Baseline Report

GROW ENRICH Global programme to improve maternal and child health and nutrition in East Africa through strengthening health and nutrition systems and operationalising gender-sensitive health and nutrition rights strategies in Kenya, Somalia and Tanzania

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World Vision Kenya

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i. Acknowledgements

The baseline survey team would like to take this opportunity to return gratitude to World Vision Kenya for entrusting us with this **Baseline Survey for BMZ GROW ENRICH Project** in Marakwet East, Elgeyo Marakwet County, Kenya. Many thanks go to GROW ENRICH Project staff; Evans Ndiege (MEAL Officer) and Evans Wanunda (Project Manager) for their technical and logistical support during this baseline survey process.

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To you all whom we might have not mentioned, we kindly request that you accept our sincere message of appreciation and God's blessings.

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ii. Affirmation

"Except as acknowledged by the references in this Initial Formative Survey Report to other authors and publications, the study process, findings, interpretations, conclusions and recommendations consist of work carried out by Infoscope Consulting Ltd on behalf of World Vision Kenya for its **BMZ GROW ENRICH Project** in Marakwet East, Elgeyo Marakwet County, Kenya" to inform project design in terms of strategies based on the lessons learnt and emerging needs, aspirations and priorities of World Vision Kenya and also to inform program management on decisions for program implementation and monitoring as part of the requirements of program implementation.

All Primary quantitative and qualitative information collected throughout the baseline Survey remains the property of the communities and families described in this document. Information and data must be used only with their consent.

May, 2024

iii. Glossary of Abbreviations & Acronyms

ADS	Anglican Development Services
AP	Area Programme
ARNS	African Regional Nutrition Strategy
CBO	Community Based Organization
CIDP	County Integrated Development Plans
DME	Design Monitoring & Evaluation
EPI	Expanded Program on Immunization
FGD	Focused Group Discussion
ENRICH	Enhancing Nutrition Services to Improve Maternal and Child Health
H&N	Health & Nutrition
IYCF (-E)	Infant and Young Child Feeding – In Emergencies
JMP	Joint Monitoring Programme
KIs	Key Informants
NGO	Non-Governmental Organization
NO	National Office
PHO	Public Health Officer
PLWD	Persons Living With Disability
PLWH	Persons Living with HIV
PPS	Probability Proportional to Size
REACTS- IN	Realizing Gender Equality, Attitudinal Change & Transformative Systems In Nutrition
SDGs	Sustainable Development Goal
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SO	Support Office
SMT	Senior Management Team
SPSS	Statistical Package for Social Sciences
ToR	Term of Reference
UNICEF	United Nations Children's Fund
WASH	Water Sanitation & Hygiene
WHO	World Health Organization
WVK	World Vision Kenya

1.0 EXECUTIVE SUMMARY

GROW ENRICH Global program aims at improving maternal and child health and nutrition in East Africa through strengthening health and nutrition systems and operationalizing gender-sensitive health and nutrition rights strategies in Kenya, Somalia and Tanzania. The Global Programme will address the root causes of malnutrition and gender inequality in the three target countries through a multi-level approach at micro, meso and macro levels. It will build on proven strategies for implementing key health and nutrition interventions through strengthening local health and nutrition systems, targeted advocacy and building the capacity of civil society and state actors at sub-national, national and regional/continental levels. The Global Programme will increase access to basic nutrition, SRHR and health services for a total of 658,339 direct participants of whom approximately 246,612 are women and 227,402 children under five in the three countries of East Africa. The Project targets direct Participants (women-40,270, Men- 39, 944-, girls-30,380, boys-30,134) and 93,822 indirect beneficiaries, in Marakwet East, Elgeyo Marakwet County, Kenya.

Before full-scale implementation can begin, WVK commissioned a baseline survey whose main objective was 2-fold 1) to provide a benchmark for all project outcome and output indicators; and to 2) to conduct a GESI assessment. This would help develop a contextualized implementation plans for the project. The baseline survey covered 3 Wards of Kapyego, Sambirir and Embobut in Marakwet East sub-County, Elgeyo-Marakwet County where the GROW ENRICH project is to be implemented.

This baseline survey was conducted using a mixed-methods[1] approach employing both participatory quantitative and qualitative approaches consisting of a documentary review; household survey, anthropometry, focus group discussions, Key Informant Interviews, Health facility capacity assessment and observations. The study sampled and interviewed 481 household caregivers and 479 children 0-59 months drawn from 3 Wards namely: Sambirir, Kapyego and Embobut. In addition, 15 focus group discussions and 11 key informant interviews were held concurrently.

The following are summarized key findings by objectives.

Overall Outcome: An enabling policy and structural environment is leading to the improved health and nutrition status of 443,161 boys, girls, women, and men and gender equity in the target districts (sub-national levels) in Kenya.

Overall Outcome Indicator 1: % increase of funding for health and nutrition services from KEN national & EM County budgets

In Kenya, the nominal expenditure on nutrition stands at KES 10.4 billion in FY 2020/21. At 0.5 per cent of the total budget in 2020/21, Kenya's spending on nutrition lags behind the regional average of about 1.7 per cent.[2] In Kenya H&N is a devolved function to the 47 county Governments. In the FY 2022-23 Elgeyo-Marakwet Country received KES 4.853 Billion from the national treasury of which KES 799,680,000 (16.5%) was allocated to Health and Nutrition Services. This was inclusive of salaries, development and commodities. Of this amount KES 150 Million went directly to supporting health commodities mainly drugs, with no dedicated budget allocation for nutrition specific commodities.

Overall Outcome Indicator 2:% of children under five years of age with reduction in wasting

Wasting stands at 3.2% (2.0 - 5.1 95% C.I.) compared to 5% at the EMC and national level.

[1] https://www.betterevaluation.org/en/resources/guides/intro_mixed-methods_impact-evaluation
2 KIPPRA Policy Brief No. 34/2023-2024

Overall Outcome Indicator 3:% of children under five years of age with reduction in stunting
About 32.9% (29.0 - 37.2 95% C.I) children in the project area are stunted which is higher than the 22% and 26% reported for the EMC and national respectively[3].

Outcome Module 1: Target countries are implementing updated National Action Plans which align with AU nutrition policy
Outcome Indicator 1: % Increase of funding provided annually by sub-national governments for local health and nutrition facilities in target districts
During the FY 2022-23, the County government of Elgeyo-Marakwet allocated a total of KES 150 Million to health facilities to support Operation and Maintenance (O&M). Of this amount dispensaries received KES 150,000 each; Health Centres-KES 400,000 each; Sub-county hospitals-KES 30 Million each while Iten county referral got KES 120 million. Currently funds are allocated variedly to health facilities to cater for Operations and Maintenance (O&M) with no clear provision for nutrition commodities.

Outcome Indicator 2: % increase of key government officials at national and sub-national levels who understand and actively advocate (participate) for the application of basic nutrition and health rights as enshrined in international and local laws
At the county level about 50 government officials participate in application of basic nutrition and health rights compared to about 8,000 nationally. Such advocacy forums targets the key decision makers like the County Assembly, Finance Officers, CEC in charge of Health, the Chief Officers, directors of Health and the Governor.

Outcome Module 2: Women of reproductive age, adolescent girls and children under 2 benefits take up improved gender-sensitive nutrition and health services in target regions
Outcome Indicator 1: % of children<6 months who are exclusively breastfed (EBF)
Exclusive breastfeeding rate among children (0-5 months) stands at 68.6% slightly higher than the national average of 60%[4] and county average of 62.9%[5]. There exist entrenched traditional cultural beliefs among the Marakwet that promote the practice of breastfeeding. Phrases like ***"Rerye chich bortanyi" (a mother must breastfeed her baby immediately after birth).***

Outcome Indicator 2: % of women aged 15-49 who used at least 4 antenatal examinations (ANC)
Uptake of WHO recommended 4+ ante-natal (ANC) visits among women aged 15-49 years stands at 42.3% (176) which is lower than the 57.6% reported nationally. Only 0.2% (1) of the women achieved 8 ANC contacts.

Output 2.1: Increased access to gender sensitive facility-based basic nutrition, health and SRHR services for women, girls and boys
Output Indicator 1: # of health facilities in target districts providing gender-sensitive primary care in nutrition and health and SRHR
All the 29 Health Facilities in the county were providing some form gender sensitive facility-based primary care in nutrition, and SRHR albeit is unstructured fashion. The youth in the project area are reluctant to seek gender-sensitive nutrition, health and SRHR services due to the fact that these services are currently integrated with adult services. There is a glaring lack of youth-friendly centres that address specific nutrition, health and SRHR needs of boys and girls in the project area.

[3] KDHS 2022
[44]Kenya Demographic and Health Survey 2022
[5] EMC CNAP 2018/19- 2022/23

Output Indicator 2: # of increase yearly nutrition & SRHR consultations in H&N facilities in project areas

Nutrition and SRHR consultations in in-patient health and nutrition facilities in project areas are being held in ad hoc manner owing to the competing needs from the health staff and inadequate capacity building refresher training for those offering nutrition and SRHR consultation.

Output 2.2: Improved community-based capacity to prevent, monitor and manage malnutrition with a gender lens

Output Indicator: # of number of community-based organizations/groups with capacity to prevent, monitor and address malnutrition from a gender perspective

Findings show that mother-to-mother support groups exist in the project area working generally on breastfeeding support, or nutrition counselling, however such organizations or groups lack capacity to prevent, monitor and address malnutrition from a gendered lens.

Outcome Module 3: Women of reproductive age, adolescent girls and children under 2 benefits from improved gender-sensitive production and use of nutritious foods in the target regions

Outcome Indicator 1: % of children aged 6-23 months receiving minimum acceptable diet

Findings show that 9.1% children 6–23 months of age in the project area were receiving Minimum Acceptable Diet (MAD) compared to 31% at the county level and 22.6% nationally.

Output 3.1. Increased availability and consumption of diversified nutrient-dense foods including biofortified crops for women, girls, boys and men"

Output Indicator 1: # of HH growing nutrient-rich crops

There is poor knowledge and practice with regards to nutrient rich crops (bio-fortified crops). This is shown by the low number of households that grow (4%) and consume meals prepared of bio-fortified crops (6.3%).

Output Indicator 2: % of HH with acceptable HH Dietary Diversity Score

About 77.1% (CI: 73.1-80.8) of the households had acceptable Dietary Diversity Score (>5 food groups). The average Household Dietary Diversity Score for the surveys was 6.42 (CI: 2-11). Meaning the households in the households in the project area were consuming about 6 food groups in the previous 24 hours preceding the survey.

Output 3.2: Families sensitized on key nutrition interventions including MIYCF and PD Hearth, GMP and food preservation of nutrient dense foods including biofortified crops.

Output Indicator 1: % and # of families with adequate knowledge and skills in nutrition in the first 1000 days as per MIYCF minimum criteria

Overall only 14.9% (female-15.6%; male-14.4%) of the caregivers were found to have adequate knowledge and skills in the first 1000 days as per the MIYCF criteria. The first 1,000 days between a woman's pregnancy and her child's second birthday offer a brief but critical window of opportunity to shape a child's development.

Output Indicator 2: # and percent of primary caregivers with improved knowledge and practice in IYCF practices.

More than half of the primary caregivers 66.1% (n=318) were found to have improved knowledge and practice in IYCF practices. Female respondents had higher knowledge and skills compared to male.

Table 1: The key baseline indicators summary

Indicator	Baseline assumption (design phase)	Baseline Values	Target values at Design Phase

Overall Outcome: Indicator 1 % increase of funding for health and nutrition services from national & County budgets	-	KES 799,680,000 (2022/2023) USD 6199069	TBD
Overall Outcome: Indicator 2. % of children under five years of age with reduction in wasting	4.2% Global nutrition report 2020)	3.2%	TBD reduce <5% by project end 2027
Overall Outcome: Indicator 3. % of children under 5 years with reduction in stunting	26% (DHS 2014)	32.9%	24%
Outcome Module 1 Indicator 1 # action plan per country, including monitoring frameworks, aligned to African Regional Nutrition Strategy 2015- 2025 (ARNS)		N/A	TBD
Outcome Module 1 Indicator 2 # of Progress Reports and Accountability Mechanism submitted by project midterm		N/A	TBD
Outcome Module 1 Indicator 3 % Increase of funding provided annually by sub-national governments for local health and nutrition facilities in target districts	-	Est-KES 200 Million	TBD 20% over baseline by project end (baseline in first project year).
Outcome Module 1 Indicator 4% increase of key government officials at national and sub-national levels who understand and actively advocate (participate) for the application of basic nutrition and health rights as enshrined in international and local laws	-	50 people	TBD
Output 1.1 Indicator 1 # of government Institutions that have integrated national and sub-national gender-responsive health and nutrition policies and protocols into their agriculture nutrition, health and sanitation sector plans	N/A	N/A	N/A
Outcome Module 2 Indicator 1% of children<6 months who are exclusively breastfed (EBF)	61% (DHS 2014)	68.6%	TBD 5% from baseline by the end of the project.
Outcome Module 2 Indicator 2 % of women aged 15-49 who used at least 4 antenatal examinations (ANC)	58% (DHS 2014)	42.3%	TBD 10 from baseline by the end of the project.
Output 2.1 Indicator 1 # of health facilities in target districts providing gender-sensitive primary care in nutrition and health and SRHR	-	100% (29 health centres, 90 dispensaries, 8 Sub-county, 1 County referral)	TBD

Output 2.1 Indicator 2 # of increase yearly nutrition & SRHR consultations in H&N facilities in project areas	-	992SRHR (486 Men,506 Women) Nutrition=0	*40% by project end; Disaggregated by type of consultations, age, gender; BL TBD*
Output 2.2 Indicator 1 # of number of community-based organizations/groups with capacity to prevent, monitor and address malnutrition from a gender perspective	-	0	TBD
Output 2.3 Indicator 1 # of districts with H&N planning/knowledge done by trained district health managers		N/A	
Outcome Module 3: Indicator 1 % of children aged 6-23 months receiving minimum acceptable diet	31% (DHS 2014)	24.7%	TBD increase by 10% from baseline the end of the project.
Output 3.1 Indicator 1# of HH growing nutrient-rich crops	-	4% (19)	TBD
Output 3.1 Indicator 2; % of HH with acceptable HH Dietary Diversity Score (HDDS)	-	77.1%	TBD increase 15% from the baseline
Output 3.2 Indicator 1 % and # of families with adequate knowledge and skills in nutrition in the first 1000 days as per MIYCF minimum criteria	-	52 (14.9%)	TBD increased by 20% from baseline by end of project.
Output 3.2 Indicator 2 # and percent of primary caregivers with improved knowledge and practice in IYCF practices		318 (66.1%)	TBD increased by 20% from baseline by end of project
Outcome Module 4 :Indicator 1 # of local CSOs officially members of 1 national or regional advocacy working group		N/A	
Outcome Module 4 :Indicator 2# of advocacy events (co)organized by local CSO			
Output 4.1 % increase in local CSO capacity assessment score	69.4%	71.4%	79.4%
Output 4.2 :Indicator 1 # of community-owned advocacy structures per target district engaging with service providers to advocate for access to and quality of gender responsive H&N services		N/A	

GESI situation

The challenges facing women and girls in the Sub-county range from violence from bandits in Kerio Valley and to societal beliefs such as FGM[6] that has caused distress to women and girls thus hampering productivity in the agricultural rich areas.

6 The prevalence of FGM stands at 19.7% in Elgeyo Marakwet

- Different forms of gender-based violence exist (denial of nutritious food due to various cultural food taboos, female genital mutilation, sexual and domestic violence, etc.). FGM, Child marriage, Child Labour, Child abuse and neglect, economic GBV, cattle raids.
- Retaliatory attacks on youth, women and children by the bandits; territorial disputes
- Violence against vulnerable population (e.g. children, the elderly, persons with disabilities) – neglect, denial of health access.
    - A rescue centre established in Chorwa, Chesoi has recently recorded a total of 271 girls. The Chorwa African Inland Church in Marakwet East Sub-county set up this rescue centre towards the last quarter of 2023 to offer shelter to girls running away from female genital mutilation (FGM) that is conducted in the month of November and December every year.
    - Plans are underway by the County Government to look for funds to construct a rescue centre to take care of other forms of GBV as even men were undergoing domestic violence but feared reporting, thus needed a place to shelter as the issues were being resolved.
- There is low awareness on the Preventive and legal measures to combat gender-based violence: GBV Support Unit established in Health facilities, Public and Private Gender Rescue Centres and Shelter to provide GBV support services in counties by 2026; Multi-sectoral Standard Operating Procedures (SOPs) for Sexual Violence Prevention and Response (2013); National Monitoring and Evaluation Framework toward the Prevention of and Response to Sexual and Gender-based Violence (2014).
- Toll free lines such as 24-hour Child Helpline (116); Kenya Police 999, 911, and 112; NACADA 24-hour Toll Free Helpline (1192) for victims of alcohol and drug abuse; Kimbilio Trust Toll-free line (1193) for reporting on human rights abuse and seeking assistance; Healthcare Assistance Kenya Toll Free Helpline 1195 has a Call Centre that works 24/7 for reporting on gender-based violence

Recommendation

Overall Outcome: An enabling policy and structural environment is leading to the improved health and nutrition status of 443,161 boys, girls, women, and men and gender equity in the target districts (sub-national levels) in Kenya.

- A suggested addition would to be to have an Advocacy target on the County Assembly to provide and 'ring-fence'' budgetary allocation to support health and nutrition services from the EM County. Resources meant for health and basic nutrition services need not be comingled with other health budget lines.

- Promote nutrient-rich bio-fortified crops/food diversification and promotion of MIYCF minimum criteria by all partners to help address the malnutrition rates to among caregivers of children in the project area.

Outcome Module 1: Target countries are implementing updated National Action Plans which align with AU nutrition policy

- Provide and 'ring-fence'' budgetary allocation from the EMC County to support health and nutrition facilities services. Resources meant for health and basic nutrition services need to ''ring-fenced'' and not lumped under Operations and Maintenance (O&M).

- Strengthen the existing high level health and nutrition advocacy forums to advocate for basic nutrition and health rights by advocating for increased funding allocation for basic nutrition and health services at the community level. More frequent grass root engagement is needed to lobby the Member of County Assembly (MCA) to allocate more resources to support basic nutrition and health services.

Outcome Module 2: Women of reproductive age, adolescent girls and children under 2 benefit take up improved gender-sensitive nutrition and health services in target regions.

- Expand caregiver access to quality counselling and support on young child feeding. Reinforce cultural beliefs that promote the practice of breastfeeding by involving traditional leaders and old grandmothers in attitude change.

- Provide capacity building trainings and facilitation to the community Health Promoters (CHPs) to continue delivering the basic health package under the Community Health Strategy (CHS). This will improve ANC uptake there is need to provide more capacity. If possible the project to provide the CHP with resources to facilitate their movement within the community such as provision of motorcycles, as the terrain is rugged with hills and escarpments making bicycles challenging.

- Establish youth- friendly centres that address specific nutrition, health and SRHR needs of boys and girls in the project area. This will go a long way in reinforcing gender-sensitive nutrition, health and SRHR services.

- Reinforce Nutrition and SRHR consultations in in-patient health and nutrition facilities by building capacity of the health staff undertaking these consultations. There in need for a clear reporting tool to capture and disaggregate data emerging from these consultations.

- Upscale gender equality and social inclusion (GESI) training to project staff and partners in order to address malnutrition from a gender lens. Such training will then be cascaded to the community level by the trained ToTs.

Outcome Module 3: Women of reproductive age, adolescent girls and children under 2 benefit from improved gender-sensitive production and use of nutritious foods in the target regions

- Promote nutrient rich crops (bio-fortified crops) by forging partnership with the county department of Agriculture to provide capacity building trainings to medal farmers through Farmer Field Schools (FFS).
-
- Investment in public health and education programs to promote healthy diet for mothers and children and the healthy start of complementary feeding. This can be done through the 1000 days IYCF campaign (communication for behaviour change)

GESI situation

- **Protect the rights of children** in unique situations, including intersex children, those with mental health issues, non-visible disabilities, living in conflict areas, migrant children, and marginalized communities like the Sengwer and Kiptani.
- Partners to **mobilize for resources to support disability friendly facilities** and equip them through leaders and forums.
- Partners to provide training of **CHWs and auxiliary nurse midwives** and **facility-level providers** on gender-sensitive family planning services that respect women's autonomy, dignity and privacy.
- World Vision should support in **formation of groups for persons with disability** so that they can interact freely and speak their common agendas as disabled people.
- World Vision to take lead in the development and/or review of a **gender strategy** for the health sector.
- Repackage reproductive health services to be non-stigmatizing or gender-discriminatory to adolescents, unmarried people and non-traditional gender identities such as intersex population and sexual orientations.

- Sensitize the community on the use of toll-free lines like 116, @WhatsApp on 0722116116, Kenya Police line 999, 911, and 112, NACADA 24 hr Toll Free Helpline (1192 etc
- **Conduct time use survey** to measure both paid and unpaid work to generate indicators for use in monitoring and evaluating interventions aimed at achieving gender equality and women's empowerment, FGM, early marriages, child labour – herding or mining

2.0. Introduction/Background

GROW ENRICH Global program aims at improving maternal and child health and nutrition in East Africa through strengthening health and nutrition systems and operationalizing gender-sensitive health and nutrition rights strategies in Kenya, Somalia and Tanzania. The Global Programme will address the root causes of malnutrition and gender inequality in the three target countries through a multi-level approach at micro, meso and macro levels. It will build on proven strategies for implementing key health and nutrition interventions through strengthening local health and nutrition systems, targeted advocacy and building the capacity of civil society and state actors at sub-national, national and regional/continental levels. The Global Programme will increase access to basic nutrition, SRHR and health services for a total of 658,339 direct Participants, of whom approximately 246,612 are women and 227,402 children under five in the three countries of East Africa. The Project targets direct Participants (women-40,270, Men- 39, 944-, girls-30,380, boys-30,134) and 93822 indirect Participants, in Marakwet East, Elgeyo Marakwet County, Kenya (Table 1).

The baseline survey covered 3 Wards in Marakwet East sub-County, Elgeyo-Marakwet County where the GROW ENRICH project is to be implemented.

Table 2: Project Participants

Project Location	Direct Participants	Women	Men	Girls	Boys
Marakwet East	140,731	40,270	39,944	30,380	30134

2.1. Baseline target audience

The baseline study targeted multiple stakeholders who will be involved directly or indirectly in the project implementation process. In particular, the following key stakeholders were involved in the baseline evaluation process:

- Community members that will be involved in the project implementation
- Local and international organizations
- Ministry of Agriculture
- Ministry of Health (MoH)
- County governments
- World Vision Kenya
- World Vision Germany.

2.2. Baseline objectives and scope

The overall objective of the baseline study was to provide a benchmark for all project outcome and output indicators. These have been as a basis for setting performance targets for monitoring project performance. ICL was to provide a comprehensive baseline survey for the above-mentioned project that identifies and measures the status quo of key project indicators at the outset of the project along main impact levels (outcome, output).

The specific objectives of the baseline study were:

a. Set and /interpret baseline values (benchmarks) for each key project indicator at outcome and output level as per the log frame.
b. To set targets against which project progress along the impact chain can be monitored and evaluated
c. To assess the current status of child and maternal nutrition status in the project areas, including accessibility and utilization of essential healthcare services by the target population and other key socio-economic factors.

3.0. METHODOLOGY

3.1. Analysis of set of (logframe) indicators

The baseline survey team articulated the indicator definition constituted in the logical framework matrix. After careful consideration, the baseline survey team concurs with the provided indicators. For this baseline evaluation in Marakwet East sub-County, all indicators were found to reflect the Kenyan context. Additional details in accordance with the programme monitoring and evaluation (M&E) plan are contained in project's the logical framework.

3.2. Survey design, sites, and population

This baseline survey was conducted using a mixed-methods[7] employing both participatory quantitative and qualitative approaches consisting of review of secondary documents, Household/caregiver survey, Focus group discussions, Key Informant Interviews, Anthropometry, GESI Assessment, field visits and checklist.

3.3. Quantitative sampling methodology

3.3.1. Cluster sampling and sample size calculation

The baseline study adopted a two-stage cluster sampling for household survey using SMART Methodology. The first stage of sampling involved sampling of the 37 clusters (villages) that served as the primary units for the survey. The population data was listed to generate the sampling frame then transferred into ENA software which randomly selected 37 clusters and 3 reserve clusters. The second stage sampling identified the households/respondents in the village at the selected clusters using simple random sampling.

The Expanded Program on Immunization (EPI) method was used to identify the first and subsequent household respondents. Data on anthropometry, morbidity, access to healthcare, maternal health, infant and young children was collected. Where there was more than one eligible woman in the household, a simple random sampling was be used to select one; and where the mother had more than one child under the age of five, all children were measured.

The sample size was determined using ENA for SMART software (11th January 2020) using the formula below:

$$\boldsymbol{n = \{t^2\ x\ \left(\frac{p\ X\ q}{d^2}\right)\ X\ DEFF\}}$$

Parameters for Anthropometry	Value	Rationale
Estimated prevalence of stunting	22 %	Accordingto2022 Kenya Demographic and Health (KDHS) survey stunting rate for Elgeyo Marakwet County was 22 per cent
±Desired precision	±5 %	The desired precision for this survey (± 5%) was chosen based on SMART recommendations for the estimated stunting prevalence

[7] https://www.betterevaluation.org/en/resources/guides/intro_mixed-methods_impact-evaluation

Design effect	1.5	The design effect chosen for this survey (1.5) was chosen to reflect potential differences between rural, urban and informal settlements.
Children to be included	431	
Average household size	5	According to KPHC 2019.
Percent of under five children	20.7 %	According to Elgeyo-Marakwet CIDP II 2018- 2022
Percent of non-respondent	3	This is the anticipated non response rate based on the previous survey experience.
Household to be included	477	Rounded-off to 481 (37 clusters by 13 HHs per cluster

This household sample (481) was distributed to selected villages based on probability proportionate to size (PPS) of the target Participants. The ward and villages level sample distribution is as shown in Appendix 7.3. Household Survey tool included general information about the household on key indicators such as socio-demographics, dietary diversity, Breastfeeding Promotion and Support, Complementary Feeding Practices, bio-fortification, Maternal Health, Hygiene etc. Household modules were applicable based on age (exclusive breastfeeding for 0-5 months; anthropometry for 6-59 months; meal frequency, dietary diversity, minimum acceptable diet targeting children aged 6 -23 months) and gender (such as biological mother aged 15-49 years). Wherever possible, advance sampling was done to ensure representativeness of the sample. Random number generator was used to select households at the selected clusters. Community Health Promoters (CHPs) supported in the identification of the households with target groups. The tool was administered to randomly selected heads of the household/caregiver, within the sampled clusters/villages.

Anthropometry (Children 6-59 months).
Guided by WVK National Office Nutrition specialist, *the nutrition indicators sample size was calculated using ENA for SMART. Key considerations in the sample size calculation were; 22% stunting, 15% of under 5 population, 5 average HH size, + or – 5% desired precision, design effect of 1.5 and none response rate of 3%.* All children 6–59 months found in the sampled households for caregiver survey were measured for weight, height, Mid-Upper Arm Circumference (MUAC) and tested for Oedema. For children 6-59 months SECA Model 874 scales with a digital display number were used to measure weight, while height and length were measured using SECA measuring boards. Children younger than 24 months were measured lying down (recumbent length), while older children were measured while standing (height). Two measurements were taken for each child 6-59 months to ensure accurate reporting of height and weight measurements. Children found to have severe acute malnutrition were referral to the nearest health facility for immediate intervention.

3.4. Qualitative sampling methodology

Focused Group Discussions

In addition to the household survey, the baseline study also conducted a total of twenty (20) focused group discussions (Table 3). The FGDs were held with the target population, including women of child bearing age (15-49yrs)/ pregnant and lactating mothers, mothers and caregivers of children 0-23 months, and farmers interested in growing nutrient-enriched (mixed group). For GESI the FGD targeted homogenous groups consisting of male & female youth, men & women, and persons with disabilities in a mixed group. Separate FGDs were conducted with men and women.

The FGD participants were selected in consultation with community leaders and taking into cognizance areas and households which had participated in household interviews to avoid duplication of efforts and redundancy of some questions. The groups were gender-segregated

and were limited to 8-10 participants and ensured adequate time, approximately 45 - 60 minutes. Typically, the FGDs were conducted by a facilitator and a note taker using pre-determined, distinct focus group guides with relevant themes. The FGDs also served to validate information/data generated by the household survey, key informant interviews and observations.

Key Informant Interviews

All key stakeholders that will participate in the GROW ENRICH project implementation were involved in the baseline study. A total of eighteen (18) KIIs were conducted during field data collection exercise (Table 3). The KII guides were developed by the Project M&E team then later reviewed and contextualized by the Consultant. The key informant interviews targeted; community leaders, health-facility staff, community health workers, line ministry staff at both county and national level. This was imperative in gathering a deeper understanding of key concepts and issues related to health, nutrition, social inclusion, and gender in the target communities. The discussions provided more details on maternal, infant and young child nutrition, management of acute malnutrition and agriculture. Additionally the discussions provided an opportunity for the Consultant to understand the operations of departments and their linkage to the project in terms of operation, management and technical support.

Table 3: Number of FGDs and KIIs

FGD Category	# of FGDs	KII Category	# of KIIs
WRA pregnant & Lactating	6	HMT representative	3
Caregivers of children 0-59 months	5	Treasury Staff	2
Farmer Group (Male)	1	County Nutrition Staff	1
Farmer Group (Female)	1	County Agriculture staff	1
Farmer Group (Mixed)	2	County Gender Officer	1
GESI (women)	1	Youth and Gender Officer	1
GESI (female youth)	1	Lead CHEW	1
GESI (male youth)	2	Village leaders. Administrators	4
GESI (persons with disabilities-mixed gender)	1	Health Facility Staff	4
Total	20	**Total**	18

3.5. Documentary review

The desk review covered the following documents:

- WV BMZ GROW ENRICH Project proposal, Log frame, M&E plan,
- Management and progress reports,
- Existing data collection tools in World Vision Kenya,
- Secondary literature studies related to the measurement of goal and outcome level indicators.
- County Government of Elgeyo Marakwet, County Nutrition Action Plan (CNAP) 2018/19-2022/23
- Kenya Time Use Survey Report. Kenya National Bureau of Statistics, 2023
- The 2022 Kenya Demographic and Health Survey
- County Government of Elgeyo Marakwet, County Annual Development Plan (ADP) 2024/2025, August 2023
- Maternal, Infant and Young Child Nutrition -_National Operational Guidelines for Health Workers
- Protecting Children Against Violence, Child Friendly Booklet
- Kenya News Agency – various online bulletins 2021 – 2024

- Voices of the People: Impediments to Peace and Community Resilience in Kenya's North Rift Region, National Cohesion and Africa, Inter-peace Integration Commission (NCIC)
- Socio-Economic Status of Elgeyo Marakwet County with COVID-19, Kenya Institute for Public Policy Research and Analysis
- Spurring the Uptake of Maternal Healthcare Services in Culturally-Endowed Communities in Elgeyo Marakwet, Kenya
- The Children Act 2022; Elgeyo Marakwet County Equity Development Act (EDA) 2015; Elgeyo Marakwet County Public Health Act, No. 4 of 2017; Elgeyo Marakwet County Education Fund Act, 2017; Elgeyo Marakwet Youth Funds act 2021

3.6. Selection and training of interviewers

Training of enumerators was conducted by the consultants at Elgon Valley Resort within Iten Township. During the training the survey objectives were reviewed in detailed, approach and the standard data collection procedures to be implemented during the survey. The instruments review not only entailed the reading and discussion of each of the questions, but also included plenary mock sessions by the enumerators to assess the flow, consistency and appropriateness of the phrases and terms used therein.

The enumerators were taken through practical sessions on how to measure weights using Digital weighing scales (SECA Model 874), length/height measurements using height boards and MUAC measurements using MUAC tape. These demonstrations on anthropometric measurements were done with support from the County department of Health led by the county Nutrition Coordinator (CNC). A pre-and post-training evaluation was conducted for the enumerators to ensure training outputs were achieved.

The training topics were structured into sessions around the survey objectives, principles, expected outcomes, terminologies and meaning, data collection process, roles and tools for effective data collection. The pre-testing was done externally in a nearby village not targeted for support under GROW-ENRICH project before debrief with all the project participants to review the observations, experiences and challenges that might be encountered. This exercise informed the final changes made in the final data collection tools and/or approach implemented during the actual data collection phase.

3.7. Field data collection

The household/caregiver questionnaire survey tool acted as the primary quantitative data collection tool. The questionnaire was designed and administered on **KoBO Collect** Application software using the WVK servers. The sample size, sampling frame, and data collection tools were designed so that data can be statistically compared to test the significance of the difference between baseline and future monitoring and evaluation activities. Additionally, certain indicators requiring data collection through observation were collected via an observation checklist integrated into the household/caregiver questionnaire. The questionnaire was integrated with items to gather information on household socio-demographics, food security, gender imbalances, breastfeeding, dietary diversity and anthropometry.

On anthropometry, weight and height measurements were recorded for children 6–59 months. Digital weighing scales (SECA Model 874) were used to measure weight, while height and length were measured using height boards. Children younger than 24 months were measured lying down (recumbent length), while older children were measured standing (height). Two measurements were taken for child 6–59 months to ensure accurate reporting of height and weight measurements. For children having severe acute malnutrition, referrals were made to

the nearest health facility for further investigation. In addition to WFH, MUAC Tapes were used to capture Mid-Upper Arm Circumference (MUAC) for children 6-59 months.

3.8. Qualitative Data Collection

Qualitative data collection techniques leveraged mainly on Focus Group Discussions (FGDs), Key Informant Interviews (KIIs) with relevant community representatives and case studies. KIIs involved respondents considered to be direct/indirect project participants cognizant of gender and representativeness. Questions were developed focusing on specific themes to triangulate some of the close ended responses in the household questionnaire. Key informant interviews targeted mainly County Health teams, County administrative, agricultural and religious leaders, and other stakeholders.

3.9. Case Studies

The baseline survey also sought to document at least two case studies of a particular person, group, or situation within the project area to complement the qualitative data. Such cases were selected by the Consultant in consultation with WVK project team. The case studies revolved around existing stories, testimonies, supportive data, and quotes for learning and sharing.

3.10. GESI-Assessment

The baseline survey integrated Gender Equality and Social Inclusion (GESI) in order to provide the necessary data and information to integrate gender, disability, and other social inclusion considerations into GROW ENRICH project implementation cycle. The GESI assessment focused on the GESI 5 key domains including; Access, Decision Making, Participation, Systems and Well-being. The process was to identify the differences between and among women, girls, men and boys especially in the context of cultural beliefs and traditional practices of Female Genital Mutilation (FGM) and Child marriage in the project area. The GESI assessment was geared towards supporting the development of interventions that address gender inequalities and meet the different needs and wellbeing of girls and boys who are the main project participants in GROW ENRICH project.

Additionally, an Intersectional gender analysis matrix (in relation to access to resources, division of labour and roles, norms and beliefs, autonomy, decision-making power, institutions, laws, and policies) Harvard Analytical Framework (examining productive and reproductive roles, responsibilities, access to and control over resources, practical needs and strategic interests), gender and power analysis (socio-cultural norms and the vested powers and privilege) as well as intersectionality analysis tool will be employed to assess Gender Equality and Social Inclusion (GESI) within the project area. Intersectionality is an analytical lens which examines how different social stratifies (such as gender, age, ability, geographic location, sexual orientation, migrant status, ethnicity, race, and economic status, etc.) all combine to create different experiences of privilege, vulnerability, and/or marginalization. Intersectionality recognizes the complexity of human existence and allows the exploration of within group differences by recognizing that the experiences of all men, women, and people of genders are not the same. Participants, were categorized into adult men and women, as well as female and male youth, and were invited to engage in focused group discussions examining specific indicators. These discussions served to inform the implementation of future programs.

3.11. Organizational assessment tool

The survey incorporated a Health facility self-assessment tool in the form of a growing seed that was used to describe organizational capacity in various areas. Health Facility in charges were asked to indicate which stage of the growth they are currently in.

3.12. Data Quality Assurance (DQA)

In the quantitative component- All data quality control measures were adhered to during this baseline survey including; reviewing of the study tools, standardization of the training (pre-testing and ensuring that the enumerators are familiar with local terminology), review of evidences against bond evidence parameters, using GPS functionality in KOBO to geo-reference the data, regular supervision and data cleaning. The administered tools were checked regularly for correctness, completeness, and consistency. After entry, the data was crosschecked to ensure accuracy of the information obtained from the field then compared and validated. During analysis, validation was done by comparing the emerging information with secondary data to ensure that any outliers were addressed. Strict supervision, guidance and backstopping was done by the Lead Consultant and the entire team. During fieldwork, daily reporting meetings were organized to address any data gaps and quality concerns. The consultants also kept a tab on the enumerators to check on their progress for spot checks. Daily data plausibility quality checks were done at the end of the day to address quality lapses. Further cleaning with logical checks were carried out on the completed data sets prior to analysis.

Additionally, to ensure validity of the research instruments this study adopted content validity to assess how relevant the instruments capture specific study questions. To minimize random error the study ensured that all items accurately address the questions. To ensure validity, the instruments were pre-tested based on the pre-testing sample size prescribed by Mugenda & Mugenda (2003) at between 1% and 10% of the study sample size.

In the qualitative component- The methodologies were designed to deliver high standard data according to research standards and ethics. The training of enumerators and FGD facilitators emphasized the importance of ethical practice, care and attention to detail in interviewing and recording responses. The process ensured experienced facilitators moderated the FGDs while experienced note-takers took notes of all the discussions and recorded them at the same time. After each FGD and KII, both the facilitators and the note-takers expanded the notes immediately and summarize key issues raised before conducting the next FGD or KII. Additionally, the supervisors conducted spot checks to see the conduct of FGDs or KII.

3.13. Ethical approvals and consideration

The Consultant applied for ethical approval from the National Commission for Science Technology and Innovation (NACOSTI) and was issued with a Research License Reference Number 428157. Additionally, the baseline study methodology was approved by both Nutrition Technical Working Group (NTWG) at WVK National Office and at the County level. Further approvals were sought by the project staff from the County Administration in Elgeyo–Marakwet County. Consent to be interviewed were sought from the prospective respondents after explaining the benefits and threats of the study. The project participant's right to withdraw from the study at any time was explained and that there would be no cost to the project participants to participate in the study. All research team members were required to sign a Confidentiality Agreement before interacting with the project participants.

The following ethical considerations were adhered to during the baseline process: **Voluntarism, confidentiality and anonymity of participants. Do No Harm:** Project and Baseline Study themes were screened for topics and questions that may cause distress to some interviewees. Mitigating approaches and referral options will be developed accordingly. **Integrity:** Data from participants were presented honestly. **Participant perspective:** To the extent possible, given logistical limitations of each context, preliminary findings will be shared with a plenary of project stakeholders to invite their reactions and interpretations. These were recorded and added to the final report. **Child Protection:** Where children (under the age of 18) were interviewed, it was

in the presence of a responsible adult from the child's family. Children were not exposed to questions of a highly personal, sensitive, potentially distressing or embarrassing nature. All Baseline Study coordinators and collectors were required to review, sign, and adhere to a child protection code of conduct and child protection policy of World Vision Kenya.

3.14. Data management plan

The study deployed the use of mobile data collection by adopting use **KoBO Collect Application** platform for various reasons including; 1) Minimizing on the errors associated with data collection and entry, and the cost; 2) Efficient administration of Baseline Study as the platform has skip patterns; 3) Less bulky compared to paper based data collection, and allows for faster turnaround time. Mobile devices are GPS enabled allowing for easier **geo-tagging** of respondents and subsequently **geo-spatial analysis**.

3.15. Data protection

Adequate measures has been put in place to ensure data from this survey is protected in accordance with the Data Protection Act No. 24 of 2019, Laws of Kenya. Infoscope will ensure that personal data are kept secure and are not disclosed to unauthorized persons. Additionally, we shall use a locked filing cabinet in a locked office for paper-based personal data. Digital data shall be password-protected or, preferably, kept in encrypted storage.

3.16. Quantitative data management and analysis

Upon completion of the survey, data was downloaded from the server in .csv and excel formats after which it was serialized to give unique serials to successful households visited. The .csv file was then converted into SPSS format for cleaning and analysis. The analysis has been undertaken in accordance with the 7 steps for data analysis as provided for by the WV Baseline Study Field Manual, May 2016.These are: -

i) clarifying survey purpose,
ii) objectives and questions,
iii) identifying target population information and analysis questions,
iv) selection of appropriate variables and measurement process,
v) conducting robust data screening and cleaning, conducting basic data analysis (descriptive),
vi) conducting inferential statistical analysis and
vii) Summarizing key findings/conclusions and recommendations.

A disaggregated has been done by gender of the household head (males vs. females) for gender sensitive analysis, and child's age (in categories) and child's sex (males vs. females).

3.16.1. Analysis of quantitative Data

A data analysis plan for each indicator was developed and guided the analysis**.** Anthropometric data was analyzed using the z-score package ENA for SMART software. The quantitative data obtained from KoBo Collect was exported to both Excel and the Statistical Package for Social Sciences (SPSS) version 22.0 software. The analysis using SPSS software involved summary, presentation (tabulation and charts) and descriptive statistics (means, standard deviations, and frequencies). Frequencies and percentages have been calculated to describe the basic characteristics of the data. This included two types of descriptive analysis, that is frequency and percentage distributions, and measures of central tendency and dispersion (mean median, mode, range, standard deviation). Second-level analysis was also be undertaken, that is, cross-tabulations, correlations (associations and hypothesis testing) when relevant variables were available.

3.16.2. Analysis of the qualitative data

Qualitative data has been analyzed using NVIVO by consolidating emerging themes from focus group discussions and comparing with quantitative data. Specific conclusions and recommendations per theme/research question has been done and presented, in relation with the quantitative results. Open ended responses from key informant interviews, discussions, and literature and project documents reviewed were recorded appropriately for further processing. Responses were coded and analyzed for themes and compared to validate quantitative results and identify any possible findings not included in the quantitative results.

3.16.3. Cross tabulations and Triangulation

Cross tabulations has been used to show the relationship between two or more Baseline Study questions. In this GROW-ENRICH Baseline Study, we have utilized a combination of several research methods to get the wide view of the results and thus triangulation is a significant tool. Triangulation facilitates validation of data through cross verification from two or more sources.

3.17. Stakeholder validation of baseline findings

The consultant in consultation with WVK has scheduled a validation meeting on 21st May 2024 to share the findings with the stakeholders in a validation workshop in Elgeyo-Marakwet County. This workshop shall bring together the relevant stakeholder where a presentation of the key findings, conclusions, recommendations and lessons learnt shall be made. Participants in the validation workshop shall be drawn from the project's catchment area. Additionally, WVK shall organize for a national level validation exercise to gather input into the report before a final product is released for publishing.

3.18. Limitations

- Insecurity- Inter-clan fighting erupted in Endo Ward shortly before field data collection could commence hence it was excluded from the survey after consultation with county/sub-county security teams. As a result, the survey resampled and distributed the sample size for Endo Ward to the remaining three wards (Sambirir, Embobut, and Kapyego). These also formed the basis of the focused group discussions and key informant interviews.
- Faulty Anthropometric Equipment- Some electronic weighing scales were found to be consistently recording wrong reading and recalls had to be made in those households hence eating on time and resources for the survey.
- Disability – Respondents with invisible disabilities like deafness meant that the survey had to enlist the services of a sign language interpreter.

4.0. FINDINGS

4.1. Introduction

The study sampled and interviewed 481 households and 479 children 0-59 months drawn from 3 Wards namely: Sambirir, Kapyego and Embobut. In addition 20 focus group discussions and 18 key informant interviews were held concurrently. This section presents the survey findings based on analysis of both quantitative and qualitative data.

4.2 Socio-demographic profiles of respondents

The survey interviewed 481 respondents (female-97.5%; male-2.5%). There were more male-headed household (91.8%) than female-headed (7.7%) or child-headed households (0.4%). Majority of the respondents were aged 18 to 30 years (68.8%) 31-40 years (22.5%). In total there were 2,488 persons living in the respondents' households (5.2 persons/HH) with 5.6% (27) of the HHs having persons living with disability. Literacy level among the respondents stood at 68.8% with 32.5% having finished primary level of education; 23.5% had finished secondary level education while 18.5% had incomplete primary. A paltry 6.7% had completed tertiary education only 2.5% having no formal education.

On marital status; majority (81.5%) of the respondents were married. The rest of the categories recorded low values with 9.2% being single; 6.9% cohabiting and 0.8% divorced (Table 4).

Table 4: Socio-demographic characteristics of the respondents

Description	Embobut	Kapyego	Sambirir	Total
Age				
Below 18 Years old	3(2.1%)	6(3.6%)	3(1.6%)	12(2.5%)
18 to 30 Years old	90(69.2%)	119(70.4%)	122(67.0%)	331(68.8%)
31 to 40 Years old	28(21.5%)	35(20.7%)	45(24.7%)	108(22.5%)
41 to 50 Years old	5(3.8%)	7(4.1%)	10(5.5%)	22(4.6%)
51 to 60 Years old	1(0.8%)	2(1.2%)	2(1.1%)	5(1.0%)
Over 60 Years old	3(2.3%)	0	0	3(0.6%)
Education				
No schooling	6(4.6%)	3(1.8%)	4(2.2%)	13(2.7%)
Never finished Primary School	27(20.8%)	29(17.2%)	33(18.1%)	89(18.5%)
Finished Primary School	44(33.8%)	64(37.9%)	50(27.5%)	158(32.5%)
Never finished Secondary School	18(13.8%)	30(17.8%)	16(8.8%)	64(13.3%)
Finished Secondary School	26(20.0%)	32(18.9%)	55(30.2%)	113(23.5%)
Higher/ tertiary education School	3(2.3%)	8(4.7%)	18(9.9%)	32(6.7%)
Vocational training	0	3(1.8%)	6(3.3%)	12(2.5%)
Marital status				
Married	107(82.3%)	143(84.6%)	142(78.0%)	392(81.5%)
Cohabiting/In union	11(8.5%)	10(5.9%)	12(6.6%)	33(6.9%)
Not currently married	7(6.9%)	14(8.3%)	21(11.5%)	44(9.2%)
Divorced/Separated	2(1.5%)	0 (0.0)	2(1.1%)	4(0.8%)
Widow	1(0.8%)	2(1.2%)	4(2.2%)	4(1.0%)
Refuse to answer	2(1.5%)	6(3.6%)	(0.5%)	7(1.5%)
Disability				
HHs with persons living with disability	5(3.8%)	9(5.3%)	13(7.1%)	27(5.6%)

4.3 Overall Outcome: An enabling policy and structural environment is leading to the improved health and nutrition status of 443,161 boys, girls, women, and men and gender equity in the target districts (sub-national levels) in Kenya.

4.3.1 Overall Outcome Indicator 1: % increase of funding for health and nutrition services from KEN national & EM County budgets

Table 5: % increase of funding for health and nutrition services from national & County budgets

Indicator	Kenya Budget 2022/23 FY	Target	National
% increase of funding for health and nutrition services from national & County budgets	KES 799,680,000 (2023)	TBD	KES 10.4 billion

Under this indicator the survey sought to establish the amount of resources allocated to support health and nutrition services from the GoK at national and county levels. In Kenya, the nominal expenditure on nutrition increased from Ksh 8.8 billion in 2015/16 to 10.4 billion in 2020/21. At 0.5 per cent of the total budget in 2020/21, Kenya's spending on nutrition lags behind the regional average of about 1.7 per cent. The World Bank developed an investment framework on financing for meeting the World Health Assembly nutrition targets by 2025. Based on the framework, countries would require an average of US$ 7 billion every year from 2016 to 2025 for financing nutrition-sensitive activities[8]. It's worth noting that in Kenya Health & Nutrition is a devolved function to the 47 Counties.

Review of documents interviews with relevant key informants revealed that total budget allocation for Elgeyo-Marakwet Country in the FY 2022-23 was KES 4.853 Billion of which KES 799,680,000 (16.5%) was allocated to Health and Nutrition Services. This was inclusive of salaries, development and commodities. Of this amount KES 150 Million went directly to supporting health commodities mainly drugs, with no dedicated budget allocation for nutrition specific commodities.

Further analysis revealed that the County department of health receives the amount KES 200 million funding from other mechanisms apart from the national exchequer. Such funding comes from Partners, like WVK, AMREF-UAT, AMREF-UAT, AMREF-HERO, Nutrition International, AMPÅTH, Facility 'Improvement Fund (FIF) from NHIF among others. This scenario was corroborated during an interview with the County M& E focal person who intimated that it is difficult to estimate the exact amount injected by the partners as they normally do not declare their resource envelop.

"Currently there nutrition services are integrated in health and there is no specific funding ring-fenced to cater for nutrition and health services per se. "

-KII with County M& E focal Person

The County Government of Elgeyo Marakwet (CGoEM) has been implementing nutrition interventions as guided by the National Food and Nutrition Security Policy with support from partners to improve the nutritional status of its population. The budgetary allocation for nutrition is spread across Maternal Nutrition, Infant and Young Child Nutrition, Integrated Management of Acute Malnutrition coordinated by the Department of Health. Other nutrition sensitive focus areas that are costed annually include Sports, WASH, Social Protection, Agriculture and Food Security in the form of nutrition-sensitive agriculture and food systems (Department of Agriculture), and School feeding programmes (Ministry of Education and Ward Representatives) that are considered under Key Results area 7 and 8 (CNAP, 2018/19–2022/23).

[8] KIPPRA Policy Brief No. 34/2023-2024

4.3.2. Overall Outcome Indicator 2: % of children under five years of age with reduction in wasting

Table 6: % of children under five years of age with reduction in wasting

Indicator	Predesigned values	Baseline value	Target at design phase	KDHS 2022 EMC	KDHS 2022 National
% of children under five years of age with reduction in wasting	4.2%	3.2%	Reduce<5% project end 2027	5%	5%

Under this indicator, the survey sought to establish proportion of children under five years of age who were wasted using weight-for-height Z-score. A total of 504 children (6-59 months) were measured for weight and height. Findings (Table 7) show that prevalence of wasting stands at **3.2%** (2.0 - 5.1 95% C.I.) compared to 4% nationally. No edema cases were observed during the assessment. Girls had slightly higher GAM 4.3 % (2.3 - 7.7 95% C.I.) compared to boys 2.2 % (1.0 - 4.8 95% C.I.) while MAM was higher in girls 3.8% (2.0 - 7.1 95% C.I.) SAM prevalence was the same for both gender, boys (1) 0.4 % (0.1 - 2.1 95% C.I.) and girls (1) 0.4 % (0.1 - 2.4 95% C.I).

Table 7: Prevalence of Wasting

	All n = 504	**Boys** n = 269	**Girls** n = 235
Prevalence of global malnutrition (<-2 z-score and/or oedema)	(16) 3.2 % (2.0 - 5.1 95% C.I.)	(6) 2.2 % (1.0 - 4.8 95% C.I.)	(10) 4.3 % (2.3 - 7.7 95% C.I.)
Prevalence of moderate malnutrition (<-2 z-score and >=-3 z-score, no oedema)	(14) 2.8 % (1.7 - 4.6 95% C.I.)	(5) 1.9 % (0.8 - 4.3 95% C.I.)	(9) 3.8 % (2.0 - 7.1 95% C.I.)
Prevalence of severe malnutrition (<-3 z-score and/or oedema)	(2) 0.4 % (0.1 - 1.4 95% C.I.)	(1) 0.4 % (0.1 - 2.1 95% C.I.)	(1) 0.4 % (0.1 - 2.4 95% C.I.)

Further analysis (Table 8) showed that children of age (30-41 months) were more malnourished (26.6%) compared to other age categories.

Table 8: Prevalence of acute malnutrition by age, based on weight-for-height z-scores and/or oedema

	All n = 504	**Boys n = 269**	**Girls n = 235**
Prevalence of global malnutrition (< 125 mm and/or oedema)	(10) 2.0 % (1.1 - 3.6 95% C.I.)	(3) 1.1 % (0.4 - 3.2 95% C.I.)	(7) 3.0 % (1.5 - 6.0 95% C.I.)
Prevalence of moderate malnutrition (< 125 mm and >= 115 mm, no oedema)	(10) 2.0 % (1.1 - 3.6 95% C.I.)	(3) 1.1 % (0.4 - 3.2 95% C.I.)	(7) 3.0 % (1.5 - 6.0 95% C.I.)

The analysis was also carried out using the MUAC cut-offs. From the findings (Table 9) the prevalence of acute malnutrition by MUAC did not use exclusion, so the analysis was performed on all 504 children. The survey reported a GAM prevalence by MUAC of 2% (1.1 - 3.6 95% C.I.) and SAM prevalence was 0.0% (0.0 - 0.8 95% C.I.)

Table 9 : Prevalence of acute malnutrition by sex based on MUAC cut-offs (and/or oedema)

		Severe stunting (<-3 z-score)		Moderate stunting (>= -3 and <-2 z-score)		Normal (> = -2 z score)	
Age (mo)	Total no.	No.	%	No.	%	No.	%
6-17	132	13	9.8	25	18.9	94	71.2
18-29	121	22	18.2	25	20.7	74	61.2
30-41	134	12	9.0	34	25.4	88	65.7
42-53	87	8	9.2	19	21.8	60	69.0
54-59	30	0	0.0	8	26.7	22	73.3
Total	504	55	10.9	111	22.0	338	67.1

4.3.3. Overall Outcome Indicator 3: % of children under 5 years with reduction in stunting

Table 10: % of children under 5 years with reduction in stunting

Indicator	Predesigned values	Baseline value	Target at design phase	KDHS 2022 EMC	KDHS 2022 National
% of children under 5 years with reduction in stunting	26% (DHS 2014)	32.9%	24%	22%	18%

Findings (Table 11) show that 32.9% (29.0 - 37.2 95% C.I) children in the project area were stunted which is higher than the 22% and 26% reported for the EMC and national respectively[9]. Anthropometric measurements (height) taken from the sample of 504 children (269 boys, 235 girls) aged 6-59 months was used to compute height for age z-scores to determine the prevalence of stunting in the sample. This yielded an overall stunting rate (<-2 height for age z-score) of 32.9% with boys having a higher stunting prevalence (37.9%) than girls (27.2%). Moderate stunting prevalence rate (<-2 z-score and >=-3 z-score) was recorded at 22% while severe stunting prevalence (<-3 z-score) was at 10.9%. In both moderate and severe stunting prevalence, boys were more affected than girls at 23.4% and 14.5% respectively.

Table 11: prevalence of stunting

	Boys		Girls		Total		Ratio
AGE (mo)	no.	%	no.	%	no.	%	Boy:girl
6-17	78	59.1	54	40.9	132	26.2	1.4
18-29	66	54.5	55	45.5	121	24.0	1.2
30-41	66	49.3	68	50.7	134	26.6	1.0
42-53	47	54.0	40	46.0	87	17.3	1.2
54-59	12	40.0	18	60.0	30	6.0	0.7
Total	269	53.4	235	46.6	504	100.0	1.1

Further analyses (Table 12) shows that severe stunting was higher in children 18-29 months (18.2%) as compared to other age categories.

Table 12: Prevalence of severe stunting by age, based on weight-for-height z-scores and/or oedema

[9] KDHS 2022

	All n = 504	Boys n = 269	Girls n = 235
Prevalence of stunting (<-2 z-score)	(166) 32.9 % (29.0 - 37.2 95% C.I.)	(102) 37.9 % (32.3 - 43.8 95% C.I.)	(64) 27.2 % (21.9 - 33.3 95% C.I.)
Prevalence of moderate stunting (<-2 z-score and >=-3 z-score)	(111) 22.0 % (18.6 - 25.8 95% C.I.)	(63) 23.4 % (18.8 - 28.8 95% C.I.)	(48) 20.4 % (15.8 - 26.0 95% C.I.)
Prevalence of severe stunting (<-3 z-score)	(55) 10.9 % (8.5 - 13.9 95% C.I.)	(39) 14.5 % (10.8 - 19.2 95% C.I.)	(16) 6.8 % (4.2 - 10.8 95% C.I.)

4.4 Outcome Module 1: Target countries are implementing updated National Action Plans which align with AU nutrition policy

4.4.1. Outcome Indicator 1: % Increase of funding provided annually by sub-national governments for local health and nutrition facilities in target districts

Table 13: % increase of funding for health and nutrition services from national & County budgets

Indicator	Baseline values FY 2022/23	Target
% increase of funding for health and nutrition services from national & County budgets	KES 150 Million	TBD increase 20% over baseline by project end (baseline in first project year).

During the FY 2022-23, the County government of Elgeyo-Marakwet allocated a total of KES 150 Million to health facilities support Operation and Maintenance (O&M). Of this amount dispensaries received KES 150,000 each; Health Centers-KES 400,000 each; Sub-county hospitals-KES 30 Million each while Iten county referral got KES 120 million. Interview with County focal point staff revealed that this budgetary allocation caters for the O&M but does not include a dedicated vote for health & nutrition services. He added that health commodities are procured centrally and constitutes mainly drugs but not nutrition specific commodities. Table 14 shows the budgetary allocation to health facilities in the FY 2022-23.

Table 14: Budgetary allocation to Health Facilities for Operations & Maintenance (FY 2022-23)

Type of Facility	Number	Amount (KES)
Health Center	29	400,000
Dispensaries	90	150,000
Sub-county	8	30,000,000
County	1	120,000,000
Total	**128**	**150,550,000**

4.4.2. Outcome Indicator 2: % increase of key government officials at national and sub-national levels who understand and actively advocate (participate) for the application of basic nutrition and health rights as enshrined in international and local laws.

Indicator	Baseline Values	Target

% increase of key government officials at national and sub-national levels who understand and actively advocate (participate) for the application of basic nutrition and health rights as enshrined in international and local laws.	50 people	TBD

The survey also sought to establish the proportion of key government officials at national and County level who understand and actively advocate (participate) for the application of basic nutrition and health rights as enshrined in international and local laws. Analysis of qualitative data from review of documents and key informant interviews with county focal staff revealed that there exist high level health and nutrition advocacy forums held quarterly at the County level. At the national level it is estimated that about 8,000 government officials participate in basic nutrition and health rights as enshrined in international and local laws compared to about 50 in Elgeyo-Marakwet County. Such forums a mainly targets the key decision makers like the County Assembly, Finance Officers, CEC in charge of Health, the Chief Officers, directors of Health and the Governor to advocate for increased funding allocation for basic nutrition and health services in line with the County Equal Development Act (EDA). Additionally the nutrition champions have been used to advocate for basic nutrition and health rights at the County level. These nutrition champions include the county Women Representative who has been in the forefront in rallying other in a bid to improve nutrition services in the County. Other champions include the sportsmen and women mainly the athletes.

Additionally because the fund are allocated at the Ward there is also the grass root level advocacy where lobbying is done with the community, the MCA and CHP to ensure more allocation of funds to the health and nutrition. Such forums engagements are held annually before ADPs. The Health Management team Executive, CEC, Directors, CNC. Health and Nutrition professionals in this region that attend the advocacy meeting annually.

Box 1: - Key informant Interview with County M&E focal Person

At the County we have what we call High Level Advocacy forums that target key decision makers, mainly the County Assembly to advocate for more resource allocation to Health and Nutrition services. The Forum also includes, CEC for Health, CO, directors. We also sometimes reach out to the Governor to reinforce. MCAs are responsible for funding allocation and also because funds are allocated at Ward level we rally the community to see the need to allocate more resources to support nutrition services.

4.5. Outcome Module 2: Women of reproductive age, adolescent girls and children under 2 benefits take up improved gender-sensitive nutrition and health services in target regions

4.5.1. Outcome Indicator 1: % of children<6 months who are exclusively breastfed (EBF)

Table 15: *% of children < 6 months who were exclusively breastfed*

Indicator	Baseline Value	Target Values at design Phase	KDHS 2022 National
% of children of children (0-5 months) who are exclusively breastfed	68.6%	70%	60%

Findings show that 68.6% (95% CI: 58.8 – 77.3) of children (0-5 months) were exclusively breastfed. This shows comparatively high rates of exclusive breastfeeding compared to the

national average of 60%[10] and county average of 62.9%[11]. From the baseline findings 100% (105) of children 0-23months were ever breast fed and 99% (104) were breastfed the previous day. Breastfeeding supports children's growth and development and also benefits the mother's health. In the first 6 months, children should be exclusively breastfed, meaning that they should be given nothing but breast milk. Exclusive breastfeeding for 6 months lowers the risk of infections that can lead to diarrhea and respiratory illnesses and provides all of the nutrients and liquid an infant requires for optimal growth.

Rerye chich bortanyi"

This is a Marakwet statement which means that when a mother gives birth to a baby, she must breast feed that baby without even being told. It is something which is obvious and every mother knows that.

-FGD with PLWD at Chemworor Health Centre, Sambirir Ward

Findings (Figure 1) show that 92.4 percent of children were breastfed within one hour of birth. Initiation of breastfeeding within the first hour of birth is important for both the mother and the child. The first breast milk contains colostrum, which is highly nutritious and has antibodies that protect the newborn from 45 infections. Early initiation of breastfeeding also encourages bonding between the mother and her newborn, especially through skin-to-skin contact, which facilitates the production of breast milk (KDHS, 2022). Further analysis also showed that 78.1% (82) of children where put directly onto the mother's bare chest so that they had skin-to-skin contact. The results for Sambirir are relatively lower than that of the other 2 Wards possibly because of the effort of the community Health Promoters (CHPs).

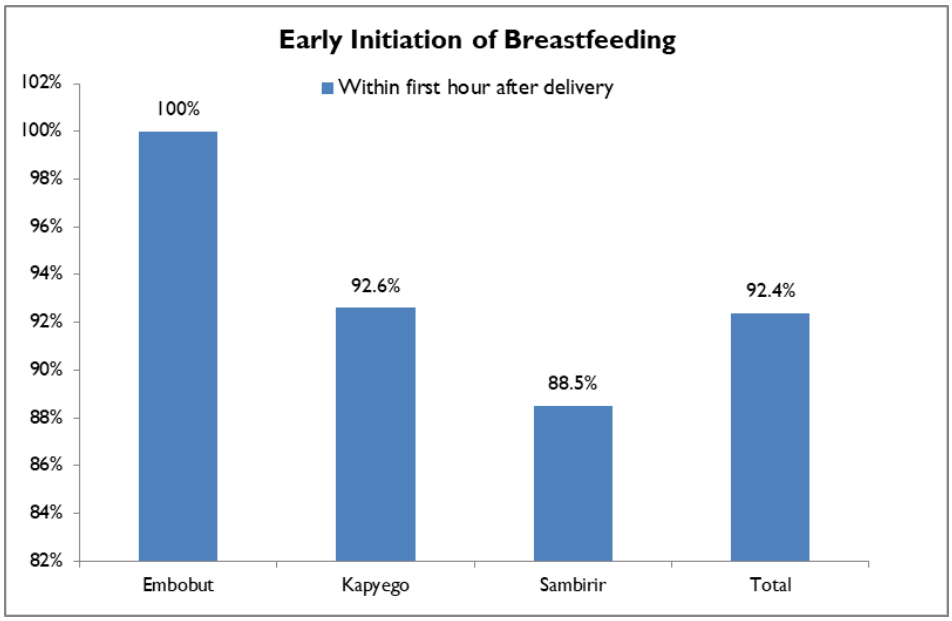


Figure 1: Early initiation of breastfeeding

"We have a cultural belief that if you do not breastfeed your child at initiation the mouth of your child might be deformed and this encourages early initiation of breastfeeding."

-FGD with Mothers of Children 0-23 months at Kamogo Health Centre- Embobut

[1010]Kenya Demographic and Health Survey 2022
[11] EMC CNAP 2018/19- 2022/23

4.5.2. Outcome Indicator 2: % of women aged 15-49 who used at least 4 antenatal examinations (ANC)

Uptake of WHO recommended 4+ ante-natal (ANC) visits among women aged 15-49 years stands at 42.3% (176) which is lower than the 57.6% reported nationally. Only 0.2% (1) of the women achieved 8 ANC contacts. Additionally 56% gave birth in the presence of a skilled birth attendant, compared to the national average of 62% (KHIS 2019). The KDHS 2022 indicated that 52% of women age 15-49 who had a live birth and had 4+ antenatal visits in Elgeyo Marakwet County.

Table 16: % of women 15-49 who used at least 4 ANC examinations

Indicator	Baseline value	Target Values at design Phase	KHIS 2019	KDHS 2022 EMC	KDHS 2022 National
% of women aged 15-49 who used at least 4 antenatal examinations (ANC)	42.3%	TBD increase 10% from baseline by the end of the project.	24%	52	57.6%
% of women aged 15-49 who achieved the WHO recommended 8 antenatal examinations (ANC)	0.2.%	N/A			4% of women had eight or more visits.

Under this indicator, the survey sought to establish the proportion of women aged 15-49 who used at least 4 antenatal examinations (ANC) during the most recent pregnancy. Findings (Table 17) reveal that 42.3% (CI 37.3 – 47.0) of the women had used at least 4 antenatal examinations with a paltry 0.2% (1) of the women achieving the WHO recommended 8 ANC contacts. Another 82.9% (358) of the women had received and took iron and folic acid supplements when they were pregnant. The supplements were taken for about 4 months on average.

Table 17: Number of Antenatal visits

Number of antenatal visits	Embobut		Kapyego		Sambirir		Total	
	n	%	n	%	n	%	n	%
Once	7	6.3	7	4.8	7	4.4	21	5.0
Twice	20	18.0	25	17.0	23	14.6	68	16.3
Thrice	45	40.5	48	32.7	58	36.7	151	36.3
Four times	29	26.1	42	28.6	47	29.7	118	28.4
Five times	7	6.3	18	12.2	16	10.1	41	9.9
More than five times	3	2.7	7	4.8	7	4.4	17	4.1
Total	**111**	**100.0**	**147**	**100.0**	**158**	**100.0**	**416**	**100.0**

Where ANC was received

Further, the survey sought to establish where the ANC was received. Majority (52.7% (222) of the women received ANC from Health Centre. Another 18.8% (79) of the women received ANC from government hospitals, 16.7% (70) received ANC from dispensary/maternity Centre, and 10% (42) received ANC from private hospital/clinic. In Kenya the CHPs conduct home visits to conduct health education and encourage the pregnant mother to attend the health facilities. Only 1.4% (6) of the women received ANC at home as shown in Table 18 below.

Table 18; Where ANC was received

Where ANC was received	Embobut		Kapyego		Sambirir		Total	
	n	%	n	%	n	%	n	%
At home	2	1.8	3	2.0	1	0.6	6	1.4
Government Hospital	13	11.7	18	12.2	48	29.8	79	18.8
Dispensary/maternity center	26	23.4	9	6.1	35	21.7	70	16.7
Health center	64	57.7	108	73.0	50	31.1	222	52.9
Private hospital/clinic	5	4.5	10	6.8	27	16.8	42	10.0
Outreach clinic	1	0.9	0	0.0	0	0.0	1	0.2
Total	**111**	**100**	**148**	**100**	**161**	**100**	**420**	**100**

Type of ANC services received

Regarding the ANC received, findings (Table 16) show that 98.8% of the women received measurements of body weight and blood pressure, 96.7% received blood test, 95.0% received urine test, 92.1% had received counselling about diet, 89.5% had received provision of tetanus toxoid (TT) vaccination, 89.3% had received counselling about danger signs and lastly 55.2% had received ultrasonography as shown in Table 19 below.

Table 19: Services offered during ANC visits

ANC services received	Embobut		Kapyego		Sambirir		Total	
	n	%	n	%	n	%	n	%
Measurement of body weight	108	97.3	146	98.6	161	100.0	415	98.8
Measurement of blood pressure	107	96.4	147	99.3	161	100.0	415	98.8
Provision of tetanus toxoid	102	91.9	131	88.5	143	88.8	376	89.5
Urine test	101	91.0	138	93.2	160	99.4	399	95.0
Blood test	102	91.9	143	96.6	161	100.0	406	96.7
Ultrasonography	59	53.2	78	52.7	95	59.0	232	55.2
Counselling about danger signs	99	89.2	134	90.5	142	88.2	375	89.3
Counselling about diet	100	90.1	141	95.3	146	90.7	387	92.1

Majority (81.8%, 355W) of the women had ANC card or any other card where TT immunization is recorded, and averagely received 1 TT injection while 89.5% received tetanus toxoid injection. The women majorly gave birth at a health center 36.6% (159) and were mainly assisted by nurses 65.4% (284) during delivery. Nearly all the women had their health check-up at 99.0% (388) and child 99.5% (390) within 2 days after delivery while still in the health facility. This was mostly done by nurses/midwives 68.7% (268). Majority of the women had CHWs visit their homes 75.5% (363) and mostly in the last month (42.4%) who were mainly giving information on hygiene (55.4%), breast feeding (53.2%), complimentary feeding (49.3%) and self-care (48.2%). The women take mostly between 15 and 30 minutes to reach their nearest health facility (45.9%) and mainly by walking (79.0%).

For the babies, immunization was regarded to be of great importance. A majority (85%) of children in the county were fully immunized in the first year of life and 84% of children under five received zinc and oral rehydration salts (ORS) for the treatment of diarrhoea (KHIS 2019). The percentage of children age 12-23 months fully vaccinated (basic antigens) were 70% in Elgeyo Marakwet and 80% nationally (KDHS 2022). The significantly high proportion of women who had their children vaccinated was validated by the FGD with new mothers and caregivers at Maina Dispensary who noted as follows;

Children are fully vaccinated and those who finish their prescribed dose are health and chances of getting sick is very low.
FGD discussants, Maina Dispensary, Sambirir Ward

4.6. Output 2.1: Increased access to gender sensitive facility-based basic nutrition, health and SRHR services for women, girls and boys

4.6.1. Output Indicator 1: # of health facilities in target districts providing gender-sensitive primary care in nutrition and health and SRHR

Indicator	Baseline Value	Target Values at design Phase	KDHS 2022
# of health facilities in target districts providing gender-sensitive primary care in nutrition and health and SRHR	100% (29 health centres, 90 dispensaries, 8 Sub-county, 1 County referral)		-

In many settings worldwide, health facilities fail to deal with the gendered aspects of care and treatment, including the challenges that clients face in accessing care and the delivery of services. Gender inequalities, unequal power dynamics, and negative provider attitudes impede respectful care for clients. In part due to gender norms and the overall low status of women in society, health providers sometimes practice gender discrimination toward clients, including — but not limited to — physical, sexual and emotional abuse, non-consented care, and a lack of privacy. On the other hand, health care providers in many societies also see reproductive health services as purely a woman's domain and sometimes alienate men from participating[12]. Women and girls suffer disproportionately from poor nutrition and are subject to social, cultural and political norms of how food is produced, accessed and consumed and how nutrition services are provided and used. Gender issues affect nutrition outcomes in many ways. Energy and nutrient requirements are influenced both by sex and biology while nutrient uptakes might be influenced by gender roles and responsibilities. For instance, women and girls often eat last and least (due to gendered norms), which restricts their ability to achieve their potential and there are also more likely to be affected by hunger[13].

This indicator was calculated using a set of questions which explored the how many health facilities were providing gender-sensitive primary care in nutrition, health and SRHR within project area. Most facilities well equipped for MCH, FP, PMTCT Services, HIV testing and counselling service, Immunizations, Child welfare clinic, lab services, and pharmacy. Analysis of qualitative data from key informants and review of documents revealed that all the 118 Health Facilities in the county were providing some form gender sensitive facility-based primary care in nutrition, and SRHR albeit in an unstructured fashion such as Community Integrated Management of Childhood Illness (C-IMCI), maternity services and Inpatient Department (IPD), are highly sought by women and are tied to their reproductive roles but men have poor health seeking behaviour. The number of households targeted for supplementation with micronutrient powders (MNPs) was 6000 FY 2023/ 2024 (CGoEM 2023). Most facilities lack nutritionists. Analysis of data from Key informant interviews reveal that even though these health facilities attempt to provide gender-sensitive nutrition, health and SRHR services, like gender-sensitive family planning services that respect women's autonomy, dignity and privacy, nutrition

[12] https://mcsprogram.org/our-work/gender/ensuring-gender-sensitive-respectful-services/
[13] https://www.nipn-nutrition-platforms.org/Background-on-nutrition-and-gender#:~:text=Nutrition%20and%20gender%20are%20inextricably,nutrition%20outcomes%20in%20many%20ways.

counseling, Voluntary medical –male circumcision (VMMC). There is low utilization of contraception by men, and low utilization of SRHS by female adolescent yet teenage pregnancies rates are high. However, these services are offered as a by-the-way due to inadequate human resource and capacity gaps among existing personnel. The youth in the project area were found to be reluctant to seek gender-sensitive nutrition, health and SRHR services due to the fact that these services are currently integrated within adult services. There is a glaring need for youth- friendly centers to address specific nutrition, health and SRHR needs of boys and girls in the project area. Few of facilities offer youth-friendly services, no facility offering comprehensive youth friendly services yet they are 1/3 of the population.

GBV Support Units are established in most Health facilities and functional community units increased from 78 to 120 in the county. Community health promoters (CHPs) were targeted for incentives in Kapyego (80), Sembirir (100), Embobut (50), and Endo (60) according to budgets of the ADP FY 2024/25 submitted to County Assembly for the promotion of universal health care (CGoEM 2023: Appendix 1: List of Projects Prioritized for 2024/25 FY, Pg 88).
In terms of quality of care and gender specific or disaggregated data, outreach HPV screening and vaccination to all girls above 10 years of age in schools, health talks were done in barazas, schools and churches for all age groups and sexes; VCT screening was done to the public mainly targeting adults; immunization campaigns were undertaken for under 5 yrs, Malezi bora training was also conducted for care givers in the health facilities and growth monitoring for under 5 years was done as well. For further analysis see the matrix below.

Intersectional Gender Analysis Matrix on Health and Nutrition Services

Intersectional Gender Analysis Ma

The true situation on this subject is well captured from the KII summary below;

" Our health facilities, try very much to provide gender-sensitive nutrition, health and SRHR services through our nurses who have undergone some basic trainings offered by our partners. However because of competing needs and inadequate staffing, such information is offered on need-based fashion. There also need for youth friendly centers to support our youth."

-Key Informant Interview-Dept. of Health, EMC

4.6.2. Output Indicator 2: Increase in # of yearly nutrition & SRHR consultations in H&N facilities in project areas

Table 20: Increase in # of yearly nutrition & SRHR consultations in H&N facilities in project areas

Indicator	Baseline value	Target Values at design Phase	KDHS 2022
Increase in # of yearly nutrition & SRHR consultations in H&N facilities in project areas	992 SRHR Consultations	TBD	N/A

The survey sought to establish the number of nutrition and SRHR consultations in health and nutrition facilities in project areas per year. Findings (Table 17) from analysis of quantitative data show that in the period beginning January 2023- April 2024, there were a total of 992

nutrition and SRHR consultations in the project area (GBV-51; 4th ANC contacts-941). Interview with key informants reveal that such consultation are being held albeit in ad hoc manner owing to the competing needs from the health staff and inadequate capacity building refresher training for those offering nutrition and SRHR consultation.

…we suffer burn-out due to few staff and a lot of clinical work so issues to do with nutrition and SRHR are normally offered in an integrated fashion during routine visits or in-patient. But there need for more partner support in terms of capacity building refresher trainings to increase our capacity.

-KII respondent-Iten county Referral Hospital

4.7. Output 2.2: Improved community-based capacity to prevent, monitor and manage malnutrition with a gender lens

4.7.1. Output Indicator: # of number of community-based organizations/groups with capacity to prevent, monitor and address malnutrition from a gender perspective

Indicator	Baseline value	Target Values at design Phase	KDHS 2022
#of number community-based organizations/groups with capacity to prevent, monitor and address malnutrition from a gender perspective	0	TBD	N/A

Under this indicator the survey sought to establish the proportion community-based organizations/groups with capacity to prevent monitor and address malnutrition from a gender perspective. Finding from analysis of qualitative data show that there exist mother-to-mother support groups in the project area working generally on breastfeeding support, or nutrition counselling, however such organizations or groups work lack capacity to prevent, monitor and address malnutrition from a gender lens. This finding was corroborated during key informant interviews with County Health Management representative and the gender desk that intimated that even though there are mother-to-mother support groups that provide breastfeeding support, or nutrition counselling there is a general gaps with regard to integrating gender equality and social inclusion (GESI) in many respects. They added that there is need to build capacity of the local organization especially the CBOs on issues around gender and social inclusion given that the Marakwet community where the project is located in predominantly patriarchal society. Additionally there has been gaps with regard to social inclusion of traditionally marginalized segments of the society like persons living with disability (PLWD), persons with HIV (PLWH) and those with invisible disability on matters nutrition in the project area.

….in Marakwet community issues to do with gender equality are normally spoken in low tones as there is a general belief that most decisions affecting the family including food production are made by men…but food preparation is mainly done by women. So there need to involve both gender on this matter to improve nutritional status of the household members.

-KII with Village Chief Kapyego Location

4.8. Outcome Module 3: Women of reproductive age, adolescent girls and children under 2 benefits from improved gender-sensitive production and use of nutritious foods in the target regions

4.8.1. Outcome Indicator: % of children aged 6-23 months receiving minimum acceptable diet

Table 21: % of children aged 6-23 months receiving minimum acceptable diet

Indicator	Baseline value	Target Values at design Phase	KDHS 2022	National
% of children aged 6-23 months receiving minimum acceptable diet	9.1%	31%	31%	22.6%

The Minimum Acceptable Diet (MAD) for children 6-23 months old, is one of eight core indicators for assessing infant and young child feeding (IYCF) practices developed by the WHO and finalized at the World Health Organization (WHO) Global Consensus Meeting on Indicators of Infant and Young Child Feeding in 2007. WHO guiding principles on feeding the breastfed child and the non-breastfed child recommend that children aged 6–23 months be fed meals at an appropriate frequency and in a sufficient variety to ensure, respectively, that energy and nutrient needs are met14. This indicator combines information on minimum dietary diversity and minimum meal frequency, with the extra requirement that non-breastfed children should have received milk at least twice on the previous day. The minimum acceptable diet is defined as:

- for breastfed children: receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day;
- For non-breastfed children: receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day as well as at least two milk feeds.

If a child meets the minimum feeding frequency and minimum dietary diversity for his or her age group and breastfeeding status, then the child is considered to be receiving a minimum acceptable diet.

MAD is a composite indicator which comprises of both Minimum Dietary Diversity (MDD) and Minimum Meal Frequency (MMF) (see Output 3.2). The survey covered 231 children 6–23 months of age who were investigated for the indicator. Findings (Table 22), show that only 9.1% of the children (9.5% boys, 8.6% girls) receiving MAD compared to 22.6% reported nationally. The proportion was lower in non-breastfed children compared to breastfed children.

Table 22: % children 6-23 months receiving minimum acceptable diet

Category	Status	Overall	Boys	Girls
Minimum acceptable diet breastfed	Not Achieved	90.2%	88.4%	92.4%
	Achieved	9.8%	11.6%	7.6%
Minimum acceptable diet non-breastfed	Not Achieved	93.0%	88.5%	93.0%
	Achieved	7.0%	3.2%	11.5%
Overall Minimum Acceptable Diet	Not Achieved	90.9%	90.5%	91.4%
	Achieved	9.1%	9.5%	8.6%

"I give semi solid after four months this is where the child cries at night which I think is the right time to give because that means the child is not full with breast milk alone."

-FGD with Mothers of children 0-23 months at Kapyego Health Centre, Kapyego Ward.

[14] Guiding principles for complementary feeding of the breastfed child. Washington: Pan American Health Organization-World Health Organization; 2003

4.9. Output 3.1.Increased availability and consumption of diversified nutrient-dense foods including biofortified crops for women, girls, boys and men"

4.9.1. Output Indicator 1: # of HH growing nutrient-rich crops

Table 23: # HH growing nutrient-rich crops

Indicator	Baseline value	Target Values at design Phase	KDHS
HH growing nutrient rich crops	4% (19)	TBD	N/A

Under this indicator, the survey sought to establish the number of households growing nutrient rich crops. Findings (Table 24) show that 4.0% (19)(CI: 2.4-6.1) of the households grow nutrient rich crops of which 27.8% grow orange flesh sweet potato, 72.2% grow iron beans, 77.8% grow orange maize, 83.3% grow zinc rice and 5.6% grow other bio fortified crops. 34.9% (168) of the participants had heard of bio-fortified crops before. Of this proportion, 6.3% (30) consumed meals prepared of bio-fortified crop(s) in the last 7 days being orange flesh sweet potato (20.0%), iron beans (80.0%), zinc rice (3.3%) and other nutrient rich foods (3.3%). The significantly lower proportion of the households having consumed bio fortified food crops is validated by FGD 8 *"Majority of the community members wish to consume bio-fortified food but they are constrained by their high cost and physical unavailability"*

Table 24: Types of bio fortified foods consumed

Bio fortified food consumed	Embobut		Kapyego		Sambirir		Total	
	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)
Orange Flesh Sweet Potato (OFSP)	0.0	25.0	0.0	0.0	0.0	37.5	0.0	22.2
Iron Beans	0.0	83.3	14.3	87.5	0.0	87.5	3.7	85.2
Zinc rice	0.0	0.0	0.0	0.0	0.0	12.5	0.0	3.7
Other foods	0.0	0.0	0.0	0.0	0.0	12.5	0.0	3.7

As to why some had not consumed meals (Table 25) prepared of bio-fortified crop(s), 56.0% did not know anything about bio fortified crops, 39.2% were not told or helped to grow bio fortified crops, 9.3% did not have land or enough land to grow bio fortified crops, 3.2% had household members who did not like it and 12.8% mentioned other reasons as shown below. The lack of awareness as the main reason why the households had not consumed meals prepared of bio-fortified crop(s) is validated by FGD 2 *"The community members should be sensitized on what food fortification is and what fortified foods are because majority of the community members do not know them."*

Table 25: Reasons for not consuming bio fortified foods

Reasons for having not consumed bio fortified crops	Embobut	Kapyego	Sambirir	Total
Do not know anything about bio fortified crops	45.3%	72.3%	48.6%	56.0%
No one told me or helped me to grow bio fortified crops	51.6%	29.5%	39.9%	39.2%
I do not have land or enough land to grow bio fortified crops	12.6%	7.7%	8.8%	9.3%
Household members did not like it	5.3%	3.0%	2.0%	3.2%
Others	14.7%	9.1%	14.9%	12.8%

The nutrient rich crops grown were mainly equally consumed and sold. Orange flesh sweet potato (42.1%), orange maize (47.4%) and zinc rice (42.1%). Iron beans was mainly consumed (52.6%). Food aid was the main source of other bio fortified food crops the households ate (36.8%). Benefits of bio fortified crops mentioned by the households included providing essential micronutrients to improve nutrition and health (77.1%), bio fortification is most beneficial to groups who are vulnerable to deficiencies in micronutrients such as vitamin A, zinc or iron (63.7%), Its greatest benefit is in contributing to the prevention of micronutrient deficiencies (38.5%) and bio fortified crops are good especially for children and Children who are fully vaccinated i.e. those who finish the prescribed dose are healthy and chances of getting sick is very low. Pregnant and breast-feeding women (19.6%).

4.9.2. Output Indicator 2: % of HH with acceptable HH Dietary Diversity Score

Table 26: % of HH with HH dietary diversity score

Indicator	Baseline value	Target value at design phase	KDHS
% of HH with acceptable HH Dietary Diversity Score HDDS	77.1%	TBD increase 15% from the baseline	N/A

The Household Dietary Diversity Score (HDDS) was released in 2006 as part of the FANTA II Project as a population-level indicator of household food access. Household dietary diversity can be described as the number of food groups consumed by a household over a given reference period, and is an important indicator of food security for many reasons. A more diversified household diet is correlated with caloric and protein adequacy, percentage of protein from animal sources, and household income (Swindale & Bilinsky, 2006). The HDDS indicator provides a glimpse of a household's ability to access food as well as its socioeconomic status based on the previous 24 hours (Kennedy et al., 2011). The following 12 food groups are used to calculate the HDDS indicator:

1. Cereals
2. Roots and tubers
3. Vegetables
4. Fruits
5. Meat, poultry, offal
6. Eggs
7. Fish and seafood
8. Pulses, legumes, nuts
9. Milk and milk products
10. Miscellaneous
11. Sugar/honey
12. Oil/fats

Each food group is assigned a score of 1 (if consumed over the previous 24 hours) or 0 (if not consumed in the last 24 hours). The household score will range from 0 to 12 and is equal to the total number of food groups consumed by the household.

Survey findings (Table 27) show that 77.1% (CI: 73.1-80.8) of the households had acceptable Dietary Diversity Score (>5 food groups). The average Household Dietary Diversity Score for the surveys was 6.42 (CI: 2-11). Meaning the households in the households in the project area were consuming about 6 food groups in the previous 24 hours preceding the survey.

Table 27: Minimum dietary diversity score categories

Question	Response	Overall Percent	by HH head gender		by Disability	
			Male	Female	No	Yes
HDDS binary categories	Not achieved (<5 groups)	22.9	22.2	30.8	23.6	11.1
	Achieved (>5 groups)	77.1	77.8	69.2	76.4	88.9
HDDS three categories	High (≥ 9)	6.0	5.9	7.7	6.4	0.0
	Medium (5-8)	86.7	87.1	82.1	86.1	96.3
	Low (≤4)	7.3	7.0	10.3	7.5	3.7

Although there is no universal cut-off or target level that indicates that a household is sufficiently diverse, FANTA suggests two alternatives for using this indicator in a performance reporting context. One option is to use the dietary diversity patterns of wealthier households as a target (the richest 33%), which requires the assumption that poorer households will increase their dietary diversity as their incomes rise. A second option is to establish a target using the average dietary diversity of the 33% of households with the highest diversity (Swindale & Bilinsky (2006).

Baseline findings (Figure 2) indicate that cereals (97.7%), milk & milk products (92.5%), and vegetables (86.9%) were the most consumed foods the previous day or night. Fish and sea food (0.8%), fruits (10.2%), meat, poultry and offal were the least consumed at 13.7%. The low consumption of seafood and fish is a result of cultural preferences and the great distances of surveyed areas from the sea.

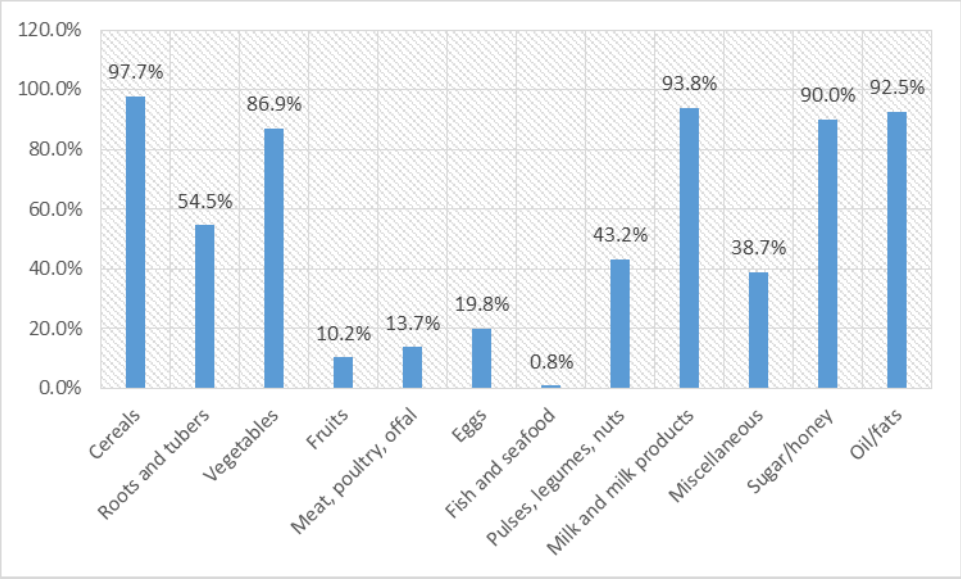


Figure 2: Proportion of HHs consuming various food groups

4.10.1. Output Indicator 1: % and # of families with adequate knowledge and skills in nutrition in the first 1000 days as per MIYCF minimum criteria

Table 28: % and # of families with adequate knowledge and skills in nutrition in the first 1000 days as per MIYCF minimum criteria

Indicator	Baseline value	Target values at design phase	KDHS 2022
% and # of families with adequate knowledge and skills in nutrition in the first 1000 days as per MIYCF minimum criteria	14.9% (52) (Female 15.9%, Male 14.4%)	TBD increased by 20% from baseline by end of project	N/A

The first 1,000 days between a woman's pregnancy and her child's second birthday offer a brief but critical window of opportunity to shape a child's development. During the first 1,000 days, the brain grows more quickly than at any other time in a person's life and a child needs the right nutrients at the right time to feed their brain's rapid development[15]. Adequate knowledge and skills in nutrition during the first 1000 days of life, which includes pregnancy and the first two years of a child's life, are critical for ensuring optimal growth, development, and long-term health outcomes. This includes nutritional needs during pregnancy, maternal nutrition and health, breastfeeding, complementary feeding, micronutrient supplementation, prevention and management of malnutrition and hygiene and food safety practices. This indicator was defined as children achieving minimum dietary diversity, minimum meal frequency and the proportion of women who consume iron containing supplements during pregnancy.

The survey sought to establish the proportion of adequate knowledge and skills in nutrition in the first 1000 days as per MIYCF minimum criteria. From the finding only 14.9% (Female 15.6%, Male 14.4%) of the children were found to have adequate knowledge and skills in the first 1000 days as per the MIYCF criteria as shown in Table 29.

Table 29: % adequate knowledge and skills in nutrition in the first 1000 days as per MIYCF minimum criteria

Indicator	Overall	Female	Male
Minimum meal Frequency	10.1%	9.5%	11.5%
Minimum Dietary diversity	26.7%	24.1%	29.0%
Iron folic supplementation	82.9%	85.0%	81.2%
Total: adequate knowledge and/orskills in nutrition in the first 1000 days as per MIYCF minimum criteria		15.6%	14.4%

a. Minimum dietary diversity

Minimum dietary diversity is a proxy for adequate micronutrient density of foods. By consuming food from at least five food groups of eight food groups, the child has a greater likelihood of consuming at least one animal source of food and at least one fruit or vegetable, in addition to a staple food such as grains, roots, or tubers. The five food groups come from a list of eight food groups: breast milk; grains, roots, and tubers; legumes and nuts; dairy products (milk yogurt, cheese); flesh foods (meat, fish, poultry, and organ meat); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables. Findings show that 40.3% (33.9 – 46.9 95% C.I) of children met this minimum dietary diversity criterion which slightly higher than the 39% national average[16]. It is noteworthy that most of these children were breastfed and were additionally given foods such as grains, meats, milk, and fruits as shown in Table 30.

[15] https://thousanddays.org/wp-content/uploads/1000Days-Nutrition_Brief_Brain-Think_Babies_FINAL.pdf
[16] KDHS 2022

Table 30: Dietary diversity for children 6-23 months

Food groups	Number	%
Group 1: Grains, Roots & Tubers e.g. bread, bulger, pasta, potato, beet root, porridge	212	91.8%
Group 2: Legumes and Nuts e.g. lentils, beans, nuts	67	29.0%
Group 3: Dairy Products (Milk such as tinned, powdered, condensed or fresh animal milk)	213	92.2%
Group 4: Flesh meats and offal's e.g. Beef, mutton, chicken, liver, kidney, fish	36	15.6%
Group 5: Eggs	59	25.5%
Group 6: Vitamin A fruits and vegetables e.g. carrots, dark leafy greens (Kales, spinach), Mangoes	148	64.1%
Group 7: Other fruits and vegetables e.g. tomatoes, citrus fruits, bananas, apples, cabbage, onions, eggplant, , watermelon	59	25.5%
Group 8: Breast Milk	174	75.3%

The poor dietary diversity was linked to financial constraints and awareness. Food insecurity also limited household access and utilization of nutritious foods.

b. Minimum Meal Frequency

Minimum meal frequency refers to the percentage of children aged 6–23 months who consumed solid, semi-solid, or soft foods (including milk feeds for non-breastfed children) the minimum number of times or more during the previous day. The minimum number of times is defined based on the age and breastfeeding status of the child:

- Breastfed infants aged 6–8 months should receive solid, semi-solid, or soft foods at least two times per day.
- Breastfed children aged 9–23 months should be fed solid, semi-solid, or soft foods at least three times per day.
- Non-breastfed children aged 6–23 months should receive solid, semi-solid, or soft foods or milk feeds at least four times per day, with at least one of the four feeds being a solid, semi-solid, or soft feed.

Egg and/or flesh food consumption by breastfed and non-breastfed children age 6–23 months increases children's energy, protein, and nutrient intake. Eggs, meat, fish, poultry, and organ meats are important sources of nutrients that support healthy child growth (WHO and UNICEF 2021).

Overall, only 16% (boys-17.5%. girls-14.4%) of children 6-23 achieved their minimum meal frequency. The proportion was even lower in non-breastfed children as shown in Table 31 below.

Table 31: Minimum Meal Frequency

Category	Status	Overall	Boys	Girls
Breastfed infants aged 6–8 months	Not Achieved	29.4%	40.0%	19.2%
Breastfed children aged 9–23 months	Not Achieved	30.1%	24.3%	37.7%
	Achieved	69.9%	75.7%	62.3%

Non-breastfed children aged 6–23 months	Not Achieved	82.5%	83.9%	80.9%
	Achieved	17.5%	16.1%	19.2%
Minimum meal frequency overall 6-23 months	Not Achieved	84.0%	82.5%	85.7%
	Achieved	16.0%	17.5%	14.4%

4.10.2. Output Indicator 2: # and percent of primary caregivers with improved knowledge and practice in IYCF practices.

Table 32:# and percent of primary caregivers with improved knowledge and practice in IYCF practices

Indicator	Baseline value	Target Values at design phase	KDHS
# and percent of primary caregivers with improved knowledge and practice in IYCF practices	66.1% (Female 66.7% Male 41.7%)	TBD increased by 20% from baseline by end of project	N/A

Improved knowledge and practice in infant and child feeding practices are closely linked to positive child health outcomes. Increased awareness and adherence to exclusive breastfeeding for the first six months of life contribute to improved child health outcomes. Breast milk provides essential nutrients and antibodies that protect against infections, reducing the risk of diarrhea, respiratory infections, and other illnesses in infants. Knowledge of appropriate timing and practices for introducing complementary foods alongside continued breastfeeding at around six months of age ensures that infants receive adequate nutrition for optimal growth and development (Table 33). Proper complementary feeding practices help prevent malnutrition and micronutrient deficiencies in young children. Understanding the importance of offering nutrient-dense foods such as fruits, vegetables, grains, legumes, and animal-source foods as complementary foods supports healthy growth and development in infants and young children by providing a diverse and balanced diet helps meet children's nutritional needs and reduces the risk of malnutrition. Knowledge of safe feeding practices, including proper food preparation, handling, and storage, reduces the risk of foodborne illnesses and ensures the safety of infant and child food consumption while hygienic practices during feeding help prevent infections and promote overall child health (Annex 4).

Table 33: IYCF knowledge versus practices

Category	Sub-category	Knowledge	Practice
Breastfeeding	Breastfeeding within one hour after birth	95.0%	92.4% (97) women Put their baby to breast within 1 hour after delivery
	Exclusive breastfeeding for 6 months	94.8%	68.6% (72) of children 0 – 5 months exclusively breastfed
Complementary feeding	Introduction of complementary foods	95.4%	89.6 % (47) of children 6 - 8 months introduced to complementary food
	Food diversification	96.2%	32.9% (76) of children 6-23 months achieved minimum dietary diversity
Maternal health	Iron and Folic Acid supplementation	80.9%	82.9% (348) of mothers consumed iron folic in their last pregnancy

This indicator measures knowledge and practices on maternal and infant and young child feeding related aspects was assessed around 5 key areas as described in annex 4:

- ✓ Breastfeeding Promotion and Support
- ✓ Complementary Feeding Practices
- ✓ Maternal Health
- ✓ Nutrition
- ✓ Hygiene

The minimum score was 10 out of possible 15 scores. From the finding 66.1% (n=318) of the primary caregivers with improved knowledge and practice in IYCF practices as shown in **Error! Reference source not found.**3. Female respondents had higher knowledge and skills compared to male.

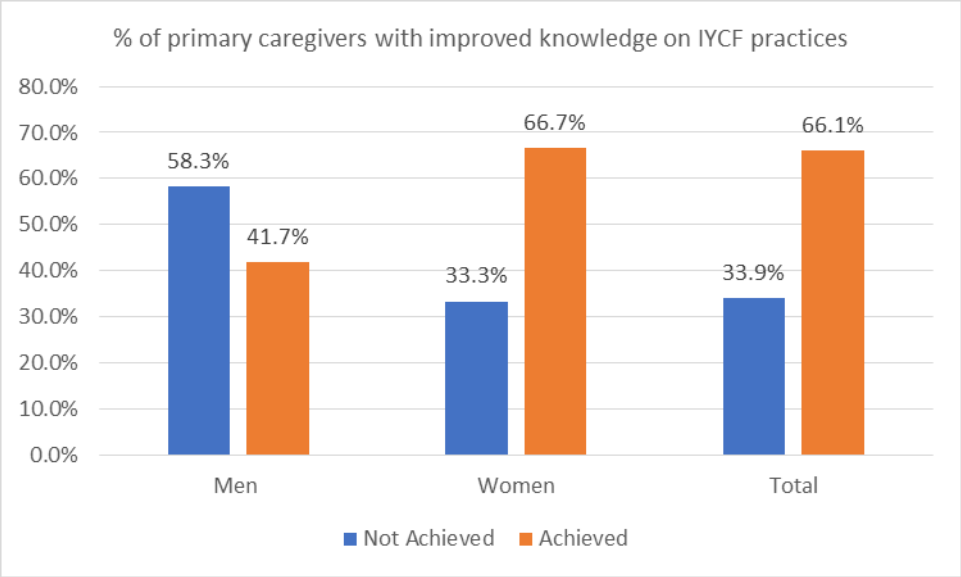
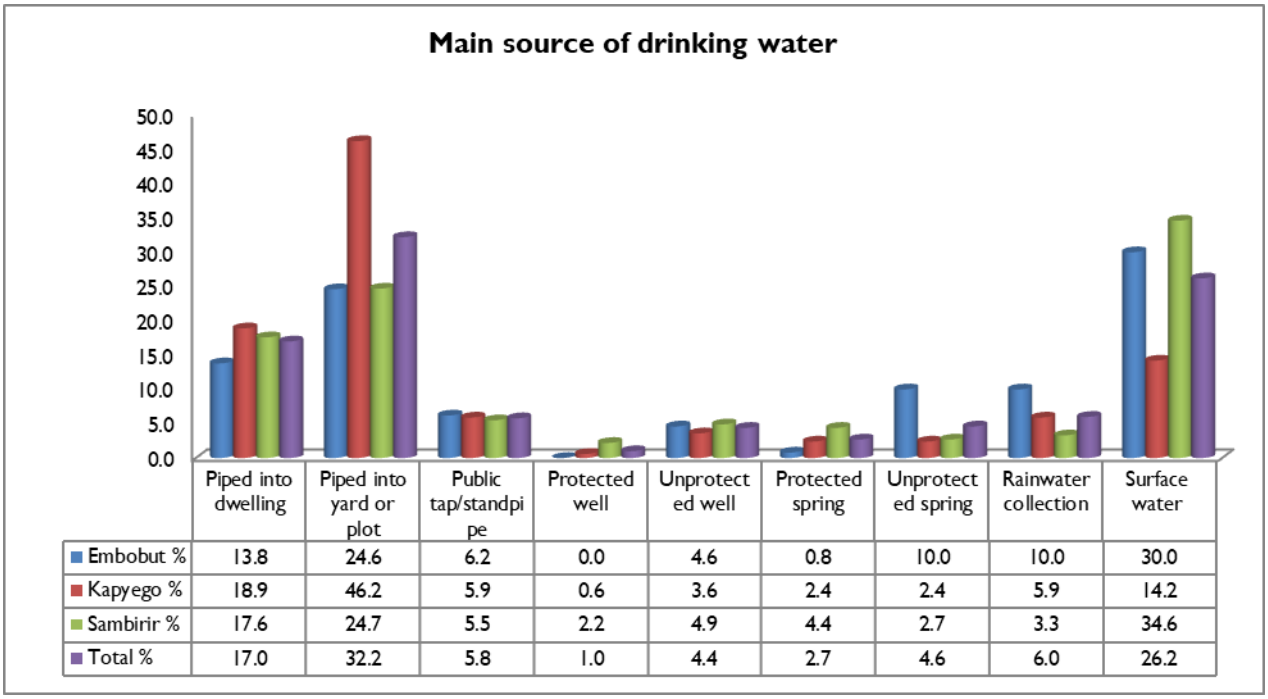


Figure 3: Percent of primary caregivers with improved knowledge and practice in IYCF practices

Additionally, the survey sought to establish the main source of drinking water for the households. Findings (Figure 4) indicate that water piped into yard or plot was the main water source for the households 32.2% (155) among surface water (river, stream, dam, lake, pond, canal, irrigation channel) 26.6%, piped into dwelling (17.0%), rainwater collection (6.0%), public tap/standpipe (5.8%), unprotected spring (4.6%), unprotected well (4.4%), protected spring (2.7%) and lastly protected well (1.0%) as shown below.



	Piped into dwelling	Piped into yard or plot	Public tap/standpipe	Protected well	Unprotected well	Protected spring	Unprotected spring	Rainwater collection	Surface water
Embobut %	13.8	24.6	6.2	0.0	4.6	0.8	10.0	10.0	30.0
Kapyego %	18.9	46.2	5.9	0.6	3.6	2.4	2.4	5.9	14.2
Sambirir %	17.6	24.7	5.5	2.2	4.9	4.4	2.7	3.3	34.6
Total %	17.0	32.2	5.8	1.0	4.4	2.7	4.6	6.0	26.2

Figure 4: Main source of drinking water

The survey further sought to establish the ways of making water safe for drinking in the project area. From the findings (Table 34), boiling was the most practiced method by 39.1% of the household, followed by 16% that let it stand and settle. Other methods less practiced by the households include; adding bleach/chlorine (4.6%), use of water filters (2.5%) and strained water through a cloth (0.2%). It is notable that that more than half of the households (53%) do nothing to the water to make it safe for drinking.

Table 34: Ways of making water safe for drinking

Ways of making water safer to drink	Embobut	Kapyego	Sambirir	Total
Boil	33.1%	30.2%	51.6%	39.1%
Add Bleach/chlorine	1.5%	0.0%	11.0%	4.6%
Strain it through a cloth	0.0%	0.0%	0.5%	0.2%
Use water filter (ceramic, sand, composite, etc.)	3.1%	1.8%	2.7%	2.5%
Let it stand and settle	15.4%	17.2%	15.4%	16.0%
Don't do anything to the water	61.5%	61.5%	39.0%	53.0%
Do not know	0.0%	0.0%	0.5%	0.2%

Sanitation facilities

Regarding the type of toilet facility used by the households, findings (Table 31) show that most of the households use pit latrine without slab / open pit (62.8%). The remaining households used pit latrine with slab (26.4%), Ventilated Improved Pit latrine (VIP) (7.3%), flush to piped sewer system (1.2%), flush to pit (latrine) (0.6%) and lastly flush to septic tank (0.2%) as shown in Table 35 below. Most of the households wash their hands in a bowl of water (sharing with other people) (52.2%).

Table 35: Type of toilet facility used by the household

Type of toilet facility used by the household	Embobut		Kapyego		Sambirir		Total	
	n	%	n	%	n	%	n	%
Flush to piped sewer system	2	1.5	1	0.6	3	1.6	6	1.2

Flush to septic tank	0	0.0	1	0.6	0	0.0	1	0.2
Flush to pit (latrine)	0	0.0	0	0.0	3	1.6	3	0.6
Ventilated Improved Pit latrine (VIP)	6	4.6	20	11.8	9	4.9	35	7.3
Pit latrine with slab	21	16.2	40	23.7	66	36.3	127	26.4
Pit latrine without slab / open pit	101	77.7	106	62.7	95	52.2	306	62.8
No facilities or bush or field	0	0.0	1	0.6	0	0.0	1	0.2
Other	0	0.0	0	0.0	6	3.3	6	1.2
Total	130	100.0	169	100.0	182	100.0	481	100.0

On key moments when the participants need to wash their hands, results reveal that most do so after toilet (92.1%). Those who wash their hands before eating were 82.5%, 68.0% wash their hands before cooking, 66.9% wash their hands before feeding a child and after eating and finally 53.2% wash their hands after cleaning babies bottom as shown in Table 36 below.

Table 36: Key moments when you need to wash your hands

Key moments when you need to wash your hands	Embobut	Kapyego	Sambirir	Total
Before cooking	59.2%	73.4%	69.2%	68.0%
Before feeding a child	60.8%	63.9%	74.2%	66.9%
After toilet	90.0%	92.3%	93.4%	92.1%
After cleaning babies bottom	51.5%	49.7%	57.7%	53.2%
Before eating	77.7%	82.2%	86.3%	82.5%
After eating	65.4%	70.4%	64.8%	66.9%
Other	3.8%	1.8%	1.6%	2.3%

4.11. Gender Equality and Social Inclusion (GESI) Assessment

This section of the assessment provides baseline information on gender, disability, and other social inclusion considerations for GROW ENRICH implementation cycle. It identifies the differences between and among women, girls, men and boys especially in the context of cultural beliefs and traditional practices of Female Genital Mutilation (FGM), Child marriage and the situation of children with disability within the four wards of Marakwet East that includes Sambirir, Embobut, Kapyego and Endo in Elgeyo Marakwet County. It also assessed the GESI domains of access, decision-making, participation, systems, and well-being in relation to health and nutrition.

Gender roles and responsibilities in the community

In the Marakwet Culture, a man is expected to provide food for his family (children and wife or wives). The women are often involved in looking after the household and are caregivers for children, sick family members and the older folks. These roles and responsibilities are not compensated economically. Socialization and education are used to implore upon the children to conform to the societal norms, live harmoniously with everyone and avert conflicts. The children are taught to regard themselves as brothers and sisters. This socialization also exposes them to expected gender roles and responsibilities in the Marakwet community and inculcate soft and hard skills to enable them survive.

Reproductive roles

Child upbringing and parenting is often in the preserve of women. At adolescent stage, the Fathers advice their sons while women advice their girls who are about to get married. The women are relegated to looking after the rural homes as part of their cultural duties and rarely venture into towns especially if they have not acquired any professional skills for formal employment, while men are free to travel and live far from homes where they perform productive roles such as gainful employment or business entrepreneurship.

> *The work exclusively done by women and girls in our community are fetching firewood and firewood on their backs, changing of diapers, washing of utensils, milking, cooking, washing clothes, smearing the house with cow dung and decorating the walls, baby sitting. Women will plant, weed and harvest crops too. Men are expected to building houses, fencing, hunting though rarely these days …. Slaughtering of animals, prepare the land for cultivation, fencing, harvesting crops (if they are at home), and bee production - harvest honey and prepare beehives.*

> *Conversely, in exceptional cases men cook when there is a special occasion such as community ceremonies where they are believed to be energetic and are able to prepare enough food. Men cook when their women are on their periods because they are believed to be unclean, men will also cook or clean and even take care of their children when their wives are sick, admitted in hospital, or when there is a newborns. Sometimes the women are away on a journey and would be back late so they are compelled to cook*
>
> *-GESI Male Youth, Kamogo Health Centre Embobut*

On average women spend approximately 5 hours per day on unpaid work, which is about five times more than men (about 1 hour). The proportion of time spent on these activities in rural areas is slightly higher compared to urban areas for both women and men. Overall, women spend approximately 7 times more time on unpaid care work (2.4 %) than men (0.4%) and about 5 times more (16.3%) on unpaid domestic work than their male counterparts (3.2%). The burden of unpaid work is higher for women than men in Elgeyo Marakwet. The time spent per day by women on unpaid domestic and care work is 17.5% more than men (KNBS 2023).

Productive roles

Agricultural and livestock production

Women are assigned household duties while men look after the animals. Where men are living in their rural homes, they are involved in the mining, farm activities like tilling the land, sowing, weeding and harvesting. In some cases, both are involved ploughing and sowing, but mostly men. The outcome is usually not optimal, because there is little effort placed in shared responsibilities and so women play a key role in mobilising labour and production on land.

> *In the Marakwet culture, initially boys were given responsibility to prepare farms with their fathers then later mother and her daughters join them to cultivate the farm but nowadays boys have engaged in drugs such as "tomato" (tobacco) and they do not want to help.*
>
> *GESI FGD with PLwDs (mixed male and female), Mureto Primary*

> *Nowadays Women and children have taken up most of the reproductive and productive roles in the households while men go to the market centre to take alcohol.*
>
> *FGD Female, Kapyego Health Centre*

Gender roles between girls and boys

The findings reveal a classification and segregation of gender roles where there are some roles that appear to be a preserve of girls while others are meant for boys. This trend shows that girls

are overburdened with household chores leaving them with little time to engage in productive activities that ensure they can compete favorably with the boys.

> *"……. In our community the girls are automatically expected to perform certain roles like; fetching water, collecting firewood, cleaning homes because boys are expected to perform difficult chores such as hunting, fencing slashing grass ……."*
>
> *FGD discussant - Female Adult - Embobut.*
>
> *Boys have been involved in raiding and cattle rustling as an old tradition that has been used by pastoralist to restock their livestock, especially after long periods of drought or disease outbreaks. The boys join men in carrying out these activities by virtue of their masculinity. The cattle rustling and acquisition of livestock compels boys to acquire livestock. They also conduct retaliatory attacks and protect the community from an imminent raid.*
>
> *In some vulnerable homes, both boys and girls undertake agricultural activities as hired farm help for other community members to assist their families with the required income. This includes tilling the land, harvesting, shelling maize from the cobs. The boys are likely to be engaged in mining in the valley and herding as child labour (willingly or forced by family" predicament).*

Discussion

Analysis of qualitative data from focus group discussions and key informant interviews indicated that as a cultural norm, girls perform more reproductive roles compared to men. This includes household chores that are family welfare related which in turn limit the amount of time they can spend in productive roles such as focusing on her school revision and take-home assignments. This affects the girls' school performance in school as they have little time to attend to school related activities in order to excel in their pursuit for education in order to actively pursue her desired profession that would enable her meet strategic gender needs and gain independence to participate in decision-making at individual, family and societal level.

Gender role reversal at the household level happens when traditional female roles are adopted boys and men for commercial gain. The boys and men will rarely collect water or fetch firewood for their families even if they are doing so to sell. It may also be due to family make-up of having children of the same sex only. In such cases they children will take up roles are required in their households.

The discussants and key informants expressed concern over prevalence of economic GBV that burden women with reproductive roles consisting of unpaid work thus leaving them little time to engage in productive roles and realize their strategic gender needs.

Women have taken up multiple roles in cases of absent fathers. This includes both productive and reproductive roles as well as community roles. In some cases roles have been reversed when men take up tasks usually performed by women to earn income. This include selling firewood and water.

Intersectionality among the Marakwet Community members

This section provides an overview of the ways that multiple forms of inequalities or disadvantages may create obstacles for some groups within the community and this is exacerbated by harmful traditional practices. Their personal characteristics (gender, age, disability) intersect with systems and structures in society to shape their experiences in a varied manner leading to vulnerability, privilege, inclusion or exclusion. Intersectionality analysis in this Gender Equality and Social Inclusion (GESI) assessment interrogates the ways in which gender, age and disability interconnects with other social characteristics to contribute to varied experiences of marginalisation and privilege. This enables development and rights safeguarding

in line with the BMZ GROW ENRICH Project to incorporate these differences into programming.

Non-vulnerable community members

In the four wards of Marakwet East, the communities that are considered not vulnerable from harmful cultural practices are non-Marakwet people; they include Government workers and business people residing in major urban centres that are cosmopolitan and the immigrant population who have settled in the area. These people are neither bound by Marakwet traditional practices nor likely to conform to them. The Marakwets who have out-migrated from the sub-county are not also bound by these harmful cultural practices. The male adults in their prime are also not vulnerable as they are in position of power and privilege to decide for their younger male and female relatives on life's decisions.

5.8.1.2. The vulnerable

The community members considered "vulnerable" are those facing deprivation or stigma due to a particular situation (in some cases only temporary such as extreme weather) that has reduced their ability to withstand shocks. This includes those living in areas affected by insecurity, landslides or drought, HIV AIDS-affected people. They are children, adolescents, older people Women with lower level of wealth and income, daughters of single mothers, uneducated women and girls, children who have experienced defilement and rape, inter-sex children, urban poor, boys at risk of being involved in cattle raids, girls at risk of early marriages, pregnant adolescents, children in the labour market, children born with HIV/ AIDs, and women who experience sexual gender-based violence are considered vulnerable to harmful traditional practices. Others in this category are women and girls with disabilities including those with non-physical disability that are likely to suffer from sexual violations and multiple discrimination including FGM and early marriages. They are often not reached when health, nutrition, sexual reproductive health promotion, contraception messages, STD prevention and protection massages are disseminated in the media, during campaigns and remain ignorant.

The included

Those with power and privilege comprise of the affluent or higher class in society such as; the Clan and Council of Elders (Kokwo[17]); men especially in high status groups; senior elderly women; dominant groups as defined in the Marakwet community. These include the thirteen patrilineal clans, each of which (with the exception of the Sogom clan) is divided into two or more exogamic sections distinguished by totems. Homesteads are in totemic settlements scattered widely throughout the sub-county. The community lives in territorial groups, which are politically distinct but interconnected by the clan structure and the age-sets. Their religious leader is known as the orgoy. He is consulted regarding the rain, outcome of war, before the warriors set out. The boys and girls whose parents are in this group flourish as they complete their schooling and acquire professional skills with numerous economic opportunities at their behest that enable them to maintain their privileged position in society. Male Champions, Religious Leaders, FBO, CBO, NGOs staff running humanitarian, emergency, health operations, awareness creation campaigns and alternative rites of passage programmes are great influencers in enhancing nutrition and wellness, combating the harmful practices thus have power and privilege as well as decision-making clout.

The excluded

Those excluded from participating in community processes and decision-making on life matters are children - children with disabilities, children with multiple disabilities including non-physical

[17] Kokwo is the highest institution of conflict management and socio- political stratum among the Marakwet community. Kokwo is made up of respected, wise old men who are knowledgeable in the affairs and history of the community. The elders are eloquent public speakers able to use proverbs and persuasive phrases effectively. Every village is represented in the council of elders. Senior elderly women contribute to proceedings in a Kokwo but must do so while sitting down.

(intellectual challenged), intersex community members, children with HIV/AIDS, adolescents, adolescent girls forced into FGM/C, early marriages and termination of schooling, female headed households, women who are economically marginalized, uncut girls and women (are not involved in any ceremonies, events, cannot feed people, and cannot get married in the community thus are cut off completely from the community social fabric), women with no children and the rural poor living in informal settlements and centers are excluded from decision-making.

Excluded groups

Economically Excluded	Poorest of all ● Low-income earners ● Location – insecurity prone areas ● Low education level ● Ethnicity ● Sex
● Women ● Landless ● Sengwer ● Kiptani ● Age - older persons and adolescent ●Language ● People with disabilities ● People of geographically remote areas such as the valley in Endo Ward ● Sexual and Gender Minorities (inter-sex, single mothers)	**Socially Excluded (specific issues of exclusion)**
Environmentally Excluded	● People residing in low rainfall areas: Lower Sambirir and Endo ● People experiencing extended drought ● People cultivating in eroded and poor soils ● Harsh weather in the valley ● Hilly terrain "Chang tulwoi" (a lot of hills)

These categories of people experience extreme marginalization within the community and are often targeted in terms in cases of abuse, molestation and exploitation. At the household level and community level they are often engaged in reproductive roles to meet their practical gender needs. They also tend to be engaged by others as farm labourers or in households on a daily basis in exchange for food.

> *"Mostly it's the disabled. They also have come to regard themselves as lesser. Here, parents who give birth to disabled children would rather hide them from the public because they are considered as shameful and embarrassing. Other groups are the orphans, widows, and widowers. These groups rarely have a voice to speak for them especially during resource sharing. We meet them when we go to the field and they complain to us a lot about the same. The reason for their marginalization is that they are considered as not worthy members of the society. They are seen as burdens who can never be of help to the community."*
>
> *-Community Health Promoter, Sambirir*

> *The Sengwer and the Kiptani of Kenya are believed to be marginalized community in the county based on their society and way of life.*
>
> *-Religious Leader*

4.11.1. ACCESS

This section examines the ability of the community members to access, use, and / or own assets, resources (financial, natural, services, information, social capital, knowledge), opportunities, services, benefits, infrastructure in relation to health and nutrition.

4.6.1.1.Access to information, assets, resources, benefits, services and infrastructure

The Marakwet people perceive land as a communal property that is administered by elders for the benefit of the whole community. This practice and belief is still prevalent in the valley where nomadic pastoralism is the best and only viable land use (ITDG-EA, 2004). They children are exposed to information on managing land resources and relating with other members of the society through informal (life skills by parents, uncles, aunties, grandparents, older siblings, churches, clubs) and formal education (life skills, social studies, guidance and counselling in school) where boys are taught how to fence while girls are taught how to cook.

In Marakwet East, there are differences in the way women and men access resources, opportunities and also exert power over social, political, and economic structures (Kiptarus, 2017). According to a Male Elder in Embobut, Marakwet culture dictates that gender, age, and rank in society is a determining factor on the area where one should take a bath in the river, failure to adhere to this norm will attract a disastrous curse. At any given instance, men are supposed to bathe upstream while women are culturally bound to clean their bodies downstream or carry the water and have a bath at home. This territoriality is evident through the way in which they use their resources in general.

> *Men are muscular and forced by culture; they automatically have more access to resources especially those related to land than women. The Cultural duties also confine women to the homes visa Vis to men who are free to travel and live far from homes.*
>
> *Religious leader*

On whether they believe men, women, boys and girls have the same basic rights to access basics of life, the GESI Female focus group discussants at Kapchebau indicated as follows:

> *They should have equal rights so that every opinion is heard but this is not the case ….. On land ownership, girls are not allowed to own land unless, their family didn't have sons. It was seen as unnecessary since women would get married elsewhere. Ownership of land sometimes depended on how the family views each other or values the women.*
>
> *Not at all! Women are "cheboloou kipor" (she can be married anywhere anytime) so she has no right to own any property.*
>
> *Embobut-Embolot Mothers of Children 0-23 Months*

The GESI FGD with PLWDs affirmed that according to Marakwet Culture, men have the right to own and control property and boys have no right of owning until their fathers grant them ownership. Boys and girls have rights depending on their parents' discretion but in most cases, it is believed that if girls are given rights to own any property they would not get married.

> *Gender roles and responsibilities tend to influence access to resources and decision-making within Marakwet East, however, poverty levels have really broken that down to a large extent. The gender roles have shifted and now, the mothers do all they can to bring something back home for food. Also, as you can see, leadership norms and traditions are shifting as well; I am a female sub-chief. The value of the girl child has also risen in the community. The parents are beginning to see more reasons to educate their girls. Christianity has greatly played a role in*

changing perceptions. However, the father still has much say especially when it comes to family resources."

Female Administrator, Embobut

4.6.1.2. Access to financial services and credit

For women, access to credit for business expansion, improved their livelihoods, economic empowerment is hampered by their nature of being risk averse. The Maendeleo Ya Wanawake (National Women's Organisation) Chairperson for Marakwet West urged women to join groups and apply for the Women Enterprise Funds, emphasizing the importance of utilizing these government-provided financial opportunities that have soft repayment terms such as lower interest rates and affordability. During an awareness creation session, she was dismayed that uptake of these funds in both Marakwet East and West sub-counties has been disproportionately low compared to other wards in Elgeyo Marakwet County (Okong'o 2024).

Youth Bunge (Parliament) has been established where they meet and talk about issues in the community, promote agriculture amongst the youth, encourage the youth to start agrovets and become stockists. In Marakwet East, milk is sold to youth groups and transported to Iten where they have a cooler and are stockists of inputs and milk to safeguard them against poor weather (Youth and Gender Officer, National Government).

4.6.1.3. Access for persons with disabilities

According to the August 2019 Census, Elgeyo Marakwet County has 0.4% persons with visual difficulties and 0.5% persons with mobility difficulties. The rest of persons with disabilities have hearing difficulties (0.2%), cognition difficulties (0.2%), self-care difficulties (0.2%), and communication difficulties (0.2%). A study by Kurumei et. al. (2021) on Youth with Disabilities indicated that there was inadequate provision of socio-cultural support services which included education and vocational training, health services and employment, subsequently hampering their access to these services.

The baseline survey used the Washington Group (WG) Short Set of questions to identify people with functional limitations and the results indicated that out of the 481 persons interviewed, 5.6% (27) experienced some form of disability with 3.8% (5) in Embobut, 5.3% (9) in Kapyego, and 7.1% (13) in Sambirir. In regards to the type of disabilities, 0.8% (4) indicated that they were able to see with some difficulty - even if wearing glasses, 0.3% (6) were hard of hearing, able to hear with some difficulty, even if using a hearing aid, 3.5% (17) had some difficulty walking or climbing steps while 0.2% (1) had a lot of difficulty walking or climbing steps, 0.8% (4) had some difficulty remembering or concentrating, 0.2% (1) stated that they experienced some difficulty maintaining self-care such as washing all over or dressing, 0.4% (2) noted that they were able to communicate with some difficulty in order to understand or be understood. WHO estimates that 10-20% of the population has disability, which suggests that official records likely underestimate the rate of disability.

The Elgeyo Marakwet County Equity Development Act (EDA) 2015 stipulates that 60% of the development expenditure should go to each of the 20 wards with each ward getting an average of Ksh40 million annually thus distributing benefits equality across the county. The Elgeyo Marakwet County Youth, Women and Persons with Disabilities Revolving Fund Act, 2020 provide for the establishment of Youth, Women and Persons with Disabilities Fund for empowering youth, women and persons with disabilities in the County; to provide for the administration of the Fund and for connected purposes. They also have access to loans through Farm-to-Market Alliance.

Youth Bunge (Parliament) has been established where they meet and talk about issues in the community, promote agriculture amongst the youth, encourage the youth to start agrovets and become stockists. In Marakwet East, milk is sold to youth groups and transported to Iten where they have a cooler and are stockists of agricultural inputs to safeguard them against poor weather (Youth and Gender Officer, National Government).

4.11.1.4. Access to Health

Access to health has been provided equally to men, women, boys and girls. All community members have the right to access good health; nobody is denied medication in this community irrespective of their status or religion (FGD Male Youth in Embobut). Heath services are inadequate and, in some cases, inaccessible across the sub-county and most residents experience financial challenges. Further, the discussants also noted that there was insufficient assistance for people living with disabilities. This was also observed by Kurumei ET. al. (2021), despite health services contributing to 9.5%, to personal development of Youth with Disabilities.

44.5% of the Youth with disabilities strongly agreed that health facilities were available and accessible to them compared to those who agreed (26.8%), were undecided (14.6%), disagreed (7.9%), and strongly disagreed (4.1%). While 27.7% agreed that they readily had access to disability specific care, 34.7% of the Youth with Disabilities strongly agreed that assistive technologies had been made affordable to Youth with Disabilities (Kurumei et. al. 2021). Furthermore, the study indicated that 34.6% of the Youth with Disabilities disagreed that they were adequate health specialist personnel to deal with disability cases while 22.2% strongly agreed with the statement. This study also sought the views of parents and guardians who disagreed (31.4%) that Youth with Disabilities had ready access to general health care while 26.6% agreed. Majority of the parents and guardians of Youth with Disabilities disagreed (35.8%) and strongly disagreed (30.9%) to the fact that they get disability-specific care, corrective services, and assistive technological devices such as hearing aids.

According to a Health worker in Chesoi, 80% of the community members are able to come for the services due to the improved roads and existence of motorbikes.

> *This being a sub county hospital, the services are mostly accessible to the people around. Compared to the other facilities around, this one is a bit ahead in its financial resources. "I can say that the services are unfortunately not favourable to Persons Living with Disabilities (PLWDs) in general. The same is true across all the facilities in the sub-county"*
>
> *-Community Health Promoter, Chesoi Sub-county Hospital*

> *Dispensaries such as St. Michael's Embobut lack ramps or special washrooms for those abled differently, who have to use wheel chairs, leg callipers or crutches and a number of facilities do not have special clinics as well as ambulances for emergency referrals. For those sick down in the valley, it is difficult to transport them up the escarpment for treatment. Since the government employed Community Health Promoters (CHPs) the services have now been taken nearer to the community members*
>
> *Female Administrator, Embobut*

> ***Viewpoint narratives***
>
> *Zawadi (not her real name) is a relatively young lady who works as a Community Health Promoter (CHP) in her own community. She is educated and exhibits a passion for improving nutrition amongst mothers and children; she is helping the members of her community by creating awareness on health and nutrition. She passionately articulated issues that require*

immediate intervention. When she talked about the plight of women, her first-hand experience of the hardships she described is clearly depicted. She believes in proper education as the most effective tool to bring change.

It is conclusive from the interview with Zawadi and the women respondents in the different health facilities that women here desire much change. There's clearly a crisis of leadership (in the household level) where women are overstepping the culturally set norms of patriarchy. The reason for this is that the men are not enlightened nor empowered. Other responses were almost similar to Zawadi's especially where men's behaviour are concerned. While interviewing Zawadi, it is clear that it is a norm amongst men to leave their homes in the morning and comeback only for meals. All this while, the mother of the home goes beyond her bounds and capacity to fend for the family. Zawadi says that men only "contribute in child siring and leaves the rest to women".

It is the mother who ensures the child is fed, taken to the health facility for treatments and is educated. However, they admit that there are few men who are responsible. These men are mostly those who are educated and those who have been influenced by Christianity (which is the dominant religion here).

The women expressed much gratitude for the opportunity to speak for community. It is evident that they believe the desired change to be possible.

The hilly terrain, nature services and opportunities do not favour children with disabilities (CwDs) where they require specialized clinics, equipment, facilities and follow-up services based on their needs such as intellectual challenges, visually impairment, hearing impairment, psychosocial challenges and epilepsy. There is a gap in knowledge dissemination, mostly, the CwDs are not taken into consideration and miss out on the health information especially when they are mixed together with those without disability.

4.11.1.5. Access to information on nutritious food

According to discussants with farmers in Embobut, majority of the community members wish to consume fortified food but they are not available to them. The benefits were well articulated as follows:

When a mother takes food which are fortified with iron supplement it reduces maternal and child anemia. Fortified foods also increase maternal and child weight thus encourages faster growth and development. My community perceives that fortified foods reduces micro-deficiency diseases, it improves active play in children …. It helps a child to be active when playing with others, it helps in formation of strong bones, and it helps in strengthening body immune system by fighting and preventing child from diseases. Fortified foods are ideal for mothers and child to grow strong and healthy. This information is provided during ANC and PNC Clinics.

-Sambirir Farmers FGD, Chesoi CDF Hall

"Most people here do not have adequate knowledge on food fortification. There is an exception of a few who are professionals and those who have attended seminars. For those who have attended the seminars, education on smart farming has been done. World Vision also recently gave out some fortified orange flesh sweet potato vines which some here were able to get. However, most of those who received vines do not understand the difference it brings. That is basically the situation here."

-Community Health Promoter, Chesoi Sub-county Hospital

Negative attitude of the community towards food fortification is prevalent, for instance, maize flour from the Posho mill (flour mill) is preferred to maize flour from the shop such as Dola (a maize meal brand in the market). This is because people say the flour from the posho mill is stronger than Dola. Further, the community does not have the fortificants and also machines for food fortification especially that for milling maize flour. The community is very interior hence they like eating their food in their natural state.

- Embobut Farmers Focus Group

The female community members had access to adequate information on exclusive breastfeeding that they obtained from visiting the health centres such as Kapyego, their mothers, grandmothers or even other relatives, from Community Health Promoters - CHPs in the area, and during their community development meetings such as 'chamas' when they normally include some topics including good motherhood. Others mentioned that they read about the information form the clinic card. They are also aware of the benefits of breastfeeding such as boosting the immunity, prevention of diseases, growth of healthy children, and bonding of the mother with their child (Mothers of Children 0-23 months, Kapyego Health Centre and Kamogo Health Centre). Overall, it was noted that access to nutrition services was curtailed since most public facilities in the sub-county are Level 2 - Dispensaries that are only open during the day on weekdays, only Tot Sub-county Hospital and Chesongoch Health Centre open 24 hours/7 days.

4.11.1.6. Access to Education and Training

In general, there are unequal opportunities for boys and girls in accessing and acquiring education. At the family level, boys are mostly supported than girls to obtain the highest attainable education and professional qualifications. Marakwet girls are viewed as a source of wealth due to dowry incentive thus not much investment is allotted to their education as they will eventually move out. Traditionally, after FGM/C, the girls are often married off and the dowry that is paid is used for school fees for boys amongst other family benefits. The County has high incidences of teenage pregnancy at 12% compared to 15% nationally, considered a negative sexual reproductive health outcome amongst adolescents. If a boy impregnates a fellow pupil, they remain in school while the girl drops out to look after their baby, performing reproductive roles that are unpaid but are instead welfare-related. This derails their education progression and may bring it to an end if she drops off completely. In case the affected girl delivers and are able to return to school, they face stigma unlike their male counterparts who move on with their education and often not associated with any children they sired. At the home front, boys do not perform reproductive roles like cooking after school which gives them adequate time for studies while most girls will fetch water, firewood, bathe their younger siblings and cook for the family before they can settle down to study (Project Staff).

Boys go and study and complete their schooling then they are able to get jobs or other economic engagement due to the knowledge and skills they acquired. But if girls study and finish one level they are told that they can't continue schooling and are advised to get married for [dowry] cows. It is imperative that girls should also complete school, so that they can have more alternatives at their disposal and gain economic empowerment including building their income generating capabilities and also obtain employment opportunities that are at the boys' disposal (Gender Officer, CGoEM).

For most of the time, young girls drop out of school and are married off very early due to teenage pregnancies, the low level of education makes one to be ignorant.

GESI Female FGD, Kapchebau Primary

The students are given lunches during the school term by the National Government and County Government of Elgeyo Marakwet. The National School Meals and Nutrition Programme (SMP) under the State Department of Early Learning and Basic Education encompass provision of a mid-day meal to public primary school children in Arid and Semi-Arid Sub-Counties where Marakwet East falls and informal urban settlements in every school day of the year. This led to improved attendance and more effort is required to ensure that the mechanisms for providing the food are efficient and effective including budgetary allocations. Child Welfare Society of Kenya (CWSK) under the Ministry of Labour and Social Protection launched a school feeding programme across 26 public secondary day schools targeting 6000 students in the county starting with Keiyo South that recorded high absenteeism owing to poverty and hunger. OVCs are provided with compulsory free primary education bursaries for secondary, tertiary education, and vocational training. This is done by the Constituency Development Funds, Member of the County Assembly Funds, Women Reps Funds, and Governor's kitty. The Re-entry Policy that permits adolescents who have been out-of-school due to pregnancy to return is yet to be implemented effectively. The policy requires school heads and teachers to unconditionally readmit teenage mothers into school after weaning their babies. It specifies that if teen parents face stigma in their previous schools, they should be enrolled into a different school. The County's Teenage pregnancy rate (15-19 years) who have ever been pregnant) rate is 12% compared to a 15% at National level (15%). Forum for African Women Educationists in Kenya (FAWE-K) is work closely with key stakeholders in 20 counties including Elgeyo Marakwet, to generate credible data on teenage pregnancies, advocate for the re-entry of girls into school after pregnancy, and conduct sensitization forums on human sexuality and prevention of early pregnancies. FAWE-K's Imarisha Msichana Project, is being implemented in partnership with MasterCard Foundation.

The CGoEM established the Elgeyo/Marakwet County Early Childhood Development Education Act, 2016 when this function was devolved. Further, Elgeyo Marakwet County Education Fund Act, 2017 and Elgeyo Marakwet Youth Funds act 2021 all work to ensure the practical and strategic needs of the relevant groups are taken into consideration when it comes to scholarships, grants and bursaries.

Kurumei et al. (2021) conducted a study in Elgeyo Marakwet amongst 289 youth with disabilities and noted that a higher proportion of female - 104 (36.0%) compared to male - 77 (26.6%) were in school. The Youth with Disabilities out of school were 52 (18.0%) male and 56 (19.4%) female respectively. The highest proportions of Youth with Disabilities in school were those aged between 30-35 years old at 33.1% (60) followed by those who were between 15 years old to 20 years at 27.1% (49).

The County has signed a Memorandum of Understanding (MoU) with KCB Foundation for the training of male and female youth through a partnership, dubbed *Tujiajiri* in which the capacity of youth is built in technical courses at different Vocational Training Centres (VTCs), which include plumbing, welding, woodwork, garment making, masonry, and cosmetology. Upon successful completion, the youth are equipped with tools of trade. The Foundation also implements Mifugo ni Mali programme which aims to strengthen cooperative societies to ensure that they are well managed through training of their officers and value addition of products for increased earnings. The Cooperative movement is reputed for enabling gender equality and social inclusion as members who include women, youth and PLWDS are able to come together, save and obtain loans for economic activities through guarantors within their groups.

4.11.1.7. Access to inclusive learning in schools by all children

There are several special schools catering for children with disabilities or abled differently and include Chebororwo Small Home; Chesoi Unit for the Hearing Impaired; Mindiliwo Primary School for Autistic and Mentally Challenged; and Chesongoch Integrated School. Assessment Forum for bursaries, registration, and funds are provided in the respective sub-county offices.

Chesongoch Small Home for Physically Challenged School in Marakwet East is a public primary school in Marakwet East. This is a mixed day school run by community and serves as a special school. The pupil to classroom ratio in this school is 1:1 and the pupil to toilet ratio is 2:1. There are total 8 classrooms, 2 boys' toilets, 2 girls' toilets and 2 teachers' toilets. The total numbers of students enrolled in this school are 8. The idea of coming up with Small Homes begun in the early 1980 when polio disease was rampant. Learning facilities for children that are physically challenged were not existence thus the need to cater for these children.

> *CwDs need a lot of support to be at the same level with other children because you find them with unique needs that if not met can deny them access to services like education and health care. …Also many children with disabilities lack assistive specialized devices such as braille, hearing and listening devices, wheelchairs, which can help them, access education"*
>
> *PLWD FGD respondent, Embobut*

Discussions:
Children with disabilities (CwDs) and Orphans and Vulnerable Children (OVCs) face numerous constraints in accessing learning due to geographical, institutional capacity barriers, informational barriers, physical barriers, and attitudinal or behavioral barriers. There are few institutions for CwDs which have the capacity to meet the special needs of those with non-physical disability. CwDs and OVC experience neglect are most affected by lack of school fees, poor parental/ guardian affection and care. Most children and youth are able to access medical treatment but some CwDs are hidden from the public and not taken for any treatment or assessment as required. The health seeking behaviour of some youth is discouraging especially when they decide not to obtain assistance in relation to their health problems. They prefer to purchase over the counter medication rather than see the health personnel for consultation some respondents indicated that there were few non-physical disability-friendly or youth-friendly services and where they had them the tended to be in a space that is too obvious by members of the public.

4.11.2. DECISION MAKING

This is the ability to make decisions free of coercion at individual, family, community, and societal levels. This includes control over assets and ability to make decisions in leadership, over ones' health and nutrition, including MCH and SRH.

4.11.2.1. Decision over family matters

The father/male household head is the ultimate head of the family and nobody can challenge or question his authority. He is the overall administrator of family matters and property including bride price, inheritance and where applicable land issues. Analyses of findings from the qualitative data collection indicate that in the Marakwet community the father/male household head makes the final decision over family matters. Fathers decide on everything in the homes, including the crops to grow, how to spend the money from the proceeds of the sale of these crops. Men are the dominant decision-makers on health seeking behaviour such as ANC clinic visits, PNC, contraception, crops to be consumed and use of collateral for loans.

Cultural norms and religious beliefs bestow upon men the powers to make decisions in the family. Men make decisions in the family because they are the head of the family and they are vested with the duty of leadership and providing directions to the family.

-Religious leader

Mostly women do make decisions in the family, men often work far away from home and many of them are drunkards in the village although in most men and fathers are decision makers. In the current era both men and women have the same capacity to make decisions in the family because both of them work to make sure they bring something to the table.

-HIV/AIDs Centre, Chesoi

Here, ideally the father is the leader of the household. He has the final say in everything that happens. However, the current men of the community are absent from their families. While claiming all the authority, they do not effectively play their roles provision. Only a few are responsible."

-Female administrator

Men …… because they are experienced in most of the family decisions so they are believed to be the best decision makers in my community. They are the heads of household …. Are the ones to decide issues of the family? Depending on the family setup if the woman is educated and the man is not then the woman is seen as superior and she can make decisions in the family. Due to adoption of western culture such us formal education and Christianity everyone is able to make decision in the family.

-GESI Male Youth FGD, Kamogo Health Centre, Embobut

"This is a men-led society. Men are in charge and give the final word in every decision. Women are the bread winners but the men are custodians of the wealth accrued. I do not know why it is so. We were born here and we found it this way. There are a few women however who are beginning to stand up for themselves against their husbands on the issues of joint custody of matrimonial property."

-Community Health Promoter, Chesoi Sub-county Hospital

4.11.2.3. Decision over family food consumption and related expenditure

There are cultural beliefs that determine which parts of animals that various family members are permitted to eat and these take precedent over the type of food consumed or recommended nutritious foods. Gender and age considerations are taken into account in the food consumption patterns based on Marakwet cultural underpinnings. Subdivision of animal body parts/meat is done according to age and gender. Among the Marakwets, men are reserved for some animal organs such as the tongue, heart, male reproductive organs and udder that are also categorised as delicacies; these foods are taboo for women and children to consume. On the other hand, liver is reserved for any expectant woman in the family (Riang'a, *et al* 2017).

It is a taboo for women, girls and young boys to eat an animal's tongue. The "rot", large intestines of slaughtered animals are only eaten by women. The chest of a slaughtered animal is for boys who always take care of animals.

-GESI Male Youth FGD, Kamogo Health Centre, Embobut

On enquiry about who between men and women has more control over family farm produce such as grain, meat, and milk the GESI Female FGD stated as follows:

Both men and women ….. They are all custodians of what they have. It varies because some things such as cow and sheep are owned by the men but chicken are owned by the women. Most women are good custodians. They know how to handle storage and plan it well.
Women ….they are the ones who hold store keys ….. both to avoid misuse of resources …. women make decisions on things like milk and meat because they can decide whether they sell or consume it at home. Women can take custody of grains because they are the ones to give orders on how much is to be consumed at a certain period.
-GESI Female Youth, Kararia Dispensary

We have money in this community; the only problem is our men who sell the potatoes. Once they sell, we pay school fees and also prepare the land for planting again. You will follow the man to give you money for your personal use but he will not give, instead, he will insult you and he will have pocketed the money. We ask development agencies to educate the men about taking care of their families. ….. women need to know varieties of nutritious food; most men are decision-makers, they are the ones to sell and receive money.
-Female farmers in Kapyego

The mothers make decisions on whether to sell or consume milk and eggs at the household level. These women are responsible for rearing chicken and looking after the livestock but due to low-income levels, they sometimes resort to selling eggs to get money to mill maize or buying meat. For this reason, some sell the micro-nutrient rich sell sweet potatoes and beans that are meant for nutrition enhancement for their household members to get funds to purchase other food commodities that they deem essential.
-Government Official

Women are tough and assertive on decision-making regarding household food requirements and consumption. In Kapyego men tend to be drunkards while women till the land grow and sell Irish potatoes. Women and children have taken up most of the reproductive and productive roles in the households while men go to the market center to partake in alcohol.
-Focus group discussant, Kapyego; Key Informant Interview with Youth and Gender Officer

Discussion:
Women, relative to men, tended to have the upper hand in household decision-making with respect to the type of food prepared, amount of food prepared, who is given which food stuff, the timing of meals, and the number of meals to have in a day. Despite this seemingly having a privileged position in household food preparation and in addition to being major contributors to daily household food consumption, food production is viewed as a feminine affair and a less privileged occupation as it is a reproductive role mainly for subsistence of the family with no financial benefit. This tends to contribute to their practical gender needs rather than their strategic interests and needs.

4.11.2.4. Decision-making on Health and Nutrition

Women play key role in decision making on the household health and nutrition as they are directly involved in food production, purchasing and the meals for the family. Men often come in very late at night and by the time they arrive, the woman has already decided on what to have for supper. In some cases, due to food insecurity, the fortified beans provided to household are sold to buy kids bread for breakfast thus does not achieve its intended purpose.

The health seeking behaviour for ANC/ PNC services were determined by the proximity of these facilities which if far, would discourage the mothers from adhering to the dates given by doctor for the next visit. Others noted that they went twice because they felt their unborn child was doing well, whereas others were ignorant, felt embarrassed because they failed to space their children or were adolescent who became pregnant. The attitude of the health workers discouraged others as they were harsh to those seeking the ANC/ PNC services. Some mothers indicated that they always go for the ANC/ PNC services due to complications in their pregnancies. Decision making was influenced by their husbands who preferred that they do not go for ANC clinics until they were about to deliver their babies.

Embobut-Embolot Mothers of Children 0-23 Months, Kamogo Health Centre; Maina Dispensary; Chesoi Sub-county Hospital

On whether they would uptake vaccination, deworming, and Vitamin supplementation services, or allow their children to uptake vaccination, deworming, and Vitamin supplementation services, most of the GESI Female FGD in Kapchebau indicated that they do so and obtained them from the facility for the benefit of their children. The children receive vitamin A supplementation to be healthy and they are also given dewormers. These services are available during the weekdays but not in the weekends. In this facility, they provide first aid to those who are sick then refer them to a larger health unit.

Yes vaccination protects one from diseases …. Yes, supplements help in growth of child …. Yes to strengthen immune of child ….. Yes, deworming helps to kill excess stomach worms …. Vitamin supplements are good in improving the vitamin level

GESI Female Youth FGD, Kararia Dispensary

Yes vaccinations strengthens immune systems of children and even prevent diseases that may arise, besides it is always a free service and so is deworming which is given to children in schools. For sure, my children should be given vitamin supplements that are essential because in this place we have no foods that are rich in vitamins so I will allow my children to take for the good health of them. On the contrary, some other vaccines are not safe like that one for polio or yellow fever ….. Some people say it is not good since they have a long term effects on children such as your child will not get pregnant.

GESI Male Youth, Kamogo Health Centre, Embobut

Food consumption and nutrition for expectant mothers

Overall, for expectant mothers, there are restrictions on nutritious food such as eggs, meat, avocadoes, while they are served liver so that they increase the amount of blood to her body, animal organs, vegetables planted on ashes, as well as recommendation of red soil. Eggs, oily food, meat, fresh milk, *Moboriet* (ugali that has stayed overnight) and cooked potatoes during pregnancy are believed to make the foetus grow excessively big, hence these foods are restricted. Oily food is also discouraged for expectant mothers who are warned of the possibility of complications during delivery as the weight of the baby would increase tremendously.

Further, a woman should avoid eating soil and soft stones (pica) because they are also believed to "suck" her blood (causing anemia). Some food restrictions are based on decency and aesthetics. Consumption of moboriet is believed by some to make a woman defecate during birth. At the same time, sugary food is believed to make the baby messy by encouraging saliva over production resulting in frequent drooling.

Riang'a, Broerse, & Nangulu, (2017) noted that the commonly cited food recommended for pregnancy include traditional vegetables (89%), milk (63%), fruits (35%), traditional herbs (34%), ugali (32%), porridge (32%), liver (24%), meat (18%), water (15%), animal blood (13%), and beans (12%). Four dominant nutritional beliefs attributed to the recommended foodstuffs emerged. These types of food were believed to "increase blood", "increase mother's strength", "build the body of mother" or "protect the mother and child from disease". The cultural practices ensure that an expectant woman has enough blood by consuming plenty of traditional vegetables, liver, animal blood, fruits, milk, beans, red soil/stones and fish during the pregnancy period. Cooked bananas and water during pregnancy are believed to increase the strength of the would-be mother. Porridge is also believed to give expectant women strength hence it is particularly recommended for consumption during breakfast and in-between the meals. Conversely, foodstuffs such as wild cabbages and kale are believed to be nutritionally less valuable foods while rice, Irish potatoes and plantain are believed to be 'light' food, supplying less energy, and should not be frequently consumed by pregnant women.

Traditional beliefs and practices related to food and its effect on child birth

For a woman to have enough energy reserves during birth, she is expected to consume foods believed to give strength during her pregnancy period. Such food includes ugali and porridge made from finger millet mixed with sorghum, and traditional vegetables, milk, traditional herbs and meat. This would facilitate labour and childbirth, as indicated below:

> *Some food restrictions are based on decency and aesthetics. Consumption of moboriet is believed by some to make a woman defecate during birth. The fetus should be kept small. It is believed that eggs will make a fetus to grow bigger and the mother will have hard times during delivery. It is considered that large fetuses are difficult to deliver, resulting in episiotomy, prolonged and obstructed labour and possibly caesarean section (CS), thus increasing chances of death of the mother or child. A prescription of herbs was used as a remedy for regulating the size of the baby and to accelerate contractions during labour.*
>
> *-Mothers of Children 0-23 Months Old, Chesoi Sub-location, Sambirir;*

> *An animal that encountered pregnancy-related complications, such as miscarriage, stillbirth or death due to placenta retention, should not to be eaten. When a pregnant woman eats such meat, it was believed the animal will transfer "bad blood" to the mother and she will encounter similar complications during pregnancy and childbirth.*
>
> *There are high malnutrition rates among children from extremely poor families. In the past World Vision gave aid through the fortified food commodities but the mothers mostly consume it they instead giving it to their children.*
>
> *-Mothers of Children 0-23 Months Old, Maina Dispensary, Sambirir*

Decision making on exclusive breastfeeding

The decision on whether or not breast feeding is dependent of a varied factors such as family care and support, availability of food, and level of resources at their disposal to concentrate on breast feeding and personal nutrition. Those vulnerable due to illness, food insecurity and insufficient income levels do not exclusively breastfeed their children as the mothers themselves lack food (Female administrator).

The initiation of breastfeeding was done within one hour after birth by most mothers who indicated that were able to do so after 15 minutes, one hour, after 20 min, after 30 min. Others stated that;

After giving birth, I showered then breastfed after 30-40 min …… I placed the baby on my belly and breastfed after 30 min. Those who took longer narrated that, 'the baby was placed on my chest but didn't breastfeed', while another mother said, 'I went through caesarean delivery and was given the baby after 2 hours"

Mothers and caregivers of 0 – 23 months, Maina Dispensary

The discussants were all in support for breastfeeding and indicated that:

> *There is no taboo or cultural beliefs in my community that prevents mothers from breastfeeding. Not doing so is considered ….."Kikiroi" (an abomination), it is not acceptable for one not to breastfeed because you can be seen as an outcast in the community. "Omooi chich tokool porpo mamanyiin" …in Marakwet this translates to … 'one must breastfeed her child as the mother of the child'.*
>
> *Mothers and caregivers of 0 – 23 months, Kamaiga Health Centre*

Decision making on contraception

The question of contraceptive use is often very sensitive in this community with the discussants divulging the following views:

> *The women decide on contraceptive use….. Yes I choose which family planning method to use because it depends with my health; men do not allow women to use family planning and neither do they use condoms. Sure, some of us women do not know which is best for a person … we only use what others have used. I have heard of a mother who used coil but it went up to the stomach and it can even cause death ……. it depends with the man. We discuss and come up with an amicable decision, but in this community men generally do not agree ……it is upon the mother to be wise and use it.*
>
> *GESI Female FGD, Kapchebau Primary School*
>
> *Yes, certainly contraceptives are very important… to get enough time for caring and providing for your children with their needs. The spacing enables the children to grow well due to plenty resources at their disposal. The mother also gets time to regain her health and even avoid unnecessary deaths that may arise during birth. …..yes to get enough time to work.*
>
> *GESI Female Youth FGD, Kararia Dispensary*
>
> *Contraceptives are necessary because it helps to plan your future well. These are hard economic times and people are experiencing food scarcity. We need to also set aside resources for shelter and clothing for the children and even provide them with good education.*
>
> *GESI Male Youth FGD, Kamogo Health Centre, Embobut*
>
> *Those elderly men complain that there are few children in nursery schools, women should not use contraceptives …… mother in laws also incite our husbands that women should give birth to many children ……. men especially the Sengwer do not want women to take contraceptives and will look for that family planning gadget such as the Norplant and get rid of it ……. so there is this man who bit the wives hand to remove the implant. Pastors in church also discourage contraceptives and they argue that the bible says that we should go forth and fill the earth, especially all churches in this community. The church member's claims family planning brings diseases like cancer.*
>
> *-Women of reproductive age 15-49 years, Tangul Dispensary, Kapyego Ward*

Decision-making on growing nutrient-rich crops

Some of the farmer discussants from Embobut were not for growing the nutrient-rich crops. They pointed out that the farms in the community are small and the residents are not financially stable. They also have limited expertise hence it is difficult for them to plant and grow bio fortified crops such as sweet potatoes.

> *"Momi matunda woli. Kaitit woli saana, kiakol marakwa, kipit mauri lakini motoptoene" meaning, (we do not have fruits because of cold weather for example beans it grows well but it doesn't flower); most women do not make decisions; it is the preserve of men. Once you propose something the man asks you if you brought soil from your home. Avocado trees do not flower it only grows taller; women need to be taught about nutrition for example seminars.*
>
> *-Female farmers in Kapyego*

The perception on growing and consuming nutrient rich crops is varied:

> *Fortified foods have been added with ingredients which is good for human health hence it fastens growth of children. I fed my baby with fortified food such as beans (saitoti) and her health is very good. A divergent opinion was, "I don't like fortified food because it is associated with lifestyle diseases such as cancer"*
>
> *-Embobut Farmers FGD*

4.11.2.5. Decision-making on FGM

It was noted by the discussants that FGM is still common in lower Sambirir Ward and Embobut Ward (where during the last season, bandits were protecting the cut girls in the forest to prevent any law enforcement agents from rescuing them). The fathers support FGM in order to have beer parties yet the practice of cutting has a negative multiplier effect on girls as it leads to school-drop out, early marriages, adolescent pregnancies and early child-bearing thus making the women vulnerable all through their lives. During the preparation for the event, the girls have to look for firewood for the occasion.

> *The men cannot make independent decisions against FGM as these entrenched cultural norms due to peer pressure.*
>
> -KII, Anti-FGM Crusader

> *The prevalent myths within the community that are also to blame, saying the community believed that it was a bad omen for a girl to get married before undergoing the rite as it would lead to her husband dying prematurely, thus leaving her a widow at a young age.*
>
> -Gender Advisor

> *A recent surge in cases of Female Genital Mutilation (FGM) witnessed in 2023 in the Marakwet region was attributed to women who were rescued from the cut when they were 10-15 years but came back to undergo the outlawed practice. These women had got an opportunity to further their education and become successful in society and their return of this age-old practice has given it undue prominence. This made the local women resolve to take their girls for the cut while still young since they will still do it anyway.*
>
> -Gender Advisor, Governor's Office, and December 2023

Chorwa African Inland Church established an all-year round rescue center that offers a safe space, food, and basic hygiene items to at-risk girls until a long-term solution would be found to ensure their safety.
UNFPA partnered with the County Government of Elgeyo Marakwet and grassroots civil society organization the Center for Enhancing Democracy and Good Governance (CEDGG) to equip the established rescue center that aims to house more than 50 girls who sought refuge from FGM. A total of 271 girls were rescued from undergoing the cut in the area, the majority of whom sought refuge, and others whose parents helped them escape.
The mission in which 6 girls were rescued from Embobut Forest sadly resulted in the killing of a Police Officer at Maron Police Station and an attack on a priest by a gang. The circumcisers and girls in the forest were being protected by a gang of bandits.

> *While the girls managed to escape the illegal practice, the challenge facing them was how they can be rehabilitated back into the community, especially those who ran away from home. Some were unsure of their fate after their parents threatened not to pay their school fees for defying them.*
>
> -Youth and Gender Officer

Embobut and Endo Wards recorded the highest number of girls undergoing FGM with more than 500 girls assembled in the forest.

-Anti-FGM Activist

How girls who avoid FGM are treated

They are considered outcast and cannot be easily accepted in the community.

Here, if a girl is discovered during delivery to have been married before undergoing FGM then will be subjected to the practice upon delivery.
- KII with anti-FGM organization crusader.

Women influence their sons to marry girls who have been circumcised, adding that those who have not been cut are subjected to the practice during childbirth by midwives.
- Gender Advisor

"Lelii snee nyolee mbo girls ndakuu chepyoso akatokol nyo kakuwoo konyii, aku mowoo kobokogoninee, ngo bii walak lelii moboyee bichochee" translates to, "girls or women who are married and they have not been circumcised, cannot feed people", these women are not allowed to address a crowd.
-GESI Female FGD

There are emerging trends in which men are actively advocating for an end to FGM and a critical mass of likeminded community members is required to halt this practice.

> *"Decades ago when I decided to marry my wife, I faced isolation. Today, I am a beacon for other men who wish to shun FGM, and I encourage them to embrace and protect women and girls who choose not to undergo the cut. I witnessed the detrimental effects of FGM on the health and socio-economic prospects of women and girls. My wife and I made the decision that our daughters will not undergo FGM, and gradually, other families in the community are adopting this change of tradition as culture is dynamic. I engage my male counterparts in impactful discussions advocating for the protection of girls from FGM.*
>
> *-Male Champion against FGM, Chesongoch Village.*

Discussion

FGM is perpetuated by the community members who hold the ceremony in high regard and look forward to the event as an opportunity to gain respect in the society, eat, celebrate and make merry as they initiate their girls into adulthood and become recognized.

Male champions against FGM and subsequent early marriages as well as school dropouts, have demystified the perceived curses on their daughters and provided access to information on the dangers of harmful traditional practices can be and have in the past been of great assistance to the cause against these cultural practices. There is a gradual change in approach when they see the change ambassadors thriving in the community and becoming role models. Further, some teenage mothers who have gone back to school and have excelled become shining examples for promotion of girl's education completion. This has yielded remarkable results when they become mentors, champions for change and whistle blowers in cases of girls and boys at risk of harmful practices.

Anti-FGM efforts by both national and county government are starting to yield some progress with the Deputy Governor herself in conjunction with the First Lady is playing an active role in campaigning to stop the vice and seeking support for victims of FGM to continue with schooling. Rescue centres are non-existent for the girls who are at risk of being subjected to harmful practices such as FGM or early marriages and other women facing forms of GBV at their homes.

4.11.3. PARTICIPATION

This section reviews ability of community members to participate in or engage in societal affairs and systems of power that influence and determine development, life activities, and outcomes.

4.11.3.1. Participation in community affairs

On whether women and youth participate in community plans, leadership and benefits in equal footing with men, the participants agreed that 4.they are engaged in public participation meetings and community projects. Some FGD discussants noted that women do not get information on public participation or are sometimes constrained by their multiple roles and time limitations at the individual, household, and community level. Further, it was agreed that even youth nowadays participate in the community projects.

> *Yes we have women who are village elders in my community, where they are recognized and respected. There is an Assistant Chief who is a woman, she has no favoritism and she treats everyone equally. She does her work with other male community leaders amicably. We also have several mentors such as Honorable Linah Kilimo who was a member of parliament for ten years and as at now she is the Director of Childfund Kenya so she is a good leader because she was the first to advocate for Anti-FGM in our area. Our County Woman Representative, is a daughter of Marakwet from Sambirir, her leadership is good and admirable …….. She gave us some water tanks and we appreciate. Our current ward administrator who is always making sure that development projects are properly implemented like here at Kamoko Health Centre; she was the one who made sure that it is constructed as proposed*
>
> *In regard to formation of committees, women and youth are included …..They have those special positions which are reserved for them. Women and youth are included in group leadership such as in community youth groups and women groups as well as in football and church leadership.*
>
> *GESI Male Youth FGD in Embobut*
>
> *Our Chief is a woman. We like her because she understands our problems as women. The Assistant Chief is also a woman. She is good in her work ….. among our village elders we have a woman. Most of our Community Health Workers (CHP) are women, they do their work with utmost dedication and are fully aware of their clients or community member's needs and even before a child is born, the CHP walks the mothers through pregnancy and also when they are*

lactating. We have a female pastor in AIC and also female catechist who help spread the word of God.

GESI Female FGD, Kapchebau Primary

The visibility and involvement of persons with disabilities in community affairs, their participation as well as contribution towards development projects, lives activities and outcomes as noted as follows:

"mito, kitengeneey irokey" meaning (yes it is there, they are excluded) ….in our community, no one is excluded, we do all our work together …. we don't leave anyone behind, if the person with disability does not make to the meeting, they send another person who is not disabled to represent them ….they are included but most of the time do not attend meetings or projects.

-

-GESI Female FGD, Kapchebau Primary

They participate where they can, for example, if the community needs to lay water pipes in the ground, those physically challenged may be constrained but those who are abled differently such as the hearing impaired or speech impaired are able to do the work. Children do not participate sometimes because their parents still hide those girls and boys living with disability from participating.

-GESI Female FGD, Kapchebau Primary School

In terms of leadership ….those community members with disabilities are not given chances in leadership positions since they are considered weak and cannot deliver in such roles. In our community disabled youths are not recognized for instance, I am educated but I have no leadership position in my community.

-GESI FGD for PLWDs, Sambirir

Yes they are included since their positions are reserved for them through the inclusive representation. They attend a few meetings because they are not able to move freely especially those who are physically challenged. They also appoint their own representatives and this can be recognized.

-GESI Male FGD, Embobut

Discussion

In general, the attendance of persons with disabilities in community planning, community meetings and their contribution may be hampered by their mobility challenges to enable them navigate the steep terrain and reach the venues. There are efforts to include them as part of affirmative action stipulated in public participation policy and inclusivity agenda.

Analyses of qualitative data from FGDs reveal that there exist cultural barriers to child participation on issues affecting them at the household level. For example, children are not allowed to openly air their views on issues to the extent that those that attempt to go against this norm are viewed as undisciplined.

4.11.4. SYSTEMS

The assessment sought to establish if the existing systems were conducive and comfortable to work with by the project participants across the project locations. It also determined the availability of equal and inclusive systems that promote equity, account for the different needs of vulnerable populations, and create enabling environments for their engagement.

4.11.4.1. Availability & safety of equal and inclusive systems of protection

In Kenya, there is a remarkable effort to ensure child care and protection policies regulate the care of children, including the type of support and assistance to be offered, good practice guidelines for the implementation of services, standards for care, and adequate provisions for implementation. This includes the care a child receives at and away from home and are in line with national legislation such as Constitution of Kenya (2010) and international law, especially the Convention on the Rights of the Child (CRC).

The Children Act, 2022 was revised from the Child Act 2001 and provides enhanced legal provisions to safeguard the rights of children. It gives effect to Article 53 of the Constitution; to make provision for children rights, parental responsibility, alternative care of children including guardianship, foster care placement and adoption; to make provision for care and protection of children and children in conflict with the law; to make provision for, and regulate the administration of children services; to establish the National Council for Children's Services and for connected purposes. It seeks to safeguard the rights of children to (i) basic nutrition; (ii) shelter; (iii) water and sanitation facilities; (iv) clothing; (v) medical care, including immunization.

ChildLine Kenya and the Government of Kenya, through the Department of Children Services, manages the Child Helpline 116. Response to cases reported through the Helpline is coordinated by the children officers situated at the County and Sub-county levels all over Kenya and the data subsequently fed into the National Child Protection Information Management System.

The ChildLine Helpline 116 links up with institutions, organizations and individuals who provide various child protection services. It is to these entities that cases reported through the Helpline are referred for additional services and support. The services offered include child therapy, medical support, legal aid, mediation and family therapy, rescue services, and temporary shelter. Most focused group discussants were not aware of these elaborate systems of child and vulnerable group protection.

To enable a more effective communication network, a network booster should be installed so that there is better communicate with service providers. For instance, if an expectant mother wants to deliver and delivers on the way to the hospital from the hanging valleys, the mother might succumb because you might not get immediate help due to poor communication network.

GESI Female FGD, Kapchebau Primary School

These systems also include The Judiciary that has set up Children's Courts in line with the new law.

Actions and Interventions that promote and secure gender equality systems

- There are women groups formed specifically for women empowerment. These include the saving for Transformation (S4T) groups and mother to mother support group. These groups are mainly for financial support but also psychosocial support. These groups alleviate

economic stress by empowering women, as it will reduce prevalence domestic violence due to financial stress.

- There are also Men Care Teams where men are taught how they can assist the mothers with child upbringing.

Actions and interventions that promote social inclusive systems

- During the chief barazas, the local leaders often sensitizing the community on human rights, economic empowerment opportunities, and environmental conservation measures to give these groups equal opportunities.
- Formation of groups by community health promoters (CHPs) to deliberate, network, and advocate for improved health provision. Through the CHPs, it has been possible to access often excluded groups and continue with the sensitization and training on the importance of having a balance diet. There has been good results from these interactions. The CHPs have provided stories of change from successful efforts they have encountered.
- The local leaders also try to bridge the social exclusivity gap through bursary and other material aid.
- Agricultural Officers provide regional groups with "maharagwe" - improved beans varieties
- The officers from Social Services Department also train community members on how to open "Chamas"/ self-help groups as well as information on microfinances.
- The often excluded and marginalized groups are engaged in public participation meetings to ensure that priority is given to roads and infrastructure by the MCAs.
- Efforts have been made through bible translation in the Sengwer and Kiptani language so that the language does not become extinct.
- Inclusion and nomination of the Sengwer and Kiptani community members into the County Assembly for diversity in representation. Recruitment of the two marginalized communities through appointment into committees at the ward level.
- Financial support is provided in the form of access loans through Farm-to-Market Alliance (FtMA) to unbankable groups such as women and youth who often lack collateral. FtMA has adopted a demand-led approach that puts empowerment of farmers at the heart of its work. FtMA invests in a network of Farmer Service Centres (FSCs) – which act as trusted links to farming communities to improve access to information, quality inputs, affordable financing, handling and storage solutions and market connections.
- Youth Bunge (Youth Parliament) has been established where they meet and talk about issues affecting the community, promote agriculture amongst the youth, encourage the youth to start agrovets and become stockists.
- In Marakwet East, milk is sold to youth groups and transported to Iten where they have a cooler, this milk storage facility also helps to safeguard them against poor weather. The groups are also supported to be stockists of agricultural inputs.
- The Governor signed a Memorandum of Understanding (MoU) with Kenya Commercial Bank (KCB) Foundation for the training of youth in Elgeyo Marakwet County under the Tujiajiri Partnership that will see 1,000 more youth from the County train in different Vocational Training Centres (VTCs). The selection of beneficiaries across all the 20 was conducted in March 2024 and trainees recruited. Tujiajiri, is a fully funded programme by the KCB Foundation and the County. During the last year (2023), 500 youth benefited from the programme and graduated in April. Upon successful completion, the youth were equipped with tools of trade. They enrolled and studied technical courses, which include plumbing, welding, woodwork, garment making, masonry, and cosmetology.

The Foundation also introduced the Mifugo ni Mali (Livestock is Wealth) programme which aims to strengthen cooperative societies to ensure that they are well managed through training of their officers and value addition of products for increased earnings.

4.11.4.2. Systems of Child Protection in the community

The structures that support child protection in the community are village elders who solve cases that may arise at the village level, the Kenya Police Service, schools, teachers, schools and churches, the hospitals through Well Baby Services on nutrition, immunization, and treat ailments.

Community structures that respondents feel at ease working with in addressing child protection issues the community include the churches after the local parish offered shelter to the young girls who were being forced to undergo FGM last year in December. The police are also compliant in enforcing those who go against the rights of children by jailing them thus they noted:

Churches are free from bias, interference, or even corruption as they advocate for corrupt free community through their normal teachings and they always and they always defend social justice for our children, the Police enforce law and instill order so they always make sure that the right of every child is protected.

GESI Male Youth FGD and GESI FGD with PLWDs

Some institutions are reactive rather than proactive …. health centers are not such as safe environment because they can only provide medication or prophylaxis in case of SGBV on children, they are not suitable for expectant adolescent who require ANC support but tend to shy off due to shame …… they are not able to avert the circumstances that made them vulnerable in the first place even for others. Schools are just teaching them the precaution of say…... Drug abuse but they don't come up with measures that can prevent the children from abusing alcohol and drugs such as Cannabis sativa.

GESI Female FGD & GESI Male Youth FGD, Embobut - Emolot

4.11.4.3. Systems of improved agricultural production

National Potato Council of Kenya (NPCK) in partnership with Agrico EA, Cropnuts, Baraka, Amiran, Fanisi, Omnia, UPL, Corteva, Bayer, and Osho chemicals, Lachlan, AAK and Hygrotech conducted field demonstrations in Elgeyo Marakwet. The demos showcased to farmers technologies/innovations and GAPs for potato production. They demonstrated benefits of adopting high yielding varieties, high quality planting materials, high quality inputs and good crop management practices in potato production. The initiative was able to prove to farmers the benefit of using good inputs and practices for increased yield and return on investment.

4.11.4.4. Challenges to Social Inclusion in Agriculture, Nutrition and Development Activities

- Despite the vigilant advocacy efforts of the World Vision's Citizens Voice for Action (CVA), they have been having challenges where most government projects remain incomplete due to non-payment of contractors, something the county and other stakeholders should address.
- In agriculture, very little has been done due to lack of personnel with many of the extension officers retiring with no replacement which they say will affect food security in the agricultural rich county.

- Most persons with disabilities are unequivocally challenged in accessing any services or engaging in food security. For those who get sick down in the valley, it is difficult to transport them up the escarpment for treatment in the health facilities. The hilly terrain and steep slopes further reduces their mobility and increases their reliance on caregivers and motorbikes to get around. According to the second Disability Inclusion Report 2024, which was released by the National Council for Persons with Disabilities (NCPWD), only 4% of public institutions have met the legally mandated 5 per cent reservation of employment for persons with disabilities in the country.

4.11.5. WELLBEING

This domain deals with the sense of worth, capability status, confidence, dignity, safety, health, and overall physical,emotional, psychological, and spiritual well-being. This includes living free from harmful practices, gender-based violence, HIV, and all forms of stigma and discrimination.

4.11.5.1. Improved sense of worth and dignity

According to a key informant interview in the health sector, the recent changes or events that have had a significant impact on the community's well-being include, World Vision training for Community Health Promoters on nutrition and improving livelihoods at the village level; medical camps have been held, the rains have been optimal for ploughing and sowing and food production is bound to be sufficient.

Citizen Voice for Action (CVA) initiated by World Vision trained some groups of citizens in some wards of the county to focus on advocacy across the health and agricultural sector following the rampant cases of stunted growth among children aged 0-5 years in the county. Their effect has however been felt beyond the two sectors. According the County Nutrition Profile 2020 (Nutrition International) estimates, cases of stunting (short for their age) and underweight (low weight for age) among children aged between 0-5 years stands at 30% and 12.6% in Elgeyo Marakwet County against a KDHS 2022, national average of 22% and 13.9% respectively. In the five wards of Sambirir, Kapyego, Kapsowar, Tambach and Soy North where the CVA's are active, the community members have witnessed an improvement in the health sector delivery of services with the wards even allocating funds for nutrition through public participation.

To gauge the level of service delivery when service providers were aware that citizens are watching, the CVA's developed a questionnaire on service delivery which was filled by both the members of the public and health personnel.

> *"We wanted to know how long the members of the public take before they receive services in a health facility, monthly reports and resources at the disposal of the department of health personnel among others,"*
>
> *Religious leader.*

He noted that the fact that the health personnel know that the citizens are monitoring them has seen cases of absenteeism and reporting to work late reduce remarkably which has in turn resulted in great improvement in the delivery of services.

4.11.5.2. Improved services to marginalized communities

Sengwer Indigenous Community, a community-based organization boosted their advocacy and lobbying efforts to safeguard their wellbeing by proactively challenging the authorities to improve service delivery to the Sengwer Community (an indigenous hunter-gatherer community that call Embobut forest their ancestral home). The CBO organized budget forums to identify the most pressing needs in the community's households. Consequently, the community drafted a petition which was presented to the budget and appropriation committee

of Elgeyo Marakwet County in September 2021. This petition was in relation to the sorry state of Tangul Dispensary which was built to serve the Sengwer, but had been out of operation for more than five years due to drugs stock-outs and lack of qualified personnel. As a result, some essential medicines were delivered to the health facility, which also received the posting of an enrolled nurse subsequently. The community further received learning materials for their education centre, Tangul Primary School. Additionally, discussions are in progress between the community and the County Government to train teachers and medical personnel from the community to serve the Sengwer (KNA 1, 2024).

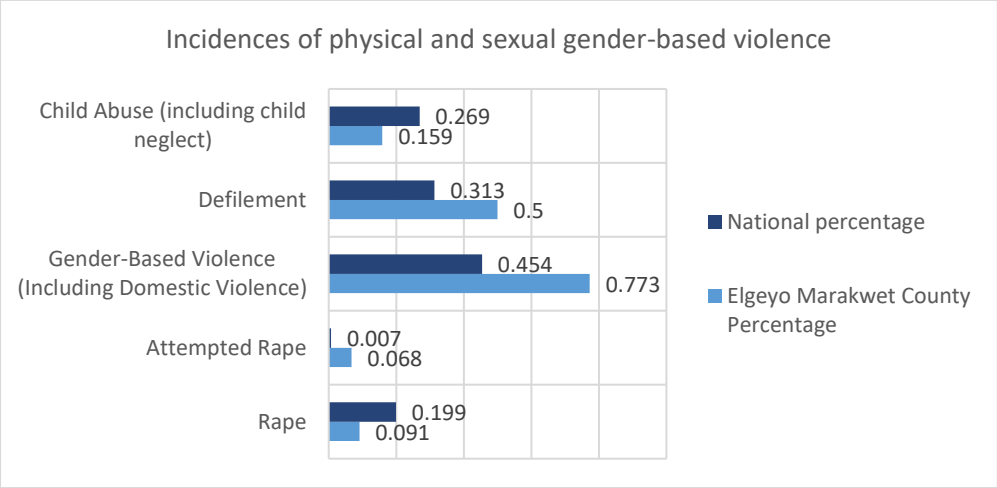


Figure 5: Safety and well-being at home

Cultural beliefs that are in place have an influence on some mothers feel compelled to deliver their babies at home. The Marakwet community believes that proper traditional management and disposal of the placenta contribute to the well-being of both the mother and the baby. In some Kenyan cultures, the gender of the child determines the placental burial/disposal spot and direction. For instance, in the Marakwet community and Kenyan Luo cosmology, the male and female child's placenta is buried in the right and left-hand direction from the house of delivery, respectively, a practice that is not viable in the health facilities (Rono et. al. 2018).

Gender-based violence (including domestic violence) is rampant in Elgeyo Marakwet County at 77.3% compared to National level figures at 45.5%[18] (National Crime Research Centre, 2020). According to Kenya DHS 2022, the percentage that has experienced physical violence since age 15 was 30.2% while those who experienced physical violence often and sometimes in the last 12 months were 15.9%. At national level, this violence is meted by the current husband or intimate partner at 54%.

The peer influence on men makes them feel like a special group in the society as they call the shots and have their way. Men view themselves to be superior beings and look down upon women…. Women are distressed at the household by men who abuse alcohol and met violence on them.

GESI Female FGD, Kapchebau Primary School

The percentage of women aged 15–49 years who have ever experienced sexual violence and percentage who experienced sexual violence in the 12 months preceding the survey, was 6.9%

18 National Crime Research Centre 2020: https://www.crimeresearch.go.ke/elgeyo-marakwet/

and 4.0% respectively especially by husbands and intimate partners (Kenya DHS 2022) as indicated the Table 33 below.

Table 37: Kenya Demographic and Health Survey Fact Sheet, Elgeyo Marakwet County 2022

Gender-based Violence	Elgeyo Marakwet County	Kenya
Women age 15-49 who have ever experienced physical violence since age 15 (%)	30	34
Women age 15-49 who experienced physical violence in the last 12 months (often or sometimes) (%)	16	16
Women age 15-49 who have ever experienced sexual violence (%)	7	13
Women age 15-49 who experienced sexual violence in the last 12 months (%)	4	7
Women age 15-49 who have ever been married or had an intimate partner & have ever experienced physical, sexual, or psychological/emotional violence committed by their most recent husband/partner (%)	31	40
Women age 15-49 who have ever been married or had an intimate partner & have experienced physical, sexual, or psychological/emotional violence committed by any husband/partner in the last 12 months (%)	26	28

Women age 15-49 who have ever been married or had an intimate partner and have ever experienced physical, sexual, or psychological/emotional violence committed by their most recent husband/partner (%) were 31% compared to the national average of 40%. Women age 15-49 who have ever been married or had an intimate partner & have experienced physical, sexual, or psychological/emotional violence committed by any husband/partner in the last 12 months stood at 26% compared to 28% nationally. Those teens aged between 15-19 years who had ever had a live birth were 9.6% and 12.1% had ever been pregnant. This compares to a national average of 12.2% compared to 14.9% respectively.

4.11.5.3. Child safety and well-being in school

The assessment sought to examine the extent to which children's well-being and safety are taken care in school environments. From findings, in the KDHS 2022, at national level most common perpetrators of physical violence among men who have ever been married or ever had an intimate partner were teachers (28%), followed by current wives/intimate partners (20%) and former wives/intimate partners (19%). Twenty-three percent of men who have ever been married or had an intimate partner experienced physical violence at the hands of other persons.

Teachers (33%) and mothers/stepmothers (25%) were the most common perpetrators of physical violence against women who have never been married or never had an intimate partner. Teachers (46%) and schoolmates/classmates (22%) were the most common perpetrators of physical violence against men who have never been married or had an intimate partner.

4.11.5.4. Legal frameworks, laws or other barriers that prevent women and men, boys and girls, persons with disabilities and other excluded groups from having equal opportunities

- In regard to International Law, Kenya is a party to seven of the eight UN human rights treaties which are most relevant to discrimination, with the exception being the International Convention on the Protection of the Rights of All Migrant Workers and

Members of Their Families. However, it has a very poor record of ratification of instruments allowing individual complaints.

- Women's political participation is curtailed due to male dominance in political process commencing with political parties that are owned and financed by men. Despite the progressive constitution providing for gender equality at all levels, data available shows women still lag behind at 26.7% in Parliament. County Government Assemblies managed to get 33% of women in leadership, courtesy of the constitutional framework in Article 177. Implementing the two-thirds gender rule in political representation from the national, county, sub-county, to the ward level is difficult. In the last general election the nominations were not inclusive of marginalized and excluded groups.
- There are gaps in legal protection, due to the absence of legislation prohibiting all forms of discrimination on particular grounds – such as sex and age– and the absence of provisions prohibiting discrimination on all grounds in particular areas of life – such as provision of education or health services.
- The lack of specific anti-discrimination law providing protection in relation to all relevant grounds means that there is an absence of legislation giving clear definitions of important concepts and providing clarity about the scope of protection and its operation.
- There are a number of inconsistencies between provisions in different laws, notably in the field of employment. For example, the scope of the protection from discrimination on grounds of race or ethnicity in employment appears to be different under the National Cohesion and Integration Act and the Employment Act, giving rise to uncertainty for both employers and employees.
- In relation to equality beyond the protections provided by the Constitution, the Persons with Disabilities Act and the National Cohesion and Integration Act, protection from discrimination in other legislation is patchy and inconsistent.
- There is poor implementation and enforcement of existing laws due to low awareness of rights and obligations among both rights-holders and duty-bearers, financial and other barriers preventing access to justice for victims of discrimination, and the apparent lack of progress in tackling discrimination and inequality by public officials – mean that even in cases where legal protections exist, these are not effectively enforced.

Other Treaties Related to Equality

- The Legal and Policy Framework on Equality in Kenya has adopted a number of key ILO Conventions prohibiting discrimination in employment, including the Equal Remuneration Convention 1951 (C100) and the Discrimination (Employment and Occupation) Convention 1958 (C111). It has not, however, signed the Indigenous and Tribal Peoples Convention 1989 (C169), a significant omission given the disadvantaged position of many of Kenya's indigenous groups. Nor has Kenya signed the 1960 UNESCO Convention against Discrimination in Education. Kenya is a party to the 1951 Convention relating to the Status of Refugees and the Protocol to the Convention, something which is particularly welcome given that the state has a large refugee population. However, Kenya has not signed the 1954 Convention Relating to the Status of Stateless Persons.

African Union Human Rights Treaties

- Protocol on the Rights of Women in Africa (2005) has not been ratified but treat was signed in 2003

Status of Treaties in National Law

- 1981 Until 2010, Kenya adhered to a dualist legal system; as such, international treaties and obligations did not take immediate effect and required implementation through domestic legislation. However, under Article 2(6) of the 2010 Constitution of Kenya, any treaty or convention which is duly ratified "shall form part of the law of Kenya", meaning that

instruments which provide important protections from discrimination – including the ICCPR, ICESCR, ICERD and CEDAW – now have effect as part of Kenyan law.

Societal Challenges

- There are cultural barriers from the attitudes of society towards the division of labour and responsibilities. Women's work is often unpaid and related to reproductive roles that meet their practical gender needs. Cultural attitudes toward women's triple roles at community, family and reproductive level are uncaring as where women's work is undervalued and not paid for. The concept of shared responsibility has not been largely embraced.
- Practice of harmful cultural practices still persists in some communities, thus compromising decision making for women for example practice of female genital mutilation and early child marriages and preference to take boys rather than girls to school when families have limited resources. In Marakwet East, FGM and Child marriage is still on the increase. Women unable to access right to sexual reproductive health and rights.
    - Continuous rise of Gender based violence despite numerous measures put in place to control the vice-legislative or policy or administrative.
    - Existence of kangaroo courts at the community level to preside over GBV cases.
    - There is a lack of a rescue centres for victims of Sexual and gender-based violence (SGBV) in Elgeyo Marakwet County. Some children who ran away from Female Genital Mutilation and early marriages are forced to stay in schools once they close lest they are forced to undergo the practices they ran away from if they go back home.
    - High cases of domestic and intimate partner violence escalating to murder and manslaughter.
    - There is limited involvement of women in community development agenda. Most community consultations happen at timings that are not conducive for women.
    - The area is occasionally hit by droughts which severely affects food production. The hilly terrain hampers mobility so during drought it is hard to reach upper areas with relief supplies.
    - The resources (inputs and technical expertise) from the government to boost food security are not sufficient for the whole area.
    - The sub-county is prone to landslides that have been exacerbated by cultivation on steep hill slopes, increased population density, and cutting down vegetation cover. On May 10, 2024, two siblings were killed at 11 pm as they slept in their home and their mother seriously injured by a mudslide at Kapkau Village, Tuturung in Sambirir, Marakwet East.
    - Women are not actively involved in environment conservation and climate change yet it affects them directly and adversely.
    - The media continues to present women negatively in relation to leadership with stereotypical remarks. In the past some prominent female leaders have been axed from re-election due to their vocal stance against FGM.
    - Available data is not always disaggregated by sex, age, disability, geographically (areas of high relief, those that are low-lying and hanging valleys) or even administratively up to ward level. Despite having the requisite machinery, the national and county governments continuously present gender-neutral data.
    - High level of teenage pregnancies with age-appropriate comprehensive sex education is not adopted in schools, because of restrictions and resistance from religious organizations. Abortion law is still restrictive despite the Constitutional provisions. There are insurmountable barriers to adolescents and young people who are sexually active accessing contraceptives thus sexual reproductive health programmes are severely constrained whereas the adolescent sexual reproductive health outcomes remain largely negative.

4.11.6. DO NO HARM

World Vision is one of the most active organisations globally using the "Do No Harm" tool. DNH field assessments help understand conflict at a project or community level. When local leaders understand which activities divide or connect people, World Vision partners with them to design projects or programs to minimise harm and support local capacities to build peace. To see an example of Local Capacities for Peace, watch these young leaders in the Philippines explain how they lead other children in assessing local capacities for peace.[19]

Findings from our baseline survey show that the communities living in the project area exhibit varies opinions with regards to conflict resolution mechanism and child safety. The project area is conflict-prone and is characterized by bandit attacks, inter-ethnic fighting caused by inequitable distribution of resources like pasture, water and land issues. Defilement and rape incidences in the county are also higher than those at national level as shown in the figure above (National Crime Research Centre, 2020). Kerio valley was identified as one of the 22 major GBV hotspots in Kenya with high occurrence of cases of Gender-Based Violence against vulnerable women and children (Ndanyi, 2022). This was confirmed by KDHS, 2022 that noted that physical violence in the county was 30% compared to 34% at national level.

In order to address these issues the project participants intimated to a raft of measures including: preventive and legal interventions to combat child abuse, community conflict and gender-based violence. Such could include, establishment of GBV Support Unit established in Health facilities, Public and Private Gender Rescue Centres and Shelter to provide GBV support services in counties by 2026; Multi-sectoral Standard Operating Procedures (SOPs) for Sexual Violence Prevention and Response (2013); National Monitoring and Evaluation Framework toward the Prevention of and Response to Sexual and Gender-based Violence (2014).

5.0. Key Lessons Learnt

The baseline survey was an inspiring experience worth learning from by World Vision and other project stakeholders across the spectrum. The team learnt five major lessons among others as listed;

- Effective and meaningful engagement of stakeholders from the beginning of assignment has immensely contributed to successful execution of the assignment.
- The project area having pockets of its location affected by insecurity due to cattle raids, the close involvement of the County leadership in the planning process had contributed to peaceful execution of the assignment without any incidences of insecurity witnessed.
- Working with local resource team in data collection was an asset since this addressed imminent challenges such as communication and language barriers.
- Addressing issues around cultural beliefs and traditional practices require tactful approaches that engages all stakeholders involved for meaningful transformation to be realized

6.0. CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions

The nominal expenditure on nutrition stands at KES 10.4 billion in FY 2020/21. At 0.5 per cent of the total budget in 2020/21, Kenya's spending on nutrition lags behind the regional average of about 1.7 per cent. Health and Nutrition being devolved function to the county governments, it seems there is no clear and deliberate budgetary provision to support health and nutrition

[19] https://www.wvi.org/peacebuilding-and-conflict-sensitivity/do-no-harm

services from the EMC County. Resources meant to support health and basic nutrition services are lumped together under the health budget with no separate ''ring-fenced'' kitty for nutrition services. The County has been implementing nutrition interventions that are aligned to the National Food and Nutrition Security Policy with support from partners to improve the nutritional status of its population. The budgetary allocation for nutrition is spread across maternal and child health and nutrition, Infant and Young Child Nutrition, Integrated Management of Acute Malnutrition overseen by the Department of Health. Other nutrition sensitive focus areas that are costed annually include Sports, WASH, social protection, Agriculture and Food Security in the form of nutrition-sensitive agriculture and food systems (Department of Agriculture), and School feeding programmes (Ministry of Education and Ward Representatives) according to the CNAP, 2018.

The Government of Elgeyo Marakwet County (EMC) has been implementing nutrition interventions as guided by the National Food and Nutrition Security Policy with support from partners to improve the nutritional status of its population.The budget for nutrition is spread across maternal and child health and nutrition, Infant and Young Child Nutrition, Integrated Management of Acute Malnutrition at by the Department of Health, Nutrition in Agriculture and Food Security in the form of nutrition-sensitive agriculture and food systems (Department of Agriculture), School feeding programmes (Ministry of Education and Ward Representatives).

Malnutrition rates are high among children under 5 as shown by the high prevalence of stunting among children under 5 years in the project area is high (32.9%) compared to the 22% and 26% reported for the EMC and national level respectively.

Outcome Module 1: Target countries are implementing updated National Action Plans which align with AU nutrition policy

- There is lack of clear funding mechanism dedicated by Elgeyo-Marakwet County to support to support health and nutrition facilities. Currently funds are allocated variedly to health facilities to cater for Operations and Maintenance (O&M) with no clear provision for nutrition commodities.

- There exist high level health and nutrition advocacy forums that targets the key decision makers like the County Assembly, Finance Officers, CEC in charge of Health, the Chief Officers, directors of Health and the Governor. Such forums advocate for basic nutrition and health rights by advocating for increased funding allocation for basic nutrition and health services.

Outcome Module 2: Women of reproductive age, adolescent girls and children under 2 benefits take up improved gender-sensitive nutrition and health services in target regions.

- There exist entrenched traditional cultural beliefs among the Marakwet that promote the practice of breastfeeding. Phrases like **"Rerye chich bortanyi" (a mother must breastfeed her baby immediately after birth).**

- Uptake of at least four ante-natal (ANC) visits as recommended by WHO is still below average with majority 36.3% doing 3 visits compared to only 4.1% that make more than 5 visits.

- The youth in the project area are reluctant to seek gender-sensitive nutrition, health and SRHR services due to the fact that these services are currently integrated with adult services. There is a glaring lack of youth- friendly centres that address specific nutrition, health and SRHR needs of male youth, female youth, boys and girls in the project area.

- Nutrition and SRHR consultations in in-patient health and nutrition facilities in project areas are being held in ad hoc manner owing to the competing needs from the health staff and inadequate capacity building refresher training for those offering nutrition and SRHR consultation.

- There are currently no organizations or groups in the project area with capacity to prevent, monitor and address malnutrition through a gender lens. As a result there is a general gap with regard to integrating gender equality and social inclusion (GESI) in many respects.

Outcome Module 3: Women of reproductive age, adolescent girls and children under 2 benefit from improved gender-sensitive production and use of nutritious foods in the target regions

- There still poor child feeding (IYCF) practices for children 6-23 months in the project area as shown by the low proportion of children receiving the Minimum Acceptable Diet (MAD). Additionally only 34.1% of the children's primary caregivers had knowledge and practice in IYCF practices.

- There is poor knowledge and practice with regards to nutrient rich crops (bio-fortified crops). This is shown by the low number of households growing (4%) and consumed meals prepared of bio-fortified crops (6.3%).

- The first 1,000 days between a woman's pregnancy and her child's second birthday offer a brief but critical window of opportunity to shape a child's development. About 14.9% of the caregivers were found to have adequate knowledge and skills in the first 1000 days as per the MIYCF criteria.

GESI-related situation

- The challenges facing women and girls in the Sub-county range from violence from bandits in Kerio Valley and to societal beliefs such as FGM that has caused distress to women and girls thus hampering productivity in the agricultural rich areas.
- Different forms of gender-based violence exist (denial of nutritious food, female genital mutilation, sexual and domestic violence, etc.). FGM, Child marriage, Child Labour, Child abuse and neglect, economic GBV, cattle raids
- Retaliatory attacks on youth, women and children by the bandits; territorial disputes
- Violence against vulnerable population (e.g. children, the elderly, invalids, persons with disabilities) – neglect, denial of health access,
- Preventive and legal measures to combat gender-based violence: GBV Support Unit established in Health facilities, Public and Private Gender Rescue Centres and Shelter to provide GBV support services in counties by 2026; Multi-sectoral Standard Operating Procedures (SOPs) for Sexual Violence Prevention and Response (2013); National Monitoring and Evaluation Framework toward the Prevention of and Response to Sexual and Gender-based Violence (2014).
- Service and care for survivors of violence and who has that access
- Toll free lines exist such as 24-hour Child Helpline (116); Kenya Police 999, 911, and 112; NACADA 24-hour Toll Free Helpline (1192) for victims of alcohol and drug abuse; Kimbilio Trust Toll-free line (1193) for reporting on human rights abuse and seeking assistance; Healthcare Assistance Kenya Toll Free Helpline 1195 has a Call Centre that works 24/7 for reporting on gender-based violence.
- A rescue centre established in Chorwa, Chesoi has recently recorded 105 girls.

6.2. Recommendation

Overall Outcome: An enabling policy and structural environment is leading to the improved health and nutrition status of 443,161 boys, girls, women, and men and gender equity in the target districts (sub-national levels) in Kenya.

- Ensure dedicated budgetary allocations for health and nutrition services, separating them from other health budget lines to prevent resource commingling..

- Promote nutrient-rich bio-fortified crops/food diversification and promotion of MIYCF minimum criteria by all partners to help address the malnutrition rates to among caregivers of children in the project area.

Outcome Module 1: Target countries are implementing updated National Action Plans which align with AU nutrition policy

- Provide and 'ring-fence" budgetary allocation from the EMC County to support health and nutrition facilities services. Resources meant for health and basic nutrition services need to ''ring-fenced" and not lumped under Operations and Maintenance (O&M).

- Enhance high-level advocacy forums to secure increased funding for basic nutrition and health services. Increase grassroots engagement to lobby for more resources at the community level.

Outcome Module 2: Women of reproductive age, adolescent girls and children under 2 benefits take up improved gender-sensitive nutrition and health services in target regions.

- Expand caregiver access to quality counselling and support on young child feeding. Reinforce cultural beliefs that promote the practice of breastfeeding by involving traditional leaders and old grandmothers in attitude change.

- Provide capacity building trainings and facilitation to the community Health Promoters (CHPs) to continue delivering the basic health package under the Community Health Strategy (CHS). This will improve ANC uptake there is need to provide more capacity. If possible the project to provide the CHP with resources to facilitate their movement within the community.

- Establish youth- friendly centres that address specific nutrition, health and SRHR needs of boys and girls in the project area. This will go a long way in reinforcing gender-sensitive nutrition, health and SRHR services.

- Reinforce Nutrition and SRHR consultations in in-patient health and nutrition facilities by building capacity of the health staff undertaking these consultations. There in need for a clear reporting tool to capture and disaggregate data emerging from these consultations.

- Provide gender equality and social inclusion (GESI) training to project staff and partners in order to address malnutrition from a gender lens. Such training will then be cascaded to the community level by the trained ToTs.

Outcome Module 3: Women of reproductive age, adolescent girls and children under 2 benefit from improved gender-sensitive production and use of nutritious foods in the target regions

- Promote nutrient rich crops (bio-fortified crops) by forging partnership with the county department of Agriculture to provide capacity building trainings to medal farmers through Farmer Field Schools (FFS).

- Investment in public health and education programs to promote healthy diet for mothers and children and the healthy start of complementary feeding. This can be done through the 1000 days IYCF campaign (communication for behaviour change)

GESI-related recommendations

- World Vision to take lead in the development and/or review of a **gender strategy** for the health sector.
- **Conduct quality assurance and quality improvement** on **gender-sensitive service delivery** in Health facilities using a standards-based supervision tool in a participatory process with providers;
- **Address gender-based discrimination** leading to mistreatment of health workers and clients, through sensitization, skills-building and mentorship of health providers and facility managers;
- Build reproductive health services that are **non-stigmatizing or gender-discriminatory** to adolescents, unmarried people and non-traditional gender identities and sexual orientations.
- **Train community health workers (CHWs) and auxiliary nurse midwives** and **facility-level providers** on gender-sensitive family planning services that respect women's autonomy, dignity and privacy.

Health Service Provision

PLWD

- Mobilizing for resources to support disability friendly facilities and equipment them through leaders and forums
- World Vision should support in formation of groups for disability so that they can interact freely and speak their common agendas as disabled people.

Child protection

- The safe reporting of child protection issues in this community can be guaranteed by offering:
  - Adequate training to village elders on reporting mechanism so that they become the first to handle child rights issue
  - sensitization to members of the community is required about the various toll-free lines as follows:
    - ✓ ChildLine Kenya/ the Director of Children Services 24-hour toll-free line 116 or @WhatsApp on 0722116116
    - ✓ Kenya Police line 999, 911, and 112 for reporting any danger
    - ✓ NACADA 24 hr Toll Free Helpline (1192) for victims of alcohol and drug abuse to report and seek assistance on substance abuse.
      - Safaricom, Telkom Kenya - calls to 1192 with no charges
    - ✓ Kimbilio Trust Toll-free line 1193 for reporting on human rights abuse and seeking assistance
    - ✓ Healthcare Assistance Kenya Toll Free Helpline 1195 has a call centre that works 24/7 for reporting on gender-based violence
  - bringing Child's Offices closer to the wards which will help handle cases of children

- World Vision should strengthen conflict free and safe local structures in addressing child protection issues in the community through
  - organizing trainings for members of community and teach them the rights of children especially those abled differently in order to create just and equal society that will treat the boy and girl child the same

- empowering community and even building more structures such as rescue centers that help in child protection
- Safeguarding the rights of children in unique circumstances such as intersex children, children with mental health problems, children with non-visible disabilities, children living in conflict areas, migrant children and those from marginalized communities such as the Sengwer and Kiptani.

Recommended areas of further research and inquiry

- Longitudinal studies on children offered protection through nutrition interventions, rescued from harmful cultural practices such as FGM, early marriages, child labour – herding or mining
- Case studies on best practices that would convince the communities to support excluded and marginalized groups (PLWDs) through technical capacity building and providing start-ups
- Conduct time use survey to measure both paid and unpaid work to generate indicators for use in monitoring and evaluating interventions aimed at achieving gender equality and women's empowerment
- Gender and power studies to establish the level of empowerment and inclusivity achieved
- Studies to ascertain the best alternative for maternal and child health services to reach the geographically excluded population as a result of rough terrain
- In line with the National Reproductive Health Priority Research and Learning Agenda (NRHPRLA) 2022-2027 that highlights Adolescence and young people's reproductive health as a key RH priority area. This includes conducting further research on
    - Negative ASRH Outcomes – Adolescent/teen pregnancy, HIV/STI's, Vulnerability due to ignorance on SRHR
    - Age of Sexual Debut
    - Menstrual Hygiene
    - The role of Cultural practices and SGBV on SRHR
    - Impact of SRH Information/education for Adolescents
-

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7.0 APPENDICES

7.1 Terms of Reference

ToR-BMZ_GROW_ENRICH_Baseline_Kenya

7.2 Data Collection tools

BMZ_Tools.zip

7.3 Sampled Clusters

BMZ Sampling Final-2142024 (4) (1).

BMZ-Sampling Frame-F.docx

7.4 Data Analyses Plan

Analysis Plan-BMZ-210324.doc

7.5 Tables

Tables.docx

7.6 GESI Related Analysis of Country and County Profile

GESI Related Analysis of Country