Barriers to Uptake of Sexual and Reproductive Health Services in Remote and Rural Kenya
The case of family planning in the Maasai Mara

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Introduction

Family planning: origins and evolution

Globally, 270 million women and girls have an unmet need for contraception, meaning their reproductive intentions do not match their contraceptive behaviour (WHO, 2020). The World Health Organisation (WHO) and the United Nations Populations Fund (UNFPA), among others, highlight that sexual and reproductive health services including family planning is one approach to address the issue (WHO, 2020; UNFPA, 2022). Family planning encompasses “the information, means and methods that allow individuals to decide if and when to have children” (UNFPA, 2022:6). As such, family planning deviates from merely using contraceptives. Methods include hormonal and non-hormonal contraceptives and natural methods such as abstinence or withdrawal (WHO Department of Reproductive Health and Research, 2018).

Family planning programmes were introduced in developing countries in the 1960s after increased child survival resulted in rapid population growth in many parts of the Global South (Seltzer, 2002:10; Cleland et al., 2006:1810). During the early years of implementation, a primary rationale for family planning projects was based on a concern for the consequences that population growth would have on economic activity, natural resources, and the environment (Seltzer, 2002:10). In the 1990’s, many advocates began including a human rights-based approach in their efforts, particularly revolving around women’s reproductive health and rights (ibid.:11) and today family planning is recognised globally as a fundamental right for all humans (UNFPA, 2022).

Efforts to reduce high fertility rates, stabilise population growth and promote family planning have been successful in most of the Global South, including Asia and Latin America. From 1960 to 2000 contraceptive practices in the targeted countries increased from 10% to 60% and births per woman decreased from six to three (Cleland et al., 2006:1810). However, many countries in Africa have not followed this pattern. Fertility rates, population growth and the unmet need for family planning in the continent’s low- and middle-income countries remains high and family planning practices are low. Yet, these trends and dynamics are masked on a national scale by sub-national differences. For example, large
discrepancies in population dynamics between Kenya’s rural and urban populations are linked to differences in family planning uptake (TMT, 2016:12; Izugbara et al., 2018).

Sub-Saharan Africa (SSA) has the highest fertility rates in the world in addition to the highest unmet need for family planning (Gahungu et al., 2021:1). Addressing the unmet need for family planning brings about an array of health as well as non-health benefits. These benefits help decrease human insecurity that pertains to e.g., people’s health, economy, and community. Health benefits include preventing pregnancy and birth complications, which is one of the leading causes of death among adolescents in SSA (CHASE Africa, 2023). Economic benefits are achieved through reduced poverty, increased labour-force participation, and expanded development opportunities (WHO, 2020). Empowerment of girls and women has proven beneficial to both individuals and communities alike with strong results being observed through education in a particularly high-risk group; adolescent females (ibid.). Sustainable population growth is furthermore an overarching benefit derived from family planning uptake (ibid.). In brief, family planning has the potential to advance the human security of millions.

The study site of this report, the Maasai Mara in Narok County, has one of the lowest contraceptive prevalence rates in Kenya (Mwarogo, 2022:2). Various barriers stand between women and family planning uptake in this area. For the purposes of this report, barriers are defined as the constraining factors standing between the number and spacing of children that a woman wants (Campbell 2006:87).
The semi-arid and arid lands of Kenya’s southwestern parts is home to the indigenous semi-nomadic Maasai people of the Maasai Mara. Located primarily in Narok West sub-county in Narok County, the Maasai Mara has a total population of around 195,000 people. The area is well-known globally for its bountiful wildlife and sustains thousands of livelihoods due to the tourism it attracts annually (Maasai Mara Wildlife Conservancies Association, 2023).
However, the ecosystem is vulnerable to growing environmental, human-wildlife and socio-economic challenges in the region. Population growth is a driving factor in this development because the Maasai communities in Maasai Mara experience one of the highest population growths in the country. While Kenya’s annual population growth is 1.9% (The World Bank, 2023), Narok County’s overall growth rate is 3.9% (DESIP, 2021:2). Remarkably, the natural population growth in the Maasai Mara alone is estimated to be 8% (TMT, 2016:11). Consequently, settlement growths, increased population densities and more exhaustive resource utilisation intensifies pressure on the already scarce natural resources (ibid.:5). In the present report I identify and examine barriers to family planning uptake as some of the possible determinants of Maasai Mara’s high fertility rates.

The majority of Maasai in this area practice pastoralism as their main source of income. Pastoralists depend on livestock and rangelands for their livelihoods (Pastoralism, 2023) and accordingly, their households are often found in remote and rural landscapes. Because pastoral communities generally have less access to economic and social services compounded on by lack of physical infrastructure, they are frequently characterised as underdeveloped and poor. However, The CEO of TMT explained that in comparison to other pastoral communities and Maasai elsewhere in Kenya, the Maasai communities in the Maasai Mara have means by virtue of their livestock and income from tourism:

“(...) you need to take into account the amount of livestock that they have, and the amount of land that they have, and then the income that they're earning from that land, rather than just looking at education or healthcare (TMT’s CEO, 5/12/22).

This means that while the Maasai in the Maasai Mara are poorer than other ethnic groups in Kenya, global poverty measurements fail to take local cultural meanings and conceptualisations of poverty into
account. Nonetheless, low education and literacy levels, strong traditional and cultural values and poor healthcare access persist and are factors that still marginalise the Maasai in many aspects.

Family planning has not been common practice in the Maasai Mara. Correspondingly, the concept has been avoided by policymakers and NGOs that regarded the issue as a controversial subject (TMT, 2016:5). These actors have just recently diverted their attention to family planning in the Maasai Mara, not only to address the rapid population growth but also to increase female empowerment.

Barriers to family planning have been deemed an important determinant for the state of gender equality and fertility decline (Campbell, 2006:87; Muluneh et al., 2019:2). Because little research has been carried out on this topic in the Maasai Mara, the underlying causes of low contraceptive prevalence rates and family planning uptake here are not yet fully understood. It is therefore necessary to get a better understanding of the present barriers in order to overcome them.

**Data presentation**

I conducted research in nine dominantly Maasai communities in the Maasai Mara between August and December 2022 in collaboration with the NGO The Maa Trust (TMT). The focus of the research was the attitudes, awareness, and practices relating to family planning. The purpose of the data collection process was to identify current barriers to uptake of sexual and reproductive health services in these communities, where the focus was more specifically on family planning services.

The data was collected primarily through:

- six focus group discussions held in five different rural communities with participation from the surrounding villages;
- interviews with six nurses, four local NGO staff, three community health mobilisers, and one charity representative which took place at medical camps or schools in one of the nine communities or at TMT’s headquarters.

The communities were Eluai, Emarti, Enchoro, Ntipilikwani, Mara Rianta, Olkimitare, Orkuruto, Osidan and Talek. TMT chose the communities based on where the organisation had existing projects as well as locations where TMT sought to expand their reach. This data was supplemented with a small
questionnaire carried out at medical camps where a total of ten Maasai women using contraceptives answered a set of questions relating to their family planning practices and with numerous informal conversations with people engaging in TMT’s family planning and sexual and reproductive health activities.

I identified five barriers that hinder uptake of family planning and contraceptive use for Maasai people in the Maasai Mara:

1. Socio-cultural beliefs and practices.
2. Lack of knowledge.
3. Inaccessibility of services.
4. Myths, misinformation, and experienced side effects.
5. Negative perceptions and stigma.

The barriers are complex and interconnected; they are experienced by individuals, couples, and communities alike. Exploring and contextualising these barriers is the focus of the present report. It is the purpose of this report to contribute with an understanding of how these barriers work to inform future work carried out by TMT, specifically, but also other NGOs, policy makers or sexual and reproductive healthcare workers in the area.

Thus far, family planning in the Maasai Mara has been within the scope of NGO’s and policy makers. This report therefore offers an academic contribution to the field of sexual and reproductive health with family planning in the Maasai Mara as a case study.
Analysis of the five family planning barriers

As an introduction to the identified barriers, the next section presents five cases centred around family planning services and contraceptive use in the Maasai Mara. All cases are fictional in the sense that they are written based on concrete dilemmas faced by actual people that were collected as part of the fieldwork. Cases have been edited so as to grant these people anonymity. They may therefore incorporate elements from several similar accounts or personal information may have been altered to preclude identification. This could be age, profession, number of children if these factors are not deemed crucial to illustrate a given dilemma. Each case addresses one of the identified barriers, but as all barriers are intertwined, cases may draw on themes from other barriers. The cases, therefore, although edited this way, reflect actual scenarios for people who are involved with family planning and contraceptives be it couples, adolescents, healthcare workers, women, and men and as such are informative of the reality faced by people in the area. The barrier and related issues presented in each case are subsequently analysed. Quotes from my research appearing in these analyses are not fictional.

Case 1: Socio-cultural beliefs and practices

In two months, Naserian will give birth to her and her husband Michael’s third child. She is 22 years old, and her other children are 5 and 3 years old. Naserian has not attended school and lives in a boma (hut) on Michael's land. Michael has divided his land so that both of his two wives have a boma each. Naserian is Michael’s second wife. Her daily routine consists of collecting firewood and clean water, as well as cooking and cleaning chores in the home. Naserian has noticed that groceries at the local Wednesday market have become increasingly expensive. The allowance she is given by her husband to secure food and other necessities is stretching thin. She is concerned about the future wellbeing of her children. At a community meeting, a community health mobiliser who works with a local NGO informed her and others about the benefits of family planning. In particular, she remembered the economic benefits of spacing one’s children. Michael, however, has made it clear that he disapproves of family planning because he views children as a blessing from God. Nonetheless, Naserian sought out
an untraceable, three-month contraceptive injection that many of her peers had told her about. She keeps this a secret from Michael.

**Barrier analysis**

*"The head comes before the neck"*

Naserian’s case reflects one of the most widely reported barriers to family planning uptake according to Maasai community members: socio-cultural beliefs and practices. The term socio-cultural encompasses the norms, structures, beliefs, and traditions that exist in a population group (DESIP, 2021). In a 2021 case study on Narok County, the UK funded programme Delivering Sustainable and Equitable Increases in Family Planning (DESIP) identified socio-cultural beliefs and practices to account for 57.1% of the challenges faced by community outreach programmes on family planning (ibid). Socio-cultural beliefs and practices are perpetuated and reinforced by “folklore, stories, sayings and proverbs” (Kipuri & Ridgewell, 2008:6) by community members. Naserian’s case exemplifies how some of these socio-cultural beliefs and practices in the Maasai community, such as that it is up to the man to decide on the number of wanted children and how children symbolise wealth, may end up conflicting with the concept of modern family planning.

Power imbalances between partners in a relationship, measured on for example differences in age and education levels, affect fertility choices. Studies find that the further apart a couple is on such factors, the less likely a female is to use modern contraceptives (UNFPA, 2022:39). This dynamic is evident in the Maasai Mara. Females are taught from a young age to respect and submit to the paternal hierarchy (Kipuri & Ridgewell, 2008:6). Men are favoured for educational opportunities (Parsitau, 2017) and it is common for them to have significantly younger partners (Stats et al., 2022:42). Moreover, polygamy is widely practised, where it is common for a man to have or want to have co-wives (Takayanagi, 2020:82). In many Maasai households, tasks and responsibilities are clearly divided between men and women in line with existing gender roles (ibid.:81). In this view, there are very different expectations for Maasai men and women. A husband is the breadwinner and a wife’s duties consist of performing daily chores centred around the homestead. It is the husband that oversees all decision-making and has the final say on all accounts, including reproductive matters. A clinical officer working with TMT, explains that one of the contributing causes of this is:
They believe that you don't have rights. Now you see, there is an issue of paying dowry, like, "I paid for you, you're mine. I own you. So, everything that I say, you're going to obey (Clinical officer, 9/12/22).

Bride prices or dowries are customary for a man to pay to the community or family of his future wife. Women are often worth a few cows, sheep, or goats (Paristau, 2017). What the clinical officer explains in this quote is, therefore, that another power imbalance between husband and wife arises from this transaction, where wives are naturally perceived as the property of husbands.

Prescribed roles are often justified by the Maasai saying “the head [man] comes before the neck [woman]” (TMT staff, 20/1/23). That the prestige for a Maasai Man is “having more children, more cattle, more women” (TMT staff, 25/11/22) continues to be one of the most perpetuated socio-cultural beliefs and practices in the Maasai Mara. Accordingly, a wife is expected to give birth to many children. In the view of multiple research participants, this type of socio-cultural belief and practice has implications for women’s contraceptive behaviour.

*Excerpt from a Women in Leadership workshop activity:* In a TMT-led workshop on Women in Leadership in October 2022, the participants, who were all female, were asked to make a list of the schedule of a typical day in the life of a Maasai husband and wife. It was evident from the lists that there were discrepancies in both the tasks performed and how strenuous they were. Both sexes carried out activities for the household, such as “money-making activities” by the men and washing clothes and fetching firewood by the women. However, women had longer days, performed more functions and their labour often centred on preparing things and performing activities in the domestic area. Men, on the other hand, primarily received the finished result from those preparations and activities. The answers, shared through laughs and words of encouragement, could indicate that Maasai women perform significantly more labour, although it may be unpaid, than their male counterparts.

“Most women are afraid of seeking the service”

The Maasai in Narok County are among the people in Kenya with the lowest modern contraceptive prevalence rates (Mwarogo, 2022:2). Nonetheless, statistics from the Kenyan Demographic and Health
Survey (KDHS) reveal that overall uptake of family planning and contraception is on the rise in Narok County. From 2014-2022 the number of married women between 15-49 who used a type of modern contraception increased from 38.1% to 52.2% (KDHS, 2014:95; KDHS, 2022:20). Notably, the use of implants increased markedly. The most recent KDHS shows that implants account for 24.5% of method use in Narok County compared to injections at 16.5% (2022:20). While I also notice an increase in implant use in my data, most women prefer the injectable contraceptive Depo-Provera. The contraceptive that can be effective for the longest period, the intrauterine device, is the least popular. Based on the explanation given by focus group participants, healthcare workers, and community health mobilisers, there are two primary reasons for Depo-Provera’s popularity: Firstly, because Depo-Provera is a short-term commodity it is appealing to women and couples who may want to delay a pregnancy for a short while. A healthcare worker explained that because it is administered only once every three months, the method offers a convenient alternative to, for example, oral pills that must be ingested daily. According to a second healthcare worker, women often do not come back for another dose, which could indicate that external factors influence women’s access to facilities as exemplified in Case 3: Inaccessibility of services and Case, Case 4: Myths, misinformation, and experienced side effects and Case 5: Negative perceptions and stigma.

The second reason for Depo-Provera’s popularity concerns part of the socio-cultural beliefs and practices that were touched upon in the previous section, namely how women are expected to obey men in Maasai societies. In the words of a TMT staff member:

“

The woman cannot decide on the number of children that she wants if the husband is not supportive. And unfortunately, because most men either are not supporting it or are not understanding family planning, they do not encourage their wives to go and take family planning. So, you find that most women are afraid of seeking the service because their husbands are not for it and they have to listen or respect what the husband says about the number of children (TMT staff, 25/11/22).

The quote illustrates that women are not expected to have a say in decision-making processes concerning reproduction. In the small questionnaire incorporating statements from ten Maasai women, the data shows a clear correlation between a partner’s consent and choice of contraceptive. In cases where the
husband is involved in the family planning and consented, long-term methods, such as the five-year implant, Jadelle, is utilised. This is the case in three out of ten instances. In the seven other instances where a woman does not obtain her partner’s consent prior to seeking out contraception, she chooses Depo-Provera. The fact that Depo-Provera is a traceless injection is a determinant in this regard:

"Most women fear using the implants and the coil because they fear their husband will notice them during sex or while touching. They fear that this will lead to being beaten up and, "why are you using family planning? So, they use Depo-Provera most of them (Clinical officer, 9/12/22)."

The clinical officer and other healthcare workers stress that contraceptive use is hidden from spouses or even other community members because of the fear of being found out. Negative attitudes towards family planning can have serious consequences for women choosing to utilise them. In this context, the socio-cultural beliefs and traditions that clash with the idea of family planning may be more sustained for the rural Maasai populations in the Maasai Mara than for the urban Maasai closer to the capital city of Narok County. This could also help explain the higher statistical prevalence for implants in the KDHS.

Studies show that women who experience intimate partner violence are more prone to hide contraceptive use from their partners (UNFPA, 2022:50). The clinical officer, along with healthcare workers and TMT staff, confirmed these circumstances to also be applicable to the Maasai Mara. If a Maasai wife goes against her husband’s wishes or fails to perform her duties satisfactorily it is customary for her husband to use violence as an appropriate means to correct and discipline her. According to a UN study carried out in 2014, intimate partner violence is generally accepted and normalised in Maasai communities (UN Women, 2014). The findings of this study correlate with the realities in the Maasai Mara where a TMT staff likened wife-beating to “punishing a child” (TMT staff, 23/11/22). As demonstrated in the quote above, women turn to injectable contraceptives in fear of physical backlash from disagreeing husbands who check for family planning use. It is a way to reassert autonomy in a milieu where their reproductive preferences frequently are being neglected (UNFPA, 2022:39).
Case 2: Lack of knowledge

Seleina is almost ready to graduate from high school. When school is over, she wants to become a nurse and marry her boyfriend, Dalmas. They have plans to start a family together, but neither is interested in becoming parents for a while. In Biology, Seleina has been taught about how her body has changed and that she is now able to become pregnant. She knows a little about sexually transmitted infections (STIs) but is not aware of how to protect herself from them. In church, she has been told to stay abstinent until marriage. At home, her parents do not talk to her about sexual and reproductive health. Matters about relationships are usually discussed with friends from school. As her and her schoolmates get older, Seleina notices that more girls than boys have stopped coming to school. Seleina does not believe she can get pregnant when she has her period, and the couple currently engages in sexual relations without using contraception.

Barrier analysis

Motherhood in and as childhood: early sexual debuts and family silences

The lack of both formal and informal education on sexual and reproductive health topics, including STIs and unplanned pregnancies, is the focal point of Seleina’s case. Providing young people with comprehensive sex education is one of the most effective ways of securing the sexual and reproductive health of young people (Mbugua & Karonjo, 2018:2; UNFPA, 2022:76). In Kenya, sex education is a controversial topic. In rural regions, abstinence-only education programmes and/or programmes with little information on sexual and reproductive health prevail, which is also the case in the Maasai Mara (Obwoge et al., 2019). Biology and Religious Studies address sexuality and reproduction to a limited degree and the Life Skills curriculum uses puberty as an entry point to only cover basic sexual health education (Wanje et al., 2017:2).
This lack of education is a contributing factor to why four in ten pregnancy cases in Narok County concern adolescents aged 10-19 (DESIP, 2022). However, as it is standard practice to only include pregnancy statistics on females aged 15-19 in national statistics (UNFPA, 2022; KDHS, 2022; Population Reference Bureau, 2021) the presented numbers are presumed to be higher. Indeed, the median age for sexual debut is ten years in rural Maasai communities, where children at this age also get impregnated (Pakdaman & Azadgolia, 2014:37; Stats et al., 2022:38). For example, in the first five months of 2021, 758 cases of pregnancies for girls aged 10-14 were recorded in addition to the 6,120 cases for girls aged 15-19 in Narok County (Keya-Shikuku & Hassan, 2021). By excluding these cases from official statistics, policy makers and other officials get an obscured idea of the urgency of proper sex education.

As early sexual debuts are characteristic for this area, what information is passed onto young people may be disclosed too late. NGOs or other actors that try to advocate for more comprehensive sex education can risk serious backlash and threats from officials at the county level. One of the women dedicated to ensuring high-quality education for Maasai youth who had attended a meeting where comprehensive sex education in school was suggested, shares:

“When I raised the issue of doing sexual and reproductive health education in schools, the most senior deputy County Commissioner stood up and said that if we do sex education in schools, they will come and arrest us (Anonymous woman).”

This means that actors advocating for better sexual and reproductive health education need to come up with creative solutions to the problem or risk coming in bad standing with the authorities. In addition to potential backlash from officials, there is also the matter of getting parents onboard, as they must consent to information about sexual and reproductive health being taught to their children. TMT staff shared how it is uncommon for parents to engage with children on intimate issues:
There are no proper ways of teaching sexual and reproductive health in the culture. So, meaning that girls and boys do not know the issues of family planning. Like, culturally, we don’t have guidance on when to engage in sex and all that, ‘cause parents don’t talk to their children on issues of sexual interactions (TMT staff, 25/11/22).

The quote showcases that communication barriers that are culturally perpetuated through generations contribute to the gap in knowledge. Communication barriers often consist of cultural taboos, lack of parental role models and a belief that the child is too young to learn about sexual and reproductive health (Wanje et al., 2017:2). One of TMT’s staff provides an example from her own childhood: “My mom is learned. She was a really powerful woman. But she never talked to me about menstrual hygiene. That really tells you a lot about everything” (TMT staff, 20/1/22). Communication barriers thus concern all aspects of sexual and reproductive health and pertains to educated and uneducated people alike. As was the case for the TMT staff, the culture dictates that it is typically mothers who are expected to handle conversations of this nature. Then, when mothers and parents fail to pass on knowledge about sexual and reproductive health topics to their daughters, girls are left to their own devices or must rely on external information sources. In many instances, this proves to be insufficient and results in life-altering consequences such as school dropouts.

**Abstinent abstinence**

Lack of knowledge about sexual and reproductive health, family planning and contraceptive use for girls and women can directly mean loss of educational opportunities. In a study from 2022 on adolescent pregnancies among Maasai girls who had been pregnant, nearly half of respondents stated that they were unaware that they would have to leave school after becoming pregnant (Stats et al., 2022:40). One third expressed that they would never have wished to become pregnant if they had known that it would intervene with their schooling (ibid.). The same study found that all respondents had an unplanned pregnancy (ibid.:39) and more than one third of the girls and women weren’t aware that sexual relations could lead to pregnancy (ibid.:40). This is emblematic of the lack or omission of proper information. Although this research was not undertaken in Narok County, it is still useful in the context of the Maasai
in the Maasai Mara because of the high rates of both adolescent pregnancies and school dropouts experienced here.

A TMT staff member working with Maasai Mara youth, is concerned about the implications of lack of knowledge:

“If youth do not have information and at the same time they can’t access information and safe spaces, then it is a crisis (TMT staff, 28/11/222)."

In his view, then, it is imperative that youth is better equipped with family planning and contraceptive awareness. Increased rates of adolescent pregnancies are projected to hit SSA over the next 20 years and Kenya is expected to be one of the countries to bear the brunt of pregnancy cases (Stats et al., 2022:37). Already upwards of 10,000 girls drop out of school in Kenya each year due to adolescent pregnancies. One of the contributing factors to this is that only three in ten sexually active Kenyan adolescents use contraception (ibid.). High adolescent pregnancy rates are found in several counties, but Narok County is one of the most affected (KDHS, 2022:16). Here, the share of females that have been pregnant or given birth at age 15-19 is 40% compared to Kenya’s national average of 18% (Population Reference Bureau, 2021:1). Girls that are forced to drop out of school often do not believe that it is possible for them to enrol again and only few do so. Adolescent pregnancies are more prevalent for females with fewer years of education and where contraceptive use is less common (KDHS, 2022:16,19). Thus, there are distinct parallels between adolescent pregnancies, low educational attainment as well as little to no contraceptive use, all of which are factors that pertain to the Maasai youths in the Maasai Mara.

Ultimately, this means that many Maasai girls and women lose out on potential educational and economic prospects which can have implications for the future well-being and prosperity of themselves and their children. This is because when poverty is passed on intergenerationally, the children of adolescent mothers may be exposed to the same economic and health insecurity (Stats et al., 2022:37).

Officials and schools at a county level, and parents and other socialising agents at a local level are all failing to deliver pertinent sexual and reproductive health information to boys and girls. Children and youth, then, do not seem to have anywhere to receive correct and adequate information in some of their most formative years. Due to the specific local circumstances found here, such as younger sexual debuts, it is imperative that correct information reach youth and adolescents at the right time.
At present, peer education has been introduced in the Maasai Mara by TMT with the purpose of conducting adolescent sexual and reproductive health sessions. Through different playful activities, sessions are carried out under the guidance of a youth coordinator and covers topics such as female genital mutilation, teenage pregnancies, and early marriages. Peer education is widely used in SSA and has many benefits. It is a cost-effective method, peers are considered to be credible, and are more successful in sharing information because people identify with them. Crucially, education from peers may be more acceptable than other types of education (Bastien et al., 2008:192-99). Nonetheless, because abstinence is still deemed one of the more culturally acceptable approaches, peers start by advocating for abstinence and youth are sometimes agreeing to stay abstinent for a certain period or “until they reach their goals” (Peer mentor, 28/11/22). Factual sexual and reproductive health information is provided afterwards, however, since peer mentors are aware that abstinence may not be “the most effective or realistic option for young people” (Peer mentor, 28/11/22). NGOs may be able to revisit the possibility of advocating for comprehensive sexual and reproductive health education in schools again within a short timeframe, however, as the persistently high numbers of adolescent pregnancies in addition to school dropouts are putting officials under pressure.

**Case 3: Inaccessibility of services**

Samuel moved from Nairobi to Nkoilale five years ago to work as a nurse. Normally he works at a healthcare facility but a few days each month he assists medical camps run by a local NGO. He does not have a lot of colleagues and oversees a lot of clients daily. Most of his clients are Maasai and he has come to learn Maa through their interactions. He is Kalenjin himself and had little knowledge about the Maasai people before his move. Helping people get better brings Samuel joy, and his favourite part of the job is the consultations. Since he started working around Nkoilale, he has noticed that more women come to him for family planning methods. Family planning practices here are very different from his previous experiences, and he rarely sees couples or youth coming for services. Due to stock-outs, he is sometimes prevented from presenting a client with a full range of family planning commodities. He hates disappointing people because he knows they have often dedicated a day to travel large distances to access services.
Barrier analysis

Commodity insecurity

Although there is much progress on making family planning services more accessible in the Maasai Mara, a variety of circumstances still obstruct access as shown in Samuel’s case. These circumstances are interconnected.

95% of Narok County’s health facilities offer family planning services (DESIP, 2022). At first glance, this reflects how family planning projects have successfully expanded the availability of services. Despite that, as demand for family planning services has increased, the spending on supplies has not (Appleford & Mbuthia, 2020:2). Inadequate funding consequently presents challenges for commodity supply. 58% of facilities do not have all family planning commodities available (DESIP, 2022) and up to 25% of facilities experience high levels of regular stock-outs on certain contraceptives (DESIP, 2021). In the Maasai Mara, the injectable Depo-Provera is the most commonly unavailable contraceptive for women, as described by a local nurse:

“(...) most of the facilities have run short of Depo for the long-term. Like, for example, in the beginning of this year there was not any Depo around, very few. So, we prefer to switch people to long-acting methods (Nurse, 16/11/22).

In this nurse’s experience, healthcare workers sometimes must make do with available commodities and encourage women to use a contraceptive they may not have wanted in the first place. The unavailability of contraceptives can thus lead to provider bias and have a diminishing effect on women’s contraceptive choices. When this is the case, accessing contraceptives becomes an issue.

Interlinked inaccessibility

While commodity insecurity has consequences for the uptake of family planning services in Maasai Mara, accessibility is a greater issue. People from rural areas report lack of access as a barrier to family planning uptake at twice the rate of urban populations (UNFPA, 2022:72). Studies have found that cost and geographic distance are common accessibility barriers for rural populations (Campbell et al. 2006:88-89; Diamond-Smith et al., 2012:421). This is echoed in focus group discussions with Maasai
community members where poor infrastructure is named as a condition that hinder access in Maasai Mara. Contraceptive stock-outs influence the price of services and where they are acquired (UNFPA, 2022:79). Nurses and Maasai women using family planning recount how some health facilities charge upwards of 1.500 Kenyan shillings (83 kr./$12) for family planning services. It is the opinion of a community health mobiliser and a TMT staff that the cost of commodities at healthcare facilities influences the choice of contraception (15/11/22). Price presents an issue for many Maasai women who “don't have money because they're jobless” (Nurse, 14/11/22) and additionally are financially dependent on their partners. Economic insecurity also means that not everyone can afford a radio, a medium through which much family planning information is successfully transmitted (Mwarogo, 2022).

The CEO of a charity that supports NGOs both in the Maasai Mara and elsewhere in rural Kenya, voices geographic distance as an inaccessibility concern in this region:

“The main challenge there is just geography and how spread out everyone is. It's not like we're in a town or an urban area, where you can walk around and reach so many people. The community health mobilisers have to go long distances to reach all of the rural homes (Charity CEO, 1/11/22).

Just as healthcare workers face difficulty when trying to reach rural communities, as highlighted above, it follows that rural communities also must overcome the same barriers to reach facilities. Studies have demonstrated that the distance between a woman’s home and any health facility affects the probability of her contraceptive use (Campbell et al., 2006:88). Women and opinion leaders from focus group discussions reveal that if a family does not have the means to buy a vehicle for transportation, women have to rely on lifts from others or spend considerable time to cross large distances on foot to reach a service point. The Maasai Mara’s generally poor infrastructure further exacerbates this problem. So, while Narok County has 221 operational health facilities dispersed across its 6 sub-counties (Kenya Ministry of Health, 2023) it raises the question of how many of these facilities are being accessed to their full potential? And this does not even take into consideration the missed hours of duties in the household that women lose out on in travelling to reach services.
Case 4: Myths, misinformation, and experienced side effects

Namunyak used to be enrolled in Talek Girl Secondary School. Here, she was fond of the subjects English and Science. Namunyak planned to become a teacher and was always one of the top pupils in her grade. When she was 18 years old, Namunyak became pregnant with her then-boyfriend, now-husband, James. Together they now have a son. Due to the pregnancy, Namunyak dropped out of school without finishing her studies. Namunyak did not wish to have another child for a couple of years and, with the consent of James, began using contraception. James is supportive of her and believes the choice to have more children is a joint decision between the couple. However, Namunyak experienced uncomfortable side effects from the type of contraception she used and chose to discontinue the method. She is starting to believe the horrible stories about what happens to women who use contraception that several women in nearby villages have told her. She is currently not utilising any family planning service.

Barrier analysis

Myths and fear: the vicious cycle

The barrier Namunyak faces is the fear of negative side effects, informed by a combination of myths, misinformation, and experienced side effects from contraceptive use. A large body of literature has pointed to issues surrounding contraceptive side effects as a barrier to uptake (Campell et al., 2006; Diamond-Smith et al., 2012; UNFPA, 2022:69), which is the focal point of Namunyak’s case. This literature tends to focus on myths and misconceptions of side effects as a hindrance or how side effects are by-products of use and thus nuisances to be dealt with (Schwartz et al., 2019:264). It is rare that research has problematised the side effects that for some are severe. While myths and misconceptions of side effects are frequently occurring barriers, the experienced side effects of women should not be overlooked. The following sections therefore address both myths and misinformation as well as lived experiences, as the common denominator for all is that they cause fear or discontinuation of contraceptives (Diamond-Smith et al., 2012:1464).

Namunyak’s case is not a separate instance. Worldwide, fears and actual experiences have surpassed lack of knowledge as the most common reason for non-use or discontinuation of contraceptive methods.
(UNFPA, 2022:68). Studies on contraceptive side effects have found fear caused by myths and misinformation to be spread by various sources, although often by people with perceived authority and credibility (Schwarz et al., 2019:268). In the context of the Maasai Mara, opinion leaders, men and religious leaders are prominent figures in communities and therefore highly influential. This barrier focuses on the role of religious leaders as the fifth and final case will discuss the importance of men. The church is an unmistakable part of everyday life in the Maasai Mara, where a vast majority of the community members that I encountered during the fieldwork identified as Christian. Most focus group discussions took place in churches and all activities commenced and concluded with a prayer. The observation resonates with a clinical officer, who explains: “for us, we really believe what the pastor says. Like, “yes, the pastor said this, God said this, he wanted this””. Drawing on a recent experience, she added:

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The other day when I went to church, the pastor spoke in front of the church and said, "God said in the book of Genesis that you should fill the earth". He's trying to tell the people that you're supposed to give birth every now and then until you have like 10 children. (Clinical officer, 9/12/22)
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In this instance, Bible verses are used by someone with strong authority to demoralise family planning to a receptive audience of “very poor” (Clinical officer, 9/12/22) people. In other SSA countries, church representatives are identified as actors who oppose family planning initiatives (Schwarz et al., 2019:268). A 2019 study on side effects from contraceptive use among Congolese and Burundian women found that religious actors spread misinformation about side effects by linking them to cancer and damaged brain cells (ibid.). It is important to note that people with strong religious beliefs do not always try to impede family planning projects. There are examples of the church aiding such initiatives (Christian Connections for International Health, 2017). Instead, the argument put forth is that when respected authorities take a stand for or against something, their audience is inclined to listen to that opinion.
Myths like cancer and brain damage are prevalent in the Maasai Mara, where informants from both focus group discussions and interviews could list a plethora of inaccurate facts about contraceptives. This list included infertility, as in the case narrated by TMT’s CEO:

"(...) she decided to come off family planning and have another child. So, she got pregnant, but then she had a miscarriage. And she blamed that miscarriage on the fact that she'd been taking family planning previously. But in fact, it's more likely that she's now almost 40 that she's had a miscarriage because she was now of old age, but she just linked it to: “I've been on family planning for the last 10 years, I've not had any problems with any of my previous pregnancies - and so that's why I've now had a problem with this last one” (TMT’s CEO, 5/12/22).

The scenario portrayed in the quote is a typical example where facts and fiction are muddled together and create fear. For the woman in this story, not being able to conceive is attributed to family planning although it likely could be due to other factors. Other examples of misinformation and myths range from oral pills that will not dissolve in the stomach, birth complications, serious health conditions to “having a disabled child” (TMT’s CEO, 5/12/22) which are said to be caused by family planning. Maasai men from focus group discussions added that women who use contraceptives will have an increased libido and “therefore become unfaithful”.

**Embodied effects**

Regularly, misinformation is in direct contradiction with facts. For example, condoms, which are highly effective in protecting against STIs and HIV transmission (WHO Department of Reproductive Health and Research, 2018:247) are believed by some to be the carriers of STIs. For others, contraceptives are thought to be the cause of cancer when studies have proven that some female contraceptives protect against certain cancers (ibid.:3,68). When women hear of or experience severe side effects from contraceptives, it is therefore plausible that knowledge about positive health outcomes associated with contraceptive use will not make a difference for their contraceptive behaviour (UNFPA, 2022:73). In the words of a clinical officer:
They believe that when you use family planning it will affect your health, which is true sometimes because, you know, we have the side effects of family planning. So, they also believe that when you use the family planning, you're going to be infertile and you're going to get ill every now and then, you're going to complain about the backache and everything (Clinical officer, 9/12/22).

The clinical officer’s observation displays how difficult it can be to distinguish between real experiences and the myths that lead to misinformation. It is clear, however, that actual side effects are frequently experienced by the women who utilise family planning services.

Experienced side effects from Depo-Provera are mentioned by both healthcare workers and contraceptive users. Women in focus group discussions list headaches, backaches, mood swings, heavier and more frequent menstrual bleedings, disturbed menstrual flow, abdominal pain, weight loss and weight gain as the most common side effects from contraceptive use. One woman explains that:

“It was so bad. It was terrible because you can actually have your menses like the whole month. And then the next month, that just goes on, and on and on and on and on. And then I stopped. And for like six months, I wasn't using Depo, I wasn't using any family planning, but I never got pregnant.” (Anonymous woman)

The above statement is far from an exception. Although Depo-Provera is meant to be a three-month commodity, many women experience the injection to last much longer and sometimes with severe additional side effects. However, women may not have much of a choice when it comes to selecting another contraceptive. The fact that the intrauterine device is seen as lasting too long, the implant requires a consenting husband because it can be felt, oral contraceptives are surrounded by myths or requires good time-management, condoms bear negative connotations as elaborated on in Case 5: Negative perceptions and stigma, other male contraceptives like sterilisation are not culturally accepted, and many partners still do not consent to family planning use are all drivers of Depo-Provera use. The current available range of contraceptive choices, then, do not seem to be suited to this population.
Coupled with the experienced side effects, this can help contextualise why uptake remains sub-optimal or why women do not turn up for additional family planning appointments.

**Case 5: Negative perceptions and stigma**

Joshua loves his job as a teacher near Mara Rianta. He lives near the town with his wife, Mary, and three children aged 10, 7 and 4. Growing up, Joshua was aware how his father and his father’s friends discussed the prestige associated with having multiple wives and as many children as possible. Joshua himself is content with having one wife and does not desire to have more than four children. Joshua was recently introduced to the concept of family planning. He knows that a lot of his peers are sceptical about the concept and contraceptive use in general. Most of the men in his community view condoms as transmitters of STIs and refer to condom use as “eating the sweet with the wrapper on”. In a week, local community health volunteers are heading a meeting about family planning where he has been encouraged to attend. However, while interested, Joshua is concerned about how he will be perceived by his peers if he attends.

**Barrier analysis**

*From restless women to marriage instability: community perceptions on family planning*

Acceptance of family planning and thus the higher chance of contraceptive utilisation is dependent on several determinants, as featured in Joshua’s case. Previous studies have shown that age, educational attainment for husband and wife, marital status, working status and place of residence are among the factors that influence contraceptive use for Kenyan women (Kamuyangu et al., 2020). Family planning projects operating in the country moreover recognise social norms such as stigma and perceptions of contraceptive use as a possible factor (Lahiri et al. 2023:3, UNFPA, 2022:81) although few studies have investigated how social norms affect contraceptive use nationally. Those that have, tend to emphasise social norms as an overlooked barrier (Lahiri et al. 2023:3).

Focus group discussions with community members from the Maasai Mara establish that social norms heavily influence the acceptance and consequently utilisation of contraceptives and family planning.
services for individuals and couples. These perceptions are shaped by the opinion of elders and men in particular. Maasai opinion leaders, men, women, and youth articulate various widely held negative perceptions and stigma that can act as a barrier to family planning uptake. According to all participants, community members who make use of family planning services are mostly perceived negatively by other members in that community.

Ideals about family values surface as one of the social norms’ themes in this context. Women are the subject of a lot of the stigma on this topic. All participants underline that individuals who use family planning services may be perceived negatively as “not wishing to have children”. Children bear significant cultural meaning to the Maasai as already explicated in Case 1: Socio-cultural beliefs and practices and individuals who are seen as not wanting children therefore risk becoming stigmatised. It was expressed by female focus group participants that women are potentially “viewed as restless” and as “forsaking their family duties”. Participating youth stated that couples who use family planning services can be an indication of “the woman having overpowered the man in a relationship” which is consistent with findings from other studies on male involvement in family planning decision-making in SSA (Vouking et al., 2014). As a result, men could be “undermined” by others in the community because it is embarrassing to be associated with a perceived female-dominated domain (ibid.). Negative perceptions pertaining to both sexes include how “one cannot take care of or support a family” and give off the impression that you are “neglecting responsibilities” if you use family planning.

The second theme surfacing from focus group discussions revolves around family planning use and its perceived effect on relationship instability and immorality. Studies find that Kenyan women who use contraceptives are more likely to be perceived as behaving promiscuously and have a decreased libido, which husbands use as an explanation for having extramarital affairs (Lahiri et al., 2023:3). In the Maasai Mara, opinion leaders imply that couples’ family planning use is regarded as a symptom of “an unstable marriage”, because someone can be believed to be “unfaithful” if they are using the services. Consequently, contraceptive users risk being viewed as immoral individuals. In this context, sex work is considered by some to be the only valid reason to use contraception. The youth specify that condoms as a family planning method are perceived to only be used by sex workers or “if a person has STIs”.

However, a clinical officer and multiple nurses revealed that the youth is the most common user of condoms. This is in stark contrast to married Maasai men: “I've never seen them coming for the services (...) for married men here, it's hard”, as a nurse remarks. According to the healthcare workers, the youth’s
uptake of condoms is due to an increased knowledge about STIs: “Even if they had Depo, they would still go to condoms for HIV and STI protection” (Nurse, 16/11/22). Healthcare workers explain that they “normally put a box with condoms outside the facility, but in the morning it's empty” (Nurse, 15/11/22) to make contraceptives more accessible to the youth. The fact that the containers are quickly emptied whenever the facilities are closed indicates that there is a willingness for youth to use condoms even though no participants admitted to condom use. Nonetheless, they find themselves needing to access the contraceptives in secret, as youth acquiring services is still somewhat viewed as “socially unacceptable” by other members of society according to healthcare workers. As per the status quo, family planning remains heavily tabooed in the Maasai Mara.

**Ambiguous improvement**

The opinion leaders and the youth from focus group discussions also bring up positive perceptions about family planning services and contraception. They explain that negative perceptions were dominant earlier, whereas the concept is more widely accepted nowadays. The change is due to a better understanding of the benefits of family planning. They acknowledge the “mother’s improved health” by having a break between pregnancies as one of the positive connotations about family planning. According to the youth, families who use family planning methods are “breaking taboos” and “bringing positive change to their communities”. Opinion leaders mention that other people accept one's choice to “live a satisfying and fulfilling life without many children, if any”, as one of these changes.

However, when this narrative is explored in interviews, responses are ambiguous at times. Such was the case in an interview with a clinical officer:

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I: So, you feel like the reception [of family planning services] has been positive?
CO: Yes, yes.
I: From men and women?
CO: Yes. Listen, as long as you go sit them down and speak logic. They are able... they can accept, it's easier to convince them.
(…)
I: So, she'll still be blamed [for using contraceptives]? And she's the one to get beaten up?
CO: Yeah.
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The excerpt above illustrates how it can be difficult to gauge actual perceptions about family planning in the Maasai Mara. In certain interview settings and focus group discussions, interest in growing acceptance of family planning seemed genuine. In other instances, I got an inkling that I was being told what they thought I wanted to hear, such as when men expressed an openness to escorting their partner to get family planning services in their focus group discussions. This is currently “very rare” in the words of local nurses (14/11/22).

Additional research is needed to be able to pinpoint the reasons for these discrepancies, as they are not within the scope of this report. Ultimately, there are examples of positive perceptions of individuals who use family planning methods, although these are still outweighed by negative perceptions and stigma.

It is challenging to ascertain which community members have the most negative perceptions about family planning services. Seeing as how men are decision-makers in Maasai communities and that a vast majority of women are keeping their contraceptive use secret from partners, men are important to factor in when it comes to acceptance of contraceptive use:

“...I feel like in this part of the world men are the decision makers. And probably if we leave them behind, then we won't be achieving a lot, especially with family planning (TMT staff, 15/11/22).”

In this respect, “male involvement” was suggested by a medical advisor and the TMT staff member in the quote above to address negative perceptions. This opinion is supported by other TMT staff who agree that “it’s all about educating and informing these men” (TMT staff, 32) in order to achieve palpable change. Focus group discussions with men demonstrated that they were aware of the benefits of family planning, but they still prefer to “hold on to the traditional way”. Serious efforts are then needed to alter this barrier.
Prospects for family planning uptake in the Maasai Mara

The purpose of this chapter is to provide recommendations for how TMT can engage further with family planning services in the Maasai Mara to increase uptake. To do so, I start by providing a broad overview of the status of TMT’s family planning project, where I find that out of the five barriers lack of knowledge and inaccessibility of services to have made the most progress and socio-cultural beliefs and practices, myths, misinformation and experienced side effects and negative perceptions and stigma to have made the least progress. Under a section for each barrier, I then proceed to present my recommendations.

Progress on family planning efforts in the Maasai Mara

The best thing that The Maa Trust is doing is they're not bringing people from outside to come and do the services, it is us in the community that are able to do the services (Clinical officer, 9/12/22).

Kenya was one of the first SSA countries to launch a nationwide family planning programme in the 1960’s (Fotso et al., 2013). However, to this day, large disparities between counties mask Kenya’s overall progression of modern contraceptive uptake (Appleford & Mbuthia, 2020). As shown in Case 1 barrier: socio-economic beliefs and traditions, this disparity in uptake can also exist within counties, especially between urban and rural populations.

Family planning projects are a relatively new phenomenon in the Maasai Mara. When TMT began working with the topic in 2020, family planning knowledge and practices were rare. In focus group discussions, Maasai opinion leaders shared that historically, Maasai communities have had “negative opinions towards family planning methods or services”. The concept was frowned upon because it was difficult to conflate with cultural ideals.

Now, approximately three years into family planning targeted activities, there is a statistical increase in uptake. An impact assessment in 2022 and household surveys in 2023 undertaken by TMT and me reveals improvements on two areas, namely community awareness and accessibility of services (Kvist
& Axelsen, 2022). This indicates that TMT has made headway on two of the five identified barriers, this being 1) lack of knowledge and 2) inaccessibility of services.

Family planning knowledge for Maasai communities in the Maasai Mara has increased substantially since TMT and other NGOs began sexual and reproductive health activities. This success is in large part owed to the use of community health mobilisers, peer mentors, and radio spots. Advancements in awareness of family planning methods are particularly evident for Maasai men. The impact assessment and household survey from 2022 and 2023 reveals that before men were typically not able to identify more than one type of contraceptive, they could now name three of the most utilised family planning methods, Depo-Provera, implants, and condoms. In the impact assessment’s responses, however, men were not in agreement on the number of years that implants are effective with some saying “four” and others “six”. Thus, there is still progress to be made.

The impact assessment reveals that TMT has effectively introduced medical camps and backpack nurses to the Maasai communities to increase accessibility. These medical interventions prove to be practical solutions to counter inaccessibility barriers and are embraced by the affected communities. Crucial in this respect are the fact that community health mobilisers are Maasai from these communities, which fosters trust. Medical camps and backpack nurses address issues of cost, geographic distance and transportation that are listed in focus group discussions as barriers to access. Another step towards decreasing general inaccessibility to sexual and reproductive health services was taken in March 2023, where Talek town inaugurated its first maternity ward due to funding secured by TMT.

These advancements should not be overlooked but considerable barriers to uptake persist. The remaining three barriers, 3) socio-cultural beliefs and practices, 4) myths, misinformation, and experienced side effects and 5) negative perceptions and stigma, all share the common characteristics that they touch upon people’s ideas and feelings about family planning. To overcome the barriers, TMT needs to recognise that they play a significant role in shaping individuals’ family planning beliefs, behaviours, and attitudes.

Based on the evidence presented in this report the ensuing section provides concrete recommendations to all barriers in the order they were presented as cases. The recommendations are tailored to TMT but other NGOs, policy makers or sexual and reproductive healthcare workers in this field are implored to draw inspiration from the suggestions. Some recommendations concern technical
adjustments or additions whereas others pertain to participatory and long-term social change which encapsulates, respectively, both top-down and bottom-up approaches to developing TMT’s family planning project.

**Recommendations**

This section presents my recommendations to TMT with regards to addressing the five barriers. I have composed two recommendations for each barrier, totalling in the following ten recommendations:

1. Continue projects that encourage open and inclusive dialogue with community members in relation to family planning services while maintaining sensitivity to social and cultural norms and values.
2. Promote platforms and opportunities for women's forums, workshops, and knowledge-sharing sessions that specifically address the unique needs and experiences of women and girls.
3. Adjust the contents of peer mentor activities in adolescent sexual and reproductive health sessions.
4. Provide parents with the tools and guidance to engage in open, respectful, and effective conversations about sexual and reproductive health with their children.
5. Explore the option of implementing motorcycle ambulances to advance general sexual and reproductive health inaccessibility.
6. Lower the financial burden of out-of-pocket spending on long-term contraception.
7. Equip community health mobilisers and/or nurses with the necessary training and skills to lead sessions on the potential side effects of different family planning methods.
8. Advocate for an expansion of contraceptive options.
9. Enhance community sensitisation on family planning services, focusing on religious leaders and men.
10. Introduce educational platforms specifically tailored to men, such as ‘husband schools’.
Recommendations to socio-cultural beliefs and practices

Recommendation (1): **Advance family planning services.** Continue projects that encourage open and inclusive dialogue with community members in relation to family planning services while maintaining sensitivity to social and cultural norms and values.

TMT should sustain projects that address sexual and reproductive health in the Maasai Mara. The current low contraceptive prevalence rates in the Maasai Mara are not an indication of a lack of demand for family planning services. Conversely, the proportionally high rate of secretive contraceptive use reflects that women in particular demand services. Indeed, it is other factors such as socio-cultural beliefs and practices, for one, that constrains a woman's contraceptive behaviour and method choice. Shifting the attitude and mentality towards family planning has the potential to be the most impactful change for increasing uptake in this area. In trying to accomplish this, open and inclusive dialogue between TMT and community members are recommended to foster a collaborative approach, where a balance can be struck between paying heed to the Maasai’s socio-cultural beliefs and practices while showcasing how the benefits derived from family planning can advance the wellbeing of future generations.

Recommendation (2): **Underpin Maasai women's communication and communities.** Promote platforms and opportunities for women's forums, workshops, and knowledge-sharing sessions that specifically address the unique needs and experiences of women and girls.

To enable women and girls in the Maasai Mara to make decisions about their sexual and reproductive health it is vital that TMT maintain activities that target empowerment for women of all backgrounds. Women’s forums, workshops, and knowledge-sharing sessions provide opportunities that help work against traditional gender roles and gender inequity in the Maasai Mara. After TMT has implemented projects that amplify women’s empowerment, women have started attending community meetings in growing numbers. Forums and workshops could last a few hours or potentially consist of two-day workshops, such as the one that was piloted in October 2022 for women on empowerment and leadership (see Excerpt from a Women in Leadership workshop activity). This workshop showed promising results and granted women a safe space to exchange thoughts and experiences with one another. It is recommended that workshops of the like are repeated.
Recommendations to lack of knowledge

Recommendation (3): **Improve peer mentoring.** Adjust the contents of peer mentor activities in adolescent sexual and reproductive health sessions

It is suggested that peer mentor activities are shortened and adjusted to concentrate on actual aspects of sexual and reproductive health. Considering that only around half of the original number of peer mentors are still active, TMT could also give thought to either paying peer mentors or covering the cost of educational opportunities for them to incentivise their efforts, both of which they have expressed interest in. While peer mentors are a great addition to TMT’s family planning project, the current design of adolescent sexual and reproductive health sessions are sub-optimal because they involve too many activities and not all activities seem to have a clear purpose. The guiding idea of learning about the different components of adolescent sexual and reproductive health through playful activities is good. However, the actual message behind each activity at times seems to be unclear or lost. For example, in one activity, youth and adolescents were tasked with making sense of how dropping an egg versus a plastic ball were related to having many responsibilities and knowing which ones were of importance, youth were unable to explain what the message behind this and other activities were, and it was ultimately up to the peer mentors to explain. Small tweaks in the contents and perhaps shorter activities can help improve the quality and learning outcomes for the youth.

Recommendation (4): **Include and empower parents.** Provide parents with the tools and guidance to engage in open, respectful, and effective conversations about sexual and reproductive health with their children

Seeing as future reproductive prospects pertain to the youth living at home, involving parents should be considered an important next point of action to increase awareness. Maasai youth’s lack of comprehensive sex education both at school and at home is one of the reasons for their little awareness about contraception and family planning. While older Maasai may have become more aware of family planning, the same cannot be said for the youth. Because youth are sexually active before marriage, there is a need for TMT to continuously address this barrier. Although lack of knowledge is no longer the most significant reason for low contraceptive prevalence rates, it is consistently associated with high
levels of unintended adolescent pregnancies which as previously discussed is a major issue in the Maasai Mara. In Ethiopia, holistic projects that connect population, health and environment have been successful in breaking communication barriers in families by involving children and their parents. This proved to drastically increase the support for family planning services and contraceptive use by over 300% (Miller, 2015). TMT should draw inspiration from these projects and offer parents with children aged 8-19 forums and workshops on how to address topics on sexuality, reproduction, sexual health, STIs and protection. It is suggested that smaller things such as menstrual hygiene are introduced first before moving onto reproduction. Due to the social and cultural setting, encouraging adequate communication between mothers and daughters should be prioritised. This will make parents more comfortable and confident with breaking communication barriers at home.

**Recommendations to inaccessibility of services**

**Recommendation (5):**
**Expand mobile solutions.** Explore the option of implementing motorcycle ambulances to advance general sexual and reproductive health inaccessibility.

In other regions of Kenya, like Turkana, motorcycle ambulances have been implemented to access women in remote locations in need of critical health care (UNFPA, 2023). Where backpack nurses mostly provide contraceptives in the privacy of the homestead, motorcycle ambulances can access women who require urgent assistance. Motorcycle ambulances are furthermore able to access women in their homesteads instead of having to rely on women coming to them. Motorcycles are driven by community health mobilisers who also spread awareness about the service by going door-to-door and providing people with the number to call in case of obstetric emergencies (ibid.). The motorcycles are equipped with a stretcher and can transport the community health mobiliser, a patient, and supplies for on-site treatment. Motorcycle ambulances are well suited to the poor infrastructure and terrain of the Maasai Mara and could be a great addition to the already broad range of services that seek to counter inaccessibility barriers of communities that are hard to reach.
**Recommendation (6):**

**Make good choices affordable.** Lower the financial burden of out-of-pocket spending on long-term contraception

To incentivise uptake of long-term family planning methods, it is recommended that TMT advocate for policy makers to decrease the price for contraceptives that last longer than a year to reduce financial constraints. While commodities at medical camps are free, that is not the case for healthcare facilities where the prices of long-term contraception can be a financial burden for some. Since some people prefer to receive family planning services at healthcare facilities, there is a need to make long-term contraception affordable at these facilities. TMT should advocate for healthcare stakeholders to make financing mechanisms such as subsidies, discreet instalment payments or the like available for long-term contraception.

**Recommendations to myths, misinformation, and experienced side effects**

**Recommendation (7):**

**Invest in local health staff.** Equip community health mobilisers and/or nurses with the necessary training and skills to lead sessions on the potential side effects of different family planning methods.

As a recommendation derived from the feedback provided by women during focus group discussions, it is crucial to inform them about the management of potential side effects associated with contraceptive use. Specifically, addressing concerns related to prolonged pains is of paramount importance. To fulfil this recommendation, a structured session format is proposed. The session could be divided into two parts, where the first segment covers the identification and clarification of common myths and misinformation surrounding side effects. Facilitators should actively work to debunk these misconceptions. In the second part, the focus would shift towards providing comprehensive information about actual side effects, both common and less common, along with strategies for managing them. Special emphasis should be placed on addressing side effects that persist over extended periods.
**Recommendation (8):**

**Push for “better” contraception. Advocate for an expansion of contraceptive options.**

The current array of contraceptive services offered in Narok County coupled with current attitudes and practices of family planning appears to heavily favour Depo-Provera, which has been associated with a higher incidence of side effects. Looking into the possibility of procuring other contraceptives therefore becomes imperative. Considering this, it is recommended that TMT collaborates with national and international health ministries and other relevant stakeholders to initiate discussions on the feasibility of introducing better contraceptive options to the Maasai communities. By diversifying contraceptive choices and increasing the uptake of contraception that has less side effects than Depo-Provera it is possible to both improve the wellbeing of Maasai women and dispel myths and misinformation about family planning.

**Recommendations to negative perceptions and stigma**

**Recommendation (9):**

**Enhance community sensitisation. Focus on the role of religious leaders and men in family planning.**

There is a pressing demand to mobilise communities, with a particular focus on engaging men and religious leaders, to enhance their awareness and active involvement in family planning initiatives. To address this need, it is recommended that TMT intensify efforts to establish robust policy dialogues with political and religious leaders, leveraging existing relationships with religious figures. By fostering these connections, TMT can begin to overcome the stigma surrounding family planning and create an environment where community members readily accept and support it. Notably, insights from focus group discussions highlight the effectiveness of emphasising the economic benefits of family planning when targeting male engagement. Therefore, TMT should strategically underscore the financial advantages associated with family planning practices to resonate with men and encourage their active participation.
Recommendation (10):

**Empower and involve men.** Introduce educational platforms specifically tailored to men, such as ‘husband schools’.

TMT has identified the need for male involvement in family planning and other sexual and reproductive health matters. A concrete recommendation to demystify family planning and specifically encourage male involvement is therefore to look to rural Niger where ‘husband schools’ have been introduced (UNFPA, 2014). The schools are supervised by healthcare workers and are voluntary for men to join. Among other factors, the schools focus on sexual and reproductive health concerns, where men gather to discuss possible solutions to problems. Communities that have implemented ‘husband schools’ have experienced a pronounced difference in family planning opinions and behaviour. In Niger, ‘husband schools’ have an age requirement of at least 25 and a husband’s wife/wives must use a family planning service. It is also a requirement that husbands who attend are accepting of women’s participation in community life. I propose an initial age requirement of 25 to be reduced to 18 gradually. Men who attend the schools should be open for women’s participation and empowerment in society, although family planning use should not be a necessity to be able to participate. If attendees have an open mind and are willing to discuss issues, TMT can utilise a platform of the like to encourage male involvement.
Bibliography


https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception.