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SUMMARY REPORT

Sex- and gender-based analysis
of adolescent health and nutrition
in Elgeyo Marakwet County, Kenya





Background and rationale

22%

of children under five are affected by stunting

14%

of children under five have underweight

73%

of households are affected by food insecurity

57%

of households face high levels of poverty

43%

of adolescent boys between the ages of 15–19 have thinness

44%

of adolescent girls between the ages of 10–14 have anaemia

30%

of women aged 15–49 have experienced physical violence since age 15



According to the 2022 Kenya Demographic and Health Survey (KDHS), Elgeyo Marakwet County (EMC) is performing poorly in key maternal, child health and nutrition indicators compared to the national average. It is reported that 22% of children under five are affected by stunting, which is higher than the national average of 18%.¹ Five percent of children under five are affected by wasting, which is on par with the national average, and 14% have underweight, which exceeds the national average of 10%. Food and nutritional insecurity in the county are high, with 73.3% of the households are affected by food insecurity. This is exacerbated by high poverty levels, which stand at 57% (compared to the national average of 46%).²

Among adolescents, the KDHS reports that 18% of adolescent girls and 43% of adolescent boys between the ages of 15 and 19 have thinness,¹ while 13% of girls and 2% of boys are affected by obesity or overweight.¹ The Kenya 2020 Malaria Indicator Survey shows the rate of anaemia among adolescent girls between the ages of 10 and 14 in EMC is 44.4%, compared to the national average of 24.9%.³ Corresponding rates among boys are 29.5% in EMC, compared to a national average of 23.8%. The adolescent pregnancy rate (which represents the percentage of those aged 15–19 years who have ever been pregnant) stands at 12%.¹ Disparities exist in school attendance and enrolment between boys and girls, with girls often facing challenges such as early marriage and cultural practices that impede their education. Between 2014 and 2022, EMC was among five counties in Kenya that reported increases in child marriage rates, with an uptick ranging from 2% to 11% in the proportion of women aged 20–24 who were married before the age of 18. The KDHS indicates that 30% of women aged 15–49 in EMC have experienced physical violence since the age of 15, and 16% reported such incidents in the 12 months preceding the survey.¹

i This is a composite indicator that includes data on height, weight and age.



In EMC, national health and nutrition policies such as the Kenya Health Policy and the Adolescent Sexual and Reproductive Health Policy are increasingly being localized through county-level frameworks like the County Integrated Development Plan (CIDP) and the County Nutrition Action Plan (CNAP). However, implementation gaps remain, particularly around coordination, data use and service reach. County departments and partners are working to bridge these gaps, but resource constraints and policy fragmentation still hinder full translation of national frameworks into local road maps.

Nutrition International is part of a consortium implementing the Realizing Gender Equality, Attitudinal Change & Transformative Systems in Nutrition (REACTS-IN) project in EMC. REACTS-IN is implementing integrated, multisectoral and evidence-based interventions that will address the key determinants of nutrition, gender inequalities and sexual reproductive health in underserved and target areas. To better understand the specific gender barriers and challenges faced by adolescent girls in this context, a sex- and gender-based analysis (SGBA) for adolescent health and nutrition (AHN) programs in EMC was conducted.

The SGBA was carried out to assess the current status of gender sensitivity and responsiveness within current projects and to provide recommendations for developing short- and long-term strategies for promoting gender equality and implementing gender-responsive programs, including youth- and gender-responsive health and nutrition systems strengthening.

The data collection team conducted key informant interviews (KIIs) with a diverse range of stakeholders, including representatives from the health and education sectors, women's organizations, county government officials, women and adolescents, among others. Focus group discussions (FGDs) were conducted with adolescent girls and boys across different age groups (10–14 and 15–19) to ensure a diverse and representative sample. Data was also gathered through four school observations and four health facility observations, while secondary data was generated from a desk review of relevant internal and external documents.

Key findings

Gendered barriers within the household

At the household level, women and adolescent girls have minimal influence over key decisions, particularly in financial matters and purchases related to food, health and education. Even in households where women contribute significantly to farming and household income, men make the final decisions on how the land is utilized and how income is spent. On the other hand, fathers or male guardians typically control food purchases, while mothers prepare and distribute meals, limiting women's ability to make nutritional decisions that benefit themselves and their children.

Caregiving responsibilities at the household level are primarily assigned to women and girls, reinforcing gender imbalances in unpaid labour. Many adolescent girls miss school or drop out entirely because they are required to help with household chores or care for younger siblings, reducing their chances of securing formal employment and economic empowerment in the future and increasing their odds of early marriage.



Mother decides but the father is the one paying for the services. Dad ... has the most influence or power regarding decisions related to visiting the doctor or spending on nutrition services or products.

— Keiyo North FGD with adolescent girls (10–14 years)

At the same time, food distribution within households reflects a parallel hierarchy. Men and boys are often prioritized when it comes to food distribution. Fathers, as household heads, have the most authority in deciding what food is purchased and how it is allocated. In many cases, boys are served first and receive larger portions, while girls and women eat later, often receiving smaller and less nutritious portions. This practice contributes to higher rates of undernutrition among adolescent girls, particularly those aged 15–19, who have increased dietary needs due to menstruation and physical development.





Control over assets

Women and girls have limited control over productive assets such as land, livestock and household income. The cultural norms and patriarchal structures dictate that land ownership and control remain predominantly male-dominated, with boys being prepared from a young age to inherit and manage these resources. Widowed and single mothers may gain some level of autonomy, especially if they inherit land, but they often face social stigma and financial challenges that limit their ability to maintain control.

Men control household finances and own communication devices such as radios, TVs and mobile phones. In households where men do not prioritize health information, family members may lack critical updates on nutrition, child health and disease prevention, as the person who owns or controls the radio, television or mobile phone often dictates what information is shared with others.



Women and girls are not allowed to control or own assets like land ... Men and boys are only allowed to own and control assets ... A girl or a woman is believed to build her home after she gets married but will not also control the assets.

— Keiyo North FGD with adolescent girls (10–14 years)

Intersectional barriers

Adolescent girls who are married face distinct barriers in accessing nutrition services due to their age, limited autonomy and lower social status within households. Adolescent brides lack the knowledge, confidence, experience and authority to advocate for their own health. Additionally, young girls are more likely to be excluded from community discussions, denied access to household resources or constrained by cultural expectations of silence and submission.

Many adolescents, particularly those in rural schools, lack direct access to health education and nutrition programs, as there is limited availability of nutritional supplements, vaccines and reproductive health services. This is due in part to poor road networks, which affect the distribution of these goods and services. Certain groups remain underserved, including adolescents with physical disabilities, low-income families and migrant workers — all of whom often lack access to information and financial resources to seek healthcare.



Some groups remain underserved, including [individuals with physical and/or cognitive impairments], foreign and domestic workers such as Ugandan farm labourers, and adolescents from low-income backgrounds. These groups often lack awareness or the means to access available services.

— Marakwet East KII with healthcare worker



Participation and representation

Adolescent girls face the most significant challenges in public and employment spaces due to gender norms, limited educational access and caregiving responsibilities. Girls aged 10–14 are often expected to help their mothers with domestic work, reducing their chances of participating in school-based leadership or vocational training. From ages 15 to 19, many are forced into informal labour, such as assisting in family businesses, engaging in petty trade,ⁱⁱ or taking on caregiving roles for younger siblings or elderly family members. This limits their ability to acquire skills or earn an independent income, making them more vulnerable to early marriage and economic dependency on male relatives.

At the village and district levels, women and adolescent girls are often included in informal decision-making spaces such as school committees, church programs and women's support groups, while men and boys dominate formal leadership positions in youth councils, education boards and local governance structures. There are some social support structures such as *Maendeleo ya Wanawake* ("Development of Women") — a women's civil society organization (CSO) that promotes women's rights and gender equality — as well as other CSOs, table banking groups,ⁱⁱⁱ and girls' school clubs that promote confidence and participation. However, deep-rooted cultural attitudes and practical time burdens remain significant obstacles.

ⁱⁱ This refers to small-scale business activities in the informal economy (such as selling produce on the roadside).

ⁱⁱⁱ Table banking groups are a community-based financial model where members of a group meet regularly to place their savings, loan repayments and other contributions on the table and then immediately borrow from the pooled fund.

Access to health and nutrition services

Adolescents in EMC face a range of structural, social and economic barriers that limit their access to essential health and nutrition services. As noted during the consultations:



Women and girls face numerous challenges in accessing healthcare. Stigmatization is a major issue; pregnant adolescents often fear seeking healthcare due to societal judgment. Many girls also lack adequate education and awareness regarding available services. Financial constraints make it difficult for poor girls to afford transport to health facilities. Some hide their pregnancies until delivery, which leads to severe complications. Menstrual health remains another barrier, as many girls cannot afford sanitary products.

— Marakwet East KII with healthcare worker

In spite of these challenges, a number of positive practices emerged from the study. Schools that have established safe and private spaces for menstrual health management have reported higher attendance rates among girls; furthermore, programs that involve male teachers and health workers have encouraged more adolescent boys to seek healthcare services. Involving community health workers, local leaders, parents and peer educators has helped bridge the gap between health facilities and adolescents, and it has enhanced acceptance and effectiveness, particularly in reaching those who are out of school. Actively engaging adolescents in decision making and leadership through youth groups, forums and peer mentorship has helped adolescents navigate health and social challenges.



Quality of service provision

Health facility observations revealed critical gaps in the availability of essential amenities required to facilitate access to health and nutritional products and information. Poor records management undermines the ability of facilities to track adolescent health trends effectively. Poor road networks and transportation challenges make it difficult to deliver essential health services to remote communities, limiting the availability of nutritional supplements, vaccines and reproductive health services.

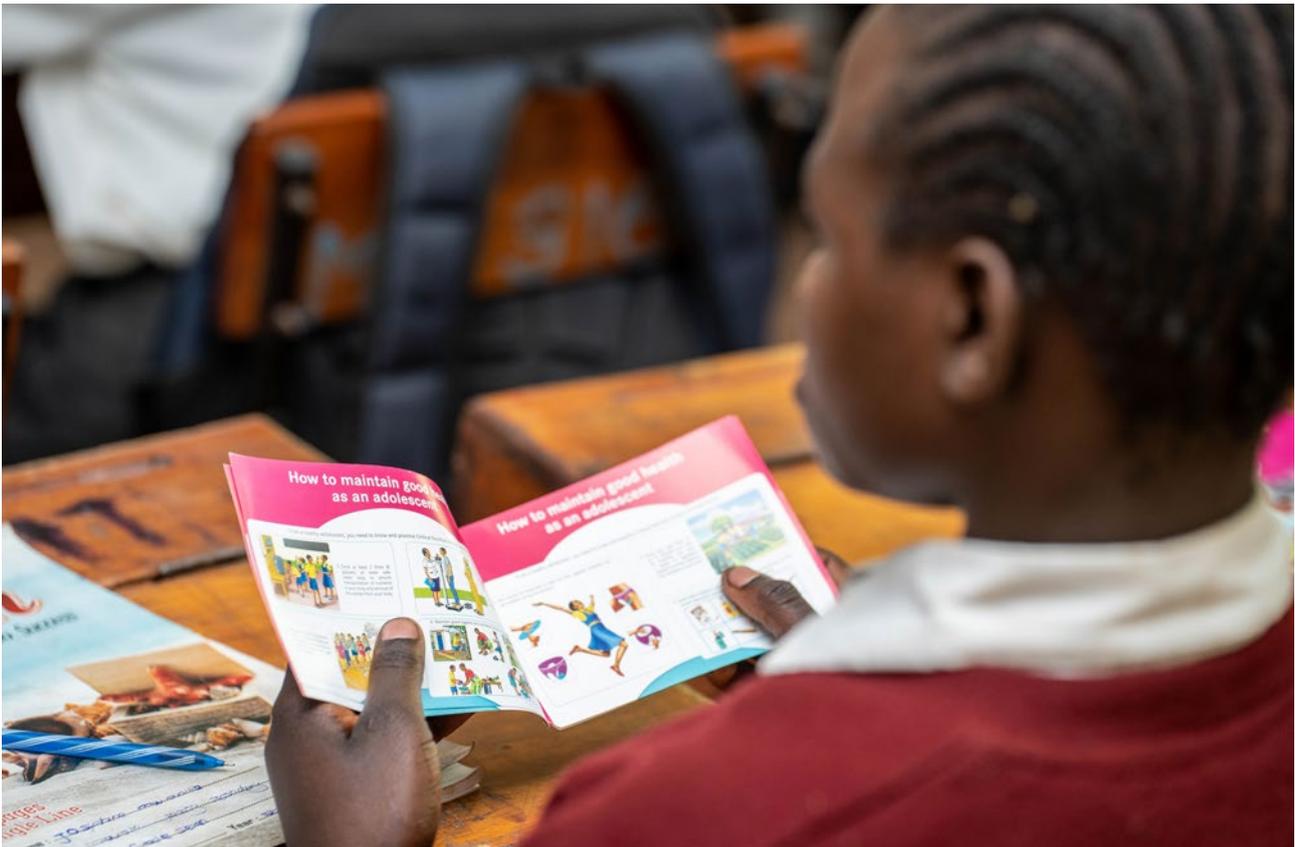
Despite these challenges, adolescents shared positive feedback regarding their interactions with healthcare workers and acknowledged that services are delivered in a manner that upholds their rights. However, they expressed concern that they are not involved in designing healthcare services and that healthcare workers have not sufficiently equipped them with the knowledge, confidence and skills needed to advocate for their health rights.

While boys also experience limited access to nutrition services, their challenges stem more from low health-seeking behaviour and cultural expectations that discourage them from prioritizing nutrition and medical care. Furthermore, adolescent boys often feel uncomfortable discussing health concerns with female providers.



The services here are affordable and run 24 hours, so anyone can access them any time. But to be honest, the gender of healthcare providers isn't really considered. I've noticed that this can be an issue, especially for young boys who might not feel comfortable discussing their health concerns with female providers.

— Keiyo South KII with a healthcare worker



Adolescent perceptions on menstrual health management

Adolescent girls in EMC primarily learn about menstruation through school lessons, mothers and older sisters, with science teachers and counselling sessions playing a key role in educating them about menstrual health. However, many girls still receive limited or unclear information and indicated in FGDs that they feel unprepared when they start menstruating.

The FGDs revealed that boys hold a range of perceptions towards menstruation, shaped largely by limited knowledge, cultural norms and educational exposure. While some boys displayed empathy and understanding, many lacked comprehensive information, leading to misconceptions and stigmatized views. When it came to discussing menstruation in schools, opinions were divided. Several boys supported including it in the curriculum, seeing it as important for building awareness and reducing stigma. Others, however, expressed discomfort or believed such discussions could lead to distraction or embarrassment. These responses reflect the tension between curiosity and cultural taboos, where menstruation is often viewed as a “female issue” that boys should not be involved in.

School-based observations revealed a mix of strengths and challenges in adolescent health and nutrition services. While some teachers had been trained to provide gender-sensitive and adolescent-friendly guidance, this was not consistent among schools. Many schools lack adequate water, sanitation and hygiene (WASH) facilities, including: private, safe spaces to manage menstruation; soap and sufficient water supply; changing rooms; or access to sanitary pads (which forces girls to miss school during their periods). The absence of school nurses, structured health clubs and dedicated support systems further limits girls’ access to reproductive and nutrition services in learning environments. Unlike boys, who experience fewer disruptions, girls must navigate stigma, school-based barriers and limited autonomy in seeking care, all of which reinforce gender disparities in educational attainment.

Conclusion

The adolescent health and nutrition programs in EMC have made strides in addressing the unique challenges faced by adolescents. Through a multisectoral approach that integrates schools, healthcare facilities, community engagement and policy interventions, these programs have worked to improve adolescent wellbeing. Despite these achievements, several gaps remain. The lack of written policies and protocols specific to adolescent health and nutrition across health facilities, lack of adolescent and youth participation in program design, inadequate funding, and socio-cultural barriers continue to affect access to health and nutrition services. Many adolescents, particularly girls, still struggle with economic and social challenges that hinder their ability to prioritize health and education. Additionally, the inconsistent availability of nutrition commodities and menstrual health products remains a pressing issue that requires policy-level interventions and sustainable solutions.

Recommendations

SHORT TERM

- **Invest** in capacity building for healthcare workers, schoolteachers and community health promoters on adolescent-friendly and gender-responsive service delivery. Train providers in non-judgmental, confidential and youth-friendly communication.
- **Create** awareness on menstrual health management for both boys and girls to reduce stigma. Ensure free pad distribution and discreet access for girls. Improve water/toilet access and provide safe spaces for girls in school to use as needed during their periods.
- **Establish** school health clubs, and include iron and folic acid supplementation, deworming and nutrition education. Introduce school gardens and cooking demonstrations using local foods.
- **Introduce** vocational training and financial literacy interventions and mentorship for girls.
- **Organize** male champion training, community dialogues and fatherhood engagement programs. Raise awareness against early marriage with community leaders.
- **Use** chiefs, religious leaders, village elders and peer educators to enhance awareness and uptake of adolescent health services.
- **Offer** counselling, food assistance and fortified foods for low-income families and at-risk adolescents.
- **Support** income projects or Village Savings and Loan Associations to keep adolescents in school.
- **Provide** information, education and communication (IEC) materials on adolescent health and nutrition in all health centres and ensure they are displayed openly. Ensure dissemination of standardized protocols, guidelines and standard operating procedures (SOPs) for adolescent health and nutrition services.

LONG TERM

- **Advocate** for county governments to mandate gender-equitable adolescent health and nutrition services.
- **Ensure** health facilities have youth-friendly spaces (create private consultation rooms and peer-led programs), nutrition counselling and mental health support.
- **Enhance** women's roles in health governance, school management and community decision making. Establish leadership mentorship programs.
- **Advocate** for equal access to land ownership, business capital and cooperative savings programs.
- **Invest** in sanitation, hygiene and clean water supply in schools, facilities and communities. Improve road networks to schools and health facilities.
- **Strengthen** multisectoral coordination and establish collaborations between health, educational institutions, nongovernmental organizations (NGOs) and the private sector for sustained impact.

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