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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Reading guide

This master's thesis is a product thesis. It is the result of a thesis collaboration with the Maasai Mara based NGO, The Maa Trust. It consists of two parts: a product and a written assignment. The product is presented in the form of an analytical report that examines 'family planning' as a concept in international development and as a set of practices among an NGO, healthcare workers and inhabitants in the Maasai Mara in rural Kenya. The report is centred around five cases that I have constructed. Each case highlights a set of barriers to uptake of family planning services followed by an analysis of the barrier in question. In the last part of the report, I present my recommendations to The Maa Trust with the intention of decreasing barriers to increase uptake of family planning services.

The second part of my thesis summarises with reference to the study regulations: "the aim of the product, including the target group and intended application, as well as present relevant theoretical and methodological issues and considerations and perspectives" (Board of Studies, Department of Culture and Society, 2019). This part of the thesis presupposes that the reader has read the report. Therefore, it does not introduce the reader to family planning which has already been thoroughly discussed. Instead, the emphasis is on relevant methodological and theoretical issues, considerations, and perspectives in relation to my fieldwork and final product. To achieve this, I have divided the written assignment into three chapters, 1) a methodological chapter connected to the inclusions and exclusions of my data collection process 2) a reflective chapter concerning the product, and 3) a theoretical chapter that presents central theoretical debates arising from my product.

Table of contents

Part I: Analytical report

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 Maasai Mara: high birth rates, low contraceptive uptake and a potential for family planning

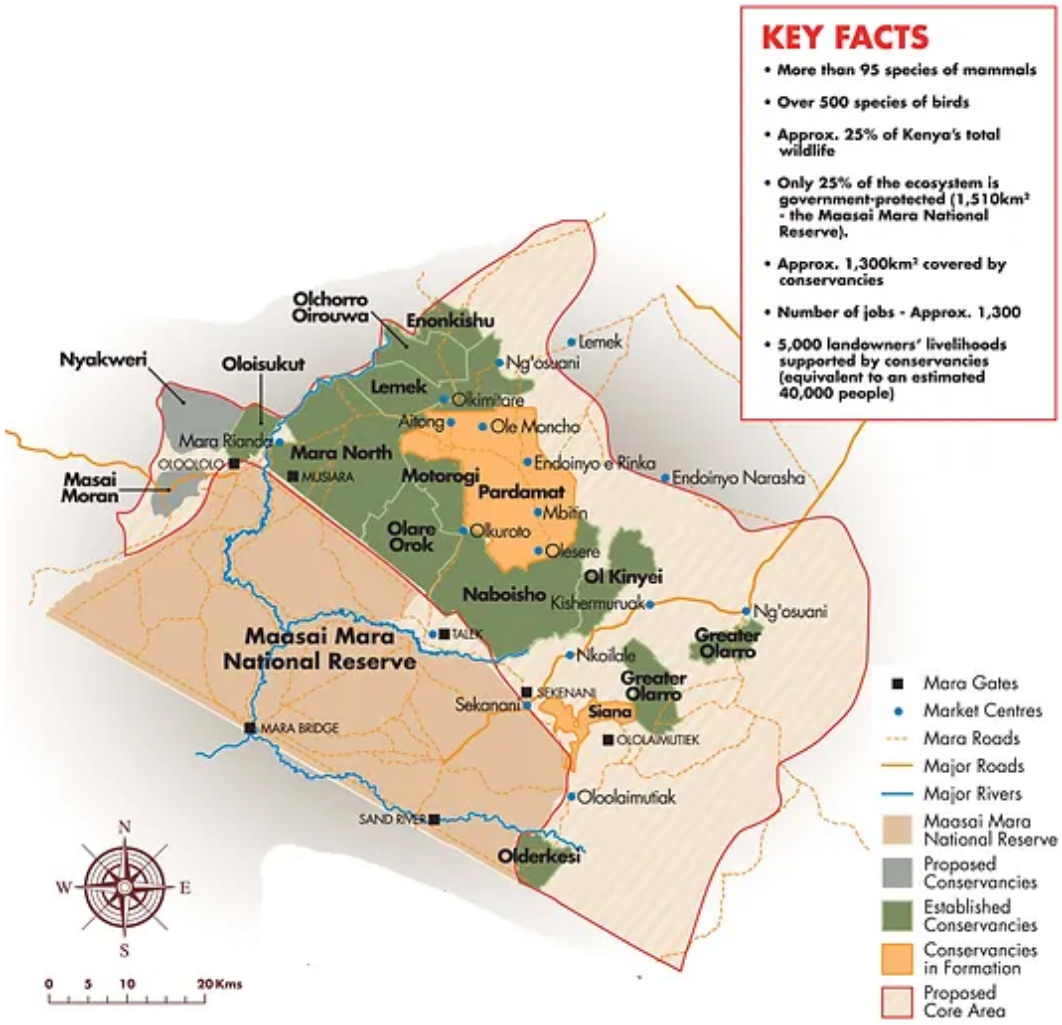

Figure 1. Map of the Maasai Mara. © The Maa Trust.

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.

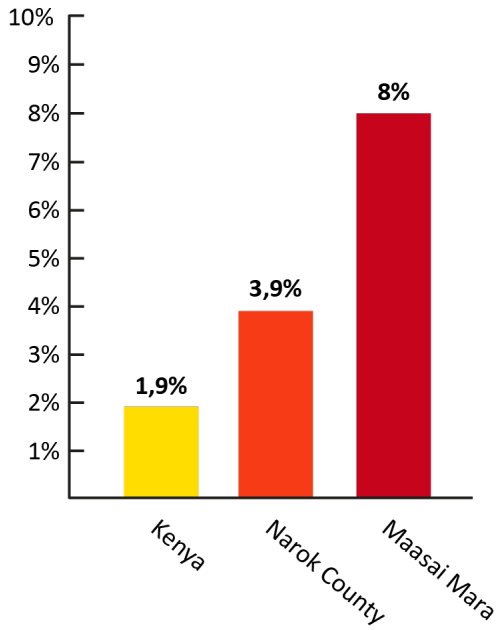

Figure 2. From left to right: Annual natural population growth in Kenya, Narok County and the Maasai Mara.

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

Naserian, 22
Michael, 29

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, 17

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).

Figure 3. Adolescent pregnancies account for 40% of cases in Narok County.

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, 33

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).

Figure 4. The price of family planning services fluctuates and can reach 1.500 Kenyan schillings (83 kr./$12).

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, 20

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:

> 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)

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, 32

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:

> *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.*

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.

Part II: Written assignment

Introduction

In this second part of my thesis, I will comment upon key methodological issues and explore central theoretical debates which relate to family planning as presented in "Part I: Analytical report".

In the first chapter I will explicate the methodological process of the fieldwork I conducted for four months in the Maasai Mara. I do this by justifying the inclusions and exclusions of the elements that make up the report. I introduce the methodology that guided my fieldwork, including reflections on methodological and ethical issues.

In the second chapter I reflect on and discuss how I processed my data to the five case studies in the report, and how this correlates with the aim of the product, its target group, and intended application. Key to this section is the translation of the main empirical findings to the report as well as the reflections and choices that arose in the creation of the report as an analytical product.

In the third and final chapter I apply two theoretical approaches - top-down and bottom-up - to 'family planning' as a concept in international development. By debating these perspectives, I can regard my research and findings from multiple dimensions and levels. Thus, I assess how the interaction between the strengths and weaknesses of both development approaches can complement one another in relation to family planning barriers.

In closing, I summarise the main findings from "Part I: Analytical report" and "Part II: Written assignment". In this context, the report's ten recommendations in addition to the methodological and theoretical issues, considerations and perspectives from my fieldwork may contribute to an increase in uptake of family planning services in future family planning projects in the Maasai Mara.

The ethical considerations and conduct I came upon as a researcher are made explicit throughout the written assignment. As such, this written assignment does not entail a distinct section on ethics.

1. Methodology

My product reflects the outcome of an ethnographic fieldwork. As a natural part of this production of knowledge, I have had to make decisions, evaluate my choices, and often revise them as the fieldwork progressed and took new turns (Carter & Little, 2007:3). The methodology for this fieldwork should therefore be understood as the careful considerations of the potential and possibilities that different theoretical and methodological resources could inflict on my research (Jespersen et al., 2017:158). In the following section I present these considerations. In this process, I reflect on the implications of these choices, i.e., the inclusions and exclusions and thereby possible limitations of my methodological framework.

Research setting

The data collection process was conducted over a period of four months from August to December 2022 in the Maasai Mara in Kenya. The area is named after its Maasai inhabitants and "Mara" which means "spotted" in Maa language due to the trees that dot the landscape (TMT, 2023a). Both ends of life's extremes co-exist in the Maasai Mara. At one end of the spectrum, the vast landscapes and open plains are a paradise for wealthy tourists willing to pay good money for a chance to spot The Big Five (elephant, rhinoceros, lion, leopard, and buffalo) on safaris. Intensive and unequal socio-economic development has made it possible for visitors to live in excess, where they have access to all the facilities and amenities they are used to in the Global North (Maasai Mara Wildlife Conservancies Association, 2023). At the other end of the spectrum, most Maasai's in this area are juggling the rising cost of living in addition to the growing resource scarcity, which is partly derived from a rapid population growth (TMT, 2016:9). Local actors, such as TMT in my case, are working with relevant stakeholders to address development disparities and strengthen Maasai communities' well-being and livelihoods.

The Maa Trust: the institutional affiliation

I carried out my fieldwork in close collaboration with TMT, an independent non-profit NGO working with the Maasai. Since 2006, TMT has been a permanent presence in the Maasai Mara, where the NGO works with sustainable human development and conservation grounded in their Maa slogan:

"Emaendaleo Tenkaraki Ing'uesi" ("Development because of wildlife") (TMT, 2023b). The organisation only operates in the Maasai Mara under the supervision of CEO Crystal Mogensen. Mogensen is not a native Kenyan but moved to the Maasai Mara from the UK and has learned Swahili and Maa. Her home is located two minutes away on foot from TMT headquarters. The NGO has programmes dedicated to Education & Skills, Sustainable Livelihoods and Water & Health (ibid.), and initiated its sexual and reproductive health project including family planning in 2020. TMT has quickly recognised the importance of this project and now lists it as a top three priority for the NGO in their strategic plan for 2022-2025 (TMT, 2022:8).

I became aware of TMT's work during my second semester at Human Security, Aarhus University, where I was doing research on development organisations in the Maasai Mara. I was looking into the possibility of doing the project placement for my master's degree in this area. At the time I was working as a student helper on a project with ties to Aarhus University's Maasai Mara Science and Development Initiative who regularly collaborate with master's students on their thesis. My former boss introduced me to a chairperson at Maasai Mara Science and Development Initiative who expressed an interest in my research's human-centred focus, as it deviated from their projects, which typically concern wildlife. She facilitated my formal approach to the NGO. After a Zoom meeting with representatives from TMT, we agreed that I could intern at the organisation while carrying out my fieldwork. Because TMT was already focusing on family planning and sexual and reproductive health matters, it was relatively simple to plan the fieldwork so that I could assist TMT with these activities while concurrently collecting my data. The NGO thus became my gatekeepers during the fieldwork by arbitrating the access to the field setting and research participants. Before commencing on my fieldwork, I attended a meeting with the CEO and CPO of TMT where we discussed my project, including the type of research that would benefit the NGO the most. By involving my gatekeepers from the beginning, we collectively paved the way for an open dialogue between us where reflections, objections, and ideas were welcomed.

In August 2022 I was granted a research permit licence to conduct my research in the Greater Maasai Mara Ecosystem by the National Commission for Science, Technology & Innovation in Kenya. To ensure that the appropriate authorities were aware of my research intentions apart from TMT, I had applied for the permit in collaboration with The Maasai Mara Science and Development Initiative prior to my departure. The licence allowed me to conduct research in several Kenyan counties, including Narok, on the topic "Conserving the Maasai Mara Ecosystem, its rich wildlife and culture through

interdisciplinary Research and Development Initiatives" until August 2023. After securing the licence I proceeded to carry out the fieldwork.

Human security relevance

Though not explicitly stated by TMT, the organisation's approach to development is intimately linked with the concept of human security. Human security was officially introduced as a new development paradigm by the United Nations Development Programme (1994). The report *Human Development Report 1994: New Dimensions of Human Security* advocated for development that "puts people at the centre of development, regards economic growth as a means and not an end, protects the life opportunities of future generations as well as the present generations and respects the natural systems on which all life depends" (ibid.:4). NGOs that have a human security-centred development approach therefore recognise that human insecurities are interconnected and that social, cultural, and environmental dimensions must be addressed in addition to economic needs.

In my four months of working alongside TMT, I gained practical experience with its everyday operations, and it is my assessment that TMT's development ideology centres around notions of human security. The organisation seeks to minimise insecurities facing individuals and communities and foster prosperous livelihoods. It does so by implementing activities and projects that address several of the human security dimensions (ibid.:24-25) such as health insecurity through its Integrated Community Healthcare Project, economic insecurity through e.g., Maa Beadwork, environmental insecurity through its work with conservancies, community insecurity through the project Eco Iko and women workshops, and political insecurity through its Youth and Women's Empowerment project (TMT, 2023c). Due to the scope of my research, I primarily saw how the organisation addressed health insecurities, although I observed how it affected other dimensions given the projects' interconnectedness. Accordingly, TMT's development agenda and projects complemented my research and fieldwork as a Human Security student.

Doing ethnography: Focus groups, expert interviews, and questionnaires

As an object of qualitative research, I found family planning in the Maasai Mara to be intricate, heterogenous, and multifaceted in character (Jespersen et al., 2017:159). It would be difficult to capture its complexity with a single research method, which is why I chose to utilise several methods and thereby obtain richer empirical data (ibid.). Because I was interested in attitudes, perceptions and practices of family planning, the fieldwork therefore comprised mostly qualitative components but also included quantitative elements. I applied an ethnographic methodology to guide the data collection process by participating in focus groups and planning and carrying out expert interviews and a questionnaire. "Doing ethnography" (Geertz, 1993:5) is particularly suited for my fieldwork, as the methodology allows the researcher to immerse herself in a social setting for an extended period to observe and make sense of the residing dynamics, realities, power structures etc. at play (Bryman, 2012:432). I lived in the Maasai Mara for four months approximately one minute away from TMT headquarters in a guesthouse meant for TMT's donors, researchers, and visitors. I spent my time either participating in activities led by TMT or interacting with staff and visitors at the guesthouse.

It was not feasible for me to conduct a full-scale ethnography because the fieldwork was limited by time-constraints to fit the writing of the present master's thesis. For this reason, I chose to carry out a micro-ethnography (Wolcott, 1990:64), where I focused on selected themes and aspects of Maasai everyday life, which was attitudes, perceptions, and practices of family planning. Consequently, the choice to pursue this perspective came at the expense of other possible perspectives (Hastrup, 2003:399). In this way I do not attempt to portray an entire cultural structure in the product but rather accentuate "particular behaviours in particular settings" (Wolcott, 1990:64).

Culture clashes: Influencing the field and getting lost in translation

Before I elaborate on the research methods I utilised during my fieldwork, I find it necessary to expound on some of the necessary steps I had to take to collect this data.

Key to this section is how I concurrently influenced and was influenced by the field. As a white, female, Danish student I was subjected to a certain treatment in and comprehension of the field. Indeed, in fieldwork settings it was impossible to blend in the background due to the colour of my skin. I was

often approached by community members who initially mistook me for a donor or a tourist. When the Maasai became aware that I was associated with TMT and was interested in their opinions, their demeanour towards me changed. I experienced that they were open to share their thoughts with me. Standing out has consequently meant that all participants that I have used in my research were aware of the purpose of my presence.

I did not speak the local language Maa and the little Swahili I had practised was insufficient in this area. I was informed that a large part of the inhabitants only spoke Maa. It was therefore necessary to use a translator in cases where I could not communicate with research participants in English. Ben, a local Maasai elder, was fluent in English and acted as a translator in focus groups discussions where all participants were Maasai. As described later, his socio-economic status was in and of itself also a cause of bias. I also required a translator to explain my questionnaire to participants who were all Maasai women. In this connection I selected the healthcare workers who carried out the questionnaire. As expert interviews were conducted with people who were proficient in English, I carried these out without assistance.

I am fully aware that while I could immerse myself in the field, I am unable to fully grasp and embody the lived experiences of the people that I encountered as a part of my fieldwork. However, I have carefully and thoughtfully selected who and what I have included in my data collection which is reflected in the product. Each section in the remainder of this chapter explains these methodological choices and reflections.

Focus group discussions

In September 2022 I participated in focus group discussions about family planning facilitated by TMT in two villages. The activity was already planned by TMT upon my arrival. TMT tends to facilitate multiple activities a day and I was later provided with data from focus group discussions in three other villages. Because the objective of discussions was to gain insight into different perspectives on family planning, the groups included a diverse segment of the Maasai population in the Maasai Mara, comprising 25 opinion leaders, 42 men, 26 women and 23 youth. Focus group discussions are a valuable method to understand a concept such as family planning because the method enables groups to interact and construct joint meanings of specific norms and phenomena (Bryman, 2012:501). To decrease the

risk of social desirability bias, the opinion leaders, men, women, and youth were not mixed, and data collection was conducted on different days.

Discussions were headed by a moderator and conducted in smaller groups of six to eight participants. I assisted a TMT staff member who was the moderator for one of the youth focus groups and was the moderator for a discussion with opinion leaders, with the help of Ben. All participants were presented with the same semi-structured questionnaire consisting of eight questions prepared in advance. The questions were written in English. In youth discussions the questions were also read aloud in English, whereas discussions with opinion leaders were primarily conducted in Maa language to ensure nothing got lost in translation.

In the youth focus group discussion, I found that my presence influenced interactions. Some of the older youths were more interested in asking me about my opinions than answering the questions from the appointed moderator. The same persons were inclined to dominate the discussion, where youths in their twenties tended to talk over participants in their teens. I was therefore aware of continuously assessing how the interactions affected all members' participation. To avoid disproportionate contributions as much as possible, I had to actively address teenagers individually to make sure that their voices were equally heard.

In discussions with opinion leaders, I would present the question to Ben who would share it with the group. However, he would often want to read the question himself and would ask for the document. I noticed how this confused participants about who was in charge, and I therefore asked Ben to explain our individual roles to participants. Most of my participants were female, who, despite being opinion leaders, still acted inferior to Ben due to his elevated status in society as a man and an elder and myself as a white researcher. I found this hierarchical imbalance to affect interactions, where participants expressed opinions that were more socially acceptable to fit in the group, rather than what they thought. I attempted to mitigate this by asking them if they had any questions for me. I wanted to create an informal setting. Once participants were more comfortable, they became more open with their responses.

After completing all focus group discussions, I compared the responses. Collectively, the results from each segment were uniform and thus revealed the ways in which the Maasai of the Maasai Mara understood family planning and their attitudes toward the concept. In March 2023 I was granted access to an additional two focus group discussions which confirmed that the family planning and contraceptive

opinions, attitudes, perceptions, and practices remained the same for the people in these villages as for the ones I visited.

Focus group discussions opened for various perspectives on family planning in the eyes of ordinary Maasai people. *Case 5: Negative perceptions and stigma* is based on the data from focus group discussions because I was able to gain a broad overview of current understandings of and opinions on the topic. However, the method was not suited to provide in-depth insights. Because I also wanted to gather concrete experiences with family planning and contraceptives in the Maasai Mara to analyse more extensively, I chose to conduct interviews.

Semi-structured interviews

In November 2022 I carried out 13 interviews and completed an additional interview in January 2023, totalling 14 interviews. Unlike much quantitative research where research participants are randomly selected to represent a population, I strategically chose mine (Tjora, 2012:145). My research participants were nurses, community health mobilisers, the Chief Executive Officer (CEO) and the Chief Programme Officer (CPO) of TMT, a Youth Coordinator and a Project Officer on Gender working for TMT as well as the CEO of a UK charity who supports TMT. I selected my research participants based on who could impart knowledge on sexual and reproductive health, family planning services and contraceptive use in the Maasai Mara. In this process I ensured to include individuals that represented different perspectives who I, accordingly, sectioned into three categories:

1. Community health mobilisers and healthcare staff.
2. TMT staff.
3. The charity CHASE Africa.

Together, the data enabled me to comprehensively regard the topic.

I decided to conduct semi-structured interviews, which is arguably the most common interviewing technique applied in human and social sciences (Brinkmann, 2014:277). I deemed the method the most fitting to capture the perspectives of my research participants due to the flexibility embedded in the semi-structured format (ibid.:285). For each category I prepared an interview guide. The guides accommodated

for minor changes depending on the job title of the interviewee to best capture their expertise. The questions I posed were open-ended, which created leeway for the interviewee's replies and enabled me to ask follow-up questions. Thus, the interviewees were actively involved in the creation of knowledge and brought new perspectives to light that I picked up on and could explore.

Community health mobilisers and healthcare staff: understanding the barriers to family planning

To gain insight into the experiences of the staff who worked daily with providing and counselling on family planning and contraceptive use in the Maasai Mara, I spoke to nurses, community health mobilisers, and a clinical officer. I was able to get in contact with interviewees through medical camps. I attended five medical camps in five Maasai communities. At every camp I selected a few people who I estimated were the most proficient in English to lose the least amount of information in translation. I approached them when they were patients around and asked if they would be willing to participate in my study. Every person was interested, and I got the sense that some were even flattered that I wanted their statements. Upon this realisation followed the risk that interviewees would try to answer my questions "correctly" instead of truthfully (Tjora, 2012:118), such as in this excerpt from an interview with a clinical officer:

> I don't know how we're going to answer that. But let me just try. (...) Yes… Have I answered that right? (Clinical officer, 9/12/22).

I accounted for this possibility in every interview where the skewed power dynamic between myself and my informant became tangible. I reassured the informant before every interview that there were no right or wrong answers and that they were welcome to object to any questions they did not want to answer. In two cases I went over the whole interview guide with interviewees to assure that they were comfortable with the questions before the interview took place.

As part of their working relation with TMT, mobilisers and healthcare staff administer contraceptives as well as provide information about family planning. In consequence, they have more face-to-face encounters with Maasai community members who are interested in family planning and/or contraceptives than any of my other research participants. I sought to obtain information on contraceptive trends in the

Maasai Mara and designed the interview guide for healthcare staff with this in mind. Because the community health mobilisers I encountered worked closely with healthcare staff I altered their guide slightly to focus more on their experiences as Maasai people who are working with and for their communities.

In the first few interviews with healthcare staff and community health mobilisers I quickly came to find that sexual and reproductive health themes in the Maasai Mara are delicate in nature. When I learned about contraceptive behaviour it was highlighted how family planning and contraceptive use is affected by secrecy and covert use. This finding proved to be intrinsically linked to socio-cultural practices and beliefs which I analysed in the corresponding barrier in the report. After learning about the secretive aspect, I opted not to interview Maasai women who used family planning services and/or contraceptives in my study. I was aware that every decision I made could result in a possible ripple effect if word travelled which could lead to unintended outcomes. I experienced first-hand how my affiliation with TMT had become known not just in the Maasai Mara but elsewhere in Kenya, when I was approached by a Kenyan man at a bar in Nairobi who asked whether "I was the Danish woman working with TMT?". Whenever I had access to potential female research participants, it was difficult to get them alone without drawing attention to us. Considering how women risk everything from vocal to physical backlash if a partner finds out about contraceptive use without their consent, I estimated the possible consequences faced by women to outweigh the benefits of their contributions if word was to spread. I therefore chose to rely on the homogeneity of interview responses from healthcare staff and community health mobilisers in addition to my own observations and countless informal conversations about the topic. Nonetheless, I still found it crucial to include the perspectives of women since barriers to uptake pertain to them in large part. In the section *Questionnaire: Women's voices and the lack of consent* I demonstrate why this method was the most appropriate to capture the family planning and contraceptive experiences of Maasai women. However, I acknowledge the possibility that valuable insight may have been lost by not conducting interviews with them.

Community health mobilisers and healthcare staff also spoke about various contraceptives and gave insights into why the Maasai community prefers certain services over others. They were moreover able to pinpoint how they work on the ground with medical camps to counter barriers to uptake of family planning services. While these interviews provided invaluable knowledge about the lived experiences of

individuals, I was also interested in how TMT approached barriers as an organisation. I therefore decided to conduct interviews with TMT staff to inform my research from this angle.

TMT staff: understanding the NGO's concerns

To complement the viewpoint of people who work in person with family planning services, I interviewed TMT's CEO, CPO, their Youth Coordinator, and their Project Officer on Gender. Their frame of reference permitted me to comprehend how the NGO planned and executed sexual and reproductive health and family planning activities with the development of the Maasai communities in mind. Throughout the fieldwork I had access to observe how their daily interactions, dynamics and responsibilities played out in an office setting compared to when we were in the field. For this reason, I was able to identify which TMT staff would benefit my research the most.

The interview guide for the CEO and CPO centred around challenges to implementing family planning initiatives in the Maasai Mara. In interviews, the two interviewees compared the past hindrances that TMT encountered when the NGO began its work on sexual and reproductive health and family planning to the obstacles they face now. Both maintained that lack of education and accessibility to services remained the primary barriers to uptake and thus the NGO's targeted areas. I learned that larger development structures are involved in the planning, implementation and evaluation of projects which can disable and enable how TMT can address these two issues. This resulted in the work behind *Case 2: Lack of knowledge* and *Case 3: Inaccessibility of services*. At the same time, they were important for how I chose to structure my report, which I explain in *Aim(s) of the product, target group and intended application*.

CHASE Africa: understanding the role of economy and international priorities

My interview with the CEO of CHASE Africa, a charity that sponsors TMT completes this interview section. The charity contributes to development projects in several African countries and is the main funder of TMT's Integrated Community Healthcare Project (TMT, 2023d). Family planning is one of three pillars that the charity focuses its efforts on (CHASE Africa, 2023) and I therefore deemed their input to be valuable. Prior to the interview I had reached out to the charity in the hopes of conducting an interview over the phone. I believed it heightened my chances of getting their perspective, since this interviewing technique is cost-efficient and did not demand means and time allocated to transportation.

When I had not received a response after two weeks, I started to abandon this angle. The reality of practising ethnographic fieldwork entails coming to terms with the fact that sometimes it is neither meticulous planning nor the strategic selection of research participants that reap the desired outcome (Bryman, 2012:435). On occasion, researchers must rely on pure luck and coincidence (ibid.), which is precisely what happened in the case of this informant. The CEO of CHASE Africa happened to be scheduled to observe activities for the Integrated Community Healthcare Project and consequently be accommodated at the same guesthouse as myself the following week. This enabled me to small talk with her and tell her about my research in person before approaching her as an informant.

Because I wanted to be attentive to why CHASE Africa chose to work with family planning, I formulated this interview guide with the role of the charity in relation to TMT in mind. Moreover, I was interested in whether their outlook on barriers deviated from TMT. I found that CHASE Africa was of the same view as TMT, meaning lack of knowledge and inaccessibility of services was of most concern. I attribute this to the great deal of trust and respect in the partnership between the organisations in the sense that CHASE Africa only provides funding to projects identified by TMT rather than the NGO being influenced by the charity to enforce their ideas. Crucially for my study, the CEO added "cultural practices" as a challenge to uptake, which led to a series of follow-up questions on my behalf that centred around the role of men in Maasai society. This exchange led to additional informal conversations about this topic afterwards with both the CEO and several TMT staff, community health mobilisers and healthcare staff. Every person I spoke to would highlight "culture", "beliefs" and "traditions" as barriers. Ultimately, this resulted in the formulation of *Case 1: Socio-cultural beliefs and practices*. The interview thus supplied me with a broader context in which to make sense of how development funding for sexual and reproductive health including family planning services were carried out by local level actors such as TMT.

The fact that CHASE Africa was the only supporting organisation that I reached is a limitation for my study. It proved difficult to establish contact with other partners who fund sexual and reproductive health and family planning initiatives, despite my affiliation with TMT. I am therefore unable to compare what other sponsors consider relevant in their work with TMT.

Questionnaires: Women's voices and the lack of consent

To ameliorate the absence of Maasai females who use family planning services from a qualitative standpoint, I chose to employ a survey as a quantitative approach. Since family planning commodities to a large degree only are utilised by women due to both the lack of male contraception and the importance of having children in Maasai culture, I needed their perspective on how family planning was practised. I was thereby able to gain an understanding of the reality of arguably the most important group to my research, which is explicated in the ensuing section.

When I attended medical camps to interview community health mobilisers and healthcare staff in November 2022, I simultaneously carried out a small survey for 10 female Maasai contraceptive users. The questionnaire was conducted by healthcare staff. If a Maasai female attended a medical camp to receive family planning services, a healthcare professional completed the questionnaire on the condition that the woman consented. I handed the questionnaire out at four of the five medical camps after a TMT staff who oversaw the medical camps approved my concept.

The questionnaire was formulated in a closed or "forced choice" format (Leung, 2001:187) where respondents could choose between options provided by me rather than formulate their own responses. Consequently, the questionnaires were easily administered and consisted of six questions. The questions covered her age, number of children, marriage status, if she had a co-wife, which type of contraceptive she utilised and if she attended the camp with the consent of her partner. Answers were written down by the healthcare staff.

Where interviews with women might have been prolonged, questionnaires could be headed by professionals as part of the consultation and thus cater to the need for discretion. Additionally, the format minimised discrimination against illiterate women who may not have been able to articulate or note their responses. While this meant that I was left out of the interaction and thus risked not being able to understand what happened in the exchange, the format made it simple for healthcare staff to relay any superfluous information to me that could not be encapsulated in the questionnaire. Moreover, since questions to some degree concerned women's health histories, I found it more appropriate to be handled by credible nurses.

The most important finding was that seven of the ten respondents attended the medical camp without a partner's consent. This led me to be curious about men's involvement in family planning processes and

informed a large part of *Case 1: socio-cultural beliefs and practices* as well as my recommendations to combat this barrier.

Maasai women tend to prefer receiving family planning services in facilities rather than at medical camps. I was told by healthcare staff that they attributed their preference to the minimised risk of family planning exposure due to the watchful eye and loud mouths of community members who attend medical camps. This is a plausible reason as to why I was able to collect no more than ten responses. While the number of responses was small, the uniformity in the answers nevertheless made me feel comfortable about using them as a relevant perspective to write about.

2. Data processing: from focus groups to case studies

Reflections on and in data collection: Consent and anonymity

While any research project necessitates reflective practice from the researcher, I thought a lot about how to best collect and analyse my data seeing as I had no prior experience with studying sexual and reproductive health or in conducting research in Kenya or SSA.

Participants' consent and anonymity are two key areas of data processing. Before I attended the focus group discussions or devised the interview guides and questionnaire, I was getting familiar with my surroundings. On a visit to the nearby community, I observed a couple of Maasai young mothers and their children at a healthcare facility. A nurse approached me and told me that I could take a picture of the two women and use it if I wanted to. He had not asked the women for their consent and told me that it was normal. I declined his offer. The experience stressed the importance of obtaining informed consent by research participants. All research participants were thus informed of the purpose of my project and how the collected information would be used. In activities led by TMT, such as focus group discussions, all participants signed a document either with their signature or a fingerprint for those who were illiterate. Interviews were recorded and I informed participants about their right to withdraw consent or pause the interview at any given time. Verbal consent was given to healthcare staff before questionnaires were answered.

The degree of anonymity I granted to participants in the product has changed during the data processing. In initial report drafts I had included the name, age, and occupation of participants that I quoted. However, when I was quoting a woman from an interview about her experienced side effects, I noticed that her colleagues would be able to identify her. Due to the particularly sensitive nature of the quote and topic in general I realised that I needed to revise my citation format to increase anonymity, which is reflected in the final product. Research participants are now unnamed. They are addressed by their occupation granted that it qualifies their statements. To prevent TMT interviewees from being identified, I have collectively addressed all as "TMT staff" except for the CEO. In the few instances where I believe that it could potentially expose the participant, I have addressed them by their gender. Here, I have also chosen to not include the date of the interview or conversation. I generally did not keep

track of the dates of informal conversations but in the cases where I have quoted something directly from such a conversation, I have included the specific date.

From collection to analysis: data processing

In September 2022 I produced an impact assessment report on family planning when TMT and I had concluded focus groups discussions (Kvist & Axelsen, 2022). The impact assessment report sums up the input and outcomes of all focus groups. The report was based on the Maasai's responses and focused on recurring themes that were composed into recommendations. This format inspired how I structured the analytical report.

Following the conclusion of interviews, I transcribed all recordings of the interviews using a combination of Word Excel and the software Otter.ai. Otter.ai has a speech-to-text function that I used to upload six of my interview recordings which were then transcribed. I selected the interviews with the healthcare workers that I found the most difficult to hear or comprehend. After the software had transcribed the interviews, I went over them again to correct any mistakes. I then proceeded with an open coding of interviews, meaning I sectioned the transcriptions into parts that I had thematically labelled (Schreier, 2014:4-5). The smaller coded sections were then arranged into larger categories. Afterwards, I was able to organise the data and examine the content.

Questionnaires were collected after every medical camp and stored in a folder. I systematically analysed the results by comparing answers, such as age in relation to number of children or type of contraceptive in relation to husband's/partner's consent. Due to the small number and uniformity of responses, it did not take long to establish patterns which I described in the report.

After processing all data, I started to consider what type of format the results would benefit the most from. Through detailed assessments of all my material I was able to distinguish five interlinked - although distinct - problems facing family planning uptake in the Maasai Mara. I decided to formulate these issues as barriers and present them through the five fictional cases.

Choosing case studies

I chose to use the five cases as my report's medium because it accorded me flexibility in how I wanted to disseminate my data.

Quantitative instruments such as numbers, tables and statistics can point to dimensions of barriers to family planning uptake but cannot speak to the experiences of people. To accomplish this, I decided to include qualitative, human perspectives. Cases grants me the opportunity to work in depth with the existing barriers. The medium enables me to explicate how people in the Maasai Mara live with barriers and what people do to cope with and/or overcome them. They complement the mostly qualitative research methods that I applied in the data collection and allow me to present my data in a format that illustrates these specific Maasai realities. However, by using a qualitative outlet I am prevented from debating how widespread my cases are. Nevertheless, all cases are based on real dilemmas that I encountered multiple times throughout my fieldwork, and I therefore believe that they reflect the lived experiences of a substantial number of Maasai.

The Maasai women and men behind the cases

The focus of each case is the barrier in question. Nonetheless, I also wanted each 'person' to have nuances and showcase how exactly the barrier becomes tangible in their everyday lives. It was important to me that each case reflected realistic circumstances which is why I decided to give substance to the dilemmas of the Maasai women and men behind the cases. My cases demonstrate that barriers affect different people which is why I chose to portray three women and two men from various parts of Maasai society. I included a young woman without education, an adolescent girl currently in school, a male nurse, a young woman who dropped out of school, and a male teacher because these were the kinds of people I often interacted with during my fieldwork. Aspects of every data collection method are reflected in all cases.

The females in the cases are either adolescents or in their early twenties because most of my questionnaire respondents were in this age group. Moreover, I believe that family planning efforts will benefit more from reaching younger people since adolescent pregnancies and early marriages are prevalent in this region and therefore weighed the need for this inclusion. Even though Maasai children also become pregnant I was hesitant to use them as an example because of the taboo surrounding adolescent pregnancies at this age. I did not present a girl at that age due to the risk of controversy and potential backlash that could face TMT if conservative authorities got access to the report. Instead, I introduced the problem in *Case 2: Lack of knowledge* without revolving a case around it.

Although close in age, the two females Naserian from *Case 1: Socio-cultural beliefs and practices* and Seleina from *Case 2: Lack of knowledge* face completely different barriers. Where Naserian represents a 'typical' scenario for a Maasai girl who has not received any schooling, Seleina illustrates that education does not necessarily equate knowledge in this regard. None of them use contraceptives or other family planning services. Their barriers stand out from Namunyak from *Case 4: Myths, misinformation, and experienced side effects*, who uses contraceptives and must deal with barriers in relation to this.

Altogether, their cases reflect current issues in the Maasai Mara experienced by Maasai women and girls and the recommendations for each are intended to improve these predicaments.

At the same time, I wanted to demonstrate that family planning cannot be restricted to just a women's issue. This is why I made sure to include men in *Case 3: Inaccessibility of services* and *Case 5: Negative perceptions and stigma*.

Samuel from Case 3 is neither Maasai nor a local from Maasai Mara. I used his profession to craft a barrier from the perspective of a service provider, not a recipient which adds another layer to family planning barriers. He is inspired by the nurses and healthcare staff that I interviewed while attending medical camps. Contrarily, Joshua from Case 5 is crafted from the outcomes of focus group discussions. Since a major barrier to uptake are the opposing views of Maasai men, it would have been more realistic to portray him as being against family planning, like Michael from Case 1. Michael reflects the most radical opponents of family planning that I encountered during my fieldwork. However, I find it important to include an example of someone who might be interested in family planning but must factor in the social norms and accompanying stigma which acts as deterrents.

Aim(s) of the product, target group and intended application

Aim(s) of the product

The overarching aim of the product is to expand the knowledge of the driving forces behind the low rates of family planning uptake in the Maasai Mara. The product's threefold objective therefore comprises:

- Understanding issues surrounding family planning uptake through primarily qualitative research of different strata in Maasai communities in the Maasai Mara.
- Identifying gaps in current NGO-led efforts on sexual and reproductive health, including family planning services in the Maasai Mara.
- Providing TMT and other professionals working with sexual and reproductive health and family planning with concrete recommendations.

The target group: TMT and other sexual and reproductive health professionals

TMT is the primary target group of my product. Other policy makers or professionals working in the field of sexual and reproductive health may also benefit from its contents. I have chosen TMT as my target group for three reasons.

Firstly, this thesis is the outcome of my thesis collaboration with TMT. The report is my way of compensating TMT for all their assistance and guidance during my fieldwork where they acted as my gatekeepers to the field. As such, TMT are my chosen target group.

Secondly, because the data is collected within a circumscribed area in the Maasai Mara it is site- and context-specific. The results may therefore not easily translate to different settings or be possible to implement on a larger scale. While this may limit my project to a certain extent, it is a strength for my target group who only works with the Maasai in Maasai Mara. The data is therefore collected to match the interests of the target group.

Thirdly, my recommendations are entirely based on what TMT is already doing. Since the family planning project started in 2020, the NGO has already gone through a trial-and-error phase. For this reason, I am not trying to propose recommendations that fit the needs of a new family planning project but rather build on existing elements of TMT's project or suggest complementary additions.

In sum, the recommendations are tailored to fit TMT and its family planning target groups' capabilities, interests, and cultural and social setting.

Intended application: Inform TMT's family planning project

The intended application of the product is to inform TMT's family planning project design to improve its effectiveness and impact. This is meant to help the NGO navigate how they should prioritise future

efforts to achieve their ambitious goals of enhancing the sexual and reproductive health of the Maasai in the Maasai Mara.

The CEO told me that TMT would favour a product that entailed recommendations to enhance their family planning project. The format of the report is structured to accommodate this request with, first, identification and analysis of barriers for uptake, and second, recommendations of how to overcome these barriers. In the construction of my recommendations, I was considerate of several criteria, including feasibility, applicability, appropriateness, and sustainability in addition to if they addressed the identified barriers.

All recommendations are feasible in the sense that I am aware that TMT can oversee certain recommendations whereas additional stakeholders are needed for achieving others. For example, it is within TMT's capabilities and responsibilities to adjust the contents of peer mentor activities as suggested in recommendation (3). This contrasts with recommendation (8) where I recognise that TMT does not hold any power over the available contraceptive options. However, they can advocate for an expansion to national and even international healthcare stakeholders.

The applicability of recommendations is moreover taken into consideration. The motorcycle ambulances from recommendation (5) are an example of a solution that could be implemented with relative ease as TMT already utilise trained community health mobilisers and have motorcycles available.

I was most concerned with ensuring that recommendations were socially and culturally appropriate. This is the reason why recommendation (4) is tailored to parents and not parents and their children even though a key issue is the lack of knowledge for youths and adolescents. I was apprehensive about whether the strict hierarchical dynamics in Maasai culture would entail that communities would find it inappropriate that the same information was provided to parents and children together. In recommendation (6) I propose financing mechanisms that can make long-term contraceptives affordable. In doing so, I estimate that individuals who take up long-term contraception agree on this choice with their partner due to women's economic dependence on men, meaning many Maasai women do not have their own bank account. This recommendation may therefore only be an option for consenting couples but appropriate, nonetheless. Recommendation (10) is another example of how the issue of male involvement can be addressed appropriately by suggesting educational platforms that have been successful in similar social and cultural contexts.

The sustainability of most recommendations are long-term efforts because that is what is required to contest barriers to uptake. However, educationally grounded recommendations such as (3), (4), (7) and (10) as well as motorcycle ambulances from (5) can be implemented within a short time span. In turn, the outcomes from these recommendations apart from (5) will be durable in line with the remaining recommendations.

Whilst in the field I entered into a verbal agreement with the CEO that the product will be shared with TMT in June 2023. I have informed the NGO that I am available for any comments, clarifications, or discussions. They have explained to me that they are open to implementing some of my recommendations, while I acknowledge that I do not hold the belief that they will do so. In collaboration with TMT, I am furthermore planning a visit to its headquarters in August 2023 to participate in ongoing family planning and/or sexual and reproductive health activities.

3. Theoretical family planning debates

The theoretical framework

In this theoretical part of my thesis, I analyse the family planning services presented in my report as examples of 'development projects' undertaken by TMT. I have chosen to do so, to highlight the circumstance, that the issues, problems, or barriers I have analysed in my report, only are barriers to the extent that the overall framework is one in which 'development' is judged as something desirable and wanted and is not questioned. Theoretically, issues, problems, or barriers of development have been dealt with in the literature that analyses and discusses international development in several ways (see e.g., McMichael, 2012; Mosse, 2011 and Ferguson, 1994). I apply elements from two contrasting but complementary approaches because they highlight a set of visible and invisible development circumstances at play in the Maasai Mara.

The first is a top-down approach to development. Top-down development is characterised as development projects where decision-making is led by a government, private companies, or NGOs, not the local population that the project is meant to enhance (Ferguson, 1994; Li, 2007).

The second is a bottom-up approach to development. This type of development is presented by Josephine Syokau Mwanzia and Robert Craig Strathdee as 'participatory development' (2016). It introduces a different way of engaging with development activities that acknowledges local people's agency.

These approaches have previously been used to debate development interventions in the Global South and as I will show in the following theoretical discussion are also applicable in the context of family planning services in the Maasai Mara. I use this chapter to expand on my choice of approaches, how I can incorporate them in my discussion of family planning as development and finally how they complement each other in this regard.

Top-down development

Central to top-down development are two concepts that are utilised by James Ferguson and Tania Murray Li to criticise this type of approach. The concepts are 'the anti-politics machine' and 'rendering technical' which constitute the first two concepts of my theoretical apparatus. Ferguson and Li provide distinct but

complementary analyses of top-down development. Both remain critical of top-down development for providing technical solutions to problems that can avoid political contention.

The Anti-Politics Machine and anti-politics

The term 'anti-politics machine' or 'anti-politics' was introduced by James Ferguson in his book *The Anti-Politics Machine: "Development", Depoliticization, and Bureaucratic Power*. Based on ethnographic fieldwork on the Thaba-Tseka Development Project, a rural development project in Lesotho, Ferguson finds that experts of development interventions tend to exclude prevalent political-economic relations by "insistently reposing political questions of land, resources, jobs, or wages as technical "problems" responsive to the technical "development" intervention" (Ferguson, 1994:270). Ferguson uses 'anti-politics' to criticise failed development projects which he maintains fail when they are not inclusive of the socio-cultural context that they operate within. That led him to describe planned development as a top-down and growth focused 'anti-politics machine' (ibid.).

Ferguson furthermore argues that the development industry sought to ameliorate issues of poverty and deprivation but without presenting issues as political. He explains that stakeholders within this so-called 'machine' practices 'anti-politics', whereby development issues were framed as technical problems. Intentionally or not, practising 'anti-politics' enabled stakeholders to extract politics from development projects. As a result, the project could garner support from certain interests such as the Lesotho government. Incidentally, some of the development 'side effects' (ibid.:255) increased bureaucratic state power.

Rendering technical

The second top-down development concept I use to discuss family planning is the concept 'rendering technical', which was coined by anthropologist Tania Murray Li (2007). The concept is defined as a set of procedures that a government uses to represent "the domain to be governed as an intelligible field with specifiable limits and particular characteristics (...) defining boundaries, rendering that within them visible, assembling information about that which is included and devising techniques to mobilise the forces and entities thus revealed" (Li, 2007:7). Thus, it entails formulating an issue in a way that requires technical or scientific fixes that do not confront the root causes of said issue.

According to Li the availability of a solution is closely connected to the identification of this problem. Developers are appointed as experts who are trusted to render issues technical. They have a specific and limited set of "diagnoses, prescriptions, and techniques" (Li, 2007:7) at hand in their repertoire. This enables them to construct a development problem so that it fits their availability of solutions. Solutions, then, help determine how a problem is articulated in technical terms. Accordingly, developers apply technical instruments such as statistics, measurements, and the like to measure the outcome of solutions.

Where Ferguson identified the mechanisms through which the development industry de-politicises their field of intervention, in the name of development, Li was able to articulate how anti-political processes are identified, problematised, and ultimately rendered technical.

Top-down development processes in family planning

The point of entry for my discussion is the exercise of top-down development by TMT which I observed during my fieldwork.

Development does not occur in a vacuum. Multiple other stakeholders apart from the Maasai communities are crucial as they, too, shape how family planning services are being planned, supported, implemented, and evaluated. It is therefore necessary for TMT to consider the need for family planning services from angles that cater to the project's different stakeholders. 'Anti-politics' is crucial to enable development in this context. 'Anti-politics' occurs as an effect of TMT's framing of certain problems, issues and barriers and facilitates access to resources and support that would not have been available to the NGO without metaphorically processing family planning through the anti-politics machine.

It should be pointed out that TMT does not view barriers purely as technical problems. They are acutely aware of how gender inequality and certain practices such as early marriage and adolescent pregnancies affect uptake of family planning services. The NGO works with members of the Maasai communities including opinion leaders, men, women, and youth to understand the complex social and political dynamics that underlie the barriers.

TMT has even tried to engage local politicians in awareness-creating processes such as suggesting that schools provide comprehensive sexual and reproductive health education. As I described in the report, however, officials were not receptive towards their recommendations. In Li's view, this would indicate that the field TMT operates within does not acknowledge this type of solution. Without support

from local politicians, TMT is unable to address issues in the way that they want without risking serious backlash. This means that TMT are compelled to match certain barriers to uptake with solutions that are available to them. The issues have therefore been reformulated and translated into activities that are socially and culturally acceptable, which in their case means adolescent sexual and reproductive health sessions taught by trained peer mentors. It seems, then, that barriers like lack of knowledge are rendered technical so as to avoid conflicts and political debates that would deter current progress. Consequently, TMT practises 'anti-politics'. While their efforts do make a difference, they have no choice but to wait for a change in the political landscape if they want to challenge the political structure behind barriers once more.

From theory to practice: TMT's practical implementation of 'anti-politics' and 'rendering technical'

The outcomes and consequences of practising 'anti-politics' and 'rendering technical' by TMT is the focus of the following section. I observed that in most instances where TMT practices 'anti-politics' or 'renders technical' happens in its affiliation with the Government of Kenya through its Ministry of Health. They work together to "extend quality healthcare *information* and *services* to the most rural communities" (TMT, 2023d, emphasis added) which is why I primarily direct my attention to the barriers that I identified concerning lack of knowledge and inaccessibility of services below. Of note, I found that out of the five identified barriers, TMT has made the most progress on these two.

While it would be unnecessarily restricting to state that the Government of Kenya government does not care about the wellbeing and development of its rural and remote populations, it can present problems for development. It is selective in the support it contributes to development which necessitates a specific framing of development projects that seek funding. From Li's perspective, TMT's progress could be indicative of TMT's achievement in rendering family planning technical. In Ferguson's view, the fact that the Government of Kenya is a key stakeholder in activities that address these issues, stresses TMT's ability to successfully frame issues as non-political.

TMT's progress on the two barriers of lack of knowledge and inaccessibility of services are intrinsically linked to the fact that barriers that are rendered technical can be subjected to instrumental measurement. Evaluations help pinpoint overseen flaws in the project's design or implementation which can then be adapted and refined. Uptake can be monitored and e.g., be used to estimate which

communities have high and low contraceptive prevalence rates. Securing an increase in uptake can be presented to the Government of Kenya and the international community as a success story, which helps strengthen the claim to more funding. In turn, the government can also take credit for the increased numbers of contraceptives and services used.

TMT has rendered lack of knowledge technical by providing community health mobilisers with sexual and reproductive health training to increase awareness levels about sexual and reproductive health and family planning in Maasai communities. Officials from the Ministry of Health were identified as experts in this process and were involved in the initial stages of raising awareness. The Ministry of Health facilitated a one-week training that encompassed a range of technical elements such as sexual and reproductive health information, including contraception and the prevention and treatment of STIs, as well as other components of ethics, hygiene, and sanitation. Training the six community health mobilisers is a cost-effective method, as it requires few resources and can be implemented relatively quickly. For an NGO like TMT, which only has limited resources to allocate to all its programmes, this is an advantage. By using technical expertise, community health mobilisers were equipped with the necessary information to impart to Maasai communities. Their outreach efforts are confirmed by the increase in awareness levels described in my report.

However, top-down development approaches to family planning also entail certain downsides.

Firstly, it is expensive to run the medical camps that offer free family planning services. Key to ensuring access through medical camps is the Ministry of Health, as they supply the family planning commodities and fund healthcare staff for medical camps and backpack nurses. TMT is reliant on the external resources from the Ministry of Health to sustain medical camps. If the Ministry of Health decides to withdraw its support due to conflicts or other circumstances this could present issues about the health intervention's sustainability in the long term.

There is furthermore a discrepancy between the information received by the Maasai and how it translates into their actual contraceptive use. Socio-cultural beliefs and practices, myths, misinformation, and experienced side effects as well as negative perceptions and stigma influences contraceptive preferences, which I discussed at length in the report. Maasai communities may therefore be informed of the various contraceptives but due to a lack of consideration of these barriers in how solutions are implemented, commodities apart from Depo-Provera and implants are almost irrelevant. The high rates

of adolescent pregnancies and rising HIV patients can neither solely be attributed to lack of knowledge. Negative perceptions and stigma around condom use are a large contributing factor behind these statistics, which a top-down development approach is not capable of addressing.

Finally, simply stating an increase in uptake of contraceptives in the Maasai Mara does not paint the whole picture. The experienced side effects from contraceptive use are not taken into consideration in statistics. Neither are the circumstances surrounding how and why a contraceptive is used. I am not attempting to negate how the growing number of women who use contraceptives are owed to TMT's achievement in increasing information on and access to services. Rather, I want to point out that when a project's success is measured on its ability to present its data from this narrative, important details are overlooked. To determine the success of family planning services in the Maasai Mara, it is key to factor in the realities of Maasai women's preferences for Depo-Provera. I found that Depo-Provera is a short-term commodity which is often either used once or irregularly since women do not reschedule or show up for a new injection. Spacing of one's children is challenging if the three-month commodity is used just once a year. For this reason, it cannot be excluded that a woman's likelihood of getting pregnant is the same as before she began using family planning services, especially if Depo-Provera is the only contraceptive used. The alarmingly high annual population growth rate in the Maasai Mara (TMT, 2016:11) is a testament to this. Therefore, while there may be a spike in contraceptive numbers, the contraceptive in question and why it is preferred needs to be considered in measurements and evaluations. It is insufficient to provide solutions where the root causes to this behaviour is not addressed.

Top-down development has been criticised for its lack of bottom-up input (Mosse, 2011:3) which aligns with my critique of the approach. It fails to consider barriers that concern people's family planning perceptions, feelings, and practices. Strictly using top-down approaches to address all barriers are thus incompatible with the realities of the Maasai in the Maasai Mara. TMT does practise an alternative to top-down development in its family planning project which is equivalent to a 'participatory development' approach. In the following section I discuss this approach and what it can and cannot contribute to family planning services.

Bottom-up development

'Participatory development' makes up the third and final element of my theoretical apparatus. The approach is one of several emanating from a shift away from conventional, top-down development towards development that have an "appreciation for human development, such as health, education, and for enhancement of life experiences" (McMichael, 2012:285). In this written assignment I draw on Josephine Syokau Mwanzia and Robert Craig Strathdee's participatory framework to complement my discussion of family planning as development in the case of TMT.

Participatory development

Participatory development as forwarded by Josephine Syokau Mwanzia and Robert Craig Strathdee in their book *Participatory Development in Kenya: Empowerment, Transformation and Sustainability* (2016) introduces a different perspective to development. The work examines participatory and people-centred approaches to development in the case of the Basic Education Improvement Project, an education project that was implemented by the Government of Kenya in collaboration with marginalised communities in "rural and urban slums to increase access to education, promote participatory development, reduce poverty, and enhance social change and sustainable development" (Mwanzia & Strathdee, 2016:1). Although not isolated from other initiatives, the project managed to facilitate the collaboration and participation of marginalised individuals to ultimately leave them more empowered than before the Basic Education Improvement Project.

According to Mwanzia and Strathdee, participatory development is concerned not just with economic progress but with addressing the multidimensional aspects of development that can enhance and improve the lives of individuals and communities (Mwanzia & Strathdee, 2016:20). Development is therefore not just about providing technical solutions to problems but primarily about people's relationships with their social, cultural, political, and economic surroundings and how development affects these. In contrast to the appointed experts from top-down approaches, it is the affected communities of development that formulate a project's objectives. The disadvantaged individuals and communities are thus the primary agents of development where the role of donors is to support the advancement of their needs, not determine the development agenda. Solutions are thereby context-specific and locally appropriate. In the words of the authors, participatory development "(...) espouses developing and respecting people's

cultures, knowledge, skills, institutions, economic, social and political processes as well as the people themselves" (ibid.:21). Consequently, the strategies and procedures to address barriers to family planning uptake stands out from the top down and technical approaches previously discussed. Participatory development therefore opens for a different lens through which to gauge other aspects of TMT's approach to family planning services.

Bottom-up development processes in family planning

Bottom-up development as 'participatory development' is an integrated part of TMT's general development approach. The organisation spends a significant amount of time going door to door to ask what the communities need before a project is commenced, which is how the organisation became aware of the unmet need for family planning. By consistently gathering the thoughts and feelings of local communities, TMT is aware of what is really of concern to the Maasai in the Maasai Mara. They do not operate on preconceived notions on what they think is better, although they know what is realistic to pursue and what is not. The NGO works with stakeholders who are keen to see social change, and which tend to support participatory development. Their role is thus to support the wishes of the Maasai communities, where CHASE Africa represents an organisation in favour of this approach.

This means that TMT (and CHASE Africa) are aware that uptake of family planning is not only determined by knowledge of and accessibility to services. It is also contingent upon people's perceptions, feelings, opinions, and experiences of family planning. Such circumstances are intertwined with barriers concerning socio-cultural beliefs and practices, myths, misinformation and side effects and negative perceptions and stigma. TMT uses bottom-up and participatory development approaches to address these aspects of family planning services.

From theory to practice: TMT's practical implementation of 'participatory development'

In this section I discuss some of the options that are and are not rendered possible when TMT practices 'participatory development' in its family planning activities.

Making sure that family planning services are available and that communities are aware of them is one task. TMT has shown to be very successful in achieving this. It is another feat to ensure that people,

and women in particular, utilise a service because they are free to choose to do so. Top-down and technical development approaches can only be used to achieve half of this objective. Given that the lack of Maasai women's reproductive autonomy is a hindrance to uptake due to e.g., socio-cultural beliefs and practices, it is insufficient to inform people about family planning or make sure there is enough physical infrastructure to provide services. Correspondingly, fear of contraceptive use has proven to require more than technical fixes, seeing as it is the biggest barrier to uptake worldwide. It therefore becomes a matter of engaging in inclusive dialogue with the Maasai to find common ground on issues while also pushing for a change in attitudes and opinions towards family planning. This is precisely what a participatory approach can offer. Although it is time-consuming to engage communities, gather input and tailor activities to be socially and culturally appropriate, the yield of the efforts have shown to be sustainable in the long-term (Mwanzia & Strathdee, 2016:40-41).

Participation in development is both a process and an objective in its own right. The participatory process is marked by using local expertise to design and implement culturally and socially appropriate projects that are relevant for the community in question. The participatory outcome or objective entails the empowerment of both individuals and communities (ibid.:21). Both aspects are evident in TMT's family planning project.

Maasai community members are instrumental in the implementation of services. All community health mobilisers and peer mentors are Maasai from the different communities that TMT works with. They have a personal understanding of the social, cultural, political, and economic background of their communities which enables them to meet the affected people at eye level. They know about the value children have for the Maasai and that family planning is not solely an issue of distributing condoms to especially adult men who will not use them due to ignorance, myths, or stigma. They are trusted a great deal by community members because they are from the same communities that the services are offered in.

TMT aims to ensure that family planning is not imposed on communities by encouraging local ownership. They involve local leaders and healthcare workers at facilities in decision-making processes by engaging them in community meetings with TMT staff. The project is thereby to some extent a product of cooperation with local communities.

Focus group discussions are another way that TMT exercises participatory development. From this standpoint, the aim of the focus group discussions held by TMT were to "increase individual agency in

development" (Mwanzia & Strathdee, 2016:20). The final question in focus group discussions was "what are your recommendations to improve family planning services in your area?" While many recommendations centred around education, the most common response was the necessity of male involvement. All groups highlighted the need to involve men in various areas of family planning processes, because men as partners and husbands are imperative in the decision-making on reproductive matters in family constellations. It was the opinion of all that educating and sensitising men on family planning matters was a crucial next step. To do so, the opinion leaders and the youth recommended community-based sensitisation *barazas* (community gathering) as well as encouraging chiefs, religious leaders, peer mentors etc. to be advocates for family planning. This signifies that focus group participants were accorded with agency to influence how family planning is shaped in the Maasai Mara.

TMT were not focusing on the inclusion of men in their initial project planning and implementation. As I also make note of in the report, this input from community members therefore pinpoints one of the most overlooked areas of concern. It would not have been possible to discover this flaw in the project without using a participatory approach.

Due to its ability to engage and empower communities it might be tempting to view bottom-up development through 'participatory development', as an attractive solution to a development project in this case. But, like other approaches, it has pitfalls.

Firstly, in a project that revolves around reproductive healthcare, a participatory approach needs to be accompanied by other development approaches where technical expertise is at the forefront. This is due to participatory development's strong emphasis on community perspectives and knowledge that can undermine actual family planning and contraceptive expertise. I encountered this paradox of expert distrust multiple times throughout my fieldwork. Here, some community members expressed a willingness to receive services, albeit they still held onto the myths or misinformation about family planning methods or side effects. While it was pertinent to include local voices it was difficult and sometimes impossible to correct these opinions and statements because they often were influenced by local community members of high standing. To achieve high-quality delivery of family planning services and corrections of myths and misinformation, experts and other top-development instruments are therefore required.

Secondly, in reality, a participatory approach does not necessarily equal participation. Not all groups in society are able to participate on the same footing. Although focus groups discussions included opinion leaders, men, women, and youth to encompass different strata of Maasai society, contributions were still uneven. I previously exemplified this in the section *Focus group discussions* of this written assignment. Here the age and gender of participants carried more weight in discussions. In my experience, youths in their twenties, who were male, took up more space than youths in their teens. Female opinion leaders held back due to the presence of Maasai elder Ben as well as me. As men and opinion leaders were used to being heard, other marginalised groups, such as women, needed to be actively sought out and questioned. The instances illustrate that although TMT tries to embrace the participation of all, social and cultural dynamics complicate these efforts.

Complementarity of top-down and bottom-up development in TMT's family planning

In the penultimate section of the written assignment, I recapitulate how family planning is practised as a development project influenced by top-down and bottom-up development processes.

To illustrate their different aspects and objectives, Table 1 summarises top-down and bottom-up approaches to development on a number of dimensions.

	Top-down development	**Bottom-up development**
Type of approach/concepts	'Anti-politics machine', 'anti-politics', 'rendering technical'	'Participatory development'
Development driver	Donor/government	NGO/community
Identified experts	Healthcare professionals, NGO workers, human security student	Locals, communities
Types of activities	Medical camps, my analytical report	Focus groups, co-creation
Resource intensity	Cost-effective and timesaving	Cost-intensive and time consuming
Success criteria	Positive (measurable) outcomes	Context-specific and appropriate interventions, empowerment

Table 1. Top-down and bottom-up development in TMT's family planning project.

Despite its flaws, top-down approaches enable the Ministry of Health to participate in development for its rural populations through TMT's project on family planning services. By 'rendering barriers technical' the government can engage with community members through knowledge-exchange, support local NGOs with funding for services, and deliver visible and measurable outcomes that can be presented as achievements on a regional, national, and international scale. Top-down development is therefore suitable to address issues of awareness and accessibility. Of note, the Government of Kenya can achieve these goals without having to address the political and structural layers behind the conditions that led to why one of Kenya's rural and remote populations face the many barriers to family planning. It benefits from the very thing it is criticised for - the 'anti-political' nature of technical solutions.

On the other hand, a 'participatory development' approach places the affected Maasai inhabitants in the Maasai Mara as the drivers and beneficiaries of several aspects of family planning as a development project. Though not an infallible solution either, the approach ensures that different strata from the communities are included in both planning, implementation, and evaluation stages. Bottom-up development through a participatory lens is therefore beneficial to counter long-term concerns like socio-cultural beliefs and practices, myths, misinformation, and side effects and, finally, negative perceptions and stigma.

The two approaches can be seen as complementary and integrated into TMT's family planning project. Top-down development funnels primarily monetary support and physical infrastructure and expertise to communities where bottom-up development in turn enables the Maasai to be empowered and take ownership in their development. In the future work TMT needs to undertake to counter barriers to uptake of family planning services it is therefore imperative that the organisation continue to incorporate both approaches as they are mutually reinforcing.

As a final observation, it is important to note that while I, as a student of Human Security, generally am an advocate for bottom-up development through 'participatory development', I can also appreciate the necessity of top-down concepts such as 'anti-politics' and 'rendering technical' in this case. In my product, the application of participatory research methods is reflected in the use of e.g., focus group discussions in the data collection process. However, as a master's student, the tools and solutions that are available to me fall within the realm of academia. The product's analytical format reflects this. Even though my recommendations are formulated with the Maasai community in mind I have not consulted

my research participants about what product they would have benefitted the most from. Therefore, while I have tried to balance the two approaches in my own fieldwork and writing process, my product is ultimately an example of a solution that has been ‘rendered technical’.

Conclusion

In this product thesis I have examined 'family planning' in the Maasai Mara, Kenya in two complementary parts, "Part I: Analytical report" and "Part II: Written assignment".

The analytical report is rooted in ethnographic fieldwork I conducted in collaboration with the Maasai Mara-based NGO The Maa Trust. This part of the thesis presents family planning as a set of practices that The Maa Trust has introduced to promote sustainable human development for the Maasai in this area - focusing on aspects where these initiatives conflict with Maasai society and everyday life.

Central to the report are five cases inspired by real problems faced by the Maasai in relation to uptake of family planning services. The cases reflect five interconnected barriers, which I identified: 1) socio-cultural beliefs and practices, 2) lack of knowledge, 3) inaccessibility of services, 4) myths, misinformation, and experienced side effects, and 5) negative perceptions and stigma. The identified barriers are supported by existing literature on sexual and reproductive health in the Global South including Sub-Saharan Africa but stresses that the conditions in the Maasai Mara at times necessitate context-specific solutions. I find that The Maa Trust has advanced on barriers pertaining to awareness and accessibility the most albeit there is a great potential to address all barriers. Therefore, I ultimately provide The Maa Trust with a total of ten recommendations to address the barriers.

The report contributes with a contextualisation of current family planning barriers to the academic field of sexual and reproductive health. Of significance, the report is the first academic contribution that presents findings about family planning in the Maasai Mara, which has thus far only been the target of national policies and NGO interventions. It thereby starts answering a pressing demand for research on the topic and serves to bridge critical knowledge gaps that are essential for overcoming current barriers.

The written assignment presents methodological and theoretical issues, considerations, and perspectives arising from my fieldwork and product.

First, I examine in depth the qualitative and quantitative research methods I applied in my data collection process. Here, I discuss the inclusions, such as incorporating research participants that represent a broad range of perspectives from different people involved in The Maa Trust's family planning project, and exclusions, such as choosing to use a questionnaire instead of interviews to capture

the experiences of Maasai women using contraception, and thereby the possible limitations of my research approach.

Second, I reflect on the data processing of my empirical data to the final product. I give insight into some of the issues I came across in my fieldwork, like consent and anonymity, that facilitated the data presented in the report. In this section I moreover present The Maa Trust as the product's target group and how the product is intended to inform and enhance the NGO's future family planning activities.

Third, I discuss the term 'family planning' in the context of international development. I showcase how top-down development as put forth by the concepts 'the anti-politics machine', 'anti-politics', and 'rendering technical' enables The Maa Trust to engage with barriers through technical solutions that avoid political contestation. As an alternative to the characteristics of top-down development, I introduce 'participatory development'. This type of development addresses barriers from a bottom-up perspective by involving and paying attention to individuals' and communities' specific needs. As a conclusion to the theoretical chapter, I argue that the development approaches from The Maa Trust empower and enable Maasai communities to take ownership of infrastructure and initiatives relating to family planning services that have been provided by stakeholders such as the Government of Kenya.

This master's thesis presents a case study of family planning in remote and rural Kenya. However, its implications for family planning in the context of international development can inspire policy makers and professionals working to promote better sexual and reproductive health, reduce poverty, empower individuals and communities and work towards sustainable population growth to increase the human security of disadvantaged groups. In particular, actors may be inspired by the five barriers to uptake of family planning services and the ten recommendations to overcome them, albeit concrete and context-specific implementation of initiatives are key for successful and sustainable outcomes. They may also consider the tensions and complementarity embedded in top-down and bottom-up development approaches in the planning, implementation, and evaluation of future family planning projects.

Bibliography

Appleford, G., & Mbuthia, B. (2020). County perspectives on Kenya's family planning program. Kenya Brief 4. [Policy brief]. ThinkWell and Avenir Health. https://thinkwell.global/wp-content/uploads/2020/08/Family-planning-brief_31-July-2020.pdf.

Bastien, S., Flisher A.J, Mathews, C. & Klepp, K. I. (2008) "9. Peer Education for Adolescent Reproductive Health" in Klepp, K. I., Flisher, A. J. & Kaaya, S. F. (Eds.): *Promoting Adolescent Sexual and Reproductive Health in East & Southern Africa*. 185-213. HRSC PRESS, Cape Town.

Board of Studies, Department of Culture and Society. (2019). Academic Regulations for Master's Degree Programme in Human Security (2019). https://eddiprod.au.dk/EDDI/webservices/DokOrdningService.cfc?method=visGodkendtOrdning&dokOrdningId=14857&sprog=en.

Brinkmann, S. (2014). "Chapter 14: Unstructured & Semi-Structured Interviewing". In: Leavy, P. (Ed.), *The Oxford Handbook of Qualitative Research*. Oxford University Press. 277–299. https://doi.org/10.1093/oxfordhb/9780199811755.013.030.

Bryman, A. (2015). *Social Research Methods* (5th ed.). Oxford: Oxford University Press.

Campbell, M., Sahin-Hodoglugil, N. N., & Potts, M. (2006). Barriers to Fertility Regulation: A Review of the Literature. *Studies in Family Planning*, *37*(2), 87–98. https://doi.org/10.1111/j.1728-4465.2006.00088.x

Carter, S.M. & Little. M. (2007). Justifying Knowledge, Justifying Method, Taking Action: Epistemologies, Methodologies, and Methods in Qualitative Research. *Qualitative Health Research*. *Vol. 17(10)*, 1316-1328. https://doi.org/10.1177/1049732307306927.

CHASE Africa. (2023). Homepage. https://www.chaseafrica.org.uk/. Last accessed 1/6/23.

Christian Connections for International Health. (2017, January 23). Why Religious Leaders Must Be Involved in Family Planning. *FP2030*. https://fp2030.org/resources/why-religious-leaders-must-be-involved-family-planning.

Cleland, J. G., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., & Innis, J. (2006). Family planning: the unfinished agenda. *The Lancet*, *368*(9549), 1810–1827. https://doi.org/10.1016/s0140-6736(06)69480-4.

Delivering Sustainable and Equitable Increases in Family Planning in Kenya. (2021). Family Planning: a key ingredient for a healthier and more productive population [Policy brief]. Delivering Sustainable and Equitable Increases in Family Planning in Kenya & Options. https://options.co.uk/sites/default/files/desip-policybrief_narok.pdf.

Delivering Sustainable and Equitable Increases in Family Planning in Kenya. (2022). Investing in Narok County's family planning programme [Policy brief]. Delivering Sustainable and Equitable Increases in Family Planning in Kenya & Options. https://options.co.uk/sites/default/files/narok.pdf.

Diamond-Smith, N., Campbell, M., & Madan, S. (2012). Misinformation and fear of side-effects of family planning. *Culture, Health & Sexuality*, *14*(4), 421–433. https://doi.org/10.1080/13691058.2012.664659.

Ferguson, J. (1994). *The Anti-Politics Machine: "Development," Depoliticization, and Bureaucratic Power in Lesotho* (8. printing.). Minneapolis and London: University of Minnesota Press.

Fotso, J. C., Speizer, I. S., Mukiira, C., Kizito, P. M., & Lumumba, V. (2013). Closing the poor-rich gap in contraceptive use in urban Kenya: are family planning programs increasingly reaching the urban poor? *International Journal for Equity in Health*, *12*(1), 71. https://doi.org/10.1186/1475-9276-12-71.

Gahungu, J., Vahdaninia, M., & Regmi, P. R. (2021). The unmet needs for modern family planning methods among postpartum women in Sub-Saharan Africa: a systematic review of the literature. *Reproductive Health*, *18*, 35. https://doi.org/10.1186/s12978-021-01089-9.

Geertz, C. (1993). *The Interpretation of Cultures: Selected Essays*. London: Fontana Press.

Hastrup, K. (2003): "Metoden. Opmærksomhedens retning" in: Hastrup (Ed.) *Ind i verden. En grundbog i antropologisk metode*. København: Hans Reitzels Forlag, 399-419.

Izugbara, C. O., Wekesah, F. M., Tilahun T., Amo-Adjei, J., & Tsala Dimbuene, Z. T. (2018). Family Planning in East Africa: Trends and Dynamics. [Report]. *African Population and Health Research Center (APHRC)*. https://aphrc.org/wp-content/uploads/2019/07/Family-Planning-in-East-Africa-Report_January-2018.pdf.

Jespersen, A. P., Mellemgaard, S., & Sandberg, M. (2017). "Kapitel 4. Kulturanalyse som refleksiv praksis" in: Christensen, S., Jespersen, A. P., Mellemgaard, S., & Sandberg, M. (Eds.) *Kulturanalyse som praksis. Etnologiske perspektiver på individualitet og fællesskab, kultur og historie*. København: Hans Reitzels Forlag. 141-184.

Kamuyango, A., Hou, W. C., & Li, C. Y. (2020). Trends and Contributing Factors to Contraceptive Use in Kenya: A Large Population-Based Survey 1989 to 2014. *International Journal of Environmental Research and Public Health*, *17*(19), 7065. https://doi.org/10.3390/ijerph17197065.

Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, National Council for Population and Development/Kenya, & The DHS Program, ICF International. (2015, January). *Kenya Demographic and Health Survey 2014*. Nairobi: Kenya, and Maryland: USA. https://www.dhsprogram.com/pubs/pdf/FR308/FR308.pdf.

Kenya National Bureau of Statistics, Ministry of Health/Kenya & ICF International. (2023, January). *Kenya Demographic and Health Survey 2022. Key Indicators Report.* Nairobi, Kenya, and Rockville, Maryland, USA. https://dhsprogram.com/pubs/pdf/PR143/PR143.pdf.

Kenya Ministry of Health. (2023). *Narok County*. Kenya Master Health Facility List. http://kmhfl.health.go.ke/#/facility_filter/results?county=93b9ddc8-a4c2-4c15-8b0b-599aa10af865&operation_status=ae75777e-5ce3-4ac9-a17e-63823c34b55e. Last accessed 1/6/23.

Keya-Shikuku, M. & Hassan, V. (2021, July 1). The Plight Of The Teenage Girl Child In Narok County. *Kenya News Agency*. https://www.kenyanews.go.ke/the-plight-of-the-teenage-girl-child-in-narok-county/.

Kipuri, N., & Ridgewell, A. (2008). *A Double Bind: The Exclusion of Pastoralist Women in the*

East and Horn of Africa. [Report]. Minority Right Groups International. https://www.refworld.org/pdfid/494672bc2.pdf.

Kvist, K. & Axelsen, T. (2022, September). *Family Planning Impact Assessment Report. Efforts and results from Ntipilikwani, Enchoro, Osidan, Orkuruto and Talek*. [Report]. *The Maa Trust*.

Lahiri S., Bingenheimer J., Sedlander E., Munar W., & Rimal R. (2023). The role of social norms on adolescent family planning in rural Kilifi county, Kenya. *PLOS ONE 18(2): e0275824*. https://doi.org/10.1371/journal.pone.0275824.

Leung, W.C. (2001, June). How to design a questionnaire. *StudentBMJ. Vol. 9, 187-189.*

Li, T. M. (2007). *The Will To Improve: Governmentality, Development, and the Practice of Politics*. Durham: Duke University Press.

Maasai Mara Wildlife Conservancies Association (2023). *The Greater Mara Ecosystem*. https://maraconservancies.org/the-greater-mara-ecosystem/. Last accessed 29/5/23.

Mbugua, S.M., & Karonjo, J.M. (2018). Reproductive health knowledge among college students in Kenya. *BMC Public Health, 18*(1), 907. 1-7. https://doi.org/10.1186/s12889-018-5760-7.

McMichael, P. (2012). *Development and social change: A Global Perspective* (5th ed.). California: SAGE Publications.

Miller, M. T. (2015). *Paving the Way: Ethiopia's Youth on the Road to Sustainability*. [Documentary]. *Environmental Change and Security Program, Woodrow Wilson International Center for Scholars*. https://www.newsecuritybeat.org/pavingtheway/.

Mosse, D. (2011). *Adventures in Aidland: The Anthropology of Professionals in International Development*. Berghahn Books.

Muluneh, M. D., Francis, L., Ayele, M., Abebe, S., Makonnen, M., & Stulz, V. (2021). The Effect of Women's Empowerment in the Utilisation of Family Planning in Western Ethiopia: A Structural Equation Modelling Approach. *International Journal of Environmental Research and Public Health*, *18*(12), 6550. https://doi.org/10.3390/ijerph18126550.

Mwanzia, J. S., & Strathdee, R. C. (2016). *Participatory Development in Kenya: Empowerment Transformation and Sustainability*. Taylor & Francis Group.

Mwarogo, P. (2022, September). *Radio Spots Monitoring Report (Round one)*. [Report]. *Health and Development Innovations*.

Obwoge, R. O., Okere, A., Chamia, L., Nduku, J., Koech, H. K., Cw, M., Kyalo, N., Wanjala, K., & Lulu, R. (2019). Health Related Challenges Among Pregnant Teenagers Attending Narok County Hospital, Narok County. *International Journal of Gastroenterology*, *3*(2), 35-40. https://doi.org/10.11648/j.ijg.20190302.12.

Pakdaman, S. & Azadgolia, B. (2014). Maasai Culture and its Effect on Sexual Health: A Field Study on the Disparities of Knowledge within the Community. *Journal of Global Health, 4(1). 36-41.* https://journals.library.columbia.edu/index.php/jgh/article/view/4898/3122.

Pastoralism (2023). About. https://pastoralismjournal.springeropen.com/about. *Springer Open*. Last accessed

30/5/23.

Population Reference Bureau. (2021, April). *Engaging Young People in Narok County in Decisionmaking Improves Youth-Friendly Family Planning Services*. [Policy brief]. https://www.prb.org/wp-content/uploads/2019/01/EEDA-Kenya-Policy-Brief-Youth-Narok-County.pdf

Seltzer, J. R. (2002). "Chapter Two. Origins and Evolutions of Family Planning Programs" in Seltzer, J. R. (Ed.): *The Origins and Evolution of Family Planning Programs in Developing Countries*. Rand Corporation. RAND: Santa Monica, California, USA, 9-44.

Schreier, M. (2014). "Qualitative Content Analysis" in: Flick, U. (Ed.) *The SAGE Handbook of Qualitative Data Analysis*, 170-183. https://doi.org/10.4135/9781446282243 https://dx.doi.org/10.4135/9781446282243.n12.

Schwarz, J., Dumbaugh, M., Bapolisi, W., Ndorere, M. S., Mwamini, M. C., Bisimwa, G., & Merten, S. (2019). "So that's why I'm scared of these methods": Locating contraceptive side effects in embodied life circumstances in Burundi and eastern Democratic Republic of the Congo. *Social Science & Medicine*, *220*, 264-272. https://doi.org/10.1016/j.socscimed.2018.09.030

Stats, M. A., Hill, D. R., & Ndirias, J. (2020). Knowledge and misconceptions surrounding family planning among Young Maasai women in Kenya. *Global Public Health*, *15*(12), 1847-1856. https://doi.org/10.1080/17441692.2020.1788112

Takayanagi, T. (2020). "Chapter 4. Socio-cultural background of the Maasai women in Kenya". In: Takayanagi, T. (Ed.) *Informal Learning and Literacy among Maasai Women: Education, Emancipation and Empowerment*. Routledge.

The Maa Trust. (2016). *Population Increase and Settlement Management. Final Report*. [Report]. *The Maa Trust*. 1-47.

The Maa Trust. (2016). *Population Increase and Settlement Management. Final Report*. [Report]. *The Maa Trust*, 1-47.

The Maa Trust (2022). *Three Year Strategic Plan for June 2022 – June 2025. The Maa Trust.* 1-27.

The Maa Trust. (2023a). The Mara Ecosystem. https://www.themaatrust.org/mara-ecosystem. Last accessed 31/5/23.

The Maa Trust. (2023b). Homepage. *The Maa Trust.* https://www.themaatrust.org/. Last accessed 31/5/23.

The Maa Trust. (2023c). Supporting Organizations & Partners. *The Maa Trust.* https://www.themaatrust.org/supporting-organizations. Last accessed 31/5/23.

The Maa Trust. (2023d). Healthcare. *The Maa Trust*. https://www.themaatrust.org/Projects/Healthcare. Last accessed 31/5/23.

The World Bank. (2023). Population Growth (annual %) - Kenya. *World Bank Group*. https://data.worldbank.org/indicator/SP.POP.GROW?locations=KE

Tjora, A. (2012). *Kvalitative forskningsmetoder i praksis*. København: Gyldendal Akademisk.

United Nations Development Programme. (1994). *Human Development Report 1994: New*

Dimensions of Human Security. [Report]. New York: Oxford University Press. https://hdr.undp.org/system/files/documents/hdr1994encompletenostatspdf.pdf.

United Nations Population Fund. (2014, June 17). *Schools for Husbands gaining ground in rural Niger*. *United Nations Population Fund*. https://www.unfpa.org/news/schools-husbands-gaining-ground-rural-niger.

United Nations Population Fund. (2022, March). *State of The World Population 2022. Seeing the Unseen. The case for action in the neglected crisis of unintended pregnancy*. [Report]. United Nations Populations Fund, 1-158. https://doi.org/10.18356/9789210015004.

United Nations Population Fund. (2023, January 12). As drought tightens its grip on Kenya, a motorcycle ambulance is helping women to access critical health care. *Africa Renewal*. https://www.un.org/africarenewal/magazine/january-2023/drought-tightens-its-grip-kenya-motorcycle-ambulance-helping-women-access.

UN Women. (2014, March 3). Empowering Kenya's Maasai women through greater voice and rights. *UN Women*. https://www.unwomen.org/en/news/stories/2014/3/empowering-kenyan-maasai-women.

Vouking, M. Z., Evina, C. D., & Tadenfok, C. N. (2014). Male involvement in family planning decision making in sub-Saharan Africa- what the evidence suggests. *The Pan African Medical Journal*, *19*. https://doi.org/10.11604/pamj.2014.19.349.5090.

Wanje, G., Masese, L., Avuvika, E., Baghazal, A., Omoni, G., & McClelland, R. S. (2017). Parents' and teachers' views on sexual health education and screening for sexually transmitted infections among in-school adolescent girls in Kenya: a qualitative study. *Reproductive Health*, *14*(1), 1-11. https://doi.org/10.1186/s12978-017-0360-z.

Wolcott, H. F. (1990). Making a Study "More Ethnographic". *Journal of Contemporary Ethnography, 19(1)*, 44-72. https://doi.org/10.1177/089124190019001003.

World Health Organization. (2020). Family planning/contraceptive methods. *World Health Organization*. https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception.

World Health Organization Department of Reproductive Health and Research (WHO/RHR) & Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Knowledge for Health Project. (2018). *Family Planning: A Global Handbook for Providers (2018 update)*. Baltimore and Geneva: CCP and WHO.