts. This has reduced the number of children born each year at risk of mental impairment due to iodine deficiency in their mother's diet from about 40

million in 1990 to about 28 million in 1997.

Vitamin A

Vitamin A deficiency (VAD) impairs the child's resistance to disease, contributing to nearly a quarter of all under-five deaths in the developing world. The lack of Vitamin A is also known to be the leading cause of blindness amongst children in developing countries.

Vitamin A, which is naturally obtainable from orange or yellow fruits and dark-green leafy vegetables, helps protect against pneumonia and also reduces the risk of childhood blindness.

About 100 million children worldwide suffer from Vitamin A deficiency and are thus more susceptible to childhood illness that may end in death.

In countries with high incidences of VAD, child mortality could be reduced by up to 23% if children received Vitamin A either through

"The impact of Vitamin A supplementation on reducing child mortality is comparable to - if not greater than - that of any single immunisation against a childhood disease."

Unicef Progress of Nations 1999

supplementation or food fortification.

During the 1990 World Summit for Children a target was set towards the eradication of Vitamin A deficiency as a public health problem by the year 2000.

Towards achieving this goal, several countries have started initiatives aimed at ensuring Vitamin A is made available to children, either through supplementation or food fortification.

So far, 35 countries are providing Vitamin A supplements for their young children, with over 80% of them regularly receiving a dose of Vitamin A.

Present coverage is inadequate in 44 countries with 29 of these countries, Kenya included, pledging to include Vitamin A supplementation in National Immunisation Days (NIDs) and special campaigns in 1999.

Marked progress has been recorded in the 90s, with the number of children affected by eye problems associated with vitamin A deficiency down from the 5 million in 1985 to 3 million in 1995.

"More than 2 billion people - principally women and children - are iron deficient. Iron deficiency anaemia weakens a child's learning abilities, lowers resistance to disease and is a serious risk to pregnant women."

Unicef Progress of Nations 1999

Iron

WHO estimates that half of all children under age four in developing countries are anaemic.

Progress: Fortification of food (commonly wheat and flour products) with iron is under

way in Latin America, the Middle East and East Asia. From 1993 to 1996, Unicef provided 2.7 billion iron/folate tablets for pregnant women in 122 countries.

"Underlying factors leading to increased life expectancy include improvements in the health care system, reduced rates of mortality, increased earnings and higher levels of education"

Kenya Human Development Report 1999

Child Mortality

The most common causes of infant and child deaths in Kenya continue to be malaria, pneumonia, diarrhoea, birth trauma and asphyxia. However, the increasing role of HIV/Aids in child mortality cannot be ignored.

According to the *Kenya Demographic Health Survey* [KDHS] the post-independence period leading up to the mid-80s witnessed a gradual but steady decline in infant and under-five mortality. However, figures from the 1998 KDHS show a gradual increase in both under-

five and infant mortality since 1985.

Under 5 mortality figures currently stand at 112 per 1,000 live births having regressed to where they stood in 1979. It has been projected that by the year 2005 under-five mortality will range between 120-125.

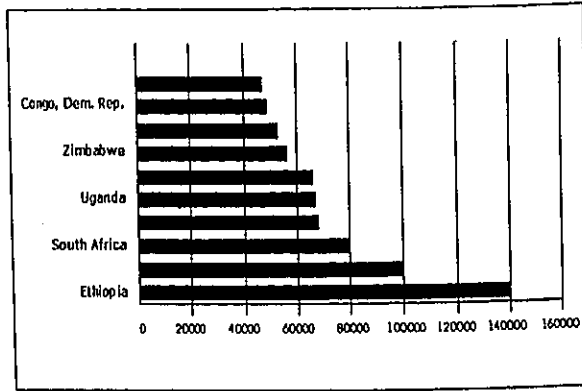
The sudden turn and continuing rise in child-mortality rates can be attributed to the HIV/Aids epidemic, which has since passed its latent phase.

Under-five and infant mortality rates in Kenya

Indicator	1960	1979	1991	1992	1993	1995	1998
Infant mortality rate (per 1,000 live births)	119	104	52	51	60	61	74
Under 5 mortality rate (per 100,000 live births)	202	112	75	74	90	90	112

Source: 1989 Census Analytical Report, Vol. V – Baseline Survey Report, and 1998 KDHS Report
Adapted from the Kenya Human Development Report, 1999

Fig: Children Living with HIV/Aids



Source: UNAids/WHO; data as at end-1997
Adapted from: The Progress of Nations 1999

Chapter 6: Children and HIV/Aids

HIV/Aids has dealt a massive blow to achievements made in child healthcare and nutrition in post-independence Kenya. Having reduced the average life expectancy of Kenyans by 15 years, HIV/Aids has had devastating effects on every section of the country's population.

Its impacts on children are evidenced in the steady rise in child mortality and in the increasing number of those orphaned by the disease.

Children living with HIV/Aids
Global statistics by the UNAids/WHO indicate that of the 590,000 children infected with HIV/Aids, 530,000 (90%) were in sub-Saharan Africa.

In Kenya between 1990 and 1997 the number of children under the age of 15 infected with

HIV increased three-fold, from 24,964 to 77,915 respectively. According to 1998 figures by NASCOP (National Aids/STD Control Programme, Ministry of Health), 91,000 children, all under 15, are HIV positive indicating a continuing rise of HIV amongst children.

Mother to Child Transmission (MTCT), which is the most common mode of infection, accounts for about 23% of the total HIV infections in Kenya.

Children with Aids in the age group 0-4 accounted for more than 7% of all reported Aids cases in 1997.

Children infected with HIV are susceptible to opportunistic infections and are therefore in need of constant medical care.

Orphans

The Aids pandemic has dealt a massive blow to children in the developing world; of significance is the rapid increase in the number

of children orphaned by the disease.

The 'Aids orphan' is any child under the age of 15 who has lost a mother or both parents as a result of HIV/Aids.

There are, to date, more than 8 million Aids orphans in the world, the majority of them living in sub-Saharan Africa.

"Children who have lost their mother or both parents are society's most vulnerable members. Socially isolated because of the stigma of Aids, they are less likely to be immunised, more likely to be malnourished and illiterate, and more vulnerable to abuse and exploitation."

Unicef 1999

According to UNAids the number of children living with HIV infected parents by far exceeds the number of children who are already orphaned by the disease. Based on this it is expected that the number of Aids orphans will continue to rise rapidly as parents who are already infected continue to succumb to the disease.

Over the past three years there has been a rapid rise in the number of orphans as a result of HIV/Aids with some developing countries registering as high as a 400% increase.

Mother to Child Transmission [MTCT]

Mother to Child Transmission of HIV may occur during pregnancy, at birth or during the first few months of the infant's life through breastfeeding.

Pre-natal Transmission

There is a high chance that a woman already infected with HIV will transmit the virus to her unborn child. It is on the basis of this that the Kenya government has put in place several interventions to minimise the risk of pre-natal

"The right of the child to survive will be enhanced by minimising mother to child transmission of HIV."

*1998 Situation Of Women And
Children In Kenya Analysis*

MTCT. Among these interventions, and perhaps the most effective, is to ensure a reduction in the number of women who are HIV carriers.

Current trials with anti-retroviral drugs such as AZT are proving successful in reducing the risk of MTCT of HIV/Aids. Trials done in Thailand in 1998 showed by administering AZT from the 36th week of pregnancy to labour, chances of MTCT of the virus were reduced by 50%. Based on the study, UNAids and WHO have initiated a two-year pilot project in Thailand.

Breastfeeding

Infants whose mothers are HIV positive run an estimated 1 in 7 chance of contracting the virus through breastfeeding.

Recent studies have shown the mixing of natural and artificial infant feeding during the first few months of life to significantly increase the chance of infection from an HIV positive mother to her infant. It is thought that artificial

feeding during the first few months of an infant's life may cause inflammation of the intestinal tract and thus open a passage for the HIV virus into the child's body.

It is with these findings that the UNAids/WHO issued a warning, in its guidelines on infant feeding, on the potential danger of mixing artificial and natural feeding methods.

Mortality

According to the National Aids and STI Control Programme, HIV alone has increased infant mortality by about 20% since a majority of children infected with HIV die before their fifth birthday (see '*Child Mortality*' in chapter. 5).

Children at risk of HIV infection

Besides MTCT of HIV there are various ways through which children get infected, sexual contact being the most common. Among those at high risk of contracting the HIV virus through sexual contact are:

- Street children,
- Children in remedial/correctional institutions,
- Sexually abused children,
- Children growing up in slums.

These constitute the groups most vulnerable to sexual exploitation. At highest risk in this high-risk group of children is the girl-child.

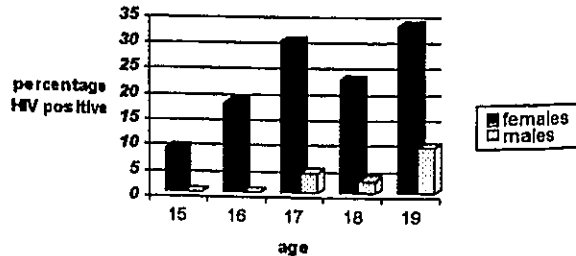
"Higher prevalence rates among girls reflect their biological vulnerability to infection, their social and physical vulnerability in sexual relations and the impact of gender discrimination"

Unicef 1999

A comparative study carried out by NASCOP showed a higher prevalence of HIV/Aids in teenage girls compared to their male counterparts. Of the total number of HIV/Aids cases between ages 15 and 19, 77% consisted of girls whereas boys accounted for only 23%.

A study carried out in Kisumu revealed similar findings as seen in the graph below.

Kisumu Adolescents 15 - 19 years by gender, and by percentage who are HIV positive



Population Council (1999)
N =372

Source: "Kenya Adolescent High Risk Behaviour" - Population Communication Africa

Note: Unless otherwise indicated all worldwide figures quoted in this chapter and the preceding chapter 5 are Unicef figures and the Kenya figures are taken from: Situation Analysis of Women and Children in Kenya 1998; the Kenya Human Development Report; and the Kenya Demographic and Health Survey.

Chapter 7: Children and Education

Acknowledging the significant role of education in human development, the UN Convention on the Rights of the Child declared that primary education should be "compulsory and available free to all".

It was the United Nations year 2000 goal to achieve universal access to basic education and completion of primary school for at least 80% of primary school age children.

Despite this projection nearly a quarter of the world's population is illiterate and millions of children are without any formal education.

In developing countries over 90% of children enrol for primary school, but only 75% complete even four years of basic education.

Out of 130 million children not attending school in developing countries 60% are girls.

Percentage of primary school age boys and girls out of school

	Boys	Girls
Sub-Saharan Africa	39	45
Middle East and North Africa	15	24
East Asia and Pacific	2	4
South Asia	25	37
Latin America and Caribbean	11	10

Adapted from UNICEF Facts and Figures 1998

Kenya's National Programme of Action for Children targets for the decade of the 90s included:

- Increased participation rates in early childhood education from 30% to 50%,
- Achievement of universal primary education,
- Achievement of a national primary school completion rate of 70%,
- Lowering national illiteracy rates from 40% to 20% and reducing regional disparities.

The Kenyan education system comprises of four broad categories, these are: Early

Childhood Education, Primary Education, Secondary Education, and Tertiary Education. Other education programmes catering for those with special needs also exist.

Early Childhood Education

Meets the education needs for the under-fives, who form 20% of Kenya's population. Early Childhood Education (ECE) equips children with basic skills and knowledge in numeracy, literacy and expansion of ideas in words.

Though there is no government policy requiring children to pass through ECE institutions, the number of institutions offering ECE has grown tremendously as individual school boards continue to make ECE an admission requirement.

The number of ECE institutions has grown from 15,469 in 1989 to 23,344 in 1997. Enrolment in the sub-sector increased by about 20% from 801,369 pupils in 1989 to 1,003,367 pupils in 1996.

Primary Education

According to the Kenya Human Development Report for 1999, the gross enrolment rate in primary schools increased from 50% in 1963 to 95% in 1989. A recent drop in enrolment rates has been recorded. With enrolment rates at 77.5% in 1996, the goal of universal primary education by the year 2000 is in jeopardy.

Owing to the high cost of education, crippling poverty, socio-cultural values, early marriages and unwanted pregnancies, primary completion and secondary participation rates have registered a decline in the past decade.

The introduction of cost sharing arrangements in 1989 had adverse effects on access to education for children from poor families; especially girls.

National statistics indicate that completion rate has increased from 43.6% for the 1981-88 cohort to 46.4% for the 1985-92 cohort, but it declined to 42.6% for the 1988-95 cohort. This,

"... average expenditure on schooling (for all children and not per pupil) by all households is Kshs 4,730 (with Kshs 3,728 in rural areas and Kshs 10,415 in urban areas)... equivalent to a four-month income for poor rural households thus making primary education unaffordable."

Kenya Human Development Report 1999

according to the 1999 Kenya Human Development Report, indicates that more than 1 million students enrolled in Standard 1 never complete their primary school education.

Most school-age children in Kenya drop out of school in the course of their primary education. Data from 1996 indicates that the transition rate from primary to secondary education is only about 45.2% (46% for boys and 44.3% for girls)

Secondary Education

In 1996, the secondary participation rate at the national level was a mere 26.5% with 24.5%

for girls and 28.4% for boys. Availability of secondary school education has been a constraint to access to secondary school education.

Secondary participation rate has been declining over time, from 30.8% in 1989 to 26.5% in 1996.

Other Education programmes

Programmes have been formulated to cater for the needs of special groups, which include the handicapped, out-of-school children, adult and continuing education, polytechnic programmes for youths and non-formal education programmes.

According to the Kenya Human Development Report 1999, adult and continuing education remains the weakest sub-sector in the entire education system. This is due to the lack of effective coordination between literacy, post-literacy and continuing education programmes.

Chapter 8: Children and War

Worldwide, war takes multiple tolls on children - civilians, including children and women, are increasingly targeted in violation of human rights. Destruction of homes, schools and communities claims more children's lives than bullets and bombs. For those who survive, dislocation, injuries and trauma take tolls that last a lifetime.

Table: Estimated numbers of child victims of armed conflicts during the past decade (in millions)

Killed	2 m
Seriously injured or permanently disabled	6 m
Left homeless	12 m
Orphaned or separated from their families	Over 1 m
Psychologically traumatised	10 m

Source: Adapted from UNICEF Facts and Figures 1998

In 1997, approximately 50 million people world-wide were displaced from their homes either within their own countries or forced to flee across borders as refugees; nearly half of them were children.

As many as 300,000 children as young as eight years in dozens of countries are directly involved in conflicts as soldiers, porters and forced labourers owing to ethnic rivalries, civil wars and political instability.

By August 1992, Kenya had absorbed about 350,000 refugees fleeing civil war in Sudan and Somalia. By 1994, Kenya hosted 400,000 refugees. Refugee children numbered more than half of the population.

Ethnic conflicts within Kenya have also led to displacement of families.

In 1993, Human Rights Watch Africa estimated 3500 people died as 300,000 people were displaced, of this number 75% were children.

According to National Council of Churches of Kenya (NCCCK), in 1992 over 255,000 people were displaced by ethnic clashes that rocked parts of the Rift Valley, Nyanza and Western Provinces; out of these at least 60% are thought to be children.

70% of the displaced children in Nakuru and Uasin Gishu no longer attend school. The children now provide cheap labour in homes and farms. Some of them are street children, while others are engaged in prostitution.

In 1997 ethnic clashes in Coast Province displaced more than 120,000 people; it is estimated that more than half of this population was children.



Chapter 9: Hints on adopting an alternative reporting format for covering youth-related issues

Pro active reporting

'Pro-active' reporting is represented as the preferred alternative to conventional "passive" reporting, particularly in the coverage of youth and related issues. It constitutes a radical break from traditional reporting norms in the sense that it demands that journalists assert their professionalism and take control of story origination and presentation in ways that they have not done in the past.

Historically, journalists have passively allowed information sources, events and newsroom policy to dictate their operation. The fundamental problem with this reporting format is that youth-related issues that are not pegged to events are lost. In the pro-active reporting mode, such problems are redressed.

Pro-active reporting places emphasis on the following:

- ❑ Brainstorming as an important aspect of story origination,
- ❑ Networking as an effective way of increasing sources of news stories,
- ❑ Multiple sourcing of information,
- ❑ Data-basing as an important way of accumulating knowledge about the subject area,
- ❑ Conferencing with editors and influencing the agenda of the newsroom in that manner,
- ❑ Moving from 'events-oriented' to 'process-oriented' journalism so as to effectively capture the political, social and economic impact of youth-related issues,
- ❑ Follow-up coverage, particularly in the process-oriented reality where issues range way beyond specific events.

The passive reporting format that has served as a standard for most journalism training

programmes contrasts with its pro-active counterpart in a number of ways: It is not versatile enough to address issues on a sustained basis; instead it finds itself limited to events. The passive style is also notorious for single sourcing of information, the source mainly being limited to people who create events. As a result, single sourcing, rather than explaining a phenomenon, too often merely represents one person's opinion and their version of the true state of affairs.

The passive news approach constitutes the biggest weakness in the work of most journalists. A lot of attention needs to be given to identifying how passive reporting undermined the effectiveness of youth-related reporting. It also disempowers the reporter and subjects him/her to the agendas of news sources and their vested interests.

Initially, most reporters will not be aware of this. They will probably feel they are doing a good job of reporting, particularly where they

accurately represent information derived from these same sources. However, it will become apparent as we raise the issue of whose worldview is being portrayed and therefore whose version of the truth is being catered for, that accuracy alone - even where it succeeds in representing what the source had portrayed - can distort the truth. It will also become apparent that by virtue of the fact that single sourcing caters for the parochial interests of only one source, it cannot really explain anything about the issues beyond that.

Multiple sourcing of information and data basing are effective ways of getting around such limitations. Brainstorming, as a form of story origination, empowers the reporter by enabling him/her to pursue issues prior to, or way after, a specific event. These are important components of the pro-active package and reporters should be encouraged to regularly engage in dialogue with their editors to influence the news agenda in such ways.

In packaging, as in the sourcing of information, reporters should maintain a pro-active format. This entails the following:

- Multiple sourcing to establish and validate issues,
- Strong introductory paragraphs that clearly established what these issues are,
- Sequencing, which takes the reader logically from one set of ideas to another,
- The use of advance organisers to hold together and lead the reader into discussions containing multiple concepts and perspectives.