

# **INAUGURAL LECTURE**

**Children in Especially Difficult  
Circumstances: The challenge of  
providing and protecting their rights**



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**Children in Especially Difficult  
Circumstances: The challenge of  
providing and protecting their rights**

**Samuel Olwambula Ayaya**

**MOI UNIVERSITY  
PRESS** 

## **Dedication**

I dedicate this work to my parents Benson Olwambula Wayaya and Mary Andeso Olwambula. To my father because he brought me up appropriately and taught me the value of education, dignity and integrity. He inculcated in me life principles that guide me to date. He advised me to do MMed at a time when I felt content to remain a medical officer. My mother for looking after me when I was suffering from marasmus during my infancy and refusing to succumb to the advice of a nurse to 'throw away this thing that is not gaining weight'. She is also the one who suggested that I would be a doctor due to my poor hand writing thus sowing the seed of medicine in me. Without my parents this lecture would never have happened.



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## List of Abbreviations

AAC	Area Advisory Committee
AAP	American Academy of Pediatrics
ADE	AIDS Defining Event
AIDS	Acquired Immuno deficiency Syndrome
AMPATH	Academic Model Providing Access to Treatment and Healthcare
ANC	African National Congress
ANC	Antenatal Care
ANPCAN	African Network for the Prevention of Child Abuse and Neglect
APHIA	Aids Populations Health Integrated Assistance
ART	Anti-Retro Viral Therapy
ARV	Anti-Retroviral drug
AST	AIDS Survival Time
ATI	AMPATH Training Institute
AU	African Union
BMI	Body Mass Index
CCI	Charitable Children’s Institution
CDC	Centers for Disease Control
COE	Center of Excellence
CT	Cash Transfer
CT-HH	Cash Transfer House Hold

DCO	District Children's Officer
DOT	Directly Observed Therapy
DSHCN	Disabled Special Health Care Needs
EAMJ	East African Medical Journal
ELISA	Enzyme Linked Immunosorbent Assay
FGM	Female Genital Mutilation
GAP	Global Plan of Action
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
HAART	Highly Active Anti-Retroviral Therapy
HLA	Human Leucocyte Antigens
IAS	International AIDS Society
IDP	Internally Displaced Person
IDU	Injecting Drug User
IeDEA	International epidemiological Databases to Evaluate AIDS
IGAD	Intergovernmental Authority on development
ILO	International Labour Organization
KAIS	Kenya AIDS Indicator Survey
KVACS	Kenya Violence against Children Study
KEMRI	Kenya Medical Research Institute
mDOT	modified Directly Observed Treatment
MTRH	Moi Teaching and Referral Hospital

MUSOM	Moi University School of Medicine
NACC	National AIDS Control Council
NCANDS	National Child Abuse and Neglect Data System
NGO	Non Governmental Organization
NASCOP	National AIDS and STI Control Program
OAU	Organization of African Unity
OI	Opportunistic Infection
OSCAR	Orphans and Separated Children's Assessment Related to Their Health and Wellbeing
OVC	Orphans and Vulnerable Children
PEV	Post Election Violence
PLWHA	People Living With HIV AIDS
PMTCT	Prevention of Mother to Child Transmission
PRWG	Pediatric Research Working Group
PTSD	Post Trauma Stress Disorder
QSS	Quality Service Standards
SC	Street Children
SICY	Street Involved Children and Youth
SOP	Standard Operating Procedure
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS

UNDP	United Nations Development Program
UNESCO	United Nations Education, Scientific and Cultural Organization
UNGASS	United Nations General Assembly
UNHCR	United Nations High Commission on Refugees
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WFP	World Food Program

## **Definitions**

**Abandonment** Leaving a child alone without someone to look after him/her

**AIDS survival time (AST):** from diagnosis of ADE to death.

**Children in especially difficult circumstances:** those who require substantial protection beyond what can be provided by the family

**Child abuse:** the denying of a child his/her basic needs like food, clothing, education and emotional support

**Catastrophes (Disasters):** relatively unpredictable disruptions appearing unexpectedly to ravage a defined area for a limited period of time.

**Child labor:** is considered exploitative when the burden becomes too great while neglecting its educational and socialization roles

**Disclosure :** the process of revealing the HIV positive status to the child/adolescent.

**Emotional abuse:** the verbal or mental or psychological maltreatment of a child

**Incubation period of HIV infection:** from infection to development of AIDS defining event

**Latency period:** from the time of diagnosing HIV infection to development of ADE

**Natural progression of HIV infection:** the progression of the disease from infection to death without any intervention.

- Neglect: the failure of a parent, guardian or any other caretaker to provide for a child's basic needs
- Nutritional abuse: malnutrition that is due to deprivation
- Orphan: child who has lost one or both parents
- Physical abuse: the non-accidental injury that is inflicted by a parent or other person who has responsibility over the child.
- Separated child: one whose parents are alive but he/she has no access to them.
- Sexual abuse: any sexual act perpetrated against a child's will.
- Street children: boys and girls aged below 18 years for whom the street has become home and/or the source of livelihood and are inadequately protected and/or supervised
- Transitioning HIV care: a multifaceted, active process that attends to the medical, psychosocial, and educational or vocational needs of adolescents as they move from the child-focused to the adult focused healthcare system.
- Violence: the intentional use of physical force or power, threatened or actual against self, another person or group of persons or community that either results in or has a high potential of resulting in injury, death, psychological harm, mal-development or harm.

Vulnerable children: those who live in a household in which one person or more is infected with HIV; dying or deceased; children who live in households that take in orphans; and children who live with persons who are too old or young to take care of them.

## **Acknowledgement**

I give thanks to God Almighty for taking care of me and helping me to be where I am. My father Benson Olwambula Wayaya for his good guiding principles by which I still live and for nurturing me; my mother Mary Andeso Olwambula who nurtured me; my family Emily Mbaye, Joyce Bwire, Dr. Joy Ayaya-Owino, Ben P. Olwambula, Sylvester Amurono, Zephania Ashira, Ben Farmer Olwambula and Samuel Shichenyi; nephews George, Oyuka, Malvin; my siblings Ayaya, Agnetta, Bakhoya, Rose, Etenyi, Grace, Tom, Joseph and Cleophus for supporting and encouraging me to reach greater heights.

My role model Prof. Nimrod Odundo Bwibo for inspiring me to do Pediatrics and inducting me into the world of child abuse and neglect; Prof. Joe Mamlin, Prof. Einterz and Sarah Ellen who made it possible for me to go for my fellowship in Dermatology in USA and took care of me while there; Prof. Evan Farmer my mentor in dermatology who also set me on the road to research; Holly B. Faust-Hahn, Pat Treadwell, Steve Wolverton, Jeanat Mirowski, and Travers who taught me dermatology.

Prof. Richard Mibey, Vice Chancellor, Prof. B.E.L. Wishitemi, Deputy Vice Chancellor, A,R&E, the Research Secretariat and the organizing committee for organizing the Inaugural Lecture; Principal, College of Health Sciences; Dean, School of Medicine, HoDs, CHAP, present and past Directors of MTRH for enabling me to research, teach and offer extension services to the children's homes; Rose Chemokos and Margaret Ondwasi for the secretarial work during my research and as HoD; Grace Chepkinyor and Esther Chepketer for passing my manuscripts between me and my colleagues; all my colleagues in the department of Pediatrics and SOM for the cooperation and working together amicably;



My very able editorial team of Prof. Ayuo, Dr. Chege, Dr Nyongesa, Dr Simba, Dr Makokha, Dr Msuo, Dr Ahoya, Dr. Ayaya-Owino, Kamanda, Songole, Oyondi, E. Ayaya, B. Olwambula, S. Ayaya, and Z. Ayaya for reading the manuscript and listening to my rehearsals and giving constructive critique that shaped this lecture. Lastly but not least, all the children in the world who live in especially difficult circumstances for whom this lecture was delivered.

## **Abstract**

Children living under especially difficult circumstances is a UNICEF concept that refers to children whose families cannot provide them with adequate care, safety and protection. The concept includes children who are: living in situations of war and conflict; living on the streets; orphaned, vulnerable and separated; abandoned; institutionalized; discriminated against; HIV infected and affected; physically, sexually, nutritionally, emotionally abused; exploited and neglected.

There are about 1.2 billion children in especially difficult circumstances; 100 million street children globally, 250,000 street children in Kenya with 2,000 in Eldoret and 60,000 in Nairobi; there are 16 million HIV/AIDS orphans in the world and 14.8 million of these are in Africa and 1 million in Kenya; there are 215 million child labourers globally with 150 million in the developing world. There are no estimates of the number of abused children in the world because of lack of consensus on the definitions. In 2007 there were 1,133 people killed and 650,000 displaced in post election violence in Kenya.

The world responded to the situation by signing convention 182 on children's rights, 138 on child labor and Children's Act 2001 of Kenya to protect child rights. The response to HIV/AIDS resulted in the establishment of the UNAIDS, NASCOP, NACC and AMPATH with a lot of success.

In conclusion, the prevalence of children in especially difficult circumstances is high with the bulk of them in sub-Saharan Africa. There is no consensus on the definition of child abuse and research on the subject is inadequate. Children are still not getting their rights.

It is recommended that consensus be reached on the definition of child abuse and more research be conducted. The laws on child rights should be enforced and the subject taught in mid-level and tertiary academic institutions. Children should be taught about their rights and how to avoid getting abused.

*“We should remember that the process of losing parents to HIV/  
AIDS for children often includes the pain and shame of the stigma  
and fear that the disease carries in most of our societies”*

*Bjorn Ljunqvist UNICEF representative*

## **Citation**

Prof. Samuel Ayaya Olwambula was born on May 6, 1957 to the late Benson Arthur Olwambula Wayaya and Mama Mary Andeso Olwambula, in Kaloleni, Nairobi. During his infancy he suffered from marasmus and his mother was advised by the clinic nurse to 'discard this thing that was not gaining weight in the Municipal Council dust bins but she refused and nurtured him to health. His father was a tailor at the Suitable stores on Moi avenue Nairobi while the mother was a housewife.

Prof. Ayaya attended Makongeni and St. John's Primary Schools in Eastlands Nairobi. He sat CPE at St. John's Primary school in 1971. When he was in class 4 his mother commented that he had such a bad handwriting like a doctor's. He joined Aquinas High School on January 10, 1972 where he was a member of the debating and current affairs clubs. They formed a formidable study group that comprised of late Meshack Odhiambo 'Olumbe', George Burns Amgahia 'original GBA', Francis Kariuki Njuguna 'Mitaro Slingo', Joseph Mwangi 'Flashy', Vincent Oketch 'Barothims' and Samuel Ayaya 'Msegeji'. Other notable students in that class were Faustine Wandera and Wilson Ogore. They all got Division I and produced the top 5 students in the 1975 EACE examinations in that school. They all ended up well: Meshack Odhiambo PhD Agriculture, George Burns Architect in private practice, Kariuki Architect, Ministry of Works; Mwangi, Bank Manager; Oketch; Insurance Company Executive and Ayaya Professor of Child Health, Pediatrics and Dermatology.

In 1976 he joined St. Patrick's High School Iten together with GBA, Odhiambo and Wando. He was classmate of Dr. Joseph Kiplagat the former Kenyan Ambassador to Southern Sudan. He forged a close friendship with Dr. Rono (MTRH) which has lasted to date. In 1977 he sat EAACE and attained 3 principals

in Mathematics, Biology and Chemistry and a subsidiary pass in the General Paper. At Iten, he was elected the Elgeyo Marakwet District Chair of YCS, Secretary, Wildlife club and member of the debating and dancing clubs.

On September 23, 1978, Ayaya joined the UoN School of Medicine. In his speech to them Prof. Maina Mungai quipped 'from now on you will hate anyone who calls you doctor because you will not be sure of becoming one'. This made him extra vigilant in his studies lest he failed to become one. While there he was very impressed by Prof. Bwibo's fatherly way of teaching and handling patients and decided to emulate him by becoming a Pediatrician. He also forged an enduring friendship with Dr. Museve who is now an orthopedic surgeon. He shared a room with Dr. Kidero the Governor of Nairobi.

He qualified with an MBChB in 1984 and was posted to the Rift Valley Provincial General Hospital, Nakuru for his internship. His desire to pursue pediatrics was reinforced by Dr. Aluvala the Provincial Pediatrician then. After internship he was posted to Narok District Hospital as a Medical Officer in 1986. In 1987, he was posted to Kitale District Hospital. While there he became comfortable doing locums for the private doctors and had no intention of doing a masters. He was advised by the late Dr. Yona Otsyula and Dr. Murgor to go for his MMed. The decision to do MMed was made by his father who one day asked him where Dr. Kibosia and Dr. Museve were and when he was told that they had gone for MMed, he asked Ayaya 'what about you?' The answer was 'daddy I am tired of reading'. The old man told him to 'go and read till you have no more exams to pass'. In 1988, he joined the department of Pediatrics and Child Health, University of Nairobi. He qualified in 1991 with MMed in Pediatrics and Child Health.

Professor Ayaya was posted to Nyamira District hospital as the Medical Superintendent and District Pediatrician. In 1993, he joined Moi University as a Senior Medical Officer in the department of Health Services. In 1994, Professor joined the department of Child Health and Pediatrics, Moi University 1994 as a lecturer and was appointed the first chairman, Moi University Medical Board in the same year. In 1996, he was appointed head of department, CHAP until 1997 to replace Prof. Anabwani. In 1997 he established the Faculty of Health Sciences Income Generating Activity that enabled lecturers in the faculty to offer clinical consultancy services to members of staff in the university. In 1997 August Professor Ayaya got an ECFMG (Educational Commission for Foreign Medical Graduates) to go for a fellowship in dermatology at the Indiana University Medical Centre through the guidance of Prof. Mamlin and Prof. Einterz. During his fellowship, his mentor Prof. Farmer encouraged him to start researching and publishing. He made his first conference presentation in Indiana. He completed his fellowship in 1998 and came back to teach and set-up dermatology clinic at the MTRH. Professor Ayaya has held various positions in the university, college, school, MTRH, professional and social organizations.

Prof. Ayaya was awarded the Distinguished Service Award in 2010 by the Kenya Medical Association, and in 2014 he was awarded an Award of Merit by St. Patrick's High School Alumni Association for distinguished public service record, service to humanity and being a good ambassador of the virtues for which St. Patrick's High School was founded"

### **Department of CHAP**

2012-2014	Professor of Child Health, Pediatrics and Dermatology
2007-2012	Associate professor
2003-2007	Senior lecturer department of CHAP
2003- Date	Chairman mid-level disciplinary committee
2000-2003, 2010-2014	Chairman departmental Postgraduate Committee
2000 to date	Chairman Division of Pediatrics MTRH
1998-2014	Consultant dermatologist MTRH
1996-1997, 2003-2008	HoD department of CHAP
1994	Lecturer department of CHAP

### **School of Medicine**

2013 Nov	Acting Dean SOM
2004-2014	Member SOMGSC
2013	Chaired SOMGSC ad hoc committee on Amendments on marking scheme for Thesis marking
2009	wrote guidelines on thesis writing for SOMGSC
2011- 2013	Chairman, SOM Research Committee
2009-2011	Member, SOM Research Committee
2009-2014	Member Kenya Journal of Health Sciences, Editorial Board



2008-2014	Chairman Quality Assurance Committees and ISO champion SoM
2007-2014	Convener MUS-OU collaboration
2001	Initiated the PSSP
2001-2005	Chairman PSSP committee and Coordinator PSSP in the SOM
1999 - 2014	Coordinator clinic-pathological Conferences SOM
1998-2014	Reviewer for IREC
1996- 1997	Chairman Income Generating Activity Committee of Faculty of Health Sciences

**Moi University**

2013	Chairman sub-committee on SOP
2013-214	SoM representative in GSAREC
2012	Chairman 17 <sup>th</sup> MU Inaugural Lecture Organizing Committee
2012-2014	Member MU Professors and Academic Affairs Committee
2009-	Member MU Consultancy Committee
2008-2014	MU Quality Assurance Committee
2005-2007	MU senate committee on student Welfare
2003-2008/2012-2014	Member MU senate
2001-2005	Member MU interfaculty PPSP Committee
1993-1994	Senior Medical Officer MU Health Services

**National**

- 2014 Chairman Kenya Pediatric Association Western Division
- 2008-2010/2002-2004 Chairman Kenya Medical Association (KMA), Eldoret Division
- 2005-2007 External examiner Department of Pediatrics, UoN
- 2003-2014 Facilitator, AMPATH training institute
- 2003-2004 KMA representative on the MPDB reciprocal accreditation committee
- 2002-2003 Chairman, Uasin Gishu PMTCT steering Committee
- 2000-2002 Vice-Chairman, KMA Eldoret, Division
- 1996-1998 Secretary, KMA Eldoret, Division

**International**

- 2009-2014 Co-Investigator Orphans and Separated Children Assessments Related to their Health and well being
- 2009-2014 Chairman International epidemiological Databases for Evaluation of AIDS (IeDEA) East Africa Pediatric Research Working Group
- 2007-2013 Co-investigator CDC project
- 2006-2014 Chairman, Indiana University (IU)-Moi University (MU) PRWG
- 2007-2014 IeDEA AMPATH site PI

- 2004-2011 Secretary, Merck Vaccine Network-Africa (MVNA)
- 2002-2014 Consultant Pediatrician and Dermatologist, researcher and trainer AMPATH

### **Conferences**

Papers presented 43

Attended 17

NB: First non-north American to present at the American Academy of Dermatology Conference in Orlando, Florida 1998

### **Research**

Publications in peer reviewed high impact journals 50

Ongoing studies 4

Areas of research interest

Disclosure of HIV positive status to children/adolescents

Adherence to Highly Active Anti-retroviral Therapy (HAART)

Transitioning of HIV infected adolescents from pediatric focused to adult focused care

Children living in specially difficult circumstances

Supervision of Masters Students

MMED CHAP

MMED Family Medicine

MPH

Social responsibility

Chairman 1818 investment committee

Vice chairman NORKWADA


Secretary MUNWA

Chairman ERWA

Former treasurer Children's Community Society

Member Panel of Visitors, Eldoret Juvenile Remand Home

Chairman AFC Leopards Fans Association, Eldoret Branch

  
**PROF. RICHARD K. MIBEY, FWIF, EBS**  
**VICE CHANCELLOR**  
**MOI UNIVERSITY**

May 29, 2014

## **Chapter One**

### **Introduction**

#### **Background**

Children in especially difficult circumstances are a UNICEF concept that refers to children who need substantial protection beyond what the family can provide. <sup>(1)</sup> They include children in situations of war and conflict; orphans; street, working, HIV infected and affected, separated, abandoned, refugee, and abused institutionalized, and discriminated children.

Catastrophes that have led children in especially difficult circumstances are disasters triggered by natural phenomena and man-made disasters. The former include drought, floods, earthquakes, volcanic eruptions and ecological disasters. Kenya experiences drought and floods perennially. Man-made disasters are usually associated with armed conflicts, civil strife and internecine wars. UNICEF was established in 1946 to mitigate the aftermath of the Second World War on children. <sup>(2)</sup> There have been coups, liberation, civil, tribal and ethnic wars in many parts of Africa which have killed and orphaned children. The first documented armed conflict in Kenya was the Mau Mau war of liberation between 1952 and 1960. <sup>(3)</sup> Since the re-introduction of the multi-party politics in Kenya in 1992, Kenya has experienced politically instigated armed violence before, during and after every general election except 2002 and 2013. <sup>(4)</sup> Poverty and HIV/AIDS are the other major causes of children living in these circumstances in Africa. In the west children find themselves in these situations because of abuse at home and family problems.

The first case of child abuse in Kenya was published by Bwibo in 1971 in the East African Medical Journal (EAMJ) as a case of the battered baby syndrome. In 1998, Bwibo organized a workshop on child abuse and neglect in collaboration with the African Network for the Protection against Child Abuse and Neglect (ANPCAN) at the Hotel Sirikwa, Eldoret to which I was invited to rapporteur and write the proceedings. This made me aware, sensitized and interested in the subject.

Having realized that there was a problem that was not being addressed adequately; I decided to research and teach about it. This inaugural lecture details research and publications on children in especially difficult circumstances including my contribution to the subject. My contribution includes several papers on the subject, participation in various projects such as being a founder treasurer of Eldoret children's community trust that runs the Rescue Center, member of the panel of visitors that was gazetted to oversee the Eldoret Juvenile remand home and being in charge of the health care of the children at the Rescue Center. As a lecturer in the department of child health and Pediatrics at Moi University I started teaching a course on children in extremely difficult circumstances to the undergraduates in 1999 and the postgraduate students in 2005. This was aimed at sensitizing and equipping students with the knowledge and skills to handle these children. As head of department I got the postgraduate students to be offering free consultation to the children at the rescue center and the Neema children's home as part of our social responsibility and my contribution to the children. In 2009 I became co-investigator in the Orphans and Separated Children's Assessment Related to their health and well-being (OSCAR) project. This is an ongoing project that is assessing the effect of various care environments on the health and wellbeing of orphans and separated children in Uasin Gishu

County. In 2001, I was involved in the establishment of the Academic Model Providing Access to Healthcare (AMPATH). This was in response to the HIV/AIDS pandemic that was and still is ravaging the western parts of Kenya. The project offers free comprehensive care to HIV infected and affected children and their families, trains adult patients on farming and entrepreneurship so that they can be self-sufficient. For children whose parents are unable to feed them free food is provided. At AMPATH in 2006, we established the Pediatric Research Working Group (PRWG) which I have chaired since then. The group has published about 100 papers on pediatric HIV in peer reviewed journals. In 2007 the international epidemiological databases for evaluating AIDS (IeDEA) was established and I became the AMPATH site principal investigator (PI). I was elected chairman of the East African PRWG in 2010. I am a member of the IeDEA East Africa executive committee and the international IeDEA PRWG. My research on the subject includes 10 papers on child abuse and neglect and 40 papers on HIV/AIDS. The latter has been mainly on adherence to pediatric HAART (Highly Active Antiretroviral Therapy), disclosure of the HIV positive status to children and transitioning of adolescents from pediatric to adult HIV care. I have published 5 international papers with data from all the IeDEA regions of the world. Currently I am principal investigator on international IeDEA papers on disclosure of HIV positive status to children and the transitioning of adolescents from pediatric to adult HIV care. Data will be from the IeDEA regions of the world.

This lecture presents my findings and experiences accruing from my research and summarizes literature on the subject; discusses the magnitude of the problem, challenges faced by the children, response to the situation, the successes and gaps in the response; and makes recommendations on the way forward. It

was informed by the fact that there is inadequate awareness of the problem and children are still living in these circumstances in spite of the responses. It is therefore aimed at bringing the plight of these children to the fore so that more can be done for them.

## **Evolution of the Problem of Children in Especially Difficult Circumstances**

Children have been known to suffer a lot when there is civil strife or war. In 1918, the First World War had 10% of the dead being children and women. In 1945, the Second World War claimed 40 million people with 50% being children and women. Though there has been no World War since 1945, there have been wars of liberation from colonialists, civil wars, cross-border wars most of them occurring in low income countries (LIC) particularly Africa.<sup>1</sup>

In Kenya, the first documented war was the Mau Mau war of liberation in 1952. This led to the first children appearing on the streets of Nairobi. The first documentation of street children in Kenya was made in 1969 by Norowjee. In 1971, Bwibo reported the first case of child abuse in the East African Medical. In 1985, children were first seen on the Eldoret streets. In 1998, Bwibo organized a workshop at Hotel Sirikwa in Eldoret to which he invited us. Following this, I introduced a course on child abuse and neglect to the undergraduate students in the department of Child Health and Pediatrics in 1999. In 2001, I published my first paper on street children from our department and school. Since 1992, there has been a cycle of PEV with the exception of 2002 and 2013. The 2007 PEV was the worst. In between there have been terrorist attacks like the 1998 attack on US embassy in Nairobi, 2013 Westgate Mall attack and many grenade attacks. There have lately been increased attacks on churches and public



service vehicles. All these have caused the deaths of many children and or their parents. Those who survived remained in especially difficult circumstances.

The HIV/AIDS pandemic has also caused very many children to either die or be left in especially difficult circumstances. It is the cause of 50% of orphans in Kenya, an unknown proportion of street children, child prostitutes and child laborers. HIV infected and affected children are stigmatized, ostracized, discriminated and predisposed to all manner of abuse.



## **Chapter Two**

### **Natural and Man-Made Disasters**

#### **Background**

Disasters (catastrophes) are relatively unpredictable disruptions appearing unexpectedly to ravage a defined area for a limited period of time. They are classified as natural (due to acts of God) and Man-made (due to acts of Man). Natural disasters are disasters triggered by natural phenomena. They are the effects of what Man's action can exacerbate but not cause. They include earthquakes, tropical storms and ecological disasters. Ecological disasters result from Man's actions in modifying the environment and constitute an important cause of the disasters. Ecological disasters include drought and floods.<sup>(1)</sup> Man-made disasters are caused by acts of man such as armed conflicts and violence.

Armed conflicts are continuous situations having traumatic results. These include world, civil, liberation, guerilla wars; tribal/ethnic cleansing or clashes and terrorist attacks.

Violence is the intentional use of physical force or power, threatened or actual against self, another person or group of persons or community that either results in or has a high potential of resulting in injury, death, psychological harm, mal-development or harm.<sup>(2)</sup> There are three types of violence, namely: self-directed, interpersonal and collective violence. Children and women suffer most from all these disasters.

## **Man-made Disasters**

### **Violence**

In 2002, the WHO received the first world report of a study on violence and health which it had commissioned in 2000. The purpose of the study was to challenge the secrecy, taboos and feelings of inevitability that surround violent behavior and encourage debate that would increase our understanding of this complex phenomenon. The self-directed violence includes suicidal behavior and self-mutilation. The interpersonal violence is divided into family and intimate partner violence and occurs within the home and community. Community violence is violence occurs between unrelated persons and usually occurs outside the home. Collective violence is 'the instrumental use of violence by people who identify themselves as members of a group against another or set of people to achieve political, economic or social objectives.' Family violence includes child abuse, violence by an intimate partner and abuse of the elderly. Community violence includes youth violence, rape or sexual assault by strangers and violence in institutional settings such as schools, workplaces, prisons and nursing homes. Collective violence takes the form of armed conflicts within or between states, genocide, repression and organized violent crime and other human rights abuses.<sup>(2)</sup>

### **Prevalence of Violence**

It is necessary to measure violence for the purpose of making sound policy and comparing notes on various situations. The lack of a standard definition of various types of abuse has made it difficult to research and compare data across communities and nations. The most readily available data is the mortality data like death certificates, registries of vital statistics and coroners' reports. Most of these are lacking in the developing

countries hence other types of data are needed to fill in the gaps. These include: health data; self-reported data; community data; economic data; policy and legislative data. This data is sourced from individuals, agency or institutional records, local programs, community and government records and population-based surveys and special studies. <sup>(2)</sup>

In the year 2002, the following was reported in the first world report on violence and health: 1.6 million people killed by violence with 50% suicides, 33.3% homicides and 20% casualties of armed conflicts. The homicide cases were 75% male, while among 15-49 year olds males suffered 5 times more than females. The males committed suicide twice as much as females and those aged more than 60 years had higher rates. <sup>(2)</sup>.

The cases of violence related deaths were ten times more among the LIC than the high income countries(HIC).<sup>(2)</sup>. In Africa and the Americas, the homicide rates were three times more than suicide rates. In south East Asia and Europe, suicide rates were twice the homicide rates. In Singapore, people of Chinese and Indian origins had higher suicide rates than ethnic Malays. In 1999 in USA, African- American youths aged 15-49 years had twice suicide and 12 times the homicide rates of the Hispanics and Caucasians of their age respectively.<sup>(2)</sup>. Most of the victims were children. When the victims were not children, they were still left orphaned, separated and living in especially difficult circumstances.

### **Armed conflicts**

During first and second World Wars, 10% and 50% of the dead were civilians, mostly children and women. <sup>(1)</sup> In recent years civilians have constituted 80% of the casualties. War causes the disruption of the family leading to children having no family,

being separated from family, or having a family that cannot cater for their basic needs and protection. The last group is the majority. The family incapacity may be temporary, chronic or absolute. Other children find themselves in abusive and neglectful families. Thus in times of war children require substantial protection beyond their families' capacity to provide.

In 1986, UNICEF reported that there were about 150 armed conflicts in about 70 countries almost all in the LIC. <sup>(2)</sup> About 60 million people had been injured with most of them being handicapped for life and 20 million people had been killed. Approximately 50% of the dead were children and 30 million had been displaced leading to international refugees and internally displaced persons (IDPs). <sup>(1)</sup> in all these situations children and women were most affected.

The war tactics have changed nowadays and do not distinguish between combatants and civilians because they are not between defined armies. This has resulted in 80% of the casualties being civilians. Usually the fighting is within the same country with assistance from outside. The total world military expenditure in 1986 was US \$ 1 trillion. It could be much higher now. It was estimated that every minute, while US \$ 1.9 million was diverted to war expenditure, 30 children died of lack of food, vaccines and so on. Seventy five percent of the arms traded in the world ended in the LIC. Weapon expenditure was shown to dampen social investment. The LIC that spent most on weapons were poor performers on socio-economic tests and had the highest infant mortality rates. <sup>(1, 2)</sup>

In Kenya, the number of people killed in armed conflicts is unknown except the 2007 PEV that killed 1,133 and displaced 650,000. The first study on violence against children, Kenya violence against children study (KVACS) was commissioned

in 2010 by the Ministry of Gender, Children and Social Development. This was necessitated by the fact that although there was evidence of violence against children, there was no systematic record of the same. The specific objectives were to: estimate the national prevalence of sexual, physical and emotional violence against boys and girls before reaching the age of 18 years, identify risk and protective factors for the abuses, recognize the health consequences of forms of violence against children, assess knowledge and utilization of services available for child victims of these forms of violence as well as barriers to accessing such services and identify areas for further research and provide information that will guide strategies to prevent, identify and respond to violence against children especially sexual abuse. The findings are detailed in the chapter on child abuse and neglect. <sup>(2)</sup>

### **Disasters triggered by natural phenomena**

Natural phenomena have triggered 60% of the disasters in the world and account for 80-90% of the victims. The death rate per disaster was estimated at 3,000 per disaster in the LIC and 500 in the HIC. <sup>(2)</sup> Historically, Asia, Africa and Latin America have been most affected. This has been due to human vulnerability because of poverty and inequality, environmental degradation due to poor land use and rapid population growth especially among low income groups. The vulnerability due to poverty is exacerbated by government policies especially those that draw people to the metropolitan cities from rural areas where most disasters occur. Population growth leads to dense populations and increased habitation of hazardous areas like steep mountain slopes and flood plains. <sup>(2)</sup>

Ecological disasters include drought and floods. While drought is most widespread, floods are fastest growing. They account for 75% of all types of disasters and 90% of the victims of the disasters triggered by natural phenomena. (1). Almost all of them occur in the LIC. This is because of misuse and consequent degradation of land resources. The misused land loses water conserving capacity to maintain crops and animals through dry spells. The unabsorbed water runs off carrying acres of precious top soil leading to land degradation and eventually poverty. (1). Most of the deaths that result from ecological disasters are among children.

Kenya experiences annual floods in Kano Plains and Budalang'i while there is drought most of the time in northern Kenya.

### **The causes of disasters**

Violence has its roots in biological, societal, cultural, economic and political factors. An ecological model used to gather data on child abuse in the 1970's was used as a conceptual tool to collect data on violence. Its advantages are that it helps to distinguish between the many influences while at the same time providing a framework for understanding how they interact. The model also explains the risk factors for committing or being a victim of violence. (2).

The individual level identifies biological and personal factors that influence how individuals behave and increase the possibility of becoming a victim or perpetrator of violence. The factors include: demographic characteristics like, age, education and income; psychological or personal disorders; substance abuse and behaving abusively or experiencing abuse. The second level is the relationship as family, friends, intimate partners and peers. The third level is the communal which explores the community



in which violence occurs such as schools, workplaces and neighborhoods. The risk factors at this level include: residential mobility, population density, high levels of unemployment or the existence of a local drug trade.

The fourth level is the societal which examines the risk factors that create the climate in which violence is encouraged or inhibited. They include: availability of arms, social and cultural norms. The norms include: those that give parental rights over child welfare, consider suicide as a matter of individual choice instead of a preventable act of violence, entrench male dominance over females and children, those that support excessive use of violence by the police against the citizens like shoot to kill orders. Other societal factors are: educational, social policies that maintain socio-economic inequalities between groups and social isolation. Social isolation is used against elders and is influenced by factors such as less respect

There has been no systematic study on the causes of violence in Kenya. However, as discussed before Kenya has experienced armed conflicts. There have been many newspaper and electronic media reports of domestic violence even against men, rape including children, sexual molestation and exploitation. <sup>(2)</sup>

### **Challenges of children living in situations of natural and man-made disasters**

The immediate challenges include: death, injury and displacement of people. Disasters also intensify diseases that exist such as diarrheal diseases and malaria. Children are more susceptible than adults to physical stress, malnutrition, fatigue, disease and displacement. Children are particularly prone to under-nutrition, respiratory, gastrointestinal and other diseases. Disasters also result in water and sanitation problems. <sup>(1, 2)</sup>

Experiencing violence has long term effects like aggression, conduct disorder, substance abuse, poor academic performance, anxiety, depression, reduced self-esteem, suicidal behavior and coming into contact with the law, behavioral health risks such as smoking and obesity and specific health problems like diabetes and ischemic heart disease, negative consequence for cognitive development like language deficits and reduced cognitive functioning, social stigmata and discrimination against the child and the family.<sup>(2)</sup>

Armed conflicts have a worse impact on children than the disasters triggered by natural phenomena. This is because during armed conflicts children watch family members being killed, are ravaged with feelings of guilt there-after, suffer from continuous and unending sense of danger and they are likely to practice violence against others in future. The experience is also dehumanizing and brutalizing.<sup>(1)</sup>

## Chapter Three

### Child Abuse and Neglect

#### Introduction

A child is a person aged below 18 years <sup>(5)</sup>. Children have been documented as victims of abuse and neglect throughout human history. <sup>(10)</sup> Psycho-historians explain that adults see children as containers into which they project the disowned parts of their psyche. <sup>(11)</sup> The first child welfare movement began in the USA in the 19<sup>th</sup>. Century. <sup>(8)</sup> At this time it was noted that there were children who were homeless, starving and roaming the streets. <sup>(10)</sup> In the 1950's, radiologists were the first to systematically document cases of infants with head injuries that they believed had been caused by their parents. <sup>(10)</sup> In 1959, the UN declaration on the rights of the child stating that 'the child shall be protected from all forms of neglect, cruelty and exploitation' was made. The term 'battered baby syndrome was coined by Kempe in 1962. This led to the promulgation by US children Bureau of a model statute for doctors to report cases of abuse in the USA. <sup>(7)</sup> This made it mandatory for doctors to report cases of abuse. In 1975, Gil described child abuse as 'any act of commission or omission by individuals, institutions or society as a whole and any conditions resulting from such acts or inaction which deprive children of their equal rights and liberties and/or interference with their optimal development, constitute abusive or neglectful acts or conditions.'<sup>(7)</sup>.In May 1979, during the International Year of the Child neglect was declared to be of concern but Kenya was not among the signatories to the declaration. <sup>(10)</sup>.

In 1999, the WHO committee on child abuse prevention in the world report on violence and health defined child abuse as 'all forms of physical, and/or emotional ill-treatment, sexual abuse, neglect or negligent or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of relationship of responsibility, trust or power'.<sup>(2)</sup> Child abuse and neglect is 'denying a child his or her basic rights such as food, clothing, education, health and emotional support'.<sup>(4)</sup> The Children's Act 2001 recognizes the following forms of abuse: physical, sexual, psychological and mental injury.<sup>(5)</sup> The American federal law of 2003 defines child abuse and neglect at a minimum as 'any recent act or failure to act on the part of the parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation' OR 'an act or failure to act which presents imminent risk of serious harm'. It recognizes the following forms of abuse: physical, neglect, sexual and emotional.<sup>(6)</sup> The Kenyan constitution does not mention neglect. However, the rights of the child are safeguarded by the Kenyan constitution in the children's act as welfare and protection rights.

### **Factors that predispose children to abuse**

The following are the common characteristics of the children who are abused, the perpetrators of abuse, societal and community factors that lead to child abuse. They apply to all types of abuse and are based on the ecological model.

### **Characteristics of the abused children**

The characteristics of the children who are prone to abuse include children who are: unwanted, difficult to rear, born out of wedlock or of incest, orphans, HIV infected or affected, employed, handicapped, have chronic illnesses, inherently

irritable, hyperactive, and premature, child's age and sex. <sup>(4,18)</sup>. In the Eldoret study on child abuse we found that the children who presented with apathy and were diagnosed with severe infections were significantly more likely to be abused.<sup>(4)</sup> Children aged below 4 years are prone to infanticide probably because they succumb easily to the shaking and battering administered to their heads. The most affected being children aged below 2 years. The peak age for non-fatal physical abuse is 3-12 years. <sup>(19)</sup>.

Girls are more prone to infanticide, sexual, educational, nutritional abuse and forced prostitution. In the USA race was also a factor with most cases occurring among the white children and the least among the African-Americans. <sup>(20)</sup>. Girls are 3 times more likely to be abused than boys. Most parents prefer to take their sons to school as girls are left at home to look after their siblings and/or work as house-girls to help the family economically. <sup>(21)</sup>. There are 60 million children not in school globally and 60% of them are girls. Boys are prone to infanticide and harsh physical punishment. This could be a cultural way of preparing boys for adult responsibilities and/or boys are considered to deserve harsh punishment. <sup>(22)</sup>.

Special characteristics like low birth weight (LBW), prematurity, chronic illness, physical and mental handicaps in the infant or child have had conflicting results in the literature as factors that increase the child's vulnerability. They interfere with the attachment and bonding of the child to the parent and make the child more vulnerable to abuse. <sup>(22)</sup>. However, when other factors such as parental and societal variables are considered, they do not seem to increase the risk for abuse. In our study on child abuse in Eldoret we did not find them to be associated with abuse. <sup>(4)</sup>.

### **Characteristics of the perpetrators of child abuse**

These include: sex, age, being a mother or father, single parents, mental illness, alcohol/ drug abuse and step-parents as explained below. Parents who: are easily angered, were abused, have poor impulse, are drug and/or alcohol abusers and have psychiatric problems. In our study in Eldoret we found that alcoholic fathers were likely to neglect their children while the mothers and fathers of the children were more likely to cause nutritional abuse.<sup>(4)</sup>

The sex of the perpetrator as a factor depends on the type of abuse. Females use more physical discipline than males. However, men are the most common perpetrators of life-threatening abuse like head injury, fractures and other fatal injuries. Men also predominantly perpetrate sexual offences among male and female victims.<sup>(23)</sup> Men were found to be more predominant in committing violence in the KVACS study and in the Eldoret studies.<sup>(4,24)</sup>

Physically abusive parents are likely to be young, single, poor, unemployed, less educated than the non-abusive ones. In many countries including Kenya it was found that low education and lack of income to meet the family needs increased the likelihood of abusing children.<sup>(24)</sup> Even though low education and poverty have been shown to be risk factors for abuse, several cases of well educated and employed parents abusing children have been reported.<sup>(25)</sup> Some of these factors operate together and augment each other. For example, an uneducated father is unlikely to be employed leading to alcoholism as a way to escaping his predicament and therefore abusing his children.

There are several personality and behavioral factors that have been associated with the causes of child abuse. For the physically abusive parents, these include parents who: have low self-esteem, poor control of their emotions/impulses, psychiatric/mental

problems and display antisocial behavior. In addition to these characteristics, neglectful parents also suffer from difficulty in planning life events like marriage, having children and/or seeking employment. Many of these characteristics compromise and are associated with disrupted social relationships making it difficult to cope with stress and reaching social support systems. <sup>(22)</sup> Some abusive parents also have unrealistic expectations of their children's development and academic performance. The abusive parents are more irritated and annoyed by their children's behavior especially those with poor control of their emotions/impulses and psychiatric/mental problems. These parents are less affectionate, tolerant, playful and responsive to their children. <sup>(22)</sup>.

Parents who were abused as children are considered more likely to abuse their children than those who were not. This could be because they think that the way they were parented is normal hence they do it to their children. However there is doubt as to whether they were actually abused. Some investigators think that they were not abused as children but other factors such as young parental age, stress, isolation, overcrowding in the home, substance abuse and poverty could be the reasons why they abuse their children. <sup>(26)</sup>. There is need for further research to elucidate this.

There is a strong correlation between domestic violence and child abuse. In India, it was found that domestic violence in the homestead doubled the risk of child abuse. <sup>(22, 27)</sup>. Among the victims of child abuse, 40% reported domestic violence in their homes. <sup>(28)</sup>. In Africa, this has been reported in Egypt and South Africa but has not been studied in Kenya. Research should be conducted in Kenya and /or Eldoret to look at this phenomenon in light of the prevalence of domestic violence. Nowadays even men are being traumatized by their wives.

### **Socio-economic factors associated with child abuse**

These include poverty, stress, marital disharmony, HIV/AIDS and social isolation, large families, over-crowding in the house, frequent change in the composition of the family and the economic status of the country or region. Although poverty has been shown to be a risk factor for abuse, this is not a preserve of the poor. There are many cases of rich people abusing their children. These could be because of other problems like alcoholism, stress and marital disharmony. <sup>(4, 19)</sup>.

In Chile and other countries, it was found that families with 4 or more children were more likely to be violent towards their children. <sup>(23, 29, 30)</sup>. A large family size causes the parents to be unable to fend for their children leading to frustration, stress, alcohol/drug abuse and violence against the children. Environments where the family composition changes frequently with some members going out and coming in also increases the chances of child abuse.<sup>(31)</sup> Stress and parental social isolation have been associated with child abuse. Stress in form of job change and loss, loss of income, health problems, or other aspects of the family environment heighten the level of conflict in the home and ability of members to cope or find support. In Buenos Aires, children living in single parent families were at much higher risk of abuse than those living in 2 parent families. Risk was lower for those who were able to access social support.<sup>(32)</sup> The child abuse rates are much higher in communities with high levels of unemployment and poverty as is found in LIC.<sup>(33)</sup>

The highest rates globally being in the WHO Africa region and the lowest in the WHO European, Eastern Mediterranean and Western Pacific.<sup>(2)</sup> because of the social capital. Social capital represents the degree of cohesion and solidarity in the community. <sup>(34)</sup> In Africa social capital is low because of poor politics, ethnicity, corruption and selective poverty.



## Physical abuse

### Background

Physical abuse is 'the non-accidental injury that results from punching, pinching, shaking, throwing, choking, hitting, burning or otherwise harming a child that is inflicted by a parent or other person who has responsibility over the child.'<sup>(4,14,15)</sup>

### Prevalence

The overall prevalence of child abuse in the world and Kenya is unknown because of the lack of consensus on the definition of abuse and its various forms, lack of sensitization of health workers and the public and misdiagnosis of abuse.<sup>(4,15,17)</sup> There has been no systematic recording and documentation of the cases of abuse in Kenya because the law does not require the doctors and other healthcare providers to mandatorily report these cases unlike the USA law.<sup>(6)</sup>

The world report of 2002 on violence and health estimated 57,000 cases of homicide among children aged below 15 years globally. Infants and young children age 0-4 years had double the rates of the 5-14 year olds. In children aged below 5 years, the homicide rate in the LIC was thrice that in HIC. Boys were more affected than girls. The highest rates were in the WHO Africa region which had rates thrice the LIC rates and six times the HIC rates. These could be underestimates because most infants are neither investigated nor are postmortems carried out globally. It is difficult to recognize and record cases of infanticide. (2). In the USA, about 1% of the children were physically abused annually with 50% having head and neck injuries.<sup>(16)</sup> A survey conducted in 1995 in various countries showed that the prevalence of physical abuse in : Hong Kong, among the Chinese was 526/1000 for mild violence and 461/1000 for severe violence; USA,

49/1000; Egypt, 37%; Republic of Korea 66%; Romania, 4.6%; Ethiopian urban and rural schoolchildren reported 21% and 64% respectively as a result of parental punishment. The children reported having suffered injuries such as loss of consciousness, fractures or permanent disability in 26% of the cases. <sup>(35)</sup>.

In the WorldSAFE study, data that could be compared across countries was collected using the same protocol in Chile, Egypt, India and Philippines and compared to USA data. The investigators administered the questionnaire to population-based samples of mothers to establish the incidence rates of harsh and moderate forms of child discipline in these countries. They specifically measured the frequency of parental discipline behaviors without labeling harsh as abusive using the Parent-Child Conflict Tactics Scale. <sup>(36)</sup>. The results gave the following incidences of harsh punishment: hitting the child on the buttocks with an object not on buttocks (4-36%), kicked the child (0-10%) and beat the child (0-25%). The former was practiced most in India and least in Chile. <sup>(36)</sup>. The most common form of moderate punishment used was spanking buttocks with the hand (29-75%) and the least common form was putting hot pepper in the mouth (0-3%). The former was practiced most in the Philippines. In the USA the most common form of moderate punishment was spanking buttocks and pulling the child's hair while the other forms were not used. The moderate physical punishment was not considered to be abuse in most of the countries because they were culturally acceptable as ways of nurturing a child. Severe forms of punishment occur more frequently in schools and other institutions by teachers and other people responsible for the care of the children. <sup>(36)</sup>. However, corporal punishment is outlawed by the UN convention on child rights which prohibits all forms of violence (including corporal punishment) against children.

The 2010 study on violence against children in Kenya (KVACS) measured physical abuse by asking respondents whether they had been slapped, pushed, punched, pinched, kicked, whipped, beaten with an object or threatened or attacked with a weapon such as a knife. Among the 18-24 year olds, 66% and 75% of the females and males respectively, reported having experienced physical abuse prior to attaining 18 years of age. About 50% of the victims of both sexes had been slapped, pushed, pinched, kicked, whipped or beaten with an object. About 3.2% and 3.1% of the females and males respectively had been threatened with a weapon. During the previous 1 year prior to the study, 50% of all females and males aged 13-17 years had experienced some physical abuse. <sup>(3)</sup>

A study on child abuse and neglect conducted at the Moi Teaching and Referral Hospital (CAN-MTRH) by Ayaya et al, found that there was overall prevalence of 2.13% of child abuse and 6.16% of physical abuse.<sup>(4)</sup> This was the fifth commonest form of abuse seen in this cohort of patients. This was unexpected because physical abuse is the most easily recognized by most healthcare providers worldwide. However, this could be explained by the fact that this was a study that clearly defined all the types of abuse being studied and hence the other rarely identified forms were recognized. For example, this was the first recorded prevalence of nutritional abuse. The children in this study had been diagnosed as having common childhood conditions like malnutrition, malaria, diarrheal disease and bronchopneumonia but not physical abuse. The doctors may have been misled by the reasons for bringing the children to hospital which were also for common childhood illnesses such as malnutrition, diarrhea, abandonment and hotness of the body. It underscores the need to sensitize the doctors and other healthcare providers and the society on child abuse and neglect. <sup>(4)</sup>

## **Clinical presentation**

### **History**

Children with the following history should be suspected of being abused: being brought to hospital by someone who is not their biological parent like a neighbor or policeman, delay in seeking medical attention, inconsistent history like different history given to different healthcare providers by the same person, caretaker trying to blame the child for his/her problem, history that does not tally with the age of the child and history of the predisposing factors. A high index of suspicion is necessary. <sup>(4,18)</sup>.

### **Physical examination**

When children with suspected child abuse are examined, the following findings corroborate the suspicion; being/having: unkempt, dirty, malnourished, skin diseases, fractures, burns, bruises, lesions that take the shape of the object used to inflict the injury, conjunctival hemorrhages, poorly aligned bones and/or abdominal distension and tenderness.<sup>(4)</sup>. The child will also be afraid of talking and uneasy in the presence of the caretaker.

### **Challenges of physically abused children**

Research has shown that there is a relationship between certain adult illnesses like heart disease, lung cancer, fibromyalgia, and irritable bowel syndrome. and child abuse experiences. The impact of the abuse depends on the child's stage of development, severity of the abuse, relationship between child and the perpetrator, duration of the abuse and other factors in the environment. <sup>(22,37)</sup>.

The immediate impact of physical abuse includes: abdominal/thoracic injuries, brain injuries, burns, scalds, other CNS (central nervous system) injuries, disability, fractures, lacerations, abrasions and ocular damage such as hemorrhage. <sup>(22)</sup>.

The most obvious impact is death. Infants who suffer shaken baby syndrome die in one third of the cases. Those who do not die suffer from mental retardation, cerebral palsy and blindness. Victims of battered child syndrome get multiple fractures of different ages, head trauma and visceral trauma with evidence of infliction. Most of these victims end up with psychiatric problems like depression. Corporal punishment has been shown to make children develop violent behavior. <sup>(36)</sup>.

There is a financial burden in the management of child abuse and neglect both short and long term. Direct costs include: costs associated with treatment, visits to the doctor and other healthcare services. The indirect costs are related to lost productivity, disability, decreased quality of life, and premature death. There is also a cost borne by the criminal justice system and other institutions including: expenditure related to apprehending, prosecuting and jailing the offenders, the cost to social welfare organizations of investigating reports of maltreatment and protecting children from abuse, costs associated with foster care, the education system and the employment sector. <sup>(36)</sup>. Some of the offenders like alcohol/ drug abusers and those with psychiatric problems need treatment also at a cost. There is data on this from a few HIC but not from the LIC. In 1996, the USA estimated that the cost for the immediate management of the abused children was US\$ 12.4 billion annually. <sup>(38)</sup>. In the United Kingdom (UK), a cost of US\$ 1.2 billion annually was estimated for the immediate welfare and legal services. <sup>(39)</sup>.

### Case 1

JD aged 2 years developed a cough. The mother went to the kiosk to get some medication for him thereby leaving him with his step-father. On returning, the mother found the child crying a lot. He was inconsolable. She brought him to the Moi Teaching and

Referral Hospital (MTRH) where he was admitted and diagnosed WITH bronchopneumonia. The attending doctors noticed that whenever the child's arms or lower limbs were touched, he cried a lot. On taking X-rays of both arms and thighs, they found all the 4 bones fractured. Further investigations revealed that the step-father had inflicted the trauma on the child.

### **Emotional abuse**

Emotional abuse is defined as 'verbal or mental or psychological maltreatment of a child' or 'acts or failure to act by parents or guardians that have caused or could cause serious behavioral, cognitive, or mental disorders'. This makes emotional abuse the most difficult to define, prove, document and prosecute.<sup>(40)</sup> This is because it is difficult to witness a caretaker commit it like shout at, ignore, or call a child names. It is usually documented by asking a child/adult about his/her past or observing the child's behavior during examination.<sup>(4)</sup>

### **Prevalence**

The WorldSAFE study looked at the verbal/psychological and non-verbal non-abusive methods of disciplining children. The findings were that shouting (70-85%), name calling (14-29%) and cursing (0-51%), refused to talk to child (15-48%) and threatened to abandon child (8-48%). the child were practiced across the countries. All these were cases of emotional abuse though they were culturally acceptable in those countries.<sup>(35)</sup>

The incidence of nonverbal and non abusive form of punishment was: explained to child why behavior was wrong (80-94%), took away privileges 3-74%), told child to stop behavior (69-91%), gave child something else to do (27-75%) and made child to stay in one place (5-75%). These were practiced most in the USA.<sup>(35)</sup>

The KVACS survey measured emotional violence by asking the respondents about such actions as being humiliated on purpose by an adult in front of others, made to feel unwanted by an adult, or threatened with abandonment by an adult. Those aged 18-24 years were asked if they had experienced these before the age of 18 years. The results for the 18-24 year olds were 25.8% of the females and 31.9% of the males had experienced the abuse prior to age 18 years. The types of abuse experienced were humiliation by 18.2% of the female and 24.5% of the males, unwanted by 14% of the females and 14.7% of the males and threatened with abandonment by 5.5% of the females and 8.6% of the males. No survey question on emotional abuse was asked those aged 13-17 years and so no overall prevalence could be calculated.<sup>(3)</sup>

In an ongoing project orphans and separated children's assessment related to their health and well being (OSCAR) that is assessing the impact of different care environments on the health and well-being of the children such as Households (HH), children's charitable institutions (CCI) and street children (SC) in Uasin Gishu County before they were admitted to the CCIs, we are finding that the prevalence of emotional abuse is 32.6% making it the second most common type of abuse. Its prevalence in the various environments is CCIs 32.6%, HHs 29.5% and SC 64.6%. SCs suffered a significantly higher rate of emotional abuse. Emotional abuse was defined as having experienced any of the following before attaining the age of 18 years: ever used drugs/alcohol that made you frightened; thoughts of death and someone threatened to hurt or kill you including invoking evil spirits.<sup>(39)</sup>

In a study led by Morantz we analyzed the prevalence emotional abuse among children in selected CCI participating in the OSCAR project and found that the prevalence of emotional abuse was 27.7% which was less than the prevalence in the child abuse

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study on the same cohort. This could have been because in the Ayaya study, some of the CCIs, HHs and street children were included. It could also be due to the fact that one was looking at the period prior to admission to residential care while the other was looking at those in residential care. Hence the increase in prevalence would have been because of abuse occurring within the residence. <sup>(41)</sup>.

In the Ayaya et al CAN-MTRH study, we diagnosed emotional abuse on examination as a child who was withdrawn, fearful, anxious, irritable and/or depressed. It was the second most common type of abuse accounting for 20.85% of the cases. We did not find any risk factors for it. In all these studies emotional abuse was the second most common type of abuse seen. The prevalence was probably higher since it is expected that every child with any other type of abuse is also emotionally abused. <sup>(4)</sup>.

## **Presentation**

### **History**

There may be history of being called names; being threatened with eviction from the household, death, hurt, beatings and/or invoking evil spirits; being shouted at and/or ignored by the caretakers. History of factors that predispose children to abuse.

### **On Physical Examination**

On examination, the child may be: anxious, depressed, fearful especially in the presence of the perpetrator, irritable and withdrawn



## **Impact of the Emotional Abuse on the Child**

### **Emotional abuse can lead to the following**

Alcohol/ drug abuse; cognitive impairment; delinquent, violent and other risk taking behaviors; depression and anxiety; developmental delays; feelings of shame and guilt; eating and sleep disorders; hyperactivity; poor relationships; poor school performance; poor self-esteem; post-traumatic stress disorder and suicidal behavior and harm.<sup>(22)</sup>

### **Case2:**

40 year old GN was staying with her 25 year old boyfriend KK and her niece 2 year old baby F in a single roomed house in Langas, Eldoret. Because GN and KK were business people and they had no house girl, they decided to be locking up baby F in the house alone from 7 am to 8 pm. The neighbors reported them to the children's officer who ordered them to return the baby to its mother if they could not get a house girl to look after her.

## **Sexual Abuse**

### **Prevalence**

The estimates of the prevalence of child sexual abuse can be collected in 3 ways namely: surveys conducted with children; adolescents and adults reporting on their childhood experiences and questioning parents about what their children may have experienced. A survey of Romanian families found that 0.1% of the parents admitted to having sexually abused their children while 9.1% of the children reported having suffered sexual abuse. <sup>(35)</sup>. this could be due to the children including abuse by perpetrators other than their parents. Published studies among adults reporting on their own childhood sexual abuse experiences, show prevalence rates of 1-19% and 0.9-45% among men and women respectively. <sup>(27,35)</sup>. International studies

conducted since 1980 reported a mean lifetime prevalence rates of childhood sexual abuse of 20% and 5-10% among women and men respectively.<sup>(42,43)</sup> The wide variation in prevalence is due to the difference in definitions, study designs and cultural contexts in which the studies were conducted. Including abuse by peers in the definition can increase the prevalence by 9% and including cases where there is no physical contact can increase the rates by 16%<sup>(44,45)</sup>.

The national study on violence against children in Kenya (KVACS in 2010 defined sexual abuse as 'all forms of sexual abuse and exploitation of children'. This encompassed various offences including: completed nonconsensual sex acts (rape); abusive sexual contact (like unwanted touching); and noncontact sexual abuse (threatened sexual violence, exhibitionism, verbal sexual harassment). It also included inducement or coercion of the child to engage in any unlawful or psychologically harmful sexual activity; exploitative use of children in prostitution or other unlawful sexual practices; and the exploitative use of children in the production of pornographic performances and materials. Sexual intercourse for females was described as someone penetrating a female's vagina or anus with their penis, hands, fingers, mouth, or other object; or penetrating their mouth with their penis. Sexual intercourse for males was described as someone penetrating a male's anus with their penis, fingers, mouth or other objects; penetrating his mouth with their penis and forcing the male's penis into their mouth, vagina or anus.<sup>(3)</sup> The findings were that those aged 18-24 years 31.9% of the females and 17.5% had experienced sexual abuse prior to attaining 18 years. The type of sexual abuse experienced was: unwanted sexual touching (20.7% females and 10.8% males), unwanted attempted sex (15.3% females and 7.2% males), pressured sex (9.6% females and 3.6% males) and physically

forced sex (7.1% females and 1.4% males). The females were more likely to have been sexually abused than the males. Of these 24.3% and 8.6% females and males respectively were unwilling to have their first sexual intercourse. When asked the age at which they experienced their first episode of sexual abuse the response were:  $\leq 13$  years females 18 % ( 9.2-28.7), males 24.9(17.4-32.5); 14-15 years females 38.9 % ( 29.8-48.0), males 37.7 (24.9-50.5); 16-17 years females 43.1(34.5-51.7), males 37.4 % ( 23.7-51.0).<sup>(3)</sup>

Those aged 13-17 years were asked if they had experienced any sexual abuse in the past 12 months to show the current status of sexual abuse in Kenya today. It was found that 10.7% females and 4.2% had been sexually abused in the past 12 months. There were no significant demographic differences between the abused and those not abused. The types of abuse were: unwanted sexual touching (8.5% females, 2.1% males), pressured sex (1.1% females, 0.4% males) and unwanted attempted sex (3.2% females, 2.1% males).<sup>(3)</sup>

In our CAN-MTRH, sexual abuse was the least prevalent and all the cases were raped. It was not possible to record the other types of sexual abuse or other manifestation of sexual abuse such as fondling of the child's genitals and so on because included only the admitted children. Even the rape cases could have been under-reported because of some of the sexually abused children not being brought to hospital or not being admitted misleading history, inconsistent history, and cultural beliefs.<sup>(4)</sup>

In the CAN-OSCAR study we analyzed the cases of sexual abuse among children in the CCIs, HHs and streets participating in the project. Like the KVACS study, the children were asked if they had experienced any of the following types of sexual abuse before the age of 18 years: forced intercourse; coerced intercourse; attempted unwanted intercourse; unwanted sexual touching of

the respondent and forced touching of the perpetrator's sexual body parts. The prevalence rates were males 155(19.5%) and females 104(18.9%) with no significant difference. <sup>(39)</sup>.

These studies showed that boys were sexually abused almost at the same rate as the girls in the OSCAR study but the rest of the studies indicated that girls were abused twice as much.

## **Presentation**

### **History**

The following history may be elicited: forced intercourse; coerced intercourse; attempted unwanted intercourse; unwanted sexual touching of the respondent and forced touching of the perpetrator's sexual body parts. History of factors that predispose to abuse.

### **On physical examination**

The following signs may be demonstrated: signs of struggle/trauma like torn clothes particularly underwear; blood stained clothes; fractures and bruises; evidence of penetration like semen deposition around the hymen/anus, per vaginal/anal discharge and torn hymen/bruised anus; cervical tears.

## **Nutritional abuse**

### **Prevalence**

Nutritional abuse is the malnutrition that is due to deprivation. This is not recognized much by most workers as a form of abuse. It was the most common type of abuse in our CAN-MTRH study though it was not identified as such on admission. To the best of our knowledge this study was the first to classify malnutrition as a form of abuse and characterize factors associated with it. The prevalence of nutritional abuse in that study was 39% making it the most common. <sup>(4)</sup>.

## **Presentation**

### **History**

The patient may present with history of predisposing factors to abuse as discussed earlier. Other history includes: father who works away from home but does not send money to the family for upkeep; single or step-parent; parents with adequate income; inability to gain weight over a period of time; staying with one or none of the biological parents; marital disharmony, domestic violence; and abandonment; inadequate and/ or inappropriate food intake, frequency of feeding per day.<sup>(4)</sup> Some of these factors were found in another study conducted in the same hospital in 2007.<sup>(46)</sup>

### **Physical examination**

The patient may: be unkempt; look frightened in the presence of the caretaker; have some features of physical abuse; have low weight for age, Z-scores  $\leq 2$  for weight for age, height for age or BMI; low left upper mid-arm circumference (LUMAC); and low skin-fold thickness; apathy; irritable; swelling of the legs; flaking of the skin; baggy pants; face looking like an old man's; enlarged liver; hair changes like being brown, sparse and easily plucked.

## **Challenges of nutritionally abused children**

These children are likely to have poor mental development leading to poor school performance; get recurrent infections due to lowered immunity; growth will be stunted; and die of low blood sugar, low temperature and infections.

### **Case 7:**

During a survey on the nutritional status of under 5 year old children in Kibera, an educated mother with good income was found to have a 4 year old child weighing 6 kg. She denied the child feeds and medical attention because she believed the father of the child was responsible for his predicament.

## **Abandonment**

### **Background**

An abandoned child is one who is left alone without anyone to take care of him/her. He/she could be abandoned in a hospital after birth or admission, by the roadside, market place and so on (4). The American definition of abandonment is 'when the parents' identity or their whereabouts are unknown, the child has been left alone in circumstances where the child suffers serious harm or the parent has failed to maintain contact with the child or provide reasonable support for a specified period of time.' (6). UNICEF defines an abandoned child as 'one who does not know where his/her next meal is coming from; does not know where he/she is spending the night; does not live with his/her mother or father'.<sup>(47)</sup>

### **Prevalence**

From 2006 to 2013, the mean rate of abandonment from 24 studies was 67.89% (59.80-80.30%). (48). More than 400 million abandoned children live on the streets around the world; every 2 seconds, a child is orphaned; every 14 seconds, a child is orphaned by AIDS.<sup>(47)</sup>

The African Orphaned and Abandoned Children's Fund estimates that 15 million children are orphaned and abandoned in Africa due to HIV/AIDS; 40 million orphaned/abandoned children are living on the streets of sub-Saharan Africa (SSA);

WHO/UN estimate that there are 1 million orphaned children in Kenya.<sup>(49)</sup> A study carried out at KNH did not look at the prevalence because they only dealt with the children who had been abandoned in the newborn unit. (NBU).<sup>(50)</sup>

Our child CAN-MTRH study found that abandonment was the third commonest type of abuse contributing to 16.9% of the cases. All these were babies who had been left by their parents outside the hospital and were brought by good Samaritans or police as cases of abandonment hence were recognized as such by the admitting clinicians. They had no other medical or surgical problems so their admission diagnosis was abandonment. This made them the only type of abuse to be recognized at admission.<sup>(4)</sup>

## **Presentation**

### **History**

An abandoned child is usually found by the roadside or pit latrine or just left on the wards by the mother after being admitted or delivered in that hospital. The baby is usually brought to hospital by the police or neighbor or a passerby (Good Samaritan). It is usually difficult to get the family history because there is no one to give it. However, the clinician strives to get as much about the circumstances under which the child was brought from the Good Samaritan that brings the child. In some cases if a neighbor or relative brings the child, there may be history such as: mother is a young student in school or college, alcoholic/ on drugs, mentally ill, is HIV positive, too poor to take care of the baby, or was raped; there may be domestic violence in the family; father is alcoholic/on drugs, mentally ill, unemployed or poor; family lives in a slum area, or there is overcrowding in the house; chronic illnesses like diabetes, sickle cell disease, epilepsy among others; disabilities; congenital illnesses like heart disease.

The history of the predisposing factors to abuse also applies and should be looked for.

### **Physical examination**

On physical examination, the baby may be unkempt, covered in dirt such as feces if he was found in a pit latrine; have features of physical abuse such as bruises, fractures, head injury, or could just be normal; he/she could be malnourished with low weight for age Z-score, low left upper mid-arm circumference, wasting, edema, flaky paint dermatitis, baggy pants; mental retardation; have congenital abnormalities and disabilities. <sup>(50,51)</sup>

In Nairobi, Otieno et al looked at the abandoned children's growth and development at KNH and other newborn units. Most of them had been delivered in those hospitals and admitted to the NBUs. They found that 70% of the babies were below 6 months of age and 73% were abandoned within 1 week of life. The abandoned babies were thinner (LUMAC 10.8 cm vs. 12.3 cm  $p= 0.02$ ), more wasted ( $p\leq 0.00001$ ) and more stunted ( $p\leq 0.001$ ) than those who had not been abandoned. Their development was also delayed. <sup>(51)</sup> We cannot compare these findings to ours because ours were not all newborn babies and they had been admitted to the main wards and abandoned there. However, these findings indicate that babies who are abandoned suffer from growth and developmental retardation. Musoke in 1994 recorded similar findings. <sup>(50)</sup> This was corroborated by the socio-economic factors that predispose children to severe malnutrition study which showed that children who were not staying with their biological parents were more likely to suffer from severe malnutrition. <sup>(46)</sup>



## **Challenges of abandoned children**

Abandonment can result in malnutrition, lack of healthcare and substandard hygiene. Long-term effects include : low self-esteem because they feel that they are not good enough which can lead to inadequate coping mechanisms; difficulty in relating with a spouse or partner; anxiety which occurs in children who are aware that they were abandoned and develop signs of anxiety to caregivers or important people, they may also manifest difficulty in separating from parents, sleep disorders and controlling behavior; attachment may be a problem: difficulty in forming lasting bonds with others especially caregivers, may not attach to new family, may lack trust in others because they expect to be lied to all the time, may fear the departure of someone else that's important to them, may rationalize that by not bonding they will not be hurt again from rejection; aggression, the child may become aggressive towards himself or others or consider suicide; criminal behavior, the child may develop criminal behavior from childhood to adulthood, he/she may steal or cause trouble with families or communities.<sup>(52,53)</sup>

## **Neglect**

### **Background**

The American constitution defines neglect as failure of a parent, guardian or any other caretaker to provide for a child's basic needs.<sup>(6)</sup> The Kenyan constitution does not define neglect. Neglect may be physical, educational, medical and/or emotional. Physical neglect is failure to provide for food or shelter or lack of appropriate supervision. Medical neglect is failure to provide necessary medical or mental treatment. Educational neglect is failure to educate a child or attend to special educational needs; emotional neglect is inattention to a child's emotional needs, failure to provide psychological care or permitting the child to use

alcohol or other drugs and allowing for excessive truancy. The poverty levels, standards of care in the community and cultural values have to be considered before diagnosis. <sup>(5, 6)</sup>.

In the child abuse study at the MTRH we defined neglect as 'a child who was denied clothing, food, and other social needs or was left to someone else to look after him/her but had no features of malnutrition.'<sup>(4)</sup>.

### **Prevalence**

The prevalence of neglect in the world is not known though it could be the highest. According to the USA National Child Abuse and Neglect Data System (NCANDS) 2012 report, neglect accounted for 78.3% of the child abuse victims. It was the most prevalent form of abuse in the USA. <sup>(54)</sup>.

There is no data on neglect in Africa including Kenya. In the CAN-MTRH study we found that neglect accounted for 26.4% of the cases of abuse making it the third most common type of abuse in the study. However, if it is considered that all the cases of malnutrition seen in that study were due to negligence, then it was the commonest type of abuse because malnutrition was the commonest at 39%. <sup>(4)</sup>.

### **Presentation**

#### **History**

Cases of negligence will commonly manifest with history of: non-compliance with healthcare recommendations; failure to seek appropriate healthcare; deprivation of food resulting in hunger and malnutrition; failure to thrive; abandonment; poor hygiene; being deprived of education. <sup>(21)</sup>.

Before attributing any form of abuse to neglect, one has to ascertain that the parent/caretaker has the ability to provide for the child especially so in the cases of nutritional abuse.

### **Physical findings**

The physical findings will resemble those of the type of neglect. That is physical, sexual or emotional abuse as described above.

#### **Impact of neglect on children**

The neglected children suffer from many problems. They may: die; fail to thrive; be malnourished; have short and long term physical disabilities; emotional problems and so on.

The NCANDS report found that there were 2.2 deaths per 100,000 neglected children; 70.3% of the fatalities were aged below 3 years; boys died at the rate of 2.54/100,000 boys population; girls died at a rate of 1.94/100,000 girls in the population; of these deaths, 85.5% were white, 38.3% were African-American and 31.9% were Hispanics, 80% were caused by parents. <sup>(54)</sup>.

## **Child Labour and Exploitation**

### **Background**

Throughout history and in all cultures it has been normal for children to work in the family context. Through this work children are socialized into adult skills and responsibilities. Working is an integral part of healthy family community life and is a powerful vehicle for their emotional and social development. Through this work children acquire skills, earn status as family and community members thus promoting their self-esteem and confidence. Traditionally children have worked to learn and develop themselves and help their families by tending flocks of animals, attending customers in small shops and caring for their younger siblings.<sup>(1)</sup>

Child labor is considered exploitative when the burden becomes too great while neglecting its educational and socialization roles. Families do not know when they are exploiting their children and

it is accepted as normal. In the worst cases families knowingly exploit their children like maiming them to enable them beg for the family, selling them as bonded laborers and encouraging them to become prostitutes.<sup>(1)</sup>

In 1986, UNICEF therefore defined exploitative work as 'work that is detrimental to a child's physical, mental, emotional or social development'.<sup>(1)</sup>

According to the 2008 Resolution II adopted during the International Conference of Labor Statisticians, the term child labor covers slavery, prostitution and pornography; illicit activities and work likely to harm children's health, safety or morals as defined in International Labor Organization (ILO) convention No. 138; hazardous unpaid household services including household chores performed for long hours in an unhealthy environment, dangerous locations and involving unsafe equipment or heavy loads.<sup>(55)</sup>

### **Prevalence**

It is difficult to estimate the number of children involved in exploitative labor. In 1981, the anti-slavery society for the protection of Human rights estimated that there were 100 million children involved in exploitative labor while the United Nations estimated them to be 145 million of children aged 10-14 years. If children working in the informal sector such as girls looking after their siblings are included, the number may reach 300 million.<sup>(1)</sup>

The 2010 ILO report estimated that there were 150 million children aged 5-14 years involved in child labor in the developing countries. According to the ILO globally, 215 million children aged below 18 years were engaged in work, most of them full time.<sup>(56)</sup> In sub-Saharan Africa (SSA) 1 out of every 4 children

aged 5-17 years work compared to 1 in every 8 in Asia Pacific and Latin America.<sup>(57)</sup> In fact, the prevalence has been reducing in the rest of the world as it has been increasing in SSA.<sup>(57)</sup> the children involved in domestic work were 90% girls.<sup>(56)</sup>

There are 3 groups of children involved in labor according to how they relate to their families. The first and largest group is composed of children who live in a family situation from which they receive continuous support. The second group is of those who are in contact with their families but whose family support and protection is inadequate. The third and smallest, group comprises of children with little or no contact with their families, lack family support and must make their own way in life.<sup>(1)</sup>

### **Factors/causes of child labor and exploitation**

The factors associated with exploitative child labor include social inequality, discrimination, poverty, sex of the child, street children, child laborers and indigenous groups or lower castes. The low social classes are more likely to have their children involved in labor because they are poor and therefore the children have to contribute to the household economy. There is also discrimination against low social classes and castes in getting jobs leading to poverty and child labor.<sup>(57)</sup>

In most parts of the world, girls bear the heavier burden than boys because they are expected to work in the fields and at home. Street children, migrant and child laborers are vulnerable to exploitation. These are children that migrate to the urban areas where the family support and protection is not available. They are made to work as domestics, “sweat shop’ factories or prostitutes.<sup>(1)</sup>

Industries that are prone to exploitative labor include weaving carpets, finishing textiles or assembly of electronics. Children, particularly girls, are preferred in these industries because of their finger dexterity, docile nature and cheap wages.

### **Challenges of child laborers**

Children who work in the exploitative industries are underpaid, overworked, and the labor leads to permanent health damage like carpet weavers lose their vision and develop permanent deformities. The children are kept in virtual bondage, isolated, ignorant, and malnourished and in poor health. <sup>(1)</sup>

In 1981, the WHO and Defense for Children International commissioned a study to look at health effects of exploitative labor. The study found that the children had more exposure and reduced resistance to diseases leading to severe disease in adulthood; were victims of industrial accidents and toxic hazards; growth retardation; emotionally cold with diminished physical capacity and low innovative and creative thinking. <sup>(1)</sup>

Heavy responsibilities for the girls lead to their inability to attend and perform well and remain in school. Chances of a rural girl getting an education are remote compared to the urban girl and even the rural boy.

Child labor reinforces intergenerational cycles of poverty, undermines national economies and impedes achieving progress towards the millennium development goals. (MDG). Child labor continues to harm the physical and mental development of children and adolescents and interferes with their education. <sup>(56)</sup>

## Chapter Four

### Street Children

#### Background

The term street children not only denotes a place of congregation but also a certain set of working and living conditions. <sup>(1)</sup>. As a place of congregation, UNICEF defines street children as boys and girls aged below 18 years for whom the street has become home and/or the source of livelihood and are inadequately protected and/or supervised. <sup>(58)</sup>. According to certain working conditions UNICEF defines 3 types of street children: street living are those who have lost their families or have been abandoned or have run away from their families and now live on the streets; street working children are those who spend most of their time working in the streets and markets of the cities but returning home on a regular basis; street families are those who live on the streets with their families. <sup>(59)</sup>. UNICEF also classifies street children according to how much the children relate to their families as 'of street children', and 'on the street children'. Of the street children are those who have severed all family ties and are on their own. On the street children are those who maintain strong family ties, have a sense of belonging to a family, and contribute to the family household income. <sup>(4)</sup>. these children are found among the abused, abandoned, HIV infected/ affected and the exploited groups of children living in especially difficult circumstances.

The street children are in the streets basically to make a living for themselves and/or their families. They spend a lot of time on the streets because of the low returns on their labor. Most of them work in the informal sector as hawkers, prostitutes and scavengers. They are on their own without family or any adult protection thus being vulnerable to abuse and exploitation. They are very vulnerable to sexually transmitted diseases including HIV.

These children have been called very many names depending on how the community thinks of them including parking boys, chokora, thrown away, beba, market children, homeless etc.

### **Prevalence**

Street children are found in almost all the world cities mostly in LIC. The prevalence of these children in the world has been quoted as 100 million since 1989 by UNICEF but the exact number is unknown. <sup>(60)</sup>.

The street children phenomenon has been documented since 1848. Orphans and abandoned children have lived in misery since time in memorial. They accounted for the majority of the boy prostitutes in Augustan Rome. <sup>(61)</sup>. They were described in Tsarist Russia in the 17<sup>th</sup>. Century and survived all the attempts to eradicate the phenomenon. In London in 1848 there were 30,000 street children; Central Mexico 1991, 11,172 with 1020 living and 10,152 working on the streets; Nepal, 5,000, Kolkata and Mumbai had 1 million each; The recent prevalence estimates by country are: Russia 654,355, China 150,000, India 400,000-800,000, Vietnam 8,000, Pakistan 1.5 million, Brazil 23,973, Philippines 1.5 million, Latin America 40 million, Vietnam 8,000, Romania 20,000, USA, 2 million children run away or are forced to run away from home with 1.6 million being homeless and Turkey 1,641. <sup>(62,63)</sup>.



In Kenya, the phenomenon documented for the first time in 1969 by Nowrojee. and was first reported in Eldoret in 1985.<sup>(64)</sup> In 2001 it was estimated that there were 135,000 street children in Kenya with towns having: Eldoret 1,500, Mombasa 5,000, Kisumu 4,000, Kitale 2,000, Nakuru 2,000, Nyeri 450 and Thika 520. It is currently estimated that there are 250,000 children in Kenya with 60,000 of them found in Nairobi.<sup>(63)</sup>

In Eldoret in 2001, it was estimated that there were 1000 street children in the streets and 500 in the shelters. The study on street children in north Rift Valley did not give the prevalence because it only interviewed the children to find out the causes of going to the streets.<sup>(63, 64)</sup>

### **Causes of Street Children Phenomenon**

Though the street child phenomenon is universal the dynamics that push children to the streets are different for the HIC and LIC. Children in HIC become street involved because of familial conflicts and child abuse while those in LIC do so because of abject poverty and abuse, familial dysfunction, and death of one or both parents. However, Street children leave their homes gradually and in LIC, 90% of them maintain ties with their families and contribute their earnings to them.<sup>(66)</sup> There are factors that push children away from home and those that pull them to the streets. The underlying problem in LIC is poverty which leads to hunger. In the HIC like the USA, the children come from working families but they run or are made to run away from home. Hence while they are regarded as criminals in the LIC, they are regarded as homeless and in need of help in the HIC.<sup>(63)</sup>

The factors cited for pushing children to the streets are: armed conflicts and natural disasters like floods and drought which lead to poverty and food insecurity; social disruption which includes:

poverty; breakdown of homes and/or families, unplanned pregnancies, parents' death, growth of a town, disrupted extended family system, HIV/AIDS and drug abuse especially alcohol; hunger at home, domestic violence, economic or political unrest; culture; sexual, physical or emotional abuse; violence; mental problems; substance abuse; and sexual orientation or gender identity issues (1,3,64, 67). In Guatemala, it was found that the children living with their families were more malnourished than the street children. <sup>(66)</sup>. In Philippines, most low social class families are so poor that they feed on one major meal a day. The poverty is said to be a result of corruption in government which bleeds 40% of the budget. In the Congo and Uganda, children who are thought to bring bad luck to the family are made to leave home. <sup>(68)</sup>. In Afghanistan, girls who commit crimes of honor like adultery or refuse arranged marriages are forced to leave home. (67). Poverty underlies most of these factors. Neglect is another important factor that results from poverty, drug abuse, mental illnesses and so on.

The major pull factor to the streets is food. Others include child being lured away from home by pimps or internet predators, comfort from friends on the streets and making some income for himself and/or the family. In Brazil, the street children had higher intelligence and were more unlikely to abuse drugs. While in Bogota, Colombia, street children immersed themselves into a network of caring and supportive friendships. In northern Nigeria, religion plays a part by forcing children referred to as almajiris to leave home by indenturing under a Muslim religious teacher known as maalam. <sup>(66)</sup>.

A study in Rift Valley that was conducted by the provincial children's officer, UNICEF, CDC, and Save the Children interviewed the government officers and the street children.

The government officers said that children were pushed to the streets by: lack of parental care, abandonment due to pregnancies, neglect and poor influence. However, the street children said that they were pushed to the streets by: hunger, abuse at home, post-election violence (PEV), inability to go to school due to cost, death of care-giver, abandoned/separated from family, displacement, loss of livelihood at home, drought, violent incidental tribal clashes, ill/ jailed care-giver, flooding and government resettlement respectively. The children gave the pull factors as: to earn money, peer pressure, friends on the streets, to socialize/ be independent, availability of glue and was born on the streets respectively. The same factors appertained when Eldoret data was analyzed separately. <sup>(65)</sup>. This shows that the children went to the streets because of hunger and therefore they went to look for food and money. This was corroborated by a study in Eldoret in 2001 on street children in which we found that the children on the streets were better nourished than those in the shelter. <sup>(64)</sup>. This meant that the children were actually getting what they were looking for on the streets. It is paradoxical that hunger should push children in the North of the Rift Valley to the streets yet it is the breadbasket of Kenya. However, this is explained by the rise in food and fuel prices, large scale land ownership of fertile land that makes it inaccessible to ordinary people, rapid urbanization, displacement by PEV, discriminatory redistribution of land during resettlement of IDPs. <sup>(65)</sup>.

The constitution of Kenya guarantees children free basic education from nursery to secondary schools. <sup>(5)</sup>. But a lot of the children could not afford the education because of irregular fees levied by the head teachers. These included: uniform (980/-); books (2,800/-); desk (1500/-); exams (300/-); Saturday tuition (7,200/-); and holiday tuition (600/-). This led to only 44% of the interviewed children to remain in school. Ninety seven percent

of the street children who had been to school dropped out before completing because of lack of school fees. While the total fees levied irregularly totaled 13,380/=, the government gave 1020/= per child. <sup>(65)</sup>.

The emergencies that contributed to the street children phenomenon in Rift Valley were the PEV and drought. Of the interviewed children, 42% had been affected by the PEV by being displaced or attacked or witnessed violence. The highest rate of displacement was in Naivasha town at 61% which was higher than the overall rate of 37%. <sup>(65)</sup>. About 29% of the children had been affected by an emergency other than PEV. These had the effect of disrupting security and protection of the child by the family and therefore pushing them to the streets. The emergencies cited by the children were PEV, drought, tribal clashes, and flooding. Forty seven percent of the children had been affected by at least 1 emergency. PEV was the most cited push factor for the children who went to the streets before 2011. Lack of food was the commonest push factor for those who joined the streets after 2011. While it is known that PEV pushed 24% of the children to the streets, it is unknown what its effect was during the 1992 and 1997 elections, the fact children were still joining the streets in 2011 shows that its impact was still being felt. About 37% of all the children currently connected to the streets are IDPs due to the PEV. The push factors for the IDP children were: displacement, poor living conditions and lack of support in the camps, humanitarian support withdrawal, and inability to re-build livelihoods, death, separation or injury of family members. Loss of livelihoods led to food insecurity. <sup>(65)</sup>.

Drought was a push factor for 12% of the children. This was common in Kitale which received children from the arid and Semi-Arid Lands (ASAL) district of Turkana. This may have been

underestimated because the children may not have recognized drought as the reason they went to the streets. <sup>(65)</sup>.

This was the most comprehensive study on causes of street children in Kenya.

## **Challenges of Street Children**

Street children are vulnerable to a lot of challenges by virtue of not having any family protection and care. They are abused, exploited, subjected to harmful labor, live in poor hovels on the streets and child prostitution. These predispose them to: health problems like acute respiratory infections, tuberculosis, sexually transmitted infections (STI) including HIV and AIDS and psychiatric conditions; physical injuries and execution by the public and police for suspicion of being thieves.

### **Health Problems**

Street children are exposed to many health hazards such as sniffing glue, unhygienic abode, and cold at night, feeding on garbage and exposure to dust, among others. This results in various diseases of the gastrointestinal, respiratory and central nervous systems. In the Philippines, the health problems seen included sexually transmitted infections, HIV/AIDS; sickness; malnutrition; physical injuries from motor accidents, street fights, harassment from extortionists and police, sexual exploitation from pedophiles and pimps; exposure to substance abuse and STI. There was no HIV testing among street children but 18% had contracted STI. <sup>(68)</sup>.The Valmiki Foundation found that the street children in India suffered from malnutrition(50%); were unlikely to be vaccinated, only two thirds had been vaccinated against TB, Diphtheria, measles and polio while 10% had been vaccinated against hepatitis, or received medical treatment.<sup>(69)</sup>.

In the street children study in Eldoret, we found that skin diseases were the most common group of diseases. The upper respiratory tract infection was the most common diagnosis. These were expected because they are predisposed to by unhygienic conditions and sniffing glue respectively. Injuries and sexually transmitted infections were not as high as would have been expected. The children were usually injured by the public, police and peers. There were cases in that study who reported having been shaved by broken bottles by government officials. They were also sexually assaulted by the night watchmen, public and peers. The STI may have been underestimated because laboratory tests were not done thereby missing some conditions. <sup>(64)</sup>.

### **Drug Abuse**

The street involved children and youth (SICY) in HIC are different from those in LIC <sup>(65)</sup>. Those in the HIC use injectable drugs and other substances that are not easily available in the LIC. <sup>(70)</sup>. A systematic review on drug use by SICY revealed that the prevalence of life-time drug use in the world ranged between 14% (Nigeria) and 92% (Honduras). In Africa, it ranged from 14% (Nigeria) to 74% (Kenya); in Asia, it was 48% (Thailand) to 81% (India) and in Central America 40% (Brazil) to 92% (Honduras). The commonly used drugs globally were inhalants (47%), tobacco (44%), alcohol (41%) and marijuana (31%). Cocaine was used by few SICY 7%. It was used most in Brazil (16%) and least in Africa (2%). The reasons cited for using the drugs in order of preference were: peer pressure; to forget their problems and escape reality; feel good and pleasurable; experiment and gain courage and strength on the streets. <sup>(70)</sup>. These were similar to the Eldoret findings. <sup>(64)</sup>.

In a study in Kenya, Cottrel-Boyce found that glue sniffing amongst Kenyan street children was functional for dulling the

senses against the hardship of life in the streets. It also provided a link to the support structure of the street family as a potent symbol of belonging. <sup>(71)</sup>. In the Eldoret study on street children we found that they sniffed glue to feel warm and dull the hunger pangs. <sup>(64)</sup>.

The prevalence of drug abuse in our street children study was 545/1000 children. The children were abusing cigarettes (37.6%), glue (31.2%), and alcohol (18.3%), marijuana (8.3%) and cocaine (4.6%). These findings were similar to the systematic review above. (64,70). Glue was most likely underestimated as most of them abuse it because it is cheap and readily available. The children may have been afraid of alluding to sniffing glue for fear of repercussions. In most cities these children are identified by the glue bottles on their mouths. The reasons adduced for abusing the drugs were: peer pressure, to feel drunk, to feel warm, to reduce boredom, for leisure, to remove bad thoughts and to catch sleep. <sup>(64)</sup>.

Embleton et al studied the facilitators and barriers to quitting drug use among SICY in Eldoret town in 2012. They found that the prevalence of any lifetime use of drugs was 74%. About 83% of the street children had used drugs in their lifetime compared to 56% of on the street children. Of the children who had lifetime use of drugs, 83% were currently using. The commonly used drugs amongst the lifetime users were glue (67%); alcohol (47%); cigarettes (45%); miraa (a plant that contains active ingredient cathione and acts as a stimulant when chewed) (33%); marijuana (29 %; petrol (24%) and pharmaceuticals (8%). Glue was often used as evidenced by the fact that 94% reported using it in the last 30 days while 78% admitted using it daily. These findings indicate that though glue was still popular, other drugs that were not in use in 2001, had now been introduced to the Eldoret SICY. <sup>(64,72)</sup>. Using focused group discussion (FGD) they found

that the barriers to stopping use of drugs were addiction; peer influence and social network; coping and survival on the streets; availability and affordability; poverty; and negative family influence. The facilitators of quitting drug use were desire to quit; positive peer influence; self care; positive family influence and programs and policies. From this it was clear that family and peer influence were key to stopping drug use. If one had a supportive family or peer group he/she was likely to quit but if one had a family that brewed and used alcohol and a peer group that were addicted to the drugs, then it would be difficult to stop.<sup>(72)</sup>



*Street girl sniffing glue*



## **Malnutrition**

Street children have been found to be better nourished than those in shelter, living with their families or households (extended family) in various studies.<sup>(64, 66)</sup> This is paradoxical because they are exposed to circumstances that predispose them to hunger and malnutrition.

In the street children study in Eldoret in 2001, we found that the prevalence of malnutrition was 31.1% (stunted) and 41.1% (wasted). The children in the shelter had the highest rate of stunting (51.8%) and wasting (64.3%). The street children had much less stunting (28.8%, 13.3%) than for on and of the street children respectively. This justifies the children being pulled to the streets for food.<sup>(64)</sup>

The street children are usually able to scavenge in the garbage, from the streets beg or even steal food for their survival while a child in a home depends on the head of the household/home to get food.

## **Child abuse**

The street children are predisposed to all types of child abuse by virtue of being alone in the streets without family or adult support, care and protection. They are subjected to physical, mental and sexual abuse and other hazards on the streets. This is because they are viewed as a nuisance by the public and police. They are made to involve themselves in harmful exploitative labor for survival. Some of the work they are involved in include: rag picking; collecting firewood; street hawking; dyeing; begging; prostitution and domestic labor. Child laborers are denied education or training that could enable them escape poverty.<sup>(69)</sup>

### **Homelessness**

The street children live in deplorable conditions on the streets. They may be homeless because they belong to street families; they have been abandoned; family is poor or migrant; orphaned or ran away from home. They live on the street corners; public toilets; cardboard shelter; markets; footpaths; railway and bus stations and garbage dumps.

### **Gender discrimination**

In India, girls are discriminated against because they have to pay dowry. They are therefore denied education, healthcare and freedom. This is extended to street life. Many girls are aborted, abandoned, neglected and underfed. Female mortality rates are higher than males. They are married off when they are still underage.<sup>(69)</sup>

### **Summary executions**

In some countries, street children are executed because of their nuisance and security risk. They are killed by the public and/or the police. During the reign of Marcos, 39 street children in conflict with the law were executed by vigilante groups in Manila. These killings were attributed to ineffective criminal justice and tendency for the authorities to take short cuts.<sup>(69)</sup>

In countries where the police have been given the shoot to kill order, street children are executed on flimsy grounds like suspicion of theft. In Eldoret, in 2013, 2 street children were killed by members of the public on suspicion of killing a student near the Sosiani river even though nobody knew the murderers.



*Pioneer grounds - Burial of a street child who was executed by public*

## **Prostitution**

Child prostitutes are usually used by sex tourists and pedophiles. It is rooted in poverty and exacerbated by foreign armies like the Clark airbase in Philippines in 1998 where bars employed children as sex workers for the American soldiers. Street children were at risk because most brothels offered children for sex. In 1996, 60,000-1.5 million children were estimated to be prostitutes. Children as young as 6 years were offered for sex. In one incident a 13 year old was made to service 15 men per night. <sup>(67)</sup>. There have been many similar reports at the Kenyan coast.



## Chapter Five

### Orphans, Vulnerable and Separated Children

#### Background

In 2004, UNAIDS recognized HIV infected and affected children as vulnerable and defined them as 'children whose survival; well being or development is threatened by HIV/ AIDS.'<sup>(73)</sup> Due to the difficulty in defining vulnerability, the World Vision identified vulnerable children in the context of HIV/ AIDS as 'children who live in a household in which one person or more is infected with HIV; dying or deceased; children who live in households that take in orphans; and children who live with persons who are too old or young to take care of them.'<sup>(74)</sup> The other factors that need to be considered while defining vulnerable children include: poverty; access to shelter, education, health facilities, or other basic facilities; HIV/ AIDS stigma; political and socio-economic crisis. Though there is no method of measuring vulnerability, Skinner et al have identified some variables to measure vulnerability. These include: death or desertion of parents; severe chronic illness of parents: HIV/ AIDS and others; illness of the child; physical or mental disability; access to basic needs: education, health, social services; inadequate clothing; emotional problems; abuse of the child; drug abuse by the caregivers or the child.<sup>(75)</sup>

An orphan is defined as a child who has lost one or both parents. A separated child is one whose parents are alive but has no access to them.<sup>(76)</sup> There are street children among all these.

## **Prevalence**

A UNICEF report in 2010 estimated that: there were 143-210 million orphans in the world; everyday 5760 children were orphaned; 2,102,400 children became orphaned in Africa annually; every 15 seconds, a child became an HIV orphan in Africa; 80% of the HIV orphans in the world live in Africa. It also reported that 250,000 children are adopted annually but each year, 14,505 grow up as orphans and age out at 16 years; each day, 38,493 orphans age out; every 2.2 seconds, orphan ages out with no family to belong to and no place to call home.<sup>(77)</sup>

In 2010, the UNAIDS estimated that there were 16 million HIV/AIDS orphans in the world. Of these, 14.8 million were in sub-Saharan Africa.<sup>(78)</sup> In some African countries HIV/AIDS orphans constitute 50% of the orphans. In southern African countries, HIV orphans form a large portion as follows: Zimbabwe 16%, Botswana 12% and Swaziland 12%. In 2009, the number of HIV orphans was: Nigeria 2.5, South Africa 1.9, Tanzania 1.3, Kenya 1.2, Zimbabwe 0.69, Mozambique 0.67 and Malawi 0.65 million children. These were 46% of all the orphans. This shows that HIV/AIDS has orphaned a lot of children in sub-Saharan Africa.<sup>(78)</sup> AIDS orphans were: Botswana 72%, Zimbabwe 71%, Swaziland 69%, Lesotho 65%, Malawi 58%, Zambia 56%, South Africa 56%, Kenya 46% and Uganda 44% of the total. These statistics clearly indicate that Africa carries the brunt of the orphan problem including the HIV orphans. There is need for strategies to mitigate this.

These statistics indicate that AIDS is responsible for most of the orphans in SSA and in its absence 50% of the orphans would not have been orphaned. Outside Africa, most AIDS orphans are found in Asia where the total number is 73 million but there is inadequate data on the contribution of AIDS.<sup>(76)</sup>

Although the prevalence varies from country to country, between different regions in the same country, rural and urban areas the age of orphans is fairly consistent as follows: 0-4 years 15%, 5-9 years 35% and 10-14 years 50% <sup>(85)</sup>. Thus most of the orphans are aged above 5 years. This thrusts the teenage child into parental roles that he/she is not prepared for.<sup>(76)</sup>

## **Challenges of Orphaned Children**

### **Emotional challenges**

Children whose parents are infected with HIV undergo many negative changes including emotional neglect before and after the parents die through ostracization, emotional abuse, exploitation and lack of support. <sup>(71,72)</sup> A study in rural Uganda found high levels of psychosocial distress including anxiety, anger and depression. About 12% of the AIDS orphans wished they were dead compared to 3% of the non AIDS orphans.<sup>(79)</sup>

In an OSCAR study on post trauma stress disorder, we found that bullying was the most common post traumatic stress disorder (PTSD). The study demonstrated very high rates of traumatization and PTSD among orphaned and separated children. The street children were more affected than children living in households. <sup>(80)</sup> In another OSCAR study on the effectiveness of cash transfer (CT) to households with orphans, it was shown that the children in households that were receiving the cash transfer (CT-HH) were more optimistic about the future than those in HH not receiving the CT in spite of some evidence of some material deprivation. This showed that the government of Kenya's efforts to alleviate the suffering of orphans was bearing fruit.<sup>(81)</sup>

## **Household challenges**

The loss of parents to AIDS leads to serious consequences for a child's access to basic needs such as shelter, food, clothing, health and education. Most of the orphans end up on the streets alone with no one to care for them. Lack of income in the households where the children are accommodated forces them to contribute financially to the household.

The 53 million orphans in SSA have overwhelmed the traditional extended families that used to cater for them. Various models of care have evolved. The OSCAR project described the models in Uasin Gishu county in a paper on cross-sectional evidence from western Kenya. Included in the study were 300 HH, 1 foster home, 19 CCI and 100 SC. There were 4 models identified for the care of orphans and separated children. These were: Institutional care sub-classified as: pure CCI (those only providing residential care), CCI plus (those residential and community based support) and CCI- shelter (which are rescue, detention or other short-term residential support); Family based care; Community based care and Self care. These models have not been described anywhere else to the best of our knowledge. It was found that the children in institutional care were significantly more likely to have their basic needs met than those in family based care. CCI were also better placed to provide an adequate standard of living.<sup>(81)</sup> This explained the finding of the children living in CCI having a better outlook for the future.<sup>(82)</sup> The HH play an essential role for the children but they are stretched economically. As explained before the CT was effective in assisting them as evidenced by the fact that those in CT-HH were less likely to have missed any days of school in the preceding 1 month, be low weight for age (age <10 years) and stunted (age 10-18 years). The non CT-HHs had some positive findings such as: children being more likely to have 2 or more pairs of clothes, no difference in food security, adequacy



of diet or possession of a pair of shoes or blanket. This is a clear demonstration that the various models had a role to play and if supported, would be able to look after the children better.<sup>(81)</sup>

Below is one of the CCI in the OSCAR project.

### **Lemoru Children's Home**



*One of the CCI in the OSCAR project in Uasin Gishu County*

### **Child abuse and neglect challenges**

Orphans are vulnerable to all the types of abuse discussed in chapter 4 because they have no family support, care or protection and are taken care of by people who are not their biological parents. In the CAN-OSCAR (child abuse and neglect OSCAR)

study, we found that the prevalence of any type of abuse was significantly higher among the street children than the others ( $p < 0.0001$ ). When abuse was analyzed by sex, males had significantly higher rates of emotional and physical abuse than females. ( $p < 0.0001$ ). There was no significant difference in the sexual abuse rates. The boys may have been subjected to more physical and emotional abuse as a cultural way of socializing them and the belief that they needed to be handled more firmly than girls.<sup>(83)</sup> The multivariate analyses also showed that street children were much more likely to have experienced any of the abuses than those in household and children's community institutions.<sup>(82)</sup> Compared to CCI, SC were 4 times more likely to have experienced sexual and emotional abuse and 5 times more likely to have experienced physical abuse. The HH and CCI had no significant difference except for sexual abuse in which HH was 1.38 times more likely to have been abused than CCI. These findings implied that the CCI was the safest place while the streets were the most insecure place for orphans and vulnerable children to live.<sup>(83)</sup> This was the first study to compare different care environments and specifically look at child abuse in the situations. The study could not assess the reasons for the abuse but is possible that the abuse in CCI and HH was due to ignorance of the law and definitions of the various types of abuse by the directors and heads of households.



*Orphan sniffing glue due to lack of parental protection and guidance*

## **Educational challenges**

Orphans are likely to have their education interrupted due to lack of school fees, school uniform and other material needs because of losing the parent who was providing them. The children who stay with the relatives may suffer from the poverty in that family. Studies have shown that the impact of orphan-hood to a child's education is interlinked with poverty. A multi-country study in 2010, showed that orphan-hood itself was not directly associated with lower school attendance.<sup>(84)</sup> Other factors such as higher household wealth resulted in better school attendance for both orphans and non-orphans.<sup>(84)</sup> This was supported by our findings in the CAN- OSCAR study which showed that providing cash to households improved the school attendance of the orphans.<sup>(82)</sup>

## **Challenges of stigmatization**

HIV/AIDS orphans undergo stigma before and after the death of their parents. The stigma is worsened by the shame, fear and rejection. They may be denied access to schooling, health care and be disinherited.<sup>(85,86)</sup>



*Street children playing an OSCAR organized football match with other children to reduce stigma*

## Chapter Six

### Pediatric HIV/AIDS

#### Background

The scourge of HIV has been there since 1981 when it was described in the USA. Since its advent, it has subjected children to some very difficult circumstances. The children are infected or affected by the virus. It has reversed the gains made in improving the child survival indicators such as the under 5 morbidity and mortality rates. It has impoverished the parents of the children thus exposing them to abuse. It has contributed to the street children phenomenon by making them orphans, to be stigmatized, ostracized and rejected by society. It has made an unknown number of children to live without family care, protection and exposed to abuse and exploitation. This section discusses the areas of my research interest.

#### Epidemiology Of Pediatric HIV/AIDS

UNAIDS global estimates among children aged below 15 years at the end of 2010 were: 3.4 million living with HIV; 390,000 became newly infected; every hour 30 children died of HIV; 16 million children were orphaned by AIDS; 90% of the infected children were living in sub-Saharan Africa and HIV is responsible for 50% of orphans in SSA.<sup>(64)</sup>

According to the 2012 Kenya AIDS Indicator Survey (KAIS) report, the HIV prevalence among adults aged 15-64 years was 5.7% . The prevalence among children aged 18 months to 14 years

was 0.9%. HIV prevalence was highest in Nyanza and lowest in North Eastern regions. The proportion of women who gave birth, attended ANC for the pregnancies and were tested for HIV increased to 92% in 2012. Of those who were diagnosed with HIV at ANC, 90% received either maternal or infant antiretroviral prophylaxis to prevent mother to child transmission of HIV. (PMTCT).<sup>(85)</sup> These would lead to a reduction in the mother to child transmission of HIV. There are 180,000 children living with HIV infection and 40,000 are on ARVs. The AMPATH program takes care of 25,000 children with 5,000 on ARVs. <sup>(87)</sup>

These children not only live in especially difficult situations but are also a source of street, abandoned, abused, exploited, separated, orphaned and vulnerable children who require substantial protection.

### **Challenges of HIV Infected/Affected Children**

The HIV pandemic has had devastating effects on the socioeconomic well-being of the country, health of the populace especially children and women and it has subjected children to abuse and discrimination. It has indirect effects on the community.

In 2005, out of the 570,000 HIV related deaths in the world, 520,000 died in SSA.<sup>(84)</sup>

At the peak of the pandemic, the prevalence rate was 30% in Kenya. Some of the economic consequences were one out of nine HH in Kenya were affected by HIV, 3 out of 4 heads of HH were affected by HIV. Between 1998-2003 (which was the period between peak of the pandemic and introduction of ART) : adult (15-49 years) mortality rates increased by 40% (women) and 30% (men). The mortality among children also increased. (NACC report 2011). Since the beginning of the pandemic, 1.7 million people have died in Kenya. In 2011, 49,126 people died of HIV related causes.

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In 2011 1.1 million children were orphaned by HIV and several thousands of children were pushed to the streets. Children with one or more parents HIV infected are less likely to be in school, more likely to be underweight, and less likely to receive medical attention.

According to the NACC report of 2011, 50% of Nairobi residents aged above 50 years reported having personally been affected by HIV/AIDS. (NACC report 2011).

Without intervention the mother to child transmission in SSA was 30-50%, the infant and under 5 mortality rates in Africa had doubled or even quadrupled in some African countries.

## **Progression of HIV/AIDS in Children**

### **Background**

Natural progression of HIV infection is defined as 'the progression of the disease from infection to death without any intervention.' It is difficult and unethical to try and document the natural progression of HIV since there are various available interventions that have been shown to be effective including: ARVs (antiretroviral drugs), prophylaxis against Opportunistic infections (OI), nutritional support and psychosocial support and also the long incubation period. The incubation period of HIV infection is 'from infection to development of HIV related signs and symptoms. The latency period is 'from the time of diagnosing HIV infection to development of HIV related signs and symptoms'. The AIDS Survival Time (AST) is 'from diagnosis of ADE to death.'<sup>(90)</sup>.

## **Incubation/latency periods**

The median incubation period is 10 years and it varies with age and mode of transmission. The infants and the very old people have a shorter incubation period. The patients who are infected through transfusion of blood and/or its products have a shorter incubation period. However, injecting drug users (IDUs) sexually infected and hemophiliacs have similar incubation periods.<sup>(84)</sup> In a study conducted at AMPATH to look at the latency period in children, we found that the mean and median periods were 217 and 112 days respectively. This was shorter than that in adults but could not be compared to other studies in children because they were not there.<sup>(88)</sup> The incubation period could not be studied because it was not possible to ascertain when the infection occurred. The factors that were associated with the latency period were: the CD 4 percent closest to the diagnosis of the HIV infection, CDC stage at diagnosis of the HIV infection, non clinical adherence, never having been on ARVs and not having attended the MTRH clinic. Children whose CD 4 counts were high at time of HIV diagnosis, those who had a less advanced CDC stage and the non clinic adherent patients had longer latency periods because they were in better health. The children who were attending the MTRH clinic had shorter periods because this was a referral centre hence it received the very sick children from the other clinics. Those who had never been on ARVs had shorter period suggesting that ARVs prolong the latency period.<sup>(88)</sup>

## **AIDS survival time**

The diagnosis of the ADE can be clinical or laboratory based. The clinical diagnosis is made when any one of the conditions in the WHO stages 3 or 4 or CDC category C is diagnosed. The laboratory diagnosis is made in children when the CD 4 percent



falls below 15% in those aged below 6 years and the count is below 200/ml in those aged  $\geq 6$  years.<sup>(106)</sup> Most of the AST in literature are based on clinical diagnosis of the ADE because few centers can carry out the CD 4 counts. The mean and median survival times in the AMPATH study were 201 and 117 days respectively.<sup>(87,90)</sup> The factors that were associated with this time were never on ARVs and CD 4 percent nearest to the diagnosis of the ADE. Thus, the patients who had been on ARVs and those who had higher CD 4 percent had a longer survival time. There is no pediatric data to compare with but among the adults the median was 330 days which was double that of the children. This was because children had an immature immune system and therefore progressed faster than the adults. The factors that were associated with the survival in the adults were age, mode of transmission of infection, definition of diagnosis, genetics, expertise in use of HAART, opportunistic infections and the ADE diagnosed.<sup>(90,91)</sup>

For reasons already discussed, the available studies on natural progression of HIV were retrospective covering the pre-HAART period. A study in United Kingdom (UK) found that by the end of 6 years 3% of the children had not progressed, 20% had progressed to category C and 25% had died. Of those who were still alive 75% were in category B or C. A European collaborative study found that by the end of year 1, 90% of the children had signs of infection while 23% had AIDS. By end of 4 years, 40% had AIDS. A comparative study of progression between Africa and the west showed: after 1 year 19-25% of children in the west and 30% of the children in Africa had progressed from infection to AIDS; while after 5 years, it was 37% and 70% for Africa respectively. Progression to death was: after 1 year, 10-20% and 34% in the west and Africa respectively; after 5 years, 30% and 75% in the west and in Africa respectively; after 10 years, 40%

and almost 100% in the west and Africa respectively.<sup>(87)</sup> These statistics indicate that the progression of the disease in African children without the current interventions like highly active anti-retroviral therapy, is double that of the western children. This is because the African children are still exposed to the usual childhood illnesses like malnutrition, diarrhoea and vomiting, acute respiratory infections (ARI), malaria and measles. These are responsible for 75% of the cases of morbidity and mortality among children aged below 5 years in Africa.<sup>(92)</sup> Poverty underlies all these problems making it difficult to provide adequate health services, prevent diseases and feed the children.

Among the children there are slow and fast progressors. The slow progressors develop HIV related signs and symptoms after the age of 2 years. The fast progressors do so within the first 2 years of life. show the characteristics of fast and slow progressors. Slow progressors have stable CD 4 counts for 2-10 years, normal birth weight, low viral loads at birth and develop opportunistic infections after 10 years. Fast progressors are low birth weight, low CD 4 counts, high viral loads and develop opportunistic infections within the first two years.

Most of the African children are fast progressors and so they get the early severe form of the infection. In fact 50% die within the first year of life in the absence of intervention. This informed the policy of putting all children aged below 2 years on ARVs irrespective of the CD 4 counts in 2006.<sup>(87)</sup> In 2013, the WHO changed the guidelines to putting all children under 5 years on ARV while the government of Kenya recommended that all the children below 10 years be put on ARVs regardless of the CD 4 counts or clinical stage of disease.<sup>(93,94)</sup>

## **Disclosure of the HIV positive status**

Disclosure is the process of revealing the HIV positive status to the child/adolescent. It involves informing the caretaker and/or the child and informing others about his/her HIV status. As more children survive up to adolescence and adulthood, the need to disclose their HIV status has increased. According to the American Academy of Pediatrics (AAP), the child should not be the last person to know his/her HIV status.<sup>(95)</sup> In Kenya and Africa, the child is usually the last person to know his/her HIV positive status because more than 75% of the children do not know their status.<sup>(96,97)</sup> There are perinatally HIV infected children on ART who reach adolescence without knowing that they are HIV infected though they attend the care clinic regularly.

## **Prevalence of disclosure**

The prevalence of disclosure of the HIV positive status to children and adolescents is high in the developed countries and low in the developing countries. In SSA where 90% of the HIV infected children in the world are found, the prevalence of the HIV status disclosure is 11-26 %.<sup>(95,96)</sup> This means that more than three quarters of children in Africa and the world do not know that they are infected with HIV. In America the prevalence was 25-90 %.<sup>(95)</sup>

## **Factors that enhance disclosure**

The factors that increased the odds of disclosure in a study that we conducted in western Kenya were being on ARVs, older age of the child, and depression in the child and the clinic attended. The patients who were attending the Webuye clinic were three times more likely to have been disclosed to than those who were attending the MTRH. It was noted that there was a nurse at the Webuye clinic who was trained and keen on disclosure. It could

also have been that the MTRH clinic had more patients and less staff hence there was inadequate time to do disclosure counseling.<sup>(98)</sup> Most studies have indicated that the older child is more likely to be disclosed to than the younger one. This may be because the health care providers and the caretakers feel that these children are mature enough to handle the information.

### **Barriers to disclosure**

The barriers to disclosure include the caregiver, child, clinic, and perceived risks and benefits.

The caregiver may be afraid of the impact of the information on the child; child informing others thereby making the family to be stigmatized and ostracized and emotional effect on the child. The caregiver may not want the healthcare provider to disclose because he/she wants to do it. He /she may have misconceptions or may not understand the issues about HIV because of the level of formal education.

The child could be a barrier due to his age, mental development, emotional development, disease progression, lack of understanding and changing adherence behavior. A young child with low understanding may not be able to grasp the significance of the information and may also be emotionally unprepared for it. The mental health of the child is also a barrier if the child is mentally challenged he may not be able to understand what is said. Disclosure should not be done to a child who is in advanced stages of the disease.

The barriers attributable to the clinic include time, available personnel, not knowing when to start, not knowing what has been discussed before, and not feeling comfortable due to lack of knowledge, training, and skills. When the staff in a clinic are few, they do not have adequate time to conduct disclosure

counseling. Most programs do not have disclosure training for their staff so they feel uncomfortable because they lack the requisite skills and do not know when, how and where to do the counseling. The National AIDS and STI control Program (NAS COP) and AMPATH have developed training manuals that are being used to train health care workers in western Kenya. This is in the nascent stages and therefore most workers are not yet trained. There are few counselors and other staff in most clinics in Kenya.<sup>(99)</sup>.

Culture is also a barrier to disclosure. There are cultures that do not think that a child is autonomous, can be given certain information, view HIV as taboo and believe that treatment is unnecessary. Some of our cultures believe that it is taboo to talk about HIV and that makes it difficult for healthcare providers to discuss it with the parents/ guardians. It is also difficult for the parents to tell their children about their status. Some people believe that prayers can heal HIV and therefore treatment is not needed thereby making it impossible to discuss HIV status of the child/adolescent.<sup>(99)</sup>.

### **Impact of disclosure**

There have been mixed findings on the impact of disclosure on the child/adolescent, parent and family. There are studies that found that disclosure of the HIV status led to a higher degree of self esteem and less depression.<sup>(95,100-102)</sup>. In one study it was concluded that interventions to promote disclosure could facilitate access to emotional and peer support.<sup>(103)</sup>. A study in Tanzania, Botswana and Zambia demonstrated that disclosure helped patients to cope with stigma.<sup>(104)</sup>. In the Democratic Republic of Congo (DRC) it was found that disclosure improved adherence to medication. This was corroborated by our work in

East Africa.<sup>(90,91)</sup> In the DRC and the USA there was no difference before, during and after disclosure to health related quality of life, mental health and social behavior.<sup>(122,123)</sup> In west Africa disclosure led to a higher retention rate in care.<sup>(96)</sup>

On the contrary, disclosure has been found in other studies to lead to stigmatization, discontent and ostracization towards the child and the family.<sup>(109,110)</sup> In our East African study, parents were afraid that disclosure would impact negatively on the children's psychological state.<sup>(105)</sup> Disclosure has also been seen to lead to some adolescents engaging in more risky social behaviors like risky sexual activity, smoking cigarettes and other substances and greater emotional distress.<sup>(111)</sup>

## **The Process of Disclosure**

The process of disclosure of the HIV status to children and adolescents is complex and has many unresolved issues. Some of the unresolved issues include the exact age to begin the process, circumstances and potential impact of disclosure.

## **Factors to consider before disclosure**

Several factors need to be taken into consideration before embarking on the process of disclosure. The process should not begin when the CD 4 counts are very low and probably the patient is ill. The CD 4 counts should be acceptably high and stable. It is preferred that the children should be asymptomatic to undergo the disclosure process. The burden of treatment and multiple drug regimes should be considered. Children on several regimes such as ARVs, OI prophylaxis and anti-TB for example may not be good candidates for disclosure. The child's intelligence quotient (IQ), cognitive and mental development should be such that he/she will be able to understand the issues being discussed. The age is of paramount importance because it

determines these factors. Though the exact age is not yet agreed upon, most programs recommend school age (about 6 years) as the appropriate time to start. Care has to be taken when discussing the mode of transmission to the child. Perinatally infected children may feel bad about their parents for having infected them with the virus. It has been shown that most children are not aware of how they got infected. It is not considered a critical part of the process.

The AAP in 1999 made the following recommendations on the disclosure process:

Counseling for parents and guardians by a knowledgeable professional about disclosure to the child; disclosure should be individualized to include the child's cognitive ability, developmental stage, clinical status and social circumstances; Younger children, if symptomatic with illness, discuss more immediate future. Do not need to be informed of the diagnosis but the illness should be discussed; strongly recommends disclosure to school age children. Symptomatic children particularly those requiring admission should be informed of their HIV status; adolescents should know their HIV status and be fully informed to appreciate consequences for many aspects of their health including sexual behavior; adolescents should also be informed of their HIV status to make appropriate decisions about treatment and participation in clinical treatment trials. Physicians should also encourage adolescents to involve parents in their care.<sup>(95)</sup>

### **NASCOP disclosure process**

Gathering information; Preparing the patient/caregivers; educating parents/caregivers; Assessing child's developmental stage Partial disclosure to child; Full disclosure to child; Post-disclosure follow-up<sup>(99)</sup>.

This process has been adapted and adopted by the AMAPTH program for training of staff and management of patients.

Unresolved issues about disclosure

There are many undetermined issues about disclosure which need further research especially in sub-Saharan Africa. At AMPATH and within the IeDEA fraternity we are addressing them.

These include: exact age for beginning and ending disclosure; who should disclose; where disclosure should be done (clinic vs home); circumstances surrounding the process; impact of disclosure on the child/adolescent, family and community.

## **Adherence to HAART**

To sustain the effects of highly active antiretroviral therapy (HAART), adherence needs to be perfect. In LIC this can be a big challenge. However, most studies from low income countries report an adherence of more than 75% while those from high income countries report less than 75% .<sup>(112)</sup>

Adherence is variously defined as taking more than 85% or 95% or 100% of the required doses. It is measured by: self-reports, caretaker reports, pill counts, pharmacy records, clinic adherence, therapeutic drug monitoring and directly observed therapy(DOT).<sup>(113-117)</sup> Most studies from LIC use self or caretaker reports for assessing adherence. This is because the cost of doing plasma levels of drugs as a means of assessment is high. When compared with the self/caretaker reports, the pill count and the plasma concentration yield lower adherence estimates.<sup>(118)</sup>

Few studies have correlated adherence to clinical or laboratory outcomes. A study in Thailand by Rongkavulik et al found that the global adherence score correlated with plasma HIV RNA at baseline.<sup>(119)</sup> In a study in western Kenya, we found that perfect



adherence was reported in 75% of the cases but it was not significantly associated with the CD 4 percent response.<sup>(120)</sup> In another study in western Kenya which looked at adherence to clinic appointments, it was found that there was no significant correlation between clinic adherence and the orphan status.<sup>(121)</sup>

### **Impact of non-adherence on viral suppression**

Adherence is a determinant of viral suppression and is fundamental to the success of any ART program.<sup>(122)</sup> Findings from prospective adult and pediatric studies have demonstrated a direct correlation between risk of virologic failure and proportion of missed doses of ARV drugs.<sup>(123)</sup> Based on work in populations of adults primarily being treated with non-boosted protease inhibitor-based regimes, 95% has been the threshold associated with viral suppression. The relationship between ARV adherence and viral suppression may vary by drug, drug class, and pattern of adherence.<sup>(124)</sup> The different patterns of inadequate adherence may have a different impact on regime efficacy depending on the drug combination.<sup>(125)</sup> Factors such as regimen potency, pharmacokinetics, viral fitness and the genetic barrier to ARV resistance influence the adherence-resistance relationship. In addition to compromising efficacy of current regime, inadequate adherence has implications for limiting future effective drug regimens in patients who develop drug-resistant viral strains and transmission to sexual partners.<sup>(126)</sup>

### **Factors associated with rates of adherence**

The factors associated with the rates of adherence include medication formulation, frequency of dosing, child's age, disclosure of the HIV status, psycho-social and behavioral issues. However, there are no clear predictors of good or poor adherence.<sup>(127)</sup>

## **Adherence issues specific to children**

In children, adherence is a complex health behavior that is influenced by the regimen prescribed, patient, family and healthcare provider characteristics.<sup>(128)</sup> There is limited availability of palatable formulation for the young children.<sup>(123,129)</sup> Children are dependent on others for the administration of medication and therefore assessment of the caregivers and their environment, ability and willingness of the child to take medication is necessary.

The caretaker barriers to adherence include forgetting doses, changes in routine, being too busy, type of occupation, child refusal, caretakers' health problems, unwillingness to disclose the HIV status to the child and others, reluctance of caretaker to refill the prescription locally, hiding or relabeling the drugs, avoidance of social support, and a tendency for doses to be missed if the caretaker is not available.<sup>(130,131)</sup> Family characteristics that may jeopardize adherence are illicit substance use, unstable housing and involvement with the criminal justice system.

## **Specific adherence issues in adolescents**

HIV-infected adolescents have special barriers to ART adherence. These include pill burden, life-style issues (not having medications on hand when away from home and change in schedule), denial, fear of HIV infection (especially among the newly diagnosed), distrust of the medical establishment, misinformation about HIV, lack of knowledge about the availability of effective ARV treatments and regime fatigue.<sup>(132-134)</sup> Other barriers are low esteem, unstructured chaotic life-style, mental illness like depression, alcohol or substance abuse, poor school attendance and advanced HIV disease. Lack of disclosure to the adolescent, caretaker or other relatives/friends and difficulty in getting where to hide the drugs from other people in the house or school.<sup>(135)</sup>

## **Adherence assessment and monitoring**

As stated above, adherence is key to the success of any HAART program. Therefore, adherence counseling should be done before initiating ART. Initiation of ART is not an emergency and therefore perfect adherence should be ascertained before initiating ART. During the adherence counseling the patient/caretaker should be informed about the HIV positive diagnosis, available treatments and that the ART is life-long. The patient/caretaker is also taught about the ARV medications in terms of dosage, side effects, time of taking drugs, and the need for perfect adherence.

A comprehensive assessment of adherence is made after the counseling sessions. Routine adherence counseling and assessment is carried out at each clinic visit. Before initiating ART, adherence assessment is conducted to find out the child's/caretaker's understanding of the diagnosis, treatments, dosage, side effects, duration of treatment, ability to keep clinic appointments among others. For the assessment of adherence to medication one can check how well the patient has been taking drugs such as septrin. We also use adherence to clinic appointments while on septrin to see how well the patient is able to adhere to clinic appointments.

At each clinic visit, the patient is encouraged to bring the remaining drugs (ARVs and OI prophylaxis) for the pill count and/or volume assessment. The patient is asked how many doses were missed in the last one week and one month for the self/caretaker reported adherence. It is also indicated if the patient has come for a scheduled visit or not. However, there is anecdotal evidence that the patients do not bring back the remaining septrin and the clinicians do not do a pill count of the ARVs brought.

## **Strategies to improve and support adherence**

During the first month of the ART, the patient should be reviewed every week to continue with the adherence counseling and monitor any side effects from the drugs. The strategies to improve and support adherence include developing patient specific focused treatment plans such as associating medication with daily activities like brushing of teeth and use of social/community support. Most effective approaches utilize multifaceted strategies like regimen-related strategies; education, behavioral and supportive strategies focused on children and families; and also focus on the healthcare providers. Within the AMPATH program we have tried to associate the treatment to daily activities. Directly observed combination therapy to adults has been shown to be successful but has not been tried in AMPATH pediatric care. The modified directly observed treatment (mDOT) in which one dose is observed by the healthcare provider while the rest are taken at home is both acceptable and feasible though it has not been tried locally.<sup>(136-138)</sup>

### **Regime related strategies**

The regime related strategies to improve adherence include: a reduction in the number of pills by the use of combination drugs, once daily instead of twice daily doses where possible, masking the taste of the unpalatable drugs by mixing with another syrup and teaching children to swallow tablets to overcome medication aversion.<sup>(139)</sup>

### **Child/family related strategies**

The child and family related strategies for improving adherence are primarily based on educating them. As discussed earlier, the education includes a discussion of the goals of the treatment, reasons for making adherence a priority and the specific plans for

supporting and maintaining a child's adherence to medication. The caretaker should understand that the first-line of treatment has the best chance of succeeding and therefore must not fail because of inadequate adherence. The family should also be provided with information and adherence tools such as written and visual materials, a daily schedule illustrating times and doses of medications and demonstration of the use of syringes, medication caps and pill boxes. These are done in the AMPATH pediatric care system. Behavioral tools such as incentives for taking medication and positive re-enforcement can also be used. Availability of mental health services and treatment of mental disorders can also promote adherence. Other strategies that have been used in clinical settings are: setting off of the patient's cell phone alarm at the time of taking medication, weekly re-filling of pill doses by the nursing or pharmacy staff and home delivery of the drugs. These were found to improve adherence in a study in Kenya though it is not used by the AMAPTH program.<sup>(94,140)</sup>.

### **Healthcare provider strategies**

The strategies that have been associated with improved adherence include: consistency, giving information, asking questions, technical expertise and commitment to follow-up.<sup>(94)</sup>.

## **Transitioning of Children on Art From Pediatric to Adult Care**

### **Background**

Transitioning of children from the pediatric care to adult care is a process that has to be planned precisely and instituted over a period of years. It is defined as 'a multifaceted, active process that attends to the medical, psychosocial, and educational or vocational needs of adolescents as they move from the child-focused to the adult focused healthcare system'. Healthcare

transition must also facilitate and foster development in other areas of life such as work, community and school. <sup>(141)</sup> This requires that the child to be transitioned be aware of his/her HIV positive status. As discussed before most children in Africa do not know their HIV status even though they attend clinic and receive care.

With the advent of ARVs, more children who were perinatally or behaviorally infected with HIV are surviving to adolescence and adulthood. These children/adolescents need to be transitioned in an orderly manner that take into account the issues of adolescence such as risky sexual behavior, drugs, mental health, work and schooling. They need to have had their HIV positive status disclosed to them before beginning the transitioning process. If disclosure has not been done by the pediatric caregivers, it will be assumed to have been done by the caregivers in the adult clinic.

Most HIV programs in SSA have no plans for transitioning children/adolescents to adult care because of the low prevalence of disclosure and lack of knowledge of the process. They do not have SOP (standard operating procedure) on transitioning and have not trained their staff. The prevalence of transitioning in Africa has not been studied but using the prevalence of disclosure as a proxy, the prevalence of transitioning is expected to be low because it cannot be done without first disclosing. Also most clinics combine the pediatric and adult care clinics in the same place and services are offered by the same staff. Hence the children are simply instructed to be coming on a different day of the week and dosage is changed. This is done without regard to the child's other needs. An adolescent clinic is necessary for proper transitioning but there are few programs with adolescent clinics.

The process of transitioning children from pediatric to adult care

There are few processes in the literature like the American Academy of Pediatricians', and the Baylor (Botswana). They suggest different ages of starting the process, duration of the process and the number of stages/ phases of the process. However, they agree that the mental and developmental status should be such that the child/adolescent should be able to understand and follow the discussion; the child should not be too ill at the time of discussion; the plan should be written in consultation with the child/adolescent and the plan should be executed over a period of time.<sup>(141,142)</sup>

While there is a lot of literature for the transitioning of children from pediatric to adult care for other chronic illnesses like diabetes, cystic fibrosis, epilepsy and spina bifida, there is scanty on HIV infection. The experience with these diseases is also only in the west but not in LIC in SSA. Hence while the physicians in the west can borrow from their experience with the other diseases, African doctors cannot.

Most HIV infected children have lost one or both parents to the disease, other chronic illnesses or violence and therefore lack someone that can assist them through the transition process. Usually the children/adolescents will have been receiving care from the same primary physician or clinician and therefore find it hostile and unfamiliar. Some of them find it difficult to mix with very old and sick people who make them think that they may die soon if they continue attending the clinics. They therefore need an adolescent clinic to help them make the transition.

The American Academy of Pediatrics (AAP) process include the following stages: find a healthcare provider who assumes responsibility for current and future coordination; provide

mandatory transition training for primary care physicians, either during residency or thereafter; generate a medical summary that is current and accessible; prepare a written healthcare transition plan together with the adolescent and his/her family; adhere uniformly to the adolescent preventive care guidelines; and ensure affordable, continuous health insurance coverage for all young adults with disabilities and special health care needs (DSHCN) throughout adolescence and adulthood. The Botswana Baylor Children's Clinical Care of Excellence (COE) suggests two phases of the transitioning periods as follows: phase 1, adolescents aged 13-16 years will be followed to meet 4 goals namely, full disclosure, understanding of disease process, disease markers, and prevention methods; phase 2 is entered if phase 1 goals are met and phase 2 goals are, medication independence, maintain adherence at over 95%, undetectable viral loads, identification and enrollment into an adult clinic. The achievement of these goals provides the patient in phase 2 with two options : transfer to an identified adult HIV clinic directly or transfer with interval visits at the COE. The long-term care plan of the adolescents who decline to transfer to an identified adult care clinic or are unable to meet the phase 1 and 2 goals by age 21 years, will be reassessed by COE's medical and mental health teams. For those unable to transfer even after being assisted, continued care at the at the COE through an existing family model clinic is an option.<sup>(142)</sup>

Countries in sub-Saharan Africa without such processes in place will need to adopt and adapt the existing processes and use them to transition their adolescents.



## **Research**

There is scanty research on the issues of transitioning process because most care providers are not yet doing it. Some are not even aware of it or the need for it. There is need for such research to determine what is currently being done, the existing gaps and how to fill them. I am leading on research on transitioning in analyses that involve 5 of the 7 regions of leDEA.

## **Challenges of HIV infected and affected children**

HIV/AIDS has caused havoc on children who are infected or affected. It has orphaned many children as discussed above and left them destitute without parental protection or support. These children have ended becoming vulnerable, abused, exploited, laborers, prostitutes, and street children. All these have their challenges as already discussed. The HIV infected children face the scourge of stigma, difficulty in accessing comprehensive care and availability of child friendly drugs. Some drugs are very bitter and have to be kept in conditions that are difficult to maintain in their homes. The children have to rely on an adult to ensure that they adhere to the treatment. Most of the children do not know that they are HIV infected even though they attend clinics for care. They are transitioned to adult care without disclosure of their status. In the adult care clinics disclosure is assumed to have been done by the pediatric care providers. In most cases the transitioning process is not followed because of lack of knowledge and skills to do it. This is producing a population of adolescents and adults on treatment who do not know the reason for the treatment. It is possible that this may reverse the gains made in the fight against HIV/AIDS should these adolescents rebel on realizing what their status is.



## Chapter Seven

### Response to the Problem of Children in Especially Difficult Circumstances

#### Background

The world responded to the plight of children in especially difficult circumstances by recognizing the problem. The UN established the UNICEF in response to difficulties faced by the children affected by the Second World War in 1948. UNICEF initially was concerned with reducing infant mortality and ensuring that the children were educated. In 1986, it realized that the children who were surviving infancy were dying from natural and Man-made disasters. It therefore came up with the concept of children living under especially difficult circumstances. The efforts resulted in the adoption of the convention 182 on child rights by the UN General Assembly (UNGASS) in 1989. This forms the basis of the laws that protect and secure children's right in the world. <sup>(143)</sup>.

The convention is of particular importance to the continents of Asia and Africa (especially SSA) which have the greatest concentrations of absolute deprivations of child rights. There is evidence that investing in child rights is both a responsibility and an opportunity. It is a responsibility because poverty, under-nutrition and other deprivations undermine children's abilities to achieve their full development. It is an opportunity because the gains made through better nutrition, provision of healthcare, education, and protection of children are likely to have far greater

and longer lasting effect than any other area of development. The convention has transformed the attitudes towards childhood by setting the minimum standards for the treatment, care, survival, development, protection and participation that are due to each individual aged below 18 years. <sup>(143)</sup>

Based on this convention and other international charters and treaties that Kenya is a signatory to, the government of Kenya enacted laws to safeguard and implement the rights of children. It put in place the Children's Act 2001, policy on children's rights and policies to actualize them.

This section will detail the efforts by various international, national, local, governmental and non-governmental organizations to deal with this problem.

## **Disasters**

It has been shown that re-uniting children with their families makes them suffer less from the impact of the disaster. It is therefore important to re-establish a semblance of family by setting up schools and playground with some continuity of family and community life. <sup>(1)</sup>

To maintain the child's development, the following should be done: placement with nurturing adults, establishment of viable day-care facilities, maintenance of basic health services and skills training. For the unaccompanied children, conscientious training and placement, re-unite them with relatives, avoid unnecessary institutionalization and avoid offering orphans for adoption. There is no agency that has the responsibility or is best placed to handle internally displaced persons. UNICEF participates in an ad hoc capacity. It is advisable to encourage families and communities to take initiatives on their own behalf. Family and community disintegration should be prevented because the

rehabilitation depends on the cohesion between the family and the community. There should be good communication between the country's assistance providers, external donors and the affected communities. It is important to maintain and reinforce indigenous capacity to respond to the emergency.<sup>(1)</sup> Civilians should be protected in accordance with the international laws that provide protection of persons participating in hostilities and for special protection for the vulnerable persons like children and women.<sup>(1,2)</sup>

## **Child Abuse**

The treatment of a child abuse victim has been discussed in chapter three. The interventions for the prevention of child abuse and neglect are important in the management of these children. Though this is universally acknowledged, not enough has been done about it. Most programs focus on the victim and perpetrator of the abuse.

The common interventions used in the prevention of child abuse include, family support such as training in parenting, home visitation, intensive family preservation services, training for healthcare professionals; healthcare services approach like screening by healthcare professionals, training for healthcare professionals; therapeutic approaches like services for victims, services for children who witness violence, services for adults who were abused as children; legal and related remedies such as mandatory and voluntary reporting, child protection services, child fatality review teams, arrest and prosecution policies, community based school programs, mandatory treatment for offenders, preventive and educational campaigns, intervention to change community attitudes and behavior; societal approaches including national policies and programs, and international treaties.<sup>(35)</sup> These approaches have been put in place in the HIC

in particular the USA but not in LIC including Kenya which have the bulk of the cases because of the low socio-economic levels.

In Kenya in 1996, a coalition was formed with the goal of raising public awareness of child abuse and neglect and improving the provision of services to victims. This followed a study that showed that child abuse and neglect was rampant in Kenya but there were no response systems in place. The coalition drew its members from government ministries, NGOs with community based programs and representatives from the police, judicial systems and the main hospitals. All the members of the coalition were trained on child abuse and neglect. There were 3 working groups established to deal with training, advocacy and child protection. The training working group worked with the ministries of Education, Health, Home affairs and Labor. The advocacy group worked with the ministry of Information and Broadcasting and various NGOs to produce radio and television programs in collaboration with the press in rural areas. Children were involved through drama, music and essay writing competitions at local, district, provincial and national levels. These competitions are now a regular feature within the Kenyan education system. This was in line with the convention on child rights that recommend participation by children in their affairs.<sup>(22)</sup>

The coalition assisted the ministry of Home Affairs to set up a database on child abuse and neglect and create a legal network for abused children known as the Children Legal Action Network (CLAN). Sensitization and training workshops were conducted around the country for healthcare professionals and researchers in the field. Consequently, more Kenyans became aware of child abuse and neglect and a system established to address the needs of the victims and perpetrators including creation of children's courts.

In Eldoret, the conference by the coalition was held in 1998 at the Hotel Sirikwa. Lecturers from the Moi University School of Health Sciences were involved. The participants were drawn from the departments of pediatrics, nursing sciences and psychiatry. This resulted in the introduction of a course on child abuse and neglect in the department of child health and pediatrics for the undergraduate and postgraduate students. The course for the undergraduate students is conducted through tutorials while the postgraduates have a 10 day symposium. The symposium is conducted by pediatricians, sociologists (county children's officer), lawyer in private practice, psychologist, coordinator of an OVC project and a director of a children's home among others. This is to enable the students to understand the plight of abused children, the laws protecting them and the roles of various experts in their management.

At the MTRH, social workers have been sensitized and involved in the management of abused children through social investigations and making recommendations on what needs to be done for the victims and perpetrators. The victims may be returned to their homes, admitted to children's homes, taken to foster homes or given up for adoption depending on the results of the investigations. The perpetrators usually undergo a psychiatric assessment and depending on the findings, they may be prosecuted or given psychiatric treatment and psychological counseling. There is a center that attends to victims of sexual abuse. This offers post-exposure-prophylaxis against HIV infection and management of the injuries and medical legal forms completed. The Sally test was started to assist the abandoned children left in the pediatric wards and prepare other children for different procedures.

## **UNICEF**

The United Nations Children's and Emergency Fund (UNICEF) has played a central role in the fight for the rights and protection of children from abuse and harm, provision of healthcare, education and their survival. It has spearheaded the evolution of the convention on the rights of the child.

### **Evolution of the international standards on child rights**

**1924:** The League of Nations (the precursor to the UN), adopts the Geneva Declaration on the rights of the Child. The declaration establishes the rights to means for material, moral, and spiritual development; special help when hungry, sick, disabled or orphaned; first call on relief when in distress; freedom from economic exploitation and on up-bringing that instills a sense of social responsibility.

**1948:** The UN General Assembly (UNGASS) passes the Universal Declaration of Human Rights which refers in article 25 to childhood as 'entitled to special care and assistance'.

**1959:** The UNGASS adopts the Declaration of the Rights of the Child, which recognizes rights such as freedom from discrimination and the rights to a name and nationality. It also specifically enshrines children's rights to education, healthcare, and special protection.

**1966:** The International Covenant on Civil and Political Rights on economic, Social and Cultural Rights are adopted. The covenant advocates protection for children from exploitation and promote the right to education.



**1973:** The International Labor Organization (ILO) adopts convention No. 138 on the Minimum Age for Admission to Employment which sets 18 years as the minimum age for work that might be hazardous to an individual's health, safety and morals.

**1979:** The UNGASS adopts the Convention on the Elimination of All Forms of Discrimination against Women, which provides protection of the human rights of girls as well as International year of the Child, which sets in motion the working group to draft a legally binding convention on the Rights of the Child.

**1989:** The UNGASS unanimously approves the convention on the Rights of the Child which enters into force the following year.

**1990:** The 1990 World Summit for Children adopts the World Declaration on the Survival, Protection and Development of children along with a work plan of action for implementing it in the 1990s.

**1999:** The ILO adopts the Convention No. 182 concerning the Prohibition and Immediate Action for the Elimination of the worst Forms of Child Labor.

**2001:** The government of Kenya enacts the laws on children in the Children's Act 2001. This domesticates the Rights of the child and brings all the laws in the constitution on children into one act.

### **The Convention no. 182**

This is referred to as the Convention. It is the most comprehensive document on child rights in the world. It has got 54 articles that are based on 4 core principles. These include: non-discrimination; best interests of the child; the right to life, survival and development; review of the views of the child. Thus it recognizes that the views of the child are important and should be sought.

It has achieved near universal acceptance by being ratified by 153 countries with the exception of Somalia and USA. It has reaffirmed the human rights by applying many of the core principles of previous human rights instruments like universality and non-discrimination. It has enriched human rights by consolidating and amplifying provisions that are included in other human rights instruments and specifying responsibilities and duties of state parties towards children. It also incorporates the rights of children previously not articulated like right to participation and stipulates that the best interests of the child should be a primary consideration in all actions towards them.

The convention also stresses that the accountability for child rights lies with duty bearers such as state parties, families and guardians. It has set the terms of childhood by outlining the minimum standards for the treatment, care, survival, development, protection and participation.

Under the convention, the children are right holders rather than objects of charity. Fulfilling these rights is an obligation that governments have pledged to meet. Of note is the optimism that it captures.

Throughout its articles the convention underscores the fundamental role of the family in the growth and well-being of children, recognizing the crucial importance of a loving, harmonious and understanding family environment for the full development of children. It obliges the states to provide the family with all the means necessary to realize its responsibilities.

However, most developing countries especially in the SSA, are not able to meet these obligations. In spite of the good intentions of the convention, there are still 500 million to 1.2 billion children living under especially difficult circumstances in the world.<sup>(143)</sup>

## **Government of Kenya**

The Government of Kenya (GoK) responded to the plight of children living in especially difficult circumstances by signing charters on children's rights, domesticating international laws and treaties, and enacting the Children Act 2001. It also put policies and instruments of implementing the Act and enforcing it through the national children's policy 2010, minimum service standards for quality improvement of OVC programs, child protection system of Kenya and the service charter.

## **Children Act 2001**

This Act is referred to as the CA 2001. This is an Act of Parliament that provides for the rights of children and seeks to enhance the welfare of children in Kenya. It was enacted mainly to put together provisions of various laws that affected children and to give effect the provision of the constitution on the rights of the child (CRC) and the African charter on the rights and welfare of the child.

## **Definitions**

It provides the definitions of a child; child abuse; parent, early marriage and female circumcision.

## **Safeguards for the rights and welfare of children**

The Act provides for the rights of children which can be classified as follows: welfare rights that include, the right to: life and development, parental care, health and health services and free and compulsory basic education; protection rights including the right to be protected from: child abuse, hazardous child labor, harmful cultural activities such as FGM and early marriage and drug abuse.

The underlying principles by which these rights will be practiced are best interests of the child and non discrimination. It also provides for the enforcement of the rights by giving the penalties for contravention of the same.

The Act spells out the responsibilities of the child as :work for the unity of the family; respect his parents, superiors, and elders at all times and assist them in case of need; serve his community; preserve and strengthen social and national solidarity; preserve and strengthen the positive cultural values of his community in his relations.

### **Parental responsibility**

Parental responsibilities refers to the duties, rights, powers and authority which by law a parent of a child has in relation to the child's property in a manner consistent with the evolving capacities of the child.

The people with the parental responsibility are the mother and the father of a child who are married at the time of the child's birth; the mother and the father of a child who were not married at the time of the birth of the child but have subsequently married.

The children's Act distinguishes between children born in a marriage and those born outside a marriage but the new constitution provides for equal parental responsibility to a mother and father whether married or not.

### **Administration of children's services**

The Act bestows the responsibility of administering of children's rights on the National Council of Children's Services; the Director of children's services; local authorities; children's institutions and the children's court. It also spells the roles of each of the stakeholders and the process of adoption/fostering of children.

## **Penalties**

Any person who is convicted of having infringed on the rights of a child shall be liable to a term of imprisonment not exceeding twelve months or to a fine not exceeding fifty thousand shillings or both fine and imprisonment.

## **The National Children Policy Kenya 2010**

### **Background**

This document was developed on recognition that the Children Act 2001 had been enacted without a framework policy to enforce it. It therefore serves as a guideline to the GoK in achieving its commitment to the children of this country.

The policy was developed in the context of international, regional and national instruments including: the UN Convention on the Rights of the Child (1989); the African Charter on the Rights and Welfare of the Child (1990); the Children Act (2001), National Early Childhood Development Policy framework; the Refugee Act (2006); the Hague Convention (1993); Employment Act (2007); ILO Convention number 182; Minimum Age Convention number 138; Refugee Convention (1951) and the Disability Act (2003). Other frameworks taken into account included the Kenya Health Policy framework (1999); the National Health Sector Strategic Plan II (2005-2010); the National Early Childhood Development Service Standard Guidelines (2006); Sexual Offences Act (2006); Food and Nutrition Policy (2007) and the National Hygiene and Sanitation Policy(2007).

### **Policy vision**

The vision of the policy is based on the pillars of the UN Convention 182 and therefore it is to create an environment where all the rights of a child in Kenya will be fulfilled.

### **Policy goals and objectives**

The broad objective of the policy is to realize and safeguard the rights and welfare of the child.

The specific objectives are: To provide a framework for addressing issues related to children's rights and welfare in a holistic and focused manner; To act as a regulatory framework to coordinate the many related policies and legislations that are geared towards the promotion of children's rights; To provide direction and purpose in establishing social and child protection mechanism while mobilizing for resources for action; To act as a criterion for evaluating and monitoring the implementation of various legislations, policies and programs on issues related to children.

### **Policy principles**

The policy is based on the following principles:

To uphold the best interests of the child in all situations; To ensure respect for human dignity, accountability, non-discrimination, equity and equality in relation to children; To ensure accessibility of services and participation by children; To commit every individual adult to take responsibility to protect the rights of the child regardless of the individual's relationship to the child.

### **NB:**

The policy also acknowledges that there are pieces of legislation that need to be harmonized such as the minimum age for sexual consent, marriage and criminal responsibility.

### **Rights provided for**

The policy provides for survival, developmental, protection, participation rights and the duties and responsibilities of the child. The survival rights take cognizance of the fact that children have a right to be born, nurtured, and to grow in a conducive and secure environment. Hence it provides for the right to health from conception and throughout life. The developmental rights include education, play and leisure, cultural and artistic activities, access to appropriate information, social security and parental care. The protection rights are based on the fact that all children especially those with disability and those with special needs have a right to be protected from any harm that may interfere with their growth and development. These rights are realized through actions that ensure children have access to birth registration and identity, as well as systematic measures against substance abuse, neglect, displacement, disasters, wars and conflicts among others. The protection rights addressed in this policy document include: identity and registration; drug abuse; physical abuse; child labor; child trafficking; child sexual abuse and exploitation; child neglect; children of internally displaced persons (IDP) and refugees; children affected by disasters, wars and conflicts; negative impact of information communication technology (ICT) and media; retrogressive cultural beliefs and practices; negative influence and harm by caregivers; orphans and vulnerable children; children under community care, adoption, foster care and charitable institutions. The participation rights have been provided for by underscoring the need for children to participate in the decision making on matters that affect them. The policy also gives duties and responsibilities to the child in line with the African Charter on child rights.

This document is comprehensive enough to ensure the rights of the children as highlighted in various documents if implemented. It is a good effort by the GoK in trying to provide the children their rights.<sup>(144)</sup>

## **The Framework for the National Child Protection System for Kenya**

### **Background**

The framework for child protection system defines the key components, the institutions involved and how they are regulated and coordinated both horizontally and vertically. This was found necessary to develop after Kenya had made great strides of addressing child rights and protection by signing and domesticating international and regional charters, enacting laws (Children Act 2001) and coming up with policies on the same. Child protection requires multi-sectoral and multi-disciplinary collaboration. The system includes a set of laws and policies that protect children from violence and exploitation; a central government coordination mechanism bringing together government departments and civil society organizations at all levels; a centralized management information system that ensures regular collection of information on both prevalence and incidence of child protection issues; services and responses that are effectively coordinated. It was important to coordinate the various groups involved in child protection work to avoid duplication and maximize the use of resources. Thus the ultimate goal of the system was to promote linkages between actors and provide coordinated interventions and responses through a statutory mechanism.



This system is a statutory mechanism whose structure defines clearly the roles and responsibilities of each level of government and its partners as they jointly undertake activities to safeguard the rights and welfare of children. This ensures that each actor is held responsible for its mandate. The system creates standards in child protection.

### **Objectives**

The objectives of the framework include:

To provide a framework as a reference for a child protection system in Kenya; To define roles and functions of all stakeholders in child protection; To facilitate effective coordination in the provision of child protection services; To facilitate reviewing and enhancing of appropriate and effective legislation and policies, capacities and resources to effectively address issues of children.

### **Guiding principles and values**

Guiding principles are fundamental building blocks that inform and shape the decisions made while designing and implementing a child protection system. The principles become standards against which day-to-day practices are judged.

The principles are:

Best interests of the child; Meeting children's rights; Efforts to protect and promote child rights must be family and community based; Creating and building partnerships and effective relationships; Non-discrimination and inclusion of marginalized children; Child participation; Accountability and transparency.

## **The components of a child protection system**

The components of a child protection system include: a set of laws and policies that protect children from violence and exploitation and ensure response in the best interest of the child when violations occur; a central government coordination mechanism that brings together government departments and key stakeholders at all levels; a centralized management information system that ensures regular information on both prevalence and knowledge of child protection issues; services and responses that are effectively regulated including accreditation and licensing of care providers; adequate and appropriate resource allocation; effective regulation including standards; monitoring and evaluation; a committed work-force with relevant competencies and mandates; and opportunities for children to express their views and be involved.

There is both horizontal and vertical interdependence.

### **Coordination mechanism for this framework**

Coordination prevents most of the issues that undermine efficiency and effectiveness of child protection efforts by different stakeholders in Kenya.

The Ministry of Gender, Children and Social Development and National Council of Children's Services (NCCS) play a key role in coordinating the various stakeholders. The ministry provides leadership for the effective implementation of the framework while NCCS remains with the role of coordination.

### **Roles and functions of stakeholders in child protection**

The framework specifies the roles of government departments, local NGOs, international NGOs and stakeholders with complementary roles. The government ministries and departments include: the ministry of Gender, Children and Social Development; NCCS; County Governments; District Area Advisory Committees (AACs); Ministry of Home Affairs; Ministry of education; ministry of Local Government; Ministry of Health; Ministry of Finance; Ministry of Labor; Attorney General; Director of Public Prosecutions; Ministry for Special Programs; Ministry of Justice, National Cohesion, and Constitutional affairs; the Judiciary.

The stakeholders with complementary roles include children; the private sector; research institutions; civil society organizations (CSOs) and international NGOs.

### **Child labour**

UNICEF has responded to child labor by supporting the roadmap for achieving the elimination of child labor by 2016 which calls for integrated response to child labor; supports communication in changing the cultural acceptance of child labor, strategies and programming to provide alternative income to families, access to nurseries, quality education and protective services; working with employers and private sector to assess and address the impact of their supply chain and business on children.<sup>(55)</sup> The ILO responded to child labor by providing the definition, holding conventions and making declarations that were binding to the countries in the world on child labor and providing a roadmap to the elimination of child labor by 2016. Thus eliminating child labor is a major plank in the ILO goal of 'Decent work for all'. It tackles child labor not as an isolated issue but as an integrated part of efforts for economic and social development. In 2010 The

ILO launched the third report on child labor, warning that the pace and profile of progress is not fast enough to achieve the 2016 deadline of eliminating worst forms of child labor worldwide. The 2010 Hague Global Conference on child labor aimed at strengthening progress towards the 2016 target and ratification and implementation of conventions 138 and 182.

### **Street Children**

The response to the street children problem is covered under all that has been described. These children are a result of disasters, orphanhood, separation and child abuse and neglect at home and community among other reasons. They are abused and neglected, orphaned, rendered vulnerable, separated, exploited, forced into child prostitution, denied their inheritance and literally suffer all the injustices aimed at children. Therefore the efforts by UN, UNICEF, regional, national efforts including the laws enacted discussed above apply to them.

Various countries respond differently to the immediate menace of street children. Some countries round them up and imprison them, others take them to juvenile remand homes, some kill them on the spot and others try to rehabilitate them.

In Kenya in general and Eldoret in particular, they are usually rounded up by the police and council *askaris* and taken to police stations with adult criminals, juvenile remand homes or to assessment centers. In Eldoret, the Rescue center is used to keep the children as they are assessed for returning them to their families, placement in children's homes, fostering or adoption. The Eldoret Juvenile remand home is used for the children found to be in conflict with the law. Their cases are heard by the Magistrates at the Children's Court.

## **Orphans and Vulnerable Children**

The OVC are protected by the laws that protect all the children in the country. They also benefit from the policies in place to actualize these laws. However, due to their peculiar circumstances, the GoK came up with the minimum standards of caring for them as described below.

### **Minimum service Standards for quality improvement of orphans and vulnerable children programs - Kenya**

#### **Background**

There are 2.4 million OVC in Kenya with 50% due to HIV/AIDS. These children are ostracized, stigmatized and generally discriminated against. They are subjected to stress, trauma, loss of parental love and care. The traditional extended family that used to take care of them has been overstretched by AIDS orphans. A situation analysis in 2009 that was conducted to determine the quality of services offered to OVC revealed the following gaps: failure of service providers to adhere to the universally accepted definition of OVC hence leaving out other vulnerable children; quality of services offered by some of the organizations has been inappropriate and led to stigmatization and discrimination of OVC by the rest of the community and wastage of resources; existing interventions only support a small proportion of OVC; lack of social mapping of OVC service providers making it difficult for the department of Children's Services to monitor and evaluate their operations; lack of regulation on the duration a service provider should support a beneficiary; inadequate and inaccurate data on the needs of the children before the intervention is launched; dependence on volunteers as program staff an arrangement that is not sustainable.<sup>(146)</sup>

The minimum standards were developed to bridge these gaps.

## **Objectives of quality standards**

Objectives of quality standards were to develop outcome based standards to improve the quality of OVC services; improve the quality of programs for OVC; support the implementation of various Government policies and guidelines at family and community levels.

### Components of the service standards

The service standards have three interdependent components namely: desired outcome with indicators; essential actions; guidelines to achieve actions with indicators.

Other sections covered in the standards include: methods of implementation of the quality service standards (QSS); intended user of the QSS; guiding principles; monitoring and evaluation and the dimensions of quality.

## **Service Charter: The Cash Transfer for Orphans and Vulnerable Children (CT-OVC)**

The cash transfer for orphans and vulnerable children is a GoK initiative that gives support to households taking care of OVC with regular and predictable monthly cash payments payable after every 2 months. It specifies the eligibility criteria; the rights of the beneficiary households; responsibilities of the caregiver; how to exit from the program; and how to communicate one's concerns to the program.<sup>(147)</sup>

## **OSCAR**

In response to the problems of OVC in Uasin Gishu County, the Moi University School of Medicine (MUSOM) and the Indiana University led consortium of friends of MUSOM established the OSCAR. This was in recognition of the fact that UNAIDS had

estimated that there would be 53 million orphans in SSA by 2010. Half of these orphans would be due to HIV/AIDS. Though the UNAIDS did not recognize OVC as high risk for HIV infection, they were at high risk for socioeconomic exploitation, sexual risk behavior, excessive drug and alcohol use, depression, post-traumatic stress disorder, malnutrition and tuberculosis.<sup>(76)</sup>

Strengthening the capacity of families and communities as used to happen in the extended African family was thought to be the ideal strategy to protect and care for OVC. However, there was evidence that families and communities had been overstretched and overwhelmed by the numbers of HIV orphans who needed care and protection. Several care environments had emerged including formal and informal foster homes; different types of orphanages; community based programs; government detention centers; homes and schools run by religious or other NGOs. These institutions were becoming overwhelmed.

To improve the health and well-being of OVC it was necessary to understand the care environments. The OSCAR project aimed at describing the different care environments in the Uasin Gishu County and determine whether they were able to meet the children's basic needs and their effect on the children's physical and mental well-being. The study involved 300 households (HH), 20 charitable children's institutions (CCI) and 65 street children (SC).

The project studied and published papers on the nutritional status, cash-transfer, drug and alcohol abuse, post-traumatic stress disorder and child abuse of the children in the various care environments. This was the first study of this kind. Generally, the findings indicated that the street children suffered most while the CCI and HH were good for the children. The CCI were found to be the safest environment for the children unlike the current belief

that they should be discontinued. Thus the HH and CCI have a major role in the care and protection of the OVC. These findings have been discussed in different parts of this lecture<sup>(76)</sup>.

### **Environments of care for OVC**

As discussed above, various environments of care have emerged including HH, CCI, streets, formal and informal foster homes, extended families, and detention centers among others. This section will describe the HH and CCI. The street environment has been discussed under the chapter on street children.

### **Community Households (HH)**

These are households that take care of OVC. There are households that receive GOK assistance through the cash-transfer (CT) program discussed above. The CT is a GoK initiative whose aim is to encourage the fostering and retention of OVC in their families and communities as well as enhancing their human capital development.

### **Charitable Children's Institutions (CCI)**

The CCI are also referred to as children's homes or orphanages. They are defined by the children's Act 2001 as charitable institutions that accommodate at least 20 OVC.(5). There has been concern in various fora by different stakeholders on the usefulness of these homes. They are thought to fuel the street children menace and therefore should be discouraged.

### **HIV/AIDS**

The HIV pandemic was first described in 1981. The world responded by forming the UNAID in 1994 which started coordinating the issues of the disease in the world. In 1996, the



highly active antiretroviral therapy (HAART) was discovered and has been in use to date. This involves use of at least 3 antiretroviral (ARV) drugs. In 1987 and 1999 NASCOP and NACC were established respectively by the GoK.

## **UNAIDS**

This is the Joint United Nations Program on HIV/AIDS which was established in 1994 by a resolution of the UN Economic and Social Council and launched in 1996. It is guided by a program coordinating board with representatives from 22 governments from all geographical regions, UNAIDS cosponsors and 5 representatives from NGOs including associations of people living with HIV/AIDS (PLHWA)

This is the main advocate for accelerated, comprehensive and coordinated global action on the HIV/AIDS epidemic. The mission of UNAIDS is to lead, strengthen and support an expanded response to HIV/AIDS. This includes prevention of transmission of HIV, provision of care and support to those living with HIV, reduction of the vulnerability of individuals and communities to HIV and alleviation of the impact of the epidemic. Thus it seeks to prevent the epidemic from becoming a serious pandemic. <sup>(148)</sup>

## **NASCOP**

The National AIDS and STI Control Program (NASCOP) was established in 1987 to implement the interventions and policies on HIV/AIDS in the country. At the height of the HIV pandemic, the prevalence was 30%.

NASCOP runs programs such as : PMTCT (prevention of mother to child transmission of HIV); HIV testing and counseling (HTC); basic education and dissemination about HIV; communication

about behavioral change and mass communication; access to male circumcision, ART (antiretroviral therapy) and treatment of STI); peer education; prevention of transmission in medical settings( safe blood transfusion and proper infection control) and condom education, promotion and distribution.<sup>(149)</sup>

NASCOP has been fairly successful in implementing the interventions and policies on HIV/AIDS care as discussed in chapter 10 below.

## **NACC**

The National AIDS Control Council was established in 1999 when the GoK declared HIV/AIDS a national disaster. It is a non-profit making institution. Its mandate includes: provision of policy and strategic framework; mobilization and coordination of resources; prevention of HIV transmission; care and support for the HIV infected and affected.

It has had achievements such as: coordinating development and implementation of the Kenya National HIV/AIDS Strategic Plans (KNASP) I and II; the development on key areas including OVC; mainstreaming gender into KNASP; engaging with key ministries to mainstream HIV/AIDS in the context of Medium Term Expenditure Framework (MTEF).

Due to this, it has 4 main objectives in KNASP II namely: number of new infections reduced by at least 50%; AIDS related mortality reduced by 25%; HIV-related morbidity reduced; socioeconomic impact of HIV reduced at household and community levels.

These objectives as stated are not SMART and will therefore be difficult to evaluate them.

## **AMPATH**

In 2001, the Moi University School of Medicine, MTRH and Indiana University School of Medicine, came together and established the Academic Model for the Treatment and Prevention of HIV/AIDS now renamed Academic Model Providing Access to Healthcare (AMPATH). This was aimed at mitigating the impact of the disease in western Kenya. It covered the former North Rift Valley, Western and Nyanza provinces. It provides comprehensive care for HIV infected patients and their families, psychosocial, nutritional support to the patients and PMTCT. There are training, research and clinical care arms of the project. The AMPATH training institute (ATI) and research working groups have been in existence for over a decade. There are several research working groups that coordinate research in various areas such as the pediatric, adult, tuberculosis, behavioral sciences and public health. The pediatric research working group was the first to be established in 2006 and has conducted research and published over 100 papers in peer reviewed high impact journals. The areas researched on include orphans, child abuse, adherence to HAART, disclosure of HIV positive status to children and transitioning of adolescents from pediatric to adult HIV care. AMPATH collaborated with other sites in East Africa in establishing the international epidemiological databases for evaluation of AIDS (IeDEA) East African consortium. This is an international organization that is present in seven regions of the world namely, East Africa, West Africa, Central Africa, Southern Africa, Asia-Pacific, Latin America and North America. The site PI for AMPATH IeDEA is the chairman of the East African IeDEA pediatric research working group (PRWG). The East African IeDEA PI is the chairperson for the international IeDEA. Many papers have been published within the IeDEA fraternity including pediatric papers on adherence, tuberculosis

and simulations. Currently, East African IeDEA researchers are leading on the international papers on adherence, disclosure and transitioning of children from pediatric to adult care. Transitioning of adolescents from pediatric to adult care is a virgin area of research.

## **Chapter Eight**

### **Discussion**

#### **Achievements of the Responses**

##### **Concept**

By initiating the concept of children living in especially difficult circumstances, UNICEF brought the plight of these children to the international community enabling them to be budgeted for and laws promulgated to protect them.

##### **Laws**

The next achievement in the response to this problem was the acknowledgement by the UN that children were suffering as a result of wars and needed protection rights. This led to the formation of UNICEF and adoption of conventions 182 and 138, African Charter on children's rights and the Children's Act 2001 which provide for children's right and protect them from abuse and harmful labor.

##### **HIV/AIDS**

The response to the HIV/AIDS has been the most successful. According to the Kenya AIDS Indicators Survey 2012: the prevalence of the disease reduced from 7.2% in 2007 to 5.2% among adults aged 15 to 64 years. At the peak of the pandemic in 1994, it was 30%. The prevalence is 0.9% among children aged 18 months to 14 years due to the PMTCT strategies. HIV levels of testing increased from 34% in 2007 to 72% in 2012, reduction

in adults unaware of their HIV status from 80% in 2007 to 53% in 2012, the number of women tested for HIV during antenatal care rose from 65% in 2007 to 92% in 2012 and 90% of those found to be HIV positive received ARV to prevent the transmission of the virus to the baby. Of the 58% adults who were eligible for ART, 63% received the treatment. Among the adults receiving ART, 78% achieved viral suppression. These statistics are good for children because they indicate a reduction in prevalence among adults which will lead to lower mother to child transmission of the virus and therefore a reduction in the prevalence among children, availability of the ART which will result in fewer HIV orphans and adults living longer in a healthy state to look after their children and the economy will improve resulting in less poverty overall. All these will result in fewer children living in especially difficult circumstances. <sup>(150)</sup>

## **Gaps in the Responses**

Inspite of the efforts made in providing children rights and protecting them from abuse, there are still unmet needs that should be addressed.

## **Prevalence**

Though UNICEF has identified and defined the children living under especially difficult circumstances but it is difficult to conduct an accurate census of the children because of lack of consensus on the definition of abuse, it is difficult to count street children because of their mobility and so on. Various authorities use different definitions, study designs and questions in their studies and or surveys thereby making it difficult to compare findings. As a result a more accurate estimate of the number of these children is unknown globally, regionally, nationally and locally. This makes it difficult to properly plan for them.

The other problem has been the lack of awareness by health workers, other relevant public servants and the general public about the problem and the existing laws and structures in place for handling the problem. This makes the cases to go unreported and unpunished.

The lack of awareness leads to lack of sensitivity and interest to the problem. Few studies and surveys are conducted as a result. The issue is rarely a subject of most pediatric and other conferences nationally and internationally. The lack of awareness and sensitivity also leads to low index of suspicion that makes clinicians not to diagnose the cases as exemplified by the study on child abuse and neglect at MTRH where all cases of abuse were missed by the admitting doctors. This makes the number of reported cases to be low and therefore prevalence to be low.<sup>(4)</sup>

### **Laws**

The Children's Act though a major step in protecting children from abuse, it does not recognize neglect as abuse. There are pieces of legislation that need to be harmonized such as the minimum age for sexual consent, marriage and criminal responsibility. There is no law that makes it mandatory for health workers and others to report cases of child abuse.

The study on street children in the Rift Valley demonstrated that there was a big difference between what the law stipulates, the child expects and what he/she gets. A few examples will suffice. The law provides the child with the right to life. But street children die from violent injuries, accidents or illnesses. They would like to be protected from violence and death; every child has a right not to be discriminated against but these children are regularly turned away from public places and treated differently in schools. They would like to be recognized and not treated

differently. Every child has a right to be protected from labor and armed conflict. SC are frequently surviving through economic exploitation and older children risk being recruited into armed gangs. They wish to be able to earn more money in a safe way that still allows them to go to school, play and support their families; every female child shall be protected from early 'marriage', FGM, and any cultural practice that affects the child. The SC would like the boys to be circumcised as a rite of passage; Every child has a right to be protected from psychological and physical abuse and neglect. SC see themselves as their own protectors and violence is a daily reality. Neglect by the GoK is a daily reality. Abuse and violence is caused by extended family, step parents and the authorities. They would like to be protected from harm, police should stop violent round ups and to be loved by parents.<sup>(65)</sup> It is likely that this happens to other children living in especially difficult circumstances.

## **Research**

There is inadequate research on children living under especially difficult circumstances globally and locally. This is attributable to the inadequate knowledge of the subject, sensitization and interest in the subject by the researchers and other stakeholders. The other reason is the lack of consensus on the definition of child abuse that makes it difficult for results to be compared. As a result of all these there is not enough discourse on the subject in most conferences on the subject and publications are also few.



## **Chapter Nine**

### **Conclusions**

The estimated prevalence (1.2 billion) of the children living under especially difficult circumstances is still high and SSA bears the burden. Due to lack of knowledge, sensitization, consensus on definitions there is inadequate research and publications on the issues of children living under especially difficult circumstances and therefore these could be under estimates. The Children's Act 2001 does not protect children against neglect, nor provide for mandatory reporting of cases of child abuse and does not provide for the minimum age for sexual consent, marriage and criminal responsibility. Strategies to implement the laws in the Act are lacking. Street children are the most abused group of children in Rift Valley region and are denied all their rights as enshrined in the Act. They represent the biggest challenge in providing and protecting children's rights. The response to the HIV/AIDS pandemic were the most successful response in Kenya. Each of the various care environments (CCI and HH) in Uasin Gishu County has an advantage to the children. The CCI was the safest care environment contrary to the current belief that it pulls children to the streets. The streets were the most insecure environment for the children to live in.



## **Chapter Ten**

### **Recommendations**

There should be consensus on the various definitions of child abuse and tools for carrying out census so that the correct number of these children can be known and help in planning for them. It will also enable researchers to compare findings on these children and more research will be conducted. Strategies to implement the laws protecting children should be formulated by the Children's department in collaboration with the NCSC, UNICEF and other interested bodies so that children can enjoy their rights. Children should be taught about their rights, what constitutes abuse and action that should be taken in case of violation from nursery to secondary school. More should be done to sensitize health workers and all government workers involved in child protection, the general public on the issues of child abuse, exploitation and protection. Health workers and other government worker should be trained on their roles in protection of children and management of child abuse cases by introducing the course at mid-level and university colleges. A laws should be enacted to make reporting of child abuse cases mandatory in Kenya to protect and punish perpetrators as well as improve on the number of reported cases; to specify the minimum age for sexual consent, marriage and criminal responsibility. More research should be conducted to address grey areas such as prevalence of the various types of children under especially difficult circumstances, factors associated with the problem and monitoring and evaluation of the different interventions. This will inform the planning of the interventions. Specific research

should be carried out on disclosure, adherence to HAART and transitioning of children to adult care in the world. This will safeguard the gains made against HIV/AIDS.

### **My way forward**

I will continue to work on the subject of children living in especially difficult circumstances through research and advocacy. The research will be on disclosure, transitioning of children from pediatric focused to adult focused care and child abuse and neglect. On disclosure, I will unresoloved issues like the age at which disclosure should be initiated and end; where it should be carried out and by whom; circumstances surrounding the process; and the impact of disclosure on the child, family and community On transitioning I will study the processes, prevalence, associated factors and impact globally. I will come up with an SOP on transitioning, develop a curriculum for training health workers on transitioning, train them and study the impact of transitioning. On child abuse I will study whether having been abused as a child and domestic violence predispose to child abuse; the cost of the management of child abuse in Kenya and the prevalence of neglect and nutritional abuse in Kenya.

I will continue with my social responsibility to the various CCI, teaching the subject and presenting papers at different for a like conferences.

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