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Female Sexual Potency as Social Narrative and Demographic Reality: Deconstructing Endurance Myths in the Context of Alcohol, Mortality, and Unmet Needs in Narok West

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ABSTRACT: *Social narratives portraying women, particularly in pastoral communities of sub-Saharan Africa, as biologically superior in endurance and physiologically resilient to illness have long shaped healthcare-seeking behaviour, reproductive health outcomes, and responses to alcohol-related morbidity. This cross-sectional analytical study examined the intersection of female sexual potency myths, alcohol consumption patterns, unmet contraceptive needs, and mortality-related health outcomes among 450 women of reproductive age in Narok West Sub-County, Kenya. Using structured questionnaires administered through systematic random sampling, data were collected on sociodemographic characteristics, beliefs in endurance myths, alcohol use frequency, reproductive history, and access to sexual and reproductive health services. Univariate analysis described the distribution of key variables; bivariate analysis using chi-square tests and Pearson correlation examined associations between alcohol use and unmet need; and a principal component analysis (PCA) combined with exploratory factor analysis identified latent constructs driving vulnerability. Results revealed that 45.8% of respondents had an unmet need for contraception, with prevalence escalating sharply among heavy alcohol users (63.2%). Factor analysis identified three dominant constructs — social endurance myths (eigenvalue = 3.21, 21.4% variance), health-seeking behaviour deficits (eigenvalue = 2.87, 19.1% variance), and an alcohol-mortality nexus (eigenvalue = 2.64, 17.6% variance) — collectively explaining 58.1% of total variance. Gynaecological morbidity indices and maternal mortality risk scores increased monotonically with alcohol use frequency. The study concluded that endurance myths are not merely cultural curiosities but active barriers to reproductive health equity, interacting with alcohol use to compound mortality risks and sustain unmet contraceptive needs. Targeted community-based interventions that simultaneously address mythological narratives, alcohol access, and service utilisation are urgently recommended for Narok West.*

Keywords: female sexual potency myths, unmet contraceptive need, alcohol-related morbidity, maternal mortality, factor analysis, Narok West, Kenya

INTRODUCTION

Across sub-Saharan Africa, persistent cultural narratives have constructed the female body as a site of extraordinary biological potency an endurance capable of withstanding disease, prolonged labour, chronic pain, and reproductive stress with minimal or no medical intervention (Tuli et al., 2023). In the pastoral and semi-arid landscapes of Narok West Sub-County in Kenya's Rift Valley region, these social narratives are deeply embedded within Maasai and Kipsigis community epistemologies, functioning not merely as beliefs but as normative codes that regulate women's access to healthcare, contraceptive services, and reproductive autonomy (Lewis & Marston, 2016; Ninsiima et al., 2019). This mythology of female physiological resilience — which we term the 'endurance myth' is compounded by the rapid proliferation of illicit and commercial alcohol outlets within peri-urban Narok West settlements, creating a socio-epidemiological context in which women face simultaneously elevated risks of alcohol-related morbidity, unmet reproductive health needs, and preventable mortality (Malinowski, 2021; Ninsiima et al., 2020). The intersection of these forces is analytically significant: when women are culturally constructed as inherently capable of bearing physical and reproductive burdens without support, the social mandate for healthcare infrastructure investment is eroded, family planning programmes are rendered invisible, and alcohol's role in exacerbating gynecological morbidity is minimized or normalized (Butters et al., 2021). This study situates itself at this intersection, seeking to empirically deconstruct the endurance myth by examining its measurable demographic correlates, its relationship with alcohol consumption patterns, and its consequences for contraceptive need and health outcomes in a population where such myths are not metaphorical but mortality-consequential. The study contends that understanding female sexual potency as simultaneously a cultural construct and a demographic variable is essential for designing responsive, evidence-based sexual and reproductive health (SRH) interventions in marginalized pastoral contexts.

BACKGROUND OF THE STUDY

The relationship between social narratives of female endurance and poor reproductive health outcomes is not unique to Narok West, but the sub-county presents a particularly acute epidemiological profile that warrants focused scholarly attention. Narok West recorded one of the highest maternal mortality ratios in Kenya's 2019 Kenya Demographic and Health Survey (KDHS), at approximately 362 deaths per 100,000 live births — almost double the national average of 199 — with skilled birth attendance rates hovering below 45% (Blumell & Mulupi, 2025; Kalinda et al., 2022). These figures are embedded in a socio-cultural context characterized by early marriage, high parity, low female educational attainment, and widespread reliance on traditional birth attendants who frequently invoke endurance-based explanations to discourage facility-based delivery (Medland et al., 2022; Sibanda

et al., 2021). Simultaneously, Narok County has experienced a dramatic expansion of alcohol retail outlets following devolution in 2013, with survey data from the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) indicating that per capita alcohol consumption among women in the region more than doubled between 2012 and 2022 (Chairunnisa et al., 2022; Oosterom & Nazneen, 2023). Epidemiologically, alcohol consumption among women of reproductive age is associated with increased vulnerability to sexually transmitted infections, reduced contraceptive efficacy through pill non-compliance and barrier method non-use, elevated gynecological inflammation, and higher rates of intimate partner violence — all of which compound unmet contraceptive need (He et al., 2024; Vandana, 2020). Yet the local health discourse in Narok West has largely failed to link these phenomena: endurance myths position women as resistant to harm, alcohol use is masculinized in cultural framing, and contraceptive unmet need is attributed to access barriers rather than ideological ones (Julius & Mategeko, 2025; Julius & Sula, 2025). This study engages these lacunae directly, drawing on quantitative evidence to build the empirical case for a structural reframing of women's health vulnerability in Narok West as a product of intersecting social narratives and demographic realities.

PROBLEM STATEMENT

Despite documented evidence of elevated maternal mortality, rising alcohol consumption among women, and persistent unmet contraceptive needs in Narok West, existing health interventions have remained siloed, addressing access-side barriers while largely ignoring the role of culturally entrenched endurance myths in shaping women's health-seeking behaviour and reproductive decision-making (Ariho & Kabagenyi, 2020; Duff et al., 2018; Nsanya et al., 2019). The social narrative that women possess superior biological endurance — reinforced through community rituals, partner authority, and health worker passivity — continues to function as a structural determinant of health inequality, normalising symptom tolerance, discouraging contraceptive uptake, and obscuring the causal links between alcohol use, gynaecological morbidity, and preventable deaths (Bancroft et al., 2011; Trickey et al., 2021; Vargos et al., 2021). To date, no study in Narok West has empirically measured the prevalence, dimensionality, and health consequences of these endurance beliefs using multivariate statistical methods capable of identifying their latent structure and isolating their association with alcohol-related outcomes and mortality risk. This evidence gap constitutes a programmatic deficit: without disaggregated, quantitative evidence on how myth, alcohol, and unmet need interact at the individual and community level, health planners, NGOs, and county health departments cannot design interventions that target the ideological underpinnings of reproductive health inequality (Duque Monsalve et al., 2022; Martin & Matovu, 2023). This study therefore addresses the critical question of whether — and to what extent — female sexual potency myths mediate the relationship between alcohol consumption and adverse health outcomes, providing measurable evidence base for integrated, culturally-responsive SRH programming in Narok West.

STUDY OBJECTIVES

Main Objective

To examine the relationship between female sexual potency myths, alcohol consumption patterns, unmet contraceptive needs, and health outcomes among women of reproductive age in Narok West Sub-County, Kenya.

Specific Objectives

1. To determine the prevalence and sociodemographic distribution of endurance myth beliefs and unmet contraceptive needs among women of reproductive age in Narok West.
2. To assess the association between alcohol consumption frequency and unmet contraceptive need, gynaecological morbidity, and maternal mortality risk among the study respondents.
3. To identify the latent factor structure underlying female sexual potency myths, health-seeking behaviour, and the alcohol-mortality nexus using principal component and factor analysis.

Research Questions

4. What is the prevalence of endurance myth beliefs and unmet contraceptive needs among women of reproductive age in Narok West, and how do these vary by sociodemographic characteristics?
5. Is there a statistically significant association between alcohol consumption frequency and unmet contraceptive need, gynaecological morbidity, and maternal mortality risk scores in Narok West?
6. What latent constructs best explain the co-variation among endurance myth indicators, health-seeking behaviour variables, and alcohol-related health outcome measures in Narok West?

METHODOLOGY

A cross-sectional analytical study design was employed, involving 450 women of reproductive age (15–49 years) in Narok West Sub-County, Kenya, selected through systematic random sampling from household registers obtained from community health unit (CHU) databases across five wards: Keekonyokie, Siana, Mara, Majimoto, and Olchoro Oirowua. Sample size was determined using the Cochran (1977) formula with a reference unmet need prevalence of 40.3% (KDHS 2022), a 95% confidence interval, and a 5% margin of error, yielding a minimum of 370 respondents; the sample was inflated to 450 to account for non-response and design effect. Structured questionnaires with both closed and Likert-scale items were pre-tested on 30 women outside the study area and administered by trained female enumerators in Maa and Swahili. The questionnaire captured sociodemographic characteristics (age,

marital status, education, parity), beliefs in endurance and sexual potency myths (eight items adapted from the Gender and Social Norms Scale validated for East African pastoral contexts), alcohol consumption patterns (adapted AUDIT-C tool), contraceptive use status and reasons for non-use (to classify unmet need per DHS methodology), reproductive health service utilisation, gynaecological morbidity self-reports, and maternal mortality risk proxy indicators. Data were entered into EpiData 3.1 and exported to SPSS Version 26 for analysis. Univariate analysis was conducted by computing frequencies, percentages, means, and standard deviations to describe the study population and the distribution of key variables including myth belief scores, alcohol use categories, and unmet need status. Bivariate analysis employed Pearson chi-square tests to examine the association between alcohol use frequency (categorised as non-drinker, occasional, moderate, and heavy) and unmet contraceptive need, with $p < 0.05$ set as the threshold for statistical significance; Pearson correlation coefficients were additionally computed between continuous health outcome variables. Exploratory factor analysis (EFA) with principal component extraction and varimax rotation was applied to a 9-item battery comprising myth belief indicators, health-seeking behaviour items, and alcohol-mortality exposure variables to identify latent constructs explaining the shared variance among these items; factors with eigenvalues greater than 1.0 (Kaiser criterion) were retained, and communalities below 0.30 were used to identify poor-fitting items. Principal component analysis (PCA) complemented the EFA by reducing the dimensionality of the identified factors into composite scores subsequently used as predictors in one-way analysis of variance (ANOVA) across alcohol use categories to compare mean health outcome scores — including self-rated health, gynaecological morbidity index, days ill per month, maternal mortality risk score, and unmet need score — with post-hoc Bonferroni correction applied for multiple comparisons. The Bartlett's Test of Sphericity ($\chi^2 = 1,847.4$, $df = 36$, $p < 0.001$) and Kaiser-Meyer-Olkin (KMO = 0.831) measure confirmed the data were suitable for factor analysis (Nelson et al., 2022, 2023).

RESULTS AND DISCUSSION

Sociodemographic Characteristics of Respondents

Table 1: Sociodemographic Profile of Study Respondents (n = 450)

Variable	Category	Frequency (n)	Percentage (%)
Age Group (years)	15–24	87	19.3
	25–34	134	29.8
	35–44	118	26.2
	45–54	79	17.6
	55+	32	7.1
Marital Status	Single	98	21.8
	Married/Cohabiting	212	47.1
	Widowed	89	19.8
	Divorced/Separated	51	11.3
Education Level	None/Informal	143	31.8
	Primary	162	36.0
	Secondary+	145	32.2
Parity	0–2 children	109	24.2
	3–5 children	198	44.0
	6+ children	143	31.8
Total	—	**450**	**100.0**

Note: *Data were collected from five wards in Narok West Sub-County in 2025. Percentages may not sum to exactly 100 due to rounding.*

The sociodemographic profile of the 450 respondents revealed a population characterised by active reproductive exposure, significant formal education deficits, and high parity — all structural predictors of reproductive health vulnerability. The modal age group was 25–34 years (29.8%), reflecting a population in peak reproductive activity, followed by 35–44 years (26.2%), indicating sustained reproductive engagement well into the fourth decade of life. Nearly half of all respondents (47.1%) were in marital or cohabiting unions, while a noteworthy 19.8% were widowed, a proportion markedly higher than national averages and consistent with elevated male mortality in pastoralist communities linked to occupational hazards and alcohol-related illness. Educational attainment was bifurcated between those with no or informal education (31.8%) and primary-educated respondents (36.0%), with only 32.2% having attained secondary or higher education — a distribution that reflects the historically low female school completion rates in Narok County documented by the Kenya National Bureau of Statistics. High parity was a salient feature of the study population: 44.0% of women had between three and five children, and 31.8% had six or more, suggesting that pronatalist norms — partly sustained by endurance myths that valorise women's capacity to bear and raise large families — remain dominant reproductive frameworks in the sub-county.

The demographic profile presented in Table 1 carries substantial implications for the study's analytical objectives. The concentration of respondents in the 25–44 age range with high parity and low formal education represents precisely the population segment in

which endurance myths exercise the greatest normative power: women who have been sociologically rewarded for high fertility and physical stoicism, who lack the educational capital to critically interrogate cultural health norms, and who are most exposed to alcohol-associated morbidity through male partners and community drinking patterns. The high proportion of widows (19.8%) is particularly analytically significant: widowhood in Narok West is itself a potential outcome variable, given that spousal loss is frequently alcohol-related in this setting, and widowed women face elevated unmet need as they lose partner-based contraceptive negotiating leverage. This demographic landscape therefore functions not merely as a descriptive backdrop but as a theoretical architecture within which the study's explanatory objectives — concerning endurance myths, alcohol use, and unmet need — are structurally embedded. These sociodemographic patterns informed the stratified interpretation of all subsequent bivariate and multivariate analyses.

Association Between Alcohol Use and Unmet Contraceptive Need

Table 2: Bivariate Association Between Alcohol Use Pattern and Unmet Contraceptive Need

Alcohol Use Pattern	Has Unmet Need n(%)	No Unmet Need n(%)	Total n	p-value
Non-drinker	41 (30.4%)	94 (69.6%)	135	—
Occasional (<1×/week)	58 (43.6%)	75 (56.4%)	133	0.023
Moderate (1–3×/week)	64 (56.1%)	50 (43.9%)	114	0.001
Heavy (4+×/week)	43 (63.2%)	25 (36.8%)	68	<0.001
Total	**206 (45.8%)**	**244 (54.2%)**	**450**	**χ^2=22.47*** **

Note: *Chi-square test applied. Reference category: Non-drinker. p-values are for comparison against non-drinker group. *** $p < 0.001$. $\chi^2 = 22.47$, $df = 3$, $p < 0.001$.*

The bivariate analysis presented in Table 2 revealed a statistically significant, monotonically increasing gradient in unmet contraceptive need across alcohol use categories ($\chi^2 = 22.47$, df = 3, $p < 0.001$), establishing a robust association between alcohol consumption frequency and the likelihood of having an unmet need for family planning. Among non-drinkers, the prevalence of unmet need was 30.4% — itself elevated relative to the national average of 18.0% (KDHS 2022) and reflective of the broader reproductive health infrastructure deficits in Narok West. However, this proportion increased significantly with each escalation in alcohol use intensity: occasional drinkers showed an unmet need prevalence of 43.6% ($p = 0.023$), moderate drinkers 56.1% ($p = 0.001$), and heavy drinkers 63.2% ($p < 0.001$). The statistically significant p-values across all drinking categories, compared to the non-drinking reference group, confirmed that the association was not attributable to chance, and the dose-response pattern strengthened the causal inference that alcohol use is a proximate determinant of unmet contraceptive need rather than merely a correlated demographic attribute. The overall unmet need prevalence of 45.8% across all respondents — nearly 2.5 times the national average — underscores the magnitude of reproductive health inequity in Narok West and situates alcohol as a critical modifiable risk factor within that inequity.

The discussion of these findings must engage both the direct and the normatively mediated pathways through which alcohol use amplifies unmet need. Mechanistically, heavy alcohol consumption may reduce women's cognitive engagement with contraceptive adherence schedules, impair decision-making during sexual encounters, and increase exposure to coercive sexual intercourse — all of which directly elevate unmet need. However, the mediating role of endurance myths is equally important: in the cultural context of Narok West, heavy-drinking women are more likely to internalise the narrative that their bodies can absorb reproductive consequences without intervention, reducing the perceived urgency of contraceptive protection. This is consistent with the broader gender and power literature (Jewkes et al., 2015) which links alcohol use among women to internalised sexual submission and reduced contraceptive agency, particularly in settings where alcohol consumption occurs within male-dominated social spaces that simultaneously reinforce endurance norms. The finding that even occasional drinkers had significantly higher unmet need than non-drinkers (43.6% vs. 30.4%, $p = 0.023$) is particularly significant from a programmatic standpoint: it implies that the association operates at low levels of exposure, and therefore that any alcohol use among women in Narok West — not merely heavy use — should trigger targeted reproductive health counselling as part of an integrated SRH service model.

Principal Component and Factor Analysis: Latent Constructs

Table 3: Exploratory Factor Analysis with Varimax Rotation — Factor Loadings and Communalities

Indicator Variable	Factor 1: Social Endurance Myth	Factor 2: Health-Seeking Behaviour	Factor 3: Alcohol-Mortality Nexus	Communality (h^2)
Belief: women can endure illness longer	**0.812**	0.134	0.092	0.683

Belief: sexual activity prevents disease	**0.776**	0.215	0.118	0.657
Partner discourages contraception use	**0.741**	0.083	0.211	0.604
Cultural norm: large family = high status	**0.698**	0.149	0.087	0.519
Utilisation of maternal health services	0.102	**0.834**	0.156	0.726
Awareness of contraceptive options	0.178	**0.809**	0.203	0.711
Frequency of alcohol consumption (days/wk)	0.143	0.177	**0.871**	0.801
Household proximity to alcohol outlet	0.089	0.091	**0.843**	0.724
Alcohol-related morbidity score	0.312	0.204	**0.798**	0.749
Eigenvalue	**3.21**	**2.87**	**2.64**	—
% Variance Explained	**21.4%**	**19.1%**	**17.6%**	**58.1%**

Note: *Extraction method: Principal Component Analysis. Rotation method: Varimax with Kaiser normalisation. KMO = 0.831; Bartlett's Test $\chi^2(36) = 1847.4$, $p < 0.001$. Factor loadings ≥ 0.60 are bolded as primary loadings. Total variance explained = 58.1%.*

The exploratory factor analysis yielded a clean three-factor solution that collectively accounted for 58.1% of the total variance in the nine-item battery — a proportion that exceeded the conventional 50% retention threshold and indicated strong factorial structure in the data. The KMO measure of 0.831 confirmed excellent sampling adequacy, and Bartlett's Test of Sphericity ($\chi^2(36) = 1,847.4$, $p < 0.001$) confirmed that the correlation matrix was significantly non-identity, validating the application of factor analysis to the dataset. Factor 1, labelled the 'Social Endurance Myth' construct, had an eigenvalue of 3.21 and explained 21.4% of total variance, with primary loadings on belief that women can endure illness longer (0.812), belief that sexual activity prevents disease (0.776), partner discouragement of contraception (0.741), and cultural status norms around large families (0.698). The internal coherence of these four indicators — all capturing aspects of culturally enforced female endurance and its reproductive consequences — lent strong theoretical validity to this factor. Factor 2, 'Health-Seeking Behaviour,' explained 19.1% of variance with primary loadings on maternal health service utilisation (0.834) and awareness of contraceptive options (0.809), capturing the attitudinal and access-side dimensions of reproductive health agency. Factor 3, the 'Alcohol-Mortality Nexus,' explained 17.6% of variance and was anchored by frequency of alcohol consumption (0.871), household proximity to alcohol outlets (0.843), and alcohol-related morbidity score (0.798) — a structurally coherent cluster of alcohol exposure and health damage variables.

The identification of these three latent factors through PCA and EFA carries significant theoretical and programmatic implications. Most critically, the fact that endurance myth items and alcohol-mortality items loaded onto entirely distinct factors — despite being conceptually related — suggests that their influence on reproductive health outcomes operates through independent pathways rather than a single, unified construct. This finding has methodological importance: interventions that target only one factor (e.g., alcohol reduction campaigns) will not automatically disrupt the endurance myth pathway, which requires separate and culturally-tailored communication strategies. The relatively high communalities across all items (ranging from 0.519 to 0.801) indicated that the three-factor model adequately captured the shared variance in most indicators, with the cultural status norm item (communality = 0.519) showing the weakest fit — suggesting that pronatalist norms, while related to endurance beliefs, contain unique variance not fully captured by the myth factor. Notably, the PCA-derived component scores for the three factors showed differential predictive value when regressed against health outcomes: the Alcohol-Mortality Nexus factor showed the strongest mean differences across health outcome groups, while the Social Endurance Myth factor demonstrated the strongest association with unmet contraceptive need — a finding that reinforces the central thesis that myths and alcohol operate as distinct but synergistic structural determinants of reproductive health inequity in Narok West.

Health Outcomes by Alcohol Use Category

Table 4: Health Outcome Variables by Alcohol Use Category (ANOVA with Bonferroni Post-Hoc)

Outcome Variable	Non-drinker Mean (SD)	Occasional Mean (SD)	Moderate Mean (SD)	Heavy Mean (SD)	F-stat (p)
Self-rated health score (1–10)	7.2 (1.4)	6.8 (1.6)	5.9 (1.9)	4.7 (2.1)	18.34 (<.001)
Gynaecological morbidity index	1.8 (0.9)	2.3 (1.1)	3.1 (1.4)	4.2 (1.7)	31.56 (<.001)
Days ill in past 30 days	2.1 (1.8)	3.4 (2.2)	5.2 (2.7)	7.8 (3.1)	42.12 (<.001)
Maternal mortality risk score	0.23 (0.11)	0.31 (0.14)	0.48 (0.19)	0.67 (0.23)	51.88 (<.001)

Unmet contraceptive need score	1.9 (1.2)	2.8 (1.4)	3.6 (1.6)	4.8 (1.9)	28.74 (<.001)

Note: *One-way ANOVA with Bonferroni correction. All F-statistics are significant at $p < 0.001$. Scores are mean (SD). Post-hoc tests confirmed significant pairwise differences between all adjacent alcohol use categories for all outcomes except self-rated health (non-drinker vs. occasional, $p = 0.09$).*

The one-way ANOVA results presented in Table 4 confirmed highly statistically significant differences across all five health outcome variables by alcohol use category, with F-statistics ranging from 18.34 to 51.88 and all associated p-values below 0.001. The most pronounced gradient was observed for the maternal mortality risk score: mean scores increased from 0.23 (SD = 0.11) among non-drinkers to 0.67 (SD = 0.23) among heavy drinkers — an absolute increase of 0.44 risk score units, representing a nearly threefold elevation in mortality risk across the alcohol use spectrum ($F = 51.88$, $p < 0.001$). Days ill in the past 30 days similarly showed a steep gradient, rising from 2.1 days among non-drinkers to 7.8 days among heavy drinkers ($F = 42.12$, $p < 0.001$), implying that heavy-drinking women spent approximately 26% of the prior month incapacitated by illness — a burden with direct consequences for child care, economic productivity, and healthcare engagement. The gynecological morbidity index, which captured symptoms including pelvic pain, abnormal vaginal discharge, dysmenorrhea, and menstrual irregularities, increased from 1.8 among non-drinkers to 4.2 among heavy drinkers ($F = 31.56$, $p < 0.001$), indicating that alcohol use is associated with a substantially higher burden of gynecological pathology, likely through immunosuppression, hormonal disruption, and reduced health-seeking due to myth internalization. Bonferroni post-hoc tests confirmed that differences were statistically significant between all adjacent alcohol use categories for most outcomes, establishing a dose-response relationship that substantially strengthens the causal interpretation.
The discussion of Table 4 findings must be contextualized within both the biological and the socio-normative frameworks that jointly explain the observed health outcome gradients. Biologically, heavy alcohol use among women is well-established to elevate oestrogen levels, disrupt ovarian function, compromise cervical immune defences, and impair the metabolic efficacy of hormonal contraceptives — mechanisms that collectively explain the elevated gynecological morbidity and maternal mortality risk scores observed in this study. However, the endurance myth construct identified in the factor analysis (Table 3) offers an important complementary explanation: women who internalise beliefs about female biological superiority are less likely to seek timely care for gynaecological symptoms, more likely to delay maternal health service utilisation, and less likely to disclose alcohol use to healthcare providers — creating a compounding feedback loop in which myth internalisation transforms alcohol-related symptoms into untreated pathology. The finding that self-rated health score declined from 7.2 among non-drinkers to 4.7 among heavy drinkers ($F = 18.34$, $p < 0.001$) is particularly instructive: even in a context shaped by endurance myths that encourage women to minimise subjective health complaints, heavy-drinking women still rated their health significantly below that of non-drinkers, suggesting that the physiological burden of heavy alcohol use eventually overwhelms even the strongest ideological pressure to perform resilience. Together, the ANOVA findings make a compelling evidence-based case for integrated interventions that simultaneously address alcohol use, reproductive health service access, and the cultural myth landscape — not as separate programme streams, but as a unified response to a multi-causal health crisis in Narok West.

CONCLUSION

This study provided empirical evidence that female sexual potency myths and endurance narratives are not passive cultural artefacts in Narok West but active structural determinants of reproductive health inequality that interact with alcohol consumption to compound unmet contraceptive needs, elevate gynaecological morbidity, and amplify maternal mortality risk. The analysis of 450 women of reproductive age revealed an overall unmet contraceptive need prevalence of 45.8% — more than twice the national average — that escalated sharply to 63.2% among heavy alcohol users, establishing a statistically significant and dose-responsive association ($\chi^2 = 22.47$, $p < 0.001$). The factor analysis identified three coherent latent constructs — the Social Endurance Myth, Health-Seeking Behaviour deficits, and the Alcohol-Mortality Nexus — that collectively explained 58.1% of total variance and operated as independent yet synergistic pathways to poor health outcomes, while the ANOVA findings demonstrated that all five health outcome measures deteriorated monotonically and significantly with increasing alcohol use. Crucially, the study demonstrated that the endurance myth construct loaded independently from the alcohol exposure construct, indicating that myth-targeted and alcohol-reduction interventions must be designed and deployed simultaneously rather than sequentially if they are to meaningfully disrupt the multi-pathway mechanisms sustaining reproductive health inequity in Narok West. These findings collectively demand an urgent reframing of women's health programming in Narok West — away from single-issue, access-focused models and toward integrated, culturally-responsive interventions that address the ideological, behavioural, and structural dimensions of vulnerability simultaneously.

RECOMMENDATIONS

Narok County Department of Health should develop and implement an integrated 'Myths, Alcohol, and Reproductive Health' (MARH) community intervention programme, delivered through existing Community Health Volunteers (CHVs), that

simultaneously addresses endurance myth deconstruction, alcohol reduction counselling, and contraceptive uptake promotion — prioritising heavy-drinking women identified through community alcohol screening protocols as the highest-risk subgroup.

The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) and the National Council for Population and Development (NCPD) should establish a joint policy framework that formally recognises the convergence of alcohol use and unmet contraceptive need as a dual public health emergency in pastoralist and semi-arid counties, including Narok, with earmarked funding for integrated SRH-alcohol services in facility and community settings.

Future research in Narok West and similar pastoral contexts should employ longitudinal cohort designs with validated instruments to measure the temporal directionality of the myth-alcohol-unmet need relationship, and should include qualitative components to document the community-specific mechanisms through which endurance narratives are transmitted, reinforced, and potentially challenged — thereby providing the rich contextual evidence needed to design and evaluate culturally resonant, equity-oriented reproductive health programmes.

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