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KNOWLEDGE, ATTITUDE AND PRACTICES STUDY ON REPRODUCTIVE HEALTH RIGHTS, GENDER NORMS AND VIOLENCE IN NAROK COUNTY, KENYA

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This Policy Brief was written by the ARCO - Foundation PIN team composed by **Maria Nannini** and **Caterina Arciprete**.

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Key messages

1. Patriarchal norms remain deeply entrenched across many communities, shaping discriminatory attitudes and behaviours that hinder the full realisation of women's rights and gender equality.
While change is underway, sustained efforts are needed to shift these deeply rooted social dynamics.

2. Despite progress in the legal and policy landscape, harmful practices such as female genital mutilation (FGM) and child marriage persist in various forms. These harmful practices are driven by persistent social norms and have evolved over time to avoid detection, pointing to a gap between legislation and lived realities that must be bridged through community-led engagement and dialogue.

3. Adolescent girls - especially those out of school - are among the most vulnerable, facing increased risks of early pregnancy, school dropout, and forced marriage. These experiences have long-lasting effects on their autonomy, health, and future opportunities.

4. Menstrual health is a matter of social justice.
Government ongoing measures are essential, still economic hardship, misinformation, and stigma exacerbate challenges in managing menstruation with dignity and safety.

5. Health literacy and access to accurate information play a critical role in fostering more gender-equitable attitudes. The findings reaffirm the transformative power of formal education in challenging harmful social expectations and advancing gender equality.

6. Strengthening the knowledge and engagement of key local actors - including teachers, healthcare providers, community leaders, and religious figures - can help detect and prevent harmful practices, breaking the link between violence, silence, and social acceptance.

Introduction

The Italian Agency for Development Cooperation (AICS) funded the project Imarisha Mwanamke Afya na Rasilimali (IMARA) in Narok County, with the objective of improving women's wellbeing, particularly in relation to Sexual and Reproductive Health and Rights (SRHR) and the prevention of Gender-Based Violence (GBV).

To support this aim, a research component was embedded within the project to generate context-specific evidence on knowledge, attitudes, and practices related to SRHR and GBV among the target population.

This study is designed to enhance the relevance and impact of project interventions by grounding them in robust, localised data. Its findings are intended to inform future activities - such as awareness campaigns and community engagement strategies - aimed at reducing GBV, promoting SRHR, and empowering young people as agents of change.

The study adopted a mixed-methods approach, combining qualitative and quantitative data collection. Ethical approval was granted by the National Commission for Science, Technology and Innovation (NACOSTI). Data collection took place in 2024 across the four sub-counties of Narok Central, East, North, and South, involving 671 survey respondents and 48 participants in focus group discussions and key informant interviews.

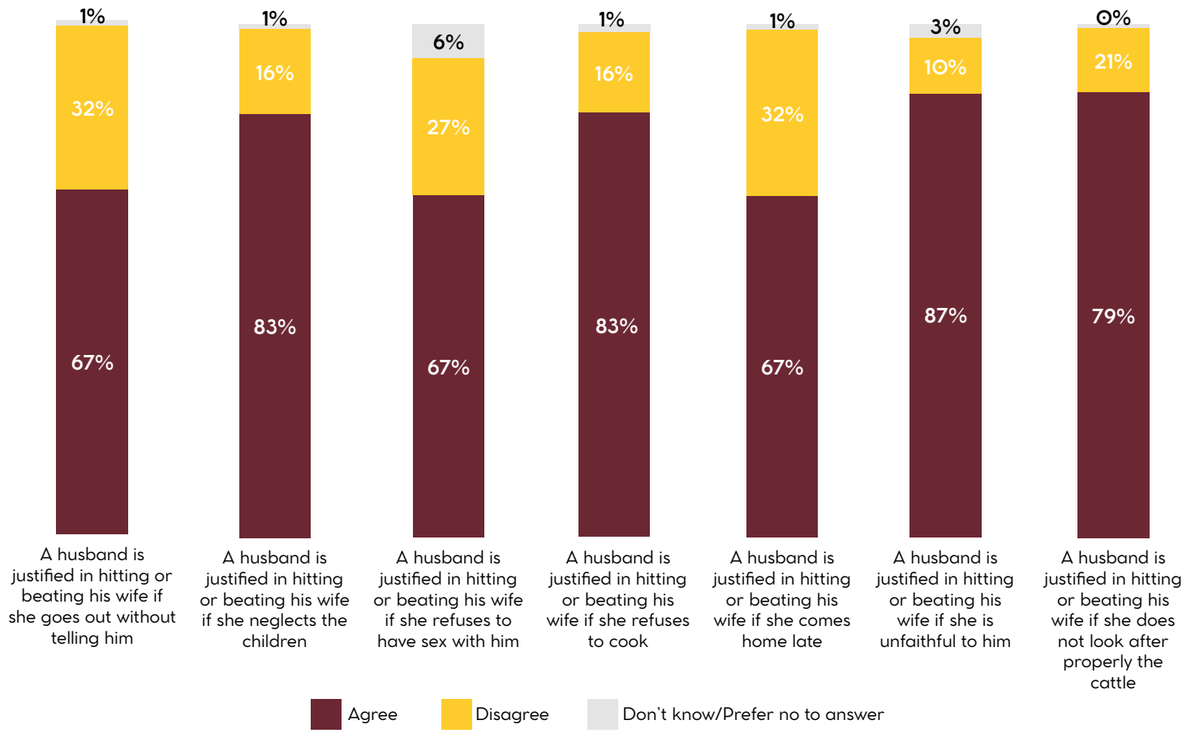
Main findings

1. PERSISTENT GENDER BIASES AND INTERTWINED DOMESTIC VIOLENCE

The study results underscore the persistence of deeply rooted gender biases in Narok County, where patriarchal norms continue to shape attitudes and justify GBV among many communities. Survey findings reveal that nine in ten respondents believe women should be primarily responsible for domestic care, and 77% agree that women are expected to tolerate GBV to preserve family unity. Social norms are central in sustaining GBV. These are reinforced not only vertically - through family elders and religious leaders - but also horizontally, through peer influence and informal community sanctions.

Social norms are so internalised that women are more likely than men to justify or normalise abuse - pointing to a widespread acceptance of unequal power relations. Nearly half of all respondents (47%) report knowing a woman who experienced physical abuse in the past year, with a notable gender gap: 66% of women versus 29% of men. GBV affects all age groups, with younger girls often perceiving violence as a justified response.

Figure 1. Attitudes towards gender violence



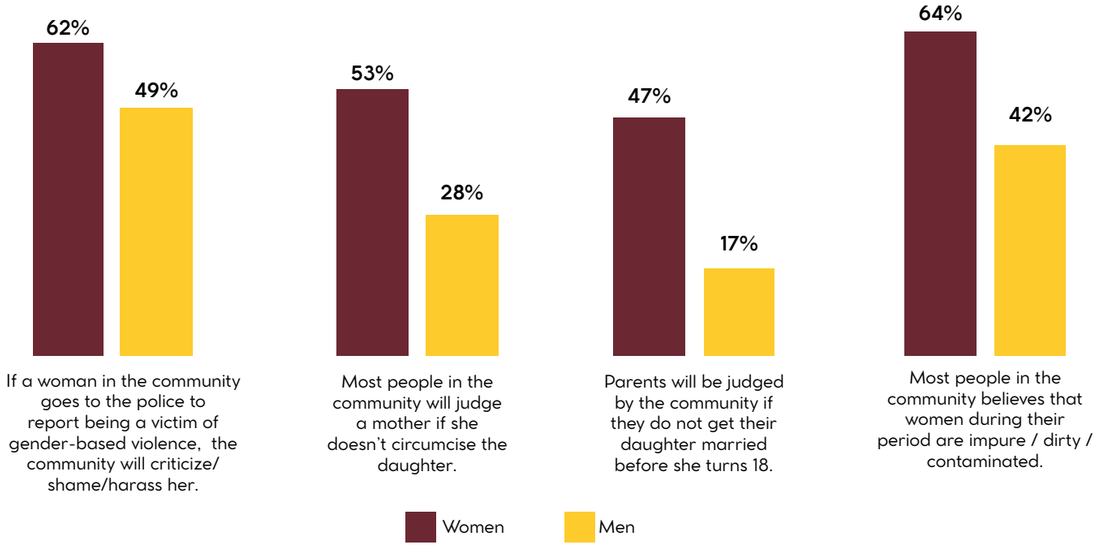
Source. Authors' elaboration

2. REPORTING GBV: OBSTACLES AND LEVERAGE POINTS

In many cases of violence, the fear of social exclusion for the victims outweighs concerns about legal consequences, fueling the persistence of harmful practices. Informal justice systems - typically led by village elders or chiefs - often priorities family cohesion over individual rights. For example, 55% of respondents believe that if a woman reports GBV to the police, she will be met with criticism, shame, or harassment from the community. Trust in religious leaders remains high, with nine in ten respondents expressing confidence in them, whereas formal justice mechanisms are widely seen as under-resourced and inconsistently applied.

As a result, women are often discouraged from reporting GBV, and survivors are frequently pressured to reconcile with perpetrators. Nonetheless, there is potential for positive change. Existing protocols and guidelines, as well as the presence of receptive institutions committed to addressing GBV at the county level provide a valuable foundation for strengthening the reporting system and enhancing the effectiveness of the response to violence.

Figure 2. Percentage of respondents who agrees to the statement, by gender.



Source. Authors' elaboration

3. HARMFUL PRACTICES: DISCONNECTION BETWEEN LEGAL FRAMEWORKS AND CULTURAL NORMS

Female genital mutilation (FGM) and child marriage remain widespread, both in perception and in practice. Although national legislation prohibits FGM, 54% of respondents believe that most girls still undergo the procedure, and 23% personally know a girl who experienced FGM in the past year.

The practice remains deeply embedded and has adapted over time to avoid detection. A considerable proportion of respondents continue to associate FGM with increased social acceptance and improved marriage prospects. Many respondents believe that uncircumcised girls face stigma or diminished marriage prospects.

Similarly, child marriage is often perceived as a means of securing economic stability, with one in three respondents knowing a girl who was married before the age of 18. These findings reveal a concerning gap between legal protections and prevailing social norms, where traditional expectations frequently override formal protections.

4. MENSTRUAL HEALTH AND HYGIENE MANAGEMENT: A SOCIAL JUSTICE EMERGENCY

Menstrual health and hygiene represent another critical area of concern. Limited access to menstrual products, clean water, and private facilities - combined with persistent stigma and misinformation - severely undermines girls' and women's ability to manage menstruation with dignity. A substantial proportion of women reported lacking adequate menstrual materials during their last period, with stark socioeconomic disparities: 56% of women in the poorest families faced shortages, compared to just 17% in the wealthiest group. These challenges are particularly acute for those affected by recent disruptions to water availability. Inadequate menstrual health management contributes to school absenteeism, psychological distress, and in some cases, harmful coping mechanisms such as transactional sex. Reports of "sex for pads" were consistently observed across qualitative data sources. Social norms underpin discriminatory attitudes towards women's SRHR: over half of respondents (53%) stated that menstruating women are considered impure by most people in their community.

5. KEY DETERMINANTS OF GENDER EQUALITY ATTITUDES

Education consistently emerges as a key protective factor. Higher levels of education are linked to more egalitarian attitudes, stronger rejection of gender-based violence, improved health literacy, and more accurate understanding of issues related to SRHR. Age also plays a complex role. Young people currently in school report fewer discriminatory views and are more inclined to question traditional norms.

Gender differences in perceptions and experiences are pronounced. While women are more exposed to and aware of violence, they often express less egalitarian attitudes - likely shaped by their lived experiences of abuse and systemic exclusion from decision-making spaces. Men, on the other hand, tend to underestimate both the prevalence and impact of gender-based violence.

Policy Implications

ENSURING PROTECTION AGAINST GBV

To effectively combat GBV, the establishment of protection facilities - such as Safe House - is essential. This has the potential to provide integrated psychosocial services and to operate in coordination with medical and legal support systems. To ensure that support for survivors is effective, it is also crucial to engage village leaders and elders as allies who can refer women to the services.

More broadly, community-based reporting mechanisms must be strengthened by leveraging existing local structures - such as village meetings, mothers' groups, religious leaders, chiefs, and schools - to disseminate information on reporting procedures and emergency contacts in cases of GBV.

SHIFTING THE NARRATIVE ON FGM

Since FGM remains deeply entrenched at the community level and driven by a complex set of cultural factors, reframing it as a pressing health concern has the potential to accelerate progress in the abandonment of the practice. Health authorities could play a leading role in advocacy and response efforts. Medical personnel, in particular, can be trained and supported to act as trusted community advocates, using their professional credibility and influence to promote shifts in social norms from within the community.

Moreover, initiatives aimed at abandoning the practice of FGM include the promotion of Alternative Rites of Passage (ARP) combined with intensive community sensitization. These approaches - linked to life skills training and comprehensive sexual and reproductive health education in schools - have shown potential in fostering both attitudinal and behavioural change. This would help ensure that ARPs are not only protective but also empowering for girls, representing a meaningful and dignified transition into adulthood. Efforts to expand the reach of ARPs should prioritize the early identification of at-risk girls and the active involvement of parents - particularly fathers - in supporting their daughters' development.

Sustainable change must begin at the family level and be reinforced through widespread education and engagement at the community level.

STRENGTHENING COMMUNITY AND SCHOOL-BASED PREVENTION

Teachers already play a vital role as early warning systems in identifying girls at risk of harmful practices, including FGM and child marriage. By equipping educators to recognize signs of vulnerability and connect students to support services, schools can represent safe entry points for protection and empowerment.

Expanding youth and men's forums is essential for addressing peer pressure and reshaping dominant narratives around masculinity, sexuality, and marriage. These spaces offer opportunities for dialogue, reflection, and positive role modelling, particularly among boys and young men. Keeping vulnerable girls in school - including pregnant adolescents and young mothers - is one of the most effective strategies for protecting them from harmful practices.

Introducing and scaling up scholarships and conditional cash transfers can help break the cycle of poverty that often underpins school dropout and early marriage. In addition to financial support, community sensitization efforts should highlight inspiring local role models - such as educated Maasai women - to broaden girls' aspirations and challenge prevailing gender norms.

IMPROVING MENSTRUAL HEALTH AND HYGIENE MANAGEMENT BY ENSURING DIGNITY AND ACCESS

To support girls' well-being, dignity, and school retention, menstrual health interventions must go beyond school-based distribution.

Free menstrual pads should be made available both in schools and at home, particularly during school holidays when girls often lack access to essential supplies. It is important to recognize that menstrual shame is a contributing factor to gendered poverty; therefore, ensuring access to menstrual products represents not only a matter of dignity and health, but also a highly effective investment in girls' empowerment and educational outcomes.

Improving school infrastructure is also essential: access to clean latrines, safe water, and private washing facilities creates an enabling environment for girls to manage their periods safely and confidently. Improving MHHM literacy among all the population is also essential as lack of knowledge is a major problem for girls and women.

DRIVING CHANGE THROUGH AWARENESS

Transforming social norms begins with reshaping the narratives that sustain them. Awareness raising sessions can promote new understandings of discipline, breaking the harmful association between violence, silence, and respectability. Sensitization efforts must be tailored to different genders and age groups and delivered through trusted community platforms.

Awareness-raising activities on sexual and reproductive health - both in schools and at the community level - are essential to strengthen health literacy and address period stigma, contributing to shift behaviours and attitudes, and ultimately shaping a more supportive environment for girls and women.

The implementation of media campaigns on sexual and reproductive health through radio messages represent a communication channel that is transversal across population groups. Empowering local champions to speak out publicly is vital in challenging stigma and promoting alternative role models.

The IMARA project

The IMARA project already aligns closely with the needs identified through this study, addressing critical gaps in SRHR and GBV response. Several ongoing interventions reflect promising practices, and their effectiveness can be further strengthened with targeted adjustments.

For instance, the project includes the establishment of a Safe House for survivors of violence and capacity-building activities to improve GBV response. It also foresees the development of guidelines and referral tools for Community Health Workers and Volunteers managing GBV cases. To enhance the quality of case management, it will be important to integrate specialised training modules on GBV and Intimate Partner Violence (IPV), including for cases involving child survivors. Such training should be extended to key local actors, including healthcare providers and police officers, particularly those serving in Gender Desk Offices.

The project already supports awareness-raising initiatives on SRHR and harmful practices such as FGM, along with teacher training on adolescent SRHR and women's rights. These efforts could be further reinforced through focused sessions on FGM prevention and clear communication of its health consequences, enabling both educators and communities to better challenge and abandon the practice.

At the community level, planned support for teenage councils and men's forums provides strategic platforms to promote positive behavioural models and improve SRHR knowledge- especially among out-of-school adolescents who often lack access to accurate information. Similarly, the establishment of young mothers' support groups and motivational meetings for pregnant adolescents is a promising approach. These could have even greater impact if coupled with targeted financial assistance to help adolescent girls stay in school and reduce dropout rates.

In terms of menstrual health, while the project already ensures free distribution of pads, there is a need to advocate for sustainable policy adoption by local authorities. This advocacy can be integrated into the broader objective of strengthening county-level gender policies. Likewise, the project is well positioned to support policy dialogue aimed at improving school infrastructure, a key enabler for girls' access to education and dignity during menstruation.

Finally, training and awareness activities on SRHR, implemented both in schools and at community level, remain essential to improving health literacy. Empowering local champions - teachers, nurses, pastors, chiefs, and survivors - to speak out is a powerful strategy to challenge stigma and promote alternative role models. The project's current efforts to train peer mentors already point in this direction and should be further expanded to foster grassroots leadership for change.

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