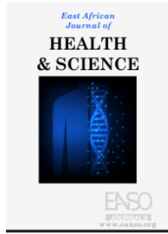


East African Journal of Health and Science
eajhs.eanso.org
Volume 5 Issue 1, 2022
Print ISSN: 2707-3912 | Online ISSN: 2707-3920
Title DOI: https://doi.org/10.37284/2707-3920

EANSO
EAST AFRICAN NATURE & SCIENCE ORGANIZATION

Original Article

Contribution of Capacity Building Program on Implementation Level of Sexual Reproductive Health and Rights Activities among Community Based Organizations in Western Kenya

Nancy Odero,[1] Dr. Charles Wafula, PhD[2], Prof. Stephen Okeyo, PhD[3] & Henry Oyugi[3]*

[1] MIFA AFRICA, P. O. Box 2224- Kisumu, Kenya.
[2] Tropical Institute of Community Health and Development, P. O. 4047 Kondele, Kenya.
[3] Great Lakes University of Kisumu, P. O. Box 2224 Kisumu, Kenya.
*Author for correspondence ORCID ID: https://orcid.org/0000-0001-8149-1371; email: nanodero@yahoo.com

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

Date Published:

04 Jul 2022

Keywords:

Capacity Building, Community Based Organizations, Sexual Reproductive Health and Rights Activities, Sustainability of Youth Programs, Sexual Gender Based Violence.

ABSTRACT

This study describes a series of Sexual Reproductive Health and Rights (SRHR) trainings and practicals received by Community Based Organizations (CBO) implemented in a three-year period from 2013-2015. The overall objective of this study was to determine the contribution of capacity building program among community-based organizations on implementation level of sexual reproductive health and rights activities in western Kenya. The analysis for this study focused on the description of trainings received where the proportions were expressed in percentages based on the participation of the CBOs in the trainings. The same proportions were used in determining the implementation levels of the SRHR activities by the CBOs within their respective communities. Capacity building program generally entailed careful planning that targeted the right people (youth involved) and build the right skills at the right time over three years' period of time. Based on the findings, the trends of the capacity building were determined based on the rating scale of low 0-49 percent, above average 50-69 percent, high 70-79%, and highest 80-100% where most training fell in the high-level category with an average of 75%. The study also revealed that there was an association between most capacity building Programs and SRHR activities implementation, except for Community Health Volunteers (CHV) roles and Service delivery which were not associated at all with Community Action Days as an activity. In conclusion, the series of capacity building given to the CBOs from 2013-2015 proved to be a long-term strategy of improving health status more so among young people. A significant

 This work is licensed under a Creative Commons Attribution 4.0 International License.

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

improvement in their level of understanding and implementation of SRHR activities to the youth by community was also demonstrated. One key recommendation for the sustainability of the youth programs was that youth SRHR programs should be enhanced and owned by the youth themselves.

APA CITATION

Odero, N., Wafula, C., Okeyo, S., & Oyugi, H. (2022). Contribution of Capacity Building Program on Implementation Level of Sexual Reproductive Health and Rights Activities among Community Based Organizations in Western Kenya. *East African Journal of Health and Science*, *5*(1), 214-228. https://doi.org/10.37284/eajhs.5.1.734.

CHICAGO CITATION

Odero, Nancy, Charles Wafula, Stephen Okeyo, & Henry Oyugi. 2022. "Contribution of Capacity Building Program on Implementation Level of Sexual Reproductive Health and Rights Activities among Community Based Organizations in Western Kenya.". *East African Journal of Health and Science* 5 (1), 214-228. https://doi.org/10.37284/eajhs.5.1.734.

HARVARD CITATION

Odero, N., Wafula, C., Okeyo, S., & Oyugi, H. (2022) "Contribution of Capacity Building Program on Implementation Level of Sexual Reproductive Health and Rights Activities among Community Based Organizations in Western Kenya.", *East African Journal of Health and Science*, 5(1), pp. 214-228. doi: 10.37284/eajhs.5.1.734.

IEEE CITATION

N. Odero, C. Wafula, S. Okeyo, & H. Oyugi, "Contribution of Capacity Building Program on Implementation Level of Sexual Reproductive Health and Rights Activities among Community Based Organizations in Western Kenya.", *EAJHS*, vol. 5, no. 1, pp. 214-228, Jul. 2022.

MLA CITATION

Odero, Nancy, Charles Wafula, Stephen Okeyo, & Henry Oyugi. "Contribution of Capacity Building Program on Implementation Level of Sexual Reproductive Health and Rights Activities among Community Based Organizations in Western Kenya.". *East African Journal of Health and Science*, Vol. 5, no. 1, Jul. 2022, pp. 214-228, doi:10.37284/eajhs.5.1.734.

INTRODUCTION

Community based organizations (CBOs) are non-profit initiatives that are representative of a community who often run-in voluntary basis and mostly self-funded and mainly engaged in meeting human health, educational, environmental, and other community needs. (Anasti et al, 2014) Capacity building as a long-term strategy of improving health status, requires careful planning to target the right people and build the right skills at the right time and over time. Evidence suggests that capacity-building program among Community Based Organizations tend to be more effective when they are carried out as an ongoing strategic commitment and more so when combined with a range of different other interventions that organizations can choose to support depending on need, context, and desired outcomes (Mitchell & Pattison, 2012)

In a study done in Victoria Australia, findings revealed that Organizations with cultures of capacity building provision are directly associated with total involvement in conducting healthcare roles and therefore, was a clear means of developing the organizational status and that of surrounding environment (Mitchell & Pattison, 2012). Another research from northern America showed that Capacity Building Interventions especially on sexual reproductive health and rights (SRHR) need to be sensitive and tailored to the local organizations for young people and adults can actually delay marriage, childbearing, and extend their student status if at all they have information about marriage, childbearing, and poverty on time. Knowledge of these different social factors are key determinants of what role young people will have in the society and the ways young people will participate in health programs and policies (Villa-Tores & Svanemyr, 2015).

In addition, a study by Mayberry and others also agreed that Community Based Organizations have positioned themselves as an essential component of national, regional, and local efforts to combat the HIV/AIDS epidemic and serve as catalysts for prevention and health promotion of activities through their own community-based interventions. The same study states that despite them having the

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

potential to promote and sustain health, prevent disease, and address health disparities, some still lack the capacity to do so due to low knowledge level and therefore capacity building should be well rolled to CBOs (Mayberry et al., 2013)

In sub-Saharan Africa, organizations such as mass media have excellent potential to promote good sexual and reproductive health outcomes among community through activities such as road shows, but around the world, media often fail to prioritize sexual and reproductive health and rights issues. (Oronje et al., 2011) Normally they advertise other media related elements sieving out reproductive health issues. Findings from the study therefore, proved that media coverage of reproductive health issues is poor due to the weak capacity and knowledge for reporting these issues by media practitioners. Enhancement of capacity building of media personnel is key for positive sexual reproductive health and rights outcome (Oronje et al., 2011). Also, in another study done in Nigeria, findings revealed that 73% of organizations made of professional healthcare providers cannot be able to follow-up and provide information to clients in the communities and more so on sexual and reproductive health because of insufficient trainings given to them (Hawe et al., 1997). Client from hard-to-reach areas for instance cannot be reached with information once they are out of the organizations and if within the facilities the health providers are not empowered enough to provide full satisfying information. This extends to the community members and parents; they are not able to give satisfying information to the individuals living within the community (Omachonu & Einspruch, 2010)

Results from nationally-representative surveys of 12-19-year-old groups in Burkina Faso, Ghana, Malawi, and Uganda in 2004 showed that SRHR services such as contraceptives, STI services, and HIV testing and counselling are still under-utilized. Results highlight the need to capacity build, create awareness, and inform young people about such services, increase availability of government health facilities, and improve youth's access to them, especially by reducing social barriers through various suitable youth friendly activities and strategies so as to increase utilization level (Biddlecom et al., 2007).

In the neighbouring Uganda, limited capacity building among CBOs and health provision organizations is a factor that undermines health systems abilities to adequately address sexual and reproductive health needs and rights of young people in general and more so those living with HIV/AIDS. Many health workers are not trained to work with young people especially those who have lived with HIV since infancy. They are, therefore not in position to provide appropriate, effective, and non -judgmental information to Young People Living with HIV to help them balance rights and responsibilities. As a result, as far as sexual behaviours are concerned, young people who have lived with HIV since infancy rarely use protection at first sex or consistently in subsequent sexual encounters. It is evident from the literature that sexual behaviours of these young people are as risky as those of their counterparts who were born HIV negative (Baryamutuma & Baingana, 2011).

In Kenya, poor sexual reproductive health is manifested in the high number of deaths and illnesses resulting from HIV/AIDS and other STIs, early childbirths, and unsafe abortion. HIV/AIDS for instance kills 140,000 Kenyans every year (UNAIDS, 2016). Out of every 100,000 Kenyan women giving birth, 488 die from complications associated with childbirth (KNBS, 2008-09) and 20,000 Kenyan women are hospitalized every year with abortion-related complications (MOH, 2006). All these indicators of poor sexual reproductive health in Kenya are as a result of lack of access to reproductive health information and services from the early stage of adolescence onwards (Oronje et al., 2011).

In Kenya still, SRHR issues continue to go high. For instance, in 2012 an estimated 464,000 induced abortions occurred. This translates into an abortion rate of 48 per 1,000 women aged 15–49, and an abortion ratio of 30 per 100 live births. About 120,000 women received care for complications of induced abortion in health facilities. About half (49 %) of all pregnancies in Kenya were unintended and 41 % of unintended pregnancies ended in an abortion. The study findings recommended for an urgent need for improving facilities and communities' capacity to fully provide safe abortion care of the law. Also, efforts should be made to address underlying factors to reduce risk of SRH

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

problems (Mohammed et al., 2015). To continue, HIV prevalence has been reported to the highest especially in parts of western Kenya; Homabay County leading with prevalence rate of 25.7% followed by Siaya County at 23.7% then finally Kisumu County which is at 19.3%. Compared with the younger age group (15–19 years), young adults aged 30–34 years are six times more likely to be HIV-positive, and the estimated HIV-positive population among women was around two times larger than among men. Other problems such as STIs and teenage pregnancies have been reported by health facilities to be high leading to school dropouts and gender-based violence among families (Hoshi et al., 2016).

Sexual and reproductive health and Rights (SRHR) on the other hand, is a crucial component of lifelong health and well-being and contributes to the health of future generations. Results that facet of SRHR of young people and adults are slowly improving but some areas still need further efforts (KDHS, 2014). Interventions have been developed to aid reduce SRHR problems; for instance, primarily in western Kenya, programs that aim at providing capacity building have been seen and majorly they have been programs around Ministry of health (MOH). The MOH guidelines today requires that every client is given a health talk and counselling after every testing and treatment sessions (MOH, 2006). Health talks given include SRHR issues, after which, it is counted that the clients come out with knowledge on how to go about some of the SRHR problems if not all. However, more efforts are still needed to ensure that SRHR problems are reduced within the communities.

It is in this regard that GLUK recognized that CBOs have positive energy to reach and influence the key target audiences including policymakers, program implementers, key stakeholders and the public or community regarding health issues. However; they found out that the CBOs had low knowledge level on strategies to pass SRHR information. GLUK therefore resorted to train the CBOs on a unique capacity building program. The engagement by GLUK with the CBOs on capacity building program over three years (2013-2015) led to notable successes which provided a rich case study to learn from and hence this study which aimed at describing the contribution of capacity building program on implementation level of Sexual Reproductive Health and Rights activities among CBO members in western Kenya. The study also described interventions and methodology used to achieve the objectives. In the process the study showed what worked well, the challenges faced, and overall lessons learnt in order to provide a learning platform for institutions seeking to adopt similar strategies.

Capacity building program of CBOs for the purpose of this study means those trainings designed with a range of different elements and practicals in the area of roles of CHV and CHC, leadership and governance, service delivery, advocacy, health, and economic empowerment for the first program period in 2013. The second phase of the program on capacity building of the CBOs focused on, a total of six training since 2014. They included comprehensive Sexual Education (CSE) package, World Starts with Me (WSWM) computer-based training which aimed at equipping CBOs with knowledge and skills of handling adolescent SRHR issues such as life skills, health talk provision, constitution development, awareness creation and sensitization, and resource mobilization. The third phase of the program which was the final phase, the elements of the training that were covered included Program planning, development and activity implementation, monitoring and evaluation (follow-up process), data collection for evidence-based reporting, manual data analysis method, feedback process (how to disseminate information), assessment and report writing, and household data validation. The expected implementation by the CBOs within the three phases of the program focused on activities such as regular informative meetings organized by young people, community dialogue days, community action days, outreaches, awareness creation and sensitization activities, advocacy events, games and skits, community clean-ups, convention and clean-ups, linkages and resource mobilizations, commodity distribution, and SRHR meetings.

METHODOLOGY

Study Design

The larger study was an operational research (OR) or implementation research (IR). The intent of OR was to learn about management, administrative,

This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

cultural, social, behavioural, economic, and other factors that either exist as bottlenecks to effective implementation of activities or could be tested to drive insights into new, more effective approaches to programming.

This study was a descriptive study design that utilized analytic methods in analysing data for its objectives. It was an intervention program carried out by Great Lakes University of Kisumu- Access Service and Knowledge program (GLUK –ASK), in three phases on capacity building through trainings and practical, covering different topics in each phase and implementation of SRHR activities. This study addressed the analysis of the results based on the endline survey carried out in 2015.

Study Area

The study was conducted in 5 counties in the western region of Kenya where poor youth SRHR outcomes were noted. They include Kisumu, Kakamega, Siaya, Bungoma and Homabay. In this area the CBOs had been operating actively for a period of three years i.e., 2013, 2014 and 2015. The CBOs were registered and structured from Community Health Units and youth groups. The CBOs were working in partnership with GLUK and MOH over the 3 years.

Study Population

The larger study targeted 75 community-based organizations which comprised of young people (15-24 years) and adults (community volunteers or representatives)

The population for this study, therefore encompassed data from the 75 CBOs after they had been trained for three years and had engaged in Sexual Reproductive and Health and Rights activities implementation for all the three years as well. However, only data from 60 CBOs finally qualified for use in the analysis of this study findings.

Sample and Sample Size Determination

The selection used purposive sampling technique where the larger study collected data from 75 CBOs, however, only 60 were used to draw findings of this study. Purposiveness was based on CBOs in GLUK- MOH partnership participating in capacity building program and finally the implementation of activities. It was also based on completeness of data

Data Collection/Source of Data

Data for analysis was collected by GLUK-ASK from 5 counties namely Kisumu, Kakamega, Siaya, Bungoma and Homabay where it was implementing its project from 2013-2015. In 2013, before initiation of the project a baseline survey was undertaken. By the end of the project an endline survey was undertaken in 2015.

It was in this basis that this study accessed data and extracted utilizable data to draw findings of this study's main objective which was to assess the contribution of capacity building among the CBOs and their implementation of SRHR activities among the youth and adults in their respective communities in western Kenya region.

Data Analysis

The unit of analysis on capacity building was based on Community Based Organizations (CBO) and the implementation level of activities. Descriptive statistics was used to answer the first two objectives. Frequencies were run to determine the level of capacity building uptake and implementation of SRHR activities. Analytic methods were used to explore the analysis of the third objective where cross tabulations were used to determine the association between the main variable's capacity building and implementation level of SRHR activities. Data was analysed using (SPSS) version 16 where quantitative analysis was provided. The chi-square test at a significance of 5 % was used to test the association between capacity building and implementation levels of the activities and the odds ratio used to ascertain the strength of association among the variables of interest.

RESULTS

Demographic Variables of the CBO members

This data was meant to describe demographic variables of the sampled CBO members and to assess for any influence on the research findings. The demographic data consisted of age, sex,

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

education level, occupation, and leadership role in the CBO and in the society as demonstrated in tables below.

Table 1: Age and sex of participants

Age group	Male	Female	Total
10-24	60	59	119
25-35	25	29	54
35+	52	87	139
Total	**137**	**175**	**312**

In *Table 1*, the age and sex information were given by individuals and not CBO. Therefore, the total 60 CBOs had 312 CBOs members. As a result, 119 members were youth 10-24 and 54 were also older youth of 25-35. 139 members were adults of ages 35 years and above. A total of 137 members were males and 175 majority being the females

The minimum respondent age was 12 while the maximum was 70 years old.

Table 2: Leadership status of the CBOs

Leadership status	Overall n (%)
Yes	44 (73.3)
No	16 (26.7)

In *Table 2*, out of 60 CBOs 44 (73.3%) had leadership roles within and outside the organization while 16 (26.7%), had no roles outside the organization but only had roles within the CBO. Roles mentioned included but not limited to, chairperson, secretary, organizing secretary, dean, church deacon, village elder, and trainer of trainees among others.

The Level of Capacity Building Program on Training to CBOs

Capacity Building on Training to the CBOs

This study revolved around nineteen main training topics with 3-6 subtopics in each main topic. They include; Community Health Strategy (Community Health Volunteer and Community Health Committee training), Service delivery training**,** World Starts With Me (WSWM) package**,** Comprehensive Sexual Education (CSE) package, life skills (Health talk)**,** Leadership, governance and sustainability training**,** Constitution development**,** Advocacy**,** Awareness creation and sensitization**,** Program planning, development and implementation**,** Monitoring and evaluation training**,** Data collection for evidence based reporting**,** Data analysis training (manual)**,** Feedback training, and finally Assessment training. The training was offered in bits i.e., in 2013, 2014 and others in 2015 depending on the complexity of the topics. Each training took three to five days to complete.

Table 3: Trainings received in 2013

Capacity Building / Trainings given to CBOs		**2013**		
		Yes	**No**	**Total**
Community health Strategy	CHV roles	44 (73%)	16 (27%)	60
	CHC roles	48 (80%)	12 (20%)	60
Leadership, governance, and sustainability		43 (72%)	17 (28%)	60
Service delivery		47(78%)	13 (22%)	60
Advocacy		45 (75%)	15 (25%)	60
Health and Economic empowerment training		56 (93%)	4 (7%)	60

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

In the first year (2013), a total of six trainings topics were offered to the CBOs. The study findings indicated that out of the total 60 CBOs 44 (73%) had received community health strategy training (CHV roles), which was the backbone of the whole program, 48 (80%) received community health strategy training offered (CHC roles). 43 (72%) CBOs reported that they had received Leadership, governance, and sustainability training while 47(78%) had benefited from service delivery training. 45 (75%) acknowledged that they had received advocacy training while the majority of the CBOs 56 (93%), reported that they had benefitted from health and economic empowerment training that was offered as demonstrated in table 3 above.

The weighted average of the capacity building level for all the six elements in the first phase of the program (2013) was 78.6%.

Table 4: Trainings received by CBOs in 2014

Capacity Building / Trainings given to CBOs	2014		
	Yes	**No**	**Total**
Comprehensive Sexual Education (CSE) package	44 (73%)	16 (27%)	60
World Starts with Me (WSWM) computer-based package	41 (68%)	19 (32%)	60
Life skills (Health talk)	55 (92%)	5 (8%)	60
Constitution development	49 (82%)	11 (18%)	60
• CBO membership and legality			
Awareness creation and sensitization training	51 (85%)	8 (13%)	60
• Mobilization skills			
Resource mobilization	45 (75%)	15 (25%)	60

In 2014, a total of six trainings were provided to the CBOs as well. The study findings showed that out of the total 60 CBOs 44 (73%) received Comprehensive Sexual Education (CSE) package while 41 (68%) received World Starts with Me (WSWM) computer-based training which aims at equipping CBOs with knowledge and skills of handling adolescent SRHR issues. 55 (92%) who were the majority received trainings on Life skills and Health talk provision and 49 (82%) received training on constitution development. The findings also showed that 51 (85%) had been trained on awareness creation and sensitization while 45 (75%) received training on resource mobilization as indicated in table 4 above.

The weighted average of the capacity building level for all the six elements in the second phase of the program (2014) was 79.1%.

Table 5: Trainings received by CBOs in 2015

Capacity Building / Trainings given to CBOs	2015		
	Yes	**No**	**Total**
Program planning, development and implementation	44 (73%)	16 (27%)	60
Monitoring and evaluation training	47 (78%)	13 (22%)	60
Data collection for evidence-based reporting	47 (78%)	13 (22%)	60
Data analysis training (manual)	46 (77%)	14 (23%)	60
Feedback (information dissemination) training	47 (78%)	13 (22%)	60
Assessment and report writing training	40 (67%)	20 (33%)	60
Data validation	46 (77%)	14 (23%)	60
• Household revisits			
• Data cleaning			

In *Table 5*, the total number of CBOs trained in 2015 were 60. In that year each CBO was trained on seven topics. Among the CBOs 44 (73%) were trained on Program planning, development, and activity

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

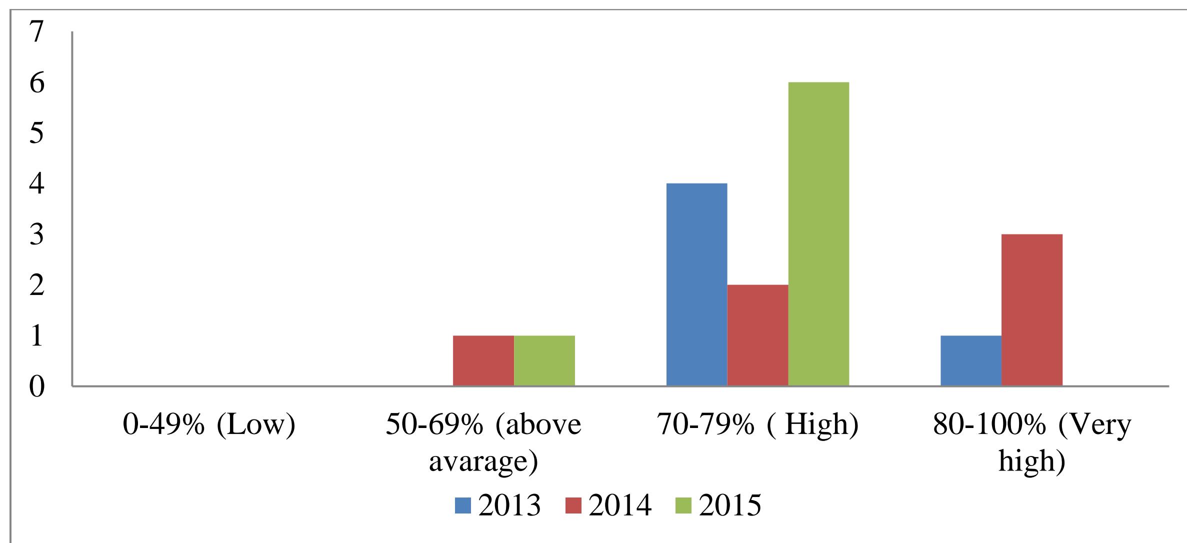
implementation, 47 (78%) were trained on monitoring and evaluation (follow-up process), 47(78%) again accepted that they had received a training on data collection for evidence-based reporting. 46 (77%) were trained on manual data analysis method while 47 (78%) had been trained on feedback process (how to disseminate information). 40 (67%) had been trained on assessment and report writing while 46 (77%) reported that they received training on household data validation and cleaning.

The weighted average of the capacity building level for all the seven elements in the third phase of the program (2015) was 75.5%.

Levels of Capacity Building Received by CBOs

In this study capacity building program was categorized in four levels either low (0-49%), above average (50-69%), high (70-79%) or very high (80-100%) depending on their implementation rate in percentages. The graph below demonstrates the categories\

Figure 1: Capacity building program received by CBOs



The total CBOs that participated in the study were 60. Among them none reported that they had not received any capacity building at all. However, among the members there are others who missed some topics/ trainings units because of different reasons. In the graph above only CBOs that received capacity building were analysed. The findings indicated that none of the topics fell under the category 0-49% (low). It also revealed that only one topic in 2014 and one 2015 were above average category of 60-69%; most topics in the category of 70-79% (high), very high levels were observed in 2015. Finally, those topics with very high category (80-100%) were observed in 2013 with one topic and three topics in 2014.

Level of Implementation of SRHR activities by CBO Members

Table 6 above shows findings of all the activities the CBOs were implementing to help educate young people and the whole community about sexual reproductive health and rights. All the CBOs drew a work plan which was to enable them carry out the activity's utmost 312 times annually. Since the activities aimed the young people, they were mostly conducted on the peak months i.e., April, August, and December. The least activity to be implemented was at 50% while the highest implementation level scored 91%.

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

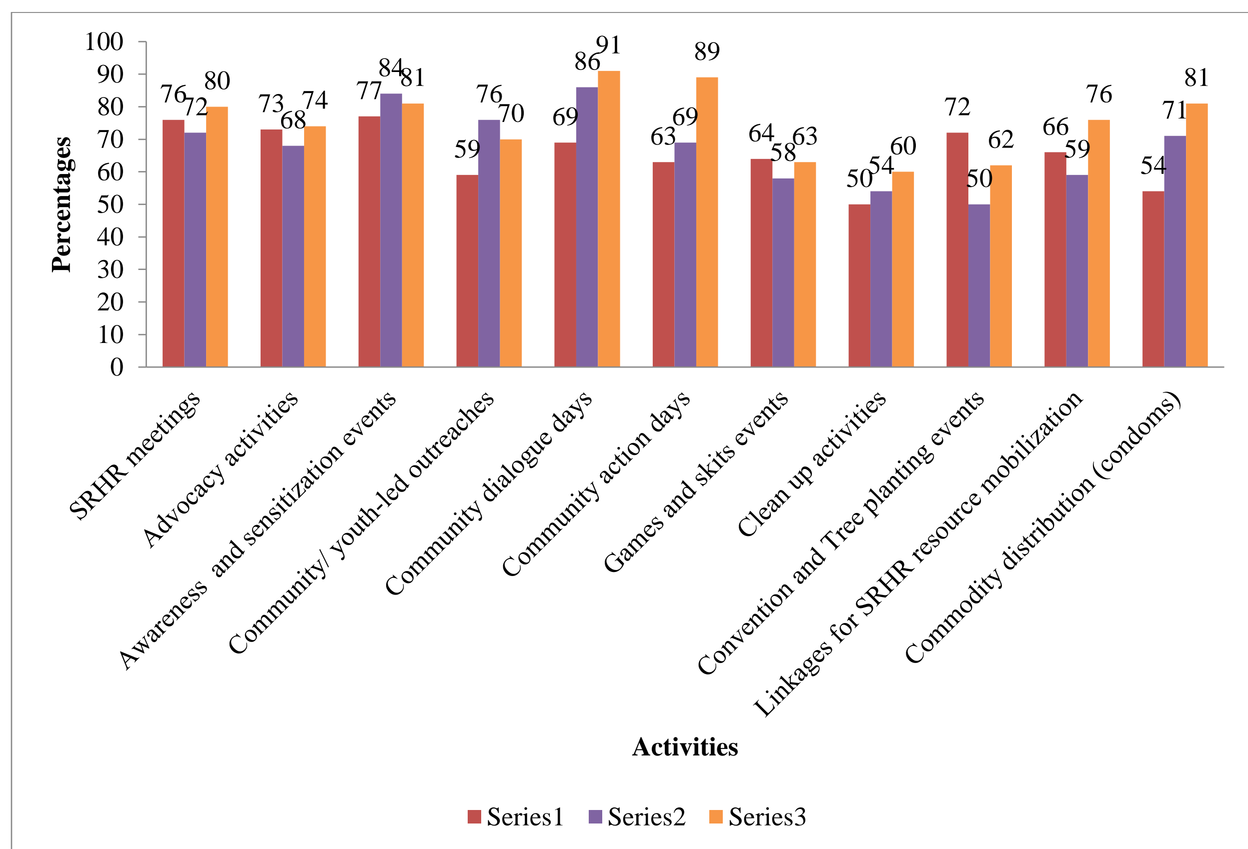
Table 6: Description of Activities implemented by CBOs

Activities held by CBOs	N=312	2013	2014	2015
SRHR meetings	312	238 (76%)	224 (72%)	251(80%)
Advocacy activities	312	231 (73%)	212 (68%)	232 (74%)
Awareness and sensitization events	312	242 (77%)	262 (84%)	253 (81%)
Community/ youth-led outreaches	312	186(59%)	238(76%)	218 (70%)
Community dialogue days	312	215(69%)	269 (86%)	285 (91%)
Community action days	312	198 (63%)	215(69%)	280 (89%)
Games and skits events	312	200 (64%)	181(58%)	196 (63%)
Clean up activities	312	158 (50%)	168 (54%)	189(60%)
Convention and Tree planting events	312	224 (72%)	158 (50%)	195(62%)
Linkages for SRHR resource mobilization	312	208 (66%)	186 (59%)	236(76%)
Commodity distribution (condoms)	312	169 (54%)	222 (71%)	252 (81%)

The weighted average of the implementation level for all the eleven activities in the first phase of the program (2013) was 66.1%, the second phase of the program (2014) was 68% while the last phase of the program (2015) was 75.4%.

The overall weighted average of the implementation level for all the eleven activities during the three phases of the program (2013-2015) was 69.8%.

Figure 2: Trends according to CBOs SRH activity implementation



Key: Series 1=2013; Series 2=2014; Series 3=2015

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

The trends of the activity implementation were unpredictable over the years since each activity had distinct rate of its implementation over the three years. Averagely, the implementations of the activities were on the rise from 2013-2015. In 2013, for activities out of 12 picked off steadily and all the CBOs implemented them within their communities, the said activities dropped slightly in 2014 and then become stable in 2015. Five of the activities implemented in by CBOs which include awareness and sensitization events, community dialogue days, community action days, clean-up activities and commodity distribution activities, grew steadily in an increasing manner throughout the years.

Three of the activities namely SRHR meetings, advocacy activities, and games and skits events showed modest change where in all the years they were implemented in almost the same level with a range of about 70% to 72 percent. 1 activity (youth convention come tree planting) rose high in the first year of implementation i.e., 2013 but dropped hugely in 2014 then picked again slightly in 2015 with implementation levels of 72%, 50%, and 62% respectively. Another activity (linkage to SRHR resource mobilization) also started off steadily in 2013 (66%), dropped slightly in 2014 (59%) and then picked up well in 2015 (76%). These changes indicated that youth activities need a specific time to be carried out an activity such as conventions and resource mobilization should always be done with a lot of technical support.

Association Between Capacity Building and the Implementation Level of SRHR Activities

A Chi-square test of association was conducted to test for relationship between Capacity Building Programs and the various implementation levels of SRHR Activities. Of the 771 CHVs trainings 706(91.69%) were implemented through Awareness creation; 670(87.01%) were implemented through Advocacy events; 563(73.02%) were implemented through outreaches; 666(86.30%) were implemented through Community dialogue while 617(80.03%) were implemented though community action days. However, there was no statistically significant association between CHV roles and Community Action Day; Service delivery and Community Action days' results (p=0.922; 0.543 respectively).

Similarly, of the 588 WSWM Packages, 559(95.23%) %) were implemented through Awareness creation; 522(88.93%) were implemented through Advocacy events; 453(77.04%) were implemented through outreaches; 535(90.99%) were implemented through Community dialogue while 493(83.84%) were implemented though community action days. There was a significant association between all the Capacity Building Programs and Awareness creation, advocacy events, outreaches, and community dialogue days. The results are presented in *Table 7.*

 | This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

Table 7: Association between Capacity building programs and SRHR activities implementation

CB Program	Implementation of SRHR activities										
	Overall	Awareness creation		Advocacy Events		Outreaches		Community dialogue		Community Action Days	
	N (%)	N (%)	Sig.	N (%)	Sig.	N (%)	Sig.	N (%)	Sig.	N (%)	Sig.
CHV Roles	771 (82.11)	706 (91.69)	<0.001	670 (87.01)	<0.001	563 (73.02)	<0.001	666 (86.30)	<0.001	617 (80.03)	0.922
Service Delivery	684 (72.84)	624 (91.36)	<0.001	597 (87.28)	<0.001	503 (73.54)	<0.001	584 (85.38)	<0.001	553 (80.85)	0.543
Health Talk	779 (83.94)	716 (92.03)	<0.001	652 (83.80)	<0.001	552 (70.86)	<0.001	665 (85.37)	<0.001	647 (83.06)	0.001
Leadership &governance training	701 (74.73)	669 (95.57)	<0.001	591 (84.43)	<0.001	549 (78.32)	<0.001	625 (89.16)	<0.001	611 (87.16)	<0.001
CHC Roles	718 (76.55)	674 (94.00)	<0.001	634 (88.42)	<0.001	483 (67.27)	<0.001	610 (84.96)	<0.001	600 (83.57)	<0.001
WSWM Package	588 (62.62)	559 (95.23)	<0.001	522 (88.93)	<0.001	453 (77.04)	<0.001	535 (90.99)	<0.001	493 (83.84)	<0.001
Constitution Development	745 (79.34)	701 (94.22)	<0.001	699 (93.95)	<0.001	505 (67.79)	<0.001	631 (84.70)	<0.001	624 (83.76)	<0.001
CSE Package	709 (75.91)	669 (94.49)	<0.001	619 (87.47)	<0.001	482 (67.98)	<0.001	604 (85.19)	<0.001	591 (83.36)	<0.001
Data Analysis	688 (73.27)	643 (93.46)	<0.001	584 (85.01)	<0.001	463 (67.30)	<0.001	595 (86.48)	<0.001	581 (84.45)	<0.001
Data Collection	677 (72.10)	631 (93.21)	<0.001	572 (84.62)	<0.001	457 (67.50)	<0.001	581 (85.82)	<0.001	567 (83.75)	<0.001

Tested at 95% CI

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

DISCUSSION

Capacity Building Received

The study findings demonstrated that there were high quality trainings given to CBOs over the three years. During the first year, six comprehensive training topics were tackled with room left in-between intervals for practice and activity implementation. These topics were primarily meant to offer the CBOs the full capacity in terms of knowledge and preparation procedures of designing and implementing SRHR activities ahead of them. In 2014, the second year, six training topics were comprehensively and intensively taught and this time the training selection was designed this way (intensively) to assist the CBOs to directly implement SRHR activity. Important to note, some of the capacity building programs were already set in that at the end they would have done an activity already. For instance, WSWM training was to be done once and once the CBO had gone through it, they would practice it directly to the youth once and for all. Finally, the trainings offered in 2015 were complex yet made so understandable because most of them were things they do on daily basis. The 2015 trainings were meant to capacitate them to be able to sustain themselves, the program, and the relationship between them and the community, the sub-county, and the county at large. That was also a package where data collection and manual analysis was trained and skilfully emphasized so that the CBOs would collect their own data analyse and reported to the chalkboards and also share with other community members through chief's barazas.

This finding is consistent with the evidence in the findings of work done by Chandra-mouli who also conducted a study on SRHR of young people where the most used intervention was capacity building. The training entailed use of a combination of health worker training e.g., comprehensive sexual education and adolescent-friendly facility improvements. The intervention was delivered in low or high dosage where dosage in this study meant how intensively and/or how long an intervention or a package of interventions was delivered. In practical terms this meant that a program that reached young people with complementary messages using a variety of delivery mechanisms (e.g., teaching sessions in school, billboards, and radio or television chat shows), has a higher "dosage" than another program that uses fewer and less-intensive approaches. Trainings with high dosage had an exclusive meaning of creating a sustainability strategy for the communities (Chandra- mouli et al., 2015)

Level of Activity Implementation by CBOs

The results on the level of activity implementation by CBOs in this study were unpredictable throughout the years though well implemented within the years. During the first phase (2013) the weighted average was 66.1%, in 2014 it was 68% while in 2015 it was 75.3%. Activities were being implemented immediately after the training while others needed good preparation by the community members to be carried out. Important to note was that activities in this study were a variety, unique and friendlier to the youth who were the target population and as the years moved by the CBOs had enough experience for enabling them conduct as may activities as possible hence the increasing trends as noted above. Activities to boost the community rights were as well incorporated making it suitable for parents and community at large.

Consistent with the finding on level of activity implementation by CBOs, it was documented that variety of SRHR activities will be received better by youth than just a single one which promotes monotony among the youth (Brazier et al., 2014). Findings of the study indicated that activities to promote SRHR used were of great varieties, direct, and well-articulated to young people.

Relationship between Capacity Building Program Received and Activity Implementation

The study findings revealed that capacity building program received by CBOs in 2014 had greater impact on the level of activity implementation. For instance, general Community Health Strategy (CHV roles) and WSWM packages training had significant impact on awareness creation and sensitization events, advocacy activities, outreaches, community dialogue day, and community action days. This was attributed to the type of training given to them. Theses trainings were designed to help boost skills on the activities implementation directly. To continue, some of the activities upon completion

 This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

were already giving room for CBO members to conduct the activity meant for it.

In consistent to these findings, also, empirical results from four studies done in South Africa, on interventions targeting sexual and reproductive health and rights outcomes of young people showed that interventions seeking to improve the comprehensive SRHR of Young people especially those living with HIV/AIDS in South Africa, had positive impacts (Bernays et al., 2015). This is due to similarities regarding the methodology used during the training – it was a combination of both the youth and the adults members of the community. The second study; having conducted a review of literature on different interventions, in their discussion, identified themes emerging across all interventions and most capacity building intervention impact positively to the activity implantation level (Pretorius et al., 2015). In the other two studies, findings support a significant relationship between capacity building and activity implementation. The studies concluded that interventions worked best in contributing to positive SRHR interventions outcomes (Oronje et al., 2011; Villa-Tores & Svanemyr, 2015).

CONCLUSION

Sexual reproductive health problems can be reduced through proper capacity building with well incorporated activities. However, it will take time, resources, and a combined effort on the part of communities and many other stakeholders. Organized trainings on health and health economic empowerment with subtopics such as Community Health Strategy, Income Generating Activities (IGA) development, youth friendly services, health education at household level, life skills topics such as World Starts with Me (WSWM), youth adult health talk and school health talk, and peer to peer communication amongst Community based organizations would help promote sexual behaviour change among the youth.

Activities that could improve adult –teen and teen-teen communication on sexual reproductive health such as community dialogue days, awareness creation and sensitization, community action days, youth – led outreaches, advocacy, and community meetings if implemented would see a decrease in sexual reproductive health problems among community members.

Recommendations

Based on the above conclusion, this study intervention is worth cascading to others counties and sub counties in and out of western Kenya region to help reduce SRHR problems among young people of ages 10- 24 years. Especially in counties where community health strategy was rolled initially, this will mark a very important program. Capacity building programs such as Community Health Strategy, WSWM, awareness creation and advocacy have proved to impact a positive change in increasing the number of SRHR activities implementation. Therefore, they are highly recommended to help in reducing SRHR problems such as teenage pregnancies, school dropout, STI infection, engagement of unprotected sex etc among communities in western Kenya.

Life-skills is taught in schools but not given enough emphasis and time due to other competing lessons. Time to teach it is not so much therefore, on top of the guidance and counselling teaching and time, registered Community based organization members and community Health workers should be allowed to freely walk into rural schools and liaise with the guidance and counselling teachers to teach the in-school adolescents about the SRHR problems e.g. HIV/AIDS and other STIs, teenage pregnancies, early marriages, unsafe abortion, gender and domestic violence, school dropout including how to tackle the problems. Furthermore, in case any SRHR activity is being conducted around the schools e.g., in the school premises, the pupils or students should be allowed to participate so that they can learn and benefit from the services provided. This in return will lead to them practicing and gradual behaviour change.

Lastly, this study adopted a descriptive study design utilizing analytic methods to analyse its main objective, most of the studies in the literature reviewed adopted pure review of literature therefore other studies should be done using a purely analytical study method to ascertain whether exposure to capacity building by communities has an association with SRHR activity implementation for behaviour change among young people.

This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

ACKNOWLEDGEMENT

My sincere acknowledgement goes to Dr. Charles Wafula, Professor Stephen Okeyo, Mr. Henry Oyugi, Dr. Jane Mumma and Mr. Oyata Balah who have played a vital role in equipping me with knowledge and skills for writing up this research thesis. I will not forget very key persons at Great Lakes University of Kisumu e.g., Dr. Atitwa, Dr. Jomama One Jomama and Dr. Dominic Mogere for their continuous assistance and encouragement which was very important during the development of this work. We are grateful to SIMAVI Netherlands who funded the project, SRHR Alliance Kenya and Great Lakes University of Kisumu - Access Services and Knowledge (GLUK-ASK) project for your contribution towards the findings of this project can never be forgotten.

Thank you.

REFERENCES

http://www.ncbi.nlm.nih.gov/pubmed/?term=Baryamutuma%20R%5Bauth%5DBaryamutuma, R. & Baingana, F. (2011). Sexual, reproductive health needs and rights of young people with perinatally Acquired HIV in Uganda. *African Health Sciences, 11*(2), 211–218.

Bernays, S; Paparini, S; Gibb, D; Seeley, J (2015) When information does not suffice: young people living with HIV and communication about ART adherence in the clinic. Vulnerable children and youth studies, 11 (1). Pp. 60-68. 1ssn 1745- 0128 DOI: 10.1080/17450128.2015. 1128581

Biddlecom, A. E., Alister, M., Susheela, S., & Vanessa, W. (2007). Africa Adolescent Health Services. *African Journal of Reproductive Health*, *11* (3), 99-110.

Brazier, E., Fiorentino, R., Barry, M., & Diallo, M. (2014). The value of building health promotion capacities within communities: evidence from a maternal health intervention in Guinea. *Health policy plan*, 30(7), 885-894.

Chandra-Mouli, V., Denno, D. M., & Hoops, A. J. (2015). Effective strategies to provide Adolescent Sexual and Reproductive Health service and to increase Demand and Community Supports. *Journal of Adolescent Health,* 56 (1), 22-41.

Hawe, P., Noort, M., King, L., & Jordens, C. (1997). Multiplying in health gains: The critical role of capacity building within health promotion programs. *Health Policy*, *39* (6):29–42.

Hoshi, T., Fuji, Y., Nzou, S. M., Tanigawa, C., Kiche, I., Mwau, M., Mwangi, A. W., Karama, M., Hirayama, K., Gato, K., & Kaneko, S. (2016). Spatial Distributions of HIV Infection in an Endemic Area of Western Kenya: Guiding Information for Localized HIV Control and Prevention. *PLoS ONE* 11(2). e0148636. https://doi.org/10.1371/journal.pone.0148636

Kane, S., Kok, M., Ormel, H., Otiso, L., Sidat, M., Namakhoma, I., Nasir, S., Gemechu, D., Rashid, S., Taegtmeyer, M., Theobald, S., & De Koning, K. (2016). Limits and opportunities to community health workers empowerment: A multi country comparative study. *Social science and medicine*, *16* (4), 27-34.

Kenya Demographic and Health Survey (KDHS). (2014). *Adolescents and human population statistics.*

Kenya National Bureau of Statistics, ICF Macro: Kenya Demographic and Health Survey 2008-2009. Calverton, Maryland; Kenya National Bureau of Statistics, ICF Macro;2010

Mayberry, R. M., Daniels, P., Akintobi, T. H., Yancey, E. M., Berry, J., & Clark, N. (2013). Community-based Organizations' Capacity to Plan, Implement, and Evaluate Success. *Journal of Community Health*, *33*(1), 285-292.

Ministry of Health (Kenya) (2006). Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services. Nairobi: Ministry of Health 1-60.

Mitchell, P. F. & Pattison, P. E. (2012). Organizational culture, intersectoral collaboration and mental health care. *Journal of Health Organization and Management*, *26* (1), 32– 59.

This work is licensed under a Creative Commons Attribution 4.0 International License

Article DOI: https://doi.org/10.37284/eajhs.5.1.734

Mohammed S. F., Izugbara, C., Moore, A. M., Kimani-Murage E. W., Ziraba, A. K., Bankole, A., Singh, S. D., & Egesa, C. (2015). The Estimated incidence of induce abortion in Kenya: Across-sectional study. *BMC Pregnancy Childbirth 15(1), 185.* https://doi.org/10.1186/s12884-0150621-1

Omachonu, V. K. & Einspruch, N. G. (2010). Innovation in Healthcare Delivery Systems: A Conceptual Framework. *The Public Sector Innovation Journal*, *15*(1), 2.

Oronje, R. N., Undie, C., Zulu, E. M., & Joanna, C. (2011). Engaging media in communicating research on sexual and reproductive health and rights in sub-Saharan Africa: Experiences and lessons learned. *Health Research policy and systems*, *9*(1), 7.

Pretorius, L., Gibbs, A., Crankshaw, T., & Willan, S. (2015). Interventions targeting sexual and reproductive health and rights outcomes of young people living with HIV: a comprehensive review of current interventions from sub-Saharan Africa. *Global Health Action*, *8*(8), 28454.

United Nations Programme on HIV/AIDS (2016). Prevention Gap Report: UNAIDS/2016

Villa-Tores, L. & Svanemyr, J. (2015). Ensuring youth’s rights to participation and promotion of youth leadership in the development of sexual and reproductive health policies and progress. *Adolescent health*, 56 (1), 51-57.

 This work is licensed under a Creative Commons Attribution 4.0 International License