SRHR alliance

Exploring the factors that influence meaningful youth involvement in the health care system management in Western Kenya

Final Report

Rutgers For sexual and reproductive health and rights | amref flying doctors | choice. FOR YOUTH & SEXUALITY | dance 4 life start dancing stop aids | IPPF International Planned Parenthood Federation | Simavi Basic health for all. | STOP AIDS NOW!

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The Access, Services and Knowledge (ASK) programme is a three-year programme (from 2013 to 2015) funded by the Dutch Ministry of Foreign Affairs with the aim of improving the SRHR of young people (10 – 24 yrs.), including underserved groups. The programme which is a joint effort of eight organizations comprising of Rutgers (lead), Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI) is implemented in 7 countries, namely Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda. Operations research (OR) was identified as an integral part of activities in the ASK programme. The aim was to enhance the performance of the program, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme Theory of Change.

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List of Abbreviations and Acronyms

AA	Africa Alive
ADS	Adventist Development Service
ASK	Access, Services, Knowledge
ARV	Anti-Retroviral drugs
CSA	Centre for the Study of Adolescence
CHAI	Clinton Health Access Initiative
CHCs	Community Health Committees
CHU	Community Health Units
CLK	Child Line Kenya
CHVs	Community Health Volunteers
CHEWs	Community Health Extension Workers
FHOK	Family Health Options Kenya
FGDs	Focus Group Discussion
GLUK	Great Lakes University of Kisumu
HCMT	Health Care Management Team
IR	Implementation Research
KIIs	Key Informant Interviews
KMET	Kisumu Medical Educational Trust
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Inter-sex persons
MAXFACTA	Maximizing Facts on AIDS
MoH	Ministry of Health
NAYA	Network of Adolescence and Youth of Africa
NEPHAK	Network of People Living with HIV/AIDS in Kenya
OR	Operations Research
RAs	Research Assistants
SGBV	Sexual Gender Based Violence
SMS	Short Message Services
SRHR	Sexual and Reproductive Health and Rights
WAYAN	World Starts With Me Alumni Youth Advocacy Network
WOFAK	Women Fighting AIDS in Kenya
YPLWH	Young People Living With HIV/AIDS

Abstract

In the ASK program, GLUK is piloting the integration of young people aged 15-24 years in the implementation of Community Health Strategy (CHS) as a way to improve their access to quality SRHR services and information. Meaningful Youth Participation (MYP) in these community health structures has however been noted to be limited. The study was an operational research (OR) or implementation research (IR). The intent was to understand the bottlenecks to effective implementation or factors that could be tested to drive insights into new, more effective approaches to programming.

In Phase 1 the IR conducted 29 Key Informant Interviews (KII) and 13 Focus Group Discussion (FGDs) in 5 community health units (CHUs) namely; Shibembe, Mutoma, Madibo, Omia Malo and Gem Nam, covering Nyanza and Western regions of Kenya. The 5 CHUs were purposively selected based on their long-term engagement with GLUK and having integrated youths into the Community Health Committees (CHCs) up to the Sub-County level. The study targeted HCMT, youths, community health workers and members. It explored roles and responsibilities of youths; acceptability of MYP on the CHC; barriers and enablers of MYP and suggested strategies for improved MYP.

In Phase 11 the IR conducted two mixed group participatory community workshops in Nyakach and Butere Sub-Counties. Using a cross sectional qualitative study design, the study conducted a comprehensive assessment to provide evidence about the best strategies to use to ensure the sustainable integration of the youth in the local health care management systems. These workshops brought together community members, DHMT members and the youth to discuss the key findings identified in Phase 1 and devise strategies for ensuring sustainable MYP in the local health care management system. The target population included the leaders of the health care management team members, youth representatives, youth group members and community health workers. This methodology was deemed appropriate as it would let each of the stakeholders commit to what they can do to realize MYP.

Results from Phase 1 of the study indicate that youths were represented in all CHCs in the five CHUs. Generally, participants had a positive perception towards youth involvement in the HCMT. However, this did not translate into the youths being given key roles on the CHCs. Currently, youth were mainly assigned service roles like peer education. On the other hand, the youth wanted to be assigned key roles on the boards that would enable them influence decisions on health service provision. The HCMT felt youth lacked the capacity needed to take them up. Individual barriers to MYP were: youths' low economic status, political differences, poor governance of youth groups, indiscipline, inadequate information on SRHR, drug abuse, not having a volunteering spirit and poor performance of roles assigned to them. Poor governance of the CHC including corruption, misappropriation of funds and not giving youth an opportunity inhibited MYP. Cultural misconceptions and practices, negative attitudes of adults towards youth and gender discrimination in the community hindered MYP. Individual enhancers to MYP were: good character traits, willingness to volunteer, local residence, good performance of assigned roles and not abusing drugs. HCMT enhancers were: motivation of youth through monetary and non-monetary incentives, building capacity of youth, providing them with opportunities and establishing an enabling environment that enhances free discussions.

The results from phase 11 of the study indicate that roles and responsibilities that stakeholders are willing the youth to be assigned to ensure MYP in the local health care management systems include: In terms of health care planning roles like resource mobilization, linkage with other youths and running income generating activities. In service delivery the consultative workshop forums confirmed that the youth can be engaged as youth mobilizers, holding of activities such as outreaches, promotion of health care serviceof like facility delivery, immunization, HIV related services and antenatal care. In leadership and governance the participants in the workshops agreed that the the youth can be involved in health management as youth representatives. These would mainly entail representing youth SRHR issues to the HCMT and participate in decision making on SRHR. In terms of health systems monitoring and evaluation all the two stakeholder workshops revealed that the youth can participate in

health monitoring and evaluation through data collection and data entry because they are computer literate hence can do data entry and interpretation of the health information collected for programmatic purposes. The strategies proposed for ensuring sustainable MYP in the mixed group workshops included: providing the youth with monthly stipends, capacity building of youth through workshops, seminars and edutainment, sensitizing youth on their rights to participation in community structures, initiating income generating activities for the youth and involving them in all community activities and structures.

The study recommends collaborative efforts on policy reviews in recruitment and organizational procedures of CHC, sensitisation of youth on their rights to participation, provision of monetary and non-monetary incentives for the youth, strategies aimed at dispelling cultural misconceptions inhibiting MYP, sensitization of different actors on the importance of MYP, expansion of opportunities for youth involvement, youth empowerment and individual development initiatives and helping youth lobby for roles that influence health service provision and consequently youth SRHR issues.

1.0 Introduction and background

GLUK has a well-established partnership infrastructure in the region covering nine Counties that form the Western Kenya region. The partnership formalization starts from the national MOU engagement with Ministry of Health (MOH), then to the County MOHs, sub-county MOHs and communities organized under the smallest administrative unit locally referred to as a sub-location. GLUK has developed and tested the Community Strategy which has been adopted by the Ministry of Health to enhance the implementation of the Kenya National Health Sector Strategic Plan II (KNHSSP II). GLUK has been working with the general population to implement the Community Based Health Strategy (CBHS) and has recorded many positive results as explained by the organization reports. GLUK is currently involved in the scaling up process through policy formulation, implementation guidelines, training manuals and key messages development and training of implementation teams from all levels of the health system in all 8 provinces. The 6 pilot districts of the intervention have become learning sites for other district teams to observe the model (GLUK SIMAVI application report).The catchment area includes 140 Community Health Units (CHU) but within the Counties the university has formal partnership engagement with 25 sub-counties grouped into 15 sub-county working areas.

The GLUK intervention in the ASK program promotes youth representation at the different Health Care Management Team (HCMT) starting from the village, sub-location, health facility, division level, sub-county level and hopefully at the County level as illustrated in Annex 1. The intervention targets both in and out of school youths aged 15-24 years. Currently the project operates in Kisii, Migori, Homabay, Kisumu, Siaya, Kakamega, Busia, Bungoma and Trans- Nzoia Counties. Youth groups have established formal representations on governance and management boards for health services at community and first level linkages with public service providers such as Community Health Centers (CHCs) and Health Facility Centres (HFCs). Research indicates that youth engagement requires innovation, challenge of normal practice and power structures possibly meeting resistance from adults and institutions (Zeldin et al., 2008). Thus, the program facilitates the youth to self-organize themselves into groups and participate in health care service delivery decision-making process at the Sub-County level through representation on the Community Health Committees (CHCs) as a way to improve their access to quality SRHR services and information. This strategy brings on board the youth as key stakeholders in the health services delivery system.

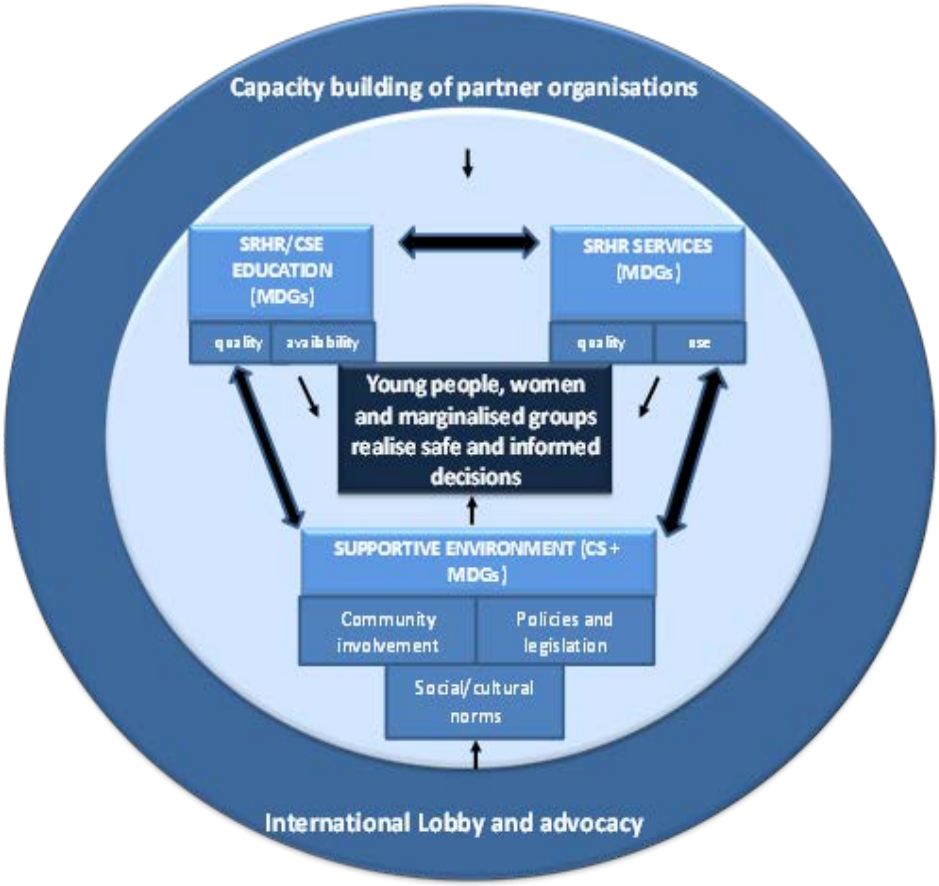
GLUK coordinates the organizing of the youths into large groups at the CHC/sub-location levels and sensitizing each CHC to establish a formal structure to incorporate youths into their functioning. The youth groups are further facilitated to enter into formal linkages with health facilities and other SRH service providers for youth in the community. The established youth group elects its officials and community based health volunteers who carry on all tasks of leadership, governance and community based health services delivery. GLUK trains the youth group officials, community based health volunteers and members in leadership, governance, issue identification and specification, program design, implementation and monitoring and evaluation.

Through the group structures, youth take up responsibilities to participate in activities targeted at improving their access and uptake of quality SRHR services and information. Key roles include; managing of a computer based SRHR information centre; conducting outreach service in collaboration with the linked health facility; conducting advocacy with policy makers and implementers; undertaking household visits among households with youth; conducting youth-led dialogue days where youth come together to discuss factors that affect their access to services and conducting community campaigns to sensitize community into supporting youth access to SRHR information and services. The youth groups meet monthly to ratify the issues they would like to be addressed for onward transmission to the CHC by the youth representatives at the different levels. The meetings at the Community and Health facility level are held quarterly.

The Access, Knowledge and Services (ASK) programme is a 3-year programme (2013-2015) funded by the Dutch Ministry of Foreign Affairs. The programme aims to enhance uptake of Sexual Reproductive Health (SRH) services among young people aged between 10-24 years, including underserved groups. In Kenya, the programme

is implemented by 15 partners comprising of Africa Alive (AA), Centre for the Study of Adolescence (CSA), Clinton Health Access Initiative (CHAI), Child Line Kenya (CLK), Family Health Options Kenya (FHOK), Great Lakes University of Kisumu (GLUK), Maximizing facts on AIDS (MAXFACTA), Nairobits Trust, Network of Adolescence and Youth of Africa (NAYA), National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK), UNESCO, Women Fighting AIDS in Kenya (WOFAK), Kisumu Medical Educational Trust (KMET), Adventist Development Services (ADS) and the World Starts With Me Alumni Youth Advocacy Network (WAYAN).The ASK programme aspires to involve young people in the development and implementation of interventions to address their Sexual and Reproductive Health and Rights (SRHR) issues. In terms of improving the services themselves (supply-side) and increasing uptake, projects strive to improve the youth-friendliness, quality and accessibility of its health clinics and clinical outreaches, including ensuring access for youth in the age group 10-24 years (demand-creation). The SRHR Alliance programmes are guided by the theory of change (see figure 1).

Figure 1: Theory of change as applied by the ASK programme



ASK has four result areas which include:

1. Young people, (including LGBTQI, YPLWH, Young adolescents (10-16), young people in remote areas and disabled young people) are better informed and thus able to make healthier choices regarding their sexuality;
2. Increased access to SRHR commodities, including ARVs and contraceptives for young people;
3. Public and private clinics provide better SRHR services, with more young people using them;
4. Greater Respect for the sexual and reproductive rights of young people including those from marginalised groups.

1.1 *Benefits of Meaningful Youth Participation*

GLUK promotes the adoption of an approach that emphasizes MYP in health care service management by the local health care management systems. 'Meaningful Youth Participation' (MYP) refers to the active engagement of young people in all phases of the development and implementation of policies, programmes and services that affect their lives[1]. The concept of youth engagement in community activities is entrenched in various international legislations committed to the promotion of children's participation like the United Nations Convention on the Rights of the Child (CRC)[2]. MYP is premised to have benefits like improving effectiveness of youth-focused

[1]Howard, S., Newman L., Harris, V. and Harcourt, J. (2002). Talking about youth participation-where, when and why? Paper presented at the Queensland Commission for Children and Young People. Australia Association for research in Education Conference, University of Queensland (2-5 December).

[2] In 1989, governments worldwide promised all children the same rights by adopting the UN Convention on the Rights of the Child, also known as the CRC or UNCRC. The Convention proposes that children should be treated as human beings with a

policies and programmes and empowering youth to be leaders[3]. Moreover, engaging young people in policy and programmes helps them to develop more confidence in themselves and their abilities. However, meaningful youth engagement requires the support of adults[4,5] (Cook, 2008; Zeldin et al., 2008). In spite of the several documented benefits of youth empowerment, requests for partnering with adults have not always been received openly and this makes the youth to feel that their voice was often devalued[6].

Evidence of the multiple health benefits of youth engagement in health care systems for individuals and communities is growing[7]. Of significance here is the fact that engagement provides for programming and health services that are more culturally appropriate (Cook, 2008). Engagement acknowledges young people's expertise on their own lived realities, and allows them to take part in and influence processes, decisions, and activities that will affect their health and that of the community in which they live. A number of benefits have been reported from general community participation.

1.2 Common Barriers Affecting Youth Participation

A research targeting stakeholders who participated in the preparation of the district annual budget and health plans in Mbarali Tanzania[8] indicates that among the most common barriers preventing MYP are attitudes and social norms that do not value young people as productive members of society. In addition, the study states that some actors simply lack experience working with young people, and youth organizations may lack the funding to support the work of the selected community representatives, connections or networks to advocate for their own involvement. The study calls for extra mentoring or coaching of the youth to enable them to participate effectively especially if the youth representatives are new to a process[9]. These findings are in agreement with the results of the current study, which proposes that the youth capacities need to be enhanced. This can be done through mentoring and provision of financial support like initiation of income generating initiatives or offering them job opportunities to enhance youth engagement.

A study focusing on indigenous Canadian youths' conceptions, voice, and efforts around health care found that youth and practitioners regard the formal health care system as ineffective and disrespectful of youth and culture[10]. This is assumed to deter many youth from participating in health care programs. The study further notes

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distinct set of rights instead of as passive objects of care and charity. These rights describe what a child needs to survive, grow, and live up to their potential in the world. They apply equally to every child, no matter whom they are or where they come from.

[3] ASK Essential Packages Manual, (2014 Edition).

Cook, P. (2008). Understanding the effects of Adolescent participation in health programmes. The International Journal of Children's Rights, 16(1), 121–139.

[5]Zeldin, S., Petrokubi, J., and MacNeil, C. (2008). Youth-adult partnership in decision-making: Disseminating and implementing an innovative idea into established organizations and communities. American Journal of Community Psychology, 41, 262–277.

[6]Natasha Blanchet-Cohen, Zora McMillan, Margo Greenwood Indigenous Youth Engagement in Canada's Health Care. A Journal of Aboriginal and Indigenous Community Health 9(1) 2011.

[7]Blanchet-Cohen, N. (2009). Children, Violence and Agency: In and Beyond the UN Study on Violence against Children. Innocenti Working Paper IWP-2009-10. Florence: UNICEF.

[8] Kamuzora P1, Maluka S, Ndawi B, Byskov J, Hurtig AK (2013).Promoting community participation in priority setting in district health systems: experiences from Mbarali district, Tanzania.. Glob Health Action. 2013 Nov 25;6

9Kamuzora P1, Maluka S, Ndawi B, Byskov J, Hurtig AK (2013).Promoting community participation in priority setting in district health systems: experiences from Mbarali district, Tanzania.. Glob Health Action. 2013 Nov 25;6

[10]Natasha Blanchet-Cohen, Zora McMillan, Margo Greenwood Indigenous Youth Engagement in Canada's Health Care. A Journal of Aboriginal and Indigenous Community Health 9(1) 2011.

that youth espouse a broader approach to health that considers the linkages between culture, identity, and health. The results highlight the value and implications of affirming youths' role as determiners of their own health[11].This is clearly brought out in the current study where participants strongly feel that youth engagement in health care is necessary to enable the local management recognise and address youth SRHR issues. The results affirms the views of most youth participants involved in the current study who felt that their views were not respected by the older members of the society, especially those in the HCMT.

1.3 Roles and Responsibilities of the youth

Studies indicate that young people have been known to play and are willing to hold various roles and responsibilities in health care management systems and that the roles that the youth can play are dynamic and are influenced by various factors. Results from a study on indigenous youth in Canada showed that youth are engaged in a variety of health-related activities, from the designing of health services and programs to youth empowerment initiatives[12]. Traditionally, indigenous children and youth participated in community activities by observing and taking part in the affairs of the family and community[13]. Each stage of growing was associated with distinct roles and responsibilities that provided children and young people with a sense of belonging to their community. However, due to political, cultural and technological changes the roles that youth can play in community structures have shifted and some have lost their role and place in society. The lack of clarity on what roles the youth should play in community activities has negatively impacted on youth participation. This does not mean that the youth are not willing to participate but rather they are confused about their roles.

Similar to the views expressed by youth representatives in the current study, results from a study among Canadian youth indicated that the primary concern of indigenous youth was to be involved in the design and delivery of health programs and services. This strengthens their ability to make an impact on health decisions through formal and informal mediums[14]. Study findings indicate that in addition to youth-led organizations, the youth advocated for access to formal decision-making, through formation of youth councils made up of only youths and then onward presenting of these ideas to the formal health care system management for inclusion in the health plans[15]. Similarly, the youth in the current study advocate for involvement in the health care decision making bodies through the youth-led organisation structures.

1.4 Current status of the pilot intervention

The integration of youth engagement in the local community Health care structures is in its initial stages with youth representatives in only 5 CHCs. The organization hopes to scale up the intervention with time. The results of the OR will feedback into scaling up and refining the intervention. Currently in most of the implementation sites only small youth groups exist mainly constituted for economic sustenance of those involved. GLUK hopes to mobilize them to form large groups incorporating youths from the whole CHU by combining the existing small groups at the village level. This will help to mobilize large numbers of youth to promote advocacy for youth SRHR issues.

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[11]Natasha Blanchet-Cohen, Zora McMillan, Margo Greenwood Indigenous Youth Engagement in Canada's Health Care. A Journal of Aboriginal and Indigenous Community Health 9(1) 2011

[12]Natasha Blanchet-Cohen, Zora McMillan, Margo Greenwood Indigenous Youth Engagement in Canada's Health Care. A Journal of Aboriginal and Indigenous Community Health 9(1) 2011.

[13]Blanchet-Cohen, N. and Fernandez, A. (2003). Women as generators of children's rights. The story of promoting Indigenous children's rights in Venezuela. International Children's Rights Journal, 11(1), 33–49.

[14]Natasha Blanchet-Cohen, Zora McMillan, Margo Greenwood Indigenous Youth Engagement in Canada's Health Care. A Journal of Aboriginal and Indigenous Community Health 9(1) 2011.

[15]Natasha Blanchet-Cohen, Zora McMillan, Margo Greenwood Indigenous Youth Engagement in Canada's Health Care. A Journal of Aboriginal and Indigenous Community Health 9(1) 2011.

This OR study directly serves the following ASK result areas:

I. *Increased access to SRH commodities, including ARV and contraceptives for young people through promotion of an enabling environment. By engaging the HCMT the project assumes that the youth representatives on the committees will help to entrench youth SRHR factors in the Sub-County health plans.*
II. *Provision of Improved SRH services in Public and private clinics, with more young people using their services. This will be done by forging collaborations and linkages between the private/public health service providers and the young people.*
III. *Meaningful youth participation in the provision of health services. This will be gained by understanding how to integrate youth into the existing health care management systems and ensure sustainability of their involvement.*

This OR is also expected to ultimately lead to greater respect for SRHR of young people by key stakeholders including the decision makers on health service provision on the CHC.

2.0 Statement of the Problem

Studies have documented a positive relationship between youth participation in policy and programmes which their SRHR needs.[16] In spite of this, little evidence exists on how to ensure effective and sustainable MYP and the best strategies of integrating youth into the existing health care systems. Moreover, youth integration into health care management systems is hampered by various factors like legitimacy of youth engagement, negative attitudes of the adults and lack of economic and social power of the youth. Currently, gaining representation on the HCMT is through having official authority - mainly accorded to government officers- and through having political power positions.

Most of the youth in the area are less likely to hold the political or formal authority needed to be part of the community health care management structures thus excluding them from the key decision making bodies on health care provision in the community. This may lead to poor access to SRHR information and services resulting in poor SRHR outcomes for the youth. It is also important to note that the Health care management in Kenya has been devolved in the new constitution dispensation thus health care decisions are mainly handled at the county level. Focusing on entrenching the youth into the local community health care management systems is thus central in ensuring young peoples' health issues are ingrained in the health management plans.

An assessment of the factors that impede and promote the integration of youth in the local community health care systems is thus imperative to inform successful implementation of the intervention. This is envisaged to promote access to quality SRHR services and information by the youth.

2.1 Purpose of the Study

The purpose of the study was to explore the factors and actors that influence the meaningful youth involvement in the existing community/sub-County health care system management structures, and the gaps, strategies and opportunities of youth participation in implementation of the community health strategy in order to improve access to SRHR information and services among young people [15-24years] in the GLUK ASK program.

2.2 Research Questions

[16]Campbell, C., Gibbs, A., Maimane, S., Nair, Y. &Sibiya, Z. (2009). Youth participation in the fight against AIDS in South Africa: from policy to practice. Journal of Youth Studies, 12:1, 93-109.

Central Research Question: How can the program institutionalize youth involvement in the existing Sub-County health care management system to ensure improved SRH services for young people (15-24 years)?

Phase 1 of the OR addressed the following sub-questions:

Sub-questions:

1. What roles and responsibilities are youth able and willing to undertake in the local community health care management systems?
2. What capacities are needed by the youth in order to be able to effectively carry out their roles and responsibilities in the local community health care management system?
3. What factors can contribute to acceptability of youth by the stakeholders at the different community health care systems (sub-location, facility, division and Sub-County levels; community members)?
4. What are the dynamics (actors and factors) that influence effective youth participation in the local community health care management system (enablers/barriers)?
5. How can the program ensure sustainability of youth involvement in the local community health care management systems?

Phase 11 of the OR addressed the following sub-question:

6. What roles are agreeable for the youth to take on to ensure MYP at the local health care management systems?
7. What strategies are agreeable for the HCMT and youth to put in place by key stakeholders **(**community health committee CHC/ MOH (DHMT)/ and partners/NGOs**)** to ensure MYP at the local health care management systems?

2.3 OR Study Justification

This OR broadly aimed to conduct a comprehensive assessment to provide evidence about the best strategies to use to ensure the integration of the youth in health care management systems. Specifically, the OR aimed to explore the barriers of youth involvement: facilitating factors, current challenges, gaps in the implementation and existing opportunities. Since health care management has been devolved to the County levels, having youth representation on the local health care management system will ensure youth SRHR factors are brought to the attention of the policy makers.

The integration of the youth into the existing health management teams is currently constrained by factors like: high turnover of youth involved in the program, Illegitimacy as it not entrenched in the current health policy; lack of power needed to gain entry into the committees by the youth and negative adult attitudes which excludes them from the decision making bodies on health matters in their communities. This makes it difficult to entrench youth SRHR factors in the health care management. Understanding the dynamics and strategies of integrating youth into the health care management systems and sustaining youth involvement is important feedback into the program in order to improve existing strategies or adopt new strategies to promote this.

2.4 Limitations of the Study

Phase 1 of the study was limited to the 5 CHUs in which GLUK had begun piloting the integration of youth in the local health care management structures. The study excluded the young adolescents aged 10-15 years as they are not addressed by the program intervention. The study targeted the members of the local HCMT and not all the key decision makers in the community as they were seen to be directly in charge of designing the community health plans. Generalisations of the results to other areas should thus be done with caution. In Phase 11 the study only held two workshops in Butere and Nyakach sub-County and not all sub-counties where the program is

implemented.

3.0 Methodology

This section outlines the techniques used in obtaining and utilizing the data required for this study. It contains research design, study setting, study population and area, the sample selection, research tools/instruments, data collection, management and analysis.

The study was an operational research (OR) or implementation research (IR)[17]. The intent of OR and was to learn about management, administrative, cultural, social, behavioural, economic and other factors that either exist as bottlenecks to effective implementation or could be tested to drive insights into new, more effective approaches to programming[18]. The implementation study aimed to:

- identify and solve program problems in a timely manner
- help program managers make evidence-based program decisions
- improve program quality and performance using scientific methods
- understand how their programs work[19]

Phase 1

Using a cross sectional qualitative study design the **first phase** of the OR involved carrying out KIIs and FGDs with Key stakeholders at each of the levels of the local Community Health System to assess the factors and actors influencing the integration of young people in the local community health care management committees at the sub-location, facility, division, Sub-County and County levels. A total of 29 KIIs and 13 FGDs were conducted, tape recorded for verbatim transcription. The study involved young people between ages 15 to 24 years old in the five sub-locations in which the program has already started implementing the project and has gained youth representation in the local health care management system. The Second Phase is expected in mid-2015 will mainly focus on policy makers.

Phase 11 Methodology

Using a cross sectional qualitative study design, the study conducted a comprehensive assessment to provide evidence about the best strategies to use to ensure the sustainable integration of the youth in the local health care management systems. The study employed the use mixed group participatory stakeholder workshops. These workshops brought together community members, DHMT members and the youth to discuss the key findings identified in Phase 1 and devise strategies for ensuring sustainable MYP in the local health care management system. The target population included the leaders of the health care management team members, youth representatives, youth group members and community health workers. This methodology was deemed appropriate as it would let each of the stakeholders commit to what they can do to realize MYP.

3.1 Study Population

The study targeted young people (15-24 years) youths (including group members, volunteers and representatives). They were interviewed to explore the roles they feel they are willing and able to play, the capacities needed to effectively participate in the HCMT, factors that may influence their participation, benefits gained from their participation and strategies that can be used to sustain their involvement in the local community health care

[17] In this study Operations Research (OR) represents Implementation Research (IR) as well.

[18] Global Fund, USAID, WHO and UNAIDS. Program Framework for Operations and Implementation Research in Health and Disease Control Programs The World Bank Global HIV/AIDS.

[19] Global Fund, USAID, WHO and UNAIDS. Program Framework for Operations and Implementation Research in Health and Disease Control Programs The World Bank Global HIV/AIDS.

management systems. The study also targeted the leaders and members of the local HCMT; youth political representatives on the local community health care structures and government health officials in the five CHUs. They were interviewed to understand the roles they feel the youths could play, capacities needed by the youth to play those roles, their attitude and perception of youth participation, factors and actors that (could) affect MYP in the local community health care management systems and strategies of ensuring sustainable youth involvement in the HCMT.

Selection Procedure for the KIIs: This included the leaders of the HCMT at the Division, health facility and sub-location level; Government representatives to the local health care management boards, religious leaders (Protestant and Catholics as major religious representation in the area) and the heads of the health care facilities. KIIs were also administered to the five youth representatives from each of the five sub-locations/CHCs sampled in the study.

Description of the study area:
The study was conducted in the western region of Kenya where poor youth SRHR outcomes were noted. The region has high rates of almost 5 births per woman. According to the latest 2014 Kenya Demographic and Health Survey (KDHS, 2014) in Western province the Total Fertility Rate (TFR) is 4.7 while that of Nyanza is 4.3. Teenage pregnancy and early child bearing is also high in the region, the percentage of women (15-19%) who have had a live birth is highest in Nyanza nationally. 4.1% in Western. There is a noted decrease in the levels of childbearing among teenage girls aged 15-19 years from 27% in 2008 to 19.2 % in 2014 in Nyanza and a slight decrease in Western from around 15% in the 2008 KDHS to 14.1 % in the 2014 KDHS[20]. Teenage girls (15-19%) who were pregnant with first child at the time of the survey were 2.7% in Western and 3.0 % in Nyanza[21].

Sexual activity and child bearing begins early in these regions with young women in Nyanza (64%) and young men in Western (69%) being more likely than those in other regions to have had sex before the age of 18 (KDHS, 2008). Knowledge on HIV prevention among the youth is also low with Nyanza recording higher levels than Western. The percentage of young women and young men age 15-24 with knowledge of HIV prevention was 56.8% among males and 65.5% among men in western region compared to 63.2% among women and 70.6% among men in Nyanza[22]. The most common consequence of teenage pregnancy is unsafe abortion. In the region youth health services have remained unattractive and less utilized.

The research was conducted in five CHUs namely; Shibembe, Mutoma, Madibo, OmiaMalo and Gem Nam. These were purposively sampled because they have already integrated youth participation in their HCMTs and their long partnership with GLUK. Two of the CHUs (Shibembe and Mutoma) are in Butere, Kakamega County while Madibo CHU is located in Busia County predominantly inhabited by Luhyia speaking communities. Omia-Malo and Gem Nam are CHUs located in Siaya and Kisumu Counties respectively and are predominantly inhabited by the Luo community. The two regions are predominantly rural, exhibit a high poverty level (67% and 61% for Nyanza and Western provinces respectively) compared to 47% at the national level. The area has been known to experience slow change in economic trends partly attributed to historic political marginalization, low literacy levels and unfavourable cultural practices.

Focus Group discussions [FGDs]:
In Phase 1 of the OR, the study conducted 13 FGDs with Community Health Extension Workers (CHEWs), community members and youths. The FGDs aimed to encourage free discussion and debate amongst a group of persons, an effect which is not attainable in a one on one interview[23] . The focus was to explore the perceptions of

[20]Kenya National Bureau of Statistics and ICF Macro, (2010). Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro.

[21] Kenya Demographic and Health Survey 2014, Key Indicators, 2014)

[22] Kenya Demographic and Health Survey 2014, Key Indicators, 2014

[23]Berg Bruce L., (1998). Qualitative Research Methods for the Social Sciences (3rd Ed.). USA: Allyn and Bacon.

youth, CHEWs and community members on the roles and responsibilities that youth could perform on the HCMT, benefits of MYP, acceptability of youth representation and sustainability of MYP in the CHC. FGDs also provided an opportunity to pursue issues, obtain additional information and to verify and triangulate the findings from the KIIs.

Identification of FGD participants
The FGDs participants were identified with the assistance of the CHEWs and the youth health volunteers attached to the different CHUs. All the FGDs consisted of members of the same sex, to allow for free expression of ideas, apart from that of the CHEWs.

Identification of Mixed group workshops for phase 11 of the study
The workshop participants for the mixed group participatory workshop held in August 2015 were based on the results of the key actors influencing integration of MYP into the local health care management system identified in Phase 1 of the study. From the results of phase 1 these included leaders and members of the health care management team, youth representatives, youth group members, community health workers and the implementing organisation (GLUK).

3.2 Pretesting of the research instruments

This was done before the actual study to ensure that the items tested what they were intended to (validity) and that they consistently measured the variables in the study (reliability).The interview instruments were pretested on non-ASK sub-locations/CHU with characteristics similar to the study sites. Respondents included in the pre-test did not form part of the final study sample. This included one FGD guide of eight females and eight males from the study area. The KIIs guides were also pre-tested among the different target groups namely one HCMT member at each of the five levels; and one youth representative. The pre-test enabled the researcher to review, reconstruct, add important questions, test the appropriateness of study tool on the target population and confirm accuracy of the translation of the semi structured questionnaire into Kiswahili and local languages and back to English. The refined instruments were then adopted for the actual study.

3.3 Data Management

The overall training and field process was supported by GLUK and Globus AQ. Data collection was carried out by GLUK with technical assistance from GLOBUS AQ and the Youth Empowerment Alliance. GLUK was in charge of recruiting the team of 6 research assistants and two supervisors. The team was trained on ethical factors involved in research, research methodology and orientation on research tools; handling sensitive questions and debriefing sessions were held after every field work to address any matters that arose. The Interviews, FGDs and workshop proceedings were tape recorded for verbatim transcription and notes were also taken. Informed consent forms were obtained and submitted to the GLUK office for safe keeping. Data transcription was carried out by trained research assistants under the supervision of GLUK. Final written reports from the FGDs, KIIs and workshop proceedings together with the original cassettes and soft copies of the transcribed data were then submitted to Globus AQ for analysis and report writing process.

Since the study was mainly qualitative, after each KII, FGD and workshop discussion, the information was translated into English during transcription (in cases where the interviews were conducted in Kiswahili, Luhya or Luo languages) and typed before coding. The field notes were transcribed, organized into a set of notes and entered into word processors. The information was then systematically organized into relevant sub-themes. The coding framework was developed based on the study guide and from reading the interviews and FGD translations from the respondents from the 5 CHUs/Sub-Locations covered in the research. QSR Nvivo 10 Software © (International Pty 2012, Australia) was used to manage the data.

3.4 Thematic framework

The final thematic framework was developed after review of the data and the research questions for each of the two phases of the study.

Phase 1

The following themes were initially used to code: General context of SRHR factors affecting youth in the study area; Acceptability of youth participation in the HCMTs; Capacities needed by young people to adequately represent the SRHR factors of young people on HCMT; Roles and responsibilities of the youth (roles currently performed by youths, Roles youths are willing to undertake on the HCMT); Benefits of MYP (current and proposed benefits and ways of ensuring youths benefit from their engagement); Factors affecting MYP in the community health care management systems (Enhancers and barriers) and Recommended strategies for ensuring MYP in CHCs and Sustainability of youth involvement. Using flow charts, the data was studied to come up with relationships. Frequent cross checks with the raw data were done to ensure quality control. Quotes from the respondents were used to illustrate and emphasize the voices and points made by respondents.

Phase 11

The following themes were initially used to code:

How would stakeholders (community health committee/CHC, MOH/DHMT), youths and partners/NGOs) meaningfully engage youth in: Planning, leadership and governance, Service delivery and monitoring and evaluation. This included looking at roles that each stakeholder is willing to take on to ensure MYP and strategies to institutionalize MYP into the local health care management systems by type of stakeholders (Community health units, Health facility level, Sub county health management level and Other stakeholders (identified by regions).

Globus AQ team worked closely with SRHR alliance and GLUK in the implementation of this study. GLUK was involved in the planning [logistics- travel, accommodation, communication of the research assistants] and in the execution of data collection and transcription of the KIIs and FGDs. The SRHR Alliance secretariat was in charge of overall coordination of the OR process and acted as a link between the implementing organizations, Globus AQ and the OR team in the Netherlands. Globus AQ was responsible for the proposal and tools development; data analysis and report writing.

3.5 Ethical considerations

The following measures were taken to ensure adherence to ethical principles:
Careful steps were taken in the development of study tools to minimize potential distress to informants. The study tool was pre-tested among a small number of people with characteristics similar to that of the study population to identify potentially negative consequences and to modify the tool accordingly to suit the different study contexts. Data collection was conducted by young researchers trained on research ethics and interviewing techniques including good listening and observation without showing judgmental attitudes and requirement for confidentiality and obtaining of informed consent from the target groups.

Written consent was obtained from all study participants (FGD & KIIs) after explaining the purpose of the study. For those who were not able to understand the English version tools were translated into Kiswahili and the major local languages spoken in the study sites then translated back into English to ensure accuracy of content. The participants were given time to ask questions if they had any and allowed to withdraw from the study if they felt uncomfortable. No names or personal identifiers were recorded on any study instruments. Individual minors and

emancipated minors[24] provided individual written consent.

All participants were informed that there were no direct benefits or compensation provided in the study. Throughout the study, privacy and confidentiality was emphasized. All data was kept separately from identifiers in the consent forms. No respondent names appeared on the questionnaires and subsequent study reports. In this report information per case is not anonymous as it is meant to provide GLUK with case specific information. However, for wider dissemination case anonymity will be maintained. All interviews were conducted in private and data access limited to the study team.

Ethical Clearance-The study protocol and the study tools were submitted to the AMREF Ethical Review Committee for ethical approval.

[24]Adolescents who may be orphaned or not living under parental or guardian control – those adolescents heading child headed households or married.

4.0 Key Findings

The findings from the Focus Group Discussions, Key Informant Interviews (KIIs) and workshop discussions are presented in the following sections:

4.1 Main SRHR issues in the region and gaps in addressing them

The study findings from the KIIs and corroborated by those from the FGDs in all the 5 CHUs revealed that the most common SRHR issues affecting youth in the study area was teenage pregnancy, abortion and post abortion complications, followed by lack of knowledge about reproductive health options, HIV and STDs, sexual abuse and finally lack of sanitary essentials. The cultural factors cited included early marriage and sharing of circumcision knife which they felt contributed to new HIV infections among the youth. The issue of cervical cancer was only mentioned in Gem Nam, Kisumu County.

"Teenage pregnancy has really affected our youths especially when it comes to girls because some of us have an experience in that it leads to early marriages and also to schools drop out" Youth, FGD 5.3

Results from the FGDs indicated that the major SRHR challenges that the youth faced was lack of adequate SRHR information among them which led to early sexual debut. The participants also felt that there was low condom utilization due to fear of obtaining condoms thus leading to unprotected sex that exposed them to the risk of contracting and spreading HIV/STIs, teenage pregnancies and school drop outs among the youth. The participants attributed the prevalence of these SRHR issues to the low economic status of the youth which they felt made girls more vulnerable to exploitation by older men and inadequate SRHR information. According to the key informants, some of the issues that affected the youth and that were not directly related to SRHR were drugs and substance abuse, peer influence, unemployment, child labour and poverty.

Source of information on youth SRHR factors by HCMT members

Participants felt that members of the HCMT obtained the information on SRHR issues affecting the young people from personal observations, institutional records such as school registers especially on issues of school drop outs, hospital records and lastly from research study reports. The information was corroborated by the FGDs carried out in the area. Other sources of information revealed from the discussions were the CHEWs monthly meetings to give feedback or reports on issues affecting youth in their area of operation, mass media such as radio and newspapers, guidance and counseling sessions for the youth, dialogue days at health centres and secondary sources information like books.

"We get to meet the victims of early marriages and school dropouts as we do the household visits" FGD, CHEWs.

"Every month we have a reporting form and we indicate some of the problems that the youth in our area experience. I know their problems because I often visit them in their homes." FGD 2.1a CHEWs

Sexual and reproductive issues adequately addressed in the area

Almost all the stakeholders targeted in the KIIs were in agreement that the youth were receiving information on SRHR factors mainly done through training, seminars, community dialogue and health talks carried out by CHEWs and other health workers in Barazas[25]. The participants observed that the HCMT also carried out resource mobilization for SRHR projects at the community level and promoting HIV and STIs prevention through ensuring condom supply.

"Yes; to avoid those HIV infections we usually educate the youths to use condoms and then also on early pregnancies we usually give health talks, usually in my area" KII, CHEW, 2.2.4a

"We are trying to our level best to address this issue by use of various forums including community dialogue days, churches and school" KII, CHC, Chairperson, 3.3.2a

SRHR factors underserved in the study sites

Some of the SRHR underserved in the area include: sexual gender based violence (SGBV), cultural issues like early marriage, Voluntary counselling and testing due to fear by the youth, provision of sanitary towels to school girls, same sex relationships (homosexuality and lesbianism), multiple sex relationships and early pregnancy. It was observed that even though condoms were distributed some of the youth do not use them or resort to having multiple relationships as they felt protected against SRHR issues like pregnancy and STIs/HIV. Other SRHR underserved in the community include unprotected sex evidenced by early pregnancies, inadequate information on SRHR among youths often leading to unplanned teenage pregnancies since the in-school youths are not targeted by out of school SRHR initiatives while the out of school youth miss out on the school based programs. There is low uptake of SRHR services like family planning by the youth due to religious beliefs and rampant sexual exploitation of young girls by older men.

"As CHEWs they should give us the test kits and materials so that when we do house visits we can be testing them because many of them fear going to the hospitals for the tests" CHEW FGD 5.1a.

"SRHR is taught in schools so schools drop outs are disadvantaged" Youth FGD Participant 2.3a.

4.2 Roles and responsibilities of youth representatives on the HCMT

This section looks at the roles the youth are currently performing on the CHC, Roles the youth representatives are willing to take up on the HCMT and the level of MYP on the CHC.

Roles currently performed by Youth representatives on the HCMT

Generally participants in all the 5 CHUs studied felt that the youths should be involved in the healthcare management teams. However, this did not translate into them being given key roles to influence SRHR agenda on the CHC. Participants felt that the youth representatives are mainly assigned fieldwork and service provision roles on the HCMT.

These included:

a. **Health data collection and management** from the community through household visits and questionnaire administration to carry out research on health issues affecting youth in the community. Community members and youth in the study felt they were suited to take up these roles since they were educated and energetic so could easily move from one place to another and could easily get information from young people.

[25] Baraza refers to community meetings

b. **Acting as linkage between facilities and the community** by referring patients to the hospital for further medical care. The youth representatives also act as conduit of information from the facility to the community through household visits and community meetings like "barazas" and providing peer education.

c. **Health promotion and education-** This was done through guidance and counselling of other youths on SRHR issues that affect them like teenage pregnancy since they were trained. The participants also felt that the youth representatives are currently conducting health education to other youth in the community through role plays and drama, door to door campaigns and sports.

d. **Mobilisation-** youth representatives are charged with **c**alling youth for community meetings since they know where to get them and modes of communication suitable for the youths like Short Message Services (SMS). Youth representative also organise youth dialogue meetings where the youth discuss and ratify the issues including SRHR that they want presented to the HCMT members.

e. **Health Service provision roles**- These were the most prevalent roles undertaken by the youth in all the 5 CHUs. These included; data collection, household visits, condom and net distribution, follow-up of clients, household registration, immunisation and Community Health Volunteers (CHVs). It is important to involve youth in health service provision in order to reach the hard to reach youth, and their peers, with SRHR information. As explained in the study youth are more receptive to service provision like condom provision and HIV testing from their peers than the adults.

f. **Resource mobilization-** this involved writing proposals for the youth groups and CHC in order to mobilize resources for the establishment of Income Generating activities for the youth groups and health care service provision for the CHC.

g. **Leadership roles-** currently youth representatives **c**hair the group meetings where they educate their peers and discuss youth issues, organize health outreaches to provide health services to the community members including the youth and management and coordination of youth group activities. They also act as role models for other youths to emulate thus promoting behaviour change among them.

h. **Running of errands**- youth representatives provide services for the HCMT like driving health facility cars, messengers and minutes taking.

"I feel it is okay for youths to be given an opportunity, because they are the leaders of tomorrow and will take leadership when adults retire." FGDs participant community members 3.2a,

A summary of possible roles, roles youth are currently performing and roles the youth are willing to take are summarized in the Table presented below:

Table 4.1 Roles and responsibilities of youth representatives

Possible roles	Current roles performed	Roles youth willing to take up
1: Health promotion and education	- Guidance and counselling of their peers - Disseminating information to other youths - Performing role plays and drama to educate youth	-Mobilisation of the youth -Sensitising youth on SRHR issues like contraceptive use -Health information dissemination
2: Mobilisation	-Calling youth for meetings -Organising community dialogue	-Organising youth events like meetings and seminars
3. Advocacy	- Not stated as one of the roles youth are	-Mobilisation of youths into large groups to

Possible roles	Current roles performed	Roles youth willing to take up
	currently performing in any of the 5 CHCs	advocate for youth SRHR issues to the HCMT
4. Health Service provision	- Data collection - Household visits and registration - Health clean ups and immunisation - Condom and net distribution - SRHR service provision - Follow-up of clients - Community Health Volunteers CHVs)	- Provision of ICT services in the management of health care services - Health clean ups
Service/Errand roles	- Minute taking - Driving health facility cars - Messengers	- None cited as one of the roles that the youth are willing to take up on the HCMT
Resource mobilisation	- Writing proposals for the youths and CHC	-Linking the CHC with partners to mobilize resources
Awareness creation	-Door to door campaigns -Participation in sports and drama	-Peer guidance and counseling -Awareness creation on youth SRHR issues through sports and theater
Leadership roles	-Chairing youth group meetings -Organizing health outreaches -Acting as role models for other youths to emulate	-Take up executive roles on the committee -Supervision and management of CHC projects - Making decisions on youth SRHR issues -Managing of funds meant for youth SRHR factors
Oversight role	Not currently being done in any of the 5 CHUs	-Check on the resource utilization by HCMT to prevent misappropriation of funds and corruption
Representation	Representing youth SRHR issues on CHC	Representing youth SRHR on CHC

Roles that the youth representatives are willing to take up on the HCMT

An analysis of the current roles and the roles that the youth are willing to take up on the HCMT points to a gap in the roles that the youth are willing to take up on the CHC and the ones they are currently assigned. The following section highlights the roles that youth are willing to take up on the CHC but are not currently assigned in any of the study sites. These include:

a. **Executive roles on the committee** like position of chairing the CHC or organizing secretary so that they can be in charge of setting the agenda of the health board meetings. Youth also wish to be accorded with project supervision and management so that they can be part of making decisions on how they are designed, implemented and evaluated. The youth felt that their representatives should be charged with managing of youth SRHR programs since they understood them better, were better educated than the older CHC members and some of them had relevant technical training to undertake such roles.

b. **Resource mobilization**- due to their knowledge and skills, participants felt the youth could take up roles such as proposal writing to mobilize funds and resources for youth activities and the CHC.

c. **Event organization**- the youth felt that they should be charged with taking care of logistics and organizing of the health care events at the village and facility level. The youth however expressed that they needed capacity on event organization to handle this role.

d. **Oversight role**- the youth felt best suited to check on the resource utilization by HCMT to ensure proper financial management and consequently prevent misappropriation of funds meant for health care service provision. They were also willing to act as a watchdog on the board.

e. **Advocacy**- this involved mobilisation of youths into large groups to gunner the numbers needed to press for change in the way SRHR issues are addressed by the HCMT and prioritisation of youth SRHR needs

on the CHC. This would ensure that the HCMT included youth SRHR in the community health care plans.

The HCMT were observed to be reluctant to let the youth to hold executive positions on the health care boards. They justified this view by stating that the youth lacked the capacity to take on these roles. Moreover, the youth representatives had no say or choice in the roles and responsibilities assigned to them by the leaders of the HCMT. This made the youth to accept any roles assigned to them irrespective of whether it would enhance the project goal of improved SRHR services and information for youths in the community. In Madibo, Gem Nam and Mutoma CHUs, the youth representatives stated that they were willing to perform any roles assigned to them by HCMT. Therefore, it is imperative to press upon the youth the importance of holding certain key positions/roles on the HCMT.

Level of MYP in Mutoma HCU, Kakamega County

The Mutoma CHU Kakamega County youth representative observed that he had not yet started active performance of roles on the CHC.

"We have not yet started work properly"…KII, Youth representative, Mutoma CHC, Kakamega County.

This finding was corroborated by CHEWs from the area who reported that the youths had not been assigned official roles on the HCMT but were just invited to attend and mainly run errands for the older HCMT members. They further added that the youth were previously not involved (on the HCMT) and were therefore still being trained and would only be able to take up executive roles on the HCMT upon completion.

"We (HCMT members) have not yet assigned the youth representative's roles on the committee". KII, CHEW, members of the CHC, Mutoma, Kakamega County.

It also emerged from the youth FGD that some of the youth were not aware that they were actually represented on the HCMT.

Summary of roles of youth representatives

Generally, the roles of the youth representatives on the CHC can be summarized into three main categories:

1. ***Roles to do with health promotion/peer education*** among the youth in the community like peer counselling, community clean ups, awareness creation among youth on SRHR issues for example through health talks, linking youth to health services like through providing referrals and distribution of commodities like mosquito nets. Although these roles were not directly linked to improved SRHR services and information for youths in the community, they were deemed necessary to promote the acceptance of the youth representatives.
2. ***Roles to put youth SRHR on the agenda***- Currently the youths are not assigned these roles on the HCMT. These include roles that can give youths the power to set the health agenda and influence health decisions of the CHC. Youth representatives should be able to lobby for roles that can give them a chance to influence health decisions, budget allocations, have voting rights on health issues and have their opinions heard. These include leadership roles on the HCMT; project management of youth SRHR programs, advocacy, representation of youth SRHR issues and oversight roles.
3. **Supportive roles to HCMT**-the youth representatives are assigned service roles that are basically aimed at benefitting and facilitating the operations of the HCMT. These include roles like driving of health facility vehicles, secretarial, organizing of community health events and taking of the boards' minutes. These roles do not improve SRHR service and information for the youth**.**

Level of MYP on the HCMT

There was divided opinion on whether there was MYP on the local health care management systems. Community members and youths in all the five CHUs studied generally felt that although youth were currently involved on CHCs, they had not been assigned any key roles. Therefore, they could not contribute to the attainment of the project goal of increasing access to SRHR information and services for the youth. In Mutoma CHU, it was

observed that youth have not been involved much at the facility level and hoped the level of their engagement would increase over time. A minority of the youths in the focus group discussions pointed out that they were not aware of any youth representation on the CHCs. In Gem Nam the youth representative rated the level of youth engagement on the HCMT as average.

> *"I'm not aware that we are represented on the HCMT….." Participant Youth FGD, Mutoma CHU, Kakamega County.*

"It (MYP) is not good enough since there are very few youth representatives on the local health care boards", KII, Youth representative, Omia-Malo, Siaya County.

Follow up workshops on roles and responsibilities

Results from a follow-up workshops conducted with community health units and members of the health management committees confirm results in the first phase on potential roles and responsibilities for young people. Similarly, they also present disagreements over actual roles hat young people can take on HCMTs. The workshop discussions helped build consensus on potential roles and responsibilities and actual roles to be taken up by young people on the health care management committees.

4.3 Roles and responsibilities that stakeholders are willing to assign youth to ensure MYP in the local health care management systems

The study sought to find out how stakeholders (community health committee/CHC, MOH/DHMT, youths and partners/NGOs) would meaningfully engage youth in planning, leadership and governance, service delivery and monitoring and evaluation in health. Strengths and weaknesses of youths to participate in these capacities were also discussed. The results are presented below:

4.3.1 Health care planning roles

The agreeable roles that the other stakeholders were willing to let the youth take on in planning included:

a) **Resource mobilization through proposal writing**- During the mixed group workshop the participants agreed that the youth should take on the role of resource mobilisation. Most participants felt that the youth are suitable for this role because they are educated and trained for instance GLUK offers capacity building for the youths, they are good in English and some of them are educated.

The DHMT members from both Nyakach and Butere sub-counties suggested that the youth can play the roles of resource mobilization via proposal writing and linkages. They however felt that the youth can write proposals but they are not in a position to perform these tasks well because they lack knowledge in writing proposals, not all youths are literate and some are not aware of availability of such positions

The workshop with the youth from both Nyakach and Butere revealed that the youth have the potential to participate in planning by mobilizing resources via proposal writing because the literacy levels among the youth are high as they have the basic education but they do not have the capacity to write proposals so they need capacity building on the same to be able to participate.

"It's in order for youths to be trained on proposal writing….They do not have the capacity or rather idea so they should be …They need the skills to do it…The potentials are there for youths the only thing they need is the capacity" Participants Youth Workshop Butere

"We are educated to do mobilization of resources….youths are energetic….we understand each other better….youths can easily socialize with other youths to mobilize resources" Youth Workshop Nyakach

"Youths don't have knowledge of writing proposals due to; Lack of knowledge of the existence….Lack of capacity….Literacy level among the youths…..DHMT Workshop, Butere.

"Some of them are educated and I think from their education background they are able…They are trained….English command- their language is good….Some of them if not all are computer literate…They have partners like GLUK that offers capacity building…Youths can write proposals because they are educated to a higher level….They have good English language, are computer literature…They have good networking with stakeholders from different organizations." Community Workshop, Butere.

> *"Yes, they can do the task though not on their own. They must incorporate us as mature people so that issues of fear and shame do not arise amongst them….There are some youth also from age 10-24 who have undergone proposal writing training/ capacity building who can be able to do it and the reason as to why am sure they can do is because I myself did the same the training with them" Community Workshop Nyakach*

The weaknesses that the youths have in terms of resource mobilization mentioned in the discussions included lack of experience and capacity on proposal writing.

> ***"****There are some who have been trained and some who have not so it's good if all of them can be trained to do the role." Community Workshop, Nyakach.*

The workshop with participants in Nyakach revealed that youth can participate in resource mobilization through operating economic projects, registering investment groups and seeking loans through proposals. They felt that the youth are up to the task because they have ideas to come up with innovations, they are focused and have the skills and knowledge, and they have community support, linkages and partnerships.

"Starting IGA projects….coming up with drama groups…innovations….Registering our group…. seeking loans through proposal development….youths are focused…youths have knowledge and skills…youths have support from the community…youths have linkages and partnerships." Participants Youth Workshop, Nyakach.

"Training on proposal writing….Supply contracts to youths…Encouragement and guidance…..financial support" Participants Youth Workshop Nyakach.

b) The youth can also act as a **linkage between the health care system and fellow youths** because they are of the same age. The DHMT members felt that the youth can act as a linkage between the facility and the community particularly the youth because most of them are educated and are aware of SRH issues, they are good in communication, and they have ICT knowledge which could be used as a medium to accelerate linking the youth to the facility. The youths are also talented and can use drama and sports as a resource mobilization strategy as it can generate income as well as using it to bring the youth together and pass information

"Youths are more educated, have knowledge of STI signs symptoms thus are able to create linkages because they are able /good in communication….Their awareness level is high to discuss with anyone….They have capacity to use the mediums like computer to link the facility and the youths and also other partners….Drama, theatre are captivating and make the youths deliver a message therefore can become an IGA and also educating – talent…Sports can be a medium to gather people and create linkage by bringing a lot of people together" Workshop, Butere.

However, the challenges that come with involving youth as linkages as discussed include low availability in terms of time because they after they have been trained then they go away for greener pastures, some are shy to express their views openly and financial constraints since the youth expect remuneration and transport compensation or facilitation to carry the assignment.

*" Their availability is low in terms of time they can be trained on how to do the linkages but the go away**….**they cannot because when it comes to linkage a person who is doing the linkage should always be available and around**…**they mostly work best with stipends. Yes, it is easier for the youths to call another youth because they are in the same age bracket…Youths are not confident to talk in front of others…Transportation is an issue*

because it's hard to reach where the linkage is." Community Workshop, Butere.

"In my opinion youth can do linkages because a youth can see the problems affecting a fellow youth and then take him/ her to the hospital….A youth and a youth get along pretty well- the reason as to why am saying that is that I also had a youth who was my child who had was pregnant and that fellow youth helped her out well." Community Workshop, Nyakach.

In terms of linkage to the facility, the youth who participated in the workshops felt that the youths are up to the task because most of them have basic education and have basic SRH knowledge that they can apply in sensitizing the community members, due to computer literacy they can get more information from the internet and they are young and energetic. The youth are also available, creative and can educate people through drama and generate income from it as part of resource mobilization. In addition they can bring people together through sporting activities.

> *"Most youths are learned, they have the knowledge…Know signs and symptoms of STIs and they can inform others…They are able to engage in the creation of linkages in the community….They are also computer literate. They can Google information" Participants Youth Workshop Butere.*

B. SERVICE DELIVERY

The analysis of the workshop discussions show that the youth can participate in service delivery both at the community and facility levels by acting as youth service providers through conducting youth led activities such as outreaches. The youth have an advantage in this because they can easily get the target population to pass information to the youth.

*"They can easily get the needed and appropriate crowd**….**They can easily penetrate through youthful ceremonies such as disco 'matangas' and talk to youth" Community Workshop, Butere.*

The challenge of involving youth in outreaches is that they are money oriented and cannot easily accept to work on voluntary basis, due to this they might end up soliciting money for free services.

"Some youth cannot work voluntarily so they can divert the activity by selling the distributed service" Community workshop, Butere.

The youths can also be engaged by serving as youth mobilizers. The strengths of youths as youth mobilizers is that they are peers to the target group so they will get the youth to come for services because of their age. However, the youths can be integrated in service provision at the above capacities through training and mentorship.

According to the DHMT members, there are several gaps in health planning that the youth can help to bridge. For instance, the system cannot manage to do some things like defaulter tracing due to shortage of staff and most of the defaulters are the youth so they can help in tracing them. They can also take up the role of promoting service utilization for instance sensitizing people on the importance of delivery at the facility.

> *"There are several aspects that the health system cannot manage due to shortage of staff…Adolescents- most of them are the youth defaulters so youths should help in tracing…Youths should take up proposals on linkage with the health facilities…Youths should be informed to sensitize people on the importance of health facility delivery" DHMT Workshop Butere*

The participants also expressed that the youth can come to bridge service in promotion of facility delivery, immunization, HIV related services and Ante Natal Care (ANC) which have low indicators owing to the shortage in human resource for health. The youths are the best people to follow up their peers in terms of HIV

and ANC services.

"There are a lot of gaps e.g. in immunization….There are several aspects the health personnel can't manage to do perfectly…Youths should be the best people to be use to follow other youths for HIV, ANC….The region experience low indicators" Participants Youth Butere

The workshops with the youth also revealed that the youth can fit in the role of **organizing outreaches** because in so doing they will own the activity and yield better results, the youth are the majority in the community hence involving them will have a larger impact due to larger coverage.

"They will be part of the activity (ownership)….They have tyranny of numbers (numerous). The effect is massive….The activity becomes theirs. (They own it)" Participants Youth Workshop, Butere.

C. Leadership and Governance

The youth can also be involved in health management as ***youth representatives in SRHR and decision making on SRHR***. They can also be involved as role models for their peers. This is because the youths can talk freely to their peers about SRHR issues compared to older people. In terms of representing other youth they have ideas on SRH issues facing the youth.

"They involve in decision then they own the thing…Possibility of getting to the real priority….Numerous then can be used as role models e.g. the footballers-used to pass message mingling between the sports and role models….The issues of sex is supposed to be private…The youths are able or get is easier to talk about SRH issues openly as compared to the older ones (they have the right methodology)…They have very good ideas, they will let the leaders know what can be done to stop a problem…Someone must represent youth in the health centre somebody must represent the youth" Youth Workshop, Butere.

"It engages the other youths when they are represented…They are already practicing this leadership in smaller groups…Helps to know what their interest is"

D). MONITORING AND EVALUATION

In terms of health systems monitoring and evaluation all the two stakeholder workshops revealed that the youth can participate in health monitoring and evaluation through data collection and data entry because they are computer literate hence can do data entry.

"Data entry using computer…Youths are digital minded….They can collect data, analyse it and come up with messages that can help them" Participants Youth Workshop, Nyakach.

They also have the capacity to collect information and come up with messages that can promote their health. The youth will come in handy in terms of data usage because the CHVs just collect data and forward them to the reporting authorities but the youth can go further and come up with messages to promote health and behaviour change amongst their peers.

"CHVs collect data and transfer them to the next level while youths can collect data and use it to create messages that they can use to create change among themselves" Participants Youth Workshop, Nyakach.

4.3 Perception on importance of MYP

The HCMT felt that having a youth representative on the CHC would enable them to understand better the youth needs. This was believed to be true as they felt the youths shared similar experiences, language and perspectives as their peers so would be in a better position to understand their views. Moreover, they believed that youth would

be more open to discuss SRHR issues with peers than adults and thus would help to bridge the age gap between the youths and adults.

"Because youths are shy to freely talk about their SRHR issues with adults, having youth representatives will enable them to share their views with their representatives who can address these factors at a higher level" KII, Youth Representative, 1.1.6a

Acceptability of MYP on the HCMT-Mutoma HCU

HCMT stated they can allow youth to vote, have their views heard, and make decisions on health factors but not to be treated as equals due to the age difference.

The HCMT felt that youth representatives did not have as many engagements on the committee as the adult members.

"Because they (youth representatives) make us understand the needs of the youth." KII, CHU Chairperson, 3.3.2a

"CHEWs who are currently there are old, if we don't have the young people, who will pick from them when they retire?" KII, CHEW, 1.1.3**a**

Most CHC members from Shibembe and Mutoma CHUs stated that MYP would help ensure continuity of the activities of the local HCMT. The youth were seen as possible replacements after the aged HCMT retired. Their engagement would help mentor the representatives to take over those roles. Furthermore, the members felt that MYP would ensure continuity of the local health care committee operations in case the older members are engaged elsewhere and thus not able to carry out their mandated roles on board.

Perception on current HCMT members' willingness to relinquish roles to the youth

An analysis of the data indicates that in Shibembe and Madibo the HCMT expressed their willingness to relinquish some of the roles currently held to the youth representatives. The HCMT were however willing to give up roles that mainly involved voluntary work and that did not require technical knowhow to effectively perform. The HCMT felt that the youth representatives lacked the capacity needed to adequately take up such roles. Reasons given for their willingness to relinquish some of their roles was to prepare the youth to take up those positions in the future and to build their capacity.

"So that they can start practicing early and learn to be responsible adults", Chairman CHC, Madibo.

"What I know is that a good leader should accept to share responsibilities. Moreover, this is voluntary work, "CHEW, member of CHC Madibo HCU.

Most of the participants in the other three study sites felt that the HCMT were unwilling to relinquish any roles to youth representatives claiming that the youths were in fact not showing any interest to take up any positions on local health care management committee. HCMT members in the latter category would relinquish their roles to youth representatives if they felt they possessed the needed capacity and were willing and ready to volunteer to take them up.

"I'm only willing if even the youths are also willing to ….volunteer their services. I can only assign to those who show that they are capable.… In case of any job I usually tell them in advance that if they are willing they should join" CHEW, FGD participant, Madibo CHU, Kakamega County.

From the results it is noted that even though some of the HCMT were willing to relinquish their roles this would not take place immediately. In Shibembe CHU, the HCMT felt that youth should be prepared to take up the roles in the future when they retired. The CHEW reported that they were willing to share any money from a donor with

the youth representatives who is assisting them to implement the project.

The CHEWs clarified that they are not paid but sometimes receive some facilitation money from stakeholders which they would be willing to share it with the youth. Monetary compensation was deemed important to facilitate the youth transport, meals and also to enable them sustain their livelihoods. Community work was noted to be involving and thus did not leave much time for the youth representatives to engage in economically productive ventures.

"Sometimes you find that I'm loaded with some other duties like ….preaching, farming and other social issues then I can be able to delegate some activities to the youths therefore making sure the role that I carryon HCMT is fulfilled." KII, Religious Leader, 1.1.5a

"Yes I would [relinquish]. When performing my roles I usually engage the youth and other parties in implementation of such programs so that in case of my absence, the program can still proceed." KII, CHU Chairperson, 3.3.2a

4.4 Acceptability of youth representation by the HCMT

The HCMT in all the 5 CHUs felt that youth engagement was important to help bridge the age gap between the adults and youths. The HCMT however felt that the youth needed more capacity to be able to perform these roles. For instance, in Shibembe HCU, most of the HCMT felt that given the right environment, knowledge and materials they can perform their roles adequately. On the other hand, the community members and youths across all the 5 CHUs perceived the youth as future leaders and thus felt that they should be given an opportunity to be actively engaged on the HCMT. The HCMT stated that they had accepted youth representation on the HCMT since they had allowed them to attend meetings and the youth were present at the facility level.

There was a strong indication from majority of the HCMT members that there was increased willingness to increase MYP in the HCMT. This was deduced from the willingness of some of the HCMT members to: relinquish roles to the youth representatives, provide support and mentorship to youth representatives and to assist in policy change to legalize youth representation on the HCMT. From FGDs it emerged that youth representation on CHCs and other committees in the community such as Constituency Development Fund (CDF) provided further credence to the growing acceptability of the youths on the HCMT.

Capacity of the youth to perform assigned roles

The issue on whether the representatives have the capacity to adequately represent youth SRHR issues on healthcare management teams elicited a lot of discussions. The youths felt that the representatives have the capacity to adequately perform any roles assigned to them. They stated that the youth were educated, had received relevant training and had prior experience working on other health projects. The youths only felt that they needed a supportive environment to be able to take up these roles. The support they needed included being given an opportunity to perform the roles; to be provided with resource materials like resource centres and equipment for learning, training on SRHR issue and being given money to facilitate them to attend the board meetings and activities.

Overall, majority of the participants agreed that the youths have some of the capacity needed to actively participate in CHC. On the other hand, HCMT felt that the youth had inadequate capacity while others felt that they did not have capacity needed to take up the roles. A few of them felt that some youths are illiterate as they do not have basic education hence can neither read nor write. They thus felt that they needed relevant education and skills in order to adequately carry out the roles. They also stated that even the youths who had been trained before needed refresher courses to be able to perform these roles effectively. Other participants felt that the youths may be knowledgeable but they still needed guidance to perform these roles.

"I understand that there are many jobs youths can do with minimal education and this job can be done with minimal education….." Participants FGD 3.2 community members

4.5 Barriers to Meaningful Youth Participation (MYP)

A summary of the barriers identified per each CHU is presented in Annex III.

Individual barriers to MYP

This section looks at the individual barriers identified in all the 5 CHUs.

Economic barriers

The most common barrier to MYP cited in all the 5 study sites was the low socio-economic status of the youth representatives. Lack of economic resources prevented them from actively participating in CHC activities as they were unable to meet their logistical requirements like lunch and transport. Moreover, participants felt that the youth had to work as they could not spend their time on the HCMT and not sustain their livelihoods. Also cited in 2 out of the 5 CHUs was unemployment which was noted to promote migration of youth in search of job opportunities thus threatening sustainability of youth engagement. This was believed to promote tokenism participation approach whereby without monetary rewards youths were unlikely to participate in the CHC activities. Youth representatives wish to be entitled to get stipend and sitting allowance as they assume that the adult members of the board do get.

Reasons why youth have adequate capacity to perform assigned roles- Shibembe, Kakamega County

The CHEW and youth group members felt that youth were capable of adequately performing the roles assigned to them. This was because of their high education attainment, necessary technical and professional knowhow from having studied community development and social work, capacity development and prior experience from participating in other health programs like GLUK.

"… The challenge is that they (youth) always want handouts every time and also do not like voluntary work …" KII, Assistant Chief, 1.1.1a.

"Some of them will be wishing to be given some stipend. Most youth are not employed and if you keep them here for free they will run away.…." KII, Health Facility In-charge, 2.2.5a

Table 4.2 Individual level barriers identified

Type of issue	*Individual/Youth Level*	*CHC identified in*	*Total*
Social factors	Character (Laziness)	Mutoma	1/5
	Lack of knowledge/information	Mutoma; Madibo; Gem Nam;	3/5
	Unavailability of youth/migration	Mutoma; Gem Nam	2/5

Type of issue	*Individual/Youth Level*	*CHC identified in*	*Total*
	Lack of skills / technological knowhow	Mutoma; Gem Nam	2/5
	Ignorance of SRHR/rights factors	Mutoma, OmiaMalo; Gem Nam; Madibo	4/5
	Indiscipline (rowdiness, bad language)	Mutoma; Gem Nam; Shibembe	3/5
	Drug and substance abuse	Mutoma; Shibembe	2/5
	Low educational attainment	Mutoma; Gem Nam; Shibembe	3/5
	Other competing needs like family	Mutoma	1/5
	Not having a volunteering sprit	Mutoma; Gem Nam	2/5
	Bad attitude of youth towards adults	Mutoma; Madibo	2/5
	Fear of elders/shyness	OmiaMalo; Gem Nam; Madibo	3/5
	Lack of motivation	OmiaMalo; Madibo;	2/5
	Inferiority complex	OmiaMalo; Madibo;	2/5
	Young age of youths	OmiaMalo; Gem Nam; Madibo	3/5
	Marital status (marriage)	Gem Nam	1/5
Role Performance	Not following procedures/rules	Shibembe	1/5
	Not accomplishing assigned tasks	Shibembe	1/5
Economic factors	Lack of resources/income	Mutoma; Gem Nam; Madibo; Shibembe; OmiaMalo	5/5
	Unemployment	OmiaMalo; Gem Nam	2/5
Political	Political differences	Gem Nam; Shibembe	2/5
Group Governance	Dictatorship/Group Conflicts	Shibembe	1/5
	Indecision on which roles to take up	Mutoma	1/5
	Not getting along with others	Mutoma; Shibembe	2/5
	Corruption	Gem Nam	1/5

Social barriers

Participants in 4 out of the 5 study sites stated lack of knowledge or information inhibited MYP. This was followed by low education attainment and ignorance on SRHR issues like Family Planning cited in 3 CHUs. The participants believed that lack of information, ignorance on SRHR rights and factors, and low education attainment deterred the youth from actively engaging in discussions of the HCMT. Participants in 3 out of 5 HCUs also felt that the bad character traits among the youth like indiscipline made them not be accepted by members of the HCMT. Fear of elders cited in 3 of the HCUs made the youth not to freely participate in CHC activities. Participants also felt that drug and substance abuse cited in 2 out of 5 of the CHUs, made the youth not to be in the right state of mind to perform the roles assigned to them and promoted negative attitude towards the youth by the HCMT. In 2 out of the 5 CHUs respondents noted that lack of skills; technical knowhow and inferiority complex among the youth made the HCMT feel they lacked capacity to perform key roles on the board. This made them not to be assigned those roles and responsibilities on the HCMT.

"If one is in-disciplined he cannot be allowed to work with us because maybe he has been brought on board and he wants to act like he knows more than the elders he found there and even insults them that they cannot think because of their old age. Such things happen, so once he insults the elders he has spoilt a big opportunity" Participants FGD, Community members, Shibembe CHU.

"Attitude will affect them because most youths lack respect; they will talk to you the way they want. Availability is also a factor since youths are always not available as compared to CHEWs who are always there. You can start a

group of 10 and after sometime they are not there, forcing you to recruit more people" KII, CHEW, 1.1.3a

"First of all there is drug abuse, because once they have taken them they do not know what they are doing. They can beat or abuse somebody ……" KII, CHC Chairperson, 1.1.2a

"They are afraid to come to where people are because of small education….." KII, Assistant Chief, 1.1.1a

"Some of them are ignorant because they do not know what is expected of them, others feel they are being ignored and others think we won't accept them." KII, CHC Chairperson, 2.2.3b

In three out of the five CHUs participants observed that sometimes the language (sheng') used by the youths was seen as creating a communication barrier between adults and youth on the board. The HCMT in Mutoma and Gem Nam also felt that youth representatives lacked a volunteering spirit and always wanted to obtain material gains from their engagement. Since most of the roles on the CHC were seen as mainly voluntary, the HCMT reported that the youth representatives did not find them attractive and thus were less likely to want to be involved.

Ensuring sustainability of youth engagement was a barrier noted by several respondents as youths migrated to the towns in search of job opportunities. This caused disruption in the running of HCMT activities. Youth were also noted to be unavailable due to other pressing engagements like attending school or colleges and thus only available during the holidays. Ensuring sustainability of the women representatives was also in question; they (girls) got married in other regions leaving a gap on the CHC. This made the HCMT to hesitate assigning roles to women representatives on the committee.

Participants in three out of the five CHUs felt that young age was a barrier to MYP as they were usually looked down upon by the older members of the HCMT who did not take their views seriously. Community members and youths in OmiaMalo and Madibo felt that the youth do not feel appreciated and motivated thus less likely to participate actively or volunteer to take up roles on the HCMT.

"For ages like 10-12 years, their parents will not allow them to join and also hinder what topics are discussed." KII, CHEW, 1.1.3a

In Mutoma CHU some of the youth were seen as bad role models since they were lazy so the HCMT were wary of assigning them any roles as they felt that they could not accomplish those tasks. However, the youth felt that the HCMT had a negative attitude towards them and this made the latter think badly about them. In Gem Nam, participants felt that the marital status of the youth could act as a barrier to youth engagement. It was explained that the community did not consider married youth as youth and this made them to be side-lined from participating in their activities. They further stated that married youth were restricted from actively engaging in HCMT activities by their spouses (mainly noted for girls) since it was deemed no to be culturally appropriate.

*"Majority of people believe that when you are married you are no longer a youth…."*KII, CHEW, 1.1.3a

Role performance issues

In Shibembe, youths were seen to lack commitment in accomplishing assigned tasks, passive in board meetings, not ready to follow the laid out rules and procedures of operations of the committee. They were thus not seen as meeting their obligations on the board and thus causing delays in the implementation of the CHC activities. This made the HCMT members to have a negative attitude towards the youth thus unlikely to relinquish or delegate any roles to them. On probing, the respondents reported that those who were seen to be passive were those not disseminating information from the CHC to fellow youth, not contributing to discussions in the committee and not attending meetings.

Another barrier highlighted by HCMT in 2 out of 5 CHUs was the negative attitude of the youth towards

community activities and adults. The participants justified that the negative attitude towards community work made youth representatives to expect material gains from any CHC engagements. They also felt that the youth saw the adults as backward, illiterate and ignorant about youth SRHR issues. The youth felt that the adults on the committee were not suited to hold those positions or address youth SRHR issues. The youth on the other hand felt that the adults had a negative attitude towards them because they feared competition from the young people who were more qualified to take up the positions on the board. The negative attitude was also borne out of the need of the HCMT to maintain the status quo.

Youth group governance issues

The way the youth groups were managed was noted to inhibit MYP. These included acts of dictatorship mentioned in one out of the 5 CHUs. The youth felt their representatives practiced dictatorship as they did not allow the members to engage in democratic discussions on SRHR issues and group activities. The youth group was also felt to be rife with conflicts mainly due to personal and political differences among the members cited in Shibembe CHU. The youth representative from Mutoma CHU reported that he faced indecision in deciding which roles to take up on the CHC in order to improve youth SRHR issues. They highlighted that there were many possible roles on the HCMT but they were not sure which ones they were best suited to perform and which roles would eventually lead to greater gains in SRHR for young people. In 2 out of 5 CHUs it was felt that the representatives could not get along well with the other members of the youth group. In Gem Nam participants felt that youth representatives were corrupt and ended up misappropriating funds and other resources meant for the group. This interfered with the group activities including the monthly meetings which are needed to ratify issues to be presented to the CHC.

Barriers to MYP identified at the HCMT level

The table below presents a summary of the barriers identified at the HCMT:

Table 4.3 Summary of barriers to MYP identified at the HCMT level

Type of issue	*HCMT Level*	*CHC identified in*	*Total*
Social	Negative attitude towards young people	Gem Nam; OmiaMalo; Shibembe	3/5
	Age difference	Gem Nam	1/5
	Not ready for competition from youth	Madibo; OmiaMalo	2/5
Cultural	Gender factors: Do not want women representatives	Shibembe	1/5
Economic	Inadequate resources	Gem Nam; Mutoma; OmiaMalo; Shibembe	4/5
Political	Political differences	Madibo	1/5
	Political interference	Madibo	1/5
CHC Governance	Embezzlement of resources meant for health care	Gem Nam	1/5
	Not giving youth opportunity	Gem Nam; Mutoma; Shibembe	3/5
	Lack of accountability	Madibo	1/5
	Corruption	Gem Nam	1/5
	Nepotism	Madibo	1/5
	Only accommodating few youth representatives	Madibo	1/5
	Corruption	Gem Nam	1/5

Type of issue	*HCMT Level*	*CHC identified in*	*Total*
	Poor prioritization of youth SRHR issues	Madibo	1/5
	Nepotism	OmiaMalo	1/5
	Legality of youth representation	Madibo; Mutoma; OmiaMalo	3/5
	Communication break down	Shibembe	1/5
	Harassment of youth representatives by HCMT members	Shibembe	1/5
	Delayed tackling of youth SRHR factors	Shibembe	1/5

Political barriers

Political differences cited in 4 out of the 5 CHUs affected the running of the HCMT affairs. The political differences among the HCMT interfered with the way members supported and voted on the health issues discussed by the board. HCMT members were believed to vote on health issues based on which political party was supporting the issue. They thus supported an issue based on their political inclination and not importance of the issue to the community members.

It was also observed that the political representatives on the CHC and HFMC swindled funds meant for youth activities. Participants claimed that they used health care funds for political campaigns or misappropriated those funds. In 2 out of 5 CHUs participants observed that politicians were also known to disrupt CHC meetings by turning them into political forums. This derailed the HCMT discussions from health issues they are mandated to address, leading to delayed implementation of the projects. Political conflicts were also mentioned in Gem Nam and these were perceived to cause sub-divisions on the HCMT.

Economic issues

In 4 out of the 5 CHUs participants felt that the HCMT lacked adequate resources to adequately address youth SRHR issues. The participants elaborated that they did not have enough staff, equipment and facilities in the health centres which made young people to prefer accessing health services from the private providers. They also stated that the public health centres did not offer Youth Friendly Services (YFS) which made them less attractive to the youth. The youth representatives faulted the HCMT for the slow implementation of youth SRHR activities which made them not to actively attend the meetings or drop out of the board altogether.

Attitude of the HCMT towards youth in Mutoma CHU

- Lazy
- Have bad language
- Rowdy
- Not organized
- Have bad attitude towards adults

Cultural issues

Participants felt that the HCMT discriminated against young women and did not accord them a warm reception on the board. This is mainly attributed to the gender discrimination in the wider community where women are not valued and the fear of the sustainability of engaging women representatives on the CHC.

Social issues

Negative attitude towards young people (3 out of 5 CHUs) and the big age difference between the adults on the board and youth representatives (1 out of 5 CHUs) were believed to inhibit MYP. Participants felt that negative towards the youth made the HCMT members unwilling to accept the youth on the local health care management boards or relinquish any roles to them. The large age difference between the adults and youths made discussions

on SRHR issues difficult. The youth feared discussing SRHR issues before the adults on the board. Other participants felt that the HCMT were afraid of the competition they were likely to get from the youth who were seen to be more learned, energetic and knowledgeable than they are. They explained that the HCMT may fear losing their positions to the more capable young representatives on the board.

HCMT governance/organizational factors

In 3 out 5 of CHUs, participants observed that lack of legality of youth representation and not assigning those key roles on the boards were the most common CHC governance issues affecting MYP. The participants expounded that there are no laws, policies or regulations that entrenched MYP in the CHC. The current Community Health Strategy does not outline clearly that youth should be involved in the HCMT and how exactly they should be engaged. Therefore, it was the HCMT members prerogative to decide if they could involve the youth representatives or not and what types of roles they are assigned. Embezzlement of resources meant for health care service provision; lack of accountability; corruption; nepotism; engaging few youth representatives on the HCMT; poor prioritization of youth SRHR issues; communication breakdown; harassment of youth representatives by adults on the HCMT and delay in handling youth SRHR issues by the board (cited in 1 out of 5 CHUs each) inhibited MYP.

"The interaction of the CHC members and the youths is never usually good" Chairman, CHU, Madibo.

Participants felt that the HCMT leaders mismanaged the funds meant for the health care service provision which in turn led to youth SRHR issues not being addressed. Expounding on nepotism, participants expressed that the leaders of the HCMT mainly appointed people known to them like relatives and friends to take up key roles on the boards. This was perceived as not promoting equal opportunity for all.

Barriers to MYP from the wider community

This section looks at barriers from the wider community.

Table 4.4 Barriers from the wider community

Type of issue	HCMT Level	CHC identified in	Total
Cultural	Clannism	Shibembe	1/5
	Religious teachings/ideologies	Shibembe; Mutoma; Madibo; OmiaMalo	4/5
	Age discrimination	Shibembe	1/5
	Gender discrimination	Shibembe; Mutoma;	2/5
	Wife inheritance	Gem Nam	1/5
	Youth not expected to speak before elders	Gem Nam; Madibo; OmiaMalo	3/5
	customs on property inheritance	Mutoma	1/5
	Early marriage	Mutoma	1/5
	Attitude towards youth	OmiaMalo	1/5
	Poverty	Mutoma	1/5
Political	Political differences	Shibembe; Gem Nam; Mutoma; OmiaMalo	4/5
	Political interference	Gem Nam; Madibo;	2/5
	Political conflicts	Gem Nam	1/5
Social	Poverty	Mutoma	1/5
	Lack of parental support	Mutoma	1/5

Infrastructural	Bad roads	Gem Nam	1/5
Governance	Lack local administration support	Madibo; OmiaMalo	2/5
	Inhibitive policies	Madibo; OmiaMalo	2/5
	Tokenism	Madibo; OmiaMalo	2/5

Cultural issues

Cultural issues were the most cited barriers to MYP in the wider community. In 4 out of 5 study sites participants felt that some religious groups' doctrines did not allow youth to discuss SRHR issues, use SRHR services like family planning or get knowledge on SRHR issues. The religious groups relay messages that portray that these sexual issues should not be discussed by unmarried youth. Youth representatives or HCMT members having such strong religious convictions are less likely to push the youth SRHR agenda on the CHC.

In 2 out of 5 CHUs cultural misconceptions were noted to make it difficult to engage young married women as they are not allowed to discuss youth SRHR issues in the presence of the men. Also noted to be inhibitive are the cultural beliefs which prohibit discussion of SRHR issues abominable or a taboo for the young people cited in 4 out of the 5 CHUs. This was especially so in the presence of adults. This creates fear among the young people who then shy away from articulating youth SRHR issues to the HCMT. Moreover, the participants felt that the community did not promote an open environment where the youth could freely discuss SRHR issues with the adult members on the boards, take up leadership roles and make decisions (cited by 1 out of 5 CHUs each) on youth SRHR issues.

Qualities of a good representative- Mutoma CHU, Kakamega County

- Role model
- Not too busy
- High self esteem
- Disciplined
- Hardworking
- Being in the youth group
- Local residence
- Punctuality
- Active
- Not abusing alcohol
- Respectful
- Accomplishing tasks allocated.
- Faithful
- Transparent,
- Available
- Literate
- Patient.

Community property inheritance customs where young people were not allowed to inherit property or own individual property when their parents still lived inhibited MYP. This made the youth representatives unable to generate income needed to facilitate their logistical requirements for board engagements like paying for transport costs. Another issue was clannism mentioned in Shibembe CHU where the leaders were noted to only appoint members from their clans to the boards. This locked out members from the other clans thus leaving them without representation on the board.

"Lack of community support in the area of sexual reproductive health makes it hard for youth to speak about sexual reproductive health issues. You want to address a certain issue to the elders about reproductive health issues and they despise you because you are young and that will dent your image instead" KII, Youth Representative, 1.1.6a

4.6 Enabling factors of MYP

Enhancers to MYP at the individual level
In Gem Nam the participants felt that the factors that enhanced MYP were good character and behavior of youth representatives. They stated that being disciplined increased the acceptability of the HCMT which enhanced their chances of being assigned roles on the board and have their views heard. They also felt that they should be ready to volunteer since gaining a position on the board did not lead to monetary gains

Education was also perceived as an enhancer in 4 out of the 5 CHUs since it enabled the representatives to understand the proceedings in meetings and make useful contributions to the board. It was felt that the youth needed to be quick learners because the board members were busy and could not take too much orienting the youths on the operations of the CHC. Being energetic and hardworking was also perceived as an enhancer in 3 out of 5 CHUs. It would enable the youth complete the tasks assigned to them on time which would promote their acceptability on the CHC.

Another individual enhancer mentioned was being a member of the local community since the community would be more likely to support an insider than an outsider. Being recognized by the local leaders was seen to promote acceptability of youth representatives as they were known to influence the opinion of community members. It is thus imperative for GLUK to bring the local leaders on board and forge a link between them and the youth representatives. Being active and proactive in HCMT matters, objectivity, not holding strong political affiliations that cause divisions and readiness to work and interact well with older members of the committee was seen to promote MYP. Other factors mentioned included: the youth's ability to act as role models to other youth, availability when required, being respectful of the procedures of the board and local residence since it was argued that if the youths come from that locality they could easily understand the context and factors within.

The different enhancers cited at the different levels of the health care management system are tabulated below:

Table 4.6 Enhancers to MYP at the different levels

Individual Level	HCMT Level
- Energetic so can walk long distances and work hard. - Availability - Possess technological know how - Educated - Well behaved/disciplined - Flexible - Quick learners - Recognized by the local leaders - Youth group support - Member of a youth group - Belonging to the community - Good work ethics e.g. punctuality - Interested in youth SRHR issues and community work - Prior experience working with community e.g. as a CHVs	- Providing Motivation/incentives - Creation on an enabling environment-providing resources friendly and supportive - Giving youths opportunity - Involving youth in decision making and leadership - Offering of employment opportunities - Relinquishing roles to the youth - Training and mentoring youth to take up their roles

Participants in Mutoma HCU felt that being accepted by other youth enhanced the performance of the representatives as it gave them the support needed to push the youth SRHR agenda on the CHC. Possessing necessary skills and knowledge obtained through training and practice from volunteering as CHVs enhanced the performance of the assigned roles. In Madibo CHU, participants felt that representatives had to be interested in community work and improved youth SRHR issues to be able to perform those roles whole heartedly.

Enhancers to MYP at the HCMT level
From the HCMT the participants felt that good governance of the CHC would enhance MYP. In Mutoma CHU,

the participants stated that assigning the representatives paying assignments and offering them monetary incentives would motivate them to actively participate in CHC activities. As earlier noted, lack of finances deterred the participation of the representatives. They had to do other jobs to be able to sustain their livelihood which reduced the time they were available for CHC meetings and activities. Also noted to enhance MYP was giving youth representatives an opportunity to perform roles on the board. They felt this made the representatives to feel valued, accepted and motivated to work hard. This was especially so in cases where the members agreed to relinquish some of their roles to the youth. Mentoring and training of representatives to take up roles on the CHC would likely enhance their performance of those tasks thus boosting their self-esteem and confidence. Finally, when the CHC members were friendly and supportive to the representatives it removed the fear and shyness from the representatives thus promoting open and free discussions on SRHR issues. These will help push the SRHR agenda on the CHC.

4.7 Benefits of MYP

According to the youth representatives the benefits currently received from their engagement on the local health care management boards included: receiving training and knowledge from the CHC facilitated trainings, helping in the creation of an enabling environment for addressing youth SRHR needs and increased opportunities for them to give back to the community through provision of voluntary services. Participants also felt that many youths also gained knowledge from the discussion forums held by the committee members. They also felt good about empowering their peers through providing them with health talks, education and creation of awareness about their SRHR. The representatives also felt that they got a chance to give their opinions and represent the youth SRHR issues to the CHC. The representatives also stated that by participating in the CHC activities they got training to become future leaders. This is illustrated in the excerpts below.

"It has helped many youths to give back to the community. I (youth representative) have helped youths know how to use and the importance of contraceptives. We are also helping youths to understand their SRHR." KII, Youth Representative, 1.1.6a

"….I say youths representative receive benefits because they get exposure and new knowledge and have first-hand access……they are given responsibilities which help to develop their skills" Community members, FGDs 3.2a.

On the other hand, some of the representatives felt that they had not received any benefits. For instance, the youth representative from Mutoma CHU stated that he had not been engaged much on the boards to be able to gauge the level of benefits so far received. This view was supported by some of the CHEWs in Shibembe CHU who felt the youths did not receive any benefits from their engagements.

Expected benefits of youth engagement

The youth expected to receive the following benefits from their involvement in the HCMT:

- The youths felt that they should be given financial motivation like stipends and sitting allowance for meetings attended. The money would enable the youth representatives to facilitate youth group activities from facilitating them to attend CHC activities and for their livelihoods.
- Becoming empowered through the experience obtained from their engagement on the board and gain vast information and knowledge from their involvement on the CHC;
- Salaries: get payment for health services rendered;
- Have free access to healthcare services in the health facilities they were linked to;
- Job placements in the community health facilities since they gain a lot of experience from their engagement on the CHC;

- Positive behavior change since youth representatives are actively engaged on the boards thus less likely to find time to engage in many social evils like other idle youths.

Proposed benefits that youth representatives should receive from involvement on the HCMT
According to the HCMT the youth representatives should be awarded with certificates from HCMTs after completion of their assignment. On the other hand the youths and community members felt that they should be provided with stipend, assisted to start income generating activities and be recognized and appreciated by the community, local administration and the HCMT.

Participants felt that in order to ensure the youth get the benefits entitled to them the following should be done:

- be given the opportunity to be part of the committee
- be sensitized on the benefits they are entitled
- creation of an enabling environment and providing equal opportunities for all
- Development of policies that will entrench youth involvement and ensure that the management committees give the youth the benefits they are entitled to.
- Empower youth representatives to lobby and demand for those benefits from the CHC management.

4.8 Suggested strategies to promote MYP

In order to enhance MYP participants suggested:
Strategies to ensure that youth are able to carry out the assigned roles

1. The findings show that the youth would like to be engaged in ***income generating activities (IGAs)*** and the other stakeholders agreed that this is something that can motivate the youth and have positive impact on their lives. The strengths of involving the youth in income generating activities (IGAs) is that they have the potential, majority are trained in Information Communication Technology by GLUK and have had capacity building in terms of resource mobilization. In addition the youth are good marketers and have the convincing power and they are able to work because they are energetic.

   *"They have the potentiality**….**They have access to places**….**They have ICT knowledge that is computer literate**….**They have been taught on how to mobilize resources**….**Most youth are good marketers they have convincing power…They are energetic and can do the work by themselves"*
2. The youths can be integrated to play these roles through *capacity building* to provide them with entrepreneurial and management skills to carry out these assignments. They should also be trained in terms of conducting the various planning tasks for instance on proposal writing.
   "Training/sharpening the youth skills to write proposal…. DHMT, Butere
3. The youth from Nyakach also proposed that the youth should be provided with *financial support* and tenders to supply materials so as to support their role in resource mobilization. This can go a long way in enhancing the economic capacity of the youth.

   To play this role well the youth need to be empowered through funding, involving them in public forums to learn, facilitate them with materials like PA systems to communicate to many youths,

"*Funding to help us explore and develop….Involve youths during the public forums…Provision of resource materials like PA systems to communicate to many youths and Attend the health talks for more support to the youths."*

4. The participants agreed that the youth should be given a *minimal monthly stipend* for sustenance and to enable them meet the logistical costs that come with participating in the health care system management like transport and airtime for communication.

5. The youth can also participate in planning through organizing for community dialogue days, outreaches and seminars. These help youth to meet and consolidate the issues affecting them for onward transmission to the HCMT. This can present the voice of the youth to the HCMT.

6. The youths can be integrated in planning through *involving them in all community activities and structures*. The youth should thus be included in all structures and activities of the community and not just health care.
7. *Sensitisation of the youth on their rights* -The participants felt that awareness creation on 30% policy[26] on opportunities for the youth should also be made to encourage meaningful youth. Youth need to be made aware that it is their right to be integrated into community development structures and activities.

*"Informing the youths about the 30%rule**DHMT Butere***

Phase 1 results

i. Strategies suggested at the individual level to ensure MYP

- Training /skills development: training youth representatives on SRHR and counselling them on the importance and benefits of their involvement in community health activities. This was envisaged to equip them with knowledge and skills needed to adequately perform their roles on the board and boost their self-esteem.
- To address the issue of poverty and unemployment, majority of the participants felt that they needed to be empowered economically through such initiatives like supporting them to start income generating activities. They also felt that skills' development would help them start projects to sustain their livelihood.
  *"They have the potentiality**….**They have access to places**….**They have ICT knowledge that is computer literate**….**They have been taught on how to mobilize resources**….**Most youth are good marketers they have convincing power…They are energetic and can do the work by themselves"*

- The youth representatives also needed facilitation and logistical support to enable them to actively participate by attending the HCMT meetings and activities.
- Another issue highlighted by the participants was to increase the opportunities for youth involvement in the health care activities in the community for example through assigning more roles on the HCMT.
- Establishment of resource centers where the youths can access information on SRHR issues.

8. Building the capacity of the youth to effectively perform their role on the HCMT so that they can know what is expected of them. The participants felt that the youth should be assisted in choosing which roles to take on the HCMT. They should also be trained in terms of conducting the various planning tasks for instance on proposal writing.
   "Training/sharpening the youth skills to write proposal…. DHMT, Butere

- The participants agreed that the youth should be given a *minimal monthly stipend* for sustenance and to enable them meet the logistical costs that come with participating in the health care system management like transport and airtime for communication.
- Increase mobilization of youth, counseling and sensitization necessary to help them overcome fears that inhibit their participation in SRHR programmes.
- Behavior and attitude change initiatives among the youth representatives in relation to adults, volunteer work and community work.
- Training, refresher courses and organizing exchange programs for youth representatives by professionals and other experienced people on areas such as income generating activities, life skills, leadership skills, comprehensive sexual education and community health work.
- The youth can also participate in planning through organizing for community dialogue days,

[26] In 2013,His Excellency the President Uhuru Kenyatta, pledged that the procurement rules would be amended to allow 30 per cent of contracts to be given to the youth, women and persons with disability without competition from established firms.

outreaches and seminars. These help youth to meet and consolidate the issues affecting them for onward transmission to the HCMT. This can present the voice of the youth to the HCMT.

- The youths can be integrated in planning through *involving them in all community activities and structures*. The youth should thus be included in all structures and activities of the community and not just health care.
- *Sensitization of the youth on their rights* -The participants felt that awareness creation on 30% policy on opportunities for the youth should also be made to encourage meaningful youth. Youth need to be made aware that it is their right to be integrated into community development structures and activities.

> *"Informing the youths about the 30% policy rule"* ***DHMT Butere***

Strategies at the HCMT level to ensure MYP

- Need for sensitization of the HCMTs on the importance of bringing youths on board and setting aside slots/positions for the youth in the HCMT.
- Giving youth opportunities where they can get paid or offering them employment in the health facilities in addition to their assigned role like clerical work.
- Giving the youth opportunities by assigning them roles and responsibilities on the CHC
- Building the capacity of the representatives for example by mentoring and counseling them to adequately perform those roles and responsibilities. Participants felt that this should be provided by the senior and experienced members of these committees. This would help the youth prepare for future roles like taking up leadership roles when HCMT members retired thereby ensuring continuity;
- Sensitizing the community about the role of the youth representatives so that they could get community support and acceptance. They also need to be recognized during community meetings e.g. by acknowledging them or giving them a chance to address the community members during community meetings.
- *C*reate an enabling environment for youth participation on the CHC by being friendly, cordial and supportive of the youth. This would enable them to freely air their views and opinion about SRHR issues that matter to them to the HCMT.
- Changing and reviewing existing policies on the composition and operations of the local community health systems in order to entrench youth participation and ensure the adaptation of the affirmative action.
- Engaging more youth representatives on the boards since they represent a large segment of the community's population. Other participants felt that the composition should include female and male representatives on each CHC to address gender specific SRHR issues.
- HCMT to draw contracts with the youth representatives to ensure commitment to the board's agenda.
- Adoption of good governance strategies like not condoning corruption, nepotism, clannism and misappropriation of health care management funds.
- Involve youth in all CHC activities including voting, decision making and determination of health budget allocations.
- Assigning youth representatives to adult mentors on the CHC so that they can be trained to perform their roles effectively.
- Sensitizing HCMT on importance of involving youth in local health care management systems.

Suggested strategies to MYP from the County governments

- Ensure that youth SRHR issues are allocated adequate funds.
- Establishing and revamping village polytechnics (training centres) where youth including the youth representatives can acquire skills in order to obtain sustainable livelihood engagements.

- Coordinate health policy review meetings to ensure more involvement of all community members including the youth.
- An education fund for the youth will also help promote literacy thereby building the capacity of the youth to participate in HCMTs in future.
- Job creation for the youths in the community to ensure economic freedom needed for the youth to volunteer their time on the CHC.
- Providing financial support and funding to youths as well as provision of sanitary towels and other social amenities.

Suggested strategies to MYP from the Political leaders

These were major actors influencing MYP in the community as they influenced policy decisions and budgetary allocation to most projects in the community. They were also mentioned as the greatest promoters of the bad handout culture of youths in the community especially during political campaigns. Participants felt they should provide:

- Political support and good will for youth SRHR programmes in the community.
- Recognition of youth representatives in political forums e.g. by giving them a chance to address the community members on youth SRHR issues.
- Financial support like CDF funds to initiate youth IGAs
- Publicize youth representatives and SRHR issues in their political forums so that community members recognize them as important.

Suggested strategies to MYP from the GLUK and other organizations serving youth in the area

The participants felt that GLUK should:

- Carry out more capacity building of the youth in the community on youth SRHR issues.
- Collaborate in initiating youth economic empowerment projects. This can help the youths deal with the challenges of unemployment and poverty that has been highlighted as one of the factors that impede MYP. They can also train youths in proposal writing skills to enable them raise funds needed to start income generating activities.
- Promotion of more opportunities for youth engagement opportunities through creation of linkages with all local health care management systems.
- Mobilizing the youth for SRHR activities like the youth dialogue meetings.
- Helping youth raise funds for youth activities.
- Offering youths representatives opportunities to access higher education e.g. through scholarships.
- Dispelling of retrogressive cultural beliefs and practices in the community e.g. through community dialogues

Suggested strategies to MYP from the parents

Most participants felt that parents should:

- Be involved in educating their children to develop a volunteering spirit to promote their participation in the HCMTs.
- Talk to their children about the importance of SRHR issues.
- Guidance and counseling of the youth representatives on their importance and performance of their roles.
- Provision of basic necessities to their children so that they can engage in MYP.

Conclusions

The study findings support the following conclusions:

Generally participants in all the 5 CHUs studied had a positive perception towards youth involvement in HCMT.

Their involvement was considered crucial in order to provide a forum for youths to air their views, play a role in devising solutions to their problems and enable the CHC to better understand youth SRHR needs.

The HCMT felt that youths should mainly perform service roles to the HCMT like secretarial and peer health education like counselling on SRHR issues, awareness creation, provide referrals and linking community members to the health facility. However, it was established that there was a gap in the roles currently assigned to the youths and the ones they would be willing to perform on the boards. In addition to the current roles the youth wanted to be assigned key roles that would enable them to influence the SRHR agenda like executive roles, management of youth health projects and advocacy of youth SRHR issues.

The study results indicate that some of the HCMT members were willing to relinquish the roles they currently held to the youth. However, the top management of the HCMT was still reluctant to let the youth take up key responsibilities on the board. They felt that the youth lacked the capacity to adequately perform those roles. The general feeling was that youth representative should be prepared to take on these roles in the future. This locked the youth representatives out of key roles on the boards like decision making and voting on health issues.

On the other hand, there was a divergent opinion from the community members and youths on whether the youth had the capacity needed to perform the roles and responsibilities assigned to them. They felt that youth could effectively perform the key roles on the HCMT since they were trained, educated and had prior experience working on other community health projects. However the HCMT felt that they needed more capacity to be able to perform these roles adequately. The capacities needed by the youths included having correct information on SRHR issues and skills like communication.

Barriers to MYP at the individual level included low socio-economic status of the youth, political differences, poor governance of youth groups, bad character traits, inadequate information on SRHR, low education attainment, drug abuse, not having a volunteering spirit and poor performance of assigned tasks like being passive in CHC meetings. Common HCMT level barriers to MYP included: poor governance of the CHC including corruption and misappropriation of health care management funds and not giving youth opportunities to be engaged on the CHC. Cultural misconceptions, beliefs, practices, negative attitudes towards the young, fear of discussing SRHR issues in front of adults and gender discrimination did not promote free and open discussion on SRHR issues on the CHC.

Participants felt that good character traits among the youth, being educated, willing to volunteer, local residence, good performance of the roles assigned to them and not abusing drugs enhanced MYP. At the HCMT level, motivating the youth through monetary and non-monetary incentives, mentoring and supporting the youth, giving youth opportunities to perform key roles on the CHC, establishment of an enabling environment that promotes free and open discussions and prioritization of youth SRHR issues were felt to enhance MYP in HCMT. Recognition by local leaders and community members, political good will and community support enhanced MYP.

There was divided opinion on whether youth were meaningfully engaged on the local health care management systems. The HCMT felt the youth were actively engaged and accepted on the CHC. On the other hand, community members and youths generally felt that youth are not meaningfully engaged on the local HCMT as they were few and had not been assigned any key roles on the boards to date.

Recommendations

At the individual level

- ***Youth empowerment and individual development initiatives-*** to take the form of capacity development through activities like mentorship, motivation, training, refresher trainings, giving youth representatives

assignments that can equip them with relevant experience that is needed to take up key roles on the CHC. This can be done through:

i. Empower the youths through edutainment like drama, sports especially during school health program can leverage to their ability. Youth concentration time is very limited so when there is an activity, they should have sufficiently interesting programs that they can engage in and captivate them to participate e.g. youths do an activity together to get funding for IGA, engaging the youths that have financial generation. Youths want activities that they are directly engaged in.

ii. Exchange program where the youths go to different programs by other youths so that they get more challenges and exposure to a variety of new things. Exposing a youth to successful programs/activities gives them the drive to face their challenges

- Facilitate the representatives to mobilize large numbers of youth to advocate for policy review and changes that can legalize their integration into the local health care management systems and the implementation of the affirmative action as stipulated in the national constitution.
- Sensitization and encouragement of youth to embrace volunteerism; change of attitude about participation in community development initiatives. The youth need to be counselled to feel that they have the capacity and it is their right to be on those boards. Creating awareness among the young people on which roles to lobby or take up on the HCMT to influence decisions on youth SRHR issues and benefits of their engagement on the boards.
- The youth representatives need to develop a legal contract with the CHC that clearly stipulates their roles, expectations and performance indicators expected from their engagement.

At the community level

- Creation of youth centres to offer youth friendly services and resource centres where youth can learn more about SRHR issues and the role of HCMT.
- Efforts to dispel the cultural practices and beliefs that inhibit MYP through participatory discussion forums that bring together all the stakeholders in the community health care systems.
- Sensitization of community members on the importance of youth participation in community health care programs through holding community dialogue; campaigns and meetings.
- ***Organizational level***

GLUK and other organizations implementing youth SRHR programs should:

- Work collaboratively on policy reviews and change in the recruitment and organizational procedures of the local health care management boards. The intent will be entrench youth representation on the CHC and clarification of the roles of the key stakeholders on the boards.
- Change the strategy used in the selection of youth representatives from being elected by the youth group to selecting from a list of youth volunteers based on their character and skills. Volunteering is believed to lead to increased commitment and sustainability of youth engagement on the HCMT more than the current practice of electing the representatives.
- Equip youth representatives with skills to advocate for improved terms of engagement on the CHC like lobbying for key roles, individual benefits and prioritization of youth SRHR issues by the CHC.
- Create awareness and sensitize all the members of the local health care management systems, the county government officials and political leaders on the value of youth participation and creation of an enabling environment where the youths feel free to air their views.
- Ensure continuity of youth representation on the boards by carrying out constant monitoring of their engagements and introducing youth representative assistants. By doing this any gap in youth representation on the CHC can easily be detected and replaced on time.
- Linking the youth to the available national and county governments funding (Youth funds and *Uwezo* fund) and training them on business management to ensure sustainability of the business initiatives to reduce the tokenism participation among the youth**.**

At the HCMT LEVEL

- Expansion of opportunities for youth involvement: there is need to lobby the local health care management systems to set aside specific number of roles and responsibilities to be undertaken by youth representatives.
- Increase the number of youth representatives engaged on the HCMT as they represent a large portion of the total community population.
- Set aside funds in the local health care budgets for motivating youths through provision of both financial and non-financial rewards. These can include providing them with stipends, reimbursement of funds used to attend board activities like costs of transport and lunch, initiating for them income generating activities and awarding them with certificates for workshops attended and roles performed.

ANNEX I: Levels. of Youth Engagement

ANNEX 1: Engagement of youth at the different levels of the health care management systems BY GLUK

Level	Description Health system	Current level of Youth involvement in the management team	Cycle of meetings
County	County Health Management Team	Not yet in ASK	
Sub-County	Health Management Team Administration	1 youth representative	They meet monthly, but youth involvement can come in quarterly
Division	Represents approx. 3 HF or 8/9 Sub-locations	1 youth representative per HF = approx. 3	Quarterly meetings
Health Facility	Health Facility Management Team. This team represents approx. 3 Sub-locations.	1 youth representative per Sub-location = approx. 3	Quarterly meetings
Sub-location	Community Health Unit/Committee, representing approx. 16 villages	1 youth representative of the youth group	Quarterly dialogue days
		Youth group at sub-location level, including all youth health workers + a governance body (chair, secretary etc)	Monthly meetings
Village		1 youth health worker per village	

ANNEX 11: Description of FGD participants

Table 4.7 Description of FGD participants

Study site	Type	Date	Number of participants	Gender composition
Medico-Kakamega County	CHEWS	19/11/2014	9	Male: 7; Female: 2
	Community members	19/11/2014	12	Male: 6; Female: 6
	Youths	19/11/2014	12	Male: 11; Female:= 1
OmiaMalo Siaya County	Community members	28th/11/2014	11	Male:7; Female: 4
	CHEWS	29/11/2014	12	Female: 12; Male: 0
	Youth	28th/11/2014	12	Female: 3; Male: 9
GemNam HCU, Kyushu County	Youths	15/11/2014	12	Females: 4; Males:8
	CHEWS	18/11/2014	12	Females: 11; Male:1
	Community members	18/11/2014	12	Male: 4; Female: 8
	Youth	13/11/ 2014	11	Female: 6; Male:5
Shibembe-Kakamega County	Community members	13/11/2014	10	Female: 8; Male: 2
	Chews	13/11/2014	9	Female: 8; Male: 1
Mutoma CHU - Kakamega county	Youths	14/11/2014	9	Males: 6; Females: 3
	CHEWs	14/11/2014	9	Males: 6; Females: 3
	Community members		12	Male: 7; Female: 3

ANNEX III: Summary of barriers cited per each study site

1. Barriers cited in Shibembe HCU, Kakamega County

Table 4.8 Summary of Barriers to MYP cited in Shibembe County

Individual level	HCMT level	Wider community
Group dynamics/politics issues - Group conflict - Political differences among youth group members Economic - Lack of financial power Demographic - Age - Gender factors Social factors - Low level of education - Drug and substance abuse - Indiscipline/rowdiness - Dictatorship - Bad language - Rudeness Role performance issues - Not following advice - Not following the laid down rules and regulations - Not getting along with others - Not accomplishing given tasks Youth group governance issues -Dictatorship	Organizational issues -Not giving youth key roles on the board -Communication breakdown Gender issues - not willing to have women representatives on board Economic issues -Lack of resources (materials and equipment) Social issues -Youths harassment by leaders of the HFMC -Negative attitude towards young people Organizational issues - Delay in handling youth SRHR issues	Political issues - Different political affiliations Cultural issues -Clannism -Religious teaching and ideologies -Age discrimination -Gender discrimination

2. **Barriers in Gem-Nam-Kyushu County**

A summary of the barriers identified in Gem Nam CHU are presented in the table below:

Table 4.9 Summary of barriers identified in Gem Nam Kisumu County

Individual Level	HCTM level	Wider community
Social issues - Low education attainment - Low knowledge levels on youth SRHR issues - Young age of youth - Language - Rowdiness of youths - Ignorance of condom/FP use - Married youth not considered as youth - Negative attitude towards adults - Lack of volunteer spirit - Migration of youth in search of opportunities - Unavailability of willing youth - Fear of elders/adults -Lack of skills/technical knowhow e.g. on budget allocations for youth SRHR issues Youth group governance issues - Corruption of youth representatives Political factors - Political differences Economic factors -Limited finances	Social issues -Bad attitude towards youth -Age discrimination Economic issues -Inadequate funds/ resources -High expectations of youth representatives Governance issues -Embezzlement of health care resources -Not giving youth an opportunity to participate on the HCMT -Corruption of HCMT	Political issues - Political interference - Political differences - Political conflict Infrastructural issues - Bad roads Social issues -Poor attitude of community members towards youth Cultural issues -Wife inheritance -Youth not expected to speak openly and freely on SRHR before their elders --Cultural beliefs

3. Barriers cited in Madibo CHU, Kakamega County

The barriers cited in Madibo CHU, Kakamega County are summarized in the Table below:

Table 4.10 Barriers to MYP in Madibo CHU, Kakamega County

Individual	HCMT	Wider community
Social issues - Fear/shyness - Lack of motivation - Not feeling appreciated - Unemployment - Inferiority complex - Ignorance - Judgmental - Low income - Age difference - Lack of information - Economic - Lack of finances	Social issues -Fear of competition from youth Organizational issues -Accountability -Nepotism–giving opportunities to those related to HCMT mothers -Few youth representatives -Not prioritizing youth SRHR factors -Legality of youth representation on CHC Political issues -Political differences -Political interference	Religious issues - Teachings/ideologies Governance issues -Lack of support from the local administration -Policies hindering youth participation -Tokenism participation Cultural issues -Not allowing youth to freely discuss youth SRHR issues. -Young people not allowed to speak/make decisions in the presence of adults

4. Barriers cited in Mutoma HCU, Kakamega County
The table below summarizes the barriers identified in Mutoma, Kakamega County.

Table 4.11 Barriers cited in Mutoma HCU, Kakamega County

Individual/Youth Level	HCMT Level	Wider Community
Social issues - Laziness - Lack of knowledge - Unavailability of youth - Inadequate of skill/technical know-how - Ignorance on SRHR issues - Indecision on which roles to take up on the boards - Rowdiness - Not organized - Drug abuse - Low educational attainment - Technological knowhow - Other competing needs - Not having a volunteering attitude/sprit - Bad attitude - Not getting along with other youth group members Economic issues - Lack of resource/income	Organizational issues -Not giving youth an opportunity -Legality of youth representation -Lack of capacity like staff, materials Social issues -Negative attitude towards youth -Age differences -Negative attitude towards the youth Economic issues -Inadequate resources Political issues -Political differences	Social issues -Poverty -Not willing to let youth take on leadership roles -Lack of parental support Cultural issues -Property inheritance customs -Religious teachings/ideologies -Cultural practices e.g. early marriage -Gender discrimination Political issues -Political differences

5. Barriers to MYP in Omia-Malo HCU, Siaya County
The table below summarizes the barriers identified in OmiaMalo, Siaya County.

Table 4.12 Barriers cited in Omia-Malo HCU

Individual/Youth Level	HCMT Level	Wider Community
Social issues - Fear - Shyness - Lack of motivation - Not feeling appreciated - Inferiority complex - Ignorance - Young age Economic issues -Unemployment -lack of finances	Organizational issues -Not willing to be challenged by youth -Legality of youth representation -Nepotism-committees made on "who you know basis" Social issues -Negative attitude towards youth Economic issues -Inadequate resources	Social issues -Negative *a*ttitude-Judgmental of youths Religious issues -Teachings Administrative issues -lack of support from the local administration -Policies hindering MYP Cultural issues Not allowing youth to air their views Political issues -Differences in party affiliations -Tokenism