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Original Article

Use of the Manyatta Model to Promote Uptake of Family Planning in Hard-to-Reach Communities in Samburu County, Kenya

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Family Planning, Tag Teams, Community Health Promoters, Patriarchal, Male Participation.

ABSTRACT

Introduction: Samburu County has a low modern Contraceptive Prevalence Rate (mCPR) of 25.4% against 57% at the national level. The country is highly patriarchal and men are the key decision-makers in women's health including family planning. The Delivering Equitable and Sustainable Increase in Family Planning (DESIP) project hypothesized that the Manyatta Model (a model implemented at the homestead level) will contribute to increased uptake of Family Planning (FP) services among the hard-to-reach communities of Samburu North sub-County. Interventions: Through the model, community health promoters (CHPs) conducted health education at the homesteads hereby referred to as Manyatta. The model utilized a structured planning and mobilization strategy dabbed the Tag-Team approach. The model was piloted in six sites supported by DESIP. Quantitative data was collected from July 2019 to June 2020 and also from July 2020 to June 2021 from the link health facility records. This was triangulated with qualitative data from 10 Key Informant Interviews (KIIs) and 6 Focussed Group Discussions (FGDs) conducted with the project beneficiaries in the pilot sites. **Findings:** The findings indicated that clients initiated on FP (first-time users) increased from 13% (n=835) in (July 2019- June 2020) to 18% (n=1,101) in (July 2020- June 2021) out of the eligible population of 6,286 women of reproductive age 15-49 years. Uptake of Implants improved from 17% in (July 2019-June 2020) to 24% in (July 2020- June 2021). From the KIIs and FGDs, it was evident that targeting males especially elders contributed to improving male participation in FP and reproductive health decision-making. This is because the Samburu Community is highly patriarchal. **Conclusion**: Based on the results of the pilot sites, DESIP proposes scaling up the *Manyatta* Model, an approach which was made possible by engaging communities in designing their trajectory to better healthcare.

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INTRODUCTION

Despite an 11% global increase in the use of modern contraception from 1994 to 2012, its prevalence remains low in many low-income and middle-income countries (LMIC) (Nations, 2020). In sub-Saharan African countries such as Mali (9.3 %), Chad (5.5 %), Sierra Leone (7.6 %), and South Sudan (4.9 %), its prevalence is under 10% (UN, 2016). Unmet need for contraception is still significant, affecting 34.2 % of women in Western Asia, 30 % in Africa, and 10.4 % in Latin America(Alkema et al., 2013; Sedgh et al., 2016) Regardless of how they are defined, demand generation interventions are often heterogeneous and include, but are not limited to the following: "development of advocacy materials for family planning; dissemination of appropriate messages for family planning by community health workers; advocacy on family planning at the community levels to involve the formal and informal leaders; sensitization and awareness creation through community radio, radio drama, television drama, etc.; targeting of special groups including male motivation etc., in the promotion of contraceptives; training of community health/extension workers and others for promotion of family planning; and social marketing of modern contraceptives" (Belaid et al., 2016). Kenya has made significant progress in reproductive health indicators. According to the Kenya National Bureau of Statistics (2019), the maternal mortality ratio (MMR) is 355 per 100,000 live births. As per the Kenya Demographic Health Survey (KNBS & ICF, 2023) Total Fertility Rate (TFR) is at 3.4, teenage pregnancy is at 15%, unmet need for Family Planning is at 14%, and the modern contraceptive prevalence rate (mCPR) is at 57%. Among sexually active unmarried women aged 15–49 years, 70% use a contraceptive method, and 59% of these women use a modern method. The use of traditional methods is more common among sexually active unmarried women than among currently married women (11% and 6%, respectively).

Some of the key barriers that limit access to contraceptives are myths and misconceptions of FP, weak FP-seeking behaviour as FP is not considered a priority health need hence not prioritised, and long distances to health facilities. In some instances, the demand creation efforts are not met with commensurate availability of commodities at health facilities. On the supply side; the key barriers include lack of skilled health care workers,

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insufficient operationalization of FP guidelines/standards, lack of necessary equipment and supplies as well as gaps in commodity supply chain management.

At the County level, similar challenges are also experienced. Samburu County, which lies within the arid and semi-arid region of Northern Kenya, is predominantly a patriarchal community with the decisions being unilaterally made by men. (Marsabit & Counties, 2016; Mira Ahlstedt, 2020). Samburu County is also characterized by poorly trending Reproductive Maternal and Newborn Child and Adolescent Health Indicators (RMNCAH). The County has a Maternal Mortality Ratio (MMR) of 275 per 100,000 live births, (KNBS & ICF, 2023). Total Fertility Rate (TFR) at 5.8, with teenage pregnancy as high as 50%, Contraceptive Prevalence Rate (CPR) at 25.4% and unmet need for Family Planning of 29% (Kenya National Bureau of Statistics et al., 2015); (KNBS & ICF, 2023) This has been exacerbated by having many children being a family pride in the society, high illiteracy level among the community, myths and misconception about the use of modern contraceptives, leads to delay in health-seeking behaviour. Effective family planning programs are a critical means of empowering women and adolescent girls, improving human capital, reducing dependency ratios, reducing maternal (through mortality depletion) and child (through birth spacing and improved nutrition) mortality, and achieving demographic dividends in low- and middle-income countries (Campbell et al., 2006). Family planning is an area of critical maternal health knowledge gaps in LMICs, as such, increasing knowledge on family planning remains a global health priority for the agenda beyond 2015 (Kendall & Langer, 2015).

To address this gap in Samburu County, the Delivering Equitable and Sustainable Increases in Family Planning (DESIP) Programme utilized the *Manyatta Model* approach to improve the uptake of FP services. DESIP (Delivering Sustainable and Equitable Increases in Family Planning) is a programme funded by the Foreign, Commonwealth and Development Office (FCDO) and was implemented in 19 Counties in Kenya including Samburu. DESIP's goal is to ensure that women and girls can safely plan their pregnancies and improve their sexual reproductive health (SRH). The Manyatta Model entailed working with the lowest administrative Structure (Homestead) to link Samburu hard-to-reach communities to the formal Health System for increased utilization of Family Planning services. Through the model, the CHPs engaged homogeneous groups of the population so as to identify barriers to access and utilization of Family Planning services. Some of the barriers to access and utilization of FP included; lack of access to accurate information on family planning, social-cultural factors such as community norms, myths and misconceptions about FP, conflicting messages from political and religious leaders on FP, as well as long distances to access health facilities.

The project engaged various stakeholders at different levels and this included representatives from the County, the Community level and the DESIP project implementing partners. Based on the gaps in FP, the project worked with all stakeholders to develop local solutions including strengthening linkages to service delivery areas and community-based referral systems. The approach focused on working with established and functional community units with community health assistants (CHAs) and CHPs playing pivotal roles in household visits, and conducting health education, through the dissemination of information through dialogues with various homogeneous groups in the community at the village level. Additionally, the CHPs conducted community mobilization and referred clients for family planning and reproductive health (FP/RH) services during integrated outreach services.

This paper therefore presents the process of implementation of the *Manyatta Model*, the methodologies used and the outcomes of the model

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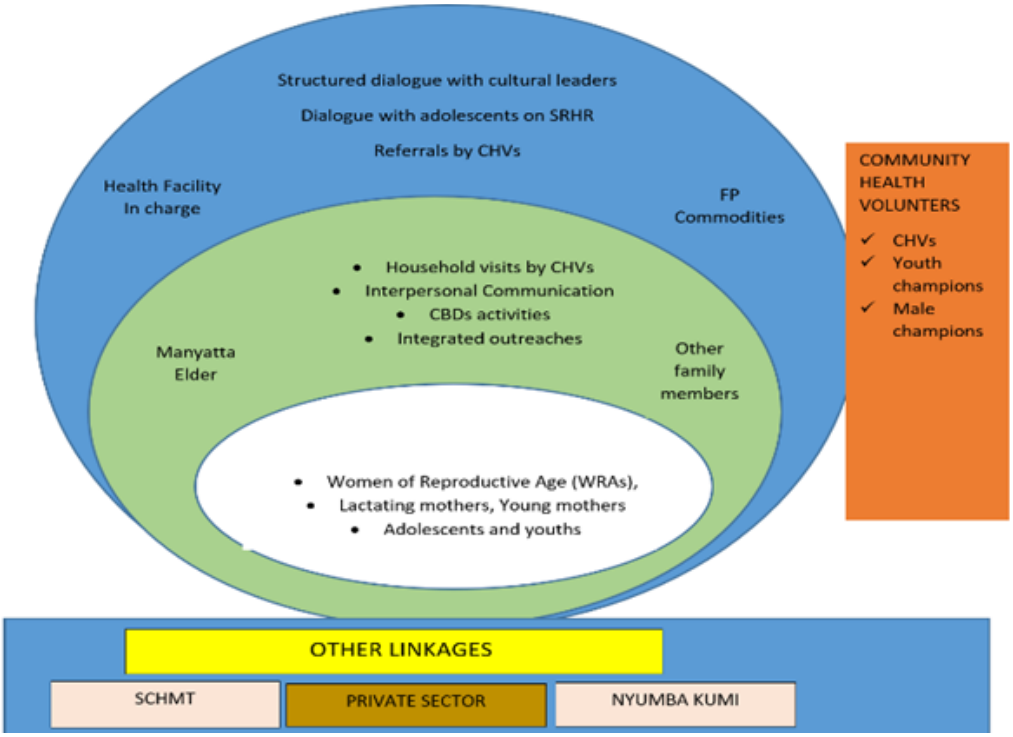
that could be adopted by entities interested in scaling up this model.

DESCRIPTION OF THE MANYATTA MODEL

The goal of the Manyatta model is to contribute to increased uptake of FP services among the hard-to-reach communities of Samburu North Sub-County by bringing together all members at the homestead and targeting them with a set of essential culture-sensitive Family Planning interventions. It involves engaging the participation of women, adolescents and youth, men and elders at the *Manyatta* level in identifying barriers to Family Planning (FP) services and developing local solutions including strengthening linkage to facilities and a community-based referral system. Through this model, the DESIP organized and formulated key FP information into palatable and culturally sensitive arguments with a view of gaining social acceptance of FP services among men and elders at the Manyatta level. This approach also involved analyzing and segmenting *Manyatta Model* beneficiaries into homogeneous groups such as lactating mothers and pregnant women, adolescents and youth, men and cultural leaders, as well as young mothers. This is important in respect to the Samburu culture where men and women do not discuss reproductive health information publicly in the same forum. These segments were then targeted with relevant information and motivation using a mix of interpersonal communication and group participatory methods led by Community Health Promoters (CHPs). The conceptual framework is indicated in Figure 1.

Figure 1 – Conceptual Framework of the Manyatta Model



Conceptualization of the Model: Representatives from the DESIP program together with the key County and Sub-County Health Management team (C/SCHMT) members of Samburu and Samburu North respectively held an inception meeting in April 2020 to discuss how to reach the marginalized communities in Samburu North of Kenya, one of the far-flung sub-counties in Samburu County. The idea of using the lowest administrative unit and reaching homogenous groups at the household level

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was conceptualized. Based on the family planning indicators, the C/SCHMT and DESIP team identified a total of six facilities (three high-volume and three low-volume facilities) as pilot sites for the implementation of the model.

The criteria used to select the six sites were: availability of staff, consistency of monthly reporting, availability of FP data (and the reference period was in June 2019 at the start of the DESIP project), availability of FP commodities, established community health units and trained community health promoters in the respective community units. The high-volume facilities identified in Samburu North Sub County were: Tuum Dispensary, South Horr Health Centre and Lesirkan Health Centre, while the low-volume facilities included Nachola Health Centre, Anderi Dispensary and Marti Dispensary. The project team then held sensitization meetings with stakeholders (Health care workers, CHPs, cultural gatekeepers to sensitize them on the model approach). The pilot was implemented from July 2020 to June 2021.

Structured dialogue sessions: The Manyatta Model utilized the Tag-Teams approach to facilitate structured dialogues targeting various groups (cultural leaders, men, women of reproductive age, adolescents and youth as well as persons with disability), with key family planning messages. Using a concerted effort, CHPs worked in Tag-Teams (observing gender representation) of three to four, pre-mobilized *Manyattas* which had about 15 to 20 beneficiaries. A general talk on healthcare was held ahead of the differentiated dialogue session with specific beneficiary groups (women, teenagers and elders).

After the talk, women, teenage mothers, and elders would sit in segregated safe spaces where they would freely discuss health issues that affect them. Older mothers, teen mothers and youth (girls) were easily reached in the afternoon after completion of their household chores, while the elderly men were always available from morning to evening with most sessions happening in between meal times. Ahead of outreach, a Tag-Team member (female CHP) would contact lead mothers to mobilize mothers to create time for health talks on specified days. A similar approach was used by male CHP to reach men and elders in the Manyatta. Through the Tag-Team approach, male CHPs were tasked to facilitate the men/elders-only session while the females would help with IEC materials and note-taking for documentation. The Tag-Teams liaised with health workers at the facility for the provision of services at the Manyatta for women of reproductive age (WRAs) seeking FP methods. To *ensure inclusivity*, the youth and adolescents in a *Manyatta* were targeted through adolescent-youth-only dialogues. The Tag Team attached to one area would plan a specific day for dialogue and mobilize the youth days ahead of the meeting. Thereafter, sensitizations on SRH were conducted for all the peer groups and were also reached with SRH messages during cultural ceremonies conducted within the Manyattas. During mobilization, households with persons with disability (PWDs) were also visited, mobilized and sensitized.

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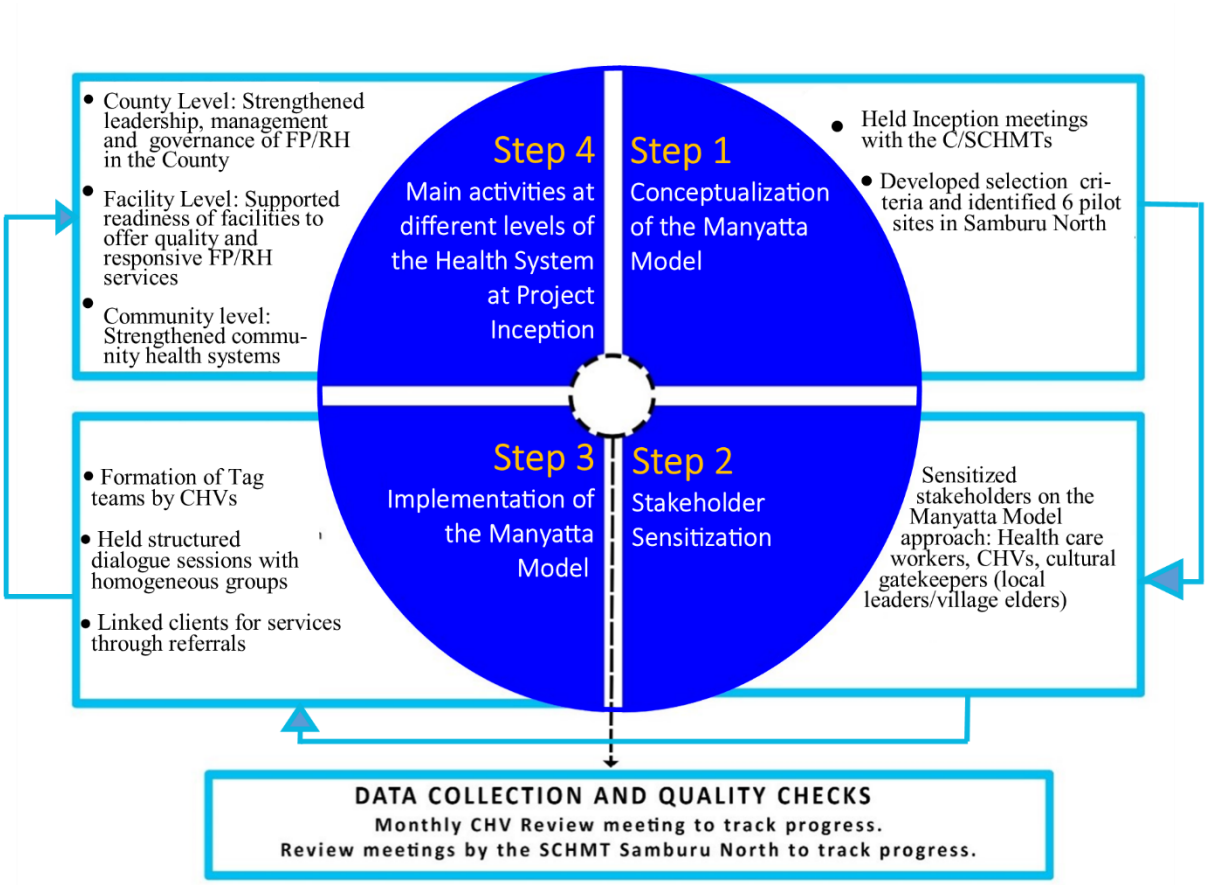
Figure 2-Stepwise approach to the implementation of the Model



At the *link facility*, FP in-reaches and outreaches were conducted. In line with COVID-19 protocols, Booked in Clients (BIC) in reaches were supported and FP services were integrated into all outreaches increasing the reach, especially in far-flung and marginalized areas i.e. Suguta Valley. *Booked in Client In Reaches (BIC):* these are health services organized for people who previously accessed health services (FP/RH among others) and were either due for the same services. Healthcare workers can book appointments for the clients who are then mobilized by the CHPs. The CHPs (members of Tag-Teams) were trained on the FP Technical Module and conducted health education sessions at the household level. The CHPs play a key role in implementing community health services and link clients to level two, three and four facilities in the sub-county. They further referred clients for services to promote community and facility linkages. The CHPs held monthly review meetings to track progress and plan accordingly.

At *County and sub-county levels*; the county and sub-county health management team members (C/SHCMT) trained 13 healthcare workers on Long Acting Reversible contraceptives (LARC), and adolescent youth and sexual reproductive health (AYSRH) so as to strengthen the knowledge and skills of healthcare workers in service provision. The sub-county managers also revitalized the existing commodity Technical Working Groups (TWGs) that provided an opportunity to strengthen supply chain management. The C/SHCMT members provided oversight mentorship and on-the-job training to healthcare workers on LARC/ AYSRH. They conducted quarterly support supervision and data quality assessments in the

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targeted facilities. The trends in service utilization were periodically reviewed for decision-making at all levels.

DEFINITION OF TERMS:

Community Health Promoter (CHP) Previously referred to as Community Health Volunteers (CHVs): According to the Community Health Strategy in Kenya, these are individuals chosen by the community (either male or female) and trained to address health issues of individuals and communities in their respective localities, working in close relationship with health facilities. A CHP acts as a catalyst and a change agent to empower people to take control of their own health achievement efforts. The CHPs are supervised by Community Health Assistants (CHAs).

Community-Based Distributors (CBD): these are CHPs trained to provide family planning services as well as information on FP/ sexual reproductive health services. In Kenya, the CBDs were piloted in a few counties by the MOH to provide DMPA SC, emergency pills and condoms.

County/Sub-County Health Management Team: The County HMT coordinates activities at the County level while providing general oversight on leadership, management and governance of health issues. The SCHMT provide oversight and coordinates activities at the sub-county level. In Kenya after devolution in 2013, the former Provinces were divided into 47 counties and one County constitutes various sub-counties.

Nyumba Kumi: this is a strategy for community policing in Kenya at the household level. The group of households can be in an estate, block of houses, manyatta, or gated community among others.

Outreaches: these are health services organized outside the health system, i.e. at the community level; they could be on FP/RH among other health services. Community members are mobilized for services prior to an outreach.

DATA MANAGEMENT

The data was collected at the target facilities and outreach sites and abstracted from the Ministry of Health data collection tools on a monthly basis for review. The MOH tools utilized included the FP register (MOH 512) and the reporting tool (MOH 711) as well as the Facility Contraceptive Consumption Data Report and Request tool (FCDRR). The data was also uploaded to the National Kenya Health Information System (KHIS). Progress reports on the uptake of family planning services in the 6 pilot sites were developed and presented during the monthly, quarterly and annual progress review of the project. The progress review was built into the normal project reporting and review mechanisms.

In order to ensure quality data was captured by healthcare workers, mentorships on documentation by the data collection registers and reporting tools were done through on-the-job training. This was to ensure that the healthcare workers appropriately documented the information being collected on FP services. On a quarterly basis, the project conducted data quality assessments (DQAs), to check on the quality of data and ensure that the data is well captured in source documents and the reporting tools. The routine data quality assessments (RQDQA) compared data from three sources; facility registers, reporting tools and data from the national Kenya Health Information System (KHIS) for completeness, timeliness, accuracy and integrity among other data quality parameters. Data review meetings were also held to review gaps for continuous learning.

Qualitative data: The project conducted 10 in-depth interviews with different groups mainly health care workers, and C/SCHMTs and 6 Focused Group Discussions (FGDs) with CHPs and project beneficiaries (men, women as well as the youth). This provided an opportunity to identify how the *Manyatta model* was contributing to the uptake of FP services and ensure Equity by reaching out to Adolescents and Youth and Persons with Disability

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(PWDs); as well as identify the key components of the model that need to be changed based on the study findings.

Data Analysis: Quantitative data collected was downloaded from KHIS using pivot tables for further analysis in Excel. Data was analyzed descriptively using frequencies and percentages. Bar graphs, tables and pie charts were used to present the findings. Qualitative data was transcribed and categorized into various themes and analyzed using content analysis.

FINDINGS

This paper presents findings of data collected periodically during the implementation of the project to assess the influence of the *Manyatta Model* on the uptake of FP services in Samburu North Sub-county. The data was abstracted from 6 facilities including Anderi Dispensary, Marti Dispensary, Tuum Dispensary, Nachola Health Centre, Lesirkan Health Centre and South Horr Health Centre.

New Clients initiated on Family Planning Methods.

The findings revealed that clients initiated on FP (first-time users) increased from 13% n =835 in (July 2019- June 2020) to 18% n=1,101 (July 2020- June 2021) out of the eligible population of 6,286, women of reproductive age 15-49 years in the six sites. The highest increase was reported at Anderi dispensary from 31 in (July 2019- June 2020) to 231 (July 2020- June 2021) (N=324), an increase by 58%. At Nachola Health Centre, out of the total eligible WRAs (N= 1,191), the new clients initiated on FP methods increased from 93 to 174 an increase by 7% in the same period (table 1) below. The increase was contributed by male engagement dialogue sessions that contributed to acceptance of FP services among community members, increased demand for FP services as well as FP referrals by community health promoters (CHPs).

Table 1– New Clients initiated family planning in the six pilot sites in the Samburu North sub-county

Health Facility	July 2019- June 2020	July 2020- June 2021	Total WRAs	Performance (%)
Anderi Dispensary	31	231	342	58%
Marti Dispensary	50	86	981	4%
Nachola Health Centre	93	174	1191	7%
Lesirkan Health Centre	228	230	1396	0.1%
South Horr Health Centre	246	220	1180	2%
Tuum Dispensary	187	160	1196	2%
Total	**835 (13%)**	**1,101 (18%)**	**6,286**	**5%**

Uptake of short-term FP Methods

On short-term FP Methods, the data from the pilot sites indicated increased uptake in four sites mainly; Anderi dispensary by 29% (N=342), Marti dispensary by 3% (N=981), Nachola Health Centre by 12% (N=1,191) and Tuum dispensary by 4% (N=1,196). However, the other two sites experienced a decrease in clients accessing short-term FP Methods (Lesirkan Health Centre by 9% (N=1,396) and South Horr Health Centre by 11% (N =1,180) between (July 2019- June 2020) to (July 2020- June 2021), table 2 below. It is worth noting that in 2021, the government directive in Kenya on COVID-19 limited the number of clients at the health facilities to avoid overcrowding which influenced uptake of the health services including FP services.

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Table 2– Uptake of Short-term Family Planning services in the six pilot sites in Samburu North sub-county

Health Facility	July 2019-June 2020	July 2020-June 2021	Total WRAs	Performance (%)
Anderi Dispensary	80	180	342	29%
Marti Dispensary	50	81	981	3%
Nachola Health Centre	52	194	1191	12%
Lesirkan Health Centre	235	113	1396	9%
South Horr Health Centre	432	297	1180	11%
Tuum Dispensary	143	191	1196	4%
Total	**992 (16%)**	**1,056 (17%)**	**6,286**	**1%**

Uptake of Long-Acting Reversible Contraceptives (LARC) Methods

On LARC methods, the findings revealed that uptake of Long Acting Reversible methods in the 6 pilot sites also increased from 258 (July 2019- June 2020) to 365 (July 2020- June 2021) out of the population of WRAs (15-49 years). The uptake of LARC services at Lesirkan Health Centre increased from 35 to 125 and an increase by 6% within the same period. At Anderi dispensary there was an increase by 9% from 4 to 34 in the same period. However, Nachola Health Centre had a decrease of 2% from 61 to 40 from table 3 below.

Table 3 Uptake of Long-Acting Reversible Contraception (LARC) services in the six pilot sites in the Samburu North sub-county

Health Facility	July 2019-June 2020	July 2020-June 2021	Total WRAs	Performance (%)
Anderi Dispensary	4	34	342	9%
Marti Dispensary	12	20	981	1%
Nachola Health Centre	61	40	1191	2%
Lesirkan Health Centre	35	125	1396	6.4%
South Horr Health Centre	68	67	1180	0.1%
Tuum Dispensary	78	79	1196	3%
Total	**258 (4%)**	**365 (6%)**	**6,286**	**2%**

Uptake of all FP Services (Short term and Long term reversible contraceptives)

In the same period, the proportion of clients accessing FP services increased from 21% (n=1,345) in the period July 2019- June 2020 to 26% (n=1,650) in July 2020- June 2021. Table 4 below. Out of the 6 sites, 4 facilities had an increased proportion of clients accessing services i.e. (Anderi dispensary at 44%), Nachola Health Centre at 12% Marti dispensary and Tuum dispensary at 4% respectively. South Horr Health Centre decreased by 4% while Lesirkan Health Centre slightly decreased by 2%. The increase was contributed by referrals from community health promoters (CHPs) as well as *Booked in Client In Reaches (BIC)* that were organized after clients were reached with FP messages and also counselled on all FP methods by healthcare workers.

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Table 4–Clients accessing All Family Planning Services in the six pilot sites in the Samburu North sub-county

Health Facility	July 2019-June 2020	July 2020-June 2021	Total WRAs	Performance (%)
Anderi Dispensary	86	238	342	44%
Marti Dispensary	78	114	981	4%
Nachola Health Centre	113	260	1191	12%
Lesirkan Health Centre	306	274	1396	2%
South Horr Health Centre	532	489	1180	4%
Tuum Dispensary	230	275	1196	4%
Total	**1,345 (21%)**	**1,650 (26%)**	**6,286**	**5%**

Family Planning Method Mix

The findings from the pilot sites revealed that there was an uptake of some of the FP methods for example clients taking up Implants improved from 17% in (July 2019-June 2020) to 24% in July 2020-June 2021). However, two FP methods had a decrease i.e. Intrauterine Contraceptive Device (IUCD) and DMPA while others remained relatively the same (Pills Combined oral contraceptive (POP), Pills progestin-only (COP).

Figure 3 –FP method mix in the six pilot sites in Samburu North sub-county (July 2019- June 2020)

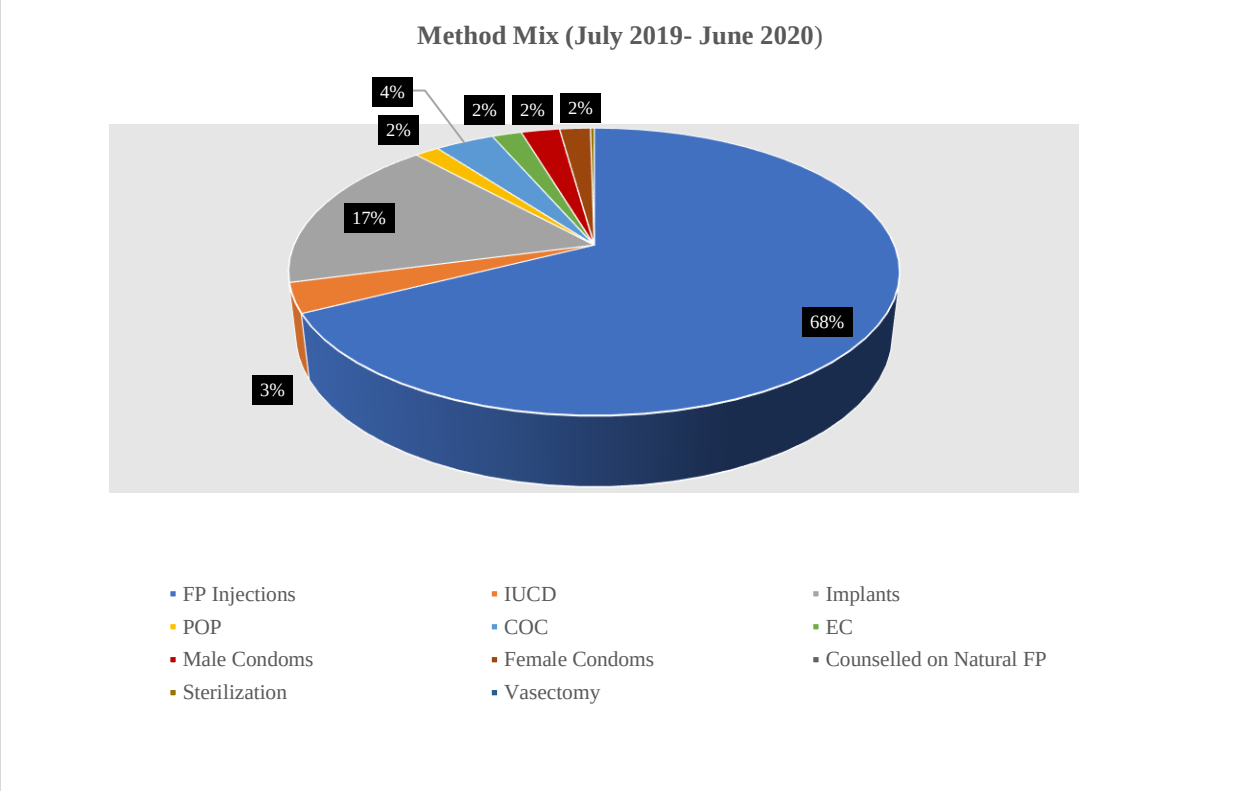

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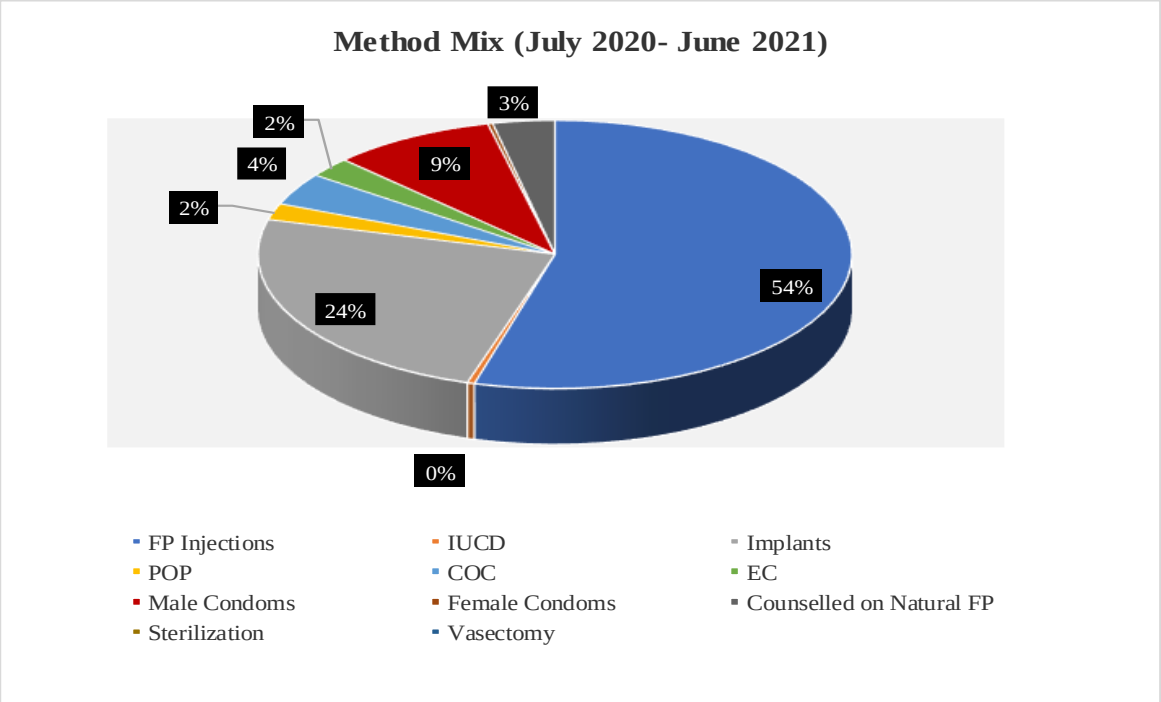
Figure 4 –FP method mix in the six pilot sites in Samburu North sub-county (July 2020- June 2021)



The project also assessed the Couple Years of Protection (CYPs) in the six pilot sites, and the findings revealed that the CYPs improved from 968 to 1,307 in the same period. In terms of other FP services, it was noted that some of the facilities initiated Post-partum family planning (PPFP) methods as 20 clients received PPFP in (July 2020-June 2021) at Anderi dispensary, Marti dispensary and Nachola Health Centre. On uptake of FP services among Adolescents and Youth, (10-19 years, there was a slight increase from 113 in (July 2019- June 2020) to 118 in (July 2020-June 2021) in all the pilot sites.

Results from the KIIs and FGDs

Working as Tag-Teams, the Manyatta Model assigned CHPs to households to identify and address the health needs therein. This resulted in referrals of women and girls to the health facilities for counselling and services including FP services. The findings revealed that there was an increase in referrals by the tag teams as these improved from 78 (July 2019) to 225 (June 2021). The majority (86%) of the clients referred were able to access FP services as documented at the link facilities. Through the Manyatta Model, the CHPs also identified and addressed health issues beyond FP, these included nutrition and food security as well as maternal and child health. The support to the link facility ensured that the community was in sync and updated with activities being conducted at the health facilities. Additionally, findings from the KIIs indicated that the commodity security committees were regularized and as such the commodity security committee strengthened supply chain management of RMNCAH commodities, including all FP methods, and this ensured that after clients made an informed choice, they were able to get the method of their choice at all healthcare facilities.

Improved meaningful participation of males in FP decisions through male involvement in Targeted Manyattas

The Samburu community is highly patriarchal; governance is by male elders who are considered to have wisdom from their ancestors. As a result, myths and misconceptions about FP remain one of the greatest impediments to access to FP services in

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the Samburu community. The *Manyatta Model*, through Tag Teams, utilized structured dialogues targeting the men and cultural leaders with key messages and giving time for plenary. The findings from the KIIs and FGDs revealed that male engagement played a key role in winning men over, as the men are the key decision-makers in the community. It was noted that male involvement led to the acceptance of FP services among the highly patriarchal community. The findings also revealed that male champions emerged who played a key role in health education sessions and linking the communities to access FP services. It was noted that through the targeted dialogue sessions, the Manyatta Model approach provided an opportunity to reach out to men at the Manyatta, thus enabling them to access accurate information on child spacing. This in turn promoted their meaningful participation in informed decision-making at *the Manyatta* level regarding reproductive health.

> *"Before the Manyatta Model, men were rarely engaged in matters concerning family planning. Most of the information they got was from women after they visited the health facility. So, men took it in a bad light for not being reached with information and assumed FP meant a complete stop in procreation. However, I appreciate the Manyatta Model which delivers FP messages in a respectful manner, setting us (men) aside and talking to us vividly about the benefits of child spacing," Elder at Lerugum, Lesirikan CU.*

The findings further revealed that male involvement also provided an opportunity to clarify myths and misconceptions that men have held over the years regarding FP and child spacing. Between August 2020 and June 2021, the male involvement resulted in men supporting family planning services and some even started accompanying their wives to the facility after referral.

> *"When my wife approached me to discuss FP issues, I was not only delighted but felt confident because I had gained information about FP at the dialogue meeting. I told her to go for FP. She was a little surprised at my take, but I assured her that I am a new knowledgeable man, and would not have any more children," he said, "My wife opted for the long-term contraception, implant." Male champion, Anderi.*

It was noted that in order to sustain the efforts made in reaching men, the male champions proposed that the younger generation of men, a junior age set, popularly referred to as the *Lkishami* should be targeted with FP information, as they will form the next generation of leaders in the community.

Ensuring Equity-Reaching out to Adolescents and Youth and Persons with Disability (PWDs)

The findings revealed that the dialogue sessions gave adolescents an opportunity to express their views on family planning. They enabled family members to talk together and discuss issues around reproductive health openly in family meetings unlike before. The findings also revealed that the pilot facilities have made progress in ensuring family planning information and services are offered free of charge to all people inclusive of persons with disability (PWDs) in public health facilities.

> *"Through the DESIP project, we have benefitted from Kenya Sign Language Charts which has assisted us to attend to our special clients who seek the services. The CHPs have assisted by referring these clients to us, we now have numbers of PWD data reported…." Health Care worker at Nachola Health Centre. "*

The findings further revealed that through the model the CHPs had an opportunity to reach all types of clients at the household level and link them for service utilization at health facilities. Through the support of in-reaches, more clients were reached across all facilities including those not implementing the Manyatta Model. Additionally, the health care workers noted that FP services were integrated into all outreaches increasing the reach of

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the services even to areas with no access to formal health service provision for example in Suguta Valley. Similarly, through RDQAs, and data review meetings, the healthcare workers and Tag Teams recorded trends in uptake of FP services and made appropriate decisions accordingly. They used the data to decide what to continue implementing and what changes to make on interventions that do not work in the respective sites.

Challenges during Implementation

During implementation the project experienced challenges that included: The vastness of the catchment area created a challenge in repeat access to some Manyattas that are beyond the ten kilometres radius as CHPs must make it on foot while carrying items like IEC materials and FP commodities, exposing the CHPs to both animal and human attacks. Interestingly, the distances to be covered increased due to demand by other Manyattas who are far from the health facility but in need of FP services offered by Tag Teams. During the COVID-19 period, some Manyattas restricted access of CHPs to its members to minimise infections. This reduced the number of sessions and group health talks to only in-person sessions for the provision of FP methods. There were also insecurity attacks in some pockets of Samburu North Sub County that delayed the implementation of community-level activities of the Manyatta Model. The team had to re-schedule activities appropriately. The project remained vigilant through active engagement with the community and county leadership while focusing more on secure areas.

DISCUSSIONS

Family planning is vital in preventing unintended pregnancies and improving maternal and child health (Speizer et al., 2014). In order to meet the FP 2030 and related sustainable development goals, the World Health Organization recommended the need to accelerate the uptake of voluntary rights-based family planning interventions. Some of the recommendations included reaching all adolescents, expanding the availability of services to the poorest and hard-to-reach populations and Broadening social behaviour change communication interventions (WHO, 2018) among other components.

The *Manyatta model* was aligned with these recommendations. Additionally, demand-driven interventions in increasing the uptake of family planning are currently commonly used and most often employ varying multilevel service delivery approaches (Speizer et al., 2014). A systematic review of evaluations targeting family planning interventions (Mwaikambo et al., 2011), indicated that more than two-thirds of the studies focused on demand-driven interventions resulted in significant improvements in knowledge, attitude, discussion and intentions. However, most of these interventions have focused on short-term outcomes targeting a specific group of people and in specified geographical regions (Bauman, 1997) with minimal impacts on sustainable behaviour change. However, in order to ensure the sustainability of such programs, it is paramount to guarantee the relevance of such programs by implementing culturally appropriate and sensitive approaches and adjusting programs accordingly based on the lessons learnt (Bongaarts, 1994). The *Manyatta Model* intervention aligned with this as men more so cultural gatekeepers were targeted during the entry meetings. Being a patriarchal society with men especially elders being key decision makers, engaging them created better attitudes towards family planning.

In the context of arid and semi-arid vast regions, issues of insecurities and a seemingly patriarchal society where women have diminished autonomy to speak about Family planning issues, a collaboration between male and female workers was necessary for this intervention to succeed. The model utilized a more structured planning and mobilization strategy where a mixed gender (both male and female) of

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CHPs worked as a team to enable them to reach the Manyattas and its members more effectively.

In order for the model to work it was important to ensure that the model is well understood by the actors, that is, community-based healthcare workers, the sub-county and county health management teams. Further, the Tag Team members needed to be trained on the FP technical module, so that they pass the correct information to household members. It is also paramount to closely work with the CHPs who understand the model. The partnerships with the different stakeholders at the community and facility level will also contribute to addressing social and structural barriers that hinder the uptake of services. At the facility level, there is a need to ensure that the healthcare workers are trained and that they have the requisite skills for service delivery. There is also a need to ensure FP commodities are available at the service delivery areas so as to ensure the uptake of services.

At the county and sub-county levels, follow-up and continuous monitoring are needed to ensure an enabling environment for the implementation of the model. To ensure the sustainability of the Manyatta Model, county government should: 1) Have a fixed budgetary allocated for support of FP activities in the county Annual Work Plans so that the Reproductive Health department can plan and implement activities consistently, 2) Support measures that ensure continuous provision of services during pandemics, for instance, the COVID-19 which led to a complete halt of activities in some sites, until personal protective equipment (PPE) were availed 3)Continuous capacity building of staff to ensure continuity in times of attrition and staff turnover, 4) Incorporation of FP and child spacing the messages in local stations through the health promotion department to increase the range of reach of the messages, 5)Build on the existing FP/RH SBC Strategy to suit sustain the gains of the Manyatta model and 6) Strengthening supply chain activities through the health products and technologies unit to ensure greater availability of FP commodities.

CONCLUSIONS

In conclusion, demand-driven, integrated family planning initiatives that utilize a team approach through the use of tag teams, culturally sensitive approaches, and gender-sensitive and uphold social inclusivity like the *Manyatta Model* effectively address unmet family planning needs in hard-to-reach counties. As a Country, there is therefore need to scale up the use of the model in other similar areas of the Country in order to meet Kenya's FP 2030 goals.

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