ARE WE FAILING OUR CHILDREN?

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What will be covered?

• Burden of ill health in children
• National child mortality trends
• Government Plans and strategies
• Kenya Paediatrics Association plans and strategies
• Achievements and gaps
• Business as usual or time to re-strategise?
Trends in Neonatal Mortality

Deaths per 1,000 live births for the five-year period before the survey

*Data before 2003 exclude North Eastern region and several northern districts in Eastern and Rift Valley regions.
Trends in Childhood Mortality

Deaths per 1,000 live births for the five-year period before the survey

*Data before 2003 exclude North Eastern region and several northern districts in Eastern and Rift Valley regions.
Summary of child mortality trends

<table>
<thead>
<tr>
<th>Year</th>
<th>Neonatal</th>
<th>Infant</th>
<th>U5Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>26</td>
<td>61</td>
<td>90</td>
</tr>
<tr>
<td>1993</td>
<td>26</td>
<td>62</td>
<td>96</td>
</tr>
<tr>
<td>1998</td>
<td>28</td>
<td>74</td>
<td>111</td>
</tr>
<tr>
<td>2003</td>
<td>33</td>
<td>61</td>
<td>90</td>
</tr>
<tr>
<td>2009</td>
<td>31</td>
<td>52</td>
<td>74</td>
</tr>
<tr>
<td>2014</td>
<td>22</td>
<td>39</td>
<td>52</td>
</tr>
</tbody>
</table>
Figure I.5  Under-five mortality by major area, 1950-2015
Nutritional Status of Children

Percent of children under 5

- Stunted (too short for age): Moderate 18, Severe 8, Total 26
- Wasted (too thin for height): Moderate 3, Severe 1, Total 4
- Underweight (too thin for age): Moderate 9, Severe 2, Total 11

MDG Target for underweight: 11

*Based on the 2006 WHO Child Growth Standards
Stunting by County

Percent of children under 5 who are stunted, or too short for age

Kenya
26%
Adolescents vs all women

Children born to:
- Adolescents (15-19 years)
- All women (15-49 years)
<table>
<thead>
<tr>
<th>CONDITIONS TARGETED FOR ERADICATION</th>
<th>CONDITIONS TARGETED FOR ELIMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Polio</td>
<td>1. Malaria</td>
</tr>
<tr>
<td>2. Guinea Worm Infestation</td>
<td>2. Mother to Child HIV transmission,</td>
</tr>
<tr>
<td>3. Maternal and Neonatal Tetanus</td>
<td>3. Measles,</td>
</tr>
<tr>
<td>4. Leprosy</td>
<td>4. Neglected Tropical Conditions</td>
</tr>
<tr>
<td>5. New / re-emerging infections</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONDITIONS TARGETED FOR CONTROL</th>
<th>RISK FACTORS TARGETED FOR CONTAINMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV / AIDS</td>
<td>1. Unsafe Sex</td>
</tr>
<tr>
<td>2. Conditions in the perinatal period</td>
<td>2. Unsafe water, sanitation &amp; hygiene</td>
</tr>
<tr>
<td>3. Lower Respiratory infections,</td>
<td>3. Suboptimal breastfeeding</td>
</tr>
<tr>
<td>4. Tuberculosis</td>
<td>4. Childhood and maternal underweight,</td>
</tr>
<tr>
<td>5. Diarrhoeal diseases in children,</td>
<td>5. Indoor air pollution,</td>
</tr>
<tr>
<td>6. Cerebrovascular diseases,</td>
<td>6. Alcohol use,</td>
</tr>
<tr>
<td>7. Ischaemic Health disease,</td>
<td>7. Vitamin A deficiency,</td>
</tr>
<tr>
<td>8. Road traffic accidents,</td>
<td>8. High blood glucose,</td>
</tr>
<tr>
<td>9. Violence including Gender Based Violence</td>
<td>9. High blood pressure,</td>
</tr>
<tr>
<td>10. Unipolar depressive disorders</td>
<td>10. Zinc deficiency,</td>
</tr>
<tr>
<td></td>
<td>11. Iron deficiency,</td>
</tr>
<tr>
<td></td>
<td>12. Lack of contraception</td>
</tr>
</tbody>
</table>
1.2.4 Adolescent health

According to the 2014 KDHS, 18 percent of children become teenage parents and this has not changed since the 2008-09 KDHS. The percentage of women who have begun child bearing increases rapidly with age, from about 3 percent among women aged 15, to 40 percent among women aged 19.

Teenagers from poor households are more likely to have begun child bearing at 26 percent than teenagers from poorer households at 10 percent. Prevalence of child bearing is highest in Nyanza region followed by Rift Valley and Coast.

According to the Plan of Action for Adolescents 2005-2015, the main issues and challenges for Kenyan adolescents are: limited access to reproductive health information and services, risky sexual behavior, engagement in harmful practices such as female genital mutilation/cutting, early and arranged/forced marriages, sexual abuse, gender based violence and exploitation, and drug and substance abuse. To improve adolescent health, adolescent programmes must be enhanced and shared widely.
1.2.2 Causes of child and maternal mortality in Kenya

i) Pneumonia

Pneumonia is the main cause of death for about 21,000 Kenyan children under the age of five, each year and it is the leading cause of childhood morbidity in areas with low prevalence of malaria (WHO 2010 and KPHC 2009). A large proportion of the caregivers of these children only initiate treatment when the illness becomes severe.

![Chart showing causes of under-five deaths in Kenya]
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3.1.18 Children and climate change

According to a 2008 UNICEF study children are more susceptible to the adverse effects of environmental degradation compared to adults. Climate change has been linked to disasters such as drought and floods, ethno-political and resource-based conflicts, and outbreaks of human and livestock diseases. (GOK and UNICEF, 2014). This further increases child protection risks in the affected community and infants and younger children are the most vulnerable.

3.1.19 Children of internally displaced families and refugees.

According to Internal Displacement Monitoring Centre (IDMC) conflict and violence are still on the rise in Kenya. In 2012, inter-communal and resource-based violence
3.1.5 Children with disabilities:

According to the Kenya Social Protection Sector Review 2012, the total number of children with disabilities is 349,086. Considering the stigma associated with disability in Kenya, the real figure may be much higher. Children living with disability may be deprived of child protection and are likely to become victims of child abuse and neglect. Children living with disability are also vulnerable to sexual abuse. There are inadequate institutions and expertise countrywide to address the needs of children living with various forms of disability. The government has developed Guidelines on Identification and Referral of Children with Disability and Special Needs. The guidelines are aimed at health workers, as well as caregivers. A training manual for health workers on prevention, early identification and intervention on disability is in use.

3.1.6 Child trafficking
More than one billion people in the world live with some form of disability, of whom nearly 200 million experience considerable difficulties in functioning. In the years ahead, disability will be an even greater concern because its prevalence is on the rise. This is due to ageing populations and the higher risk of disability in older people as well as the global increase in chronic health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders.
VIOLENCE
Against Children in Kenya
Findings from a 2010 National Survey
Highlights

- Three out of every ten females and nearly two out of every ten males aged 18 to 24 reported at least one experience of sexual violence prior to age 18.
- Seven percent of females aged 18 to 24 reported experiencing physically forced sexual intercourse prior to age 18.
- Of females whose first sex occurred before age 18, 24% reported that it was unwilling, meaning that they did not want it to happen and were forced, pressured, tricked or threatened to engage in sexual intercourse.
- In the 12 months prior to the survey, about 11% of females and 4% of males aged 13 to 17 experienced some type of sexual violence.
- Among 18 to 24 year olds, almost two-thirds of females and three-quarters of males reported experiencing physical violence prior to age of 18.
- During the year preceding the survey, approximately half of all females and males aged 13 to 17 experienced some type of physical violence.
- About one-quarter of females and one-third of males aged 18 to 24 years reported experiences of emotional violence prior to age 18.
A survey in 17 counties by NACADA showed a high use of drugs and alcohol by school going teenagers with alcohol the most abused and prescription drugs the most accessible. PHOTO | FILE
Drug Abuse Among The Youth In Kenya

Richard Kipkemboi Chesang

Abstract: Drug abuse is one of the top problems confronting the nation today especially among the youth. Incidences of drug and alcohol abuse and related anti-social behaviour have tremendously increased in recent years. This has become a matter of concern to the government, parents, teachers, Non-governmental organisations and all other relevant agencies. The Kenya government has recognised the seriousness of the drug problem and initiated the National Campaign against Drug Abuse (NACADA) in early 2001. This organisation is charged with the responsibility of coordinating activities of individuals and organisations in the campaign against drug abuse. Its mandate is to initiate public education campaign and develop an action plan aimed at curbing drug abuse by the youth. The study found that drug use and abuse among youth is increasing despite the control mechanisms that have been put in place. The paper recommended that as a first step to prevent and control drug abuse, parents should be sensitised on the dangers of drug abuse, the attendant problems and their functions as role models; schools should have a drug prevention curriculum from Kindergarten onwards teaching that drug use is wrong and harmful and that there is need for initiation of rehabilitation programmes for drug dependent persons.

Key Terms: Addiction, Drug abuse, Effects, youth

1. Introduction
Drug abuse is one of the top problems confronting the youth in Kenya. In a recent survey conducted by the National Drug Abuse Treatment and Rehabilitation Service (NADATR) it was reported that about 30% of the youth in the age bracket 15-17 years have tried drug at least once. Half of these have become regular users. Up to 30 to 40% in class seven, eight and form one have taken drugs at one time. The problem has become of great concern to the government, parents and teachers.
Quality of Services – Professional competence
JANUARY 2009

BASED ON FURTHER ANALYSIS OF THE
2004 KENYA SERVICE PROVISION ASSESSMENT SURVEY

Annah Wamae
George Kichamu
Francis Kundu
Irene Muhunzu

No. 2
Figure 1.6 Complete physical examination by qualification of health provider

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Doctor</td>
<td>10.0</td>
</tr>
<tr>
<td>Clinical officer</td>
<td>4.6</td>
</tr>
<tr>
<td>Reg. Nurse</td>
<td>0.0</td>
</tr>
<tr>
<td>Reg. Midwife</td>
<td>1.8</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>12.1</td>
</tr>
<tr>
<td>Enrolled Midwife</td>
<td>2.6</td>
</tr>
<tr>
<td>Male</td>
<td>5.0</td>
</tr>
<tr>
<td>Female</td>
<td>4.1</td>
</tr>
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</table>
Figure 1.5 Complete Physical Examination by Facility Type

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centre</td>
<td>543</td>
<td>3.7</td>
</tr>
<tr>
<td>Dispensary</td>
<td>697</td>
<td>4.4</td>
</tr>
<tr>
<td>Clinic</td>
<td>14</td>
<td>7.1</td>
</tr>
<tr>
<td>Hospital</td>
<td>101</td>
<td>9.9</td>
</tr>
<tr>
<td>Maternity</td>
<td>27</td>
<td>14.8</td>
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</table>
Figure 1.7 Proportion of sick children counselled on oral drugs and if 1st dose of oral drug given by facility type

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Counselling on Oral Drugs</th>
<th>1st Dose of Oral Drug Given</th>
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</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>14.8</td>
<td>27.3</td>
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<tr>
<td>Dispensary</td>
<td>10.5</td>
<td>17.7</td>
</tr>
<tr>
<td>Clinic</td>
<td>10.5</td>
<td>21.4</td>
</tr>
<tr>
<td>Health Centre</td>
<td>10.3</td>
<td>10.5</td>
</tr>
<tr>
<td>National Referral Hosp</td>
<td>5.0</td>
<td>9.8</td>
</tr>
</tbody>
</table>
**Strategies: what will save newborns?**

The Lives Saved Tool (LiST) analyses the potential impact of delivering and scaling up various evidence-based interventions on maternal and child mortality.

![Bar chart showing total neonatal lives saved by interventions in 2020, 2025, and 2030](chart.png)

- **Infant/young child nutrition**
- **IMCI**
- **Postnatal care**
- **Childbirth/Newborn Care**
- **Maternal nutrition in pregnancy**
- **Antenatal Care Package**
- **Periconceptual care**

**Total neonatal lives saved by interventions in 2020, 2025, and 2030**
Strategies: what will save children?

The Lives Saved Tool (LiST) analyses the potential impact of delivering and scaling up various evidence-based interventions on maternal and child mortality.

![Bar chart showing total under-five lives saved by interventions in 2020, 2025, and 2030.]

- WASH
- Expanded immunization
- Infant/young child nutrition
- IMCI

Total under-five lives saved by interventions in 2020, 2025, and 2030.
Strategies: Community-level interventions reach poor children

The Lives Saved Tool (LiST) analyses the potential impact of delivering and scaling up various evidence-based interventions on maternal and child mortality.

Interventions at community level, including diarrhea and antibiotic treatment and interventions at and after childbirth (thermal care, chlorhexidine, breastfeeding promotion, and micronutrient supplementation), can reach and save the poorest children.
What must be done?

• Focus on childbirth, newborn, and postnatal interventions to improve maternal and newborn survival
• Improve equity: focus on poorest and underserved regions
• Strengthen the health system to improve access to services at and around birth, but also expand interventions at the community level
• Meet the sexual and reproductive needs of adolescents by expanding youth-friendly services
• Address the nutrition crisis, particularly during pregnancy and especially in the Northeast and East
• Continue increasing investment in reproductive, maternal, newborn, child and adolescent health, and reduce out-of-pocket costs
What is mandate and role of The Kenya Paediatric Association come in?
KPA CONSTITUTION PROVISIONS

KPA was created in 1968 to provide members with professional support and share clinical information that would enable them to handle new and emerging children’s diseases.

VISION: To make Kenya a Country where Children achieve Physical, Mental and Social Well being in the Absence of Disease or Infirmity.
KPA STRATEGIC PLAN 2013 - 2017

MISSION

To Promote Better Child Health in Kenya, Enhance Knowledge on Child Health and Improve the Management, Prevention as well as Eradication of Paediatric and other related diseases through Collaboration, Research, Advocacy, Education, Training, Sharing of Experiences and Implementation of Best Strategies

Core part of the association’s commitment to its members is to support and enhance their professional growth to enable them deliver excellent services that will give children quality, healthy lives.

..................CPD & QUALITY CARE AS OUTCOME.............
Highlights of KPA Constitution and Strategy

PROFESSIONAL DEVELOPMENT
- Advance careers of members
- Promote quality sub-specialty trainings

HIGH STANDARDS OF PAEDIATRICS PRACTICE
- Support and advocate for quality Basic training of UGME and PGME in Paediatrics [Role for Kenya Board of Paediatrics]
- Oversight on quality of paediatric services – curative and rehabilitative via EB policies and guidelines
- Advocacy & Lobbying for application of effective preventive and curative interventions
- Public health awareness and National and Sub-national levels
2013 -2017 KPA Strategies

**Strategy 1:** Carry out organizational assessments and develop operational plans for action

**Strategy 2:** Mobilise, recruit, engage and motivate members and affiliated paediatric healthcare professionals

**Strategy 3:** Proactive engagement with government and stakeholders to influence and develop child health policies

**Strategy 4:** Enhance the research capacity of KPA members

**Strategy 5:** Develop a partnership and collaboration policy framework

**Strategy 6:** Establish a professional Kenyan College of Paediatrics
# Specialties in Paediatrics

<table>
<thead>
<tr>
<th>DISCIPLINE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatology</td>
<td>13</td>
</tr>
<tr>
<td>Cardiology</td>
<td>9</td>
</tr>
<tr>
<td>Gastro-enterology</td>
<td>8</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>8</td>
</tr>
<tr>
<td>Neurology</td>
<td>6</td>
</tr>
<tr>
<td>Critical Care</td>
<td>5</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>81</strong></td>
</tr>
</tbody>
</table>

Total membership = 516
Public sector 257
Private sector 259
Remaining Agenda
What is needed to fill the gaps?

**Professional development**
- Child Health - Disabilities, Child abuse & Violence
- Psychiatric, Substance abuse & Behavioral disorders
- Malnutrition – stunting, PCM & Obesity
- Adolescents Health

**Policies and advocacy**
- Representation in MOH and County Policy forums
- Lobby for budgetary allocation & Transparency
- Lobby for scale up of proven interventions for mother & Child
- Public education and empowerment on rights of children

**Quality of trainings and services**
- Kenya Board of Paediatrics – Accreditations
- Expert Consensus statements on important health issues
- Audit quality and uptake of child health interventions at facility and community levels and DEMAND IMPROVEMENT
Recommended next actions

• KPA establishes Panels of sub-specialty Expert Committees
• Fast track Kenya Board of Paediatrics for training standards oversight
• KPA to set up national Children Rights Advocacy Task Force
• Wage national campaign on zero tolerance of preventable deaths of newborns, children and adolescents
• Educate and empower citizens to demand for access to basic effective interventions via constitutional provisions
• Active recruitment of members to commit annual time contribution to support priority actions at national and county levels – Start a “children are our future” movement under Big 4 cover

THANK YOU